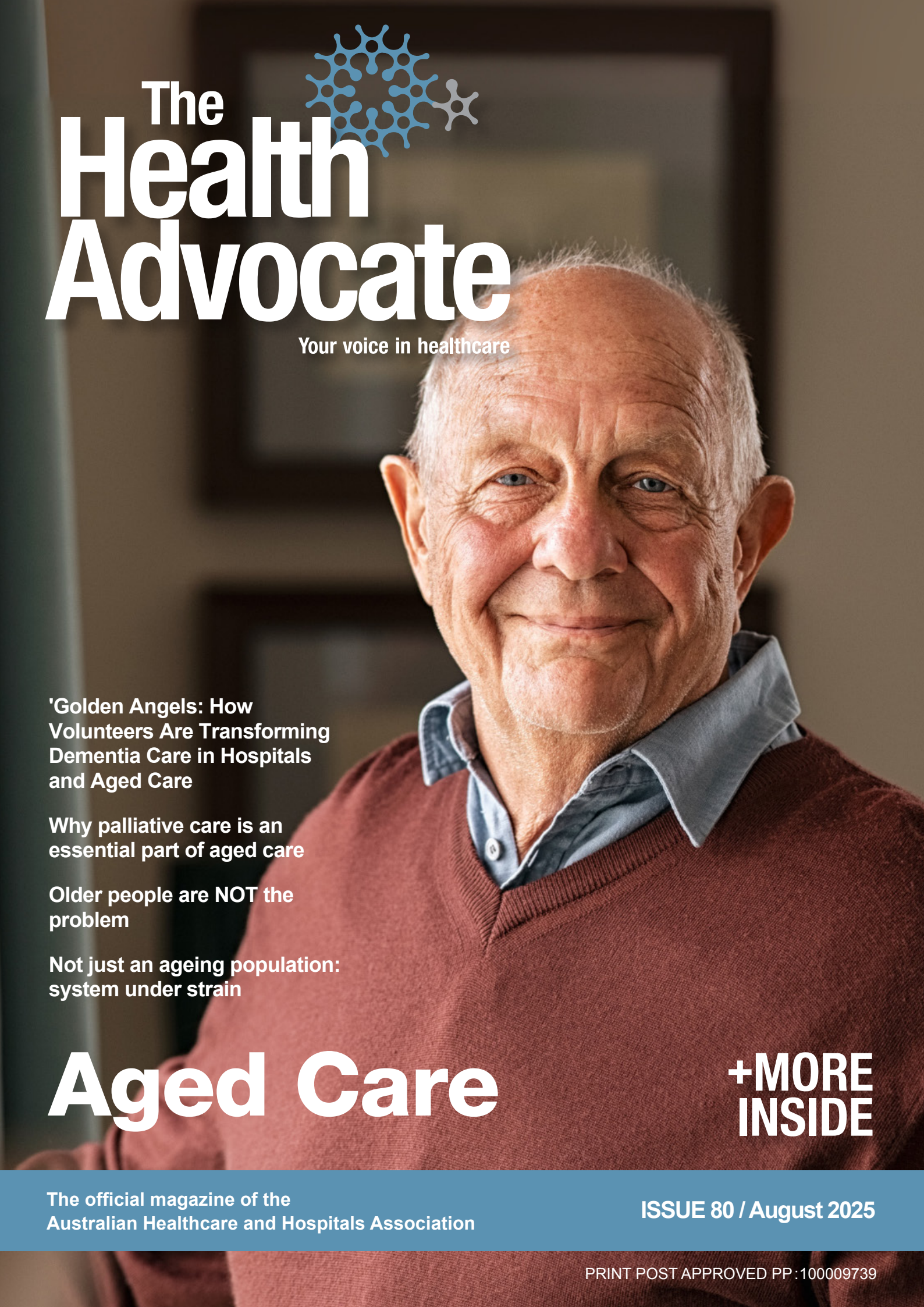

The Health Advocate

Your voice in healthcare

'Golden Angels: How Volunteers Are Transforming Dementia Care in Hospitals and Aged Care

Why palliative care is an essential part of aged care

Older people are NOT the problem

Not just an ageing population: system under strain

Aged Care

+MORE INSIDE

The official magazine of the Australian Healthcare and Hospitals Association

ISSUE 80 / August 2025

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ELDAC

TONY FARLEY
AHHA LTD CEO

The Age for Change

Regardless of where you might be in life, aged care is always personal. Our consciousness is deeply imbued with the concept that to be old is to have earned certain privileges such as wisdom, respect, deference and the care of others.

While each person's journey to old age is unique, our needs when we get there are remarkably similar. Throughout most of history, those needs have been met primarily by family and to some extent by broader, close-knit communities. Cultural and community bonds have been the foundation of care and inclusion for the old who were, until recently, relatively few in number.

And yet so much of this has changed over the last 70 years. Life expectancy in 1955 was 67.1 for men and 72.8 for women, and is now 81.3 for men and 85.4 for women, which, put simply, means that we have many more old people to care for. Running parallel to increased life expectancy is a growing societal expectation that governments will supply the care that was once directly provided by family and communities.

The natural consequence of these and so many other forces of constant change in contemporary society, is the need for public policy makers to adapt and change rapidly in response. The catalysts of change we are enduring are more than likely going to guide us in how we successfully meet community expectations and find alternative ways of seeing the problems clearly and working through them.

What won't suffice in aged care and in so many other areas of public policy is the failure to grasp that at the heart of each of these issues is a human being — in other words, it's personal. Public policy developed solely in terms of functionality and transactions is bound to fail because emotional and psychological needs are intrinsic to all care — whether it be aged, health, disability, educational and the many other ways we arrange our lives to survive and thrive.

The rinse and repeat cycle of blame in politics is particularly ill-suited to developing public policy responses to our communities' human services needs. What seems to be lost in the debates about what should be done and who should pay for it is the need to respectfully engage with the community about the problems at hand, and the potential solutions available.

“While each person’s journey to old age is unique, our needs when we get there are remarkably similar.”

Using a combination of face-to-face interactions, digital technologies that can tell us what people really think, and the expertise of professionals and representative groups in aged care is the surest way of finding new solutions to the many problems we see. Respectfully and factually done, we can handle the truth and will ultimately respect those who allow us the dignity to hear it. ha

AHHA in the news

5 JUNE 2025

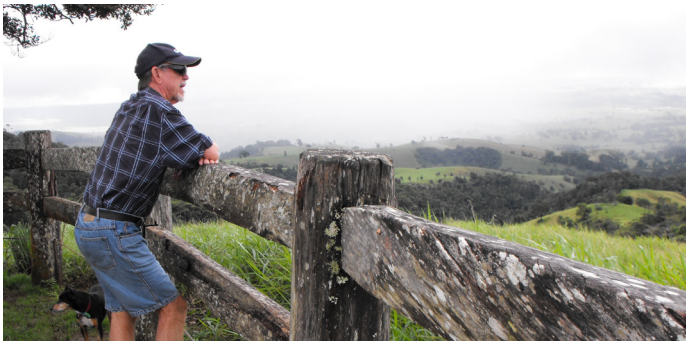
Australia needs to consider environmental impacts in healthcare decisions and planning

Australia's healthcare system, like many other industries and services, is a significant contributor to national greenhouse gas emissions. Yet we still don't consistently measure or assess the environmental cost of healthcare design and delivery.

