HEALTH AND QUALITY OF LIFE FOR OLDER WEST AUSTRALIANS

Health Department of Western Australia
DISCUSSION PAPER
ACKNOWLEDGMENTS

The Aged and Continuing Care Branch would like to acknowledge the many people who gave generously of their time, experience and information in the preparation of this document.

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EXECUTIVE SUMMARY
Executive Summary

There has been much debate around the issue of population ageing, not only in Australia but also in other parts of the world. In particular, the focus has been on ‘baby boomers’ – that cohort of people born after World War II, the first group of which will reach 65 in the year 2010. For the purpose of this Paper, 65 years of age has generally been taken as indicating the start of the ‘older’ part of the life-cycle.

Older people are not a homogeneous group and there is considerable variation in their health and related aged care needs. As with any group, there are internal differences and subgroups so that the ageing experience can differ for individuals depending on their age, gender, ethnicity, socioeconomic status and geographic location. It can also depend on the individual’s health status. For example, someone ageing with a longstanding disability such as cerebral palsy or Down’s syndrome will have an entirely different experience of ageing than someone who is relatively fit and well. Furthermore, people with longstanding disabilities may actually experience ‘premature ageing’ and require access to services well before reaching the age of 65. Older women can also be considered to be another subgroup as they are more likely to live alone, be in greater need of community-based care, and be at greater risk of admission to residential care.

The aim of this Paper is to provide the foundation for the development of a whole-of-sector and cross-jurisdictional approach to the planning and provision of a comprehensive range of services which will meet the health and aged care needs of the older population of Western Australia, including all subgroups. It considers the ageing of the West Australian population, their characteristics over time and factors which are likely to impact upon their health and wellbeing. Major disabling chronic conditions, illness and diseases in older life are outlined, as are the current service delivery systems available to address them.

The first chapter sets the Paper in the context of the United Nations International Year of Older Persons providing a brief background to the Year and also to the Commonwealth Government’s response, the National Strategy for an Ageing Australia. The chapter also looks at the State context and the results of the consumer consultation process carried out by the Office of Seniors Interests in 1997 which resulted in the publication of Time On Our Side: A Five Year Plan For Western Australia’s Maturing Population. The Plan outlines a coordinated whole-of-government approach to providing policies and services which take account of the different needs of the older population.

The Health Department of Western Australia (HDWA), is the key agent in carrying out a number of the commitments, one of which is to identify the long-term strategic impact of an ageing population on health services. This Paper is intended to assist in that process.

The next chapter describes the major demographic characteristics of older people in Western Australia. It looks at the ageing phenomenon and notes that although WA has a comparatively young population, older people are an increasing proportion of the State’s growing numbers and the older old
population (those aged 80 years and over) is also increasing. It looks at the issue of age dependency ratios – i.e. the estimate of the number of people in the workforce available to support those in need of care. There has been concern expressed in some quarters in relation to this issue but the impact of the ageing of the population as measured using dependency ratios, can be influenced and counteracted by a number of factors. These include economic growth, workforce productivity and government strategies and policies for income security in old age. One example of this is the Commonwealth’s compulsory superannuation scheme.

The distribution of older people throughout WA is outlined and one of the points noted is that although those aged 65 years and over form only four per cent of the total remote population, they are dispersed over a vast geographic area embracing the Kimberley, Pilbara and the Goldfields. This has implications for service delivery as noted in the next section of the chapter in which the characteristics and issues related to older Aboriginal and Non-English Speaking people are described. The chapter also notes some of the services that are currently in place for both these subgroups.

The third chapter looks at some of the factors which can relate to health and quality of life for older people such as participation in the community (as volunteers or in paid employment), economic security and independence and support. It notes that the workforce participation rate of older people was declining up to 1984, but has been relatively stable since then. It also notes that in 1996/97 government pensions and benefits were the main source of income for nearly three-quarters of households of people aged 65 years and over and that by 1995, women’s superannuation coverage was close to that of their male counterparts. It also notes that with women’s greater longevity and tendency to marry older men there are substantial numbers of women aged 65+ who live alone while older men are more likely to be living with a partner.

Chapter Four considers the issues of health promotion and prevention interventions. It notes that a substantial proportion of chronic disabling conditions associated with ageing are potentially preventable, and not an inevitable accompaniment of growing old. It looks at a number of risk factors which impact on good health and notes that a lifestyle approach needs to be developed encouraging healthy habits from an early age – but also shows older people can still benefit from healthier lifestyle changes such as exercising (including resistance and aerobic training) and giving up smoking. It then considers strategies such as cancer screening, injury control, influenza vaccinations and the promotion of community participation by older people through the School Volunteer Program. It notes that an expected outcome of the Program is an enhanced sense of wellness in the volunteers and a decreased need to use health services.

The next chapter considers some issues relating to health status in later life including the effects of impairment, disability and handicap. It notes that in 1995, 33 per cent of Western Australians over the age of 65 reported that they had only fair or poor health. The chapter also looks at some of the chronic health conditions which can impact on older people. Those which are discussed are emerging as priorities for the health,
community and residential aged care sectors. The other illnesses that are discussed include those which, although they may affect an individual at any age, have a high profile amongst older people. Chapter Six looks at the funding and provision of health and related aged care services. It notes that in 1996/97 people aged 65 years and over accounted for about 37 per cent of expenditure on acute public hospital services, 35 per cent of expenditure on acute private hospital services, 22 per cent of expenditure on medical services, 94 per cent of expenditure on residential care, and 81 per cent of expenditure on home and community care services. This chapter also notes that the provision of health and related aged care services for older people is undertaken within the context of several overarching service streams, namely primary care, community care, hospital and assessment services and residential care.

Chapter Seven deals with primary care and notes that general practitioners (GPs) account for the largest volume of these services in Australia. Primary care is important as it generally represents the first point of contact an older person has with the health care system. GPs play a pivotal ‘gatekeeping’ role by providing access through referral to other parts of the health system including acute hospital care, specialist care or assessment for residential care.

The chapter notes that in order to improve the integration of general practice services with other health care services, in 1992/93 the Commonwealth supported the establishment of Divisions of General Practice, the numbers of which had grown to 123 across Australia by 1998. There are 15 Divisions located in Western Australia.

More recently the Commonwealth Government, supported by the State, has sought to further integrate general practice services with other health care services by enhancing the participation and involvement of GPs with multidisciplinary case management and coordinated care planning. These initiatives, announced in the 1999/2000 Commonwealth Budget, are expected to assist older people in particular to receive care which is better coordinated with community and other health care providers.

The chapter notes that the State, in collaboration with the General Practice Division of WA, has also instigated several initiatives to foster and enhance the involvement of GPs in the development of State Government health policy and the planning of health services to improve patient care.

The next chapter, Chapter Eight, looks at both the formal and informal aspects of community care. It notes that in the last ten to fifteen years the emphasis of support services has moved from residential care to the provision of care in the community in as ‘normal’ (i.e. non-institutional) a setting as possible given the care needs of the client. Most Australians live in the community and/or in their own homes and never need to draw on formal care services such as those provided through Home and Community Care (HACC).

Older people are the predominant beneficiaries of the HACC Program which is jointly funded by the State and Commonwealth and administered by the State. HACC services are provided by a wide range of not-for-profit non-government organisations, as well as local government
and some State government organisations. The chapter provides more detailed information as to the HACC target population and its characteristics as well as noting some of the new developments to improve the efficiency and effectiveness of the HACC program.

The Carer is the service provider in the informal system of the community care sector. A Carer is defined as a person such as a family member, friend or neighbour who provides regular and sustained care and assistance to another person without payment other than a pension or benefit. The chapter looks at some of the characteristics of Carers in general, some of the issues involved in the caring role and support services available to Carers.

It also notes the initiative of the State Government in developing a Carers Strategy which will acknowledge the importance the State Government places on the role of Carers. The Strategy is intended to provide an overarching framework of principles outlining a general State Government commitment to Carers.

Chapter Nine looks at hospital services as well as some of the other services which are provided through the hospital system including specialist geriatric and assessment services. It notes that the majority of hospitals situated throughout Western Australia are public hospitals owned and operated by the State. Private hospital services are limited to the Perth metropolitan area, Mandurah, Geraldton and Bunbury. It notes however that in recent years, cooperative ventures between the State government and the private sector have led to the development of services for public patients in some privately managed hospitals. This has included services which are specifically targeted towards older people.

The chapter provides information from analyses of trends in in-patient activity and notes that older people are more likely to use hospital services than younger people with those aged 65 and over accounting for 37 per cent of public acute hospital services, and 35 per cent of private acute hospital services. It provides some information on Commonwealth-funded aged care programs including the Aged Care Assessment Teams (ACATs) and notes some of the new initiatives in regards to rehabilitation for older people, Care Awaiting Placement and Hospital in the Home Programs.

Chapter Ten deals with the area of residential care and notes that a reasonably common image of later life is its association with residential care. However it also notes that in Western Australia in 1996/97, approximately 92 per cent of people aged 70+ lived in the community while only some 3.9 per cent of the 70+ population lived in hostels, with a further 3.9 per cent living in nursing homes.

The chapter notes that the provision of residential aged care services is an acknowledged area of Commonwealth responsibility, and that in August 1995 the State Government announced a plan to retire as a direct provider of nursing home care leading to the major restructuring of the State Government Nursing Home (SGNH) sector.

It notes the main outcome of this decision has been the opportunity for the State to reinvest SGNH funds resulting in the establishment of new, non-government nursing home facilities and other aged care services in the north, south and east.
metropolitan regions closer to where people live. The chapter notes that the reinvestment strategy has also allowed problems older people have had in accessing aged care services in the country, to also be addressed. It provides more detailed information on other major elements of the SGNH Restructure Project and notes that where alternative Commonwealth-funded services are not available, the Health Department ensures the provision of Nursing Home Type accommodation for people living in rural and remote areas.

The next chapter, Chapter Eleven, looks at mental health services for older people, the focus of which is service provision within the community and close to where people live. It notes that this is achieved by the integration of mental health services with mainstream health services. It also notes that specialist mental health services for older people are required when the assessment and treatment of mental disorder is complicated by physical conditions of ageing such as physical frailty, degenerative illness and dementia.

It notes that the Health Department’s Mental Health Division is currently pursuing a number of service provision reforms in order to maximise the mental health of older people and their families, and notes the planning principles underpinning these reforms.

Chapter Twelve considers a number of the other health care and support services available to older people including Multi-Purpose Services (MPSs) and Palliative Care. It notes that the Multi-Purpose Service (MPS) model is an important policy and planning instrument for the improvement of services for older people living in small rural centres.

It notes that pooled Commonwealth and State funds within a designated area are applied flexibly across all health and aged care programs and that currently, there are 15 MPS sites operating in WA with further sites likely to become operational in the course of 1999/2000.

It notes that Palliative Care focuses on the wellbeing of a person with terminal illness in order to ensure dignity and comfort for the person over the duration of his or her illness. The chapter notes that the Health Department is currently supporting the development of Palliative Care services in WA by investing in equitable access to community-based care to support people in their own homes or equivalent, and inpatient care where care at home is not possible.

This chapter also looks at the availability of a number of other support services including those related to the Domiciliary Dental Service which is provided on a demands-basis attending to bedridden and/or home-bound patients in the community, nursing homes and hostels in the metropolitan area. It notes the service is available to clients on referral by medical practitioners and provides basic dental care including dentures, extractions and fillings.

The final chapter of the Paper presents a brief commentary on the current system of service provision, the key issues that face the State in relation to the ageing population and implications for services delivery. It looks at the need for greater collaboration between the various sectors such as primary care, acute care and community care; the need for more promotion strategies which specifically target the older population; and the need
for growth in the community care sector to ensure continued support for Carers.

It notes that many older people require management of their complex and/or chronic health conditions from different types of service providers and that a number of initiatives are beginning to emerge which examine ways in which care, support and other services can be integrated more effectively, thereby overcoming the fragmentation of care which often characterises the current system. It notes the need to determine what may be done to reduce or even remove the boundaries, both real and perceived, between services, service providers, State government departments and State and Federal government departments.

Finally the chapter notes that the planning and development of health and related aged care services to meet the future needs of older West Australians requires a number of steps. These are analysing the current system of services delivered to older people, analysing the implications for service delivery of growth in the numbers and proportion of older people and then developing new models of service delivery to ensure there are adequate and appropriate services available. The Paper suggests this be done on a whole-of-sector and cross-jurisdictional basis and invites interested parties to respond accordingly.
I. A NEW VISION OF AGEING
1. A new vision of ageing

Over recent years, the world’s population has continued on its remarkable transition from a state of high birth and death rates to one characterised by low birth and death rates. At the heart of this transition has been the growth in the number and proportion of older people, the like of which has never been seen in the history of civilisation.

Worldwide, the current demographic revolution is predicted to continue well into the coming centuries. One of every ten persons is now 60 years of age or older. By 2050, one in five will be 60 years or older; and by 2150, one in three persons will be 60 years or older.

The older population itself is ageing. The increase in the number of old people aged 80+ years, on the global scale, is projected to grow eight to ten times over the 100 years from 1950 to 2050. Currently, the oldest old constitute 11 per cent of the population aged 60 and above. By 2150, about one-third of the older population will be 80 years or older.¹

In comparison, Western Australia has a relatively young population, although older people are forming an increasing proportion of the State’s population. In 1997, people aged 65 and over comprised 10.5 per cent of the total population. This figure is expected to grow to 12 per cent by 2011.

The older West Australian population is also ageing. In 1981, people aged 80 years and over comprised 14.3 per cent of all those aged 65+. By 1997, this age group made up 23.7 per cent of all older people.² It is projected that people aged 65 years and over will continue to be a growing proportion of the population, and that the proportion of those age 80+ will also continue to increase.

There is a window of opportunity over the next few years to develop bold and innovative strategies to deal with the implications of these changes. The peak of the ‘age wave’ will not occur for another ten years, when the first of the post-World War II ‘baby boomers’ reach retirement age.³ It is important to use this time for action that will not only ensure people reach the last phase of their life in optimum health but which will also support their health and independence throughout that phase. This may require new and flexible ways of thinking about roles and responsibilities for health and quality of life and the forming of partnerships within and across the health, aged care and community sectors.

A NEW CONTEXT

INTERNATIONAL YEAR OF OLDER PERSONS

Building on previous work by the United Nations in the interests of older people, the United Nations General Assembly decided to observe the year 1999 as the International Year of Older Persons (IYOP). This initiative is also in recognition of humanity’s demographic coming of age and the promise it holds for maturing attitudes and capabilities.

The International Plan of Action on Ageing, endorsed by the United Nations General Assembly in 1982 was the first international instrument on ageing. The Plan of Action discusses the multidimensional nature of ageing and promotes the potential of a positive and developmentally-oriented view
of old age. The plan identifies the need for policies and programs that reflect the aspirations of older persons and its sixty-two recommendations form the basis of global targets on ageing for the year 2001. The recommendations address the key issues of education, employment and income security, housing and the environment, health and hygiene, social welfare and the family.

Ensuring the means of livelihood and income security for older persons has become a major concern for all countries. The economic situation of older persons is affected in many places by loosening attachments to the workforce, skills obsolescence, devaluation of savings and pensions, and old-age (as well as family and society-wide) poverty.

In 1991 the United Nations General Assembly adopted eighteen Principles for Older Persons in appreciation of the contribution that older persons make to their societies. These principles address five core components of quality of life for older people:

- Independence
- Participation
- Care
- Self-fulfilment
- Dignity.

**A WHOLE-OF-LIFE APPROACH TO LATER LIFE**

In all cultures, accumulated life experience has the potential to make late life a period of enrichment and fruition, even as it is also a time of decline and loss. While the tension between growth and loss is at its most poignant in later life, it is an integral part of every phase of an individual’s life.

The addition of years to life is transforming the second half of life in a way which has major implications for its earlier stages. The United Nations theme for the IYOP 1999, Towards a Society for all Ages, explores these implications.  

**LATE LIFE: RE-WRITING THE SCRIPTS**

Today, older people are demographic and social pioneers who have opportunities to transform the roles and meaning associated with later life. New terms, images and scripts are required to challenge narrow stereotypical images of older persons. The developmental potential and diversity of later life needs to be explored and supported at the same time as the health-care and income-security needs of people in this stage of life are addressed.

**MIDLIFE: A TIME OF ADJUSTMENT**

With the emergence of a new old age, midlife becomes an important transitional phase which may be considered a prelude to active ageing as adolescence is to active adulthood. Midlife is a time of adjustment in family life, work and personal identity. Research has shown that it is a developmentally flexible time, a time to assess experiences to date and plan for the future. These actions have the capacity to release individual potential and reduce the possibility of disease, decline and exclusions in old age and their associated human and financial costs.

**ADULT YEARS: A TIME FOR BUILDING UP CAPITAL**

The adult years are a time for launching career and family and for engaging in continuing self-development and civic
activities, all of which build up the economic, social and human capital which can help ensure a person’s wellbeing in later life. However, men’s and women’s lives are increasingly dominated by work or the search for it. Unemployment is associated with material poverty, while employment can create ‘time poverty’ which relegates family, community and education to the evenings and weekends. A more flexible scheduling of adult years would enable a more balanced mix of education, work and leisure throughout the entire life course and allow individuals to accumulate human, social and economic capital in their most active years.

**YOUTH: WHEN LIFESTYLES FOR LONGEVITY BEGIN**

Youth today are likely to live longer than their parents, adding longevity to the many challenges they face. Youth cannot know the distant future, but they can know the likely consequences of early lifestyles and habits of mind. The late-life consequence of missed or missing education and work opportunities is likely to be poverty. The consequence of hunger, stress, addictions and other manifestations of material and psychological poverty is chronic disease in mid and late life. Longevity challenges youth to acquire foresight and an ability to adopt the best elements of innovation and tradition in their lifestyle.

**CHILDHOOD: THE CRADLE OF LONGEVITY**

The physical, intellectual and emotional foundations of long life are laid in childhood. In addition to meeting the full range of physical, intellectual and emotional needs of children, the presence of calm, insightful and supportive adults imparts knowledge about how to be and how to live together. Through these contacts with adults, children learn resilience, trust, independence and interdependence – qualities that will guide and sustain them throughout their life. Measures to support more age-interactions in family, neighbourhood and society could help ensure that childhood is a firm beginning to a long life.

The ageing of individuals calls for a developmental perspective encompassing interventions beginning at early age to promote self-reliance over the entire lifespan. As these interventions are improved and refined, the capabilities and resourcefulness of each succeeding cohort will expand to enable those in that cohort to arrive at a high age with ever-improved work and life skills and health status.

**NATIONAL STRATEGY FOR AN AGEING AUSTRALIA**

In October 1997, in a statement to the United Nations, the Commonwealth announced that it would develop a National Strategy for an Ageing Australia as its major policy response to the International Year of Older Persons 1999. The aim of the National Strategy is to provide a broad-ranging framework to identify challenges and possible responses for Government, business, the community and individuals to meet the needs of Australians as they age.

In May 1999, the Commonwealth released a Background Paper outlining the Strategy’s purpose and proposed the development of four discussion papers based on four themes as a means of progressing the National Strategy.
The four themes are:

- **Independence and Self-Provision** – to examine the implications of an ageing population for income support programs, superannuation, patterns of workforce participation, retirement and retirement planning and long-term care insurance.
- **Attitude, Lifestyle and Community Support** – to examine community attitudes and expectations in relation to ageing and older people. It will also examine other issues that impact on older people’s capacity to remain active and independent. These issues include physical safety; housing and urban designs; transport; and recreation and tourism.
- **Healthy Ageing** – to look to consolidate and extend the health gains for older people in recent years through population health measures and promotion and prevention interventions.
- **World Class Care** – to examine the implications of an ageing society for the health and aged care systems.

The Commonwealth also established the Healthy Ageing Taskforce as a key vehicle for coordinating Commonwealth and State/Territory responses to the IYOP. In addition, the Taskforce has developed a draft National Healthy Ageing Strategy. Following broad community consultations, it has identified six desired outcomes:

- Improved community attitudes to ageing and older people
- Improved health and wellbeing for older Australians
- More older people in employment and community activities
- The provision of financial and other support for older Australians by
- Government, communities and individuals in a way which is realistic and fair
- Appropriate living environments and local communities for older people
- Appropriate and affordable support so that older people can choose the care and support which best meets their needs and aspirations.

It is anticipated that the National Healthy Ageing Strategy will be launched before the end of 1999 as part of the IYOP.

**KEY CONCERNS OF WEST AUSTRALIANS**

In Western Australia the Office of Seniors Interests carried out an extensive consumer consultation process during 1997 to underpin the development of a plan to address the ageing of WA’s population. This consultation highlighted a number of key concerns related to ageing and identified the community’s view on how these issues should be addressed, including:

**ATTITUDES TOWARDS OLDER PEOPLE**

Negative stereotypes and myths about ageing still prevail. Seniors should be portrayed in a realistic and positive manner. There is still a tendency to see seniors as a homogeneous group, yet they are very diverse and have an enormous range of interests, talents and experience.

**POLICIES, PROGRAMS AND SERVICES**

Seniors should have access to government services and programs which are suited to their needs, are flexible and allow them to remain living in their local community.
Physical, cultural, financial and other barriers often reduce seniors’ access to government programs and services and, as a consequence, their participation in the community.

**INFORMATION AND COMMUNICATION**
Seniors should have improved access to information about government services and policies. Government agencies have a responsibility to ensure seniors have relevant information to enable them to make the most of available services.

**HEALTH AND WELLBEING**
Seniors should enjoy optimum health and wellbeing, with health services being culturally appropriate, well coordinated and designed to assist independence.

**FAMILY AND CARERS**
Seniors should be supported in their roles as family members and Carers. Many seniors with disabilities rely entirely upon care provided by a spouse (44 per cent) or a live-in daughter (29 per cent) without calling upon government services. It is vital that Carers receive acknowledgment and, where required, adequate information and support.

**HOUSING AND INDEPENDENCE**
Seniors should be able to live in a community environment which helps them to remain independent.

**SAFETY AND SECURITY**
Seniors should feel safe and secure in their homes and in the community. During public consultations, it was consistently suggested that improvements to the safety of roads, footpaths and buildings were needed. The security of private homes and public places was also a concern to seniors.

**TRANSPORT**
Seniors should have access to transport services, particularly in rural areas, to enable them to contribute to society and enjoy an independent lifestyle.

**MATURE EMPLOYMENT**
Seniors should have increased opportunities to be involved in employment and volunteering. Despite the ageing of the population, older Australians remain under-represented in the workforce. Volunteers, many of them older people, also need recognition and practical support to get jobs done without personal costs.

**EDUCATION AND TRAINING**
Seniors should have improved access to education and training.

### THE STATE’S VISION

Our vision is a Western Australia for all ages, where seniors lead safe and independent lives, where the relationships between generations continue to grow stronger and our ageing population is secure and healthy.³

To achieve this vision, the Government of Western Australia has developed Time on Our Side: A Five Year Plan For Western Australia’s Maturing Population.³ This plan outlines a coordinated whole-of-government approach to providing policies and services which take account of the different needs of an older population.

