Health and Environment Committee

From: Stephanie Power [redacted]
Sent: Thursday, 23 December 2021 4:40 PM
To: Health and Environment Committee
Cc: Mark Tucker-Evans
Subject: Submission: Inquiry into the provision of Primary, Allied and Private Health Care, Aged Care and NDIS Care Services and its impact on the Queensland Public Health System
Attachments: Health systems Inquiry_COTA QLD_20211223_final.docx; Health systems Inquiry_COTA QLD_20211223_final.pdf

Sent on behalf of COTA Queensland, Chief Executive, Mr Mark Tucker-Evans

Committee Secretary
Health and Environment Committee
Parliament House
George Street
Brisbane Qld 4000

Dear Health and Environment Committee Secretary,

Submission to the Inquiry into the provision of Primary, Allied and Private Health Care, Aged Care and NDIS Care Services and its impact on the Queensland Public Health System

The Council on the Ageing (COTA) Queensland, a for-purpose registered charity, is the peak body for older Queenslanders. COTA has advanced the rights, needs and futures of older Queenslanders since 1957. COTA advocates for government policies and programs that enable more supportive community attitudes towards ageing and older people. COTA helps foster social change by providing leadership and expert advice on ageing issues, working with other stakeholder groups across Queensland. The consideration of local community needs for best access to health care services and supports and better consumer outcomes for healthy ageing is a large part of COTA Queensland's work.

COTA Queensland acknowledges that access to health services is vital no matter where older adults and their families live, no matter the health service and system e.g., primary, allied health, aged care, and NDIS to address acute and/or chronic health care needs in private and/or public systems.

The insights captured in our submission demonstrate that we must promote healthy ageing at the core (as part of a wider *age-friendly* framework). By 2049, 21.9% of the Queensland population will be aged 65 years and over and 4.5% will be aged 85 years and over, which indicates there are ongoing implications for health resource planning in a post-pandemic world, particularly for chronic disease management, priority cohorts who experience ongoing health inequities, and those in regional, rural and remote communities who continue to experience issues with accessibility and availability of health services and supports.

Regards

Mark Tucker-Evans
Chief Executive

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Our vision for an integrated health system throughout the lifespan that places people at the centre of care.

COTA QUEENSLAND

Inquiry into the provision of primary, allied and private health care, aged care and NDIS care services and its impact on the Queensland public health system

16 December 2021

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Executive Summary

COTA Queensland's vision is for **an integrated health system throughout the lifespan that places people at the centre of care**. This means the system:

- Ensures equitable access, no matter a person's diagnosis, age, location, or resources.
- Acknowledges health as interconnected to other community domains including transport, housing, and participation, and the Queensland Government encourages, tests, and embeds integrated models that connect these domains.
- There are clear and navigable pathways to services for diverse and changing needs.
- There is collaboration across Federal, State, and Local Government responsibilities including co-design with consumers to work towards an integrated system.[1]

Recommendations

1. Gain accurate insight into local community access to and availability of health services and supports, particularly in regional, rural and remote communities, and diverse cohorts which historically are under-represented or experience disadvantage (e.g., culturally and linguistically diverse; First Nations communities; inequities with housing or transport; low socio-economic background; under- and unemployment; bereaved; living on their own; experiencing elder abuse).
2. Gain accurate insight into local community (including individuals, community groups, service providers, and local councils) understanding of funding responsibilities, and where they see Commonwealth and State Government gaps or strengths in their local health systems.
3. Explore strengths of local government's role (advocacy, guidance, and input) in better understanding needs in their communities e.g., idea of a regional government model.
4. Consult, co-ordinate and collaborate with communities and networks on a regional response e.g., strategy or proposal to present evidence-based case to government as part of effort to explore more Commonwealth funding opportunities.
5. Use of existing community resources and opportunities to expand upon the volunteer network for needs such as transport, running errands, home and yard maintenance, social connection, and similar activities.
6. Increase availability of bulk billing services and messaging to GPs and health clinics regarding provision of access to primary health care services for cohorts experiencing inequities particularly in regional, rural and remote communities.
7. Provide more education and information around private health and public health, and planning for future health/care needs and supports.
8. The Queensland Government adopts a strong framework to ensure diverse older consumers, as partners, co-design an integrated system of care (including services, health promotion activities, information and supports); consumers oversee and plan their own care.
9. The Queensland Government continues to invest in telehealth services and these are integrated into care models across Queensland Health.
10. The Queensland Government increases current expenditure in areas greatly needed e.g., palliative care to match Palliative Care Queensland's estimate of required funding.[2]

[1] Integrated health vision has been adopted from COTA Queensland, *2022/23 State Budget Submission.* (2021).
[2] Recommendations 8 – 9 have been adopted from COTA Queensland, *2022/23 State Budget Submission.* (2021).

Introduction

Council on the Ageing (COTA) Queensland welcomes this opportunity to provide a submission to the the Health and Environment Committee for the Inquiry into the provision of primary, allied, and private health care, aged care and NDIS care services and its impact on the Queensland public health system.

COTA Queensland is the Seniors peak organisation, advancing the rights, needs, interests and futures of people as we age. With the large and growing number of older people in our state at the centre, we have worked to influence positive outcomes for Queenslanders for over sixty years. We provide a connection point for older people, their families and communities, organisations, and Governments at all levels to address issues for Queenslanders and co-create change.

COTA Queensland provides independent information and education for older people, their communities, and organisations as well as education and training, advice, and other services to the public and private sectors. We work across diverse issues, including the following areas which we consider pertinent to this Inquiry: aged care, general health and health systems, mental health, palliative, and end of life care; and those factors which interact with or impact on accessibility to services and supports in these areas including, for example, human rights and legal protections, digital inclusion, age discrimination, housing, and transport.

Given the breadth and complexity of this Inquiry matter and the limited time frame for submission, COTA Queensland presents some key issues around the provision of health care services through case studies and recent observations through our work. We also provide insights into the impacts on availability and accessibility of these services and supports, and considerations and recommendations, particularly in Regional, Rural and Remote (RRR) communities.

Problem statement

COTA Queensland identifies that *access to health services is vital no matter where older adults and their families live*, no matter the health service and system e.g., primary, allied health, aged care, and NDIS to address acute and/or chronic health care needs in private and/or public systems.

Vision

COTA Queensland's vision is for an integrated health system:

> *[…] for the whole of life that places people at the centre of care. The system ensures equitable access, no matter a person's diagnosis, age, location, or resources. Health is seen as interconnected to other areas of communities including transport, housing, and participation, and the Queensland Government encourages, tests, and embeds integrated models that connect these domains. There are clear and navigable pathways to services for diverse and changing needs throughout the lifespan. The Queensland Government leads collaboration across Federal, State, and Local Government responsibilities including co-design with consumers to work towards an integrated system.*[3]

[3] COTA Queensland, *2022/23 State Budget Submission*. (2021).

Areas previously highlighted by COTA Queensland

In 2019 and 2020, we investigated and advocated for older people's needs across health services and supports in areas such as the National Disability Insurance Scheme (NDIS), aged care, and the role of carers.

National Disability Insurance Scheme (NDIS)

Recent studies have shown that for adults with disability the NDIS process is complex and there are sometimes missed opportunities, despite some elements of the Scheme working well.[4] We have heard directly from service providers who indicated that consumers have been responsive towards the NDIS model, and that family members feel part of a bigger picture e.g., family is involved in staff rostering, and in turn staff feel compelled to their best, for the consumer and their family as well. This was described as a '360' [degree] model of care. However, it was also noted that the role of consumers and their families is highlighted differently across the disability and mental health sectors (in comparison to aged care).[5]

In 2019, COTA Queensland noted that despite the positive outcomes from the disability reforms, that positive impacts were only experienced by those individuals who were able to navigate access to the (then new) systems.[6] Further, we uncovered that an individual's vulnerability was enhanced due to feeling overwhelmed or a sense of fear from their engagement with health system/s during the transition to the NDIS. From an individual perspective, areas of concern included self-directed care, health literacy, the importance of interpretation and use of language and having the communication skills to convey needs and have one's needs understood, individual responsibilities, feeling like they had to jump through hoops to get access to information and supports, self-advocacy, loss of supports, and maintaining quality of life.

From a system perspective, there were concerns around assessment and coordination of supports, gaps in service provision, service providers, system focus instead of a focus on the individual, accountability, consistency, and transparency, promised supports versus actual supports, and the impact of reforms on consumers.

Consequently, we recommended 'upstream' investment in targeted supports such as assistance for people to understand, access, navigate, and negotiate in and around the NDIS and Queensland Community Support Scheme (QCSS), and/or safety net of appropriate care and support during transitioning to these Schemes. We also recommended provision of support for cohorts who experience disadvantage and whose needs may evolve over time, and they become at risk of falling through the gaps (between systems – unseen, unheard), and the enablement of support from independent consumer focussed organisations.

Aged Care

COTA Queensland believes in aged care that has at is core a person and relationship-centred approach which recognises and encompasses holistic ageing (health and wellbeing – physical,

[4] Lloyd, J., K. Moni, M. Cuskelly, and A. Jobling, *National Disability Insurance Scheme: Is it Creating an Ordinary Life for Adults with Intellectual Disability?* (2021).
[5] COTA Queensland, *Opportunities for a people-centred future*. (2021c).
[6] COTA Queensland, *The Crushing Reality of Reform: A Consumer Perspective*. (2019a).

mental, social, and spiritual depending on the individual and their needs), and that service provision must reflect and be designed with diverse and unique needs of individual Queenslanders.[7][8]

According to the Older Person's Advocacy Network (OPAN), key advocacy issues for older persons this past year in and around aged care have included:

- COVID-19
- Abuse of older people
- Diverse and marginalised groups
- Commonwealth Home Support Program (CHSP)
- Home care packages
- Transition care, short-term restorative care, and respite
- Residential care
- Assessment services.[9]

Further, some of their recommendations, which are key to the cohorts that COTA Queensland work with, included:

- COVID-19 health directives e.g., the Department of Health to provide clear directives regarding residential aged care facilities and specific public health directives which therefore impact or not impact visitation and resident rights, and that these rights are upheld accordingly.
- Initiatives such as the Advocates as Agents pilot (where advocates become conduits between older persons and My Aged Care) to become an ongoing program.
- Training for staff including My Aged Care system (including assessment triaging, phone-based assessment as alternative medium of communication only when face to face is not possible, and assessment based on person's needs and not availability of service; role and scope of aged care advocacy); eligibility for specific cohorts such as First Nations people; communication needs of culturally and linguistically diverse cohorts (including the engagement with interpreters); roles and responsibilities of Enduring Powers of Attorney (EPAs)/Guardians and supports for people experiencing elder abuse by their EPAs/ Guardians; supported decision making; general consumer engagement skills; care planning; cultural awareness including culturally appropriate and trauma informed care; responding to challenging behaviours.
- Home care packages guidance for service providers, consumers and advocates regarding 'excluded' items in addition to the type of evidence required to justify the purchase of an 'excluded' item, and The Department of Health to introduce the pathway to having excluded

[7] COTA Queensland, *The Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee Inquiry into the Health Transparency Bill 2019*. (2019b).
[8] Recent feedback received from one consumer stated: *I've been asked to add my comments regarding moving into Aged Care Facilities and it's always negative. I would like to prove the naysayers wrong. I've been living in Aged Care for nearly seven years.* COTA Queensland, *Internal data.* (2021d).
[9] Older Persons Advocacy Network (OPAN), *The National Aged Care Advocacy Program 2020 – 2021. Raising the Voice of People Accessing Aged Care*. (2021).

items approved under certain circumstances, and this to be supported by the creation of a direct communication channel for advocates seeking advice on excluded items.[10]

COTA Queensland has previously commented in 2019 on the gaps in the aged care system[11] including:

1. Wait times and service availability

There was a clear preference for home care in Queensland, however, wait times for home care packages, suggested that demand was exceeding service availability (particularly demand not being met for higher-level packages of home care). Similar observations were noted regarding wait times and availability for residential aged care. We projected that service availability had to increase at a fast rate in order to maintain the 2019 service levels. Further concerns highlighted by COTA Queensland included the supply in aged care services in RRR communities and availability of services to meet the needs of diverse (and vulnerable) cohorts.

2. Navigation and administration of aged care system

We found that the aged care system was unnecessarily complex to navigate, and more focus and improvement was required on the quality and safety of services including consumer satisfaction, and the administrative charges for home care services.

3. Workforce

We also discovered that the aged care sector required skill development within its workforce.

4. Palliative care

We highlighted that service provision around palliation and end-of-life care were not sufficient in meeting Queenslanders' needs, and that there was a need for further dialogue about this type of care, including encouragement of planning ahead.[12]

5. Hospitalisation

We proposed that hospitalisations for older people should be reduced (and prevented).

6. Approaches to care

Overall, COTA Queensland surmised that aged care services in Queensland should focus on home-based and community-based approaches that make the most of the existing community support and technology that is already available.[13]

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[10] Older Persons Advocacy Network (OPAN), *The National Aged Care Advocacy Program 2020 – 2021. Raising the Voice of People Accessing Aged Care*. (2021).

[11] COTA Queensland. *The Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee Inquiry into the Health Transparency Bill 2019*. (2019b).

[12] We note that since these 2019 observations, the *Voluntary Assisted Dying Act 2021* has been passed by Queensland Parliament and will come into effect 1 January 2023, see Queensland Government, Queensland Health*, Voluntary Assisted Dying in Queensland*. (2021).

[13] COTA Queensland. *The Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee Inquiry into the Health Transparency Bill 2019*. (2019b).

Key priorities for the future that were identified in 2019 and which remain for 2022[14] include:

- User-friendly and accessible information which enables people to plan for the future and make well-informed decisions.
- Individuals, carers, family, and support network want to be involved in decision making processes that impact their loved one's life and their own lives.
- Government responses to aged care and end of life care require multi-layered response, and thus need to expand beyond standard healthcare and aged care systems.
- Close examination and sound arrangements for emergency situations e.g., in the evacuation of individuals during emergencies, natural disasters, etc. from aged care facilities.[15]

In Case study 1, we provide an example of one service provider and their diverse and multi-layered observations and insights into the future of aged care services and supports.

[14] COTA Queensland, *The Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee Inquiry into the Health Transparency Bill 2019*. (2019b).
[15] COTA Queensland, *The Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee Investigation: Closure of the aged care facility at the Earle Haven Retirement Village in Nerang*. (2019c).

Case study 1 – Service provider insights into the future of aged care services and supports[16]

The service provider is a community based and not for profit organisation which sits within the market of retirement communities, care centres and in home support services.

