Submission to the Productivity Commission Inquiry into Caring for Older Australian

by
Professor Hal Kendig
Ageing Work and Health Research Unit
Faculty of Health Sciences, University of Sydney
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Introduction:
In my estimation the Productivity Commission (PC) Inquiry offers an historic opportunity to make a major advance in support and care for older people, and their carers, and for governments for decades into the future. The PC recommendations need to take account of the increased aspirations and expectations by older people, their increasing financial diversity, and recognition of the values of choice, self determination, and positive approaches to improving ageing experiences.

The impetus to advance support and care for older people is accentuated by rising life expectancy in later life, ageing of the large baby boom cohort, and the time necessary to invest in care and support systems that can respond effectively to increased demand. The number of people over age 85 years is projected to increase fourfold over the next 40 years.

Australian research has demonstrated that a majority of older people live in the community until death without ever entering residential care and, further, that healthy ways of living increase the chances of continued community living as well as longer and higher quality life (Kendig, et al., 2010).

It is heartening to note areas of broad agreement in directions for reforming care for older people, for example, in the National Aged Care Alliance Vision for Support and Care of Older Australians.

In this submission I wish to make selected comments within my areas of expertise on opportunities and obstacles to reform; what older people and carers want as the fundamental criteria for their support; the case for taking a care systems approach and setting performance requirements; national re-configuration of programs; developing a regional approach to aged care; and strategies to build an ongoing evidence base. I aim to speak informed by evidence but, regrettably, the evidence is limited and often dated because support for applied research and evaluations has been declining. My views are my own but they have been developed with colleagues (see references below) and discussed in recent symposia and conferences.

I would be pleased to discuss this submission and provide further information if requested.

Opportunities and Obstacles to Reform:

After several decades of useful but modest developments in aged care, we have an opportunity to make the first major advance since the community and residential care reforms of the mid 1980s.

The opportunities for major advances that have arisen in the current 'window of opportunity' include:

- The policy momentum built by the National Health and Hospital Reform Commission's 2010 recommendations including the goals of consumer choice and responsiveness, expenditure effectiveness, and equity; the recommendation to fund consumers rather than providers; to separate accommodation and care funding programs and to facilitate consumer

choice and equity across residential and community programs; and to allow bonds for high level residential care.

- The Productivity Commission's expert capacity to make balanced, progressive recommendations in the public interest independent of political direction taking into account a range of interests and building on its own thorough review of trends in its 2008 report that recommended consideration of 'unbundling' accommodation and care; noted the strong rise in consumer oriented care; made a case to simplify planning and allocation controls; and raised major concern for the aged care workforce.

- The unprecedented opportunity to develop and implement an integrated, coherent support and care system as a result of policy consolidation with the Commonwealth of responsibility for the Home and Community Care program (HACC) (as of 2011-2012) as well as residential care; primary health care (including a strengthened focus on health promotion); developments in community housing programs; and the moves towards Commonwealth leadership of hospital funding and policy (with management less certain in the current political contests).

- The projections of the Intergenerational Report 2010 that underscore cost imperatives to manage health and care better in ways that improve outcomes for individuals as well as cost effectiveness for governments.

- The election cycle which will see a newly elected government well positioned to act on the Commission's recommendations next year.

Over the past 50 years successive policy developments have built high quality care for older people – a notable success story - but these legacies have also entrenched substantial challenges to change that need to be recognised and confronted:

- Australia has a tradition of residential approaches to care for older people, notably nursing homes, that include community expectations for 'beds' in hospital and nursing homes as the solution to care needs (as we are seeing now in the election campaign and earlier in the year in the COAG bidding contests by State governments in health care reform).

- Public advocacy and lobbying by some existing residential care providers for public subsidies that would increase care provision in ways that further their financial viability and profits.

- The comparative weakness in advocacy and lobbying by the community care sector (largely smaller organizations) and vulnerable older people and caregivers who do not have strong public voice.