The value of older people to the State’s social and economic future is clearly recognised in this plan, as is the need to break down the myths that older people do not contribute to society. Strategies have been developed which detail the role of all sectors of government, business and individuals ensuring that West Australians
can make the most of their increasing life spans.

In its Five Year Plan, the State Government has made a series of commitments to address each of the issues identified by the community and which sets the pace for all sectors of government, business and individuals to contribute to positive ageing in Western Australia.

To ensure that older people enjoy optimum health and wellbeing, the Government has, among other things, undertaken to:

- Identify the long-term strategic impact of an ageing population on health services
- Develop new and innovative health promotion strategies for seniors
- Continue the State Government Nursing Home Restructure Project to redistribute nursing home beds to ‘under-bedded’ locations, especially in country areas
- Further develop the State/Commonwealth Multi-Purpose Service Program to improve access to residential aged care in rural and remote communities.

The Health Department of Western Australia (HDWA) is the key agent in carrying out these particular commitments.

**THE ROLE OF THE HEALTH DEPARTMENT OF WA**

The Health Department’s overall objective is to improve the health of the West Australian community by:

- Reducing the incidence of preventable disease, injury, disability and premature death
- Restoring the health of people with acute illness
- Improving the quality of life for people with chronic illness and disability.

In order to secure the greatest possible improvement in the health and quality of life for all West Australians, the Health Department recognises that all individuals should have a fair opportunity to gain their health potential irrespective of age, gender, race, ethnicity, socioeconomic status or place of residence. The differing needs of individuals, groups and communities must also be understood.

Resources must be targeted where needs are greatest, and the clinical- and cost-effectiveness of services must be maximised to secure the greatest benefit from resources available. The health system also needs to be clinically and economically sustainable. There is considerable variation in the health and care needs of those in the older age groups. Older people may be well, frail or disabled and they may suffer from acute or chronic illness or both, over time, and their health status is subject to change. Further, it is important to recognise the extent to which the social, physical and economic environment in which older people live influences their capacity to attain and maintain optimum health and wellbeing.

**THE AGED AND CONTINUING CARE BRANCH**

In March 1997, HDWA formally established the Aged and Continuing Care Branch to bring together the direction and management of a wide range of HDWA programs and initiatives related to the health and wellbeing of older people. The broad responsibilities of the Unit are:
- Strategic planning and service development of aged and continuing care services
- Operational management of ongoing State Government Nursing Home Restructure Projects
- Administration and management of the HACC and Aged Care Assessment Programs.

**MEETING THE CHALLENGE**

The major focus of HDWA involvement in providing health and health-related care for older West Australians is on their health, wellbeing and independence. One challenge is to expand the focus so that intervention strategies are directed at younger cohorts in the population to ensure that they will experience improved health, wellbeing and independence when they are older.

The history of the provision of health care and support services for older people highlights some issues and concerns. One of these in particular is the fragmentation of care to a population group which frequently has complex and interacting needs. Fragmentation and a general lack of interaction and collaboration have been evident at a number of points across the care spectrum. It can be seen between: medical specialties; professions within clinical practice; service providers and organisations catering for medical, functional and social needs; primary, secondary and tertiary medical care; and episodes of contact with health and social care systems. A further issue has been a conceptual orientation towards accommodation and support rather than the possibilities for treatment, functional recovery and prevention.?

While there has been much innovation and reform in the delivery of health and aged care services to older people, the growth in the numbers of older people and their expectations of a high quality of life are resulting in pressure for further change. To establish defined, integrated, viable and high-quality services in which older people and their Carers can have confidence, will require flexible thinking and some fundamental changes in the priorities and delivery systems of health and aged care in the future, particularly if services are to be delivered which better meet needs within available resources.

Before this, however, a picture needs to be established of what the older population in Western Australia looks like, including the varying factors and issues which impact on them. The following chapters describe the major demographic characteristics of older people in Western Australia and explore some of the issues which have the potential to affect their health and quality of life.
2. OLDER WEST AUSTRALIANS
Western Australia is experiencing an increase in the proportion of older people in the population. The increased population of older people is mainly due to a declining birthrate and changes to patterns of immigration.

There are two issues. Firstly, there is growth in the number of older people and secondly, there is growth in the proportion of older people in the population. This is partly attributable to a gradual, long-term increase in life expectancy for West Australians, the ageing of the ‘baby boomer’ generation born after World War II, immigration patterns and a declining birthrate.

The changing age profile of the West Australian community has important implications for the provision of health services and several key factors are likely to impact on the health and wellbeing of older people. These factors are the level of participation in the community, economic security, independence and health status.

THE AGEING PHENOMENON

The population of Western Australia is not static, but is constantly changing. There are presently approximately 1.7 million people living in Western Australia. Between 1996 and 2011, the West Australian Ministry of Planning has projected that the size of the total State population will increase at a rate of approximately 1.5 per cent each year. It is estimated that there will be 2.2 million West Australians by 2011.

Although the total number of people in WA is growing, a population does not grow evenly and is affected over time by factors such as birthrate, immigration (such as Australia experienced after World War II) and also, to some degree, prevailing economic conditions.

The post-World War II ‘baby boom’ between 1947 and the mid-1960s led to a rapid growth in the population over a period of nearly 20 years, boosted by postwar immigration. Figure 2.1 shows how this period of rapid population growth has been followed by an ‘echo’ of this initial growth period as the baby boomers themselves became parents. However since the early 1970s, the State’s birth rate has declined.

The initial ‘baby boomers’, born around 1947, are now entering their 50s. Within 10 years, this large group of people will be approaching old age. For many, the ageing of the population relates to the impact in the next century of the ageing of the ‘baby boomers’ from the post-World War II period, as the very size of this group and their much longer life expectancy will inevitably bring about significant changes to the demographic make-up of society. There is considerable debate about the expected nature and implications of these changes. However it is generally accepted that this cohort has different expectations of retirement, is consumer oriented, expects service quality and value for its money, is better educated and more ethnically diverse – largely as a result of the post-World War II and continued immigration programs.
Figure 2.1 Annual trend in Australia’s population distribution by age, 1976–1996

It is also the first generation to contain a substantial proportion of people with longstanding disabilities. Advances in technology, medical care and community support mean that more people with longstanding disabilities, who once would have died before reaching late adulthood, now have a life expectancy that approximates that of the general population. The significant issue of the ageing of those with longstanding disabilities has not been dealt with in this Paper. However it is one which of itself requires due consideration and planning such as outlined in a recent report by Professor Lindsay Gething from the University of Sydney. (See Resources for Further Information, page 136.)

LIFE EXPECTANCY AT BIRTH

The population is increasing in part due to a gradual, long-term increase in life expectancy at birth. In the period 1901 to 1910, life expectancy at birth was 55.2 years for men and 58.8 years for women. By 1984, men could expect to live until they were 70 years of age. Between 1984 and 1997 their life expectancy at birth increased a further four years, to 74.2 years. A similar trend is evident for women, with an average life expectancy at birth of 77.3 years in 1984, which had increased to 81 years by 1997.

Increasing life expectancy and improvements in the health status of people in their retirement years are bringing into question the definition of old age.
Figure 2.2 Life expectancy at birth, Australia, 1885–1996

![Graph showing life expectancy over time]

Source: Australian Bureau of Statistics, Deaths, Australia, Cat. 3302.0. Reproduced with permission.

Figure 2.3 Median age of persons, Australia, 1978–1998

![Graph showing median age over time]

Source: Australian Bureau of Statistics, population by Age and Sex, Australian States and Territories, Cat. 3201.0

A CHANGING AGE PROFILE

Western Australia has a comparatively young population. However, older people are an increasing proportion of the State’s growing population. In 1981, people aged 65 years and over made up 8.7 per cent of the State’s population of 1.3 million. In 1997, there were about 188,000 Western Australians aged 65 years and over, comprising 10.5 per cent of a population of 1.7 million people. By 2011, it is expected that this group will have grown to around 264,300 persons, making up 12 per cent of the population. This represents a growth rate of about 2.5 per cent each year, which is higher than the average growth rate for the State’s population as a whole.

The older West Australian population is also ageing. In 1981, those aged 80 years and over comprised 14.3 per cent of all those aged 65 years and over. By 1997, this age group made up 23.7 per cent of all older people.
Conservative forecasts of population growth predict that this ageing of the older population will continue. It is expected that older people will make up a growing proportion of the population, and that the proportion of persons aged over 80 years in the population will continue to increase.

**Figure 2.5 Age groups as a percentage of total population, Australia, 1997–2051**

**AGEING AND DEPENDENCY**

With an ageing population, there may be concern for society’s capacity to care for those in need of support. An indication of the number of people available to support those in need of care is generally expressed as a dependency ratio. Since the 1920s, there has been a steady increase in the proportion of older people as a percentage of all persons, of those in the workforce and those of working age.
People in the workforce are the primary providers of resources which support health and other social support programs through taxation and the Medicare levy. The ratio of the number of working age persons to the number of younger and older people not in the workforce provides a general indication of the social support needs of younger and older people upon the working population.\textsuperscript{10}

The dependency of older people upon the working population can also be estimated separately from younger people. Figure 2.6 demonstrates that as the proportion of older people in the total Australian population increased between 1901 and 1996, the relative dependency of older people upon both people of working age and the workforce has also increased. Projections of dependency ratios for the older population to 2016 suggest that the dependency of the older population upon the workforce is likely to continue to increase, as shown in Figure 2.7.

These measures, known as dependency ratios or rates, may be used as a general guide to the potential impact of an ageing population. The information suggests that Australia could be at risk of increased pressure to provide support to older people as the population ages.

However, the actual impact of the ageing population upon the population can be influenced by other factors.\textsuperscript{11} For example, workforce participation rates, unemployment levels, median age of entry to the workforce, median age of retirement, older people’s income and their economic security, economic growth including the productivity of the workforce, and the mechanisms of redistributing wealth from people in the workforce to other people, may each affect the dependency of older people upon government health and other social supports.
**Figure 2.7 Projected dependency ratios, Australia, 1997–2016 (per cent)**

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>15</td>
</tr>
<tr>
<td>2001</td>
<td>18</td>
</tr>
<tr>
<td>2005</td>
<td>21</td>
</tr>
<tr>
<td>2009</td>
<td>24</td>
</tr>
<tr>
<td>2011</td>
<td>26</td>
</tr>
</tbody>
</table>

Source: Australian Bureau of Statistics, Population projections, Cat. 3222.0; Labour Force Projections, Australia, Cat. 6260.0

**DISTRIBUTION OF OLDER PEOPLE IN WA**

Currently the State’s older population is not evenly distributed either in WA as a whole, or in the Perth metropolitan area. Furthermore the projected rate of growth in the number of older people is expected to differ between different areas within the State, and between different areas within Perth itself. The total number of older people in WA is expected to grow by 44 per cent between 1996 and 2011. However, while the growth in both the metropolitan and rural areas is expected to be close to this figure on average, the number of older people in remote areas is expected to grow by 92 per cent over the same period, more than double the State average expected population growth.

**METROPOLITAN AREA**

Communities have life cycles which are defined by the age profile of its members. There are five main stages in the life cycle of a given community: the youthful stage, the young families stage, the older families stage, the maturing stage and the ageing stage. Inspired, to some extent, by the models published in Hugo’s *Australia’s Changing Population*, a Departmental analysis of the population of the Perth metropolitan area identified clusters of the community which are at different points in the community’s life cycle.

The existence of these clusters of communities at different stages of the community life cycle demonstrates that older people do not live evenly dispersed throughout the Perth metropolitan area. Instead, there are clusters of older and younger people in different regions.
Figure 2.8 Distribution of communities at different stages of the community life cycle, Perth, 1996

Source: Australian Bureau of Statistics, Census of Population and Housing
The populations within these different regions of the metropolitan area are expected to grow at different rates during the next decade, and the number of older people will also grow at different rates between the different regions. This means that the location of clusters of older people in the Perth metropolitan area can be expected to change over time. For example, between 1996 and 2011, there are expected to be rapid increases in the number of older people in the North Metropolitan, Mandurah (Peel), Rockingham-Kwinana, Armadale-Kelmscott, and Swan Health Service catchment areas. In the North Metropolitan Health Service, this rapid increase is expected to be concentrated in Joondalup and Wanneroo. Rapid growth in the number of older people is also expected in the South West of the State.

**Figure 2.9** Projected growth in persons aged 65 years and over by metropolitan health service, Perth, WA, 1996–2011

![Chart](chart.png)


**RURAL AND REMOTE AREAS**

People living in rural and remote areas tend to have poorer health than those in metropolitan areas. Possible contributory factors are relatively poor access to health services, lower socioeconomic status and employment levels, exposure to comparatively harsher environments, sparse infrastructure and occupational hazards.

In 1997, about 20 per cent of Western Australians aged 65 years and over lived outside the Perth metropolitan area. At present in rural WA, older people make up 11 per cent of the population, slightly higher than the proportion of the Perth metropolitan area. However, in remote WA, people aged 65+ represent only 4 per cent of the population. This means that there is a very small number of older people in remote Western Australia, dispersed throughout the enormous geographic areas of the Kimberley, Pilbara and Goldfields.

**CULTURAL DIVERSITY**

Different cultures have different demographics, health conditions and lifestyle risk factors. People from different
cultures may have different health service needs, and may differ in their use of types and levels of health services. It is essential to consider the multicultural mix of the population to ensure that West Australians from different cultures and/or other countries have access to health services in a fair and equitable manner.

**ABORIGINAL PEOPLE**

Aboriginal people represent 2.8 per cent of Western Australia’s total population. On average they have a significantly lower life expectancy than the general population. Aboriginal people aged 65+ represent only 2.5 per cent of all Aboriginal people whereas in the general population persons aged 65+ represent 10.8 per cent of the population.

Aboriginal people generally tend to experience poorer health and encounter problems of ageing at a younger age than the rest of the population, which is consistent with a lower life expectancy. They also need to be considered for aged care services at a younger age than the general population.

The premature ageing of the Aboriginal population, their lower life expectancy, their wide dispersal throughout the State and the need to provide an effective health service that takes into account social and cultural needs, present particular service planning and delivery challenges. Although the recipients of aged care services receive them based on need, frailty or incapacity rather than age, in the planning of aged care and community services, the Commonwealth and State tend to focus on the number of persons in the total population aged 70 years and over, and the number of Aboriginal people age 50 years and over.

Aboriginal people aged 50+ represent 8.9 per cent of all Aboriginal people in WA. From an Australia-wide perspective on the use of aged care services, Aboriginal people comprise 3 per cent of Home and Community Care clients, 6 per cent of community options clients and only 1 per cent of residential aged care services, consistent with their desire to remain on the land and with their families. Community-based services enable people to remain in remote communities despite being frail, aged or having a disability. While the costs involved in providing services in remote locations can be higher, the ability to be supported in a preferred location is often vital to the person and his/her family.

A Home and Community Care (HACC) project under the sponsorship of the Ngaanyatjarra Council (Aboriginal Corporation) operates in conjunction with a Commonwealth-funded Aged Care Pilot to provide culturally-appropriate aged care services to people in the Ngaanyatjarra Lands of Western Australia. The two projects are based on the principle of providing services appropriate to the needs of people living in their traditional lands. Community support, participation and ownership in service delivery are integral to these projects.

A range of other HACC initiatives and/or one-off funding projects specifically target Aboriginal people. These include increased service opportunities for remote Aboriginal communities through the East and West Kimberley Remote Project Development Scheme; vehicles for Pilbara Homecare to enable delivery of meals and to provide transport for Aboriginal HACC workers; equipment for Ngangganawilli Aboriginal
Corporation and Leonora HACC; and renovations, repairs and refurbishment to the Balgo Community HACC service venue. Further information regarding HACC services and the Aboriginal population in WA can be found in a later section of this Paper.

Death rates for Aboriginal people, after adjusting for age, are higher than for other Australians both overall and for almost every specific cause of death. In relation to risk factors associated with health outcomes, Aboriginal people are more likely to be classified as obese; are twice as likely to smoke (and thereby be at greater risk of heart and lung disease and cancer); and although less likely to drink alcohol than other Australians, those who do are more likely to drink at unsafe levels.

The Health Department of Western Australia, aware of these and other issues particular to the Aboriginal people of the State, established the Office of Aboriginal Health (OAH) in 1996. The OAH has statewide responsibility to improve the health and wellbeing of Aboriginal people in WA and works in partnership with Aboriginal communities to ensure they receive culturally appropriate care. It also works in partnership with other Aboriginal organisations and mainstream health providers in working to improve the health and wellbeing of Aboriginal people throughout the State.

During 1997/98, a joint multi-site Coordinated Care Trial was developed involving the OAH, the Perth Aboriginal Medical Service and the South West Aboriginal Medical Service in Bunbury. The Trial covers more than 2,000 Aboriginal people and extends the platform of cooperation among the Aboriginal community, Government and private health service providers. Although the Trial is not aimed specifically at older Aboriginal people, they form part of the population it covers, and plans for future services in the preventative area targeting older Aboriginal people are being considered. Among the results expected to be generated by the Trial will be effective case management for the client and service cooperation incorporating both community and mainstream health service provision. It will also provide improved data on the health of Aboriginal people, their health service needs and their actual utilisation of services.

Another OAH program is the Family Futures program which, although it too is not specifically aimed at the older population, will meet some of their needs with one key area being flu immunisations for older Aboriginal people.

The OAH has also identified a number of key areas through which health outcomes for Aboriginal people will be improved including a number of prevention and health promotion strategies, some of which are specifically mentioned in the next chapter. In addition to these the OAH will, during the period 1999–2002, purchase a number of other lifestyle management programs including community-based anti-smoking education programs; exercise programs; and community-based alcohol education, prevention and intervention programs.
**Figure 2.10** Aboriginal and non-Aboriginal persons by age and sex, WA, 1997 (persons)

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Source: Health Department of Western Australia, Epidemiology and Analytical Services Rates Calculator, 1999
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**MIGRANT COMMUNITIES**

For more than 50 years WA has had a substantially higher proportion of overseas-born people in its population than any other State or Territory in Australia. In 1996, about 548,000 of all people in Western Australia were born overseas (about 31.7 per cent). Half (50.0 per cent) of these overseas-born people were from non-English speaking countries. About 16 per cent of the population aged 60 years and over spoke a language other than English at home.

Immediately after World War II, the majority of Non-English Speaking Background (NESB) migrants to Western Australia came from Europe, particularly Italy, Germany, Poland and the Netherlands. Since the 1970s, there has been an increase in immigration from countries in South East Asia, such as Vietnam. Many of the immigrants who formed part of the post-World War II immigration and associated family reunion schemes are now approaching old age.

In Australia as a whole, the number of people from a Non-English Speaking Background (NESB) aged 65 years and over in 1997 was 272,000, representing 14.3 per cent of all older people. This figure is projected to increase to 660,000 (25 per cent of older people) by 2001. Studies done by the Australian Institute of Health and Welfare (AIHW) have shown that the age profile of NESB aged care service users (receiving community and/or residential services), is not greatly different from that of clients from English-speaking backgrounds. The main difference is that there is a greater proportion of younger aged groups (i.e. 55–79 years) among NESB users.
People from ethnic groups may face barriers in accessing health services posed by a lack of proficiency in English, as well as cultural and other social factors. They can have problems in obtaining information, explaining their problems or understanding explanations of their condition and treatment. Those who have different values and customs are more likely to suffer from stress, depression and disorientation, be intimidated by large institutions, be offended or frightened by some forms of examination or treatment, and receive inadequate attention while in care. Not having access to the right information may result in not knowing when to seek medical assistance, the services that are available, or how to access them.²⁰

Improved access to appropriate health and community care for people from culturally and linguistically diverse backgrounds requires the increased awareness of health and community care workers to the needs and values of people who do not speak English well, or who come from a non-Anglo-Celtic background. A system of language services which is readily accessed by health workers is essential, as is the employment and development of bilingual staff within the health and community care system. There is also a need for a limited range of targeted and well-supported specialist services for high priority groups within the culturally and linguistically diverse population.²⁰

**Figure 2.11 Persons 65 years and over by region of birth, persons born in non-English speaking countries, WA, 1996 (per cent)**

![Pie chart showing region of birth](image)

Note: Excludes persons born in Australia, New Zealand, United Kingdom, South Africa, Canada and United States.

Source: Australian Bureau of Statistics, Census of Population and Housing
Older women in WA from culturally and linguistically different backgrounds are particularly vulnerable in that they are likely to be living alone and on a low income, with a minimal or declining command of English and possibly reduced family support. This can lead to isolation which may, in turn, result in psychological and physical susceptibility to illness.\textsuperscript{20}

As is the case for older Aboriginal people, there is a range of HACC services specifically targeted to the needs of older people from culturally and linguistically diverse backgrounds including the establishment of culturally appropriate food services for identified communities in all areas of the metropolitan region. One example of this is the specific kosher food service established to take into account particular requirements for preparation of kosher food for Jewish seniors living in the City of Stirling. Another example is Meals on Wheels delivered through the Fremantle Community Day Centre for East Timorese seniors living in that area.

Other HACC services tailored to meet the special needs of older people from NESB and culturally diverse backgrounds, include the establishment of respite services in both Day Centres and in the individual’s home. Examples include the North Perth Migrant Centre which runs a Day Centre respite service for five different cultural groups with two additional days for mixed cultural groups, one day of which is for people with dementia. Culturally appropriate meals are also provided as part of the Day Centre’s activities. A similar multicultural Day Centre service is provided in the City of Stirling.

An example of services provided in the individual’s home is the specialised program of home help and personal care services delivered to 23 aged and disabled persons of diverse linguistic and cultural backgrounds in the Cockburn and Fremantle area. Carers who are also from diverse linguistic and cultural backgrounds are recruited and matched to the client’s specific background.

A National Reference Group, which includes representation from WA, has been established to address the needs of people from culturally and linguistically diverse backgrounds in regards to the provision of HACC services. (Further information regarding the HACC Program in WA can be found in Chapter Eight of this Paper.)
3. FACTORS RELATED TO HEALTH AND QUALITY OF LIFE FOR OLDER PEOPLE
3. Factors Related to Health and Quality of Life for Older People

There are a number of social and economic factors which play significant roles in the health and wellbeing of older people. These factors are participation in the community, economic security and independence.

PARTICIPATION IN THE COMMUNITY

The health of older people is influenced by their social setting and relationships. Older people who have a high degree of involvement with others and have economic security are more likely to be part of a support network and be able to live independently. Social contacts have been found to be important to wellbeing and are also important for health promotion behaviours. Sedentary older people are more socially isolated than those participating in regular physical activity.21

The extent to which older people participate in the community provides evidence of social networks, independence and involvement in reciprocal relationships. The capacity to contribute through gainful employment, either through the workforce or as a volunteer, is an important source of self-esteem to individuals. Older people as volunteers are discussed in more detail in the next chapter.

Figure 3.1 Age distribution of the workforce, Australia, 1986–1996 (per cent)

Over the last ten years there has been a change in the age distribution of the workforce. Young people are entering at an older age, a growing proportion of the workforce is in the 45 to 54 year age group and there is an increasing proportion of people working past the age of 65.

