



**COTA OVER 50s**

**SUBMISSION**

**Department of Health and Ageing**

**REVIEW OF SUBSIDIES AND SERVICES IN  
AUSTRALIAN GOVERNMENT FUNDED  
COMMUNITY AGED CARE PROGRAMS**

**January 2007**

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Authorised by  
National Policy Council  
COTA Over 50s

COTA Over 50s National Policy Council consists of eight State-and Territory-based entities – Councils on the Ageing in ACT, NSW, NT, QLD, SA, TAS, VIC, and WA, - plus the national organisation, ARPA Over 50s Association.

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### **Supporting older people to lead their lives requires a new vision for health and community services**

COTA Over 50s believes that our starting points for reform should be a “new vision” of community care in which service users are at the centre of the process and a change strategy to realise that vision. This vision needs to include the concept of recognising the whole person not just their functional disabilities in assessment and development of service options.

Attention should be focussed on building on the personal and community assets available to maintain and improve the quality of life of service users rather than being limited to compensating for deficits. Some of the implications of such a change in perspective around the provision of services to older people may be gauged from similar approaches practised in some disability services. Others need to emerge from a systematic process for reflection and learning as changes are implemented.

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## Introduction

Council on the Ageing (COTA) Over 50s Vision embraces the shaping of a just, equitable and humane community in which older people, in all their diversity, are able to contribute and grow to their fullest capacity and potential.

COTA Over 50s has adopted the United Nations Principles For Older Persons as the basis on which to build policy (see Attachment 1). COTA Over 50s' position on aged and community care service development and issues stems from these principles and emphasises the rights of older people, as users of services, in terms of :

- **choice** as to their short and long term care needs,
- **access** to appropriate and affordable services regardless of location, income or any other factor,
- **maintenance of independence** in their own home as long as they wish and are able to remain at home with support,
- **high standards of care**, that are based on **dignity, respect, security and safety** of the older person,
- **equal participation and consultation** in the community and planning of services.

COTA Over 50s sees the provision of community care as one aspect of the support and care that people may access to differing degrees and at various stages as they age. This continuum encompasses the provision of:

- programs that promote positive and healthy ageing,
- preventative measures and risk reduction campaigns,
- primary health and acute care services,
- community support,
- care of people living in the home,
- residential care and
- palliative care.

COTA Over 50s sees that all Residential Care, HACC and other community programs aimed at individuals should be seen as part of a continuous spectrum, not only in conceptual terms but linked legislatively.

We believe the Government should focus its efforts and investments in community based care and support for older people. Necessarily this will also mean addressing the interface with other components of the health and care continuum. This is in line with the fact that older Australians have expressed their preference for remaining in their own homes for as long as possible.

It is important to note however, that there are many older people, people with a disability and people living with a chronic illness who do not need, nor seek, support in their day to day living. Programs that enhance their independence would best serve the interests of these people, rather than programs that encourage them to become more dependent.

## Our Vision of Community Care

COTA contributed to *A Vision for Community Care* (ACSA et al, 2003) in collaboration with a range of organisations concerned with the delivery of care to older and disabled Australians. COTA Over 50s supports the vision of community care outlined in that document:

*Our Vision is of a community care system where both formal and informal care are brought together to maximise the capacity of people to enjoy life in the community of their choice.*

*Our Vision is one of a connected and flexible service. Ideally the mechanisms behind formal service provision should be invisible to the client – they get quality services tailored to meet their own needs to stay in their own community, whatever and wherever that may be. This will enable people to move through the different parts of the system unimpeded and untroubled by bureaucratic issues of funding sources and government demarcations.*

*The support will be provided in:*

- *community settings – home*
- *retirement living settings*
- *sub-acute settings*
- *residential care settings*

*to people of all ages, who require support as a result of a functional disability, and their carers. This is a very diverse group of people. Community care support will need to respond appropriately to:*

- *people of culturally and linguistically diverse backgrounds*
- *indigenous people*
- *people in rural and remote areas*
- *homeless people*
- *people with dementia*
- *people with a mental illness.*

*(pp 4-5)*

COTA Over 50s believes that this vision of community care, in which service users are at the centre of the process, is the starting point for reform. This vision needs to include the concept of recognising the whole person, not just their functional disabilities in assessment and development of service options. Attention should be focussed on building the personal and community assets available to maintain and improve the quality of life of service users rather than being limited to compensating for deficits.