Broad observations and issues regarding aged care and factors which impact on ability to enact change

- Aged care sector getting the attention it deserves, which is positive; however, general perception of aged care sector especially in media during the COVID-19 pandemic exemplified need to have accurate representation and/or reframe
- Accommodation options for under 65 years of age e.g., rapid change in demographic going into residential aged care and accommodation needs to match demographic. Long-term government strategy to get younger people out of aged care system, and more funding and push to build appropriate facilities, but this will take time. Lack of accommodation options for older people due to people not listening to what is required. There is need for more practice standards and work on industry requirements
- Time for innovation and opportunities for transformation. Need to identify where the barriers exist (and confirm what they are), not just focus on regulatory framework. They feel positive about anticipated funding but feeling doubtful that actions will come to pass (and what is/will be adequately resourced)
- Lack of resources to implement change leads to increased frustration (rather than excitement about change)
    - without funding, how to undertake program development e.g., diversional therapy - two lifestyle people working with up to 60 residents
    - whole team seen as something additional rather than being central to care
    - qualified team with personalised and tailored programs for each person - not achievable under current model
    - expectations with restricted practice e.g., emphasis on reporting and documentation instead of having time to be present with consumer, work with them and meet their needs

Factors identified to ensure the workforce can deliver best possible consumer experience and outcomes

- Need more staff on the floor and higher wages (government funding required to offer required wages)
- Qualifications and upskilling of staff who are remunerated appropriately e.g., during pandemic the demand increased, offering more money than what could be paid. Campaign to increase wages is part of valuing people
- Dilemma - costs more to provide care than the funding that can be attracted from government; e.g.,
    - Catch 22 – Unable to pay higher wages, yet cannot place more staff on the floor if costs can't be covered
    - Instance of more funding made available but not as many places available, so funding gets spread out. Ability to pay to attract quality staff. A lot of staff undertake work for love rather than salary, but they are restricted by government funding.
    - Care hours funded by 'charity' not by government which is not unique to aged care industry
- Ageism part of reason there is lack of funding for workforce
- More (community) awareness and understanding regarding how funding works and implications
    - Australians reliant on taxpayer and government monies e.g., social benefits; change can happen if prepared to contribute personal monies or assets to meet needs
    - Structural change and additional funding in home care and traditional services required
    - Community attitudes
- Some lack of clarity, feelings of insecurity and uncertainty regarding how Aged Care Quality and Safety Commission recommendations are being implemented
- Workforce pressures and disappearing workforce which won't be resolved until people are remunerated appropriately, and other factors such as immigration.

Biggest issues experienced for the training and upskilling of staff

- Remuneration for training yet not having enough staff to cover shifts while staff undertake training
- Expectations are such that staff must fit in with training schedule, rather staff team schedule, so training expected to be undertaken at times on days off, or complexities in rosters makes training problematic
- Retention of trained and skilled staff in the organisation when they leave for better paid position.

[16] COTA Queensland, *Internal data.* (2021d).

Carers

The dialogue around the quality, accessibility and availability of services also highlights duty of care (which is recognised as a legal construct) and dignity of risk (which is not recognised as a legal construct), and how informal carers carry out these concepts within their roles. COTA Queensland has previously highlighted the role that family and community supports have in the provision of aged care and end of life care and supports. Family members may act as primary (informal and unpaid) carers.[17]

In 2018, 1 in 9 Australians provided unpaid care to individuals living with disability and older Australians.[18] An example of an informal care dyadic, are older adults caring for their adult children, or adult children caring for older parents. A recent study estimated the total value of the provision of mental health support provided by family and friends as informal carers.[19] The study estimated 8.4 billion Australian dollars (with informal mental health carers providing 186 million hours of support in 2018), and further estimation as high as 13.2 billion dollars in 'replacement cost'. These findings echo the ABS conclusions that informal carers provide substantial hours in care, in this instance, mental health supports which emphasises the importance of carers' roles and their contribution to the mental health system and increased need of support services for carers.[20]

Culture also plays an important part in the framing of care, particularly informal care. For example, an individual from a collectivistic culture who is caring for their older mother, may have different expectations around their care responsibilities, and a different approach to seeking further supports (if they are unable to continue provision of care), in comparison to someone from an individualistic culture. There is an assumption that individualist families may show a reliance on formal supports, while collectivist families may rely on the family network. Factors which may impact this include family ethics, levels of contact and interdependence, and caregiving practices and meanings. [21] This has been noted in specific care contexts such as dementia, where duty of care is viewed as a sense of obligation towards older parents in collectivistic cultures. Therefore, seeking out external or formal supports may cause a feeling or sense of shame, concern or guilt, or prolong the decision-making process around formalised care.[22]

The recent Older Persons Advocacy Network (OPAN) report[23] has indicated that as a policy framework there needs to be more focus on public education around the rights and responsibilities of substitute decision makers and of people who have substitute decision makers.[24] We also note the critical role of services such as the Government initiated Carer Gateway[25] in supporting informal carers and decision makers through information, counselling, forums, coaching and courses.

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[17] COTA Queensland, *The Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee Inquiry into the Health Transparency Bill 2019*. (2019b).
[18] Australian Bureau of Statistics, *Disability, Ageing and Carers, Australia: Summary of Findings*. (2019).
[19] Diminic, S., Y.Y. Lee, E. Hielscher, M.G. Harris, J. Kealton, and H.A. Whiteford, *Quantifying the Size of the Informal Care Sector for Australian Adults with Mental Illness: Caring Hours and Replacement Cost.* (2021).
[20] Diminic, S., Y.Y. Lee, E. Hielscher, M.G. Harris, J. Kealton, and H.A. Whiteford, *Quantifying the Size of the Informal Care Sector for Australian Adults with Mental Illness: Caring Hours and Replacement Cost.* (2021).
[21] National Council on Family Relations. *Caring More or Less: Individualistic and Collectivist Systems of Family Eldercare*. (1996).
[22] Hanssen, I., P.T.M. Tran. *The Influence of Individualistic and Collectivistic Morality on Dementia Care Choices*. (2019).
[23] Older Persons Advocacy Network (OPAN), *The National Aged Care Advocacy Program 2020 – 2021. Raising the Voice of People Accessing Aged Care*. (2021).
[24] Older Persons Advocacy Network (OPAN), *The National Aged Care Advocacy Program 2020 – 2021. Raising the Voice of People Accessing Aged Care*. (2021).
[25] Australian Government, *Carer Gateway*. (n.d.).

Health of older Queenslanders

In 2019, coronary heart disease, followed by dementia and Alzheimer's disease, and cerebrovascular disease, were leading causes of death for older Australians. Cancer had the largest fatal component, followed by infectious diseases and cardiovascular diseases. The health burden due to hearing and vision disorders, oral disorders and musculoskeletal conditions was largely non-fatal. It was also noted that chronic diseases such as cardiovascular and kidney diseases, certain types of cancer, type 2 diabetes, and high blood pressure are related to lifestyle factors; however, older Australians rated 'better' than younger Australians regarding behavioural risk factors such as less likely to smoke, but more likely to be overweight and physically inactive.[26]

In terms of mental health and wellbeing, the latest national report released by ABS suggests that as previous years, younger people (particularly 16 – 34 years) were more likely to experience high levels of psychological distress than older adults (defined by a 65 – 85 years age bracket). [27]

From 2019, we learnt from the Healthy Ageing: A Strategy for older Queenslanders,[28] that there were approximately 150,000 frail Queenslanders aged 65 years and over with 342,000 experiencing pre-frailty. We read that the older population grew by 47% in Queensland which was higher than the national rate of 38%. Further, chronic conditions cited were arthritis, vision and hearing impairments or issues, and high cholesterol. In 2019, 1 in 10 older adults (aged 65 years and over) had dementia which increased in those aged 85 years and over to 3 in 10 older adults. Further, older adults were more likely than younger persons to live outside of urban centres, with 40.1% of older Queenslanders living in regional and remote areas compared with 36% of those aged under 65 years of age. Despite assumptions that are often made about older people living on their own, 58% of older Australians continued to live with a spouse or partner compared with ¼ of older Australians who lived on their own. Those aged between 65 and 74 years of age were more likely to lived with someone else while those aged over 85 years of age were more likely to live alone. Further, due to the lower life expectancy of men, women were more likely to live on their own (31% lived alone compared to 18% of older men). Most older adults lived in private residences while only 5.7% lived in 'non-private dwellings'. [29]

In the State of the Older Nation (SOTON) survey,[30] Queensland respondents reported that they exercise more than 2 hours each week (including going for a walk and swimming) with 27% reporting more than 2 hours, and 23% reporting more than 5 hours. Seventeen percent indicated 1 – 2 hours of exercise per week. The remaining 33% reported less than one hour per week of exercise (with 6% indicated 31 – 59 minutes; 12% indicating up to 30 minutes; and 15% indicating no exercise).

Respondents indicated they undertook anywhere between one hour and up to 45 hours per week in unpaid work, volunteer work and care[31]. Caring activities were reported most often, with caring for a

[26] Australian Government. Australian Institute of Health and Welfare (AIHW), *Health of Older People.* (2020).
[27] Australian Bureau of Statistics, *First Insights from the National Study of Mental Health and Wellbeing, 2020-21*. (2021). This report presents findings from the first cohort of the National Study of Mental Health and Wellbeing (NSMHW), a component of the wider Intergenerational Health and Mental Health Study (IHMHS). These findings will be used to gain insights into mental health at a national level, including social and economic factors and how people utilise health services and supports. More findings are due to be released in June 2022, including statistics regarding depression and anxiety.
[28] Queensland Government. Queensland Health, *Healthy Ageing: A Strategy for Older Queenslanders*. (2019).
[29] Queensland Government. Queensland Health, *Healthy Ageing: A Strategy for Older Queenslanders*. (2019).
[30] COTA Federation, *The State of the Older Nation (SOTON) Report*. (2021).
[31] Some people indicated more than one response.

partner due to age, illness and disability as most frequently reported. For example, *caring for a partner due to age, illness or disability*, 27% of respondents did more than 21 hours per week (up to an average of 45 hours) per week. *Caring for your parent/s due to age, illness or disability,* 11% of respondents did 21 hours or more (up to an average of 45 hours) per week. *Caring for a non-immediate family member or non-family member,* 14% of respondents did more than 21 hours or more (up to an average of 45 hours) per week; and *Caring for any children of any age due to disability or illness,* 20% of respondents indicated 21 hours or more (up to an average of 45 hours) per week.

Key areas that were identified as getting better or worse[32] for older Queenslanders included:

- Rising cost of living (general) / difficult to make ends meet / financial stress (15%)
- Less opportunities / jobs for older people (as a result of COVID-19) (14%)
- Pension is not enough to live off / pensions have decreased / pensions have stayed the same (10%)
- Older people don't seem to matter / nobody cares / people don't respect older people / over 50 years of age is considered 'old' (8%)
- Healthcare is good or better and better services and medical advancement (8%).

Seventy-two percent of Queensland respondents felt younger and 13% felt older than their actual age. Most respondents rated their quality of life as very good to excellent (72%), 16% rated their quality of life as good, and 12% rated their quality of life as poor to very poor. Under half of respondents (43%) felt calm and relaxed about what the future held for them over the next year or two and 14% felt worried to very worried about what the future held for them over the next year or two.

On average 22% of Queensland respondents aged 50 years and over indicated that they were not content with their friendships and relationships. Five percent of Queensland respondents indicated they have not had contact with anyone in the last week. Approximately 8% of Queensland respondents reported they felt lonely all or most of the time. On average 15% of respondents did not feel welcome in their local suburb or town, 16% did not feel part of their community, and 21% felt like an outsider, and 20% felt they could not trust most people in their community.

Support from family and friends (57%) and exercising (57%) rated highly with Queensland respondents regarding what they found most helpful (personally) in supporting their mental health and wellbeing. Good nutrition (47%) was also identified as very important in maintain mental health and wellbeing, followed by maintaining hobbies (e.g. music, arts or crafts) (46%), connection with nature (41%), and use of technology to stay connected with family and friends (40%).

Also helpful to older Queenslanders was having pets (38%), consulting their regular (e.g. GP) or another medical practitioner (32%), and religious or spiritual connection (20%). The remaining aspects of life that were identified by as helpful included medication (18%), meditation or mindfulness practice (16%), and/or support from a psychologist, counsellor or other mental health professional (11%). Three percent of Queenslanders mentioned an external social support service

[32] In some instances, respondents indicated more than one response.

such as Telecross, Friendline, Community Visitor Scheme (2%), or a service such as the Red Cross (1%).[33]

Queensland health system

The State Government currently oversees the public hospital and health services through the Queensland Health system. The Federal Government along with private and non-government organisations oversee aged care and primary care services. Primary care services may include General Practitioners (GPs), nurses, nurse practitioners, dentists, community health centres, allied health (e.g., physiotherapist, social worker, podiatrist, pharmacist, speech pathologist, dietitian, occupational therapist), and platforms which enable use of technology for health consultations such as video consultations or telehealth services. Private and non-Government organisations oversee the private hospital services.

In 2016, it was identified that state health challenges included ageing population, chronic disease managements, consumer expectations and limited resourcing, in addition to the unknowns around future technology and treatments options[34] – these issues remain with us in 2021, and with the impact of the pandemic have become enhanced.

Chronic diseases in particular were projected to increase including the occurrence of diabetes with Queensland having had the highest rate of obesity for adults, and the primary causes of death including cardiovascular disease and cancer.[35] This echoes the ABS findings around mortality figures for older adults[36] and also touches upon the individual factors which may influence the prevention and mitigation of social isolation and loneliness which has been a focus of investigation in older cohorts during the pandemic.[37]

The Queensland Audit Office in their report *Planning for sustainable health services* provide a reminder that the health care system:

> *[…] does not operate in a vacuum. Factors such as income levels, education, social supports, and individual lifestyle choices and behaviours influence the health of individuals. Apart from seeking to influence lifestyle choices, addressing these factors is largely outside the responsibility of Queensland Health, but they can make a difference to the level of healthcare that Queensland Health needs to provide.*
>
> *Queensland Health is one part of the health system, working with others such as […] Health and Wellbeing Queensland, general practitioners, private hospitals, and aged care providers. In some instances, HHSs have partnerships with other providers within their region, but this can be enhanced. […]*

[33] COTA Federation, *The State of the Older Nation (SOTON) Report*. (2021).
[34] Queensland Government. Queensland Health, *My Health, Queensland's Future: Advancing Health 2026*. (2016). This resource was developed for across the lifespan with a consumer focus and wide consultation.
[35] Queensland Government. Queensland Health, *My Health, Queensland's Future: Advancing Health 2026*. (2016).
[36] Australian Government. Australian Institute of Health and Welfare (AIHW), *Health of Older People.* (2020).
[37] COTA Queensland, *It feels like the world is closing in on me.* Submission for Parliamentary Inquiry into Social Isolation and Loneliness. (2021b).

