Submission to Senate Select Committee Inquiry into Health

September 2014

National Seniors Australia

About National Seniors Australia

National Seniors Australia is a not-for-profit organisation that gives voice to issues that affect Australians aged 50 years and over. It is the largest membership organisation of its type in Australia with more than 200,000 members and is the fourth largest in the world.

We give our members a voice – we listen and represent our members' views to governments, business and the community on the issues of concern to the over 50s.

We keep our members informed – by providing news and information to our members through our Australia-wide branch network, comprehensive website, forums and meetings, bi-monthly lifestyle magazine and weekly e-newsletter.

We provide a world of opportunity – we offer members the chance to use their expertise, skills and life experience to make a difference by volunteering and making a difference to the lives of others.

We help our members save – we offer member rewards with discounts from thousands of businesses across Australia. We also offer exclusive travel discounts and more tours designed for the over 50s and provide our members with affordable, quality insurance to suit their needs.

Contact

Head Office

National Seniors Public Affairs, Level 18, 215 Adelaide Street Brisbane QLD 4001

P: 1300 765 050 F: (07) 3211 9339

E: policy@nationalseniors.com.au

W: www.nationalseniors.com.au

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Health workforce

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Recommendation 19: Explore training opportunities for establishment of primary health care assistant positions, similar to aged care assistant positions.

Recommendation 20: Provide income support payments to job seekers who participate in aged care training for personal care attendants and community care workers. This could be promoted to mature job seekers who are re-entering the workforce or need to retrain.

INTRODUCTION

Australia's health system is amongst the best in the world. In 2011, our health expenditure of 9.1 per cent of GDP and life expectancy of 82 years placed us among the best performing of similar countries in the OECD. With the exception of the United States of America, Australia has the lowest level of public funding (68 per cent) and the highest contribution from out of pocket costs and private health insurance (29 per cent), among like OECD countries.[1]

Access to universal health care through Medicare is highly valued by all Australians and contributes to our enhanced health status. However the cost of providing such access continues to escalate with the federal and state budgets increasing to meet the demand on the system.

The Medicare budget in 2014_2015 is estimated at $19 billion, of which the Medicare levy contributes $9 billion. Medicare is the third most expensive federal government program, after the age pension ($39 billion) and family tax benefits ($20 billion). Next year, Medicare will become the second most costly government program and by 2016-17, it is projected to cost more than $23 billion each year. [2]

In spite of the lowest growth in health expenditure in decades, the ratio of health expenditure to GDP, at 9.67 per cent, continues to outstrip growth in GDP, reflecting the decline in revenue. Claims of the unsustainability of the healthcare system are based on this difference and the projected fiscal imbalance in the Commonwealth budget beyond 2030.[3]

Yet when expenditure in 2011 across like OECD countries was adjusted for costs of living, our per capita expenditure was in the lower band. At US$3,800 per capita it exceeded that of only two countries; the United Kingdom at US$3,405 and New Zealand at US$3,182.[4]

The Australian Institute of Health and Welfare (AIHW) estimates health expenditure in Australia to be $147.4 billion in 2012–13, approximately $6,430 per person. This represents the lowest growth in health expenditure since the 1980s, with Government funding falling by 0.9 per cent in real terms for the first time in the past decade. In contrast, non-government funding increased by 7.2 per cent in real terms in 2012–13, at a much higher rate than the average 5.4 per cent for the decade.

The Commonwealth, States and Territories contribute 68 per cent of healthcare funding and non-government sources provide the remaining funds. The Commonwealth's 41 per cent funds MBS, PBS and public hospital services while the States' 27 per cent funds mainly public hospital activity. [5]

Public hospital services absorbed the most resources ($42 billion at 31.8 per cent of recurrent expenditure), followed by medical services ($23.9 billion at 18.1 per cent) and medications ($18.8 billion at 14.2 per cent). [6]

In spite of the high quality of health care in Australia, inequities in access and outcomes are experienced by sections of the population who report difficulties in accessing affordable and timely health care.

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[1] Duckett, S. 2014. *Australian health care: where do we stand internationally?* The Conversation accessed at http://theconversation.com/australian-health-care-where-do-we-stand-internationally-30886

[2] Bramston, T. Make or Break For Medicare 'The Australian' – Accessed 3February 2014 http://www.theaustralian.com.au/opinion/columnists/make-or-break-for-medicare/story-fnbcok0h-1226816145677#mm-premium

[3] Stoelwinder, J. 2013. *Healthcare: Reform or ration*. Centre for Economic Development of Australia.

[4] Robin Osborn and Cathy Schoen, 2013. The Commonwealth Fund 2013 International Health Policy Survey in Eleven Countries. The Commonwealth Fund. (Australian per capita expenditure from The Commonwealth Fund international Health Policy Survey 2010.)

[5] Australian Institute of Health and Welfare 2014. Health expenditure Australia 2012–13. Health and welfare expenditure series no. 52. Cat. no. HWE 61. Canberra: AIHW.

[6] Australian Institute of Health and Welfare 2014. Health expenditure Australia 2012–13. Health and welfare expenditure series no. 52. Cat. no. HWE 61. Canberra: AIHW.

Health outcomes are reduced for Indigenous populations who experience shorter life expectancy of 10 years and higher burden of chronic diseases at younger ages. People in poorer households experience worse health outcomes, chronic disease patients have high levels of health costs and report deferring treatments, and people living in rural and remote locations experience access and cost barriers contributing to their reduced health outcomes. [7]

Future government budgets will come under further pressure from increasing demand for health services. The Grattan Institute claims that rising healthcare costs are driven not by an ageing population alone but by people of all ages having more consultations, tests and operations; adopting new and effective treatments; and taking more prescription and other medications.[8]

As healthcare becomes more successful at managing acute and chronic disease, new ways of managing the health of the population and maintaining patients' independence in the community are essential to avoid escalations of chronic disease and unnecessary hospitalisations.

[7] Duckett, S. 2014. *Australian health care: where do we stand internationally?* The Conversation accessed at http://theconversation.com/australian-health-care-where-do-we-stand-internationally-30886

[8] Daley, J., McGannon, C., and Savage, J., 2013. *Budget pressures on Australian Governments*. Grattan Institute.

