Commonwealth Department of Health and Ageing

SUBMISSION TO THE HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON AGEING

To inquire into and report on long term strategies to address the ageing of the Australian population over the next 40 years

January 2003

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INTRODUCTION

The Commonwealth Department of Health and Ageing (the Department) welcomes the Inquiry into long term strategies to address the ageing of the Australian population over the next 40 years.

The Inquiry provides an opportunity for continued consideration of the challenges presented by the structural ageing of Australia's population. These were raised in the process which led to the *National Strategy for an Ageing Australia* which has been running over the last few years. These issues are important for individuals, business and the community, as well as for governments.

The Commonwealth has a national responsibility to highlight and facilitate debate about the possible implications of demographic change and the structural ageing of Australia's population. The appointment of a Minister for Ageing within the Health and Ageing portfolio highlights this priority for the Commonwealth Government, as does the release of two key documents:

- the *National Strategy for an Ageing Australia* released by the Minister for Ageing, the Hon Kevin Andrews MP in February 2002; and
- the Treasury's *Intergenerational Report* released by the Treasurer as part of the 2002-03 Federal Budget in May 2002.

Furthermore during 2002, the Minister for Ageing facilitated a series of discussions within Australia and participated in deliberations overseas about the implications of population ageing and the possible long term strategies to address the emerging policy issues. This occurred through consultations organised by the Office for an Ageing Australia with regional communities, researchers and academics, peak business, seniors and health and aged care stakeholder groups, and through active participation in United Nations sponsored conferences in Madrid and Shanghai.

These documents and discussions have contributed to the increasing awareness of population ageing issues in Australia and overseas, and have provided an important starting point for dialogue between Governments and the community on the development of sustainable and positive economic and social outcomes for current and future generations of Australians. Within this dialogue, Minister Andrews has identified six distinct but inter-related policy themes. These are:

- Financial security and self-provision – that is, giving all Australians the opportunity to provide for their financial security throughout life, together with a safety net for low income earners;

- Workforce participation – ensuring that all Australians have access to employment, education and training throughout their working lives regardless of age;

- Productivity and Prosperity – setting economic and social parameters to sustain continued economic growth, and to ensure an equitable distribution of costs and benefits across generations;

- Social inclusion and participation – ensuring that older Australians have opportunities to contribute to, and participate in, all aspects of social and community life;

- Healthy ageing – promoting policies, behaviours and social attitudes that enable Australians to live healthy, active and independent lives regardless of age; and

- World class care – providing frail older Australians with affordable and quality health and aged care services supported through a mix of public and private contributions based on capacity to pay.

These emerging policy themes relate to the policy development and program management responsibilities of a number of Commonwealth and State and Territory Government departments to varying degrees. Thus, strategies to address the ageing of the Australian population need to be viewed and developed in a cross-portfolio and cross-jurisdictional context.

The Department has engaged in the development of cross-portfolio strategies to address population ageing due to the importance of:

- good mental and physical health (at an individual, community and population level) to Australia's productivity and economic growth, as well as to the ongoing economic and social participation of mature age Australians;

- effective delivery of quality health and aged care services to the independence and quality of life of Australians in their later years, as well as to the ongoing economic and social participation of their carers; and

- effective management of the growth in health and ageing expenditure (and thereby contributing to responsible economic management) given the significance of that expenditure as a proportion of GDP and government outlays, and the future growth in expenditure projected by the Treasury in the *Intergenerational Report*.

- better integrating health promotion and disease prevention across the health and aged care system in order to promote health and well being throughout life;

- encouraging the independence of mature age Australians for as long as possible by, inter alia, shifting the balance of aged care toward community based care, rehabilitation and step down options;

- encouraging greater continuity of care across the primary, acute and aged and community care sectors and through better coordinated person-centred care for the growing number of older Australians with chronic and complex care needs; and

- enhancing the cost-effectiveness and efficiency of the health and aged care systems through an appropriate mix of public and private financial contributions.

Policy Context

The long term strategies being developed in response to the ageing of Australia's population are based on both realistic and positive assumptions about the cultural, social and economic implications of demographic change. The Department recognises that demographic change provides a cost driver that will maintain pressure on the health and aged care system to deliver quality care cost-effectively. At the same time there is a positive aspect to these demographic trends.

Along with declining fertility rates, the ageing of Australia's population is being driven by increasing life expectancy which is the result of improved living conditions and healthier lifestyles, as well as sound public health policy and advances in health and aged care over the last hundred years. While there is some debate about the impact of increased life expectancy on the level of ageing related disability experienced at the end of life, there is no reason to assume that the majority of mature age Australians will not experience a positive and healthy ageing process for much of their later years. Older Australians can be expected to want to continue to contribute to the cultural, economic and social life of the community, which in turn may impact on some of the assumptions underpinning social, economic, retirement, and health and ageing policy in the future.

The pressures arising from demographic changes may be complemented by other challenges stemming from the continually increasing community expectations about the health outcomes the health care system can achieve to support ongoing independence and longevity in later years. The health care and public health policy successes to date have lead to Australians' implicit expectations of continuous improvement in health care and healthy ageing outcomes into the future.

Good health can be supported well into Australians' later years with good health policy and the effective management of resources across the preventive, treatment and care spectrum. The challenge for the health and aged care system will be how to respond effectively to the increasing numbers and expectations of older people as they become frail in their later years of life, using an appropriate mix of private and public funding sources.

Structure of this submission

Section 1 of this submission provides an overview of the demographic trends and health status of the Australian population with some international comparisons.

Section 2 summarises the history, processes and emerging major policy themes underpinning ageing policy development to date with an indication of some of the inter-relationships between policies and programs in the Department of Health and Ageing and other Commonwealth, State and Territory Government portfolios.

Section 3 outlines the current level of activity and investment in health promotion and disease prevention to enhance the health and well being of current and future cohorts of mature aged Australians.

Section 4 provides information on developments in the health care system to help meet the chronic and complex health care needs of an ageing population, including strengthening the

capacity of the primary health care sector to promote disease prevention as well as care management.

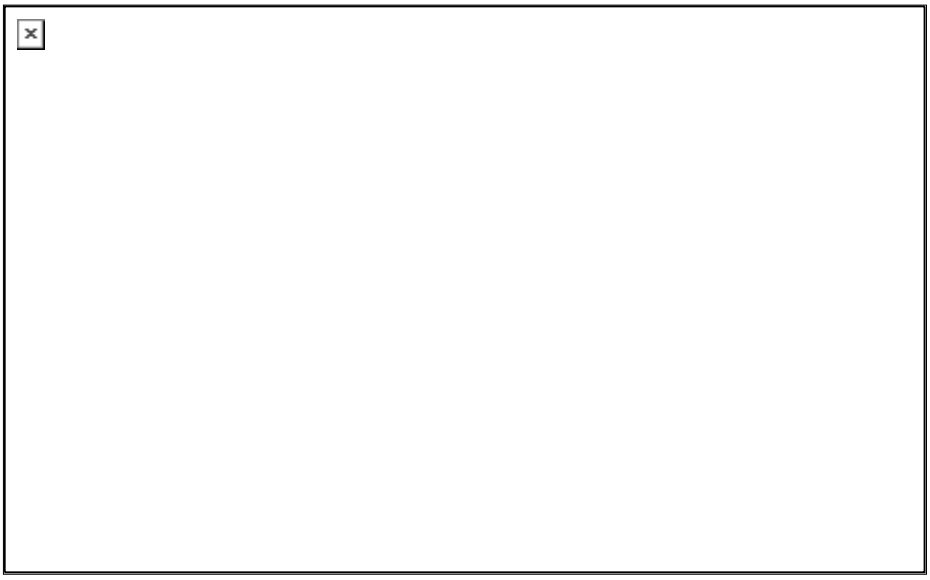
Section 5 provides information on developments to help better management of aged and community care, including increased integration, choice and continuity of care for older Australians across the acute, residential aged and community care systems.

1. DEMOGRAPHIC TRENDS AND HEALTH STATUS

1.1 Demographic change in Australia – an overview

Australia, like most OECD countries, has an ageing population and a changing population profile. The population pyramid in Figure 1 displays the projected changes in the structure of Australia's population from 1997 to 2041. The structural shift pivots around the 50-55 year age cohorts, resulting in a marked decline in the proportion of the population aged less than 50, while the proportion over 50 increases.

Figure 1. Projected population of Australia in 2041 compared to 1997



These changes are a result of a declining birth rate since the early 1960's, and improved life expectancy.

After peaking at 3.5 births per woman in 1961, Australia's birth rate has been rapidly falling since the mid 1970s. Today our birth rate has fallen to 1.7 births per woman, significantly below the replacement level of 2.1[1]. In addition, Australia's infant mortality rate has steadily declined over recent decades. By 2000, there were only 5.2 deaths per 1,000 live births.[2] Therefore, Australian women have been having fewer babies and, while these babies are more likely to survive, the overall effect is a declining proportion of the population of a young age.

Australians are also living longer, and life expectancy continues to increase. Life expectancy at birth in Australia has increased dramatically from around 55 years for people born in 1901 to 76.7 years for males and 82 years for females born in 1996. For those people who reach 65 years of age, there is a further increase in their overall life expectancy. For males, life expectancy at 65 years increases to 81.9, an increase of 5.1 years. For females, life expectancy at 65 years rises to 85.5 years, up 3.5 years.[3]

[1] ABS (Australian Bureau of Statistics) 2002 Australian Social Trends. Cat no. 4102
[2] ABS, *Deaths 2000* Cat No. 3302.0
[3] *ibid*

In Australia, male life expectancy is gradually catching up with female life expectancy. It is projected that by 2051 life expectancy for males will be 83.3 years while for females it will be 86.5 years.

1.2 Structural and numerical ageing

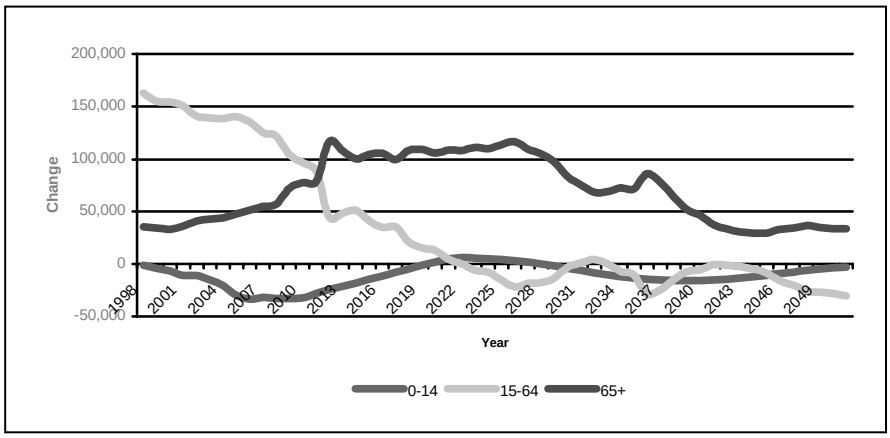
As a result of the sustained decline in Australia's fertility rate and the increase in life expectancy, Australia is about to experience a sustained period of structural and numerical ageing.

At the Australian Census of 2001, nearly 2.4 million Australians or 13 per cent of the population were aged 65 years or older. In 2051 it is estimated there will be 6.6 million people, approximately one quarter of the population, aged 65 years and over.[4]

Increased life expectancy will mean that a greater number of people will live to be aged 80 years and over. By 2051 the current numbers of people aged over 80 are likely to treble to 2.3 million people or over nine per cent of the population. This increase will be more than matched by the increase in the numbers of people aged over 100. At the last census in 2001 there were 2,503 people aged 100 years or over. This is projected to grow to 38,000 people by 2051.

During the next 40 years the proportion of people aged 65 years and over compared with the total population will increase. Over this same period the proportion of people aged less than 15 years is expected to fall. Figure 2 illustrates the dramatic demographic shift between those Australians achieving workforce age and those achieving 'retirement' age. The projected numerical increases in the oldest age groups are of significance in relation to the sustainability of the health and aged care system.

Figure 2. Annual change in numbers by age group 1998-2051



Source: ABS Population Projections 1997-2051

[4] Commonwealth Department of Health and Ageing, *National Strategy for an Ageing Australia* 2000

1.3 Composition of Australia's older population

As well as increasing in absolute numbers, and as a proportion of the total population, the older population is also changing in its internal structure. There will be important regional, gender and culturally based differences in the scope and timing of the changes.

It is projected that rural and regional areas will age more rapidly than metropolitan areas. By 2051 the ABS estimates that over 21 per cent of people in regional areas will be aged 70 years and over compared with approximately 19 per cent in metropolitan areas. Regional areas such as Tasmania and the south-eastern corner of South Australia are ageing faster than the metropolitan areas of Sydney and Melbourne. Popular retirement destinations along the New South Wales north coast and coastal areas in south-eastern Queensland are also ageing at a faster rate than the rest of the country.

As noted earlier, women have a longer life expectancy than men. This is true across all population sub-groups[5]. As a result women make up a larger proportion of those Australians aged 65 years and over (approximately 56 per cent). This predominance increases with age. In 2001, the proportion of women in the over 85 years age groups was 69 per cent.[6] However, the gap between the life expectancies of men and women has been closing over the last few decades and this trend is expected to continue.