> *Long-term planning with other Queensland government agencies is another area that Queensland Health and other agencies can improve.* [38]

Despite the Queensland Audit's Office clear presentation of the Queensland Health system as three bodies – State Government – Department of Health and hospital and health services; Australian Government – primary health networks; and Private and non-government organisations, which oversee a range of services that are packaged up visually into 'public hospitals', 'private hospitals', 'aged care' and 'primary care' with slight overlap across roles and responsibilities including funding,[39] the reality of the health system is far more complex due to the administration and funding across multiple levels of government, non-government organisations and the private sector.[40] The following diagram from the *My Health, Queensland's Future: Advancing Health 2026* provides, what we propose, as a more realistic view of how current health services and supports operate in Queensland – overlapping, supporting each other, similar to a jigsaw puzzle. This jigsaw highlights the multiple roles and responsibilities of funding bodies and providers across several jurisdictions, and the consumer perspective and how their interaction with the health system/s is influenced by current funding including the subsidies to GP, medication, and hospital services.[41]

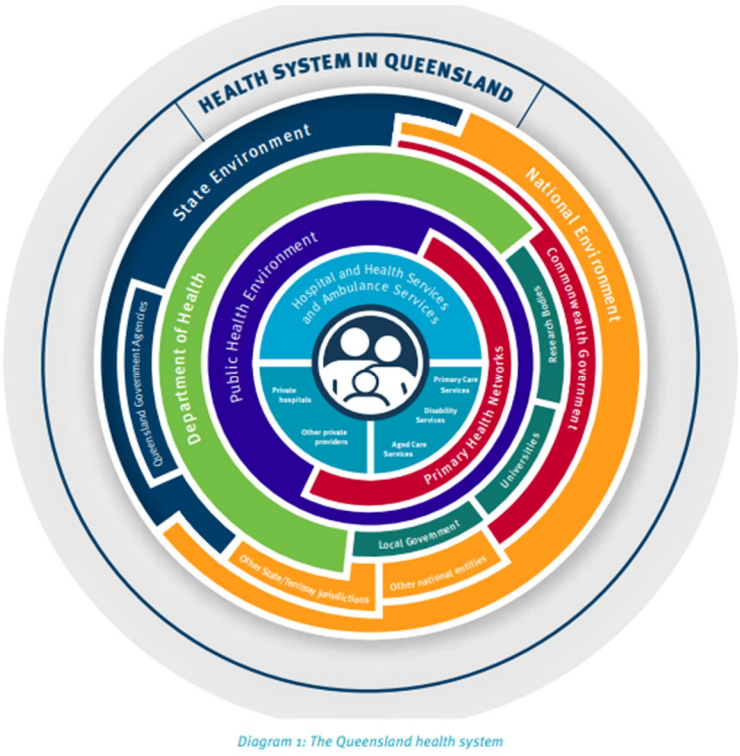

Figure 1. Diagram of the Queensland health system as captured in 2016 by the My Health, Queensland's Future: Advancing Health 2026.[42]

[38] Queensland Audit Office, *Planning for Sustainable Health Services (Report 16: 2020 – 2021)*. (2021a).
[39] Queensland Audit Office, *Planning for Sustainable Health Services (Report 16: 2020 – 2021). Appendix C. Overview of Queensland's health system*. (2021b).
[40] Queensland Government. Queensland Health, *My Health, Queensland's Future: Advancing Health 2026*. (2016).
[41] Queensland Government. Queensland Health, *My Health, Queensland's Future: Advancing Health 2026*. (2016).
[42] Queensland Government. Queensland Health, *My Health, Queensland's Future: Advancing Health 2026*. (2016).

Further, some of the principles from 2016 still hold in 2021, and with ongoing considerations of the pandemic, particularly new variants of COVID, three of the principles remain pertinent including sustainability, inclusion and empowerment:

- Sustainability to ensure the availability of resources are utilised in an efficient manner for now and for the future
- Inclusion to ensure responsive health systems with the goal of better health for everyone; this means meeting the health needs of all Queenslanders regardless of their background and life circumstances; and
- Empowerment to ensure that consumers remain at the centre of the planning and delivery and improvement to health services and supports, and through this process they are always making informed decisions around their own health care and of those they care about.[43]

Part of the aspirations outlined for 2026 were promotion of wellbeing where the model of health care is centered on wellness rather than illness and this would mean e.g., increased life expectancy for all including First Nations cohorts. Maintaining consumers at the core as partners, and increasingly bringing care into the home and away from the hospital, and patient data and insights are collated regularly and used to better inform practices, planning, and improve upon health outcomes (with benefits to consumers and health service providers), and this would mean that e.g., there would be successful delivery of a 10 year Health Workforce Strategy, and ensure that people receive clinical care within a reasonable time frame (regardless of their physical location). Further aspirations included sustainability around the funding model with involvement from local, state and Commonwealth governments and whole of government collaboration where each Department better informs and reinforces better health outcomes, some examples of this has been the Nurse Navigators who assist patients or clients through end-to-end care services for complex health conditions. Further measures of success included improving availability of digital data and information to health consumers and health professionals (to inform decision making), having support from digital platform primarily for clinical practices, increase technological consultations through telehealth models for outpatient care, decreasing the rate of hospital admissions for preventable diseases and conditions e.g., chronic disease management, and implementation of funding models for better connected health networks (and health outcomes). Finally, there were aspirations for innovation and research to be driven primarily by the health consumer, workforce and external industries, and change will be 'translated' and implemented into operationalisation of services.[44]

Budget considerations

The 2019 – 2020 Budget dedicated $1.1 billion to bolstering primary care services in addition to an earlier $512 million dedicated in support of doctors and specialists to deliver improved consumer access and outcomes. The Strengthening Primary Care package was co-designed with the Australian Medical Association and included $448.5 million in additional funding for doctors to support more flexible care models (rather than a Medicare fee-for-service model) to encourage prevention and management of chronic diseases, initially with a focus on persons aged 70 years and over. These initiatives were part of government investment of $6 billion in Medicare from $25 billion in 2018 –

[43] Queensland Government. Queensland Health, *My Health, Queensland's Future: Advancing Health 2026*. (2016).
[44] Queensland Government. Queensland Health, *My Health, Queensland's Future: Advancing Health 2026*. (2016).

2019, $26 billion in 2019 – 2020, $27 billion in 2020 - 2021 and $29 billion in 2021 – 2022, and $31 billion in 2022 – 2023 to support national health care.[45]

The latest report released by the Royal Australian College of General Practitioners indicates that government investment in primary care is decreasing (e.g., 36% in 2012 – 2013 to 33.5% in 2018 – 2019); however, general healthcare investment is projected to increase e.g., public hospital funding is doubling between 2020−21 and 2031−32.[46] For professions such as GPs, whose core role includes management of multiple morbidities for diverse cohorts (from babies, children through to older adults and frail adults), which leads to more complex care requirements, funding for general practice remains a key policy issue. However, the expenditure breaks down as only 7.4%, despite GPs providing twice the number of care 'episodes' per annum (in comparison to hospital but at 1/6 of the investment amount).[47]

Use of health services and key issue areas

In 2018, according to the Australian Institute of Health and Welfare[48], people aged 65 years and over were more likely (70%) to have seen a medical specialist for their own health in the last 12 months than people aged under 65 (59%). However, people aged under 65 years were more likely (51%) to have accessed dental services in the previous year than people aged 65 years and over (48%). Home support was accessed by more than 826,300 older adults (aged 65 and over and Indigenous Australians aged 50–64 years) in 2018 – 2019. In 2019, almost 183,400 older clients were in residential aged care and 105,200 were using home care services.[49] In 2018–19, there were over 36 million Medicare claims GP visits for people aged 65 years and over, which accounted for 29% of the total claims for GP visits (124 million claims). There were more than twice as many claims per person for those aged 65 years and over. [50]

From the State of the Older Nation (SOTON) 2021 survey, COTA Queensland uncovered multiple insights regarding older Queenslander's health and use of health services.[51] Fifty-two percent of older Queenslanders indicated that they do not have private health insurance and 2% were unsure if they had private health insurance or not. Forty percent indicated they had private health insurance (hospital and general/ancillary/extras cover) and 6% had hospital cover only.

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[45] Australian Government. Department of Health, *Australia's Long Term National Health Plan to Build the World's Best Health System*. (2019).

[46] Royal Australian College of General Practitioners, *General Practice Health of the Nation 2021*. (2021).

[47] Royal Australian College of General Practitioners, *General Practice Health of the Nation 2021*. (2021).

[48] Australian Government. Australian Institute of Health and Welfare (AIHW), *Health of Older People.* (2020).

[49] Australian Government. Australian Institute of Health and Welfare (AIHW), *Health of Older People.* (2020). *This included almost 104,200 people aged 65 and over, and 900 people aged 50–64 who identified as Indigenous, using home care; around 177,000 people aged 65 and over, and around 360 people aged 50–64 who identified as Indigenous, living in permanent residential care; round 5,900 people aged 65 and over, and almost 20 people aged 50–64 who identified as Indigenous, living in respite residential care. National Aboriginal and Torres Strait Islander Flexible Aged Care Program provided culturally appropriate care for Indigenous people in locations close to their communities.*

[50] Australian Government. Australian Institute of Health and Welfare (AIHW), *Health of Older People.* (2020).

[51] COTA Federation, *The State of the Older Nation (SOTON) Report*. (2021). Queensland respondents totalled n = 458. Queensland provided the third largest group of respondents for the national survey after New South Wales (n = 568) and Victoria (n = 557). Most respondents were aged between 55 years and 74 years. The remaining respondents identified as being from the 50 – 54 years cohort, followed by 75 – 79 years; and then 80 – 84 years, 85 – 89; one individual indicated they were aged between 90 – 94 years of age. Over half of the respondents lived in regional Queensland (n = 245), while the remaining respondents (n = 213) resided in metropolitan areas in the Brisbane region. Just over 80% of respondents came from 1 – 2 person households, approximately 15% of respondents came from 3 person or 4 person households, and under 5% came from households with 5 people or more.

Many respondents (66%) indicated that it was *not difficult* at all for them to access the health and medical services they require. Eleven percent indicated it was relatively difficult for them to access services (due to e.g., personal, physical, financial or for any other reasons), and 8% indicated that it was somewhat to very difficult to access services. Four percent indicated that it was extremely difficult to access health and medical services.

Thirty-nine percent indicated (again) that they had no specific difficulties in accessing health and medical services. The top five reasons listed as difficulties in accessing health and medical services were (in order): long waiting list; the cost of services; the distance to travel to access services; impact of COVID-19 restrictions; and the cost of medication.[52] Further, other reasons listed as barriers to accessing services (but listed less frequently) were cost or access to transport; lack of availability of suitable services; concern or embarrassment about requesting help; technological access to services such as Telehealth; or something else.

COTA Queensland is aware of the recent Senate petition regarding upcoming funding changes to allied health services which will impact on access and affordability of allied health services for older people. As of October 2022, the government will not longer fund allied health services within nursing home facilities.[53] Allied health professionals are key to maintaining physical wellbeing, particularly in the management of chronic disease, post-surgical recuperation, and daily capacities for participation for older people. As shown by the Queensland registration of employed health professions, physiotherapists number the highest in terms of allied health professions, which indicates the needs for their services in local communities.[54]

Older and more frail residents in facilities without access to allied health professionals will be at risk of experiencing more pressure injuries, physical pain (and therefore effects from pain medication), and more change of hospital admissions (which could otherwise be preventable). Overall, it is anticipated this will cause more financial and emotional stress to the older individual and their families, the workforce, the facility, and the hospital system.[55] The Change.org petition calls for funding to make sure each individual in a nursing home facility receives as at minimum 20 minutes daily of physiotherapy and/or allied health service beyond October 2022.[56]

As highlighted by the Queensland Audit Office (QAO),[57] access to specialist outpatient services has become problematic despite improvements such as newer systems equating to more efficiency particularly in the area of administrative processing, system integration, and quality referral processes. Further, alternate models of care increasing capacities of the public health system and provision and access to more responsive services, which has led to decreased wait times in some specialty areas. However, it was noted that they need to be utilised widely to improve capacity and enhance the benefits. For example, it was indicated that patient-centred care was improved through access to some specialised services.

However, the report also showed that more engagement from GPs is required, particularly in relation to digital referrals, which can impede efficiency of the system. Further, demand for service is higher than what is available, particularly for non-urgent cases, and this has been impacted by the

[52] Respondents indicated more than one response.
[53] Change.org, *Nursing Home Health Services Cut*. (2021).
[54] Australian Government. Department of Health, *Summary Statistics, State. Queensland, Registered and Employed in Australia, 2020*. (2021b.)
[55] Change.org. *Nursing Home Health Services Cut*. (2021).
[56] Change.org. *Nursing Home Health Services Cut*. (2021).
[57] Queensland Audit Office. 2021c. Improving access to specialist outpatient services (Report 8: 2021 – 22). https://www.qao.qld.gov.au/reports-resources/reports-parliament/improving-access-specialist-outpatient-services

pandemic and the additional stress on the health system.[58] Despite access to systems and system improvements, recommendations for further improvement included: GP engagement (and PHN engagement to identify training required and implement required training and support as part of implementing wider use of GP digital/electronic 'smart' referrals), embedding care models (working with hospital and health services to implement evidence-based innovative care models, and implement health solutions statewide, and implement non-urgent referrals where clinically indicated), releasing capacity (demand exceeding workforce availability and capacity), and addressing pressure points in the system (and early intervention; this is despite access and system improvement, long wait times steadily increasing, development of objectives for the future including *Connecting your Care* project, in order to examine whether or not the benefits have been achieved).[59] The Director-General, Dr John Wakefield further highlighted the current state of specialist outpatient services:

> *[…] the complexity of patient conditions is increasing, and it is becoming increasingly difficult for complex conditions to be managed in the primary care and community care setting within the current system structures. […] a lack of understanding and community between primary and acute care settings and no clearly defined healthcare pathways out of our public hospitals has led to a culture that supports rescheduling of reoccurring specialist and outpatient review appointments. Combined, these factors are driving increased utilisation of, and reliance on, public outpatient and specialist outpatient services for conditions that would be more appropriately managed within the primary and community setting.*[60]

GPs play a key yet often unacknowledged role in caring for older people in residential aged care facilities and local communities. Less than one in five GPs has worked in aged care facilities in the past month (approximately in the November 2021 period), and 56% of those GPs said they were unlikely to wish to work in this environment. [61] People aged 65 years and over account for 16% of the Australian population but represent *nearly 30%* of all general practice consultations. However, GPs have indicated that they would require e.g., better remuneration via MBS item numbers for aged care, less administrative issues, more clinical staff in aged care settings, improved infrastructure with software, and better qualified staff to practice in aged care settings.