Commonwealth Funding to States and Territories

a. *the impact of reduced Commonwealth funding for hospital and other health services provided by state and territory governments, in particular, the impact on elective surgery and emergency department waiting times, hospital bed numbers, other hospital related care and cost shifting;*

Recommendation 1: Commonwealth, State and Territory governments assess the current funding arrangements for health services provided in States and Territories in the light of the forthcoming White Papers of the Federation and Taxation Reviews.

Recommendation 2: address wait lists for elective surgery as a matter of urgency to ensure that older Australians are able to remain independent and healthy in the community and to reduce progression to more serious health conditions.

Recommendation 3: implement measures to reduce non-urgent presentations to emergency departments eg access to nurse practitioners in bulk-billed clinics for minor ailments.

Hospitals around the country are under enormous pressure to meet growing demand from an ageing population and greater numbers of people of all ages with complex and chronic conditions that require hospital care. [9] The cessation or delay of Commonwealth funding of State and Territory public hospital and adult dental programs announced in the 2014-15 federal budget are likely to impact heavily on people with chronic health conditions. These cuts will also place additional pressure on the continuing decline in public hospital capacity, particularly for patients over 65 who have more hospital treatment than young people. [10]

Between 2001–02 and 2011–12, total growth of $11.5 billion in state and territory government funding for hospitals was almost double that of the Australian Government ($6.2 billion) and 2.4 times non-government expenditure growth ($4.8 billion). [11] Cessation of the National Health Reform Agreement removes the commitment for the Commonwealth to meet 45 per cent of efficient growth in hospital services between 2014-15 and 2016-17 and 50 per cent of efficient growth from 2017-18. [12]

Reductions in funding to health services in the out years challenges States and Territories to raise additional revenue in order to maintain current service levels, or to find further cost efficiencies. However the current vertical fiscal imbalance in raising tax revenue places the States and Territories at a disadvantage as they raise 18 per cent of total tax revenue but are responsible for 40 per cent of expenditure. [13] The Commonwealth provides approximately 45 per cent of State and Territory revenue, of which $65.5B is expended on health services. [14]

Therefore rather than removing funds, there is a strong argument for the Commonwealth to transfer more funds to the States and Territories or allow them to raise more tax revenue. The forthcoming Taxation and Federation White Papers will address the complexities of revenue raising and the responsibilities for service delivery between the States and Territories and the Commonwealth.

The reduced funding to hospital services raises the need to address the lack of systematic monitoring of the outcomes of common healthcare interventions. The Grattan Institute estimates that $1 billion of avoidable public hospital costs could be saved each year if hospital practices and

[9] Comment May 2014 at http://www.medicalsearch.com.au/Continuing-decline-in-public-hospital-capacity-report/f/14578

[10] Australian Institute of Health and Welfare (AIHW). Australian Hospital Statistics 2012-13 report

[11] Australian Institute of Health and Welfare 2014. Health expenditure Australia 2011–12: analysis by sector. Health and welfare expenditure series no. 51. Cat. no. HWE 60. Canberra: AIHW.

[12] Council of Australian Governments. 2010? National Health Reform Agreement. Commonwealth of Australia.

[13] Business Council of Australia, 2014. The Future of Tax: Australia's Current Tax System.

[14] Department of the Prime Minister and Cabinet, 2014. Reform of the Federation White Paper A federation for our Future: Issues Paper 1.

performance were benchmarked against nationally efficient and effective prices. [15]Although activity-based funding models have the potential to provide more accountable and transparent funding arrangements for hospitals, they do not adequately compensate hospitals for the cost of treating serious trauma cases, with likely shortfalls of millions of dollars.[16] A more coordinated, national, approach to tracking outcomes of care across a variety of interventions may improve understanding of the most effective treatments in various settings. [17]

In 2012_13, in-patient separations remained static, and there was no improvement in the medium waiting time for elective surgery. Bed numbers as a ratio per 1000 of the general population have not improved since 2009-10 and reduced from 2.6 in 2011-12 to 2.59 in 2012-13. Public hospital bed numbers per 1000 of the population aged 65 and over reduced from 18.6 in 2011-12 to 17.8 in 2012-13.

Since 2009-10, the capacity of private hospitals has increased to keep pace with demand. If the same day services continue at twice the level of overnight services, it is likely that public hospitals will face a higher burden of complex cases requiring overnight care and hence higher costs. Private hospitals also had a substantial increase in outpatient care – 18.1 million services in 2012-13, which is a 7.2 per cent increase from previous year.[18]

Elective surgery waiting times

The current wait lists for elective surgery in the public health system are a source of great concern among older Australians. Although wait times for specialist appointments are in the mid-range among OECD countries, they could be improved. [19] The COAG Reform Council report on healthcare in Australia for the five years to 2012_2013 found that wait times increased for 14 out of 15 selected elective surgical procedures. [20]

Delays in access to elective surgery are likely to result in reduced quality of life and escalation of chronic conditions for older Australians. This in turn may result in avoidable admissions to hospital, as an example for conditions such as falls or scalds caused by delays in cataract surgery. Many older Australians are forced to choose between paying privately for the procedures or meeting the costs of other essential services. National Seniors members report out of pocket costs as high as $5,000 to $10,000 for some procedures in the private sector.

Member comment:

> *I am 70 and have been investigating health insurance because I have cataracts and the surgeon told me that I would not even be put on the waiting list until I was almost legally blind. A friend was badly injured waiting for surgery and her Dr told her that she should hope her name comes to the top before she is 70. Two other women were told that after 70 there was no chance of getting a hip or knee replacement. I expect to live for 20 more years and cannot afford insurance for that length of time.*

In 2013, the ACT, NSW and South Australia performed well against their specific State/ Territory elective surgery targets for seeing patients within clinically recommended times, average overdue

[15] Duckett, S. and Breadon, P. 2014. *Controlling costly care: a billion-dollar hospital opportunity*. Grattan Institute.

[16] Partel, K. 2014. Can we improve the health system with pay-for-performance? Deeble Institute for Health Policy Research.

[17] Australian Commission on Safety and Quality in Health Care and Australian Institute of Health and Welfare. *In Brief – Exploring Healthcare Variation in Australia: Analyses Resulting from an OECD Study*. Sydney: ACSQHC, 2014.