An Issues Brief released by the Deeble Institute for Health Policy Research, *Consideration of environmental impacts in health technology assessment*, urges government and industry to take immediate action. It calls for environmental sustainability to be embedded into healthcare decision-making, design and delivery as part of business-as-usual operations.

Co-authored by Deeble Institute Scholar Mr Jake Williams, the Brief identifies Health Technology Assessment (HTA) as a key opportunity to drive this much-needed change. HTA is a critical process used to evaluate the safety, effectiveness, and value of new health technologies. However, environmental impacts are not routinely taken into consideration.

19 JUNE 2025



Rural health held back by national policy misalignment

Despite longstanding efforts to improve health outcomes in rural and remote areas, current health, aged care and disability policies remain poorly aligned, resulting in overly burdensome administration and hindered collaboration between services, which ultimately reduces access to care for communities.

A Policy Perspectives Brief from the Deeble Institute for Health Policy Research, *Policy alignment for place-based solutions for better health outcomes in rural and remote communities*, provides solutions to address the fragmented funding and policy settings that are challenging the delivery of equitable health care in rural and remote Australia.

The Brief calls for greater transparency in the reporting of funding flows to empower local decision-making and improve accountability and identifies several practical opportunities to address these issues, including:

- aligning federal and state policy and funding to better support place-based solutions,
- developing a shared commissioning and evaluation framework to enable integrated care, and
- establishing nationally coordinated workforce development approaches that reflect the unique needs of rural and remote communities.

HAVE YOUR SAY...

We would like to hear your opinion on these or any other healthcare issues.
Send your comments and article pitches to our media inbox: communications@ahha.asn.au

25 JUNE 2025

Mental health reform must start with people, not bureaucracy

The Productivity Commission's interim report of its review of the National Mental Health and Suicide Prevention was a 'critical wake-up call' for the Commonwealth, States and Territories.

AHHA Ltd CEO Tony Farley said that maintaining the status quo while expecting different outcomes reflects a system stuck in its ways, holding back progress and damaging trust — Australians deserve better.

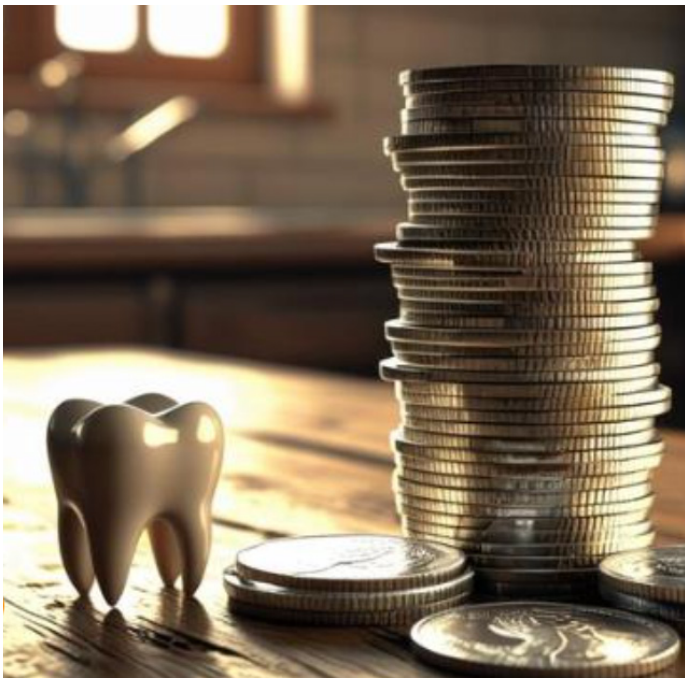
'The report simply reinforces what we already know — care is inaccessible, unaffordable, and uncoordinated, with people at breaking point wherever you turn.'

Tony Farley says the first step out of this avoidable cycle of failure is for 'Commonwealth, State and Territory Ministers to stop creating more committees and bureaucratic processes and put people in charge to make the reforms happen'.

'We need to see health as an investment, not just a cost. This takes time to get right, particularly in building the trust and support needed to work together, where people are seen and treated as more than just their care needs.'

AHHA in the news

9 JULY 2025



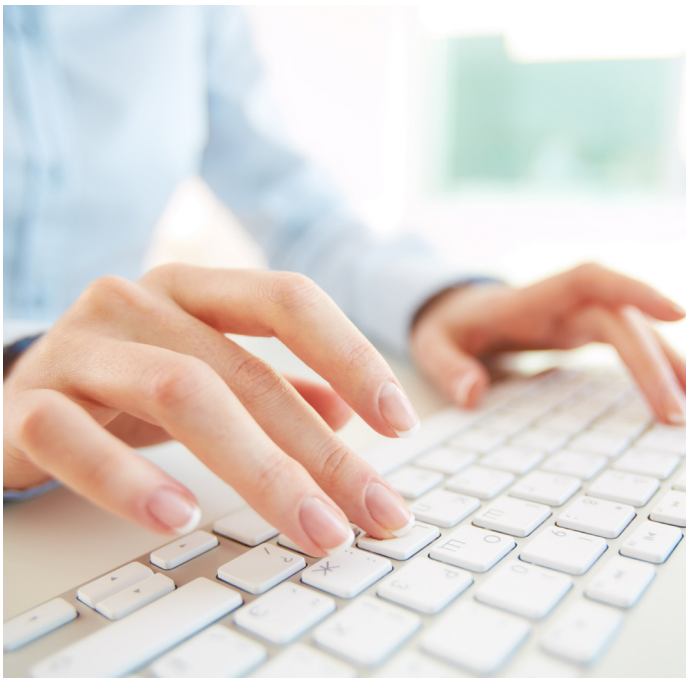
Funding fix needed to bridge Australia's oral health divide

Oral healthcare is one of Australia's biggest out-of-pocket health expenses, and the system is failing too many Australians. We need national funding reform to include our oral health care system — not just more money, but smarter, fairer investment.

An Issues Brief, *Universal access to essential oral healthcare through a priority-setting approach*, outlines a clear, staged and evidence-based funding strategy to transition from ad hoc responses to a sustainable, equitable, and high-value oral health system.

The Brief calls for a nationally consistent, evidence-based approach to defining essential oral healthcare, underpinned by a structured, priority-setting framework such as the Assessing Cost-Effectiveness (ACE) methodology.