The composition of Australia's culturally and linguistically diverse older age cohorts is also changing. This composition varies from cohort to cohort reflecting the immigration patterns of previous decades. In 2001, the main countries of birth for non-English speaking older people were Italy, Greece and the Netherlands.[7] For future generations this composition will reflect the increase in migration from Asia occurring since the 1970s.

Indigenous Australians aged 65 and over are a small proportion of all indigenous Australians (2.8 per cent), much smaller than the equivalent proportion for non-indigenous Australians (12.8 per cent). In addition, indigenous Australians represent 0.5 per cent of the total population aged over 65 years. This is much smaller than their representation within the wider population, owing to the lower life expectancies experienced within indigenous communities, which is some 20 years below those of other Australians.[8]

1.4 Health status

During the twentieth century, Australia saw a shift in the reasons for loss of health and premature mortality. Improvements in living conditions, medical advances and sound public health policy contributed significantly to the increased longevity of the Australian population, as evidenced by the marked decline in deaths resulting from communicable diseases such as pneumonia and tuberculosis. These improvements were accompanied by a shift towards chronic, non-communicable diseases as the major causes of mortality (death) and morbidity (loss of health), largely as a result of changes in lifestyles. In recent years, significant improvements have been made in addressing the causes of and managing

[5] Australian Institute of Health and Welfare, *Older Australia at a Glance 2002 (page 8)*
[6] *ibid (page 4)*
[7] *ibid (page 50)*
[8] *ibid (page 48)*

chronic diseases (eg reductions in smoking rates). The result has been declines in levels of mortality, although the total burden of disease in terms of morbidity continues to increase.[9]

The prevalence of chronic disease increases with age, as does the extent of co-morbidity. However, the proportion of the population with a severe or profound disability remains relatively constant until they reach the age of 75. The ABS 1998 Survey of Disability, Ageing and Carers also found that females have higher rates of profound or severe core activity restrictions than do men, particularly at older ages. For example, at age 80 and over, 51.1 per cent of females and 36.5 per cent of males had a profound or severe core activity restriction. In comparison, only 9.2 per cent of women and 7.8 per cent of men in the 65 to 69 age group had a similar restriction.[10]

The Australian Institute of Health and Welfare has considered this disability burden by type of impairment. Dementia, adult-onset hearing loss and stroke are the three leading causes of non-fatal disease burden among people aged 65 and over. Table 1 shows that vision disorders, osteoarthritis and coronary heart diseases also cause considerable disability burden.

Table 1: Top 10 causes of healthy years of life lost due to disability[11] for females and males aged 65 and over, 1996

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 2002 page 32

The Australian Institute of Health and Welfare has considered the contributors to loss of healthy life among older people. Tobacco smoking is the risk factor responsible for the greatest burden of diseases in older Australians, followed by high blood pressure. Other important risk factors are physical inactivity, high blood cholesterol and inadequate intake of fruit and vegetables.[12] Table 2 shows the prevalence of established risk factors for illness and disease amongst the older population.

[9] Bulletin of the World Health Organisation 2001, 79 (2)
[10] Australian Institute of Health and Welfare, *Australia's Health 2002*, page189
[11] "healthy years of life lost due to disability" measures both the incidence of illness and the severity or level of impact on functioning due to that illness
[12] Australian Institute of Health and Welfare, *Older Australia at a Glance 2002*, (page 33*)*

Table 2: Risk factors for illness and disease (per cent of population group)

	Females				Males			
Risk factor	**45-54**	**55-64**	**65-74**	**75+**	**45-54**	**55-64**	**65-74**	**75+**
Overweight	58.1	67.2	70.7	56.4	72.5	74.0	73.7	64.3
High blood pressure	22.8	42.3	66.7	77.2	30.5	46.5	69.7	75.1
High blood cholesterol	54.7	71.6	74.0	65.2	60.7	61.8	54.1	49.2
Impaired glucose tolerance	11.2	15.2	22.9	20.7	8.4	14.8	20.4	25.5
Tobacco smoking	17.5	13.5	6.6	4.4	22.0	15.2	11.0	4.8
Risky alcohol consumption	11.6	4.9	2.5	0.9	18.6	13.6	7.7	3.3
Physical inactivity	52.0	46.9	46.1[a]	n.a.	47.6	50.1	45.8[a]	n.a.

a. Data for ages 65-75

Source: AIHW, Older Australia at a Glance 2002 page 34

The main causes of death for people aged 65 and over are diseases of the circulatory system (eg heart disease and stroke), cancers and diseases of the respiratory system (eg emphysema). This is shown in Table 3. The Australian Institute of Health and Welfare reports that these trends are similar to those appearing in the total population.[13]

Table 3: Deaths for selected major causes in people aged 65 and over, 2000

Cause of death	**Females**	**Males**	**Females**	**Males**
	Number		*Per cent*	
Circulatory	24, 466	19, 960	47.5	40.7
Cancer	11, 003	14, 874	21.4	30.3
Respiratory	4, 509	5, 276	8.8	10.8
Injury and poisoning	1, 162	1, 128	2.3	2.3
All Causes	**51, 462**	**49, 012**	**100.0**	**100.0**

Source: AIHW, Older Australia at a Glance 2002 (page 31)

While coronary heart disease and stroke are major causes of death in the Australian population, death rates from these conditions among older people have decreased markedly over the last decade.[14] This is thought to reflect successful primary prevention (through reduction in levels of tobacco smoking, changes in diet, better control of hypertension and high blood cholesterol, and other risk factors) and improvements in treatment.[15] The fact remains that a large proportion of premature mortality and much of the morbidity associated with chronic disease, including the National Health Priority Areas, is preventable.

The death rate from breast cancer in older females has also dropped over the last decade, while that from prostate cancer in men has changed little. Death rates from emphysema have changed marginally in females, while those for older men have declined. In contrast the death rate from accidental falls, which is substantially higher in the 75 and over group compared with the 65-74 age group, has changed little over the last decade.[16]

Indigenous people experience substantially higher death rates than non-indigenous people. For example in 1997-99, death rates per 100,000 population for people aged 65–74 were more than twice as high for indigenous males than for the general male population and around three times as high for females.[17] The need to improve the health status of Aboriginal and Torres Strait Islander people is well documented. Diseases of the

[13] Australian Institute of Health and Welfare, *Australia's Health 2002*, page 191
[14] Australian Institute of Health and Welfare, *Older Australia at a Glance 2002* page 31
[15] Mathers C, Vos T, Stevenson C 1999 The Burden of Disease and Injury in Australia AIHW cat. No. PHE 17 Canberra AIHW
[16] Australian Institute of Health and Welfare, *Older Australia at a Glance 2002* page 31
[17] *ibid* page 48

circulatory system, respiratory illness, injury and cancer are the leading causes of death. The health status of indigenous Australians and the need for policies and programs to support continuous improvement will remain a high priority. The Department is pursuing a two pronged approach, which aims to both improve accessibility and responsiveness of the mainstream health system and to provide complementary action through indigenous specific health programs. All programs within the Department have a core responsibility to meet the specific needs of indigenous Australians.[18]

Australian studies have demonstrated a link between self-rated health and subsequent health outcomes for older Australians. Self-assessed health has been shown to be a powerful, independent predictor of both current physical health and future health care use and survival. In Australia, many older people have a positive view of their health even though older age is generally associated with increasing levels of disability and illness. For example, 70 per cent of Australians aged 65 years or older rate their health as good, very good or excellent.[19]

Finally, social participation has been linked with important indicators of health, such as self-rated health.[20] Older Australians actively participate in society in many ways. Social participation can include involvement in formal and informal social activities, volunteer work or the paid workforce. In 1997 Australians aged 65 years and over spent around 40 per cent of their time in recreation or leisure activities, 30 per cent of their time in unpaid work (including formal volunteer work, domestic duties, care for family members and purchasing) and 1.6 per cent of their time in employment related activities.[21]

With increased longevity and an increased emphasis on healthy ageing, older people will have a greater opportunity to participate in and contribute to society. This, in turn, is likely to have positive effects on health and wellbeing through improved levels of activity and social support.

[18] Commonwealth Department of Health and Ageing, *Portfolio Business Plan 2002-03: Aboriginal and Torres Strait Islander Health* 2002
[19] Australian Institute of Health and Welfare, *Older Australia at a Glance 2002* page 28
[20] Benyamini Y, Idler E, Leventhal H, Leventhal E Positive *Affect and Function as Influences on Self-Assessments of Health: Expanding Our View Beyond Illness and Disability* 2000
[21] ABS *Time Use Survey* unpublished data 1997

2. AGEING POLICY

Ageing policy has been evolving over the last few years from being primarily a matter of interest to a few program delivery departments, to the realisation that the profound demographic changes over the next four decades will have significant social and economic implications potentially affecting all areas and levels of government.

Long term strategies to address issues related to population ageing need to be viewed and developed in this broader context, and will require ongoing collaboration between governments, their agencies and a variety of other industry and community-based stakeholders, as well as a process of ongoing communication and engagement with the wider community.

In collaboration with other departments, the Department has been progressing the development of a strategic approach to ageing issues for several years through the development and release of the *National Strategy for an Ageing Australia* and other work being undertaken by the Office for an Ageing Australia.

2.1 International Year of Older Persons 1999

The International Year of Older Persons (IYOP) presented an opportunity to promote the needs of, and issues affecting, older Australians. Federal, State and Territory Governments provided almost $27 million to support the International Year and to raise the profile of all older Australians.

The IYOP was an important step towards cultural change in the way Australians view older people and ageing. The promotion of mutual responsibility between the younger and older generations, recognising the important contribution of older people and promoting positive images of ageing were achieved through a variety of initiatives. These initiatives included national and State communication strategies, broad based media and marketing campaigns, recognition award processes and many specific projects promoting positive and healthy ageing.

This process has continued in the international arena with the World Health Organisation (WHO) releasing its "Active Ageing, A Policy Framework" document. The Office for an Ageing Australia has also supported Australia's involvement in the United Nations Second World Assembly on Ageing, held in Madrid, Spain, April 2002 and a follow up UN Economic and Social Commission for Asia and the Pacific Seminar, held in Shanghai, China, in September 2002 through delegations lead by the Minister for Ageing, the Hon Kevin Andrews MP.

2.2 The National Strategy for an Ageing Australia

The *National Strategy for an Ageing Australia* arose out of the IYOP. The release of the *National Strategy* demonstrated the Commonwealth Government's commitment to ensuring that the ongoing contribution of older Australians was recognised, and that all avenues were explored to help meet the needs and aspirations of Australians as they grew older.

The *National Strategy for an Ageing Australia* provides a broad framework for addressing current issues facing older people as well as preparing for future demographic changes. The

National Strategy also provides leadership for other sectors of the community to take action on population ageing issues within their sphere of influence. As such the *National Strategy* identifies a set of principles, goals and actions to guide the responses by Governments, business, the community and individuals in the community.

The *National Strategy* is based on a number of principles which include:

- all Australians, regardless of age should have access to appropriate employment, training, learning, housing, transport, cultural and recreation opportunities and care services that are appropriate to their diverse needs, to enable them to optimise their quality of life over the entire lifespan;
- both public and private contributions are required to meet the needs and aspirations of an older Australia;
- a strong evidence base should inform the policy responses to population ageing; and
- the delivery of services and pensions for our ageing population should be affordable as long as we have a well managed economy and continued economic growth, combined with the effective management of Government outlays.

The *National Strategy* has provided the impetus for a number of activities to inform continuing policy development over the medium to longer term. These include:

- a series of community and stakeholder consultations conducted by the Minister for Ageing in 2002;
- the appointment of a National Advisory Committee on Ageing;
- identification of the need for improved community awareness of, and better information on, the range of government services and programs available to mature age Australians; and
- building ageing research capacity to develop the evidence base necessary to inform ageing policy decision making.

Further information on the *National Strategy* is provided at Appendix 1.

2.3 Intergenerational Report

In May 2002, the Treasurer released the *Intergenerational Report* prepared by the Treasury in collaboration with other Commonwealth Government departments. This report projected that, assuming continuation of current policy settings, the required adjustment by 2041 in taxes and spending would be about 5.0 per cent of GDP or $87 billion in today's dollars. Spending on health and aged care accounts for much of this projected rise in government outlays over the next forty years.

The report found that the drivers of the growth in health and ageing outlays are technological advancement and community expectations as well as the structural ageing of the population. The report concluded that there was time to make the necessary changes to policy settings and programs through coherent forward planning because "the ageing of the Australian population is not expected to have a major impact on the Commonwealth's budget for at least another 15 years"[22].

[22] Commonwealth Department of the Treasury, *Intergenerational Report Budget Paper No. 5* May 2002 page 1

The report concluded that of the seven key priorities for ensuring fiscal sustainability, three affected the Health and Ageing portfolio, namely:

- maintaining an efficient and effective medical health system, including supporting private health insurance;
- containing the rapid growth in the Pharmaceutical Benefits Scheme; and
- developing an affordable and effective residential aged care system.

As this spending is sensitive to demographic change, effective management of the health and ageing portfolio will be critical to sustaining fiscal sustainability and to good economic management.

2.4 Major emerging policy themes

Out of the various discussions and policy processes described above, several major policy themes emerge. These are of importance to a range of Commonwealth Government departments to varying degrees. This Department has an interest in each of these policy themes because of the fundamental importance of health and well being to economic and social participation.

