

# Older Australians

## An Agenda for the New Millennium in Health and Aged Care

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# Guide to this report

This report presents two submissions from the Council on the Ageing (Australia).

**1. World Class Care: A Response to issues paper  
for the National Strategy for an Ageing Australia** **page 4**

The first submission was presented to the Federal Government in 2000 in response to its discussion paper on World Class Care for the National Strategy for an Ageing Australia. This submission reflects COTA's long term of view of how the Government needs to plan for health and aged care well into the 21<sup>st</sup> century.

**2. Federal Budget Submission 2001-200** **page 25**

The second submission was presented to the Federal Government in 2001 with a compendium of recommendations for uptake in the Budget of 22 May 2001. It reflects COTA's short term priorities in health and aged care. Some of these recommendations were taken up in the 2001 Federal Budget brought down on 22 May. There is a small degree of overlap between these two papers.

COTA's budget analysis is available on the website at [www.cota.org.au](http://www.cota.org.au)



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## An Agenda for the New Millennium in Health and Aged Care

### **The Work of Council on the Ageing (Australia) (COTA)**

The Council on the Ageing (COTA) is the peak consumer organisation dedicated to protecting and promoting the well-being of older people. It has the members, skills, knowledge base, and resources to support this role. The Council on the Ageing (Australia) has a number of functions including:

- policy analysis and policy development
- provision of information and advice to older people on Commonwealth policies and programs
- provision of information and advice to the Commonwealth Government about issues of importance to present and future generations of older people based on consultation with older people and research.

The Government provides financial support to assist COTA (Australia) in fulfilling its policy, consultation, representation and information dissemination roles.

At the State and Territory level, COTAs are involved in both service delivery to older people and policy work primarily focused on State issues. Individual members play an important role in maintaining the State-based organisations. Through their consumer base, State and Territory Councils on the Ageing provide the management structure for the Council on the Ageing (Australia) and thereby inform policy and priorities.

COTA (Australia)'s membership includes key national organisations which represent consumers and service providers. These organisations make a substantial contribution to the Council's policy development process.

COTA's membership is open to people over 50 years of age. While most members are over 60, our concerns cover issues including access to aged and community care services, health services, housing, employment and income of Australians over 50.

COTA has both individual members and organisational members, which indirectly provide a very large membership base. Whether members or not, many older people, their carers and relatives as well as organisations come to COTA for information and advice and to alert us to problems they are experiencing with Government policies and programs. The Seniors Information Services which COTA runs or auspices in most of the States and Territories fields around 100,000 calls per annum.

Further information about COTA is available on our website:

**<http://www.cota.org.au>**

*These submissions were prepared by Veronica Sheen,  
Council on the Ageing, Australia.*



# Submission One:

## World Class Care: Response to National Strategy for an Ageing Australia Discussion Paper

### Introduction

One of the largest and most important tasks for the Government as a result of population ageing will be to carefully plan for the health and aged care systems.

There will be a large number of considerations including:

- the needs and expectations of the ageing population and the whole community
- the financing of the system including the relative contributions of private contributions, health and aged care insurance, co-payments and public financing
- the place of high cost medical interventions in the health system
- the comparative roles of, and links between, the private and public systems
- the links between the various parts of the system
- the needs of special groups particularly indigenous Australians.

This response to the World Class Care paper outlines COTA's vision of the health and aged care system. The World Class Care paper presents a great many facts about the health and aged care system that form a useful background to understanding the issues that need to be considered. However, we note that the discussion paper does not give a definition of "world class care" nor does it consider "best practice" models or innovative approaches of care from various parts of the world.

Health and aged care policy is a very complex area. COTA's contribution to the National Strategy in this area is to propose what would constitute a health and aged care system to the highest standards available anywhere in the world. The Government's role is to develop the implementation processes for these principles and strategies.

COTA has developed a twelve point action plan or strategy for achieving world class care.

**Strategy 1:** Maintaining and strengthening universal services as the foundation for equitable outcomes in population health accompanied by high levels of effectiveness and efficiency in the health system.

**Strategy 2:** Fostering strong integration between all parts of the health and aged care system.



- Strategy 3:** Ensuring that health promotion and prevention of ill-health are adequately funded as the basis for high levels of population health.
- Strategy 4:** Promotion of the sound use of pharmaceuticals amongst older people.
- Strategy 5:** Developing specific targeted health strategies for indigenous Australians which also incorporate a strategy for improved access to mainstream health services.
- Strategy 6:** Improving access to allied health services to ensure that people have access to the most appropriate forms of treatment for their condition.
- Strategy 7:** Implementing and funding a national dental health strategy.
- Strategy 8:** Developing a mental health strategy for older Australians
- Strategy 9:** Enhancing home and community care services as a means of preventing admission to hospitals and residential care in order to meet the expectations of older Australians to remain at home as long as possible.
- Strategy 10:** Strengthening discharge planning, post-acute, rehabilitation and palliative facilities to ensure the maximum effectiveness of treatments in the acute sector.
- Strategy 11:** Developing a residential care system that meets the needs and expectations of older Australians
- Strategy 12:** Supporting carers to the fullest extent.

## Twelve Point Strategy For World Class Care

### **Strategy One:**

**Maintaining and strengthening universal services as the foundation for equitable outcomes in population health accompanied by high levels of effectiveness and efficiency in the health system.**

COTA begins this section with the following statement from the recently released *World Health Report 2000* of the World Health Organisation:

*The ultimate responsibility for the overall performance of a country's health system lies with government, which in turn should involve all sectors of society in its stewardship.*

*The careful and responsible management of the well-being of the population is the very essence of good government. For every country it means establishing the best and fairest health system possible with available resources. The health of the people is always a national priority: government responsibility for it is continuous and permanent. Ministries of health must therefore take on large part of the stewardship of health systems.*



**The Council on the Ageing has long held the view that a universal health system has immense advantages in both equity and efficiency terms. By having a system that is accessible to all, we all have an interest in the continuous improvement of its quality.**



*Health policy and strategies need to cover the private provision of services and private financing as well as state funding and activities. (World Health Organisation, 2000, p 4)<sup>1</sup>*

COTA concurs with this view that more than in any other element of a national economic system, the provision of health services and the allocation of health related resources requires intensive and extensive government resourcing, policy direction and program administration.

The Council on the Ageing has long held the view that a universal health system has immense advantages in both equity and efficiency terms. By having a system that is accessible to all, we all have an interest in the continuous improvement of its quality. A universal system means that whether you are rich or poor, you will receive the same standard of treatment.

In addition, a universal system keeps costs under control. Medicare has the purchasing power to ensure taxpayers get the best deal in health services because it is a single major purchaser – thus it is a price giver rather than price taker.

The Government has made a substantial financial commitment to boost the private health insurance sector through a 30 per cent rebate on premiums. COTA opposed this measure because it reduces resources that could be available to the public system and because there is no evidence that it constitutes an efficient and effective use of resources.

In contrast, COTA supports Lifetime Health Cover as it is a sound, structural way of encouraging those who can afford it to take up private health insurance. In addition, Lifetime Health Cover does not impose any budgetary pressure.

COTA believes that the Government's drive to bolster private health insurance may result in a two-tiered health system in Australia based on socio-economic status. There is a risk that over time high and middle income earners will want to opt-out of the public system and will refuse to subsidise the public system through general taxation and the Medicare levy (see for example the views of John Deeble, the architect of Medibank, Australian Financial Review, 11 October 2000, p40).

Lower income earners, including many older people, may be relegated to an increasingly under-resourced and residual public system.

COTA considers that the public system should deliver high quality, free and accessible health care. This system provides the best health outcomes for the population and is able to keep costs down.

We believe that older people should have confidence in this system and should not feel forced to take on private health insurance because they are

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<sup>1</sup> World Health Organisation (2000) *World Health Report 2000 Health Systems: Improving Performance*, Geneva, World Health Organisation.

concerned that they will not receive adequate treatment through the public system. Private health insurance should be an optional extra for older people if they want it and can afford it. It should not be seen as a requirement for people on low incomes who should have guaranteed access to all forms of treatment through the public system.

COTA is concerned that older people's demand for private health insurance is currently driven by a range of negative factors. We have found through our own membership that many older people struggle to maintain private health insurance for the following reasons:

- fear of long waiting periods for non-urgent types of surgery such as hip replacements
- fear of not receiving treatment for potentially life-threatening but non-acute conditions such as severe angina
- fear of ill-treatment in a public hospital in the event of an emergency such as being left for hours on a trolley in a corridor
- the perception that ongoing cost cutting in the public hospital system has seriously undermined the quality of care in that system; and
- the perception that it is better to over-insure than take risks in gaining access to health care.

In addition some older people believe that private health insurance will give them greater control and comfort if hospitalised such as, choice of doctor and a private room.

As a result of these factors many older people whose main source of income is the Age Pension are paying for private health insurance premiums they can ill-afford. Premiums can present 15 per cent of a pensioner's total income.

It will be essential that Australia's public health system continues to operate as a world class system providing an optimal service for all citizens. It will do this by continuing to be a universal system.

### **Long term objectives for the health system**

The OECD (1994)<sup>2</sup> identified a number of desirable objectives for national health systems. These provide a useful basis for the future planning of Australia's system.

#### **1. Adequacy and accessibility of health care: a minimum core of health services available for all citizens, with treatments available according to need.**

COTA believes that Australia meets this criterion reasonably well under the present system but that it should be continuously strengthened. It is possible that increasing privatisation will undermine this objective.

***It will be essential that Australia's public health system continues to operate as a world class system providing an optimal service for all citizens. It will do this by continuing to be a universal system.***



2 OECD (1994) *The Reform of Health Care Systems: A Comparative Analysis of Seven OECD Countries*, Paris, OECD.

**COTA believes that under the current health system health promotion and prevention are inadequately resourced and are not given the priority needed to improve the health outcomes of the older population.**



We are concerned about the continuing reports of significant failures within the public hospital system and we believe there is inadequate attention paid to allied health and community care. COTA believes that under the current health system health promotion and prevention are inadequately resourced and are not given the priority needed to improve the health outcomes of the older population.

**2. Equity of outcomes from health care: a system should ensure that all population groups share the benefits of the health system in terms of health outcomes.**

Australia does have reasonably equitable outcomes from its health system with the major exception of indigenous health. COTA recommends that indigenous health is the basis for a specific strategy as outlined below.