[18] Australian Institute of Health and Welfare (AIHW). Australian Hospital Statistics 2012-13 report

[19] Robin Osborn and Cathy Schoen, 2013. The Commonwealth Fund 2013 International Health Policy Survey in Eleven Countries. The Commonwealth Fund.

[20] COAG Reform Council 2014. Healthcare in Australia 2012–13: Five years of performance Report to the Council of Australian Governments. Quotes from John Brumby.

wait time and ensuring 10 per cent of the longest wait over-due patients were seen by December 2013. Performance of all other States and Territories, especially Tasmania and Queensland was unsatisfactory. (States claim to have made substantial inroads on the previous wait lists.)[21]

Emergency department wait times

Emergency department presentations increased by about 2.9 per cent on average each year between 2008–09 and 2012–13. Between 2011–12 and 2012–13, the largest increases in emergency department presentations were in Tasmania (3.8 per cent) and Queensland (3.7 per cent).

However, the National Emergency Access Targets were not met by any of the States and Territories who are aiming for 90 per cent of emergency department visits to be completed in 4 hours or less by 31 December 2015. In 2012–13, just over two-thirds (67 per cent) of emergency department visits were completed in 4 hours or less—an increase from 64 per cent in 2011–12. Western Australia had the highest proportion (77 per cent) of emergency department visits completed in 4 hours or less and the Australian Capital Territory had the lowest (57 per cent). No State or Territory met their target for treating emergency department patients within four hours in 2013, with five jurisdictions 10 per cent or more below target. [22]

Thirty-two per cent of emergency department presentations in 2012-13 (2.2 of 6.7 million) were for potentially avoidable GP-type consultations. The highest proportion of these patients (24 per cent) lived in the lowest SES areas with the lowest proportion (16 per cent) living in the highest SES areas. These figures lend support to the suggestion that inability to afford GP visits or the referred services determines non-emergency presentations. Opportunities to utilise nurse practitioners and other allied health professionals, with agreed referral and escalation guidelines could be explored.

Member comment:

> *Hospital emergency sections are indeed clogged by people seeking free treatment for minor ailments. They should be referred to 24 hr. clinics for attention, charging the medicare fee. It would be helpful if those clinics were on hospital premises or immediately close for access.*

Costs and affordability of Medicare

b. the impact of additional costs on access to affordable healthcare and the sustainability of Medicare;

Recommendation 4: Address the barriers to accessing universal health care services for patients with chronic disease, including long wait lists for specialist services and elective surgery.

Recommendation 5: Support patients with low vision and hearing loss that impact on their ability to participate in employment and within their community by subsidising access to assistive technologies, regardless of their age or income.

Recommendation 6: Explore options for private health insurers to fund the widening gap payments between Medicare rebates and medical charges for those patients with chronic health conditions.

Many commentators point to the moral hazard generated by the current arrangement whereby public health care is funded predominately from tax revenue and neither the patient nor provider experience a significant financial cost, therefore encouraging consumption, even if only potentially

[21] COAG Reform Council (2014) *National Partnership Agreement on improving public hospitals: Performance Report for 2013* COAG Reform Council. http://www.coagreformcouncil.gov.au/reports/healthcare/national-partnership-agreement-improving-public-hospital-services-performance-0.html

[22] Australian Institute of Health and Welfare 2013. Australian hospital statistics 2012–13: emergency department care. Health services series no. 52. Cat. no. HSE 142. Canberra: AIHW.

beneficial. This is further complicated by the incentives of a predominantly fee-for-service payment for doctors and other health practitioners. Increases in healthcare utilisation are considered to result from these factors and higher co-payments are suggested to act as a brake on rising costs. [23] [24]

However, consumers report increasingly that they are unable to afford, and therefore forego necessary health care. [25] The Australian Medical Association states that aggregate Medicare gaps have grown on average by 11.7 per cent per annum between 1984-85 and 2011-12, reflecting the increasing costs of Medicare eligible services compared with the Medicare or private health insurance benefits paid. [26]

When compared with like OECD countries, Australians report the second highest level of out of pocket health care costs, with 25 per cent spending more than US$1,000 (only exceeded by 41 per cent in the USA). Twenty-nine per cent of Australians report skipping dental care in the last year, the third highest among the OECD countries. [27]

Member comment:

> *Medicare was supposed to make access to basic health services affordable and accessible, but the level of rebate provided has not kept pace with the fees and charges levied by doctors and other health care services covered by Medicare.*

In particular, people with multiple chronic health conditions are finding that the range of services and the number of occasions of service required to treat their condition/s can quickly impact on their ability to fund other living expenses. Households aged 50 and over report spending between 25 and 50 per cent of their disposable income on essentials such as groceries, transport, communication and medicine.[28]

The exclusion of dental care, allied health services and emerging treatments from universal health access under Medicare and the long wait lists for elective surgery all place pressure on the budgets of older Australians whose needs for such services increase with age.[29] In particular, the differences in access to assistive technologies for older Australians with low vision when compared to those with hearing loss is seen as inequitable and has negative consequences for their future independence and potential for avoidable hospitalisations.

Research commissioned in 2012 by National Seniors revealed that 570,000 people aged 55 and over spend more than 10 per cent of their income on health while about 250,000 spend over 20 percent which represents significant financial stress for people with chronic health conditions as they tend to have lower fixed incomes. On average, older Australians spend $353 per quarter on out-of-pocket health care costs while those with five or more chronic conditions spend $882 per quarter, almost six times as much as those with no chronic conditions.[30]

Older Australians are committed to maintaining their private health insurance for as long as possible. The main reasons given by the over 50s for purchasing private health insurance are

[23] Stoelwinder, J. 2013. *Healthcare: Reform or ration*. Centre for Economic Development of Australia.

[24] Barnes, T. 2013. A Proposal for Affordable Cost Sharing for GP Services funded By Medicare. Australian Centre for Healthcare Research.

[25] National Health Performance Authority, 2012. *Healthy Communities: Australians' experiences with access to health care in 2011–12.* Canberra.

[26] Australian Medical Association 2013. *Key Health Issues for the Federal Election 2013*. Canberra.

[27] Osborn, R. and Schoen, C. 2013. *The Commonwealth Fund 2013 International Health Policy Survey in Eleven Countries.* The Commonwealth Fund.