A third of GPs reported that over 75% of their clients have multiple chronic conditions, and four out of five GPs reported that clients often have most of their mental health supports provided within a general practice environment. Almost two-thirds of GPs reported that physical and mental health conditions are treated concurrently, and aged care services are the fourth-highest priority health policy area among GPs. Therefore, ensuring access to adequate primary care across diverse care settings is important.[62]

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[58] Queensland Audit Office, *Improving Access to Specialist Outpatient Services.* (2021c).
[59] Queensland Audit Office, *Improving access to specialist outpatient services*. (2021c).
[60] Director-General, Department of Health, *Appendix A. Entity responses. Comments received from Director-General, Department of Health*. (2021).
[61] Royal Australian College of General Practitioners, *General Practice Health of the Nation 2021*. (2021).
[62] Royal Australian College of General Practitioners, *General Practice Health of the Nation 2021*. (2021). "*We know people with dementia entering the aged care system are less likely to experience an increase in prescriptions for medications like antipsychotics if they retain a relationship with their usual GP. […] Helping GPs […] helping older people in aged care is essential. It is also important to remember that GPs are the only medical practitioners that specialise in managing patients with multiple health conditions. Almost three-quarters of GPs surveyed reported that most of their patients have multiple medical conditions […] [and] who are at heightened risk of ending up in hospital, we must change how we structure general practice funding. […] Medicare discourages GPs from treating almost one condition in the same consultation. It is vital that we remove this barrier and incentivise longer consultations to support comprehensive care by GPs."*

We also draw attention to key areas highlighted at the COTA National Policy Council workshop:

- Complexity in navigating and understanding origin and provision of funding for health services and supports (e.g., which fall under Federal Government responsibility, and which fall under State Government responsibility), and accurate data and identification of older cohorts who are missing out
- When there are gaps in service provision, who is responsible for meeting needs ('picking up the slack'?). What is the knock-on effect of this on local staff and resources e.g., limited number of allied health professional to meet local community needs
- Actual current state of service provision (accessibility and availability) versus assumed state of service provision, and factors which impact this understanding of local community needs e.g., capture of accurate data (community members' experiences versus publicly available data); community attitudes and feedback regarding service provision; availability of workforce and impact on perception of current service provision, etc.
- Better understanding of how local resilient RRR communities engage with services available, and what they do when there are no services available (their other supports; how they live with no supports; how they access limited supports; their workarounds with no to limited services and supports), particularly rural and remote communities
- Balance of private and public health system 'traffic' and the impact of one system on the availability of service provision in the other system. For example, a recent policy issue cited across states and jurisdictions from the COTA perspective has been dental health for older adults[63]

COVID-19 impact

The recent $200 million funding provided in preparation for anticipated rise in cases of the Omicron variant in Queensland indicates the State Government's commitments to easing the pressure on health systems impacted by ongoing management of COVID-19. It is also a reminder of the unique climate we currently find ourselves in – in the review and assessment of the state of health in Queensland.[64]

COTA Australia has acknowledged the internal resources such as resilience that individuals and communities have shown throughout the pandemic. This resilience has been created over time, and they are keen to learn more about these skills and experiences from older adult aged 75 years and over as to how they have navigated the pandemic. They plan to use this opportunity to explore further around mental health and wellbeing impacts, supports, and hopes for the future. They will use this data to inform work with the National Mental Health Commission to improve national response to current future crises.[65]

Eighteen percent of Queensland respondents in the SOTON survey indicated they were affected personally by coronavirus either socially, financially, physically, mentally or by another way, and 11%

[63] COTA Federation, *National Policy Council Workshop.* (2021).
[64] ABC News, *Queensland Hospitals Given $200m Funding Boost Amid Forecast COVID-19 Case Surge*. (2021).
[65] COTA Australia, *Your Pandemic Story*. (2021).

were highly to extremely affected by the pandemic. Queenslanders over 50 years of age reported that multiple things had changed for them personally, in comparison to before the pandemic, including a decrease in their personal income (this impacted 20% on average), their ability to pay rent or a mortgage on time (20%), the number of work hours (19%), household income (18.5%), physical exercise (18.5%), and volunteer hours (14.5%). The following things had also changed for respondents including an increase in the use of technology (17.5% on average), increase in visits to the specialist and allied health professionals (17.5%), visits to their General Practitioner (GP) (17%), and an increase in use of telehealth options (17%).[66]

Aged and Disability Advocacy (ADA) Australia have recently highlighted issues in aged care due to impact of the pandemic, particularly around interstate services and advocacy e.g., refusal of unvaccinated workforce; personal care issues and running out of food; separation from family and support network due to isolation; access to home testing kits and vaccinations. Further issues included safe access to hospital and respite care, in person ACAT assessment, burden on hospital and community services, digital literacy and access to COVID vaccination evidence, communication issues around fear and the unknown, and utilising digital technology daily. [67] These are issues Queensland needs to keep front of mind in aged care sector particularly with anticipated surge in cases of the Omicron variant into the year 2022.[68]

Further COVID-19 related and (most) common complaints within aged care from September 2020 and March 2021 included visitor restrictions, prevention, and preparedness, retaining quality of care, impact on other vaccination schedules such as the flu, and planning around next steps with positive COVID test results.[69] Within residential aged care services specifically, issues included visitor restrictions; provision of essential support by visitors and partners; services to be mindful of applying "just in case" restrictions or lockdowns when it is not indicated; and service expectation around safe visitation. In terms of individual wellbeing, the monitoring of physical conditioning and psychosocial wellbeing; and maintenance of routines for residents. Within home care services, issues or considerations include the safety and continuity of care; ongoing communication and reassurance for those receiving care; staff training for personal protective equipment; mindfulness around 'footprint' of staff visits; and COVID regulations around reporting symptoms, and contingency planning for any disruption to staff schedules.[70]

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[66] COTA Federation, *The State of the Older Nation (SOTON) Report*. (2021).

[67] ADA Australia, *Consumer Rights in a COVID-19 World*. (2021).

[68] ADA Australia, *Consumer Rights in a COVID-19 World*. (2021). It is also important to keep front of the mind the following aged care considerations around rights such as safe and high quality care and services; receiving services in a safe manner; flexibility and adaptability as required; not just physical but also emotional care and wellbeing; being treated with dignity and respect; ensuring the older person feels validated and involved throughout processes; being informed about services and understanding service provision and rights; ensuring face to face communication where possible; consider communication and any possible issues (and workarounds). It is also important that older adults have control over and make choices about their own care including their personal and social life, and when the choices involve personal risk. They also need to ensure individual needs and preferences are heard, and the consideration of diverse communities and vulnerable cohorts. Further need to ensure that there are appropriate advocates, and that the individual has chosen these advocates to support them and speak on their behalf. This means plan, communicate and reassure, acknowledge and respect individual circumstances, and needs and other supports as required, conduct regular check ins, and adapt.

[69] Australian Government. Aged Care Quality and Safety Commission, *Regulatory Response to COVID-19 in Aged Care*. (2021).

[70] Australian Government. Aged Care Quality and Safety Commission, *Regulatory Response to COVID-19 in Aged Care*. (2021).

It is important to note that primary care services administered more than half of all doses during the first five months of the COVID-19 vaccine rollout. [71] Assumptions, however, continue to be made about the 'universal' vaccine coverage across Queensland.[72] We have heard that the clinical networks in Queensland are doing a lot of work with RRR communities, particularly Aboriginal and Torres Strait Islander communities with clinicians, doctors, and medical professionals with direct engagement and messaging around COVID care/vaccinations/precautions while carrying out vaccinations. We are also being told to be realistic in preparedness for COVID surge of cases and for factors which may compound this such as extreme weather events, emergency and disaster management, higher rates of hospitalisation, and greater use of primary and clinical care services. We are also reminded to be compassionate and responsive as much as possible in the weeks ahead. Upcoming focii for individuals and their interaction with health systems have been identified as e.g.,:

- Immuno-compromised and their regular ongoing supports and access to services
- Income supports for families and individuals if left without work due to prolonged lockdown/impact of having COVID etc.
- Who has access to their daily/weekly/monthly services and supports and how will this change once COVID cases surge
- Plan now e.g., food, medication, key support network, wider health supports, and key contacts especially during periods of isolation
- As a consumer talking now to care providers, allied health professionals, community organisations and service providers re: upcoming changes with COVID
- Limit exposure to vulnerable family members and loved ones but think about how you can support them virtually and in other ways or who else will step in as supports if you can no longer assist
- Have a 'phone a friend' in place; having conversations with someone you trust
- As much as possible, complete regular or required appointments and treatments now ahead of COVID e.g., dental, allied health appointments; treatment plan move forward if possible; secure medications or scripts; etc.
- Remember that services will continue for those who need them but there are unknowns re: how it will impact QLD Health services and supports
- Remember social connection but balance between being with others and taking precautions/limiting exposure as cases surge
- COVID care GPs – those GPs who have put their hands up for virtual care and those GPs who have indicated they don't wish to be COVID care GP. It is important for individuals to check in now with their GP to determine if they will offer COVID virtual care or not.[73]

[71] Royal Australian College of General Practitioners, *General Practice Health of the Nation 2021*. (2021).
[72] Health Consumers Queensland (HCQ), *COVID is Coming to Queensland – Are you "Storm-ready"?* (2021).
[73] Health Consumers Queensland (HCQ), *COVID is Coming to Queensland – Are you "Storm-ready"?* (2021).

Case study 2 – COVID vaccination mandates and social inclusion and participation

Brian works for an organisation that has older people as part of their target cohort. They described 'casting a net wide' to seek advice or support regarding COVID vaccination mandates ahead of the interstate borders opening. The individual expresses concern regarding the interpretation of the mandates by their regular consumers, who hold diverse views regarding the COVID vaccination, and the problematic nature of maintaining membership and participation when there are diverse views in the community regarding vaccination. Due to the nature of their organisation's work, they are also conscious of their role in the prevention and mitigation of social isolation and loneliness and are aware of potential implications for those unvaccinated or those vaccinated and hesitant to be out and about in the community.

Case study 3 – COVID vaccination mandates and digital literacy

Samantha voiced concern over vaccination mandates, specifically the linking of vaccination certificates to Medicare accounts through myGov, and via QR type apps on smartphones. Samantha is 75 years of age and identified as being highly educated and health literate family. Her husband, brother and sister, also in their seventies, having received higher education and through their previous professional roles, identify as having high computer literacy and sound digital literacy, using the internet and smart devices throughout their daily and professional lives. They all found the linking of evidence to myGov accounts (via desktop compute and via apps on smart devices), cumbersome and often taking up to three hours to complete (for themselves or on behalf of others, when they became frustrated or their was time sensitivity).

Samantha originally contacted Services Australia, after receiving advice that they may be able to assist with the technological steps for linking vaccination evidence. Services Australia were helpful in their guidance, and Samantha ended up setting up required evidence for her husband.

Samantha's high health literacy is in part due to previous professional roles held in not-for-profit type organisations often within the aged care industry. When Samantha investigated alternatives for online evidence for her husband, she discovered that there would be a 10 - 14 day wait for a hardcopy vaccination certificate. She was concerned about there being no immediate provision of physical vaccination certificates and felt that there was a gap in advice and assistance, which she viewed as a government responsibility.

Samantha had contacted news stations to raise awareness regarding this barrier with the vaccination mandate to highlight the invisibility of older persons and the expectations and reliance on digital technology to comply with the mandates. Samantha's main concern was for older persons living on their own who have no relatives to assist them with this process, or with the information around changes to mandates and regulations following interstate border openings. She felt some Seniors would be left isolated without assistance and that it would be "absolute neglect", and/or they would be too fearful to leave their homes and be out in the community e.g., they may not know that they are safe to visit essential services to run errands and go grocery shopping. She felt with Media coverage, older people would be reassured that they are not alone, and that there is assistance for those wishing to comply with the vaccine mandates, particularly for those who are already fully vaccinated.

Workforce

The Inquiry briefing 29 November 2021 highlighted that the Queensland health system is stretched, and this is due to multiple factors including but not limited to e.g., geography, service gaps, impact of the pandemic, and general inequity, particularly in regional, rural and remote communities. Primary Queensland Health services are often used as a last resort for health care in these communities. Chronic disease management, in addition to mental health, specialist outpatient and emergency services, for example, are key areas which require more attention.

Communities continue to experience issues around accessibility and availability of health services across primary, allied health, disability services, and across aged care services. The Inquiry briefing further revealed that in terms of primary health care supports, there was, for example:

- 1 General Practitioner (GP) for every 766 people in metropolitan communities
- 1 GP for every 1160 people in rural communities
- 1 GP for every 1428 people in remote communities.[74]

For many, the pandemic has changed the way they access health services, and for primary health professions, such as GPs, it has changed service provision. For example, in March 2020, telehealth Medicare Benefit Scheme (MBS) item numbers were expanded to include virtual care. Telehealth was previously available for e.g., enabling access to care for rural and remote communities. Then in October 2020 these items new numbers were restricted claims by GP practices in identified COVID-19 'hotspots'. Between 2019 to 2020, GP related MBS telehealth items jumped from 0.05 million to 36.96 million, which, in turn, corresponded with the decrease in standard consultations from 100.86 million to 77.99 million.[75]

This has led to telehealth services becoming a permanent component of national healthcare following its importance throughout the beginning of the pandemic.[76] COTA Queensland's community engagements have also indicated the importance of telehealth in RRR communities, and its role in healthy ageing communities in general. We have heard, however, that telehealth has been challenging for some services e.g., follow up access to appropriate equipment on time. Western Queensland PHN reported connectivity and patient literacy were barriers to successful implementation, with supports such as hardware, software and training required. Both GPs and consumer reports suggest that telehealth is effective for consumers and although not a direct substitute for in person consultations, it can complement other services, including other digital services via the internet for access to informational supports e.g., Medicare and service availability.[77]

From the summary of 2020 statistics published by the Department of Health, it is clear there is a decrease in availability of key primary care services across multiple professions (who are listed as registered and employed in Australia).[7879] A comparison across several health professions and those undertaking full-time work schedules in Table 1. show that e.g., supports tends to decrease according to area of remoteness, except for Aboriginal and Torres Strait Islander Practitioners where the number of practitioners is highest in outer regional areas followed by very remote areas. Another observation is the sudden decrease in numbers between outer regional and remote (e.g., Dental Practitioners); or between a major city and an inner regional area (e.g., Medical Practitioners); or between inner regional and outer regional areas (e.g., Medical Radiation Practitioners). The lowest number recorded by profession with available data were optometrists. The Queensland workforce, depending on the profession, accounted for roughly 18.5% - 25.5% of the national workforce.

[74] Health and Environment Committee. Queensland Parliament, *Inquiry into the Provision of Primary, Allied and Private Health Care, Aged Care and NDIS Care Services and its Impact on the Queensland Public Health System*. (2021).
[75] Australian Government. Department of Health, *General Practice Workforce providing Primary Care services in Australia. General Practice Workforce Commentary – 2020 Calendar Year*. (2021d).
[76] ABC News. *Telehealth services to become a permanent part of healthcare system, following COVID-19 success*. (2021b).
[77] COTA Queensland, *2022/23 State Budget Submission*. (2021a).
[78] Australian Government. Department of Health, *Summary Statistics, Remoteness Area*. (2021c).
[79] Australian Government. Department of Health, *Summary Statistics, State.* (2021b).