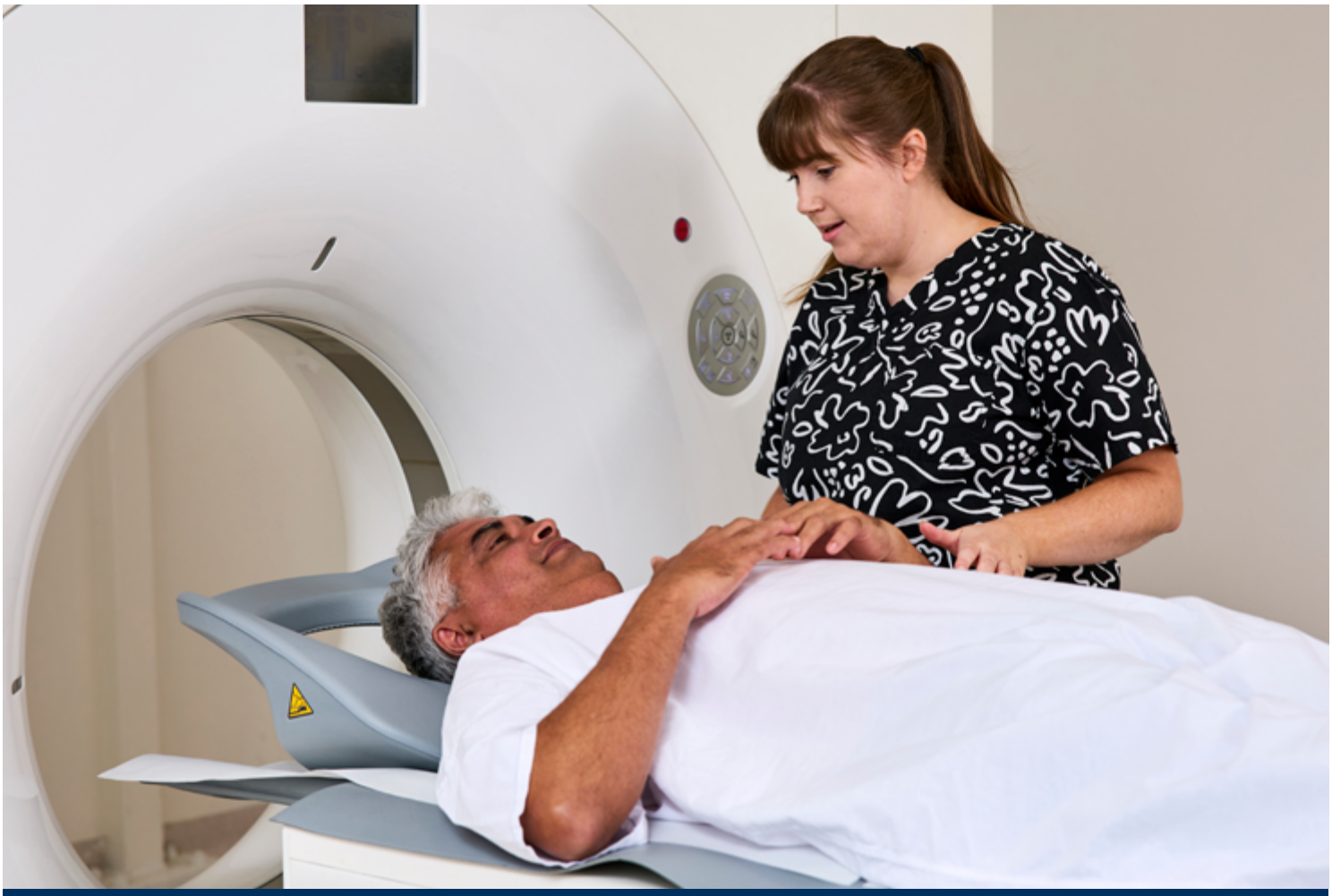
17 JULY 2025



AI in healthcare: Policy must keep pace with innovation

Artificial intelligence has the potential to reshape healthcare delivery, but only if it is introduced in ways that are safe, transparent, and earn the trust of clinicians and patients alike. To get this right, we need nationally consistent frameworks that support innovation while safeguarding patient care and clinical accountability.

The Deeble Institte Perspectives Brief *Advancing AI Integration in Hospitals: An Appendicitis Case-Study Approach*, uses a key case study of paediatric appendicitis machine learning model to explore how artificial intelligence (AI) can improve diagnostic accuracy, streamline emergency care, and reduce unnecessary procedures; but warns that poor governance and inadequate validation could put patient safety and clinician confidence at risk.



THE NATIONAL LUNG CANCER SCREENING PROGRAM IS NOW AVAILABLE

Healthcare providers play a critical role in the success of the program.

If you have patients aged 50 to 70 with a history of smoking, they may be eligible for a free low-dose CT scan to look for signs of lung cancer.

Education and resources are available to support you to deliver the program and save lives.

For more information
scan the QR code or visit
health.gov.au/nlcsp-hcp-toolkit

Australian Government

NATIONAL LUNG CANCER SCREENING PROGRAM

PROFESSOR JENNIFER TIEMAN
Director, Research Centre for Palliative Care, Death and Dying, Flinders University

ELDAC
End of Life Directions for Aged Care

"The primary goal of palliative care is to optimise the quality of life. It helps people to live their lives as fully and as comfortably as possible when living with a life-limiting or terminal illness."

Why palliative care is an **essential part of aged care**

As a population, we are living longer and dying older. This change in population demography is significant as we need to consider how to plan and provide care, support those who are dying, and respond to bereavement and grief. It has implications across the health, aged care, and primary care systems, as well as for older people, their families and friends, and the communities in which they live.

In 2023, 68% of deaths were among people aged 75 or over. Not only are people dying older, but most people who die over 65 years of age will have used aged care services. AIHW data shows us that in the eight years preceding their death, 80% of older people had used some form of aged care, and three-fifths were current clients of aged care programs when they died. When we look at where people over 85 years of age died, more than half died in residential aged care. These numbers tell us that aged care is already a key player in providing care in the last years, months and days of life.

What do we mean by palliative care?

Both aged care and palliative care aim to provide care that is person-centred and tailored to what is needed and wanted by the person. The primary goal of palliative care is to optimise the quality of life. It helps people to live their lives as fully and as comfortably as possible when living with a life-limiting or terminal illness. It identifies and treats symptoms which may be physical, emotional, spiritual or social. Different health and care professionals can be involved in providing palliative care as a multidisciplinary team to meet the person's needs. Being able to adequately address symptoms and concerns may also mean the involvement of a specialist palliative care team. Advance care planning is seen as an important part of both aged care and palliative care as it allows the person's wishes about their

This series of articles is presented in collaboration with the ELDAC (End of Life Directions for Aged Care) consortium, which includes the AHHA among its members. ELDAC provides aged care staff with practical information, guidance, and resources to support palliative care and advance care planning.

end-of-life to be respected even if they can no longer speak for themselves.