In addition, the AIHW (1998)<sup>3</sup> points to the poorer health status of people in rural and remote areas. Australia has very low coverage of general practitioners in rural and remote areas. Public hospitals have progressively been cut back in rural areas. It is essential that the health system in rural and remote areas is rebuilt and maintained to ensure that people living in these areas have access to as high a standard health care as people living in urban areas.

**3. Income protection for the individual.**

A good health system needs to provide health services that will not impoverish users of the system. Australia's health system is reasonably effective in protecting individual incomes. As a universal health insurance system, financed principally through taxation, the risk of sickness and the need to use expensive health services is shared across the community.

We have reason to greatly fear the Americanisation of Australia's health system which would mean that a substantial proportion of the population, the most disadvantaged, would have greatly reduced access to high quality services.

**4. Macro-economic efficiency: the proportion of GDP absorbed by health expenditures.**

Australia's system measures up well on this score at around 8 per cent of GDP or the average for the OECD over the last decade. COTA is concerned that greater privatisation of the health system would push up this level of expenditure without achieving any improvements in health outcomes but increased profits of private entrepreneurs.

Private hospital treatment is more expensive than public hospital treatment. Public hospitals are more efficient and effective than private hospitals. They have lower costs because they are under greater financial pressure than private hospitals. Privately insured patients receive more procedures than public patients.

3 Australian Institute of Health and Welfare (1998) *Australia's Health*, Canberra, Australian Institute of Health and Welfare.

The Australian Institute of Health and Welfare reported in the *Health Expenditure Bulletin* (November, 1998) that private hospitals were a fast growing area of health expenditure between 1989-90 to 1995-96 at 8.4 per cent per year compared to 2 per cent per year for public acute care hospitals.

**5. Micro-economic efficiency: the extent to which the system operates efficiently and effectively, offering value for money, consumer satisfaction etc.**

The extent to which Australia's health system operates as efficiently and effectively as it can, is a matter of dispute in a number of areas. In recent years a number of sensible measures have been introduced which make the system both more efficient and effective at the micro-economic level.

Of particular note are the initiatives in Enhanced Primary Care including health assessments for people aged 70 and over and case conferencing which are having an important role in moving Australia's health system to greater efficiency and effectiveness. There is an ongoing need for such measures of continuous improvement in Australia's health system. The Coordinated Care Trials are also an important initiative in terms of achieving greater micro-economic efficiency.

**6. Consumer choice**

Consumers in Australia have the choice of doctor they attend in general practice but no choice if they are admitted as a public patient in a public hospital. For some people, this is a major issue and those who can afford to (and some who can't) choose to take out private health insurance for this reason. Choosing a specialist is largely a myth, as choice is usually made by the general practitioner.

In the broad perspective, choice of doctor has not proved a major issue for most people. Many public patients receive treatment from first rate doctors and specialists. All Australian doctors are trained to world class standards and there are stringent registration requirements for foreign doctors.

Consumer choice must be accompanied by consumer education if it is to have genuine meaning in the health system. Consumer education must cover the full range of services, entitlements and rights in the health system. Consumer education will have an important bearing on maintaining the efficiency and effectiveness of the health system.

A strong complaints mechanism is also necessary for an effective consumer role in the health system.

**7. Provider autonomy**

In Australia, medical practitioners form a group of powerful, well-educated and well-resourced professionals preferring to make their own decisions about how they work and how much their work is worth.

It is not in the best interest of the community, however, that they should be allowed to operate from a totally self-regulating position. Medicare has been most effective in placing some caps on doctors' fees and hence has succeeded in controlling the cost of the health system. There is no reason

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for any change in the current balance between self-regulation and the disciplines on the sector provided by the Medicare system.

Cost escalation is apparent in the specialities where there are shortages and these medical practitioners can demand high fees in addition to Medicare rebates. There is a need for research to determine the number of specialists needed in the future.

### **Strategy Two:**

#### **Fostering strong integration between all parts of the health and aged care system.**

A critical element of a successful health system is strong integration between all parts to achieve the maximum levels of efficiency and effectiveness.

To a significant extent the Coordinated Care Trials are attempting such integration and it will be important for these to be further developed and refined for general application across the health system.

It is also important that there is a high level of coordination between the health and aged care systems as well between parts of each system.

### **Strategy Three:**

#### **Ensuring that health promotion and prevention of ill-health are adequately funded as the basis for high levels of population health.**

Public health measures play an important role in promoting many aspects of health status for older people. Older people constitute a population group that have a particular interest in the appropriate application of public health measures.

More than any other age group, the population of older persons represents tremendous diversity in their physiological, social, psychological and economic characteristics. While only a minority of the aged fulfil the stereotype of the ill, confused and isolated, many are active, healthy and independent. This diversity is extremely important to the discussion of preventive health strategies for this population.

Health promotion for older people is not simply about the absence of disease and the avoidance of premature death. It is about supporting older people to stay independent and maintain active and fulfilling lives despite the possible presence of illness. Health promotion aims to create long term changes, not only in the structures and environments which can improve the social, psychological, physical health and quality of life of older people, but also in community attitudes about our older population.

The range of public health issues which are of special relevance to older people are very wide and include:-

- chronic illness
- mental health, suicide and depression

- male specific health issues
- female specific health issues
- cancer screening
- neurodegenerative disorders
- cardiovascular disease
- dementia
- injury
- medication control.

Public action in all of these areas makes a substantial contribution to the quality of life of older people in terms of the following:

- prevention of health problems;
- appropriate treatment of health problems; and
- support for carers and people affected by health problems.

The great strength of public health is in its focus on prevention and early identification of health problems which is particularly crucial in the case of older people. For example, good nutrition and exercise is a much more cost effective way of dealing with osteoporosis rather than expensive hip replacement and subsequent rehabilitation. There are also examples of imbalances between treatment and prevention such as free treatment for an individual under Medicare for a disease but a cost for a vaccination (as is the case for hepatitis).

COTA is of the view that prevention and health promotion plays a vital part in cost control in the health system. We believe that many common health conditions of older people are preventable and their prevention would mean huge savings to the public purse.

Health promotion should be funded to a fixed proportion of overall expenditure in the health system.

#### **Strategy Four:**

##### **Promotion of the sound use of pharmaceuticals amongst older people**

Management of the costs of and access to pharmaceuticals will be a critical part of achieving a world class health and aged care system.

Present and future governments will need to balance the growth in outlays under the Pharmaceuticals Benefits Scheme against therapeutic outcomes. Any policy which aims to reduce the access of sick people to the medicines they need is inappropriate. Pharmaceuticals are a method of treatment under the terms of evidence-based medicine.

Planning for the future must particularly take account of the needs of low income people many of whom will be elderly and with chronic conditions. It will be essential that pharmaceuticals remain accessible and affordable for these groups.

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COTA however, believes that education is an important mechanism for restraining growth in expenditure on PBS. As McCallum and Geiselhart (1996, p59)<sup>4</sup> point out,

*'Drug companies are major funders of all aspects of the medical industry... Consumers need to be as aware of this as they are to tobacco advertising. The polypharmacy problem is a structural issue that can be addressed immediately by controlling pharmaceutical advertising and doctor training. Older people's behaviour is a secondary issue'.*

Doctors, consumers and pharmacists need better education on drugs which allow them to independently evaluate drug effects and uses.

The Council on the Ageing has particular concerns regarding the inappropriate use of medicines and the rapid growth in use of pharmaceuticals as a substitute for other forms of treatment amongst older people specifically. These factors, we believe, have contributed to the growth in outlays for the Pharmaceutical Benefits Scheme.

Our work with older people has identified the need for:

- more information and education about prescribed medicines for older people;
- better communication between consumers and health professionals about the wise use of medicines;
- strategies to encourage older people to manage their own medicines and improve the quality of consumer decisions about the wise use of medicines.

In 1996 and 2000 the Council on the Ageing has run a highly successful national project with Commonwealth funding on the Wise Use of Medicines which involved the training of older people to speak to groups of older people about the use of pharmaceuticals. We believe there is an ongoing need for the education of older people about pharmaceuticals using a range of appropriate methods.

### **Strategy Five:**

**Developing specific targetted health strategies for indigenous Australians which also incorporate a strategy for improved access to mainstream health services.**

According to the Australian Institute of Health and Welfare (AIHW, 1998, p28)<sup>5</sup>, life expectancies for Aboriginal and Torres Strait Islander men and women (living in Western Australia, Northern Territory and South Australia) are 14 to 20 years below those of other Australians.



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4 McCallum J and K Geiselhart (1996) *Australia's New Aged*, Sydney, Allen and Unwin.

5 Australian Institute of Health and Welfare (1998) *Australia's Health*, Canberra, Australian Institute of Health and Welfare.

The AIHW points to the many diseases to which Aboriginal people fall victim, resulting in premature death or disability. These diseases are in the main, preventable.

Clearly the factors that contribute to the poor health and reduced life expectancy of older Aboriginal people are very complex and there are many experts in this area who can be consulted by Government.

Improvement in the health status and life expectancy of Aboriginal Australians will only be achieved by an integrated, multi-dimensional approach that incorporates a recognition of the cultural values and underpinnings of Aboriginal people themselves.

At a minimum, Aboriginal communities need the following to improve the life expectancy and health status of members:

- adequate, culturally appropriate housing
- good nutrition
- clean water supply
- access to educational opportunities particularly for children and young people
- adequate income
- access to good quality and culturally appropriate health and community services.

We note that Aboriginal people themselves place a high priority on land rights as the basis for any improvement in the basic circumstances in which they live. Without land rights, they argue, Aboriginal people will never have sufficient confidence and self-esteem to move beyond the depressed conditions they currently find themselves in.

COTA is concerned that so few Aboriginal people get to reap the benefits bestowed on other older Australians:

- an age pension, health and community services and various other amenities
- the enjoyment of reasonable health and facilities to support frailty and ill-health in old age
- the opportunity to engage in the life of the community and to be part of a family watching children and grandchildren develop.

While a Strategy for Ageing in Aboriginal Communities must take a broad multi-faceted approach to the task of improving life expectancy and health status of Aboriginal people, there also needs to be immediate improvements to the services that are available for older Aboriginal Australians.

Service arrangements should reflect the known health needs and deficits of older Aboriginal people. Primary health care services and public health programs should be located wherever possible within or close to Aboriginal

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communities. Opportunities for participation by members of Aboriginal communities in service planning should ensure that services are culturally appropriate.