Table 1. Comparison of example health professions in Australia which decrease in numbers according to area of remoteness

Profession	Number	Full-time employment	Area
Aboriginal and Torres Strait Islander Health Practitioners	112	118	Major city
	107	108	Inner Regional
	177	**192**	**Outer Regional**
	97	107	Remote
	121	**134**	**Very remote**
Total (national)	**614**	**659**	
Total (Queensland)	***118 (19.5% of national workforce)***	***123 (18.5% of national workforce)***	
Dental Practitioners	17,113	15,301	Major city
	3,090	2,890	Inner Regional
	1,136	**1,054**	**Outer Regional**
	130	**124**	**Remote**
	53	54	Very remote
Total (national)	**21,522**	**19,423**	
Total (Queensland)	***4,520 (21%)***	***4,209 (21.5%)***	
Medical Practitioners	**83,147**	**84,782**	**Major city**
	14,868	**15,156**	**Inner Regional**
	5,818	6,225	Outer Regional
	913	1,005	Remote
	432	492	Very remote
Total (national)	**105,178**	**107,660**	
Total (Queensland)	***21,785 (20.5%)***	***22,168 (20.5%)***	
Medical Radiation Practitioners	12,094	11,160	Major city
	2,433	**2,212**	**Inner Regional**
	748	**710**	**Outer Regional**
	74	71	Remote
	26	28	Very remote
Total (national)	**15,375**	**14,110**	
Total (Queensland)	***3,290 (21%)***	***3,131 (22%)***	
Nurses and Midwives	253,817	221,915	Major city
	62,690	53,782	Inner Regional
	26,413	23,549	Outer Regional
	4,056	3,877	Remote
	2,506	**2,626**	**Very remote**
Total (national)	**349,482**	**305,749**	
Total (Queensland)	***73,929 (21%)***	***65,151 (21.5%)***	
Occupational Therapists	16,884	15,026	Major city
	3,296	2,848	Inner Regional
	1,289	1,160	Outer Regional
	159	148	Remote
	69	72	Very remote
Total (national)	**21,697**	**19,254**	
Total (Queensland)	***4,451 (21%)***	***4,029 (21%)***	
Optometrists	4,267	3,691	Major city
	859	797	Inner Regional
	276	258	Outer Regional

	22	23	Remote
	--	--	Very remote
Total (national)	**5,424**	**4,769**	
Total (Queensland)	***1,140 (21%)***	***1,020 (21.5%)***	
Pharmacists	20,784	18,976	Major city
	4,011	3,727	Inner Regional
	1,670	1,596	Outer Regional
	218	226	Remote
	93	98	Very remote
Total (national)	**26,776**	**24,623**	
Total (Queensland)	***5,455 (20.5%)***	***5,074 (20.5%)***	
Physiotherapists	24,622	22,526	Major city
	4,152	3,761	Inner Regional
	1,441	1,337	Outer Regional
	185	176	Remote
	105	108	Very remote
Total (national)	**30,505**	**27,908**	
Total (Queensland)	***6,155 (20%)***	***5,761 (20.5%)***	
Podiatrists	3,865	3,588	Major city
	916	861	Inner Regional
	242	231	Outer Regional
	32	31	Remote
	20	18	Very remote
Total (national)	**5,075**	**4,729**	
Total (Queensland)	***913 (18%)***	***887 (18.5%)***	
Paramedicine Practitioners	10,469	11,919	Major city
	4,174	4,825	Inner Regional
	2,021	2,526	Outer Regional
	315	449	Remote
	211	322	Very remote
Total (national)	**17,190**	**20,041**	
Total (Queensland)	***4,488 (25.5%)***	***5,280 (25.5%)***	
Psychologists	26,162	22,315	Major city
	4,014	3,359	Inner Regional
	1,197	1,072	Outer Regional
	145	128	Remote
	67	63	Very remote
Total (national)	**31,585**	**26,937**	
Total (Queensland)	***5,811 (18.5%)***	***5,172 (19%)***	

Note: '—' = not published due to data confidentiality.

COTA Queensland observes that local governments are good advocates for their communities, and there is a potential a regional government model where individual community needs particularly around availability, accessibility of services and workforce change required could be gauged more accurately. We are aware in many RRR communities where Queensland Health provides much of the primary health services and there are 'fly-in' specialists and visiting clinics, however, more insights and data are required around the ratio of primary services provided by Queensland Health and provision of services by independent specialists, and a comparison of this RRR data to metropolitan areas. We are also aware that many community members are accepting that e.g., travel is always required or long waits to see specialist or required services, or they have lower expectations regarding service provision in their local area (and observation that it is common that there are no market-based mechanisms in the local area – the 'last resort' factor). This is where telehealth comes into play as a key resource. In regional areas where there is some more access to services, there may

be community attitudes of where people do expect more accessibility and availability of services because they have some insight into what that looks like, but it still doesn't meet local needs of the community and individuals, for example.

Initiatives such as the Nurse Navigators (within aged care and NDIS system interaction) are key in RRR communities, even though they don't undertake direct support for e.g., referrals. There is a sense that some of these initiatives pick up the work of the federally funded programs. We view a subsidised model (and cross-subsidised as required) as being key to provision of more balanced equitable health services within e.g., statewide or regional health service environments.

Other examples COTA Queensland is aware of is where Queensland Health is picking up the demand in RRR communities for people with significant disabilities e.g., they live in Queensland Health facilities with complex disabilities, and families are reluctant to move them. And again, in the aged care and community care spaces (and NDIS), the question of adequate funding for services to accommodate extra costs for delivery of services in RRR communities, and this puts pressure on the local workforce and makes it e.g., harder to recruit, hay to pay more for qualified staff, or offer more work hours to attract the staff required, inclusion of travel costs, and similar issues. They may or may not have backfill in some instances when they are an aged care provider, for example. This has been evidenced by figures which indicate health workforce shortages.[80]

Therefore, Queensland Health often moves beyond acute health provision but messaging in and around facilities and in local communities can sometimes be mixed or different as to what is and can be provided.

Priority cohorts

The Aged Care Quality and Safety Commission require greater insight into the needs of diverse and marginalised cohorts, including Aboriginal and Torres Strait Islander communities, which will come through engagement in cultural competency and inclusiveness in the planning and co-design of services (generation, implementation, and delivery).[81]

In 2019, it was noted that Aboriginal and Torres Strait Islander cohorts aged 45 – 64 years were referred to as 'young old people' due to higher mortality rates (four times that of the average Australian) in addition to higher burdens for morbidity and disability including dementia. In the 'older-old people' cohort (aged 75 years and over), they had higher levels of dementia and disability. LGBTIQ+ cohort was referred to as an 'emerging' cohort and 25% of Queenslanders identified themselves as culturally and linguistically diverse, with 10.7% being born in non-English speaking countries. [82]

COTA Queensland notes that in some key reports, diverse cohorts who experience ongoing inequities are often 'left out' of the datasets. A recent example is the ABS study on mental health and wellbeing where it was stated that those excluded in the data collection included:

[80] Australian Government. Australian Institute of Health and Welfare (AIHW), *Rural and Remote Health*. (2020c). *Australians living in remote and very remote areas experience health workforce shortages, despite having a greater need for medical services and practitioners with a broader scope of practice […] for nearly all types of health professions there is a marked decline in the rate of clinical full-time equivalent (FTE) practitioners per 100,000 population once outside major cities.*

[81] Older Persons Advocacy Network (OPAN), *The National Aged Care Advocacy Program 2020 – 2021. Raising the Voice of People Accessing Aged Care*. (2021).

[82] Queensland Government. Queensland Health, *Healthy Ageing: A Strategy for Older Queenslanders*. (2019b).

- *visitors to private dwellings […]*
- *people who usually live in non-private dwellings, such as hotels, motels, hostels, hospitals, nursing homes and short-stay caravan park (people in long-stay caravan parks, manufactured home estates and marinas are in scope)*
- *people in very remote areas*
- *discrete Aboriginal and Torres Strait Islander communities.*

The exclusion of persons living in very remote areas and discrete Aboriginal and Torres Strait Islander communities is unlikely to impact on national estimates and will only have a minor impact on any aggregate estimates that are produced for individual states and territories, except the Northern Territory where the excluded population accounts for around 21% of persons.[83]

This suggests that the cohorts we have spoken about previously e.g., inaccessible or experiencing inequities in terms of housing, transport, lower socio-economic background, transient due to chronic health conditions/domestic violence, etc. are potentially not captured.

An example of an initiative from Brisbane North and Brisbane South PHNs regarding improving accessibility to and supports around COVID-19 vaccination, especially for some of the priority cohorts (that were identified earlier): culturally and linguistically diverse, First Nations, those without Medicare eligibility, those experiencing disability, homelessness, and those who are house bound.[84]

In the SOTON 2021 report, a higher vulnerability group was identified as female, aged over 70 years, living in Queensland and outside capital cities. Higher vulnerability has increased since 2018. Higher vulnerability indicators included:

- **Having a low personal annual income** (< $30,000k per capita)
- **Living with a disability**
- **Speaking a language other than English at home**
- **Bereaved in the past year**
- Indigenous
- Experienced domestic violence in the past year
- Experienced homelessness in the past year

The indicators in bold have been identified in the wider literature as being factors or causes that contribute to social isolation and loneliness.[85]

Individual insights across interaction of aged care, private and public health systems

We provide case studies across the interaction of aged care, private and public health systems. Our final recommendations speak to these type of lived experiences from individual and communities regarding the interaction with multiple health systems and supports for complex conditions, one-off health events, or for longer-term care needs for loved ones, for example.

[83] Australian Bureau of Statistics, *First Insights from the National Study of Mental Health and Wellbeing, 2020-21*. (2021).
[84] Brisbane North PHN, Brisbane South PHN, *Pathways for vaccinating Greater Brisbane's vulnerable people*. (2021).
[85] COTA Queensland, *It feels like the world is closing in on me.* (2021b)

Case study 4 – Specialist service provision across public and private health systems

Malcom is in his early eighties and has Chronic Obstructive Pulmonary Disease (COPD). He was told by a hospital doctor of his diagnosis and visited is local GP to learn more about what COPD is. The GP provided a brief outline, and Malcolm sought further information from the Lung Foundation where he felt he learnt so much. He also undertook an eight week rehabilitation course and met other people with the same condition. He has become close to this COPD community and a few years later, they still meet up once per month. This group would appreciate follow up rehabilitation to continue to improve their wellbeing but this service is not available.

Malcolm feels that by ensuring follow up courses the community benefits from the up to date information and treatments and health services would save money when exacerbation occurs and results in hospitalisation. Malcolm further states that prevention is better than taking up bed space in hospitals. Follow ups to inform COPD community of the latest treatments is also required.

Malcolm comments on the “horrendous cost” of surgery even with private health insurance, and considers this a travesty. During his 40 years while working he had medical insurance that did not cover a heart complaint and still had to engage with the public health system. When he became a widow, he could no longer afford it and now fears he will have to wait for treatment. His friends suffer continual pain waiting for hip transplants even with having private health insurance and observes that their gap payments are huge.

Case study 5 – Interaction of public and aged care systems for complex conditions including during COVID

Maria has had two strokes after a home invasion. It has taken her 20+ years to recuperate. In 2016 her husband was diagnoses with cancer and ended up in age care. She looked after him until he passed away last March, just when COVID commenced.

Maria is honoured to be a consumer representative at an regional hospital and is passionate about helping others, including involvement in disability advocacy over the last 20 years. Maria observes that the health system is stretched to its limits and with "reduction expected from bureaucrats." Maria understands how hard it is for regional areas and the high expectancy of cuts through the hospital. She feels patients are being discharged too early and this can cause harm as she experienced this herself this year in an outer regional hospital and had to be re-admitted.

Maria has a friend who had to travel from a regional town to a metropolitan area three times for cancer operations and was sent home within two days. He had multiple stitches and had to travel on the plane which was hard for him. He was assessed over the phone for aged care mid this year and is still waiting for help and service. He was then told he was clear of cancer and then re-admitted once cancer was found again. It breaks Maria's heart to see her friend going through this, and she feels the lack of staff does not help, in addition to a breakdown of appointments for herself and others, often being told their appointment has been cancelled or they don't receive notification about the appointment. Maria reported the latter and it was fixed. She feels these types of issues need to be addressed particularly when people are travelling longer distances to attend the appointment and they are not booked in.

Maria feels that hospitals need spare beds and is concerned about the interstate borders opening e.g., COVID surge and their local hospital has ten bed, emergency has 48- 50 beds (with the usual current rate of 200 patients per day). She is also concerned about low socioeconomic and homeless cohorts and tourists who may require beds, and about the lack of availability of 24 hour health clinics and pharmacies. Maria feels she could have started a petition for their local health system and keep it safe.

Maria feels that regional and remote areas miss out on the treatment that the cities patients receive, and RRR communities need to be able to have the same resources. She feels that the health directors, doctors and staff are doing their best and work extremely hard.

Maria also highlights that there should be an increase in public housing particularly for more remote communities e.g., Torres Strait Islander communities. Long Stay patients like NDIS need to have safe, quality homes or villages to live. These communities need help e.g., there is also a lack of knowledge for a lot of patients which creates anxiety. Maria mentions that four surgeries have closed recently and so it is very difficult to get appointments and can sometimes take up to nine days. A lot of GP surgeries cannot take any new patients.

Maria reflectes that aged care was very good when her husband first went into residential care, but the quality care did not last. She virtually lived at the facility every day and nearly all day to protect him. Maria taught staff how to attend to his care needs for a specific condition which required attendance to equipment and re-positioning his body regularly. Maria sometimes became angry, when processes were done incorrectly and when she felt his dignity wasn't respected. She said her breaking point was when she walked in and saw him trying to drink from his catheter. Maria went in early a couple of days before he passed away and noted that "he had started to die." No one called her to notify her of the change and when he died a few hours later she went and asked when the undertaker was coming to pick him up, and she was told that the night shift nurse had relayed that Maria herself had organised the arrangements when this was not the case.

Maria feels they need more help in regional areas and that the State and Federal Governments don't seem to care about the people who voted them in.

Case study 6 – Private health system

Erin feels her and her family's health needs are met and is able to access health services in their community including GP services and allied health services in a timely manner. She accesses the majority of these services through the private health system. Her only frustration is the requirement for a referral from the GP for a standard/routine annual check-up (for another service).

Erin feels there are enough health and allied health service providers in their community and these are readily available, but also acknowledges that her and her family are not reliant on 'government/public' health system. The services she uses the most (at least once per year) and that are readily available in her community include GP, physiotherapy, remedial massage, dentist, optometrist, diagnostic imaging, proctology, and podiatry.

Erin doesn't think of local government and health services in one 'bubble' and acknowledges that health services are State and Federally funded services. She feels local government could and does provide wellness services through environmental commitments such as quality parks and outdoor exercise facilities and services, and social connection services.

Case study 7 – Interaction of private and public health and aged care systems

Veronica and her husband have significant out of pocket expenses for cardiologist services even with private health insurance with the need to regularly consult with private cardiologists. Veronica explains that the Private Health Cover was irrelevant to the fees that could be charged and the refund amount expected. They therefore decided to request referrals to specialists through the Public Health System. Since that time they have been very happy and satisfied with the care they have received through this avenue. Veronica and her husband wonder how many other older adult opt for the public health system because of this out-of-pocket issue with private practitioners. Veronica feels that, understandably, this will add to the pressure that the public health system already experiences. Veronica highlights ways to address this issue including the regulation of fees that specialists are able to charge and increase the Medicare refund. This reads simple, but perhaps the individuals on benefits, pensions, etc. could receive an increased refund after an eligibility assessment has been made. Age Discrimination for out-of-pocket health related expenses is also a concern for Veronica. Her husband was 76 years of age when he required an MRI for his knee. He was shocked to discover that because of his age he was not entitled to any refund and therefore had a $200 out-of-pocket expense. This seemed to be a blatant age discrimination matter, particularly as there was an injury involved (not just deterioration of the knee).