- The hitherto divided responsibilities (and blame game) and fragmented service delivery as a result of contention and cost-shifting between the Commonwealth and State governments (and neglect of local government) as well as policy and funding divides between the health, care, and housing sectors.

- The progressive emphasis on regulation which is essential to protect vulnerable people. It needs to be recognized that regulation is essential to mitigate (and deflect) political risks in care for older people. However, excessive regulation can reduce flexibility and innovation, and impose unnecessary costs. Managing risks requires a careful, balanced approach

including enhanced consumer choice, training for aged care workers and carers, and close relationships between funding and quality assurance.

- More fundamentally, the deep-seated negative view of ageing in Australia (and other countries) that makes it difficult to see and act on the potential for positive approaches including the efficacy of prevention approaches and for recovery of capacities after health set-backs. A more constructive view of ageing would address the deep-seated ageism in Australia that older people experience in their engagement with health and care services (Minichiello et al. 2000).

Since the mid 1980s we have progressively developed a range of quality care services, with some individualised care and improved carer support, and a workforce that is progressively more skilled. There has been important (but as yet incomplete) re-balancing from residential towards more community care, an improved focus on individual needs and rights, and more support for caregivers. However, cost shifting between the acute, residential, and community sectors (and Commonwealth and State governments) is persistent and pernicious. Service integration and coordination require major improvement and, as reviewed below, regional management offers a promising direction to overcome deep impediments to forming an effective support and care services system.

At the core of our present 'cross-roads' in care services are the strengths and limits of 'program' approaches to aged care. The program approach is the main machinery of government now – setting program objectives and target groups, needs based planning, guidelines and funding rules, accountability arrangements etc; it has yielded a more effective and equitable allocations of care. But over time there has been a proliferation of programs that while valuable in themselves nonetheless set up artificial divides and barriers in service provision. Commonwealth-funded programs have developed on top of and across prior programs, with strong direction from Canberra, presenting complications in integration and continuity for clients and carers at a local level.

What Older People and Carers Want (and need):

The fundamental purpose of support and care services for older people is to meet the needs of older people and their carers as viewed by themselves informed by experts in care-giving. As an essential step towards achieving this we need enabling legislation to guide care systems that focus clearly and strongly on delivering opportunities, care and support appropriate to each individual and their family in the context of their particular living circumstances in their local communities.

Unlike other areas of public policy delivering aged care is not just a simple matter of declaring entitlements to given kinds and levels of service (although adequacy and rights are important). It requires systems of care building on ongoing processes of identifying and responding to 'needs' responsive to individuals and 'caregiving unit'.

There is a small but important literature (see references below) identifying the personal goals of frail older people themselves:

- A fundamental striving to 'continue to be oneself', that is to maintain one's personal identity, notwithstanding ageing-related erosion of resources, increased vulnerability, and the impositions of others who many not appreciate the views of older people themselves.

- An often 'fierce will' to maintain independence (and not to impose burdens on others) and to maintain autonomy and control over one's own life.

- An imperative for ageing in place, that is to remain in one's own home with its personal meanings and provision of a 'home base' for activities, social life, and access to friends, neighbours and community life (Davison et al., 1993). This contrasts sharply with the experience of older people in residential care who feel they no longer have a home and that they are basically living in someone else's workplace, that is, a 'factory of efficient and safe care delivery'.

- Life goals of maintaining quality of life with health viewed as a resource to maintain identity, independence, social participation, contributions to others, and to feel well. The majority of older people in fact have one or more chronic disease – and recognise the importance of healthy life styles and treatment of disease – but rate their health as good.

- For care and support of older people it is essential to recognise fundamental differences in the life situations of what can be termed the 'young-old' and the 'old-old'. The 'young old' can be understood in terms of active ageing extending middle-age life styles. The primary emphasis for them needs to be on enabling social participation, promoting good health, and opportunities to contribute in work, family, and community life.

