Submission 171

Tasmania

PREMIER

19 AUG 2003

Dr Andrew Southcott MP
Chairman
House of Representatives Standing Committee on Ageing
Parliament House
Canberra ACT 2600

Dear Dr Southcott

I refer to the House of Representatives Standing Committee inquiry into long-term strategies to address the ageing of the Australian population over the next 40 years.

The Tasmanian Government is strongly committed to the proactive development of strategies to address the ageing of Tasmania's population.

Indeed the ageing of Tasmania's population presents key challenges and opportunities to enhance the contribution of older people to society. This issue occupies an increasingly prominent place in public policy within our State.

Like the rest of Australia, Tasmania's population is ageing – but is doing so at a faster rate.

Within the next 10 years Tasmania will overtake South Australia as the nation's 'oldest' state, with its median age likely to increase to 41.1 years. By 2051 Tasmania's median age will be 53.2 years of age.

Tasmania is moving towards a community where one-third of its population will be aged 65 years or more, with a significant proportion being aged 85 years or more. Tasmania's population over 85 years of age is likely to double by 2021, and double again over the following 30 years.

Tasmania will be the first state to deal with the profound ageing of its population. The dispersion of our population and a large number of rural and regional centres relative to our population size further complicate Tasmania's ageing profile.

The ageing of Tasmania's population will lead to a greater demand for Government services, especially the health and community care system, and there will be significant resource and budgetary implications for the Tasmanian Government in providing these services. Already the demand for aged care services in regional communities, including residential aged care, is affecting our health care system and limiting the capacity of local services to respond.

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Given Tasmania's socio-economic status, it is likely that a significant proportion of the elderly will also be dependent on Commonwealth Government pensions.

The Commonwealth, State and Territory Governments have recognised the important economic and social implications of the projected ageing of Australia's population. As you will be aware, the December 2002 meeting of the Council of Australian Governments agreed to request the Productivity Commission to undertake a research study into the future impact of ageing with a particular focus on the productivity and labour supply implications of an ageing Australia; and the potential fiscal impacts on all levels of government resulting from an ageing population.

Regrettably, the Commonwealth, States and Territories have not yet been able to agree on the terms of reference for the Productivity Commission study. The Commonwealth has indicated a preference for narrow terms of reference, while the States and Territories favour a broader inquiry encompassing regional and indigenous factors as well as revenue-raising issues associated with a declining tax base.

Ageing policies and services for the aged are developed and delivered by all levels of government and therefore all governments must work together and focus on the implications of an ageing population.

The Tasmanian Government recognises that from a national perspective, the particular needs of Australia's smallest State cannot drive the implementation of policy changes to national programs, such as residential aged care. However, national policy implementation and funding must take into account the particular demographic circumstances of different States and regions, and do so in a timely manner.

The Tasmanian Government is strongly committed to the development of strategies and programs that address both the challenges and opportunities posed by Tasmania's ageing population.

The *Tasmanian Plan for Positive Ageing 2000-2005* is a significant Tasmanian Government initiative that provides a broad framework for enhancing the lives and community involvement of older Tasmanians.

"Positive ageing" is an important goal in itself with benefits including harnessing the enormous contributions older people make to society, and the experience and skills they bring to the community, including to the economy and business sectors, the voluntary sector, and social support networks.

Social participation and healthy lifestyles are also well recognised as building individual, family and community reliance. In turn this supports maintenance of good health, speedier recovery from illness and improved capacity to manage chronic health conditions, which not only improve life, but also reduce demand on the health care system and other social services.

However, the fact remains that there will be very significant growth in demand for aged care services in Tasmania over the next two decades and beyond with a consequent need for effective forward planning and resource provision.

The Tasmanian Government is convinced of the need for greater collaboration between the three spheres of government in delivering aged care services.

On 1 October 2002, I and the Tasmanian Minister for Health and Human Services, the Hon David Llewellyn MHA, wrote to the Commonwealth Minister for Ageing, the Hon Kevin Andrews MP, and Ms Lynn Mason, President of the Local Government Association of Tasmania, proposing a Tripartite Partnership Agreement "focussing on the provision of aged care services throughout the State". This proposal recognised the long-term implications of population ageing but raised the immediate issue of planning and providing for aged care services now and into the future.

With the agreement of the Commonwealth Minister for Ageing and the Tasmanian Local Government Association, a Steering Committee of officials from the Tasmanian Departments of Health and Human Services and Premier and Cabinet, the Commonwealth Department of Health and Ageing and the Local Government Association are now developing a tripartite framework to facilitate a collaborative response to the policy implications of an ageing community, including:

- providing better exchange of data, including access to quality information and research to better plan service delivery;
- increasing the level of information and education of ageing issues available within the community; and generating a coordinated focus on "positive ageing" activity; and
- facilitating enhanced planning of residential and community aged care service delivery including streamlining processes for the provision of residential aged care services and greater certainty for private providers.

In March this year, the Commonwealth also released for limited consultation a draft discussion paper, entitled *A New Strategy for Community Care.*

The draft Commonwealth strategy purports to set out a blueprint for a more easily accessible and cost effective community care system, which aims to reduce the overlap and duplication of the existing system.

Tasmania is in general supportive of these directions, and has been developing service models in line with many of the proposed directions, particularly in the area of complex and packaged care. However, the State is still working through the implications of the new strategy and is seeking more information, in particular how the access, information and support tier might work and the impact on the availability of direct basic care to older people in the Australian community. It is unclear at this stage what other issues specific to Tasmania would emerge from broader consultation.

The Tasmanian Government is keen to encourage community debate and discussion on the implications of demographic change.

At the initiative of my colleague, the Minister for Health and Human Services, the Tasmanian Parliament's Joint Standing Committee on Community Development is conducting an inquiry into the impact of Tasmania's ageing population.

The terms of reference and other information about the Tasmanian Joint Standing Committee's inquiry can be found on the Tasmanian Parliament's website at www.parliament.tas.gov.au/Ctee/commdev.htm.

The Tasmanian Government has made two submissions to the Tasmanian Joint Standing Committee inquiry, a submission by the Minister for Health and Human Services dealing with aged care issues and a submission prepared by the Department of Premier and Cabinet outlining the *Tasmanian Plan for Positive Ageing* and related programs and activities. Both submissions deal with the substantive issues that are the subject of your inquiry.

I enclose for the information of your Committee a copy of the Department of Premier and Cabinet submission to the Tasmanian Parliamentary Committee inquiry and a paper on aged care issues that reflects information provided in the submission of the Minister for Health and Human Services. The latter paper has been updated to include the most current information.

I hope that your Committee will find these papers of interest and assistance in relation to your current inquiry into strategies to address the ageing of Australia's population.

Yours sincerely

Jim Bacon MHA
Premier

Submission to the Tasmanian Parliamentary Joint Standing Committee on Community Development

Inquiry into the Impact of Tasmania's Ageing Population

Department of Premier and Cabinet
June 2003

Submission to the Tasmanian Parliamentary Joint Standing Committee on Community Development

Inquiry into the Impact of Tasmania's Ageing Population

Contents **Page**

1. Introduction

1.1 This submission has been prepared by the Department of Premier and Cabinet to provide an overview of the *Tasmanian Plan for Positive Ageing 2000-2005* and the work of the Seniors Bureau which form part of the context for the Committee's inquiry.

1.2 Tasmania's population is ageing at a faster rate than the rest of Australia. 18 per cent of Tasmania's population is currently aged 60 years and over. It is predicted that this figure will increase to 25 per cent by 2025. The relative dispersal of our population and the large number of rural and regional centres relative to the State's small population size further differentiate Tasmania's demographic profile from the rest of Australia.

1.3 The promotion of "positive ageing" – the idea that individuals have opportunities and choices enabling them to maximise their independence and control over their lives as they grow older – is an important part of the Tasmanian Government's response to the opportunities and challenges posed by our ageing population.

1.4 "Positive ageing" is an important goal in itself. It also has potentially significant benefits by reducing demands on the health care system and other social services.

1.5 Social participation, healthy lifestyle choices, physical and intellectual exercise are all well recognised as building individual, family and community reliance. In turn this supports maintenance of good health, speedier recovery from illness and improved capacity to manage chronic health conditions, which not only improve life, but also reduce demand on the health care system and other social services.

1.6 The *Tasmanian Plan for Positive Ageing 2000-2005* is a significant Tasmanian Government initiative in response to the opportunities and challenges posed by Tasmania's ageing population.

1.7 In due course it will be necessary to review the implementation and outcomes of the Plan and more broadly consider future policy and planning in this field. The findings of the current inquiry by the Joint Standing Committee will make a significant contribution to this process.

2. Tasmanian Plan for Positive Ageing 2000-2005

2.1 The *Tasmanian Plan for Positive Ageing 2000–2005* was developed during the 1999 International Year of Older Persons.

2.2 Released in December 1999, the Plan for Positive Ageing provides a vision of a Tasmanian society in which people of all ages are recognised and valued, treated with dignity and respect and encouraged to contribute their wealth of experience and skills.

2.3 Together with the related work of the Seniors Bureau, the Plan is based on a recognition that the health and well-being of older Tasmanians is determined by a wide range of factors including income, social status, community participation, social support networks, education, employment, social environments and access to services.

2.4 The Plan for Positive Ageing further embraces the notion that individuals have opportunities and choices enabling them to maximize independence and control over their lives. It encourages both individual independence and participation in all aspects of community life.

2.5 The Plan provides a broad policy and planning framework for the Tasmanian Government, the Tasmanian community including local government, businesses and community based organizations and individuals.

2.6 The full text of the Plan for Positive Ageing can be found on the Seniors Bureau website.[1]

2.7 The Plan for Positive Ageing was developed in consultation with older people, state government departments, local governments, community-based organisations and others interested in contributing towards positive ageing. Consultations were based on a Discussion Paper: *Our Future – Towards Positive Aging in Tasmania*, released by the Tasmanian Government's Positive Ageing Steering Committee.[2]

[1] www.dhhs.tas.gov.au/seniors/pdfs/dhhs_tasposageplan2000-5.pdf
[2] www.dhhs.tas.gov.au/seniors/pdfs/dhhs_towardsposageing1999.pdf

2.8 The Plan for Positive Ageing addresses five major issues, each with a key objective:

1. Community Attitudes

Objective: To develop a more positive community attitude to older people and ageing.

2. Participating in Your Community

Objective: To increase the participation of older Tasmanians in recreation, paid work and voluntary activities.

3. Living in Your Community

Objective: To improve local planning and design and access to transport to better meet the needs of older Tasmanians and to enhance their feelings of safety and security both within their homes and within the community.

4. Health, Independence and Community Support

Objective: To support and promote older peoples' maintenance of a healthy lifestyle and independence in the community.

5. Education and Information in Your Community

Objective: To improve older Tasmanians' access to and understanding of information, continuing education and technology.

2.9 The Plan includes a wide range of strategies that the Tasmanian Government has committed to in order to advance the interests of older members of the community.

2.10 These strategies and programs embrace a wide range of activities including promoting positive attitudes to ageing and older people; expanding the operation of the Seniors Card scheme; encouraging intergenerational links between older and younger people; increasing the participation of older Tasmanians in volunteer and recreation activities; improving local planning and design and access to transport; and addressing safety and security issues for older Tasmanians within their homes and within the community.

2.11 The Plan aims to facilitate links and initiatives across government departments within the State and also with Commonwealth agencies to meet the needs of older Tasmanians.

2.12 The Plan for Positive Ageing is linked with local government through Local Government Partnerships and with the broader community through the Tasmania *Together* process.

2.13 The objectives of the Plan for Positive Ageing are consistent with and complement the goals and benchmarks adopted through Tasmania *Together*. Tasmania *Together* has set goals directly supportive of the welfare of older persons. In particular, the development of healthy lifestyles is a key priority under Tasmania *Together* with benchmarks set around factors that affect people's health, including increasing levels of exercise and healthy diets.[3]

2.14 The Tasmanian Plan for Positive Ageing also links with national responses to the challenges arising from Australia's ageing population, including the National Strategy for an Ageing Australia. Key principles underlying the National Strategy include:

- The ageing of the Australian population is a significant common element to be addressed by governments, business and the community.

- All Australians, regardless of age, should have access to appropriate employment, training, learning, housing, transport, cultural and recreational opportunities and care services that are appropriate to their diverse needs, to enable them to optimise their quality of life over their entire lifespan.

- Opportunities should exist for Australians to make a life-long contribution to society and the economy.

- Both public and private contributions are required to meet the needs and aspirations of an older Australia.

- Public programs should supplement rather than supplant the role of individuals, their families and communities.

[3] www.tasmaniatogether.tas.gov.au/goals_benchmarks.html

- A strong evidence base should inform the policy responses to population ageing.

- The delivery of services and pensions for our ageing population is affordable so long as Australia has a well managed economy and growth.[4]

2.15 The Tasmanian Plan for Positive Ageing is not intended to be all-inclusive in meeting all needs of older people. Rather it provides a broad framework for further planning and policy implementation. As the Plan is implemented and projected population and demographic trends unfold, new issues will emerge and new objectives and strategies will be identified.

2.16 The Seniors Bureau, with advice from the Tasmanian Government's Positive Ageing Consultative Committee, has responsibility for monitoring the implementation of the *Tasmanian Plan for Positive Ageing 2000-2005*.

2.17 An initial progress report on implementation of the Plan can be found on the Seniors Bureau website.[5]

3. Positive Ageing Consultative Committee

3.1 The Positive Ageing Consultative Committee provides advice and support on government initiatives within the Seniors Bureau and on broader positive ageing issues. One of the major functions of the Consultative Committee is to assist in monitoring the *Tasmanian Plan for Positive Ageing 2000 – 2005.*

3.2 The current members of the Consultative Committee are: Mr Ken Lowry, Mrs Mollie Campbell-Smith, Dr Sheila Given, Mr Bill Flassman, Mrs Jill Burbury, Mr Max Stuart; Mr Barry Issac, Mrs Stella Goiser, Mr Jan Siejka, Mr Ron Clarke, Mrs Rowena MacKean, and Mrs Jan Blizzard.

[4] www.health.gov.au/acc/ofoa/ageing_policy/nsaa/nsaabk.htm
[5] www.dhhs.tas.gov.au/seniors/pdfs/progreport_tasplan_positiveaging00-05.pdf

4. Seniors Bureau

4.1 Following the 2002 State Election, the government moved the Seniors Bureau from the Department of Health and Human Services into the Department of Premier and Cabinet.

4.2 The location of the Seniors Bureau within the Premier's portfolio supports a stronger, more integrated and coordinated approach to seniors issues across the whole of government. The interests of seniors will now be advanced in a more high profile and holistic manner.

4.3 The Seniors Bureau promotes the continuing contribution of older people to the Tasmanian community. The purpose of the Seniors Bureau is to promote positive ageing and to encourage the community to plan for its ageing population. The Bureau does not focus specifically on aged care issues which are the responsibility of the Department of Health and Human Services.

4.4 The work of the Seniors Bureau is guided by the *Tasmanian Plan for Positive Ageing 2000-2005*. At present the Seniors Bureau has three major areas of responsibility: whole of government policy in relation to positive ageing, the coordination and administration of the Seniors Card Scheme and the coordination of Seniors Week. The Bureau also facilitates community consultation and supports research into the needs and interests of older Tasmanians.

4.5 The Seniors Bureau has three full time staff, with two dedicated to administering the Seniors Card Scheme. The Bureau's budget for 2003-2004 is $0.44 million.

5. Seniors Card

5.1 The Seniors Card Scheme is important for seniors and for Tasmanian businesses. It provides discounts and concessions to seniors that augments their spending power, which in turn enables seniors to continue or increase their participation in community life.

5.2 The Seniors Card Scheme has grown significantly. In 1999 there were 40,000 cardholders. There are now 69,000 which represents approximately 86% of the people 60 and over in Tasmania.

5.3 In 2002, the Seniors Card Scheme commenced a major business recruitment and media campaign to encourage more Tasmanian

businesses to join the Scheme and offer discounts and advantages to Tasmanian seniors.

5.4 Prior to the recruitment campaign, there were over 300 businesses in the Scheme offering discounts to Seniors Card Holders. Over 85% of seniors are card holders and businesses are encouraged to recognise this important and growing sector in the community. Currently there are some 400 businesses involved in the Scheme.

5.5 More than 50,000 copies of the new 2003-2004 Seniors Card Directory have been distributed to Tasmanian Seniors Card holders. The Seniors Card Directory provides a list of Government concessions and Business Provider discounts available to Seniors Card holders. There are 360 listings and 80 advertisements in the 2003-2004 edition, detailing the discounts available from participating businesses in Tasmania.

5.6 The Seniors Card Scheme is resource intensive and requires two full time staff to administer. However, the Scheme's high take up rate of cardholders indicates the value that seniors place on this government program.

6. Seniors Week

6.1 The Tasmanian Government recognises the role that older people play in the community and the potential for them to contribute their wealth of wisdom, skills and experience. Seniors Week provides opportunities for older people to participate in their community and promotes recognition of the life-long contribution they have given to Tasmania.

6.2 The Seniors Bureau is responsible for coordinating the events of Seniors Week. The 2002 Program of Events Booklet outlined over 300 events and activities that were organised for Seniors Week. Copies of the Program of Events Booklet were made available from Service Tasmanian Shops, State Libraries, Centrelink Customer Centres, Local Councils Community Health Centres and the Seniors Card Scheme office. Last year was the sixth year that the Tasmanian Government has coordinated Seniors Week and each year the event grows in significance and profile throughout Tasmania.

6.3 The theme for last year's Senior Week was *'together* LEARNING & SHARING'. This served to demonstrate that seniors are one of the many groups in the community and that learning is life-long.

6.4 There was a very positive response from community organisations, clubs, groups, businesses churches, government agencies and individuals, willing to organise and sponsor events. These events were spread across the State with at least 130 in the south, 85 in the north and 100 in the northwest.

6.5 A diverse range of activities was offered during Seniors Week with something on offer for everyone. Activities included; computer activities, a concert, fly fishing, experience exercising at a local gym, a watercolour art group or enjoying a walk in Launceston, Hobart, Deloraine, Latrobe or Ulverstone.

