Australian Workplace Innovation and Social Research Centre

THE STRETTON CENTRE

Age of Change

AGEING, AGED CARE AND WORK IN THE 21ST CENTURY

Kate Barnett & John Spoehr

August 2013

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CITY OF Playford

THE UNIVERSITY of ADELAIDE
AUSTRALIAN WORKPLACE INNOVATION AND SOCIAL RESEARCH CENTRE

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The Australian Workplace Innovation and Social Research Centre (WISeR) *focuses on work and socio-economic change. WISeR is particularly interested in how organisational structure and practices, technology and economic systems, policy and institutions, environment and culture interact to influence the performance of workplaces and the wellbeing of individuals, households and communities.*

WISeR also specialises in socio-economic impact assessment including the distributional impacts and human dimensions of change on different population groups and localities. Our research plays a key role in informing policy and strategy development at a national, local and international level.

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1 SETTING THE SCENE

1.1 PURPOSE OF THIS REPORT

This report was commissioned by the Stretton Centre and summarises key directions in ageing and aged care policy and their implications for training and employment opportunities for residents to live and work in the Northern Adelaide region.

The report summarises the key drivers in aged care and reforms in the sector that increasingly focus on enhancing the quality of life of older people and their capacity to continue active involvement in their communities, and on choice and control regarding services and supports. It also draws out some of the broad industry and workforce development implications of this, indicating that significant growth in demand for goods and services will flow from the impact of population ageing. This will translate into new training and employment opportunities in a wide range of sectors.

1.2 POPULATION AGEING: MULTIPLE IMPACTS

As with other developed countries, Australia faces the challenge of managing effectively the opportunities and the risks associated with an ageing population. Much has been written about the risks, particularly in relation to aged care and ageing workforces. Less has been written about the opportunities, including the growth in the number of consumers seeking a range of services and products, beyond those meeting the need for care.

The ageing of the population is a function of two major demographic processes – reducing fertility rates and increased longevity (Hugo 2007). Australia's total fertility rate has been falling since 1961 but in recent years has been relatively stable. Improved health care and advances in a range of medical treatments and technologies have been largely responsible for increased longevity.

Of particular significance, however, has been the fact that Australia has been adding extra years of life to the population aged over fifty. Since the early 1970s, 7.6 extra years have been added to the lifespan of men aged 50 years or over and 6.3 extra years for women in this older age group. This represents a very significant change that Hugo refers to as 'the ageing of the aged' (Hugo 2007: 171).

It is important to acknowledge that life expectancy varies greatly for different groups in the population. Indigenous Australians have a life expectancy that is 20 years less, on average, than for other Australians, while the most disadvantaged non-Indigenous Australians have a life expectancy that is six years less than that of more advantaged Australians (Prime Minister's Science Engineering & Innovation Council, undated page 8). While aged care programs usually target people aged 65 and over, those focusing on Indigenous people take the age of 45 years as the chronological entry point to aged care services.

At the 2011 Census, South Australia was the 'oldest' mainland State in Australia, with 22.3 per cent of the population aged 60 years and over (compared with the national average of 19.6 per cent) (ABS 2013).

South Australia's 2012-2013 Thinker in Residence, Dr Alexandre Kalache, refers to this demographic trend as the *'Longevity Revolution'* (Kalache 2013), a term originally coined by Dr Robert Butler, a leading US researcher in the ageing field who had also introduced the concept of 'ageism' (Butler 2008). The *Longevity Revolution* refers to the consequences of this demographic change and focuses on the opportunities it brings, or as Kalache refers to it, its inherent 'gift'.

> ***The extra years of life afforded to us in the 21st century are a condition never before experienced by humanity. The 20th century has given us the gift of longevity – but for what? The longevity revolution forces us to abandon existing notions of old age and retirement. These old social constructs are quite simply unsustainable in the face of an additional 30 years of life (Kalache 2013: 2).***

Increased numbers of people living to advanced ages creates demand for a range of consumer products and services other than those normally associated with older people – namely, those associated with health and aged care needs. In other words, it is essential to take a holistic view of ageing, and this requires a whole-of-government policy agenda. Older people are not only users of services, they are also contributors to the social fabric – for example, nearly 20 per cent of Australians over the age of 65 are active carers – and their use of services feeds workforce growth.

1.2.1 Demand for services and products

Australia's ageing population is growing in its influence as purchasers of goods and services. Analysis by the National Centre for Social and Economic Modelling (NATESM) shows that more than 37 percent of the nation's wealth is held by Australians born between 1946 and 1960, up from 33 percent in 1986. Each Baby Boomer has on average accumulated a net wealth of $381,100, about 42 per cent of which is based in home ownership. This average net worth compares with an average net wealth for all Australians of about $292,500 per person. Four out of five baby boomers are home owners, which is high not only by international standards but also when compared with other past and present generational groups (Kelly & Harding, 2007: 16 – 17, 21).

Furthermore, workforce participation rates among Australians aged 45-64 are increasing, Baby Boomers are increasing their superannuation contributions and mostly paying off their home loans before they turn 64. Retirement income policy allows them to draw tax-free income from their superannuation once they turn 60 (Kelly & Harding, 2007: 16 – 17).

Not surprisingly, spending by older generations in Australia and other developed countries has been rising since the first decade of the 21st century. In Britain, this spending power is referred to as the "grey pound." The Baby Boomer generation own most of Britain's assets, especially housing (Kingman 2012: 5-6).

In the USA Baby Boomers are the largest consumer group, accounting for 40 per cent of total consumer demand, controlling 70 per cent of the total net worth of American households (equating to $7 trillion) and owning 80 per cent of all money in savings and loan associations (Baby Boomer Magazine.Com, 2013).

1.2.2 Aged care implications

As more people live to advanced ages, their need for aged care services can be expected to grow given that people in this age group are the most intense users of health and aged care services. For example, 32% of people aged between 65 and 74 need assistance with personal and everyday activities, compared with 86% of people aged 85 and over. Chronic disease is also more prevalent among the oldest age groups. The number of people with dementia is expected to more than treble by 2050. Not surprisingly, the proportion of GDP spent on aged care is projected to increase from 0.7 per cent in 2007 to 1.9 per cent by 2046 (Productivity Commission 2008: xvi-xviii, 36, 44-45).