Aged care and palliative care

The importance of palliative care is now firmly on the agenda for aged care. Later this year, as the aged sector transitions to the new Aged Care Act, strengthened standards and the Support at Home Program, new governance and funding elements highlight palliative care and end-of-life. The main elements are:

- A Statement of Rights which requires equitable access, including the right to palliative care and end-of-life care
- A Clinical Standard which includes a specific outcome focused on palliative care and end-of-life care
- he Support at Home Program (replacing the Home Care Packages Program and the Short-Term Restorative Care Programme) which includes an End-of-Life Pathway.

Aged care providers will have the responsibility to recognise and address the needs, goals and preferences of individuals, ensure that their pain and symptoms are actively managed, with access to specialist palliative and end-of-life care when required, and make sure the person and family are informed and supported, including during the last days of life. The End-of-Life Pathway within the new Support at Home Program will provide additional funding for in-home aged care services for older people who have three months or less to live. This aims to help them stay at home for as long as possible.

These changes, which address the reality of population ageing in terms of aged care, will also influence health care. Palliative care for older people using aged care services will require the skills of health professional providers outside of aged care, including GPs, Nurse Practitioners, allied health professionals and paramedics. Health services are also likely to be involved in the provision of specialist palliative care and other acute services such as geriatric outreach and virtual care.

Supporting the demand for care arising from demographic changes requires us to look at how we can build workforce capability, strengthen communication and integration between sectors, and create responsive and purposeful approaches to palliative care for older people regardless of their setting. The National Palliative Care Program has funded a range of projects and initiatives, such as ELDAC, PACOP, PEPA, palliAGED and CarerHelp, that are available to help primary care, aged care, and health care prepare for changes and be more confident in meeting the palliative care and end-of-life needs of older people. ha

DR PRIYANKA VANDERSMAN
Senior Research Fellow
End of Life Directions for Aged Care (ELDAC) Project

ELDAC
End of Life Directions for Aged Care

"Patients are offered a one-off assessment to enable initial investigations and interventions, while navigation into the most appropriate ongoing care provider is assessed and facilitated."

The value of online knowledge in supporting **palliative care**

In 2023, 68% of deaths in Australia occurred among people aged 75 years and older. Data from the Australian Institute of Health and Welfare shows that 80% of older Australians used aged care services in the eight years before their death, and three-fifths were receiving care at the time. Among those aged 85 years and over, more than half died in residential aged care. These figures underline the significant role aged care services play in supporting people at the end-of-life, across both home and residential settings.

Care at the end-of-life, commonly known as palliative care, has become a core part of aged care. As health declines in later life, most older Australians will require some level of palliative support, often continuing until death. Much of this care is delivered by the aged care workforce. Providing high-quality care during this stage is complex and demanding. It requires clinical expertise, effective communication skills, and the ability to respond to changing and challenging needs. With ongoing reforms and increasing expectations for safety and quality, aged care workers need timely and reliable information to guide their practice more than ever.

Reliable online knowledge is central to supporting this workforce. In a sector shaped by reform, demographic change, and high staff turnover, having trustworthy information available at the point of care is essential to maintaining quality and confidence. Digital sources, including health and educational websites, are increasingly used by aged care workers to inform decision-making, strengthen practical skills, and access evidence-based guidance. This enables staff to make informed clinical decisions, communicate effectively with families, and deliver care with greater assurance.

This series of articles is presented in collaboration with the ELDAC (End of Life Directions for Aged Care) consortium, which includes the AHHA among its members. ELDAC provides aged care staff with practical information, guidance, and resources to support palliative care and advance care planning.

However, not all online resources meet these standards. Many of these resources are difficult to navigate, lack clear guidance, or are not grounded in evidence. These shortcomings are especially concerning in end-of-life and palliative care, where access to accurate, evidence-based information is critical. The quality and timeliness of information available to workers can significantly affect the care experience of older people nearing the end-of-life and the support provided to their families.

Addressing these challenges requires online resources that are dependable, user-friendly, and tailored to the realities of aged care practice. Digital tools must deliver evidence-based guidance in a practical and accessible way for workers who are often time-poor and working in complex care environments.

The End of Life Directions for Aged Care (ELDAC) website was developed to meet this need. Created in partnership with the aged care sector and co-designed with workforce input, the site was recently redeveloped to make information easier to find and more relevant to daily care. Content is organised around common care tasks and situations, allowing workers to quickly access guidance on advance care planning, symptom management, cultural safety, grief, self-care, and wellbeing. Each resource is evidence-based, developed with input from sector experts and practitioners, and informed by research and best practice. This ensures staff can rely on ELDAC to support timely, high-quality care for older people and their families.

As the aged care workforce evolves, access to dedicated support becomes increasingly important. Many new staff join with limited experience in palliative care. Without clear guidance, they may feel uncertain or overwhelmed, contributing to turnover and impacting care quality. ELDAC bridges this gap by providing reliable, practical knowledge directly to workers, enabling them to build confidence and competence while delivering care, rather than relying solely on formal training or on-the-job experience.

Digital platforms also extend knowledge access at scale. In a sector spanning metropolitan, regional, and remote communities, online access ensures all workers can reach the same high-quality, evidence-based resources. This consistency supports safe practice and helps services meet growing expectations for palliative and end-of-life care. Importantly, ELDAC goes beyond clinical guidance to include resources addressing staff wellbeing, grief, and self-care, recognising the emotional challenges involved in caring for those nearing the end-of-life.

As aged care reforms continue and demand for palliative care grows, strong digital knowledge will become increasingly critical. Investing in platforms like ELDAC ensures workers have the tools to deliver evidence-informed care confidently. Ensuring that evidence-based, easy-to-use online information is always accessible in everyday practice empowers the aged care workforce to deliver consistent and quality care to older Australians nearing the end-of-life. ha

EMMA WALSH
Policy Officer
Australian Healthcare & Hospitals Association Limited

ELDAC
End of Life Directions for Aged Care

"Action is needed for Australians living with and dying from chronic, life-limiting conditions to have timely, accessible and appropriate palliative care that prioritises comfort and dignity in their final months and weeks."

Not just an ageing population: system under strain

Ongoing advances in disease control and detection, medical innovation, and diagnosis and treatment has seen Australians living longer than ever before. In 2022, the proportion of the population aged 65+ was estimated to be 17%. By 2071, this estimate is projected to increase to between 25-27% of the population (ABS, 2023).

An ageing population has brought with it a range of new healthcare challenges — notably, a rising prevalence in chronic comorbidity. This has demanded from the system a shift away from the historically acute, episodic care towards continuous, coordinated models of care, emblematic of the quality of care delivered and received in Australia.

