Submission to *Caring for Older Australians*

Productivity Commission

Brotherhood of St Laurence

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Summary

> An equal society protects and promotes equal real freedom and substantive opportunity to live in the ways people value and would choose, so that everyone can flourish. An equal society recognizes people's different needs, situations and goals and removes the barriers that limit what people can do and be.(UK Government 2007).

What do Australians living their second fifty years want to do and be? Here is the fundamental question to be answered by the Productivity Commission as it conducts the current inquiry into Caring for Older Australians. The Australian Government, through its social inclusion agenda, seeks to reduce disadvantage, increase social, civic and economic participation and develop a greater voice and greater responsibility. This inquiry provides a platform for promoting these forms of inclusion for all older Australians and particularly those for whom aged care services are essential.

At a time when the rights of older people in Australia are often undermined by social stereotypes that equate ageing with deficit and by well-intentioned social and care services that, in a risk-averse environment, often curtail independence and choice, a stepping off point for this submission is a vision of aged care as an investment in which Government sees its role as investing in those capabilities that older Australians need to develop or maintain for full inclusion in Australian society.

The Brotherhood of St Laurence welcomes this opportunity to contribute to the Productivity Commission's review of aged care. We have addressed seven areas in this submission:

- housing
- funding
- assessment
- regulatory compliance – residential care
- carers and respite care
- choice and continuum of care
- social inclusion – social support services, capabilities and work, income, information communication technology and transport

These seven areas have a significant impact on the future of aged care and relate either directly or indirectly to the Productivity Commission issues paper *Caring for older Australians*.

As our population ages, Australia faces increased aged care costs. We need to learn from the experience of other developed countries in designing policy to address this issue. The foundation of aged care policy needs to shift from addressing ageing as a deficit and focus instead on people's capabilities. This will effectively shift the ground from a dependency model to a model where older people as adults exercise their full complement of choices and rights.

Housing

Appropriate housing is both a fundamental need and a human right. There is a need to disaggregate funding for housing (accommodation) and funding for care. As people age, an excellent variety of housing options is the first priority for promoting wellbeing. Care can then be provided in the setting of choice. There needs to be a new strategic approach to innovative housing for Australia's older population, including universal design, environmental sustainability and an adequate supply

of social housing in age-friendly neighbourhoods, together with government support for remodelling homes or downsizing.

Funding

It is timely to investigate the establishment of a universal, contributory scheme to provide Australians with entitlement to a standard level of long-term care. An assisted independence model for provision of aged care would increase flexibility and quality in the system and increase the choice and control of older people and their carers over the services they receive. An accompanying public information strategy will ensure that entitlements are clearly understood and universally accessed and promote choice and control by service users.

Assessment

Assessment for aged care services should be based solely on the level of need and eliminate any requirement for the separation of community and residential care. Need for services should relate to level of disability and the level of informal support available. Assessment should be outcomes-based, made by the service provider of choice, take place at point of entry and be lodged with the insurer for payment. People should hold their own comprehensive record of past and present care use and options.

Regulatory compliance – residential care

Residential care accreditation and certification, to its credit, drove up standards of care and quality of services in its early years of operation; however, its ongoing modifications and refinements have imposed an increasing burden of regulation and compliance and a punitive approach to monitoring. This has diminished the time staff can spend with residents and has compromised care. It is time for development of a single national regulatory scheme focused on achieving high quality outcomes for residents.

Carers and respite care

Family carers of people with chronic illnesses, dementia or other forms of disability frequently experience extreme stress which impacts on their health and wellbeing. The aged care system needs to give increased attention to their specific needs through integrating services and reducing the number of service models to enable delivery of interventions via one provider rather than multiple providers. A service model that incorporates carer support with other primary health services should be considered, together with increased opportunities for consumers to direct their own care. The availability of respite care, and particularly overnight respite care, should be expanded to enable family carers to continue in their support roles without jeopardising their own health and wellbeing and thus their ability to provide care.

Choice and continuum of care

Adequate choice and an assured continuum of care are vital to meeting older people's needs The aged care currently on offer is inflexible and broadly limited to residential care on one hand, and on the other hand, community care services through local authorities and/or packaged care, flexible care and carer support services. There should instead be a full range of care choices based on people's needs and capabilities. The care continuum should include restorative health care, accommodation and long term care, provide a self-managed cash option and enable changes to care management as people's needs change.

Social inclusion

Social inclusion of older people must take into account many dimensions. Relationships are essential to a good life and to ensuring people's social, emotional, intellectual and physical needs are met. They are important in helping a person to retain their rights and responsibilities and to maintain self-esteem, self-confidence, self-identity and purpose in life. Loneliness is emerging as a unique risk factor for such conditions as high blood pressure and onset of dementia. There is urgent need to broaden the Australian Government's social inclusion agenda for older people to include a greater focus on increasing social participation rather than simply on increasing economic participation and employment, and to expand resources that enable people to maintain and enlarge their own social networks.

Workforce participation and continuation promote capabilities and provides economic, social and health benefits. Restorative and rehabilitative aged care services would enable more people to work for longer and could also help to combat age discrimination in the workplace.

Information communications technology (ICT) is pivotal to social inclusion today. A level of understanding and use of all forms of information communications technology (ICT) is necessary for completing everyday tasks from obtaining information and paying bills to communicating with family and conducting social life. Older Australians are often disadvantaged by lack of ICT knowledge and skills or affordable access to technologies. Ageing is a time for learning and aged care services should support learning opportunities in this and other fields.

Effective transport options enhance older people's quality of life, which is closely linked to the ability to visit friends, participate in activities and access community and medical services. Large numbers of older people do not have access to a private car for their travel needs and rely on community transport to access services, facilities and activities. Yet community transport is routinely overlooked as an area of public policy and aged care services. This is a significant problem with Australia's urban sprawl and sparse population, leaving many older people with no independent mode of transport. Appropriate community transport options and supports for older people must be a priority if we are to achieve a socially inclusive Australia.

Based on the above responses, the Brotherhood of St Laurence has formulated a number of recommendations (detailed on pages 30–34) that it believes will provide the necessary positive impetus to change Australia's aged care system into the future. These recommendations will lead to a sustainable aged care system based on choice and capacity building for older people, thus significantly enhancing their experience of life in their second fifty years.

1 Introduction

The Brotherhood of St Laurence and *Caring for Older Australians*

The Brotherhood of St Laurence (BSL) is an independent non-government organisation with strong community links that has been working to reduce poverty in Australia since the 1930s. Based in Melbourne, but with a national profile, the BSL continues to fight for an Australia free of poverty. We undertake research, service development and delivery, and advocacy with the objective of addressing unmet needs and translating the understandings gained into new policies, new programs and practices for implementation by government and others.

The context

Our ageing population

The rise in the aged population across OECD countries is well documented. Western Europe and Japan have already reached a 10 per cent increase of their aged population 10 years ahead of Australia. Australia is therefore in the fortunate position to be able to learn from overseas experience in planning for the long-term care needs of its older population over the next 40 years.

The increase in Australia's older population is not in itself a concern. Any number of older people can be supported as long as there are enough younger people to drive the economy and provide needed services (Productivity Commission 2005). However, when the rise in numbers of older people is coupled with a decrease in younger population due to declining fertility and the percentage of GDP needed to support the health and long-term care needs of the older population increases at a rapid rate, as is the case in Australia, the implications for the economy need to be carefully managed.

Australia's current aged care system is predominantly funded through the federal government and the taxation system. Current expenditure is approximately $10 billion per annum, with the majority of this funding going to residential care. With the first of the baby boomer cohort turning 65 years in 2011, and the consequent increased demand on these services over the next two decades, continued funding solely through the current tax-based system is likely to be unsustainable. In the UK, with a similar tax-based care system, there is also considerable debate about the sustainability of the long-term care system (AARP 2006).

In Australia, 28 per cent of men and 46 per cent of women aged over 65 years will at some time in the future be admitted to residential care. The majority are admitted aged over 80 years (Myer Foundation 2002). Given the current trends, the Productivity Commission predicts the 'oldest old' will increase from 1.4 per cent of the population in 2001–02 to 8 per cent by 2044–45 and nearly 14 per cent by 2100–01. In raw numbers, this would represent an increase in the number of the oldest old from 277,000 to 2.1 million by 2044–45and 3.7 million by 2100–01.

Capabilities and social inclusion

> An equal society protects and promotes equal real freedom and substantive opportunity to live in the ways people value and would choose, so that everyone can flourish. An equal society recognizes people's different needs, situations and goals and removes the barriers that limit what people can do and be.(UK Government 2007)

What do Australians living their second fifty years want to do and be? Here is the fundamental question to be answered by the Productivity Commission as it conducts the current inquiry into caring for older Australians. The Australian Government, through its social inclusion agenda, seeks to reduce disadvantage, increase social, civic and economic participation and develop a greater voice and greater responsibility. This inquiry provides a platform for promoting these forms of inclusion for all older Australians, and particularly those for whom aged care services are essential.

At a time when the rights of older people in Australia are often undermined by social stereotypes that equate ageing with deficit and by well-intentioned social and care services that, in a risk-averse environment, often curtail independence and choice, a stepping off point for this submission is a vision of aged care in which government sees its role as investing in those capabilities that older Australians need to develop or maintain for full inclusion in Australian society.

The capabilities approach to understanding and increasing social inclusion is growing both in Australia and internationally. Its particular value is that it is 'multidimensional, dynamic, relative, recognises agency and is relational' (Scutella et al.2009) and goes beyond orthodox economic indicators of poverty and disadvantage which concentrate primarily on income, arguing rather that there are many dimensions which interact to cause deprivation—particularly the dimensions of material resources, employment, education and skills, health and disability, social, community connectedness and personal safety (Smyth 2010).