There has also been an increase in the training of older people over recent years. This seems to indicate increased commitment to work by older people and recognition of their potential to develop new skills and actively contribute to the workplace.
Figure 3.2 Workforce training by age group, Australia, 1989–1997 (per cent)

Source: Australian Bureau of Statistics, Education and Training Experience, Australia, Cat. 6278.0

OLDER PEOPLE AND PAID EMPLOYMENT

Between 1969 and 1984, as was the case in most industrialised countries, the workforce participation rate of older people in Western Australia declined. Since 1984 their workforce participation rate has been relatively stable rising from 4.6 per cent in that year, to 5.8 per cent in 1996.

Figure 3.3 Participation in the labour force, Australia, 1969–1996 (per cent)


The workforce participation rate of the pre-retirement age group, however, has increased since 1985. While there is a certain volatility in the figures, there has been a steady trend towards part-time work for all people age 55 years and over.
A major factor in the climbing workforce participation of this group is the increased participation of women. The greater number of working women aged 45 to 64 has led to considerable change in the ratio of women to men in the workforce over the 20 to 30 years. Women currently make up 43 per cent of the workforce and are projected to comprise 46 per cent by 2011. Participation rates for all age groups, except for the 15 to 19 year age group, are expected to continue to rise. However, the rate of ageing is projected to exceed the rate of increased workforce participation.

**NON-PARTICIPATION IN THE WORKFORCE**

Some people elect not to participate in the workforce and there are clear age-related trends in what people do when they are not in paid employment. The main reasons for people not working are that they study, have home duties or care for others. As expected, those studying are mostly young and finish their studies before they are 25 years of age. Parenting and home duties are major activities for those aged 25 to 44 years and then, as children age, there is a flow back into the workforce. The move to retirement starts at 55 years of age.

**Figure 3.4 Non-participation in the labour force by reason, Australia, 1998 (per cent)**

![Bar chart showing non-participation reasons by age group](chart.png)

Source: Australian Bureau of Statistics, Persons Not in the Labour Force Australia, Cat. 6220.0

**HOW OLDER PEOPLE USE THEIR TIME**

Compared with the average, older people appear to spend more time on activities related to being at home, such as personal care, domestic activities and recreation and leisure.
**Figure 3.5** Main activity of older people, Australia, 1997 (minutes per day)

Comparing use of time in 1992 with that in 1997, the changes in time use by older people reflected the overall change for the average of the population. In 1997, less time was spent on child care and community interaction, while more time was spent on physical activity.

**Figure 3.6** Changes in amount of time spent by older people on main activities, Australia, 1992–1997 (per cent)

**ECONOMIC SECURITY**

Economic security is an important determinant of health and quality of life. People who have reasonable economic security are less likely to experience anxiety associated with financial strain, and people with higher disposable incomes possess financial resources which facilitate greater lifestyle choice and access to resources to manage a crisis, should one occur.
INCOME OF OLDER PEOPLE

Older people tend to have lower incomes than other age groups. In 1996/97, 78.7 per cent of income units (groups of people who share income) where the reference person was aged 65 years and over had incomes of less than $400 per week compared with 42.4 per cent for all households.

Figure 3.7 Income distribution by age group of reference persons, Australia, 1996/97

![Graph showing income distribution by age group.]

Source: Australian Bureau of Statistics, Income Distribution, Australia, Cat. 6523.0

MAIN SOURCE OF INCOME

In 1996/97, government pensions and benefits were the main source of income for 65 years and over, and over half of the households of older people received more than 90 per cent of their income from government.

Figure 3.8 Principal source of income by age group of reference person, Australia, 1996/97 (per cent of age group)

![Graph showing the main sources of income by age group.]

Source: Australian Bureau of Statistics, Income Distribution, Australia, Cat. 6523.0
Over the seven-year period from 1986/87 to 1993/94, there has also been an increase in the proportion of people aged 65 years and over with a non-taxable income. The largest increase has been in those aged 70+, where 3.6 per cent had a non-taxable income in 1986/87 compared with 14 per cent in 1993/94.

**Figure 3.9 Older taxpayers who do not have any taxable income, Australia, 1986/87 – 1993/94**

![Bar chart showing the percentage of non-taxable income by age group]

Source: Australian Taxation Office, Taxation Statistics Series

This information suggests that a substantial proportion of older people have limited disposable income and that these people rely heavily upon government assistance.

**SUPERANNUATION**

Superannuation is a means of ensuring that people have access to an adequate level of private income in their retirement years. As a result of compulsory superannuation cover, more of the workforce than ever before are covered by superannuation. When comparing superannuation coverage in 1974 with coverage in 1995, it is of particular interest to see that women’s superannuation coverage has come close to that of their male counterparts.

Superannuation is expected to make a major contribution to increasing the income of older people after leaving the workforce, once sufficient time has passed for accumulated savings to make a real impact upon the income of retired people.
SPENDING PATTERNS OF OLDER PEOPLE

The patterns of spending in older person households (aged 65+) are significantly different from those of younger age groups. Older person households spend 1.5 times more on medical care and health services than households where the reference person is less than 25 years of age, and 17 per cent more than households where the reference person is aged between 55 and 64 years. Other areas where older person households spend more are household services and operation; fuel and power; and personal care. The areas where they spend less than households of other age groups are: housing costs; alcoholic beverages and tobacco.

Figure 3.11 Spending patterns of households with reference person age 65 years and over compared with households of selected other age groups, Australia, 1993/94

Source: Australian Bureau of Statistics, Household Expenditure Survey, Australia: Household Characteristics, Cat. 6531.0
INDEPENDENCE AND SUPPORT

As people get older, many rely on social and physical support from others to maintain their independence. Independence is an important component of health and quality of life, and it is important that older people have a strong network around them to help them maintain their independence as long as possible.

HOUSEHOLDS OF OLDER PEOPLE

Older people tend to have different living arrangements from younger people and are more likely to live in a non-private dwelling such as a nursing home. They are also more likely to be living alone or as a partner in a couple. Women’s greater longevity and tendency to marry older men combine to create substantial numbers of women aged 65+ living alone, while older men are more likely to be living with a partner with no children living at home.

Figure 3.12 Living arrangements by age group, persons, WA, 1996 (rate per thousand persons)

Source: Australian Bureau of Statistics, Census of Population and Housing
**Figure 3.13** Living arrangements by sex, persons aged 65 years and over, WA, 1996 (rate per thousand persons)

Source: Australian Bureau of Statistics, Census of Population and Housing
4. OLDER PEOPLE AND PROMOTING HEALTH
Evidence suggests that a substantial proportion of chronic disabling conditions associated with ageing are potentially preventable, or at least postponable and are not an inevitable accompaniment of growing old. Postponement or prevention of these conditions may not only increase longevity but, more importantly, reduce the period of illnesses such that the majority of older persons may maintain good health free of disability, until very shortly before death.

Attitudes and policies in relation to ageing are recognising that there is now the potential for more positive experiences of ageing. In a 1997 address to the United Nations General Assembly in relation to Australia’s preparations for the International Year of Older Persons, the Federal Government stated that it recognised older people are not a homogeneous group and that programs and services should be based around positive and productive ageing. This led to the establishment of the National Strategy for an Ageing Australia. Four key themes of the Strategy are independence and self-provision; world-class care; attitude, lifestyle and community support; and healthy ageing. This last theme looks to consolidate and extend the health gains made for older people in recent years through population health measures and promotion and prevention interventions.

Health promotion is a broad concept which extends beyond prevention to incorporate partnerships between health care providers, the individual and the community. The definition of health promotion is related to an expansive definition of health as a resource for daily life. Health status, from this perspective, goes beyond level of illness.

Illness prevention is an important component of health promotion and has been characterised at three levels. Primary prevention stops illness or disease before it starts, an example being immunisation for influenza. Secondary prevention minimises the progress of a disease by early detection, e.g. mammography screening for breast cancer. Tertiary prevention aims to limit the effect of disease once it is established, such as rehabilitation or appropriate use of medication.

In considering the prevention of diseases common in old age, it is useful to make a distinction between ‘age-dependent’ and ‘age-related’ diseases. Age-dependent diseases are those in which the disease process is an intrinsic part of ageing, whereas age-related diseases are those which may become more common with age but are not necessarily related to the ageing process.

While age-related diseases can be prevented if an individual is not exposed to the causative agent, age-dependent diseases cannot be completely prevented. With age-dependent diseases, the aim of prevention is to extend the period of life free of disablement by delaying disease onset or by slowing down the disease process.

Until recently, older people have not been specifically targeted by health education and promotion activities because of views that little could be done to improve their health.
This view no longer holds sway and health educators and promoters are increasingly turning their attention to older age groups. However, for these programs to be successful, it is important to design programs based on an understanding of how older people conceptualise their health. The effectiveness of any such program is also influenced by the material circumstances of older people. No amount of promotional activity will change behaviour or attitudes if the target group has inadequate material resources to incorporate recommended changes into their lifestyle.26

However older people today not only have more resources (both social and personal) than their predecessors, but also have more knowledge of the risk factors which impact on good health such as smoking, excessive alcohol consumption, inactive or sedentary lifestyles, diet and bodyweight.26

**PRIMARY AND SECONDARY PREVENTION**

The goal of preventive medicine and promoting health in older people should not focus just on the reduction of premature morbidity and mortality or the curing and prevention of disease. It should also have the broader focus of aiming to preserve function and quality of life. A range of measures such as falls prevention and better use of medication can prevent loss of function, improve quality of life and postpone the need for long-term care. Often small gains in capacity can mean not only large gains in quality of life, but also swing the balance from dependence to independence.

Furthermore, attempts to prevent diseases of old age should start in youth, for the older the patient the less likely the possibility of primary and secondary prevention, and the greater the stress must be on tertiary prevention.21 A lifestyle approach needs to be developed that encourages healthy habits from an early age – such as exercising, following healthy eating patterns and not smoking. However as shown in some of the studies discussed below, older people can still benefit from healthier lifestyle changes such as exercising (including resistance and aerobic training) and giving up smoking.

Non-communicable diseases in people of all ages are the cause of much morbidity and mortality in the community and the cost of providing health care to people with non-communicable disease comprises a large proportion of the health care budget.

The purpose of the HDWA Chronic Disease and Health Enhancement Branch is to identify and act on opportunities for primary and secondary prevention in non-communicable disease control. It is the task of this Branch to inform the community about the risk factors associated with preventable non-communicable diseases and to provide opportunities for individuals to make informed decisions about their lifestyles. The adoption of a healthier lifestyle by West Australians will lead to an improvement in the health status of the population due to a reduction in the incidence and prevalence of preventable chronic health conditions. Four lifestyle factors – smoking, alcohol consumption, exercise, nutrition and weight control – are well-established risk factors for a variety of diseases.

Emphasis should be on offering the best proven and most effective interventions to the individuals at highest risk of significant
problems such as cardiovascular diseases, malignancies, infectious and endocrine diseases, and other major threats to function in older people. Breast cancer screening, smoking cessation, hypertension treatment and vaccination for infectious diseases are thus far among the most firmly proven and well accepted specific preventive measures, with nutrition and physical activity also being particularly promising.\textsuperscript{21}

**SMOKING**

Cigarette smoking remains the major cause of preventable disease and death in Western Australia. Tobacco is a major risk factor for several cancers, cardiovascular diseases such as coronary heart disease, atherosclerosis, stroke and hypertension, chronic obstructive pulmonary disease and other respiratory diseases, asthma and low birthweight infants. Tobacco is responsible for 80 per cent of drug-caused deaths and 15 per cent of deaths from all causes. Almost 1,500 West Australians die prematurely each year from tobacco-related causes.

The prevalence of smoking among the adult population in Western Australia has fallen significantly from 32 per cent in 1984 to 25 per cent in 1997. There are sub-population groups in which the prevalence of smoking remains higher, particularly Aboriginal adults (48 per cent) young men (36 per cent), young women (30 per cent) and adults of lower socioeconomic status (37 per cent).\textsuperscript{27} This behaviour places people in these sub-populations at higher risk of chronic disease as they age.

The 1995 National Health Survey showed that older West Australians are much less likely to smoke than their younger counterparts. Of those surveyed who were 65 years and over, 11 per cent smoked tobacco compared with 25 per cent of people aged from 18 to 64 years. Older people are much more likely to be ex-smokers, with ex-smokers comprising 44.4 per cent of older people compared with 28 per cent of those aged 18 to 64 years. There was a significant difference in smoking patterns between men and women in Western Australia with 27 per cent of males being smokers compared with 19 per cent of females. A larger proportion of women had never smoked (55 per cent compared with 39 per cent of men).\textsuperscript{28}

Over half (55 per cent) of all persons aged 65+ have been tobacco smokers at some time in their lives. However, more than 80 per cent of older people who have been smokers have quit smoking. Only 11 per cent of older people continue to smoke.
While most studies of smoking have looked at the health risks of those who are middle aged, one longitudinal US study found an excess mortality amongst smokers aged 60 to 94 years when compared with non-smokers. Those who gave up smoking in later life occupied an intermediate position of risk of excess mortality. The evidence now suggests that giving up smoking even in the seventh decade of life brings health benefits. Active steps should be taken to encourage older people to quit smoking.26

**HDWA SMOKING AND HEALTH PROGRAM**

The objective of the Smoking and Health Program is to reduce the incidence of diseases for which tobacco is a risk factor by:

- Monitoring and enforcing compliance with the Tobacco Control Act 1990
- Reducing the prevalence of smoking in the adult population
- Reducing the uptake of smoking among younger people
- Raising and maintaining awareness of the health risks of active and passive smoking
- Motivating smokers to attempt to quit or cut down on their smoking
- Supporting the establishment of smoke-free policies
- Reducing access of young people to cigarettes.

The Smoking and Health Program implements a range of strategies which target specific populations and settings within the community. These strategies include workforce training and support, marketing campaigns, community development and legislation.

**ALCOHOL CONSUMPTION**

Alcohol is the second leading cause of drug-related death in Western Australia. Over the three years from 1993 to 1995, it accounted for 3.3 per cent of all deaths and 1.8 per cent of all hospital admissions. In people aged 60 years and over it accounted for 46 per cent of deaths and 30 per cent of hospital admissions caused by alcohol.
Three conditions were responsible for over half of the alcohol-caused deaths between 1984 and 1995: alcoholic liver cirrhosis (20 per cent) stroke (18 per cent) and road injuries (18 per cent). After a minor peak in the 20–24 year age group, the age-specific rates for alcohol-caused deaths steadily increases from the age of 30–34 years to peak in the oldest age group. This pattern of mortality reflects the high rates of injuries caused by excessive alcohol intake in young people and the preponderance of deaths from chronic conditions with long latent periods that are related to long-term alcohol use.29

Alcohol consumption is associated with acute injury, chronic health problems, and psychosocial problems. Younger people are more likely to drink alcohol than older people, and are more likely to engage in ‘binge’ drinking, where hazardous or harmful levels of alcohol are drunk on a single occasion. In contrast with younger people, people aged 65 years and over are less likely to drink alcohol and tend to drink smaller quantities of alcohol than younger people.

**Figure 4.2 Self-reported alcohol consumption levels, WA, 1995 (per cent)**

![Graph showing self-reported alcohol consumption levels by age group]

Source: Australian Bureau of Statistics, National Health Survey

**HDWA ALCOHOL PROGRAM**

A comprehensive approach to the reduction of alcohol-related harm in the community is required as it is a complex issue. Simplistic interventions have proved inadequate in the past. It is now recognised that models of intervention need to address both individual and environmental factors as determinants of health.

The key objective of the Alcohol Action Plan is to reduce premature death, illness and injury associated with alcohol use by:

- Reducing the proportion of the population which drinks at levels above that indicated by the NHMRC as being low risk
- Reducing the incidence and consequences of heavy or binge drinking, particularly among young people
● Reducing the rate of road crashes involving drivers who have consumed alcohol beyond the prescribed blood alcohol content
● Reducing the incidence of alcohol-related crime, violence and disruption to public order.

It is recognised that only some components of the Alcohol Program are likely to have relevance for older people, such as the mass media and community education campaigns which aim to minimise alcohol misuse and educate the public about alcohol-related harm.

**DIET AND NUTRITION**

Dietary habits cover a range of areas including the frequency and regularity of eating, the type of meal consumed and the regularity with which certain types of food such as fruit are eaten. Many factors contribute to inadequate nutrition, including health status, financial capacities, mobility, exercise, and physiological needs.\(^{30}\) As the population ages, it is increasingly important to understand the factors which affect the nutritional status and thus the health status of older adults.

Healthy eating patterns are defined by the NHMRC Dietary Guidelines for Australians and include promotion of a low-fat, low-salt, moderate sugar diet which is high in fruit, vegetables and cereal food. Dietary Guidelines for Older Australians are currently being developed by the NHMRC.

There is overwhelming evidence linking poor nutrition to a number of common causes of illness, hospitalisation and death in Western Australia. Nutrition-related disease includes ischaemic heart disease, stroke, hypertension, breast and colorectal cancer, diabetes, osteoporotic fractures in the elderly, dental caries and gall bladder disease. There are 1,800 deaths in Western Australia each year that are directly attributable to diet, making up 18 per cent of all deaths.

Related to diet and nutrition is the extent to which people, in the interests of health, maintain their weight within desirable limits. The prevalence of overweight and obesity in Australia is increasing at 1 per cent per year. People who are overweight or obese are at greater risk of developing long-term health problems such as hypertension, diabetes, heart disease and stroke. Middle-aged people (aged 45–64) are more likely than older people or younger people to be overweight or obese.

The 1995 National Health Survey found that 9.4 per cent of West Australians aged 65 to 74 years were obese, a similar proportion to the younger population (9.6 per cent of those aged 15 to 64 years). This is a noticeable change from the 1988/89 survey results, where 13 per cent of the older age group were found to be obese, compared with 7.7 per cent of the population aged 15 to 64 years. Of those aged 75+, 4.1 per cent were found to be obese in 1995 compared with 3.7 per cent in 1988/89. However being underweight appears to be more of an issue for this age group, increasing from 11.9 per cent in 1988/89 to 14.6 per cent in 1995.\(^{31}\)
**ABORIGINAL FOOD AND NUTRITION POLICY**

During 1997/98 the Aboriginal Food and Nutrition Policy for Western Australia was compiled and launched after extensive statewide consultation with Aboriginal organisations, communities and individuals. A joint initiative of the Office of Aboriginal Health and the Department’s Health Promotion Services, the policy seeks to reduce the number of low birthweight babies, the incidence of diabetes and other diseases.

Sixty Aboriginal health workers have been trained to use the Aboriginal Nutrition Manual to implement nutrition education in their communities.

**HDWA NUTRITION AND PHYSICAL ACTIVITY PROGRAM**

The objective of the Nutrition and Physical Activity Program is to increase the prevalence of healthy eating behaviours consistent with the Dietary Guidelines for Australians by:

- Improving knowledge, attitudes and skills to enable all West Australians to select a healthy diet
- Promoting increased availability and accessibility of nutritionally acceptable food
- Advocating on nutrition issues and promoting adoption of healthy food and nutrition policies
- Maintaining ongoing monitoring and surveillance of the food and nutrition system.

The components of the 1998/99 program which are of most relevance to older people are the continuation of the Food Cent$ training, the monitoring of food standards, development of resources to support nutrition programs and campaigns, involvement in the development of strategies to address the Nutrition Policy for Aboriginal People in WA, and participation in forums and policy development related to the promotion of physical activity.
PHYSICAL ACTIVITY

Regular physical activity is an important component of a healthy life at all ages, and scientific evidence has linked exercise to a wide array of physical and mental health benefits. Physical activity in the form of carrying out activities of daily living can be seen as an essential ingredient of health for people of all ages, and exercise in earlier stages of life may be of significant benefit to individuals as they reach older age.

There is an accepted body of evidence that demonstrates the protective effect of physical activity on cardiovascular-related and all-cause mortality. Further, the protective effect of activity is seen in diverse groups of older people and in more than just mortality. Higher levels of physical activity have also been associated with higher scores on a quality of life scale.\(^{21}\)

The physiological effects of exercise have been well documented as having the loss of muscle mass and aerobic capacity associated with ageing. Without emphasis on maintaining physical activity into later years, the age-related loss of muscle mass and diminishing exercise tolerance may mean that large numbers of older people are living at, or near, thresholds of physical function necessary for independent living.\(^{21}\) While physical training improves muscle strength and aerobic capacity in older people as it does in younger people, it may have a greater impact on older people inasmuch as they are likely to be living closer to their threshold of physical function.

Recent intervention studies have shown that older people who maintain or adopt a lifestyle with increased moderate daily physical activity have better health status and outcomes. Studies suggest that exercise may improve gait and balance and promote bone mineral density, thus preventing falls and decreasing fracture risk. Arthritis patients may experience long-term functional status benefits from exercise, including improved mobility and decreased pain symptoms.\(^{32}\)

Musculoskeletal and cardiovascular systems, regardless of age, can respond to both resistance and aerobic training using measures such as strength and maximum oxygen uptake. Though the magnitude of the physiologic effect may be dampened in frailer individuals, exercise programs in frailer individuals appear to have greater effect on gait speed and chair rise time than they do with healthier individuals.\(^{33}\)

Exercise and physical activity are important for older people but the prevalence of habitual physical activity is lower than ideal.\(^{21}\) The 1995 National Health Survey results showed that 37.4 per cent of those aged 65 years and over had a sedentary exercise level compared with 28.3 per cent of those aged 15 to 64 years.\(^{26}\)

Moderate, regular exercise is promoted as beneficial to health. About 65 per cent of persons aged 65+ take some form of exercise. However, the rate of participation in exercise is lower in older people than in younger people. About 80 per cent of West Australians aged 15–24 undertake some form of exercise, but the rate of participation in some form of exercise gradually decreases with age, particularly participation in vigorous exercise.
Older people who exercise tend to undertake mild to moderate levels of exercise. Just over a third (35 per cent) of all older people walk for exercise, and another 25 per cent undertake moderate exercise which may or may not include walking.

**Figure 4.4** Self-reported exercise levels by age group, WA, 1995 (per cent)

Source: Australian Bureau of Statistics, National Health Survey

**Figure 4.5** Type of exercise undertaken by persons 65 years and over, WA, 1995 (per cent)

Source: Australian Bureau of Statistics, National Health Survey
CANCER SCREENING

The prevention and early detection of some cancers has been proven to reduce associated morbidity and mortality, particularly cancer of the cervix, breast and skin. The Health Department of WA operates two cancer prevention programs: the Cervical Cancer Prevention Program and BreastScreen.

CERVICAL CANCER PREVENTION PROGRAM

Cervical cancer can be prevented by the detection of abnormal cervical cells and intervening to prevent their development into a malignancy. The most common type of cervical malignancy is squamous cell carcinoma, comprising about 85 per cent of currently reported cases. It is estimated that squamous cell carcinoma is about 90 per cent preventable if an organised two-yearly screening program is adopted.

