

# THE DEMENTIA EPIDEMIC: ECONOMIC IMPACT AND POSITIVE SOLUTIONS FOR AUSTRALIA

## Chapter 4 - Options and Challenges

Prepared for  
ALZHEIMER'S AUSTRALIA  
by



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## 4. OPTIONS AND CHALLENGES

*“While much has been done to assist people with dementia and their families and carers, much remains to be done. Given the scale and progression of the epidemic, simply doing whatever the community is already doing means going backwards and going backwards at an ever-increasing rate.”*

Alzheimer Australia’s submission to the 2003-04 Federal Budget

### 4.1 SETTING THE SCENE

#### 4.1.1 National Action Plan for Dementia Care

This section briefly outlines where we have come from in strategic planning for the dementia epidemic. The five-year National Action Plan for Dementia Care (NAPDC) was instituted in 1992. It set a strategic direction for dementia care designed to strengthen the capacity of the aged care system to better meet the needs of people with dementia and their families and carers. Rather than advocating a separate stream for dementia care services, it aimed to integrate the various aspects of dementia care through the aged care sector and programs. The Action Plan set targets and actions for achievements between 1992-93 and 1996-97 in seven key areas, namely:

- diagnoses and assessment;
- services for people with dementia;
- services for families and carers of people with dementia;
- quality of service;
- community awareness;
- research and evaluation; and
- policy and planning.

Midterm review of the NAPDC identified the priority need for a more coordinated approach to dementia care training for all staff working in residential aged care facilities. The National Residential Dementia Training Initiative (NRDTI) was thus established to provide systematic training for staff in Commonwealth funded residential aged care facilities in order to improve dementia care practice. The NRDTI also aimed to facilitate the longer term capacity of the aged care industry to sustain dementia care training beyond the Initiative.

Other challenges highlighted by the NAPDC included special problems in rural and remote communities and continued harnessing of political will, particularly at State and Territory government level. The NSW Government implemented the five-year NSW Action Plan on Dementia 1996-2001 and has recently released the next plan “*Future Directions for Dementia Care and Support in NSW 2001-2006*”.<sup>91</sup> Victoria has also produced an excellent policy statement, “*Dementia Care and Support in Victoria: 2000 and Beyond*.”<sup>92</sup> All States and Territories have to some extent either produced dementia-specific strategic plans and/or incorporated dementia aspects into mainstream service planning.

The 1997 Aged Care Reforms were introduced in part to improve the structural service delivery for older Australians with complex physical, mental and psychogeriatric needs. Fine-tuning continued through the National Strategy for an Ageing Australia<sup>93</sup> (2001), towards the thematic goal of ‘world class care’.

<sup>91</sup> The NSW strategy is at <http://www.add.nsw.gov.au/PDF/Future%20Directions%20CD%2010.9.pdf>

<sup>92</sup> Victorian Government Department of Human Services, November 2000, available on [www.dhs.vic.gov.au/acmh](http://www.dhs.vic.gov.au/acmh)

<sup>93</sup> The National Strategy is available on [www.health.gov.au/acc/foa/documents/pdf/nsaabook.pdf](http://www.health.gov.au/acc/foa/documents/pdf/nsaabook.pdf)

#### **4.1.2 Aged care reforms and the Two Year Review**

Professor Len Gray reported specifically on dementia care in the Two Year Review of Aged Care Reforms, which was finalised in 2001. He stated that the government is working towards a national dementia policy framework, with first steps being the August 1999 Dementia Forum, additional DESP funding, expansion and enhancement of respite services including Carer Respite Centres, carer training, new funding for the Early Stage program and the national helpline, growth in PGUs and training in dementia care for people from diverse cultural and linguistic backgrounds.

He noted that the former Personal Care Assessment Instrument (PCAI) and the Resident Classification Instrument (RCI) had not adequately recognised the amount of staff time required to care for residents with dementia, as also recognised by Rosewarne et al (1997). Also, because funding levels were not linked to the severity of behavioural problems of people with dementia and did not recognise the resource intensive nature of dementia-appropriate care, he concluded that “a major disincentive to caring for these residents was built into the system” Gray (2001, p214). Gray noted that Cuthbertson, Lindsay-Smith and Rosewarne (1998) found that the ‘new’ Resident Classification Scale (RCS) introduced in 1997, increased funding for residents with cognitive impairments and behavioural needs by some 20%.