Aboriginal health workers should have an important role in the care of older Aboriginal people. There needs to be an expansion of training opportunities in this area.

At the same time, it is important that older Aboriginal people have access to appropriate residential aged care facilities. Facilities such as the *Aboriginal Community Elders Services* in Melbourne need to be supported and their availability expanded.

Geographically accessible and culturally appropriate health services, community services and residential aged care for older Aboriginal people need to be expanded.

An effective national policy on Aboriginal health must also ensure access of Aboriginal communities to the mainstream services that are available to other Australians. The reality is that many Aboriginal people need to use mainstream services and indeed do use mainstream services where they are available. Accessibility to services and successful use of services however, can be impeded where there is lack of cultural awareness and understanding.

Any strategy for improving Aboriginal health and life expectancy must be underpinned by mainstream services with staff trained for working with Aboriginal people or with trained Aboriginal people themselves, and in ongoing communication with Aboriginal communities.

Aboriginal health policy needs to incorporate both specific services run for and by Aboriginal people and mainstream services which are culturally sensitive and provide appropriate services for Aboriginal people.

Aboriginal communities need to have access to mainstream services which are staffed by people who have the cultural awareness skills to ensure that Aboriginal people are able to successfully use the services.

### **Strategy Six:**

**Improving access to allied health services to ensure that people have access to the most appropriate forms of treatment for their condition.**

Medicare does not cover many important areas of treatment under the umbrella of allied health services such as physiotherapy, podiatry, chiropractic and psychology. Low income, older people are excluded from these services if they do not have private health insurance. However, insurance may not offer a large enough rebate to make them affordable, especially for people paying health insurance out of a full Age Pension.

Older people may gain more benefit from allied health services than from pharmaceuticals. These are often prescribed because other, more appropriate treatments are not affordable or accessible. However, the use of pharmaceuticals as the only form of treatment is a false economy if underlying



conditions are not treated and lead to further deterioration which then need more expensive and radical treatments. (It needs to be recognised that pharmaceuticals do have an important role in delaying or minimising the effects of certain conditions).

It is vital that those allied health services which are subsidised, especially hearing and optical, continue to meet the needs of the ageing population.

The Co-ordinated Care Trials may in the future offer more options for older people to gain access to allied health services.

Access to allied health services needs to be strengthened, particularly in rural and remote areas.

### **Strategy Seven:**

#### **Implementing and funding a national dental health strategy.**

COTA considers that dental health should be an essential component of a health and aged care system of world class standards. It is an intrinsic element of primary health care as pointed out in the discussion paper (p14). The greatest deficiency of our national health system is that there is no assistance for people to maintain oral health. One of the worst examples of poor public policy is in divorcing the oral health of individuals from all other aspects of their health care.

There are three aspects of the importance of good dental care we wish to highlight.

#### **1. Good nutrition**

Good dental health, meaning well-maintained natural teeth or well functioning dentures, is a basic pre-requisite of good nutrition which is a building block for good health. Well maintained natural teeth are always preferable to dentures. Modern dental treatment emphasises maintenance of natural teeth where at all possible.

Poorly maintained natural teeth or poorly functioning dentures constrain the dietary choices of older people. Poor diet is linked to a wide range of conditions in older people such as cardio-vascular disease and bone-thinning. In older people poor diet can contribute to memory loss and poor cognitive functioning. These conditions cause suffering for the individual, their families and carers. These conditions will be more expensive to treat in the long term than some adequate dental care in the short term.

#### **2. Freedom from pain and discomfort**

Lack of dental treatment causes physical pain and suffering. This can lead to depression and other mental health problems. It can mean the long term use of pain killers and anti-depressants that have negative effects on overall health and well-being.

***COTA considers that dental health should be an essential component of a health and aged care system of world class standards.***

***The greatest deficiency of our national health system is that there is no assistance for people to maintain oral health.***



**COTA considers that there will be ongoing need for public dental health services that ensure that low income people receive a minimal standard of dental health care.**

COTA argues that poor dental health can contribute to the deterioration in the overall health of older people that can lead to premature admission to a nursing home or death.

### **3. Social functioning and independence**

Good dental health has important implications for adequate social functioning and the independence of older people. Older people can feel constrained in socialising if poor teeth or dentures compromise appearance, speech or eating. We believe that good dental care has a vital role in contributing to the quality of life of older people.

Early intervention for dental problems is important in preventing further deterioration and to encourage preventive dental health practices such as regular and appropriate cleaning.

Many of the older generation have dental health problems as a result of a number of factors:

- the ageing process which results in the wearing down of teeth, fillings and gums
- the loss of most or all natural teeth (edentulism) necessitating dentures due to past dental care practices - this is quite common in people over 65
- heavily filled teeth which require ongoing maintenance and replacement from time to time

COTA considers that there will be ongoing need for public dental health services that ensure that low income people receive a minimal standard of dental health care. COTA does not envisage that there will be any diminution in need for many years into the future. Older people - people over 55 - will make up a very significant proportion of those requiring public dental health services.

Many people will be reaching older age groups with their own teeth rather than dentures and this will have significant implications in the future for the need for good dentistry to maintain those teeth in good working order. This is especially the case if the teeth have been filled as they are most likely to be for the pre-fluoridisation generation (AIHW, 1994, p97)<sup>6</sup>.

A national dental health policy is needed. To achieve the aims of the policy, the Commonwealth will need to provide funding for dental care in addition to that already provided by the States and Territories. The national policy must set standards which:

- focus on preventive dental services including: regular check-ups, fillings and restoration rather than extractions



<sup>6</sup> Australian Institute of Health and Welfare (1994) *Australia's Health*, Canberra, Australian Institute of Health and Welfare.

- ensure that treatment is appropriate and timely: swift, remedial action when problems do arise that aim to save teeth rather than extract them
- ensure that dentures are well-fitting and comfortable
- enable the public dental service to contract private dentists or services
- ensure that people in rural and remote areas have access to public dental services
- ensure that people in institutions including residential aged care have access to dental services when they need them
- provide services for special needs groups:
  - people on low incomes
  - older, frail people
  - people with dementia
  - people in rural and remote areas
  - people in residential aged care

### **Strategy Eight:**

#### ***Developing a mental health strategy for older Australians.***

Many older people suffer from depression and mental illness. Very often the conditions are undiagnosed or incorrectly attributed to old age or dementia. Hence older people are recorded as having the lowest levels of mental illness (AIHW, 2000, p 77)<sup>7</sup>

In addition, depression is very often linked to other diseases associated with old age.

Older people as a group, have not been targetted for mental health policies in the past.

COTA advocates for a strategy that seeks to ensure that older people are correctly diagnosed for mental illness, particularly depression and are offered high quality treatment.

### **Strategy Nine:**

#### ***Enhancing home and community care services as a means of preventing admission to hospitals and residential care and meeting the expectations of older Australians to remain at home as long as possible.***

Services provided through the Home and Community Care program (HACC) and Community Aged Care Packages (CACPs) and the Coordinated Care Trials play an increasingly critical role in health maintenance of an ageing population. Community care represents an important complementary system to the health system.

***COTA advocates for a strategy that seeks to ensure that older people are correctly diagnosed for mental illness, particularly depression and are offered high quality treatment.***

<sup>7</sup> Australian Institute of Health and Welfare (2000) *Australia's Health*, Canberra, Australian Institute of Health and Welfare.



**A timely, adequate and appropriate level of community care can mean that a frail, older person or couple can continue to live at home for longer periods. This can mean less reliance on health services and residential care.**



A timely, adequate and appropriate level of community care can mean that a frail, older person or couple can continue to live at home for longer periods. This can mean less reliance on health services and residential care.

The people we are concerned about are quite capable of self care and independent living in the community but have difficulty with maintaining a home and garden due to frailty or a low level of disability.

We believe that many older people have their living standards and health compromised because of lack of basic support services. The result can be premature admission to residential aged care or at worst, hospital admission or death.

The other major problem in community care which we are concerned about is the cost-shifting between hospitals and HACC.

In some States the pressures on HACC are associated with increased rates of early discharge from hospitals caused by case-mix and cuts to hospital funding. Reform and cost-cutting in hospitals has placed more pressure on the HACC program, eroding its capacity to provide adequate preventive services for low level users.

Clearly, Commonwealth funded community care through HACC and CACPs is experiencing pressures due to a wide range of problems elsewhere in the health and aged care systems. These problems are often linked to the constant tensions between the States and the Commonwealth in terms of financing and roles.

The recent report *Targeting in the Home and Community Care Program* (National Ageing Research Institute and Bundoora Extended Care Centre, 1999)<sup>8</sup> shows that there needs to be a fundamental reconsideration of how resources within the HACC program are distributed between competing priorities between various levels of care needs.

COTA supports the three tier structure proposed in the report:

- Tier 1: Basic HACC – this level to be characterised by broad eligibility and open access.
- Tier 2: HACC “Plus” – at a certain level of service use or identified need, clients would be referred to a Comprehensive Assessment Services. All additional services to be funded through brokerage funds. It is estimated that 15 per cent of clients would be eligible for HACC plus.
- Tier 3: HACC “Exceptional Clients” – high need clients identified through the Comprehensive Assessment Services. This group would be funded through a pool of funds allocated on a case by case basis rather than HACC funds. It is estimated that 2 per cent of clients would be in the “exceptional” group.

<sup>8</sup> National Ageing Research Institute and Bundoora Extended Care Centre (1999) *Targeting in the Home and Community Care Program*, Canberra, Department of Health and Aged Care.

COTA considers that this model would substantially assist in ensuring fair allocation of resources between the varying levels of demand for services between low, medium and high need clients.

### **Strategy Ten:**

#### **Strengthening discharge planning, post-acute, rehabilitation and palliative facilities to ensure the maximum effectiveness of treatments in the acute sector.**

COTA believes that convalescent facilities or step-down facilities need to be much more developed in Australia. The paucity of convalescent facilities has a number of undesirable consequences:

- premature discharge from hospital back into the community
- excessive pressure on community care services, which means that they are unable to fulfill their primary preventative purposes for people with low care needs.
- higher rates of readmission and relapse to hospital.

The availability of timely and appropriate rehabilitation for older people is essential to maintaining function and quality of life. Levels of functioning in areas such as mobility, continence, hearing and vision for example can be maintained and deterioration in function can be significantly reduced through early intervention and health promotion strategies.

In addition, Australia needs to strengthen its palliative care facilities to ensure that the end of life is as positive and humane an experience as it can be.