6.6 Seniors Week 2003 will be held from 1-7 October. The planning and organising of this event has already begun.

7. Community consultation and forums

7.1 The Seniors Bureau has facilitated a range of community forums to promote Positive Ageing. Most recently, the Seniors Bureau and the Burnie City Council hosted a one-day forum on *The Power of Positive Ageing* at the Burnie Civic Centre on 21 March 2003.

7.2 Open to all members of the community, this forum provided an opportunity to define ageing in the 21st Century and showcase a range of positive ageing initiatives currently in progress across Tasmania. The Cabinet Secretary, Steve Kons MLA on behalf of the Premier, and North West Coast identity, Mrs Mary Binks, delivered the Opening Addresses and Dr Barry Jones delivered the Keynote Address. The Burnie Forum followed a similar successful forum in Hobart in 2002.

8. Research and Other Projects

8.1 The Seniors Bureau seeks to identify the needs and priorities of older Tasmanians. The Bureau undertakes and supports research both to identify emerging problems and what constitutes best practice in the delivery of services to older people.

8.2 The Seniors Bureau has funded research by the Office of the State Service Commissioner into Employment Issues Facing Mature Age

Workers and Jobseekers in Tasmania.[6] This research was released in November 2001 and, together with local initiatives, has given rise to a pilot project, the North West Mature Age Jobseeker Service which aims to improve the employability of mature age job seekers on the North West coast.

8.3 Together with the Department of Education, the Seniors Bureau supports positive interaction between older people and schools, including through the preparation and distribution of the booklet *Partners in Time: Building active partnerships between schools and older people*. Information concerning the Partners in Time scheme can be found on the Department of Education website.[7]

8.4 Other projects the Seniors Bureau is involved in include:

- Empowering older People in Personal and Household Safety with the Department of Police and Public Safety.

- Involving Older People as Peer Educators within Community Outreach programs within the Department of Health and Human Services.

- Developing marketing strategies to promote positive attitudes to ageing and older people.

9. Future Directions

9.1 The *Tasmanian Plan for Positive Ageing 2000-2005* has now been in place for three years. In due course it will be necessary to review the implementation and outcomes of the Plan and more broadly consider future policy and planning in this field. The findings of the current inquiry by the Joint Standing Committee on Community Development will contribute to this process.

In developing future plans to promote positive ageing, it will also be useful to take into account the findings of a number of other inquiries and forthcoming reports. These include:

- the comprehensive paper on Tasmania's population foreshadowed in the Treasurer's 2003-2004 Budget speech;

[6] www.ossc.tas.gov.au/issues/mature-age-workers.pdf
[7] www.education.tas.gov.au/equitystandards/ace/partners.htm

- the Productivity Commission's research study into the productivity, labour supply and fiscal impacts of an ageing Australia (commissioned by the December 2002 COAG meeting)[8]; and

- the Commonwealth House of Representatives Standing Committee on Ageing inquiry into long-term strategies to address the ageing of the Australian population over the next 40 years.[9]

9.3 Positive Ageing strategies have the potential to make major contributions to the health and well-being of Tasmania's ageing population. In turn this has the potential to reduce demands on the health care system.

9.4 As Tasmania's population ages, there will be a need to invest more in positive ageing programs. This will require commitment from the Tasmanian Government, local government and the Tasmanian community. At the same time, Government services will nevertheless be stretched to meet increasing and immediate demands for acute, high care and complex health services for the elderly, making the capacity to increase investment in promoting social participation and self-reliance more difficult. Developing a broad based response to this situation will be a major policy challenge.

[8] http://www.pmc.gov.au/docs/DisplayContents1.cfm?&ID=150
[9] http://www.aph.gov.au/house/committee/ageing/strategies/index.htm

THE IMPACT OF TASMANIA'S AGEING POPULATION

This paper contains information provided to the Tasmanian Parliamentary Joint Standing Committee on Community Development Inquiry into the impact of Tasmania's Ageing Population. Some information has been updated to reflect the most current information.

JULY 2003

Contents

1. Tasmanian demographics and morbidity trends

1.1 Tasmanian Perspective on Population Ageing

Australia's population is ageing – a combination of reducing birth rates, improvements in public and environmental health and management of disease, and the roll-through of the baby boomers that will continue to the 2050's. Service cost projections indicate that population ageing will be a driver of increased costs for health and aged care, along with new technology and the need for an increasingly specialised workforce

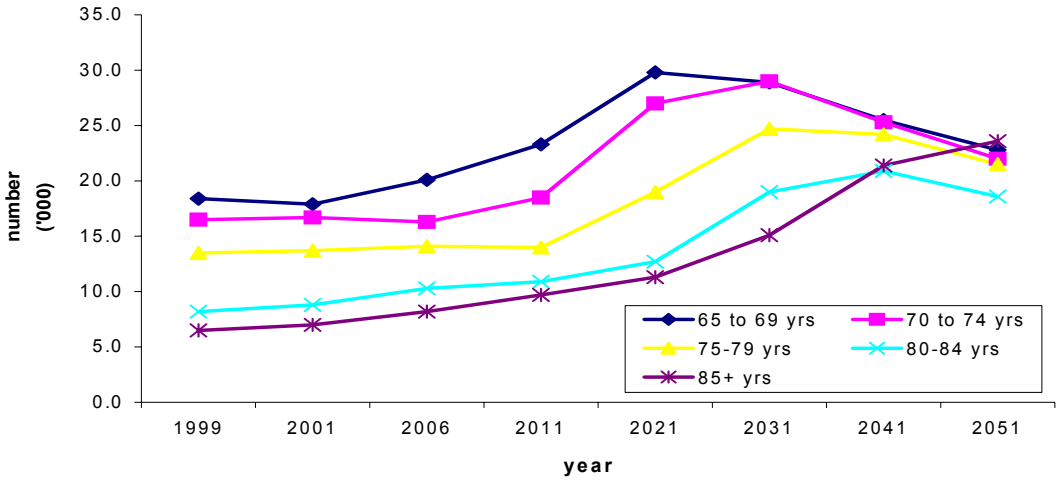
Over the coming decades, the number of people in Tasmania's older age groups is expected to increase and at the same time the number of people in younger age groups is expected to fall. Tasmania's population projections indicate that this is likely to coincide with a fall in the total population. At minimum this is likely to require "a revision of many per capita-based regional funding principles and policies (under which population growth means additional funding, and population decline, less, at the very moment when more may well be needed), and differential treatment by region"[1].

Within the next 10 years Tasmania will overtake South Australia as the nation's 'oldest' state, and its median age is likely to increase to 41.1 years. By 2051 Tasmania's median age will be 53.2 years of age.

The number of people in the over-65 population will increase until about 2020, and then start to decline. However, the number of people in the over 85 population is likely to continue increasing over the next five decades.

The population over 85 years of age is likely to double by 2021, and double again over the following 30 years. These trends are also reflected in the older age groups as a proportion of the total Tasmanian population.

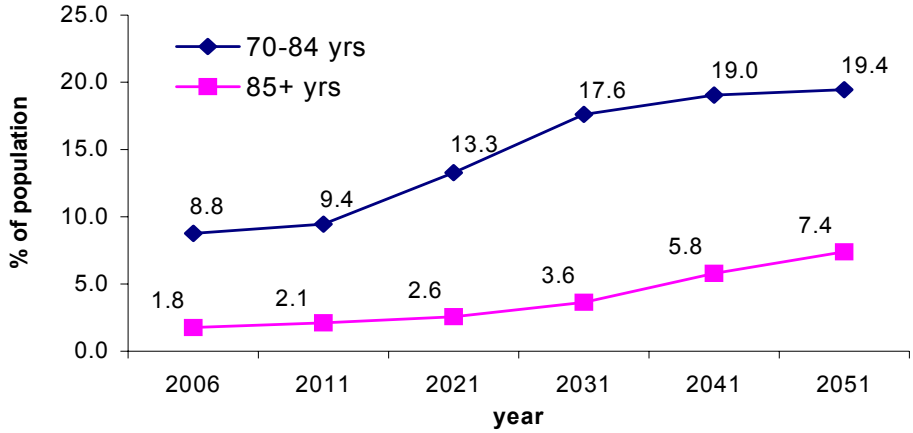
Figure 1.1: Projected number of persons aged 65 years and over by age group, Tasmania, Series II, 1999-2051



ABS Population projections 1999-2051, Series II.

[1] See N. Jackson, *As The Population Clock Winds Down* (in press, 2003).

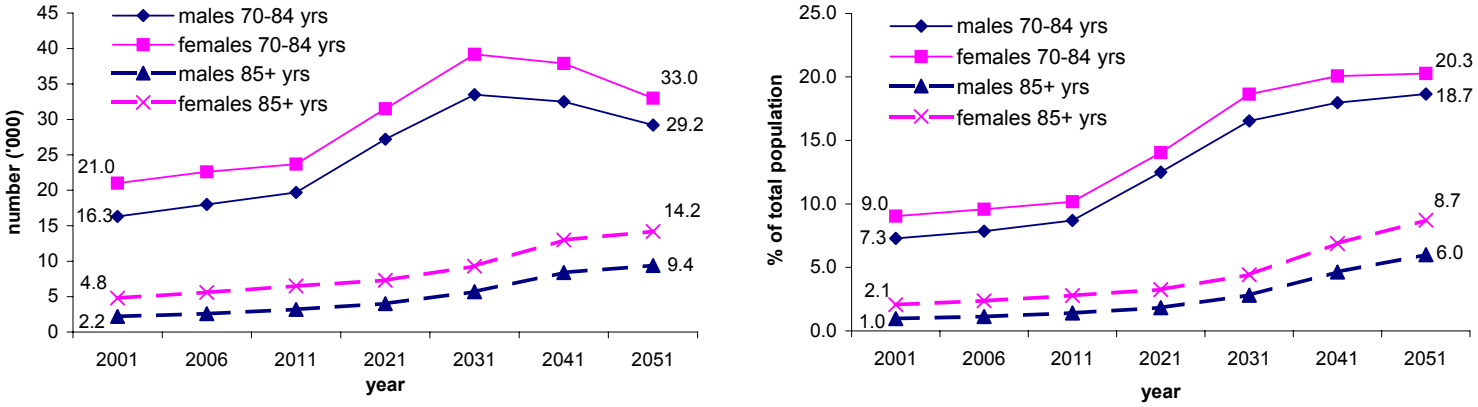
Figure 1.2: Projected Proportion of Population Aged 70-84 years and 85 years and over, Tasmania, 2006-2051



ABS Population Projections, 1999-2101, Series II

In the older age groups there are more women than there are men, and the gender differential between them increases within each successive age cohort

Figure 1.3: Number of People 70 years and over, and as a proportion of the total population, by sex and age group, actual and projected, Tasmania, 2001-2051



ABS, Basic Community Profile, Table 3, *Preliminary Census Results*, 2001. & ABS Population Projections Australia 1999-2101. Cat. No. 3222.0

1.2 Geographic Factors and the Dispersed Nature of Tasmania's Population

Tasmania's older population is dispersed across the state, and much of it is in small, rural areas with 40% of the population living in towns of less than 5,000 people.

Research indicates that the older population is increasing at a faster rate in rural, regional and remote Australia compared to the total Australian population.[2] People living in rural and remote areas generally have poorer health outcomes and less access to health care[3]. Older people in rural and remote communities face particular difficulties in accessing the health and aged care services they need[4].

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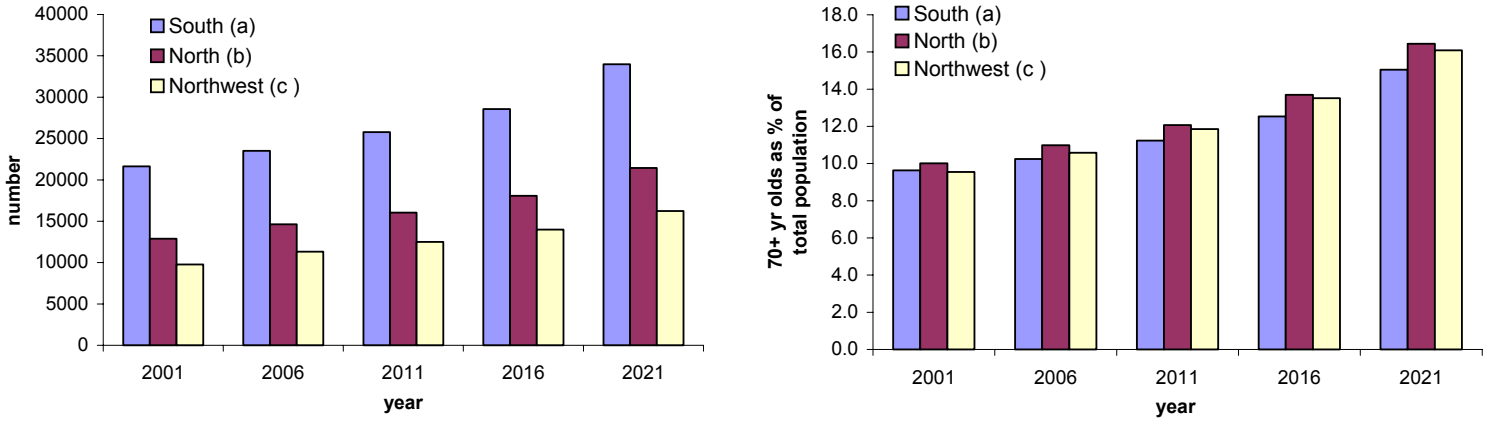
[2] National Rural Health Policy Forum and the National Rural Health Alliance for the Australian Health Ministers' Conference, 1999. *Healthy Horizons: A Framework for Improving the Health of Rural, Regional and Remote Australians 1999-2003*.

[3] Strong, K., Trickett, P., Titulaer, I. & Bhatia, K. 1998. *Health in Rural and Remote Australia*. AIHW: Canberra.

[4] Department of Health & Aged Care, 2000. *National Strategy for an Ageing Australia: World Class Care*. Commonwealth of Australia: Canberra.

The proportion of over 70's to overall population is similar across Tasmanian regions, but the highest number is in the South, consistent with the number of people living in greater Hobart, and the lowest is and will continue to be in the North West.

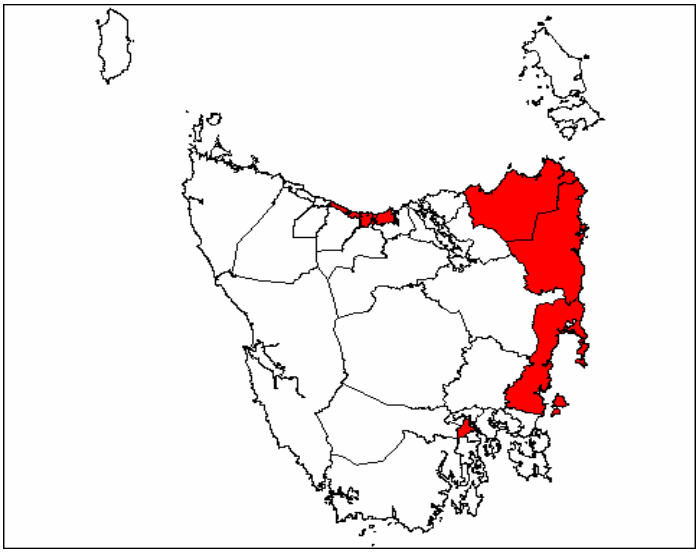
Figure 1.4: Number of people 70 years and over, and as a proportion of the total population, by region, actual and projected, Tasmania, 2001-2021



ABS, Basic Community Profile, Table 3, *Preliminary Census Results*, 2001. & ABS *Population Projections, Tasmania, 1999-2021*. Cat. No. 3222.6

a) South region comprised of the Greater Hobart and Southern Statistical Divisions
b) North region comprised of the Northern Statistical Division
c) Northwest region comprised of the Mersey-Lyell Statistical Division

- It is not just older Tasmanians that are dispersed across the State. Tasmania's population is the most dispersed of any state and territory, and its regional population centres are smaller.
  - Many small facilities make economies of scale more difficult to achieve. As this submission will show, this has significant implications for the delivery of residential and home-based aged care, and for ambulance and health care services.
  - Outreach services provided by services located in population centres are more expensive and resource intensive.
  - There is increased reliance of older Tasmanians on services that can only be delivered from a small number of sites because of their specialisation, infrastructure requirements and scale issues.
- Tasmania has geographic areas where the *proportion* of older people is noticeably higher than the state average of 13.4%. This is particularly the case on the Northern East coast, the central North, and Glenorchy.



ABS, Basic Community Profile, 2001 - Population aged 65+ greater than 15% of total population

- When considering the rural and regional retirement belts, it is important to be cautious, and not to assume that they represent the locations where infrastructure development should be focused. That is because:
  - The population is diverse, with different preferences and capacities to access and/or purchase services, own, maintain and modify dwellings, and to manage independent living;
  - More information is needed about settlement and relocation patterns of people living in these areas. For the East coast in particular, while the percentage of aged is higher, absolute numbers are relatively small, and for those who retire to the coast, they may relocate to be closer to family and services as they become more frail;
  - The location of retirement belts may change over time – for example, there is significant real-estate activity on the North-East coast, with interest from developers in products that would be attractive to older Tasmanians, particularly retirees; and
  - Informal support networks (carers) may not be in the same area, placing different demands on public health and aged care services.
- As a regional economy, Tasmania is a net 'exporter' of patients and a large number of people are sent interstate to receive treatment not available here by virtue of the lack of critical mass and specialist expertise. This is done through an Interstate Charging Agreement with Victoria.
  - There are two drivers for this: quality and safety issues for complex procedures, where very low volumes would reduce experience, depth of capacity and currency of skills; and economies of scale making these procedures uneconomic.
  - In addition, the Australian Health Care Agreement stipulates that states should enter into bilateral agreements with other states in respect of patients treated either by referral or because they happen to be temporarily resident in another state.
  - The expectation is that the treating state will recover costs from the state of residential origin. Interstate charging obligations have doubled since 1993/94, increasing to $7.3 million in 2000/01.

1.3 Health Status and Chronic Conditions Experienced by Older Persons

The health and social wellbeing of older people is influenced by a range of factors including access to appropriate housing, local transport, good social networks with friends and families, opportunities to participate in employment, education, recreation and voluntary activities, feelings of safety and overall level of physical and mental health.