In conjunction with this *person-centred approach*, recognition needs to be given to 'informal' carers who play an essential role in the provision of community care, and the maintenance of the care recipient in their home setting.

## An Integrated Approach

With the growing complexity of the service system, and the increasing demand for community care options by older people, COTA welcomed the Australian Government's review of community care and the resultant *The Way Forward – A New Strategy for Community Care*, which has set the agenda for national community care reform, and has as its stated aim the streamlining of the wide range of services which have evolved at State and Commonwealth levels.

Similarly we welcome the opportunity to have input into the current review of Commonwealth funded Community Aged Care Programs. We applaud the Government's intention to ensure that maximum outcomes can be achieved for people with the resources that are made available.

However, while the current review is identified as building on the input provided by the consultation process for *The Way Forward*, COTA Over 50s is concerned that the framing of the issues for consideration isolates the Commonwealth Community Aged Care Programs from the significant work achieved through the previous review and implementation process, and other program areas.

In order to achieve the best possible outcomes for older people requiring care and support to remain in the community, it is essential that the review of Community Aged Care Programs take a whole of Government and inter-Government approach. In particular to look at their integration with programs which impact on them e.g.:

- issues concerning the progression through levels of care and support, including HACC services and the relationship with Veteran's Home Care and Disability programs
- transition to and from acute and sub-acute settings
- and transition to residential aged care.

Our consultation and engagement with older people has shown that people are not concerned with funding sources and administrative arrangements – their concerns are with the services and support they require, and receive, to enable them to continue to live at home, and/or to continue to care for the person requiring care, as their care needs fluctuate and increase.

## Factors Impacting on Community Care Provision

The outcomes sought by clients and carers generally remain consistent:

- ability to access different care as needed with ease and confidence
- flexible services that meet their interests and needs
- improved quality of care
- nationally consistent high standards of care
- increased independence and control over their own lives
- access to services in their local communities
- availability of culturally appropriate care services.

However, despite the growth in the numbers of packages, increased demand for community care options, and community care reform undertaken in recent years, the changing demographics and social and economic contexts are impacting, and will continue to impact, on the ability of Community Care programs in their current configuration to achieve these outcomes.

### 1. Increasing Demand and Diversity

The growth in the ageing population is well documented. The increased demand this will place on the service system is one of the main drivers of reform and service system development. However, along with this generational shift, is the increasing diversity and mix of requirements within the ageing population.

Increased pressure on services is resulting from the changing expectations among older people and their families in relation to service provision arrangements, and the demand for more comprehensive and responsive community care services growth in the cultural and linguistic diversity of the ageing population.

### 2. Increasing Complexity in Care Needs

Reform of the way health services are delivered has seen the increasing shift of responsibility for care of older people from acute care settings to the community. As well, the increase of chronic and degenerative conditions is adding to the complexity of care needs.

### 3. Reliance on Carers

The provision of community care is reliant on the role of informal carers to supplement the funded care and support. However, the numbers of unpaid carers are reducing, and will impact on the long term viability of effectiveness of community care. In addition to this constraint, is a range of issues in relation to the support of carers, which must be carefully managed and addressed by any community care/service system reforms.

### 4. Erosion of Value

There is evidence to suggest that the service purchasing power of a CACP has diminished considerably since their introduction in 1995, due to lack of appropriate indexation (VAHEC 2006). This is exacerbated by lack of accountability for CACPs and EACH administrative and brokerage fees.