A world class health and aged care system does not only relate to acute hospital services and aged care but also to supporting services in discharge, post-acute, rehabilitation and palliative care.

### **Strategy Eleven:**

#### **Developing residential care system that meets the needs and expectations of older Australians.**

Australia's residential care system must continuously adapt to the changing demography and the needs and expectations of older people and their families.

COTA welcomed the Government's leadership in providing resources for the restructuring of residential aged care. This initiative needs to be maintained and extended. Residents need a viable and sustainable industry which is able to deliver quality care. To achieve restructuring, new approaches will be needed and some of the current policies will need amending.

There have been some important recent improvements in residential aged care in the areas of quality assurance, complaints mechanisms and prudential arrangements.

Major issues remain as to the long term future of the industry and the options for its development.

***The availability of timely and appropriate rehabilitation for older people is essential to maintaining function and quality of life.***

***In addition, Australia needs to strengthen its palliative care facilities to ensure that the end of life is as positive and humane an experience as it can be.***



***The interface between community care and residential care needs to be carefully assessed with a view to achieving the right balance. Many people who go into residential care would prefer to stay in their own home but there are insufficient community services.***

There is a need for some definitive information about consumer requirements and expectations of residential aged care accommodation and services. Research on older people's expectations of aged care facilities is needed. This research is imperative at a time when aged care services are expected to rebuild or build new facilities.

The interface between community care and residential care needs to be carefully assessed with a view to achieving the right balance. Many people who go into residential care would prefer to stay in their own home but there are insufficient community services.

In addition, there are practical, ongoing issues of concern in the following areas:

- Capital funding for residential aged care: it is not clear what the long term capital requirements are. Further research is needed.
- Additional income tested fees which are returned to the Government: the fees do not add to the pool of funds for residential care but offset the costs to the Government. COTA argues that co-payments and fees should only be used to augment the funding base.
- The up-front payment of accommodation bonds for residential care: an ongoing issue is that people going into low care residential services are required to pay the bond immediately necessitating the sale of the family home. COTA believes it would be more humane and just to allow a six month deferral of payment until the future of the person is properly assessed.
- The residual assets limit of two and half times the annual single Age Pension: COTA believes that this is inadequate protection for older people. They need to be able to reserve more of their savings and assets when going into residential care.
- Issues surrounding dementia care: residential care needs to develop more sophisticated facilities for people with dementia.
- Respite care: there is an ongoing shortage of respite places for older people in the community living with carers.

### **Consumer information and consumer rights**

Older people and their carers need access to information regarding residential care through a multitude of distribution points, e.g. libraries, older people's organisations, etc. A website directory is the best way to achieve ready access to up-to-date aged care service information.

Council on the Ageing (Australia) and the Seniors Information Service (SIS) of South Australia have prepared a proposal to develop a National Website Directory of Aged Care Services.

A National Directory mounted on a website will provide older people and their carers with up to date information on residential facilities. The Seniors Information Service has already undertaken preparatory work which would form a base for this project.



The first phase of the project would produce a model data base, the design of the website and the cooperation of each State and Territory Seniors Information Service. The second phase would be the implementation of the National Directory. The third phase would be the maintenance and ongoing functioning of the National Information Service.

Consumer information is fundamental to the development of a strong culture of consumer rights in residential aged care.

### **Complaints mechanisms**

A critical aspect of a healthy aged care system is a strong complaints mechanism. The mechanism needs to ensure the confidentiality of persons making complaints and a guarantee of timely action on the issues. Complaints are an important part of any quality management system. The complaints mechanism should be entirely independent.

The handling process needs to guarantee that there is an immediate response to matters that constitute serious breaches of health and safety regulations with the aim to resolve the complaint promptly. Appropriate, specified time-frames need to be established for the treatment of other complaints which, although of less immediate seriousness, constitute an ongoing risk to the health and well-being of residents.

### **Workforce planning**

One of the most important elements of developing a world class aged care system will be to ensure that there is an adequate workforce to meet needs in the future.

Employment in aged care services requires sophisticated and ongoing training to ensure staff have the most up-to-date skills and knowledge in the area.

The aged care industry must be prepared to offer conditions and pay salaries that will attract the highest calibre nursing staff and other care workers.

There is an increasing number of high care residents in residential care. Complex, chronic conditions and episodic acute care require skilled responses.

### **Financing long term care**

With the ageing of the population, particularly the growth in the proportion of the population aged over 80, Australia needs to plan to ensure that it will manage the growth in costs for care in the future.

Should private health insurers develop products for long term care?

Do we need some form of social insurance for long term care such as recently introduced in Germany, Singapore and Japan?

Should long term care be primarily funded through general revenue?

***A critical aspect of a healthy aged care system is a strong complaints mechanism. The mechanism needs to ensure the confidentiality of persons making complaints and a guarantee of timely action on the issues.***



**Carers play an essential role in the development and maintenance of a system of world class care.**

**The difficulties that carers face cannot be underestimated. Many are older people who are caring for a loved one. They may have their own health problems to contend with.**



What is the relative balance between user contribution and public subsidy for long term care?

It will be essential that any option adopted, ensures equity of access to high quality care for all groups in the community regardless of income or other factors.

### **Strategy Twelve:**

#### **Supporting Carers**

Carers play an essential role in the development and maintenance of a system of world class care.

Although there have been significant improvements in recognition of the role of carers in recent years, such as the 1998 *Staying at Home* package, it must be recognised that carers issues have emerged from a very low base.

In addition, a number of those needing care and their carers have also been affected by increased user charges for health, aged care and community care services in recent years offsetting some of the benefits.

The difficulties that carers face cannot be underestimated. Many are older people who are caring for a loved one. They may have their own health problems to contend with. There may not be a family or community network to support them and they may be at risk of depressive illness.

For younger carers, the caring role may mean that they are unable to work or work full time. This can have very significant long term social and economic implications such as retirement savings.

The caring role, while having its rewards, can involve immense emotional, physical and economic pressures for carers. Caring for a seriously ill or disabled person is a difficult and challenging undertaking.

People who choose this role should be given the maximum level of support available. At the same time, they should also have a choice as to the extent and nature of their caring roles. Appropriate community care, residential care and respite services must be available when needed.

For carers of people with dementia, there are special support needs. Alzheimer's disease can develop over a very long period of time and there are different phases of the disease. The carer will have evolving support needs over this time.

There are a number of priorities for the ongoing support of carers.

#### **Respite care**

Respite is of paramount importance to carers. Carers need a range of options which provide them with regular breaks from the demands of caring.

People with dementia or sensory loss may be unable to use residential or centre based respite. For this group in-home respite must be available.

While a person is receiving respite care, the carer is still paying accommodation costs. During respite the person in care pays 85 per cent of the Age Pension to the nursing home and 85 per cent of the Age Pension to the hostel. Families of older people can be faced with a double financial burden if they have to pay for a respite bed and also their normal accommodation costs.

It is essential that there is adequate funding for, and access to, respite. In addition, the nature of respite services are constantly adapting to the changing needs and circumstances of carers and the people they are caring for.

#### **Community care**

It is essential that carers are supported by adequate services provided through HACC. The strains of the caring role can be substantially eased by home help and other services to the frail elderly or disabled person being cared for.

#### **Training of carers of people with Alzheimer's disease**

Alzheimer's disease is a complex condition requiring specialised training of carers for the benefit of both the person and the carer. In addition, there is emerging evidence that there is a range of innovative, ameliorative measures that can be employed for people with Alzheimer's disease. However, it is critical that training should not be seen as a substitute for respite and support services for Alzheimer's carers but rather as a facet of an overall package of support.

Specifically trained Alzheimer's carers in residential aged care results in improvements to the quality of care for all residents.

## Conclusion

Australia is well-positioned to develop a system of world class care to meet the needs of the ageing population. This objective however, will require careful long term planning, ongoing research and assessment of risk factors.

It will be critical that the strengths of our present system are not lost in the future.

We must build up a system on the foundations of:

**Social equity** – this means devising health policies which ensure the equal treatment of all members of the population irrespective of income, social class, location or other factors in relation to their access to world class care.

***Australia is well-positioned to develop a system of world class care to meet the needs of the ageing population. This objective however, will require careful long term planning, ongoing research and assessment of risk factors.***



**Allocative efficiency** – this means allocating resources in health and aged care to those policies and programs that produces the greatest benefit to the most numbers of people.

**Cost effectiveness** – this means implementing policies and programs which are effective in improving the health and well-being of the population.

These objectives require careful management of policies in the macro sphere of the health system such as in the areas of resource allocation between public and private systems. They also require attention at the micro sphere such as in ensuring that programs which have measurable benefits to the population are delivered efficiently and effectively.

As we stated at the beginning, the Government is the cornerstone in the stewardship of Australia's health system.

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# Submission Two:

Submission to Federal Budget  
2001-2002



# Introduction

The past three years have been a period of intense policy activity and change which has had profound implications for older people.

There have been major policy reforms in:

- tax reform and the introduction of the GST
- health financing including introduction of lifetime health cover for private health insurance and a 30 per cent rebate for private health insurance premiums
- restructuring of residential aged care.

In addition there have been major inquiries and developmental projects:

- Two Year Review of Aged Care Reform
- Welfare Reform Reference Group inquiry into Australia's welfare system
- House of Representatives inquiry into mature age employment
- Human Rights and Equal Opportunity Commission inquiry into age discrimination.
- National Strategy for an Ageing Australia

Now that these policy reforms and inquiries have been completed, it is time for review, response and forward **movement** in Government policy as it affects older people in the context of the next Federal Budget. The Government's response to the recommendations of the Welfare Reform Reference Group will now require funding commitments to see through the promises it has made to improve opportunities for social and economic participation of older Australians of workforce age.

For older Australians there are a number of critical questions in relation to directions in Government policy:

1. Are the policy reforms having a positive, negative or neutral impact?
2. *What adjustments are needed to those policies?*
3. *Is the Government prepared to take up the recommendations of the major inquiries and in what configuration?*

It is essential that the Government responds to the issues of the major reviews and inquiries under the guidance of the following principles.



# Policy Principles

## **Protecting and Extending Australia's Infrastructure of Social Services**

The maintenance and improvement of Australia's infrastructure of social services must be an ongoing priority for the Commonwealth Government. These services are vital for the health and well-being of all older Australians. They include Medicare, residential care, social housing and Home and Community Care. In addition, it is vital that there is an adequate "safety net" of services and income support which older Australians can access according to fair and equitable eligibility criteria.