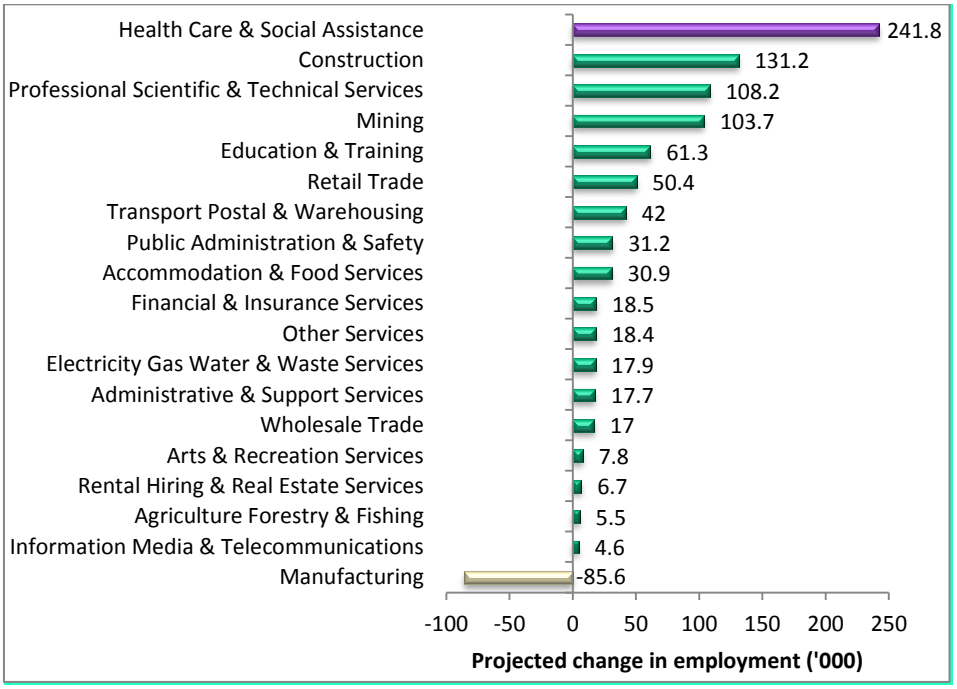
Consequently, the demand for aged care is going to be significant over the short, medium and longer term. Ensuring that there are sufficient aged care workers to meet this projected demand is a major challenge.

GROWTH IN THE AGED CARE SECTOR

The Health and Community Services industry now employs 9 per cent of Australia's workforce and is the largest industry in this country. Employment is projected to grow by at least 35 per cent over the next ten years. Apart from the driver of population ageing, including the longer lifespans of people with disability, the sector needs workforce development which will support the adoption of consumer directed or client led care in both the aged care and disability care sectors (CSHISC 2013: 6 - 11). The establishment of *DisabilityCare Australia*, the national disability insurance scheme, is likely to further increase the demand for care and support workers with the capacity to respond to consumer-led services.

As Figure 1 demonstrates, the Health Care and Social Assistance industry sector has by far the largest growth of all industries with a projected increase of 241,800 jobs, almost double that of the second highest projected growth in the Construction industry.

FIGURE 1: PROJECTED EMPLOYMENT GROWTH TO 2016-2017, BY INDUSTRY



Source: Community Services & Health Industry Skills Council 2013: 12, citing DEEWR 2012 data

GROWTH IN DIRECT CARE WORKER EMPLOYMENT

The aged care sector's direct care workforce is now largely comprised of care workers who are trained in the vocational education and training (VET) sector. Recent VET reforms under the *Skills for All* agenda parallel those in aged and disability care, with funding following the individual rather than the provider. It is not known what impact this will have on the demand and supply of training for the community services industry.

The most recent national Census of the aged care workforce identified more than 240,000 workers in direct care roles - 147,000 in residential aged care and 93,350 in community services. Direct care workers comprise 68 per cent of the residential direct care workforce and 81 per cent of the community direct care workforce (King *et al* 2013: xv).

In the five year period 2006 to 2011, workforce growth has been strongest in the VET trained direct care workers whose numbers increased by 30,800 – equating to a 40 per cent growth in the aged and disability care workforce. Other fast growing occupations in the sector over this period were:

- ✓ Occupational and Environmental Health Professionals – 75% growth
- ✓ Personal Service Workers other than Aged and Disability Carers – 48%
- ✓ Dieticians – 47%
- ✓ Health and Welfare Services Managers – 43%
- ✓ Welfare, Recreation & Community Arts Workers – 41%
- ✓ Nurse Educators and Researchers – 41%
- ✓ Psychologists – 38% (CSHISC 2013: 10 -11, drawing on ABS Census data).

1.2.3 Broader workforce implications

Over the three decades between 2011 and 2031, those aged 65 and over are going to grow not only in numbers but as a proportion of the working age population (that is, people aged between 15 and 64) (Hugo 2007: 170). ABS projections find that by 2016 more than 80% of the labour force will be aged 45 years and over age.[1]

Increasingly, mature aged people are participating in work, particularly in professional occupations, and this trend is expected to continue. More than half of 60-64 year olds now participate in the labour force, increasing from one third in 1991. Participation has also increased for people aged 65 and over, from 7 per cent in December 1991 to 12 per cent in December 2011 (AWPA 2012: 14, citing Atkinson & Beddie 2011, McDonald 2011 and ABS 2012).

As people live longer and to relatively healthy older ages than previous generations, their capacity to participate in paid work can be extended, and is likely to do so due to the confluence of a number of factors. Current Australian government policy encourages the continued employment of mature age workers and the phased raising the Age Pension age of entry reflects this policy direction. A further incentive for individuals to lengthen their work years exists in reduced superannuation savings as a result of the global financial crisis, as well as relatively low average superannuation savings for the Baby Boomer generation, particularly women.

In 2011, the South Australian government added to its Strategic Plan **Target T48 Ageing Workforce Participation– *Increase the proportion of older South Australians who are engaged in the workforce by 10 percentage points by 2020*.**

It is likely that the upper extreme of what we define as 'working age' will need to change in light of trends to reject 65 as the presumed age of retirement and also changing notions of retirement away from a sudden and complete cessation of paid work to a phased process typically involving shorter and more flexible working hours and patterns. Ideally, the use of chronological age as a marker of capacity to work should be abandoned given the highly individualised nature of the ageing process, as should the tradition of linking Pension Age to an expected age for retiring from paid work.

Recent research (Deloitte Access Economics 2012) highlights the positive impact of extending paid working lives while the negative impact of a reducing ratio of working to retired Australians is well understood (as outlined in the Treasury's Intergenerational Reports from 2002 onwards). Commissioned by the Australian Human Rights Commission, Deloitte Access Economics modelling quantified the

[1] http://www.abs.gov.au/ausstats/abs@.nsf/featurearticlesbytitle/6CB978B9C9A0B299CA2569DE0021ED2F?OpenDocument

critical role of mature age participation in tipping the balance between the number of future retirees and the number of workers available to support them. Specifically this identified that –

- ✓ An extra 3 percentage points on participation among workers aged 55 and over would result in a $33 billion boost to GDP – or around 1.6% of national income.
- ✓ A 5 percentage point lift in participation among this group would see around $48 billion in extra GDP – or 2.4% of national income.