### 5. Workforce Issues

In order to provide adequate community care for older people who wish to remain in their own homes, Australia needs a well trained community care workforce with supports and infrastructure that recognise and value its importance. In a recent NSW Forum on community care workforce problems such as difficulty in recruiting staff (particularly rural and remote); lack of trained Aboriginal or culturally and linguistically diverse staff; increased casualisation of the community care workforce; low wage and lack of a career path. The anticipated shortage of trained workers in the aged care and community care sector is an ongoing and urgent issue that will impact on the ability of the service system to meet demand and achieve the optimal outcomes for clients.

## Issues in Current Community Aged Care Programs

The growth in the numbers of Community Aged Care Packages (CACPs), and the introduction of Extended Aged Care at Home (EACH) and EACH Dementia packages has been a welcome development in the community care suite of services. However, despite the increasing demand for services and resources to meet more complex and higher level care needs, a number of issues have been identified in the provision and uptake of the packages.

### 1. Gap in funding levels between CACPs and EACH

One of the main issues of concern is the significant leap in funding levels between CACPs and EACH packages. While CACPs are currently equivalent to category 6 in Residential Aged Care (\$12,154 per annum) EACH packages are equivalent to level 2 of the Residential Classification Scale of high level residential care (\$40,631 per annum). The 2002 CACP Census identified that an average of 6.1 hours of care is provided through CACPs per week.

Because of this discrepancy, it means that people need to manage on the lower level of support, often only through the provision of informal care, although their care needs are increasing until they are assessed as requiring higher level care.

Added to this is the concern that many people are remaining on HACC funded services even though their care needs may be higher and eligible for packaged care, for a variety of reasons (see comments below), and may be accessing CACPs when their care needs are already high and exceeding the ability of the package to adequately support.

The resultant situation is of people managing on less funding and support than they require, for a longer period of time, while the service provider struggles to support a level of care higher than the program was intended to provide.

Notwithstanding some flexibility allowed by varying funding allocations to meet higher or lower care needs, COTA Over 50s feels there needs to be a graduation of care levels to replace what are current EACH and CACP packages. At present with EACH-dementia, there are only three levels and the gaps are too large between them.

### 2. Lack of uptake

There are reports of variability in uptake across regions and areas – while in some areas there are waiting lists, in others services report vacancies. Some of the reasons cited for this situation include:

- clients and carers preference for remaining on HACC programs – due to personal costs, flexibility in services, continuity in care and workers, access to other subsidised programs such as activity groups, aids and equipment etc.;
- referral processes are variable and some reports suggest a reluctance to refer to some providers of CACPs.

### 3. Management of Demand

In conjunction with the growing numbers requiring community support and care, is the increase in complexity of care needs. Consequently community care services are constantly facing demand beyond that of available resources. Some of the mechanisms employed to counter this demand are:

- Creation of waiting lists
- Rationalisation of service hours to all clients
- Development of prioritisation criteria.

There is evidence that waiting lists are not well managed (although a trial of an electronic waiting list management system in the Eastern Metropolitan Region of Melbourne has been very successful), that clients are reluctant to go on a waiting list, preferring to continue with HACC programs rather than lose services.

#### 4. Integration with other programs

While each of these mechanisms have impact on the outcomes for clients, it is the development of prioritisation criteria that has the greatest impact on CACP clients. As a result of the development of prioritisation criteria to assist with the management of demand, clients who are on or commencing on a CACP, have reported loss of access to other subsidised programs, such as:

- Some HACC services such as personal care, meals on wheels, home maintenance, socialisation support and planned activity groups
- State funded personal alarm response call out subsidies
- Independence aids and equipment through State Government Aids and Equipment scheme.

Loss of eligibility to such subsidies has social and financial impacts on clients and carers. COTA Over 50s consultation with older people indicate that those who use community care services are not concerned with funding sources or eligibility criteria, but are frustrated by the seemingly petty and incomprehensible blocks to their access services and support.

We are advised by older people that they often have difficulty in obtaining:

- household support
- community transport
- gardening and home maintenance
- essential home modification.