Ageing in Australia is too often equated with illness and disability rather than with living a fulfilling life and being of value to society. Ageing is not in itself a disability or an illness, although for some, disability or illness may accompany ageing. Ageing in Australia has largely been pathologised, and related policies and funding are concerned much more with care and management of illness and disability than with promoting rights, independence and a valued place for older people in society. Yet for the majority of older adults, the bulk of spending on the care required for age-related health and disability is made in the two years immediately preceding death. As the Commission itself reports, around half of Australians aged 70 years and over report need assistance with personal and everyday activities, compared with 85 per cent aged over 85 years.

According to Stephen Judd, speaking at the HammondCare 8th Biennial International Conference on Dementia in June 2010:

> The rights of our older citizens are being eroded [and] the aged-care industry and government regulators are deliberately or carelessly conspiring to erode those rights of citizenship.

Aversion to risk insinuates itself not only into care programs and relationships between professional carers and their clients but also into the choices that older people are encouraged to make. Social activities such as going to the movies or a trip to the mountains, or participation in adult education, if organised by aged care providers, are subject to a myriad restrictions to comply with the care system. Yet other adults of the same age and level of health are free to engage in whatever activity or take any risk that they choose. It appears that care staff tend to take on the responsibility *in loco parentis*, like staff in schools and kindergartens. This undermines people's capabilities, threatens their dignity and subverts their human rights and responsibilities. Infantilisation reaches its apotheosis in residential aged care facilities where not only are capabilities overlooked but adult rights are undermined by ceding of decision making and control to those in command.

Recommendation

- Uncouple the nexus between ageing on the one hand and disability and health on the other so that expectations about ageing are positive and lively. Care can then be focused on a disability or illness, as it is throughout the rest of the life course, rather than taking a different tack at a specified chronological age.
- Identify what constitutes a 'good life' for older adults in Australia—what they value, what they are capable of and how they want to live their lives.
- Develop government policies and programs to improve capabilities and maximise individual choice.
- Restore human rights and dignity through:
    - changing language use, using the term 'older adults' in all references to people in their second fifty years of life
    - distinguishing between 'right to risk' and 'responsibility for risk' to determine where each properly lies—with the individual or the care provider
    - fully informing older adults of rights, responsibilities and risks
    - supporting older adults to take 'risks' of their own choosing
    - training all aged care personnel in the theory and practice of supported decision making.

Areas addressed

This submission addresses the following matters:

- housing and care
- funding
- assessment
- regulatory compliance – residential care
- carers and respite care
- choice and continuum of care
- social inclusion

Community voices

An important component of preparing this submission was collecting the views of Brotherhood aged care clients. To this end two forums were organised on 7 and 8 July and attended by more than forty people receiving aged care services and/or caring for those receiving services. The World Café approach enabled all participants to engage with all topics: future needs of carers; regulatory compliance; staying active and healthy in later life; information communication technology; future housing needs; eligibility, assessment, access; and social inclusion. This submission draws on their input.

2 Breaking the nexus between housing and care

There has been a strong focus in the aged care system on caring for older Australians through the delivery of services through three separate programs, HACC, Community Care and Residential Care, each funded through separate approval processes. Government subsidised aged care services provided in the community and in residential facilities are determined by an older person's eligibility either to receive assistance at home or to reside in a facility according to their family's ability to meet the needs of the older person. However, policy that focuses only on these care options neglects the importance of housing in enhancing the wellbeing of older Australians.

It has been recognised that the majority of older Australians wish to remain in their own homes as they age and this has led to the government's increasing provision of Community Aged Care Packages of support to enable this. If the system provided a pathway to disaggregate the funding for care and accommodation, it would allow more flexible choices for older people in how they wish to be supported through care services and where they would like to live while receiving this support.

Aged care providers and the retirement villages industry have recognised the opportunity and need to provide service-integrated housing which enables provision of support and care in housing built for older people. This constitutes a different choice which sits between community care and residential care. The opportunity for different models of service-integrated housing needs to be explored. Jones and colleagues (2008; 2010) have provided an overview of some models and suggest that these have developed in spite of aged care regulations. These models allow for the possible disaggregation of funding mentioned above and the disentanglement of Residential Aged Care Regulation in the provision of accommodation for older people which happens to have care and supports provided. The separation of care and accommodation will also provide for other innovative affordable housing models for older people such as homes for life, cooperatives that are self-organised and self-controlled, housing clusters, intentional communities, housing that is well connected with the wider community, housing for older people built as part of an integrated community or mixed with open-generational communities. To date, the housing needs of lower income or disadvantaged people have most often been addressed through public housing or community organisations. Australia already has an extensive service-integrated housing sector, but its contribution towards meeting the accommodation and care needs of older Australians has received little policy recognition.

Retirement villages cover a range of accommodation, from independent living to assisted living and with widely varying costs of entry and ongoing charges. These costs form a barrier to low income/disadvantaged older people gaining access to retirement village living. As participants in our recent forums said:

> 'Retirement villages are only for the well off.'
>
> 'There could be a government subsidy for those that cannot afford it.'
>
> 'We need an affordable option of retirement village living.'

However not all of the clients saw retirement villages as meeting their desires or needs.

> 'It's an individual matter.'
>
> 'I'd rather be in my own place'

(BSL forum 2010)

It is noted that the Productivity Commission has focused its questions on retirement villages and regulatory requirements, but we suggest that other housing options would gain favour if they were available. Often retirement villages encourage a sense that all of a retiree's social, support and health needs are met within the village, creating a reduction in the person's engagement with the wider community and, even if inadvertently, tending to institutionalise the residents. Appropriate housing in the community should be a key focus of government policy rather than increasing housing developments such as retirement villages.

> 'We need more information to be available about all housing options such as shared housing, retirement villages, apartments and cluster housing.'
>
> 'Could there be swapping of houses with financial assistance?'
>
> 'Could there be financial incentives if we wish to downsize—that would keep us out of resi care— that would be important.'
>
> 'I want a place where you can have animals and a garden.'
>
> 'Apartments would be good as long as they don't feel like an institution. If it felt and looked like community it would be good.'

(BSL forum 2010)

A recent survey (July 2910) conducted by Galaxy Research for the Benevolent Society indicates that many Australians are concerned about the need to create more affordable housing for older people. After describing 'Apartments for Life' as offering older residents age-friendly design, access to services, shops and transport and ongoing connection with familiar community, with the goal of maintaining control over their own life and staying in the same apartment for the rest of their lives, 92 per cent of those surveyed supported the model. These findings indicate that, given the opportunity to consider new accommodation options, Australians of all ages, and in particular older people, are open to different housing models especially if they also address the benefits of maintaining independence, having easy access to health care services, proximity to family and friends and staying within their neighbourhood.

Recommendations

- That government recognise the need for the separation of accommodation and care to enable flexible options and choice for older people in respect to where they live and the care services available to them. This would include the choice for different combinations of services as required, such as living in one's home but being able to access short-term residential care at times of higher need or crisis, with the option to return to one's home.

- That there be more recognition and exploration of suitable housing types for older people and that funding be made available to assist in the provision of this housing.

- That financial assistance options for older people be considered– 'a type of first owner grant for purpose built homes if an older person needs to change homes' and 'that there be no stamp duty.' (client at BSL forum)

- Equity release opportunities for older people, controlled by protective legislation, should also be considered. This would enable older people to use their equity in their home to provide for their needs.

- That the needs of disadvantaged older people be taken into account and options be developed for affordable housing addressing the specific needs of older people.

Design

Most houses in Australia do not cater for the whole of life course, due to changing needs as people age. The decisions made now about housing design for later life will have a profound effect on Australians' ability to live independently at home as they grow older.

In the UK, the government published its 2008 report, *Lifetime homes, lifetime neighbourhoods: a national strategy for housing in an ageing society*, recognising the implications of an ageing population for the future design of age-friendly homes and communities (Department of Communities and Local Government 2008). It was a major shift that put housing in the frontline in supporting both older people's aspirations and preventative care, and placing the needs of older people at the heart of policy making.

Subsequently the Homes and Communities Agency and Local Government, in partnership with the Department of Health (UK), set up the Housing our Ageing Population Panel for Innovation (HAPPI) to gather evidence of innovative practice from across Europe and to put together new and creative proposals for housing for older people. The panel's brief was to:

- improve the quality of life of the ageing population by influencing the availability and choice of high quality, sustainable homes and neighbourhoods
- challenge the perceptions of mainstream and specialised housing for older people, for existing and future generations
- raise the aspirations of older people to demand higher quality, more sustainable homes
- spread awareness of the possibilities offered through innovative design of housing and neighbourhoods (Housing and Communities Agency 2009).

We know that most of the housing available even in purpose-built environments cannot meet the needs of frail older people or those with mobility problems. Even retirement villages which provide 'ageing in place' do not cater for a person to remain in the one home, but provide hostel and/or residential aged care facilities on their estates to which a person will move as their health and mobility needs increase and become complex.

For those older people living in housing that does not cater for their needs, government assistance with home adaptation would be helpful. This could be achieved through one-off grants for renovations/modifications.

As participants at the BSL forum (July 2010) pointed out, public housing which is built for those with a disability does not meet the requirements for those with a disability who are ageing.

> 'The front door is smaller by 200mm than it should be and I have to fold my wheelchair to get through.'
>
> 'I would knock a wall down and have open living so that I can get around more easily.'

Recently BSL was involved in advocacy for a client who has complex health and mobility issues which are deteriorating quite rapidly. She lives in public housing and receives a CACP and requires home modifications which are being refused by the government department responsible. It was revealed through discussion that in fact it is the housing department which is making decisions on what will be provided/altered, without reference to the disability arm of the same department. This bureaucracy and lack of integrated assistance means the person is being denied appropriate accommodation and support for a fulfilled life.