- The 'old-old' are likely to havd health limitations and social losses that require major adaptations and supports. At advanced ages people are likely to have enhanced concerns for security, comfort, dignity, and continuity of close personal ties – while imperatives for choice as to one's own fate continue. Quality of care for frail older people requires attentiveness to these crucially important concerns, particularly so since disempowered older people can all too easily retreat into passivity and silence.

- A 'good death' is part of a good life and this requires advance planning for individuals as well as a care and health system focused on comfort and dignity to the end of life.

A major advance in aged care since the mid 1980s has been the recognition of and responsiveness to family caregivers. In many cases, support for frail older people is best achieved by sharing responsibilities for care and providing respite and other services that can lessen stress. Research has shown that caregiver stress is one of the main predictors of entry to residential care. It is important to recognise, however, that the interests of frail older people and their caregivers can diverge, and it is important to listen to and respond to both parties.

Overall, there now is considerable support for increasing person-centred care as will be seen in many submissions by advocacy groups and service providers to this Inquiry by the Commission. The hard choices emerge most conspicuously when many service providers argue for financial resources for their residential care provision when this care is rarely the first priority for older people themselves. Community care services are proving to be increasingly capable in enabling frail older people to remain in the community with a reasonable quality of life for themselves and their carers.

Aged Care Systems and Performance Requirements:
A focus on aged care systems highlights the need to ensure that support is responsive to the multiple and varying needs of older people wherever they are best addressed including within mainstream health and other services. This requires careful attention to ensuring the supply of an adequate range and choice of service, in each local area, with close attention to interrelating them to provide comprehensive and responsive aged care.

Key features of a high quality aged care system include the following:

- Responsive to ageing changes (trajectories) and diversity (in preferences as well as needs)

- 'Upstream' action (enabling people to maintain and regain health and independence) as well as 'downstream' care and support when needs increase

- Client centred delivery with mechanisms to ensure continuity, integration, transitions, & timeliness for older people with multiple needs

- 'Whole of government' approaches including mainstream services delivered appropriately to older individuals (housing, health, income, etc)

- Focused effort to overcome the fragmentation of program delivery across departments and levels of government

The key questions are: How can we organise the system better with attention to the combined effects of policies in terms of outcomes for individuals over time?

It is recommended that key objectives for the aged care system be clarified through the PC Inquiry process and that these objectives and principles) have centre stage in new enabling legislation as well as in the design of improved aged care systems.

National Directions and Program Re-configuration:
The new reality for aged care – after the COAG processes earlier this year – is that funding and management responsibility will be fully consolidated at a national level. Having one level of government as the single budget holder will provide clear management authority and accountability for aged care programs, and it should assist in coordinated policy development with related sectors of Commonwealth responsibility such as primary and acute health care. If managed well the 2010 COAG reforms of aged care (and foreshadowed health reforms) should go a long way towards ending (or at least minimising) the cost shifting and blame-game between the Commonwealth and State governments.

Consolidation of aged care responsibilities with the Commonwealth entails risks as well as opportunities. Some state governments, notably Victoria, have developed substantial expertise in delivering innovative, effective, and coordinated community care delivery including coordination with mainstream housing, health, and other programs that are crucial to aged care. This expertise should not be lost; nor should there be an attempt to manage community care and other aged care in a centralized, bureaucratic way from Canberra. It is important to ensure effective, integrated aged care program management at a more localized level across and within community and residential care. For this reason I recommend that the Commonwealth establish regional Aged Care Authorities that operate with substantial delegation of management and funding decision-making (see below).

A priority for the Commonwealth government is to 'unbundle' the residential care program into separate funding for accommodation and care. As I and others have argued elsewhere, it would be more equitable and effective to assist with accommodation on the basis of means tests (older people paying fully for the capital component if they can afford it) along with separate care programs allocated on the basis of needs. This separation would provide more choice and independence for older people as they would not have to move into residential care in order to receive high levels of care. The Commonwealth would benefit because it would not have to pay for accommodation components of aged care for those individuals who can afford to meet their own accommodation costs.