RESPONDING TO WORKFORCE AGEING: AGE MANAGEMENT

As older workers are encouraged to delay retirement, industries like aged care with mature aged workforces will need management strategies that ensure each worker can participate to the maximum of their capacity. *Age Management* (see box below) is a cluster of strategies that build on the strengths of older workers while addressing functional barriers to their continued engagement in paid work. In the European Union, the development of age management practices has significantly affected the extension of work careers of employees in enterprises adopting these strategies (Ilmarinen, 2005: 394). Age Management strategies are designed to create *age-friendly* workplaces.

AGE MANAGEMENT: KEY COMPONENTS

THERE ARE SEVEN DIMENSIONS IDENTIFIED FOR STRUCTURING AGE MANAGEMENT INITIATIVES –

1. JOB RECRUITMENT – ENSURING THAT MATURE WORKERS ARE NOT DISCRIMINATED AGAINST AND HAVE EQUAL ACCESS TO AVAILABLE JOBS.
2. LEARNING, TRAINING, AND DEVELOPMENT– ENSURING THAT OPPORTUNITIES FOR TRAINING ARE OFFERED THROUGHOUT THE WORKING LIFE, AND POSITIVE ACTION IS TAKEN TO REDRESS PAST DISCRIMINATION, CREATING LEARNING ENVIRONMENTS IN THE WORKPLACE, AND TAILORING TRAINING TO THE NEEDS OF OLDER WORKERS.
3. PROMOTION AND INTERNAL JOB CHANGES.
4. FLEXIBLE WORKING PRACTICE – IN THE HOURS OF WORK AND THE OFFERING OF REDUCED HOURS.
5. WORKPLACE DESIGN AND HEALTH PROMOTION – INCLUDES ERGONOMICS, DESIGNING JOBS AND WORKPLACES TO PREVENT OR ADDRESS FUNCTIONAL DECLINE.
6. EMPLOYMENT EXIT AND THE TRANSITION TO RETIREMENT - IN THE TIMING AND NATURE OF RETIREMENT, INCLUDING GRADUAL OR PHASED RETIREMENT.
7. CHANGING ATTITUDES TO AGEING WORKERS WITHIN ORGANISATIONS – INCLUDES ADDRESSING AGEISM AND RAISING AWARENESS ABOUT THE BENEFITS OF RETAINING OLDER WORKERS (TAYLOR, 2006: 24).

Age management strategies are crucial to attracting and retaining mature aged care workers but hold equal relevance for very young workers, and applying this approach is likely to assist with retaining, and possibly attracting, younger workers.

RESPONDING TO WORKFORCE AGEING: LEGAL REFORM

In 2012, the Australian Law Reform Commission undertook a wide ranging inquiry into barriers facing mature age people participating in paid work. In line with ABS definitions, this focused on anyone aged 45 and over. Collectively, its

recommendations enshrine a rights-based approach to employment for adult Australians.

The Inquiry arose out of concerns about the implications of an ageing population and the accompanying need to increase the workforce participation of older Australians by removing legal and other barriers to their participation. The final report (ALRC 2013) reflected the number of reform-seeking reports and policies that have been generated in the past decade in its 36 targeted recommendations.

A number of recommendations are directed towards removing age discrimination in legislation and practice. In some cases the ALRC recommends amendments; in some, reviews. Some recommendations are directed towards promoting awareness of the rights and entitlements of mature age workers, and others address social security and superannuation system features which can inhibit workforce participation

Two recommendations in this Report are directed towards enabling carers to retain an attachment to the paid workforce. These recommendations recognise the compatibility of paid work and caring responsibilities, and support the flexibility in work that enables choices to be made in relation to caring.

The keystone recommendation of the Report is for the development of a **National Mature Age Workforce Participation Plan**, with the other recommendations constituting specific strategies for its implementation. The ALRC describes their combined effect as providing:

- a coordinated policy response to enabling mature age workforce participation;
- consistency across Commonwealth laws and between Commonwealth and state and territory laws to support mature age workforce participation;
- a reduction in age discrimination;
- a greater awareness of mature age workers' rights and entitlements;
- support for maintaining attachment to the workforce for mature age persons; and
- work environments, practices and processes that are appropriate for mature age worker (ALRC 2013).

1.3 Triple Jeopardy: the aged care workforce

The aged care workforce is increasingly characterised by three inter-linked challenges which reflect the 'triple jeopardy' of –

- having to manage a significant increase in demand for aged care due to wider population ageing,
- while at the same time managing an ageing workforce,
- and attracting and retaining appropriately skilled workers in the face of an annual average turnover rate of around 25% (Productivity Commission 2005 and National Aged Care Workforce Census – DoHA 2008).

> ***The aged care industry has no precedent to follow in its age management practices. It is creating its own pathway and identifying the lessons along the way. Those lessons include developing new mindsets and expectations about the implications of workforce ageing, understanding those implications, and creating new strategies to manage those implications. Rather than submitting to a potential double jeopardy situation, the aged care industry is well placed to be a leader in effective workforce age management (Spoehr & Barnett 2008).***

The challenges facing the aged care sector are compounded by broader social and economic changes that are reducing the availability of family carers, the lynchpin of a

community based aged care system – see *Section 1.4.* Given the mature age profile of the aged care workforce, many aged care workers are likely to experience work-family responsibility conflict that may be compounded by their own ageing-related health issues.

Reforms in community services towards consumer directed care (see *Section 2.1.3*), and increasing community-based service delivery will require the redesign of existing roles and the design of new roles, the acquisition of new skills and changes to both pre-service and in-service training programs. Most recently, national training packages for Certificate III care workers have re-titled these roles as 'support workers', reflecting consumer preferences to see the purchase of services as a source of 'support' rather than 'care'. Further discussion of aged care reform is given in *Section 2.*

Recruiting young people into the aged care sector can help to address the challenges associated with an ageing workforce, as well as the challenges associated with ensuring that sufficient numbers of skilled workers exist to meet the growing numbers of consumers requiring care. However, there are many difficulties associated with achieving this outcome, most linked to the lack of attractiveness for many young people of working in the sector. New and evolving roles as part of a reformed aged care system, and improvements in pay and working conditions as part of the national *Workforce Compact*, may enhance their recruitment – see *Section 2.1.3*.

