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What makes a good old age? Aged Care Roundtable Discussion Paper May 2018

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Contents

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Synopsis

This paper is based on discussions with Aged Care CEOs at the National Ageing Research Institute (NARI) Aged Care CEO Roundtable on 26th March, 2018.

Twelve CEOs (or their delegates) participated in the discussion representing aged care providers from Victoria, South Australia and New South Wales.

The purpose of the roundtable was to reflect on the following questions:

1. *What should a future aged care system look like in response to changing demographics and the current and future policy environment?*
2. *What will be required to design the next generation of aged care services to meet this future?*
3. *How can data help?*

Author

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Executive Summary

It is time to rethink how aged care should be in Australia.

In May 2018, the National Ageing Research Institute brought together aged care leaders from around Australia to consider some of the burning issues in aged care in a bid to envisage what a future aged care system could look like. Twelve CEOs (or their delegates) participated in the discussion, representing aged care providers from Victoria, South Australia and New South Wales. Roundtable participants considered the current aged care system, the policy context and demographics and likely demands and drivers into the future.

We know Australia has an ageing population and people are living longer. Aged care as it is currently will not meet future demand. Not just numerical demand, but demand for different types of care, diversity in options and a strong preference by older people for remaining in their homes and communities. The workforce is not keeping up with demand, and there are fewer family carers despite the policy of 'ageing in place' relying on informal carers and a skilled and sufficient workforce.

At the same time, the baby boomer cohort is more diverse – in sexuality, culturally and linguistically, and in what they are seeking. Residential care, as it is currently portrayed, does not appeal to this generation.

Three questions were presented to the Roundtable:

1. What should a future aged care system look like in response to changing demographics and the current and future policy environment?
2. What will be required to design the next generation of aged care services to meet this future?
3. How can data help?

The ensuing discussion resulted in a number of ideas for action being identified. The most frequently endorsed being: the need for better understanding of what good ageing and good death looks like. All participants felt that we do not yet have a sufficient understanding of these issues. Other important areas for action included: early prevention; home care packages, workforce; dementia care and the need for better data and access to data for timely analysis and use.

Central to the discussion was the need to define what makes a good old age, and that any new aged care model has to be based on an understanding of this. Critically, the Roundtable questioned whether the current emphasis on ageing in one's own home was the best way to achieve this. The Roundtable agreed that a future aged care system should reflect a life course approach to ageing and support a good old age (including a good death), rather than being a last resort to be turned to when the older person and their family can no longer manage.

A future model should integrate health and aged care. This would include building in incentives for pro-actively maintaining health and wellbeing across the life course, and extend into aged care. The new model should have a properly recognised, skilled and remunerated workforce with adequate training, meaningful job roles, career pathways, and security of employment.

The design of the next generation of aged care services requires flexible options for older people ranging from low to high level and end-of-life care with both in-home and in communal living options at each level. This requires an understanding of the future demand for aged care, including client characteristics and preferences. Adequate training is needed to help residential and home care staff to manage their increasingly complex roles, particularly working with people living with dementia.

Integral to the creation of a robust aged care sector is the need for research and data to draw together what is already known, not just within that aged care sector but in acute, sub-acute health and primary/preventive health, and to disseminate the findings and knowledge across the sector. The Roundtable believed that existing datasets would answer many questions if they were made available, although additional qualitative studies may be needed to explore the questions of a good old age. In addition, research was vital to explore the relationship between spending on aged care (by both government and consumers) and client outcomes.

Overall, the aged care Roundtable agreed: it is time to look forward, to build on the work of the Tune Review, the Aged Care Workforce Taskforce and others, and envisage a future where aged care contributes to a good old age (including a good death) and is seen as doing so.