Separate care and accommodation programs could be used flexibly to resource service-integrated housing. New supportive accommodation models offer the advantages of age-concentrated, purpose-built accommodation to which care could be delivered flexibly and economically as needed by residents. Separate accommodation and care programs could still be used to support people in hostels and nursing homes where these care models are most appropriate for them.

A second priority is to develop a single, integrated care funding program after review of the range of HACC services, Commonwealth packages and carer support, and the care component of current residential care programs. The aim would be to overcome the fragmentation, gaps, and inconsistencies of current programs that have evolved in an incremental, opportunistic way. A single, integrated care and carer support funding program would increase the capacity to deliver flexible, effective support in whatever ways are most appropriate for communities and individuals. In devising a new integrated care funding program the following would be important considerations:

- Movement beyond the current HACC mandate to provide community services that are basically ongoing support and maintenance (although this may sometimes be the appropriate response), as this can encourage dependency for people with the potential for recovery.

- Allocations based on care plans with specific objectives for each individual including recovery and regained independence at which time support would cease. The Home Improvement Model in Western Australia (Lewin and Vandermeulen, 2010) and the Active Service Model in Victoria are proven models here.

- Provision of aids and home modifications where these environmental supports can enable independence as an alternative to ongoing service dependency.

- Incorporation of health promotion and rehabilitation within care programs as well as through active coordination with primary health care and community programs.

- Flexible use of the range of carer benefits, respite, and day care programs as per individual choice and preference.

- Progressive development of the alternative of consumer directed support including cash allocations for older people and their carers to purchase support from a full range of providers.

- Policy harmonisation and advocacy on behalf of older people to ensure integrated action for older people including aged care, general practice, health promotion, and other mainstream programs.

Flexible support that meets the priority needs of individuals accentuates major issues concerning rationing of scarce resources. As a matter of principle it is unacceptable that rationing be achieved partly by providing support in ways that people do not prefer, eg, residential care if people want high level care. A principled approach would allocate resources (and re-allocate them) on the basis of comparative (and changing) needs as judged by experienced professionals across pools of people with similar levels of need.

A thorough review and costing study for aged care is required with consideration given to the following:

- Moving beyond indicative planning ratios of residential care places to funding pools based on numbers aged 85 years and over (as recommended by the NHHRC) for regions as per below.

- Regional funding pools for clients and carers using a case mix approach as per a revised Aged Care Funding Instrument (ACFI) that would apply across community and residential settings.

- Allocations to individual clients and carers by care coordinators on the basis of comparative need within the pool (rather than any specific entitlement)

- A coherent and nationally consistent system for setting user charges.

Accommodation for people requiring care requires equally comprehensive consideration of principles and guidelines including public contributions of capital and recurrent funding and consumer protection for residents and their contributions, extending to privately funded retirement villages and other forms of service integrated housing.. Attention is required to retention/dispersal of capital value when residents depart as well as recurrent costs. Restructuring of accommodation subsidies and protections is needed to develop a coherent funding approach that is equitable, efficient, and transparent and takes account of the range of provider arrangements. New Commonwealth community housing schemes and public housing should provide important 'home bases' of accommodation for people receiving community care.

Quality assurance can be advanced by an approach geared to the vulnerability of the older person and carer rather than the setting of care. This should include an assessment of the environment supports and risks in home care as well as residential care, with attention to facilitating independence and safety for frail older people as well as occupational health for paid and unpaid workers in both settings.

The Commonwealth has major responsibilities for ensuring an intelligent aged care system through education and training of age-skilled professionals and other workers; leadership in information systems; applied research and evaluation (see below); and ongoing analysis and dissemination of information to inform ongoing improvement.

The Commonwealth Department of Health and Ageing would take responsibility for developing care policies; ensuring coherent policies across aged care, health, and housing programs; and overseeing their implementation by regional authorities having delegated responsibilities and accountability.