[28] Kelly S. *A squeeze on spending? An update on household living costs for senior Australians*. Melbourne; National Seniors Productive Ageing Centre: 2013.

[29] Martin, S., 2013. *Healthcare:Reform or Ration*. CEDA

[30] National Seniors Australia Productive Ageing Centre 2012. *The Health of Senior Australians and the Out-of-Pocket Healthcare Costs They Face*. Canberra.

security, protection or peace of mind followed by choice of doctor, private treatment and shorter waiting times for treatment. People on pensions and allowances and lower income earners are more likely to report that they are unable to afford private health insurance.[31]

However, their ability to contribute to the cost of their own health care and decrease the burden on the public health system is under attack with rising out-of-pocket health costs, caps on Medicare rebates, the phasing out of the Net Medical Expenses Tax Offset, higher proposed thresholds for the Extended Medicare Safety Net and changes to the private health insurance rebate.

Health insurance management of access to primary health services are utilised in a number of countries, including Singapore, the Netherlands and the USA. A 2012 International Health Survey concluded that insurance and payment policies targeted at primary care can strengthen access, including after-hours care. However they cautioned about the need to reduce complexity in the design and to control costs while safeguarding access for those vulnerable because of chronic disease or limited incomes. [32]

In the Netherlands and to a lesser extent Singapore, pooled funds from workers' contributions to health insurance and general taxation revenue are assigned and managed at the individual level. Health funds then actively purchase care for their members and negotiate prices and payment models while ensuring that basic services determined by Government are maintained for each individual. Consumer choice allows some trade-offs in terms of prioritising service access while maintaining basic services. An advantage of such a system is that it reduces fragmentation and cost shifting, pursues innovation in workforce and health service delivery, and places the focus on purchase of the most efficient services to deliver health outcomes for the individual.[33]

Older Australians are not hopeful of any improvement in affordability of their health care in the future. In a 2012 survey of 2,000 older Australians, only four per cent of people thought they would be more satisfied with Government spending five years into the future while 45 per cent thought they would be less satisfied and almost one-quarter were unable to state their opinion.34

The exclusion of many services from universal Medicare and state hospital services increases the use of private health insurance and individuals' own funds. Non-government sources account for large portions of the funding for dental services, private hospitals, aids and appliances, medications for which no government benefit has been paid ('all other medications') and other health practitioner services. [35] In 2012_2013 nearly one in five Australians aged over 25 years delayed seeing a dentist because of cost and this figure rose to one in four in the most disadvantaged areas. [36]

Member comment:

> *I'm 58 years old and still working and paying my taxes and private health fund premiums. I need hearing aids to be able to hear my customers and my work colleagues. I get something back from Medicare for the test, but nothing for the aids. My Health fund will only cover $1300 for each ear, so I would have to come up with between $8,000 to $12,000 dollars. I need these aids*

[31] National Seniors Australia Productive Ageing Centre. 2011. *A carrot and a big stick: understanding private health insurance and older Australians.* Research Monograph No. 1, October 2011.

[32] Osborn, R. and Schoen, C. 2013. *The Commonwealth Fund 2013 International Health Policy Survey in Eleven Countries.* The Commonwealth Fund.

[33] Fitzgerald, V. 2013. *Healthcare reform in an ageing Australia*. In Healthcare: Reform or Ration. CEDA. 2013

[34] National Seniors Australia Productive Ageing Centre. 2012. *Seniors Sentiment Index: A report by National Seniors Australia and Challenger*. Canberra.

[35] Australian Institute of Health and Welfare 2014. Health expenditure Australia 2012–13. Health and welfare expenditure series no. 52. Cat. no. HWE 61. Canberra: AIHW.

[36] COAG Reform Council 2014. Healthcare in Australia 2012–13: Five years of performance Report to the Council of Australian Governments.

to perform my job, but I can't afford them. I'm still paying off a mortgage and personal loan for a car to get to work. I don't think this is fair, Medicare should cover the shortfall from my private health fund.

Health promotion, prevention and early intervention

c. the impact of reduced Commonwealth funding for health promotion, prevention and early intervention;

Recommendation 7: Continue funding for effective health promotion, prevention, and early intervention programs as part of Australia's national health system.

Recommendation 8: Include efficacious vaccinations for elderly Australians under the National Immunisation Program, in line with the Australian and New Zealand Society for Geriatric Medicine Position Statement.

Recommendation 9: Continue evaluating the effectiveness of programs using measures that take account of quality of life and contribution to society and ensure that measures are wider than life expectancy or years of life gained.

The 2014 budget saw cuts to Indigenous Affairs programs (exceeding $121 million over four years), dental health programs ($635 million over four years), the National Partnership Agreement on Preventive Health (exceeding $367 million over four years) and the Partners in Recovery mental health initiative ($54 million over two years).

Great advances in the health of the general population have come from public health measures and these deliver returns in terms of increased life expectancy and quality adjusted life years or through the cost effectiveness of their interventions. When life expectancy or years of life lost measures alone are used to compare health interventions, they fail to take account of quality of life and ongoing demands on the health system and the impact of broader socioeconomic and environmental factors such as clean water, employment and good nutrition. [37]

The current fee-for-service primary health care model offers little encouragements to adopt best practice and prioritise prevention and early intervention treatments to reduce costs in the acute and rehabilitation sectors. Australia spends 1.7 per cent of total health spending and less than 0.2 per cent of GDP on prevention, the third lowest among 24 OECD countries. However our actual spend of US$1.95 billion, equivalent to US$85 per person ranks Australia at 14th in actual expenditure.[38]

Judicious selection of preventive and early intervention health issues yields benefits as high as $2 for every $1 spend as occurred for tobacco cessation and early treatment of wet macular degeneration.[39] The COAG Reform Council report on healthcare in Australia for the five years to 2012_2013 found almost 63 per cent of Australian adults are overweight or obese and one in 25 Australians are suffering from type 2 diabetes. Even more concerning is the fact that a quarter of people with type 2 diabetes do not know they have it, and half of people who know they have type 2 diabetes are not managing their condition properly. [40] Screening and early intervention programs are essential to reduce this burden of disease.

