Policy Document
Healthy Ageing and Aged Care (2022)

Position Statement

AMSA believes that:

1. The health and wellbeing of the growing ageing population is of fundamental importance and requires urgent attention.
2. Our longer lives are a remarkable collective achievement, and, in order to appreciate and take advantage of the opportunity this presents, a positive shift in perspective is required to ensure the rights and dignity of older people are respected and valued.
3. The determinants of health among older people and the disease burden they experience are varying and complex, and require a multidisciplinary healthcare approach to ensure the best outcomes.
4. Access to healthcare and financial support should be equitable for all older Australians. Currently, many population groups face higher barriers to healthy ageing, including but not limited to: Aboriginal and Torres Strait Islander peoples, LGBTQIA+ peoples, culturally and linguistically diverse people, those living in rural and remote areas, and older Australians with disabilities.
5. A dearth of evidence exists regarding the barriers to and facilitators of quality and culturally safe care among older populations, in particular the vulnerable populations listed above, and further research is required to develop adequate policies and programs.
6. The aged care sector in Australia needs to be reformed, in accordance with the recommendations made by the Royal Commission into Aged Care Quality and Safety, to ensure the provision of quality services to older people who require long-term care.

Policy points

AMSA calls upon:

1. **The Australian Government to:**
    a. Implement the recommendations of the Royal Commission into Aged Care Quality and Safety (2021);
    b. Facilitate improved access to online health literacy programs for older Australians to support and supplement their care;
    c. Increase promotion (including, if required, rebranding) of the Community Visitors Scheme, and support relevant organisations

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(e.g. home care providers, residential care providers, NGOs) to network and share information required to improve program uptake;

d. Promote awareness of and increased compliance with the *Age Discrimination Act 2004* among businesses and employers, particularly regarding hiring practices that discriminate against older people;
e. Strengthen governance of the aged care sector by:
    i. Maintaining the aged care portfolio as a Cabinet ministerial position;
    ii. Establishing specific roles for the governance of the various facets of aged care, including:
        1. A systems governor, to approve new providers and manage complaints, funding, aged care research and data collection, workforce planning, and market governance;
        2. Quality and safety regulator, to manage quality and safety monitoring and compliance;
        3. Prudential regulator, to monitor financial risk and regulate aged care providers;
    iii. Consulting with First Nations stakeholders, including Aboriginal Community Controlled Health Organisations, to develop First Nations controlled healthy ageing and aged care services;
f. Improve funding of the aged care sector by:
    i. Creating an aged care levy on taxable income;
    ii. Creating a special appropriation of the Consolidated Revenue Fund for aged care;
    iii. Creating an independent pricing authority;
    iv. Creating a senior dental benefits scheme;
    v. Providing concessional loans to aged care providers to help phase out capital financing via Refundable Accommodation Deposits;
    vi. Removing the requirement of older people to pay co-contributions for their clinical and personal care in residential facilities;

vii. Improving the means-testing methods for determining the contribution older people make towards their accommodation and cost of living in aged care, in accordance with the recommendations of the Royal Commission;

viii. Allocating annual capitation payments to enrolled aged care general practices based on the number of older people enrolled at these practices, and the level of their assessed need;

g. Support informal carers to take extended leave in order to care for an older person by adjusting the National Employment Standards;

h. Create a national registration scheme for primary aged care workers to improve the quality and safety of aged care services through the following means:

   i. Minimum aged-care-related qualifications;

   ii. Continued professional development surrounding crucial areas including but not limited to:

      1. Dementia;
      2. Palliative and end-of-life care;
      3. Mental health;
      4. Skin care and wound management;
      5. Medication management;
      6. Hygiene, including incontinence, infection, and oral health;
      7. Nutrition;
      8. Discharge summaries and clinical handovers;
      9. Cultural safety;
      10. Trauma-informed care;
      11. Care for the LGBTQIA+ community

i. Develop aged care guidelines for the crucial areas highlighted in point h., which providers must abide by;

j. Increase accountability for malpractice through improvements to the complaints handling process, including;

   i. Improved reporting pathways and defined consequences for malpractice;

ii. Staff training in complaints processes and open disclosure;
iii. Complaints monitoring, data collection, and regular reports to the systems governor;
iv. Regular public reports on complaints in aged care from the systems governor

k. Ensure an appropriate composition of the aged care workforce by:
   i. Enforcing minimum quotas of nurses and allied health workers within the staffing mix of an aged care service for given number of consumers over a given time period;
   ii. Mandating the presence of an appropriately qualified infection control officer at residential aged care facilities;
   iii. Enforcing higher minimum pay rates for aged care workers to match those of workers in equivalent roles in the public hospital system;
l. Reduce barriers for older people and their families to access aged care by:
   i. Providing personalised consultants whose role is to assist consumers identify and procure appropriate care;
   ii. Streamlining My Aged Care with Carer Gateway to reduce confusion and combine resources.

2. State and territory governments to:

a. Increase the amount of affordable, appropriate social housing available to older people;
b. Establish state and territory-based offices for aged care, whose role is to:
   i. Identify and respond to relevant state and territory-specific issues;
   ii. Continuously collect data pertaining to the quality and safety of aged care services and relevant complaints processes to forward on to the federal systems governor.
c. Work with local governments (where relevant) to research, develop, and deliver evidence-based initiatives aiming to make public transport more accessible to older people and adequate for their needs;

d. Promote and support the inclusion of intergenerational activities (e.g. intergenerational reminiscence therapy) in primary and secondary school curricula;
e. Improve engagement with local governments, businesses, service organisations, and community members in pre-planning processes for local infrastructure developments that impact on public space accessibility, especially for older people;
f. Bolster multidisciplinary outreach services for aged care by:
    i. Establishing these services in areas of identified clinical need;
    ii. Ensuring they are available 24-hour on-call.

3. **Local governments to:**
    a. Work with community service providers and other organisations to provide and facilitate community-based programs, including walking and rolling groups, intergenerational activities (such as school and nursing home collaborative projects), health literacy programs, and other initiatives that increase social participation among older people;
    b. Research, develop, and deliver evidence-based initiatives aiming to make public transport more accessible to older people and adequate for their needs;
    c. Facilitate the creation of advisory Councils of Elders, which consists of local older community members, to better engage with and provide services for local First Nations communities;
    d. Help create community groups for informal carers.
4. **Government health departments to:**
    a. Promote life course approaches when planning and delivering preventative health care initiatives to promote healthy ageing;
    b. Develop deprescription protocols based on multidisciplinary care models to combat polypharmacy;
    c. Support networking and information sharing among relevant organisations (e.g. home care providers, residential care providers, NGOs) to improve uptake of the Community Visitors Scheme;
    d. Expand translation and interpreting services for ease of provision in residential and home aged care services;

e. Direct development of healthy ageing and aged care services to be provided on Country for First Nations consumers in accordance with local First Nations priorities.

5. **Australian medical schools, universities and tertiary educational institutions to:**
    a. Provide greater incorporation of geriatric care into healthcare curricula, with a particular focus on understanding, identifying, and addressing ageism;
    b. Facilitate increased exposure to geriatric care environments through opportunities such as placements and internships;
    c. Ensure professional education includes critical, multi-disciplinary, and self-reflective thinking that encourages students to engage with ideas of autonomy and care.
6. **Medical, nursing, and allied health professionals and students to:**
    a. Treat all older people and their loved ones with respect;
    b. Advocate for the incorporation of health and exercise regimes into care plans for older people;
    c. Engage in empathetic and reflective practice when working with older people to ensure their autonomy is respected and to identify inherent ageist bias.
    d. Facilitate engagement and education in pharmacological compliance for older patients.
7. **Aged care workers to:**
    a. Treat all older people and their loved ones with respect;
    b. Follow national guidelines for aged care, ensure their registration is up to date, and engage in continuing professional development, upskilling, and training;
    c. Report staff misconduct to the relevant complaints authorities.
8. **Health research organisations to:**
    a. Undertake place-based research into the needs and barriers for older people accessing public transport, specifically in relation to accessing health services and social participation outcomes;
    b. Undertake research into the healthy ageing experiences and priorities of vulnerable populations including but not limited to:
        i. First Nations older people, particularly through First-Nations-led research;

ii. LGBTQIA+ older people;
iii. Culturally and linguistically diverse older people;
iv. Older people living in rural and remote areas;
v. Older people living with disability;
vi. Older people experiencing low socio-economic status/financial hardship.