The impact of the Cervical Cancer Prevention Program is shown by the decline in incidence of cervical cancer from 13.4 per 100,000 in 1982 to 4.9 per 100,000 in 1997. Over the same period, the mortality has declined from 4.2 per 100,000 to 2.0 per 100,000.34

The Program is particularly targeted to older women, who have a higher prevalence of the disease. Younger women are much more likely to be screened regularly, even though they are at lower risk of cervical cancer.

Its objective is to reduce the morbidity and mortality of West Australian women from cancer of the cervix by increasing the cervical cancer screening rate in WA by 10 per cent within the next five years. This would take screening coverage up to 80 per cent of women in the target group.

Figure 4.6 Self-reported screening for cervical cancer by age group, WA, 1995 (per cent)

Source: Australian Bureau of Statistics, National Health Survey
The Program maintains the cervical cytology registry which is used to recall women up to the age of 70 years for Pap smears when they are due. In 1997, 48,774 reminder letters were sent to women who had not had a smear recorded in the three years since their last normal smear.

**BREASTSCREEN WA**
Cancer of the breast is the most common form of cancer diagnosed in women in Western Australia. The HDWA provides a dedicated breast cancer screening and assessment program for the women of Western Australia. The early detection and management of breast cancer can significantly reduce the morbidity and mortality associated with the disease. It has been estimated that regular, widespread screening of women in the target age group will lead to a 25 to 35 per cent reduction in mortality from breast cancer.

The target group is all women aged 50 to 69 years, this being the group in which studies have demonstrated significant reductions in morbidity and mortality from breast cancer among those participating in mammography screening. Significant benefits have yet to be demonstrated for women aged 40 to 49 years and those 70 years and older.

Sixty per cent of WA women were screened by BreastScreen WA for breast cancer in the 27 months prior to 30 June 1999. Of the 53,986 women who were screened in the 1995/96 year, 257 (0.5 per cent) were diagnosed with cancer.

**Figure 4.7 Self-reported screening for breast cancer by age group, WA, 1995 (per cent)**

BreastScreen WA provides a free-of-charge mammography screening service across the State to ensure equitable access to the whole of its targeted population. With a recommended rescreen rate of two years for the majority of women, the provision of this service statewide poses real challenges. Each woman who has entered the screening program will be recalled for rescreening with a reminder letter every two years until
the age of 69 years. Women with a family history of breast cancer in a close relative are recalled annually, as are women who have themselves had breast cancer. The program is supported by a mammography screening registry.36

During 1997/98 the Department, in conjunction with the Perth Aboriginal Medical Service, designed and developed culturally appropriate promotional materials and a poster for Aboriginal women.

**PROTECTION FROM THE SUN**

Excessive exposure of the skin to the sun is associated with skin cancers such as melanoma. Melanoma is the third highest form of cancer diagnosed in all women and the fourth highest form of cancer diagnosed in men in Western Australia.35 The incidence of melanoma is higher in Western Australia than in other Australian States and Territories, and this incidence increases with age. People of all ages can reduce the risk of developing skin cancer by avoiding exposure to the sun and by using sun protection methods such as sunscreen, and wearing long-sleeved clothing and hats.

**Figure 4.8 Use of sun protection methods by age group, WA, 1995 (per cent)**

As can be seen from Figure 4.8, people aged 65 years and over are less likely to be exposed to the sun than younger people. However, older people who are exposed to the sun are less likely to use sun protection methods than younger people. Approximately 78 per cent of older people use sun protection methods, compared with 88 per cent of people aged less than 65 years.

**INJURY CONTROL**

Injuries are a common, potentially preventable cause of premature hospitalisation, loss of function or death in older people. Leading causes of injury-related death in persons aged over 70 years are traffic-related injuries and self-inflicted injuries. Fire, burns and scalds are also a common cause of injury-related hospitalisation.38 However, by far the
The greatest injury-related cause of death or hospitalisation in older people is falls, which account for 46 per cent of all injury-related deaths and 54 per cent of all injury-related hospitalisations in people aged 70 years and over in Western Australia.

**FALLS AND FRACTURES**

About 30 per cent of people aged 70+ fall each year, and about one in ten of these falls results in injury. Every year, more than 3,000 older West Australians are admitted to hospital as a result of injury due to falls. Hip fractures are the most serious fall-related injury and often lead to loss of mobility and independence. In 1995 there were 1,162 hospitalisations for hip fracture, with 78 per cent of these cases being women.39

**Figure 4.9 Age-specific hospitalisation rates for falls by sex, Western Australia 1985–1994**

Source: Ashwell M, Pinder T and Thomson N (1996) An Overview of Injury in Western Australia Health Department of Western Australia

**STAY ON YOUR FEET WA**

The Health Department’s Injury Control Program is coordinating the Stay on Your Feet WA project, a collaborative falls prevention program to reduce the risk of falling among people aged 70+. This program is guided by the philosophies of coordination, cooperation and community involvement. The role for the health sector in this program is to bring together community groups, government and non-government agencies, health professionals and individuals who are already working to maintain, restore and promote positive ageing.

The Stay on Your Feet WA action agenda addresses a number of key issues including:

- Falls prevention among older people – a community priority to be highlighted in the work of all public and private sector agencies as well as addressed through falls prevention programs
- Safe home environments – with attention to housing design along with increased access to safety products for the home and empowering seniors to identify and reduce potential hazards in the home
- Safe public environments – the promotion of safe design is of critical importance to ensure that public places do not pose hazards which increase the risk of falls
- Physical activity, balance and gait – these can help maintain independence and reduce the risk of falling by maintaining or improving important physical factors such as balance, muscle strength and osteoporosis. Programs of exercise with a balance component have been shown to reduce the incidence of falls
- Medications – some medications cause dizziness and light-headedness that may lead to an increase risk of falling, as do some combinations of medications.

The Stay on Your Feet program in NSW demonstrated a 20 per cent reduction in the expected rate of hospitalisation for hip fracture based on comparison with the previous four years and an excess of cumulative savings over cumulative costs at the end of three years. Similar reductions are anticipated in Western Australia.⁹

**HIP PROTECTOR STUDY**

About a quarter of the hip fractures occurring each year in WA occur in nursing home residents, suggesting a high incidence in this population. A logical first-line prevention strategy is to reduce the risk of falls by addressing the risk factors in the environment and the prevalence of risk factors in nursing home residents. A further strategy is to reduce the likelihood of a fracture in the event of a fall.

Garments have been developed which contain small shields which sit over the greater trochanter of the femur and protect the bone from the direct impact of a fall.

Study results indicate that fractures do not occur in people who fall while wearing a hip protector. Any remaining fracture-risk relates to the extent to which people comply with wearing the garment. The rate of compliance appears to depend on factors such as resources available to check compliance, discomfort to the wearer, level of incontinence and perceived risk of falling.

A study undertaken by Health Department’s Injury Control Program tested the use of hip protectors in eighteen residents in a sample of Perth nursing homes. The average number of falls in the month of the trial was three falls per study participant, although the range was from zero to 18 falls per resident. None of the trial residents sustained a hip fracture. The results of this trial showed hip protectors to be an acceptable intervention for nursing home residents, though some modification of the garment design was recommended.

The annual cost of $320 per person for a set of garments was seen to be a major constraint to their widespread use by residents in nursing homes. However the cost of this preventive intervention compares very favourably with the average cost of treatment of hip fracture at $15,000.¹⁰

**INFLUENZA VACCINATION PROGRAM**

Influenza vaccination is an intervention strategy of proven efficacy for older people, reducing hospitalisation and deaths from influenza and halving the incidence of infection.²¹

Major or minor outbreaks of influenza occur most years in Western Australia, usually during the winter months. These outbreaks are associated with increased morbidity and
mortality in elderly persons. The Commonwealth Government provided funds in its 1998/99 budget for the purchase of influenza vaccine to be provided free for all Australians aged 65 years and over. Funding was also provided for purchase of influenza (and pneumococcal) vaccine to be offered free to all persons aged 50 years and over of Aboriginal or Torres Strait Islander (ATSI) origin, as well as to ATSI people aged 15 to 50 years with a range of specified chronic medical conditions.

In Western Australia the Health Department’s Communicable Disease Control Branch coordinated the program, with the administration of vaccine to eligible persons undertaken predominantly by general practitioners (GPs). The Communicable Disease Control Branch distributed vaccines to GP surgeries across the metropolitan area, while in rural and remote areas, regional Public Health Units arranged distribution to GPs, Community Health Centres and nursing posts. The Communicable Disease Control Branch has assessed uptake of influenza vaccine in West Australians aged 65 years and above through random telephone surveys conducted since 1997. In that year, coverage was 61 per cent, rising to 72 per cent in 1998. It is estimated that coverage in 1999 will exceed 80 per cent, given the availability of free vaccine and an enhanced promotional campaign.41

PROMOTING COMMUNITY PARTICIPATION

As discussed earlier in this Paper, community participation can play a significant role in the health and wellbeing of older people. Older people make a major contribution to the community as volunteers and the capacity to contribute to their community through such work is an important source of self-esteem for many older people.

VOLUNTARY WORK

In 1995, 348,300 people aged 65 years and over worked in a voluntary capacity across Australia, comprising 13.2 per cent of the total volunteer workforce. At that time, this age group worked as volunteers at the rate of 17.4 per 1,000 compared with an average of 19 voluntary workers per 1,000 across all ages.

Older people make a major contribution as volunteers in the areas of welfare and community service and health.
In Western Australia volunteers annually contribute an estimated 46 million hours of unpaid work to the community worth more than $460m per annum, and nearly one quarter of the State’s 262,000 volunteers are aged 55 years and over. To investigate the health outcomes of supporting older people to participate in worthwhile community activity, the Health Department has funded the School Volunteer Program.

**SCHOOL VOLUNTEER PROGRAM**

This program is an innovative approach to funding activities that support the health and wellbeing of older West Australians. It enlists volunteers to work in schools with children who are identified as requiring extra support in their educational, social or emotional development. The Health Department has entered into a three-year arrangement to purchase the participation of volunteers aged 55 years and over with the intent of contributing to improvements in their health and wellbeing. The expected outcomes are an enhanced sense of wellness in the volunteers and a decreased need to use health services.

The program will be evaluated to test the validity of this type of approach to health promotion. If it proves successful, there is wide scope for other applications of this approach.
5. HEALTH ISSUES IN LATER LIFE
5. Health Issues in Later Life

The continuing increase in the number and proportion of older West Australians makes the health of older people an important public health issue. Generally, older people are more likely to develop some form of disability or handicap than younger people, are more likely to have a long-term health problem and, as discussed in Chapter Four, are less likely to exercise. There is therefore a widespread perception that poor health is a natural attribute of normal ageing while youth is a time of vitality and good health. Although there are many exceptions to these stereotypes, (as also seen in the previous chapter) they form a powerful context within which to consider the reality of changing health needs and the expanding scope of medical interventions to improve quality of life as people age.

HEALTH STATUS

As people age, they are less likely to feel that they are in good health. Only about 10 per cent of younger West Australians aged between 15 and 24 report that they have fair or poor health, compared with 33 per cent of West Australians aged 65 years and over.

**Figure 5.1 Self-reported health status by age group, WA, 1995 (per cent)**

![Health Status Chart]

Source: Australian Bureau of Statistics, National Health Survey

**IMPAIRMENT, DISABILITY AND HANDICAP IN AGEING**

One of the reasons older people may feel themselves to be in poorer health than younger people may be that they are more likely to have some form of disability or handicap.

As outlined in the Report on Government Services 1999, the 1980 World Health Organisation’s International Classification of Impairments, Disabilities and Handicaps provides a definition of these terms as follows:
- Impairment – any loss or abnormality of psychological, physiological or anatomical structure or function
- Disability – any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or range considered normal for a human being
- Handicap – a disadvantage for a given individual, resulting from an impairment or a disability, that limits or prevents the fulfilment of a role that is normal (depending on age, sex and cultural factors) for that individual.

The Report also notes that the Australian Bureau of Statistics used the above framework in its 1993 Survey of Disability, Ageing and Carers and classifies handicaps as:

- Mild – person requires no personal help or supervision and has no difficulty with day-to-day tasks, but may require an aid or have a mild mobility handicap
- Moderate – person requires no personal help or supervision but has difficulty in performing one or more tasks
- Severe – person sometimes requires personal help or supervision
- Profound – person always requires personal help or supervision.

A person may experience problems due to loss of hearing, chronic or recurring pain, head injury, stroke or some other long-term condition that restricts everyday activities. For some people there may be little impact upon their everyday functioning while others may face significant restriction in their ability to perform core everyday activities such as self-care (bathing/showering, dressing, eating and using the toilet), mobility (moving around at home and away from home, getting out of a bed or chair and using public transport), or communication (understanding and being understood by others).

The likelihood of having a core activity restriction increases with age. Approximately 40 per cent of West Australians aged 65–74 years have some form of core activity restriction. This figure increases to about 60 per cent for those aged 75–84 years; and about 80 per cent of people aged 85+ have some form of core activity restriction. However it should be noted that more than half of people aged between 65 and 84 years of age have little or no difficulty performing core activities.
**Figure 5.2** Self-reported core activity restrictions by age group, WA, 1998  
(rate per thousand population)

Source: Australian Bureau of Statistics, Disability, Ageing and Carers, Summary Tables, Western Australia, Cat. 4430.5.40.001

**CHRONIC CONDITIONS**

Older people are more likely to have a chronic health condition than younger people. By age 65, almost all West Australians have some form of chronic health condition such as eyesight problems, arthritis, hypertension, high cholesterol, heart disease or deafness.

In many cases, these conditions are very mild or easily managed, such as eyesight problems which can be corrected with spectacles. However, older people may also have more complex conditions such as Alzheimer’s disease, Parkinson’s disease or cardiovascular disorders which may be more disabling or difficult to manage.

**Figure 5.3** Prevalence of self-reported long-term health conditions by age group, WA, 1995 (per cent)

Source: Australian Bureau of Statistics, National Health Survey
DISABLING CHRONIC CONDITIONS

The future will probably be more about managing chronic conditions rather than responding to acute illness. In 1995, for the first time, more people died of chronic illness than from an acute illness. The continuation of this trend will have a huge impact on future needs for health and health-related services and their models of delivery. Some predict a continuing contraction not only in the number of people going into hospital but also in their length of stay, and that in the future, most health-care will be delivered in the home or at the workplace. However, the older old population will be one group which will continue to require in-patient hospital care as appropriate.

As has been indicated earlier, increasing age brings with it an increasing risk of disability and loss of independence due to functional impairments, such as loss of mobility, hearing and vision. Certain chronic conditions, particularly gait/balance disorders and depression, have been found to be associated with significant decline in the capacity of older people to carry out activities of daily living. However, the wide variation in the age-adjusted incidence of major chronic diseases suggests that there are strong environmental determinants for these conditions. As indicated in the previous chapter there is evidence that a substantial proportion of disabling conditions associated with ageing are preventable or postponable and are not an inevitable accompaniment of growing old.

The disabling conditions that are discussed below are emerging as priorities for the health, community and residential aged care sectors. They include cognitive impairment (dementia), stroke, osteoarthritis, osteoporosis and incontinence. Cataracts can also be the cause of significant impairment.

COGNITIVE IMPAIRMENT

Dementia is the single most common condition seen by geriatricians in Australia, and it has come into prominence with the unprecedented increase in the numbers of people who survive until their 70s or 80s. Its prevalence increases exponentially with age from about 7 per 1,000 in the 60 to 64-year-old age group, to about 236 per 1,000 in the age group 85 years and over.

Because Western Australia’s population is progressively ageing, there are more people in the age groups where dementia prevalence is highest. Assuming no change in the age-specific prevalence for dementia, it has been estimated that the number of people with dementia in WA will increase from about 11,000 in 1995 to 48,400 in 2041.

The impact of dementia on individuals, families and communities is profound. Cognitive impairment drives the residential care sector and is evident in 90 per cent of nursing home residents and 50 per cent of those living in hostels.

Dementia is due to changes in the brain which cause a person to have a poorer memory and to be less able to think and reason in daily life. Other manifestations of dementia include apathy, deterioration in social behaviour, occasional aggressiveness, delusional ideas and hallucinations – a range of features which show the widespread changes in the brain.

Numerous disorders can produce dementia in the elderly, the most common being
Alzheimer’s disease, vascular dementia and a combination of the two. All of the dementias are progressive disorders, but there is great variability in their course.

The extent to which the onset and progression of dementia can be prevented in the future is uncertain. There is suggestive evidence that a small number of factors may operate to reduce the risk of developing Alzheimer’s disease. Anti-inflammatory drugs and oestrogen replacement therapy may show a protective effect in some studies. Better educated and more intelligent people are known to perform better on dementia screening tests, but whether these factors decrease the risk of developing dementia is uncertain. Vascular dementia presents the greatest scope for prevention because of the number of risk factors which are modifiable, with the control of hypertension and smoking are the most likely to be successful.43

STROKE

Stroke is a devastating and frightening event among older persons, often resulting in death or major loss of independence. Attitudes of the past have assumed an inevitable and immutable course of stroke risk progression with age. Although stroke is strongly age-associated, there is growing evidence that the stroke rate can be reduced by preventive interventions in older patients with risk factors.50 In 1996 it accounted for 9.9 per cent of all deaths among Australians. However mortality from stroke across all age groups is currently declining at 3.5 per cent per year among males and 3.9 per cent among females.16

Growing recognition of the major impact of stroke has also led to greater attention being paid to stroke management and the provision of care to improve outcomes after stroke. This includes comprehensive stroke services to provide early assessment and investigation of stroke disease in both in-patient and outpatient settings, acute care for stroke in-patients to manage their medical and surgical problems, and rehabilitation for patients with persisting functional problems. Other components may include outpatient, day hospital or domiciliary rehabilitation facilities, and continuing care and support facilities for patients discharged from hospital.51

OSTEOARTHRITIS

Osteoarthritis is a type of arthritis characterised by the eventual loss of the cartilage of the joints and usually affects large weight-bearing joints such as the hips and knees. It may also involve the hands, feet and spine. Although largely associated with older people, osteoarthritis can often be found in joints which have been exposed to both major and minor trauma over many years. Loss of cartilage causes friction between the bones, leading to pain and limitation of joint mobility. Inflammation of the cartilage can also stimulate new bone outgrowths to form around the joints.

The most common symptom of osteoarthritis is pain in the affected joint(s) after repetitive use. Occasionally there can be swelling and warmth of the affected joints, and often pain and stiffness of the joints after long periods of inactivity. In severe cases there may be pain at rest or with limited motion.

The goal of treatment in osteoarthritis is to reduce joint pain while improving and maintaining joint function. Most people benefit from conservative measures such as rest, exercise, weight reduction, physical and occupational therapy, and mechanical support devices. Medication may sometimes
be taken orally or injected into the joints to decrease joint inflammation and pain.

When the condition is severe and unresponsive to conservative treatments, surgery may be appropriate. Osteotomy is a bone removal procedure that can help realign some of the deformity, usually in knee disease. Severely degenerated joints are best treated by surgery and total hip and total knee replacements are now commonly performed bringing dramatic pain relief and improved function.

**OSTEOPOROSIS**

Osteoporosis, which literally means ‘porous bone’, is not a normal part of ageing and while there are treatments that prevent further bone loss and may increase bone mass, there are no known cures. The known risk factors for osteoporosis include being female, being small or thin-boned, having a fair complexion or a family history of osteoporosis, having a low-calcium diet, smoking or drinking excessive alcohol.

Often the first outward sign of osteoporosis is a broken bone from a fall as it cannot be detected by conventional X-rays until 30 to 40 per cent of bone is lost. Further bone loss can be avoided by careful attention to nutrition, lifestyle and medical factors which affect bone. Fractures associated with the disease can also be prevented through reduction in falls as discussed in the previous chapter. Medications may be indicated in people with a risk of further fractures.

Research has led to major advances in reducing disability following fractures and the risk of a further fall. However, 33 per cent of people over the age of 70 have a fear of falling which becomes, in itself, a significant disability in maintaining an active and fulfilling lifestyle.\(^{48}\)

**INCONTINENCE**

Urinary incontinence is a widespread problem that often goes undiagnosed and untreated. It can have a detrimental effect on the quality of life of older people and even precipitate admission to a nursing home. It affects an estimated 30 per cent of all older persons, and 50 to 70 per cent of older residents in nursing homes.\(^{53}\) The rates are typically higher among women than men and it affects up to 35 per cent of older women.\(^{54}\)

A study of the efficacy of non-surgical incontinence therapy found that it provided long-term benefit to older women, particularly those who were younger and those with more severe incontinence. Subjects considered pelvic muscle exercises, delayed voiding and caffeine restriction most effective in reducing incontinence severity.\(^{54}\) Behavioural methods are becoming increasingly important in the management of incontinence and controlled studies indicate that between one-third and one-half of nursing home patients will respond with decreases in incontinence to such methods.\(^{55}\)

Age and gender are significant independent predictors of incontinence and older cohorts of older adults have been found to be significantly more likely to be symptomatic for urinary incontinence than their younger counterparts. However, the younger cohorts were more likely to be screened for incontinence by their physicians.\(^{56}\)

Interventions are needed to remind health practitioners to screen high-risk patients and to encourage those with urinary incontinence to communicate with their
There is a need for routine inquiry about symptoms and reassurance that appropriate treatment can often lead to improvement in symptoms or return to continence. Older adults and their caregivers need to know that urinary incontinence is common and treatable, so that they will identify it promptly and bring it to their doctor’s attention.

**CATARACTS**

A cataract is a clouding of the normally clear and transparent lens portion of the eye which prevents light from being properly focused on the retina and impairs normal vision. If a large portion of the lens becomes cloudy, sight may be partially or completely lost. This can have a significant impact on the older person and, depending on the extent of vision loss, lead to problems in maintaining independence in carrying out everyday activities.

Most cataracts are caused by a change in the chemical composition of the lens which can be an outcome of the normal process of ageing or prolonged exposure to sunlight. This disorder affects 60 per cent of people aged 60+ and will affect most people if they live long enough. Symptoms of developing cataracts include double or blurred vision, sensitivity to light and glare, less vivid perception of colour and frequent changes in spectacle prescriptions. Surgical removal is the only effective way to remove the cloudy lens.

Recent advances in technology have led to this being a highly successful procedure with most of the patients who undergo surgery regaining useful vision. It can also be carried out as a same day procedure with the person returning to their own homes on completion. Once the cloudy lens of the eye is removed a substitute lens is required to focus light. These may include glasses, contact lenses or intraocular lenses which are permanent lenses surgically implanted inside the eye in place of the natural lens.

**OTHER ILLNESSES AND DISEASES**

There are a number of illnesses and diseases which, although they may affect an individual at any age, have a high profile amongst older people. While some of these conditions may have a chronic and disabling impact on the older person, their management is usually no different than it would be for any other age group unless there are other, co-morbid, conditions present.

Included among the conditions which are major causes of poor health and/or death in older people, are cardiovascular disease, cancer, depression and adverse drug reactions. Oral health is also of increasing importance as more older people retain their natural teeth.