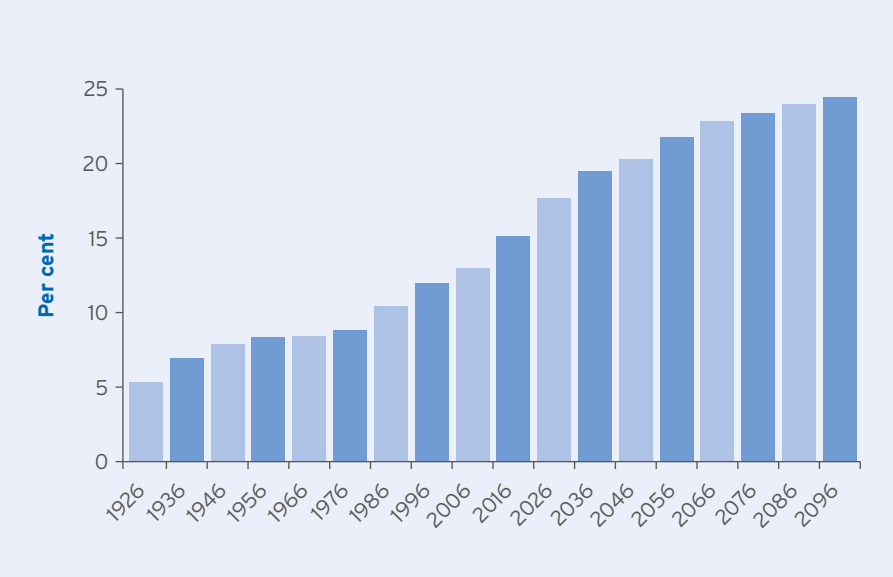
Background

There are a number of current trends that are likely to continue into the future and to impact on aged care provision.

The Australian population is ageing.

Figure 1 below shows the proportion of the Australian population aged 65 and over from 1926 to 2096 projection.

Figure 1. of Australian population aged 65 and over (Australian Bureau of Statistics, 2013, 2014)



There are increasing numbers of older people using aged care services.

Table 1 (below) shows the increase in residents living in aged care from 2000-2015. The total number of operational residential and flexible aged care places at 30 June 2017 was 209,626. While the proportion of older people accessing residential aged care is declining, the absolute numbers are increasing.

Table 1. Percentage of age-and sex-specific usage rates for residential aged care in Australia (Australian Bureau of Statistics, 2015)

	2000	2003	2006	2009	2012	2015
Male						
65-74	1.40%	0.97%	0.92%	0.89%	0.86%	0.83%
75-84	4.28%	4.05%	4.05%	3.89%	3.77%	3.54%
85+	17.32%	16.14%	15.28%	15.57%	15.24%	14.47%
Total Number of Males 65+ in care	**33,625**	**35,620**	**39,505**	**42,911**	**47,284**	**51,025**
Female						
65-74	1.14%	1.03%	0.96%	0.92%	0.86%	0.81%
75-84	7.01%	6.75%	6.62%	6.18%	5.74%	5.16%
85+	30.89%	29.47%	28.40%	28.12%	26.94%	25.50%
Total Number of Females 65+ in care	**93,678**	**98,590**	**105,659**	**109,429**	**113,474**	**114,778**

There is a trend to higher acuity for aged care clients and residents, including increased numbers of residents and clients living with dementia. In 2011 it was estimated that 30% of people with Dementia were living in Aged Care in Australia (House of Representatives, 2013). At 30 June 2017, half of all residential aged care residents with an Aged Care Funding Instrument (ACFI) assessment had a diagnosis of dementia.

Families provide the bulk of care and continue to be part of the care team even when aged care services are provided. As of 2012 around 85% of older Australians living in a community receive care from informal providers such as family, friends, or neighbours to assist them with self-care, mobility or communication (Productivity Commission, 2015).

Family members also provide also provide the vast majority of care for people with dementia living in the community (91%) (Brooks, Ross, & Beattie, 2015). This equates to over 200,000 Australians providing care to people living with dementia, with 22% of the people receiving care relying only on care from their friends or family, with no access to formal aged care services.

We have an ageing and culturally diverse aged care workforce. Migrant and culturally and linguistically diverse (CALD) workers make up almost one-third (Table 2) of the aged care work force in Australia which equates to over 366,000 workers (Department of Health, 2017). The majority of these care providers are personal care attendants for both migrants and migrants who speak a language other than English (LOTE).

Table 2. Percentage of CALD residential care workforce, by occupation: 2016 (Mavromaras et al., 2017)

Occupation	Worker (migrant)[1] (Column 1)	Worker (migrant + LOTE)[2] (Column 2)
% of direct care employees	28.7	22.2
Distribution:		
Registered Nurse	19.8	19.8
Enrolled Nurse	6.0	4.8
Personal Care Attendant	70.3	72.1
Allied Health	3.9	3.3
Total	**100**	**100**