Also considered unsuitable for older people were other public housing types such as 'the very high rise apartment blocks which provide for the basics only'.

It is part of the Australian culture to enjoy outdoor living so useable outdoor space for enjoyment and gardening remains a feature for wellbeing. However, the space needs to be accessible to those who are frail or have mobility problems.

Environmentally sustainable design needs to be a feature of housing for older people, to address their needs for temperature control and minimise the rising costs of water and energy due to climate change. Solutions can include the installation of water tanks, north-facing windows, insulation and natural ventilation, as well as clever technological design and materials use.

Recommendations

- That the Australian Government consider a similar approach to the UK in developing a strategic approach to housing in an ageing society, which provides standards that are more suitable for ageing in place and require building to universal design specifications and incorporating environmentally sustainable features, together with the flexibility for future major modifications at minimum cost.
- It is noted that the Parliamentary Secretary for Disabilities announced on 13 July 2010 that leaders of the housing industry, the disability sector and community have agreed to an aspirational target that all new homes be built to disability-friendly liveable housing design standards by 2020. At this stage, however, this is a voluntary set of guidelines. It is recommended that the government take a stronger policy lead in this area.
- That a panel similar to HAPPI be established to investigate all innovative options for housing for older people.
- That public housing stock be adapted to the needs of the growing numbers of older Australians who live in it, to preclude any necessity for them to be rehoused elsewhere.
- That environmental sustainability and rising costs of utilities be considered in housing design policy.

Neighbourhoods

It is important not only to consider types of housing and their design but also to consider the neighbourhood environment. Housing for the older person needs to have shops and services within walking distance or easily accessed by public transport close by. Neighbourhoods need to be age-friendly with paving, street lighting, public toilets, benches and open spaces, in order for the older person to participate in community life and to feel safe. Although some local governments are attempting to address these issues, there are no national guidelines to ensure that this is a requirement now and into the future.

Recommendation

- That a national set of age-friendly guidelines for cities and neighbourhoods be adopted which reflect the World Health Organization's *Global age friendly cities: a guide* (WHO 2007).

3 Funding

National funding of long-term care

Currently Australia is facing escalating costs in the provision of long-term care; however we have no universal scheme to defray these costs. Overseas policy and practice demonstrate how some of the costs of long-term care can be funded through compulsory social insurance schemes. Such aged or chronic care insurance is additional to health insurance and provides care rather than cure. Such schemes are policy in Japan, Germany and the Netherlands. For its part, the UK is reconsidering the future sustainability of its long-term care system. The UK Department of Health has just released a green paper *Shaping the future of care together* (July 2009) which proposes examination of three options:

- a partnership model under which individuals are left to meet their care liability themselves after provision of a basic entitlement
- an insurance model under which people would be invited to enrol in a state-backed insurance scheme—either run by the state or private insurers— and then get all of their care costs covered
- a comprehensive model under which all people over 65 would be compulsorily enrolled in a state insurance scheme (Brody 2009).

In this context, the UK Commission on Funding Care and Support has commenced examining the sustainability of the UK long-term care system (see <www.carecommission.dh.gov.uk>).

Social insurance schemes in other countries are funded through a compulsory payroll tax, some with a co-payment from employers and with government paying the contributions for people on low incomes or benefits.

The Netherlands has had in place since 1968 a system of long-term care which covers all chronic care needs (domestic assistance is excluded as this is provided through local municipalities under a different scheme). The current scheme, AWBZ, is funded from 70 per cent social security contributions, 22 per cent taxation and 8 per cent user charges. The AWBZ premium is 12.15 per cent of income in the first two income brackets, capped at 32,000 Euros (Mot 2010).

In Japan, all employees aged 40 or over are required to pay a contribution for long-term care insurance (1.2%). Overall, salaried workers over 40 years of age have 11.5% (half of a total of 23%) of their monthly pay cheques withheld for various kinds of insurance, in addition to taxes (Tatara & Okamoto 2009).

Germany's statutory long-term insurance, Pflegeversicherung, is financed through contributions scaled according to income with a contribution gap of 3,675 Euros. The contribution rate is 1.95% of income with an employer's contribution of 0.975% being half the rate, (German Government 2009).

Historically Australia has never had a social insurance scheme. In relation to health insurance, Australia has the Medicare scheme, where a levy of 1.5–2 per cent collected through the tax system provides Australians with universal entitlement to a standard level of health care. In the area of provision for retirement, the Superannuation Guarantee has been introduced, in which an employer contribution of 9 per cent of wages (currently in 2010) is paid into a superannuation fund of employee choice to boost retirement incomes. Presently on the table, and being strongly promoted by people with disabilities, is the National Disabilities Insurance Scheme which involves funding 'by all tax payers through general revenue collection or an extension of the Medicare levy' in order to provide a no fault insurance scheme for everyone who has, or who acquires, a disability (NDIS 2009). An entitlement scheme built on or included in one of these models would provide all citizens with a standard level of care in later life should they need it. If the Superannuation Guarantee model were selected, accrued funds could be managed in a manner similar to compulsory superannuation funds, with returns from investments accumulating in the fund to the benefit of fund holders.

BSL forum participants were in general agreement that a universal contributory scheme would improve the sustainability of the aged care system. Comments included

> 'We could introduce something like a social insurance scheme: $5 per fortnight—like Medicare levy.'
>
> 'A social insurance scheme is OK, I would pay a percentage of my pension to get cover.'
>
> 'When I was a young man, I worked three jobs and I would have paid a social insurance scheme.'
>
> 'My children are 38–45 yrs. They may need insurance imposed.'

Recommendation

- Investigate the establishment of a universal contributory care scheme to provide Australians with entitlement to a standard level of long-term care.

Allocation and management of community care funds

Current in the UK, the US and some European countries, and now attracting considerable attention in Australia, are individualised funding programs. Variously known as self-directed care, consumer-directed care (Australia), self-managed funding, cash for care (US), direct payments and individual budgets (UK) and direct payments, they constitute variations of a funding model designed to increased consumers' choice and control of the aged care services to which they are entitled. Essentially they can be divided into three categories:

- Individual's funds held by the consumer to employ support workers from all sources including informal networks (family, friends and neighbours)
- Individual's funds held by the consumer to recruit and manage support workers from the open market, but not from family
- Individual's funds held by service provider (Ungerson & Yeandle 2007).

Laragy and Naughtin (2007) point out that while Australian consumer-directed care projects have been categorised similarly, there have been two notable differences:

> First, they do not actively encourage recruitment of family members, although some do allow it. Second, when the consumer holds the funds, some projects require that support workers be engaged from approved service providers and not recruited from the open labour market. (Laragy & Naughtin 2009)

Since 2009, the Brotherhood of St Laurence, together with UnitingCare Community Options, has been an industry partner in People at Centre Stage (PACS) an Australian Research Council Linkage project at Deakin University which involves a trial of consumer-directed care.

In response to the challenges of providing appropriate care to the increasing numbers of older people in Australia and ongoing criticism that the current aged care system lacks flexibility and quality, the project team is designing, piloting and evaluating a seamless, flexible service model for community-based aged care that increases the choice and control older people and their carers have over the services they receive:

> The PACS model is an 'assisted independence' model. That is, it acknowledges the fact that all people require assistance to make good decisions and that people value, and often need, assistance to maintain independence and autonomy when faced with disabilities associated with old age. The PACS model recognises that traditional services can reduce older people's decision making capacity and choice and thus includes support services that seek to restore or maintain the cognitive, physical, and social capabilities of a person. (PACS 2009)

More recently (April 2010), the Department of Health and Ageing announced implementation of a small number of Consumer directed Care Packages both in community and respite care, suggesting that the Department is itself testing the concept in funded services, which may lead to an increased allocation for consumer-directed care in the future.

Recommendations

- Continue to explore consumer-directed care as an alternative model for carers who want to take up this option

Access to information

With the introduction of a universal care scheme and new funding models, there would need to be increased public knowledge and understanding of entitlements and procedures. If people have an enhanced role in managing their own care and are contributing to it financially, they are more likely to seek information. Prior to commencement, and as the system is introduced, it would be expected that a substantial, long-term public education campaign would run providing information on the benefits and entitlements of the scheme with ongoing information provided by clearly designated organisations at the local level.

Recommendation

- Provide a significant publicly funded media campaign to promote the benefits of a universal aged care scheme and citizen entitlements.

4 Assessment

In overseas models, with people's entitlement to care assured through long-term insurance, assessment for services is based solely on need and eliminates any need for separation between community and residential care. Broadly, need is related to level of disability, level of informal support available and people's income. All overseas examples require people to be professionally assessed to determine level of need.

In Holland, assessment services sit outside the insurance agencies and receive no financial incentives based on the outcomes of assessments. Assessments are a four-step process based on presence of disease / disorder limitations / participation problems: looking at other ways to address care; looking at how care could be delivered; needs such as usual care, restorative treatments and or environmental adjustments/equipment; and finally, whether care is to be delivered in home or in an institution (Mot 2010).

In Japan, to be eligible for the benefit the individual must apply to the municipal government for needs assessment. Assessments are performed by case managers using an assessment tool which consists of 73 items that predict the individual care need with certain accuracy. The tool is fully computerised and is used nationwide. GPs play an integral role in determining eligibility (Tatara & Okamoto 2009).

In Germany, people are eligible for care if they require frequent or substantial help with normal day-to-day activities on a long-term basis (that is, for an estimated six months or longer). There are three levels of need: considerable, severe and extreme. Assessment is made by care advisers who may be employed by the insurance company or through an external agency (German Government 2009).

Assessment for Australia's aged care system is currently carried out through aged care assessment teams or services (ACAT/S). ACAT/S is the second part of a double gate keeping system—the first gate keeper is the fixed allocation of aged care services per 1000 of the older population. The ACAT/S role is to assess both eligibility for aged care services and the person's level of care needs.