Early findings from research occurring as part of the national DoHA funded TRACS Program (Teaching and Research Aged Care Services) indicate that appropriately designed clinical placement opportunities, where young students and aged care services are effectively prepared and supported, change negative expectations about working in aged care and increase the professional attraction of aged care because of the range of skills it requires.[2]

1.4 Dwindling supply of family carers

Most people prefer to grow older in their own homes and community based aged care has grown in response to this demand. Critical to the future of the community care model, and its ability to manage limited workforce resources, is the availability of informal carers. What is not known is the future willingness and capacity of informal carers to accept this responsibility.

ABS surveys of carers show that the key motivator for them is a wish to provide the best possible care and to fulfil family obligations. While this driver is unlikely to change, there is an increasing prevalence of factors which may work against it, including increasing rates of relationship breakdown, reduced family formation among young adults, widespread changes in the traditional role of women as carers, and separation of parents from adult children due to greater mobility in choice of work and place of living. In the past decade or so, there has been a 64 per cent increase in lone person households and this trend is predicted to continue (AIHW, 2004: xv).

Two other factors that affect motivation to provide informal care are the costs (direct and indirect) to informal carers, and participation (or need to) in paid employment.

Women and paid employment

Women, the traditional source of informal care, now comprise a significant part of Australia's skilled workforce with their labour force participation increasing and expected to increase across age groups, particularly for **older** women (TOCC, 2007:

[2] WISeR is undertaking the national evaluation of TRACS and a full report of findings will be provided in late 2014.

12, citing Treasury data). The degree to which this trend is likely to affect the future supply of informal carers has been modelled in Australia, and those findings are discussed below.

In assessing the future of community aged care, the degree to which workplaces support informal care is becoming increasingly apparent. This includes **workplace conditions** that provide appropriate leave and flexibility for carers, and broader **legislative provision** to prevent the discrimination of employees needing time away from the workplace to manage the care of older people. While some protection exists through State Government anti-discrimination legislation, at Federal level, there is a significant gap regarding caregivers (TOCC 2007: 18).

THE COSTS OF FAMILY CAREGIVING

Informal carers carry a number of direct and indirect costs, which will have an impact on their motivation and ability to provide care. Carers Australia and others have documented these well. Nearly 20 per cent of people aged 65 and over are active carers.

- More than half of carers experience decline in their physical health and two-thirds believe that their mental and emotional health has suffered from providing care. Some 55 per cent of older carers themselves have a disability (ABS 2012a).
- One-third have been physically injured in the course of providing care and 30 per cent face difficulties in attending to their health and other appointments because of their caring duties (AMP:NATSEM, 2006: 17, citing previous research findings).
- Carers are less likely to be working than non-carers and if working, to be working fewer hours.
- The annual opportunity cost of caring has been estimated to be $9,300 for a primary carer and $2,600 for other carers.
- Added to this is forgone superannuation contribution which affects retirement income (AMP: NATSEM, 2006: 17, citing previous research findings).

MODELLING THE FUTURE SUPPLY OF INFORMAL CARERS

Carers Australia commissioned the National Centre for Social and Economic Modelling (NATSEM) to develop a model that would project the future demand for and supply of carers of older people in Australia (Percival & Kelly: 2004). Among their findings were that by 2031, the ratio of carers to older people needing care is projected to fall from 57 primary carers for every 100 older people needing care, to **35 carers for every 100** needing this care. The shortfall will need to be met by the formal care system with obvious fiscal implications.

2 REFORM IN THE AGED CARE SECTOR

The aged care sector and reform are constant companions. However, recent years have brought the most extensive reform since 1985 when the Home and Community Care (HACC) program denoted an increasing shift to community based care of older people. In 2012, the Australian Government released its *Living Longer, Living Better* (LLLB) Strategy, responding to a raft of significant changes recommended by the Productivity Commission (2008).

The Productivity Commission was given the brief by the Australian Government to undertake a wide ranging enquiry into Australia's aged care system, with a view to reform and redesign in order to better address increasing levels of demand and meet changing community expectations about the nature of aged care. The Commission consulted widely and its findings reflect the significant input by and views of the aged care sector and of ageing and aged care advocates. Its findings are presented in two reports, the first in 2008 and the final in 2011.

The LLLB Strategy is being implemented in a context of other reforms that give a positive focus to older people and the way they can live their lives. LLLB resonates with broader policy on healthy and active ageing (the *Positive Ageing Agenda*), the appointment of an Age Discrimination Commissioner (www.hreoc.gov.au**)** and the establishment of the Panel on the Economic Potential of Senior Australians (http://epsa.treasury.gov.au/EPSA/content/default.asp) and more recently, the Advisory Panel on Positive Ageing - http://www.treasury.gov.au/Policy-Topics/PeopleAndSociety/positive-ageing/scope .

The reforms enhance consumers' capacity to be informed in the choices they make (eg through the establishment of the *Gateway* and the *MyAgedCare* website). Informing these and other reforms were the three reports produced in late 2011 by the Advisory Panel on the Economic Potential of Senior Australians (EPSA) - *Changing Face of Society, Enabling Opportunity* and *Turning Grey into Gold* – which were focused on removing barriers to the full and effective participation of older people in all aspects of living, and supporting the WHO *Active Ageing* policy agenda and its associated *Age-Friendly Cities Project*. The final *Turning Grey into Gold* report called for a whole-of-government Active Ageing policy agenda and recommended the establishment of a Panel to embed this agenda. This led to the establishment of the **Advisory Panel on Positive Ageing** which is designed to lead a national conversation on ageing issues, to improve policy coordination across portfolios, to work with Government on designing and implementing ageing policy, including the recommendations of the EPSA.

2.1.1 ENHANCED FOCUS ON COMMUNITY BASED CARE

From July 1st 2012 the Commonwealth became fully responsible for the HACC program (previously jointly funded by the Commonwealth and States) and is streamlining all community based care programs into a single umbrella program known as the *Commonwealth Home Support Program*.

In order to foster a seamless continuum of care in the home, the levels of home care packages have been increased from two (CACP or low level care and EACH for high level care) to **four**. The two new packages provide for Level 1 to support a lower level of need than was addressed by a CACP, and an intermediate Level 3 package to enable a more seamless transition between levels. EACH Dementia packages were replaced by a subsidy available for the care of all people with dementia.

An additional 80,000 care packages are to be provided over the next 5 years, changing the current provision ratio from 113 places per 1000 people aged 70+, to **125 places: 1000.** Nevertheless, despite these increases supply continues to fall short

of demand. In the most recent funding round of 2013 applications for care packages outnumbered those funded by a ratio of 18 to 1.

2.1.2 Focus on Re-ablement and Restorative care

The LLBB Strategy promotes the independence of older people and the addressing of functional issues that may impede that autonomy, with a dual focus on 're-ablement' and 'restorative' care.