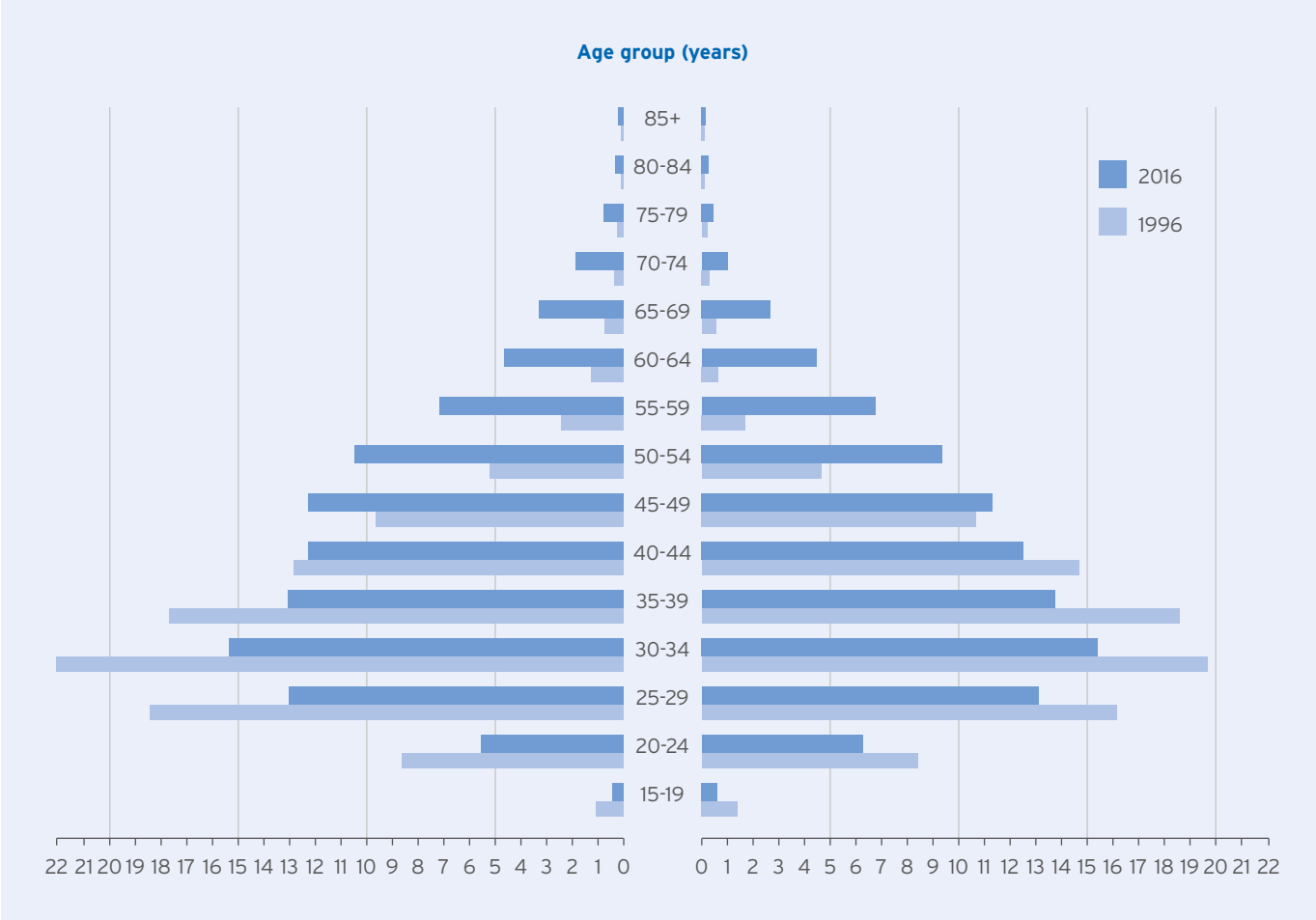
The current aged care workforce will not meet projected demand.

A recent Australian Unity commissioned report by Price Waterhouse Coopers (PWC) projects a shortfall of 120,000 nurses and over 400,000 aged care workers by 2040 (PWC, 2018). In addition we are seeing increased workforce participation amongst women, including older women, leading to less availability of family carers. There is also a risk of distributing this problem to other countries as we seek to employ carers from other countries, such as Asian and Pacific countries, where there is a strong tradition of family care as the care workers coming to Australia are often also the primary carers for their own elders and children.

The **cultural and sexual diversity of** older people receiving care is increasing. 23% of people aged 65 years and over in Australia were born overseas in countries with primary languages other than English (Department of Health, 2017), with 18.3% of aged care residents being born in non-English speaking countries as of 2015 (Petrov L, Joyce C, & Gucciardo-Masci T, 2017).

It is estimated that 11% of Australia's population identifies as LGBTI, with an increase of same-sex couples aged over 50, from 9.2% to 27% from 1996 to 2016 (Australian Bureau of Statistics, 2016b). Figure 2 below shows the large increase in same-sex couples in age groups 50 years and older over that period but it should also be noted that currently there is no way of identifying LGBTI identifying older Australians who access aged care services (Australian Institute of Health and Welfare, 2017).