The majority of older people lead independent lives and many are actively involved in the workforce, voluntary work, sport, physical activity, and travelling. Older people have a wide range of interests and commitments and their involvement with families and friends continues throughout their lives.

Older people are not a homogenous group. They have diverse needs, interests and abilities and come from different cultural and socio-economic backgrounds. This also means that health and social wellbeing is unequally distributed among older people in Tasmania.

Life expectancy is an important indicator relevant to premature and preventable mortality and general levels of health and wellbeing. Since the late 1800s, life expectancy in Tasmania has increased by 25 years for Tasmanian males and 29 years for Tasmanian females. Nevertheless, the life expectancy of Tasmanians has remained shorter compared to Australian life expectancy. Even though Tasmania now has one of the oldest populations in Australia, its life expectancy rates for males and females are the second lowest in the country.

Table 1.1: Life expectancy at birth, by sex and by State/Territory, Australia, 1998-2000*

	NSW	Vic	Qld	SA	WA	Tas	NT	ACT	Aust
Male life expectancy at birth	76.4	77.1	76.4	76.6	76.9	75.7	70.3	77.9	**76.6**
Female life expectancy at birth	81.9	82.3	81.9	82.3	82.6	81.2	75.2	81.8	**82.0**

*Australian Bureau of Statistics, Cat. No. 3302.*0

*Life expectancy was calculated over the three-year period 1998-2000.

Between 1998-2000 Tasmanian males who reached 65 years of age could expect to live an additional 16.3 years of life, and Tasmanian females an additional 19.8 years. This is shorter compared to the Australian rate of 16.8 additional years of life for males, and 20.4 additional years of life for females[5].

The long-term mortality assumption for Tasmania is that over the coming decades life expectancy at birth will increase to 85.5 years for females and 82.4 years for males[6].

The proportion of people who assess their health as good, very good or excellent declines with age. Nearly two-thirds of people aged 65-74 years assess their health as good, very good or excellent, reducing to around fifty percent in people aged 75 years and over.

In addition to self-assessment, *National Health Survey* data indicates that people aged 65 years and over have higher rates of experiencing a recent illness or recurrent episode of a long-term illness, and of undertaking a health-related action such as visiting a doctor or taking medication. The older population also has higher prevalence of long-term health conditions, and higher medication usage rates[7].

Although chronic conditions are not necessarily diseases of the old, or the consequence of ageing, these conditions occur with greater frequency in older persons[8]. The *National Health Survey*[9] and other research shows that the prevalence and complexity of medical conditions, including chronic disease and disability, increase with age.

- In Tasmania, the main chronic conditions among older people are:
  - Cardiovascular disease, being the fourth highest cause of life years lost to a disability for over 65's, and with over 65's accounting for almost 60% of hospitalisations.
  - Cancer where, for the 60 and overs, the most common for men is prostate, then lung and colon, while for women the most common is breast, followed by colon and lung.
  - Diabetes, which rises from 2.5% in people aged 35-45 years, to 23.6% for those 75 and over. Tasmania has the highest rate of diabetes and impaired glucose metabolism.
  - Dementia, with the risk increasing significantly with age. Almost 20% of those aged 80 and over suffer some dementia, with it higher in residential care – 28% of hostel, and 60% of nursing home residents. Over the next 40 years the number of people with dementia is expected to increase by 2.5 times.
  - Arthritis, which rises with age, so that by age 65 nearly 30% of females and 18% of males report having osteoarthritis.
  - Falls are the major cause of injury burden in people aged 75 years and over. In 1998 falls resulted in nearly 1,000 deaths and 50,000 hospitalisations of older Australians.
- For those over 80 years of age, vulnerability to ill health and disability increases dramatically. The proportion of people with profound or severe core activity restriction (communication, mobility and self-care) rises from 2.1% in 15-24 year olds, to one-quarter of 75-84 year olds, and nearly three-quarters of 85 years and over.

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[5] Australian Institute of Health & Welfare, 2002. *Australia's Health 2002*. Cat. No. AUS 25. AIHW: Canberra. p. 361.

[6] ABS, *Population Projections, Australia 1999*-2101

[7] ABS, 1999. *Older People, Australia: A Social Report*. Cat. No. 4109.0, pp.47-48.

[8] AIHW, 2002. *Chronic Diseases And Associated Risk Factors In Australia*, 2001. AIHW: Canberra. p.2.

[9] Australian Bureau of Statistics, National Health Survey 1995. See also ABS, Australian Social Trends 1999.

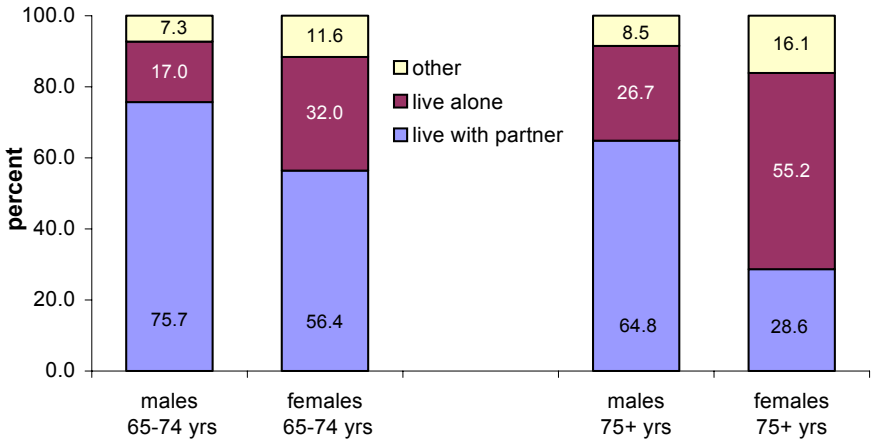
- There is increasing pressure on specialist medical services for older people, due to co morbidities, and the unique complexity in the diseases and degenerative conditions of the elderly. For example, there is a high representation of older people in acute care services for kidney failure, cancer, endocrine disorders especially diabetes, neurological conditions such as Altzheimers Disease, and cardiovascular disease.

1.4 Living Arrangements

The majority of older people live with a partner, and this will continue to be the trend over the coming decades. However, the proportion of older people living alone will also increase. By 2021, the Australian Bureau of Statistics projects that of all the states and territories, Tasmania will have the highest proportion of people living alone[10].

In 2001, nearly two thirds (65.7%) of people aged 65-74 lived privately with a spouse or partner, dropping to 43.2% for those over 75 years. However, nearly one third (32%) of women aged 65-74, and more than half (55.2%) of women over 75 live alone.

Figure 1.5: Relationship in household of persons aged 65 years and over living in occupied private dwellings, by age and sex, Tasmania, 2001



ABS, Basic Community Profile, Table 14, *Preliminary Census Results*, 2001.

Household and family projections indicate that by 2021 nearly one-quarter of Australians living alone will be aged 75 years and over, and of this group about three-quarters will be women. As the submission will highlight, this is likely to result in increasing demand on a range of health, community and aged care services.

1.5 Socioeconomic Status

Although health status generally declines with age, health and wellbeing status also reflects socio-economic differences with inequalities in the health of younger Australians persisting into older ages[11].

The experience of socioeconomic disadvantage over a lifetime also tends to negatively impact on health and wellbeing status in a cumulative way[12]. Across a range of measures of socioeconomic disadvantage, there is a consistent relationship between socioeconomic status and health among people aged 65 and over. Of all people in the community, those of low socioeconomic status were most likely to suffer disability, to have a serious chronic illness, to suffer recent illnesses, and to report being only in fair/poor health. Many

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[10] ABS, 1999. Media Release for Household and Family Projections 1997-2021, Australia (Cat. No. 3236.0)

[11] Mathers, C. 1994. *Health Differentials Among Older Australians*, Health Monitoring Series No. 2. AIHW: Canberra.

[12] Blane, D. 1999. 'The Life Course, 'The Social Gradient, and Health', in Marmot, M. & Wilkinson, R., *Social Determinants of Health*. Oxford University Press: New York. See also, Lynch, J.W., Davey Smith, G., Kaplan, G.A. & House, J. 2000, 'Income Inequality and Mortality: Importance to Health of Individual Income, Psychosocial Environment, or Material Conditions', *British Medical Journal*, 320: 1200-1204.

of the disorders, which disproportionately affect those of low socioeconomic status, are associated with certain behavioural risks that are more prevalent in those of low socioeconomic status[13].

Compounding this issue of lower health status, is reduced capacity to pay. That means there is a double impact on public health services – not only are poorer people sicker, but they also have less capacity to pay for health services.

Consequently, the cost of providing care to older people is increasing disproportionately more for older people with low socioeconomic status. This makes the ageing factor even more critical for Tasmania, given that it has the second highest level of socioeconomic disadvantage, as well as one of the oldest populations in Australia.

An additional impact for older Tasmanians as they become increasingly frail, and consider moving to appropriate housing proximate to services is the cost of housing. Difficulties can include

- Housing in rural and remote locations is cheaper than housing in larger population centres, meaning that owners' equity and lending institution policy will not yield sufficient funds to buy into better located appropriate homes, or for renters, the rental cost in the general market can be unaffordable;
- Reduced capacity to maintain or modify homes, compromising the opportunity for people to continue living independently; and
- Reduced capacity to pay transport costs to access services.

[13] National Health Strategy, 1992, 'Enough To Make You Sick: How Income and Environment Affect Health', *National Health Strategy Research Paper,* No. 1, Treble Press.

See also, Mathers, C. & de Looper, M. 1994. *Health Differentials Among Older Australians*. AIHW Health Monitoring Series, No. 2. Australian Government Publishing Services: Canberra.

2 Economic Impacts of Ageing

2.1 The Broad Perspective

Commentators suggest that population ageing has far-reaching economic impacts that we need to understand and which challenge many of the traditional frameworks relating to the economy. This is clearly an issue for portfolios at both levels of government such as Economic Development, Treasury and Industrial Relations/ Employment, and also for the private sector. Population ageing is changing consumption patterns, wealth generation and disbursement trends, and workforce structures. Economic frameworks need to take account of the participation of older Australians as carers and volunteers, and how increasing consumption of health services is funded.

Population ageing over the coming decades is likely to bring increased demand for aged pensions, and health and aged care spending. According to the Commonwealth Government's *Intergenerational Report,* this increased demand will occur alongside a projected slowing in both economic and employment growth[14].

Population ageing will pose challenges in the provision of adequate income support, the need for more flexible working and caring arrangements for those older people who remain in the workforce, and incentives for retirement saving through legislated superannuation provisions and voluntary savings.

Aged pensions are projected to rise from 2.9% of GDP in 2001-02 to 4.6% of GDP in 2041-42. Although there will be growth in the aged pension, overall safety net spending is likely to reduce due to projected decreases in payments to families with children, and unemployment and disability allowances.

At the same time that aged pensions will rise, there is also likely to be an increase in self-funded retirees whose incomes will come from superannuation. At present the large majority of Australians of pensionable age receives either the full or part pension and only around 20 percent are self-funded retirees or are still earning their income through employment. Superannuation savings are likely to offset reliance on pensions and to increase the adequacy of future retirement incomes. However, this will be conditional on the size of the superannuation payout and the extent to which lifetime earnings have been stable, secure and high enough to provide for basic needs at earlier life-stages and across all sectors of the population.

The current labour market is now characterised by casual and part-time employment. Those on low incomes, who have insecure employment and who move in and out of the workforce will find it difficult to accumulate a superannuation payout that will significantly reduce the amount of public aged pension that they will need.

Reduced capacity for self-reliance in retirement can result for mature age workers who have prematurely left the workforce, for example because of redundancy or caring responsibilities for ageing parents or disabled spouses, and who then face a depletion of superannuation well before the end of their life.

The combined effect of these factors is that, with fewer people working full-time, no significant shift in the capacity of older people to self-fund health care costs, and an increasing aged population, there will be increased demand and cost pressures on government health services. This is a particular issue for Tasmania given the profile of our population ageing, and socio-economic status of the population.

Increased wealth and income is already allowing people to choose to self-fund support services either in the home services or in a range of 'retirement' type options such as Abbeyfield or Village Life. However, the effect of increasing wealth and income on demand for aged care services will depend on the distribution of that wealth and income. Present indications are that while wealth is increasing, the number of people reliant on government support is also increasing.

Population ageing is also resulting in a changing workforce. There is a need for a more age-friendly, diverse and productive workforce. There are moves by the Commonwealth government to improve the capacity of older people to work beyond the age of 65 years, and a recognition that mature age workers have a vital role to play in Australia's economic future. However, achieving change will in significant part

[14] Department of Treasury, 2002. *Intergenerational Report*. Commonwealth of Australia: Canberra.

depend on employers being willing to employ older people, and this will require a shift in attitude around perceived productivity and acknowledgment of the retraining benefits that older workers can bring to the labour market.

It is notable that the Tasmanian State Service Act does not stipulate a mandatory retirement age, and in the Health sector strategies promoting workforce re-entry in fields such as nursing and allied health are seen as both appropriate and necessary.

2.2 Issues for resourcing the Provision of Services

In the environment painted, with an increasing aged population putting growing demand on the service system, and with a reduction in the wealth-generating population, there are many contentious issues being canvassed internationally and in other Australian jurisdictions. These include

- Consideration of cost recovery mechanisms that include user pays, or co-payment arrangements. Any such arrangements must be underpinned by safety nets that ensure equity of access for people who do not have the capacity to pay. For Tasmania, where the population that is dependent on social security and other safety net provisions is already one of the highest in the country, user-pays options might in any case recoup less revenue than in other jurisdictions
- The growing gap between increasing technical capacity for medical intervention and the cost and efficacy of providing them is a major challenge. In some places a combination of processes involving expert and lay people, and the setting of clear guidelines for priority setting are being explored[15].
- Funding agreements between the Commonwealth, states and territories are a mechanism for addressing both cost of services and service system improvement. Areas to pursue include resource allocations that enable a balance between different service areas, and flexibility with regard to program boundaries.

  However, experience in renegotiation of the Housing, Disability Services and Australian Health Care agreements does not augur well in reaction to either the level or flexibility of funding arrangements.

  Further, Tasmania as a small state is highly sensitive to variations – small changes in funding in one area can have large and rapid affects on other areas.
- Sustainability of the workforce, with scarcity of health and aged care practitioners in hospital and residential and community aged care settings, particularly in rural communities. Competition for health professionals is high, and the capacity to fund the remuneration packages needed to attract them is a constant challenge. In addition, the capacity for Tasmania to replace its workforce is impacted upon by a workforce that itself is ageing, emigration patterns unique to Tasmania that result in significant loss of the 18-44 year old population, and a lack training facilities within the state.

2.3 Carers and other volunteers

Within our civil society, the contribution of carers and other volunteers is a fundamental part of the fabric of our community. It is important to recognise this contribution for the way in which it reflects our shared values, and helps maintain Tasmania's capacity of caring, community services and support networks.

Older people make valuable and significant contributions to the economy through time and money given to their families in the form of child-care, other carer roles and financial assistance, and to their communities through their voluntary work. The majority of volunteers are older people. In 1999-2000, the estimated worth of work performed by volunteers nationally through community service organisations was $1,269 million, and household members were providing 6 times the number of hours in welfare services compared to hours provided by health and welfare workers[16].

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[15] Ham & Coulter, 2001. Explicit and implicit rationing: Taking Responsibility and Avoiding Blame For Health Care Choices'. *Journal of Health Services Research and Policy*, 6(3).

[16] AIHW, 2002. *Australia's Welfare*. pp.13-17.

In addition, there is the economic impact of informal care provision. NSW, for example, conservatively estimates the value of the unpaid work of carers living in NSW to be worth $5.4 billion per annum[17]. Informal care will become even more important as larger numbers of older people live at home, with increasing levels of dependency. Of the care received by older people, their spouse provides over half and the most of the remainder is provided by offspring, mainly women. Changes in the number of older people living alone, increasing rates of childlessness, geographic separation of older people and their children and the substantial increase in workforce participation of women can directly limit the capacity of the informal care system.

[17] Council of Australian Governments, 2002. Background Paper on the Economic and Social Implications of Australia's Ageing Population.

3 Positive ageing, maintaining health and wellbeing

3.1 The Broad Perspective

Positive ageing is about the development of a fair society where people of all ages are recognised and valued, treated with dignity and respect, and encouraged to contribute their wealth of experience and skills. It aims to support independence; encourage a good quality of life for Australians as they age; promote fairness and equity; recognise interdependence; recognise and respond to Australia's growing diversity; and encourage personal responsibility while providing support for those most in need.

The *Tasmanian Plan for Positive Ageing 2000-2005* makes it clear that growing older is a lifelong process and aims to support people to take a lifelong positive approach to their ageing. It recognises that healthy ageing allows people to realise their potential for physical, social, and mental wellbeing throughout their lives and allows them to participate in society according to their needs, desires and capacities, while providing them with adequate protection, security and care when they require assistance.

The *Tasmanian Plan for Positive Ageing* acknowledges that positive ageing is much broader than just being about health. However, its strategic focus extends to nclude a range of health and human services issues like affordable housing, Home and Community Care; mental health (particularly dementia) care; intellectual disability; palliative care; rehabilitation; rural health; hospital and ambulance services, including admission and discharge planning; early intervention and prevention services such as falls prevention; immunisation; nutrition; and physical activity.

3.2 Positive Ageing and Health Status

It is generally understood that effective positive ageing policies and initiatives can have a significant impact on individuals' health status. The view is that the conditions that are now the leading causes of morbidity, disability and mortality can be prevented or postponed. While the origins of risk for chronic conditions such as diabetes and heart disease begin in early childhood or even earlier, this risk is subsequently shaped and modified by factors such as socio-economic status, choices, behaviours and experiences across the whole lifespan. That makes it important to focus on preservation of function and quality of life as well as prevention of disease.

There is now a view that as people live longer, they experience more years of disability-free life[18] and any disabilities they do suffer occur at an older age[19]. This has also contributed to a changing view of the life stages through which people move. Rather than conceptualising the life cycle as 3 stages: childhood; adulthood; and frail old age, an additional stage has emerged in which people experience a lengthy period of active life following retirement characterised by good physical and mental health – the 'Third Age'[20].