- 're-ablement' involves intensive and time-limited care that is multidisciplinary and designed to help people with poor physical or mental health to learn or re-learn the skills needed to manage their illness (Ryburn *et al* 2009: 227).
- 'Restorative' refers to care that is designed to help people to do things for themselves, rather than to do things for them that they cannot do independently. It is focused on restoring independent function (Francis *et al* 2011: 1).

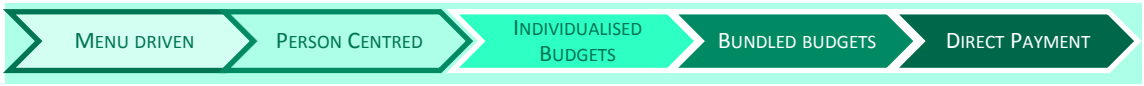
2.1.3 Consumer Directed Care as the centrepiece

The LLLB promotes the consumer directed care model as the underpinning approach to the care of older Australians. From 1/7/2013 all new Home Care packages allocated to providers were offered to care recipients **on a CDC basis**, and existing packages will be converted by July 2015.

> ***The term consumer-directed care is used to cover a range of mechanisms that give people receiving public support greater control of the funds allocated to meet their care and lifestyle needs. One of the aims of consumer-directed care is to improve the responsiveness, flexibility and effectiveness of human services (Laragy & Naughtin 2009: 1).***

CDC is also distinguished by providing consumers with control over the way in which funds allocated for their care are expended, and as such, offers greater transparency in how funding is allocated. This shift is summarised in the figure below which depicts a continuum of choice and control by consumers over the aged care services they receive. It shows a shift from a menu driven approach, to a person-centred approach, but with increasing control and choice of budgets for the care received. The final phase of the continuum (not yet being implemented as part of the reforms) involves cashing out of funding to individual consumers who then engage providers in the same way as individuals purchase services from businesses. It is a model which has been operating in the disability services sector from where significant lessons are being transferred to the aged care sector.

Figure 2: Continuum of Choice and Control



Source: The ACH Group, Adelaide

From a workforce perspective, CDC involves a different relationship with providers than has occurred traditionally, and a different culture of service provision that is more of a partnership of care, with care being 'purchased' by consumers who will have significantly more control over their care than has been the case traditionally. It is likely that new workforce roles will evolve to support the model, for example, in identifying for consumers the range of aged care and other forms of support outside of the aged care sector and linking them to these, or in developing user-friendly care budgeting and management services and tools.

CDC is not simply a model of care, it also represents a mindset shift from delivery of care by a service provider to a consumer, to a negotiated partnership of care. Under

a fully developed model, consumers become the employers of service providers. In this sense, CDC can be seen as the most significant reform since the implementation of the HACC program in 1985. CDC has been described by the National Aged Care Alliance as –

> ***'… a major paradigm shift in aged care from a rationed provider-led dependency and deficit model to an individual entitlement model designed to support wellness and independence.'***

CDC will require different skill sets and guiding values from the aged care workforce and different approaches to risk management and the design of guidelines for the management of staff. The full range of workforce implications will be better understood following evaluation of CDC initiatives and the development of an evidence base regarding the application of this model in Australia.

3 POLICY TO SUPPORT AGEING AND QUALITY OF LIFE

Ageing policy has traditionally focused on care for older people until the past decade or so, when attention has also been directed to the broader ageing process as well as to aged care.

At the beginning of the twentieth century, charitable and religious organisations provided most of the health and welfare services for older people, and non-government organisations continue to play a dominant role in today's aged care system. With Federation in 1901, the Australian government assumed responsibility for income security for older people in need, with the Age Pension being paid from 1909 onwards. In 1954 the passing of the *Aged Persons Homes Act* provided grants to charities that built or purchased homes for older people in need, beginning a shift in emphasis in the care of frail and older people towards institutional care, and relatively limited care in the home (George 2008). Concern about the dominance and cost of institutional care and the scarcity of home care alternatives was expressed in various reports [3] and governments' response culminated in 1985 with the establishment of the *Home and Community Care* (HACC) Program.

Later, the *Community Options* Program was established to support case management of community services. This provided higher levels of home-based care than had previously occurred and its successful implementation across the country was followed by the introduction of Community Aged Care Packages for older people assessed as needing admission to residential care. Initially Community Aged Care Packages (CACP) provided the equivalent to hostel or low level care, and were followed by Extended Aged Care in the Home (EACH) Packages which provided the equivalent to nursing home or high level care (Commonwealth of Australia 2000).

3.1 FOSTERING POSITIVE AGEING

For the past decade or so, international, national and State[4] ageing policy has focused on the opportunities brought by growing older with four key terms representing this trend – 'positive ageing', 'successful ageing', 'active ageing' and 'healthy ageing'. Collectively, these represent a move away from policy that focused solely on the negative aspects of ageing and on dependence and loss.

While there is considerable overlap between each construct given that all are designed to support enhanced quality of life, there are also subtle differences. For example, 'successful ageing' has a more specific meaning that involves maintaining physical and mental reserves needed to withstand the stresses associated with loss of these capacities later in life (Walters *et al* 1999). It is used widely in the fields of geriatrics and gerontology.

This shift in policy is also accompanied by a growing promotion of a rights-based approach to ageing policy. The appointment of a Commonwealth Commissioner on Ageing as part of the Australian Human Rights Commission reflects this, as does the adoption by numerous countries of the World Health Organisation's *Active Ageing* agenda (see Section 3.1) and the associated *Age-Friendly* communities agenda (see Section 3.2).

[3] For example, the 1975 Report of the Social Welfare Commission, the 1982 McLeay Report *In a home or at home* and the1986 *Nursing Homes and Hostels Review.*

[4] See Government of South Australia (2006) *Improving with Age: our Ageing Plan for South Australia*

3.1.1 Active Ageing

The World Health Organisation described active ageing as a process of *'optimising opportunities for health, participation and security in order to enhance quality of life as people age'* (WHO 2002). Active ageing has benefits for individuals as well as for society as a whole, reducing dependencies and generating a range of cost savings in the process.

A key dimension of active ageing is maintaining functional capacity over a person's lifetime, moving individuals to the highest level of functions that is possible for their age. For older people, this means maintaining independence and preventing disability (Oxley 2009: 9).

There are four Pillars that are seen to uphold quality of life in the WHO Active Ageing agenda. These are Health, Participation, Security (which includes stable housing, financial security, protection from harm and good healthcare), and Lifelong Learning (added after the first three, this reflects the importance of information and learning to remain connected and to support participation).