9. **Community service organisations to:**
    a. Advocate for increased community-based medical programs that combat social isolation and engage in a strengths-based medical approach with patients;
    b. For organisations working with older people at risk of or experiencing homelessness, coordinate and collaborate with aged care providers to ensure adequate services are available for this population;
    c. Improve availability of crisis and support helplines for elder abuse.
10. **Residential aged care and aged care organisations to:**
    a. Treat all older people and their loved ones with respect;
    b. Partner with local schools and community groups to promote and facilitate intergenerational activities (e.g. intergenerational reminiscence therapy);
    c. Inform consumers about their responsibility to identify who they would like to make care, financial, and medical decisions for them should they lose capacity;
        i. Support consumers who wish to nominate non-relatives to decision-making roles;
    d. Ensure consumers entering aged care facilities have read, understood and been offered the opportunity to sign the Charter of Aged Care Rights;
    e. Develop plans to deal with acute deteriorations in residents' health, including:
        i. Coordinating with residents' primary health physicians to develop such action plans;
        ii. Maintaining up-to-date records of residents' health conditions, their medications, and any advanced health directives or other substitute decision makers;
    f. Closely monitor staff performance, safety and adherence to

guidelines;

g. Work with the Commonwealth government to professionalise aged care workforce by providing professional development, training and staff support;
h. Ensure personal protective equipment stocks are adequate;
i. Collect data reflecting the vulnerable populations in their care to inform provision of locally applicable and culturally safe care.

11. Businesses and other employers to:

a. Adopt more inclusive hiring practices, and develop and implement organisational frameworks that improve participation and retention of older members of staff.

Background

The Australian Medical Students' Association (AMSA) is the peak representative body of Australia's medical students. AMSA affirms that all communities have the right to the highest attainable level of health and quality of life. Accordingly, AMSA advocates for a holistic approach to address the biopsychosocial issues impacting the health and wellbeing of the growing ageing population. AMSA further recognises the complexities in delivering safe, high quality, and culturally appropriate aged care and advocates for accessibility, excellence, transparency, and accountability in all aged care settings. Two publications that have substantially influenced the development of this policy document have shaped current political and public discourse around healthy ageing and aged care at both the national and international levels: the Final Report of the Australian Royal Commission into Aged Care Quality and Safety, and the World Health Organization's *Decade of Healthy Ageing 2020–2030* Plan. As such, this policy echoes many of the recommendations made in these publications.

This document refers to 'older people' as the focus of considerations and policy for healthy ageing and aged care. For the sake of clarity and consistency with research, statistical information, and popular understanding, older people are generally considered to be those aged 65 or over. However, AMSA acknowledges that the determinants of healthy ageing are relevant to people across different age groups, and that a broad spectrum of physical, mental, and cognitive capacity will be represented by the population described by the term 'older people'. While ageing is associated with general decline in these capacities, it should not itself be considered burdensome. Rather, AMSA believes ageing should be viewed according to the World Health Organization's *Decade of Healthy Ageing 2020–2030* plan, which considers our longer lives as 'one of our most remarkable collective achievements' and an 'opportunity for rethinking not just what older age is but also how our whole lives might unfold' [1].

In 2020, those aged 65 and over made up approximately 16% of Australia's

population, and this proportion is projected to grow to 22% by 2066 [2]. As we progress through the Decade of Healthy Ageing, AMSA looks to the future of geriatric care with the aim to develop a comprehensive and adaptable policy to advocate for older Australians and those providing them care.

Healthy ageing

Demographics

Australia's older population is diverse. More than one third (37%) of older Australians were born abroad, and approximately one fifth (18%) speak a language other than English some or all of the time. The rate of exclusive English use is closely linked with the country of birth, with almost all older Australians (99%) born in Australia speaking only English, compared with 54% of those born abroad. The most common non-English languages spoken by older Australians are Italian, Chinese (including Mandarin and Cantonese), and Greek. Among those born abroad, the most common regions of origin were Europe and South-East Asia. In the 2016 census, 78% of older Australians identified their religious background as Christian, while 18% reported secular beliefs or no religious affiliation. The remaining 4% comprises other religious traditions, chiefly Buddhism (1.5%) [2].

Two thirds (66%) of older Australians live in major cities, 23% live in inner regional areas, and the remaining 11% live in outer regional, remote, and very remote areas. This is in contrast to a greater proportion of the general population living in the major cities (72%). A significant plurality of older Australians with a disability (34%) live in rural and remote areas. The proportion of older Australians with a disability has been largely unchanging in recent years, holding steady at approximately 50% [2].

Approximately 4% of First Nations people are aged 65 or over. Life expectancy is estimated at 10 years lower than the overall population life expectancy. Older First Nations people experience significantly higher multi-morbidity than non-Indigenous Australians, with a 2.59-fold increase in risk [2, 4].

Population data about the LGBTQIA+ community is limited, though the 2016 census did reflect that there were approximately 4,800 cohabitating same-sex couples aged 65 and older. As the census only collects data that relate to couples who cohabitate, this figure likely underrepresents older LGBTQIA+ people [2].

Vulnerable populations

First Nations people and healthy ageing

Many older First Nations elders are custodians of important cultural knowledge and traditions within their communities. Recognition of the crucial role older First Nations people play in the health and wellbeing of their communities is essential in developing a culturally safe healthy ageing policy [4]. First Nations perspectives on healthy ageing may differ from Western outlooks, emphasising not only the importance of absence of disease, but also the continued ability to fulfil cultural roles and traditions [5, 6]. It is also crucial to recognise the inherent

diversity among First Nations and to resist homogenising the cultures of the hundreds of Nations which predate colonisation, each with unique languages, beliefs, and practices [5, 6].

Aboriginal and Torres Strait Islander people experience widespread health inequity, attributable to the long-term effects of colonisation, intergenerational trauma, and racism [9, 10]. The impacts of colonisation must be understood through the lens of loss of family, culture, language, traditions, and land [5]. The removal of children from their families during the Stolen Generations and subsequent forced assimilation has had long-lasting impacts on health disparities and social disadvantage, including adverse mental health outcomes, substance misuse, economic disenfranchisement, and experiences of violence in the home [6]. These communities now demonstrate a longstanding and profound resilience in grappling with these challenges while maintaining a strong connection to community and Country; a substantial protective factor for First Nations health [6].

The number of Aboriginal Australians over the age of 65 is set to almost triple from 22,700 people in 2011 to 61,900 people in 2026 [4]. With this fast-growing cohort comes an expected increase in service use. In 2020, First Nations Australians accounted for 1.0% of people living in residential aged care and 2.4% of people accessing home care [2]. The health priorities of First Nations people in Australia are under-researched, with a paucity of primary research, a growing but still small base of Indigenous-led research, and very poor indexing in medical literature databases. Recognition of First Nations healthy ageing as a research priority is essential as service use grows with the growing population over 65.

Some key health concerns of First Nations people include a higher prevalence of chronic conditions such as diabetes, cardiovascular disease, and respiratory disease, age-related conditions such as dementia, and mobility related concerns such as falls and pain [4, 5]. In the absence of culturally safe care, older First Nations people can experience negative feelings such as despair, anger, and embarrassment associated with living with chronic illness or decreased mobility, issues which in turn can present their own challenges to ageing well by limiting independence [5, 6, 7]. Protective social and cultural factors for healthy ageing include maintaining strong connections to Country, tradition, family, and community [5, 6, 8]. Older First Nations people are also concerned about the health of younger generations, with particular focus on mental health, substance use, and suicide [4].

Barriers to wellbeing cited in the literature include a lack of First-Nations-controlled health services, transport and financial barriers to accessing care, a lack of flexibility in mainstream services, and social isolation [5, 6, 7]. Multimorbidity and increased age are associated with difficulty navigating the healthcare system and challenges in finding and appraising relevant health information, resulting in further disenfranchisement of older First Nations people [9]. Exercising autonomy and participating in decision-making, conversely,

promote healthy ageing [5]. Culturally safe, First-Nations-led programs of care have been repeatedly identified as key enablers to First Nations healthy ageing [4, 5, 7].

LGBTQIA+ people and healthy ageing

Older lesbian, gay, bisexual, transgender, queer, intersex, and asexual people have faced unique challenges to healthy ageing, including homophobic, biphobic, transphobic and intersexist violence, discrimination, social rejection due to sexuality, gender identity, or intersex status, state-based opression, and trauma incurred from living through the HIV/AIDS crisis [11, 15]. Intersectionality is key in understanding the discrimination facing older people with multiple marginalised identities, as is caution in avoiding homogenising the experiences of all queer and gender diverse older people [11, 12, 19]. Despite these challenges, LGBTQIA+ older people demonstrate a high degree of resilience and a desire for generativity [13, 15].

LGBTQIA+ older people are at a greater risk of physical health conditions such as cardiovascular disease, stroke, hypertension, diabetes, and certain cancers, with a disproportionate burden of poor health outcomes for transgender people, lesbians and bisexual women [12, 16, 17, 18]. LGBTQIA+ older people also experience greater rates of mental illness and distress, particularly depression and anxiety, compared to their cisgender and heterosexual counterparts [12, 13, 16, 18]. These complex physical and mental health outcomes are in part linked to elevated levels of stress incurred by living in a deeply cisheteronormative society, lifetime experiences of discrimination, and limited access to inclusive healthcare [17].