We believe that many older people have their living standards and health compromised because of lack of basic support services due to inflexible program boundaries and poor integration of services. The people we are most concerned about are having difficulty with maintaining a home and garden due to frailty or low level care needs, although they are capable of continuing to live independently in the community.

COTA Over 50s is concerned by comments to our services indicating that services have been cut or restricted:

*Home care used to cut my lawns once a fortnight but now they only do it once a month. That is not enough for me and I can't do it myself, as the lawn is on a fair size of a hill.*

*I am only allowed one day per fortnight in the activity centre. Before I was going once a week.*

*The home care girls are excellent and the service is good value, but they cut my service and that is not so good. Instead of 2 hours per week, I only get 1 hour.*

To enable clients and carers to access a flexible continuum of care, integration and collaboration between service providers and programs is required across the community care service system.

#### 5. Recognition of Carers

The support of family members and friends is essential to the provision of community aged care. Many carers are older people themselves, and may have their own care and support needs, or in the case of children and other family members of the care recipient, may need to put their careers, financial situation, or well being at risk to provide the care required. Community care services need to recognise the care situation and support carers in their roles.

We commend to the Review, the Victorian Government's *Recognising and Supporting Care Relationships – A Policy Framework* (DHS 2006), which acknowledges the role of carers and the care relationship setting, and endeavours to address the interdependent and independent needs of the carer and care recipient across a range of program areas.

Along with the need to build support for carers into any community care program, is the need to address the broader issues and needs of carers:

- Poverty
- Superannuation
- Long term care needs
- Workforce needs and conflict in maintaining carer role

All these in relation to carers will in one way or another impact on the quality and type of care that older Australians receive in their homes.

## **6. Restorative Approach**

Commonwealth funded community aged care programs need to adopt a restorative or 'active service' model which aims to increase or maintain people's independence and level of functional ability rather than solely palliative or dependency approaches. Evidence shows that strength training and activity has enormous benefits on older people's well-being and ability to continue to live in the community.

COTA has introduced successfully into a number of states one such strength training program: Living Longer: Living Stronger (LLLS) with the aim of increasing the range and quality of strength training opportunities for older Australian. A recent report, done by Edith Cowan University in WA, on the program's impact on the lives of participants showed overall positive physiological results. As well, in terms of the participants' perception of their physical and psychological health and wellbeing, considerable improvements were reported.

Participation in the LLLS program resulted in positive changes in physical ability which the report concluded should delay transition to dependent care and for them to maintain or improve their quality of life. The mental health outcomes were also notable. They were both general and also reduced "fear of falling" which also contributes considerably to quality of life.

**7. Interface with Disability**

Community aged care services and programs need to collaborate and better integrate with disability packages to ensure that people with a disability have access to appropriate care to meet their needs.

**8. Evaluation and Monitoring**

Evaluation of CACPS and EACH is needed to better ascertain their effectiveness in meeting the needs of older and disabled people, and their carers.

Monitoring and accountability needs to better identify issues in relation to distribution, referral, management and uptake of packages.

## COTA Over 50's Response to Review Questions

### 1. What range and diversity of community care services are required for frail older Australians with complex care needs, and their carers?

- Access to a range of other subsidised programs is needed to provide flexible continuum of care, most notably
  - HACC services such as personal care, meals on wheels, home maintenance, socialisation support and planned activity groups
  - Independence aids and equipment through State Government Aids and Equipment scheme
- Access to packages when care needs are already high means that funding less able to purchase adequate services to meet needs
- Carer support needs to be included in package arrangements
- Respite needs to be integrated to community care packages