While in theory this might be true, critics argue that it does not occur in practice and that, as validated by the RCS assessors, the RCS is *hostile* to dementia care. This is because questions 8-14 of the RCS, the behaviour questions that most likely relate to dementia specifically, constitute as little as 16% of funding and that Q 8 and 12-14 are four of the six most *downgraded* questions by validators. Moreover, *negative* incentives occur since the system rewards perverse behaviours, rather than rewarding quality care that effectively prevents and manages those behaviours.

The Two Year Review noted “some participants considered that access to care for people with behavioural problems has *not* improved, as some providers are reluctant to admit residents who exhibit difficult behaviours and are unable to provide secure accommodation.” Gray (2001) also concluded that:

- there is a lack of data regarding dementia in residential care, although proxies can be derived from RCS weighted scores of those who *probably* and *possibly* have dementia; these data showed that 91% of residents in high care homes and 58% in low care homes fell into either category, including almost *all* RCS1 (99%) and RCS2 (95%) residents;
- the consultation process highlighted a lack of specialised and secure accommodation for people with moderate to severe dementia, and insufficient financial support for providers to supply it;
- there was insufficient data to comment on the need for secure and segregated accommodation, although noting that the government identified priority pockets of need for dementia-specific care for the first time in the 2000 capital works Approvals Rounds;
- priority in Approval Rounds and the changes in the RCS will not necessarily deliver an appropriate quantum of dementia specific homes in every region of Australia.
- *It is recommended that further investigation be undertaken into the needs for and provision of accommodation and care options for people with dementia. Such an investigation should include a focus on infrastructure and options for addressing identified deficiencies.*

For a two-year review, this single recommendation for ‘further investigation’ is insubstantial. One would hope that such investigation was ongoing anyway. In the discussion, there also seems to be little appreciation of the problems related to the various capital and recurrent funding issues for high care and low care facilities respectively or the problems in the RCS, which had the opportunity to identify and provide for dementia behaviours and environments and did not. Rather, although the ACAT/RCS

instruments have improved on the former PCAI/RCI instruments, they have not addressed the key issues as they continue to classify and weight needs primarily in terms of nursing needs, provide insufficient data for the evaluation of dementia outcomes, and fail to address the issues associated with financing capital costs. The review also failed to look at particular non-residential care needs for people with dementia.

The fairly blunt industry response to the review is summarised in Aged and Community Services Australia (2001), including a number of 'real world aged care economics' examples and case studies precipitating negative returns on investment, concluding (p10) that:

"The Report... leave[s] the reader with the view that the reforms have fixed all the significant problems in aged care and that all of the measures introduced since 1997 are working smoothly and effectively. As this Industry Response has shown, nothing could be further from the truth.

The aged care industry is fast reaching a crisis point in terms of its ongoing viability. It is unable to gain access to the capital required to make necessary building improvements or to finance the new beds needed. The industry is drowning in an increasing volume of red tape and is facing increasing difficulty in recruiting staff it needs to provide quality care...

Older people still suffer the consequences of poor coordination between the health and aged care systems. They still experience significant problems in gaining access to the services they need. They still suffer from failures in the quality of care. Older people deserve better.

Resting on its laurels is not a viable option for any Federal Government. That should be the real conclusion of the Two Year Review of Aged Care Reforms and the basis for a genuine Government response."

In its response to the Two Year Review, the government accepted the recommendation and pointed to:

- Claims that average funding per dementia resident had increased 124% since 1997 (no data provided, and no description of how dementia residents were identified);
- \$92.5 million over 4 years to expand respite for families and carers of people with dementia; and
- establishment of a working group to consider the care and accommodation needs of people with dementia.

The Report of the Working Group on Dementia Specific Aged Care has just been released, concluding that there is scope for improvements to accommodation and care options across all tiers of dementia needs. Specific conclusions and departmental responses are<sup>94</sup>:

1. *More research and evaluation is needed on effective care services for people with dementia.*

Response: Making services more effective for people with dementia will be considered further in the Community Care Review.

2. *Joint Commonwealth/State/Territory action is required for people with extreme or severe behavioural and psychological symptoms of dementia.*

Response: The Commonwealth Government will discuss options with the State and Territory Governments.