2.4.1 Financial security and self-provision

Australia's retirement income policy is built on the three 'pillars' of means tested pension payments, compulsory employer superannuation and voluntary savings. The financial security derived from the three 'pillars' may also be affected by the cost and access to publicly subsidised health and aged care services funded by the Department of Health and Ageing. Eligibility for a Pensioner Concession Card or Commonwealth Seniors Health Card is particularly valued by older Australians for the access it gives to pharmaceuticals and primary health care services at concessional rates.

2.4.2. Workforce participation

In addition to financial security in retirement, policies and programs administered by the Department of Health and Ageing also assist the capacity of mature age Australians to contribute economically and socially.

By the 2020s, growth in the Australian workforce will decline substantially as the number of new entrants will not replace the number of older Australians leaving the workforce unless workplace participation rates of mature age workers increase. Currently, Australia's workforce participation rate in the 55-64 year old age group is 51.3 per cent.[23] By contrast, the participation rates for the same age group is 60 per cent for the USA, 63 per cent for in New Zealand and between 59 and 87 per cent in Scandinavian countries.

In the future, employers can be expected to place an increased emphasis on strategies to attract and retain the skilled labour needed for growth in their industries. This can be expected to include mature aged workers with the necessary skills for the jobs of the future.

[23] ABS *Labour Force Survey* November 2002

Data available to date would suggest that, in addition to economic factors, poor occupational and population health outcomes have played a significant part in the declining workforce participation rate of older workers. Further investment in, and coordination of, disease prevention and health promotion strategies across jurisdictions will be important to arrest this trend and to sustain older workers' productivity and participation leading into the 2020s and beyond.

Good health also enables mature age Australians to exercise a choice regarding productive ageing which can include continuing in paid employment past traditional retirement age. Employment can also contribute to mental and emotional well-being in later life and provide additional retirement savings.[24]

2.4.3 Productivity and prosperity

Continued economic growth will be important for Australia to maintain health and aged care standards as its population ages, and maintenance of health and prevention of disease will be important to maintain the levels of workforce participation necessary to support economic growth over the coming decades. As the health and aged care system is funded in the main from public resources, fairness in the way those funds are collected and applied across generations is also an issue.

The *Intergenerational Report* focuses on intergenerational equity and the need to maintain fiscal sustainability and strong economic growth by, among other things:

- promoting fairness in distributing public resources between generations of Australians; and
- ensuring governments continue to provide essential goods and services that the private sector does not provide sufficiently.[25]

The notion of intergenerational equity and investment is a potentially complex area of debate and analysis. For the purposes of this submission it is possible to identify three areas of intergenerational activity across the categories of youth, working age and retirement age.

First there is the investment in personal savings that those of working age make in order to support the quality of life and financial security that they wish to have when they reach retirement age. This will affect the capacity of mature age Australians to contribute financially to their increasing expectations of health and aged care services.

Second there is the investment that those of working age make in the health and education of today's youth to ensure that there is a productive workforce contributing to economic growth and tax transfers when today's workforce reach retirement age. This is supplemented by the investment that today's youth make in their own higher education in order to maximise their productivity and their economic outcomes when they join the workforce.

[24] Access Economics *Population Ageing and the Economy* prepared for the Department of Health and Ageing 2001

[25] Commonwealth Department of the Treasury, *Intergenerational Report Budget Paper No. 5* May 2002

Third there is the investment today's workforce makes in providing a quality health and aged care system for their parents and grandparents. This provides current support to older Australians as well as ensuring that there is a quality system in place in the future for when today's working generation has retired and need these services in the latter years of their life.

In addition to demographic change, the sustainability of Australia's economic growth will be affected by a range of other factors including international economic trends, resource use and availability and environmental quality.[26] Such factors will also impact on the intergenerational transfers sustained over the coming decades.

2.4.4 Supporting social inclusion and participation

Health and social participation have a reciprocal relationship. Social participation and inclusion of older Australians has direct benefits to both the individual and the community. The benefits to individuals include increased well-being and lower levels of mental and physical illness.[27] In addition, many forms of social interaction, such as voluntary work, yield direct community benefits.

The Department's current programs aim to improve and maintain the health of older people and encourage active social interaction. Community care programs managed by the Department give older people the opportunity to stay in their own homes and remain involved in their community.

A positive community attitude towards older people also increases feelings of social inclusion and encourages social participation. The Office for an Ageing Australia has been raising the profile of older Australians in the community via print and media advertising during both the International Year of the Older Persons (IYOP) in 1999 and more recently through the *Positive Images Campaign* and sponsorship of the *Senior Australian of the Year* award. Activities such as these encourage the positive portrayal of older Australians by the media and the broader community, and support recognition of the valuable and ongoing contribution that older people make to our society.

2.4.5 Healthy ageing

There are clear benefits for individuals, for society and for the economy in having people spend as much of their lives as possible in good health. The maintenance of health and functional capacity is vitally important to an individual's capacity to participate in society and to contribute to Australia's productivity and prosperity. Reducing the incidence of preventable diseases, delaying the onset of conditions associated with ageing, and effectively managing those illnesses which do occur, are all important for minimising the length and impact of ill health on older Australians.
Achieving healthy ageing of the population requires action by governments, businesses, care professionals, communities and individuals. It is also affected by changes in social and economic conditions, and requires action across a person's lifespan, as early life factors

[26] CSIRO Sustainable Ecosystems report to the Department of Immigration and Multicultural and Indigenous Affairs *Dilemmas Distilled Options to 2050 for Australia's population, technology, resources and environment*, October 2002
[27] Kendig, H. & Brooke, L. (1997) *Australian Research on Ageing and Social Support*, Australian Journal on Ageing, Vol 16, No. 3, 127-130

and the accumulation of health risks throughout an individual's life, combine to affect the risk of experiencing ill health in later life.

Accordingly, the Department of Health and Ageing's contribution to supporting healthy ageing is multifaceted. The Department has been actively investing in public health education and promotion for over thirty years and prevention strategies will play an increasingly important role as the population ages. Programs have targeted, for example, a reduction in tobacco consumption, an increase in Australia's immunisation rate, increases in physical activity and an awareness of the importance of good nutrition. Other programs focus on injury prevention and chronic disease self management. In addition, sports, recreation and cultural programs are clear examples of cross-portfolio and cross-jurisdictional activities impacting on healthy ageing outcomes.

The Department of Health and Ageing has a role in encouraging the development and implementation of sustainable national policies and strategies relating to environmental health. That is, those aspects of public health concerned with the factors, circumstances, and conditions in the environment or surroundings of humans that can exert an influence on health and well-being. These include sanitation, drinking water quality, food safety, disease control, and housing conditions, as well as emerging health risks arising from the pressures human development places on the physical environment. These are also intergenerational equity and investment issues of importance to the health and quality of life of future generations.

A key characteristic of the Department's approach to these issues has been extensive collaboration with other Commonwealth, State and Territory departments, professional and consumer groups, researchers, the non-government sector and the wider community.

2.4.6 World class care

An increasingly older population highlights the question of the capacity of the health and aged care system in the future to balance sustainability with choice and access to quality care regardless of individual circumstances. A major imperative for acute, aged and community care systems will be to achieve better integration and continuity of care, and to deliver new models of care for people with complex and chronic health conditions.

The potential contribution of health services to healthy ageing has been given a greater emphasis in recent years through policies and programs designed to improve the capacity of the primary health care system in particular to better prevent and manage chronic and complex conditions. For example, through the *Enhanced Primary Care Package*, new Medicare Benefits Schedule items for annual health assessments for those over 75 years (for indigenous people over 55) and multi-disciplinary care planning and case conferencing, have been introduced.

The *Coordinated Care Trials* are testing innovative approaches to better coordinate, deliver and fund health services for people such as those with chronic and complex conditions who require health care from several different providers. It is also proposed to support better coordination of care in future by better coordination of patient health care information through the Health*Connect* initiative.

The Department funds a subsidised aged and community care system for those frail older Australians who need it. The system focuses on assisting people to remain living in their own home for as long as possible and recognises the role of the family and other informal care arrangements. A national accreditation system supports quality of residential care for older Australians.

The effectiveness of health and aged care services depends in part on the availability of informal carers. In turn, the capacity of carers to continue to maintain their caring role for a family member or friend and their attachment to the labour market, depends on the availability of quality, accessible and affordable aged and community care services, including respite care services.

This symbiosis could be placed under greater pressure in the 2020s through the increased workforce participation by mature age Australians who might otherwise be caring for family or friends. The projected decline in the number of new entrants into the workforce in the 2020s as a result of declining fertility rates could have significant implications for the demands placed on the aged and community care system to deliver greater choice, flexibility and integration of care options.

2.5 Investing in knowledge

Given the breadth of policy issues facing governments, business and individuals, there is a significant need to enhance the evidence base to support policy decision making about ageing issues. This implies that multidisciplinary research on ageing needs to be given higher priority, and the infrastructure put in place to ensure that ageing research effort is translated effectively into policy and practice.

The Prime Minister announced four national research priorities on 5 December 2002 to guide research into key areas that can deliver significant economic, social and environmental benefits to Australia. One of these priorities is 'promoting and maintaining good health'. The focus for this priority is for research that promotes the healthy development of young Australians, enables older Australians to age well and productively, and advances health and well being across the lifecycle through evidence-based health promotion and disease prevention strategies.

As indicated earlier, the *National Strategy for an Ageing Australia* also recognises the need for an informed evidence base to support policy and program development. Sound research is essential in developing this evidence base. This research is required to improve our understanding of the process of ageing across the lifespan, the barriers to, and opportunities for healthy, productive ageing and the actions governments, communities and individuals need to take to address the causes and consequences of population ageing.

The Department is providing on-going support for ageing research through strategies including:

- direct financial support provided through research grants or fellowships awarded by the National Health and Medical Research Council, and in particular by the Strategic Research Development Committee (SRDC). The SRDC was established in 1997 to address areas of under-developed health research within designated priority areas. Ageing is currently one of these priority areas. $2 million has been

made available for research projects on the biomedical and psychosocial aspects of healthy ageing;

- the *Building Ageing Research Capacity* (BARC) Project, a joint project between the Office for an Ageing Australia and the Australian Institute of Health and Welfare (AIHW). The main purpose of the BARC Project is to encourage and support collaboration and coordination between Australian researchers on ageing issues. Better sharing of information and research findings is also seen as a key element in improving the quality and range of the evidence base to inform policy development and decisions by government, business, the community and individuals; and

- the establishment of the Productive Ageing Centre, a collaborative policy and research venture supported by the National Seniors Association. The Commonwealth is providing $1m over four years for the Centre to conduct research into all aspects of productive ageing and to inform related policy and program development.

3. INVESTING IN GOOD HEALTH

The increasing numbers of older people provides a powerful imperative for Australia to invest in policies and practices that promote good health throughout life as well as healthy ageing. This investment is essential to reduce pressure on the health and aged care systems and ensure sustainable and positive economic and social outcomes for current and future generations of Australians.

The World Health Organisation states that good health (both physical and mental) is "a resource for living", rather than an end in itself. It has concluded that:

> "even the smallest gains accumulated across the life course, and preventative steps in the older years, can result in improvements in health status, functional capacity, independence and quality of life for older people'.[28]

Based on the current burden of disease and expected future trends, a key to maintaining the health of Australians as we age will be the prevention of chronic disease. Many of the conditions that contribute to the greatest proportion of the burden of disease exhibit multi factorial patterns of causation and share common modifiable risk factors. Preventive action on common risk factors can therefore provide benefits across a range of conditions.

However, effective prevention of chronic disease is not a simple issue. Prevention efforts need to be sustained over the long term, and require coordination both within and outside the health system.

3.1 Policy context

3.1.1 Common risk factors

Australia has, for some time, made concerted efforts to improve the prevention and management of chronic disease and injury through the *National Health Priority Areas*. These priority areas seek to focus public attention and health policy on those areas that contribute most to the burden of illness in the community, with a particular emphasis on areas where the burden can be significantly reduced. This national approach is currently tackling seven identified priority areas:

- cardiovascular health;
- cancer control;
- injury prevention and control;
- mental health;
- diabetes mellitus;
- arthritis and musculoskeletal conditions; and
- asthma.

Together the National Health Priority Areas represent around 70 per cent of the burden of illness and injury experienced by the Australian population. All of these national priority areas are relevant for older Australians, for example:

[28] WHO *Active Ageing: A Policy Framework* 2002

- from the current cancer incidence rates, it may be expected that one in three men and one in four women could be directly affected by cancer by the age of 75;
- arthritis is estimated to affect 15 per cent of the population, being more common in older people, especially women. It has been estimated that nearly 75,000 years of healthy life are lost to arthritis every year, making it a significant cause of disease burden;
- falls by older Australians currently account for the largest proportion of injury-related deaths and hospitalisations; and
- over 68 per cent of people with cardiovascular disease as their main disabling condition were over the age of 65 years.[29]

There are common patterns of causation and 'shared' risk factors for many of these conditions as well as significant interrelationships between the conditions themselves. 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 benefits in terms of prevention of a range of conditions simultaneously.

The impact of many risk factors for ill health can be reversed quickly, and most benefits from prevention campaigns accrue within a decade. Even modest changes in risk factor levels can bring about significant benefits, for relatively modest expenditures in prevention. The WHO have estimated that Australians can gain on average another six years of healthy life through greater preventive measures.[30] It can be argued then that this is where Australia can make substantial health, economic and social gains for an ageing population.