Figure 2. Age of partners in same-sex couples by sex 1996 and 2016 (Australian Bureau of Statistics, 2016b)



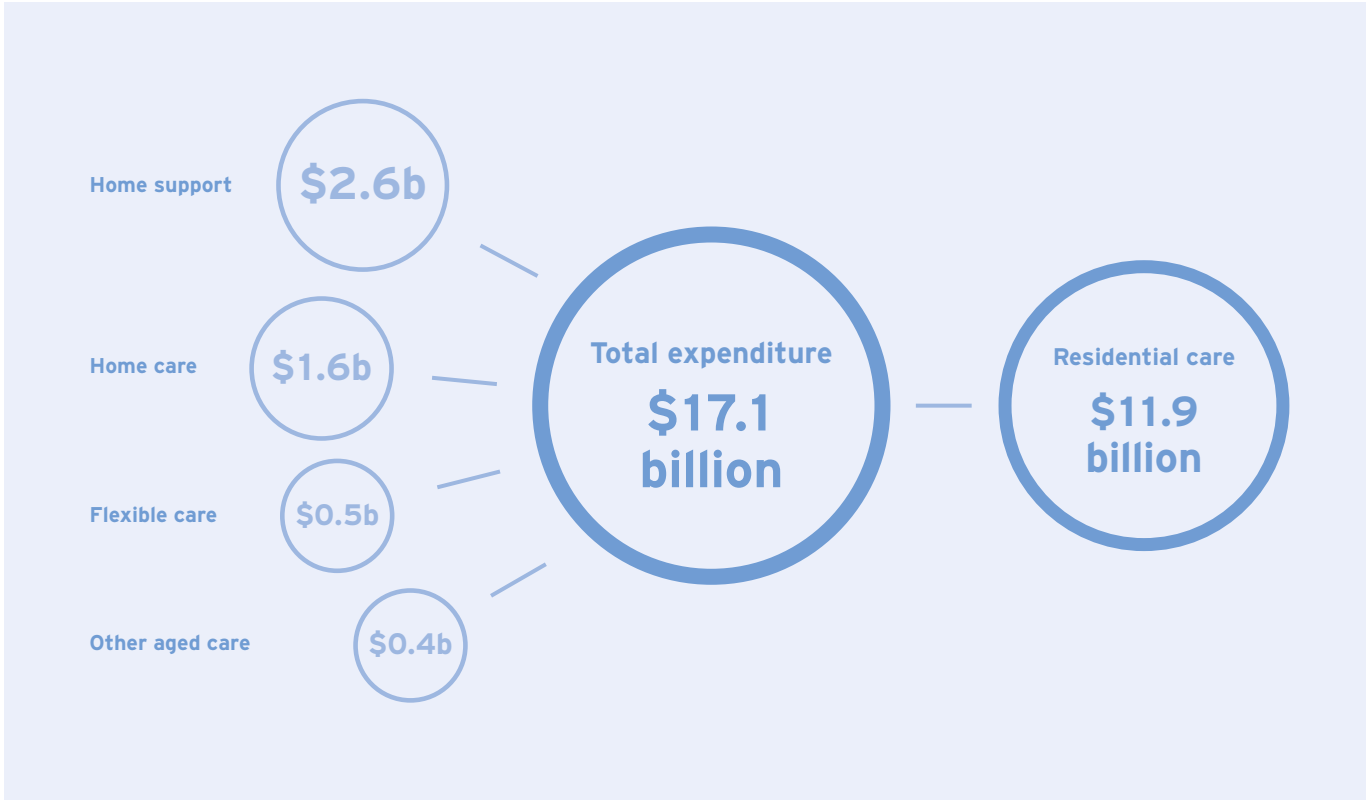
Approximately 3% of the Australian population identifies as being from **Aboriginal or Torres Strait Islander origin** (Australian Bureau of Statistics, 2016a) and 22.2% are aged over 45 years (Australian Bureau of Statistics, 2015). Although they are generally a younger population, they often experience problems usually associated with ageing at a younger age so have a proportionately high incidence of conditions, such as dementia (LoGiudice, 2016).

Aboriginal and Torres Strait Islander Australians are over represented in Home Care Levels 1 and 2 but underrepresented in all other service types and people from CALD communities are also over represented in Home Care Levels 1 and 2 and 3-4 but underrepresented in all other service types (Productivity Commission, 2017). Aboriginal and Torres Strait peoples are also under represented in the workforce for culturally specific care so they are underrepresented in both care and the care workforce.