The majority of people lead healthy and disability-free lives until well into their 70s or early 80s, when they enter the 'Fourth Age' which is characterised by increasing frailty and dependence. It is the final two to four years of life in which frailty and final dependence requiring high care generally occurs – for the most part, this is the same whether people live to 65 years or 100 years. Further, with healthier lifestyles and health ageing, some experts say that this 'Fourth Age' could reduce further.

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[18] Measures that take account of years of life affected by reduced functioning include 'HALE' and 'DALYs'. 'Healthy Life Expectancy' (HALE). HALE is a measure of the expected number of years to be lived without reduced functioning; in which overall life expectancy is adjusted by the years of life lived with reduced functioning due to ill health. In 2000, the AIHW reported that Australian males could expect to live 69.6 years of life without reduced functioning (representing 90.9% of overall life expectancy), and Australian females could expect 73.3 years of healthy life (representing 89.3% of overall life expectancy). 'Disability Adjusted Life Years' (DALYs) is a summary measure that combines information on the impact of premature death and of disability and other non-fatal health outcomes. One DALY is one lost year of 'healthy' life.

[19] DHAC, 1999. *Compression of Morbidity: Workshop Papers*. Occasional Papers Series No. 4. Commonwealth of Australia: Canberra. p. 1.

[20] Jones, B. 2002. *The Chronically Gifted*. http://homepage.powerup.com.au/~deangr/ChrGifHr1.htm

However, there is a counter view that this is not the case because only some disease onset can be delayed. "Only some degenerative diseases are being delayed, for example CHD [Coronary Heart Disease], but others like cancer or dementia have, are or may be increasing… When we prevent one disease or death, other diseases are in place ready to reduce the quality of life gained or can be expected to be real risks in the future. … The characteristic of an ageing society is the co-existence of many diseases for the one person and the present expectation of other diseases as death approaches. As the fight against death is successfully fought, the disability consequences of diseases will become increasingly important for the quality of our existence."[21] In addition, other complex events and syndromes – such as the incidence of falls among older people – become more important influences on quality of life and the need for assistance and care[22].

The prevalence of chronic conditions in older people, as well as the highest care requirements occurring in the final two to four years of life, indicates that health and aged care systems will continue to face major demand on high cost services. Over the coming decades this can be expected to occur irrespective of changes in population health over time.

Despite the debate canvassed above, the strategy of increasing attention to prevention and early intervention is supported and advocated, because it not only improves outcomes for individuals, but also can reduce demand on the system. Even given that there are high costs in the last 2-4 years of life, better health management is a realistic option for reducing the need for high cost interventions.

For example, a person maintaining optimum health will not place the same demands on the service system as a person with poorer health and less effective management of chronic conditions, who accesses the high cost end of the service system with acute episodes associated with poor self-management, and progresses to sustained high cost demand for management of severe, multiple conditions.

While beyond the scope of this inquiry, it is important to note that, if long-term demand on health services is to be reduced, and recognising the significant life expectancy at birth currently projected, it is important to address these issues from birth, including nurturing and development of our children. Focusing on early childhood development, supporting parenting, and early intervention is critical to the life experience and health of our future population. Equally, with a reducing birth rate, and consequent reduction in people moving into the workforce, we need to pursue strategies that maximise workforce participation and social connectedness of young Tasmanians.

3.3 Keeping people healthier longer

The development of Healthy Lifestyles is a key priority under Tasmania *Together*. The community has set goals around factors that affect people's health and on which, the community can, if it works together with government, make an impact. Priorities include an increase in the level of exercise and healthy diets, and a reduction in smoking.

Health promotion, and strategies to engage people in healthy lifestyles, both to minimise the likelihood of chronic disease, and to minimise its impact should it occur are national priorities. Jurisdictions are working together on population health issues and strategies to address the national health priority areas of CVD, cancers, injury, diabetes, mental health, asthma and musculoskeletal/arthritis.

There is a strong focus on coordinated effort to address the common risk factors – Smoking, Nutrition, Alcohol use and Physical activity (SNAP). The Premier's Physical Activity Council provides a leadership and coordination point in relation to physical activity, while community organisations such as the Cancer Council Tasmania, Diabetes Australia, the Heart Foundation, QUIT and Eat Well Tasmania are looking to coalitions of effort.

While the Government can set frameworks such as the State Nutrition Plan and the new smoking legislation, there needs to be an increased focus on working locally and directly with communities who can do most to make the lifestyles of Tasmanians healthier.

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[21] McCallum, J. 1999. The New Morbidity Picture: Substitution Versus Compression. In *Compression of Morbidity: Workshop Papers*. Occasional Papers Series No. 4. Commonwealth of Australia: Canberra. p.63.

[22] Creasey, H. 1999. Compression of Morbidity: Evidence in Relation to the Age of Onset of Neurological Disorders. In *Compression of Morbidity: Workshop Papers*. Occasional Papers Series No. 4. Commonwealth of Australia: Canberra.

In the short-to-medium term, the capacity to increase investment in prevention, early intervention and better self-management of chronic disease is limited. Current funding negotiations between the Commonwealth and States place insufficient emphasis on a reform agenda. Negotiation of the AHCA has focussed on the financial considerations in terms of what the Commonwealth will offer and what the States need. Health CEOs have now agreed to ask that the wider health and aged care issues taken up by the Reference Groups be put back on the agenda for further work and for more collaborative effort between the Commonwealth and States. Nevertheless, it is likely to be difficult to get attention back on these areas. Consequently, it is unclear at this stage as to the possibilities for reform, and the direction any reforms would take.

There is, however, general agreement that health promotion, early intervention, and better developed care planning (including the participation of the patient) can lead to both improved outcomes for the patient and their carers, and reduced demand on the health system.

Achieving a better balance needs to involve community groups, the business sector, other parts of government, and non-government services, particularly in the areas of health promotion, prevention and early intervention. Ways of doing that might include

- Maintaining and strengthening coordination of strategies and services. In Government the Department is partnering with Education in the area of healthy lifestyles and with Police in the area of crime prevention or domestic violence intervention, including elder abuse. In the business and community sectors, promotion of healthy behaviours and product use is directly relevant to most chronic diseases.
- Developing the notion of Health Impact Assessments in developing or redeveloping infrastructure, services or products. This could not only apply to government, but could be taken up by industry, the voluntary and community sectors.
- Communications strategy to modify community expectations, raise public awareness of the issues. This could include focused public consultations, focus groups, public forums, and public education strategies.

3.4 Primary health care

Primary health care plays a vital role in providing opportunities for health promotion and disease prevention, as well as early diagnosis and health care planning with clients to minimise the impact of chronic conditions. Primary health practitioners are often the first and most frequent points of contact for individuals and families seeking information, advice and treatment for health problems. To promote improved planning and coordination in this area, a Memorandum of Understanding has been established between the DHHS and Tasmanian General Practice Divisions.

The role of the primary health in the aged care service system is discussed more fully in the following section.

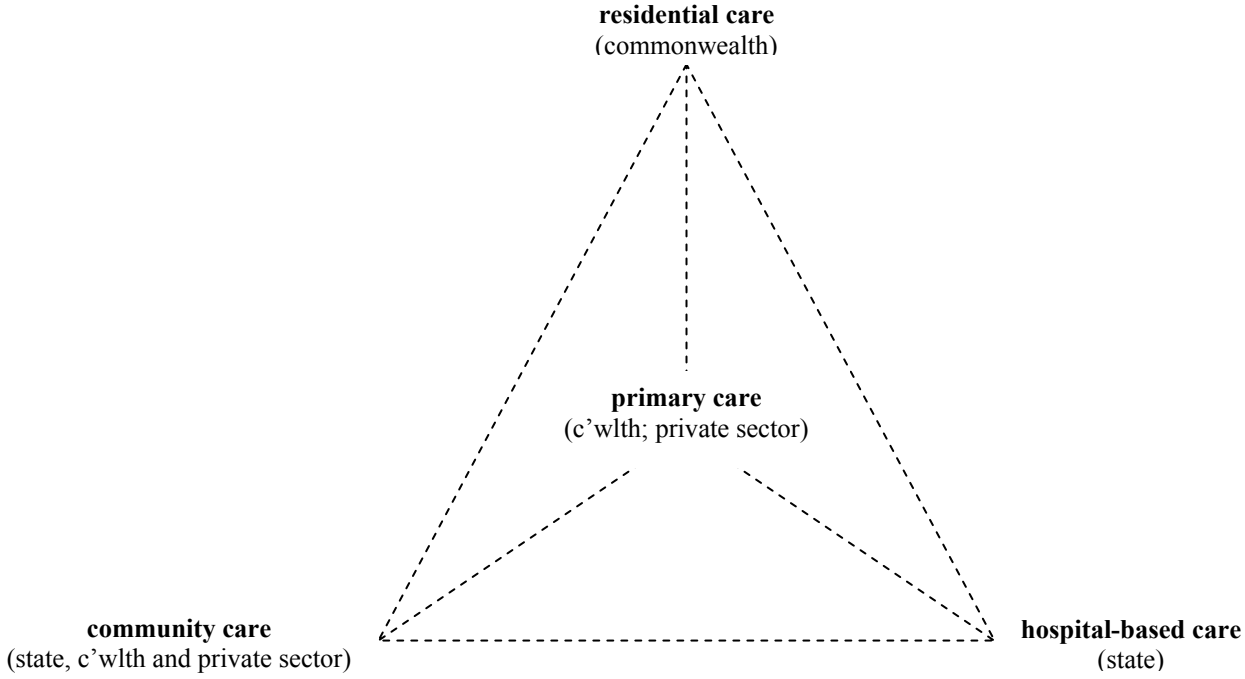
4 The impact of ageing on the health and aged care systems

4.1 Conceptualising the Service System for Older People in Tasmania

The terms of reference give particular emphasis to the frail aged in relation to demand on the service system, and the appropriateness of services. Aged care has generally referred to care for the frail aged that is delivered through residential and community services. However, ill health and disability that creates high care needs, inevitably involves a complex array of sophisticated technical and informal support services that are not always well coordinated.

Hospitals provide older people with a range of services including acute care, geriatric medicine and rehabilitation and convalescent services. Ambulance services provide the transport for elderly patients both in emergency and non-emergency cases. Primary care providers, in particular GPs, provide medical care within the community as well as residential settings. In addition to formal service provision, family and friends provide a significant amount of care to older people in their home and support them in their local community.

Figure 4.1: Areas in which services for older people are provided, and by whom



This diagram represents that while older people are living in the community, usually with some support services as they become more frail, acute episodes may put them into the hospital system, or longer-term care requirements may result in admission to residential services. In both community and residential care, they will rely on the primary care system (GPs, allied health services and pharmaceuticals), while effective primary care services have a big impact on duration in acute services.

The parts of the service system that older people need to access are generally designed and managed independently (although effort is being made to improve coordination), which can result in fragmentation that limits access to timely, consistent and appropriate care. Because they are funded and managed by different levels of government, there are program design, policy agenda, funding arrangements, and cost and demand management issues that complicate the system.

Commentators have observed that Australia's health and aged care system is extensive, loosely organised, complex and technically sophisticated. Health and aged care responsibilities are split between different

levels of government and between the public and the private sectors. The diverse funding arrangements add to the complexities in terms of the Commonwealth and the states/territories respective policy positions and responsibilities for service delivery and health outcomes.

4.2 Summary of health and aged care system components providing aged care

The following is a brief description of the major components of the health and aged care system servicing older Australians, including the funding and program arrangements.

- **Community (Home-based) Care** is funded by Commonwealth and state/territory governments, either separately or combined with local government contributions and modest consumer co-payments. Services include district nursing, home help, day care, respite care, and food services. Some case management or service coordination is provided for people with complex needs. Programs include Home and Community Care (HACC), Community Aged Care Packages (CACP), Extended Aged Care at Home (EACH), and Veterans Home Care (VHC).
- **Hospital Care** is funded through Commonwealth-state agreements and managed by the states. Services include acute health care, geriatric assessment units, rehabilitation and a range of specialist community and ambulatory services including clinics and day hospitals.
- **Ambulance Services** are provided free of charge to all Tasmanians, and the elderly are the largest user group.
- **Primary Health Care** is funded by the Commonwealth on a fee for service basis, and by individual co-payments. Primary health practitioners include general practitioners, medical specialists and allied health professionals. Primary health practitioners are often the first and most frequent points of contact for frail aged people and their carers seeking information and advice as well as treatment.
- **Residential Care** is funded by the Commonwealth to provide both accommodation and care. Funding includes co-payments from recipients for both care and accommodation. Services include residential care covering both high and low care. Supply of residential care is limited by a predetermined planning ratio (40 high care, 50 low care and 10 community aged care packages per 1000 people aged 70 years and over and for indigenous people aged 50 years and over).

Funding responsibilities for health and aged care

Commonwealth	State
• primary care (eg. general practitioners, specialists, imaging/diagnostics. Funded under Medical Benefits Scheme) • public hospitals (under the Australian Health Care Agreement) • *pharmaceuticals* (under the Pharmaceutical Benefits Scheme) • *private health care* (rebates for health insurance) • *residential aged care* • *community care for aged* (HACC) • public health	• *public hospitals*, including inpatients, outpatients, emergency departments • *ambulance services* • *mental health care* (in Tasmania a significant area of concern is provision of dementia care to older people) • aged care (as a provider of residential aged care at rural sites across Tasmania) • *community care for general population* • *public health* (eg. prevention, public awareness, food and drinking water standards)

QLD Health, 2002. *2020 Discussion Paper*. p.66 – adapted to include Tasmanian perspective

Italics denote level of government with primary responsibility

A major issue is the way in which Commonwealth and state responsibilities interact. Delineation in funding issues, differences in priorities, and targeting of services can lead to dysfunctional service delivery based around funding responsibilities rather than a client-focused, integrated approach to care.

In Tasmania's case, the issue of Commonwealth versus state funding responsibilities is significant, given the geographic dispersion of Tasmanian communities, the difficulty attracting sufficient GPs, nurses and allied health professionals to rural and remote areas, and the diminishing numbers of GPs in both

metropolitan and rural areas offering after-hours GP services. In many circumstances, Tasmania's hospitals often have to fill the gap where GP services are not available.

In addition, the different parts of the aged care system do not always work in a coordinated way, making it more difficult for older people to get access to the advice, support and care services they need when they most need it. An older person may need a number of types of care, either temporarily as they recover from a serious illness, or on a long-term basis.

Currently there is increasing pressure on hospital services due to the increasing number of older people occupying hospital beds while awaiting placement in residential care facilities.

There is increasing pressure on community support services because more people being assessed as requiring residential aged care are having to continue living in the community because of the lack of suitable aged care beds. Shorter lengths of stay in the acute sector, leading to higher levels of acuity in those discharged to the community, are also putting greater demand on community-based support services. In addition, there is also an increasing level of dependency among older people who require assistance to remain living in their own home.

Therefore, to help people remain independent for longer and reduce the early movement into residential and high-end care, a key issue is managing the interfaces between the different types of services so that older people can receive timely care that is appropriate to their needs. This also means managing the different funding sources and responsibilities that can impede the smooth transition between services.

4.3 Improving Interfaces within the Service System

More attention to the interfaces between different service sectors that provide care to older people would result in better management of the transitions between them. There are particular issues relating to discharge planning, case management, respite care, and balancing the management of clinical need with other care needs.

DHHS is working to develop an appropriate Tasmanian response – not only to hospital patients awaiting transfer to residential aged care – but also to the needs of older Tasmanians throughout the acute care system, including the interface with primary health and community care. In order to achieve this, national models are being used to inform solutions appropriate to local needs.

Tasmania participates in the Care of Older Australians work program, and in the provision of advice to Australian Health Ministers on the interface between aged and acute care. However, new models aimed at improving transitions can have financial impacts for patients.

The Extended Rehabilitation Service project has highlighted co-payment issues for clients. Clients using this service are paying for accommodation costs associated with the service as well as costs associated with their private dwelling. This can be a significant pressure for clients, given that most are pensioners.

Another cause of patients not moving from acute to residential aged care is the high number of people on the Aged Care Assessment Team's waiting list in some regions of the State. Large number of people waiting for residential aged care results in aged care providers needing to determine to which person they are going to offer a vacancy. As the Commonwealth Government does not provide any guidelines in this matter and there is no priority list, providers have to "choose" a person. There are many factors that contribute to the providers "choice". Some issues would be similar across the industry, while other issues may be particular to individual providers. This situation does create a group of individuals that are not providers "first choice". It is this group of people that often end up waiting in hospital for extended periods of time.

An improvement that can impact across each of the interfaces is better linking general practitioners with patient management. The DHHS has a Memorandum of Understanding, for example, with the Division of General Practice, through which they are beginning to address interface concerns.

4.4 Balancing Service Delivery

The balance of services needs to change, and effective transitions between them need to be improved so that

- Nursing home type patients in hospitals are more appropriately placed
- People are discharged from hospital with appropriate rehabilitation and community supports in place
- People in the community in need of residential care can be placed in a timely way
- Respite options can provide timely and adequate relief to carers, and
- Delivery of primary health care can be enhanced within residential and community settings.

There are key components in the system, particularly the primary care (GP) services and residential aged care, which are Commonwealth funded and regulated. Effective strategies to improve interfaces therefore require more jointly sponsored effort, and flexibility in service models.

5 Mapping current residential care and home-based services for aged people in Tasmania

Residential Aged Care

5.1 Overview of the Provision of Residential Aged Care in Tasmania

Residential aged care is controlled and funded nationally by the Commonwealth Government through the *Aged Care Act 1997*, which is administered by the Department of Health and Ageing. In summary the objectives of the Act are to:

- provide a high quality of care and accommodation that meets the needs of individuals,
- protect the health and well being of individuals receiving aged care services,
- ensure that aged care services are provided to people with the greatest needs,
- provide flexible and responsive aged care services,
- facilitate the independence of individuals receiving aged care services ensuring choice, and rights available to all other people in Australia,
- provide equity in access, and
- ensure access regardless of race, culture, language, gender, economic circumstance or geographic location.

The provision of residential aged care is based on the Commonwealth's planning ratio of 40 high care, 50 low care and 10 community aged care packages per 1,000 people aged 70 years and over and indigenous people aged 50 years and over. Access to residential aged care is not restricted by age, but to be eligible for admission a person is required to be assessed and approved by an Aged Care Assessment Team as needing residential aged care.