3.1.2 Public health approaches to health promotion

Australia spent $931 million on public health activities in 1999-00. Almost 50 per cent ($465.2 million) of this was provided by the Commonwealth Government through the Department of Health and Ageing. The Department provided $116.3 million to States and Territories through the Public Health Outcome Funding Agreements and a further $69.4 million through Specific Purpose Payments. $279.5 million was spend directly by the Department on public health services. This public health expenditure is 1.8 per cent of recurrent expenditure on all health services in Australia.[31]

Much of this public health expenditure was on health protection measures such as immunisation, communicable disease control and environmental health. Expenditure by the Commonwealth on selected health promotion activities, that is, measures which are designed to help people make healthy lifestyle choices, was $36 million. This expenditure included:

- chronic disease self-management;
- falls and injury prevention projects;
- safety promotion projects;
- nutrition awareness projects;

[29] *ibid*
[30] WHO *Reducing Risks, Promoting Healthy Life* 2002
[31] AIHW *National Public Health Expenditure Report 1999-00*, 2002

- the promotion of increased physical activity; and
- provision of information and referral services with respect to sexual and reproductive health.[32]

3.1.3 Preventive health services

Public health contributions to health promotion and illness prevention are complemented by preventive opportunities across the continuum of care. Early identification of risk factors can prevent development of disease. Even for those with established disease, addressing risk factors can help prevent progression of the condition and complications.

The primary care sector offers the most immediate opportunities to better integrate prevention with the curative system. However, its potential to respond effectively to changing demographic and morbidity patterns is not being fully realised. The Department has made significant investments in recent years in improving the capacity of the primary care system to deliver effective chronic disease prevention and management services.

3.1.4 Collaborative efforts

Australia has a range of strategic partnerships and other collaborative arrangements around chronic illness, disease prevention and healthy ageing.

The National Public Health Partnership (NPHP) provides the formal structure for the Commonwealth, States and Territories to develop and implement an agenda for public health.[33] The NPHP Background Paper *Preventing Chronic Disease: A Strategic Framework May 2001*, is the basis for on-going collaborative action in chronic disease prevention. Through its sub-committees, the Strategic Inter-Governmental Forum on Physical Activity and Health (SIGPAH) and the Strategic Inter-Governmental Nutrition Alliance, the NPHP also supports collaborative approaches to addressing key risk factors.

In addition, the Department is working with State and Territory health departments to strengthen the primary health and community care sector, including its capacity to contribute to illness prevention. The Department has also supported the formation of the Australian Chronic Disease Prevention Alliance (ACDPA), a national alliance of non government health organisations, formed in late 2001. The alliance has as its mission to *"achieve through heightened, coordinated and effective primary prevention activities, measurable decreases in the risks of major chronic diseases for all Australians and a reduction in health inequality"*. Membership of the ACDPA currently includes the Australian Kidney Foundation, Diabetes Australia, The National Heart Foundation of Australia, the Cancer Council Australia and the National Stroke Foundation.

The SNAP (Smoking, Nutrition, Alcohol and Physical activity) Framework for General Practice is a key example of collaborative action by governments, health professionals, non-government organisations, and consumer organisations.

[32] *ibid*
[33] The NPHP is a sub-committee that reports to the Australian Health Ministers Advisory Committee.

The Positive Ageing Taskforce (PATF) is a forum of Commonwealth, State and Territory officials responsible for ageing issues and seniors interests.[34] PATF produced the *Commonwealth, State and Territory Strategy on Healthy Ageing* which was endorsed by Ministers and released in March 2000. The NPHP and PATF have established a joint working group to prioritise and co-ordinate Commonwealth, State and Territory activities on healthy ageing.

3.2 Healthy ageing issues for older Australians

3.2.1 Workforce participation

Health has an impact on the duration and productivity of workforce participation, and workforce participation in turn can have an impact on health. Overall, Australia's participation rates for men is comparable to other industrialised countries, however, women's participation rates are lower.

In Australia in December 2001, about 73 per cent of men aged between 55-59 years were still in the labour force. This decreases significantly for men aged 60–64 years to 47.4 per cent. For women in the 55–59 age group, about half were participating in the labour force (48.7) and their participation for the 60–64 age group also significantly decreased to 24.7 per cent.[35]

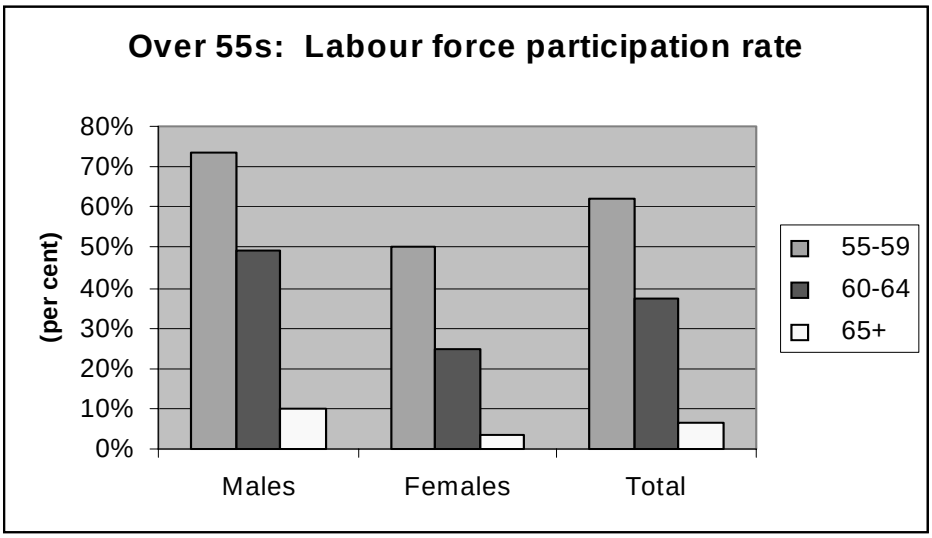


Figure 3. Percentage of Males and Females over 55 participating in the labour force
Source: ABS *Labour Force Survey* September 2002 cat no 6291.D

The causes of premature or early exit from the labour force are complex and interrelated. They include: voluntary early retirement, a reluctance among employers to recruit mature age people and low demand for the skills or expertise mature age workers possess.[36]

The relationship between work and health is complex. As yet there is no agreement as to whether good health status is a cause or an effect of employment. The 'social causation' hypothesis argues that employment protects and fosters good health. One explanation of

[34] PATF is a sub-committee of the Community and Disability Services Ministers Advisory Committee.
[35] AIHW *Older Australia at a Glance* 2002
[36] NSW Committee on Ageing *Too Young to Go: Mature Age Employment and early Retirement in NSW*

this association is that employment increases status, power and financial security as well as conferring non-economic rewards such as social support and recognition from others and these benefits translate directly and indirectly into better health status.[37]

On the other hand the 'social selection' or 'healthy worker' hypothesis postulates that good health improves an individual's chances of finding and maintaining employment.[38] The health consequences of unemployment are much clearer. In its submission to the House of Representatives Standing Committee on Employment, Education and Workplace Relations, the Australian Institute of Health and Welfare (AIHW) presented evidence which demonstrated that unemployment causes higher levels of mortality and both physical and mental ill health.[39]

The Commonwealth's health spending assists many people to manage health conditions that would otherwise reduce their workforce participation and productivity. But there are adverse trends that suggest that we need to do more to prevent conditions that result in illness, disability and early retirement. Chronic illness and functional decline are largely determined by adult lifestyle factors, some of which also exhibit adverse trends. For example:

- 1 in 3 Australians who retire from a full-time job before the age of 65 do so because of illness or disability;[40]
- 25 per cent of men and 40 per cent of women aged 45 to 64 are not in the labour force;[41]
- 1 in every 6 of those aged 45 to 54, and 1 in every 4 of those aged 55 to 64 in 1998 had a disability that restricted their employment;[42] and
- 55 per cent of men aged 45 to 54 who are not in the labour force report fair or poor health, compared to 15 per cent for those who are employed.[43]

In summary, effective prevention campaigns can ease the pressure on the health care system and maintain workforce participation. For example, studies would suggest that government investment in the national tobacco campaigns has resulted in significant financial savings to government. There is also evidence that prevention programs delivered through workplaces can make a significant contribution to prevention and management of disabling conditions.[44]

Greater focus on the prevention and treatment of chronic illness and disability may not only enhance people's lives, but also increase their labour force participation and reduce associated involuntary retirement of older workers, as well as their participation in the community more generally.

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[37] Ross C & Mirowski J (1995) 'Does employment affect health?' *Journal of Health and Social Behaviour,* 36, 230-240

[38] Commonwealth Department of Health and Ageing, *Labour Force Patterns And Self-Perceived Health Status Among Older Australians: Implications For Healthy Ageing* 2002

[39] House of Representatives Standing Committee on Employment, Education and Workplace Relations *Age Counts: An Inquiry into Issues specific to Mature Age Workers* June 2000 page 61

[40] ABS 6238 *Survey of Retirement and Retirement Intentions* 1997

[41] ABS 6203 *Labour Force Survey* September 2002

[42] ABS 4433 *Survey of Disability, Ageing and Carers, Disability and long Term Health Conditions* 1998

[43] FaCS *Household, Income and Labour Dynamics in Australia (HILDA) Survey* 2002

[44] Commonwealth Department of Health and Ageing *Labour Force patterns and Self-Perceived Health Status Among Older Australians: Implications for Healthy Ageing* 2002

3.2.2 Nutrition

Good nutrition benefits almost every aspect of health, from birth to old age. Health problems linked to poor nutrition such as heart disease, diabetes and some cancers place an enormous burden on individuals, families and society as a whole.

The Australian Health Ministers, in 2001, endorsed *Eat Well Australia 2000-2010.* This strategy has highlighted the need to improve nutrition for vulnerable groups, particularly older people, those with a chronic illness and those living with a disability. Ensuring that vulnerable people have access to sufficient and good quality food is a complex issue. *Eat Well Australia* aims to influence services, work practices and policies of agencies that have contact with vulnerable people and so improve their clients' access to adequate amounts of nutritious food.

The *Dietary Guidelines for Older Australians* promote the potential benefits of healthy eating particularly for people over 65 years of age. There are also *Dietary Guidelines for Australians,* the *Dietary Guidelines for Children and Adolescents,* and the *Infant Feeding Guidelines for Health Workers,* to encourage healthy eating throughout the different life stages which ultimately contribute to healthy ageing in later life.

3.2.3 Obesity

An emerging issue for Australia is obesity among all age groups. In 1999-2000 an estimated 67 per cent of adult males and 52 per cent of adult females were classified as overweight or obese. Obesity and overweight in children and adolescents has doubled in the past 15 years, with between 20 and 25 per cent of children and adolescents now estimated to be overweight or obese.[45] Obesity is a major health risk factor for many serious chronic diseases such as diabetes, heart disease, stroke and some cancers. The Department has recently developed draft clinical guidelines on weight control and obesity management. The guidelines provide detailed evidence-based guidance for doctors and health professionals in assessing and managing overweight and obesity.

Australian Health Ministers agreed at their meeting in November 2002, that:

- overweight and obesity are significant public health problems that threaten the health gains made by Australians in the last century and require a national response;
- a National Obesity Taskforce be established under the auspices of the Australian Health Ministers Advisory Council; and
- an interim report from the National Obesity Task Force be provided to Health Ministers 6 months after establishment, and a final report after 12 months.

The Department is leading the work of the Taskforce, with the Secretary to be the Chair. The Task Force will act as the mechanism for national collaborative action to tackle obesity, and will have a focus on prevention. Many of the actions needed to tackle the problem lie outside the health sector and will require changing the macro environment of food supply and opportunities for physical activity, as well as the development of initiatives that aim to influence behaviour. In order to do this, the Task force will

[45] *NHMRC Clinical Guidelines for Weight Control and Obesity Management in Adults* and *Guidelines for Weight Control and Obesity Management in Children and Adolescents* 2002

identify and collaborate with key partners across a range of sectors to develop an implementation plan which identifies actions and responsibilities of all parties.

3.2.4 Physical activity

The health benefits of physical activity apply to all age groups including frail older people. Physical activity can assist in the management of chronic diseases, promote cardiovascular fitness, provide opportunities for social interaction and is a key strategy in injury prevention.

Currently 43 per cent of Australians do not meet the recommended amount of physical activity for health. This lack of physical activity is responsible for an estimated 8,000 deaths per year and 7 per cent of the total burden of disease, ranking second only to tobacco use. Insufficient levels of physical activity contribute to high direct health costs. This contribution is conservatively estimated at around $400 million each year in Australia.[46]

In 1996 the Commonwealth Government launched *Active Australia*, a national initiative developed to encourage participation in physical activity by all Australians. It commits key stakeholders in the sport, recreation and health sectors to a strategic and cooperative approach. More recently, *Getting Australia Active*, launched in April 2002, has reviewed the evidence on physical activity interventions in general practice, schools, work sites, the media, communities, the environment, government policy and transport settings. The review of the evidence shows that a coordinated and intersectoral approach to the promotion of health enhancing physical activity offers the best hope of encouraging Australians to become more active.