For the past 30 years we have also seen **increased government spending on aged care.** There was a 19% increase on government spending on aged care services between 2011-12 and 2015-16 (Australian Institute of Health and Welfare, 2016). Figure 3 below shows the proportions of aged care funding in various program areas for 2016-17.

We also see a long standing trend of fear and reluctance of older people to go into residential aged care and preference for ageing in place. This is partly fuelled by adverse media coverage of aged care but also by the lived experience of older people and their family members. For example, in NARI's recent consultation with older consumers, aged care was identified as the issue of greatest concern with concerns about isolation and segregation from mainstream society and poor treatment, poor communication and information and lack of empathy and powerlessness being raised.

Figure 3. 2016-17 Government Aged Care Spending (AIHW, 2017) (Department of Health, 2017)



Government policy and policy reviews

These trends have been responded to in recent years with extensive reforms of the aged care system, based on the recommendations of the Productivity Commission's Caring for Older Australians report of 2011.

The aim of these reforms was to improve equity, effectiveness and efficiency in aged care (Productivity Commission, 2011). The Living Longer Living Better Reforms were introduced and passed into legislation 26 June 2013. The My Aged Care website and national call centre was also introduced at this time.

The overall policy direction, which has bi-partisan support is for funding to follow the consumer, to enable ageing in place as much as possible, to limit government spending on aged care and increase the component paid by consumers who have the ability to pay and to have a nationally consistent aged care system.

While there are a number of Commonwealth Government policies, frameworks, strategies and legislation relating to older people and ageing, there is no overarching ageing strategy.

There are also a number of policy documents on the health of specific groups within the population. Some of these recognise older people and address issues affecting them; others do not. These include strategies for LGBTI and CALD communities which are not generally supported by action plans or specific funding but seem to influence the direction of government funding rounds, such as the Dementia and Aged Care Services funding:

- The National Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Ageing and Aged Care Strategy

  https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/08_2014/national_ageing_and_aged_care_strategy_lgbti_print_version.pdf

- National Ageing and Aged Care Strategy for People from Culturally and Linguistically Diverse (CALD) Backgrounds

  https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/07_2015/dss1582_aged_care_strategy_cald_a4_vaccessible.pdf

Further, most states and territories have ageing strategies or frameworks, with the notable exception of Victoria. SA, NSW and Tasmania have current comprehensive strategies on ageing. Queensland, WA, NT and ACT all also have ageing framework documents.

The main Victorian policy documents of relevance are the Victorian Public Health and Wellbeing Plan; Improving Care for Older People: A Policy for Health Services; and the Social Isolation and Loneliness report.

Current policies and strategies show a gradual move from an approach where ageing is a problem to be solved, to one where older people's contributions and strengths are recognised and valued. There is still a lack of recognition, however, of older people as a population group with specific needs in many policies particularly at a Commonwealth level.

As David Tune points out in his recent review of aged care (Tune, 2017), not all of the reforms recommended by the Productivity Commission were implemented, particularly those addressing the issue of uncapping supply. Tune argues that there are four pre-conditions that are required before a demand driven system can be put in place. These are:

- Better understanding of demand for aged care services
- Increased consumer contribution for those who can afford to pay
- Robust system for assessing eligibility for government funded services
- Ensuring equitable supply of services across different population groups and settings

Most recently the Aged Care Workforce Strategy Taskforce completed its report *A Matter of Care – Australia's aged care workforce strategy,* which calls for better education and training of the aged are workforce, a voluntary code of practice for aged care and a new Remote Accord for providers in remote parts of Australia. It also calls for cultural change in the way we view aged care. it is hoped that the strategic actions from the Taskforce will be implemented over the next 1-3 years but at the time of writing, the government's response to this strategy was not known.

Outcomes of roundtable discussion

The main theme to emerge from the CEO roundtable was the need to define what makes a good old age? The CEOs wanted to see an aged care system that reflects a life course approach to ageing and supports a good old age and a good death, rather than being seen as a last resort to be turned to when the older person and their family can no longer manage. They questioned whether the current emphasis on ageing in one's own home was the best way to achieve this.

Related to this was the need to direct resources to health promotion and preventive health strategies at both a structural and individual level. There is already considerable evidence for the benefits of a healthy lifestyle in reducing risk of many of the health problems associated with older age. They believed we should be promoting these at a population level, with messages tailored for a range of age groups and life stages.