Finally, and arguably the most important challenge, is for the Commonwealth to appreciate fully the capacities in local service systems necessary to provide high quality care and support for frail older people and their carers. The Commonwealth will always have a primary responsibility for articulating a national strategy for achieving priority outcomes and for ensuring that the system is accountable and financially sustainable but more is needed. It is essential that national action is based on a deep understanding of what it takes to develop and deliver integrated care and support systems on the ground - and to ensure that Commonwealth actions enable (rather than frustrate) its delivery.

Regional Aged Care Authorities:
Aged care systems have progressed to the point where the advantages of regional management can be realistically envisaged and achieved. This next stage of development – arguably as significant

as the 1980s aged care reforms – make it possible to deliver aged care systems that would meet the person-centred performance criteria outlined earlier in this submission.

Regional management, within a national framework of policy guidelines and funding, would enable decision-making and coordination that was closely informed by and sensitive to the complexity and sensitivity of aged care services on the ground. Key responsibilities for Regional Aged Care Authorities would include:

- Management of the regional service delivery system including access arrangements for older people and their carers, advice and information, coordination among providers (eg for the majority of clients having multiple service use), and rigorous procedures for changing, increasing, and decreasing service use in line with changing needs.

- Ongoing quality assurance and improvement based on local knowledge including feedback to inform funding decisions, service development, and training across agencies.

- Investing in the supply of services on the basis of locally determined priorities for filling gaps in provision, with progressive reconfiguration of supply in line with evolving directions in aged care.

- Enable more whole of government action with the regional Authority ensuring close working relationships (and advocacy where necessary) with the local health system, housing programs, land use planning and transport services, and other areas of government.

- Guidance by and accountability to local communities, older people and carers in implementing the national framework of policy.

An integrated regional approach would require a small management and support team working in one office and working to national guidelines and oversight as well as a Regional Management Council. They would manage an integrated aged care budget (or at least devolved implementation of the current program budget). Their care coordinators would form the backbone of integrated care and quality assurance. They would provide oversight or directly manage regional client assessment services in close collaboration with regional health services and local aged care services. They would maintain a strong, integrated information system on clients, available remotely (and in real time), to inform care provision as well management information.

The broader responsibility for the Aged Care Authorities would be to articulate a positive, comprehensive vision for older people and their carers in their communities. It would build on the United Nations principles of a Society for All Ages, and the World Health Organisation's Active Ageing and Age Friendly Cities strategies. Following this vision the Authorities could work with community and consumer groups to enable social participation and healthy ways of life for older people. The Authorities can establish a collaborative, trusting atmosphere among service providers in order to develop a common mission and information sharing in providing support and care for older people.

The regional management team would support and take guidance from an independently chaired Aged Care Regional Council of key stakeholders. Membership would include representatives of older people and carers, a range of aged care providers, and significant mainstream health and other mainstream agencies in the area. The Council would provide oversight (but not management) and enhance communication across the organisations and communities in their catchments.

Actions necessary to achieve the transition to regional management would include the following:

- Determining regions at an appropriate scale (containing the full spectrum of aged care services) with meaningful boundaries, for example, to align with local health and hospital networks and primary care divisions. An indication of scale might be a total population in the order of 300,000 to 500,000, containing perhaps 5,000 to 15,000 older people requiring support with daily living**.** In NSW, for example, Aged Care regions should be co-terminous with the 15 Local Health Networks being implemented as part of the national Health and Hospitals Agreement.

- Developing consistent and workable mission and procedural statements for the Authorities drawing on a thorough review of best practice in existing regions – for example, the important advances already made in some regions of Victoria – should be developed jointly by Commonwealth and State Officers; deep consultation with service providers is essential to facilitate better service delivery.

- Establishing a small number of leading pilot regions in each state that – with support from the Commonwealth and States and advised by leading aged care manager experts – would work together to develop operations that enable best practice.

- Establishing regional offices building on transfers (or subcontracting) of resources in regions (eg Assessment Services in state health systems). Redeployment of staff (eg from Commonwealth and State offices) would be advantageous where individuals had or could develop the necessary skill sets.