### 2. How could funding arrangements be improved?

- i. There should be a separation of care funding from accommodation funding so that care is funded irrespective of setting.
- ii. There will need to be recognition that certain care situations will require a 'nursing home' type of environment and this needs specific funding.
- iii. HACC funding for older people and younger people with disabilities should be separated and disability funding run through Disability Services in each state and territory.
- iv. HACC funding should be focussed on lower level, flexible, largely client managed, quick response, ongoing or episodic as required, support required to assist an older person maintain independence in a community setting.
- v. HACC funding should be increased by 20% immediately with all of this additional funding going to older people,
- vi. This should be followed by a review of an appropriate growth index for next decade.
- vii. All current packages of care come from HACC or from the 'packages' part of Residential care funding. At present some people are on bigger packages under HACC than through CACP or EACH).
- viii. The cap the number of packages should be removed or substantially lifted so that these are always available on demand.
- ix. There should be adequate indexation of funding to ensure packages can purchase the full range of services required to support people in their homes.
- x. There should be a sliding scale of funding levels to support transition through levels of care and need.

### **3. How can the Australian Government improve the effectiveness and sustainability of its community aged care programs?**

- Waiting list management
- Carer issues need to be addressed, including:
  - Poverty
  - Superannuation
  - Long term care needs
  - Workforce needs and conflict in maintaining carer role
- Distribution of packages to ensure adequate access in all areas
- Evaluation of CACPs and EACH to ascertain effectiveness in meeting client and carer needs
- Accountability – especially in relation to administration and brokerage fees

### **4. How do you expect service requirements to change into the future?**

- In 2002–04 males aged 50 years could expect to live a further 31 years on average to age 81 years. The female life expectancy at 50 years of age increased by 6.5 years over the same period. In 2002–04 females aged 50 years could expect to live an extra 35 years to almost 85 years of age. The rate of increase of people aged 80 years or more will have a significant impact on demand for services.
- Ageing of population, increase in complexity of needs and changing expectations among older people and their families will continue to place pressure on services and provision arrangements.
- Improved integration and collaboration between services and programs across the community aged care service system to provide a flexible continuum of care to meet the needs of clients and carers.
- The ratio of CACPs funded per 1000 people aged 70 and over, needs to be increased from 20 to 30 over the next decade to respond to the continuing shift in older people's preferences away from institutional to community care.

## Conclusion

COTA Over 50s believes that our starting points for reform should be a “new vision” of community care in which service users are at the centre of the process and a change strategy to realise that vision. This vision needs to include the concept of recognising the whole person not just their functional disabilities in assessment and development of service options.

Attention should be focussed on building on the personal and community assets available to maintain and improve the quality of life of service users rather than being limited to compensating for deficits. Some of the implications of such a change in perspective around the provision of services to older people may be gauged from similar approaches practised in some disability services. Others need to emerge from a systematic process for reflection and learning as changes are implemented.

### Illustrations of the “new vision”

The Myer (2002) Vision used a number of case studies to highlight issues in relation to care needs. But we compensate for them let's look at the assets that there may be in the situation. could look at these from a quite different perspective. Instead of looking at their deficits and how to

The Myer (2002) Vision used a number of case studies to highlight issues in relation to care needs. But we could look at these from a quite different perspective. Instead of looking at their deficits and how to compensate for them let's look at the assets that there may be in the situation.

#### Case study 1

*Mr Adams is cared for by his wife after suffering a series of strokes. Mrs Adams is helped with day care, nursing visits, occasional respite care and housekeeping. But they had to wait a long time to get this care and Mr Adams was assessed at least five times by different teams and visited by more people than Mrs Adams can remember. (Myer 2002)*

*A “new vision” community care response*

Mr Adams retains his passion for pigeon breeding and racing but cannot manage his birds now. The community officer worked with Mr Adams, local breeders and the nearby racing club. Club members now take Mr Adams to meetings and race days. He enjoys the company and is a great source of advice to new breeders. He is no longer bored and boring but interested to share his experiences with his wife and hear about what she has been doing in his absence. Mrs Adams has reduced anxiety, enjoys the time he is out to pursue some of her own interests and needs less support with house keeping.