Brenda mentions similar insights in regards to breast screening that these is a need to "unpack" the age limit which for some means far less priority in being seen and wait times and gaps to pay still, even with private health insurance, which makes it unaffordable for older adults.

Veronica comments on the aged care "ladder" assessment and search for service providers. Recently her husband had open heart surgery which resulted in his inability to tend to their garden. Veronica is also actively involved in the garden maintenance but the short-term need was for outside assistance. After some enquiries she was told to contact My Aged Care. She did this promptly and was told she was eligible for assistance and would need assessment. The assessment process was smooth and simple, but she thought it was odd that she was assessed when the need for extra assistance had only arisen with her husband's surgery.

Veronica questions whether it was necessary to spend funding on home visit. She furthers describes the "fun and games" she had to find a service provider who offered garden maintenance in her region, which she was surprised by the lack of availability. She was also told a similar story repeatedly, "We don't have capacity". She was not sure what was meant by this and understood this to mean e.g., they hadn't received any funding for any new clients to be added to their book or that they haven't received sufficient funding for gardening. After much questioning of one service provider, she discovered that no new funding had been received for nearly 12 months. She had the option (fortunately) to be added to their books or to continue to phone to follow up each month. It became obvious that the short-term need could not be met and by the time that perhaps it could be met her need would hopefully no longer exist. Veronica wonders how older people with less technology skills, less assertiveness skills, less empowerment manage this process and resolve the problem that exists for them.

People like Brenda and Veronica implore that Seniors' organisations need to continue advocating loudly and consistently for not only extra funding to meet existing health needs but for funding bodies to act smarter and more transparently in the delivery of programs and outcomes.

Case study 8 – Living alone and navigating the aged care system

Mary Anne is in her eighties and lives alone in a unit. Mary Anne shared that she does not have any family who live nearby and is worried about having a fall in her home. She said that after a previous incident she now has installed a key safe outside so emergency services are able to enter her home. Mary Anne says she sometimes struggles to get into her shower as she has to access this via her bathtub. She also said she struggles to keep the floors and bathroom clean in her home due to an injury to her back.

Mary Anne told the Aged Care Navigator that she has never received help at home before and would like assistance to register with My Aged Care. When Mary Anne was contacted, she declined an offer to participate in a three way phone call with My Aged Care, stating that she finds it "confusing" and "is not sure when I should talk". The Aged Care Navigator instead carried out the registration process with her via the My Aged Care website, explaining to Mary Anne that the information she was collecting from her would be used to ensure she was eligible for an assessment. Once the registration process was completed, there was a discussion with Mary Anne about what to expect next regarding a phone call from someone about an assessment and arranging a time for this.

Approximately one week after completing Mary Anne's online registration, The Aged Care Navigator received a call from a gentleman at My Aged Care saying he had been trying to contact Mary Anne by her landline and mobile phone number. He was unable to speak with her and had not had a return phone call. This was followed up by the Aged Care Navigator contacting Mary Anne by phone. Mary Anne stated she had not received any phone calls or messages but did say she does not know how to access her messages on her mobile phone. A phone call was made by the Aged Care Navigator to My Aged Care to ask if they could contact Mary Anne again. This time it was different representative who answered the call. They stated that they have tried to contact Mary Anne numerous times and as they have had no response, her registration was unsuccessful and she would need to be referred again. The person at My Aged Care said that their phone number will come up as "Private" or "Unknown" and Mary Anne should be encouraged to answer it and listen to any voicemail messages as they will include a reference and return number.

Due to these issues, the Aged Care Navigator asked Mary Anne if she would consent to her becoming an Advocates as Agents representative for her. Mary Anne declined stating that although she knows she sometimes becomes "muddled up" she wants to be as independent as possible.

Mary Anne has been referred back to My Aged Care and is still waiting for an assessment to be arranged. She has had missed calls from assessors, sometimes becoming confused and phoning the Aged Care Navigator thinking she is the assessor. This case highlights the challenges for vulnerable people who live alone and may be experiencing a degree of cognitive impairment and have no other support. It also identifies a need for calls from organisations such as My Aged Care to be easily identifiable on Caller ID so that a person knows who is calling them and it is not assumed to be a "scam call".

Case study 9 – Logistics of navigating the aged care system

Jim is aged in his late 70s, lives alone and receives some support from his son. Jim shared that he was unable to keep his home clean and tidy. He is no longer able to manage these tasks himself as he has chronic back pain and blood pressure problems as well as some memory loss. Jim says he has never received any services before but thinks he might have been eligible for meal delivery services in the past.

Jim did not know how to access services and said he was pleased his friend Julie had come with him. He added that his mobile phone was broken and he wasn't able to make calls himself at the moment. Jim said that he was in hospital three weeks ago and the hospital referred him on for meal delivery services. With Jim's consent, the Aged Care Navigator was able to assist him to call My Aged Care. On checking with My Aged Care, he had not been previously registered so Jim agreed to register now over the phone.

During the registration process, the person at My Aged Care had some computer issues and advised she would need to re-enter the assessment information she had just collected from Jim. She put us on hold for a lengthy period of time. She then came back and said she was still having problems and asked if Jim was okay to wait longer and he agreed to continue to hold. This time while on hold, the line suddenly disconnected. At this stage, Jim was happy to call back so we went ahead and tried again. This time he/they spoke with another person at My Aged Care who was able to give them Jim's AC number. He advised however that as the information had not been saved the first time Jim/they called, Jim would need to provide the assessment information again.

At this point in the interaction with My Aged Care, Jim stated that he was not feeling well and was beginning to feel uncomfortable. In addition to the frustrations with the call, the Navigator and Jim had needed to meet in an outside setting due to COVID-19 restrictions. Whilst this was a good last-minute arrangement, it was too hot for everyone involved, they decided to end the session with the Navigator offering to assist Jim to follow up the issue with My Aged Care the following week. Jim reports that he has so far been pleased with the service we have been offering.

This case highlights the challenges for older people in attempting to understand and use the My Aged Care system when they are not experienced in systems use and do not have someone supporting them through the process. The experience of having to repeat his information to My Aged Care followed by technology failures would have been insurmountable if Jim had not had someone sitting alongside him and reassuring him that it was not his lack of experience or knowledge impacting the interaction.

This case also highlights the missed opportunities for timely intervention and support in the lives of older people, when there is not a support person to assist through the journey across systems and places of care. This was evident in Jim's case. There had been an opportunity for Jim to be linked with My Aged Care following a recent hospital admission. Jim did not have support at the time to understand how this works and to follow it up, therefore this opportunity did not progress.

Understanding regional, rural and remote community health care needs

In 2018, 33% of older Australians lived in outer regional, remote and very remote areas, compared with 25% of Australians under 65 years of age.[86] People living in remote and very remote areas usually have poorer access to health services compared to people in regional areas and major cities. Rural and remote areas experience barriers such as long distance travel to seek out care due to lack of availability of services in the area. Despite this, bulk-billing rates were highest in very remote areas (89%), similar to major cities (87%) and slightly lower but similar in regional areas (84% in inner regional and 85% in outer regional areas). [87] In 2018 – 2019, Medicare data highlighted that the numbers of non-hospital non-referred attendances e.g., GP visits, were lower in remote and very remote areas communities.

It must also be noted that rural and remote areas on average received lower incomes but spent more for goods and services, and in 2017 - 2018, Australians living outside capital cities had, on average, 19% less household income per week than those in major cities. [88]

The Australian Institute of Health and Welfare (AIWH) highlights areas of concerns for RRR communities[89] including higher rates of chronic disease, higher rates of arthritis, asthma and diabetes; kidney and urinary diseases, and injuries. Mental and behavioural conditions were higher in inner regional areas compared with outer regional and remote areas and major cities, and remote and very remote areas had lower rates of cancer (bowel, breast and cervical). In 2017–18, people living in inner regional and outer regional and remote areas were more likely to smoke and drink alcohol at levels that put them at risk of lifelong harm. They had higher mortality rates and higher rates of potentially avoidable deaths (under the age of 75 years) that are potentially preventable through primary or hospital care, and but higher rates of potentially preventable hospitalisations.

More First Nations people live in non-remote areas (81%) than remote areas (19%). However, First Nations people have lower life expectancies, higher rates of chronic and preventable illnesses, poorer self-reported health and a higher likelihood of being hospitalised than non-First Nations people.

In October 2021, Seniors Month provided an opportunity to celebrate Seniors and to bring awareness to and take care of social, emotional, physical and mental health and wellbeing through connection, learning, sharing and general participation. COTA Queensland notes, from the perspective of social inclusion and participation, the 2021 Seniors' Month data illustrated that out of a total of 1331 events:

- **n = 2 (Very remote)**
- **n = 14 (Remote)**
- **n = 70 (Outer regional)**
- n = 361 (Inner regional)
- n = 846 (Major city)
- *n = 38 (Online)*.

[86] Australian Government. Australian Institute of Health and Welfare (AIHW), *Health of Older People.* (2020).
[87] Australian Government. Australian Institute of Health and Welfare (AIHW), *Rural and Remote Health*. (2020c).
[88] Australian Government. Australian Institute of Health and Welfare (AIHW), *Health of Older People.* (2020).
[89] Australian Government. Australian Institute of Health and Welfare (AIHW), *Rural and Remote Health*. (2020c).

This illustrates that **6.5% (n = 86)** of events or activities took place in outer regional, remote, and very remote areas. More opportunities need to be made available to very remote and remote communities, and more support or encouragement for implementation of opportunities in outer regional areas and for online events, particularly in the ongoing climate of the pandemic.

Classification of remoteness

The Modified Monash Model (MMM)[90] is used to work out eligibility for health workforce programs e.g., bulk billing, incentive programs, Bonded Medical Program, and more recently as part of the aged care funding/grant opportunities.[91] For example, Commonwealth Home Support Providers (CHSP) can negotiate a Rural and remote Loading with the 2022/23 CHSP National Unit Price Ranges. This will become limited to MM 6 and 7 as the unit price costs for MM 1 through to 5 are considered similar[92], although COTA Queensland would argue that this is not the case (e.g., COTA Queensland would disagree that the costings and experiences of aged care providers in MM2 to MM7 would differ from MM1). What was originally generated for the health workforce has been applied directly to aged care discussions and opportunities, and therefore MM1 to MM5 has been considered similar in experiences in terms of access, availability, and affordability of health care services (inclusive of aged care), which we view as problematic in the policy, research and advocacy spaces. We do not dispute the rating of MM and provide some example towns below:

- Caboolture (MM1)
- Pomona (2)
- Bribie Island (3)
- Charters Towers (4)
- Cherbourg (5)
- Sapphire (6)
- Bollon (7)

However, the application of MM across multiple opportunities and workforces across communities with unique needs warrants concern. COTA Queensland is aware of workforce challenges in certain towns and the potential need for higher unit costings, but with their current MM rating, they would not be eligible for Unit Costing Loading. Example of these towns include:

- Pomona (2) *(Regional)*

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[90] Australian Government. Department of Health, *General Practice Workforce providing Primary Care services in Australia. General Practice Workforce Commentary – 2020 Calendar Year*. (2021d).
Note regarding GP workforce: "How the general practitioner workforce varies by rurality according to the Modified Monash Model (MMM) classification Regionally, the number of GPs in MM 3-5 and MM 7 areas decreased over the most recent period (2019 to 2020). In MM 6 areas, the number of GPs has been decreasing since 2018. This decrease is a major concern, as the current policy settings are designed to train doctors in rural areas and retain them once qualified. It is not possible to say what level of decrease might have occurred without these policies, but even so, it suggests that major new investment and innovations are needed to boost the rural GP workforce. The same pattern of decreased rural GP workforce is seen in Queensland as in other states. This is despite their considerable success in training rural generalists who work across primary and secondary care. *If the same pattern occurs nationally, as has occurred in Queensland, the investment in the National Rural Generalist Pathway will assist with numbers of the doctors providing important primary and secondary care from rural hospitals. Policies and systems will need to encourage these doctors to provide the longitudinal and preventive care that contribute to the cost-effectiveness of primary care."*
[91] COTA Queensland, *Internal data.* (2021d).
[92] COTA Queensland, *Internal data.* (2021d). MM1 – Metropolitan; MM2 – Regional centres; MM3 – Large rural towns; MM4 – Medium rural towns; MM5 – Small rural towns; MM6 – Remote communities; MM7 – Very remote communities. Ratings are provided according to geographical remoteness, as defined by the Australian Bureau of Statistics (ABS), and the size of the town.

- Atherton (4) *(Medium rural)*
- Innisfail (4)
- Mareeba (4)
- Tolga (4)
- Bell (5) *(Small rural)*
- Tablelands (5)
- Ravenshoe (5)
- Malanda (5)
- Milla Milla (5)
- Babinda (5)
- Tully (5)

Role of community organisations

The Foundation for Rural Regional Renewal released a report recently which explored how not-for-profit organisations and community groups in remote, rural, and regional communities are coping and progressing following two years of the pandemic. The aim of the research was to highlight the importance of community organisations with a focus on their resilience and strength across social, economic, cultural, and environmental facets in different regions. A further aim was to gain more insight into the collective impacts of natural disasters and the pandemic. Finally, they wished to enhance the authority and influence these organisations have in policy/investment/solution design for longer-term sustainability.[93]

Key findings relevant to the health services discussion include:

- Nine out of ten organisations (87% of respondents) contribute to local economies, and the majority also contribute socially and culturally with support to communities. Respondents included 44% from regional areas, 49% from rural areas, and 7% from remote areas. Fifty-nine percent of the organisations were volunteer-led, and 53% had a turnover of less than $50,000 per annum (73% with a turnover of less than $250,000 per annum).
- Close to half were impacted by drought (48%), and others were impacted by bushfire, flood, mouse plague or cyclones. Despite natural disasters to contend with, the most damaging event was the ongoing pandemic and related restrictions, with 95% of respondents indicating they had been impacted by the inability to meet with each other, which in turn impacted on their wellbeing (stress and resultant isolation).
- Having access to enough funding is important to the ongoing operationalisation of community organisations and to sustain and expand upon their capabilities. For example, smaller organisations (with an income of less than $50,000 per annum) are often funded through donations, events, and other fundraising. Very few organisations are in receipt of philanthropic or ongoing funding, which meant decreased ability, and less income from funders and supports, or an inability to run events.
- Operationalisation costs made up 58% of revenues received by community organisations, and more than half respondents spent at least 75% of income on operating expenses, with funders often restricting administrative costs to 10%.
- The effects of natural disasters have led to an exhausted and frustrated workforce in community organisations, with less volunteer staff, and paid staff working longer hours; in

[93] Foundation for Rural Regional Renewal (FRRR), *Heartbeat of Rural Australia*. (2021).

addition to enhancing the digital divide between metropolitan and country areas including instability of the internet.[94]

Further, it was indicated that changes to funding can make a difference; however, what is most needed is flexibility e.g., in how and when funding can be utilised, secure longer-term funding, and less bureaucracy. Community organisations also indicated they would like the funders to know them better and understand their unique context (factors, circumstances) in each community. Close to half of the respondents indicated that they feel like they can influence decisions or that funders will listen to and consult them about local community issues. Community response for what was needed most was the volunteer workforce, followed by access to training e.g., to assist with operationalisation of organisations, and in-kind support e.g., to reach experts in different fields, and networking e.g., groups wish to network with one another to share ideas.[95]

In order to highlight the key issues outlined above, we present three examples from two regional towns, Bundaberg and Biggenden, and one remote town, Cooktown where Queensland Health is observed (and sensed) by COTA Queensland Community and Engagement team as a 'last resort' option at times. Interestingly, both Bundaberg and Childers – Biggenden are listed with the same ratings across DPA and DPA Bonded despite being treated as 'accessible' and 'moderately accessible' respectively.