Overall 19 ideas for action were identified and the most frequently endorsed priorities have been grouped under the following headings:

- Understanding what good ageing looks like
- Early prevention
- Homecare packages
- Workforce
- Dementia
- Data

These are discussed in more detail below.

Other issues that emerged in the discussion and in pre-roundtable input from CEOs who couldn't attend were:

- The need for better translation of existing research and knowledge into practice, including broader roll out of successful pilot programs
- The need to change the funding model to encourage re-ablement approaches in aged care, including in residential care and to enable portability of packages across settings of care
- The need to define what is meant by quality – there was consensus that legislation for safety and security is essential but, as quality is perspective driven, it is not possible to legislate effectively

What makes a good old age?

'Ageing is part of the human condition. Everyone gets to grow old unless they die young. But there is little consensus as to what good ageing looks like in Australia.'

Existing narratives equate staying in your own home with good ageing but this does not take into account the experience of many older people who are lonely, bored or fearful in their own homes. We need to better understand how individuals, families, communities and the health and aged care systems can contribute to a good old age for all. There is a need to understand what a good old age means from the perspective of older people themselves as well as those approaching older age and younger generations. If we can gain consensus as to a good or good enough old age, policy and programs can be designed to maximise this and families and older people themselves can contribute.

We know that older people value good health, maintaining control over their lives and deaths, and living in their own homes and communities but the Roundtable questioned whether the latter was in part a response to fear of residential care, losing control and independence. What about the value of social connection, feeling safe, meaningfully engaged. How can these aspects of a good old age be maintained and how can aged care services contribute to this?

Questions for further exploration

- What outcomes are important for a good old age? Health, wellbeing, avoidance of frailty, avoidance of hospital, avoidance of residential care, prevention of falls, staying at home, social connection, family relationships, a good death?
- How do we measure these?
- To what extent are these built into the current aged care system?
- What outcomes do the current Home Care Packages(HCPs) deliver for older people?
- What inputs are needed to achieve these outcomes?
- How can consumers get the best outcomes from HCPs? Need for better consumer-directed-care (CDC) literacy, to avoid problems such as 'saving for a rainy day' leading to large volumes of unspent funds.
- Residential care has a role to play in a good old age – how can this be defined and promoted?
- What is the role and benefit of group activities, such as Senior Citizens Centres, U3A, Planned Activity Groups etc. in achieving these outcomes

'A good old age is not just about health, it should be about living a life.'

Issue: Early prevention: health promotion across the lifespan

'There is a need for integrated health and aged care systems that focus on health promotion across the lifespan. Consumers and systems should be rewarded for focussing on health and wellbeing as well as for treatment and care.'

There is considerable existing evidence about the contribution that lifestyle makes to cognitive, emotional and physical health in older age. Generally, good management of the same lifestyle factors, such as exercise, diet, and management of hypertension, contributes to risk reduction for a range of chronic conditions, such as cancer, dementia, cardiovascular disease, and osteoporosis. Strength and balance training are also important in reducing falls risk.

The CEOs identified the need to invest 'upstream' in preventive health measures at all life stages, taking into account the latest evidence about the contribution of lifestyle factors at different life stages to the risk of developing dementia in older age. A life course approach to health promotion is needed.

There is also a need for health and health system literacy. This is an issue for many older Australians and particularly for older Australians from CALD backgrounds. The CEOs noted that much of the current preventive public health campaigns are directed at children and young people, rather than middle aged or older people and that this needs to change. We need to better understand how older people respond to healthy ageing messages, whether approaches that work with younger populations also work with older people, who may feel that there is no point in taking up healthy lifestyle behaviours later in life. They also questioned the role of government in this, noting that there is a role for individuals, services and government programs but at present it is not clear what level of government, if any, take responsibility for preventive health policy and programs.

The CEOs identified a need to understand better the cost benefits of preventive health. As the benefits are often long term, it is challenging to determine the relationship between lifestyle changes and health outcomes. There is also a need to reward aged care providers to maximise the health and function of aged care residents. It was noted that the current Aged Care Funding Instrument (ACFI) model acts as a disincentive to reducing residents' functional dependency.

Questions for further exploration

- What are the 'down-stream' benefits of health promotion in terms of individual health and wellbeing outcomes, incidence of dementia and other chronic health conditions, reduction in hospital admissions and inappropriate admission to residential care?
- How can aged care providers be incentivised to prevent or reverse frailty and improve functional outcomes for clients and residents?
- How can individual lifestyle behaviours be incentivised across the life course?