The Department also has funded the development of a physical activity prescription for use by general practitioners. The prescription assists GPs to assess how physically active a patient is and to prescribe appropriate levels and types of physical activity. The physical activity prescription is being implemented in Victoria as part of a comprehensive program which includes GP education and resource development as well as development of capacity outside of the GP setting to support patients to maintain their levels of physical activity. The physical activity prescription paves the way for development of broader lifestyle prescription programs, which could include assessment and provision of advice about lifestyle behaviours such as good nutrition and smoking cessation, which are important for chronic disease prevention.

3.2.5 The cost of falls

In 1999-00, the number of hospital separations from falls was 55,539. Falls accounted for 55 per cent of total injuries reported in the 65 years and over age group, with one third of total falls occurring in the 85 years and over age group. Female rates exceeded male rates in each age group and rates increased exponentially with age in both males and females.[47]

The majority of falls (49 per cent) take place in the home, with 17 per cent occurring in public places and 14.8 per cent in residential care environments.[48] The risk of

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[46] Strategic Inter Governmental forum on Physical Activity and Health (SIGPAH) http://www.nphp.gov.au/sigpah/gaa/release.htm

[47] AIHW *Hospital Separations due to Injury and Poisoning,* Australia 1999-00

[48] AIHW *Australia's Health* 2002

hospitalisation resulting from falls increases with age. The incidence of falls has also been recognised as a leading risk factor for entry to residential aged care.

The Commonwealth Government's *National Falls Prevention for Older People Initiative*, introduced in the 1999-00 Budget, aims to reduce the incidence, morbidity and mortality associated with falls in people aged 65 and over. The initiative targets older people living in the community, in residential aged care facilities and those in acute care. To date the activities have included research, best practice demonstration projects and the development of resources for specific target groups.

3.2.6 Arthritis

Fifteen per cent of the population (2.6 million Australians) have some form of arthritis, 60 per cent of which are female. The prevalence increases sharply with age: by 65 years, nearly 30 per cent of females and 18 per cent of males report having osteoarthritis.

The economic impact of arthritis is related to in-patient and out-patient care, residential aged care, medications and lost productivity. The health system costs in 1993-94 were estimated to be $624 million, and hospital separations for osteoarthritis have increased 42 per cent over the 7 years to 1999. Osteoarthritis is also the third most common problem for which imaging is ordered by GPs, accounting for 4.1 per cent of all imaging ordered.

Managing behavioural risk factors have been identified as being of benefit in osteoarthritis. Avoiding joint trauma, preventing obesity, exercising to strengthen bones and muscles and modifying occupational-related joint stress and repetition through ergonomic approaches can all help prevent osteoarthritis.[49]

In the 2002-03 Budget, $11.5 million was allocated over four years for better arthritis care. The aims of the initiative, through general practitioner management and self care, are to:

- provide better diagnosis of arthritis;
- promote best practice treatment and management;
- provide multi-disciplinary care;
- promote self management; and
- support proven arthritis self management options.

The two main causes of osteoporosis are an inadequate build up of bone mass during growth and a rapid loss of bone mass with age. Hip fractures are a serious outcome of osteoporosis, as virtually all people with a hip fracture are hospitalised. Two thirds of people who fracture a hip do not return to their pre-fracture level of functioning, with many requiring nursing home care. It is possible to increase peak bone mass and reduce bone loss by lifestyle changes, for example adequate calcium intake and exercise. Alcohol abuse, tobacco smoking and some drug treatments can also result in osteoporosis.[50]

3.2.7 Smoking

[49] *ibid*
[50] *ibid*

The risk of death from tobacco consumption exceeds that of any other addiction, exposure or injury. In 1996 tobacco caused an estimated 16,875 deaths in Australia. The Department has now established that this figure would have been significantly higher if the rate of tobacco consumption had not declined substantially over the preceding twenty years. Between 1974 and 1995 the percentage of adult male smokers fell from 45 to 27 per cent of all adult males. During the same period adult female smokers fell from 30 to 23 per cent of all adult females.[51]

Anti-smoking expenditure has grown from an estimated $5 million per annum during the mid 1980s to a peak of $19 million in the financial year 1989-90. The end result has been a marked fall in tobacco consumption. The health benefit of this has been dramatic. In 1998 it is estimated that these benefits totalled $12.3 billion. This comprised longevity gains of $9.6 billion, improved health status valued at $2.2 billion and lower health care costs of approximately $0.5 billion.[52]

When these figures are analysed next to expenditure data, there is a net gain to public finances. Analysis suggests that there would be a saving of about $2 for every $1 of expenditure on public health programs to reduce tobacco consumption.

The Department has developed and supported education programs and media campaigns designed to reduce the level of tobacco consumption, including the 'National Warning against Smoking' campaign between 1972-75; the campaign aimed at reducing teenage smoking in 1994; and the national tobacco campaign 'Every Cigarette is Doing you Damage' in 1997. In conjunction, the *National Health Policy on Tobacco* in Australia, a joint Commonwealth, State and Territory initiative, aims to eliminate or reduce the exposure to tobacco in all its forms.

[51] Applied Economics, *Returns on Investment on Public Health: An epidemiological and economic analysis*, unpublished report prepared for the Commonwealth Department of Health and Ageing
[52] *ibid*

4. MANAGING HEALTH CARE

In the future, the health care system will need to operate more efficiently and effectively and further incorporate health promotion and disease prevention as a fundamental component of primary care in order to meet the health care needs of growing numbers of older people in a fiscally sustainable manner. Improved 'step down' care and rehabilitation services will also be important aspects of the future health care system, along with better coordination between the post-acute, primary, residential and community care sectors.

The Australian health system is characterised by a commitment to choice, particularly between the private and public sectors, and by the provision of various health services and programs through a federal system. The delivery of integrated primary health, acute and aged and community care services poses challenges for the coordination of services. At the same time, the need for greater coordination across the health and aged care continuum is becoming increasingly important as the population ages and the incidence of chronic and complex conditions increases.

4.1 Health Expenditure and Expected Growth

The *Intergenerational Report* concludes that spending on health and aged care will account for much of the projected rise in Commonwealth Government spending over the next four decades.[53] The ageing of the Australian population is not expected to have a major impact on the Commonwealth's budget for at least another 15 years. However, forward planning is important to ensure that governments will be well placed to meet emerging policy, program and fiscal challenges. A key priority for ensuring fiscal sustainability will be maintaining an efficient and effective medical health system, complemented by widespread participation in private health insurance, while containing Government outlays as a proportion of GDP.[54]

For the financial year 2000-01 Australian health expenditure (combined Commonwealth, State and local and non-government) totalled approximately 9.0 per cent of GDP ($60.8 billion). This proportion of GDP spending is below the levels in the USA, Canada and European OECD countries with the exception of the United Kingdom.[55]

[53] Commonwealth Department of the Treasury, *Intergenerational Report Budget Paper No. 5* May 2002
[54] *ibid*
[55] AIHW *Health Expenditure in Australia 2000-01* September 2002

Table 4: Total health expenditure, by broad source of funds, current prices, 1990-91 to 2000-01 ($million)

	Government				
Year	**Commonwealth(a)**	**State and local**	**Total**	**Non government(a)**	**Total**
1990-91	13,200	7,958	21,158	10,109	31,267
1991-92	14,167	8,138	22,305	10,818	33,123
1992-93	15,291	8,202	23,494	11,605	35,098
1993-94	16,683	7,868	24,550	12,440	36,990
1994-95	17,551	8,460	26,010	13,205	39,216
1995-96	18,997	9,260	28,257	13,825	42,082
1996-97	19,806	10,271	30,077	15,118	45,195
1997-98	21,443	11,409	32,852	15,508	48,360
1998-99	23,563	11,975	35,538	16,142	51,680
1999-00	26,121	12,998	39,119	16,549	55,668
2000-01(b)	28,845	13,678	42,523	18,257	60,779

(a) Commonwealth and non-government expenditure has been adjusted for tax expenditures.
(b) Based on Preliminary AIHW and ABS estimates.
Source: AIHW Health Expenditure in Australia 2000-01

Health spending per person was $3,153 in 2000-01, an increase of $231 or 3.8 per cent in real terms from 1999-00. The main drivers of health expenditure growth were hospital and medical services and pharmaceuticals. This has been the case for the entire decade of the 1990s.

The main drivers of that growth have been technological innovation, that is, a greater use of diagnostic procedures and the listing of new medications on the Pharmaceutical Benefits Scheme (PBS). Expenditure on pharmaceuticals in particular grew rapidly in 2000-01, rising by 14.6 per cent.[56]

The Commonwealth is exposed to these expenditure increases because it directly funds key elements of the Australian health care system:

- the Medical Benefits Scheme (MBS);[57]
- the Pharmaceutical Benefits Scheme (PBS);[58]
- the Australian Health Care Agreements, which make a major contribution to the funding of public hospital services provided by State and Territory governments; and
- the 30 per cent rebate to subsidise the cost of private health insurance.

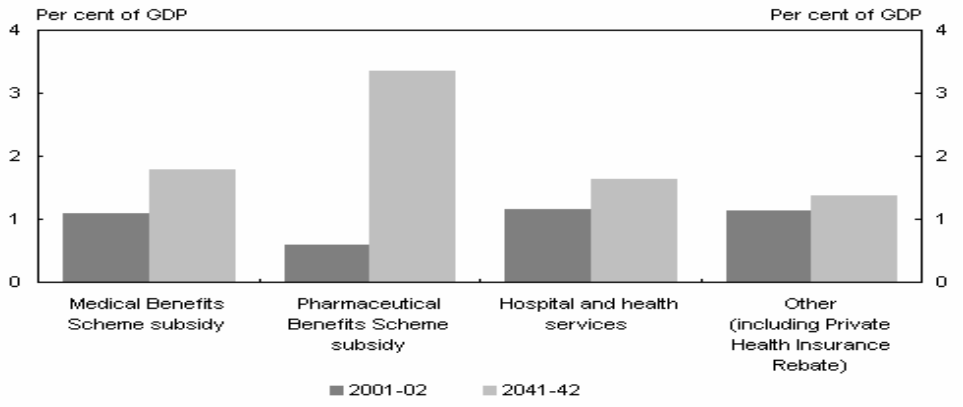
In addition the Commonwealth provides funding for residential aged care and a range of community care services equivalent to approximately 0.7 per cent of GDP ($5.1 billion) in 2001-02.[59]

The Commonwealth also provides financial support to medical research, public health, indigenous health services and medical workforce development and infrastructure.

[56] *ibid*
[57] The MBS provides patient subsidies for medical and diagnostic services listed under the Medicare Benefits Schedule
[58] The PBS subsidises a select list of pharmaceuticals to provide patients with timely, reliable and affordable access to necessary and cost-effective medicines
[59] Commonwealth Department of Health and Ageing *Report on the Operation of the Aged Care Act 1997* 2002 page 23

Commonwealth spending on health is projected by the Commonwealth Treasury to increase from 4 percent of GDP in 2001-02, to 4.3 per cent of GDP by 2011-12 and to 8.1 per cent of GDP by 2041-42. The PBS is projected to grow five-fold in this period, from 0.6 per cent of GDP currently to 3.4 per cent of GDP in 2041-42.[60]

Figure 4. Projected Growth by Components of Commonwealth Health Spending

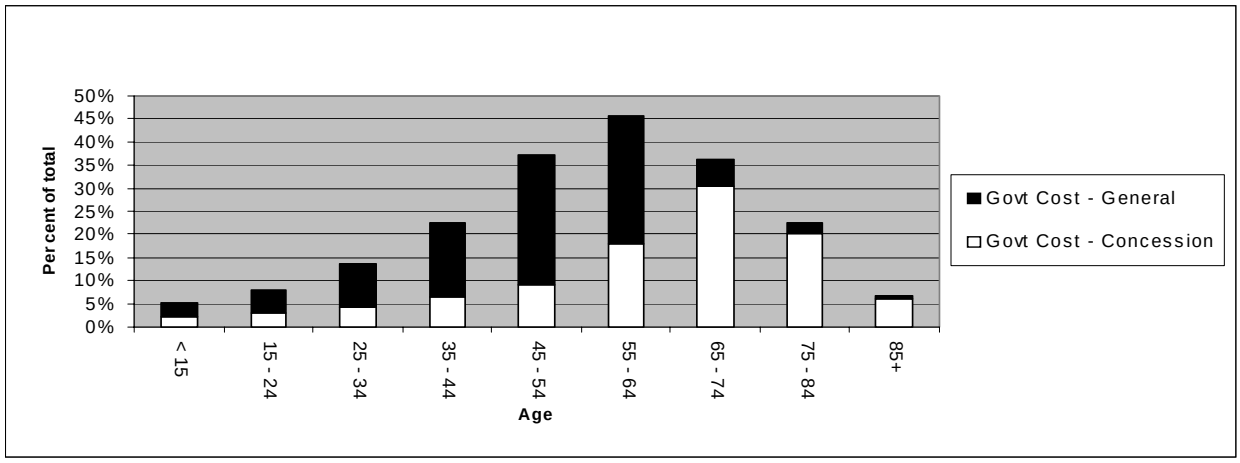


Source: Intergenerational Report Budget Paper No 5 May 2002

Hospital data for 2000-01 indicate that people aged 65 years and over account for approximately one third of all hospital separations but account for approximately 41 per cent of the cost. The average cost of a hospital stay for a person aged 0–64 years was $2,186, whereas the average cost for someone aged 65 years and over was $3,103.[61] The complexity of health issues for older people, including co-morbidities and the compression of morbidity into the last few years of life, would account for these increased costs.