Currently there are 43 organisations providing residential aged care at 70 locations throughout the State. The majority of residential aged care providers in the State are in the not-for-profit religious and charitable sector. Appendix 1 "Residential Aged Care Places and Community Aged Care Packages, March 2003" provides a full list of services, location, the number of operational places and the operator of each service. It should be noted that the attachment details "mainstream places" and does not include flexible places operated by services such as multi-purpose services. Additional information is available from the source document at http://www.health.gove.au/acc/rescare/servlist/servlist.htm. The attachment indicates that 3,967 residential aged care places and 761 community aged care packages are being provided throughout the State.

The Commonwealth Government reports on the provision of residential aged care primarily through the annual "Report on Government Services", the "Report on the Operation of the *Aged Care Act 1997*" and the Commonwealth Department of Health and Ageing's annual report. As a consequence the majority of data available is at June 2002. These publications are available at http://www.pc.gov.au/gsp/2003/index.html, http://www.health.gov.au/acc/reports/acarep.htm and http://www.health.gov.au/pubs/annrep/ar2002/index.htm

Table 5.1: The target population for residential aged care as at June 2002: Persons aged 70 years and over including Indigenous Australians aged 50-69 years

	Unit	Tas	Aust	Unit	Tas	Aust
Capital city	' 000	19.8	1091.9	%	41.0	60.8
Metropolitan areas	' 000	0	155.1	%	0	8.6
Rural areas	' 000	28.1	509.5	%	58.2	28.4
Remote areas	' 000	0.4	38.8	%	0.8	2.2
All areas	' 000	48.3	1795.3	%	100.0	100.0

Report on Government Services 2003 - Attachment 12A.2

Based on a target population of 48,300 the number of operational places required to achieve the Commonwealth's planning benchmark would be 1,932 high care places, 2,415 low care places and 483 community aged care places.

The Report on Government Service 2003 (Table 12.2) reported the number of operational places, as at 30 June 2002, to be 47.0 high care and 36.4 low care, a total of 83.4 places per 1,000 people aged 70 years and over. The number of operational community aged care packages as at 30 June 2002 was reported as 15.8 packages per 1,000 people aged 70 years and over. The number of operational places reported included flexible places. The Report on Government Service 2003 (Table 12.2) did not include Indigenous Australians aged 50 – 69 years, which are included in the Commonwealth's target population. The following table details the number of operational places as at 30 June 2002 and the number of places per 1,000 people in the target population.

Table 5.2: Operational places as at 30 June 2002 and places per 1,000 people aged 70 years and over including Indigenous Australians Aged 50 - 69 Years

	Unit	Places	Per 1,000
Operational High Care	no.	**2 199**	**45.5**
MPS / Flexible Places	no.	25	0.5
Mainstream High Care Places	no.	2 174	45.0
Operational Low Care	no.	**1 703**	**35.3**
MPS / Flexible Places	no.	22	0.5
Mainstream Low Care Places	no.	1 681	34.8
Operational CACP	no.	**739**	**15.3**
MPS / Flexible Places	no.	32	0.7
Mainstream CACP	no.	707	14.6
Total Operational Places	no.	**4 641**	**96.1**

Report on Government Services 2003 - Attachment 12A.10; DoHA Annual Report 2002 – Table 3.1

The Department of Health and Ageing Annual Report 2002 indicates that as at 30 June 2002 there were 93.5 residential aged care places and 16.0 community aged care packages per 1,000 people aged 70 years and over, allocated to the approved providers in the State. This would indicate 4,376 residential aged care places and 749 community aged care places have been allocated of which 3,902 residential aged care places and 739 community aged care packages are operational. Therefore it has been estimated that as at 30 June 2002, there were 474 residential aged care places and 10 community aged care packages available but not operational.

The following table provides a profile of residential aged care in Tasmanian as at June 2002

Table 5.3: Profile of residential aged care in Tasmania including national profile as at June 2002

		Unit	Tas	Aust
Mainstream places		no.	3,855	144,139
Residential services		no.	99	2,962
Occupancy rate		%	97.7	96.1
Places by locality	Metropolitan areas	%	45.2	71.9
	Rural areas	%	54.3	26.9
	Remote areas	%	0.6	1.2
	Total	%	100.0	100.0
Service size	1–20 places	%	22.2	10.9
	21–40 places	%	37.4	36.3
	41–60 places	%	25.3	29.9
	61+ places	%	15.2	22.9
	Total	%	100.0	100.0
Proportion of total places	Religious	%	49.2	37.5
	Private for-profit	%	9.6	27.4
	Community-based	%	27.7	16.1
	Charitable	%	9.0	9.7
	State government	%	2.8	7.3
	Local government	%	1.7	2.0
	Total	%	100.0	100.0
Percentage high care residents	RCS 1	%	15.8	18.9
	RCS 2	%	26.8	25.1
	RCS 3	%	20.8	14.7
	RCS 4	%	6.0	4.6
	Total	%	69.5	63.3
Percentage low care residents	RCS 5	%	10.6	10.5
	RCS 6	%	8.2	10.8
	RCS 7	%	10.9	13.8
	RCS 8	%	0.8	1.6
	Total	%	30.5	36.7

Report on Government Services 2003 - Attachment 12A.4, 12A.5 and 12A.6

Table 5.3 indicates that the majority of residential aged care places in Tasmania are located in rural and remote areas of the State. The distribution of residential aged care places is not dissimilar to the distribution of Tasmania's population aged 70 years and over as detailed in Table 5.1. Tasmania is the only State where the majority of the target population for residential aged care resides in non-metropolitan areas. As a consequence of Tasmania's relatively small but widely disbursed population groups, the size of residential aged care services are also small. With the exception of the Northern Territory, Tasmania has the largest number of services with less than 40 places. The large number of small residential aged care services, together with the rurality of Tasmania's services makes them more sensitive to change and this has implications for long-term viability.

The majority of Tasmania's residential aged care services are provided by the not-for-profit sector. Again with the exception of the Northern Territory, Tasmania has the lowest participation, by the for-profit sector across the country. Generally, not-for-profit organisations do not have the same access to resources that would enable expansion within the time frames available to larger for-profit organisations.

Residential aged care services receive a basic daily subsidy based on the care needs of each resident. The assessment of a resident's care needs results in a score between 1 and 8 on the Resident Classification Scale (RCS). An RCS score of 1 represents the highest level of dependency and receives the highest subsidy. A

resident who has been assessed and approved as high care would be expected to have an RCS of 1 to 4. A low care resident would have an RCS of 5 to 8.

In June 2002, 69.5% of residential aged care residents were classified as high care. This level is above the national average and with the exception of Northern Territory, is the highest of all States and Territories. The higher level of high care residents may indicate a lower health status amongst Tasmania's older population. The variation between Tasmania and the national average is particularly evident with residents in the RCS 3 classification (see Table 5.3).

The higher number of high care residents is provided for through the Commonwealth's policy of "ageing in place". This allows a person who is low care to remain within the same service when their level of dependency becomes high care, subject to the service being able to provide the higher level of care required. While the principle of "aging in place" is supported, the policy does result in some negative implications. As at June 2002, there were 2,174 mainstream high care places, where as the number of high care residents have been estimated at 2,679. While it is likely that a small number of high care places are occupied by low care residents, the net effect is that 30% or 505 low care places are being occupied by high care residents. This inturn means that the provision and availability of low care places in the State is lower than the 35.3 places per 1,000 people in the target population as indicated in Table 5.2.

5.2 Effectiveness of the Allocation Model for Residential Care Places in Tasmania

The effectiveness of the Commonwealth's residential aged care program to meet the needs of older Tasmanians is difficult to quantify due to a lack of specific indicators. Generally, the number of people occupying a hospital bed while waiting placement in residential aged care and the number of people on the Aged Care Assessment Team's waiting lists, together with the average length of time these people wait, have been used.

The use of these items as indicators has been the subject of significant debate between the States and the Commonwealth. An individual on the Aged Care Assessment Team's waiting list might not accept the first available place offered because it is not their preferred service; others may list, but when offered a place may choose not to accept the place. Allowing for these and similar issues, the waiting list does provide an indication as to the level of demand. Similarly, concerns have been expressed with using the number of people waiting in a hospital bed for residential aged care as an indicator. This particular issue is a significant issue for all State Governments and has been discussed separately in this submission. Not withstanding the concerns in using hospitalisation as an indicator, hospitals, particularly the major public hospitals, have introduced specific initiatives and alternative programs to minimise the impact on the functioning of the hospital. Therefore, hospitalisation is not overstated and changes in the use of hospital beds by people waiting residential aged care placement is a useful indicator of the residential aged care program's effectiveness in meeting the needs of the community.

In respect to the regional distribution of residential aged care, the Commonwealth Department of Health and Ageing's Annual Report 2002, Table 3.1, provides the number of residential aged care places and community aged care packages allocated and operational per 1,000 people aged 70 years and over as follows:

Table 5.4: Allocated and Operational residential and CACP places per 1,000 people aged 70 years and over as at June 2002

	Ratio of Allocated Places			Ratio of Operational Places		
Aged Care Planning Region	**Residential**	**CACP**	**Total**	**Residential**	**CACP**	**Total**
North Western	87.4	15.9	103.3	82.6	15.9	98.4
Northern	89.6	16.2	105.8	81.9	15.7	97.6
Southern	98.7	15.8	114.5	84.8	15.8	100.6
State Total	**93.5**	**16**	**109.4**	**83.4**	**15.8**	**99.2**

DoHA Annual Report 2002 – Table 3.1

Table 5.4 indicates that while the southern region of the State has more residential aged care places allocated at 98.7 places per 1,000 people aged 70 years and over, it also has the largest number of places that have not become operational. The north western region which has the lowest allocation against the

Commonwealth's planning benchmark, has more places available than the northern region which has the lowest number of operational places per 1,000 people aged 70 years and over in the State.

Table 5.5 uses the Aged Care Assessment Teams' waiting lists to highlight the demand on residential aged care services that has been experienced across the State. In the southern region demand for all care types exceeds demand of the other regions. The waiting time in the southern region also exceeds the waiting times in other regions for each care type.

Table 5.5: Average number of people waiting for residential aged care services and the average number of days waiting by region, June 2002

Region	Care Type	Av. Number People	Number per Target Pop.	Av. Number of Days Waiting	Av. Number Waiting in Hospital	
North Western	High Care	10.5	1.0	46.86	1.5	(14.3%)
	Low Care	64.0	6.1	170.81	1.0	(1.6%)
	CACP	17.0	1.6	100.27		
Northern	High Care	61.5	4.4	102.35	22.0	(35.8%)
	Low Care	83.0	6.0	167.44	2.5	(3.0%)
	CACP	41.0	2.9	109.16		
Southern	High Care	167.5	7.5	146.30	59.0	(35.2%)
	Low Care	222.5	10.0	252.63	18.0	(8.1%)
	CACP	77.0	3.4	144.82		

Aged Care Assessment Team – Fortnightly Waiting Lists June 2002

The pressure being experienced in the southern region of the State has no clear explanation. The southern region has more available places per 1,000 people aged 70 years, nearly 3 places more per 1,000 people aged 70 years and over than the northern region. A number of factors have been investigated that are linked to increased demand, such as a greater percentage of older aged people in the target group, but there is no single characteristic in the southern region that adequately explains the current level of demand. Similarly, the demand for high care in the north western region is lower than expected, without adequate explanation.

While the June 2002 data enables comparison with the Commonwealth's release of residential aged care data, the higher than expected demand in the southern region and the lower than expected demand for high care in the north western region has been evident for a extended period of time. Ideally, if waiting lists could be maintained across the State at no more that 1 person per 1,000 people aged 70 years and over, and if waiting times averaged less than 60 days, this would have a significant and positive outcome on the whole health and aged care system.

In regard to the number of people waiting in hospital for residential aged care, particularly high care, even though the northern region has a lower number of people waiting than the southern region, the percentage of people waiting in hospitals are similar. A significant difference between the northern and southern regions in respect to people waiting in hospital for residential aged care is that in the northern region 61.4% of the people waiting in hospital were waiting in a public hospital other than the Launceston General Hospital, while in the southern region only 6.8% of people were waiting in a public hospital other than the Royal Hobart Hospital.

Table 5.6 details the southern region's waiting list for residential aged care by people assessed and approved as needing high care. This table not only clearly demonstrates the increase in demand over the past four years, but the increased use of hospital beds for people waiting placement. The significant increase in the number of people waiting in hospital as a percentage of the total waiting list may indicate a trend of people choosing to remain in their own homes for as long as possible. The desire of people to remain in the community for as long as possible contributes to an increase in the number of people entering residential aged care with a higher dependency level. It also contributes to the increasing number of people needing access urgently, as they are no longer able to be safely cared for in the community.

Table 5.6: Comparison of the southern region's high care waiting list and the use of hospitals beds by people waiting placement as at July for years 1998 to 2002

	July 1998	July 1999	July 2000	July 2001	July 2002
Average number of people waiting in the month.	84.0	109.0	150.5	141.5	177.5
Average number of people waiting in hospitals.	13.0	26.0	44.5	45.0	66
Average number in hospital as a % of the total average number waiting in the month.	15.5%	23.9%	29.6%	31.8%	37.2%

Aged Care Assessment Team Fortnightly Waiting Lists July 1998 - 2002

The high numbers of people waiting for residential aged care in some regions, and the resulting extended length of time that a person is required to wait to access appropriate care, creates significant demands on other health services. The above tables demonstrate the impact people with high care needs have on hospital services, but it should also be recognised that the impact extends wider than hospital services.

The majority of people on the Aged Care Assessment Teams' waiting list, people approved under Commonwealth guidelines as having care needs that cannot be met more appropriately through non-residential care services, are in the community while waiting access. Increasing numbers of people waiting in the community stretches community health services and places enormous pressures on family, friends and carers.

As previously noted, in June 2002, there were an estimated 474 places allocated but not operational. Had these 474 places been operational in June 2002, the impact for people waiting for residential aged care placement would have been positive and significant. Pressure on the State's health system would have also been reduced enabling resources to be more appropriately allocated. The 474 non-operational residential aged care places in June 2002, was equivalent to 77.8% of the total number of people approved and waiting placement for residential aged care at that time.

The effectiveness of the State's health system is dependent on the capacity of the Commonwealth's aged care programs. There is a need to ensure that residential aged care places are allocated and operational in accordance with established benchmarks. The Commonwealth's aged care programs also need to provide a flexible safety-net arrangement to address regional and local aberrations in demand when they occur.

5.3 Appropriateness of the Allocation Model for Future Residential Care Places in Tasmania

The Australian Institute of Health and Welfare has modelled the likelihood of Australians using residential aged[23] care as well as the expected length of stay in residential aged care over a lifetime[24]. The modelling results revealed that on average, a woman at age 65 would spend 2.6 times longer than her male counterpart in residential aged care. The study found that the expected length of stay gradually increases with age until it peaks in the mid to late eighties. The probability of ever entering a residential aged care facility for permanent or respite care was 65% for females at age 65, increasing to 85% at age 85.

The Aged Care Assessment Program "National Minimum Data Set Report July 2000-2001"[25] reported that in Tasmania the proportion of people being assessed by the Aged Care Assessment Teams who are aged over 80 years has increased from 59.6% in 1995 to 66.7%, and compares with 59.3% nationally. In Tasmania the number of people recommended for residential aged care is 60.5% of assessments compared with 43.4% nationally.

Over the next 50 years the greatest growth in the older population in Tasmania, will be in the population aged 85 years and over. The predicted increased in the numbers of older aged people will change the profile

[23] Mason F, Liu Z, Braun P. 2001. The probability of using an aged care home over a lifetime (1999-00). AIHW Canberra

[24] Liu Z. 1999. Expected length of stay in nursing homes and hostels over a lifetime in Australia AIHW Canberra

[25] Lincoln Gerontology Centre, September 2002, Aged Care Assessment Program National Minimum Data Set Report July 2000-June2001, La Trobe University

of the Commonwealth's target population for the allocation of residential aged care. The increasing numbers of older aged people will increase the probability of more people in the target group needing residential aged care with an increased length of stay. This raises questions as to the appropriateness of the Commonwealth's allocation model to meet the future aged care needs of the State.

Table 5.7 details the projected population in Tasmania of people aged 70 years and over, and the number and percentage in that age cohort who will be aged 85 years and over.

Table 5.7: Number of people aged 85 years and over as a percentage of the population 70 years and over

Year	70+ ('000)	85+ ('000)	85+ as a % of 70+
2003	47.8	7.5	15.8%
2006	49.5	8.3	16.8%
2011	54.3	10.0	18.3%
2016	60.6	11.2	18.4%
2021	71.6	11.8	16.5%
2031	87.7	15	17.1%
2041	91.8	21.4	23.3%
2051	85.8	23.6	27.5%

ABS, Population Projections 1999 to 2101.Cat. No. 3222.0

As previously highlighted there is sound evidence that the older aged population are the predominate users of residential aged care services. To demonstrate the impact an increasing older aged population may have on the provision of residential aged care, the following allocation modelling is provided.

The model uses 2001 Census data that identifies a total of 1,710,291 million Australians aged 70 years and over with 262,689 people aged 85 years and over. For simplicity the indigenous population aged 50-69 has not been included in the example and therefore total numbers have been understated.

The modelling results, calculated on the current planning benchmark, reveal that 153,927 residential places would be required to achieve the current national planning benchmark of 40 high care and 50 low care places per 1,000 people aged 70 years and over.

This allocation measure was arrived at by calculating the national population over 70 years of age x current benchmark x 1000-(1,710,291 population x 40 places÷1,000=68,412 high care places and 1,710,291 population x 50÷1,000=85,515 low care places).

The modelling results calculated on the same benchmark but using the population aged 85 years and over reveals that a ratio of 260 high care and 326 low care places per 1,000 people aged 85 years and over would be required to achieve the same number of places.

This allocation measure was arrived at by calculating the number of places required to achieve the current national benchmark÷national population over 85 years of age x 1000 (68,412 high care places ÷ 262,689 x 1,000 = ratio of 260 high care places and 85,515 low care places population ÷ 262,689 x 1,000=ratio of 326 low care places.

Table 5.8 compares the current planning benchmark with a benchmark based on the population 85 years and over. Using census data, as at 2001 both benchmarks would produce the same number of places, nationally, for the 2001 year i.e. the application of either planning benchmark that would be cost neutral for the Commonwealth as at 2001.