With a universal long-term care scheme, where people have built an entitlement, the need to assess eligibility is removed, leaving level of care as the only necessary assessment. With case management and care coordination already embedded in Australia's aged care system, assessment of care needs already occurs at the service provider level in relation to specific care requirements.

With a standardised assessment tool across all of aged care, such as the current Aged Care Funding Instrument (ACFI), older people could have their level of care need assessed at point of entry with the service provider of their choice, community or residential. An outcome-based assessment would then be lodged with the insurer for payment. A comprehensive record of past and present care options would be held by older people themselves .The older person might or might not have an ongoing relationship with the agency, depending on their care choices and whether their needs change over time. Key to the sustainability of the aged care system into the future is regular reassessment with a focus on ensuring improved living outcomes for people. The current system rewards providers as people become more dependent, rather than rewarding older people and providers for providing restorative services to older people with appropriate capacity.

BSL forum participants believe that assessment is necessary to ensure sustainability of a long-term universal care scheme into the future:

'A just, equitable and fair system—individual-based needs assessment.'

'Assessment—must remain as we don't have a bottomless pit of dollars. [It should focus on] illness-based needs.'

'Need an independent assessor.'

'Assessor needs to have authority to override insurance to some degree.'

Recommendation

- Develop a care needs assessment tool to cover both residential and community care that matches assessed needs with costs of care, and promotes and rewards restorative gains in older people's functioning.

Interface between aged care and health care sectors

ACAT/S is a specialised, limited and costly resource and would be better used at the critical interface between aged care and the health care system—a source of frustration for both sectors for a considerable time. This has led to poor client outcomes through mishandled discharges and admissions in both sectors, often resulting in premature readmission to the acute health system or residential care sector. A seamless transition between health care and aged care has long been the goal of both sectors. We should capitalise on ACAT/S expertise in both sectors, including restorative sub acute.

Recommendation

- ACAT/S should specialise in the interface between the aged care sector and health sector to ensure the seamless transition of older people in and out of both systems.

5 Regulatory compliance – residential care

The residential care sector has under gone significant and much needed change since the introduction of the *Aged Care Act 1997*. The accreditation/certification process was introduced by Minister Bishop with the intention to drive up standards of care and support quality service providers while identifying those providers that would be best assisted out of the industry. Residents, carers and staff were to benefit through the Complaints Investigation Scheme, an impartial body that was to act on reports of substandard care.

While this was the intention, the on the ground experience has been that an ever-increasing regulatory and corporate governance compliance burden with its punitive approach to policing can actually compromise rather than enhance quality care provision. Four standards, with forty four outcomes, come at a cost; and that cost is the diminishing amount of time that staff have to spend with older people.

Current level and scope of regulation and enforcement

As the processes for accreditation/certification have grown, there have been some benefits for resident outcomes such as training of staff, both in-house and externally, improved food quality and nutrition, and the expanded residents' activities programs.

At the same time, however, the role of the accreditation agency has become subjective and process-driven, rather than focused on good quality outcomes for residents. The emphasis is on compliance

and, while service providers with multiple facilities have the resources across the group to ensure the correct implementation of quality systems, there is no flexibility within the system to respond to the circumstances of smaller providers which, as standalone facilities, have to manage with in-house resources only. This has a direct effect on staff morale, and many good aged care staff leave the industry, taking their local intellectual property with them. This undermines retention of quality, trained staff in residential care which, in a vicious circle, then becomes an issue for compliance. We believe that the government agencies have fragmented the regulation framework with too much intervention. As a result, the residential care industry is now required to deal with the Complaints Investigation Scheme, Accreditation Agency, DOHA, certification, state laws and local laws, all of which contribute to system complexity that only distracts from real care needs.

Impacts of compliance on residents, staff and service providers

There has been a dramatic shift in the way residents experience residential care, as staff spend more time on process compliance rather than on person-centred care. In our experience, this results in staff with experience, drive, and compassion deserting the industry due to the impost of regulation and the associated anxiety and sense of intimidation and stress caused by getting their daily work done while feeling under the constant surveillance of compliance assessors. One extreme consequence is increased work cover claims attributed to burnout or depression. This has a direct impact on residents' continuity of care, as stability of staffing is paramount to the success of the facility.

As is well documented, workers in the health and aged care industry are ageing as fast as the older people they support. With the impending work force shortage in aged care and other skilled areas, we have to ask, why would people stay in this industry when there is such a culture of risk aversion imposed by funders that aged care workers are strained under the burden of compliance. Obviously there must be accountability, and vulnerable people must be protected from exploitations and abuse, but the quality of their daily care must not be lessened.

The current standards and compliance requirements have done their initial job. The residential care industry is much improved and, overall, good quality providers remain. What is now needed is a transparent, common-sense, client outcome approach to regulation and compliance for this essential component of the aged care system.

BSL forum participants complained that the burden of compliance in residential care diminished the quality of care of the older people themselves:

> 'Accreditation how does it work? We don't think residents benefit.'
>
> 'Residents need the attention of the staff, not for staff to be buried in notes.'
>
> 'Administration is too much of a burden on aged care services.'

Gate keeping

Older adults wishing to gain access to health services within the aged care sector often find the regulatory arrangements difficult to understand. People are often met with misinformation, out-of-date information, social workers 'cherry picking' residents for particular facilities and not enough social workers understanding the complexities of aged care. So much time wasted in trying to understand the process often leads to high levels of frustration among older people and relatives as they go through the maze of attempting to find suitable accommodation.

BSL forum participants were well aware and very concerned that:

> 'There is conflicting information between ACAS teams and social workers.'
>
> 'There is misinformation about the private/public sectors.'
>
> 'The process for assessment is too long and complicated.'

A needs-driven entitlement through a long-term universal care scheme would improve care outcomes. Residents would be able to source care efficiently and the industry would be driven to become a more marketable sector. We believe that care assessment would be best provided by care providers, which would further streamline older people's access to care. The assessment could be performed using a standardised, industry-tested tool across community and residential care and used to develop a care plan so staff can provide person-centred care and review it as required. Too much time is wasted on documentation and unnecessary assessments so that funding can be justified.

BSL forum participants supported change to the residential care sector into the future

> 'There needs to be a 10–20 year program to allow for change and upcoming generations.'

Flexibility of regulations on funding streams, are they flexible enough?

Under current funding arrangements, the residential care system has skilled, clinical staff and management tied up with complicated, lengthy and unnecessary documentation in order to justify the quantum of care given. Hours are wasted at nurses' stations describing what happened during the day. This must be validated by DOHA but then is often clawed back to justify a validation audit.

One BSL forum participant commented:

> 'The human element of contact is missing.'

We believe that bonds for entry to high care are now a necessity to ensure facilities reaching the end of their attractiveness to residents (and thereby their commercial reality) are able to make renovations to meet the new requirements of building codes and compliance issues as well as resident preferences regarding their built environment. This promotes flexibility when funding the accommodation aspects of residential care.

The supplements that are provided for various care needs are often overlooked because clients, service providers, social workers and doctors have limited knowledge of their existence or purpose.

Recommendations

- A single national regulatory scheme. Currently the aged care regulatory environment is replete with self-contradiction and conflict between legislation at the three levels of government affecting planning, design and construction
- Clear and accessible national goals and targets for quality in residential aged care and funding adequate to sustain a continuous improvement program
- Accreditation standards that provide sufficient flexibility for review and adaptation to changing circumstances such as staffing vacancies, including well-planned short-term alternative solutions

- Standards that demonstrate outcomes for clients rather than rigid adherence to process
- Standards that reflect stakeholder views about safety and quality in residential aged care, and realistic benchmarks
- Review of QA documentation to enable gathering of multiple information items from a single record
- An appropriate balance between compliance and continuous improvement fostered by a regulatory framework. Current documentation requirements are too onerous for smaller providers without specialist administration staff.
- Standards and accreditation processes that foster innovation and encourage higher quality performance (as opposed to setting a lowest common denominator)
- Requirement for all residential aged care accreditation assessors to have mandatory current aged care industry knowledge and experience and understand the complexities of aged care
- Encouraging assessors to mentor facilities managers to improve their quality processes, meet standards and achieve client-preferred outcomes
- Appropriate processes for managing public risk arising as a consequence of accreditation processes and sanctions. These need to be structured to drive compliance and improvement, and vigorously combat non-compliance. However, currently sanctions are often issued without adequate consultation and understanding of what is happening within the service, which undermines effective planning and drives managers from the industry.
- Exploring options for relaxing supply constraints in the provision of aged care beds to include a wider range of housing options such as individual homes, cluster housing and co-housing that meet universal design standards
- Production and dissemination of more accessible and comprehensive information available at the touch points of daily life to help older and frail Australians make better informed decisions and compare different options for service.

6 Carers and respite care

The strain of caring for somebody who is elderly or has a disability has been well documented. Most primary carers cited family responsibilities as the reason for taking on the caring role; other common reasons given by the carers were ‘could provide better care’ and ‘emotional obligation’. A similar proportion of partner and parent carers said that they could offer the best possible care for their family member, yet the negative consequences of a primary caring role reported by carers in 1998 include reduced hours of paid employment and resignation for positions of employment, lower overall life satisfaction and a reduced feeling of wellbeing, and increased feelings of fatigue and depression. This is supported by Brodaty (2005) who also states that caring for somebody with dementia is often more stressful and demanding than caring for somebody who is physically impaired. The opportunity to remain at home for as long as possible reflects the wishes of most people and is consistent with the policy of community care. However to sustain people in the community, increased attention to the specific needs of family carers is required.