Expenditure on the PBS in 2001-02 was $4.2 billion. People aged over 65 years account for 47 per cent of PBS expenditure (see Figure 5) due to the large proportion (over 90 per cent) of people aged over 65 with a concession card.

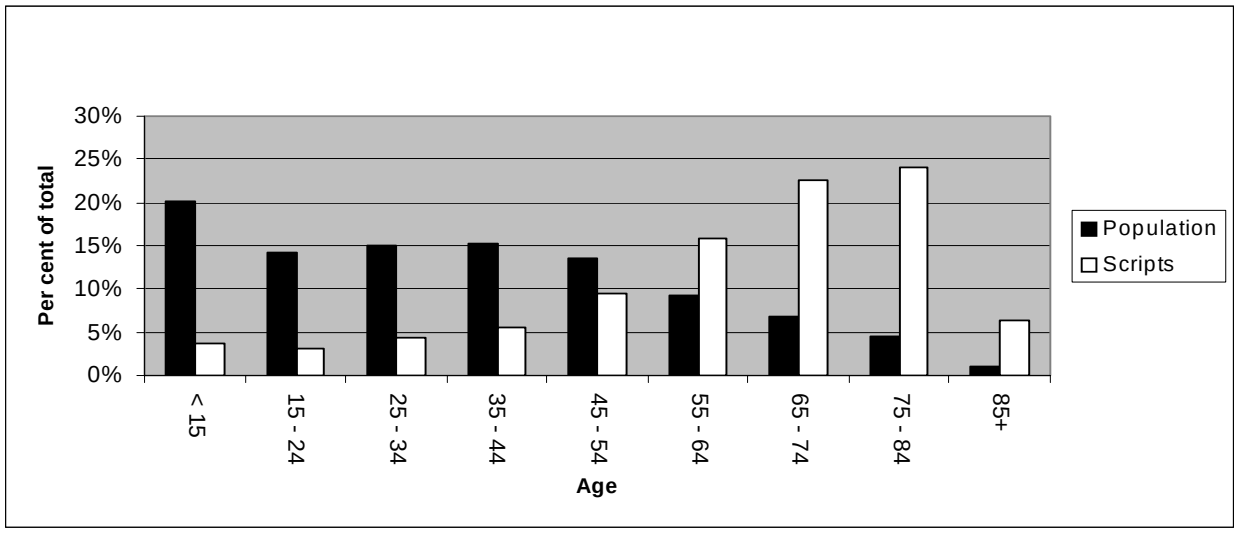
Figure 5: Distribution of PBS Costs by Age



[60] *ibid*
[61] Commonwealth Department of Health and Ageing unpublished data based on DRG groupings

Figure 6 shows the distribution of PBS scripts across age cohorts. The higher use of scripts by the older age groups relates both to increased health care need and the lack of price signals given, in part, to the large proportion of people over 65 with a concession card. The PBS data does not include the estimated 25 per cent of scripts that receive no subsidy through the PBS as the scripts cost less than the standard co-payment. However, given that most people over 65 years of age pay only the concessional co-payment which is much less than the cost of a script, these scripts are most likely to be issued to people under 65 years of age and without a concession card. Data on the use of the PBS by those 65 years and over has not been collected until May 2002, therefore, no comparisons can be made over time for usage by this group alone.

Figure 6: Distribution of Population and PBS Scripts by Age



Source: Commonwealth Department of Health and Ageing unpublished data.

Expenditure on the MBS in 2001-02 was $7.8 billion (not including DVA expenditure). People over the age of 65 years accounted for just over one quarter of the services (26.4 per cent) and 27.4 per cent of the expenditure whereas they account for only 13 per cent of the Australian population. On the whole:

- women use the MBS services more than men;
- services per capita increase with age for both men and women;
- there is a decrease in services for men over the age of 75 years, probably due to decreased male life expectancy; and
- there is a significant increase in the benefits per capita for the 65 years and over age group.[62]

4.2 Strengthening the primary health care system

Globally there has been increasing attention paid to the need to strengthen the primary care sector's capacity to deal with the increasing demands for services as a result of the ageing of the population and the increasing prevalence of people with chronic and complex conditions.

[62] *ibid*

Through a series of initiatives in recent years, Australia is achieving an important shift in focus from ad-hoc, or reactive approaches, to an emphasis on a more integrated and population health based approach in general practice and between general practice and other primary health and community care providers. These initiatives are particularly important for older Australians presenting with complex morbidities. Examples of initiatives designed to improve access to quality, integrated primary health care services and to address chronic and complex conditions include:

- the introduction of the *Enhanced Primary Care Program* items in the Medicare Benefits Schedule designed to promote multidisciplinary team approaches to care (such as case conferencing and care planning) for people with chronic and complex care needs, and annual health assessments for older Australians aged 75 and over;
- the extension of the above program to cover services in aged care homes in order to improve preventive care and facilitate better coordinated care in this setting;
- the *Nursing in General Practice Initiative* which provides subsidies through the Practice Incentives Program for general practices in rural areas and areas of high workforce pressure to employ a practice nurse;
- The *Divisions of General Practice Program* which aims to improve health outcomes for patients by encouraging GPs to work together and link with other health professionals to enhance the quality of health service delivery at the local level;
- The *More Allied Health Services Program,* administered through Divisions of General Practice, which aims to improve the health of people living in rural communities by providing additional professional allied health services, in both quantity and range, to rural areas;
- a range of chronic disease initiatives aimed at improving care for people with asthma, diabetes, mental health conditions, and improving cervical screening rates for under-screened women;
- *Home Medicines Reviews* which enable pharmacists and general practitioners to review medications for patients, particularly older patients, at risk of medication misadventure;
- more funding for longer consultations through the Medicare Benefits Schedule;
- *Palliative Care in the Community* initiative which aims to improve the capacity of the primary care workforce through education and training, and to improve systems to ensure adequate specialist backup and better coordination between hospital and community care settings;
- improved health status of Aboriginal and Torres Strait Islander people through the development of the *Aboriginal and Torres Strait Islander Health Portfolio Business Plan* which aims to both improve accessibility and responsiveness of the mainstream health system and provide complementary action through indigenous specific health programs; and
- the Coordinated Care Trials will test innovative approaches to providing care for people who are experiencing difficulties in receiving the right combination of services at the right time. The two main target groups are people with chronic illness requiring several different kinds of services (who are primarily older people), and indigenous people who, overall, have much poorer health and shorter life expectancies than the non indigenous population. The trials are primarily an initiative of the Commonwealth Government, developed in collaboration with State

and Territory health authorities to generate evidence to inform new ways to organise, deliver and fund health services.

Together these initiatives are intended to give general practice and other primary care practitioners a greater range of choices so that they can deal more effectively with the needs of patients with co-morbidities, especially older patients.

The health care needs of the increasing number of older Australians with chronic and complex care needs also has implications for service delivery at the interface between hospital and community care. This aspect is discussed further in Section 5: Managing Aged and Community Care.

4.3 Supporting Self-management of Chronic Conditions

The *Sharing Health Care Initiative*, introduced in the 1999-2000 Budget as part of the Enhanced Primary Care (EPC) Package, is seeking to promote and support self-management within the Australian health system through more effective collaboration between individuals, their families and health service providers.

The initiative focuses on people with chronic and complex care needs and specifically targets adults 50 years or over (35 or over for Aboriginal and Torres Strait Islander people) suffering from one or more chronic conditions. The core of the initiative is twelve demonstration projects that are testing chronic condition self-management service delivery models in urban, rural and remote settings across all States and Territories. Associated education and training resources and clinical guidelines are being tested within the demonstration projects. The demonstration projects are being evaluated to inform future policy development.

International experience shows that health systems can be designed to prevent and manage chronic disease more effectively. The United Kingdom, building on the ideas set out in their 1999 White Paper, *Saving Lives: Our Healthier Nation*, is currently implementing the pilot phase of the "Expert Patients" program, with a view to main streaming self-management throughout the NHS by 2007.

4.4 HealthConnect – connecting health information for quality care

One of the biggest challenges for consumers and health care providers at the point of care is the limited flow of essential patient health information associated with the current paper based system of health records. As a result, unnecessary stress and pressure can be placed on individuals to remember details of their medical history, at times leading to reliance upon inaccurate information in clinical decision-making processes. It can also result in costly and unnecessary duplication of diagnostic and pathology tests. This situation can particularly effect the care outcomes for older Australians with chronic an complex conditions or who are experiencing dementia.

The Commonwealth/State and Territory based National Electronic Health Records Taskforce has proposed the concept of a voluntary national health information network – Health*Connect* – to address the above situation. The aim of Health*Connect* is to improve the quality and safety of Australia's health care system by allowing patient information held in electronic records to be collected, safely stored and exchanged between health

professionals within strict privacy safeguards. This process could only happen with the individual consumer's permission.

Health*Connect* is still a concept but development work is taking place. The Commonwealth, in partnership with the States and Territories, has embarked on an extensive research and development program involving work on national infrastructure and standards, and investigation and evaluation of different models for the proposed health information network. This is being done in consultation with stakeholder groups and members of the community.[63]

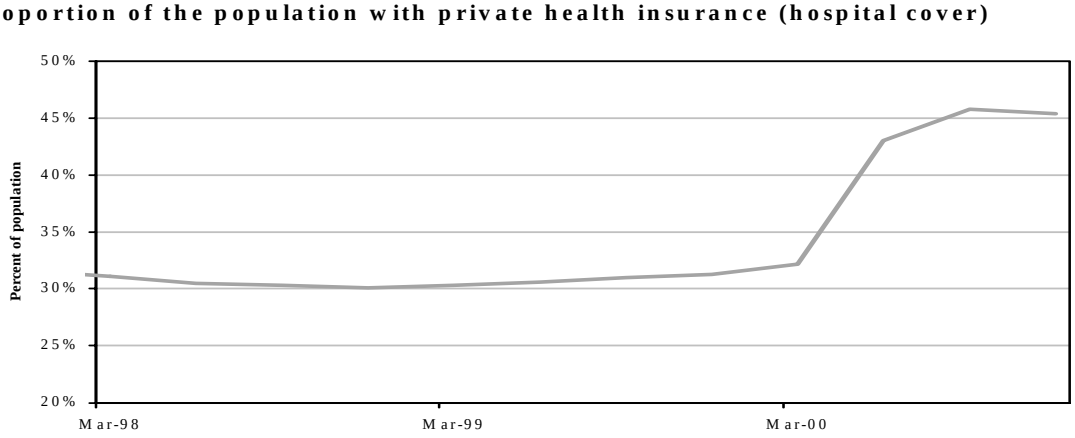
4.5 Private Health Insurance Reforms

The Government has made a commitment to reforming the Australian health insurance sector. Incentives have been put in place to encourage the take-up of life time private health insurance cover. These measures are intended to maintain and enhance the present mix between public and private health provision in Australia.

Lifetime Health Cover encourages people to join a private health fund early in life and maintain their membership. Currently approximately 45 per cent of the Australian population is covered by private health insurance.

People who take out private hospital cover by the time they are 30 years of age, and maintain their membership, pay lower premiums throughout their life relative to people who delay joining. This will ultimately increase the capacity of Australians to contribute to their health care needs when they are older and to access a wider range of health care options, as well as provide a greater financial security in retirement.

Figure 7. Proportion of the Population with Private Health Insurance



[63] Commonwealth Department of Health and Ageing *Privacy, Confidentiality and Security; Questions and Answers; Case Studies; Progress on* Health*Connect; The Building Blocks; Standards Development; and* Health*Connect Trial Sites.* www.healthconnect.gov.au

4.6 The Health Care Workforce

In recent years there has been increasing concern about the current and future supply of health and aged care professionals, not only in Australia but also around the world. The Department is currently taking steps to better understand the causes and consequences of this potential shortage and is monitoring the situation carefully in liaison with State and Territory Health departments. There are initiatives in place to address emerging shortages in certain areas of the workforce. The Department is committed to continuing to ensure that there is a good balance between the need for health services and the availability of health practitioners to meet this need.

The Department has developed structures and practices that involve health professionals in health policy development, planning and implementation for all areas of the health care system, including aged care. The Australian Health Ministers' Advisory Council (AHMAC), through recent reforms to the Australian Medical Workforce Advisory Committee (AMWAC) and the Australian Health Workforce Advisory Committee (AHWAC) process, is pursuing an integrated approach to health workforce planning.

The health and aged care services workforce, like those in other industries, is ageing. The ABS *Private Medical Practice Industry* survey 2001-02 has shown that 62 per cent of Australia's General Practitioners (GPs) were aged between 35 and 54 years. A further 19 per cent were aged between 55 and 64 years. Ten per cent were already over 65 years.