- The progressive transfer of responsibilities for managing aged care programs to the Aged Care Regions, initially through periods of joint management with States.

Improving the Evidence Base for Aged Care:
Research and evaluation are critical to identifying the support and care needs of frail older people and their carers, and for informing ways of increasing the appropriateness, effectiveness and efficiency of services and other actions on their behalf.

At a broad strategic level the Department of Health and Ageing and the Australian Institute of Health and Welfare (2003) established the Framework for an Australian Ageing Research Agenda as part of the Building Ageing Research Capacities Initiative. The Framework included a priority for research addressing the goal 'Providing accessible, appropriate, high quality health and aged care' in the National Strategy for an Ageing Australia 2001. This was followed by the establishment of a National Research Priority on Ageing Well/Ageing Productively, the ARC/NHMRC Research Network in Ageing Well (2005-2010), and the NHMRC/ARC Ageing Well, Ageing Productively (AWAP) research funding program 2005-2010.

There have been some promising research developments but they remain limited particularly in informing service and practice developments. AWAP program grants are now underway on topics including prevention and Aboriginal health although none were funded in the area identified as 'Approaches to Care Supporting Independence'. The ARC/NHMRC Research Network supported proposal development for services and practice research, and developed guidelines for involving consumers in research www.ageingwell.edu.au. The NHMRC has increased health services research and translation and ARC Linkages grants support research partnerships including consumer groups and service providers. An ARC Population Ageing Centre of Excellence (2011-2017) will include components on aged care and prevention, and the Centre will have supplementary financial support from government and industry.

Two further research programs are important for aged care and support. First, the valuable Dementia Collaborative Research Centres, managed by the Department of Health and Ageing, inform practice and service delivery for client care, carer support, and prevention strategies for people with dementia. However, comparable research has not been supported for the care of aged care clients whose difficulties arise from other health conditions; nor of the operations of aged care systems. Second, the Australian Housing and Urban Research Institute has emerged as important for funding and disseminating valuable reports on applied research concerning accommodation and care for older people (eg, Bridge et al, 2008; Jones et al. 2010).

On occasion small scale, innovative research is funded by other agencies such as the Australian Health Ministers' Advisory Council (eg Lewin 2010 below), State HACC programs (Jorm 2010 below), and foundations and trusts.

The development of aged care, including deliberations by the Productivity Commission Inquiry, requires quality information from Government. It therefore is unfortunate that Commonwealth support for research and evaluations has fallen to levels far below those that proved to be very valuable in developing and implementing the community and residential care reforms of the 1980s and 1990s. Consultancy reports are seldom released into the public domain where they could inform service improvements. National cornerstones of information over the past decade - the Ageing and Aged Care Unit in the Australian Institute of Health and Welfare (AIHW) and the Australian Bureau of Statistics (ABS) – have had significant reductions of resources over recent years.

The Commonwealth Department of Health and Ageing has conducted commissioned studies or evaluations over recent years but few have been released into the public arena where they could be of wider use. The extensive data collected through the aged care assessment teams has been progressively less available for informing aged care research and development. In the 1990s the Department's valuable Health Services Research and Development Grants program – which supported valuable applied research in developing the 1980s reforms – was absorbed into the NHMRC with little subsequent work in aged care.

As for the future, Aged and Community Services Australia, The Australian Association of Gerontology, and the ARC Research Network in Ageing Well (2010) produced the Community Care Research Agenda based on a rigorous consultation and priority setting process (the top priorities are listed in Appendix 2). The Research Network in collaboration with the Australian Association of Gerontology produced the draft Ageing Research Challenge for Australia (2008) - see Appendix 1 for recommendations concerning services - but there has been little government interest in developing a full research program. The NHMRC's new strategic plan has set Ageing and Health as a priority; and it aims to support health services research and translation.