Table 5.8: Comparison of residential aged care benchmark based on people aged 85 years and over with the current 70 years and over benchmark on Tasmania's projected population

Year	70+ ('000)	85+ ('000)	90 places per 1,000 people 70+	586 places per 1,000 people 85+	Variation
2003	47.8	7.5	4 298	4,421	-123
2006	49.5	8.3	4 452	4,880	-428
2011	54.3	10.0	4 887	5,837	-950
2016	60.6	11.2	5 456	6,537	-1,081
2021	71.6	11.8	6 448	6,915	-466
2031	87.7	15.0	7 893	8,790	-897
2041	91.8	21.4	8 262	12,540	-4,278
2051	85.8	23.6	7 722	13,830	-6,108

ABS, Population Projections 1999 to 2101.Cat. No. 3222

Table 5.8 demonstrates that the current benchmark based on the population 70 years and over may not provide a sufficient supply of residential aged care places to meet the increasing demand created by an increase in the number of people aged 85 years and over. This is the segment of the older population that that are more likely to need residential aged care.

There is a need for the Commonwealth's residential aged care program to review allocation guidelines to ensure that the provision of residential aged care meets the needs of a changing demographic in the targeted population.

5.4 Issues for Residential Aged Care Providers in Tasmania

There has been national concern within the residential aged care industry with the Commonwealth Government's funding arrangements. In response the Commonwealth in the 2002-2003 Budget committed $7.2 million for a comprehensive review of the pricing arrangements in residential aged care. As a part of the review a number of background papers have been published and are available on the review's website at http://www.health.gov.au/acc/rescare/acprtask.htm. The taskforce undertaking the review is required to report to the Minister for Ageing by the end of 2003, with its recommendations.

DHHS has recommended that the Review of Pricing Arrangements in Residential Aged Care undertake an audit of the adequacy of Commonwealth's response to the Productivity Commission's Inquiry Report "Nursing Home Subsidies" dated January 1999, as much of the current issues were identified in the Productivity Commission's review. The Commonwealth's response to the recommendations made by the Productivity Commission has been inadequate.

Not withstanding the outcome of the Commonwealth's review, the Commonwealth's residential aged care program needs to be flexible enough to take into consideration local issues and the particular "shape" of segments of the industry.

Tasmania's residential aged care providers, in comparison to the national average, operate smaller services, in non-metropolitan areas by not-for-profit organisations as the following table demonstrates.

Table 5.9: 'Shape' of Tasmania's residential aged care services in comparison with the national average

	Tasmania	National Average
Services with 40 places or less	59.6%	47.2%
Places in non-metropolitan areas	54.9%	28.1%
Places operated by not-for-profit providers	85.9%	63.3%

Report on Government Services 2003 - Attachment 12A.4, 12A.5 and 12A.6

These factors contribute to a residential aged care industry in Tasmania that does not have economies of scale, has less infrastructure support, and higher capital costs than the majority of other States. The

structure of Tasmania's residential aged care industry is not being adequately addressed in the allocation of resources within the Commonwealth Government's Residential and Community Care Program.

While the Commonwealth Government has introduced Accommodation Bonds and Charges to fund capital redevelopment, these are insufficient forms of assistance for the majority of Tasmanian providers. The Commonwealth Government's annual capital and restructuring grants are allocated to a relatively small number of providers in an ad hoc framework that lacks the certainty that once was provided in the form of capital payments available on each place held. The ad hoc nature of grants creates a high level of uncertainty to boards in their planning for expansion and redevelopment of residential aged care services.

Lower property prices in Tasmanian, particularly in non-metropolitan areas results in an inability to obtain bond amounts that are available in metropolitan areas. The Commonwealth's "Report on the Operation of the *Aged Care Act 1997*" noted that for the 2001 – 2002 year the average new bond was $82,989 up from $69,200. Smaller bonds reduce the income derived, and restrict the capacity to retire capital debt.

Likewise, accommodation charges and concessional payments do not produce a sufficient income stream to meet total cost of providing accommodation at standards required by the Commonwealth or expected by the community. For small services, the unit cost per place is significantly higher than for larger services and as a consequence smaller services have a higher cost structure.

Building costs in non-metropolitan areas are also significantly higher than in metropolitan areas. The Department of Health and Human Services' own experience would indicate that including a 30% location allowance is often not sufficient to cover tenders actually received for capital redevelopments.

The large number of small providers in Tasmania, the majority of which are not-for-profit organisations, means that the majority of Tasmanian services do not have the technical, infrastructure or financial support that is available through large organisations that operate in mainland states.

In addition, there is national, industry wide concern that recurrent funding of residential aged care has not kept paced with the cost of providing appropriate care. In Tasmania, this is of greater concern as Tasmanian providers are experiencing the largest reduction in funding, in real terms, under the Commonwealth's Funding Equalisation and Assistance Program.

The result of these factors is likely to be that a significant number of residential aged care providers will not be able to expand to meet the anticipated increase in places required. While the relatively small number of new places available at any one location in the State will not be sufficient to attract new providers to high need areas, particularly those outside the larger metropolitan areas.

5.5 Adverse Implications of Ageing in Place

As stated in Section 5.1, the Commonwealth's policy of "ageing in place" allows a person who is low care to remain within the same service when their level of dependency becomes high care, subject to the service being able to provide the higher level of care required. This policy is supported in terms of the continuity of care and community links for the resident. However, a consequence of the policy is that it is impossible for high/low care ratios to be maintained.

In addition to the impact on planning ratios discussed previously, a consequence of the "ageing in place" policy has been that, as the level of ageing in place increases in a low care service, the staffing model required to deliver appropriate care must become more consistent with a high care service. This results in overall costs equivalent to a high care service while funding is provided on the basis of the mix of high care and low care residents creating viability issues unless the facility is supported through other resources within the service provider's organisation.

Service providers who do not change staffing mix and attempt to maintain financial viability run the risk of not being compliant with the Commonwealth's requirements under the *Aged Care Act*.

There is increasing evidence that this situation is resulting in residential aged care providers who were providing hostel (low care) accommodation prior to the 1997 Aged Care Reforms moving to become a high care only service, increasing the loss of low care places. In small rural communities where there is a single or a small number of providers, this creates the potential for an over supply of high care places and an under

supply of low care places. Potentially it also puts associated additional financial pressure on all health services in the community, as a result of an imbalance of service provision.

Funding arrangements for services that are ageing in place should ensure that such services have the financial capacity to provide appropriate levels of care to residents with high care needs. The funding structure should also enable a service to continue providing places to people with low care needs.

5.6 State Government provision

Generally, the Department of Health and Human Services provides residential aged care services in those communities that have been unable to establish a residential aged care service with a private provider. DHHS currently provides residential aged care at King Island, Smithton, Queenstown, Ouse, Oatlands, Campbelltown, Beaconsfield, Scottsdale and Flinders Island. Table 5.10 details services and the number of aged care places currently being provided.

Table 5.10: The level of residential aged care services provided by the State through the Department of Health and Human Services

Location of state-provided residential aged care services	High Care	Low Care
King Island MPC	8	6
Smithton District Hospital (Ambrose)	22	
West Coast District Hospital (Lyell)	3	8
Ouse District Hospital	6	
Midlands Multipurpose Health Centre (Oatlands)	8	10
Campbell Town Community and Health Service (MPS)	12	8
West Tamar Community and Health Service (MPS)	12	6
North East Soldier's Memorial Hospital (James Scott Wing)	24	
Flinders Island MPC	5	4
State-provided beds not receiving Commonwealth funding		
West Coast District Hospital	5	

Department of Health and Human Services

Residential aged care services provided at Beaconsfield and Campbelltown are delivered through a Multi Purpose Service (MPS) model, resulting in greater flexibility to meet the health needs of smaller communities.

In communities where the number of residential aged care places available under the Commonwealth's planing ratios do not provide sufficient numbers for a viable service (40-60 beds), the State has been the provider of aged care through community based health services or through district hospitals.

The State can and has obtained residential aged care places to enable Commonwealth funding to be provided. Although the small number of places provided at each location means that the State in providing residential aged care does so at a highly subsidised cost. The subsidising of residential aged care by the state limits resources being directed to community-based care and infrastructure to provide access to specialist services in metropolitan areas.

The State also directly supports the Commonwealth's residential aged care program through a subsidy reduction applied by the Commonwealth. The Productivity Commission's 1999 inquiry into Nursing Home Subsidies concluded that there was no reason why the basic subsidy regime should differentiate based on ownership, and recommended that the current subsidy reduction for government-run homes and those transferred to the non-government sector be phased out over a five year period.

The Commonwealth rejected the Commission's recommendation and the State continues to provide supplementary funding on 406 beds (360 ex state government) at a cost, currently totalling $1.4 million per annum.

New places can become operational as soon as these are allocated, but usually take up to two years to become operational while service providers build the accommodation. With the significant increase of places needed in future years, there is need to consider enhancements in the planning of residential aged care service delivery, to more quickly make allocated places operational. This is an issue recognised by the Commonwealth, which has agreed to develop a tripartite approach with the Tasmanian Government and Local Government to address issues of mutual concern.

One option would be simplifying planning schemes (noting that there is a current project being undertaken under the auspice of the Premier's Local Government Council). This could build a shared picture of future residential care need in local government areas, ensure planning provided for adequate zoning and regulation requirements to meet that need, and engage community support for developments.

Another option particularly relevant to the smaller providers in Tasmania is to allocate places for future years earlier. This could be achieved without the Commonwealth increasing its financial obligations by restricting commencement of operation until the designated year. Such an option could give greater certainty to providers for medium term planning, provide opportunity to structure funding well in advance of the places coming on line, while providing certainty that recurrent funding would be assured into the future. It would also provid an opportunity to create an allocation that may achieve a viable number to encourage a new provider into an area that otherwise would not be possible.

Home-Based Care

Commonwealth and state governments, as well as non-government providers and informal carers, provide home-based services. Providing home-based services not only matches the personal preferences of the overwhelming majority of older people, but is also an economical and effective care model when compared with residential aged care. This approach is being encouraged with several programs specifically targeted to help people remain in their own home.

The Home and Community Care program (HACC) is a key program supporting people in their homes. HACC services are provided in the client's home or community to frail people, to people with a severe, profound or moderate disability and to their carers. The Productivity Commission estimates that in Tasmania around 68.2% of HACC recipients are aged 70 years and over[26].

The number of hours of HACC services received by over 70 year olds is higher in Tasmania's rural and remote areas, as is the number of meals received.

Table 5.11: HACC Services received (per 1000 people aged 70 years and over, plus Indigenous people aged 50-69 years) [(a)], by urban-rural area, Tasmania, 2001-2002

	Capital city	Other major urban areas	Rural areas	Remote areas	All areas
Total hours (b)	5,604	-	8,039	15,339	7,085
Total meals (c)	4,723	-	6,800	6,497	5,945

Report on Government Services, 2003. Table 12.6

a. 73% of HACC funded agencies submitted data for 2001-02

b. Hours received for the following services: allied health care at home and in centres, assessment, case management & planning, counselling/ support/ information/ advocacy, domestic assistance, home maintenance, nursing care at home and in centres, other food services, personal care, respite care, social support.

c. Includes home meals and centre meals

The following is the Commonwealth's indicative allocation model, which indicates that the distribution of the HACC *target* population for different age groups relative to the total population is evenly spread. This would suggest that services should be evenly spread around the state, but priority, complexity of service need,

[26] Steering Committee for the Review of Commonwealth/State Service Provision, 2003. *Report on Government Services 2003*. Productivity Commission: Canberra, Table 12A.30.

capacity to pay, availability of other care services and support shape demand and the pattern of service. Not all the target population are eligible, and only ~20% are currently assessed as needing services.

Table 5.12: HACC Target Population by age group and region, Tasmania, 2003

		Age group (years)				
		0-49	50-59	60-69	70-79	80+
North	HACC	5,960	1,691	1,797	1,812	1,669
	Total	90,539	16,588	11,542	8,987	4,923
	% of total population	6.6	10.2	15.6	20.2	33.9
South	HACC	10,386	2,942	2,941	2,908	2,680
	Total	157,772	28,860	18,892	14,427	7,905
	% of total population	6.6	10.2	15.6	20.2	33.9
North West	HACC	4,840	1,378	1,487	1,401	1,211
	Total	73,518	13,522	9,553	6,951	3,573
	% of total population	6.6	10.2	15.6	20.2	33.9

The HACC program conducts an annual consumer consultation process and formalised consultation processes with service providers in order to establish priorities for growth funding within each region. Funds are targeted towards those services prioritised as having the greatest demand. The program is required to allocate funds equitably across regions according to the commonwealth formula. At present, about 50% of HACC funding supports DHHS provided services.

As people age their care needs increase significantly resulting in a need for tailored packages to enable them to remain in their home. Community Aged Care Packages (CACPs) provide the equivalent of low-level residential care at home.

Table 5.13: Total Community Aged Care Packages as at Feb 2002 (ACAT Waiting List as at 15 July 2002)

	Total	Provisional	Operational	C'wealth Benchmark	Over (Short)*	ACAT Waiting List	Av. Days Waiting	No. Waiting in Hospital
South	331	23	308	226	82	84	157.6	Nil
North	207	9	198	140	58	31	120.5	Nil
North West	167	9	158	107	51	18	113.0	Nil
Total Low Care	705	41	664	473	191	133		

* Operational places against the Commonwealth's planning benchmark

Provision of CACPs is highest in the South, which also has the largest waiting list, and longest length of time waiting to receive CACPs.

The state government is a major funder of community nursing. Community nursing is a home visiting service providing nursing support such as wound care, diabetes management, assistance with self-care etc. It is fully utilised at present, and demand is expected to increase.

Table 5.14: Community nursing home visits, occasions of service, DHHS, Tasmania, 2001/02

		Age group (years)		
	All	65 - 84	85+	Cum 65+
Number of visits				
Male	94,127	60,806	13,293	74,098
Female	140,024	81,014	28,023	109,037
Total	**234,151**	**141,820**	**41,315**	**183,135**

DHHS, *Aged, Rural & Community Health Services*

The Department of Health & Human Services (DHHS) provides a range of community rehabilitation and allied health services across the state. Most of these services are not targeted specifically for older people,

although older people are significant users of these services. Table 5.15 summarises services for those aged 65 years or over.

Table 5.15: Community Rehabilitation & Allied Health Service Usage, DHHS, Tasmania, 2001/02

Service Unit		Number of clients			% of total clients using the service unit
		Male	Female	Total	
Aged Care Rehabilitation Unit	65+	306	384	690	80%
Hobart Day Centre	65+	90	138	228	20%
Southern Community Equipment Scheme	65+			4755	68%
NW Community Equipment Scheme	65+			16	21%
Community Occupational Therapy	65+			1673	78%
Community Podiatry	65+	960	5440	6400	40%
Statewide Continence Service	65-84	1448		2128	45.2%
	85+	680			21.2%
Statewide Continence Aids Scheme	65+			2275	
Orthotic Prosthetic Services Tasmania	65-84	262	315	577	10.6%
	85+	192	95	287	5.5%

DHHS, *Community Rehabilitation and Allied Health Services*

Palliative Care is also a service provided by the State government. This is a state-wide specialist service that provides interdisciplinary care, consultancy, support and advice to people living with a life threatening illness and to their families through specialist inpatient and community outreach services.

Palliative Care services consist of three urban-based community teams, one each in Hobart, Launceston and Burnie that provide outreach to rural and remote areas and two inpatient care facilities (the JW Whittle Ward located in Hobart and Philip Oakden House located in Launceston).

Palliative care services are accessed by people of all ages. However, a palliative care interdisciplinary team mapped usage by age, and found that approximately 80% of all community clients visited were aged over 65 years.

Table 5.16: Clients using palliative care services over 8-12 months in 2001/02*

	Age (years)		Total
	65-84	85+	
Number of clients			
Male	175	87	262
Female	144	71	215
% of all clients using the service	53%	26%	79%

DHHS, *Palliative Care Services*

*Data was collected for 8 months from the North and 12 months from the South and North West. The data does not include the JW Whittle and Philip Oakden House Hospices.

The proportion of older people living alone is increasing. People with a terminal illness who live alone require additional support, resources and coordination to ensure their quality of life.

Growth in the demand for palliative care services is growing in Tasmania's rural areas, and is a reflection of Tasmania's dispersed population.

5.8 The Distribution and Delivery of Home-Based Services

The plethora of funding programs and packages make it difficult for both providers and consumers to navigate the system. Recognising this, the Commonwealth have just initiated a cross-jurisdictional consultation process for a New Community Care Strategy. The New Community Care Strategy proposes a three-tiered approach to the delivery of community care service provision

- Packaged Community Care Tier
- Basic Community Care Tier
- Access, Information and Support Tier

Consultation for the New Strategy for Community Care will explore streamlining of community care provision to reduce overlap and duplication; an integrated community care system modelled around regionalised access centres and a tiered model of service provision; and use of a standardised community care intake and assessment system to achieve greater equity of access and simplify entry points for people requiring care.

Tasmania will participate in the consultation process, and is already making good progress on the 'Packaged Community Care Tier'. Tasmania will need to work closely with the Commonwealth on the development of the other two tiers, particularly the 'Access, Information and Support Tier'.

In small, rural communities DHHS can become the provider of last resort (as in the case of community nursing) due to the absence of non-government service provision in the area. See discussions in Sections 4.1 and 5.1 & 5.2.

5.9 Matching Home-Based Services to Need

The wait for residential aged care places puts a serious burden on families and on community care systems in Tasmania which need to provide resources to support these older people to remain safely at home. The ACAT waiting list indicates that there are a group of clients in the community recommended for residential aged care who never get it. There needs to be a better understanding of this cohort, including review of the acuity of their care needs, whether they move into case management services or continue without support.

5.10 Improving the Coordination and Delivery of Community Based Services

Improved service coordination and delivery requires the development of better processes for the planning and delivery of care while maintaining the diversity and commitment of carers, service providers and community volunteers. Consultation for the New Strategy for Community Care will address these concerns. See discussion in Section 5.4.