Fear of stigma, discrimination, exclusion, and removal of autonomy in aged care are among the most substantial barriers to access for LGBTQIA+ older people [11, 14]. It is essential to remember that an LGBTQIA+ person who is currently accessing aged care services grew up in a world where their identity was illegal and could be forced to undergo medical intervention to ‘cure’ them [19]. Queer and gender diverse adults of all ages report experiencing discrimination by healthcare staff and systems because of their sexuality or gender identity, disproportionately affecting transgender people [16]. For older transgender people, the fear of discrimination may extend beyond fear of verbal attacks and physical mistreatment, to the preclusion of them living authentically as their gender identity [11]. Affordability of long term care, uncertainty as to the future of their care, and complexities of end of life care are also common concerns held by this demographic [11].

LGBTQIA+ older people rely strongly on informal support networks [11]. In many cases, this may be linked to estrangement from the family of birth, and not having children of their own. Inclusion of family of choice is an important way that care systems can maintain a sense of community which itself promotes healthy ageing in this cohort [11, 12, 13, 14]. Consistent use of correct pronouns, inclusion of details of sexuality and gender identity in documentation, inclusion

of partners regardless of gender, and ensuring LGBTQIA+ older adults are cared for in a way they would choose for themselves are essential steps in connecting this historically disenfranchised group with the care they deserve to access [12, 14, 19].

Despite increasing social visibility of LGBTQIA+ people in general, there is a paucity of primary research exploring healthy ageing, particularly in the Australian context and in the demographic of queer and gender diverse older people [12, 18]. Population-based ageing research often fails to include sexuality and gender identity demographic information, which reflects an absence of targeted primary research but also precludes inclusion in later meta-analysis [16]. For further discussion of these points, see *AMSA's LGBTQIA+ Health (2019)* [20] *and Transgender Health and Access to Care (2021)* [21] *policies.*

Culturally and linguistically diverse older people and healthy ageing

The older culturally and linguistically diverse (CALD) community is a heterogenous group, largely composed of people who came to Australia in their youth, and those who migrated later in life [22]. This community of people, despite coming from a wide range of cultural backgrounds and experiences, has broadly similar needs for healthy ageing [25]. For example, the importance of a strong sense of community to combat the negative sequelae of isolation has been emphasised across the literature [25]. As understandings of ageing are strongly informed by culture, the ability to cultivate cultural wellbeing throughout all stages of life is essential [25]. There is very little primary research focused on the delivery of aged care services to the ageing CALDcommunity, particularly in Australia [22, 24].

Many CALD older people face challenges in accessing healthcare due to limited English proficiency, a lack of interpreters or bilingual staff, and difficulty navigating technology [22, 23, 25]. Other important barriers to care particularly in the setting of residential aged care include culturally inappropriate care, cultural barriers in relation to food (halal, kosher, etc), and the use of informal interpreters, most often family members [22, 24]. Key outcomes of care such as length of stay for hospital admissions are improved upon the provision of culturally and linguistically appropriate care [23].

Older people living in rural and remote areas

The ageing population in rural areas is growing at twice the rate of metropolitan centres [26]. As such, there is a growing demand for aged care services in the regions, positioning those aged 65 and over living in rural and remote areas as a key community for promoting healthy ageing. Rural communities face unique barriers to healthy ageing not present in urban communities, such as limited health infrastructure, limited transport options, difficulty retaining a qualified health workforce, long wait times in accessing limited specialist care, and geographic isolation [26, 28, 29]. Equity of service provision between rural and urban communities is a commonly cited concern of older Australians in the regions [26, 28]. Close-knit rural communities also provide several benefits for

older Australians, such as increased levels of volunteering and social support [26].

Current research output on healthy ageing in rural and remote Australia focuses on mobility, falls risk, and continence screening and management [27]. However, there remains a paucity of research on rural aged care and rural healthy ageing experiences [26, 28].

Disability and older people

According to the Australian Bureau of Statistics (ABS), 49.6% of older Australians had a disability in 2018, with 35.4% of these having a profound or severe disability. Most of this population is living in care accommodation (96%). More than a third (38%) of older Australians need assistance with everyday activities [30]. Older Australians with disabilities include those who acquired disability at a younger age and are now ageing with a disability, as well as those who have acquired disability at an older age. These populations have different life experiences and therefore different needs; however, they are currently treated as a homogenous group by Australian statistics [31, 32] and there is a lack of research that distinguishes between them.

It is important to note that the National Disability Insurance Scheme (NDIS) only covers Australians under the age of 65,unless the disability was acquired before this age. *Refer to AMSA Disability Care and Support* [33] *for more information on the NDIS*. Beyond the age of 65, support may come from the Disability Support for Older Australians program [34], which provides support to people who are ineligible for the NDIS but are 'existing client[s] of state-administered specialist disability services at the time the NDIS commenced in their region'. Those who are not eligible for this program are referred to My Aged Care. As noted in the Royal Commission into Aged Care Quality and Safety, these support programs are not as comprehensive or accessible as the NDIS. Furthermore, the NDIS' exclusion of older Australians is inherently discriminatory, leaving many older Australians with a disability feeling excluded [35]. *Refer to the Funding and Training section of this policy for more information on My Aged Care*.

The life expectancy of people with intellectual disabilities is increasing, and many of them are experiencing ageing with greater multimorbidity than others of the same age [36]. Despite this, there is a paucity of research regarding healthy ageing for people with intellectual disabilities. Current research [37, 38] identifies some key issues regarding ageing within this population:

1) Not-for-profit support organisations are currently unable to support the needs of people with intellectual disabilities with their current knowledge;
2) There is a wide gap between rural and urban areas in terms of health outcomes and accessibility of support services;
3) Ageing carers of persons with intellectual disabilities require satisfactory care and support for their children (who may be ageing themselves);
4) A lack of interaction between the aged care and disability sectors.

Determinants of health

Basic needs

Healthy ageing is dependent on a complex interaction of multiple factors at the individual, social, cultural, economic, and environmental levels. Given that healthy ageing spans the life course, the determinants of general health are synonymous with the determinants of health ageing. According to the WHO, the determinants of health include income and social status, education, physical environment, social support networks, health services, and gender, as well as an individual's personal characteristics and behaviours and the broader social and economic environment [39]. The impact of each of these determinants is not equally and consistently experienced across populations: it can vary between communities and according to gender, race, sexuality, and ethnicity.

Globally, the basic requirements for health and healthy ageing are not readily available or accessible for all people. It is widely acknowledged that a significant gap in health status and outcomes exists between lower and higher countries. While increases in national average income alone does not necessarily correlate with universal accessibility to healthcare for the local population, on average it is a good predictor of improved outcomes – particularly in the lowest-income countries, where small increases to average income can produce significant increases in health [40]. Addressing the global dimensions of health inequity is immensely complex, and requires multilateral efforts at cooperation and governance [41].

Disparities in the health status and outcomes of individuals and social groups also exist within all countries, regardless of income status. This inequality follows economic lines, too, but can also depend heavily on other social determinants. Historically, macro-level policies such as welfare state expansion, improved health care access, and enhanced political incorporation have significantly improved health inequalities at the national level [42].

While the social determinants of health are well known, reducing their impact on unequal status and outcomes for healthy ageing requires an understanding of how these disparities are generated over an individual's lifetime [43]. Many are even generated in early childhood. [44]. Life course approaches are gaining increasing attention for their capacity to promote healthy ageing before issues arise or people reach older age. According to the NHS, 'a life course approach considers the critical stages, transitions, and settings where large differences can be made in promoting or restoring health and wellbeing' [45]. Interventions that target these critical stages can have a preventative effect on a range of issues, including health outcomes, which can be more difficult and costly to achieve with later intervention [43, 46]. Life course approaches looking to address inequalities that emerge during childhood often take the form of cross-sector partnerships that involve families and communities in the design of interventions [46].

Autonomy

The WHO's *Decade of Healthy Ageing 2020–2030* plan states that the 'inherent dignity and individual autonomy' of older people must be 'respected and their human right to participate fully in the civil, economic, social, cultural, and political life of their societies promoted and protected' [1]. In this context, autonomy can be defined as the 'capacity to influence the environment and make decisions, irrespective of having executional autonomy, to live the kind of life someone desires to live in the face of diminishing social, physical and/or cognitive resources and dependency' [47]. Due to age-related decline or other health conditions, many older people, while being able to exercise their autonomy through active decision-making, will experience impairments that significantly impede independent action.