A fundamental difficulty is that research important to advance the support and care of older people does not fit easily into current approaches for either Departmental consultancies (usually short term program management issues without public release) nor into the ARC/NHMRC research programs that are driven by scientific excellence of international significance. I would urge the Productivity Commission to consider recommending three directions for research initiatives that can inform cost-effective service development that meets priority needs:

1) That the Commonwealth Government establish an Aged Care and Support Research Program – modeled on the outstanding success of the Australian Housing and Urban Research Institute. The Community Care Research Agenda 2010 and the Ageing Research Challenge for Australia (Appendices 1 and 2 below) would provide a valuable starting point for this research. The Program should be based on deep consultation as to priority

information needs, and have a strong emphasis on translation, dissemination, and collaboration with older people and service providers.

2) That the Commonwealth strengthen its leadership in research and analysis through strategic investment in the AIHW, ABS, Assessment and other data bases, and consultancies and evaluations carefully planned alongside the implementation of the new Aged Care system. Guidelines for consultancies could follow the recommendations made by Warwick Bruen (2006), who formerly led the Commonwealth HACC Branch, in his background paper prepared for the ARC/NHMRC Research Network in Ageing Well.

3) That the NHMRC/ARC be urged to develop a second round of the valuable Ageing Well, Ageing Productively Program grants, including a specific focus on research concerning aged care and support systems.

Next Steps:
In summary, Australia is poised to make a major advance in aged care and support, building on the recommendations of the NHHRC and the COAG reforms in health and community care responsibilities. Key to these developments would be:

- A New Aged Care Act Affirming Principles for Older Individuals, Carers, & Care Systems.

- Reform of Commonwealth funding programs to separate support for accommodation and care.

- The establishment of regional Aged Care Authorities that with devolved responsibilities establish and ensure the successful operations of comprehensive, integrated systems of aged care.

These developments can be every bit as significant as the landmark aged care reforms of the 1980s. They can better meet older people and carer needs now and set a foundation for a constructive response to rapid population ageing over the decades ahead.

Further Reading:

Aged and Community Services Australia, Australian Association of Gerontology, and ARC/NHMRC Research Network in Australia, Researching Community Care with Older People, ACSA, Melbourne, June, 2010.

ARC/NHMRC Research Network in Ageing Well in collaboration with the Australian Association of Gerontology, 'The Ageing Research Challenge for Australia', Discussion Document, July 2008.

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Bruen, W. [with Ann Peut and Diane Gibson] Use of Consultants in Aged Care Research: Governments, Universities and the Private Sector, Background paper for the National Symposium on Ageing Research, Canberra, 2006
http://www.ageingwell.edu.au/download/policy_colloquia/MorningWorkshop3_ResearchConsultancies.pdf
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B. Davison, B, Kendig, H. Stephens, F. and Merrill, M. "It's my place", older people talk about their homes: A report on the study options and references—older people and their homes. Canberra: Australian Government Publishing Service, 1993.

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Jorm, L., S. R. Walter, S. Lujic, J. E. Byles and H. L. Kendig "Home and community care services: a major opportunity for preventative care." BMC Geriatrics, 2010, 10 (26): 1-9.

Kendig, H, Andrews, G, Browning, C, Quine, S, Parsons, A. (2000) A Review of Healthy Ageing Research in Australia. Community Services Ministers' Advisory Council Report, 2000.

Kendig, H. and Duckett, S. Australian directions in aged care: The generation of policies for generations of older people, Australian Health Policy Institute at the University of Sydney, Commissioned Paper Series 2001/5 (113 pp.). [note this monograph provides an in-depth analysis of many of the proposals in this submission including the value of a regional approach to aged care service delivery]

Kendig, H., R. Pedlow, C. Browning, Y. Wells, and S. Thomas. "Health, social, and life style predictors of entry to residential aged care: An Australian longitudinal analysis," Age and Ageing, March 15, 2010, pp 1-7.

Lewin, G. and Vandermeulen, S. A non-randomised controlled trial of the Home Independence Program, an Australian restorative programme for older home care clients, Health and Social Care in the Community, 18(1), 2010, 91-96.