## **Promoting the Rights of Disadvantaged Older People**

COTA believes that all older people have the right to an old age which is marked by security, dignity, respect, safety, high quality treatment, high standard care and being part of their community regardless of income status or any other social or economic factor or their geographic location. Government should focus on those people in the older population who are most vulnerable or disadvantaged in terms of these criteria.

As people age they are at increasing risk of advancing frailty, disability, ill-health and social isolation. Government needs to ensure the highest standards in health care, residential aged care and community services.

## **Maximising Opportunities For Social and Economic Participation**

Opportunities for social and economic participation of older Australians must be maximised. Age discrimination needs to be addressed particularly in employment but also in all other areas of social and economic life. The Government must seek to promote positive views of older people and the ageing population.

Government needs to recognise that older Australians both in retirement and pre-retirement years have less ability to change their circumstances than younger, working age people. Therefore, governments must carefully manage policy changes because of the potential effects on the arrangements people have made to fund their retirement which are not amenable to change.

# The National Strategy For An Ageing Australia

The National Strategy for an Ageing Australia show the necessity of planning now for the ageing population.

It is critical that the Government begins to develop pragmatic policy responses to the ageing population across each portfolio.

***COTA believes that all older people have the right to an old age which is marked by security, dignity, respect, safety, high quality treatment, high standard care and being part of their community regardless of income status or any other social or economic factor or their geographic location.***

***Government needs to recognise that older Australians both in retirement and pre-retirement years have less ability to change their circumstances than younger, working age people.***



**Services provided through the Home and Community Care program (HACC) play an increasingly critical role in health maintenance of an ageing population. Community care represents an important complementary system to the health system.**

The 2001 Budget will be important in developing policy frameworks which will assist in the long term management of the changing demographics.

The policy framework needs to encompass:

- A health and aged care system that will be suitable for the needs of an ageing population.
- Policies to encourage mature age people to remain in employment longer
- A retirement incomes policies to maximise the living standards of people in retirement
- A social security system which assists people in the pre-retirement years if they are unable to participate in paid employment.

This Council on the Ageing Budget submission directed to the Health and Aged Care portfolio aims to assist the Government in developing a suitable policy framework for our ageing population. COTA Budget submissions have also been prepared for other portfolio areas of the Federal Government including Family and Community Services and Employment, Workplace Relations and Small Business.

## A. Aged Care

### **1. Home and Community Care**

Services provided through the Home and Community Care program (HACC) play an increasingly critical role in health maintenance of an ageing population. Community care represents an important complementary system to the health system.

A timely, adequate and appropriate level of community care can mean that a frail, older person or couple can continue to live at home for longer periods. This can mean less reliance on health services and residential care.

The people we are concerned about are generally capable of self care and independent living in the community but have difficulty with maintenance activities including maintaining a home and garden due to frailty or a low level of disability.

We believe that many older people have their living standards and health compromised because of lack of basic support services. The result can be premature admission to residential aged care or at worst hospital admission or death.

COTA was pleased that in the last Federal Budget, the Government made attempts to draw additional resources into HACC.

This has been done, in part, through a new program, the *Veterans' Home Care Program* which is aimed at assisting veterans to stay in their own home and prevent admission to residential facilities. By allowing many veterans to



access this program, there will be additional resources for older people who are not veterans in the mainstream HACC program. The Government estimates that up to 20,000 non-veterans could benefit. It will be well into 2001 until we could expect to see a flow through of benefit from this initiative. However, the Government must continue to ensure that HACC is adequately indexed.

The recent report *Targeting in the Home and Community Care Program*<sup>9</sup> shows that there needs to be a fundamental reconsideration of how resources within the HACC program are distributed between competing priorities and between various levels of care needs.

COTA supports the three tier structure proposed in the report:

- Tier 1: Basic HACC – this level to be characterised by broad eligibility and open access.
- Tier 2: HACC “Plus” – at a certain level of service use or identified need, clients would be referred to a Comprehensive Assessment Services. All additional services to be funded through brokerage funds. It is estimated that 15 per cent of clients would be eligible for HACC plus.
- Tier 3: HACC “Exceptional Clients” – high need clients identified through the Comprehensive Assessment Services. This group would be funded through a pool of funds allocated on a case by case basis rather than HACC funds. It is estimated that 2 per cent of clients would be in the “exceptional” group.

COTA considers that this model would substantially assist in ensuring a better spread of resources between low, medium and high need clients.

### **Recommendations**

- 1.1 *Maintain real growth of HACC*
- 1.2 *Adoption and implementation of the recommendations for improved resource allocation in the report Targeting in the Home and Community Care Program.*

## **2. Residential Aged Care**

### **Restructuring of aged care**

The reforms to residential aged care are now over 3 years old. COTA welcomed the Government’s leadership in providing resources for the restructuring of residential aged care. This initiative needs to be maintained and extended. Residents need a viable and sustainable industry which is able to deliver quality care. To achieve restructuring, new approaches will be needed and some of the current policies will need amending. We are awaiting the outcomes of the Two Year Review of Aged Care Reform.

**COTA welcomed the Government’s leadership in providing resources for the restructuring of residential aged care. This initiative needs to be maintained and extended. Residents need a viable and sustainable industry which is able to deliver quality care.**



<sup>9</sup> National Ageing Research Institute and Bundoora Extended Care Centre (1999) *Targeting in the Home and Community Care Program*, Aged and Community Care Service Development and Evaluation Reports, July 1999-No. 37, Department of Health and Aged Care, Canberra

### **Fees, charges and capital funding**

COTA is not seeking major capital funding as current accommodation bonds and charges should be adequate for most services. There is a very strong case for maintaining capital funding for small facilities in rural and remote Australia. Facilities in these areas have viability issues not faced in major urban centres. Small facilities cannot achieve economies of scale. Bonds in depressed areas are hard to obtain as residential properties are of little value or cannot be sold.

COTA supports the continuation of the Industry Restructuring Fund.

Bonds and accommodation charges are assessable and payable on admission. About one third of residents move or die within six months. Facilities go to great lengths to conduct assets tests for bond and charge assessment. This is a waste of provider staff resources for those people who leave so soon. COTA believes that both facilities and older people would benefit if the bond and charge assessments were undertaken after admission. There could be a recalculation of the draw down to capture the first six months. The benefits of a delayed assessment and payment would be: admission clearly on the basis of need; a chance for residents to realise non liquid assets; a less hurried assessment; time to enable the resident to move to another service; less administrative cost for the provider.

There are other issues relating to user-pays elements of residential care.

- COTA believes that the revenue from income tested fees should be used for improvement in care and in particular to meet the ever widening gap between wages bills and the formula indexation. At present the revenue from these fees is returned to Government.
- The current rate of interest payable on bonds of approximately 9.86 per cent (the Treasury note yield plus 4 per cent) is too high particularly as providers are not required under legislation to quarantine bonds for capital improvements.
- There are a number of anomalies that have become part of the system as a result of compromises at the time of the implementation of the Aged Care Act. One example relates to the concessions offered to residents in care at the 1st October 1997. It is time to review these arrangements and bring all in line while protecting the individual situations of residents.

### **Recommendations**

- 2.1 *Maintain a special capital grants program for facilities in rural and remote Australia.*
- 2.2 *Retain the Capital Assistance Program to enable those services that do not have access to adequate bonds or charges to have resources to maintain or upgrade the physical structure of their buildings.*
- 2.3 *Maintain the Industry Restructuring Fund to assist those services that could improve their efficiency, and therefore care, through amalgamations and negotiated shared services.*



- 2.4 *Delay the income testing for accommodation bonds and accommodation charges for residents until after 6 months as around one third of residents leave in that time.*
- 2.5 *Revenue from income tested fees be used for improvement in care and in particular to meet the ever widening gap between wages bills and the formula indexation.*
- 2.6 *Reduce the interest payable on unpaid accommodation bonds from the current 9.86 per cent (approx) to twice the lower deeming rate.*
- 2.7 *Review, through a committee of providers, consumers and unions, of the anomalies that have arisen as a result of the introduction of the Age Care Act. An example is the situation of residents in care at 1 October 1997.*

#### **Access to care**

State and Territory COTAs report that people are having increasing difficulty finding low care and high care beds. There are a multitude of factors including the time lag for new bed allocations to come on line and the closure of services in 2000. Given the impossibility of bringing new beds on line quickly, the immediate expansion of Community Aged Care Packages would assist in meeting some of the need.

#### **Recommendation**

- 2.8 *Expansion of CACPs to relieve the pressure on residential aged care prior to new bed allocations coming on line.*

#### **The Residual Assets Limit**

COTA believes that the residual assets limit of two and half times the annual single Age Pension for people entering residential aged care after paying accommodation bonds is inadequate. COTA continues to receive reports of some residents having no income left after paying medical, pharmaceutical and continence aid co-payments. There are ongoing costs that must be met by the resident:

- dental care
- medical copayments
- pharmaceutical copayments
- over the counter drugs
- allied health services including podiatry, physiotherapy, speech therapy (these are prescribed services only in high care facilities)
- custom-made aids and motorised wheelchairs
- incontinence aids for lower level dependency residents
- hairdressing
- personal clothing
- gifts or loans to family
- cost of outings
- funeral expenses
- psychological counselling.

***COTAs report that people are having increasing difficulty finding low care and high care beds. There are a multitude of factors including the time lag for new bed allocations to come on line and the closure of services in 2000.***



**The situation remains that seeking accommodation for a relative is a horrible task due to the paucity of information and advice. This situation is intolerable for the tens of thousands of families that seek care for their loved ones each year.**

**Consumer information is fundamental to the development of a strong culture of consumer rights in residential aged care.**



#### **Recommendation**

2.9 *The residual assets limit be increased from 2½ times the annual single Age Pension to 5 times the Age Pension.*

#### **Consumer Information And Consumer Rights**

A number of studies have been carried out on behalf of the Department of Health and Aged Care on consumer information needs. These have occurred without the benefit of external advisory committees. The situation remains that seeking accommodation for a relative is a horrible task due to the paucity of information and advice. This situation is intolerable for the tens of thousands of families that seek care for their loved ones each year. Older people and their carers need access to information and advice regarding aged care through a multitude of distribution points, e.g. seniors information services, libraries, older people's organisations, etc.