'We have to start talking about healthy ageing at 40 or 45'

'There is an asymmetry with information: navigating the system is difficult and people are neither health nor system literate'

'It is time we moved from a medical compliance model to a quality of life model'

Issue: Home care packages

'Home care packages may be fostering isolation.'

The question of optimal use of home care packages was discussed at length. Currently there is no way of linking health and wellbeing outcomes to the way that home care packages are configured and used. The CEOs noted a lack of creativity in how we are approaching home care packages. They suggested that some clients are not using them for 'healthy ageing' purposes and making poorly informed decisions about how to use the packages, noting that it is the client's right to determine how their package should be spent. Clients are also sometimes saving their packages up for a rainy day so there is a large pool of funds that could be put to better use.

CEOs said it would be useful to have an evidence base that could inform clients' decisions about the best way to maintain their quality of life.

There is also a need to better understand the cost of ageing in the home. The current government rhetoric of 'ageing in place' is very compelling, as it is a low-cost alternative to residential care and suits the preferences of most older Australians. However the CEOs said that we need to be careful that the aged care industry does not 'buy' into the government spin about the benefits and importance of 'ageing in place' but takes an informed approach with the benefits and costs fully articulated and understood.

They were concerned that some people are staying on at home when it is no longer the best option for them due to fear of residential care or concerns about costs. Some older individuals who are receiving home care are socially isolated, have poor nutritional status, have little or no family support and are at high risk of falling. It may be better for their quality of life and also cost effective for them to move into a residential care setting. They also noted the limitations of the Community Home Support Program (CHSP) not funding transport, which is an essential component of social engagement.

Questions for further exploration

- The Home Care Package model – is it the right model?
- Is it possible that a low-cost home care package may mean someone ends up in high cost setting prematurely? This is particularly the case where they have a level 1 or 2 package and are waiting on level 3 or 4 but are unable to access it due to demand.
- How do we get people out of home and meeting with others to prevent social isolation?
- Should we be reconsidering the 'old hostel model' or options such as, blended living, communal living, naturally occurring retirement communities (NORCs) as an alternative?

'Home care packages are fostering isolation.'

Issue: Workforce

'Need to look at payment; aged care workforce has to be valued for what they do and pay rates have to equate to similar jobs'

'We need to attract people into the industry with roles which are attractive and have a career progression'

Given the well documented issues with future demand and supply of the health and aged care workforce, workforce issues were a key issue of concern for the Roundtable. Some of the issues raised were the tensions between a consumer directed model of care and the need for clear boundaries and guidelines for workers, particularly in home care.

Most CEOs were trying to have permanent workforce of at least 85% and some had already achieved this. However, this aim is at odds with the increased casualization of the home care workforce and the practice of some workers of picking and choosing shifts that suit them best from a range of employers.

The other issue in Home Care is one of the client's right to choose who provides the service and when, which directly competes with the needs of the workforce for a stable, predictable roster. How can these sit together and affordable quality of care be delivered? Similarly, when the client holds the budget, how do providers fund statutory minimum engagement periods, travel and such?

Given the ageing of the aged care workforce, the issue of care workers being 'fit for work' was also discussed.

Many care workers are dealing with their own chronic or acute health concerns so strategies need to be found to ensure they are physically and mentally able to undertake the work. A 'fitness for work' approach was suggested, which includes giving everyone a physical before they are employed and matching people to work situations.

Alternatively, an 'accommodations' approach that would make use of technology, workplace and workforce design options to accommodate staff specific requirements across their working life was suggested. This would enable people who have some physical limitations but who want to work to continue to work and the employer to maintain their knowledge and productivity until they are ready to retire.

As identified by the Aged Care Workforce Taskforce, there is a need to raise the status of working in aged care. Some potential solutions discussed were: to increase wages to expand the pool of potential care workers; to better recognise the scope and complexity of the roles; to have more opportunities for career progression within direct care roles; and to introduce new roles, such as care navigators and independent health coaches.

It was also acknowledged that families provide the bulk of the aged care workforce and health and aged care services need to consider how to better engage with families as partners in care.

Questions for further exploration

- How can we raise the status and conditions for workers in aged care?
- What is the relationship between workforce characteristics and client outcomes?
- Is matching of cultural background important?
- What about ratios, qualifications and training?
- Can we develop a mechanism for aged care providers to share existing successful models?
- How do we better integrate family and formal aged care services for the benefit of all?