3.1.2 Healthy Ageing

Healthy ageing involves optimising opportunities for older people to have good physical, mental and social health. Relying strongly on prevention and health promotion, healthy ageing policy has an individual as well as a population focus that includes addressing health inequalities and their underlying socio-economic causes (Oxley 2009: 9) Interventions designed to promote healthy ageing include the promotion of healthy eating and nutrition, active lifestyles, reducing substance abuse and misuse, enhancing local environments, and improving health literacy[5]. Healthy ageing policy is also linked to policy which promotes *age-friendly communities* – see below.

Healthy ageing is best promoted by taking a lifelong approach that involves health promotion and prevention strategies across age groups. Many of the health issues faced by mature age people are the accumulated impact of behaviors initiated earlier in the life cycle. Consequently, it is important to view healthy ageing as an integral part of community health, which in turn, requires an integration of a range of programs, services and infrastructure including recreation, sport, education and training, employment, and community development. Much of this is reflected in the City of Playford's *Healthy Ageing in Playford 2008-2011* Strategy.

SA Health's *Health Service Framework for Older People 2009-2016* identifies the strategies which it will undertake to meet the future health needs of older people. *Integrated health service delivery* is central and the key strategy of the Framework is the establishment of specialised interdisciplinary older people's health care services that work across all care settings within a defined service catchment. This includes homes, residential care facilities, GP Plus Health Care Clinics, and the outpatient and inpatient areas (including rehabilitation services) of hospitals. These regionalised older people's health services will use a common model of care and approach to service delivery for older people. The *Northern Adelaide Older People's Health Service* will be the relevant regional service structure for older people living in the region.

In 2007 the Central Northern Adelaide Health Service released the *Healthy Ageing for all Framework Context*. This is designed to promote and support healthy ageing in the region and reflects the underpinning principles of the statewide Framework for older people and healthy ageing.

[5] Health literacy is the ability to access, use and understand health information in order to make appropriate decisions about their health and health care. It has a critical bearing on individual health but tends to fall as age increases.

3.1.3 POSITIVE AGEING

Positive ageing is a broad term that is underpinned by a goal of enabling a positive experience of growing older and good quality of life. It promotes the continued participation of older people in the community and focuses on promoting individual responsibility, such as improving lifestyle choices, while also addressing the broader role that families, communities and governments play in ensuring a positive ageing experience.

As such, positive ageing takes a *whole of life* and a *whole of community* approach to ageing. It is multi-dimensional, and includes attention to health and wellbeing, information, social interaction and support, transport, environment, service provision of all kinds and capacity building. Examples of local level approaches to positive ageing are plentiful.[6]

3.2 AGE-FRIENDLY COMMUNITIES

An age-friendly community can be defined as one in which older people are valued by their community, involved in the life of that community and receive the supports needed for positive ageing (Alley *et al* 2007). Recent research shows an emerging consensus about the characteristics of age-friendly communities, including:

- ✓ Sensitive community and housing design
- ✓ A wide range of transport options
- ✓ Access to health and support services and care
- ✓ Opportunities for participation in the community (Center for the Advanced Study of Ageing Services 2009: 4).

An age-friendly community can be conceptualised as having three over-arching features:

- ⇨ **Continuity** – that is, growing older and its associated functional challenges do not prevent people from participating in their community and pursuing their interests.
- ⇨ **Compensation** – accommodations and supports help older people to address functional challenges.
- ⇨ **Challenge** – people of all ages have the opportunity to develop new interests and sources of fulfilment (Lehning *et al* 2007).

The perspective offered by the age-friendly model is one which can benefit people of different ages, although designed with the needs of older community members in mind.

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[6] Examples include:
City of Darebin (2011) *Darebin Active and Healthy Ageing Strategy 2011-2021-* https://www.darebin.vic.gov.au/Files/Active_and_Healthy_Ageing_Strategy_E_version_single_pages.pdf
West Tamar Council Positive Ageing Strategy 2011-2015 http://www.wtc.tas.gov.au/documents/WTC_Positive_Ageing_Strategy_2011-2015.pdf
City of Joondalup, *Positive Ageing Plan 2009-2012* www.joondalup.wa.gov.au/.../Positive%20Ageing%20Plan%202009-2012.pdf
City of Ballarat *Positive Ageing Strategy (2008-2013)* http://www.ballarat.vic.gov.au/media/135605/positive%20ageing%20strategy%202008-2013.pdf
Strategy for Positive Ageing in Nova Scotia (2005) http://www.gov.ns.ca/seniors/pub/2005_StrategyPositiveAging.pdf

> ***It uses the needs and wants of older people as a lens to view the urban environment and see how it may be reconfigured in a manner that benefits all ages. [It] … is very deliberately titled 'age' friendly, not 'senior' or 'old-age' friendly, because the intention is to stimulate change that will result in more useable environments for people of every age. If a bus is easier to get in and out for an older person, and safe to take him or her from A to B or Z, it will be easier and safer for a person of whatever age and functional status to use it. Using the 'ageing lens' means creating a society for all ages (Kalache 2013: 69).***

Age-friendly communities and cities support *active ageing*. Building on its *Active Ageing Policy Framework* of 2002, the World Health Organisation (WHO) undertook a global initiative called the *Age-friendly Cities Project*. This identified indicators of age-friendly cities in 22 countries with findings provided in two documents – a Guide to developing Age-friendly Cities[7] and a Checklist with the indicators for age-friendly cities.[8]

The Checklist groups these indicators into eight categories:

- ✓ Outdoor spaces and buildings
- ✓ Transportation
- ✓ Housing
- ✓ Social participation
- ✓ Respect and social inclusion
- ✓ Civic participation and employment
- ✓ Communication and information
- ✓ Community and health services.

Because active ageing is a lifelong process, an age-friendly community enhances the mobility and independence of young as well as old people, and of people with varying degrees of capacity. Age-friendly design encourages accessibility, safety and security, participation and inclusion bringing benefits across the generations.

> ***The operative word in age-friendly social and physical urban settings is enablement (WHO 2007:6).***

In the past decade there has been a considerable amount of research on healthy ageing and the factors which shape this, and these include longitudinal studies that follow people over the course of their lives. Among the findings of these studies are that there is a statistically significant relationship between housing and healthy ageing. People living in accessible 'age-friendly' homes, who perceive their home in positive terms, are more independent in daily activities and have a better sense of well-being (Oswald *et al* 2007). Older people who live in homes with *universal design* features are more likely to be able to continue living in the community even with disabling conditions (Campbell & Memken 2007; CDC Healthy Ageing Research Network 2010).