**CARDIOVASCULAR DISEASE**

Cardiovascular disease, including stroke, was the leading cause of death in Western Australia in 1995. This disease was responsible for the deaths of 2,075 males (39 per cent of all male deaths) and of 1,972 females (43.5 per cent). It is a major cause of mortality and morbidity among people who are older than 65 years of age. However, declines in cardiovascular mortality have occurred in the elderly as well as in the middle-aged population. Risk factors which influence the occurrence of cardiovascular disease in older people are much the same as those which operate for other age groups, and the potential benefits of correcting the major
risk factors in the older adult are at least as great as for younger people.\textsuperscript{59}

Structured educational programs which include exercise and modification of risk factors have been shown to reduce the risk of subsequent coronary events, but studies show that older adults enrol in these programs at a significantly lower rate than those who are younger.\textsuperscript{60}

**CANCER**

Cancer primarily impacts on the older population given the greater incidence of the disease with advancing age and the increasing numbers of older people in the population. In 1996, 54.4 per cent of all cancers diagnosed in WA were in people aged 65 years and over.

In Western Australia in 1995, a total of 6,908 new cases of cancer were diagnosed across all ages. There were 3,847 (55.7 per cent) new cases in males and 3,061 in females (44.3 per cent). The estimated lifetime risk of developing cancer was 1 in 3 for males and 1 in 4 for females (up to age 74 years). The most common cancers diagnosed were prostate cancer in men (1,193 cases), followed by breast cancer in women (939 cases). Among both sexes, the most common cancers were colorectal cancer (448 males; 411 females), malignant melanoma of the skin (437 males; 340 females), and cancer of the lung (449 males; 217 females).\textsuperscript{58}

As discussed in the previous chapter, health promotion and prevention strategies such as Quit campaigns and cancer screening services have a major role in reducing mortality and morbidity from cancers which can be prevented or detected early.\textsuperscript{61}

**DEPRESSION AND STRESS**

A substantial literature is developing on the ways in which social support may protect against illness, enhance coping with stress and improve illness outcomes. Being married in old age has been associated with survival and many other positive health outcomes for older Australians, and social support appears to reduce the likelihood of depression in old age.\textsuperscript{62}

Depressive symptoms have been found to contribute to dysfunction, poor health perception and a reduced sense of wellbeing.\textsuperscript{63} A US study found evidence that older people who report depressive symptoms are at higher risk of subsequent physical decline over a four-year period, even among those at the high end of the functional spectrum who reported no disability.\textsuperscript{64} These findings highlight the importance of detection and management of symptoms of depression in older people and suggest that prevention or reduction of depressed mood could play a role in reducing functional decline in older people. As discussed in more detail in the chapter *Older People and Mental Health* even minor mental health problems may affect everyday activities to the extent that individuals cannot function as they would wish, or be expected to, within their family and community.

There is evidence of a relationship between stress, social support and psychological distress among older people. The psychological distress among older people caused by financial strain has been found to be mitigated, at least in part, by social relationships.\textsuperscript{65} However, tangible and emotional supports are found to be less effective coping mechanisms when financial strain is present.\textsuperscript{66} Greater independence in
activities of daily living and greater perceived control of events have also been shown to attenuate the adverse effects of stress and strain on the psychological wellbeing of the very old.\textsuperscript{67}

Another study has shown that for residents in residential aged care facilities, feelings of control over one’s self and the environment were reported to be important factors in resident satisfaction. There was more satisfaction when the resident not only managed his/her own finance but also could be active in the various social activities of the facility.\textsuperscript{66}

**ADVERSE DRUG REACTIONS**

Pharmaceutical drugs are an indispensable part of modern medicine. They make a great contribution to saving lives in emergency and trauma situations, provide alternatives to surgery and other interventions, prolong and improve the quality of life in chronic conditions, and relieve pain and discomfort in many short-term illnesses.\textsuperscript{69} Their use is widespread with millions of prescriptions being issued each year through community pharmacists through the Pharmaceutical Benefits Scheme, and millions of dollars being spent on drugs each year by public hospitals which provide them free of charge to in-patients. In Western Australia in 1996/97, approximately $455 million was expended on pharmaceuticals. The sheer volume of prescribed drugs creates enormous potential for adverse drug reactions.\textsuperscript{69}

An adverse drug reaction (ADR) may be defined as any response that is noxious and unintended and that occurs at doses normally used in humans for diagnosis, prophylaxis or therapy, and excluding a failure to accomplish the intended purpose.\textsuperscript{20} Studies of all-age patient groups have found a significant skewing towards the elderly concerning drug-related hospital admissions. It has been estimated that up to 25 per cent of hospital admissions of older people in Australia are medication-related.

Although many older people may experience adverse drug reactions, the extent to which age is of itself an independent risk factor is somewhat uncertain given that adverse drug reactions are related to the number of drugs concurrently used and the high prescribing rates associated with severity of illness. However the fact that older people have increased co-morbidities which require higher medication use indicates that the effective management of medication is an important avenue for reducing preventable morbidity in older people.\textsuperscript{21}

The higher incidence of drug-related illness in the elderly may also largely be due to age-related changes in drug metabolism and excretion, multiple health problems requiring multiple medications and unintentional misuse of medications due to impaired vision, motor and memory abilities.\textsuperscript{71}
The dramatic increase in the number and availability of therapeutic agents has undoubtedly contributed to the observed high proportion of drug-induced morbidity among acute geriatric hospital admissions. Although numerous studies have sought to identify risk factors for ADRs, the only truly independent predictor is the absolute number of concurrently used medications. The challenge for the future is the evaluation of various new initiatives such as dispensing drugs in weekly blister or unit dose calendar packaging, regimen simplification, pharmacist chart review in residential care facilities, supervision by domiciliary nursing staff and improved post-discharge communication between hospital and community doctors. Another area for improvement is in doctor to patient communication about medications and their side-effects including prescribing advice to avoid potentially harmful combinations of medications.

**DENTAL HEALTH**

Over recent decades, the proportion of older people who are edentulous (i.e. who have no teeth) has declined significantly and those who are dentate have more teeth. This increases the risk of caries and periodontal disease in this group. Multiple medical problems and use of various medications complicate oral disease and its treatment and an individual’s ability to perform adequate oral care is likely to be jeopardised by medical and physical difficulties associated with ageing.

Older West Australians are less likely to have consulted a dental practitioner in the past two years than those between 15 and 64 years (55.6 per cent had not compared with 37.4 per cent in the younger age group). A US study found that people with a dental visit in the past two years had considerably less accumulated oral neglect and fewer self-perceived oral health-related problems than those without a dental visit in the past two years.
A direct association has been found between specific areas of physical disability and current caries and edentulism. Once these related risk factors were controlled for, the risk of poor oral health did not increase with advancing age. Oral health is important to general health because disease in the mouth affects more than the oral area. The improved preservation of teeth among present and future cohorts of older people has increased their risk for serious disease from oral pathogens. As a result of bacteraemia or aspiration of oral contents, organisms originating in the mouth can be responsible for serious infections in other body systems.

A US study found that compared with independent elderly, those who were functionally dependent have higher rates of tooth loss; greater prevalence of denture-related problems; greater prevalence and severity of dental caries; higher prevalence of gingival and periodontal disease; and typically, have not seen a dentist in the last five years.

Declines in oral care abilities may be difficult to identify, with the result that they go unnoticed and unaddressed. However, clinicians caring for older people need to recognise the importance of oral health by including an oral component in the multidisciplinary geriatric assessment and supporting the education of patients on aspects of dental health.

Barriers which prevent self-care and the accessing of professional care must be removed, and prevention and early intervention strategies formulated to reduce the risk of oral disease. Risk factors for oral diseases in the elderly can be reduced by personal home-care regimens, professionally provided preventive, diagnostic and therapeutic care, changes in high-risk behaviour and a supporting environment.
6. SYSTEM OF HEALTH CARE FOR OLDER PEOPLE
6. System of Health Care for Older People

Good health clearly contributes to a sense of satisfaction with life. Health problems can contribute to a sense of loss in older people because they limit what they can do and increase their dependence on others. Health problems which impair mobility also reduce opportunities for activities, recreation and socialisation. 68

The majority of health care services in Western Australia are provided and/or funded by the Commonwealth and State governments, complemented by a strong private health care sector. There is also a large number of individuals who work as unpaid Carers to provide informal care and support to many older people.

**Figure 6.1 Health care expenditure by source of funding, 1996/97**

Health care expenditure in WA is dominated by the acute hospital sector, which consumes approximately 40 per cent of recurrent health expenditure. Primary care services such as medical services and pharmaceuticals also represent a substantial component, making up about 12 per cent and 18 per cent respectively of recurrent health care expenditure. Nursing homes, community and public health are relatively small components of the health care system, consuming only 6 per cent and 5 per cent respectively of total expenditure on health.
Dental services consume some 5 per cent while allied health and other health services consume the remainder of recurrent health expenditure.

**Figure 6.2 Health care expenditure by service, WA, 1996/97**

The Commonwealth and State governments have different roles in administering, funding and providing health care services. Health care in WA and Australia is generally managed through established programs for specific purposes which may be Commonwealth funded, State funded or jointly funded.

The Commonwealth is responsible for developing health policy on issues of national interest, such as public health, research and national information management, and makes funding available for a wide range of health services. For example, primary care services such as medical services and pharmaceuticals are substantially funded by the Commonwealth and administered through the Medicare and Pharmaceutical Benefits programs. The Commonwealth is also responsible for provision of funding for specific aged care services such as residential care.

The Commonwealth provides joint funding with the States and Territories for the provision of public hospital and community care services. Some funding is also provided for smaller, specific-purpose activities such as the Royal Flying Doctor Service, Women’s Health Services and the Australian Red Cross Blood Donation Services.

The States and Territories have primary responsibility for the delivery and administration of health care, maintaining relationships with most health care providers, and the regulation of health professionals. The WA State Government provides public acute and psychiatric hospital services and a wide range of community and public health services, including school, dental, environmental, maternal and child health programs. The distribution of State and local government recurrent expenditure on health, excluding
Commonwealth contributions such as specific purpose programs grants, is shown in Figure 6.3.

**Figure 6.3 State and local government expenditure on health by program, 1996/97**


**OLDER PEOPLE AS USERS OF HEALTH CARE**

People tend to use health services differently at various stages of life. For example, infants and young children are more likely to use hospital services than older children, and very old people are more likely to use hospital services than younger adults, (apart from women in their child bearing years who are highly likely to use hospital services). About 39 per cent of bed-days are utilised by older people, although people aged 65 and over represent only 10.5 per cent of the total population.

In general, other than the first few years of life, older people are much more likely than those who are younger to require health and medical services. They are also more likely to use different services than younger people. For example, almost all nursing home residents are aged 65 years and over.

Expenditure on health services for older people is also high relative to younger people, consistent with their high levels of utilisation of health services. People aged 65 years and over accounted for about 37 per cent of expenditure on public acute hospital services, 35 per cent of expenditure on private acute hospital services, 22 per cent of expenditure on medical services, 94 per cent of expenditure on residential care, and 81 per cent of expenditure on home and community care services in 1996/97.50

As the health care needs of the State’s older population consume a substantial portion of the State’s health care expenditure, it is important that health care services are delivered with consideration of their needs.
It is also important that the available health services are integrated in an efficient and effective manner to deliver comprehensive and appropriate care to older people.

**THE HEALTH CARE SECTORS**

Services for WA’s older population are embedded in major State and Commonwealth health programs, most of which are relatively longstanding. They are undertaken within the context of the following broad sectors:

- Primary care – GPs
- Community care, comprising the formal system of funded community care providers (both profit and not-for-profit), and the informal system of Carers (i.e. family, friends and neighbours)
- Acute care – hospitals
- Residential care, comprising nursing homes, hostels and Nursing Home Type Patient facilities located generally in the State’s country hospitals.

Each of these sectors is discussed in further detail in the next chapters.
7. PRIMARY CARE FOR OLDER PEOPLE
7. Primary Care for Older People

General practitioners (GPs) represent a key component of the health care system accounting for the largest volume of primary care services delivered in Australia. GPs generally represent the first point of contact an older person has with the health care system and play a pivotal ‘gatekeeping’ role providing access to other parts of the health system. Where appropriate the GP will refer the older person on to other sectors such as acute hospital care, specialist care, comprehensive assessment or assessment for residential care, and endeavours to ensure continuity of care by maintaining overall responsibility for the patient.

A report on the potential contribution of family doctors to the care of the older person proposed a number of key principles for good primary care for this group of people. These included the prevention of unnecessary loss of function, the prevention and treatment of health problems which adversely affect quality of life in old age, and to supplement the informal (community) care system and prevent its breakdown. However, although primary care is the ideal setting for identification of people at risk of cancer and cardiovascular disease, levels of screening in general practice are low across all age groups and are likely to be even lower for people in older age groups.

Visits to GPs are charged on a fee-for-service basis subsidised in part or in full by the Commonwealth through the Medicare system. Older people are commonly billed for medical services by direct billing to Medicare, a practice which avoids out-of-pocket costs to the older person. In Western Australia during 1997/98, 76 per cent of medical services for males aged over 65 and 79 per cent of medical services for women aged over 65 were direct billed to Medicare.

**INTEGRATION OF GENERAL PRACTICE**

To improve the integration of general practice services with other health care services, the Commonwealth supported the establishment of Divisions of General Practice. The number of Divisions of General Practice in Australia has grown from 10 Divisions trialed in 1992/93, to 123 in 1998 of which 15 are located in Western Australia. Division activities focus on projects or issues such as health promotion, service delivery, shared care arrangements and management of specific health issues.

The Commonwealth Government in its 1999/2000 Budget announced a major package of initiatives to further enhance primary health care in Australia through the introduction of a number of new Medicare Benefits Schedule (MBS) billing items. Several of these are directed at older people and provide incentives to GPs to:

- Be involved in coordinated care planning ($54.5m over 4 years)
- Participate in multidisciplinary case conferences for those with chronic and complex needs ($11.8m over 4 years)
- Conduct annual voluntary health assessments for people aged 75 years and over ($44.3m over 4 years).
Other Budget initiatives to improve access to primary care include funding GPs to participate in multidisciplinary care planning for patients aged 65+ with chronic health conditions and complex care requirements, and retention payments for long-serving GPs in rural and remote areas.

In response to the initiatives announced by the Commonwealth, the Office of the Chief Medical Officer of the Health Department of Western Australia, in collaboration with the Commonwealth Department of Health and Aged Care, Divisions of General Practice and other stakeholders, is developing a proposal to ensure best practice and quality health outcomes for older persons in the State. The proposal provides a framework which enables clinicians, ACATs, GPs and community service providers to work in partnership and facilitate a seamless health service delivery. The proposed model of care aims to improve the integration of primary care with acute care, and is expected to reduce the number of hospitalisations of older patients following a minor acute event. Other collaborative projects between the Health Department and the Divisions of General Practice, designed to reduce and/or prevent the need for hospitalisation, are described in a later section of this Paper.

A STUDY IN DOCTOR AND HOSPITAL SERVICES FOR PEOPLE IN WA

In 1998 a collaborative study was initiated between the WA and Commonwealth Government health departments to combine Commonwealth data collections on doctor services, with State data collections on hospital services. 86

Each data collection can be used independently to establish frequency profiles and trend data for cohorts of persons. For many years State hospital data collections have been used to identify acute care episodes for age cohorts and than extrapolate such cohort information to larger population groups. However even the comprehensive WA collections of State hospital data cannot capture information on people that do not frequent hospital.

Commonwealth MBS data can be used to determine the number of people who use Medicare supported doctor services. Almost all West Australian residents are enrolled in Medicare, and each enrolled person makes an average of 10 MBS claims each year.

The study of Commonwealth MBS data for Western Australia showed that 9 per cent of users of Medicare over a three-year period accounted for 34 per cent of all Medicare services. Approximately 25 per cent of Medicare users had been admitted to hospital within the past two years. Fifteen per cent of those admitted accounted for 43 per cent of all hospital episodes.

Persons in the most elderly group, aged 80+ years, numbered about 46,000 over the two-year sample period (3 per cent of persons and 5 per cent of doctor services) and nearly 28,000 were hospitalised (5 per cent of hospitalised persons and 7 per cent of hospital episodes).

People aged 65+ amounted to 190,000 persons. This group had 7.6 million doctor services over a 26-month period (an average of 3 per month), 95,000 of those persons were hospitalised with 245,000 hospital episodes over two years. In terms of doctor services, they account for 11 per cent of persons and 20 per cent of services. In terms of hospitalisations, they account for
18 per cent of persons and 25 per cent of hospital episodes.

As already indicated in the previous chapter of this Paper, this study also shows that the impact of persons aged 65 and over is quite significant as the average rates of doctor services and hospital admitted episodes are approximately twice the overall population rate.

**AFTER HOURS MEDICAL CARE**

People requiring medical care during the night or on weekends may be obliged to attend acute hospital emergency departments for care, as there are currently limited primary care services available outside normal working hours.

To improve patient access to medical services outside of these hours and reduce the need for people to attend acute hospital emergency departments, a telephone assessment service, HealthDirect, has been implemented. This is a combined initiative of both the State and Commonwealth Governments whereby people can obtain assessment of a health problem and appropriate referral to medical services. Initially, HealthDirect, which is available on a 24-hour 7 days a week basis, is being offered to everyone in the Perth metropolitan area.

In association with the service, additional general practitioner after-hours services from nine different locations across the metropolitan area have been established. These additional services will enable people to have better access to after-hours medical care that is closer to home. This approach is expected to be of particular benefit to older people, as they are more likely to require medical services than younger people.

**STATE HEALTH LIAISON GENERAL PRACTITIONER**

The Health Department of Western Australia and the General Practice Division of Western Australia have recently appointed a new liaison position to foster and enhance communication between the Department and general practitioners. It is intended that the medical officer appointed to the position will help to promote the involvement of GPs in the development of State Government health policy and the planning of health services to improve patient care.

This new initiative will help meet the objective of the Health Department and the Division to optimise the quality and continuum of patient care through liaison between the Department, Divisions, general practitioners and other Health Workers.
8. COMMUNITY CARE FOR OLDER PEOPLE
8. Community Care for Older People

THE FORMAL SYSTEM
Most Australians live in the community and/or in their own homes and never need to draw on formal care services – although, as the numbers of the very old have increased, so have the calls on support services. In the last ten to fifteen years the emphasis of support services has moved from residential care to the provision of care in the community in as ‘normal’ (i.e. non-institutional) a setting as possible given the care needs of the client.

The provision of formal services such as those provided through Home and Community Care (HACC) do not substitute for the informal services provided by Carers but rather strengthen the care-givers’ capacities. In addition to the HACC range of services (discussed below) more intensive forms of community care are provided through Community Care Packages (CCPs) and the HACC-run Community Options Projects (COPs). The latter apply to highly dependent people of any age although the vast majority of COP clients are aged 60+, while CCPs were intended to allow people of any age who would otherwise have been admitted to a hostel, to receive hostel level care in their own homes. In July 1999 there were 1,176 CCPs throughout the State.

Another community care service, in addition to those mentioned above, is the public hospitals’ post-acute discharge programs which assist people to rehabilitate after serious illness which required hospitalisation. Older people are the major recipients of such post-acute care services.

The community care an individual receives often involves services from a wide variety and range of service organisations. These organisations aim to provide integrated care which requires collaborative and joint efforts of service providers working across program delivery boundaries.

The Health Department is currently introducing a model of integrated aged care service delivery in country regional areas that aims to promote greater flexibility and improve coordination of services. The service strategy aims to coordinate and monitor service delivery in consultation with all aged care service providers in each region including Aged Care Assessment Teams (ACATs), HACC, and other non-government providers.

The objective of this initiative is to create a central focal point for a network of government and non-government agencies involved in the delivery of health care for the aged population in regional areas. It also allows for more efficient use of existing funding leading to greater flexibility in planning and targeting to better meet clients’ needs.

This model was initiated in the Kimberley and Pilbara regions and has recently been adopted in the Goldfields. Developmental work is currently being undertaken to establish an integrated model in the South West region. There are plans for a similar framework to be adopted by the Midwest, Midlands and Great Southern regions during 1999/2000.
HOME AND COMMUNITY CARE PROGRAM

The Home and Community Care Program, a joint initiative of the State and Commonwealth Governments, commenced operation in WA in 1985/86. Its target population is frail older people, others with a disability and their Carers. The Program aims to:

- Provide a comprehensive and integrated range of basic support services for the target population
- Help them be more independent at home and in the community, enhance their quality of life and prevent their inappropriate admission to long-term institutional care.

The Program is cost-shared on a ratio of approximately 60 per cent Commonwealth and 40 per cent State funds. In Western Australia it is funded to around $80m annually which is distributed to about 300 projects around the State. This is a higher level of per capita funding than the national average in recognition of the State’s geographical distances.

Most HACC clients require assistance to support and maintain their existing levels of independence in the community. This care may last for long periods of time, such as months or years. A small proportion of HACC clients receive short-term care such as post-acute care after a stay in hospital.

Figure 8.1 Type of Home and Community Care assistance provided, WA, 1998

![Chart showing type of assistance provided in different regions of WA, 1998](chart.png)

Source: Health Department of Western Australia, unpublished data

Of the wide range of HACC services available, the five most commonly provided services are home help, centre day care, home-delivered and centre-based meals, transport, and home nursing.

Other services provided under HACC include personal care, allied health services, advocacy, community options brokerage services, and information and coordination services. Services are provided by a wide range of not-for-profit non-government organisations, as well as local government and some State Government organisations.
**Figure 8.2 Home and Community Care services provided, WA, 1998**

**TARGET POPULATION**
The HACC target population in WA is approximately 159,000 persons. The rate of growth in this target population from now to 2011 is expected to be faster in WA (30 per cent) than nationally (23 per cent). Based on the 1998/99 HACC service provision data collection there are, on average, 35,000 people who receive HACC services in any one month.

**Age and gender profile**
The majority of HACC clients are older women. Women aged 70+ represent more than half of all HACC clients in Western Australia while men aged 70+ represent nearly 20 per cent. In contrast, only 7 per cent of all people in the general population are aged more than 70.

**Figure 8.3 Home and Community Care clients by age and sex, WA, 1998**

(per cent)


Source: Health Department of Western Australia, unpublished data
Carer availability
Although nearly two-thirds of HACC clients have a Carer who either lives with them or who visits on a regular basis, people who live alone represent nearly half of all HACC clients in WA. Carers in general are discussed in more detail under the next section entitled the Informal System.

Figure 8.4 Percentage of Home and Community Care clients living alone, WA, 1998

Source: Health Department of Western Australia, unpublished data

Aboriginal and Torres Strait Islander people
Clients of Aboriginal or Torres Strait Islander (ATSI) descent represent 3.1 per cent of the HACC client population of whom the majority (97.4 per cent), were identified as Aboriginal people. ATSI clients as a percentage of total HACC clients were highest in the Kimberley (78.8 per cent) and Pilbara (55.9 per cent).