This evolution in care has also brought a significant increase in the need for palliative and end-of-life care, reflecting the increasing complexity and duration of illness. It also speaks to the growing expectation that people should be supported by care that not only values their life, but also their death, through person-centred approaches that prioritise dignity, respect and choice.

Yet current data presents a confronting picture of end-of-life care for older people in Australia. Despite recommendations for palliative care to be available to people from the time they are first diagnosed with a life-limiting illness to improve quality of life, the average time in Australia that someone receives palliative care for the first time is just 15 days before death (AIHW, 2024).

Action is needed for Australians living with and dying from chronic, life-limiting conditions to have timely, accessible and appropriate palliative care that prioritises comfort and dignity in their final months and weeks.

Meeting people where they are: the role of primary care in palliative care

Palliative care needs are highly complex and evolve quickly, demanding flexible models of care that

embrace a multidisciplinary care approach across acute, primary, specialist, community, residential, and aged care settings. Achieving this level of ongoing coordination is complex within a health system that is inherently siloed, short of critical workforce across multiple disciplines, and is resource poor — not just in finances, but often in time and capacity.

Primary care is well-positioned to provide and coordinate care across a range of settings, with a diverse group of health and social support professionals and backgrounds essential to the palliative care team. As the first point of contact within the health system, primary care providers are often the first to identify when and what kind of palliative care is needed.

Their trusted, ongoing relationships with the older person place them in a vital position as an advocate to align their care with the values, wishes and goals of the person. In navigating what are often sensitive conversations about prognosis and end-of-life, they are well-positioned to not just support the older person, but their family and community.

Despite this, delivery of palliative care is often highly institutionalised, placing acute services like hospitals under significant demand for care that does not align with increasing preference to die at home.

Better together: driving integrated end-of-life care

Where care is delivered in community settings, the complexity of needs often requires additional time to coordinate with aged care providers, travel to patients' homes, and respond to rapidly evolving care demands. These responsibilities add to already demanding clinical and administrative workloads. For many providers working within their own practices, this also means balancing patient care with the challenges of managing a small business while keeping up to date with evolving clinical guidelines and best practices in end-of-life care.

While primary care professionals value their role in providing palliative care and are seeing increasing demand for it, long-term delivery remains constrained by the challenges of insufficient remuneration, workforce capacity, and practice support (PCA, 2025).

Without action to address these challenges, the growing demand driven by Australia's ageing population will overwhelm not only residential aged care facilities at the brink of overflow, but primary care services already stretched thin. It will only be in coming together across sectors that we can collaboratively solve the complex challenges that face not the aged care or primary care sector in isolation, but that exist across the health system, that we can deliver the palliative care that Australians expect and deserve.

Recognising this, the AHHA has been a proud consortium member of the End of Life Directions for Aged Care since its establishment in 2017, championing the role of primary care in delivering quality palliative and end-of-life care. As part of this work, the Primary Care Toolkit has recently been updated to support primary care professionals and primary care practices to deliver safe and quality palliative care, reflective of the current operating environment and the needs and constraints of the sector as a whole. ha

HESTA | An Industry SuperFund

Salary sacrifice for employees

Have any of your employees asked you to add more to their super before tax? They might have heard about its benefits from us.

Every year, we remind our members they can boost their super by making extra before-tax or after-tax contributions. So in the lead up to 30 June, you might have a few requests rolling in.

Before-tax contributions can be a great option for people to boost their super and reduce their taxable income.

Here's what you need to know about before-tax, or 'salary sacrifice', super contributions.

How do before-tax contributions work?

Your employee can redirect, or 'sacrifice', part of their before-tax salary or wages into super, if you agree to it. You then pay the sacrificed amount to your employee's super fund on their behalf.

Why agree to salary sacrifice?

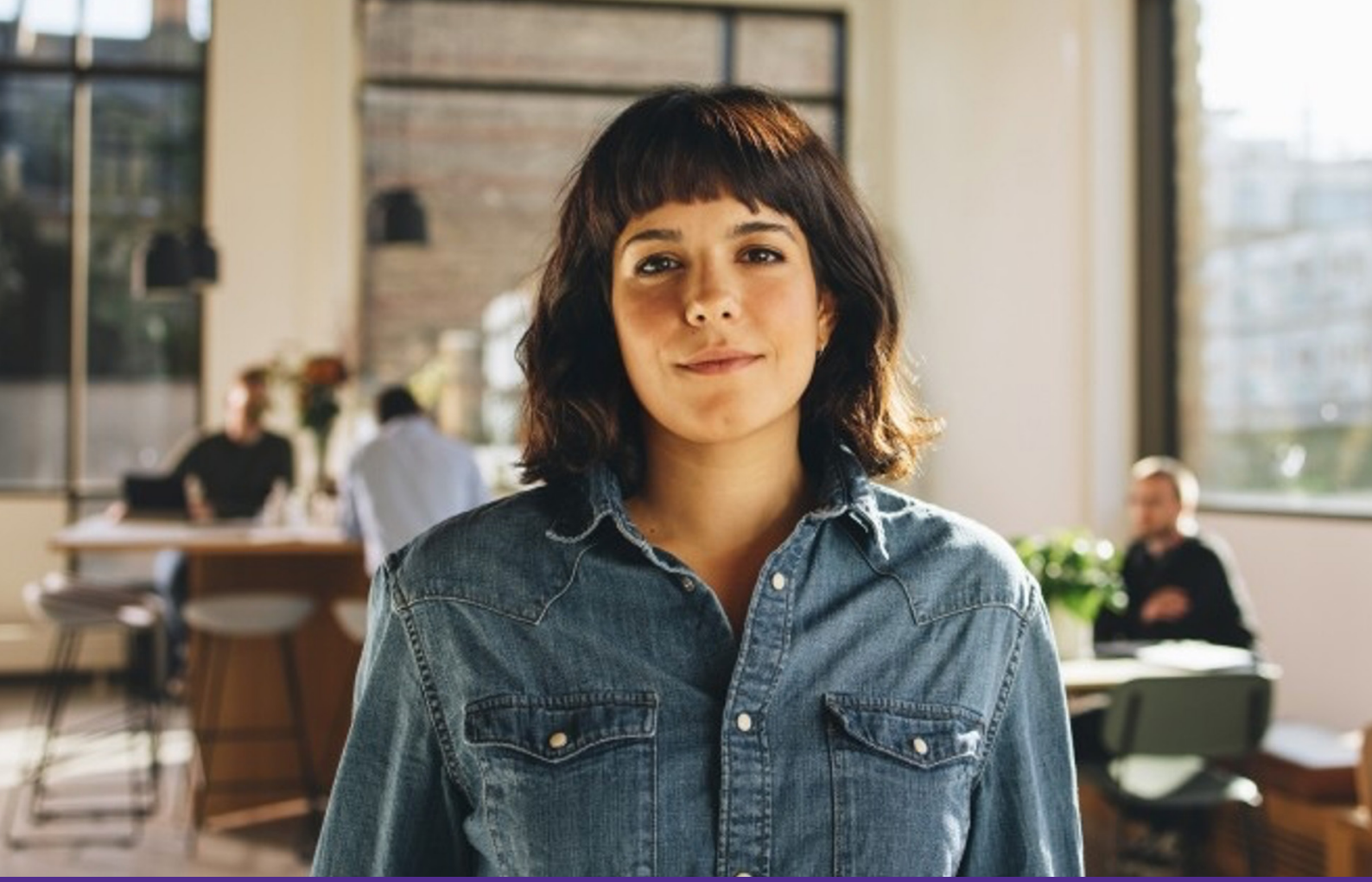
It can be a win-win for both of you, as long as the contributions are made under an 'effective salary sacrifice arrangement' to a complying super fund.