[37] Partel, K. 2014. Can we improve the health system with pay-for-performance? Deeble Institute for Health Policy Research.

[38] Australian National Preventive Health Agency (ANPHA). *State of Preventive Health 2013*. Report to the Australian Government Minister for Health. Canberra; ANPHA, 2013.

[39] Deloitte Access Economics & Macular Degeneration Foundation. 2011. Eyes on the future - A clear outlook on age-related macular degeneration.

[40] COAG Reform Council 2014. Healthcare in Australia 2012–13: Five years of performance Report to the Council of Australian Governments. Quotes from John Brumby.

Member comments:

1. *Australian and State Governments have greatly cut expenditure on health promotion (the preventive area) while being forced to spend increasing vast amounts of money on treatment for ill-health, now they are planning more cuts to both health care itself and considering reducing financial benefits to those like me on the Age Pension. This is morally bankrupt and financially ridiculous.*

2. *Prevention is better and cheaper than cure. Educating and empowering people to take responsibility for their health and wellbeing will lead to healthier people and less cost in terms of hospital and treatment services. Healthier people make better people – better parents, partners and community members.*

The proposal to disband the Australian National Health Preventive Agency is currently under discussion in the Senate. If functions are transferred to the Department of Health, it is essential that national leadership continues on preventive health measures, including healthy lifestyle and good nutrition; reducing tobacco use and harmful alcohol consumption; discouraging substance abuse; and reducing the incidence of obesity.

In spite of immunisations delivering proven returns in reduced health care costs and personal pain and suffering, vaccinations of the elderly do not receive the same commitment under the National Immunisation Program as do those for younger cohorts.

Shingles vaccination of adults aged 60 and over can reduce shingles episodes by 51 per cent, reduces acute and chronic pain by 61 per cent and the progression from shingles to post herpetic neuralgia (PHN) in 55 per cent of those who develop shingles.[41] The cost of $250 for the injection is beyond the means of many older Australians on low and fixed incomes. Yet PHN affects the elderly disproportionately and results in individual suffering, significant loss of quality of life, increased costs for medical treatments, reduced independence and limited community and family participation of sufferers.[42]

Member comment:

> *I first suffered Herpes zoster at the age of 18 and still have recurrences at times of unrelated illness or stress. Recently my shingles has recurred requiring chinese herbs for pain and prednisone. Perhaps a vaccine would alleviate the severity of recurrences as I age.*

Tetanus also continues to be a threat for people whose immunity has waned or for those who did not complete the full set of earlier immunisations. A single booster at age 50 and booster doses in those reaching age 50 who have not been vaccinated in the last 10 years are recommended.[43]

[41] Australian and New Zealand Society for Geriatric Medicine. 2011. *Position Statement No. 7 Immunisation of Older People* – Revision Number 2, 2011.
[42] Gronow, D. 2014. *Can the impact of Herpes Zoster on quality of life be improved?* – Presentation to Elderly Vaccines Workshop, Melbourne, 2014.
[43] Australian Government Department of Health. 2013. National Immunisation Program Schedule. Accessed http://www.immunise.health.gov.au/internet/immunise/publishing.nsf/

Interactions between elements of the health care system

d. the interaction between elements of the health system, including between aged care and health care;

Recommendation 10: Enable greater integration between primary health care Medicare and aged care services. In particular, encourage greater delivery of health services from dedicated nurse practitioners and GPs to recipients of aged care packages, in the community and residential facilities.

Recommendation 11: Enhance the use of assistive technologies to monitor the health of older Australians and enable them to live safely within their own homes and remain connected to their community.

Recommendation 12: Implement trials of outreach multidisciplinary dental health teams to provide services to aged care recipients.

The current array of funding sources and responsibilities for delivery of services combined with a fee for service primary health care focus leads to a lack of incentives to integrate services for more effective patient outcomes. This can lead to a lack of timely attention to health problems and potential for development of more complex conditions including avoidable hospitalisations for older Australians. This shifts the costs to another part of the health care system and causes loss of productivity due to time off work and inability to contribute to family and community.

Our ageing population requires further reforms to health and aged care delivery. Primary health care could be more effective at reducing costs if patients with chronic and complex disease were enrolled in comprehensive packages of care with multidisciplinary teams. Failure of integration can lead to duplication of services, missed opportunities to prevent or identify further escalation of chronic conditions and avoidable hospitalisations.

Although recent initiatives have seen improvements in access to public specialist outpatient appointments and subsequent elective surgeries, older Australians still experience significant blocks to timely access to services. Rationing of aged care and primary health care services that are provider centric are limiting our responsiveness and fail to support older Australians at a time when they are most vulnerable. It also results in unnecessary costs for other parts of the healthcare sector.

Member comment:

> *I am housebound due to severe arthritis and other health problems and consequently I'm quite isolated. I was originally allocated six hours per week of HACC carer assistance that has gradually been whittled down to four hours for a carer to purchase my food and maintain domestic cleaning. I have no transport support which would enable me to attend community activities.*

In five years, the percentage of elderly Australians waiting more than nine months for high residential care rose from just over three per cent to more than 14 per cent.[44] This results in bed block in hospitals, risks to the health and safety of the individual still living in their home or with family, pressure on primary health care services and inappropriate allocation of community aged care services which results in reduced access for other people in the community.

[44] COAG Reform Council 2014. Healthcare in Australia 2012–13: Five years of performance Report to the Council of Australian Governments.

The Commonwealth is fully responsible for funding aged care and primary health care services. However the programs are quite separate with a focus on packages of care in community and residential aged care services. The HACC programs are the closest to a fee for service arrangement as exists for GP primary care and referred services.

Many busy GPs are reluctant to conduct "house calls" to frail older clients who require longer appointments to address more complex conditions, consultation with families and carers, and coordination of ongoing services. Medicare rebates for services provided by doctors and practice nurses must reflect the time and complexity of providing ongoing dementia, palliative and medical care in the community.[45]

Telehealth and assistive technologies have great potential to monitor the general health of patients with chronic and complex conditions and improve access to health services for people who are house-bound, in aged care facilities or living in rural and remote locations. [46]

Although opportunities are emerging to utilise assistive technologies and real time in home monitoring of older clients, Australia's broadband network and uptake of internet packages are not sufficiently developed to allow reliable monitoring. In addition, consideration of changes to the scope of practice of outreach nurse practitioners and community health nurses would enhance capacity and affordability of in-home monitoring and visits. [47] [48]

No-where is inequity in access more obvious than in residential aged care where access to GP and dental care services is significantly lower than for older people in the community. In spite of guidelines and additional payments to GPs to attend clients in residential care facilities, dedicated GP and allied health staff are rare in aged care facilities. [49] However, some providers such as BUPA care have established dedicated GP services for their residential clients.