Aboriginal and Torres Strait Islander clients are generally younger than other HACC clients with their median age being
65 years while that of the total HACC client group is 77 years. ATSI clients aged 50+ represent 2.8 per cent of total HACC clients, whereas Aboriginal and Torres Strait Islander people aged 50+ represent only 1.1 per cent of all West Australians aged 50 years or more. The majority (61.7 per cent) of ATSI clients are women. This percentage is higher than the average percentage of senior Aboriginal women aged 50+ (approximately 55 per cent). However, the percentage of female Aboriginal HACC clients is less than the percentage of total female HACC clients for Western Australia which stands at 68.3 per cent.

**Figure 8.6 Age distribution of Aboriginal and Torres Strait Islander clients by sex, 1998**

Source: Health Department of Western Australia, User Characteristics Survey, 1998

**Migrant clients**

An earlier section of this Paper provided a general description and background of the older migrant population, as well as examples of some of the HACC services which specifically target their needs. From the perspective of the HACC Target Population, just under half (47 per cent) of all clients are immigrants to Australia. Of these, 53.2 per cent were born in the United Kingdom and Ireland. An additional 3.2 per cent were born in other English speaking countries (that is, New Zealand, United States of America, Canada and South Africa).

The most common non-English speaking countries of birth for HACC clients are Italy (12.6 per cent), India (4.8 per cent), the Netherlands (3.5 per cent) and Poland (3.2 per cent). Nearly 20 per cent of HACC clients aged 60+ are from non-English speaking backgrounds (NESB), compared with 17.2 per cent of all West Australian NESB persons aged 60 years or more.

The percentage of HACC clients who speak a language other than English at home and were not born in Australia is highest for the Wheatbelt (31.7 per cent), Pilbara (25.0 per cent) and Kimberley (20.0 per cent). Just under half (47.0 per cent) of HACC clients from non-English speaking backgrounds and not born in Australia were reported to speak English well (30.2 per cent) or very well (16.8 per cent). Some 14.8 per cent of HACC clients from non-English speaking backgrounds and not born in Australia were
reported to be unable to speak English at all. Clients from non-English speaking backgrounds living in the Pilbara were least likely to be able to speak English well or very well.

**Regional differences**
As has been indicated by the preceding paragraphs, the profile of HACC clients differs between regions. The 1997/98 HACC User Characteristics Survey showed that those differences are most marked in the Pilbara and Kimberley regions.

The Kimberley region has a high proportion (78.8 per cent) of ATSI clients, although this group comprise 35.4 per cent of the Kimberley population.99 HACC clients in this region are more likely to live with others and to have a Carer, although nearly half of HACC clients as a whole live on their own. They typically have very high service needs, including high levels of transport, centre day care and home meal services. Almost the entire client group in the Kimberley region receives some form of pension or benefit.

Client profiles in the Pilbara region demonstrated the lowest level of service coverage per client of all HACC regions, and the second highest of ATSI clients (55.9 per cent). As in the Kimberley, and compared to clients from the other regions, those in the Pilbara are more likely to live with others and to have a Carer. They have high service needs for home help, centre day care and home meals services but a low level of home nursing. Almost 90 per cent of Pilbara clients receive some form of pension or benefit.

These profiles are consistent with regional program initiatives to establish remote Aboriginal community-based HACC projects which target frail older and younger disabled ATSI people, some of which were described in an earlier section of this Paper.

**Geographic and demographic constraints**
In some regions, most notably the Pilbara, Goldfields, Kimberley and Gascoyne regions, service providers face challenges due to the geography and demographic characteristics of the region, namely the large distances and the widely dispersed, low-density population. Infrastructure to house projects and the availability of potential sponsoring bodies are also limited or even absent in some areas. These factors necessitate a flexible approach to project management and service provision delivery models and pose significant challenges in the delivery of culturally relevant and effective services to potential HACC clients.99

**NEW DEVELOPMENTS**
Since 1996, the Department’s Aged and Continuing Care Branch (ACCB), which has the management and administrative responsibility for the HACC Program, has been developing a reform framework to identify and introduce reforms which will improve the efficiency and effectiveness of the HACC sector as a whole. These include measures to enhance and introduce economies of scale, increase purchasing power and linkages to other services, allow integration and reduce duplication. ACCB is also examining implementation strategies to improve streamlining of assessment resources and HACC clients based on complexity of care levels. This will allow funding streams to be more closely linked to consumer complexity of care with more effective identification of resource gaps at regional levels.99
There has also been considerable developmental work undertaken to improve data quality and collection systems. This has resulted in increased accountability and transparency facilitating improved monitoring of HACC projects. It also allows more efficient targeting of resources on a local and regional basis during the annual growth round resource allocation process.

In another recent development the Health Department of WA has recently sponsored the introduction of a Safeguards Policy in relation to charging fees for all clients receiving Home and Community Care services. This is in line with the National Fee Principles which came about following the 1996/97 Commonwealth Budget decision that replaced a portion of anticipated Government funding for HACC services with revenue from client fees. The Western Australian HACC Fees Working Group, comprising representatives of peak industry, consumer, Commonwealth, HDWA and other State Government organisations, was formed to advise the State Minister for Health on a recommended approach to this issue.

The Working Group found that, as permitted under the *Home and Community Care Act (1985)*, more than 50 per cent of funded agencies were already charging clients for services, or requesting donations in lieu of fees. However these agencies were using a diversity of methods to determine how much should be paid and at what income level.

Concerned at the lack of equity, inconsistencies in amounts charged and in the means by which clients were assessed as being able to afford fees, the Working Group developed the State’s Safeguard Policy. It includes a uniform income assessment tool, reduction and waiver tools and a fee cap based on the client’s self-assessment of income. This will ensure that people with multiple service needs will pay up to a maximum amount per week and no more, regardless of how many services they receive.

It is intended that by 1 January 2000, all clients will be making a contribution to the cost of their HACC services unless their income assessment indicates that they are unable to do so. All client contributions will remain in the HACC Program and be used to enhance and/or expand HACC services. An ongoing review of the impact of the Safeguards Policy, which will be completed by January 2001, will ensure the HACC Program remains affordable and accessible to clients.

THE INFORMAL SYSTEM

CARERS

The Carer is the service provider in the informal system of the community care sector. A Carer is defined as a person such as a family member, friend or neighbour who provides regular and sustained care and assistance to another person without payment other than a pension or benefit. Carers make an enormous contribution to the health and quality of life for people who, due to frailty, illness or disability, require assistance in managing the activities of daily living.

There are approximately 200,000 Carers in Western Australia who play an important role in enabling dependent persons to remain at home longer and with a much greater level of disability. Carers provide the support required to about three-quarters of frail aged and dependent persons in need of care in the home. Home
and Community Care services provide formal support for a further 10 per cent, while privately arranged and commercially provided services meet the needs of a further seven per cent.93 The absence of a Carer has been identified as a significant risk factor in contributing to institutionalisation among frail and dependent older people.91

The caring role can be physically, emotionally and mentally demanding and older Carers have their own health risks and needs in addition to the challenge of caring for others who are ill, disabled or dependent. Research on care-giving has shown anxiety, depressive symptoms and low self-rated health among care-givers. Sixty-seven per cent of Carers in Australia reported some change in their physical and emotional wellbeing as a result of their caring role.94

The demands of care-giving are variable, with the presence of cognitive impairment in the person being cared for being a key factor in the level of stress experienced by Carers. It has been found that stress associated with caring for a cognitively normal older person with a disability is relieved with home service whereas such support does not assist with the stress of caring for someone with cognitive impairment.95 Long-term Carers of mentally impaired older people who have limited social supports are at high risk for psychological distress or depression.96

The problems in adequately servicing the needs of those with dementia living at home and their Carers, often mean that residential care becomes the only option. However the costs required to maintain an older person in his or her own home with increased community supports are generally less than those of residential care. Therefore in addition to the health and social justice issues involved in recognition of Carers, there is an economic case for supporting them. Helping people stay in their own homes for as long as possible produces better outcomes for care recipients and better economic outcomes for government.97 The Australian Institute of Health and Welfare estimated the value of the informal care sector in 1998 to be $16 billion. This would have been the cost to replace Carers if they were unable or unwilling to continue providing care.

The growth of models of home-based care relies heavily on the availability of Carers to provide the day-to-day support to people who are ill or disabled. With growing numbers of older people living on their own (and a concomitant decrease in the numbers of older people with spouses and daughters to act as Carers), a reduction in the availability of unpaid Carers can be expected. This eventuality needs to be incorporated into the planning of health service delivery approaches for the future.

**CARER SUPPORT – RESPITE SERVICES**

A survey of Carers and services undertaken by the Carers Association of WA Inc in 1998, and the results of the First State Conference of Carers and Caring Issues, showed Carers required support in areas relating to personal, financial, mobility and relationship issues; that improved communication and better-established support groups would assist Carers to carry out their role more effectively; and that respite is a vital issue of support that cannot be overlooked.98

In its last Budget (1999/2000), the Commonwealth announced the provision of
an additional $82m over the next four years to further boost respite services for Carers, and particularly for those in rural and remote areas.

The Commonwealth’s National Respite for Carers Program recognises that Carers need continuing access to adequate information and advice about the services and help they can obtain, including financial assistance. The Carers’ Association in each State runs a Carer Resource Centre which acts as a centralised contact point to improve Carers’ ability to gain access to information and advice.

They also provide connections to the national network of over 58 Carer Respite Centres – 12 of which are in Western Australia – located in metropolitan, rural and remote areas. These Centres are run by a wide variety of community organisations and were established to improve access to assistance when Carers need a break from caring both in an emergency, and on a regular basis. They act as a single contact point for information needed by Carers and purchase, organise or manage the delivery of respite care assistance packages utilising formal and informal services for Carer support. These Centres also work closely with other existing respite services, many of which are funded through the Home and Community Care Program.

The following information is on Carers in general, but is also applicable to the older population.

**CARERS OF SEVERELY HANDICAPPED PEOPLE**

In 1998 there were an estimated 905,800 people in Australia with severe or profound core activity restrictions who received assistance from informal Carers such as family and friends.\(^2\)

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**Figure 8.7 Carers of disabled persons, Australia, 1998 (per cent)**

Source: Australian Bureau of Statistics, Disability, Ageing and Carers: Summary of Findings, Cat. 4430.0
Nearly 90 per cent of persons with a Carer were cared for by an immediate family member. When a severely handicapped person is young, the care is largely provided by parents. In mid-life, the care is mostly provided by the spouse, while in later life, the care is provided by a son or daughter.

More than 75 per cent of Carers of severely handicapped older people are the spouse of the person requiring care, highlighting the extent to which older people are themselves Carers.

Women are nearly three times more likely than men to be primary Carers in Australia. While the task of caring seems to be undertaken predominantly by women, many men also play a major role in care-giving, but are more likely to be a supporting Carer than a primary Carer.

Older people are more likely to be Carers than younger people, with those aged between 65 and 74 years being twice as likely to be a Carer compared with the overall population.

**Figure 8.8 Likelihood of being a carer by age group, WA, 1998**

As Carers often have close relationships with the recipient of their care, it may be difficult for the Carer to obtain respite from the care-giving role. This seems to be especially true when the person being cared for is over 65 years, and largely cared for by the spouse. About 16 per cent of Carers have indicated that they require additional respite care assistance.92
Figure 8.9 Provision of respite care to carers of disabled persons, Australia, 1998 (per cent)

Principal Carers of those who have a disability or who may need help because of their age, have similar attributes to Carers of severely handicapped persons. In 1998, there were twice as many women as men who were primary Carers of people who were frail aged or disabled.

STATE GOVERNMENT CARERS STRATEGY

Led by the Office of Seniors Interests (OSI), a Carers Strategy is being jointly developed by representatives from OSI, Family and Children’s Services, Health Department of Western Australia and the Disability Services Commission. The Strategy will acknowledge the importance the State Government places on the role of Carers and provide an overarching framework of principles which outline a general State Government commitment to Carers.

The intended outcome of the Carers Strategy is to make it easier for Carers to continue the caring role and for others to become Carers by ensuring that government programs are more oriented towards their needs.
9. HOSPITAL AND ASSESSMENT SERVICES FOR OLDER PEOPLE
The majority of hospitals in Western Australia are public hospitals owned and operated by the State government. These hospitals are situated throughout the State, many of which are integrated with other components of the health care system to form a Health Service. Private hospital services are limited to the Perth metropolitan area, Mandurah, Geraldton and Bunbury. In recent years, cooperative ventures between the State government and the private sector have led to the development of services for public patients in some privately managed hospitals. This has included services which are specifically targeted towards older people, such as the assessment and restorative care services at the Mercy Hospital in Mount Lawley; the purchase of aged care in-patient restorative services from the new Joondalup Hospital; and the purchase of in-patient palliative care and Nursing Home Type Patient bed-days from the new Peel Hospital as well as from Joondalup Hospital.

As shown in Figure 6.2 earlier in this Paper, the hospital sector (including both public and private hospitals) is the most resource-intensive sector, accounting for 40 per cent of total recurrent health care expenditure in WA in 1996/97.

Over the past 20 years, Western Australia has experienced growing demand for hospital in-patient services arising from growth in the population and growth in the proportion of older people. The rising level of throughput of people through West Australian public and private hospitals is also partly attributable to improved anaesthetics and medical treatments, and the use of less invasive surgical techniques.41

To manage the growing demand for in-patient services, there has been a reduction in the average length of stay of patients in hospital and a corresponding increase in the number of separations, as shown in Figure 9.1. The average length of stay for all persons in WA hospitals dropped from 7.1 days per separation in 1978, to 3.8 days per separation in 1996.
**Figure 9.1** Average length of stay, WA, 1978–1996 (all hospitals by age group)

![Graph showing the average length of stay for patients aged 65+ and 85+ from 1978 to 1996.](image)

Source: WA Hospital Morbidity Data System

As shown in Figure 9.2, the decrease in average length of stay is mainly attributable to a strong increase in the rate of same day surgery conducted in WA hospitals, which has increased six-fold from 27,000 separations in 1978 to 204,000 separations in 1996.

**Figure 9.2** Same day separations, WA, 1978–1996 (all hospitals by age group)

![Graph showing the increase in same day separations from 1978 to 1996.](image)

Source: WA Hospital Morbidity Data System

The number of separations increased from 290,000 in 1978 to 527,300 in 1996. This represents an increase from 227 separations per 1,000 persons to 299 separations per 1,000 persons.

In some instances the reduction in average length of stay per separation has arisen due to changes in admission practices. For example a patient may be admitted for a number of episodes of care, each of which is a short-stay episode (such as a diagnostic intervention, followed by a pre-admission clinic, followed by surgery), rather than for a single, long-stay episode of care.
The State has also addressed the demand for in-patient care through strategies such as post-acute care programs, hospital in the home programs, and increasing the focus on community-based care.

**ACUTE IN-PATIENT CARE**

As people grow older, the likelihood that they will require acute care and treatment in hospital increases. As the population ages, it can be expected that older people will form a greater proportion of in-patient episodes in Western Australia. The health system will need to ensure that an appropriate mix of health services is available to meet the needs of this growing group and that hospitals are adequately staffed and equipped to meet their care needs.

Hospital services in WA are provided through in-patient, outpatient and emergency services. A number of public hospitals in Western Australia offer additional, specific services which address the needs of older people who may have complex clinical conditions, or who may experience a reduction in their capacity to function independently as a result of their illness or from being restricted to bed. These services assist older people to receive appropriate care while in hospital, and to return to the community on discharge, or to be provided with alternative care if unable to return to their own homes.

A recent analysis of in-patient activity in West Australian public and private hospitals between 1978 and 1996 has highlighted a number of key trends in in-patient activity. The analysis shows that the representation of older people among in-patients is higher than for younger people. People aged 65 years and over account for 24.5 per cent of acute hospital in-patient separations and about 37 per cent of acute hospital in-patient expenditure, although people aged 65+ represent only 10.5 per cent of the general population. The proportion of older in-patients is slightly higher in public hospitals than in private hospitals.

People over the age of 65 years are, on average, three times more likely to require hospitalisation in a twelve-month period compared with people under the age of 65 years. Older people who require hospitalisation also have an average length of stay in hospital approximately twice as long as younger people.

People in their late seventies or older are even more likely to use hospital services and stay longer than people who have recently reached retirement age. For example, people aged 85+ had an average length of stay of 10.2 days per separation in 1996, compared with people aged 65–74 who had an average length of stay of 4.6 days. People aged 85 years and over were also more likely to be admitted.

In WA in 1996, there were 886 hospital separations per 1,000 persons aged 85+ compared with 803 hospital separations per 1,000 persons aged 75–84 years and 624 hospital separations per 1,000 persons aged 65–74 years. There were only 251 hospital separations per 1,000 people less than 65 years of age in 1996.
There is other evidence suggesting that older people are placing increasing demand upon the State’s hospital system. For example, while the overnight separation rate for people aged 65 years has declined by 24 per cent since 1978, the overnight separation rate for people aged 65+ has increased by 21 per cent. The rate of growth in the hospital separation rate is highest for people aged 85+, for whom the rate of separation from hospital increased 38 per cent between 1978 and 1996.
Figure 9.5 Overnight separations per thousand population, WA, 1978–1996 (all hospitals by age group)

Although the average length of stay in hospitals of persons 65+ has fallen over the past 20 years, the total number of bed-days utilised by this age group has increased. This increase is placing demands upon the hospital system to provide adequate infrastructure to meet the health care needs of this group.

For example, the number of bed-days occupied by persons aged 65 years and over increased 29 per cent between 1978 and 1996. For people aged 85+ the number of occupied bed-days doubled over the same period.

Figure 9.6 Hospital bed-days, WA, 1978–1996 (all hospitals by age group)
The relative proportion of bed-days occupied by older people is also increasing. Occupied bed-days for persons aged 85+ represented 4 per cent of total bed-days in 1978. By 1996, this proportion had doubled to 8 per cent. People aged 65 years and over occupied 30 per cent of total hospital bed-days in 1978, compared with 39 per cent of total hospital bed-days in 1996.

**EMERGENCY CARE**

It is essential that public hospital emergency departments have access to staff who are skilled in the diagnosis and emergency treatment of older people who experience sudden acute illness.

Older people, on average, have a relatively higher risk of sudden onset of acute illness such as stroke, heart attack or serious injury because of a fall. Rapid access to the emergency department of an acute hospital will often lessen the severity of sudden illness and the risk of subsequent permanent disability.

Hence the State provides access to emergency services in the majority of public hospitals in Western Australia. Where necessary the admitting hospital will arrange the transfer of emergency patients to a higher level regional or tertiary hospital to ensure the patient receives appropriate specialist care.

**ELECTIVE SURGERY**

An important role of acute public hospitals is to provide elective treatment including surgery for older people to limit the disabling effects of disease and injury. Older people who have been diagnosed as requiring elective surgery have the option of treatment in a public hospital free of charge. Nearly 40 per cent of all admissions to metropolitan public hospitals in WA in 1997/98 were people referred from public hospital waiting lists. This percentage is similar for older people admitted to public hospitals.

The waiting time for public hospital elective treatments depends upon the urgency of the patient’s condition. Older people make up about 25 per cent of all persons waiting for elective surgery at metropolitan public hospitals. About 5 per cent of older people placed on a waiting list are placed on Category 1, which is for people whose treatment needs are the most urgent, another 18 per cent are placed on Category 2, and other people placed on a hospital waiting list are accorded Category 3 status. Specialties with high numbers of older people waiting for Category 3 elective surgery are orthopaedics, general surgery, ear, nose and throat surgery, and ophthalmology. Where possible, and if clinically appropriate and in accordance with the choice of the patient, elective treatments are increasingly being provided at the hospital closest to the patient’s place of residence.

**OUTPATIENT SERVICES**

For many conditions admission as a hospital in-patient is not necessary. Public hospital outpatient services enable older people to access medical specialists and treatment for complex conditions, which otherwise would not be readily available.

Some forms of long-term therapy such as renal dialysis and chemotherapy can be provided more effectively through outpatient services, which enables the patient to receive high quality health care while retaining their family and social support networks at home.
Outpatient care is provided in the majority of public hospitals in Western Australia and is available free of charge to patients who elect to be treated as public patients.

**REHABILITATION**

After an episode of care in hospital, most people return to the community to continue to live independently. One of the principal objectives of health and related services for older people is to help them to retain and maintain their best possible functional independence. However it is well recognised that people, particularly when they enter their middle and late seventies, are highly susceptible to loss of function in normal daily living following acute illness or injury. There is also an increasing likelihood for older people to experience progressive and accelerating increase in functional dependence associated with one or a number of chronic illnesses, thereby reducing their capacity to function independently in the community.

It is accepted that appropriate medical and allied health therapies can play a decisive role in enabling people, particularly the elderly, to regain loss of function following serious illness, and can greatly assist in moderating the impact of disease and injury-related disability on their functional independence. Such therapies can also assist individuals to develop self-care and self-enabling practices which achieve functional improvement for those people with severe and moderate disability, as well as slow the progressive effects of chronic disease and injury on functional independence.

Rehabilitation therapies for older people have been shown to play an important role in assisting them to regain their independence and to enjoy a higher quality of life than may otherwise have been the case. Without appropriate rehabilitation, older people are at considerable risk of an escalating disability as a result of chronic illness or injury. This in turn can lead to premature admission to a nursing home or other residential aged care service. Research into rehabilitation suggests it can also:

- Reduce costs related to Carer stress and family dysfunction
- Reduce dependence on long-term home and community care services
- Provide valuable information on the allocation of services to target groups.

While the therapeutic and social benefits of functional rehabilitation for older people are widely acknowledged, rehabilitation services continue to be largely concentrated in the provision of hospital services for people who have experienced relatively sudden and major loss of functional independence. Insufficient attention has been given, to date, to the potential benefit of rehabilitation therapies for people who have experienced moderate loss of functional independence who are living at home or in residential care facilities.

**SPECIALIST GERIATRIC MEDICAL CARE**

Most older people admitted to a public teaching hospital will be treated by doctors with specialist qualifications which are appropriate for the immediate care needs of the patient. In non-teaching hospitals and country hospitals patients will often be cared for by their local general practitioner. Where necessary the general practitioner will consult with relevant medical specialists.

However, many older people have a number
of complex conditions that require ongoing treatment. To adequately diagnose and treat serious and acute illness in older people it is often necessary for the sick older person to be admitted to a specialist medical unit for comprehensive assessment of the illness. Such assessments are normally undertaken by a geriatrician. It is well established in Australia and internationally that the diagnosis, care and treatment of disease in older people require specialist skills and knowledge, and that geriatric specialists have contributed substantially to improved therapeutic outcomes and a more appropriate balance of care for older people. They are assisted in achieving this by a multidisciplinary allied health and nursing team who also have additional training and experience in the care and treatment of older people.102

The process of a geriatric assessment can therefore be defined as a multidimensional diagnostic procedure designed to quantify the individual’s medical, psychosocial and functional capabilities and problems with the intention of arriving at a comprehensive plan for therapy and long-term follow up. It also focuses on the individual’s family and Carer support systems and not just on the individual and the illness. Investigating all the factors is vital because there is usually a multiplicity of problems. Furthermore the interaction between the physical and psychosocial ailments of the older person makes it difficult for a single discipline to provide a comprehensive and accurate diagnosis.102

All metropolitan public hospitals have access to geriatricians. Metropolitan geriatricians also make regular visits to rural and remote regional centres of the State, and are available to provide consulting advice to local general practitioners and to other medical specialists. To ensure that there are adequate services to meet the needs of a rapidly growing older population, the Health Department of Western Australia is continuing to expand specialist geriatric medical services throughout the State.