The level of care a person requires and whether that care is formal (i.e. professional home care or residential care facilities) or informal (i.e. at home, provided by family or community) are key factors influencing autonomy. In formal care, issues of autonomy are often at odds with the practical requirements and procedures of care, particularly in the absence of adequate funding, staffing, and training, and are often complicated by the varying professional and personal characteristics of both carers and recipients of care [47, 48]. This is particularly true in residential aged care, where issues such as scheduling, lack of choice, deployment of temporary personnel, and lack of personal space compound barriers to autonomy [47]. These issues may also be present in informal care, and negative self-esteem relating to the requirement for care from known and loved ones – in particular, from adult children – may be more prevalent in this setting [49].

Recommendations for improving autonomy in aged care highlight that it involves overlapping domains that constitute a network that needs to be 'responsive, integrated and collaborative, and geared to patient outcomes' [48]. Improvements depend on policy and funding environments, professional education (e.g. promoting critical, cross-disciplinary, and self-reflective thinking,particularly regarding ageism), and mental health interventions (e.g. targeting self-esteem for individuals who find themselves in need of care) [47-49].

Mobility

While much of the discussion regarding healthy ageing is centred around the provision of care, healthy ageing also requires physical spaces (both public and private) to be accessible to and safe for older people. Many of the physical barriers to accessing services and quality of life for older people are similar to those experienced by people across all ages experiencing disability, and as such are covered in more detail under *AMSA's Disability Care and Support (2022)* policy [33].

Age-friendly communities

The WHO has proposed an age-friendly cities framework, which describes eight overlapping domains key to facilitating social participation, positive health outcomes, and a sense of belonging for older people in their communities [50]. Key to these at the local level are the built environment, accessible public transport, and social participation.

Social interaction has been noted as 'the overall motivator for going outdoors' among older people [51], and physical infrastructure barriers have clear negative impacts on social participation and experiences of isolation among this population. Research has identified inadequate public transport as a major barrier to participation when older people can no longer drive, especially for those in rural communities and with mobility issues. Addressing this requires preparation for driving cessation at the individual level, but also tailored transport initiatives that improve public transport accessibility for older people [52]. One example of such an initiative in Australia was the introduction, in 2019, of free off-peak travel for seniors on public transport operated by Brisbane City Council. Local built environment considerations are also key for promoting social interaction. This is often described as the 'walkability' of a neighbourhood (noting that these considerations also apply to people with different mobility requirements), and involves issues such as levels of road traffic, footpath integrity and dimensions, available and adequate seating, sheltered spaces, pedestrian access to shops and other businesses, signalled crosswalks, and community safety, among others [51, 53]. Neighbourhood walkability has also been found to have strong links to increased physical activity among older people, and as such is important for optimising health outcomes [53].

Falls

According to the Australian Institute of Health and Welfare (AIHW), falls are the largest contributor to hospitalised injuries and a leading cause of injury deaths in Australia, and have a disproportionate effect on older people. On average, almost one third of people aged 65 and over will have experienced a fall in a given twelve-month period, one fifth of which will have required hospitalisation [54]. In 2018–19, 3,402 people per 100,000 aged 65 and over were hospitalised following a fall, compared to 920 per 100,000 for the general population – accounting for 58% of fall-related hospitalisations and 94% of fall-related deaths [55].
Causes of falls are varied and include physical changes (both age-related decline and specific health problems) and environmental risks (such as uneven surfaces, slippery surfaces, incorrect footwear, and poor lighting) that are exacerbated by these physical changes. Falls that don't result in death can lead to serious complications including hip fractures, wrist fractures, head injuries, and reduced confidence in movement, which can impose a heavy long-term burden, including an increased chance of requiring formal care [54].

Social relationships

It is widely recognised that social isolation and loneliness are major concerns for older people in middle- and high-income countries, particularly among the vulnerable populations identified above, and are linked to increased risk of premature mortality from all causes, higher rates of depression and anxiety, increased risk of dementia, and lower quality of life [56, 57-59]. Public health responses to COVID-19 such as lockdowns, physical distancing, and visitor restrictions in residential care facilities have further exacerbated these risks [60]. Many interventions have been developed that aim to foster and promote social inclusion for older people. Among them, intergenerational activities (particularly

intergenerational reminiscence therapy), music and singing programmes, art and culture activities, and multi-strategy programmes that incorporate social support components have been shown to have an overall positive effect on various health outcomes, including depression, quality of life, and social health [61, 62]. Technological interventions have also been shown to be effective at alleviating loneliness and social isolation [62], particularly in response to COVID-19 restrictions. One Australian study found that 63% of a sample of community-dwelling older Australians used new technology during lockdowns (predominantly video conferencing for social and work purposes), and that this use was associated with better emotional health and quality of life [60].
Since 1992, the Australian Government has managed a social inclusion program called the Community Visitors Scheme (CVS), which aims to provide friendship and companionship, and develop social connections, for older people who may be at risk of loneliness or isolation [63]. A 2017 review found that 'a lack of awareness of the CVS and its operations (particularly referral processes) is a key barrier to uptake of the scheme in both home and residential care settings', and that improved networking and information sharing among relevant organisations was vital for increasing participation [64].

Homelessness

Homelessness among older people has been increasing in recent years. Between 2011 and 2016, the proportion of people in Australia aged 55–64 experiencing homelessness increased by 26%; for older people aged 65–74, the increase was 37.9% [65]. In particular, women over 55 are the fastest-growing population experiencing homelessness in Australia [66]. Homelessness increases a person's experience of social isolation, and has significant adverse effects on mental and physical health [67]. A 2019 study of homelessness services for older Australians, undertaken by the Australian Housing and Urban Research Institute, found that 'the current system of supporting older people who experience homelessness is fragmented, too poorly resourced, and unable to provide long-term solutions,' and that 'homelessness service provision is disconnected from aged care services' [65]. The study identified five areas of focus for policy and services that could improve quality of life for people experiencing or at risk of homelessness: 1) more affordable, appropriate social housing; 2) better coordination, integrations, and collaboration between and within service systems; 3) more government funding and support; 4) frontline service providers who can empathise with clients; and 5) empowerment and education for older people of their rights.

Contributing to society

Ageism

Ageism is one of the key barriers to social, cultural, and economic inclusion for older people. The WHO's *Global Report on Ageism* says: 'Ageism refers to the stereotypes (how we think), prejudice (how we feel) and discrimination (how we act) directed towards people on the basis of their age. It can be institutional, interpersonal or self-directed' [68]. According to the report, ageism develops early

in life through exposure to stereotypes and prejudices, and often intersects with other forms of discrimination, particularly those based on ability, sex, gender, and race. It is also present in many institutions and parts of society, including those providing health and social care, making it a wicked problem to address.
Ageism is broad in scope and can have a negative effect on older people's physical, mental, and cognitive health and wellbeing outcomes [69, 70]. This is true of ageism being directed at individuals, and of negative perceptions they may direct at themselves: positive self-perceptions of ageing have been shown to increase lifespan across age, gender, functional health, and socioeconomic status [71].
Despite the widespread nature of the problem, research has found that interventions aimed at addressing the prevalence of ageism among youth and adults are associated with substantial reductions [70]. In particular, education, intergenerational contact, and a combination of both have been found to be effective. The WHO has recognised this in its Global Campaign to Combat Ageism, which highlights the three following areas for strategies to reduce ageism: 1) policy and law; 2) educational interventions; 3) intergenerational contact interventions [68].

Employment and workforce participation

In 2018–19, the average age of retirement in Australia was 55.4 years [72]. Once a person is fully retired, they are able to access their superannuation; however, they are not eligible to receive the Age Pension until between 65 and 67 years (depending on their year of birth). According to the AIHW, the labour force participation of older Australians has marginally increased over the last ten years; however, it also reports unemployment rates almost tripling among this population over the same period [72].
Research by PricewaterhouseCooper has suggested that raising employment rates among people over 55 could add approximately $3.5 trillion of GDP to OECD countries as a whole [73]. In Australia, research from Deloitte Access Economics in 2012 suggested that increasing workforce participation for workers over 55 by 3 percentage points could result in a $33 billion boost to GDP [74]. However, individuals wishing to remain in the workforce until or beyond Age Pension eligibility may face barriers to maintaining or gaining new employment.
The likelihood of someone having one or more chronic health conditions increases with age [75]. Unsurprisingly, people with chronic disease across all ages are less likely to participate in the workforce than those without – and this becomes increasingly pronounced for people aged 55 and over [76]. Research has shown that the five most prevalent chronic conditions for people aged between 45 and 64 are back problems, arthritis, mental and behavioural disorders, cardiovascular disease, and depression and account for approximately 61% of individuals out of the workforce due to chronic conditions [76].
Despite the enshrinement of the national *Age Discrimination Act (2004)*, the pervasive nature of ageism means it also has a significant impact on people's ability to participate in the workforce. Widespread perception exists that older workers may lack the technical skills and adaptability, and be at greater risk of injury, than younger workers. In addition, it is often assumed that productivity

declines substantially with age. While it is evident that older people will be unable to participate in some job roles, in practice it is difficult to draw a causal link between age and overall decline in productivity [77] and, depending on job type and industry, the reverse can also be true [78]. A report by the Australian Human Rights Commission found that, despite employers appearing to value older workers and identifying no major differences in their performance, they also profess reluctance at hiring older people and have increasingly adopted a younger age bracket for what they consider an older worker (i.e. between 2018 and 2021, a significantly greater proportion of employers identified 'older' as being between 51 and 55) [71]. The circumstances brought on by COVID-19 appeared to highlight this bias: only a third of respondents said their organisation 'somewhat sought' to keep older workers employed during the pandemic.