#### Case study 2

*Until the age of 83, Mr Banh has lived alone in his family home with 10 steps at both entrances. After fracturing his hip, even with hospital-based rehabilitation, he can no longer get in and out of his home and his family is concerned about his safety. Mr Banh and his family must decide if he can move back home or if he needs to move to a low care residential facility when he is discharged from hospital. (Myer 2002)*

*A “new vision” community care response*

Mr Banh received intensive rehabilitation in his home. A local handyman installed a temporary ramp. The community officer facilitated a family conference to address their fears, Mr Banh's views about the risks he wished to take, his options and possibilities. Mr Banh decided to sell his home and buy a unit that is located a few doors from his granddaughter. She and her family enjoy the crops of fresh vegetables that he now produces in their formerly neglected garden

and he feels happier about being able to call on them if necessary. He is learning the computer and using the Internet to communicate with overseas family and friends.

### **Case study 3**

*Mrs Costos is a very frail 79 year old who suffers moderate dementia. Her husband, who has heart problems and osteoarthritis, cares for her at home. Mrs Costos was admitted to hospital after a fall. Now back home, she needs more assistance than she did previously. Mr Costos learnt he would have to wait for six months before receiving additional community services to help him care for his wife. The staff at the hospital have advised him to arrange residential care for her. (Myer 2002)*

*A "new vision" community care response*

Mrs Costas is a talented oil painter. Her GP referred her to a Day Therapy Centre where a strength training program was implemented enabling her to gain muscle mass and strength and improve her balance. Falls were avoided or intensive rehabilitation focussed on getting her back to painting and into a painting group for people with mixed abilities where she is comfortable. She spends hours at her easel. Members of her extended family are interested in her new art work and she is able to show some of the youngsters different techniques even though she cannot describe them very articulately. Mr Costos is benefiting from pain management and exercise.

### **Case study 4**

*Mrs Donaldson managed to live alone with constant support from her daughter. As she became more frail, her daughter worried about her nutrition and safety. After a fall, Mrs Donaldson became incontinent. As a pensioner, she has no assets apart from her home. She is not able to afford any more help and with her daughter, decided to apply for residential care. (Myer 2002)*

*A "new visions" community care response*

Mrs Donaldson was referred to a strength training program through a community care program. As well as the direct physical benefits she felt so much more alive in the company of others in the group and in her new confidence in doing a range of activities at home and in the community. Her appetite improved remarkably and she really enjoyed her turn to organise a lunch for the three new friends she made at the gym. She has joined the local "walking train" providing safe, healthy transport to school for local youngsters. The continence problem remains but she realises that she can manage with the support of a self-help group she has been referred to. She now values herself more highly, rather than seeing herself as a burden to her daughter and has decided realise some of her home equity for a holiday, a personal trainer and home renovations to make life easier.

Of course the people are much more complex than these brief paragraphs suggest but skilled community workers can use a variety of innovative techniques to enable people to focus on what is most important to them and the most valuable form of assistance to help them achieve it. The consumer would then drive the resulting service mix, some of the activities may look the same (home care, attendant care, personal care) but the meaning attached to them would be very different. We believe the paradigm we propose also signals a changing population of users of community care.

Community care needs to be planned against a backdrop of understanding the rapidly changing demographics amongst the older population.

## References & Supporting Documents

ACSA et al 2003	“A Vision for Community Care”
Department of Human Services 2006	“Recognising and Supporting Care Relationships – A Policy Framework”
Myer Foundation 2002	“A Vision for Aged Care”
VAHEC 2006	“From Good to Better – Issues Challenges and recommendations for the Community Aged Care Packages Program in Victoria”
Victorian Community Care Aged	“Moving to Centre Stage: Community Care for the

## What is COTA Over 50s?

COTA Over 50s is a national peak seniors organization, representing 1,500 member organizations with a reach of over 500,000 older Australians. Its National Policy Council, located in Canberra, consists of eight State and Territory-based entities – Councils on the Ageing in NSW, Victoria, Tasmania, Western Australia, South Australia, ACT, Queensland and the Northern Territory – plus the national organization ARPA Over 50s.