For your employee

- Salary sacrifice allows people to boost their super while reducing their taxable income.
- It's a tax-effective way for people to save more for their future, as long as they stay within their contribution caps.
- Salary-sacrificed super contributions don't attract the fringe benefits tax.

For you

- If you offer salary packaging, your employees' thresholds, limits and benefits are not affected by salary sacrifice contributions made into super. They can work together to produce maximum tax benefits.
- Salary sacrifice is another benefit you can offer to help attract and retain employees. It gives them flexibility in how they can plan for their future.



Quick tips

- It's a good idea for you and your employee to clearly set out and agree on all the terms of the salary sacrifice arrangement. Check with the Fair Work Commission before you sign off on an agreement.
- Salary sacrifice contributions you make on an employee's behalf must be included on their annual payment summary as reportable employer super contributions.
- If you decline a salary sacrifice request, your employee can make a personal contribution and later claim a personal tax deduction (subject to eligibility and caps). This can ease your admin burden and give you peace of mind that your employees have another option to reduce their taxable income.

What to do next

1. Think about speaking to a tax adviser to understand how employee salary sacrifice can work for your business.
2. Visit the ATO's website for more about employee salary sacrifice.

By BARB CORAPI
as told to her by
Ms CATH BATEMAN

The Australian National University

"Wearing bright gold polo shirts, the volunteers became affectionately known as 'golden angels'. "

Golden Angels: How volunteers are transforming dementia care in hospitals and aged care

When Alison* speaks about her mother's first hospital admission, the distress in her words is clear.

'In the end, I asked if I could bring her home,' she recalls. 'She wasn't eating, she was getting confused. The staff just don't have time to sit and feed elderly, confused people.'

Alison's mother lives with dementia. Her hospital stay triggered delirium, an all too common and distressing experience for older adults with cognitive impairment.

Clinical Nurse Consultant, Cath Bateman, saw this scenario play out time and time again: older patients with dementia becoming anxious, agitated, and unwell in unfamiliar hospital environments. She knew something had to change.

In 2009, together with Barbara Williams from Alzheimer's NSW and Associate Professor Katrina Anderson from The Australian National University, Ms Bateman and team launched a groundbreaking pilot program. The idea? Train volunteers to provide emotional and practical support for patients with dementia in hospitals.

The training, grounded in person-centred care principles, equipped volunteers to understand

Photo credit: Southern NSW Local Health District

the emotional and psychological needs of people living with dementia. They learned how to reduce common hospital-related risks like delirium, dehydration, and falls, and how to support physical wellbeing through meaningful interactions.

Wearing bright gold polo shirts, the volunteers became affectionately known as 'golden angels'. Their impact was immediate and profound.

'Volunteers provided emotional support, sat one-on-one with patients, offered gentle hand and foot massages, and helped engage them in therapeutic activities,' Ms Bateman explained. 'They also assisted with practical tasks like encouraging hydration and nutrition, promoting gentle exercise, helping with hearing and vision aids, and keeping patients oriented.'

Families felt the difference.

'I talked to the volunteers to work out when I couldn't be there so they could be with Dad,' one family member shared. 'And when I was around, they could go help someone else.'

Staff noticed the change too. A hospital manager commented, 'the flow on effect of volunteers assisting with feeding, hydration, supervision and >

“As for Alison’s* mother, the difference of being supported by a volunteer on a subsequent visit to hospital was deeply personal and transformed her experience.”

social interactions was providing staff with time to be able to plan, prioritise and deliver their clinical care more effectively and equitably. It really helped us manage our workload.’

Encouraged by the success of the pilot, the NSW Agency for Clinical Innovation (ACI) funded Ms Bateman to develop a Volunteer Dementia and Delirium Care Implementation and Training resource to support replication in other NSW hospitals. Subsequently, the Commonwealth Department of Social Services funded a larger study using this resource across seven rural hospitals in Southern NSW in 2016–2017. The results echoed the pilot — fewer falls, happier patients, more supported staff.

Then, in 2020, the volunteer training program was adapted for residential aged care homes, where it continued to thrive.

Recognising that face-to-face training wasn’t always practical, the team partnered with Dementia Training Australia in 2023 to bring the program online. With support from the Department of Health and Ageing, they developed a free, interactive, evidence-based course accessible nationwide.

Now, volunteers, nurses, personal care assistants, family carers, and community support workers can all take part.

Meanwhile, work is underway to convert the ACI hospital-based face-to-face training program into an online format as well.

As for Alison’s* mother, the difference of being supported by a volunteer on a subsequent visit to hospital was deeply personal and transformed her experience.

‘They helped feed her when she couldn’t do it herself,’ Alison said. ‘Just knowing someone was with her — I can’t even explain what a relief that was. Without them, she would’ve been disoriented and scared.’ ha

**Alison is a pseudonym*

SUSAN MCKEE
CEO
Oral Health Victoria

A Senior Dental Benefits Scheme is no longer optional. **It's urgent.**

"Oral disease is one of the most preventable health issues we face, yet nearly one-third of adults aged 55–74 have dental caries (tooth decay), and more than half experience periodontitis (severe gum disease), rising to 70% among those aged 75 and over."

Older Australians are carrying an invisible burden that too often goes untreated and unnoticed until it becomes a crisis.

Oral disease is one of the most preventable health issues we face, yet nearly one-third of adults aged 55–74 have dental caries (tooth decay), and more than half experience periodontitis (severe gum disease), rising to 70% among those aged 75 and over. People aged 65 and over also have the second highest rate of potentially preventable hospitalisations for oral conditions in Australia, surpassed only by children aged 4 to 9.

The issue isn't complexity. It's access. And the solution is clear: Australia needs a Senior Dental Benefits Scheme as a first step towards universal access.

Oral health care is essential health care

Despite its impact on overall wellbeing, oral health is still siloed from the rest of the health system. It is excluded from Medicare, inconsistently delivered, and underfunded. But the consequences of inaction are serious. Poor oral health contributes to malnutrition, frailty, aspiration pneumonia, cardiovascular disease, and diabetes.