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<sup>94</sup> Department of Health and Ageing (2002b), p21.

3. *While appropriately structured residential aged care services are sufficient for many people with dementia, planning should take account of the need for dementia specific care, both residential and community.*

Response: The needs of people with dementia will be considered in the Review of Pricing Arrangements of residential aged care and the current review of RCS funding options.

4. *Access to respite care for people with behavioural and psychological symptoms of dementia needs to be enhanced.*

Response: The needs of people with dementia will be considered in the Review of Pricing Arrangements of residential aged care and the current review of RCS funding options. It should also be noted that the 2002-03 Federal Budget provided \$10m for Commonwealth Carer Respite Centres to top-up payments to facilities offering dementia specific accommodation. Additionally, the 2002 Budget includes \$10 million over four years to expand the Psychogeriatric Care Units to achieve national coverage as a Commonwealth only program.

5. *A greater emphasis is needed in community care on the provision of dementia specific programs delivered by trained staff.*

Response: This will be considered further in the Community Care Review.

6. *There are gaps in the early intervention services for people with dementia and their families. Depending on the outcomes of the evaluation, the Alzheimer's Association Australia Early Intervention project (funded by the Commonwealth) may be a model for such a service.*

Response: This will be considered in the evaluation of the Early Stage Dementia Support and Respite Project.

## **4.2 THE FUTURE VISION**

Disease and disability associated with dementia are not inevitable consequences of ageing. The challenge of the dementia epidemic that is now, in 2003, becoming increasingly evident, is to attain declining disease and disability rates amidst a steep rise in the number of older people. The task is urgent. But there is broad scope to implement a positive agenda that can sustain an effective response over the coming decades.

In Australia, our mental health and broader health goals should be aimed primarily at *increasing 'healthspan'* – years of healthy, active life expectancy. To this end, we must adopt a longer term national vision about future action – not just in terms of disease management, but also in terms of action that government, academia and the private sector can jointly pursue to prevent and ultimately cure dementia.

A national vision requires a *nationally coordinated approach*. Commonwealth and State and Territory governments must come together with health professionals, people with dementia and their families and carers to acknowledge and plan for the demands of an illness that is poised to become Australia's number one health issue in the next two decades. Secure political commitment and consensus among stakeholders is essential.

With the first wave of baby boomers commencing retirement in 2005, the demographic transition is now firmly underway. In that fiscal context, it is crucial to not simply put more money into ineffectual systems but rather to shift health spending from acute to *chronic care models* to maximise returns from limited resources and to utilise evidence based approaches. Moreover, many interventions to date have been suboptimal, if not myopic, focusing on direct costs rather than the enormous benefits of investments in

wellness. *Whole economy analysis*, including impacts on the labour market and other sectors, must be considered from now on in policy development for healthy ageing and dementia care.

Strangely, the enormity and priority of the dementia epidemic has not yet been acknowledged in national policy making. Dementia is already intricately linked with recognised national health priorities including cardiovascular disease, diabetes and depression, and it is the mostly costly area of mental health. Dementia prioritisation, and a *national strategy to realise the vision*, is long overdue.

Five key elements of the future strategy must involve:

- a significant investment in research for cause, prevention and care;
- early intervention through improvement in diagnosis, and the provision of cost-effective pharmacotherapies;
- comprehensive provision of support, education and respite services – in place in the community as far as is optimal;
- quality residential care, appropriately financed, that are centred on the person with dementia and their family/carer; and
- provision for special needs, including people with younger onset dementia, people with special BPSD needs, people from culturally and linguistically diverse backgrounds, indigenous Australians and people in rural and remote areas.

If, starting today, we embark on such positive strategies, Australia can lead the way in effectively and smoothly managing the dementia epidemic transition.