Access to information and support

A major barrier to integrating services for carers is the number of separate service models currently in place. In the report *Effective Caring: a synthesis of the international evidence on carer needs*

and interventions (Eagar et al. 2007), it is stated that case management models appear promising and would not necessarily be an expensive way to overcome the complexity of the system. There are different levels of case management support and various models of care coordination and navigation operating in the carer support sector; however feedback from carers (BSL forum 2010) indicated that carers still were not clear on how the service system was set up to assist them in their caring role.

There is evidence that consistent delivery of interventions by a single service provider is more effective than delivery by several providers. For many carers and care recipients, the general practitioner is the first port of call when support is needed. It was evident from the carers' feedback at BSL forums (July 2010) that access to good information was imperative, especially at time of diagnoses (this was in reference to carers of people with dementia):

> 'I noticed my husband was changing and it wasn't until I insisted for further tests that he was diagnosed with dementia and then I was left on my own to deal with it.'
>
> 'The GPs should have a suite of information for carers once a person is diagnosed with dementia. I had to learn things the hard way. I never knew that there was an 1800 number for carers.'
>
> 'It took years for GPs to acknowledge what help I needed (to care for my husband). They're too busy, they don't know, they don't tell you or help you to find out. They need more community nurses to keep them educated. Carers don't know enough either.
>
> 'Carers need to have access to information when they need it.'
>
> 'Carers need training in becoming a carer. We need to know what we are going to be faced with.'
>
> 'Caring is a 24/7 job. It is tiring, stressful and I know I cannot do it alone.'

Dröes (2004) stated that there were several reasons to recommend an integrated comprehensive support program above regular day care. In order to develop a successful program, cooperation between all primary health care workers is required. It has been our experience at the Brotherhood of St Laurence that an integrated approach provides carers with the additional support they require to continue in their caring role. As a provider of respite care, we are aware that we cannot support the person with dementia without supporting the carer at the same time. At times the assistance offered has been carer support, counselling and short-term case management such as referring carers to other providers.

The government's discussion of the implementation of the hospital and health reforms does not directly address any changes to or implications for respite services or carer support. However, there are indications that the reforms will encourage smoother transition across health and community programs for older people, for example between hospitals, convalescent care, transitional care, residential care. This suggests that there is a potential for multiple services to be provided through single programs to ease transitions. A service model that incorporates carer support with other primary health service types may need to be considered by the Commonwealth Government.

Recommendations

- Public carers' campaign to inform about opportunities and services which are available to carers (short-term strategy)

- Better interface between health providers, carer support and respite providers to ensure better outcomes for carers as well as for the care recipient (long-term strategy)
- Having a range of services in a single location, funded through a variety of sources enables additional flexibility and economy (Refer also to Respite Services in this report)

Funding models

One of the recommendations in the report from the inquiry into better support for carers (HRSCFCHY 2009) was that the Minister undertake pilot studies to test the potential for the Australian Government's funding for carer respite and in-home assistance to be re-allocated directly to carers through 'individualised funding programs' also known as 'consumer-directed care' and 'self-managed funding' as outlined above. As one client said at the BSL forum:

> 'Managing my own respite funds would give me total control; however I do not think that this funding model is appropriate for all carers.'

Eagar et al. ((2007) reported strong interest from carer representatives in exploring alternative funding and delivery arrangements such as consumer-directed care. In April 2010, the Department of Health and Ageing announced the implementation of a small number of Consumer Directed Care Packages, for respite as well as for community care and, if successful, this may lead to significant funds being directed to carers in the future.

The National Respite for Carers Program (NRCP) funded by the Commonwealth Government funds service providers and Commonwealth Respite and Carelink Centres to deliver a range of respite options and carer support services to different target groups, including people with disabilities. The NRCP also funds professional counselling through the National Carer Counselling Program delivered through Carers Australia. The Victorian Government also provides respite funds through Home and Community Care (HACC) and Disability Services. The fact that there are several funding sources within different departments and levels of government only reinforces the need for a more coordinated, systematic approach for carer support.

Recommendations

- Have one government department responsible for funding carer support services and respite

Respite services

Respite care is integral to the provision of community care. It is especially important for carers of people with dementia, a condition whose incidence is increasing and rises rapidly with age. In Australia, it is suggested that the number of people with dementia under the age of 65 will rise from about 9990 in 2005 to 14,220 in 2020 (National Framework for Action on Dementia 2006). At the same time, there is the expectation that people with dementia will be cared for by their families and will remain living in the community for as long as possible.

In the report *Effective caring* it was recommended that the research agenda must include the capacity to identify the current and future unmet and under-met needs of carers (Eagar et al. 2007). On all the available evidence, the number of Australian carers will increase, as will the competing demands on them. Yet respite care sometimes falls well short of relieving carers' stress:

> 'My husband came home from respite in a terrible state. He was dirty, half his clothes were missing and I know that they did not provide the appropriate care. I will never send him to respite again.'

As a provider of respite services to carers of people with dementia, the Brotherhood of St Laurence has identified the need to provide overnight respite care to people with high care needs (this may be related not only to complex care needs but also to the symptoms of dementia). Most carers are committed to providing care over an extended period, but in most cases institutionalisation is inevitable when a carer's capacity and/or motivation to care are exhausted. Respite care—giving carers time off from caring—has been shown to be an effective way of reducing the stress of caring. One of the interventions most helpful to carers is the provision of day care. Eagar et al. (2007) state that the needs of dementia carers are for increased day care and respite, help with practical information and behaviour management particularly of negative traits such as stubbornness, uncooperative behaviour and apathy. Carers, particularly younger ones, expressed a need to have regular time for themselves and for contact with their peers, away from their caring responsibilities:

> 'When my husband goes to Banksia (overnight respite) I catch up on my sleep.'

> 'Knowing that I can have a three day break once a month is invigorating.'

It was clearly evident from the carers feedback (July 2010) that carers were dissatisfied with limited options available for people with high care needs. Some carers living on the Mornington Peninsula reported that there was no access to emergency residential respite for people with high care needs:

> 'I was recently told by my care manager that there were no services in the Peninsula where my wife could go because her needs were too high.'

Although in 2007 under the $1.7 billion Securing the Future of Aged Care for Australians package the Australian Government committed $26.5 million to NRCP to fund an extra 100,000 days of community-based respite for the carers of frail older Australians with high care needs, there has been no additional funding since. Currently in the Southern Region of Melbourne only two providers are funded to provide high care; and no funding was allocated to overnight respite for people with high care needs. As the research states, carers need regular breaks from caring. Residential respite provides carers with a two-week break every couple of months; however this should not be the only option for carers.

Community overnight respite enables carers to have regular short breaks, so they can recharge their batteries (and then resume their caring role) or plan events at short notice. The additional benefit to this respite option is that it forms part of the continuum of care. This is critical for carers of people with dementia as well as for the person with dementia.

Recommendations

- Increase respite options for carers of people with high care needs, especially in the area of overnight respite. It is important to consider the interface of respite services with funded services such as post-acute care, convalescence care, transitional care and palliative care—and to make services available to purchase either privately or through consumer -directed care packages.
- Continue to focus on the provision of respite so that carers can remain in the workforce
- Develop a specialist workforce to meet the needs of people with high care needs

7 Choice and the continuum of care

We believe that aged care should provide a full range of care choices based on people's needs and capabilities. While the need for a form of care combining accommodation with care, especially towards the end of life, may remain for some older people, what is evident is a desire by older people to remain in their own homes and communities as they age, with an adequate mix of care to meet their changing needs over time.

What is currently on offer is inflexible and broadly limited to residential care on one hand, and on the other community care services through local authorities and/or packaged care, flexible care and carer support services. One of the difficulties with these broad groupings is that support provided is *either* residential care *or* community care, and there is an assumption that, once in residential care, people cannot move back into community care. But residential care need not be seen as the end of road. People may need residential support for a variety of reasons at different times throughout their life, and being able to move in and out of residential care could contribute to people remaining in the community in the longer term.

The unbundling of accommodation and care could go some way to achieve a seamless transition in and out of different types of aged care. In Germany and Holland, for example, the accommodation costs, food and board, of residential care are borne by the older person, while their care needs are met through a universal long-term care scheme.

Care models both overseas and in Australia demonstrate many flexible options in aged and disability care, from consumer-directed care with the provision of cash to purchase services as people see fit such as in the UK and France, to personal budgets such as in Holland and in the Australian disability sector, These models of care may be provided with or without case management and coordination support, through approved providers in residential and community care as seen in the UK, Germany and Australia. As mentioned previously the Australian Government has recently released a small number of consumer-directed care packages for older people and their carers. The key to a robust, sustainable aged care system is to offer a range of choices to enable people to make their own decisions on how to best meet their needs, rather than provide a predetermined quantum of funding, into which the care must be fitted. The older person's level of decision making should be equal to the level of responsibility they take for those decisions. Why is it assumed that when a person ages they can no longer be responsible for their destiny, despite having successfully managed their own long life so far?

BSL forum participants supported greater choice in relation to how needs are met:

> 'I like the idea of cash-out of services. Assessment should be level of need, not level of service.'
>
> 'Offer a full suite of options.'

Recommendation

- Provide a full range of options to meet older people's needs that matches their capacity and willingness to take responsibility for their care choices. The care continuum should include restorative health care, accommodation and long-term care. Include minimalist options such as a self-managed cash option and enable changes to care management as people's needs change.

8 Social inclusion

When older Australians are asked what they value in life, they frequently talk about their good relationships with family, friends and neighbours. Relationships are essential to a good life and ensuring people's social, emotional, intellectual and physical needs are met. They are important in helping a person to retain their rights and responsibilities and to maintain self-esteem, self-confidence, self-identity and purpose. Given the predicted rise in disability and illness with a growing number of people aged over 65 years, a major challenge for Australia's ageing population is ensuring that people do not become socially isolated and lonely. A sudden stroke, the onset of chronic illness or the death of a partner can greatly reduce a person's ability to continue activities, interests and friendships and maintain good mental and physical health.