Table 2. Case study locations ranked according to Commonwealth Distribution Priority Area (DPA), DPA Bonded, and Aria rankings[96]

GP Catchment	DPA 2021 GPs	% Above or Below Benchmark	DPA 2021 Bonded	% Above or Below Benchmark	ARIA 2016+ category[97]
Bundaberg	Yes	-5 to -10	Yes	-5 to -10	Accessible
Childers - Biggenden	Yes	-5 to -10	Yes	-5 to -10	Moderately accessible
Cooktown	Yes	<-10	Yes	<-10	Remote

We also note the role of the Multi-Purpose Health Service (MPHS) to provide flexibility in the delivery of health care which combines e.g., acute hospital care, residential aged care, in home and community care and other health related services.[98]

[94] Foundation for Rural Regional Renewal (FRRR), *Heartbeat of Rural Australia* (2021).
[95] Foundation for Rural Regional Renewal (FRRR), *Heartbeat of Rural Australia* (2021).
[96] Australian Government. Department of Health, *Distribution Priority Area*. (2021e).
Distribution Priority Area (DPA) refers to location where communities don't have sufficient access to doctors, based on the local needs of the community. The rankings include 'DPA 2021 Bonded' which refers to the Bonded Medical Places (BMP) Scheme which encourages doctors to work and remain in rural and remote areas. DPAs use Modified Monash Model (MMM) boundaries. Rankings between 0 → -10 (minus 10) = GP DPAs and/or Bonded DPAs are 'just below' → 'significantly below' benchmark for service provision (accessibility and availability). Rankings between 0 → 10 = GP DPAs and/or Bonded DPAs are 'just above' →3 'significantly above' benchmark for service provision (accessibility and availability). There are locations where a positive ranking is still categorised as a DPA (due to lower positive ranking, for example, in one or both areas across GP DPA and Bonded DPA) and may be listed as 'partial' DPA or as a DPA.
[97] Hugo Centre for Population and Housing Research, *ARIA+ 2016 Demonstration Map*. (n.d.).
[98] Queensland Government. Queensland Health, *Community Multi-purpose Health Services*. (2018).

Case study 10 – Health services in 'remote' Cooktown

Queensland Health is a 'last resort' provider and steps in with service provision when there is limited service provision (or not working well) for NDIS and Aged Care Services. The role of MPHS is a joint State/Federal initiative in remote areas is to deliver services and it works fairly well and acknowledges the importance of provision of required services across age and disability. Cooktown is an example of where it works well e.g., through community care services, but there is a lack of choice and diversity in remote areas. Queensland Health QLD put significant funding into MPHS; however, there is a sense that Queensland Health carry much of the funding demand for running the MPHS and Federal funding is not sufficient (and this is being reviewed). This pattern is repeated in many places (but not all) where there is MPHS.

Case study 11 – Health services in 'accessible' Bundaberg

There are very low socio-economic cohorts in the area. In discussions with the hospital, even though they have just expanded the hospital it is full already, and the demand on public health services is significant. There are developments towards hospital upgrade to a tertiary (teaching) hospital.

They have CHSP and aged care packages. There is a reasonable amount of residential aged care and home care providers, but not sure if Queensland Health interacts with NDIS items, with their focus on primary health components when service provision not available e.g., GP and specialist services, therefore, there are longer wait times and impact to the public health system (in comparison to people who may access private health systems at a higher rate in metropolitan areas).

First Nations community controlled health service is large and popular and by all accounts, does a really good job. There is a NDIS local area coordination contract and this provides 'wrap around' services e.g., drug and alcohol, family counselling, and mental health supports.

Case study 12 – Health services in 'moderately accessible' Biggenden

Biggenden is an example town where there is not a huge amount of people on the waitlist yet the waitlist for essential needs is "ten years long" e.g., housing. In conversation with the HHS Allied Health team, there is acknowledgement of Federal funding to deliver allied health services across NDIS and aged care; however, recruitment for allied health professionals is difficult and routes of access to allied health are multiple e.g., three access points are federally funded – GP, NDIS, and aged care. Allied health professionals work independently and in some cases are provided by Queensland Health due to 'last resort' option.

Creation of equitable, affordable, and quality health care

COTA Queensland has identified the creation of and access to equitable, affordable and quality health care as a priority issue for older Queenslanders within an integrated system. This includes care across multiple areas: primary health care, hospital services, medications, health information, support for health literacy, and activities that help people to age well, in addition to aged care, oral health, mental health, palliative and end of life care.[99]

We are currently advocating that health, care and support services need to be viewed as part of a bigger picture of essential needs, for example, housing, transport, and social participation, that underpin an individual's wellbeing. An integrated health system that fully supports older Queenslanders is part of an age-friendly framework that places the older person and their families

[99] Adopted from COTA Queensland, *2022/23 State Budget Submission.* (2021).

at the centre of care across e.g., primary health, aged care, mental health, oral health, dementia, carer, disability, palliative and end of life services. This requires understandable, accessible and navigable pathways, which means having the health care literacy, and access over time to the integrated system regardless of external factors e.g., pandemics, funding, geography, including through telehealth support. The integrated system needs to be responsive, safe, efficient, and innovative – receiving responsive appropriate placed based care, which includes all terminally ill Queenslanders being able to readily access palliative care and retaining autonomy in decision making regarding where and how they end their life. [100]

During COTA's National Policy Council workshop,[101] multiple issues were identified, and ideas, suggestions or recommendations were put forward across diverse areas of health and wellbeing:

Rural communities

- Need for creative solutions around transport. They have good ideas but need local solutions for rural communities.
- Workforce planning - instead of silo solutions e.g., trying to get more doctors and nurses in one area, there is recommendation for wider planning, but how to get more creative about who provides what sort of service.
- Need to keep fighting hard for people for aged care services e.g., access to allied health such as physiotherapy in residential aged care; access to residential aged care; Government has to fund this care.

Care (integrated and long-term)

- Explore COVID-19 impact and responses to older populations further to collate learnings for the future e.g., Did policies/settings work? How was mental health addressed?
- Work still to be done around implementation of laws and creation of more dialogue at the national level.

Aged care and facilities

- Need to identify underlying cause of mental health (recognition of link to family dynamics, family relationships breaking down and interplay of this with pressure of caring for family members with ongoing or chronic health concerns, or pre-existing family/domestic abuse or concerns; and lack of availability to appropriate health services) and the complexity of multi-layered health issues
- More interest from Federal Government organisations and providers to move beyond certain geographic locations in terms of provision of aged care packages
- Need more aged care appropriate spaces in rural communities to ease burden on major hospitals.

Aged care reform

- Need to challenge status quo despite comprehensive agenda. Paradigm shift required regarding service provision, alternative options that place older person in position of control

[100] Adopted from COTA Queensland, *2022/23 State Budget Submission.* (2021).
[101] COTA Federation, *National Policy Council Workshop.* (2021).

over their care, and shifting the aged care model more to consumer-directed care particularly in residential aged care. Better definition and highlighting of preventative health and dialogue with GPs, who are often the ones most with their ear to the ground regarding what is currently happening for older adults

- Public health is example of a field multi-disciplinary work e.g., diet and nutrition, general health, promotion of health messaging, and similar initiatives. There are many needs that could be met by allied health appointments and GP trips, rather than place further burden on the hospital systems e.g., emergency departments.

Digital inclusion and technology

- Increase mobile multi-disciplinary/integrated health services in RRR areas as this is determined as better use of resources and a more agile tailored response to meeting community needs; this includes the navigation of cultural traditions (e.g., taboo) in a culturally appropriate way so this isn't a barrier to access
- Subsidise support to enable access to the digital world as part of the basic needs of participation in a modern society and in planning and accessing health services and supports (which is a universal right).[102] Continue the promotion of assisted technologies as priority. Also require acknowledgement of reticence at times for digital engagement and therefore encouragement, training and education is also required to overcome e.g., uncertainty, low confidence, fear, confusion, not just cost barriers.

Health and wellbeing

Oral and preventative health

- Royal Commission recommendation of Seniors Dental Benefit Scheme/Schedule. National partnership agreement from 2019 is still current and extension until 2022. However, we need to lobby for increased funding.
    - Drawing more awareness to rural and remote communities' limited access to basic health care services and supports e.g., GP availability; and interaction of perennial issues such as transport to get to health appointments; capacity of local health and hospital systems (at 'bursting point'); increased funding for preventative health

COVID-19 impacts (short and long term)

- Need to find and create more opportunities to assure supports for longer-term impacts of COVID-19 e.g., reconnect or connect to health (physical, psychosocial, mental) supports and increase social participation and encourage group membership again – U3A example of membership dropping 33% due to pandemic; training, education and access to devices to increase digital inclusion and connectivity; accessibility to subsidised community or private transports such as subsidised taxi fares; and mitigate isolation due to restrictions imposed, not only lockdowns and social distancing, but also from delayed

[102] These points were also raised at the 'Our Future Health' webinar hosted by COTA Queensland in October 2021. In the Australian Digital Inclusion Index (ADII) report (ADII, 2020), the cohort most impacted for access, affordability, and ability were females aged 80 years and older. The ADII have just released the 2021 report at the time of drafting the Issues and Trends report, where they surmise that digital inclusion still is closely associated with age but there are indications that digital inclusion from mid-life to senior cohorts is gradually improving, with the highest increase (for 2020 – 2021) recorded by the 75 years of age and over cohort. COTA Australia provided comment on the 2020 findings.

vaccination schedules or in instances where vaccination is medically indicated as not possible for the individual. This all requires increased funding for those with reduced capacity.

Informational supports and health literacy

- Lesson learnt during COVID-19 is to target at-risk groups with Government health messaging but need more input and creative solutions to reach inaccessible groups. Need more coordination and collaboration between health system and state governments.

Social isolation and loneliness

- Exploration of social prescription models.[103]

Example initiatives

We provide examples in Table 3. of initiatives that support an equitable health care system/s with provision of required information and pathways to support. We also provide a final case study that illustrates evidence-based initiative providing tailored information and support for local communities, the *Volunteer Community Peer Navigator* program.

[103] This precedes and echoes the recommendations in the Social Isolation and Loneliness report findings released in December 2021 by Queensland Parliament.

Table 3. Example initiatives for equitable health care and access to information and supports

Initiative	Focus	Purpose
Mental Health First Aid[104]	Mental health – psychiatric and psychological supports	- To mitigate the number of mental health supports requests, lack of appropriate health workforce, and provide support for mitigation of mental health conditions - New ways to tackle mental health during the pandemic (for the sake of economic recovery) - NSW government dedicating $130 million to train 275,000 people in rural areas in mental health first aid - People from community centres, libraries, schools, sporting clubs or social clubs encouraged engage with mental health first aid training as 'gatekeepers' for local communities to determine if the individual requires professional help - Evidence showed the training was effective to raise awareness and remove stigma associated with asking for help - Funding also to provide more appointments for psychology and psychiatry services.
Integrated Team Care Program[105]	Complex chronic health supports	- Provides supports for Aboriginal and Torres Strait Islander people living with complex chronic health conditions. - Provides one-to-one support for management of the conditions and to receive health care they require, also helps health services provide culturally appropriate care. - Implementation guidelines are provided[106]
Aged Care workers paid to study[107]	Aged care workforce	- Tackling workforce shortages in RRR communities through providing education opportunities and incentivisation.
Ageing Well in Our Region: A Healthy Ageing Strategy 2022 – 2027[108]	Healthy ageing strategy	Developed by Central Queensland, Wide Bay and Sunshine Coast PHN. **Four strategic priorities** 1. People stay healthy, well and independent as they age

[104] ABC News. *NSW Announces 'Largest Mental Health First Aid Program' in the World.* (2021c).
[105] Australian Government. Department of Health, *Integrated Team Care Program*. (2021g).
[106] Australian Government. Department of Health, *Integrated Team Care Program Implementation Guidelines*. (2021h).
[107] ABC news, *Worker Shortages Inspire Incentive-based Recruitment Drive for Aged Care Staff.* (2021d)
[108] Anderson, A., R. Cole, K. Waru, and P. Martinez, *Ageing Well in our Region: A Healthy Ageing Strategy 2022 – 2027*. (2021).