Nearly three-quarters of adults aged 55 to 74 require dental treatment within three months. Yet only 60% see a dental practitioner annually, and 34% delay or avoid care due to cost. For those on low incomes, cost is a significant barrier. Among the most disadvantaged, over one in four adults (27%) report cost as a reason they didn't seek care.

Oral health inequities don't just affect individuals. They have system-wide implications, from preventable hospitalisations to increased pressure on aged care and general health services.

Acting on the Royal Commission's vision

The 2018 Royal Commission into Aged Care Quality and Safety clearly recognised that good oral health is fundamental to dignity and quality of life. It called for stronger oral health provisions, including routine care, hygiene support, and better access to professional services.

Yet despite progress in nutrition standards and staffing levels, a critical piece is still missing. Without guaranteed access to essential oral healthcare, older Australians cannot optimally benefit from improved food or aged care environments.

At Oral Health Victoria, we support the Commission's call to introduce a Senior Dental Benefits Scheme for people living in aged care and in the community.

This scheme should:

- Prioritise prevention and early intervention to reduce disease progression and avoid hospital admissions.
- Fund essential oral health care focusing on function and quality of life over expensive, unnecessary procedures.
- Leverage the full oral health workforce including oral health therapists and oral health educators.
- Enable outreach and mobile care, particularly for residents in aged care homes.
- Train and support other care professionals — such as nurses and personal care assistants — to assist with oral hygiene and referrals.

The benefits go far beyond the mouth. Cost modelling shows that improving dental hygiene care in residential aged care could deliver more than $4 million per year in system savings, and up to $200 million in broader health and social savings. Every preventable hospitalisation avoided can save over $20,000.

A universal or phased approach — but we must begin

Oral Health Victoria recommends a universal Senior Dental Benefits Scheme for everyone aged 65 and over. If a staged approach is needed, we suggest starting with those who face the greatest barriers — aged care residents, people on low incomes, and those with chronic or complex health conditions.

The scheme should be underpinned by the principles of value-based health care: prevention-first, outcomes-focused, and built around the needs and goals of older people themselves.

This is not without precedent. Countries such as Japan and the UK already offer universal or subsidised oral health coverage for older adults. These systems recognise that maintaining oral health is essential for healthy ageing and healthcare system sustainability.

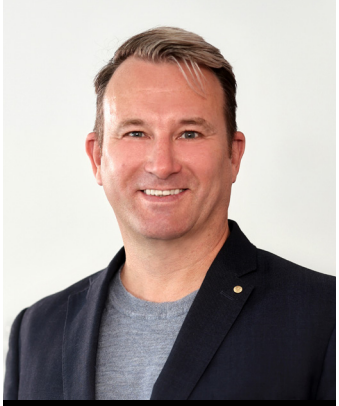
It's time to finish what we started

We know that oral disease is preventable. We know older people are missing out. And we know that public investment in early, essential care saves lives and money.

The Royal Commission laid the groundwork. What's needed now is the political will to act.

A Senior Dental Benefits Scheme would close a gaping hole in Australia's health system. It would bring oral health into the mainstream of aged care and finally treat the mouth as part of the body, not an optional extra.

Let's give older Australians the care, comfort and dignity they deserve. ha



CRAIG GEAR OAM
CEO of the Older Persons Advocacy Network (OPAN)

"Access to a hospital bed should be predicated on a person's clinical need — not their age bracket. Older people have a right to high quality, safe, respectful care in all settings."

Older people are **NOT the problem**

A term like 'bed-blocking' suggests inappropriate use of the health care system

When it comes to the national shortage of hospital beds, let's get one thing straight: older people are NOT the problem.

Commonly used terms such as 'bed block' and 'long-stay patients' give the impression older people are clogging up the health care system and/or using it inappropriately.

Some states have gone so far as to propose punitive measures, such as charging an older person more than $3000 a night if they refuse an offer of placement in a residential aged care home. Others have said that older people must take the first residential care place available, even if that means disconnection from family and community.

According to the Australian Commission on Safety and Quality in Health Care (ACSQHC), 'discharge should not be considered the end of care. It is a transition point along the patient's health journey.'

Research shows healthcare professionals have a more negative view of ageing than the general population, which leaves older people vulnerable to systemic bias in relation to the expectations surrounding old age.

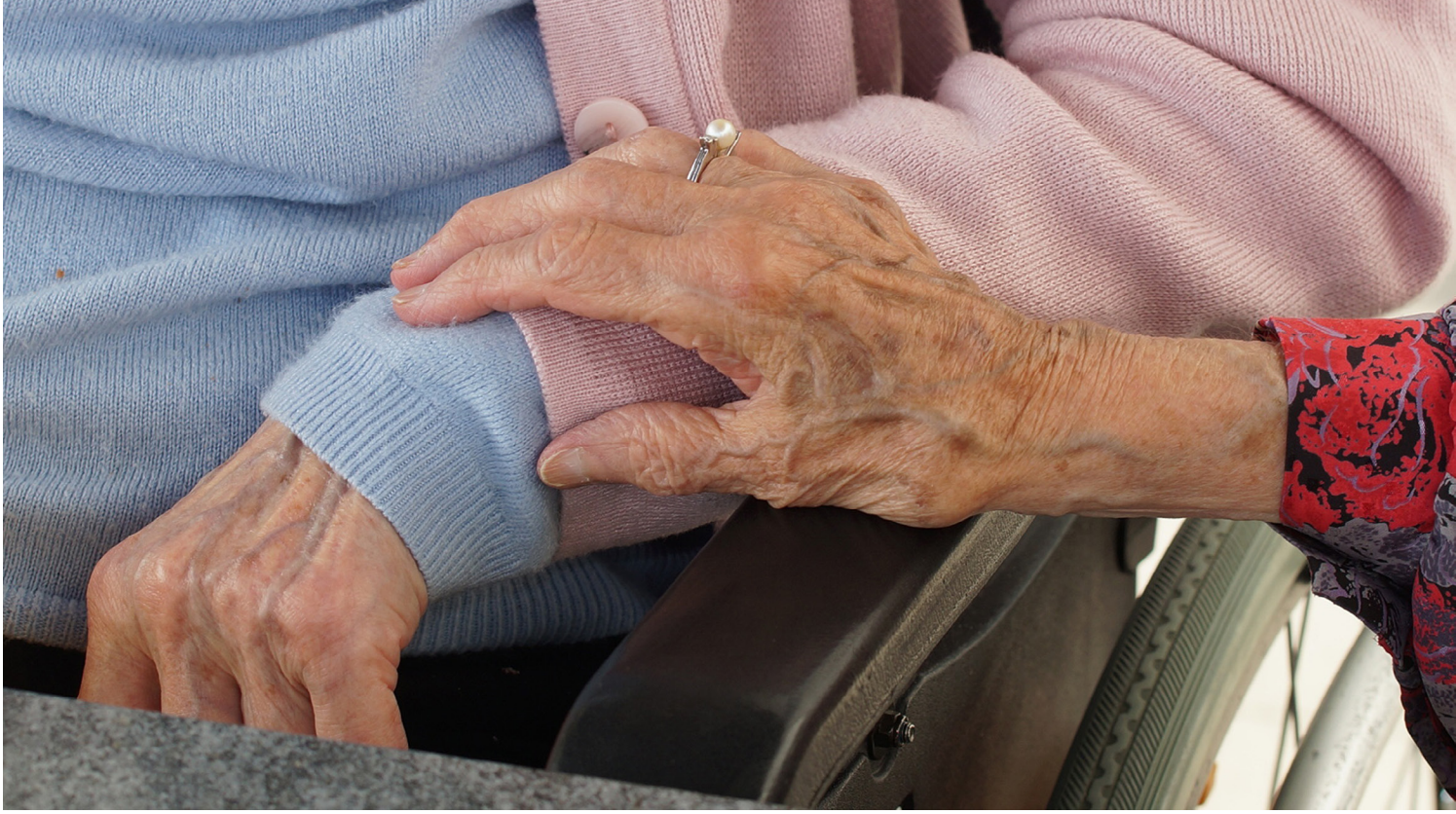
A landmark 1999 study of over 9000 hospitalised patients diagnosed with one of 9 different illnesses, for example, found that healthcare professionals were more likely to withhold life-sustaining treatments for older people even after prognosis and patient preferences were taken into account.