Workforce planning is an important mechanism through which community based service coordination and delivery can be improved. DHHS is currently addressing workforce planning for community-based services through a number of processes, including:

- A Community Nursing Strategic Plan
- A Statewide Rehabilitation Plan
- The ACAT Review which includes recommendations to refocus ACAT roles and enhance effectiveness of the service
- The development of Medical, Nurse, and Allied Health Professionals Workforce Planning Strategies
- A review of Community Options Services (case management and the management of high need, complex care clients) – currently in progress

5.11 Ambulance services

The trend data for ambulance demand in Tasmania shows a continued increase in ambulance emergency (10-18% increase) and non-emergency transports (10.2% increase) across all regions in 2001-02. In addition, air ambulance movements have risen 7.6% over 2001-02, and 4% over the last 3 years.

With the exception of critical patient recovery (trauma), ambulance services in all Australian states confirm consistent growth in ambulance demand that can be generally attributed to factors such as:

- Advances in treatment of numerous chronic health conditions enabling people with these illnesses to live longer.
- Ageing of the population and consequent increased ambulance utilisation. People over 65 access hospital services at four times the rate of other age groups and ambulance utilisation ratios are similar.

  During 2002, ambulance usage for emergency, urgent and non-urgent types of service showed that people over the age of 65 years used 41% off all ambulance trips to hospitals, and these trips represented 20% of all hospital separations.

Table 5.17: Ambulance Services attendance, by type of incident and region, by whether persons are under or over 65 years of age, Tasmania, 2002

	South			North			North West		
Incidents	**under 65**	**65+ yrs**	**total**	**under 65**	**65+ yrs**	**total**	**under 65**	**65+ yrs**	**total**
Emergency (a)	7885	4390	12275	3369	1953	5322	2564	1846	4410
Urgent (b)	3883	2492	6375	1604	1243	2847	1286	1023	2309
Non-urgent (c)	1453	1782	3235	927	992	1919	682	558	1240
Total Incidents	13221	8664	21885	5900	4188	10088	4532	3427	7959

a. Emergency: immediate response under lights and sirens (incident is potentially life-threatening)
b. Urgent: response desirable within 30 minutes without lights and sirens
c. Non-Emergency: response by ambulance or patient transport service

Table 5.18: Ambulance Services attendance as a proportion of all hospital separations and ambulance trips, by whether persons are under or over 65 years of age, Tasmania, 2002

Under 65 across the state:	23,653 trips
as proportion of all hospital separations	29%
as proportion of all ambulance trips	59%
Over 65 across the state:	16279 trips
as proportion of all hospital separations	20%
as proportion of all ambulance trips	41%

- Trends toward more home-based palliative care treatments of people with terminal conditions, requiring ambulance movements for periodic hospitalisations or movements to palliative care wards; and
- Advances in specialised hospital-based diagnostic and treatment services requiring more people to be transported for this advanced care either in Tasmania (by road ambulance) or interstate (by air ambulance).

  2002 data shows that people over 65 years of age consume three quarters of all assisted trips, and such assistance represented was nearly three times higher than for all people under 65 years of age.

Table 5.19: Hospital Separations and Use of patient Travel Assistance, 2002

	Under 65 Years	**Over 65 Years**
Total Hospital Separations	55497	25994
Total PTAS Trips	1474	4277
Proportion of all trips	25.6%	74.4%
Trips as proportion of separations	2.7%	16.5%
Trips as proportion of all separations	1.8%	5.3%

A range of health reforms has also impacted on the delivery of ambulance services in Tasmania. These include:

- De-institutionalisation/community integration of people with mental illness and intellectual disabilities;
- The closure or bypass of many rural health facilities for quality and safety reasons, making rural ambulance cases trips longer to definitive care (ie more case kilometres travelled, more drugs used en route etc); and
- Trends to increased day surgery and shorter lengths of hospital stay impact on ambulance movements to and from hospitals for day surgery, re-admission and/or return to their homes for community-based care.

The Tasmanian Ambulance Service has identified the following impacts from increased service demand:

- resource pressures (physical infrastructure; workforce) in the face of increasing demand
- increased response times
- Impact on the capacity to sustain current models of service delivery including mixed salaried/ volunteer models of service delivery affecting 13 of our stations
- Impact on volunteer recruitment & retention, with volunteer fatigue, and inability to work extra cases due to impacts on their families, businesses, employment, sleep patterns etc
- Fatigue levels creating problems to maintain Branch stations crews, which can drive OH&S & industrial concerns for staff who work 4 days and nights consecutively (days on duty and nights on call); and
- Queuing at hospital emergency departments resulting in extra ramp time (turn around time of crew) adding to a decline in response capacity.

5.12 Carers and Volunteers Supporting People in Their Homes?

"With the growing emphasis on home-based care, informal care by family, friends and neighbours is increasingly being recognised as an important source of support to people of all ages. Carers play a key role in assisting older people to remain in the community and the need for this support is expected to increase. While informal care is important in helping older people with disabilities to remain living in the community, it is important to recognise that older people themselves provide a lot of informal care."[27]

The 1998 ABS survey of Disability, Ageing and Carers found that two-thirds of carers were women, and the majority of carers of older people were themselves over the age of 65.

[27] AIHW, 2002. *Older Australia at a Glance*, 3rd Edition. AIHW: Canberra. p.42

Table 5.20: Primary carer of persons aged 65 years and over, by age and sex of the carer and care recipient, Australia, 1998

	male carer		female carer		all carers	
	25-64	**65+**	**25-64**	**65+**	**25-64**	**65+**
	number					
female care recipient						
65-74	*3,700	11,800	*3,800	**800	*7,600	12,600
75+	*4,600	17,400	25,100	**2,500	29,700	19,900
total females 65+	*8,300	29,200	28,900	*3,300	37,300	32,500
male care recipient						
65-74	**1,200	**0	8,900	14,700	10,100	14,700
75+	*2,600	**0	*3,300	24,900	*5,900	24,900
total males 65+	*3,800	**0	12,200	39,600	16,000	39,600
total 65+	12,200	29,200	41,100	42,900	53,200	72,100
	percent					
female care recipient						
65-74	*18.5	58.4	*18.9	**4.2	*37.4	62.6
75+	*9.3	35.1	50.6	**5.0	59.9	40.1
total females 65+	*11.9	41.9	41.4	*4.8	53.4	46.6
male care recipient						
65-74	**4.9	**0.0	36.0	59.1	40.9	59.1
75+	*8.4	**0.0	*10.7	80.9	19.1	80.9
total males 65+	*6.9	**0.0	22.0	71.2	28.8	71.2
total 65+	9.7	23.3	32.8	34.2	42.5	57.2

AIHW analysis of ABS Disability, Ageing and Carers Survey, 1998. Cited in AIHW, 2002. *Australia's Welfare* 2001.

Note: Estimates marked ** are subject to sampling variability too high for most practical purposes. Estimates marked * have an associated relative sampling error of between 25% and 50%. These estimates should be interpreted accordingly.

The Tasmania *Together* process recognises the importance of carers, and the need to ensure appropriate, affordable and accessible care so that Tasmanians can participate at all levels, particularly in the workforce.

Particular issues in relation to carers include

- Informal carers are an integral part of providing care and support to older people – they need to be assisted so that this care is sustainable. The burden of caring can reduce health and wellbeing of carers. The 1999 National Survey of Carer Health and Wellbeing, found that the physical, mental and emotional health and wellbeing of most carers in Australia is the poorer because of caring responsibilities[28].
  - Improving the interfaces between different types of services can help to lessen this burden; and
  - Adequate and timely respite care options help sustain carers, as does access to counselling, information and support.
- Changing demographics may contribute to a reduced pool of informal carers. For example, increasing lone person households, reducing fertility, changing work patterns for women, and more children separated from their parents by long distances.
- With more demand on formal health and aged care services, the role of volunteers in the delivery of services may include consideration of other service models. Carers currently play important roles across services, but any rethink or change would inevitably raise scope and constituent issues for employee advocates and representatives, and could result in increased costs in the form of entitlements, workers compensation etc.

[28] Carers Association of Australia, 2000. *Warning – Caring is a Health Hazard: Results of the 1999 National Survey of Carer Health and Wellbeing*.

6 Options for dealing with the current crisis of nursing home type patients in Tasmania's public and private hospitals[29]

While the vast majority of patients 65 years and over are admitted to the public hospital system requiring acute care, patients requiring rehabilitation and nursing home type services are proportionally more costly, and require longer hospital stays. In 2000-01, the average length of stay (ALOS) for all acute patients over 65 years was 5.51 days, compared to an average length of stay for nursing home type patients (NHTPs) of 35.03 days.

The following table shows numbers of NHTPs in the three public hospitals in 2000-01. In the RHH these patients, only 1.2% of the total 65 years and over group, take up over 11% of all bed days, and over 6% of all costs, for this age group.

Table 6.1: Tasmanian Public Hospital Patients 65 years or Over - Separations by Admission Type '6' Nursing Home Type – by Hospital 2000-01

	No Pats	Days	ALOS	Avg cost Per Day	Avg cost Per Pat	Total Costs	*%All Pats*	*%All Days*	*%All Costs*
RHH	155	6,873	44.34	$424	$18,811	$2,915,635	1.22	11.03	6.63
LGH	57	2,083	36.54	$389	$14,215	$810,259	0.65	4.64	3.14
NWRH	31	750	24.19	$452	$10,936	$339,028	1.05	3.89	2.54
State	**243**	**9,706**	**35.03**	**$422**	**$14,654**	**$4,064,922**	**0.97**	**6.52**	**4.10**

Tasmanian Hospitals Morbidity System

The separations data in the following table shows the most common Diagnostic Related Groups (DRGs) for patients admitted as Nursing Home Type Patients. The general nature of the diagnosis makes it clear that the majority of these patients could be cared for in a more appropriate setting than that of a public hospital.

Table 6.2: Tasmanian Public Hospital Patients 65 years or Over - Separations by Admission Type of Nursing Home Type by DRG v4.1 [(a)] by Hospital 2000-01

DRG	*Original diagnosis at admission (prior to treatment)*	RHH	LGH	NWRH	*TOTAL*
Z64A	Other Factors Influencing Health Status Age>79	81	39	11	131
Z64B	Other Factors Influencing Health Status Age<80	55	24	6	85
B63Z	Dementia and other chronic disturbances of cerebral function	7			7
Z01A	Operating room procedures with diagnoses of other contacts with health services with catastrophic or severe complications	5			5
I62C	Fractures of pelvis and femoral neck without catastrophic or severe complications	2			2

Tasmanian Hospitals Morbidity System

(a) DRG – Diagnosis Related Group: A patient classification scheme that provides a means of relating the number and types of patients treated in a hospital to the resources required by the hospital.

If the average length of stay for all patients 65 and over was applied to the 9,706 bed days occupied by the 243 NHTPs it would equate to an additional 1,762 acute care separations. If these patients did not have to be accommodated, there would be a freeing up of resources to enable better throughput of more appropriate patients.

Hospitals are in effect the 'provider of last resort' to nursing home type patients occupying acute care beds whilst awaiting transfer to residential aged care. This disadvantages those patients directly, because it is not

[29] The information in this section should be read in conjunction with the tables in the current residential care provision section, which detail numbers of operational and provisional places, and NHTPs in acute hospitals for that period.

an appropriate setting or care model for them, and also increases waiting times for elective surgery for other patients.

There is a flow-on effect from this, because blocking elective surgery places not only results in increased waiting lists as throughput is curtailed, but the condition of those waiting deteriorates. In the end, elective surgery becomes emergency surgery, other elective patients are postponed, and the cycle continues.

DHHS is participating in strategies to strengthen service interfaces and community services to reduce preventable demand such as unplanned readmissions to hospital, to reduce clinical risk and social isolation. An example is the National Hospitals Demonstration Program (NHDP4): Improved Hospital Based Care Options for Older Australians.

6.1 Reducing the Number of Nursing Home Type Patients in Acute Hospitals

As the previous discussion on provision of residential aged care places, community based services and primary health care shows this is a whole-of-system issue, and not just one for hospitals.

DHHS has engaged a number of interim residential aged care beds for hospital patients waiting residential aged care. In the North and North West of the state these are located in district hospitals. In the south, interim beds are provided in an ongoing capacity at Vaucluse Gardens. However, this is a 'Stop-gap' measure – it alleviates pressure on our acute hospitals but shifts the cost of residential care from the Commonwealth to the state.

The availability of and effectiveness of transitional care programs is essential and would be further enhanced by the provision of flexible brokerage funding to enable the purchase of additional services during periods when demand for existing aged care services, particularly residential aged care services exceeds supply.

Improving medical or specialist nursing care provided in residential aged care facilities could also reduce hospital emergency department presentations and save hospital inpatient bed days.

The employment of medical officers in residential aged care facilities is an area of development for private providers, with potential for Commonwealth assistance. A review of the HACC program parameters could facilitate increased specialist nursing input into residential aged care. Alternatively, acute care nurses could provide assistance on an outreach basis from the major hospitals.

Improved assessment and discharge of older patients from hospitals could be pursued if resourced. While effort is made within the resources of the acute hospitals system, areas that could be further developed include hospital screening procedures, and referral to community services for patients found to be at risk of relapse. This would of course be predicated on providing discharged patients with easy access to HACC/Community sector services, an area where there are existing resource constraints.

Tasmania is participating in a number of national projects. Introduction of new models of care relating to presentation, admission, and discharge can reduce the number of nursing home type patients in Tasmanian hospitals, but requires additional resources within community and hospital services to both implement and sustain. To operate at optimum level, the other parts of the system, particularly primary care and residential care services need to be in scope for any system improvement initiatives.

7 Identification of special needs groups within the frail aged population, such as people of non-English speaking backgrounds, and options for service provisions into the future

7.1 People from Culturally and Linguistically Diverse (CALD) Backgrounds

In Tasmania there is a cohort of migrants now becoming frail and aged who need specific services now and in increasing numbers for the next 10 years[30]. The influx of people from both interstate and overseas between 1954 and 1974 were mostly young people, who have since aged in place and now contribute to Tasmania having the fastest rate of population ageing compared to Australia as a whole

Groups who migrated in the early post-war years (1950s and 1960s) – predominantly families from the UK and Europe – dominate Tasmania's overseas born population. As a consequence, there is strong representation of English-speaking groups among Tasmania's overseas born population. In addition, "the non-English-speaking Europe-born groups that were a major element in immigration during the first three postwar decades are relatively well represented, especially the non-Southern Europe born groups such as Poland, Germany, Austria, Latvia and Czechoslovakia-born."[31]

Tasmania was the largest recipient of international migrants in the early post-war period, and this has profound implications for the composition of its overseas-born population compared with the other states[32]. Furthermore, before the migration program had its current focus on skilled migration, Tasmania took in a greater proportion of family migrants than other states.[33]

The need for further support for targeted services in Tasmania becomes clear when given this unique profile of the culturally diverse population of post-World War II immigrants. Tasmania has a disproportionately large share of immigrants from the Netherlands and is relatively well represented by non-southern European-born groups such as Poland, Germany, Austria, Latvia and Czechoslovakian-born. These people are now aging and creating pressure on government to respond to their needs.

Only the Dutch are in greater numbers, and so a culture-specific facility can have appropriate staff and environment, and be quite self-sufficient. With the small numbers of many other ethnic groups, individuals in aged care facilities may be in a state of complete isolation. Ensuring support for these residents is made difficult due to the lack of culturally diverse aged-care workers, and compounded by the fact that in Tasmania their respective 'communities' may consist of only a few people dispersed around the state and ageing at the same rate.

Post World War II immigrants from Culturally and Diverse Linguistic Backgrounds naturally revert to their first language and culture, and there are increasing needs to address their WWII torture and trauma experiences. Although these are issues currently relating to World War II and post-war European migrants, these will continue to be issues for different migrant populations into the future, particularly given Australia's refugee policy.

Overseas-born aged 55 and over are not healthier than Australian born, and among groups who come from countries with lower levels of English proficiency men and women reported poorer health and greater need for assistance[34].

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[30] The AIHW predicts with extended life expectancy the culturally and linguistically diverse background population aged 80+, will have a growth rate over 15-years (1996-2011 of 132% in Tasmania. They are also projected to make-up 8.6% of the Tasmanian population aged 80+; an increase from the 5.5% reported in 1996.

[31] Hugo, G. 2000. *Population Issues in Contemporary Australia: A Tasmanian Perspective*, p. 40.

[32] Atlas of the Australian People, 1996 Census, Australian Population, Immigration and Multicultural Research Program.

[33] Multicultural Tasmania.

[34] Benham, C & Gibson, D. 2000. *Independence in Ageing: The Social and Financial Circumstances of Older Overseas-born Australians.* AIHW and DIMA: Canberra.

The use of community and residential aged care services is lower among people from non-English speaking background countries (even after taking account of age structures in the population). Lower English proficiency seems to be an important contributing factor in the lower use of services, along with cultural factors and preferences[35].

In the residential care sector some nursing homes are developing cultural service nodes, with the Polish, Italian and Chinese communities having partnerships with particular nursing homes. This includes targeting specific populations with community aged care packages, and with home and community care and other community support services.

In summary, the main issues are a proportionally large cohort aging and beginning to need residential and palliative care services now and increasingly in the near future, managed with respect and dignity, as well as ensuring a workforce which is informed and has the capacity to respond.

Due to the cultural and linguistically diverse characteristics of Tasmania's overseas-born population, it is important to recognise the need for:

- More social support within residential care
  - innovative visitors schemes that focus on a community
  - sharing of specialist departments across aged care homes
- Expansion of volunteer visiting schemes to include home visiting and hospital visiting
- Advocacy specifically for people from CALD backgrounds
- Further CACPs as these are appropriate for and appealing to people from a CALD background than HACC or residential care services
- Dedicated CALD ACAT assessors familiar with specific CALD backgrounds.

7.2 Dementia care

Although the majority of older people are not, and will not become, sufferers of dementia the risk of dementia increases significantly with age and the prevalence of dementia among those aged 80 years or more is almost 20 percent.

The average rate of moderate to severe dementia amongst Australians aged 65 years and over is about 1 in 15. Among people aged 80-84 years the rate is 1 in 9, and among those aged 85 years and over it is 1 in 4[36]. However, dementia affects many more than those represented by these figures.

There are a large number of people with early symptoms. Also, many Australians provide care for these individuals, and the majority of these carers are also ageing. 55% of people with moderate to severe dementia live in the community either in their homes, or in the home of their carer. The average length of time a person will live with dementia is 10-14 years.