*“Thanks to the efforts of thousands of carers, the last 20 years have seen the stigma of dementia at best reduced but not removed. A positive approach to planning dementia care now will ensure that in twenty years time the quality of life of people with dementia, their families and carers will be much improved – a society truly committed to the prevention of dementia. That is the vision of the Alzheimer’s Association Australia.”*

Alzheimer’s Australia,

Submission to the Parliamentary Inquiry on the Ageing of the Australian Population, 2002

### **4.3 STRATEGIES AND RECOMMENDATIONS**

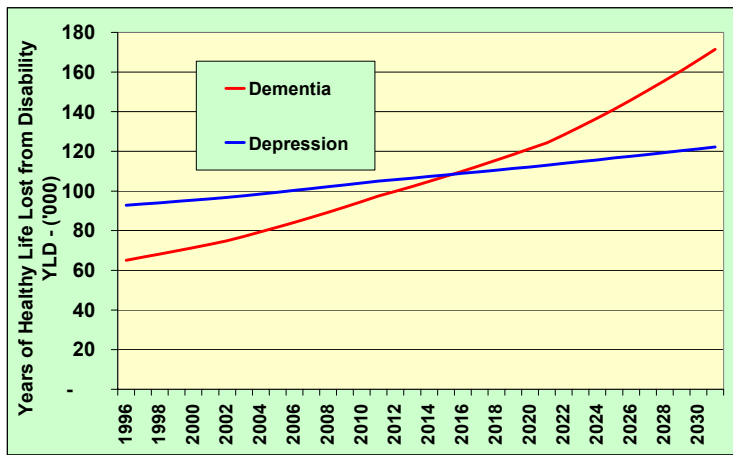
#### **4.3.1 Prioritisation of dementia**

Because of the impact of demographic ageing and the importance of dementia in overall health costs and disease burden, dementia (and the nexus between ageing and mental health more generally) must be incorporated in Australia’s priority setting for health and ageing.

Most telling is that dementia, after depression, is already the second largest cause of disability burden in Australia (ahead of diabetes, asthma, osteoarthritis and the other health priority areas), and it is growing much faster than depression so is set to become the number one cause of disability burden by 2016.

Dementia should be a national priority. It is set to become the Number One cause of disability burden in Australia by 2016. It will touch many of us directly or indirectly.

**Chart 15: Burden of disability of dementia and depression, ‘The Big Two’, 1996-2031**



Source: Access Economics projections, based on AIHW and ABS data.

The issue is how and where to prioritise. Dementia does not fit completely comfortably in either the aged care or mental health portfolios. Currently dementia care is funded primarily through aged care programs and the risk of dementia increases sharply with age. Moreover, some stakeholders are not comfortable with the mental health categorisation of dementia in international and disease classifications given remaining stigma.

Although mental health is one of Australia’s seven national health priorities, together with cardiovascular disease, cancer, injuries, diabetes, asthma and chronic musculoskeletal disorders (notably arthritis and osteoporosis), the National Mental Health Strategy has not embraced dementia. The mental health care resources list on the federal departmental website has 666 words, none of which is ‘dementia’ or ‘Alzheimer’s’ (see [www.mentalhealth.gov.au/resources/](http://www.mentalhealth.gov.au/resources/)). Searching the mental health home page for the word ‘dementia’, yields no hits at all ([www.mentalhealth.gov.au/index.htm](http://www.mentalhealth.gov.au/index.htm)).

Whatever decision is taken on the most effective point of coordination of planning dementia, it is clear that a whole of government approach is needed. This is because dementia care is so broad ranging, covering aspects of aged care, community care, residential care, medical services, psychiatric and specialist services, pharmaceuticals, workforce and housing.

**Recommendation 1:** *Dementia should be a national health priority. Because dementia issues are so broad ranging – covering aspects of aged care, community care, residential care, medical services, psychiatric and specialist services, pharmaceuticals, workforce, housing, research, technology, finance and so on – a coordinated sector-wide approach needs to be adopted in addressing these recommendations. It is vital that dementia initiatives are no longer lost between bureaucratic divides or governmental tiers, being referred from one review to the next without concrete action. Rather, priority should be accorded within public sector programs, resources and funding in a coordinated and comprehensive manner.*

*The current National Mental Health Strategy review and the Residential Aged Care Pricing Review should provide concrete proposals for addressing the issues raised in this report. Consideration should be given to including a central coordination point for future ongoing dementia planning and care, perhaps as part of a more strategic approach to neurodegenerative disease.*