Physical and mental health

Disease burden

Unsurprisingly, people aged 65 years and over contribute disproportionately to healthcare statistics in Australia. Older people are more likely to visit a GP in a given 12-month period (97.5%) than those under 65 (90.1%). Correlating with this trend, in 2020 where 68% of people under 65 gave themselves an 'excellent or very good' assessment for their health, only 42% of people over 65 rated themselves the same [79].

For older people in Australia, the fatal disease burden contributed to 61% of the total health burden, with the non-fatal burden contributing the remaining 39%. The leading causes of death of older Australians in 2020 were coronary heart disease, dementia and Alzheimer's disease and neurovascular disease. However, per disease, cancer was the most fatal (92%), followed by infectious diseases (84%) and cardiovascular disease (78%). Finally, the burden of hearing, vision, oral and musculoskeletal issues all had significant quality of life impacts but did not have direct fatal burdens [79].

This burden of health is impacted by lifestyle conditions experienced by many older Australians. In 2020, they had higher rates of being overweight or obese (75.6%) compared to those aged 18–24 (46.0%), higher lifetime risk guidelines for alcohol consumption (15.3% vs 10.6%), and insufficient physical activity (71.9% vs 44.6%). These factors contribute to the emergence of diseases within the older Australian population. Broader biopsychosocial factors also contribute to this disease burden beyond immediate lifestyle factors. As has been discussed in this document, the negative health aspect of loneliness and social isolation is a major risk factor in the development of mental and physical health conditions [80]. Importantly, distinctions must be made between low social support (engagement in the community) and loneliness (interpersonal engagement) that independently contribute to quality-of-life metrics [81], with more older men reporting themselves as lonely and isolated than women [82]. This isolation has correlated health risks, including for cardiovascular [82, 83] and mental health [84]. Furthermore, older Australians have a high risk of presenting with nutritional deficiency [85], which has broader health implications [86].

Non-communicable diseases

Non-communicable diseases are a major factor in the health of older people, with cardiovascular, neurodegenerative, and neurovascular diseases being the three leading causes of death in older Australians. The proportion of older Australians who experience a cardiovascular event such as stroke or heart or vascular disease increases with age, from 16% in those aged 65–74 to 26% in those aged 75 or older [79]. Cardiovascular events are disproportionately higher in older men than women, with coronary heart disease being the leading cause of disease burden in men 65 and older [87].

For neurological conditions, while they comprise a very broad and diverse field, there are several major conditions prevalent in older Australians. The broad classification of dementia (including its diverse subtypes) increases with age, although it is not a normal part of the ageing process [88]. Due to the progressive nature of dementia, the exact prevalence is unknown; however, by 2030, 550 000 Australians are estimated to be living with dementia, with those aged 65–84 making up over half of this [79]. Conditions such as Myasthenia Gravis [89], Alzheimer's [90], and Parkinson's [91] can also present with ageing, exacerbating existing health conditions and impacting quality adjusted life years [79].

Due to both age-associated degeneration and exposure to environmental factors, older Australians are more vulnerable to chronic respiratory conditions. Chronic obstructive pulmonary disease (COPD) impacts 7% of all older Australians, and asthma impacts 12%. Lifestyle and environmental factors like asbestos exposure and smoking all contribute to these conditions, with some evidence suggesting medication may also contribute [92].

Factors such as lifestyle choices and population health have impacted the prevalence of endocrine disorders, with a doubling in diabetes among older Australians from 1995 (8.5%) to 2018 (16.8%) – although improved public awareness, management, and detection have contributed to the recorded rise of these disorders [93]. Renal disorders also play a significant role in older Australians' quality of life, with chronic kidney disease increasing rapidly with age [94]. This is a significant pathology when considered alongside the increased incidence of hospitalisation due to renal diseases, and the lack of end-stage kidney disease transplants in older patients. Liver disease is also associated with age, linked to both accrued damage from lifestyle factors such as alcoholism and to diminishing of hepatic function with age [94–97].

While not a direct contributor to mortality, ear and eye pathologies impairs general quality of life. It is estimated that 1 in 3 older Australians have some form of deafness that impairs their capacity for communication, social participation, and employment. A significant majority of older Australians (93%) reported a chronic eye condition in 2020 [79]. Both factors are important in considering general health due to their impact on quality of life in areas such as social engagement and engagement with health services.

Contrary to GP, hospital, and medical specialist presentations, older Australians are less likely to have seen a dentist in the past 12 months than those under 65. Oral health includes both tooth and gum health, and decline has been linked to general infection susceptibility, cardiovascular disease, and respiratory conditions [97]. Neurological conditions and other factors that impair quality of life correlate with decreased oral health [98].

Musculoskeletal conditions are another area of health, and are simultaneously over-represented and offer one of the best avenues for multi-disciplinary management [99]. Among musculoskeletal conditions, arthritis is the most common – affecting 49% of older Australians – and is broadly divided into osteoarthritis and rheumatoid arthritis. This is compounded by a large presentation of back problems and osteoporosis, which profoundly impact quality of life [100, 101].

For broader examination of non-communicable diseases and the underlying societal causes, *refer to AMSA's Non-Communicable Diseases (2022)* policy [102].

Infectious diseases

Infectious diseases also present a significant disease burden for older Australians. Community-acquired infections, such as community-acquired pneumonia are a major source of hospitalisation and mortality among older people [103]. Gastroenteritis and influenza, while typically non-lethal in the general population, represent a high risk to older people [79]. This risk is compounded by shared living arrangements such as residential care and retirement villages, which can allow infectious diseases to rapidly spread [104]. Sexual health is largely under-reported with regards to the health of older people. Sexually transmitted infections prevalance is increasing at a faster rate in older women than in people aged 15–34 [105]. Urinary tract infections also present a common route of sepsis, hospitalisation, and reduced quality of life [106].
Due to the generally decreased immunity of older people and their increased rate of hospital admissions, they contribute to a significant proportion of nosocomial infections [107]. However, this is an area of limited research, with no national-healthcare-associated infection surveillance program. Hospital-acquired infections were significantly more likely in patients with dementia, highlighting how comorbidities play a significant role in elderly health [108].

COVID-19

Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2 or COVID-19) has demonstrated a higher mortality and worse outcomes in older adults [109]. This is attributed to weakened immunity and increased presence of comorbidities such as COPD and cardiovascular disease [110]. As discussed above, the consequence of this disease is not just mortality but also the worsening of social isolation experienced by older people [111]. Older Australians have shown a significant worsening in psychological stress and anxiety over the course of the pandemic [112].

Mental health

While physical health is important, consideration of mental health is significant for ensuring a high quality of life for older people. Due to the wide array of factors impacting mental health, such as psychological, biological, socioeconomic, and cultural [113], presentation of mental health varies widely in this population. Good mental health supports healthy outcomes with age, with the contrary also being true [114]. This works in both directions: good physical habits support good mental ageing (and vice versa) [115]. Mental health is a broad area, but it is commonly examined through the lens of mental illnesses such as anxiety, depression, psychotic disorders, and substance use disorders [116]. Aged care residents represent a high-risk group for mental health, with 87% being diagnosed with one form of mental health or behavioural condition [79].

Prevention and management

Targeted medical and clinical programs for individual healthcare can assist in reducing the disease burden among older people.

A major avenue for minimising deterioration of identified conditions such as arthritis is the use of multi-disciplinary teams, which incorporate physicians, physiotherapists, and other allied health professionals into medium- and long-term care plans [117, 118]. This can be seen in the implementation of fall prevention programs, which is a major adverse event for older Australians [119, 120]. While screening for risk can reduce fracture rates in high fall risk individuals, use of exercise regimes as delivered by physiotherapists is a cost-effective way to minimise injury in relation to falls [121].