For specialist medical practitioners (specialists), including anaesthetists, paediatricians, dermatologists, obstetricians and gynaecologists, the problems are more immediate. In 2001-02, 38 per cent of all specialists working in private practice were aged 55 years or more. The profession of psychiatry had a particularly high proportion of practitioners aged 55 years or more, at over 54 per cent. In contrast diagnostic imaging and dermatology have relatively fewer older workers with around one quarter of each profession aged over 55 years.[64]

The Department is currently monitoring medical practitioner supply and distribution, and in recent years has introduced a range of strategies to ensure that Australia has a sustainable medical workforce, now and in the future. The Australian Medical Workforce Advisory Committee (AMWAC) is presently undertaking workforce supply modelling, looking at current medical school intakes on a national basis and the ability of current numbers to meet anticipated future vocational training intake levels, as well as general growth in the expected requirement for medical practitioners. This work takes into account the ageing and feminisation of the medical workforce and changes in clinical roles.

Recent AMWAC Workforce Reviews have identified current shortages in a number of disciplines, namely anaesthesia, radiology (radiodiagnosis), dermatology, thoracic medicine, oncology (medical & radiation), rehabilitation medicine, geriatric medicine and intensive care. The identified shortages are at the national level; while they disproportionately affect rural and regional Australia, they also impact upon metropolitan areas, particularly in the public hospital system.

[64] *ibid*

To address current and emerging shortages, AMWAC has recommended increases in vocational training places in a number of disciplines. Around 90 per cent of training intake adjustments recommended by AMWAC are in place (AMWAC Annual Report 2001-02).

The Australian Health Workforce Advisory Committee (AHWAC) is currently conducting a project to profile the composition and structure of the nursing workforce in different settings. The project is being conducted in a number of phases and the Australian Institute of Health and Welfare (AIHW) has provided base line data for this project.

This research will identify similarities and differences by States and Territories. This will incorporate public, private and not-for profit sectors, in the acute, community, remote/rural, aged care, maternity and mental health sectors in all Australian States and Territories as well as New Zealand. This project will assist in providing AHMAC, and AHWAC, with a strategic overview of the current nursing workforce and service delivery models, as well as possible scenarios for the future.

The Commonwealth Ministers for Health and Ageing, and Education, Science and Training also released the report of the National Review of Nursing Education, *Our Duty of Care*, in September 2002. The review examined and reported on a range of issues impacting on nursing and nursing education in Australia, including issues around the aged care nursing workforce.

Further information on workforce issues as they affect the aged care sector is provided at Section 5.10.

5. MANAGING AGED AND COMMUNITY CARE

As its population ages, Australian society will continue to expect a sustainable, affordable, accessible and high quality aged care system. In meeting this expectation, a number of significant challenges need to be addressed, including:

- ensuring appropriate, sustainable funding mechanisms to meet the increasing demand for quality residential and community care services;
- meeting the increasing demand for dementia specific services;
- designing a system that meets the changing expectations of older Australians and the unique needs of individuals; and
- maintaining and enhancing quality assurance measures.

Total Commonwealth funding for residential aged care was approximately $3.9 billion or 0.58 per cent of GDP in 2001-02. In September 2002, Australia's Aged Care Program provided care and support to 139,606 residential care residents and 25,115 Community Aged Care Package recipients.

Detailed descriptions of current residential and community based programs administered by the Department are at the *Report on the Operations of the Aged Care Act 1997*.[65] Further information and analysis will be provided in Background Paper No 1 of the Review of Pricing Arrangements, released in January 2003. Information about the operations of the *Home and Community Care Program*, partly administered with the State and Territory Governments, can be found at http://www.health.gov.au/acc/hacc/index.htm.

5.1 Demographic drivers of demand for aged care

Currently 1.76 million people are aged 70 years and over (9 per cent of the population). This is expected to grow to over 3.98 million (16.9 per cent) in 30 years. Refer Section 1.

Commonwealth aged care planning is based on a population-driven planning benchmark to ensure that the supply of aged care increases as the population aged 70 years and over increases, whilst also effectively managing government outlays within a sustainable and predictable framework. This benchmark provides 100 aged care places, comprised of 90 residential care places and 10 community aged care packages, for every 1,000 people aged 70 years and over. The ratio of all places *allocated* to service providers at 30 June 2002 was 108.4 per 1,000 persons aged 70 or more.

The planning ratio not only sets a balance between the provision of more and less intensive forms of care, it also directly links the planning of care to the numbers of older people in each geographic region of Australia in order to achieve a more equitable distribution of places between regions.

Eligibility for residential and community aged care is assessed by independent *Aged Care Assessment Teams* (ACATs). ACATs approve people for different forms of aged care based on their care needs, so that resources are better targeted and care needs met. They also provide information to residents, carers, providers and health professionals to help people make informed decisions about care needs and the care options available.

[65] www.health.gov.au/acc/reports/acarep

At the moment, people aged 85 years and over constitute 1.4 per cent of the Australian population or 263,000 people. By 2051 the ABS predicts this will increase to approximately 4.8 per cent of the population or 1.2 million people. The majority of people currently in residential care are aged 85 years and over.

At June 2002 around:

- 8.5 per cent of people aged 70 years and over were in residential care or receiving an aged care package of service, and an additional 407,000 people aged 70 and over received a HACC service each year;
- 18.9 per cent of people aged 80 years and over were in residential care or receiving an aged care package of service, and an additional 323,000 people aged 80 and over received a HACC service each year; and
- 29.5 per cent of people aged 85 years and over were in residential care or receiving an aged care package of service, and an additional 121,000 people aged 85 and over received a HACC service each year.[66]

The increased numbers of people aged 85 and over will increase the demand for residential and community care services, particularly the demand for dementia services. This will be particularly felt in the community care sector due to the growing preference for home-based care.

5.2 Commonwealth expenditure on aged care

The *Intergenerational Report* estimates that Commonwealth expenditure on residential aged care will increase from approximately 0.58 per cent of GDP ($3.9 billion) in 2001-02 to 1.45 per cent of GDP in 2041-42.

In 2001-02, the major components of Commonwealth recurrent expenditure on aged care were:

- $3.9 billion on residential care (including residential respite care) under the *Aged Care Act 1997 and the Veterans' Entitlement Act*;
- $246 million on Community Aged Care Packages;
- $615 million on the Home and Community Care Program – (States and Territories contributed an additional $396.8 million);
- $72.9 million on the National Respite for Carers Program;
- $40 million on the Aged Care Assessment Program; and
- $29 million on the Day Therapy Centre Program.

5.2.1 Review of pricing arrangements in residential aged care

In the 2002-03 Budget context, the Government announced the *Review of Pricing Arrangements in Residential Aged Care*. The Review will examine long-term financing options for the residential aged care sector and will take into account the improved care outcomes that are now required under accreditation and underlying cost pressures, including movements in nurses' and other wages, and increases in workers' compensation and other insurance premiums.

[66] Commonwealth Department of Health and Ageing unpublished data 2002

Minister Andrews has appointed one of Australia's most respected economists, Professor Warren Hogan, to conduct the Review. Professor Hogan brings a wealth of economic and business expertise to the Review. He is currently Adjunct Professor of Economics at the University of Technology, Sydney and has had a distinguished career including 30 years as Economics Professor at the University of Sydney, of which he is now Emeritus Professor, and Directorships at Westpac, AMP and AGC.

The Terms of Reference focus on the future needs of the sector and provide broad scope for Professor Hogan to examine future funding needs and options. The Review will be calling for written submissions from the aged care sector, aged care consumers and interested parties in the near future. Additionally, the Review will be conducting consultations on submissions in capital cities and several regional centres. The Review will report to the Minister for Ageing at the end of 2003.

5.3 Changing expectations of older Australians

The growing desire among older people for independence, to maintain quality of life in retirement, to exercise choice and have control over their personal affairs and the opportunity to contribute to, and participate in, society will continue to be key drivers of consumer expectations within the aged care sector. The potentially larger personal finances of future generations of older people arising from growing national wealth, increased retirement savings, changing attitudes towards savings and increasing family inheritances will underscore these expectations.

These expectations are currently being expressed through increased demand for services which give older people the choice of ageing at home for as long as possible or purchasing the level of personal care and amenity they desire. This trend can be expected to continue.

Commonwealth Carelink Centres (56 across Australia) have been established to assist older Australians with their choice of services, including their choice to remain living independently in their own home. The Centres act as a single point of contact, providing information and guidance to consumers, their carers and health professionals about community care services and aged care homes available in the local community. They also provide information to people with disabilities and their families and carers.

5.4 Meeting expectation through innovation in community care and greater choice

A number of new and existing programs are demonstrating the opportunities to enable better access to aged care services for older Australians in different settings.

The rapid growth in the number of *Community Aged Care Packages* (CACPs), and the growth in the *Home and Community Care Program*, has meant that an increasing percentage of frail older people who would otherwise have sought at least low level residential care now have the choice of being cared for in their home. Of the 100 places planning benchmark currently in place (refer section 5.1). 15 places are now being provided through CACPs. In addition the HACC Program also supports a proportion of frail older people with complex care needs through the provision of coordinated packages of care.

The *Extended Aged Care in the Home* (EACH) Pilot has demonstrated that many frail older people who would otherwise have needed to access high level residential care (ie. nursing home care) can also be successfully and cost effectively maintained in their own home. Development of this pilot into a mainstream program is currently occurring.

In the 2002-03 Budget the Federal Government provided $14.9 million over four years to pilot the provision of community care into Retirement Villages. *The Retirement Villages Care Pilot* (RVCP) initiative focuses on residents of retirement villages as a sub group of those older Australians who require additional services to assist in their choice to stay at home for as long as possible.

The RVCP initiative will be cost effective as it will supplement the care and well designed environment already available in many villages. It will build on and encourage the self provision people are making for their future care needs by moving to a retirement village, a choice that is becoming more common for older Australians. Two hundred places are available for this initiative in 2002-03 comprising a mix of high and low care equivalent places.

An important element contributing to the success of the above programs is the provision of respite care and other carer supports provided through the *National Respite for Carers Program*, which has also received significant growth.

The following table shows the growth in Commonwealth funding for the three major community care programs.

Table 5: Growth in Community Care, Commonwealth Expenditure

Program	1995-96	2001-02	Growth (%)
Home and Community Care (HACC)	$423 million	$615 million	45%
Community Aged Care Packages (CACP)	$33 million	$246 million	645%
National Respite for Carers	$14.5 million	$72.9 million	400%

The *Multipurpose Services* (MPS) program is giving many older Australians in rural areas the choice of remaining in their communities. The program is a joint Commonwealth, State and Territory initiative currently providing support for 65 rural communities that would not have been able to receive the full range of residential aged care without the pooled, flexible funding offered by this program. The MPS is particularly suited to communities with total populations in the range of 1,000 to 4,000 people. The aim is to deliver a mix of aged care, health and community services, providing for economies of scale where services may not have been viable individually.

To expand diversity and choice for people in residential aged care accommodation, providers may offer residents the option of receiving accommodation and "hotel" services on an extra service basis. Extra service status offers flexibility and greater choice for those who are prepared to pay for additional, higher levels of service.

Extra service status involves the provision of a higher standard of accommodation, food and services to residents, at a higher charge. These hotel type services may:

- be provided to all residents in the home, or to those living in a distinct part of the home; and
- include, for example, a choice of meals from a three course a la carte menu, larger rooms with ensuites and an expanded range of services such as massage, cable TV, brand name toiletries and additional entertainment.

Extra service status does not mean higher standards of care. The quality of care to be provided to residents is set out in the *Quality of Care Principles* and is the same regardless of whether or not a place has extra service status. Extra service status is not approved if it would mean unreasonably reducing access for persons aged 70 years or more who would have difficulty in affording an extra service amount.

Residents may be asked to pay an accommodation bond at the time of entry to an extra service place, including residents admitted to high care places. This is in addition to the daily extra service fee to be charged.

Nationally, just under 4 per cent of all residential aged care places are approved by the Commonwealth for extra service status, although the distribution is not even among regions or States.

5.5 Meeting expectations through integration and continuity of care

Better integration and continuity of care provided to people within and between sectors will become increasingly important for affording older people independence for as long as possible and the choice of ageing at home. As people age they are more likely to need care from a number of different services and providers. For the frailest in the community, with multiple complications and co-morbidities, the aged care system of the future will need to maintain continuity of care across health and other care sectors.

Linkages with the hospital and health care systems will be of particular importance. Interventions such as step down care and rehabilitation must work in parallel with community care and residential aged care.

Step down care and rehabilitation are intended to restore a measure of independence after an acute episode. With the support of community care services, this would allow more older Australians to make the choice to stay at home for as long as possible.

Residential aged care will continue to provide accommodation and support for people who can no longer live at home.

Several initiatives serve as demonstration projects for improving the interface between hospitals and the aged and community services sectors.

5.*5.1 Innovative pool*

The Aged Care Innovative Pool, established in 2001-02, is a national pool of flexible care places available for allocation to innovative services. The pool allows for pilots for

innovative service provision, in partnership with other stakeholders including State and Territory Governments and approved providers.

The flexible care places through the Innovative Pool are used to conduct an evidence-based test of alternate service models to address current policy priorities. They can also be used to provide mainstream places for providers who are willing to provide permanent aged care services to meet identified high and specific needs. Evaluation will be an integral element of all projects involving alternative service models.

A major focus of the Innovative Pool is on models of post-hospital rehabilitation, called Innovative Care Rehabilitation (ICRS) Pilots.

These pilots combine personal and nursing care (Commonwealth funded) and rehabilitation (State/Territory funded), with the aim of:

- increasing the number of frail 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 of readmission to hospital of recently discharged frail older people; and
- improving the quality of life of participating frail older people.