### **4.3.2 Research**

**Recommendation 2:** *The funding of dementia research should form an essential part of the government's response to the dementia epidemic, as well as forming part of a more general reprioritisation of health research resources on the basis of projected prevalence, costs and disease burden. In view of Australia's international comparative advantages in health research investment, as well as the potentially enormous cost-effective returns (potentially saving up to \$4 trillion in Australia in long term health costs), urgent action should be taken to substantially boost the level of research funding for dementia including:*

- Official research funding for dementia should be increased to \$49m per annum within three years, with prioritisation of specific projects determined in conjunction with Alzheimer's Australia.*
- Research priorities should be directed towards:*
  - **Cause:** *Understanding of the biomedical causes of dementia, including epidemiological (population-based) medical risk factors and public health research<sup>95</sup>;*
  - **Cure:** *Measures that prevent or postpone the onset of dementia, or that slow or reverse disease progression<sup>96</sup>;*
  - **Care:** *Effective models of care (best clinical practice) for people with dementia, including ways to enhance primary care, dementia services (as per Section 3.2.5) and effectiveness of training interventions.<sup>97</sup>*
- Research should be collaborative and multidisciplinary, including the interaction of other conditions on dementia (eg, diabetes), and the interconnections between different types of dementia, with emphasis on prevention, healthy brain ageing and effective quality care.*

### **4.3.3 Prevention and early intervention activities**

**Recommendation 3:** *Promotion of dementia prevention activities should be initiated, targeting the community and health professionals (particularly in primary care), possibly in conjunction with other stakeholders including consumers groups (such as the Heart Foundation) and official bodies, including:*

- addressing cardiovascular risk factors – reducing hypertension, cholesterol and homocysteine (folate) and anti-platelet treatments;*
- promoting good diet, exercise, quitting smoking, and drug and alcohol programs as dementia prevention activities as well as promoting health generally;*
- promoting ongoing awareness to reduce other dementia risk factors such as head trauma (eg, seat-belts, helmets etc), occupational hazards (eg, exposure to electromagnetic fields) and others as revealed or confirmed by ongoing research.*

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<sup>95</sup> This research, together with awareness campaigns, has enabled diseases such as lung, skin and breast cancer to be seen as conditions with preventable elements subject to a public health approach.

<sup>96</sup> Specific research priorities might include amyloid-based treatments (including immunisation), new drug treatments (including with memantine), anti-inflammatories, oestrogen therapies, anti-oxidants and nerve growth factor supplementation.

<sup>97</sup> Specific priorities include research on diagnosis, effects of care standards (community care, long term care, terminal care, care needs and planning), carers' support, alleviating distressing behavioural symptoms and pain for non-verbal patients, medication for nursing homes and research into true levels of awareness (insight) in dementia (Maller and Rees, 2002).

#### **4.3.4 General practice**

**Recommendation 4:** To address the gaps and unmet need in current service provision, measures to enhance GP services should be initiated or expanded, including:

- GP education and support in implementing models of care that include early diagnosis, care planning and information about the support available for people with dementia, their families and carers;
- GP training and appropriate remuneration for ongoing management of dementia;
  - introduction of a program for ‘dementia-accredited’ GPs
  - review the rebate scheme for GPs visiting patients in residential care;
- teleconferencing and other initiatives to support more isolated GPs in diagnosis and treatment.

#### **4.3.5 Other medical and acute care services**

**Recommendation 5:** To address quality, cost and workforce issues in acute care, measures are required to:

- ensure quality person-centred dementia care is available throughout the acute care system;
- prevent admission to the acute care system through better treatment of people with dementia in their own (family or residential) home, including possibly psychogeriatric services to complement ACATs;
- assessment of acute care hospital waiting times for transfer into residential facilities, relative costs and potential mechanisms for reducing these, such as ‘Innovative Places’ or similar models; and
- measures to enhance recruitment, retention and training of nurses in dementia care, possibly utilising moneys from the \$47.5m (2002-03 to 2005-06) announced last budget for aged nursing;
- workforce measures to increase training, recruitment and retention of specialist geriatricians; and
- greater investment in specialist referral services (such as memory clinics) to support GPs in diagnosis and management of people with early stages of dementia.