Many healthy older adults experience increasing social disconnection as their incomes, social circles and independent transport options diminish or as they find themselves required to provide care to life partners who can no longer care for themselves. There is now a well-established connection between social isolation/loneliness and mental and physical illnesses which intensify over time. While many older Australians will need health care as they age, even more urgently they need non-health assistance to remain connected to their families, communities and the wider world and so maintain their physical, emotional and mental health.

The Brotherhood believes that community aged care services can do a significant amount to help people maintain positive relationships at these times of transition and adjustment. This does not imply that the death of a spouse or close friend is easily compensated for, nor does it discount the profound sense of discontinuity that occurs when a person struggles to reconcile their past and present lives due to a major disability. However, the Brotherhood believes that lacking social contact during these times further increases a person's sense of loss and discontinuity. Sadly, this can lead to increased levels of loneliness, depression and despair, further exacerbating ill health.

Loneliness is now emerging as a unique health risk factor. A four-year study by the University of Chicago shows a direct link between chronic loneliness and high blood pressure, even when controlling for external factors such as body mass index, a person's age, smoking and alcohol. Even for people with a modest level of loneliness their blood pressure was affected. The loneliest people in the study sample had their blood pressure increase by 14/4 mm compared to their socially connected counterparts (Hawkley 2010).

Loneliness is also emerging as a risk factor for onset of dementia. Research by the Rush University Medical Centre (2007) indicates that lonely individuals may be twice as likely to develop Alzheimer's as people who are not lonely. A number of previous studies have also shown that social isolation (a limited number of social interactions with others) also increases a person's risk of dementia and cognitive decline. This recent research highlights the association between loneliness and Alzheimer's Disease in 823 older adults over a four-year period. Using a loneliness scale of one to five, the Centre discovered that older adults whose loneliness score increased from 1.4 to 3.2 had increased their risk of developing Alzheimer's disease by 51 per cent.

Associated research shows that older people who are socially isolated are:

- more likely to enter into residential aged care compared to people who are socially connected

- less willing to seek medical advice, adhere to a medical regime, or make positive lifestyle changes.

The Australian Institute of Health and Welfare (AIHW 2008) estimates the total health care expenditure for cardiovascular diseases in Australia in 2004–05 was $5.9 billion, more than any other disease group. Access Economics, on behalf of Alzheimer's Association of Australia, has forecast the direct health care costs of dementia to increase by $6 billion in 2011 and this does not factor in costs of home and community care spending (Access Economics 2003).

Governments and society in general, the Brotherhood argues, needs to be concerned about how older people spend their time. Research increasingly shows that a person's health and wellbeing is inextricably linked to their ability to have meaningful and fulfilling social relationships. However, Australian Bureau of Statistics (ABS) research suggests that people with moderate or severe disabilities spend 80–85 per cent of their waking time alone (equivalent to 8–10 hours each day) and in many cases with nothing to do (ABS 1999). In 2006, more than one-third of men aged 75–84 years and almost one-fifth of women aged 75–84 had had no face-to-face contact in the previous week with family and friends (AIHW 2007).

Client experiences

The human cost of extreme social isolated and lonely is significant, as highlighted by client experiences reported at the BSL forum:

> 'I was stuck in one room wondering 'what will I do?' It was sheer isolation which led me to despair.'
>
> 'Spent a lot of time feeling sad.'
>
> 'Depression. A real downward spiral.'
>
> 'I was unable to go out. I was sociophobic.'

Recommendations

- A focus on capabilities, not deficits, is central to helping older people.
- Addressing social isolation and loneliness in later life must be a national public health priority, with a significant increase in recurrent health promotion funding targeted at improving older people's social wellbeing.
- Broaden the Australian Government social inclusion agenda for older people to include a greater focus on increasing social participation rather than simply on economic participation and employment. More attention needs to be focused on making the key transition out of the workforce for those people whose 'retirement' is unwished for ,as well as those who retire voluntarily, through programs such as volunteering and staying connected to sports and personal interests.
- Helping older people, as well as to friends, neighbours and the wider community, is good mental health promotion. When aged and community care services assists a person to have fun, pursue an interest or be involved in a group that takes collective action to improve community life, they can have a positive effect, by improving the person's confidence and capacity to deal with his or her own difficulties.

- The Brotherhood of St Laurence, after extensive consultation with older people and their families, has identified that people want to participate in community-based leisure activities that:
    - are close to where they live
    - recognise and promote their talents
    - provide opportunities to meet like-minded people for friendship
    - encourage a spirit of volunteerism and the capacity to help others
    - enable their family and friends to become involved as well.

People want to be involved and engaged in the areas of life that give them pleasure—no matter the severity of their illness or level of immobility. The specifics of these areas of life—for example, friendships and leisure interests—may change over a person's life course, but engaging in them remains critical to wellbeing.

The Brotherhood discovered early on that helping older adults improve their social wellbeing was not easy. Many of the people using Brotherhood care services have a long history of social isolation and loneliness prior to old age. Also, people experience ageing and social isolation in different ways, often reflecting the socioeconomic context of their lives. Significant research indicates that material factors such as income, occupation and social status affect social relationships, health and functional ability in old age.

Similarly, the personal resources available to people vary, as does how they maintain their relationships in response to life changes, whether at a psychological, interpersonal, community or societal level. It is also more difficult—but not impossible—to help a person who has always been socially isolated to re-engage with social supports and increase his or her social networks through the opportunities that old age presents. It is also challenging for services to change their view on ageing and old age.

Aged and community care social support services

Around Australia, there are about 400 day centres or planned activity groups run by local councils and not-for-profit services such as Brotherhood of St Laurence. Day Centres are important services as they provide older people with:

- social activities
- outings and day trips
- individual care
- meals at a minimal cost
- transport, if required
- various therapies.

Given their importance, day centres are struggling to adapt to the changing lifestyle preferences of older people who feel uncomfortable in large communal settings or find the activities offered inappropriate for their requirements. Despite a centre's best efforts it is difficult to address the

different needs of people, such as making friends, improving daily living skills and maintaining independence at home.

Some day centres do not offer a variety and choice that attracts people. Many social activities are generically structured rather than individualised, so they often meet only minimal social needs of participants. This is especially the case where day centres are funded to support both people with core needs and people with high needs. Core group sessions are suitable for participants who are physically independent and do not require personal care, specialist dementia care or other specialist care in order to participate in activities. High needs group sessions are designed for people in one or more of the following groups:

- frail older people who require personal care
- people with acquired brain injury (ABI)
- people with disabilities who have a challenging behaviour
- people with disabilities who require assistance with toileting, eating or mobility in order to participate in activities (HACC 2003).

This presents a problem for day centres because core and high clients often have quite different capabilities, expectations and social wellbeing needs. At present, there is no service to support people with low (core) needs into mainstream community activities, particularly when many day centres are focused on supporting people with complex (high) needs such as dementia.

The activities take place within the day care centre, with little encouragement for participants to explore wider community offerings or to pursue friendships throughout the week, for example by meeting for coffee.

This lack of engagement of day centre participants in local community activities is problematic given that 50 per cent of all participants in the Southern Region of Melbourne live alone. As already indicated, there is a growing body of evidence which underscores the benefits of social networks and relationships to older people, especially those who live independently in the community. Activities need to foster informal friendships outside the structured program.

Conversely, to what extent are day centres inadvertently providing activities for people who are already well connected to their family and community, rather than engaging hard-to-reach socially isolated older people? What approach can be used to engage socially isolated older people, particularly if they have depression and anxiety issues, and do not have the social confidence to engage in a structured group activity? Many day centre activities tend to be passive (cards, board games, afternoon tea) and to be more female than male oriented (Gravell 2005 unpub.). There is a need for more activities that are relevant to males and that encourage life skills and promote good health, such as cooking nutritious meals and developing physical fitness.

People want activities that reinforce their personal worth and self-esteem, enabling them to give something back to their peers and the community at large. This can only occur when day centres support their participants to plan, develop and assess the value of the recreation and leisure activities.

Limited research has been done to date to assess the effectiveness of day centre programs in meeting the purpose to ‘maintain an individual’s ability to live at home and in the community, by providing a planned program of activities directed at enhancing the skills required for daily living and providing physical, intellectual, emotional and social stimulation’ (HACC 2003, p.122). There

has been a lack of conceptual clarity around the implications of 'enhancing the skills required for daily living', and this is reflected in the limited emphasis day centres place on helping older people maintain and increase their own social networks and supports within their local communities.

Recommendation

- The view must change from a deficit model of overwhelming loss, deterioration and social withdrawal, where people are passive recipients of services and illness and disability are categorised as unproductive periods of life, to more of a strengths-based model that acknowledges that ageing is as much about opportunities for personal development and growth as it is about loss and adjustment. The challenge is to help older people compensate for their losses and optimise opportunities to maintain and improve their skills and talents through funding and promotion of innovative, value-adding, social inclusion programs beyond day centres for older people .

Capabilities and work

With life expectancy now at 79 years for men and 84 years for women and rising, the great majority of people will have 15–30 years of potentially good living to do between retirement (or non-employment) and death. Most will not require extensive or intensive care services until many years after reaching pensionable age.

However, once people leave the workforce they lose much of their connection to the community at large and many of their social networks. This is particularly difficult for those with fewer financial and educational resources. As one forum participant pointed out:

> 'Work gives self-esteem, confidence, social skills, interaction, communication, dollars, security. You feel better all round.'