5.5.2 Australian Health Ministers Advisory Council Working Group on the Care of Older Australians

Commonwealth, State and Territory Health Department officials are working co-operatively on a series of projects to gather information to better understand how care for older people may be improved.

To date, five projects are being undertaken by the Working Group:

1. mapping of services at the interface of acute and aged care;
2. service provision for older people in the acute aged care system;
3. examination of length of stay for older persons in acute and sub-acute sectors;
4. review of assessment and transition practices for older people in acute public hospitals; and
5. a feasibility study on linking hospital morbidity and residential aged care data to examine the interface between the sectors.

The Working Group reports to the Australian Health Ministers Advisory Council. Overall, it is likely that the findings will demonstrate that the situation with regard to care of older people is a complex area that will require a broad policy response across all jurisdictions.

5.6 Review of community care

In response to the growth in the size and number of community care programs, the Minister for Ageing has requested an internal review of community care. Specifically, the Department has been asked to advise whether it would be feasible to design and implement

an integrated community care system, with improved access, assessment processes and continuity of care for people seeking help for themselves and their carers.

The following themes have been central to the internal review of community care:

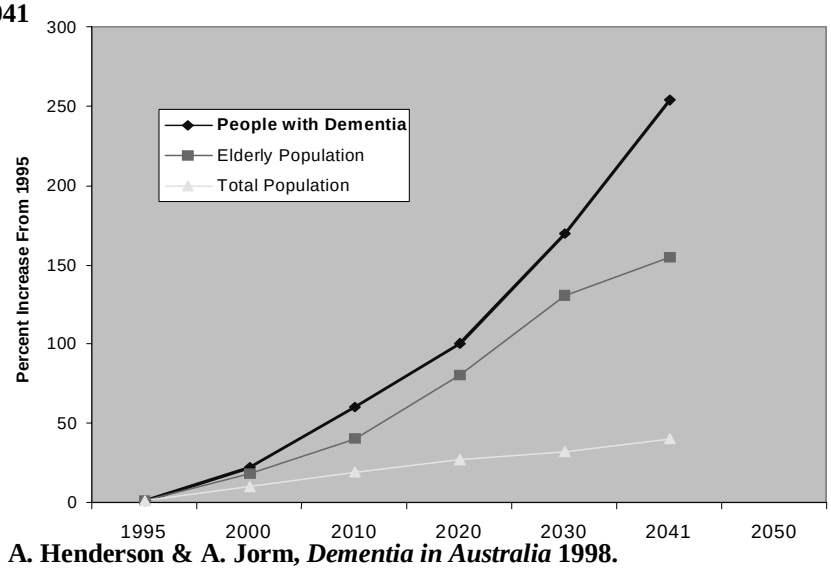
- an overriding rationale that supports the consumer preference for community care where this is practical, sustainable and cost effective;
- the need for a consistent approach to assessment and eligibility across all community care programs to eliminate the need for multiple assessment;
- the need for transparent access and recognition of the different pathways into community care;
- the diversity and dynamic nature of community care requirements;
- the significance of the contribution of informal carers and their need for support; and
- the capacity or otherwise of individuals to negotiate and fund their own care.

The challenge will be to better integrate processes for the planning and delivery of care while maintaining the diversity and commitment of carers, service providers and community volunteers.

5.7 Dementia

Currently over 160,000 Australians have dementia. The Alzheimers Association of Australia and the Centre for Mental Health Research have predicted that this figure will increase by over 250 per cent to approximately 450,000 by 2041.[67] This increase can be almost entirely attributed to the increase in the numbers of people over 80, who are most likely to suffer from dementia. Henderson and Jorm estimate that the prevalence rate for the disease doubles with every 5.1 years of age after the age of 60.[68]

Figure 8. Projected increase in dementia cases, elderly population and total population for Australia, 1995-2041



Source: A. Henderson & A. Jorm, *Dementia in Australia* 1998.

[67] Maller, J. & Rees, G *Research Priorities: Dementia A Submission to the National Research Priorities Taskforce* August 2002

[68] Henderson and Jorm *Dementia in Australia* 1998

Support for people with dementia and their carers is an important element in the Government's aged care policy. The Commonwealth has a number of new and continuing programs designed to meet the specific needs of people with dementia. These include:

- the Dementia Education and Support Program;
- the Early Stage Dementia Support And Respite Project;
- the Carers Education and Workforce Training Project;
- the National Dementia Behaviour Advisory Service;
- over 100 dementia specific respite services across Australia;
- Psychogeriatric Care Units; and
- Dementia Support For Assessment Program.

The anticipated increase in the incidence of dementia has the potential to increase significantly government outlays on aged and community care. This, together with the care needs of people with dementia, will require continuing close attention to the effectiveness of existing dementia programs and policies.

5.8 Availability of carers

The effectiveness and sustainability of the community care system depends in part on the availability of unpaid informal carers. In 1998, 2.3 million people provided some form of assistance to those Australians who needed help due to disability or ageing,[69] of these 450,900 were primary carers.[70] Most commonly carers are spouses, other family members or close friends. Assistance largely consists of support for the following activities: self care, mobility, communication, transport and housework.

More women than men take on the role of primary carer, with 71 per cent of all primary carers aged 15 years and over being women. One in five of these women are aged 65 and over.[71] In terms of care provided for a person aged 65 years and over, women continue to provide much of the care, although the proportion of male primary carers who are themselves 65 and over is much higher at 37 per cent.

Currently in Australia 78 per cent of primary carers are of workforce age (between 15 and 64 years). Of these, 59 per cent do not participate in the paid workforce. The economic imperative for increased workforce participation may have implications for the supply of carers and the demand for more flexible working arrangements in the future. This may also lead to greater pressure on government to provide additional community care and support for the frail aged and their carers.

5.9 Developing a quality system for the future

The Government has established a number of mechanisms to ensure continuous quality improvement within the sector including the accreditation and certification processes for residential care. A standards framework underpins the quality of care received by older people in residential care. This framework places emphasis on residential care services

[69] ABS *Disability, Ageing and Carers, Australia: Summary of Findings*, 1998
[70] *ibid*
[71] ABS *Disbility, Ageing and Carers* 4430 1998

taking responsibility for providing, maintaining and continuously improving quality services.

The Aged Care Complaints Resolution Scheme has become an integral part of this quality assurance framework. It provides a free and accessible complaints resolution mechanism for Commonwealth funded care recipients, their families, guardians or representatives.

A broad accountability framework has been endorsed for the CACP and EACH programs, and more detailed development and implementation strategies should be finalised during 2003. As with residential care, the quality assurance aspects will emphasise service provider responsibilities in evaluating their services with a focus on continuous improvement in quality. When implemented, the accountability framework should also provide reports against benchmarked levels of service provision and provide improved program management data to enhance planning and administration of community aged care programs.

Agencies funded through the HACC are also required to report on aspects of quality, including service standards. The National Service Standards Instrument has been developed to provide a nationally consistent method for evaluating and monitoring the quality of service provision, as well as assist in the planning aspects of service delivery on a regional, State, Territory and national level. Under the HACC Amending Agreements, all States and Territories are required to implement the service standards across all agencies, whose performance against these standards are reviewed triennially.

5.10 Aged care workforce

The Government has a number of initiatives in place to examine the reasons for the nursing shortage in aged care, and to develop appropriate responses as well as strategies to raise the profile of nurses in aged care. These initiatives seek to encourage and facilitate the return of qualified nurses to aged care, rewarding those who have made significant contributions to this sector and encouraging providers to continuously improve occupational, health and safety standards.

As part of the 2002-03 Budget, the Government announced $47.5 million in funding for workforce initiatives in the aged care sector:

- $26.3 million will be distributed over four years to fund up to 1000 scholarships for students from rural and regional areas valued at up to $10,000 each per annum. In addition, postgraduate, re-entry and continuing professional development opportunities for nursing in the aged care sector will be available;

- $21.2 million over four years to fund the training of care staff in smaller, less viable aged care homes. This funding will be used to assist up to 10,000 staff to receive significant and diverse additional training with the objective of upgrading the skills of personal care workers, increasing the flow of skilled staff in aged care homes, and freeing registered nurses to concentrate on clinical care; and

- an Aged Care Workforce Strategy, which will provide a framework for a viable aged care sector. This will include a survey of current and future workforce needs. The Workforce Strategy will enable better planning to meet the future demand for

aged care nurses and other paid care workers with the appropriate skills and qualifications to meet residents' care needs. The aged care sector is being encouraged to embrace a minimum qualification for aged care workers to Certificate III level or its equivalent before 2008.

The Department has supported research into nurses who left aged care nursing, examining why qualified nurses are working in professions other than nursing and identifing what factors would encourage their return to the aged care sector. The results of this research has been published in the report *Recruitment and Retention of Nurses in Residential Aged Care*[72] and this will provide direction for the aged care industry on areas for further development to improve recruitment and retention of staff. The factors identified by this research as influencing nurses' views included:

- the status accorded to nurses and aged care workers;
- issues around working conditions, wage levels and disparities with the acute sector;
- limited professional development and career opportunities; and
- the need for career advancement and a flexible, supportive work environment.

[72] www.health.gov.au/acc/reports/

APPENDICES

APPENDIX 1

NATIONAL STRATEGY FOR AN AGEING AUSTRALIA

Development

The development of the *National Strategy* was first announced in 1997. It was envisaged that the Strategy would provide a mechanism to address the short, medium and long-term challenges presented by Australia's ageing population and form the basis of the Government's policy response to IYOP.

Beginning during IYOP, an extended process of consultation guided the development of the National Strategy. Six discussion papers were prepared to provide an up to date information base for the Strategy. These papers covered a wide range of issues associated with demographic change and its impact on Australian society. In addition, Access Economics was commissioned to prepare a research report on mature age workers. Areas covered included:

- Healthy Ageing;
- Employment for Mature Age Workers;
- Independence and Self Provision;
- World Class Care; and
- Attitudes, Lifestyle and Community Support

The discussion papers were widely distributed throughout Government agencies and the community. The Department of Health and Ageing received over 300 formal responses to the papers. These were used to inform the policy process and further refine the *National Strategy* document. Copies of the papers are available at www.olderaustralians.gov.au/ageing_policy/index.htm

Community Consultations

In the first half of 2002, 14 local communities representing rural regional and metropolitan Australia were involved in discussions with the Minister for Ageing on the *National Strategy*. The aim of these discussions was to engage communities on the issue of ageing and to draw on the expertise and experience of local people to seek their practical ideas about specific actions and initiatives to address local and national issues. Major stakeholder groups, including professionals, consumer and advocacy groups and the aged care industry, have also been consulted to work through areas where collaborative effort is required to meet the needs of an ageing population. The consultations have been successful in establishing an awareness of ageing and encouraging responses to the challenges and opportunities of an ageing society at the local level.

National Advisory Committee on Ageing

The Department is providing support for the National Advisory Committee on Ageing announced by Minister Andrews on 29 October 2002. The Committee will advise the Minister on issues relevant to the ageing of Australia's population. It is also anticipated that the Committee will help to facilitate further discussion and debate about the causes and consequences of population ageing.

The Committee is chaired by Sir James Gobbo and comprises a wide group of people including older Australians, indigenous Australians, aged care providers, researchers, health professionals, social commentators, business and financial leaders. The membership represents the diversity of Australian experience and perspectives on ageing.

The Terms of Reference are to:

- provide a forum for the Federal Government to consult on ageing issues;
- provide advice to the Minister for Ageing on policies and priorities for an ageing population;
- identify ways of responding to the medium to long term challenges of an ageing Australia; and
- consider the need for further research in relation to population ageing.

The Committee met for the first time on 1 November 2002. Members agreed to initially pursue three key issues:

- mature age employment;
- ageing research; and
- ageing within indigenous communities.

Building Ageing Research Capacity Project

The Building Ageing Research Capacity (BARC) Project is a joint project between the Office for an Ageing Australia and Australian Institute of Health and Welfare (AIHW).

The main purpose of the BARC Project is to develop and encourage maximum collaboration and coordination between Australian researchers on ageing issues. Better sharing of information and research findings is seen as a key element in improving the quality and range of the evidence base available to inform policy development work.

The project is being guided by a Steering Committee chaired by AIHW, which comprises representatives of consumer groups, researchers, practitioners and policy makers in the field of ageing. Outcomes being sought are the establishment of:

- agreed National Research Priorities for an Ageing Australia which can be communicated to relevant funding bodies, such as the National Health and Medical Research Council (NHMRC) and the Australian Research Council (ARC), to influence research funding priorities;

- a web-based National Ageing Research Network in Australia (NARNA), as a means of enhancing communication and collaboration between researchers of ageing issues and supporting the strategic development of the evidence base;

- an on-line Australian Ageing Research Directory, as an up-to-date information resource for both the consumers and producers of ageing research; and

- a National Symposium on Ageing Research (mid July 2003), to further the development of national priorities for an ageing Australia and to raise the profile of ageing research among new and established researchers, and to the users of that research in government, business and the community generally.

Data Collection and Publication

The Department has recently contracted AIHW to update and publish the third edition of Older Australia at a Glance. This is an important publication that contributes to the dissemination of a sound and broadly accepted set of data on ageing and aged care. The presentation of the information reflects the priorities identified in the *National Strategy for an Ageing Australia* and the UN International Plan of Action on Ageing 2002.