However WA has a relatively low number of consultant geriatricians at a time when there is a very rapid growth in the numbers of older people. This growth is resulting in unsustainable geriatric medicine workloads which, in turn, act as a major disincentive to the entry of doctors into the specialty.

The Australian Medical Workforce Advisory Committee (AMWAC) report of October 1997 confirms the shortage of geriatric medicine specialists. It shows that WA is in a worse position than most other States when it comes to the ratio of geriatric medicine specialists to persons aged 75 years and older, and the hours of service provided by this specialty to this age group. AMWAC projects that the demand for geriatric services will increase by approximately 30 per cent over the next ten years.103

To overcome the projected serious shortfall in specialist geriatricians, AMWAC recommended that the number of positions in WA’s three-year Advanced Trainee Program in geriatric medicine be increased from five to twelve positions.

In response to the report and its recommendations, HDWA consulted with the WA Division of the Australian Society for Geriatric Medicine (ASGM) to help plan for the future and inform the Department on areas of geriatric medicine requiring urgent attention. The result was a plan
proposing in addition to the AMWAC recommendation that: there should be an increase in all levels of the geriatric medical workforce; an increase in the concomitant support staff; an increase in academic geriatric consultant staff; allocation of funds for aged care health services research; and improved linkages between primary, secondary, tertiary and related care services particularly GPs, psychogeriatric services and providers in rural and remote areas.

The Department is working with ASGM (WA Division) on how to implement the plan’s proposals.

AGED CARE ASSESSMENT PROGRAM

The Aged Care Assessment Program, established in 1984, is a Commonwealth-funded program managed by the Health Department of WA. It covers the whole State and is carried out by Aged Care Assessment Teams (ACATs) which conduct comprehensive assessments of older people in the main, although others who are disabled and/or have significant chronic conditions may also be assessed.

AGED CARE ASSESSMENT TEAMS

Comprehensive aged care assessment plays a vital role in the proper diagnosis and care management of older people with multiple and complex conditions. Aged care assessment services are available in metropolitan and country Western Australia, and are usually collocated with public hospitals. There are six teams located in the metropolitan area, and an additional nine teams located in regional centres of the State. The prime source of ACAT funding is from Commonwealth grants which form part of the overall budget of the local Health Service to which the ACAT is attached. Additional costs pertaining to geriatric/aged care are borne out of the general Health Service budget.

An Aged Care Assessment Team (ACAT) typically is made up of a geriatrician, social worker and community nurse. In addition the team will sometimes include or will have access to occupational therapy, physiotherapy and other allied health services. Some teams include Aboriginal Liaison Officers or Aboriginal Health Workers to enable other team members to better respond to the particular needs of Aboriginal clients. Most staff are full-time WA Health Service employees, and some work not only in the ACAT but also in other geriatric or aged care related areas of the Health Service.

ACATs assess an older person’s abilities and the actual or potential disabilities which may affect his or her daily activities of living. They play a crucial role in the determination of the best care options for older people including rehabilitation, community care or residential care. They focus not only on the older person but on that person’s family and/or Carer.

Addressing key issues and concerns from the Carer’s perspective and organising appropriate community and home-based support can lead to earlier discharge, lower readmission rates and maintain the older person in the community for longer periods of time.

To assist frail or disabled older people gain access to the appropriate services that they require, ACATs maintain strong localised networks with general practitioners, social support and community services, acute care services and residential care.
ACATs assess the eligibility of (generally) older people for Commonwealth subsidised residential aged care services and/or Community Care Packages (CCPs). Some Team members are also authorised delegates of the Secretary of the Commonwealth Department of Health and Aged Care and in that role, can sign approvals for admission to respite or residential care in nursing homes and hostels. Approvals for flexible care packages and/or CCPs also may be signed.

ACATs also assess the needs of other people who are disabled or have significant chronic conditions including dementia. Assessments are undertaken for these people regardless of age. Such assessments enable appropriate referrals to Home and Community Care (HACC) or other agencies providing home support and home nursing services, as well as the determination of aids and appliances that will assist individuals to become or remain independent.

**ADDITIONAL AGED CARE PROGRAMS**

The Commonwealth also funds a number of other programs which are administered by the State including the following:

- **Dementia Support for Assessment** (for the benefit of residents in country areas), which helps people with dementia and their Carers obtain more accurate diagnosis and assessment of care needs, more appropriate and timely treatment, care and support. It is available for projects assisting individual Aged Care Assessment Teams, statewide or regionally-based support services, or a combination.

- **Psychogeriatric Unit** (based at Royal Perth Hospital), which is funded to provide specialist diagnosis, assessment, advice and support services to aged care service providers, and to improve care options for frail older people who have severe cognitive deficits and difficult behaviours. The Psychogeriatric Unit is intended primarily to be a resource for nursing homes and hostels and to have a statewide focus.

- **Multicultural Aged Care Service** (based at Osborne Park Hospital), which assists the aged care industry and ethnic communities to develop and implement best practice models of care for ethnic older people.

**POST-ACUTE CARE**

It is essential that older people discharged from hospital and recovering from acute illness continue to receive appropriate visiting care services at home until their health has been restored. Public hospitals need to ensure that older people are discharged safely from hospital after acute illness. In some cases this is done by the hospital providing its own post-acute care home visiting services or by ensuring that the person has access to home nursing or personal care services available from a local home care provider.

Post-acute care services can significantly reduce the time required to stay in hospital. By using strategies such as effective discharge planning, pre-admission clinics, and ensuring the availability of appropriate home nursing and personal care services, the average length of stay for some types of hospital care can be significantly reduced. It is believed that patients experience less family disruption on an earlier return to the home and local community, which can facilitate their recovery.
SATISFACTION WITH HOSPITAL CARE

In general, older people view the importance of various aspects of hospital services differently from younger people and tend to report a higher level of satisfaction with hospital care than younger people. The results of surveys in Western Australia are consistent with this tendency and show that care and treatment as a person, availability of hospital staff when needed, access to the hospital and waiting times are the most important service issues for people aged 65 years and over. People aged less than 65 years also consider care and treatment as a person to be the most important criteria of health care but they are more concerned than older people about being given information about care and treatment. Communication with hospital staff and access to hospital services are less important to younger people.

The physical attributes and hotel aspects of the hospital were ranked of lowest importance by both age groups for all types of hospitals.

NEW INITIATIVES

REHABILITATION FOR OLDER PEOPLE

The Health Department of Western Australia has recently approved an initiative to promote the development of a statewide community-based rehabilitation service for older people. This is part of an earlier State Government commitment for which $1m annually will be provided over three years. An objective of the initiative is to introduce a systematic rehabilitation ethos into government-funded home and community care and post-acute care. The program is aimed at assisting older people to restore and maintain their functional independence, to reduce premature dependence on long-term home and community care services, and to enable available home and community services to be better targeted.

The Rehabilitation for Older People initiative comprises the following elements:

- The development of community-based rehabilitation protocols for use by home care service providers
- The provision of ongoing professional support in the skills required to ensure the provision of high quality community rehabilitation services for older people living in rural and remote areas
- The introduction of specialist multidisciplinary diagnostic and treatment clinics in regional areas for:
  - Dementia-related memory loss
  - Falls and balance problems in older people
  - Incontinence in older people.

REHABILITATION-LINKED COMMUNITY CARE PACKAGES

Another rehabilitation initiative is a proposed trial using Community Care Packages (CCPs) incorporating a rehabilitation treatment plan. The overall aim of this initiative is to improve the health and wellbeing of older, frail disabled people living in the community, through the development and evaluation of a community-based rehabilitation program.

A rehabilitation component in the CCPs could assist individuals to improve and maintain functional independence and reduce the proportion of community services that are allocated to them. This could in turn increase the number of people supported on CCP funding. The proposed
initiative would link the CCPs to an intensive home-based rehabilitation intervention of between 14 and 28 days, and evaluation would include comparisons being made between physical function, resource utilisation (costs) and quality of life for individuals receiving a standard Community Care Package, with a package incorporating a rehabilitation plan.

**CARE AWAITING PLACEMENT**

The Care Awaiting Placement (CAP) Program provides transitional care for patients waiting for supported residential accommodation who, although no longer having a medical requirement for remaining in an acute care setting, nevertheless have care needs which prevent them from being discharged to their own homes. These patients have been assessed by an ACAT as requiring residential care.

CAP services operated at Mount Henry Hospital from 1994 to 1998 and have operated at Hawthorn Hospital since 1995. With the closure of Mount Henry Hospital it was necessary to find alternative means to provide Care Awaiting Placement. A replacement strategy was approved in 1998 with the CAP budget being equitably distributed to those metropolitan Health Services which do not have access to other alternatives.

The major objective of the CAP initiative is to avoid acute bed blockages due to inappropriate lengths of stay of persons awaiting discharge to a residential care option. Specifically designated CAP funds are distributed to the metropolitan Health Services (including Mandurah) on a 70+ target population basis. This provides the opportunity for each Health Service to develop innovative CAP service delivery models specific to the requirements of their local population whether this be in the community or at residential aged care facilities.

**HOSPITAL IN THE HOME PROGRAMS**

In the past, hospital in the home programs, where patients receive high quality health care in their homes, have generally been hospital-based programs which focused on early discharge or post-acute care after admission to hospital.

The Health Department has more recently been working in collaboration with the General Practice Division of Western Australia (GPDWA) to develop a model of comprehensive community-based care for patients with acute illness that would avoid the need for acute hospital care.

**FLU TRIAL**

The Hospital in the Home Trial for Influenza and Winter Respiratory Illness (Flu Trial) was developed in response to a request from the HDWA Winter Strategy Taskforce. The purpose of the trial was to develop a model of care which would enable people with influenza and other winter respiratory illness to be cared for in the community, and avoid the need for hospital admission. The model was driven and developed by general practitioners, and provided additional resources in the community to care for people at home under the guidance of a GP. In addition to the objective of avoiding unnecessary hospitalisation, the trial was a pilot of a management model with collaboration between General Practice and Silver Chain.

Although the trial did not target older people, 75 per cent of those provided
services during the trial were aged 65 years and over, demonstrating that this model is of major potential benefit to older people. The vast majority of patients, Carers, nurses, and GPs surveyed in the evaluation of the trial thought that the Flu Trial provided effective care for patients with severe influenza and winter respiratory illness.

The success of the management model led directly to the development of a broader and more extensive hospital in the home program, HomeWard 2000.

**HOMEWARD 2000**

HomeWard 2000 is a new program developed by HDWA and GPDWA in collaboration with Sir Charles Gairdner Hospital. GPDWA holds an agreement for service provision with the Osborne Park and Perth Central Coastal Divisions of General Practice and with the Silver Chain Nursing Association for home help and nursing support. The program enables people who would normally require hospitalisation for any of a broad range of acute conditions to be treated at home by their doctor and a Silver Chain nurse. These conditions, including influenza, respiratory problems, cellulitis and diabetes management, would typically involve a minimum of five nights of stay in hospital. Other health practitioners, including physiotherapists and dietitians, will be available if it is determined necessary by the doctor. The program, which is available at no cost to the patient, is only available at present in certain parts of the north metropolitan area. However there are contingency plans that would allow the program, on a temporary basis, to be extended to the south and east metropolitan areas if this was required as a winter ‘flu response’.
10. RESIDENTIAL CARE FOR OLDER PEOPLE
THE RESIDENTIAL AGED CARE SECTOR

A reasonably common image of later life is its association with residential (or institutional) care. However, although the percentage of older people living in institutions increases with age, it is always much less than the percentage living in the community. In Western Australia, approximately 92 per cent of people age 70+ live in the community. Current government policy is to assist people stay in their own homes for as long as possible through increasing the range of services available (as described in an earlier section of this Paper). However approximately 7.8 per cent of the 70+ population do live in a residential aged care facility – 3.9 per cent in hostels and 3.9 per cent in nursing homes.109,110

The provision of residential aged care services is an acknowledged area of Commonwealth responsibility, and funded as such. In 1997/98 the Commonwealth provided $3.2b in funds to the residential aged care sector.111

In the previous year, 1996/97, the Federal Government announced a significant program of reforms to residential aged care services. The enabling legislation, the Aged Care Act 1997, was passed in June 1997 and implemented from 1 October that same year. Major elements of the reform program included:

- Extension of the capacity to seek accommodation payments from residents towards the costs of building and care
- Introduction of a single funding and classification system across nursing homes and hostels
- Introduction of a new system of income-tested daily care fees across nursing homes and hostels
- Changes to the accountability and regulatory framework and the introduction of the Aged Care Standards and Accreditation Agency.

In Western Australia as at July 1999, there were 5,834 Commonwealth-funded nursing home beds and 6,171 Commonwealth funded hostel beds.117 These were located in approximately 281 residential aged care facilities spread throughout the State. (It should be noted that following the Commonwealth aged care reforms in 1997, nursing homes and hostels were combined into the one system and referred to by the generic term of ‘residential aged care facilities’.)

Although funded by the Commonwealth, the vast majority of residential aged care facilities are owned and operated by the private and the religious/charitable sectors amounting to 86 per cent of nursing homes and 92 per cent of hostels.118 Recipients of aged care services receive them based on need, frailty or incapacity, not just on age. However the Commonwealth in the planning of and determining the need for aged and community care services, tends to focus on the number of the general population aged 70 years and over, and the number of Aboriginal people age 50 years and over.
The Commonwealth also controls and manages the distribution of places for residential aged care accommodation through a national benchmark which it has set at 40 nursing home beds, 50 hostel places and 10 Community Care Packages per 1,000 people aged 70+ years. However the actual level of provision of residential aged care accommodation varies throughout Australia with 83.4 places per 1000 people aged 70 and over in Victoria being the lowest, and with 98.0 places in the Northern Territory being the highest. In WA the figure stands at 89.3 places per 1,000 people aged 70 and over. There are also variations in the level of provision within each State as the majority of facilities tend to be concentrated in metropolitan areas and large rural centres. The State Government, with the cooperation of the Commonwealth, has been working to overcome this situation particularly for smaller country communities.

**STATE INVOLVEMENT IN RESIDENTIAL AGED CARE**

At one stage the State Government played a fairly major role in the direct provision of residential aged care. However in August 1995, the State Government announced a plan for the major restructuring of the State Government Nursing Home sector with the establishment of the State Government Nursing Home (SGNH) Restructure Project.

There were a number of factors that led to the Government announcing this reform. One was that the provision of residential aged care is an acknowledged area of Commonwealth responsibility as noted above. The State’s decision was also as a result of the following:

- The view that the non-government sector could provide services not only more cost efficiently, but in more suitable facilities. Although the highest quality of care was provided, including a higher staff to patient ratio, SGNH facilities such as Mount Henry and Sunset were built in a time when buildings were very institutional and provided little privacy for residents with non-contemporary accommodation and communal bathrooms.

- The need to relocate existing aged care services to areas of need by distributing beds and services in the metropolitan area closer to where people are living.

- The need for the State to start reducing the relative disadvantage country communities have had in accessing residential care for the aged by transferring bed approvals from Mount Henry.

### MAJOR ELEMENTS OF SGNH RESTRUCTURE PROJECT

A major result of the above decision has been the opportunity for the State to reinvest funds that had previously been somewhat narrowly focused. It has led to the establishment of not only a number of new, non-government nursing home facilities but also other aged care services in the north, south and east metropolitan regions closer to where people live. It has also allowed the problems in the country to be addressed mainly through the joint State/Commonwealth initiative of Multi-Purpose Services (MPSs).

The main achievements of this reinvestment strategy are highlighted below.

**Metropolitan Initiatives**

- A new replacement 60-bed nursing home on the Mount Henry site owned, managed and operated by Anglican Homes.
• 20 bed approvals transferred from Mount Henry to Amaroop nursing home in Gosnells, together with $1m capital towards development of new facilities.

• The Young People In Nursing Homes (YPINH) project has seen the transfer of $6.116m recurrent funding from HDWA to the Disability Services Commission (DSC). This is to enable 95 young people from both Mount Henry and Brightwater to relocate to more appropriate accommodation of their choice. The SGNH Restructure Project has also contributed approximately $5m in capital to this joint venture project with the DSC.

• An Additional Care Subsidy Scheme for residents formerly residing in SGNHs whose complex care needs require funding in excess of the Commonwealth residential subsidies. The Aged and Continuing Care Branch purchases this service from the Brightwater Care Group to the value of approximately $2.8m per annum.

• A new, purpose-built 24-bed assessment and restorative care service as well as 20 day-hospital places for the Perth inner metropolitan area at the Mercy Hospital in Mount Lawley. HDWA has a 20-year contract with Mercy to provide this service to public patients which was previously located at Mount Henry.

• Care Awaiting Placement (CAP) service for people who are in hospital awaiting transfer to a nursing home, with $1.3m per annum being equitably distributed to metropolitan health services.

• 10 day-hospital places from Mount Henry Hospital permanently transferred to Bentley Hospital.

• 16 restorative beds initially transferred from Mount Henry Hospital to Osborne Park Hospital to provide a service to residents of the Perth inner metropolitan area. The funding for this service has now been transferred to Bentley as this is more accessible for that population.

• A therapies block associated with restorative care services at Osborne Park Hospital built at a capital cost of $1m.

• 12 nursing home beds at Goline House (Armadale/Kelmscott Health Service) converted to restorative beds.

• A Chair in Geriatric Medicine established at the University of Western Australia and funded by HDWA for $2.5m per annum over 10 years.

• Allocation of $19.6m as the State’s contribution to the Brightwater Redevelopment Project to reduce the number of beds at the Subiaco and Inglewood sites and establish two new 60-bed facilities on each site. The remaining beds from those sites are being transferred to three new 60-bed facilities in Stirling, Joondalup and Waikiki.

• The SGNH Restructure Project has contributed $1.3m capital towards the redevelopment of the Silver Chain Nursing Association (SCNA) 50-bed nursing home in Hilton Park.

(It should be noted that both the SCNA and Brightwater residential aged care services are considered by the Commonwealth to be SGNHs, and are funded as such. That is, they receive a lower subsidy from the Commonwealth than other aged care facilities. The State provides ‘top-up’ funding for SCNA and Brightwater nursing home facilities in order to bring them up to the same level of funding as other providers. As a consequence of being considered SGNHs, neither organisation was ever able to apply for capital grants from the Commonwealth in order to upgrade or redevelop their facilities.)
Country Initiatives

- Approximately $1.5m capital has been distributed to country health services for the development of palliative care suites within the local hospitals.
- 42 SGNH bed approvals from Mount Henry have been committed to the MPS initiative in an attempt to redress the current imbalance of nursing home places in the country compared to the metropolitan area. In addition 20 bed approvals from various country SGNHs have also been reallocated to MPSs in areas of greater need. A further 22 bed approvals have also been identified for country aged care service development.
- 10 bed approvals transferred from Mount Henry to the Baptist Homes’ nursing home in Busselton together with $700,000 capital towards development of the new facilities. This amount equates to more than 20 years of ‘top-up’ funding.
- Redevelopment of the SCNAs 50-bed nursing home in Claremont is yet to commence but HDWA has indicated a preference for Silver Chain to relocate the 50 beds to the South West where there is a greater community need. The SGNH Restructure Project will contribute capital towards the redevelopment.
- The second stage of the Restructure Project which involves Country SGNHs has also commenced. Currently these six facilities, located in Albany, Augusta, Brookton, Bunbury, Derby and Port Hedland, are at various stages of restructure and redevelopment. The end result will be the transfer of their bed approvals to the non-government sector and/or the redevelopment of the existing facilities in keeping with contemporary residential aged care standards. It is intended that some of the bed approvals will be redistributed to areas of relative need in other parts of the country.

**NURSING HOME TYPE PATIENT SERVICES**

The Nursing Home Type Patient (NHTP) is an individual who, because of a continuing need for 24-hour medical and nursing supervision and/or services, requires long-term residential care. Such individuals may sometimes be found in metropolitan and larger country hospitals, but remain in those facilities only for as long as it takes to be accommodated in a Commonwealth-funded nursing home. These individuals are usually in the Care Awaiting Placement (CAP) category.

However where the Nursing Home Type Patient situation arises for people living in regional areas where Commonwealth-funded nursing homes (including country SGNHs) are not available, the Health Department provides Nursing Home Type care in the local country/district hospital. This care, generally given within a framework of an integrated health service and part of a greater, related whole, is provided in an environment which is as homelike as possible.

The actual number of NHTP beds throughout the State varies according to need and demand, but generally lies between 290 and 310 beds.

**STANDARDS AND QUALITY OF CARE**

In regards to other responsibilities for residential aged care services the Health Department, under the provisions of the *Hospitals Act 1927*, has been responsible for the licensing of nursing homes and for ensuring that psychiatric residential care facilities and services for older people meet
minimum standards. A Review of the Licensing of Private Sector Health Facilities in Western Australia was undertaken in 1998/99 followed by a period of stakeholder and community consultation. The Review is considering the need for the State to continue the licensing function with its attendant monitoring and regulatory responsibilities, or whether changes should be made.

The Review was brought about by a new accreditation-based quality assurance system for services providing residential care which is part of the Commonwealth’s reforms to the quality of care for older Australians. To achieve this, the Aged Care Standards and Accreditation Agency Ltd, established under the Commonwealth’s Aged Care Act 1997, took over the standards monitoring function from the Department of Health and Aged Care in July 1998. The Agency’s core functions are to:

- Manage the residential aged care accreditation process
- Assist services to improve service quality through education and training, information dissemination and identification of best practice to promote and encourage better quality care
- Conduct assessments and strategically manage services not yet ready for accreditation
- Liaise with Department of Health and Aged Care regarding those services identified as not meeting the Residential Care Standards.

To gain accreditation, services are assessed against five main areas:

- Accreditation standards (of which there are four – management systems, staffing and organisational development; health and personal care; resident lifestyle; and physical environment and safe systems)
- Building quality
- Prudential arrangements
- Concessional and assisted resident ratios
- User rights.

If a service is not accredited by January 2001, it will no longer receive Commonwealth funding.

Also in October 1997, the Commonwealth established the Aged Care Complaints Resolution Scheme to operate as a free, independent and unbiased mechanism to resolve complaints relating to aged care services funded under the Aged Care Act 1997. The Scheme operates on a negotiation/mediation framework to ensure that the process is appropriate to and effective in meeting the needs of aged care service consumers and providers alike.
II. OLDER PEOPLE AND MENTAL HEALTH
II. Older People and Mental Health

Mental health relates to emotions, thoughts and behaviours. A person with good mental health is generally able to handle day-to-day events and obstacles, work towards important goals and function effectively in society. However, even minor mental health problems may affect everyday activities to the extent that individuals cannot function as they would wish, or are expected to, within their family and community.113

The prevalence of mental disorder generally decreases with age.113 The 1997 National Survey of Mental Health and Wellbeing of Adults (SMHWB) found that young adults aged 18 to 24 years had the highest prevalence of mental disorder (27 per cent) and that prevalence declined steadily to 6.1 per cent in those aged 65 years and over.113

In Western Australia in 1996/97, older people comprised about 10 per cent of the population yet represented approximately 14 per cent of mental health service users. Organic psychotic conditions accounted for the largest proportion of treated conditions at 43 per cent, while mood disorders accounted for 16 per cent, schizophrenia, paranoia and acute psychotic disorders 10 per cent, anxiety disorders 9 per cent and substance abuse disorders 5 per cent.