The COVID-19 pandemic, and associated debates around the rationing of resources and who should live, die and self-isolate, brought age discrimination in the health care system into sharp relief. OPAN is aware of cases where older people were not sent to hospital or were discharged prematurely.

Access to a hospital bed should be predicated on a person's clinical need — not their age bracket. Older people have a right to high quality, safe, respectful care in all settings.

When they move into the sub-acute care phase, they also have the same right to rehabilitation pathways as anyone else. But currently, ageist stereotypes are driving them in a single direction: one in 3 older people enter residential care from hospital, according to the Australian Institute of Health and Welfare. In many cases, they feel pressured to do so. Sometimes, it's presented as their only choice.

The Older Persons Advocacy Network (OPAN) is funded by the Australian Government to uphold the right of older people to make their own decisions,



guided by relevant rights-based principles and legislation such as the *United Nations Charter of Human Rights and the United Nations Principles for Older Persons (1991)*.

Our independent aged care advocates support older people to access quality aged care services that meet their needs. With a focus on wellness and reablement, our advocates can support older people in hospital to address issues that impact their ability to return home.

Options include:

- home care support*
- transition care, which provides up to 12 weeks of care and rehabilitation
- residential respite care
- state health post-acute care
- hospital in the home programs.

Older people shouldn't be forced to move prematurely into residential care or to remain in hospital due to an absence of viable alternatives. While lack of capacity in the residential aged care and community/home care sectors is clearly a contributing factor, whole-of-system action and investment is required to address access and flow issues in hospitals. Older people should not be blamed for larger systems and design issues.

'Part of delivering comprehensive care,' as the ACSQHC reminds us 'is planning for transition from the health service to home or another service.'

The aim of person-centred discharge planning is to:

- ensure appropriate post-discharge care or support
- improve the coordination of services following discharge from hospital
- improve patient experience of care
- reduce hospital length of stay and unplanned readmission to hospital.

*Long wait lists for assessments (up to 6 months) and home care packages (up to 12 months) may be dissuading older people and those who support them from exploring this option. However, older people who have been assessed as high priority are currently receiving their Home Care Package within a month. ha

If an older person needs assistance to access new or additional aged care services, or to express their views and wishes when considering after hospital care options, they can call the Aged Care Advocacy Line on 1800 700 600 for free, independent and confidential advocacy support.

Become an AHHA member

Help make a difference on health policy, share innovative ideas and get support on issues that matter to you – **join the AHHA**.

The Australian Healthcare and Hospitals Association (AHHA) is the 'voice of public healthcare'. We have been Australia's independent peak body for public and not-for-profit hospitals and healthcare for over 70 years.

Our vision is a healthy Australia, supported by the best possible healthcare system. AHHA works by bringing perspectives from across the healthcare system together to advocate for effective, accessible, equitable and sustainable healthcare focused on quality outcomes to benefit the whole community.

We build networks, we share ideas, we advocate and we consult. Our advocacy and thought leadership is backed by high quality research, events and courses, consultancy services and our publications.

AHHA is committed to working with all stakeholders from across the health sector and membership is open to any individual or organisation whose aims or activities are connected with one or more of the following:

- the provision of publicly-funded hospital or healthcare services
- the improvement of healthcare
- healthcare education or research
- the supply of goods and services to publicly-funded hospitals or healthcare services.

Membership benefits include:

- capacity to influence health policy
- a voice on national advisory and reference groups
- an avenue to key stakeholders including governments, bureaucracies, media, like-minded organisations and other thought leaders in the health sector
- access to and participation in research through the Deeble Institute for Health Policy Research
- access to networking opportunities, including quality events
- access to education and training services
- access to affordable and credible consultancy services through JustHealth Consultants
- access to publications and sector updates, including:
  -Australian Health Review
  -The Health Advocate
  -Healthcare in Brief
  -Evidence Briefs and Issues Briefs.

To learn about how we can support your organisation to be a more effective, innovative and sustainable part of the Australian health system, talk to us or visit ahha.asn.au/membership.

More about the AHHA

AHHA Board

The AHHA Board has overall responsibility for governance including the strategic direction and operational efficiency of the organisation.

Hon Jillian Skinner
Chair

Dr Michael Brydon
University of Notre Dame

Ms Yasmin King
SkillsIQ

Ms Susan McKee
Dental Health Services Victoria

Ms Nicole Bartholomeusz
coHealth

Ms Annette Crothers
Marathon Health

Mr Michael Culhane
ACT Health Directorate

Mr Anthony Schembri AM
Independently Appointed Board Director

Mr Mike Bosel
Brisbane South Primary Health Network

Dr Tina Janamian
Australian General Practice Accreditation Limited

AHHA National Council

The AHHA National Council oversees our policy development program. The full list of Council members can be found at: ahha.asn.au/governance

Secretariat

Mr Tony Farley
Interim Chief Executive

A/Prof Rebecca Haddock
Executive Director
Knowledge Exchange

Ms Ellen Davies
Communications Manager

Mr Kevin Chacko
Research and Policy Officer

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Director, Business Development

Ms Emma Walsh
Policy Officer

Ms Emma Hoban
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Ms Brooke Rees
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AHHA sponsors

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Other organisations support the AHHA with Corporate, Academic, and Associate Membership and via project and program support.

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