A website directory is an important way to achieve ready access to up-to-date aged care service information. Unfortunately, the commercial attempts to produce website or printed directories lack the back-up support of advice. Council on the Ageing (Australia) and the Seniors Information Service (SIS) of South Australia prepared a proposal some years ago to develop a model for a Website Directory of Aged Care Services. Departmental support was not given.

A National Directory mounted on a website would help to provide older people and their carers with up to date information on residential facilities. Seniors Information Service in three States have undertaken preparatory work which would form a base for this project.

The first phase of the project would produce a model data base, the design of the website and the cooperation of each State and Territory Seniors Information Service. The second phase would be the implementation of directories in each State and Territory. The third phase would be the maintenance and ongoing functioning of a National Information Service.

Consumer information is fundamental to the development of a strong culture of consumer rights in residential aged care.

#### **Recommendation**

2.10 *The Department support the development of a model residential aged care data base and then support its implementation and maintenance.*

#### **Aged Care Complaints Resolution Scheme**

The Division of Consumer Affairs within the Department of Treasury has issued *Benchmarks for industry-based customer dispute resolution schemes*. When compared with these Benchmarks, the current aged care complaints system does not rate well. Further, the Secretary of the Department of Health and Aged Care in the Annual Report 1999-2000,<sup>10</sup> identifies:

<sup>10</sup> Commonwealth Department of Health and Aged Care (2000) *Annual Report 1999-2000*, Commonwealth of Australia, Canberra

*“an insufficient integration of the Aged Care Compliance, the Complaints Resolution Scheme and the Accreditation process”. (P7)*

The solution offered in the Annual Report is not in keeping with guidelines issued by Treasury. The main principles that are not followed are:

- Independence from the scheme providers
- Accountability: the Scheme is not “publicly accountable for its operations by the publishing of its determinations and information about complaints and highlighting any systemic industry problems”.
- Effectiveness: the Scheme is not subject to periodic independent reviews of its performance. (It has been the subject of a review by the Ombudsman but this was not invited as part of a review process).

Much more could be said, but suffice to say, the Aged Care Complaints Resolution Scheme is structurally flawed and needs to be established as an independent authority that conforms to the Benchmarks issued by The Commonwealth Treasury.

#### **Recommendation**

2.11 *The Aged Care Complaints Resolution Scheme be reestablished as a separate authority utilizing as its guiding principles the Benchmarks for Industry-Based Customer Dispute Resolution Schemes released by the Minister for Customs and Consumer Affairs in 1997.*

#### **Workforce planning**

One of the most important elements of developing a world class aged care system will be to ensure that there is an adequate workforce to meet needs in the future.

Employment in aged care services requires sophisticated and ongoing training to ensure staff have the most up-to-date skills and knowledge in the area.

The aged care industry must be prepared to offer conditions and pay salaries that will attract the highest calibre nursing staff and other care workers. Concern is being registered with COTAs around Australia that staffing levels have deteriorated. The industry reports that it cannot compete for nursing staff when their salary levels are lower than those paid in the acute sector. The indexation method used by the Department, the Commonwealth Own Purposes Outlays (COPO) index, is unsuitable to the aged care industry as it does not take into account the cost pressures faced by the sector. The inevitable consequence of insufficient indexation is the reduction in both the number of and skill level of staff.

There is an increasing number of high care residents in both high and low residential care services. Complex, chronic conditions and episodic acute care require skilled responses.

**Employment in aged care services requires sophisticated and ongoing training to ensure staff have the most up-to-date skills and knowledge in the area.**



**For carers of people with dementia, there are special support needs. Alzheimer's disease can develop over a very long period of time and there are different phases of the disease. The carer will have evolving support needs over this time.**



#### **Recommendation**

2.12 Discard the Commonwealth Own Purposes Outlays (COPO) index and adopt an indexation formula that reflects the cost pressures experienced by the residential aged care industry.

### **3. Carers and Special Care Needs**

#### **The state of play**

The initiatives from recent Budgets and the 1998 *Staying at Home* package mark significant advances in terms of policy for special care needs in the areas of dementia and policy for carers.

Nevertheless, it must be recognised that there are significant community needs in these areas that are only now gaining recognition and that there is a backlog of need. We welcome the progress made to date but there is still a long way to go. A number of those needing care and their carers have also been affected by increased user charges for health, aged care and community care services.

The difficulties that carers face cannot be underestimated. Many are older people who are caring for a loved one. They may have their own health problems to contend with. There may not be a family or community network to support them and they may be at risk of depressive illness.

For younger carers, the caring role may mean that they are unable to work or work full time. This can have very significant long term social and economic implications such as retirement savings.

The caring role, while having its rewards, can involve immense emotional, physical and economic pressures for carers. Caring for a seriously ill or disabled person is a difficult and challenging undertaking. People who choose this role should be given the maximum level of support available. However, they should also have a choice as to the extent and nature of their caring roles. Appropriate community care, residential care and respite services must be available when needed.

For carers of people with dementia, there are special support needs. Alzheimer's disease can develop over a very long period of time and there are different phases of the disease. The carer will have evolving support needs over this time.

COTA has identified several priorities for the 2001 Budget.

#### **Respite care**

The 1998 *Staying at Home* package provided \$80 million for Carer Respite Centres over 4 years. This adds an additional 15 Carer Respite Centres for problem and high need areas with services in existing centres to expand for more difficult and emergency cases. In addition, \$16 million for respite can be used outside residential aged care to provide more flexible options.

The *Staying at Home* package provided \$10 million over 4 years to expand community based respite service options for carers of people with dementia enabling respite to occur at home.

In addition, the Government allocated a further funds over 4 years to expand community-based respite care options for carers of people with dementia. This was estimated to fund around 133,000 hours per year.

Respite is of paramount importance to carers. Carers need a range of options which provide them with regular breaks from the demands of caring. Through the aged care reforms there has been increased access to respite care but utilization has been below the targets. Despite the allocation of new resources and a modest increase in utilization, particularly in high care, there is wide spread dissatisfaction. This dissatisfaction relates to the lack of availability and flexibility. There is still a considerable level of unmet need for people in high care situations for both in-home and residential respite services according to Council on the Ageing.

People with dementia or sensory loss may be unable to use residential or centre based respite. For this group in-home respite must be available.

While a person is receiving respite care, the carer is still paying accommodation costs. During respite the person in care pays 85 per cent of the Age Pension to the nursing home and 85 per cent of the Age Pension to the hostel. Families of older people can be faced with a double financial burden if they have to pay for a respite bed and also their normal accommodation costs.

### **Recommendations**

- 3.1 *Increased funding for the Carers Respite Centres.*
- 3.2 *In depth research into the reasons that carers are finding difficulty in obtaining residential respite care and determine solutions.*
- 3.3 *Increased funding targeted towards HACC respite services by \$20 million a year, with matching funding from the States and Territories to be negotiated.*

### **Community care**

It is essential that carers are supported by adequate services provided through HACC. The strains of the caring role can be substantially eased by home help and other services to the frail elderly or disabled person being cared for.

### **Recommendation**

- 3.4 *Additional funding through HACC to specifically provide support services in households where there is a carer of a frail elderly or disabled person. Housework and personal care assistance should be provided to the person to ease the burden on carers.*

***It is essential that carers are supported by adequate services provided through HACC. The strains of the caring role can be substantially eased by home help and other services to the frail elderly or disabled person being cared for.***



**Research needs to focus on a number of key areas:**

- **quality assurance in aged care**
- **international standards in aged care**
  - **dementia care**
  - **other special care needs such as that relating to people with disabilities who are enjoying increased longevity and the needs of carers in a wide range of situations.**

### **Training of carers of people with Alzheimer's disease**

Alzheimer's disease is a complex condition requiring specialised training of carers for the benefit of both the person and the carer. In addition, there is emerging evidence of a range of innovative, ameliorative measures that can be employed for people with Alzheimer's disease. It is critical however, that training should not be seen as a substitute for respite and support services for Alzheimer's carers but rather as a facet of an overall package of support. An important point about adequate and appropriate training for Alzheimer's carers in residential aged care, is that it results in improvements to the quality of care for all residents.

#### **Recommendation**

- 3.5 *Funding for training of carers of people with Alzheimer's disease in both the community and in institutions to ensure adequate knowledge of the complexity of the condition, the appropriate type of care and skills to assist the carer in best managing his or her role, in the context of an overall package which includes respite and support services.*

## **4. Research and Evaluation**

COTA believes that there is an urgent need for a much higher level of Commonwealth funded research into "best practice" for both residential and community care. COTA, as the publisher of the Australasian Journal on Ageing is very aware that there is a paucity of "best practice" articles. Practitioners report they have little time and few resources to research and report their work.

Research needs to focus on a number of key areas:

- quality assurance in aged care
- international standards in aged care
- dementia care
- other special care needs such as that relating to people with disabilities who are enjoying increased longevity and the needs of carers in a wide range of situations.

The Australasian Journal on Ageing management committee which consists of some of Australia's leading ageing researchers would be able to provide advice as to how such a research program should be structured, as well as key research priorities.

#### **Recommendation**

- 4.1 *Establishment of a well-structured and well-funded research program funded by Government to cover all aspects of aged care. Funding be established as a fixed proportion of the aged care budget, say, .001% (approx \$4 million) per annum.*



## **5. 2002 International Federation on Ageing (IFA) 6<sup>th</sup> Global Conference on Ageing – Maturity Matters**

The Council of the Ageing is a partner with the Western Australian Government in hosting the International Federation on Ageing Conference in Perth in November 2002. The Government of Western Australia has contributed \$200,000 to underwrite the conference.

The Conference presents a unique opportunity for the Commonwealth to make a major contribution to an international conference on ageing as well as obtain invaluable information from local and international speakers. The conference will be particularly targeted to regional delegates from Asia and surrounding areas. The Government will obtain benefit from making contacts with relevant government and non-government bodies in the region. In September 2000, COTA and the Western Australian Government entered preliminary discussions with United Nations/ESCAP to call a high level meeting of Ministers and officials with responsibility for ageing. The meeting would occur at the time of the global conference.

### **Recommendation**

- 5.1 *The Commonwealth matches the contribution of \$200,000 by the Government of Western Australia by providing the same amount over 2 years for the organisation of the 2002 IFA conference.*

## **B. Health**

### **6. Public Hospital Access**

The Council on the Ageing has long held the view that a universal health system has immense advantages in both equity and efficiency terms. By having a system that is accessible to all, we all have an interest in the continuous improvement of its quality. A universal system means that whether you are rich or poor, you will receive the same standard of treatment.