Due to the broad effects of age-related decline, paired with an overall reduction in positive lifestyle factors, programs that aim to improve diet and increase physical activity present a cost-effective management strategy for the deterioration of chronic disease [122, 123]. Such programs can be developed by multidisciplinary teams and have positive correlation with reducing inflammatory expression [124], cognitive decline [125], and metabolic disease [126], among other chronic diseases [127, 128]. They can also be paired with programs that aim to increase health literacy throughout life,especially digital health literacy to further improve outcomes [129]. By implementing course-of-life programs, not just those focused on outcomes for older people, the lifestyle factors that can impact healthy ageing can be successfully managed.

Australia already implements a variety of screening programs, such as for prostate and breast cancer [130]. Furthermore, vaccinations for herpes zoster and pneumococcal are funded by public health initiatives. However, health literacy and actions of medical practitioners can impact the screening intention in older Australians [131]. Hence, correct training of medical practitioners, especially general practitioners, with regards to recommendations for screening and vaccinations is key for promoting engagement with these services among older people [132]. While older Australians do demonstrate health literacy seeking behaviour such as reading online, access to tailored resources is important for resulting in improved outcomes [133]. By engaging older Australians in their health, improved outcomes are found in high-risk areas such as medication compliance [134]. This can extend to emphasising the importance of mental and dental health [86, 135].

Another area that older people are at a high risk of is medication non-compliance and polypharmacy. This is due to their increased risk of adverse drug reaction paired with multiple drug regimens for different conditions, resulting in an increased chance of drug-drug interactions [136]. This has been found to correlate with increased risk of injuries such as hip fractures [137]. A consequence of this polypharmacy is the risk of prescription cascades [138], leading to unnecessary and possibly harmful drug programs. This can be reduced by implementing deprescribing protocols [139], which aim to reduce this drug burden via evidence-based programs [140, 141]. Another avenue of reducing polypharmacy is the use of multidisciplinary practice with older patient involvement, which has shown improved patient outcomes [142].

Finally, community-based programs for older people have been shown to improve broader health engagement and health outcomes in areas such as mental health [143]. Residential care facilities and seniors' centres offer unique concentrations of this demographic, allowing a high level of engagement in health promotion [144, 145]. Community-based walk and roll groups have been shown to improve both physical and mental outcomes of older Australians, as have collaborative research projects between nursing homes and schools [146]. The efficacy of

these programs is further improved via the community-based incorporation of specific vulnerable groups, such as First Nations Peoples, in accessible and culturally safe ways [4].

Aged care

Aged care standards

The Aged Care Quality and Safety Commission has codified eight standards to which compliance by organisations providing aged care services is expected. These standards reflect the level of care the community and individuals can expect from Commonwealth-funded aged care service providers [147, 148].

The first standard, *Consumer dignity and choice*, protects the rights of consumers to dignity and respect, identity, access to culturally safe care, decision-making, and privacy. Of particular note, culturally safe care is defined by the consumer and is delivered in line with the consumer's individual preferences. Choice and independence must be protected by aged care services, with respect to both clinical decision-making and maintenance of the consumer's social connections.

Ongoing assessment and planning with consumers, closely linked with concepts touched on in Standard 1, supports consumers in shared decision-making. Assessment and planning must be undertaken in partnership with the consumer, and must address the consumers current and future goals of care, including the development of an advanced care directive and end of life planning. Care plans must be regularly reviewed.

In response to the dual nature of aged care, *Personal care and clinical care* affirms that consumers are entitled to both personal care and clinical care that is individualised. Personal care or clinical care may be delivered by the aged care service, or via timely referral to other providers. This standard also requires that infection risk be minimised through standard infection control measures and antimicrobial stewardship, and that deterioration or decline in function must be recognised and responded to in a timely manner.

The fourth standard, *Services and supports for daily living,* addresses assistance needs with activities of daily living, but also ensures that consumers are supported in pursuing activities that give meaning and enhance social connectedness. This standard links closely with Standard 3, in promoting personal wellbeing. Key requirements of organisations include the provision of services and supports that allow consumers to participate in their community and do things that interest them, information-sharing within the organisation regarding the consumer's needs and preferences, and the provision of varied and culturally appropriate meals as required.

Standard 5, *Organisation's service environment*, protects consumers' right to feel safe and comfortable within the aged care service environment. This standard not only requires service environments to be clean, well maintained and comfortable with suitable furniture, fittings, and equipment, but also requires the

environment be welcoming, accessible, easy to understand, and designed to enhance consumers' sense of autonomy and belonging.

Feedback and complaints affirms the right of consumers to feel safe and supported in giving feedback and complaints. Organisations meeting this standard are regularly seeking feedback from consumers, their families, and the workforce, and engaging in continuous improvement. In order to protect the autonomy of consumers in raising concerns, they must be made aware of and have access to advocates, translators, and institutional support. Feedback and complaints must be actioned as appropriate, and open disclosure undertaken when things go wrong.

Organisations are required to employ a workforce capable of delivering safe and quality care and services under Standard 7, *Human resources*. The workforce is required to be qualified and competent to perform their roles and of a safe number to ensure all consumers are provided good care.

The final standard, *Organisational governance,* requires organisations to be accountable for the delivery of safe and quality care and services. This standard encompases requirements for information management, financial governance, workforce governance, regulatory compliance and management of feedback and complaints. It also requires the governing body to promote a culture of safety and accountability.

The Charter of Aged Care Rights is a commitment made by aged care organisations and care providers to uphold the Quality Standards to all aged care consumers. All consumers are required to be supported in understanding the charter and their rights, and may be given the option to sign to acknowledge they have received and understood the charter [149]. The rights affirmed in the charter include the right to safe and quality care, the right to dignity and respect, the right to information about care and services, the right to make clinical, personal, social, and financial decisions, the right to an advocate or support person, and the right to exercise these rights without it impacting on the quality of the care being accessed [150].

Workforce and aged care provider issues

The aged care workforce consists of a roughly equal number of formal workers and informal carers, although the latter is likely underreported due to its informal nature [35, 151]. Formal workers include clinical health staff like nurses and geriatricians and personal workers who help older people with their daily activities. In 2016, 84% of formal workers were paid, with the remainder being volunteers [35]. These proportions do not include agency, brokered, or self-employed workers, which comprise a minor fraction of the aged care workforce [35]. Formal workers are pivotal in ensuring continuing skilled care of older people and professional management of their health and wellbeing. Informal

workers are also crucial to reduce the need for formal care and help maintain social and community connections for older people [152].

Most aged care providers are owned by non-for-profits (NFPs) like community, charity, or religious organisations, although some are run like commercial businesses and others by state or territory and local governments [35]. Notably, the proportion of providers owned by large commercial conglomerates has increased over the past decade, from 16% of all residential aged care in 2009–10 to 39% in 2018–19 [35].

The Royal Commission into Aged Care identified a number of aged care workforce issues. The most prominent of these was that residential aged care providers were understaffed, and that workers were underpaid and undertrained [35]. The mix of staff employed also did not match the needs of older people. In residential care, 47% of those interviewed expressed concerns about staff, including understaffing, unanswered call bells, high rates of turnover, and agency staff not knowing the individual needs of residents [35]. In home care, 33% had similar concerns, and in respite care, the percentage was 30% [35]. Overall, it was found that one third of all those interviewed had received what they considered to be substandard aged care [35]. Additionally, it was noted that smaller, government-owned residential services were reported to be better than larger facilities owned by NFPs or for-profits [35], making the increase in the number of larger providers particularly concerning.

Certain areas of aged care are particularly lacking in quality. It is estimated that more than half of people in residential aged care have dementia, and many require palliative and end of life care, yet due to lack of training, many providers lack the skills and capacity to adequately manage these areas of aged care [35,153]. With regards to mental health, it is difficult for residents to access psychologists and psychiatrists, and personal care workers and other staff are poorly trained in this domain [35]. Compounding residents' mental health challenges, staff are often reported to lack empathy and are responsible for numerous small oversights like placing a cup of tea just out of reach [35]. The COVID-19 pandemic has been especially deleterious on older people's mental health generally [35,154, 155], and especially for those in nursing homes who have been prevented from having visitors during lockdowns [156]. The Royal Commission also highlighted a lack of understanding and appreciation of diversity, particularly of LGBTQIA+, First Nations, rural or remote, homeless, and veteran residents [35].

Sixty-eight per cent of residents are estimated to be malnourished, largely due to a lack of assistance with eating and drinking [35,157, 158]. Oral health is poor, with limited access to dentists, and lack of staff time and inadequate training meaning even simple daily tasks like teeth brushing and denture care do not get done [35, 159, 160]. This lack of staff time also means residents are not able to be assisted to the toilet in a timely manner and thus incontinence is a major issue [35]. In response to this, rather than employing more staff, providers have

resorted to the use of incontinence pads. These are infrequently changed and their use has led to shortages in the pads themselves [35]. Furthermore, there is a lack of focus on residents' mobility, with limited access to physiotherapists and occupational therapists [35]. Many residents develop pressure sores due to inadequate staff training in their prevention and treatment [35]. Providers have poor training in infection control and hygiene, as well as limited stock of personal protective equipment and disinfectant [35]. These issues have been shown to have contributed to the numerous outbreaks that have occurred in Australian residential aged care facilities over the past two years [161, 162].