There is significant synergy between the concepts of healthy ageing and age-friendly communities, and in turn, both sit well with the SA Government's vision expressed in *Safe Communities, Healthy Neighbourhoods* - one of the seven strategic priorities contributing to the achievement of many of the targets in South Australia's Strategic Plan. The table below provides the long term targets involved.

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[7] http://www.who.int/ageing/publications/Global_age_friendly_cities_Guide_English.pdf
[8] http://www.who.int/ageing/publications/Age_friendly_cities_checklist.pdf

The South Australian government, in collaboration with the Local Government Association of SA, is promoting the concept of age-friendly cities and local areas. During 2013 all local councils in South Australia have begun working with the State Government to develop, in conjunction with local residents, public health plans for local communities (AGD 2012).

TABLE 1: SAFE COMMUNITIES, HEALTHY NEIGHBOURHOODS - SASP TARGETS

Long term targets (2020)	SA Strategic Plan Target #
Increase the proportion of South Australians participating in social, community and economic activities by 2020	23
Increase the healthy life expectancy of South Australians to 73.4 years (6%) for males and 77.9 years (5%) for females by 2020	78
Increase the use of public spaces by the community	1
Reduce victim reported crime by 38% by 2014, maintaining or improving thereafter	17
Reduce deaths and serious injuries on South Australian roads by at least 30% by 2020	22

3.3 SUPPORTING INDEPENDENCE

Older people and people with a disability have always needed aids and equipment designed to address functional limitations. However, the combination of this need with technological progress, has seen the development of the field known now as Assistive Technologies (AT). As more people with lifelong disability reach older ages, and as our population of older people grows, this is a field which is expanding, and will continue to do so for some time.

> ***In the last three decades, technological development has lifted home modification and aids to a highly sophisticated level. Known variously as 'assistive technology', 'telecare' or 'smart house technology' … assistive technology has presented a tantalising glimpse of a complementary care strategy that could potentially reduce hours of care, improve safety and function of the care recipient, as well as reduce the burden of care (McIntosh et al 2012: 3).***

There is no universally agreed framework for categorising the range of ATs available but a major report prepared for the Department of Health and Ageing developed a typology which groups ATs into four key categories:

1. Aids, appliances and equipment
2. Environmental adaptations
3. Remote monitoring devices
4. Integrated systems (Connell *et al* 2008: 23).

Assistive Technologies have a critical role to play in enabling people to live independent lives, and to live better quality lives. Not only can they assist in the provision of services, but they can be part of enhanced lifestyles (for example, in the form of 'Smart' houses). Aligning end-user needs with AT requires co-design by consumers and technology experts, and while the growth of ATs in itself can be expected to be rapid over the next decade, there is significant untapped potential in developing co-designed ATs.

4 Future Directions: Impact of the Thinker in Residence

South Australia's **2012-2013 Thinker in Residence**, Dr Alexandre Kalache, brought with him a wealth of experience including from his time at the World Health Organisation and the development of a positive agenda on ageing, and the associated age-friendly communities agenda. His final report (Kalache 2013: 25) was submitted to Cabinet in the second half of 2013 and is widely supported by service providers and advocacy organisations. It will shape the updating of the State's Plan for Ageing and is being adopted by a number of local councils in South Australia as they pursue an *Age-Friendly* agenda.

The report brings together the policy agendas on active, healthy and positive ageing, and on age-friendly design. These agendas have in common the shift to a **rights-based** approach to growing older (rather than a needs-based approach). A rights approach integrates the principles of human rights law into decision making processes, policy development and service design and implementation. The Australian Human Rights Commission sees this as a significant shift for the aged care sector which it describes as traditionally using the language of 'priorities' and 'goals' rather than that associated with 'rights' (AHRC 2012: 3). The move to consumer directed care, however, does take a rights based approach to service provision because it takes as its foundation the principles of choice and control.

> ***A comprehensive rights-based approach to policy making will result in structures and programs that will empower and stimulate older people, their families, carers and healthcare professionals (Kalache 2013: 25).***

The Thinker's report identifies the issues to be addressed using the WHO Active Ageing framework – structuring reform under the pillars of Health, Participation, Security and Lifelong Learning. Together the report and its recommendations support the generation of an age-friendly South Australia, with recommendation 27 seeking the appointment of a Commissioner for Active Ageing to progress the age-friendly agenda across the State (Kalache 2012: 78).

The *Age-friendly Cities* agenda, led by the World Health Organisation, is being implemented across the world, allowing local level and tailored applications of a life course perspective to, and a rights-based understanding of, the ageing process. This expands the support of older people beyond a narrow focus on care needs to a more holistic, lifestyle focused agenda.

As Alex Kalache points out in his final report as Thinker in Residence, this is a positive outcome but also requires macro level policy across a number of portfolios, including employment, access to social and health services, transport and housing. He describes this as an 'opportunity is on offer for South Australia' to further develop already strong capacity and achieve national and global recognition. His description of those opportunities provides an Agenda for Positive Ageing.

> ***SA is well equipped to extend the age-friendly approach to new heights – from city to state level. It is a state that could become a global reference on multi-sectoral policies on ageing. It is a state that could easily position itself to attract thousands of degree students seeking training opportunities on ageing-related issues from all over the world. And, it is a state that could pioneer innovative public–private partnerships in the field of ageing. South Australia could demonstrate to the world how to fully include older people in policy making and policy monitoring. It could develop long-awaited and truly intergenerational policies and become a fertile global focal point for ageing research…. In so doing, South Australia would become in practice a society friendly to all ages (Kalache 2013: 97).***

REFERENCES

ABS (2013) 2011 Census QuickStats, Australian Bureau of Statistics – www.censusdata.abs.gov.au/

ABS (2012) Labour Force Australia, Cat No 6291.0.55.001, Table 01, http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/6291.0.55.001Mar%202012?OpenDocument

ABS (2012a) *Australian Social Trends,* Cat No 4102.0

ACCI (2012) *The business case for recruiting and retaining mature age employees*, Australian Chamber of Commerce and Industry, Melbourne - http://www.acci.asn.au/

AGD (2012) *Safe Communities, Healthy Neighbourhoods,* Attorney-General's Department, Government of South Australia - www.agd.sa.gov.au/safe_healthy

AHRC (2012) *A human rights approach for ageing and health*, Australian Human Rights Commission, Sydney

AIHW (2004) *Carers in Australia: assisting frail older people and people with a disability,* Aged Care Series No 8, AIHW Cat No AGE 41, Australian Institute of Health and Welfare, Canberra

Alley D *et al* (2007) 'Creating elder-friendly communities: preparation for an aging society', *Jl of Gerontological Social Work*, 49, 1-18