Older people are at higher risk of gum disease which is present in 53 per cent of those aged 65 and over. They also have an average of 12 missing teeth, while 21 per cent have no natural teeth and 47 per cent of those with some natural teeth wear dentures. [50] Although oral health programs have been developed specifically for use in aged care facilities, staff are not always skilled or available to devote time to oral health care and public adult dental services do not provide site visits to facilities. This has a significant impact on the nutrition and overall health status of residents.

[45] AMA, 2013. *Key Health Issues for the federal election 2013*.
[46] Brown, M, 2013. Australian healthcare: Out of pocket and out of date. *Journal of the Consumers Health Forum of Australia.* Issue 12, April 2013, p15.
[47] Dods, A. *A Digitally Enabled Health System of the Future*. CSIRO Health Service Leader. CeBit eHealth Conference Sydney, May 2014.
[48] von Rump, S. 2014. *Giraff: a practical application to improving older persons care experiences in Europe.* Griffith University Robotics Symposium, March 2014.
[49] Department of Human Services. 2013. *Practice Incentive Program: General Practitioner Aged Care Access Incentive Guidelines– September 2013*. Australian Government Canberra.
[50] AIHW 2014. *Oral health and dental care in Australia: key facts and figures trends 2014*. Cat. no. DEN 228. Canberra: AIHW.

Improvements to health services

e. improvements in the provision of health services, including Indigenous health and rural health;

Recommendation 13: Expand current multi-disciplinary models of care that involve allied health professionals with expanded scope of practice alongside dental and medical professionals.

Recommendation 14: Extend the usage of telehealth and assistive technologies to monitor the health of individual patients.

Service delivery to Indigenous and rural communities needs to be responsive to their cultures and living environments. Huge advances in technology are improving responsiveness, and telehealth services which reduce the tyranny of distance are well established for certain consultations, diagnoses and monitoring of patient outcomes. However travel away from home is still required for many specialist services.

As raised in the previous section, expansion of telehealth services and the use of assistive technologies can enhance access to primary health care and specialist services, and reduce the opportunity costs experienced by patients who need to travel to access health services. Queensland lead Australia in the use of telehelath services in rural communities using stellite technology. Assistive technologies and smart applications linked to base monitoring services would allow patients to monitor their biochemical and health status. [51]

New models of multidisciplinary professional practice would reduce professional silos, overcome hierarchical relationships, allow overlap of roles and address current gaps in access to health providers. In addition, costs would be reduced and highly specialised medical staff would be released to deliver services for which they are trained.

Nurse Practitioners with advanced level of clinical practice in a general or specialised context, along with theoretical education to a Master's level or beyond deliver primary health care services in isolated rural and remote locations in partnership with GPs within their region. Research in Australia and overseas demonstrates that Nurse Practitioners are safe, efficient and economical in providing quality primary health care which is well received by patients.[52]

More than a million people, one in 20 Australians, live in the seven under-served rural areas discussed in a recent report by the Grattan Institute which proposes solutions to reducing restrictions on practice and improving access to quality health care. The role of pharmacists is far more limited in Australia than in many other countries. With the agreement of GPs and patients, pharmacists could provide repeat prescriptions to people with simple, stable conditions. They could also provide vaccinations and work with GPs to help patients manage chronic conditions.

Evidence exists that physician assistants under the supervision of a doctor expand the care available in under-served areas, without compromising quality or safety, at an affordable cost. In 2011-12, these proposals would have resolved the worst shortages for just $30 million. The costs would mostly have been offset by fewer, or less costly, hospitalisations as a result of better population health.[53]

[51] My Health Clinic At Home, part of LifeLink Telehealth Monitoring provided by Feros Care. Accessed at: http://www.feroscare.com.au/services/lifelink-telehealthcare/mhcah/

[52] Siggins Miller, 2011. Rural and Remote Health Workforce Innovation and Reform Strategy. Draft Background Paper, August 2011. Health Workforce Australia.

[53] Stephen Duckett and Peter Breadon, 2013. Access all areas: New solutions for GP shortages in rural Australia. Grattan Institute.

Medicare integration and coordination

f. the better integration and coordination of Medicare services, including access to general practice, specialist medical practitioners, pharmaceuticals, optometry, diagnostic, dental and allied health services;

Recommendation 15: Improve the uptake of the Patient Controlled Electronic Health Record and investigate opportunities and implement strategies to address barriers to uptake. This could include revisiting introduction of an opt-out rather than opt-in system, improved security of patient information and a trial in selected regions.

Recommendation 16: Develop packages of health funding for chronic disease patients that engage multidisciplinary teams in case management, monitoring and treatment and move away from reliance on fee-for-individual services, adopt preventive and early intervention approaches and enhance patient centred responses.

Recommendation 17: Explore opportunities for private health insurance to link refunds for private services to enrolment in chronic disease packages.

Australia's current health care system includes multiple funding and delivery sources, overlapping responsibilities between levels of government and a mix of public and private operators. Our Medicare Levy raises approximately half of Medicare healthcare costs and is not hypothecated. Taxation revenue pays for most of the remainder of health care in the public system. Private insurance is limited to private hospital and ancillary services that are not available under Medicare's primary health care or public hospital services. Thus incentives to reduce consumption or find more efficient ways of managing care are limited.

The complexity of tied funding arrangements and restrictions on flexible use of funds allocated to universal healthcare reduces efficiency and effectiveness and the focus on patient outcomes. At its worst this encourages elaborate cost shifting behaviour between the tiers of government and service providers. The result is poorer, and relatively more expensive, outcomes for patients and few incentives to achieve ongoing innovation in the healthcare sector.