COTA Over 50s' prime objective is to promote, improve and protect the circumstances and wellbeing of older Australians, not just its members, and particularly the vulnerable and disadvantaged. Its work draws on views of today's seniors and on concerns for future generations of Australians.

In doing so the COTA Over 50s members adhere to five main principles:

**Policy Principle 1 Maximise the economic, social and political participation of older Australians and challenge ageism.**

COTA Over 50s supports policies and programs that encourage and facilitate the inclusion of seniors in all aspects of Australian life.

**Policy Principle 2 Promote positive views of ageing, reject ageism and challenge negative stereotypes.**

COTA Over 50s supports initiatives that recognise the capacities and contributions of seniors and actively combat ageism. COTA Over 50s believes that the impact of ageism, based on negative age stereotypes, restricts the participation of older people in all aspects of Australian life. This has adverse effects on the community and on older people.

**Policy Principle 3 Promote interdependence and consciousness across generations**

COTA Over 50s promotes policies that meet the specific requirements of seniors whilst taking account of the needs of the entire community for sound economic and social development. Senior Australians share an interest in long-term policies that serve the welfare of all Australians.

**Policy Principle 4 Redress disadvantage and discrimination**

COTA Over 50s believes that all people have the right to dignity, to security, to access high quality services, and to equality in participation in the community regardless of their income, status, background, location or any other social or economic factor. COTA Over 50s recognises that seniors are a diverse group with differing backgrounds and social, economic and health status and advocates strongly for those who are most vulnerable and disadvantaged.

**Policy Principle 5 Protect and extend services and programs that are used and valued by older Australians.**

COTA Over 50s develops policies and provides advice on maintaining and improving services and programs that seniors use and value. These include primary health care, hospitals, pharmaceuticals, employment services, utilities, public transport, residential care, housing and community care. It will seek to ensure that there is an adequate "safety net" of services and income support, which all seniors can access according to fair and equitable criteria in order to maintain a reasonable quality of life.

**ATTACHMENT I****United Nations Principles for Older Persons****INDEPENDENCE**

1. Older persons should have access to adequate food, water, shelter, clothing and health care through the provision of income, family and community support and self-help.
2. Older persons should have the opportunity to work or to have access to other income-generating opportunities.
3. Older persons should be able to participate in determining when and at what pace withdrawal from the labour force takes place.
4. Older persons should have access to appropriate educational and training programs.
5. Older persons should be able to live in environments that are safe and adaptable to personal preferences and changing capacities.
6. Older persons should be able to reside at home for as long as possible.

**PARTICIPATION**

7. Older persons should remain integrated in society, participate actively in the formulation and implementation of policies that directly affect their wellbeing and share their knowledge and skills with younger generations.
8. Older persons should be able to see and develop opportunities for service to the community and to serve as volunteers in positions appropriate to their interests and capabilities.
9. Older persons should be able to form movements or associations of older persons.

**CARE**

10. Older persons should benefit from family and community care and protection in accordance with each society's system of cultural values.
11. Older persons should have access to health care to help them to maintain or regain the optimum level of physical, mental and emotional wellbeing and to prevent or delay the onset of illness.
12. Older persons should have access to social and legal services to enhance their autonomy, protection and care.
13. Older persons should be able to utilise appropriate levels of institutional care providing protection, rehabilitation and social and mental stimulation in a humane and secure environment.

14. Older persons should be able to enjoy human rights and fundamental freedoms when residing in any shelter, care or treatment facility, including full respect for their dignity, beliefs, needs and privacy and for the right to make decisions about their care and the quality of their lives.

### **SELF-FULFILMENT**

15. Older persons should be able to pursue opportunities for the full development of their potential
16. Older persons should have access to the educational, cultural, spiritual and recreational resources of society.

### **DIGNITY**

17. Older persons should be able to live in dignity and security and be free of exploitation and physical or mental abuse.
18. Older persons should be treated fairly regardless of age, gender, racial or ethnic background, disability or other status, and be valued independently of their economic contribution.  
over the next 10 Years”