ALRC (2013) *Access all ages, Older workers and Commonwealth laws, ARLC Report 120,* Australian Law Reform Commission http://www.alrc.gov.au/publications/access-all-ages-120-summary

AMP-NATSEM (2006) *Who cares? The cost of caring in Australia 2002-2005*, AMP-NATSEM Income and Wealth Report Issue 13, May 2006

Atkinson G & Beddie F (2011) 'Introduction' in Griffin T & Beddie F, Older Workers: Research Readings, NCVER Adelaide http://www.ncver.edu.au/publications/2422.html

AWPA (2012) *Future Focus Australia's Skills and Workforce Development Needs: A Discussion Paper for the 2012 National Workforce Development Strategy,* Australian Workplace and Productivity Agency, Canberra

Baby Boomer Magazine.Com (2013) Baby Boomers are still the largest consumer group in America even in a Recession, 3/4/13 - http://www.babyboomer-magazine.com/news/165/ARTICLE/1217/2013-04-03.html

Butler R (2008) *The Longevity Revolution: the benefits and challenges of living a long life,* Public Affairs, New York

Campbell N & Memken J (2007) 'Accessible housing availability for the growing US elderly population, *Housing and Society*, 34 (1), 101-115

CDC Healthy Ageing Research Network, Spring 2010 - http://www.prc-han.org/

Center for the Advanced Study of Ageing Services (2009) *Creating aging-friendly communities: final report,* University of California at Berkeley

Commonwealth of Australia (2000) *A comparison of aged care in Australia and Japan*, Commonwealth of Australia - http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-publicat-ausjap.htm/$file/austjap.pdf

CSHISC (2013) *The Care Industry: a Time for Action, Environmental Scan 2013*, Community Services and Health Industry Skills Council, Sydney – www.cshisc.com.au

Deloitte Access Economics (2012) *Increasing participation among older workers: the grey army advances,* Report prepared for the Australian Human Rights Commission –

http://www.humanrights.gov.au/publications/increasing-participation-among-older-workers-grey-army-advances

DoHA (2008) *2007 National Aged Care Workforce Census and Survey – Who Cares for Older Australians? A Picture of the Residential and Community Based Aged Care Workforce – Final Report*, Dept of Health and Ageing, Canberra

Francis J, Fisher M & Rutter D (2011) *Reablement: a cost effective route to better outcomes,* Social Care Institute for Excellence, London

George J (2008) 'Changing concepts in ageing: a social policy perspective', *Asian Jl Gerontol Geriatr*, 3, 40-45

Health Workforce Australia (2011) *National Health Workforce Innovation and Reform Strategic Framework for Action 2011-2015, Background Paper*

Health Workforce Australia (2011a) *National Health Workforce Innovation and Reform Strategic Framework for Action 2011-2015*

Hugo G (2007) 'Contextualising the 'crisis in aged care' in Australia: a demographic perspective', *Aust Jl of Social Issues,* 42 (2) 169-182 http://acoss.org.au/images/uploads/AJSI_Vol_42_No_2.pdf

Kalache A (2013) *The Longevity Revolution: Creating a society for all ages*, Adelaide Thinker in Residence 2012-2013, Government of South Australia – http://www.thinkers.sa.gov.au/Thinkers/Kalache/report.aspx

Kelly S & Harding A (2007) - *Baby Boomers - Doing It For Themselves*, AMP.NATSEM Income and Wealth Report Issue 16, National Centre for Social and Economic Modelling, Canberra http://www.natsem.canberra.edu.au/storage/AMP_NATSEM_16.pdf

King D *et al* (2013) *The National Aged Care Workforce Census and Survey 2012*, National Institute for Labour Studies, Flinders University of South Australia, commissioned by the Commonwealth Department of Health and Ageing

Kingman D (2012) *Spending Power across the Generations*, The Intergenerational Foundation, London - www.if.org.uk

Laragy C & Naughtin G (2009) *Increasing consumer choices in aged care services: a position paper,* Brotherhood of St Laurence, Melbourne

Lehning A, Chun Y & Scharlach A (2007) 'Structural barriers to developing 'aging-friendly' communities, *Public Policy & Aging Report*, 17, 15-20

MAV (2009) *The WHO global age-friendly cities guide and checklist: a review of their use by local government,* Municipal Association of Victoria and COTA Victoria

McDonald P (2011) 'Employment at older ages in Australia: Determinants and Trends in Griffin T & Beddie F, Older Workers: Research Readings, NCVER Adelaide http://www.ncver.edu.au/publications/2422.html

Oswald F *et* al (2007) 'Relationships Between Housing and Healthy Aging in Very Old Age', *The Gerontologist,* 47 (1) 96-107

Percival R & Kelly S (2004) *Who's going to care? Informal care and an ageing population,* Report for Carers Australia, National Centre for Social and Economic Modelling, University of Canberra - www.bsl.org.au/pdfs/informal_care_NATSEM.pdf

Prime Minister's Science Engineering & Innovation Council, undated, *Promoting healthy ageing in Australia,* http://www.innovation.gov.au/Science/PMSEIC/Documents/PromotingHealthyAgeing.pdf

Productivity Commission (2011) *Caring for older Australians*, Productivity Commission Inquiry Report No 53, Volumes I and II, Australian Government

Productivity Commission (2008) *Trends in aged care services: some implications*, Productivity Commission Research Paper, Australian Government

Productivity Commission (2005) *Australia's health workforce*, Australian Government

Ryburn B, Wells Y & Foreman P (2009) 'Enabling independence: restorative approaches to home care provision for frail older adults', *Health and Social Care in the Community*, 17, 225-234

Spoehr J & Barnett K (2008) *Ageing Nation, Ageing Workforce – challenges for aged care provision in the 21st century,* Keynote Presentation to the ACSA National Conference, Aged Care in the Fast Lane, Adelaide, 29/9/2008

TOCC (2007) *The hidden face of care: combining work and caring responsibilities for the aged and people with a disability*, Taskforce on Care Costs www.tocc.org.au

Taylor P (2006) *Employment initiatives for an ageing workforce in the EU15,* European Foundation for the Improvement of Living and Working Conditions, Luxembourg www.eurofound.europa.eu/

Walters R *et al* (1999) *Proven strategies to improve older people's health,* Eurolink Age Report prepared for the European Commission, Brussels

WHO (2007) *Checklist of essential features of age-friendly cities,* World Health Organisation - http://www.who.int/ageing/publications/Age_friendly_cities_checklist.pdf

WHO (2007) *Global age-friendly cites: a guide,* World Health Organisation - http://www.who.int/ageing/publications/Global_age_friendly_cities_Guide_English.pdf