In addition, a universal system keeps costs under control. Medicare has the purchasing power to ensure taxpayers get the best deal in health services because it is a single major purchaser – thus it is a price giver rather than price taker.

The last 2-3 years however, have seen immense changes in Australia's health system which have greatly increased the number of Australians now with private health insurance – 41 per cent of the population at the end of June 2000 compared to 30 per cent at the end of June 1999.

The reasoning behind the creation of the incentives for participation in private health insurance has been to relieve the pressures on the public health system. The extent to which the public health system is drawing relief from the higher rates of private health insurance is unknown at this stage.

***In addition, a universal system keeps costs under control. Medicare has the purchasing power to ensure taxpayers get the best deal in health services because it is a single major purchaser – thus it is a price giver rather than price taker.***



**COTA believes that the Commonwealth needs to carefully consider these limitations to its policy of increasing private health insurance membership.**

Problems have been identified by the Australian Consumers Association ([www.choice.com.au](http://www.choice.com.au)) with regard to the types of policies that have been taken out by some older people in the lead up to the lifetime health cover implementation.

It is likely that many policies include exclusions for important categories of medical intervention for older people including joint replacements, coronary surgery and cataract surgery. As these are the areas for which waiting lists have traditionally been highest, people with these policies are unlikely to relieve pressures on public hospitals.

In addition there are serious questions as to whether increased private health insurance membership will relieve the pressures on emergency services in the public system. Emergency is an important area of admission of older people but most private hospitals are not able to provide intensive care and emergency treatment to the level of the public system. Less than one third of acute care hospitals in Australia are in the private system<sup>11</sup> (AIHW, 2000, p 266).

Gap payments continue to be a problem for many people with private health insurance and deter many from admission as a private patient in a public hospital. COTA notes, however, the statement by The Minister for Health on 30th November, 2000 that “sixty percent of private health care was provided with no gaps in the September 2000 quarter” (Media Release MW126/00)

There will not necessarily be a translation of high private health insurance into reduced pressures on public hospitals covering reduced waiting times for non-urgent surgery and increased capacity for handling emergency cases.

COTA believes that the Commonwealth needs to carefully consider these limitations to its policy of increasing private health insurance membership. While COTA recognises that the Government is committed to providing a subsidy of around \$2 billion to the private health insurance industry, it will need to balance this with a continuing commitment to provide high quality services in the public health system.

Under the terms of the Commonwealth State Health Care Agreement there is an adjustment in Commonwealth funding of public hospitals in line with the proportion of the population with private health insurance. However, there may not be a clear link with the rise in private health insurance participation and a reduction in pressure on public hospitals.

It is critical that the Government evaluates the outcomes of its new policies in terms of real effects on access to health care.



11 Australian Institute of Health and Welfare (2000) *Australia's Health*, Australian Institute of Health and Welfare, Canberra.

12 Duckett S and T Jackson (2000) “The new health insurance rebate: an inefficient way of assisting public hospitals” in *Medical Journal of Australia*, Vol 172, 1 May 2000.

The analysis of the effects of the private health insurance rebate recently undertaken by Stephen Duckett and Terri Jackson<sup>12</sup> (2000, p439) shows that “*the subsidy cannot be justified on efficiency grounds, as, on the basis of available evidence and taking casemix into account, public hospitals are more efficient than private hospitals.*”

COTA believes that Lifetime Health Cover has been the correct response to the Government’s concern about the decline in participation in private health insurance and will provide stability to the industry over the long term. However, the rebate for private health insurance is:

- inequitable in that it provides a subsidy to high income earners, many of whom were in private health insurance anyway. High income earners are not particularly price sensitive to the cost of private health insurance anyway
- inefficient because of the greater efficiencies in the public system
- unsustainable because of the high costs involved and the marginal outcomes in relieving pressure on public hospitals
- poorly targeted as it aims to increase the numbers of Australians with private health insurance rather than provide a rebate to people who use private health care including private hospitals.

Given that a large number of low to middle income earners have taken up private health insurance because of Lifetime Health Cover, there are difficulties in removing the 30 per cent rebate. However, one response could be to means test the rebate so as to exclude high income earners from the benefit.

#### **Recommendation**

- 6.1 *The Commonwealth contribution to public hospitals should be based on accurate assessment of need rather than any other factor.*
- 6.2 *Government to investigate means testing the 30 per cent rebate for private health insurance.*

## **7. Discharge Planning, Convalescent and Palliative Care**

### **Discharge planning and convalescence**

COTA continues to receive reports throughout Australia – with some variations between states/territories – about older people’s premature discharge from hospitals, when they are still quite ill and without social or community supports. Reports of older people in acute care being labelled as “bed blockers” are also consistently received. COTA resents older people being identified as the problem when the problems are structural and responsibility of governments.

COTA has long been concerned about the lack of discharge planning and the paucity of convalescent facilities throughout Australia, although we are unable to find information through the Australian Institute of Health and Welfare about these.

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***In an era of debate about the issue of euthanasia, it is particularly important that high quality palliative care is available for all terminally ill people who need it.***

***Older people may gain more benefit from allied health services than from pharmaceuticals. These are often prescribed because other, more appropriate treatments are not affordable or accessible.***



COTA believes that convalescent facilities or step-down facilities need to be much more developed in Australia. We observe that the paucity of convalescent facilities has a number of undesirable consequences:

- premature discharge from hospital back into the community
- excessive pressure on community care services, which means that they are unable to fulfill their primary preventative purposes for people with low care needs.
- higher rates of readmission and relapse to hospital
- admission to permanent residential care to relieve the pressures on acute care but at the expense of a person's recovery and return home.

Acute hospital services need to be backed by adequate supporting services in discharge, post-acute, convalescence and rehabilitation facilities.

In an era of debate about the issue of euthanasia, it is particularly important that high quality palliative care is available for all terminally ill people who need it. In this context, it is important that people have a choice of care at home (including in residential aged care) or in a hospice. This implies a need for both hospices and services that can be accessed at home.

#### **Recommendations**

- 7.1 *Assessment of the need for and development of a national system of discharge planning, post-acute and convalescent facilities.*
- 7.2 *Assessment of the need for and extension of palliative care facilities.*

### **8. Allied Health Services**

Medicare does not cover many important areas of treatment under the umbrella of allied health services such as physiotherapy, podiatry, chiropractic and psychology. Low income, older people are excluded from these services if they have not taken out "extras" in private health insurance. However, insurance may not offer a large enough rebate to make the premium affordable, especially for people paying health insurance out of a full Age Pension.

Older people may gain more benefit from allied health services than from pharmaceuticals. These are often prescribed because other, more appropriate treatments are not affordable or accessible. However, the use of pharmaceuticals as the only form of treatment is a false economy if underlying conditions are not treated and lead to further deterioration which then need more expensive and radical treatments. (It needs to be recognised that pharmaceuticals do have an important role in delaying or minimising the effects of certain conditions however).

It is vital that those allied health services which are subsidised, especially hearing and optical, continue to meet the needs of the ageing population.

Access to allied health services need to be strengthened in rural and remote areas.

## **Recommendations**

- 8.1 *Older people's access to allied health services needs to be increased through the extension of Medicare items and the extension of co-ordinated care and Multipurpose Services*

## **9. The Co-ordinated Care Trials/Enhanced Primary Care**

Coordinated Care trials started in 1997 with the conclusion, for evaluation, in December 1999. The final national evaluation report is being considered in late 2000 with an expected release date of February 2001. Selection for a second round of trials is underway. It is vital that the successful methodologies developed with Coordinated Care Trials begin to be implemented on a more universal basis in the next Budget. The Secretary to the Department of Health and Aged Care noted in the 1999-2000 Annual Report<sup>13</sup>(p8) that the extension of the Coordinated Care Trials was one of the areas to be progressed with the States and Territories.

COTA is particularly interested in the following aspects of the Trials:

- individualised care planning
- a more organised approach to prevention, early intervention and treatment
- pooling of funds
- linking of medical services with community services

COTA also supports the recent initiatives in Enhanced Primary Care (EPC) announced in the 1999 Budget. From November 1999 to August 2000 85,011 EPC services were provided and \$11.824 million benefits paid. Of the services provided, 85.4% were for health assessments. There is a large difference in take-up rates for health assessments in the different States and Territories.

Health assessments have the potential to reduce the need for assistance and more extensive care.<sup>14</sup> To date, the emphasis has been on educating professionals regarding EPC items. COTA recommends that the education program be extended to consumers. Through techniques such as peer education, older people would be advised on how to maximise the benefit of a health assessment with the view to improving their health.

## **Recommendations**

- 9.1 *A further allocation be made to extend the successful components of the Coordinated Care Trials*
- 9.2 *Fund COTA to conduct a consumer education component in Enhanced Primary Care Package with particular emphasis on maximising older people's use of health assessments to improve their health.*

13 Australian Institute of Health and Welfare (2000) *Australia's Health*, Australian Institute of Health and Welfare, Canberra.

14 See report of a study in Julie E Byles "A thorough going over: evidence for health assessments for older persons" in *Australian and New Zealand Journal of Public Health*, v24no2.

***Health assessments have the potential to reduce the need for assistance and more extensive care.***

***Through techniques such as peer education, older people would be advised on how to maximise the benefit of a health assessment with the view to improving their health.***



**The Council on the Ageing continues to advocate for Federal Government financial and policy involvement in dental care.**

**COTA argues that poor dental health can contribute to the deterioration in the overall health of older people that can lead to premature admission to a nursing home or death.**



## **10. Dental Care**

One of the worst examples of poor health policy is in divorcing the oral health of individuals from all other aspects of their health care. The greatest deficiency of our national health system is that there is no assistance for people to maintain oral health. We continue to hear that many older people are missing out on basic dental care throughout Australia and are subject to very long delays in receiving treatment. While there is a lack of good information about waiting times, we hear:

- a number of public dental services have closed off their bookings
- others report waiting times well over 12 months
- treatment is emergency only, impacting on many older people who need dentures or denture repairs.

The Council on the Ageing continues to advocate for Federal Government financial and policy involvement in dental care. The 2001 Budget provides an excellent opportunity for the Federal Government to repair this black spot in its health care policies. COTA argues that poor dental health can contribute to the deterioration in the overall health of older people that can lead to premature admission to a nursing home or death.