'Need to look at payment; aged care workforce has to be valued for what they do and pay rates have to equate to similar jobs'

'We need to attract people into the industry with roles which are attractive and have a career progression'

Issue: Dementia

Given the prevalence of dementia in older age and amongst aged care residents, dementia was identified as a key priority for consideration in any future aged care system. Current funding models do not reflect the intensity and expertise of staffing required to provide quality care for people with dementia. There is also a need for appropriate environmental design and integrated palliative care programs to meet the needs of people with dementia and their families living in residential care.

Currently there is inadequate assessment on entry into hospitals, retirement living and aged care and even if there is assessment, this may not be reflected in the provision of appropriate services, environments and care.

Home care workers get little training on how to work with people living with dementia, yet they are expected to work with minimal supervision and taking on a range of complex tasks.

A whole of society response to dementia is required. There are many good examples in Australia and internationally of dementia friendly initiatives. These need to be rolled out in context-appropriate ways rather than funded in a piecemeal or pilot fashion and then abandoned for the next project.

Questions for further exploration

- How do we adequately fund all components of the health and aged care system to meet the needs of people living with dementia?
- How do we better equip home care workers to build relationships and meet the care needs of people living with dementia?
- What existing pilots could be rolled out if adequately translated? Is this an issue of funding and/or better information for providers as to how they might improve services in a more manageable way?
- How can innovation be funded?

Issue: How can data help?

We could get predictive if we shared data.

There are many ways that data can help to answer the questions raised at the Roundtable. Qualitative studies and population based surveys can assist to understand better what a good old age should look like. There are also extensive existing data sets that can be linked and analysed to better understand client trajectories and characteristics, the unmet needs of family carers, issues for people from CALD populations and many other topics. These include Australian Bureau of Statistics (ABS) surveys, Medical Benefits Scheme data, State government hospital admission, ACFI and Australian Institute of Health and Welfare (AIHW) aged care data sets. In addition, as recommended by the Aged Care Industry Information Technology Council, a common base data set for the industry would enable exchange of data within the industry.

It would be beneficial to conduct a study of outcomes for home care clients and relationship to services provided. This could be linked to the proposed quality standards for home care, thereby enabling providers to also understand the relationship between services provided, health and wellbeing outcomes and the quality standards.

Sharing of existing data collected by aged care providers could also help to extend existing good practices across the sector. The Roundtable also suggested the need to investigate how to translate knowledge into practice, including successful pilot programs that have the potential to be scaled up and implemented more broadly and in different settings.

Conclusion

In conclusion, the Roundtable identified a series of questions and issues that need to be grappled with now to inform the way forward for the future of aged care in Australia.

In short, a future aged care system should be based on an understanding of what a good old age looks like. It should be an integrated health and aged care system, and disincentives for maintaining health and wellbeing across the life course removed, including in aged care. It should have a properly recognised and remunerated workforce with adequate training, meaningful job roles, career pathways, security of employment; and consist of flexible options ranging from low to high level and end-of –life care with both in-home and in communal living options at each level with permeable boundaries in both directions.

A host of requirements have to be put in place in the design of the next generation of aged care services to meet the future. These include an understanding of future demand for aged care, client characteristics and preferences, adequate training for home care staff to manage their complex roles, particularly working with people living with dementia, and the drawing together of what we already know and disseminating this knowledge across the aged care sector.

Finally, data can help. Thorough and targeted analysis of existing data sets would answer many of these questions. Additional qualitative studies may be needed to explore the question of a good old age, and research exploring the relationship between spending on aged care and client outcomes is vital.

Appendix A

– Roundtable participants (including those who provided input prior to the meeting)

Attendees:

- Mr Derek McMillan, (facilitator)

CEOs

- Mr David Moran, CEO Southern Cross Care
- Mr John McNamara, Director, Property and Business Development, Southern Cross Care
- Mr Patrick Reid, CEO IRT Care (via teleconference)
- Ms Penni Michael, General Manager Business Development, MiCare
- Mr George Lekakis, CEO Fronditha Care
- Mr Kevin McCoy, CEO Australian Unity
- Mr Hugh Cattermole, Chief Operations Officer Jewish Care
- Ms Michelle Lewis, CEO Mecwa Care
- Mr Craig Bardrick, CEO Bass Care
- Mr Phillip Wohlers, CEO, Old Colonists Association of Victoria.

Contributed but unable to attend:

- Ms Sandra Hills OAM, CEO Benetas
- Ms Cynthia Payne, CEO Summit Care

NARI

- Associate Professor Briony Dow, Director, NARI
- Ms Debra O'Connor, Deputy Director, NARI
- Dr Frances Batchelor, Director, Clinical Gerontology NARI
- Ms Penny Underwood, Media Consultant, Mediawise

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