Another added:

> 'You lose some sense of belonging when you no longer work'

Increasing numbers of older adults are being encouraged and are choosing to remain in the workforce past current pensionable age. This will increase as the pensionable age rises to 67, and if the mooted removal of age restrictions to superannuation contributions and workers' compensation coverage come into effect. However, many Australians aged 65 years and over are reluctant 'retirees' ejected involuntarily because of such factors as age discrimination, inability to upgrade knowledge and skills, health conditions that prevent continuation in their former occupation, or lack of transport.

> 'Grey hair—I was a community health nurse in a community health centre. They made me accept a redundancy package because I was older. Later I was offered a part-time job but I didn't know how to sort out my husband's care. It took years for GPs to acknowledge what help I needed and by then I'd lost the chance to go back to work.'

> 'I was retrenched. I could only get a pension after spending all my super and long service leave savings. I was looking for jobs all the time but I live in the country and the bus service ceased. When I finally got a job, it cost too much to get there. I gave writing lessons to children or I would have starved. I lived on the lunch leftovers the kids left behind. Most of my income goes on rent.'

Recommendations

- Aged care services support older adults to continue in the workforce and present them as capable, energetic and enthusiastic about the present and the future
- Aged care services promote and practise anti-ageist work practices both in their own workplaces and in providers of services that they fund
- Aged care services liaise closely with other government services to set up joint programs that rehabilitate people for work and enable them to retain employment throughout their 50s and early 60s and to continue employment into their later 60s and 70s if they so desire.

Information communication technology

Social inclusion today requires universal access to all forms of information communications technology (ICT). The rapid growth in such technology in Australia has changed how we think and carry out the tasks of daily life, where we obtain information and how we communicate with others. The change is equivalent to the Industrial Revolution in its significance. Information communications technology is life-changing.

Access to a computer and the Internet is increasingly becoming an important determinant in a person's health and wellbeing. The digital divide is also a reflection of an overall socioeconomic divide in Australia. Despite the rapid increase in older people using the Internet, a large number are still missing out. For example, in 2004–05 just 20 per cent of people aged 65 years and over had used a computer at home in the previous 12 months; and four-fifths of adults aged 65 years and over have no home use of a computer and two-thirds have no access to the Internet (AIHW 2007).

This is concerning given the myriad benefits ICT offers older adults for enhancing their independence and social wellbeing. Digital exclusion of disadvantaged people is the result of both market failure and a lack of government policy direction to exploit the potential of ICT products and services. The ICT industry must undertake further research into understanding the ICT needs and preferences of older adults, particularly the barriers they face in accessing and using technological products and services.

Broadband costs and packages

This was illustrated at the BSL forums, where one participant in her late eighties expressed her frustration at Internet service providers only offering broadband packages with a standard contract period of 24 months. Given that she had poor health and could not plan past a three to six-month period with any certainty, she was not prepared to sign up to this plan. She enquired about a broadband plan with a reduced contract period, only to be advised that the standard monthly fee would go from $39.95 to $59.95, which she could not afford. This experience is reflected in a community development project, AccessIT, where only one ISP was prepared to provide the wireless broadband to BSL for the project given the 12-month timeframe and the budget cap of $49.95 per month for each participant's broadband costs. Surprisingly, other large providers were unable or unwilling to match this.

Recommendation

- Older adults should not be penalised with broadband speed and price if they require an ISP package that is shorter than 12–24 months.

Access to information

Research shows that older adults' understanding of how the Internet and computers work is often very low, but their knowledge about its potential uses and benefits is surprisingly high. People rate finding information, particularly about government entitlements and benefits, as important. This is closely followed by medical information, for instance understanding the potential side-effects of their medication or learning how to better manage their chronic illness or disability. Obviously there are dangers for people in self-diagnosing by using the Internet, but there are greater dangers in remaining ill-informed or unaware. Increasingly there are websites that offer people useful, accurate and accessible information and health-related applications that offer to monitor health conditions, such as diabetes, heart rate and blood pressure. These ICT applications are still in their infancy considering the potential market. Therefore governments have an important role in regulating e-health products and services and facilitating people's access to trusted websites .

BSL supports the current Australian and Victorian governments' initiatives to assist older adults and disadvantaged community groups to use computers and the Internet. The NEC Broadband for Seniors Program <http://www.nec.com.au/Solutions-Services/Broadband-for-Seniors.html> should be commended, a $15 million federally funded project which is rolling out 2000 Internet kiosks around Australia over three years. The program provides computers to organisations that support older adults. BSL believes one significant barrier for disadvantaged older adults in accessing these Internet kiosks regularly is health and disability. Also, there are considerable ongoing costs for adults who require personal care or transport to access these kiosks.

BSL recommends that, in addition to the NEC for Seniors Program, the Australian Government should fund projects that offer market incentives to ICT companies to provide more services and products to disadvantaged older adults. This should be through the new National Broadband Network (NBN) as part of the Australian Broadband Guarantee that is designed to help residential and small business premises access a high quality broadband service. The $237.7 million subsidy is to assist people living in rural and remote parts of Australia to have access to high quality broadband.

This scheme could be extended to include disadvantaged groups such as older adults. If a person is housebound, receives a government entitlement or is a family carer they would be eligible for free or concessional broadband services. This would create significant demand for ICT services and products as older adults (particularly those with a chronic illness and disability) become a larger segment of Internet users in Australia. This creates a greater market opportunity for mainstream telecommunications, multimedia and social networking services , as well as niche services providing telemedicine and e-health applications to older adults.

There are significant opportunities for the non-profit sector to assist in the uptake of older adults using computers and the Internet. The Brotherhood of St Laurence has identified that good quality training and support is vital to assist older adults who have had little exposure to the Internet and to engage the large number of older adults who are digitally dismissive of the Internet.

The value of IT training is clearly evident in the AccessIT a partnership project between aged and community care services (BSL and AccessCare Southern) and the local council, Chelsea Community Renewal, City of Kingston. When the project advertised for the 20 participants, based on the eligibility criteria: people aged 55 and over, managing a chronic illness or disability and who live in the Bonbeach and Chelsea area. In three days, the Council received calls from over 280 people (aged from 55 to 93) wanting to participate.

This was with minimal marketing with an article in the City of Kingston, Home and Community Care Newsletter promoting the project. Analysis showed the demand was not simply for the free broadband or the refurbished PC, it was one-to-one training that most people wanted. They valued the opportunity to learn at their own pace and to meet people like themselves in a small group learning environment. The AccessIT evaluation progress report indicates participants have enjoyed the informal support network as much as the new skills they have gained.

Involvement in ICT cannot be regarded as a simple matter of age. Rather demographic and socioeconomic stratifications have an impact on whether or not older Australians utilise ICT for their needs. For example, the better-educated 'older old' are more often involved in the Internet and computers than the less educated 'younger old'.

The value of Internet and computer access needs to be viewed in the context of a broader social inclusion agenda, as digital exclusion is the result of an interconnected social and economic process of exclusion. Disadvantaged population groups who cannot access ICT risk being further excluded, particularly as Australia becomes an information society. Aged and community care services will be important stakeholders in helping older adults access the Internet as will be essential to exercising citizenship rights and safeguarding the health and wellbeing.

Recommendations

- The Australian Government fund an awareness raising campaign that highlights the specific benefits of the Internet to older people, to help demystify the Internet and allay concerns over security and things going wrong.
- Fund training courses that are designed to meet the learning needs of older people
- Provide free Internet and computer tuition and home IT support for older people with mobility problems
- Provide free access or discounted broadband access to the Internet

Transport

As is pointed out in *No way to go* (Stanley et al. 2007), while transport and social exclusion is now a principal research and policy field in the UK, Australia lacks a comparable research and policy emphasis. Yet, according to the United Nations *Human Development Report* 2001, fundamental to building human capabilities is to be able to participate in the life of the community (UNDP 2001). The importance of this was endorsed by Saunders and Sutherland, whose examination of indicators of disadvantage in Australia found a significant nexus between housing, location and transport:

> This emerged as a factor that played a major role in determining the overall standard of living for many, and the choices and sacrifices that had to be made in these areas exerted an influence that spilled over into others. Put simply, it was far easier to attain a decent standard of living in all of its dimensions on a platform consisting of adequate and well-located housing that facilitates connections into local community networks (Saunders & Sutherland 2006, p.36).

A preliminary report (Currie et al. 2009) from the current Australian Research Council Industry Linkage Project 'Investigating Transport Disadvantage, Social Exclusion and Well-being in Metropolitan, Regional and Rural Victoria'—a project to which the Brotherhood has provided one of the Chief Investigators—concludes that there is 'a remarkably clear mismatch between public

transport supply and social needs … in Australian cities' and that this is a significant factor leading to forced car ownership among people with incomes below $500 per week. In turn the high cost of vehicle ownership leads to less travel. While to date this research has not reported specifically in respect of older people, it may be surmised that, given the low levels of income of most Australians aged 65 years and over, lack of accessible public transport is a significant contributor to social disconnection.

However, public transport and car ownership are not the only possible forms of transport that might be available. Community transport is routinely overlooked as an area of public policy and aged care services. This is a significant problem with Melbourne's urban sprawl and sparse living arrangements which often force older people to rely on cars as the main mode of transport. Large numbers of older people do not have access to a private car for their travel needs and rely on community transport to access services, facilities and activities.

Quality of life for a person of any age is dependent on the ability to visit friends, participate in leisure groups and access community and medical services. Appropriate community transport options and supports for older people must be a priority if we are to achieve a socially inclusive Australia.

Community transport plays an important part in achieving these aims for older people. It is generally a response by not-for-profit organisations and local government to gaps in the transport system. Although a necessary part of the transport network, community transport is not a unique mode of transport.

Community transport provides a range of services including:

- direct transport provision
- supported transport
- information provision
- advocacy
- financial support.

Road transport will remain the primary means of transportation for older people (particularly with a chronic illness and disability) and particularly for people who live in the outer suburbs of capital cities and regional towns. Therefore community transport is likely to increase in importance, relative to public transport.