Early intervention for dental problems is important in preventing further deterioration and to encourage preventive dental health practices such as regular and appropriate cleaning.

Many of the older generation have dental health problems as a result of a number of factors:

- the ageing process which results in the wearing down of teeth, fillings and gums
- the loss of most or all natural teeth (edentulism) necessitating dentures due to past dental care practices - this is quite common in people over 65
- heavily filled teeth which require ongoing maintenance and replacement from time to time.

COTA considers that there will be ongoing need for public dental health services that ensure that low income people receive a minimal standard of dental health care. COTA does not envisage that there will be any diminution in need for many years into the future. Older people - people over 55 - will make up a very significant proportion of those requiring public dental health services.

Many people will be reaching older age groups with their own teeth rather than dentures. This will have significant implications in the future for the need for good dentistry to maintain those teeth in good working order. This is especially the case if the teeth have been filled as they are most likely to be for the pre-fluoridisation generation<sup>15</sup> (AIHW, 1994, p97).

<sup>15</sup> Australian Institute of Health and Welfare (1994) *Australia's Health*, Australian Institute of Health and Welfare, Canberra.

A national dental health policy is needed. To achieve the aims of the policy, the Commonwealth will need to provide funding for dental care in addition to that already provided by the States and Territories. The national policy must set standards which:

- focus on preventive dental services including: regular check-ups, fillings and restoration rather than extractions
- ensure that treatment is appropriate and timely: swift, remedial action when problems do arise that aim to save teeth rather than extract them
- ensure that dentures are well-fitting and comfortable
- enable the public dental service to contract private dentists or services
- ensure that people in rural and remote areas have access to public dental services
- ensure that people in institutions including residential aged care have access to dental services when they need them
- provide services for special needs groups:
  - people on low incomes
  - older, frail people
  - people with dementia
  - people in rural and remote areas
  - people in residential aged care

#### **Recommendation**

10.1 *Development of a national dental health policy with funding for a national dental health scheme.*

### **11. Health Promotion**

Public health measures play an important role in promoting many aspects of health status for older people. Older people constitute a population group that have a particular interest in the appropriate application of public health measures. The fifteen leading causes of burden of disease have been identified by the Australian Institute of Health and Welfare<sup>16</sup> (Mathers et al 1999). Most of these causes are conditions experienced by older Australians. The Government's National health priority area initiative has been a welcome measure to identify actions and interventions in the identified priority areas. COTA would like to see the initiative further extended.

The range of public health issues which are of special relevance to older people are very wide and include:-

- mental health, suicide and depression
- male specific health issues

***A national dental health policy is needed. To achieve the aims of the policy, the Commonwealth will need to provide funding for dental care in addition to that already provided by the States and Territories.***

***Public health measures play an important role in promoting many aspects of health status for older people. Older people constitute a population group that have a particular interest in the appropriate application of public health measures.***



16 Mathers C, T Vos and C Stevenson et al (1999) *The Burden of Disease and Injury in Australia*, Australian Institute of Health and Welfare, Canberra

**The great strength of public health is in its focus on prevention and early identification of health problems which is particularly crucial in the case of older people.**

- female specific health issues
- cancer screening
- neurodegenerative disorders
- cardiovascular disease

Public action in all of these areas makes a substantial contribution to the quality of life of older people in terms of the following:

- prevention of health problems;
- appropriate treatment of health problems; and
- support for carers and people affected by health problems.

The great strength of public health is in its focus on prevention and early identification of health problems which is particularly crucial in the case of older people. For example, good nutrition and exercise is a much more cost effective way of dealing with osteoporosis rather than expensive hip replacement and subsequent rehabilitation. In addition such preventive practices mean less social disruption to individuals and their families. There are also examples of imbalances between treatment and prevention such as free treatment for an individual under Medicare for a disease but a cost for a vaccination (as is the case for hepatitis or pneumonia).

COTA is of the view that prevention and health promotion plays a vital part in cost control in the health system. We believe that many common health conditions of older people are preventable and their prevention would mean huge savings to the public purse.

#### **Recommendation**

- 11.1 *A fixed proportion of the health budget dedicated to health promotion measures.*
- 11.2 *Extension of the National health priority areas to other causes of the burden of disease.*

## **12. Mental Health**

Many older people suffer from depression and mental illness. Very often the conditions are undiagnosed or incorrectly attributed to old age or dementia. Hence older people are recorded as having the lowest levels of mental illness<sup>17</sup> (AIHW, 2000, p 77)

In addition, depression is very often linked to other diseases common in old age and can be a result of pain and discomfort.

Older people as a group, have not been targeted for mental health policies in the past.



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<sup>17</sup> Australian Institute of Health and Welfare (2000) *Australia's Health*, Australian Institute of Health and Welfare, Canberra.

The National Review of Mental Health has been concluded and a report of the review is due to be released in late 2000.

#### **Recommendation**

12.1 *Development of a national mental health strategy for older people.*

### **13. Indigenous Health**

According to the Australian Institute of Health and Welfare<sup>18</sup> (AIHW, 1998, p28), life expectancies for Aboriginal and Torres Strait Islander men and women (living in Western Australia, Northern Territory and South Australia) are 14 to 20 years below those of other Australians.

The AIHW points to the many diseases to which Aboriginal people fall victim, resulting in premature death or disability. These diseases are in the main preventable.

Clearly the factors that contribute to the poor health and reduced life expectancy of older Aboriginal people are very complex and there are many experts in this area who can be consulted by Government.

Improvement in the health status and life expectancy of Aboriginal Australians will only be achieved by an integrated, multi-dimensional approach that incorporates recognition of the cultural values and underpinnings of Aboriginal people themselves.

At a minimum, Aboriginal communities need the following to improve the life expectancy and health status of members:

- adequate, culturally appropriate housing
- good nutrition
- clean water supply
- access to educational opportunities particularly for children and young people
- adequate income
- access to good quality and culturally appropriate health and community services.

While a health policy for Aboriginal people must take a broad multi-faceted approach to the task of improving life expectancy and health status, there also needs to be immediate improvements to the services that are available for older Aboriginal Australians.

Service arrangements should reflect the known health needs and deficits of older Aboriginal people. Primary health care services and public health programs should be located wherever possible within or close to Aboriginal

***Improvement in the health status and life expectancy of Aboriginal Australians will only be achieved by an integrated, multi-dimensional approach that incorporates recognition of the cultural values and underpinnings of Aboriginal people themselves.***



<sup>18</sup> Australian Institute of Health and Welfare (1998) *Australia's Health*, Australian Institute of Health and Welfare, Canberra.

**Geographically accessible and culturally appropriate health services, community services and residential aged care for older Aboriginal people need to be expanded.**

**An effective national policy on Aboriginal health must also ensure access of Aboriginal communities to the mainstream services that are available to other Australians.**

communities. Opportunities for participation by members of Aboriginal communities in service planning should ensure that services are culturally appropriate.

Aboriginal health workers should have an important role in the care of older Aboriginal people. There needs to be an expansion of training opportunities in this area.

At the same time, it is important that older Aboriginal people have access to appropriate residential aged care facilities. Facilities such as the *Aboriginal Community Elders Services* in Melbourne need to be supported and their availability expanded.

Geographically accessible and culturally appropriate health services, community services and residential aged care for older Aboriginal people need to be expanded.

An effective national policy on Aboriginal health must also ensure access of Aboriginal communities to the mainstream services that are available to other Australians. The reality is that many Aboriginal people need to use mainstream services and indeed do use mainstream services where they are available. Accessibility to services and successful use of services can be impeded however, where there is lack of cultural awareness and understanding.

Any strategy for improving Aboriginal health and life expectancy must be underpinned by mainstream services with staff trained for working with Aboriginal people or with trained Aboriginal people themselves.

Aboriginal health policy needs to incorporate both specific services run for and by Aboriginal people and mainstream services which are culturally sensitive and provide appropriate services for Aboriginal people.

Aboriginal communities need to have access to mainstream services which are staffed by people who have the cultural awareness skills to ensure that Aboriginal people are able to successfully use the services.

#### **Recommendations**

13.1 *Strategies to ensure indigenous peoples' access to mainstream health services used by all Australians*

13.2 *Strategies to develop specific services to meet the special needs of indigenous Australians.*

#### **14. Pharmaceuticals**

Management of the costs of and access to pharmaceuticals is a critical part of the health and aged care system.



Government needs to balance the growth in outlays under the Pharmaceuticals Benefits Scheme against therapeutic outcomes. Any policy which aims to reduce the access of sick people to the medicines they need is inappropriate. Pharmaceuticals are a method of treatment under the terms of evidence-based medicine.

However, COTA believes that education is an important mechanism for restraining growth in expenditure on PBS. As McCallum and Geiselhart<sup>19</sup> (1996, p59) point out,

*Drug companies are major funders of all aspects of the medical industry... Consumers need to be as aware of this as they are to tobacco advertising. The polypharmacy problem is a structural issue that can be addressed immediately by controlling pharmaceutical advertising and doctor training. Older people's behaviour is a secondary issue.*

Doctors, consumers and pharmacists need better education on drugs which allow them to independently evaluate drug effects and uses.

The Council on the Ageing has particular concerns regarding the inappropriate use of medicines and the rapid growth in use of pharmaceuticals as a substitute for other forms of treatment amongst older people specifically. These factors, we believe, have contributed to the growth in outlays for the Pharmaceutical Benefits Scheme.

Our work with older people has identified the need for:

- more information and education about prescribed medicines for older people
- better communication between consumers and health professionals about the wise use of medicines
- strategies to encourage older people to manage their own medicines and improve the quality of consumer decisions about the wise use of medicines.

In 1996 and 2000 the Council on the Ageing has run a highly successful national project with Commonwealth funding on the Wise Use of Medicines which involved the training of older people to speak to groups of older people about the use of pharmaceuticals. The 2000 project has been successfully carried out through a partnership with the Pharmacy Guild of Australia and COTA. We believe there is an ongoing need for the education of older people about pharmaceuticals using a range of appropriate methods.

#### **Recommendation**

14.1 Ongoing funding for COTA's Wise Use of Medicines programs.

**Government needs to balance the growth in outlays under the Pharmaceuticals Benefits Scheme against therapeutic outcomes. Any policy which aims to reduce the access of sick people to the medicines they need is inappropriate.**



<sup>19</sup> McCallum J and K Geiselhart (1996) *Australia's new aged*, Allen and Unwin, Sydney.