#### **4.3.6 Pharmacotherapy**

**Recommendation 6:** Affordable access to medications appropriate to their diagnosis should be expedited for all people with dementia. Current PBS arrangements should be replaced by a simpler access regime comprising:

- diagnosis confirmation by a specialist or by a dementia-accredited GP;
- ongoing access predicated on best clinical practice, which might involve, for example:
  - regular monitoring of broad patient outcomes such as maintenance or improvement in cognition and/or social functioning, including for people who have non-Alzheimer dementia;
- access to telephone approval of authority scripts.

Pharmaceutical expenditures should not be seen as a cost but rather as an investment in wellness:

- PBS cost-cutting measures that are not evidence-based should be avoided;

- subsidies should encourage pharmaceutical interventions for dementia based on Clinical Practice Improvement studies, and noting that this study shows returns to investment in cholinesterase inhibitors of 7:1 due to delays in institutionalisation and reduced carer burden, together with improved quality of life;
- treatment of agitation in dementia and access to anti-psychotics should reflect existing evidence; and
- longer term differences, rather than just those limited to six months, should be considered.

#### **4.3.7 Home and community support services**

**Recommendation 7:** While much has been done to enhance home and community services in recent years, remaining priorities include:

- a one-off 20% increase in the Home and Community Care (HACC) program funding;
- 6% growth per annum in HACC funding (to cover demographic ageing based prevalence increases) plus an indexation amount that more adequately covers increased costs in service delivery, to be negotiated in consultation with key stakeholders;
- greater inclusion of the voluntary sector (including families and carers) in the formulation and implementation of policy with respect to people with dementia and their families and carers.

#### **4.3.8 Families and carers**

**Recommendation 8:** Family and carer support, education and respite remain an ongoing challenge, as well as one of the most important aspects of managing the epidemiological dementia transition. A long term strategy is required to be developed by key stakeholders. There have been advances in family and carer services in recent years, but current evidence suggests that care support remains sub-optimal (ie, an undue burden on families and carers). Additional measures should include:

- consideration of “optimal” informal care levels with a view to setting guidelines and targets for long term planning purposes;
- additional recurrent funding to promote best practice in respite care including:
  - incentives for implementation and diversification of ‘carer friendly’ models of respite care, including facility-based respite services, building on pilot studies; and
  - respite services which cater for people with the specific behavioural and psychological symptoms of dementia (BPSD);
- applying best-practice carer education and support models identified by research, pilots, trials and evaluations which, as with cholinesterase inhibitors above, show potential average returns around 7:1;
- improve incentives to encourage increased employment participation and retention of families and carers, including flexible work practices such as part-time home-based work, work-based adult day programs, workplace dementia awareness and destigmatisation.

**Please remember this:** Community care is good policy – but only if it acknowledges that the home-based care of a person with dementia can be a skilled, exhausting, costly, long-term, lonely job for the person doing the caring. It must be properly resourced to be accessible to all Australians.

Alzheimer’s Australia (2001a)

#### 4.3.9 Strengthening community services provided through Alzheimer's Australia

**Recommendation 9:** Any strategic national plan to address the dementia epidemic in Australia must include nationally consistent and longer-term funding arrangements between governments and the voluntary groups providing services to people with dementia, notably Alzheimer's organisations, which are cost-effective and high quality delivery vehicles, due in part to the dedication of volunteers. Long term recurrent funding arrangements need to be negotiated with Alzheimer's Australia, including:

- a one-off increase in funding for Alzheimer's Australia from \$5m pa in 2001-02 to \$13m by 2003-04, with annual indexation reflecting both cost-price factors and increases in numbers of older people, to enable:
  - (i) extension of Carer Education and Workforce Training (CEWT) courses, accredited courses for workers in residential care, and to meet special needs of families and carers;
  - (ii) increased Dementia Education Support Program (DESP) funding for national expansion of counselling services, including additional full time counsellors in NSW and Victoria and part time staff in other States and Territories;
  - (iii) expansion of the Early Stage Dementia Support and Respite Program (ESDSRP) (currently being evaluated), and/or additional funding provided for a new program for support and respite for people with mid-stage dementia, based on the results of successful pilot projects undertaken by State and Territory organisations;
  - (iv) additional funds to meet the specific requirements of people with dementia and their families and carers with special needs, including people from culturally and linguistically diverse backgrounds, indigenous people and people with low levels of literacy, and people in rural and remote communities;
  - (v) expanded information resources projects including on Down's Syndrome and dementia;
  - (vi) dedicated funding to build infrastructure for national data collection.
- an expansion of psycho-geriatric units (PGUs) has been funded by the Commonwealth. This will follow a review of the operation of current projects. The expansion of PGUs on a national basis using a consistent behaviour advisory model and focusing on meeting the needs of staff working with people with challenging behaviours would form a useful part of the overall service network.