Additionally, staff often have poor training in medication management, leading to incorrect timing, dosing, and administration methods, and sometimes even the administration of the wrong medicines, as well as a failure to ensure residents have completely swallowed their medications once administered [35]. Finally, communication between aged care and health care services, especially when residents need to be transferred to health care facilities, is severely lacking. Clinical handovers and discharge summaries often exclude key health information including medication lists and details of health conditions, impacting continuity of care and patient outcomes [35].

Many of the specific issues seen in residential aged care are attributable to inadequate training and understaffing. Apart from funding, major reasons for this include poor wages, particularly when compared to equivalent roles in the health care sector, undesirable employment conditions, and limited career progression [35,163-165]. Prior industry-led attempts at rectifying the wage gap between aged care and health care workers have failed thus far [35]. Additionally, the *Aged Care Act 1997* enabled providers to decide for themselves the number and type of staff they employ [166], effectively leading to the replacement of permanent, skilled, professional staff with semi-skilled and cheaper personal care workers [35]. All of the above has led to issues attracting and retaining skilled staff, particularly nurses. From 2003 to 2017, the percentage of registered nurses declined from 21% to 15% of the total formal aged care workforce and for enrolled nurses the decline was from 13% to 10% [35]. The issues of understaffing are likely to worsen with the growth of the older demographic, as the number of direct aged care workers needed to ensure quality provision of aged care must increase by 70% from 186 000 workers in 2020 to 316 500 by 2050 [35].

Alongside formal workers, informal carers are largely unsupported. This is partly due to many informal carers not identifying themselves as being a carer of an older person, often because they are a family member [35]. As such, many informal carers do not know what supports exist for them. Even if they do identify as a carer, the existing support system is severely lacking. Informal carers often need to provide details for both themselves and the older person to multiple different care agencies, placing a confusing administrative burden on themselves [35]. Additionally, the two current online carer support systems – Carer Gateway and My Aged Care – do not share any information, making it difficult to find and

compare different aged care services available to them [35]. Moreover, there are currently no provisions in the National Employment Standards which enable informal carers to take extended leave to care for older persons [167], placing a significant financial burden on carers having to balance employment with their carer responsibilities.

Funding issues

The aged care system is currently funded by rationing out aged care packages to a fixed proportion of the population over 70 years of age [35,168]. The majority of this is funded by the Australian Government. In 2018–19, $27 billion was spent on aged care, of which $19.9 billion came from the federal government [35]. This contribution increased to $21.2 billion in 2019-20 [35]. Correcting for inflation, aged care spending is expected to increase by 4.0% per annum over the next decade, surpassing the average yearly spending increase of 2.7% to reach 5.0% of total government spending (compared to 4.2% in 2018–19) [35]. In addition to government contributions, older people are expected to contribute to their care through co-contributions and means-tested fees [35]. These co-contributions include costs outside of accommodation and daily living expenses (e.g. for food, utilities, and cleaning) like clinical care services, social support, transport, home modifications and assistive technology, domestic assistance, and respite care [35]. In 2018–19, this represented $5.6 billion of total aged care spending [35].

Growth in aged care expenditure has been purposefully restrained by successive sitting governments despite the burgeoning need for increased funding to provide adequate access to quality aged care [35]. Until 2020, the Minister for Aged Care was not a Cabinet level position, meaning the sector had lower budgetary weight [35]. Historically, it has been treated with ambivalence, timidity, and detachment, and whose responsibility it is for goal setting, close monitoring, and timely interventions has not been adequately articulated [35]. Funding of aged care through general revenue processes has exposed it to annual budgetary cycles and the fiscal priorities of the sitting government, and funding allocations to the sector have been based on historical precedents & *ad hoc* decisions rather than actual need [35].

The government has little active management in market governance despite it controlling decisions about entering and exiting the market, the response to changes in demand, and broader changes in market conditions [35]. This lack of governance has led to a concentration in the number of suppliers, with there being a greater proportion of larger ones, as stated above [35]. It has also led to a rapid expansion in home care providers, without any concern for their suitability [35]. At the regional and local levels, there has also been little governance, leading to gaps in planning, development, and management of services, as well as a 'one-size-fits-all' approach to aged care [35].

In addition to a general paucity of funding and passivity of market management, complex capital financing arrangements for aged care providers have resulted in

higher costs for older people. Currently, capital is raised from two main sources: equity (25.7% total provider assets in 2018–19) and Refundable Accommodation Deposits (RADs; 57.4% total assets in 2018–19) [35]. RADs are lump-sum contributions by unsupported residents (i.e. those whom the government has deemed ineligible for accommodation subsidies) to their residential aged care provider [169]. Should the resident choose to depart their aged care facility, their provider is expected to refund their deposit in full. In 2019, the average RAD was $318 000, and this value is rapidly increasing, having doubled since 2013–14 [35].

There are several issues with the RAD capital financing scheme. First, it makes it difficult for providers to secure high accommodation deposits in regional, rural, and remote areas [35]. Second, it decreases providers' liquidity, especially during times when there is pressure on occupancy rates as has been the case during the COVID-19 pandemic [35]. Third, due to the rising cost of RADs, there has been an increased proportion of residents opting for the alternative of Daily Accommodation Payments (DAPs), which are daily payments made to the provider for accommodation [35,170]. This trend has made it harder for providers to attract replacement funds when required to repay RADs [35]. Exacerbating these issues is the fact that a significant minority of providers operate on a loss, accounting for 31% home care providers and 42% residential aged care providers in 2018–19 [35]. Ultimately, these capital raising arrangements have incentivised providers to continue to raise accommodation costs demanded of residents [35]. Given these factors and the known power imbalance between incoming residents and providers, it is clear such arrangements are unsustainable [35].

Apart from the financing methods, the means-testing arrangements for deciding the contribution older people will make to their aged care are inequitable, with there being a disproportionate impact on those with medium-level assets compared to wealthier people [35]. They may also result in very high marginal tax rates for certain people [35].

The current funding scheme also impacts provision of health services to older people. GP aged care services are currently funded on a fee-for-service basis [35]. This incentivises doctors to respond only to episodes of ill health rather than being proactive and organising consults with aged care recipients which focus on prevention [35]. Additionally, multidisciplinary outreach services, including geriatricians, palliative care specialists, and allied health professionals, are subject to local funding restrictions and are not always available [35].

Older people living with disability have very few options for disability support. This is largely due to the National Disability Insurance Scheme's (NDIS) current eligibility criteria. NDIS packages are unavailable to those who acquire a disability after the age of 65, those who already had a disability but were over 65 when NDIS was introduced in their area, and those who access residential or home care services on a permanent basis after the age of 65 [35]. As discussed above, while alternatives for disability support exist through aged care support packages

and the Disability Support for Older Australians Program, which supports those who had a disability but were over 65 years old when the NDIS was introduced in their area, these do not provide the same level of supports as the NDIS and often require the older person to pay in part for their care [170, 34]. This has led to many older people with disabilities lacking the support they need. *Refer to AMSA's Disability Care and Support Policy* for recommendations to address this gap [33].

Recommendations from the Royal Commission [35]

The Royal Commission advocates for stronger national leadership of the aged care sector, via either an independent Aged Care Commission or government-led model. If responsibility for the sector remains with the latter, aged care should remain a Cabinet-level ministerial position. Different bodies should be responsible for different functions: a systems governor will be responsible for approving new providers, managing complaints, funding, workforce planning, and market governance; quality and prudential regulators will manage quality and safety monitoring and compliance, financial risk monitoring, and provider regulation; and an independent pricing authority should determine the cost of delivering quality aged care based on need rather than precedent or *ad hoc* decisions. Efforts should also be made to establish regional and local aged care governance centres and devise methods to receive advice from older people in the community so aged care may be tailored to the populations it services.

Workforce and provider recommendations

The Royal Commission suggests improved collation and modelling of workforce data to address workforce shortages and plan for future need. It advocates for national registration schemes for aged care workers (including minimum qualifications, English proficiency, and criminal history screens, among other requirements), standardised training programs, and improved training in areas of need, which have been identified in previous sections. A greater proportion of staff must be permanent to ensure continuity of care, and more clinical staff, especially nurses, and allied health workers should be employed to ensure an appropriate mix of aged care workers for older people's needs. Reporting systems should be established to monitor compliance with guidelines. In accordance with the *Fair Work Act 2009*, pay for aged care workers should reflect that of those working in equivalent roles in the health care sector and more attractive career pathways should be developed. These may include opportunities for personal care workers to move horizontally between aged care, disability care, home care, and primary health care, as well as vertically in aged care into managerial roles or skilled roles such as nursing. National media campaigns to increase awareness of such career pathways should be considered. Tertiary institutions should review the curricula of their health-related degrees to have a greater focus on aged care, and placements in aged care should be encouraged. To assist those entering the aged care system for the first time, older people and informal carers should be entitled to consult with 'care

finders', who will help them find the option best suited to them, and community groups for informal carers should be established to further assist in this process.