The funding model used to support healthcare needs to be individual focused rather than institution or process focused.[54] Opportunities for restructuring the current system arise in responding to the challenges of an ageing population, chronic disease levels, improved technology and survival rates, and increased consumer expectations. A more effective health system would improve health outcomes across the continuum of care and deliver savings in hospital, primary health care and pharmaceutical services.

Medicare is particularly deficient when it comes to meeting the needs of an increasing number of Australians who have multiple chronic conditions.[55] The current fee for service approach to GP visits and lack of widened scope of practice for allied health workers limits a patient-centred focus and creates reluctance to spend additional time monitoring the overall health of patients.

Enrolment in Medicare chronic disease management programs goes some way to addressing these concerns but these are not widely applied, especially if collaborative team care arrangements are not a feature within the practice. The MBS Chronic Disease Management Plans are GP-managed, limit patients to only five referrals for allied health visits and follow-up is inadequate for many patients. Patient-centred care for chronic disease patients would allow for targeted care that suits the needs of the patient and prioritises treatment options within an evidence-based approach.

[54] Taylor, N. 2013. Healthcare: Reform or ration. Centre for Economic Development of Australia.
[55] Mend Medicare Alliance. 2013. *Mend Medicare.*

A focus on rewards for maintaining health and prevention and achieving health outcomes rather than throughput is more likely to be consumer-directed and prevent escalation of chronic conditions.[56] [57] The AMA supports a more proactive approach to managing the care of individual patients the development of a broad coordinated care program to tackle chronic and complex disease based on the model of care and funding arrangements developed for the Coordinated Veterans Care program. [58]

Individualised approaches to health treatments are challenging previous practice whereby patients were prescribed standard treatment regimes based on population wide research on patients across broad disease categories and definitions. As computer analysis and biotechnology improve the ability to tailor treatments to individual patients' genetics, biochemistry and responses to treatments; a bewildering array of options may be presented to the patients and their treating health professionals. [59] While this allows quicker responses and adjustments throughout the treatment period, patients are becoming more informed but less able to judge the efficacy of their health care.

Older Australians who are engaged in managing their health care are more likely to maintain and see value in the Patient Controlled e-Health Record.[60] Increasing uptake among higher users of health care would ensure access to a complete patient history, reduce duplication of tests including pathology and radiology services, and reduce adverse events such as medication interactions as patients move between sectors of the health system. Australia has an opt-in system whereas other countries require individuals to opt-out.

However uptake of the PCeHR is dependent on the confidence of older Australians in the integrity and confidentiality of their data. Members have raised concerns with us regarding the centralisation of data through the MyGov portal which is used by 2.5 million Australians to access their Centrelink, Medicare, Child Support, Department of Veteran Affairs, e-health, and National Disability Insurance Scheme government accounts.

Linked accounts provide information including name, date of birth, phone numbers, email address, Medicare number, child immunisation records, dates of doctor visits and drugs prescribed, welfare and childcare reimbursement payments. The lack of two-factor authentication whereby a code is sent to a device and used to gain entry to personal records rather than direct entry of personal information being sufficient to gain entry is seen as a weakness of the current system. [61]

The National Health Performance Authority report on access to health care in 2011_12 concludes that the average health of local populations has little bearing on access to primary health care or other services.[62] A combination of individual funding for chronic disease and complex patients and block payments for particular populations (as implemented in New South Wales, Ontario, New Zealand and the United Kingdom) would allow targeted programs to address priority health needs for particular demographics, risk factors and health status. [63]

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[56] Carey, K, 2013. Australian healthcare: Out of pocket and out of date. *Journal of the Consumers Health Forum of Australia.* Issue 12, April 2013, p19.
[57] Taylor, N., 2013. *Healthcare:Reform or Ration.* CEDA.
[58] Australian Medical Association 2013. *Key Health Issues for the Federal Election 2013*. Canberra.
[59] Report on Professor Moscato in Medical Observer 16 September 2014.
[60] Greenhalgh, T., Hinder, S., et al., 2010. Adoption, non-adoption, and abandonment of a personal electronic health record: case study of HealthSpace. *BMJ2010;340:c3111*
[61] Grubb, B. and Towell, N. *Australians' private government details at mercy of hackers, say IT security experts.* Sydney Morning Herald. 28 Apr, 2014.
[62] National Health Performance Authority, 2012. *Healthy Communities: Australians' experiences with access to health care in 2011–12.*
[63] Penno et al. How are population-based funding formulae for healthcare composed? A comparative analysis of seven models. *BMC Health Services Research* 2013, 13:470 Accessed at http://www.biomedcentral.com/1472-6963/13/470

The health system stands to benefit from reforms which deliver improved productive, allocative and technical efficiencies. Examples include:

- Sharing client information, for example through the Patient Controlled eHealth Record to reduce duplication of services by providers.
- Enhanced scope of professional practice among allied health, pharmacists and nursing staff, especially in rural and remote areas could reduce demand for GP and specialist services.[64]
- Ensuring hospital services are delivered using nationally efficient prices adjusted for regional differences.[65]
- Improved outpatient clinics and surgical practices to reduce wait periods for elective surgery.
- Substituting cheaper generic medicines and more favourable purchasing agreements with drug companies would increase access to medicines. [66]
- Enrolling consumers with chronic or complex conditions in bundled care packages with multidisciplinary teams delivering care coordination and more flexible consumer directed services.[67]

The use of private health insurance to better manage chronic health conditions and improve prevention and early intervention services in primary health care has been trialled in Australia eg in Brisbane North Medicare Local. However there is not wide acceptance of such a move which would need to be carefully managed to avoid development of a two tier system with reduction of care to those older Australians without private health insurance.

A study of OECD countries concluded that insurance and payment policies targeted at primary care can strengthen access, including after-hours care. However insurance coverage and design are pivotal for ensuring access and affordability. [68]

Health workforce

g. health workforce planning; and

Recommendation 18: Pursue opportunities to utilise expanded scope of practice of accredited allied health professionals, including nurses and pharmacists to address the current constraints on access to, and affordability of primary health care and preventive health services.

Recommendation 19: Explore training opportunities for establishment of primary health care assistant positions, similar to aged care assistant positions.

Recommendation 20: Provide income support payments to job seekers who participate in aged care training for personal care attendants and community care workers. This could be promoted to mature job seekers who are re-entering the workforce or need to retrain.