Minichiello, V., Browne, J. and Kendig, H. Perceptions and consequences of ageism: Views from older persons. Ageing and Society 2000; 20:253-278.

Appendix 1 Recommendations for research on better health and care services from the Ageing Research Challenge for Australia (2008)

- We need to develop evidence-based models of health care for older people that work seamlessly the current tangle of Commonwealth and State programs and across hospitals, community health and residential and community based aged care.

- We need to make sure that as we increase emphasis on prevention in the health system generally, this includes older people, whose independence is often most vitally at stake and who are frequently excluded preventative health programs.

- We need evaluations on how to develop services facilitating rehabilitation and the supported return to full functioning in an appropriate community setting including focus on accommodation and care

- We need to know how well service systems target the needs of carers including their health and psychological wellbeing, provision of advice and assistance with care coordination

- We need to identify best practice on appropriate palliative care for providing comfort, dignity and support in line with the preferences of older people and their family through to the end of life

- We need to test ideas for reform, and to see how health and care workforce work to meet these needs.

Appendix 2 Research Priorities from the Community Care Research Agenda (2010)

1 Which models of care in the community best support older people who have little informal support?

2 How can the involvement of older people themselves in decisions about their care be increased?

3 How can community and residential care be better integrated and what are the structural barriers preventing this?

4 Development of an agreed set of outcome measures, both quantitative and qualitative, for measuring the impact of community care.

5 Explore Aboriginal and Torres Strait Islander specific community care and appropriate models for various communities.

6 What are the support and service needs of people living with a mental illness/mental health problem? What role can/does community care play in meeting these needs and how can this be improved?

7 How can we manage the community care/acute care interface to ensure seamless pathways without creating additional areas of tension between state and federal governments?

8 Investigate consumer directed care i.e. conduct studies of the effectiveness of different models in the
Australian context.

9 How many and what type of clients fall between existing funding programs (HACC, CACPs and EACH)? What would be the most effective way to bridge the gaps?

10 How can we better meet the transport needs of older people?

11 How can we more effectively attract and retain care staff?

12 Is the provision of community care at a comparable level to residential care cost effective?

13 Gain a population-based knowledge of those who do (and do not) use services, the individual and carer factors that precipitate entry to and change of services over time, the influence of the local availability of the mix of services on service use, and the overall duration of service use in the community and in residential care over the course of later life to death.

14 How can aids and equipment be most effectively accessed, provided, used and funded — to maximise cost effectiveness? (This should cover the spectrum of aids from low to high tech and include home modifications)

15 In a community-based restorative model: What are the staff competencies for assessment and direct care? How does it link with rehabilitation? How is seamless delivery of care between hospital, rehabilitation and home to occur?

16 How viable would the different models of long-term social care insurance be for community care, especially given other countries' experiences?

17 What outcome measures are appropriate for services delivered within a wellness model and how can these be incorporated into reporting models?

18 Is there any impact on client outcomes of using staff with 'lesser' or no professional qualifications (e.g. ENs rather than RNs, coordinators with no health or human services tertiary qualification rather than those who have a qualification) in community care services?

19 What are the jobs and associated skills required for community care now and in the future, are they the same or different?

20 How do different housing and neighbourhood features impact on the delivery of, and benefits gained from community care.

21 Case management. Who needs it, who wants it, who gets it? Is it for everybody? What are the benefits?

22 Does the quality of community care meet consumer expectations? How much would it cost to deliver the full range of services that consumers actually want, at industry standard?

23 What are we trying to achieve with restorative care/recovery based models of community care and what are appropriate outcome measures?

24 What is the impact of low income on community care use and outcomes?

25 How can we work better across the different sectors providing support to older people with mental health problems?

26 How effective is the wellness approach at improving quality of life as well as health and functional status?

27 What factors positively contribute to outcomes associated with ageing well?

28 What works when and how to maintain the health and well being of family carers?

29 Identify what interventions (particularly early intervention approaches) are effective and under what circumstances.

30 Why does care at home fail and what is needed to make it succeed?