Barriers that prevent older people from accessing community and public transport, identified over the past 10 years in a series of government transport reviews, include:

- concerns about personal safety
- accessibility of services
- lack of information about services
- lack of understanding of older people's needs
- lack of integration between different transport modes.

For those who experience growing frailty and a loss of mobility, the negative impact on day-to-day life is much greater. These people have reduced access to transport and significantly increased

transport and support costs. Their options are limited to high-cost taxi transport and paid carer support or community transport options with volunteer support.

For many people with a reliance on taxis and carers it becomes mostly about affordability. Currently any Victorian can access metropolitan public transport all day for under $15; but for those reliant on taxis, this equates to a trip of less than 10 kilometres.

Even with half-price taxi subsidies, regular use of taxis as a primary mode of transport is unaffordable for most Australians, let alone older Australians on low incomes. Combine this with paid carer costs of around $35 an hour and the impact on a person's capacity to participate in day-to-day life outside their home is significant.

Clearly there is a marked lack of equity for older Australians in accessing transport. Any improvements to transport services to older Australians will require adequate resourcing, coupled with equity of access.

Recommendations

- Improve access to transport through the establishment of a 'one stop shop' for transport information and support.

The concept involves information and support, cross referral and advocacy. The service would 'case manage' the transport needs of older Victorians and assist to negotiate the often 'unfriendly' referral paths. It would also allow more efficient and appropriate use of existing transport resources

- Central coordination of community transport resources, including buses and staff.

Currently there are significant community assets including vehicles and volunteers attached to individual organisations. Resource sharing would maximise availability of and efficient use of these resources.

- Incorporate supported transport services (Community Transport) into overall service planning
- Commit to an equity model which allows all Victorian to access the most appropriate transport option at public transport prices.

9 Recommendations

A capabilities approach

- Promote capabilities. Uncouple the nexus between ageing on the one hand and disability and health on the other so that expectations about ageing are positive and lively. Care can then be focussed on a disability or illness as it is throughout the rest of the life course rather than taking a different tack at a specified chronological age.
- Identify what constitutes a 'good life' for older adults in Australia—what they value, what they are capable of and how they want to live their lives.
- Develop government policies and programs to improve capabilities and maximise individual choice.
- Restore human rights and dignity through:
    - Changing language use. Utilise the term older adults in all references to people in their second fifty years of life
    - Distinguishing between 'right to risk' and 'responsibility for risk' to determine where each properly lies—with the individual or the care provider
    - Fully informing older adults of rights, responsibilities and risks
    - Supporting older adults to take 'risks' of their own choosing
    - Training all aged care personnel in the theory and practice of supported decision making.

Breaking the nexus between housing and care

- That government recognise the need for the separation of accommodation and care to enable flexible options and choice for older people in respect to where they live and care services available to them. This can include the choice for different combinations of services as required, such as living in one's home but being able to access short-term residential care at times of higher need or crisis, with the option to return to one's home.
- That there be more recognition and exploration of suitable housing types for older people and that funding be made available to assist in the provision of this housing.
- That financial assistance options for older people be considered—'a type of first owner grant for purpose built homes if an older person needs to change homes' and 'that there be no stamp duty' (client at BSL forum).
- Equity release opportunities for older people which are controlled by government legislation to protect older people, should also be considered. This would enable older people to use their equity in their home to provide for their needs.
- That the needs of disadvantaged older people be taken into account and options be developed for affordable housing addressing the specific needs of older people.

Housing design

- That the Australian Government consider a similar approach to the UK in developing a strategic approach to housing in an ageing society, which provides standards that are more

suitable for ageing in place and require building to universal design and incorporating environmentally sustainable features, together with the flexibility for future major modifications which can be made at minimum cost.

- It is noted that the Parliamentary Secretary for Disabilities announced on 13 July 2010 that leaders of the housing industry, the disability sector and community have agreed to an aspirational target that all new homes be built to disability-friendly liveable housing design standards by 2020. At this stage however this is a voluntary set of guidelines. It is recommended that the government take a stronger policy lead in this area.
- That a panel similar to HAPPI (in the UK) be established to investigate all innovative options for housing for older people.
- That public housing stock be adapted to the needs of the growing numbers of older Australians who live in it, to preclude any necessity for them to be rehoused elsewhere.
- That environmental sustainability and rising costs of utilities be considered in housing design policy.

Neighbourhoods

- That a national set of age-friendly guidelines for cities and neighbourhoods be adopted which reflect the World Health Organization's *Global age friendly cities: a guide* (2007).

Funding

National funding of long-term care

- Investigate the establishment of a universal, contributory care scheme to provide Australians with entitlement to a standard level of long-term care.

Allocation and management of community care funds

- Continue to explore consumer-directed care as an alternative model for carers who want to take up this option.

Access to information

- Provide a significant publicly funded media campaign to promote the benefits of a universal aged care scheme and citizen entitlements.

Assessment

- Develop a care needs assessment tool, to cover both residential and community care, that matches assessed needs with costs of care and promotes and rewards restorative gains in older people's functioning.

Interface between aged care and health sectors

- ACAT/S should specialise in the interface between the aged care sector and health sector to ensure the seamless transition of older people in and out of both systems.

Regulatory compliance – residential care

- A single national regulatory scheme. Currently the aged care regulatory environment is replete with self-contradiction and conflict between legislation at the three levels of government, affecting planning, design and construction.
- Clear and accessible national goals and targets for quality in residential aged care and funding adequate to sustain a continuous improvement program.
- Accreditation standards that provide sufficient flexibility for review and adaptation to changing circumstances such as staffing vacancies, including well-planned short-term alternative solutions
- Standards that demonstrate outcomes for clients rather than rigid adherence to process
- Standards that reflect stakeholder views about safety and quality in residential aged care, and realistic benchmarks
- Review of QA documentation to enable gathering of multiple information items from a single record
- An appropriate balance between compliance and continuous improvement fostered by a regulatory framework. Current documentation requirements are too onerous for smaller providers without specialist administration staff
- Standards and accreditation processes that foster innovation and encourage higher quality performance (as opposed to a low common denominator)
- Requirement for all residential aged care accreditation assessors have current aged care industry knowledge and experience and understand the complexities of aged care
- Encouraging assessors to mentor facilities managers to improve their quality processes, meet standards and achieve client preferred outcomes
- Appropriate processes for managing public risk arising as a consequence of accreditation processes and sanctions. These need to be structured appropriately to drive compliance and improvement, and vigorously combat non-compliance. However, currently sanctions are often issued without adequate consultation and understanding of what is happening within the service, which undermines effective planning. and drives managers from the industry.
- Exploring options for relaxing supply constraints in the provision of aged care beds to include a wider range of housing options such as individual homes, cluster housing and co-housing that meet universal design standards
- Production and dissemination of more accessible and comprehensive information available at the touch points of daily life to help older and frail Australians make better informed decisions and compare different options for service.

Carers and respite care

Access to information and support

- Public carers' campaign to inform about opportunities and services which are available to carers (short-term strategy)
- Better interface between health providers, carer support and respite providers to ensure better outcomes for carers as well as for the care recipient (long-term strategy)

- Having a range of services in a single location, funded through a variety of sources enables additional flexibility and economy (Refer also to Respite Services in this report)

Funding models

- Continue to explore consumer directed care as an alternative for carers who want to take up this option
- Have one government department responsible for funding carer support services and respite

Respite services

- Increase respite options for carers of people with high care needs, especially in the area of overnight respite. It is important to consider the interface of respite services with funded services such as post acute care, convalescence care, transitional care and palliative care—and to make services available to purchase either privately or through consumer-directed care packages
- Continue to focus on the provision of respite so that carers can remain in the workforce
- Develop a specialist workforce to meet the needs of people with high care needs

Choice and continuum of care

- Provide a full range of options to meet older people's needs, that equals their capacity and willingness to take responsibility for their care choices. The care continuum should include restorative health care, accommodation and long-tern care. Include minimalist options such a self-managed cash option and enable changes to care management as people's needs change.

Social inclusion

- A focus on capabilities, not deficits, is central to helping older people
- Addressing social isolation and loneliness in later life must be a national public health priority, with a significant increase in recurrent health promotion funding targeted at improving older people's social wellbeing.
- Broaden the Australian Government social inclusion agenda for older people to include a greater focus on increasing social participation rather than simply on economic participation and employment. More attention needs to be focused on making the key transition out of the workforce for those people whose 'retirement' is unwished for, as well as those who retire voluntarily, through programs such as volunteering and staying connected to sports and personal interests.
- Helping older people maintain connections to family, as well as to friends, neighbours and the wider community, is good mental health promotion. When aged and community care services assist a person to have fun, pursue an interest or be involved in a group that takes collective action to improve community life, they can have a positive effect, by improving a person's confidence and capacity to deal with his or her own difficulties.
- Extensive consultation with older people and their families has identified that people want to participate in community-based leisure activities that:
    - are close to where they live
    - recognise and promote their talents

  - provide opportunities to meet like-minded people for friendship
  - encourage a spirit of volunteerism and the capacity to help others
  - enable their family and friends to become involved as well.

Aged and community care support services

- The view must change from a deficit model of overwhelming loss, deterioration and social withdrawal, where people are passive recipients of services and illness and disability are categorised as unproductive periods of life, to more of a strengths-based model that acknowledges that ageing is as much about opportunities for personal development and growth as it is about loss and adjustment. The challenge is to help older people compensate for their losses and optimise opportunities to maintain and improve their skills and talents through funding and promotion of innovative, value-adding, social inclusion programs beyond day centres for older people.

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Information communication technology

- Older adults should not be penalised with broadband speed and price if they require an ISP package that is shorter than 12–24 months

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