The current health workforce consists of various disciplines each with their own scope of practice and responsibilities for decision-making. The highly hierarchical workforce developed as medicine evolved and while role delineation delivers efficiencies and specialised skills it can also limit flexibility and responsiveness to changing situations.

[64] Duckett, S. and Breadon, P., 2013. *Access all areas: new solutions for GP shortages in rural Australia.* Grattan Institute.
[65] Duckett, S. and Breadon, P., 2014. *Controlling costly care: a billion dollar hospital opportunity*. Grattan Institute.
[66] Clarke, P. *The price is wrong: Pharmaceutical expenditure in Australia over the last decade and options for reform* in Committee for Economic Development of Australia. April 2013. *Healthcare: Reform or Ration* Melbourne.
[67] Mend Medicare Alliance. 2013. *Mend Medicare.*
[68] Osborn, R. and Schoen, C. 2013. *The Commonwealth Fund 2013 International Health Policy Survey in Eleven Countries.* The Commonwealth Fund.

The increasing use of technology to monitor patients and deliver treatments allows reduces the potential for error which is often raised as an impediment to utilising a wider range of practitioners. Opportunities to develop variation in health provider roles raised in this and earlier sections have implication for future training.

Primary health care has been slow to adopt widened scope of practice and funding mechanisms have not always assisted early adoption. The recent negotiations to restore the inclusion of health assessment tasks performed by practice nurses and Aboriginal and Torres Strait Islander health practitioners in accordance with accepted medical practice and under the supervision of the GP in MBS items illustrate the difficulty of shifting practice when funding does not support more efficient use of GP time and skills. At a time of budgetary pressure, it is important to continue to fund reform which will deliver future efficiencies. [69]

Opportunities to widen the scope of practice of allied health providers have been suggested for many years with little uptake in Australia. There is substantial evidence across OECD countries of the effective use of pharmacists, practice nurses and physician assistants to deliver less complex health services at a reduced cost and to improve patient access.

National Seniors is supportive of expanded scope of practice of accredited allied health professionals, including nurses and pharmacists to address the current constraints on access to and affordability of primary health care and preventive health services. Such practice should operate within the context of guidelines that require escalation to more advanced levels of care eg GPs.

Strong international evidence also supports the delivery of “less complex” services by pharmacists and research by the Grattan Institute estimates that with additional training, pharmacists could take on five per cent of the workload of GPs in less accessible rural and remote areas. The Pharmacy Guild is proposing that pharmacies provide government funded cholesterol and blood pressure checks, vaccinations and non-prescription treatments for minor ailments.

The Consumer Health Forum supports the view that appropriately trained allied health professionals including pharmacists and nurse practitioners should be able to provide basic primary and preventative care and vital health services such as vaccinations. They are particularly supportive of this approach if services are affordable for consumers and are more accessible to the elderly and young families, and communities in rural and remote areas. [70]

The AMA has proposed that the transparent Medical Services Advisory Committee (MSAC) process is the appropriate place for the consideration of government funding for expansion of current scope of practice of pharmacists, rather than the less public Community Pharmacy Agreement negotiations. [71] Mechanisms for delivery could include referral from the patient’s medical practitioner and accreditation of allied health providers for expanded practice as occurred when enrolled nurses were trained to deliver medications to aged care residents.

The aged care workforce of approximately 250,000 is ageing with the majority aged over 45 and a third nearing retirement. [72] By 2050 an estimated 827,100 workers will be engaged in the provision of aged care and will account for about 4.9 per cent of all employees in Australia. In absolute terms, by 2050, the demand for LTC [long-term care] workers (on an equivalent full time basis) is expected

[69] Medicare Health Assessments; Online Fact Sheets. Accessed at:
http://www.health.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-MedicareHealthAssessments

[70] Consumer Health Forum Media Release Wednesday, September 3, 2014.

[71] Government Must Dispense With Pharmacy Guild Plan To Plunder Primary Care AMA media release 3 September 2014. Accessed 19 September 2014 at: https://ama.com.au/media/government-must-dispense-pharmacy-guild-plan-plunder-primary-care

[72] Sydney Morning Herald *Aged care can't meet growing demands of the population*. Accessed May 23, 2013
http://www.smh.com.au/national/aged-care-cant-meet-growing-demands-of-the-population-20130522-2k189.html#ixzz2nKAvRloZ

to about double in Japan, the USA and Canada, and about triple in Australia, New Zealand, Luxembourg and the Slovak Republic. [73]

Most direct care workers are employed on a permanent part-time basis (72 per cent of those in residential facilities and 62 per cent in community outlets) and a quarter of the residential direct care workforce and a third of the community direct care workforce would like to increase their hours. Under current policy arrangements the aged care workforce will need to increase by between two and three times as a direct result of Australia's ageing population. [74]

In particular, carers who were unable to work because of their caring responsibilities and mature people who have experienced breaks in their work history due to family responsibilities may be interested in retraining to provide support and care to aged care clients. Older Australians are distressed by the lack of support they experience when they seek to re-enter the workforce.

Member comment:

1. *50's plus carers need help, they are not recognised as workers they have no one to fight for their rights they have no retirement to look forward to yet they " work " more hours than any other worker in Australia.*

2. *After I placed my mother into care, the first thing that happened was that Centrelink immediately cancelled the Carer's Allowance of $100. I was then given fourteen weeks, seven payments of the Carer's Payment, to figure out what I wanted to do, i.e. find suitable employment.*

   Government policy does not recognise the "human side" of the carer, having cared for an individual, then relinquishing that role. People can be burnt out, as I was, and quoting my then GP, she stated that "you are emotionally and physically exhausted".

   Government policy needs to take into consideration a different approach, or a different scale of payment When it came time for primary carers to come off the Carer's Payment, they could be placed onto an interim payment, other than Newstart, and whilst on that payment be given the opportunity to consider Educational Courses, that would equip them for suitable work.

h. any related matters. – No further comment.

[73] Productivity Commission 2011, *Caring for Older Australians: Overview*, Report No. 53, Final Inquiry Report, Canberra.
[74] King D, Mavromaras K, Wei Z, et al. *The Aged Care Workforce, 2012*. Canberra: Australian Government Department of Health and Ageing; 2012