Funding recommendations

The Royal Commission recommends the introduction of an Aged Care Levy on taxable income similar to the Medicare Levy. The aged care budget will be derived from a special appropriation of the Consolidated Revenue Fund to make it less susceptible to fluctuations due to annual budgetary pressures, and will mean funds will automatically be allocated each year rather than having to be applied for. An independent pricing authority is necessary to ensure sitting governments cannot influence pricing of aged care services. Its decisions should be binding on the government and not merely advisory. RADs should be phased out of provider capital financing arrangements in favour of concessional loans funded by government bonds, and the government should cover the cost of RAD repayments to facilitate this process. Additionally, people should not have to pay co-contributions for clinical and personal care that extends beyond that needed to cover accommodation and daily living (e.g. food, utilities, cleaning) costs. The government should consider funding a Senior Dental Benefits Scheme to provide free dental care to all older Australians. To discourage reactive primary healthcare, GP clinics should be enrolled to become accredited aged care practices, where they will receive annual capitation payments for each enrolled older person based on the level of their assessed need. This will hopefully incentivise a more preventative approach to primary healthcare. Finally, multidisciplinary outreach services should be funded to ensure coverage in places of need.

Long-term care

Long-term care (LTC) services are required by older people with reduced functional capacity necessitating support with basic daily activities [171]. There are a variety of informal and formal sources of LTC, such as from family and friends or from health and social services, respectively [172, 173]. Demand for LTC provision in Australia is rising due to the increasing elderly population and associated increase in patients with chronic health conditions [174]. The demand for formal aged care services in community settings is set to increase, while the proportion of care provided informally is expected to decrease [175]. Nevertheless, informal family caregivers need additional support, such as further education, access to allied healthcare services and assistive devices, and assistance with financial and housing arrangements [171]. To date, there is insufficient evidence on appropriate alternatives to residential LTC such as day-care or shared accommodation [176]. More information is also required regarding the risk factors for entry and determinants of duration of stay, to assist in planning necessary services [176]. Additionally, there is an increasing number of deaths occurring in residential aged care, indicating a need to optimise palliative care in this setting [177].

Home care

The federal government provides support for elderly people to maintain independent living through the Commonwealth Home Support Programme (CHSP) and Home Care Packages Programme (HCPP) [178]. Both programs are government-subsidised and provide support for older people to remain at home with a view of maximising their independence. The CHSP does so for older people who require entry-level support, while the HCPP caters to older people requiring complex care. In both instances, support can take various forms, such as help with daily tasks, modifications to living spaces, assistance with transport and nursing care. Currently, increasing demand and high waiting times for HCPs indicate a need for more efficient fund allocation and more service providers to reduce preventable hospitalisations and premature entry into residential aged care [171].

Residential care

Residential aged care provides support for older people who can no longer live independently at home. As discussed above, the federal government subsidises the cost of residential care for consumers following an assessment of care needs and means testing [179]. Aged care residents are provided with assistance with various facets of their life, such as: day-to-day tasks, including cleaning and cooking; personal care, including bathing, dressing and going to the toilet; access to clinical care and health practitioner services; and, access to other supplementary services, such as social support and entertainment [171]. In some instances, residential respite care, where short-term residential care is provided for a consumer in order to provide a break for the consumer and their usual carer from their routine care arrangements.

Coordinating care

Due in large part to their age, many aged care consumers have multiple co-existing healthcare problems which require complex and coordinated care. More than half of all aged care consumers have a dementia diagnosis; complex, dementia-related care should be at the forefront of aged care service provision. Similarly, depression is very common, and aged care consumers ought to have access to appropriate mental health support, such as psychologists and psychiatrists. However, as was reported by the Royal Commission, aged care providers often fail to deliver, facilitate, and coordinate such complex care requirements [180].

End-of-life care

End-of-life care is afforded to patients with an active, progressive, and advanced disease with little to no prospect of recovery and for whom the principal goal is to optimise the quality of remaining life. This often entails a broad, multi-factorial approach that seeks to address numerous aspects of a person's disease, including: symptomatic relief, such as from pain, vomiting and shortness of breath; familial support and counselling; and preparing end-of-life arrangements [181]. As this represents an emerging field of service provision, little is currently offered by way of end-of-life care. The Royal Commission observed that appropriate care for people in their final weeks and days of life was often severely lacking [180]. Insofar as aged care, especially residential aged care,

often represents a person's final place of living before death, aged care service providers ought to position end of life and palliative care at the centre of their business model. High quality palliative care is essential to ensuring that an older person can live their life as fully and as comfortably as possible as they approach death. Compassionate, respectful and individualised support for older people approaching the end of their lives is a necessary component of aged care services [180].

Difficulty accessing aged care

For many older people and their families, the aged care service system is complex and difficult to parse. Being met with such difficulties at a time that is already likely emotionally fraught has been described by those attempting to procure aged care services as 'time-consuming' and 'frightening' [180]. Chief among the factors thought to contribute to this are the paucity of available information, the lack of in-person assistance, and the federal government's current adoption of a generalised, one-size-fits-all experience for those seeking assistance [180]. Once a person can navigate the aged care service system, they are met with frustratingly long wait times. Throughout 2018–19, the waiting times between being assessed as eligible for a Home Care Package to being assigned a package ranged from seven months for a Level 1 package to 34 months for a Level 4 package [180]. As of 30 June 2020, 102,081 older people were waiting for a package at their approved level [180]. These issues are compounded among already vulnerable populations, such as those residing in regional or remote areas and Aboriginal and Torres Strait Islander people [182]. Aged care in regional or remote areas is significantly lower than that experienced in metropolitan areas; for example, people aged 85–89 in metropolitan areas had an aged care usage rate of more than 10 times that of people in very remote communities [182].

Substandard care

Elder abuse

Elder abuse refers to any single or repeated act, or omission of an act, within a relationship of trust which harms an older person, and in so doing, violates their human rights [183]. This type of violence takes various forms, such as but not limited to physical, sexual, psychological, and emotional, and is commonly perpetrated by both residents and staff members. Some risk factors include cognitive impairment and disability, social isolation, carer stress, traumatic life events, and misalignment of social and individual values [184]. During the Royal Commission, significant elder abuse was identified and reported. It was concluded that one in three people accessing residential aged care and home care services have experienced substandard care [180]. Additionally, there is a clear overuse of physical and chemical restraints in residential aged care, coupled with a concern among 47% of people regarding understaffing, unanswered call bells, high rates of staff turnover, and agency staff not knowing the residents and their needs [180]. In home care, 33% of people have concerns about staff, including continuity of staff and staff not being adequately trained [180]. In respite care in residential facilities and in the Commonwealth Home Support Programme, about 30% of people have concerns about staff, including

understaffing, continuity, training, and communication [180]. Ultimately, the Royal Commission concludes that substandard care has become normalised in some parts of the aged care system; those who run the aged care system do not seem to know about the nature and extent of substandard care, and there has been a reluctance to measure quality [180].

Current prevention and intervention strategies for elder abuse include education, an emphasis on effective listening, counselling and thorough research on effective ways to prevent abuse and empower victims of elder abuse. Education is an effective tool to address age-based discrimination. Counselling services provided by elder abuse helplines also greatly assist in empowering victims through effective listening [185, 186]. To date, there is limited evidence on the efficacy of strategies to prevent abuse against older people, and further research is warranted [180]. Strategies for better preventing and responding to elder abuse have been discussed above.

Complaint systems

Presently, there are various decentralised channels through which one can lodge a complaint regarding aged care. My Aged Care fields concerns directly related to its service and home support assessments [187]. Aged care consumers are advised to contact their comprehensive Aged Care Assessment Team (ACAT) in the event of concerns relating to assessment outcomes, before proceeding to contact the Secretary of the Australian Government Department of Health if concerns are not properly addressed [187]. In the event of elder abuse, there is a national hotline available in addition to state-based elder abuse prevention and various assistance lines.

As discussed above, the Royal Commission recommended the adoption of an independent commission model to centralise governance, regulation, prudence and pricing of aged care services. In doing so, the conception of a Complaints Commissioner was suggested and the importance of a transparent, effective complaints handling process was restated in light of prevalent dissatisfaction with the current complaints process [180]. The Royal Commission stipulated that the Complaints Commissioner ought to deal with a broad range of complaints in a centralised manner before responding, such as by directing providers to take specified remedial action.

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