		2. People with acute and chronic conditions live well with the care they need when they need it as close to home as possible 3. Equitable access to systems for long term care and respectful end of life is available for people that need it 4. The aged care system is progressive, sustainable, and equitable through integrated and continuous system improvement **Underpinning principles** Intrinsic value; empowering and patient centred; respecting autonomy; contribution and participation; equity; diversity; progressive health system. **Vision** *As people age, they have a valued place in community, are healthy, active, resilient and connected and are empowered to live the life of their choice*. [109] We also note within this strategy document, the nationwide five-year pillar of aged care reform which provide opportunities for improvement to the integration of health systems and supports which contribute to healthy ageing communities. The pillars include key issues such as: - home care (home support and care according to needs assessment; investment in home care packages, home care and respite services and support for aged care navigation); - residential aged care services (including sustainability, service suitability to ensure individual care needs and preferences are met); - residential aged care quality and safety (including access to quality residential care); - workforce (including upskilling and expansion of, compassionate and values-based workforce); and - governance (stronger governance and new legislation). The PHN strategy highlights the 'system and service landscape' and provides a good model which frames the older person at the centre of care supported by GPs and primary health care; acute and sub-acute care; informal carers, families, neighbours, friends and volunteers; community providers; and other community services and social supports.[110] Enablers are further highlights which assist PHNs to support wider health system/s and supports include: Governance (coordinated, inclusive approach in planning through to evaluation); Relationships and alliances (focus on relationships across all levels of business, community and government); Health and system

[109] Anderson, A., R. Cole, K. Waru, and P. Martinez, *Ageing Well in our Region: A Healthy Ageing Strategy 2022 – 2027*. (2021).
[110] Anderson, A., R. Cole, K. Waru, and P. Martinez, *Appendix 2: Context and Strategy Framing*. (2021c).

		intelligence (embedded data, continue quality improvement, demonstrate consumer experience); Investment (leverages existing funding, sufficient financing, and this all reflects integrated care); and Innovation (autonomy and adaptation to regional and consumer needs, work towards reducing barriers and therefore inequalities).[111]
		
		Healthy ageing 'indicators' are listed and include, for example, system health: accessibility and receipt of high quality care; physical health: lifestyle behaviours, and management of chronic disease; mental health: mental and cognitive health and wellbeing; and social-emotional health: strong and positive relationships and networks.[112]
		
		The PHN strategy also provides insight into additional opportunities for health service collaboration or integration,[113] for example:
		• Mental health, wellbeing and social support
		  ○ Training and capacity building in relation to mental health and wellbeing for older people to appropriate stakeholders including all types of carers (e.g., community based, informal workforce, and volunteers)
		  ○ Initiatives that offer mental health support and social connect to individual in residential aged care
		• Safety, accessibility and liveability as people age in their own homes
		  ○ Increase opportunities and initiatives for older people in these areas.
		• Workforce strategies
		  ○ Shared strategy for secondary (acute) and primary health sectors (to enable sustainability of workforce and support management of workforce)
		  ○ Regional strategy for capacity building and support of unpaid informal workforce (family, volunteers, carers, etc.)
		• Advocacy opportunities
		  ○ 'Third age' initiatives including opportunities for older works in the health workforce. [114]
		
		Very importantly, the PHN strategy identifies current priority groups including Aboriginal and Torres Strait Islander population in the PHN, LGBTIQ+, culturally and linguistically diverse backgrounds, rural and remote

[111] Anderson, A., R. Cole, K. Waru, and P. Martinez, *Appendix 2: Context and Strategy Framing*. (2021c).
[112] Anderson, A., R. Cole, K. Waru, and P. Martinez, *Appendix 2: Context and Strategy Framing*. (2021c).
[113] Anderson, A., R. Cole, K. Waru, and P. Martinez, *Ageing Well in our Region: A Healthy Ageing Strategy 2022 – 2027*. (2021a).
[114] Anderson, A., R. Cole, K. Waru, and P. Martinez, *Ageing Well in our Region: A Healthy Ageing Strategy 2022 – 2027*. (2021a).

		communities, and those cohorts experiencing disadvantage or vulnerabilities such as veterans, those who are widowed or live on their own, those experiencing disability, and those living in residential aged care.[115][116] Finally, the PHN strategy also outlines evidence-based approaches to healthy ageing which include support for older adults around: • Building intrinsic capacity • Maintaining and enhancing cognitive, physical, psychological, and social functions • Diagnostic assessments • Addressing age discrimination • Attending to specific conditions • Creating supportive environments; and • Provision of (age-friendly) integrated care.[117]
Primary Health Care 10 Year Plan[118]	Health care plan (over a decade)	- Implementation of 10 year health care plan including implementation of Voluntary Patient Registration (VPR) with overall goal of bolstering the primary health care system. In relation to older adults, the Steering Group recommended the following (verbatim and emphasised in italics): **Recommendation 1** (One system focus): Reshape Australia's health care system to deliver care through one integrated system, including reorientation of secondary and tertiary systems to support primary health care to keep people well and out of hospital It is important to acknowledge the funding differences across sectors and *support efficient use of funding available across health, mental health, aged care and the National Disability Insurance Scheme (NDIS) to deliver integrated outcomes for people*. This needs to consider and assess the impact of any unintended consequences that primary health care funding reform may have on secondary/tertiary care.

[115] Anderson, A., R. Cole, K. Waru, and P. Martinez, *Appendix 3: Population Data and Community Consultation*. (2021d).
[116] Some of these groups were also identified by the Primary Health Reform Steering Group Committee (in their consultation for their report of recommendations regarding the 10 year strategy for primary health care); however, they explicitly mention 'older Australians', 'those that experience health inequities', 'gender and bodily diverse people' (in reference to LGBTIQ+ communities, those experiencing chronic disease, mental health conditions and frailty, and those people experiencing socio-economic disadvantages. Australian Government. Department of Health. *Report from the Primary Health Reform Steering Group. Recommendations on the Australian Government's Primary Health Care 10 Year Plan* (2021a).
[117] Anderson, A., R. Cole, K. Waru, and P. Martinez, *Appendix 4: Effective Approaches to Healthy Ageing*. *Ageing Well in our Region: A Healthy Ageing Strategy 2022 – 2027*. (2021e).
[118] Australian Government. Department of Health, *Report from the Primary Health Reform Steering Group. Recommendations on the Australian Government's Primary Health Care 10 Year Plan*. (2021a).

		Recommendation 2 (Single primary health care destination): Formalise and strengthen the relationship of individuals, families and carers with their chosen primary health care provider and practice and create an ongoing partnership and 'home base' for safe and comprehensive individual and family health care over time. VPR will embed and build upon current pilot initiatives relating to primary health care reform as described by the Health Care Home principles of care for general practices, ACCHs, and rural multipurpose health services and facilitate broadening practice funding beyond the MBS. This change will benefit people in greatest need of accessible, community-based and coordinated primary health care, particularly […] *people with complex chronic conditions, including mental illness; and older Australians.* As part of consultation process, there was support to *addressing equitable access and funding complexity for disadvantaged groups and better understanding on how disability, aged care,* justice systems can work together. **Recommendation 8** (Equitable access for people with poor access or at risk of poorer health outcomes): Support people to access equitable, sustainable and coordinated care that meets their needs. It will also involve *advocating for improving access to the NDIS and aged care and improving the interface of these systems to ensure those with a disability or who are aged can better navigate these systems and make choices on how they engage with these systems* rather than the complex system that sees many people excluded from entering relevant programs. Across the pillars, the Steering Committee also made short-term and medium-term recommendations which highlight the complexity and interaction of health systems. We draw attention to those items which impact on older adults (verbatim and emphasised in italics): **One system focus (Pillar 1)** Interface with aged care, disability and mental health: Develop a *gap analysis of allied health service provision in primary health, aged care and disability sectors*. **Medium-term:** Interface with aged care, disability, child and maternal health and mental health - Trial of funded primary health care providers (whatever profession best suited) *located within aged care services to scaffold clinical skills of existing staff and to help transfer/discharge/keep care in place.* This MUST include

		community care services for people living independently at home. *Actions should link in with the Government's response to the Royal Commission and recent Budget measures, including supporting improved integration of aged and primary health care for Indigenous Elders*; *aim to support expansion of ACCHs to include aged care.* **Equitable experience of evidence-based primary health care (person, family, carer, community) (Pillar 2)** **Short-term:** It will also *enhance the delivery of preventative health activities by GPs to keep older people healthier*. Payments would be tiered for the *delivery of comprehensive care for people over the aged of 75 and Aboriginal and Torres Strait Islander people 55 and over.* Propose higher payments would be provided for more complex care, including home visits. To encourage continuity of care, these SIP payments would be limited to enrolled patients residential aged care facilities and disability care homes - Involve primary health professions in Clinical Governance and Safety. Community based home aged and disability health care, including in rural and remote areas - VPR driven supplementary funding to support coordination and service provision **Medium-term:** Incentivise primary health care nursing - Use block payments to increase the utilisation of, and to *reduce the disparity between primary health care and aged care nursing and the other parts of the health sector.* *Introduce health assessments for those aged 65 to 74* - This measure would amend GP Management Plan eligibility criteria or *expand health assessments to include all over 65s*. Eligibility could be linked to patients who are voluntarily enrolled with their practice. This investment could be measured through linking VPE data to MBS item number reports. **Continuous quality improvement, safety and future focus across the system, for consumers and providers (Pillar 3)** **Short-term:** Improved communication and multidisciplinary team care - Develop digital platforms to support continuous quality improvement and multidisciplinary teamwork across the continuum of care, while reflecting on and addressing barriers experienced in the Health Care Homes trial in relation to shared care systems and My Health Record.

		e-prescriptions: *expand e-prescription capability, prioritising aged care.* One health system - Patient flow - cope/build digital infrastructure required to *include primary and aged care in a whole of system approach to patient flow*, building on currently available data, for example LHNs and ambulance services. This should support appropriate patient discharge from hospital by providing visibility to available GP appointments and aged care beds, improving patient flow and informing appropriate service planning. **Bolstering Rural Health (Pillar 4)** Coordinated holistic care - Consider complexities and interactions with social determinants of health, mental health conditions, sociodemographic disadvantage and aged care to avoid potential siloed service delivery. Local analysis, planning and coordination - *Support local and community controlled workforce needs analysis, planning and coordination, including health pathways. Rural and remote workforce and funding planning needs to consider all sources of funding* including MBS, NDIS, private health and block and blended payments to *match local needs and to support integrated services that provide value in the community. It should also consider local aged care, social and community care services.* **Aboriginal and Torres Strait Islander health (Pillar 5)** **Short-term:** *Develop/test new models of integration for ACCH delivery of primary health care, aged care AND disability services,* consistent with the Government's Response to the Aged Care Royal Commission's Report/Recommendations. Workforce - *Develop and support the Aboriginal and Torres Strait Islander workforce to work to their full scope in delivering primary health, mental health, aged care, disability* and family support services to communities over the next ten years. This includes ensuring ACCHs have access to highly trained GPs and other primary health care providers and that Aboriginal and Torres Strait Islander Health Practitioners and Workers are supported to increase the vital contribution they make to improving the health and wellbeing of communities, *including through completion of Certificate Four qualifications in aged care and mental health.* **Medium-term:** *Expand integrated ACCH primary health care, aged care and disability services models across the country* - Effectively resource/support ACCHs in priority Regions (ie. those with low levels of access) to expand their scope of services to include *provision of home and residential aged care to Indigenous Elders and their families*. **Long-term:** Integration of Services within ACCHs - Integrated Aboriginal *community-controlled primary health care, aged care and disability services scaled up and operating across the country.*

		Workforce - Major development of an *internationally recognised Aboriginal and Torres Strait Islander health, aged care, disability services workforce.* **Health workforce (Pillar 6)** **Short-term:** Allied health - *Develop a coordinated National Allied Health Workforce Strategy covering planning and distribution across health, mental health, disability*, early childhood intervention and *aged care, with identification of measures to address workforce shortages and maldistribution, including education initiatives and student placements.* Models of care – NPs - Define current NP models of care and build into national nursing strategy. This *includes integration of NPs into aged care and mental health care services.* Health assistance workforce - *Includes existing and emerging health assistant workforce, for example allied health assistants, assistants in nursing, personal care workers in aged care, mental health peer workers, disability support workers and physicians' assistants*. Unregulated: Other *unregulated health care workers, particularly in the aged care sector*.

Case study 13 - Volunteer Community Peer Navigator program

COTA Queensland's original pilot of the *Volunteer Community Peer Program* was linked to the *Planning for Wellbeing*[1] which was delivered by the Older Persons Action Group (OPAG) from May 2019 to June 2020. This pilot program aimed to improve knowledge in general regarding available information and resources for older people, including increasing community knowledge and General Practitioner (GP) awareness of supports and services, engaging older people in conversation (to promote health seeking behaviours) via the Peer Navigators who were stationed in local council libraries; the engagement scope included carers.[1]

COTA Queensland and Moreton Bay Regional Council partnered to extend the program across the North Brisbane and Moreton Bay regions with funding from Brisbane North PHN (*Mental health, social isolation and loneliness support for older people impacted by COVID-19)* from April 2021 – March 2022.

The program has elements of the social prescription approach where individuals are referred to community services or informational resources or supports, which may assist in increasing quality of life, wellbeing, community participation and abate or prevent mental health conditions such as anxiety and depression.[1]

To date, in addition the growing base of resources, the volunteers have identified the following additional training/support needs e.g., carer services and supports (e.g., Carers Queensland and Wellways Carer Gateway and Arafmi); My Aged Care including processes, Home Assist *versus* Home Assist Secure, transport, knowledge of changes coming up; information on dyslexia and literacy issues; and QR Scanner - training on how to download vaccination certificate to the QR app.

Recommendations

We must promote *healthy ageing* at the core (as part of a wider *age-friendly* framework) of what is discussed, developed, and proposed as changes or improvement to accessibility and availability of health systems and supports, given that 21.9% of the Queensland population will be aged 65 years and over, and 4.5% will be aged 85 years and over, by 2049. [119] This means that one in five Queenslanders (1.7 million) will be aged 65 years and over, and 350,000 persons will be aged 85 years and over,[120] which signals implications for health resource planning and development in a post-pandemic world, particularly for chronic disease management, priority cohorts who experience ongoing inequities in health care needs, and RRR communities who experience issues with accessibility and availability of health services and supports.

To best meet the needs of our current and future ageing populations, we recommend to:

1. Gain accurate insight into local community access to and availability of health services and supports, particularly in regional, rural and remote communities, and diverse cohorts which historically are under-represented or experience disadvantage (e.g., culturally and linguistically diverse; First Nations communities; inequities with housing or transport; low socio-economic background; under- and unemployment; bereaved; living on their own; experiencing elder abuse).

[119] Queensland Government Statistician's Office, Queensland Treasury. 2020. *Who are older Queenslanders?* [Fact sheet]. https://www.dsdsatsip.qld.gov.au/resources/dsdsatsip/seniors/population-fact-sheet.pdf
[120] Queensland Government Statistician's Office, Queensland Treasury. 2020. *Who are older Queenslanders?* [Fact sheet]. https://www.dsdsatsip.qld.gov.au/resources/dsdsatsip/seniors/population-fact-sheet.pdf

2. Gain accurate insight into local community (including individuals, community groups, service providers, and local councils) understanding of funding responsibilities, and where they see Commonwealth and State Government gaps or strengths in their local health systems.
3. Explore strengths of local government's role (advocacy, guidance, and input) in better understanding needs in their communities e.g., idea of a regional government model.
4. Consult, co-ordinate and collaborate with communities and networks on a regional response e.g., strategy or proposal to present evidence-based case to government as part of effort to explore more Commonwealth funding opportunities.
5. Use of existing community resources and opportunities to expand upon the volunteer network for needs such as transport, running errands, home and yard maintenance, social connection, and similar activities.
6. Increase availability of bulk billing services and messaging to GPs and health clinics regarding provision of access to primary health care services for cohorts experiencing inequities particularly in regional, rural and remote communities.
7. Provide more education and information around private health and public health, and planning for future health/care needs and supports.

Further, from a budget perspective, COTA Queensland currently advocates for the following[121]:

8. The Queensland Government adopts a strong framework to ensure diverse older consumers, as partners, co-design an integrated system of care (including services, health promotion activities, information and supports); consumers oversee and plan their own care.
9. The Queensland Government continues to invest in telehealth services and these are integrated into care models across Queensland Health.
10. The Queensland Government increases current expenditure in areas greatly needed e.g., palliative care to match Palliative Care Queensland's estimate of required funding.[1122]

[121] COTA Queensland, *2022/23 State Budget Submission*. (2021).
[122] Palliative Care Queensland, *Palliative Care Queensland 2021-22 Pre-Budget submission*. (2021).

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