#### 4.3.10 Residential care

**Recommendation 10:** Residential dementia care remains problematic. In general, the principles of ageing in place and including dementia care within mainstream aged care are desirable, however the mechanisms for addressing identified constraints need to be addressed within the context of the current Pricing Review. Priorities include to:

- incorporate behavioural and environmental recommendations in Aged Care Assessment Team (ACAT) assessments, so that people with dementia and the nature and stage of that dementia are identifiable;
- revise the Resident Classification Scale descriptors to accord better with ACAT assessments, reflecting behavioural and environmental care needs as well as nursing and personal care needs, so that people with dementia and the nature and stage of that dementia are identifiable;
- in the context of the federal Review, and in close consultation with providers and other key stakeholders, review and make recommendations to implement changes to subsidies and possibly

accommodation bonds and other funding vehicles in ways that remove the disincentives to provision of quality dementia residential care, in particular addressing:

- capital constraints to high care facilities for people with dementia, including with BPSD; and
  - recurrent funding constraints to low-care facilities for people with dementia/BPSD.
- joint review by government, providers and stakeholders of the long term capital requirements for new dementia facilities based on better models of dementia care, with consideration of a full range of finance vehicles including insurance mechanisms;
  - change the residential care planning guidelines to ensure that all facilities have the capacity to care for people with dementia and that at least 10% of residential care places are dementia specific for those with special support needs;
  - assess supply and demand factors driving growth in overall numbers of places and ensure that supply growth is adequate and sustainable to meet demand growth over the longer term;
  - promote and fund new aged care facilities built on the cluster campus model on a provider-government partnership basis;
  - extend the number and diversity of newer models of quality care to help residents with dementia, with ongoing cost-benefit evaluation in particular in relation to quality of life;
  - increase ongoing nursing training in dementia-specific and quality person-centred care principles, ensuring that all residential care staff have completed formalised competency based training at the Certificate III level in Aged Care, and understand the needs of people with dementia and how that impacts on service delivery;
  - increase specialist geriatrician input into diagnosis, management and training;
  - introduce government support for the cost of staff training in facilities with limited financial resources or whose ability to provide staff training is otherwise constrained;
  - ensure guidelines are developed that identify appropriate staff to resident numbers linked to dependency that address understaffing;
  - tighter accreditation and monitoring of standards to promote quality care, with restrictions placed on chemical and physical restraint practices;
  - review of nursing and personal care worker remuneration;
  - improved access to specialist behaviour advisory services;
  - greater access to care for people with dementia with serious psychiatric symptoms, as well as those with serious mental health problems who develop dementia.

#### **4.3.11 Cross-cutting issues**

**Recommendation 11:** *Issues that cut across all aspects of dementia care, reflecting the different needs of different groups of people, and that require intervention include:*

- improved access to community, residential and medical services for people with younger onset dementia, including separate strategic planning to meet their specific needs outside the aged care sector;
- improved access for people with dementia and their families and carers who are from culturally and linguistically diverse backgrounds, including improved assessment tools;
- improved access to services for indigenous Australians living with dementia;
- greater public efforts to destigmatise dementia; and

- *smarter use of new information technologies in delivering services, particularly to people in rural and remote areas, including cost-benefit studies of information technology instruments such as web-based information resources and messaging, moderated chats and forums, videoconferencing and clinical communications.*

#### **4.3.12 Health financing**

**Recommendation 12:** *Intergenerational planning needs to acknowledge the need for health, aged and dementia care spending to grow in real and relative terms, with strategies for successfully managing the change. Various tiers of government are already taking steps in this direction. Action-oriented planning, integrally involving stakeholders, needs to address:*

- *appropriate savings or insurance schemes to provide for future health, ageing and dementia needs, including consideration of quarantined increases in the Superannuation Guarantee levy;*
- *consensus on and planning for the future private-public mix of care provision and of insurance provision.*