The *Survey of Disability, Ageing and Carers 1998* found that 86% of dementia sufferers were aged 75 and over. Because these conditions generally require high levels of assistance, three-quarters of older people restricted by Alzheimer's disease or other dementias live in cared accommodation[37].

National mental health related separations data for all hospitals 1999-00 shows that separations for dementia and other chronic disturbances of cerebral function accounted for 11% of same-day mental health separations, resulted in 156,387 patient days, and 66.1 days as average length of stay.[38]

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[35] Benham, C & Gibson, D. 2000. *Independence in Ageing: The Social and Financial Circumstances of Older Overseas-born Australians.* AIHW and DIMA: Canberra.

[36] Henderson & Jorm, Dementia in Australia

[37] Australian Bureau of Statistics, 1999. *Older People in Australia: A Social Report*. p.52.

[38] AIHW, 2002. *Australia's Health 2002*. p. 298.

Over the next 40 years the number of people with dementia in Australia is expected to increase two and a half times. This is because the very old, who are most likely to suffer from dementia, are expected to increase at a faster rate than either the total population or those who are the 'young old'.

In 1999, dementia estimates for Tasmania indicated that 3,868 Tasmanians had moderate to severe dementia (or 1 in 120 people). It is unknown how many people have mild or early stage dementia. Based on research by Henderson and Jorm (1998), it is predicted that 4,800 Tasmanians will have the diagnosis of dementia in 2006 (1 in 96) and 5,500 by 2011 (1 in 83)[39].

It is likely that over the next two decades dementia will become the largest source of disease burden in women, and will remain the 5th largest for men[40]. This expectation is based on the assumption that over the coming two decades there will be no big advances in the prevention or treatment of dementia. There is going to be a continued (and growing) need for health and aged care services for people with dementia, their families and carers."[41]

The Tasmanian Dementia Care Plan (2001) identifies four stages in the progression of dementia as an illness, and the type of care that is needed at each of these stages. Services will be required across the continuum of care in terms of initial assessment, community services, and specialist services and residential care.

Early difficulties in activities of daily living skills (stage 1) will require comprehensive aged care assessment; specialist cognitive assessment and diagnostic services; and carer information and support.

Significant difficulties in activities of daily living skills/reduced capacity for independence (stages 2 & 3) will require community care packages; community rehabilitation and allied health services; community nursing, home help, meals on wheels; home based and residential respite care; and day centres some of which are dementia specific.

High dependence on care and incapacity (stage 4) will require short-term in-patient specialist assessment and treatment; community (outpatient) assessment and treatment; dementia specific units within aged care facilities; and short and long term psycho geriatric services.

A mix of services is required to meet dementia care needs, and this has been recognised in the *Dementia Care Plan*[42] developed by the DHHS. Key challenges in the provision of dementia care include

- Ensuring that diagnosis, early assessment and early intervention are an integral part of dementia care
- Provision of a range of client-centred service delivery options, including respite care for people with dementia and their carers
- Improved access to dementia care in rural and remote areas and for people with culturally specific needs
- De-stigmatising dementia and promoting working in the aged care industry
- difficulty of placing people with dementia/challenging behaviour in residential aged care
- Need for training of care workforce to better manage and understand dementia/challenging behaviour
- Rehabilitation issues in care of older people due to presence of psychosocial and physical co-morbidities

[39] DHHS, 2001. *Tasmania Dementia Care Plan*. p. 9.

[40] Results of the Victorian Burden of Disease Study: Mortality (1999), cited in Jorm, A. 2001. *Dementia: a major health problem for Australia*. p. 3.

[41] Jorm, 2001, p. 4. See also Jorm, A. Prospects for the Prevention of Dementia. *Australasian Journal on Ageing*, Vol 21, no.1, March 2002. p. 5.

[42] DHHS, 2001. *Tasmanian Dementia Care Plan*

8 Legislative and other requirements around aged care provision

8.1 Regulation of planning and infrastructure

The timely development of appropriate infrastructure is important for ageing Tasmanians. In planning community and residential environments we need to take account of the ageing population, including planning requirements for residential facilities, private homes, streetscapes and public spaces to ensure that people can live in the community with quality of life, participation, access to businesses and services.

There is opportunity through the Tripartite Agreement on Ageing between the Commonwealth Government, Tasmanian Government and local government to address issues relating to planning for, and approvals processes for residential aged care. In addition, the Simplifying Planning Schemes project, and the review of the Local Government Act provide opportunities for consultation on improving the process to get provisional aged care places operational.

In addition, several councils have initiated development of social plans for their community, a process that provides excellent opportunities for consultative development of both supportive environments, and services matched to community needs.

The appropriateness of existing housing influences the capacity to remain at home. The ability to modify housing in a cost-effective manner to meet the needs of an older person is increasingly becoming an important issue. Homes that are well designed can support people to live in the community longer, which is an issue with more services being provided in the home. Doorway widths allowing wheelchair access, shower recesses without steps, anchor points for support rails, and adequate circulation space can all underpin independence.

Housing Tasmania, a Division of DHHS developed the *Get Smart Homes* initiative, in consultation with the Housing Industry Association, Master Builders' Association and Australian Institute of Architects and local government to promote good practice in flexible, affordable housing. However, it is promotional, and many builders and developers do not apply the principles because there are some cost margins involved, and there can be buyer resistance in the residential construction market, that is very much price driven.

A review of building standards and the introduction of design features that would accommodate the needs of older people and facilitate appropriate modifications may significantly reduce demands on residential aged care services in future decades.

8.2 Regulation of the residential aged care industry

The Commonwealth Aged Care Act of 1997 and its principles control residential aged care, which means the Tasmanian Government does not take a role in regulating service quality, performance governance or infrastructure design standards issues.

This submission has demonstrated that the range of services and delivery systems for provision of services to older Tasmanians, whether in their homes, in the community, in residential care or acute settings is complex, fragmented, and driven by different policy agendas by different levels of government. Inevitably that leads to duplication or overlap in administrative and funding processes, data collection and reporting requirements. Service providers indicate that this can impose significant effort on people working in the system. There are views that this compromises quality care, and draws resources away from direct care provision.

Service Name	Town	Places	Provider
Southern Planning Region - Residential Aged Care Places			
Adards Nursing Home	Warrane	36	Adards Nursing Home Inc
Barrington Lodge	New Town	10	The Salvation Army (Tasmania) Property Trust
Bishop Davies Court	Kingston	78	OneCare Limited
Bowditch Hostel	Lindisfarne	24	Freemasons Homes of Southern Tasmania Inc
Corumbene Hostel	New Norfolk	33	Corumbene Nursing Home for the Aged Inc
Corumbene Nursing Home	New Norfolk	39	Corumbene Nursing Home for the Aged Inc
Eastside Care Lillian Martin Home	Warrane	53	Eastside Care
Eastside Care Lillian Martin Hostel	Warrane	44	Eastside Care
Eastside Care Ningana	Sorell	32	Eastside Care
Esperance Multipurpose Health Centre	Dover	8	Huon Valley Council
Esperance Multipurpose Health Centre	Dover	8	Huon Valley Council
Freemasons Homes of Southern Tasmania	Lindisfarne	124	Freemasons Homes of Southern Tasmania Inc
Gardens, The	Claremont	56	AJ & BJ Smith Pty Ltd
Glenview Home	Glenorchy	118	Glenview Home Inc
Guilford Young Grove Home	Sandy Bay	27	Southern Cross Care (Tas) Inc
Guilford Young Grove Hostel	Sandy Bay	29	Southern Cross Care (Tas) Inc
Hawthorn Village	Blackmans Bay	37	Association for Christian Homes for the Aged Inc
Huon Districts Eldercare Home	Franklin	43	Huon Districts Eldercare Home Association Inc
Huon Districts Eldercare Hostel	Franklin	32	Huon Districts Eldercare Home Association Inc
Maranatha Hostel Rosny	Rosny	32	Tasmanian Conference of The Seventh Day Adventist Church
Mary Ogilvy Home	New Town	43	The Mary Ogilvy Homes Society
Mary Ogilvy Home	New Town	30	The Mary Ogilvy Homes Society
Mary's Grange	Taroona	14	Marys Grange Incorporated
Mary's Grange	Taroona	74	Marys Grange Incorporated
May Shaw Hostel	Swansea	9	Municipality of Glamorgan/Spring Bay
May Shaw Nursing Home	Swansea	16	Municipality of Glamorgan/Spring Bay
Midlands Multipurpose Health Centre	Oatlands	10	The Tasmanian State Government
Midlands Multipurpose Health Centre	Oatlands	9	The Tasmanian State Government
Ouse Nursing Home	Ouse	6	The Tasmanian State Government
Pleasant Pines Hostel	Claremont	29	Tasmanian Deaf Society
Queen Victoria Home	Lindisfarne	72	The Queen Victoria Home Inc
Queen Victoria Home	Lindisfarne	67	The Queen Victoria Home Inc
Rosary Gardens	New Town	195	Southern Cross Care (Tas) Inc
Sandown Apartments	Sandy Bay	60	Southern Cross Care (Tas) Inc
St Ann's Homes Compton Downs	Old Beach	107	St Ann's Homes Inc
St Ann's Homes Davey Street	Hobart	108	St Ann's Homes Inc
Strathaven Hostel	Berriedale	35	Strathcare
Strathaven Nursing Home	Berriedale	60	Strathcare

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Southern Planning Region - Residential Aged Care Places Cont.

Service Name	Town	Places	Provider
Strathglen Nursing Home	Berriedale	45	Strathcare
Tasman District Nursing Home	Nubeena	18	Tasman Council
Tasman Hostel	Nubeena	7	Tasman Council
Vaucluse Gardens Lodge	South Hobart	51	Vaucluse Gardens Pty Ltd
Windermere Hostel	Claremont	30	St Ann's Homes Inc
Total Operational Places		**1958**	

Southern Planning Region - Community Aged Care Packages			
Bishop Davies Court CACP Service	Kingston	17	OneCare Limited
Community Based Support South Inc.	New Town	31	Community Based Support South Inc
Corumbene CACP Service	New Norfolk	7	Corumbene Nursing Home for the Aged Inc
Dementia & Alzheimer's Association (Tasmania) Community Aged Care Package Service	New Town	10	Dementia and Alzheimer's Association (Tasmania) Inc
Eastside Care CACP Service	Warrane	32	Eastside Care
Glenorchy Community Options	Glenorchy	27	Glenorchy City Council
Glenview Outreach	Glenorchy	29	Glenview Home Inc
Guilford Young Grove CACP Service	Sandy Bay	8	Southern Cross Care (Tas) Inc
Hawthorn Village CACP Service	Blackmans Bay	2	Association for Christian Homes for the Aged Inc
Huon Districts Eldercare CACP Service	Franklin	10	Huon Districts Eldercare Home Association Inc
Independent Health Care Service Aged Care Packages	Moonah	10	Independent Health Care Services Pty Ltd
Mary's Grange CACP Service	Taroona	20	Marys Grange Incorporated
May Shaw Nursing Centre Community Aged Care Packages	Swansea	24	Municipality of Glamorgan/Spring Bay
Migrant Resource Centre Community Aged Care Packages	Hobart	8	Migrant Resource Centre (Southern Tas) Inc
Ouse Nursing Home CACP Service	Ouse	3	The Tasmanian State Government
Parkside Brokerage	Battery Point	10	The Parkside Foundation Pty Ltd
Rosary Gardens CACP Service	New Town	32	Southern Cross Care (Tas) Inc
Salvocare CACP Service	New Town	12	The Salvation Army (Tasmania) Property Trust
Setac CACP Service	Cygnet	20	South East Tasmanian Aboriginal Corporation
South Eastern Nursing & Home Care Association CACP Service	Sorell	25	South Eastern Nursing & Home Care Association Inc
Southern Midlands Community Care Service	Oatlands	5	The Tasmanian State Government
St Ann's CACP Service	Hobart	28	St Ann's Homes Inc
Total Operational Packages		**370**	

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Service Name	Town	Places	Provider
Northern Planning Region - Residential Aged Care Places			
Ainslie House Hostel	Low Head	22	Ainslie House Association
Ainslie Nursing Home	Low Head	40	Ainslie House Association
Aldersgate	Launceston	38	Aldersgate
Aldersgate Hostel	Launceston	43	Aldersgate
Aldersgate Village	Rocherlea	54	Aldersgate
Cadorna House	Riverside	23	Cadorna House
Cosgrove Park Nursing Facility	Kings Meadows	102	The Park Group Pty Ltd
Flinders Island Multipurpose Centre	Whitemark	4	The Tasmanian State Government
Flinders Island Multipurpose Centre	Whitemark	5	The Tasmanian State Government
Fred French Hostel	Newstead	20	Fred French Masonic Nursing Home Inc
Fred French Nursing Home	Newstead	62	Fred French Masonic Nursing Home Inc
Grenoch Home	Deloraine	28	Grenoch Home Inc
James Scott Wing Nursing Home	Scottsdale	24	The Tasmanian State Government
Kanangra Hostel	Deloraine	32	St Marks Homes Inc
Launceston Presbyterian Homes	Norwood	75	Launceston Presbyterian Homes for the Aged
Manor Hostel	Kings Meadows	30	OneCare Limited
Manor Nursing Home	Kings Meadows	30	OneCare Limited
Maranatha Retirement Homes-Legana	Legana	53	Tasmanian Conference of The Seventh Day Adventist Church
Masonic Peace Memorial Haven	Norwood	48	Masonic Peace Memorial Haven of Northern Tasmania
Masonic Peacehaven Hostel	Norwood	41	Masonic Peace Memorial Haven of Northern Tasmania
Medea Park Hostel	St Helens	20	Medea Park Association Incorporated
Medea Park Nursing Home	St Helens	24	Medea Park Association Incorporated
Mount Esk High Care	St Leonards	40	Southern Cross Care (Tas) Inc
Mount Esk Low Care	St Leonards	58	Southern Cross Care (Tas) Inc
North East Aminya Hostel	Scottsdale	31	North East Aminya Hostel Inc
Tamar Park	Legana	40	The Park Group Pty Ltd
Toosey Aged and Community Care	Longford	46	Toosey
Tyler Village	Prospect Vale	75	The Salvation Army (Tasmania) Property Trust
Total Operational Places		**1108**	
Northern Planning Region - Community Aged Care Packages			
Ainslie House Association	Low Head	14	Ainslie House Association
Aldersgate Community Aged Care Package Service	Launceston	34	Aldersgate
Community Options Service (Nesb) CACP Service	Launceston	22	Community Options Service (Nesb)

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Northern Planning Region - Community Aged Care Packages Cont.

Service Name	Town	Places	Provider
Community Options Service Launceston	Launceston	25	The Tasmanian State Government
Family Based Care (N) CACP Service (Housing Linked Care Package)	Launceston	45	Family Based Care Association (Nth) Inc
Launceston Presbyterian CACP Service	Norwood	6	Launceston Presbyterian Homes for the Aged
Manor CACP Service	Kings Meadows	30	OneCare Limited
Masonic Peace Memorial Haven of Northern TAS Inc	Norwood	27	Masonic Peace Memorial Haven of Northern Tasmania
Medea Park Community Aged Care Package Service	St Helens	6	Medea Park Association Incorporated
West Tamar Health And Community Service MPS CACP Service	Beaconsfield	4	The Tasmanian State Government
Total Operational Packages		**213**	
North Western Planning Region - Residential Aged Care Places			
Adaihi Nursing Home	Ulverstone	24	Society of St Vincent de Paul (Tas)
Coroneagh Park Hostel	Penguin	44	Eliza Purton Home for the Aged Inc
Eliza Purton Home for the Aged	Ulverstone	52	Eliza Purton Home for the Aged Inc
Eliza Purton Hostel	Ulverstone	40	Eliza Purton Home for the Aged Inc
Emmerton Park Hostel	Smithton	33	Emmerton Park Inc
Karingal Home for the Aged	Devonport	73	Karingal Home for the Aged Inc
Karingal Home for the Aged	Devonport	30	Karingal Home for the Aged Inc
King Island Multipurpose Centre	Currie	6	The Tasmanian State Government
King Island Multipurpose Centre	Currie	8	The Tasmanian State Government
Levenbank Aged Care Facility	Ulverstone	34	The Salvation Army (Tasmania) Property Trust
Meercroft Home for the Aged	Devonport	50	Meercroft Home for the Aged
Meercroft Hostel	Devonport	59	Meercroft Home for the Aged
Melaleuca Home for the Aged Inc.	East Devonport	35	Melaleuca Home for the Aged Inc
Mount St Vincent Nursing Home	Ulverstone	44	Society of St Vincent de Paul (Tas)
Queenstown Hostel	Queenstown	11	The Tasmanian State Government
Smithton Nursing Home	Smithton	22	The Tasmanian State Government
Spencer Nursing Home	Wynyard	60	Conform Health Group Pty Ltd
Strathdevon Nursing Home	Latrobe	37	Strathcare
Tandara Lodge	Sheffield	27	Tandara Lodge Community Care Inc
Tandara Lodge Hostel	Sheffield	8	Tandara Lodge Community Care Inc
Umina Park Home for the Aged	Burnie	84	OneCare Limited
Umina Park Hostel	Burnie	53	OneCare Limited
Yaraandoo Hostel	Somerset	67	Southern Cross Care (Tas) Inc
Total Operational Places		**901**	

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Service Name	Town	Places	Provider
North Western Planning Region - Community Aged Care Packages			
Eliza Purton CACP Service	Ulverstone	30	Eliza Purton Home for the Aged Inc
Emmerton Park Community Aged Care Package Service	Smithton	10	Emmerton Park Inc
Karingal CACP Service	Devonport	4	Karingal Home for the Aged Inc
Levenbank Community Care	Ulverstone	23	The Salvation Army (Tasmania) Property Trust
Mersey Leven Aboriginal Corporation	East Devonport	8	Mersey Leven Aboriginal Corporation
Strathdevon CACP Service	Latrobe	36	Strathcare
Tandara Lodge Community Care Service	Sheffield	7	Tandara Lodge Community Care Inc
Westcare	Zeehan	8	West Coast Health & Community Services Ltd
Yaraandoo CACP Service	Somerset	52	Southern Cross Care (Tas) Inc
Total Operational Packages		**178**	