Within the older age groups, there is significant variation in the usage of mental health services. Age-specific prevalence of use of mental health services by older West Australians in 1996/97 shows a significant increase from 10 occasions of service per 1,000 persons aged 65 to 69 years to about 45 occasions of service per 1,000 people aged 85+.114 The much higher usage of mental health services by those aged 75 years and older reflects the increasing incidence of dementia and associated mental disorders. This has major implications for future mental health services, given the rapid increase in the numbers of older old people in the population. Men over the age of 75 years have higher rates of suicide than younger adults, although the actual numbers of suicides are much lower. All health services need to be alert to this risk and provide appropriate support.

The mental and emotional health of people of all ages is related to how well they cope with or adapt to the stresses and changes in their lives. Although risks to health do increase with advancing age, stress is not an inevitable consequence of old age. Two transitional stressors that are more common with increased age are the onset of illness and/or physical impairment and the death of loved ones.115 The results of the SMHWB show that, for those aged 65 years and over who had a mental disorder, nearly all had a co-morbidity of some kind of physical condition.113 This is consistent with study findings that show, for example, that what appear to be age-related effects on depression, are attributable to physical health problems and related disability.116

STRATEGIC DIRECTIONS

The focus of mental health services for older people in Western Australia is on service provision within the community and close to where people live. This is achieved by the integration of mental health services with mainstream health services.

The Mental Health Division of the Health Department of WA is pursuing major
reforms in the provision of services to older people to maximise the mental health of older people and their families. The planning principles underpinning these reforms are:

- Services need to assist people to remain living as independently as possible in their own homes and communities
- Wherever possible, assessment and treatment should be provided in the person’s home, whether the person is living alone, with a Carer or in a hostel or nursing home
- Older people with pre-existing mental disorder should continue to be seen by adult community and in-patient mental health services where these services meet their needs
- Older people experiencing mental disorder for the first time should, preferably, be seen by mental health services for older people
- Specialist mental health care is required for older people when mental disorder is complicated by the physical and cognitive conditions of ageing
- Mental health services for older people should be closely integrated with mental health services for adults, health services for older people and other aged care services
- Disability associated with having a mental disorder should not exclude older people from accessing other aged care services unless those services are inappropriate or cannot be adapted to meet their needs
- Developments in treatment will be adopted by services on the basis of evidence of effectiveness.

There is a requirement for detailed planning about what constitutes a comprehensive community-based mental health service for older people and the funding and purchasing arrangements required to put them in place. An important component of this planning will be consideration of the effectiveness of current models of community-based mental health service provision in meeting the needs of older people and the costing of the key service elements.

This planning aims to build on a shared vision of how specialist mental health services will become an integral part of a broader service system for older people.

**SPECIALIST SERVICES FOR OLDER PEOPLE**

Specialist mental health services for older people are required when the assessment and treatment of mental disorder is complicated by physical conditions of ageing such as physical frailty, degenerative illness and dementia.

Of itself, dementia is not a criterion for referral to a mental health service. Many people with this condition are treated effectively by other sectors of the health and aged care systems. A specialist mental health service is appropriately involved when concomitant mental disorder and/or serious behavioural disturbance results in the person being difficult to manage and therefore in need of specialist skills and facilities. The major service elements in a comprehensive regional mental health service for older people are:

**COMMUNITY MENTAL HEALTH SERVICES**

Community mental health services for older people need considerable expansion in order to meet the demand and provide
alternatives to in-patient care. The expansion of these services has been a priority of the Mental Health Division. Since 1996/97, all metropolitan services and all country regions have received additional staffing for this purpose, with the exception of the North West. This is the first time that specialist positions have been included in rural mental health services.

**IN-PATIENT ASSESSMENT AND TREATMENT**

These services have the role of assessment and treatment of complex conditions, and should be integrated with both adult psychiatric and geriatric in-patient services. In-patient facilities for older people should be purpose built so that physical frailty and behavioural disturbance associated with neurological impairment can be managed in an environment that is comfortable and safe for patients and staff.

Psychiatric Extended Care Units have, historically, played an important role in the in-patient care of older people with mental disorders. The success of community-based and mainstream responses to the care of older people with mental disorders has led to a reduction in the demand for this type of care.

Moss Street Lodge was closed in 1997 and the resources were shifted to expand the provision of community services in the South West Metropolitan Region. Some beds in Selby-Lemnos Hospital were also closed in 1998, with the funding being used to develop community services in the North Metropolitan Region.

Lemnos Hospital was closed in 1999 and funds are being used to expand clinical community services across the metropolitan area and to establish a special residential care service for a small group of people with very challenging behaviours. Planning for a new inpatient unit for the Inner City area is also occurring.

**RESEARCH, TEACHING, TRAINING AND PROFESSIONAL SUPPORT NETWORKS**

The recent establishment of a Faculty of Old Age Psychiatry by the Royal Australian and New Zealand College of Psychiatry has led to the development of a state training program for psychogeriatricians. The increased numbers of trained specialists will improve service availability and enable greater emphasis on research and teaching.

Specialist mental health services play a key role in supporting mainstream services in their assessment and care of older people with mental disorders. Education of mainstream health and aged care providers is an important strategy in improving mental health care and treatment of older people. Often when older people experience a mental disorder, the first point of contact is a general practitioner or other primary health care or community service provider. The capacity of these providers to determine the need for specialist assessment and treatment is important in ensuring that older people get the services they require.

Shared care is another approach which facilitates the least intrusive provision of services. Support of hostels and nursing homes in the appropriate management of residents with serious behavioural disturbance is another important role for specialist mental health services.
12. OTHER HEALTH CARE AND SUPPORT SERVICES FOR OLDER PEOPLE
12. Other Health Care and Support Services for Older People

MULTI-PURPOSE SERVICES

There is a range of factors which affect the provision of services in rural and remote areas. These include:
- The difficulty in delivering a number of discrete and cost-effective services to small populations
- Isolation of these from mainstream services
- Costs of infrastructure and support
- The challenges in attracting and retaining staff.

In 1991 the Multi-Purpose Service (MPS) model, created as a national initiative of the States and Commonwealth, was designed to address some of these issues and allow the establishment of flexible service configurations in rural communities. The aim of the model is the achievement of maximum health service availability by overcoming some of the barriers faced by small rural and remote communities in providing an effective and viable health and aged care service. The first pilot projects were established in 1993, but it has since moved on from this phase.

The aims of the MPS Program are to:
- Improve targeting of services to meet the needs of the community
- Improve access to appropriate services
- Increase coordination of services
- Promote flexible and innovative service delivery.

The MPS model pools Commonwealth and State funds for health and aged care within a designated area, to enable integration and development of hospital and community health services, hostels and nursing homes, Home and Community Care, medical and pharmaceutical benefits, and ambulance and allied health services. It uses an existing health board as an incorporated community body to direct services and activities for the area in line with health and aged care priorities identified in a detailed service plan. Pooled funds are applied flexibly across all health and aged care programs.

The development of an MPS is a community-driven decision. Although a range of services is provided under a three-year agreement with the State and Commonwealth, the MPS remains part of the rural health service district structure. This means that all the services are under single management responsibility and program constraints are removed. Accountability is for the total range of services rather than each separate component.\(^{117}\)

The uptake of this national initiative has been particularly well received in WA as the model suits the geographic and demographic situation of the State. The development of MPS sites throughout country regions of WA has also been assisted by the transfer of beds from State Government Nursing Homes as part of the SGNH Restructure Project, described in an earlier section of this Paper. To date, a total of 62 beds have been committed to MPSs and a further 22 beds have been identified for country aged care service developments. Currently there
are 15 MPS sites operating in WA and it is anticipated that further sites will be approved and become operational in the course of 1999/2000. The current sites are located at Dalwallinu, Northampton-Kalbarri, Boyup Brook, Laverton-Leonora, Eastern Wheatbelt, Central Great Southern, Murchison, Denmark, York, Dundas (Norseman), Ravensthorpe, Lake Grace, Kondinin/Kulin, Augusta and Cunderdin/ Meckering/Tammin.

**DENTAL SERVICES**

Many adults are now retaining teeth longer than was common for previous generations. The principal dental diseases are dental caries (decay) and periodontal (gum) disease. Preventive care for the whole community is provided through fluoridation of drinking water, and the development and distribution of oral health information, training and education materials.

Oral cancer occurs in older persons and accounts for about 55 deaths per year in WA. It is closely related to alcohol consumption and smoking, and its incidence should therefore respond to health promotion activities targeted at these risk factors. These programs have been described in an earlier section of this Paper.

Dental care for adults is provided mainly by private sector dentists, though the cost of this may be prohibitive for financially disadvantaged individuals.

In WA, financially and geographically disadvantaged people have access to dental services through the Perth Dental Hospital, seven metropolitan dental clinics and eleven country clinics, supplemented by mobile and domiciliary services. In the metropolitan area, this care is provided through public dental clinics while in country areas, it is provided primarily by private sector dentists with financially disadvantaged persons being subsidised through the Country Patients’ Dental Subsidy Scheme. The dental health needs of financially disadvantaged persons have become more acute since the cessation of the Commonwealth Dental Health Program in 1997. It was found that although 300,000 people over the age of 18 are eligible for publicly-funded dental care in WA, only about a quarter gain access, possibly due to long waiting lists. The State-funded Domiciliary Dental Service which commenced operations in 1966, is provided out of the Perth Dental Hospital. Although the previous metropolitan State Government Nursing Homes received regular visits from the Service, in all other cases it has been, and continues to be, provided on a demand-basis attending to bedridden and/or home-bound patients in the community, nursing homes and hostels, in the metropolitan area. The service is available to clients on referral by medical practitioners and provides basic dental care including dentures, extractions and fillings. During 1998/99 it visited 72 per cent of Commonwealth-funded nursing homes and treated 323 patients. However with an annual budget of approximately $100,000 it has limited resources. Therefore, although urgent and emergency conditions such as pain and sepsis are dealt with immediately, it otherwise operates on a waiting list basis. It is understood that some residential aged care facilities have arrangements with local private dental practitioners to provide care for those residents who have the means or whose families can afford to pay for private treatment.
PALLIATIVE CARE

Palliative care focuses on the wellbeing of a person with terminal illness, working to ensure dignity and comfort for the person over the duration of his or her illness. The goal of palliative care is the best quality of life for the time that remains.\textsuperscript{118}

It is little more than a decade since hospice and palliative care services began to emerge as a distinct component of health care in Australia. Increased official recognition and funding from governments has resulted in hospice and palliative care services becoming more generally available and increasingly integrated with mainstream care.

The expected growth in the number of people who will be diagnosed with and die from cancer will increase the demand for palliative care services. This demand for services can be expected to increase as a consequence of the ageing of the population and with the majority of deaths now occurring in later life, older people tend to be the major users of palliative care services. There is also likely to be an increased demand from other people with progressive deteriorating illness such as HIV/AIDS, motor neurone disease and end-stage cardiac, respiratory, renal and liver disease.\textsuperscript{119}

CURRENT ACTIVITIES AND FUTURE DIRECTIONS

The Health Department of WA is currently supporting the development of Palliative Care services in WA by investing in equitable access to community-based care to support people in their own homes or equivalent, and in-patient care where care at home is not possible.

In 1997/98 these services were funded by a mix of Commonwealth and State funds to a total of around $11m, with over half of this amount provided by the State. The State contribution for 1999/2000 has increased to over 75 per cent of the total investment in palliative care with more than $7m being provided for home-based palliative care alone. This amount, which previously had been jointly funded with the Commonwealth as part of the HACC Program, is now purely State funded.

While there is not expected to be a significant amount of new money available for palliative care over the next few years, the Health Department of WA is considering the possibility of redirecting some funds from the acute public hospital sector to community-based palliative care services.

GEOGRAPHIC DISTRIBUTION OF AVAILABLE RESOURCES

A high priority exists for increased recurrent funding allocation to rural areas. In 1997/98 the proportion of palliative care funds spent in rural areas was 9 per cent, whereas 25 per cent of the State’s population lives in rural WA.

In November 1997 the Minister for Health approved the transfer of approximately $1.5m from the State Government Nursing Home Restructure Project to fund capital developments in rural palliative care services. In April 1999 applications for a non-recurrent rural grant of up to $30,000 were invited from each of the rural palliative care fund holders.

METROPOLITAN IN-PATIENT PALLIATIVE CARE

It is government policy to ensure care closer to home. The uneven distribution of in-patient palliative care beds in the
metropolitan area is recognised, with provision of services in the eastern suburbs being a priority.

The need for palliative care services is generally related to population size and the proportion of older people in the population. The national recommended planning ratio of 50 in-patient beds per million population indicates a requirement of 72 beds in the metropolitan area by the year 2001.

Currently, there are 79 in-patient palliative care beds available in the metropolitan area. Fifty-two are concentrated in the north/south coastal corridor, in particular in the lower north-west sector. To improve access for residents south of the river, the equivalent of 12 public patient bed-days at any one time is currently purchased from the Murdoch Community Hospice. This replaces the palliative care service that was previously located at Mount Henry.

**SUPPORT SERVICES**

**AIDS AND APPLIANCES**

The Community Aids and Equipment Program (CAEP) provides aids and equipment to people with long-term and permanent disabilities living in the community. The program commenced in April 1996, with the Disability Services Commission (DSC) managing its funding and administration. An earlier similar scheme had been the Program of Aids for Disabled People (PADP). This had been run jointly by HDWA and DSC since 1988/89 when the Commonwealth transferred funds and responsibility for the scheme to the State.

The operation of the new CAEP is advised by a State Aids and Equipment Advisory Committee comprising representatives of professional associations, consumers, HDWA and DSC. The establishment of this new program clearly separated the provision of aids and equipment to people with disabilities living in the community from the provision of such equipment to people who are hospital in-patients, outpatients or attending a day hospital.

It has a statewide service delivery system for a standardised list of aids and equipment which ensures a consistent approach to the provision of aids and equipment throughout Western Australia. The program has resulted in improved access by country residents and the use of a broader range of Service Providers. The distribution for 1996/97 represented 36 per cent country Health Service Providers, 38 per cent metropolitan Health Service Providers and 26 per cent alternative Service Providers.

To access CAEP a person must be permanently disabled, not currently a hospital patient, live independently and/or in the community most of the time, and have a pension concession card, health care card, Commonwealth Seniors Health Care Card or be eligible for Child Disability Allowance. Eligibility can also be determined by demonstrated financial hardship to the State Aids and Equipment Advisory Committee. A person must reside in a private home to be eligible for home modifications.

The CAEP is not available to hospital patients who have been discharged without aids or equipment, nor to residents in Commonwealth-funded Aged Care Accommodation. Those eligible for equipment under other government-funded programs, such as the Commonwealth Rehabilitation Services, are also ineligible.
SPECTACLES SUBSIDY SCHEME
The State’s Spectacles Subsidy Scheme commenced in November 1988 to assist WA Aged and Disabled Pension Concessions Card holders to purchase spectacles. It was later extended to include holders of the Western Australian Senior’s Card and to Veterans Affairs pensioners who are not entitled to DVA concessions. It provides a subsidy of 50 per cent of the cost of prescribed spectacles to a maximum of $50.00 within any two-year period.

Under this Scheme 48,121 claims were processed in 1997/98. Of that number, 49 per cent of claimants (or their spouse) were recipients of a Government aged pension, while another 30 per cent were holders of the Western Australian Seniors’ Card.

INFORMATION AND SUPPORT
Information and support services are supplied not only by State and Commonwealth departments, but also by a wide and extensive variety of non-government organisations. The nature of the information and/or support may be generic in nature – such as that provided through the Citizens Advice Bureau – or quite specific such as that provided by the Carer Resource Centre.

Advocacy services are also either generic – for example the State and Commonwealth Ombudsman offices – or specific such as those provided by AdvoCare. AdvoCare, funded by both the State and the Commonwealth, looks after the rights of people living in residential aged care facilities or receiving HACC services. It provides advocacy and representation for individuals and their Carers who cannot represent themselves and where other sources of personal advocacy support are not available or practical. It also provides information, referral to other community support agencies if required, as well as support and education to the wider community on its services.

MULTICULTURAL ACCESS UNIT
The Multicultural Access Unit, established by the Health Department in the early 1980s, works to facilitate access by culturally and linguistically diverse clients to the public health system. The unit aims to enhance access and communication by promoting the use of professional interpreters in crucial health care situations; the use of translated information and phrase cards where appropriate; the delivery of services in a culturally appropriate way; the education of health staff about migrant health issues; and the circulation of health promotional material to people from ethnic minorities who may not speak English well.

To achieve this aim, the unit undertakes a range of activities:

- Provision of translating services for health-related projects
- Development of pamphlets and other information materials in a range of languages for use by ethnic minorities
- Contribution to the training of health interpreters via the Health Interpreters Certificate Course
- Coordination of the Ethnic Contact Person Network, comprising 44 health professionals across the state, and provides three in-service training sessions per year
- Provision of cross-cultural education for health care practitioners and support staff
- Research and development in the area of migrant health.
The unit also carries out a number of activities targeted specifically to the needs of older people from culturally and linguistically diverse backgrounds. These include the development of a Multicultural Resource Kit for nursing homes and hostels and developing resources, as required, for the Commonwealth-funded Multicultural Aged Care Services.
13. THE WAY FORWARD
In Western Australia today older people represent a considerably larger proportion of the population than even 20 years ago. Therefore the ageing of the population is already affecting the way in which health care services are being delivered and a variety of measures to address the needs of older people have been implemented. These measures vary from increasing available funding for programs dedicated to older people, redirecting aged care services closer to where people live, to finding new ways of increasing the volume of, and access to, health care services.

New initiatives and mechanisms such as reducing average length of stay, same-day surgery, Care Awaiting Placement services, post-acute care and hospital in the home programs have evolved to deliver existing health care services in more cost-efficient ways, and have had a considerable impact on the ability of the health system to manage the increasing demand for its services. However they are not in themselves sufficient to address the changing needs that will be experienced during the next 20 years and beyond.

The Health Department of Western Australia, as the State Government’s principal health authority, is charged with the duty of promoting, protecting, maintaining and restoring the health of the people of Western Australia. It is critical that the Health Department, in collaboration with other stakeholders, ensures that the health care needs of older Western Australians continue to be met in accordance with this duty.

**KEY ISSUES**

The two fundamental changes occurring in the State’s population, growth in the number and growth in the proportion of older people, form the foundation from which to consider the need to change the priorities and delivery systems of health care in the future. The growth in the absolute number of older people in WA will result in greater numbers with health care needs. This poses a challenge to not only continue and at least maintain existing levels of health care service provision, but ensure that there are systems in place which will meet the demand arising from these increases.

It is also important to recognise that as older people frequently have complex and chronic health conditions, their appropriate care and management may require involvement from more than one type of health and aged care service provider. This will require the establishment of effective communication and integration strategies involving all or any number of points across the care spectrum, thereby overcoming fragmentation of care for a group of people with complex and interacting needs. An analysis of the current systems delivering health and related aged care is required in order to determine what may be done to reduce or even remove the boundaries, both real and perceived, between services, service providers, State government departments and State and Federal government departments.

Although the number of older people in WA will grow rapidly, some areas of the State will experience more rapid growth than
others. It is important that growth in health care services, particularly those targeted towards older people, takes into account the growth in demand in these areas, some of which may be quite small, such as the South Metropolitan region.

However such expansion of health care services for older people in high growth areas of the State will need to be balanced against the need to ensure that people living in rural and remote areas of WA also have equitable access to health care. In addition, any models of reform will need to take into account the concerns and needs of other specific groups particularly Aboriginal people, people from non-English speaking backgrounds and people with disabilities.

Another issue is the need to expand existing geriatric services in Western Australia. In particular it will be necessary to expand the existing geriatric workforce and to ensure that there are strategies in place to encourage medical, nursing and other staff to enter and remain in the geriatric care area. Within geriatric medicine itself there is a need to further develop services specific for problems of old age such as incontinence, dementia, Parkinson’s disease, psychogeriatrics and osteoporosis.

**THE CURRENT SYSTEM**

As described in earlier chapters of this Paper, the provision of health and related aged care services for older people is undertaken within the context of the following overarching service streams:

- Primary care
- Public hospital services
- Residential care
- Community care.

On the whole, these services have been embedded in relatively longstanding health programs of both the State and the Commonwealth. As a result the current aged care system in Western Australia has been defined more by its target group (older people), rather than possessing an overall funding and service delivery strategy which would allow the system to function as an integrated whole.

In practical terms the aged care system has been effectively managed for the majority of older people through well-structured programs administered by the Commonwealth and State that have addressed the core service needs of older people (i.e. acute, community, residential and primary care). However, the traditional program-based approach needs to be balanced by processes which ensure older people are comprehensively assessed and their needs appropriately met from available aged care services. These processes need to be supported by strong collaboration between the different providers of health and aged care for older people.

As the demand for health care services increases from the ageing population, the system will be increasingly challenged by funding and budgetary constraints to provide high quality, timely, integrated and affordable health and aged care services to this large and growing target group. The State, Commonwealth, private sector, non-government sector and individuals who fund or deliver health care services for older people, will need to work together to seek better and more cost-effective models of providing health and related aged care services. Such models of reform should be managed on a whole-of-sector basis taking into account and incorporating small, localised initiatives.
IMPLICATIONS FOR SERVICE DELIVERY

To manage the ageing phenomenon effectively, it is important that planning is undertaken to assess the demand for health and related aged care services, and to ensure that these services can be delivered.

It is also important to define which services are particularly required by older people, for, as their number grows, there will be a greater consequential need for care which addresses their specific needs, such as rehabilitation services, sub-acute care, community care and specialist geriatric medical care.

It is also necessary to quantify the volume of services required by the population. It is difficult to project accurately the long-term demand for different types of care, as treatments become available over time which can manage conditions in more effective ways or can reduce the length of time required in hospital. However, it should be possible to calculate with reasonable confidence the short-term demand for health and related aged care services from older people over the next few years based on current trends such as, for example, the likely need for increased sub-acute care, palliative care, community services and/or the location of care closer to where people live.

The infrastructure for health services can be an important factor which determines the limit of services that can be provided, irrespective of the demand. The health system needs to ensure that there is adequate capital and recurrent funding to at least maintain the current levels of service provision including an appropriately trained workforce which expands in line with the growth in the older population in WA.

Finally, any expansion to health care services for older people must be targeted towards areas which are currently under-resourced and areas which are expected to have rapid growth in the number of older people. This means that additional health and related aged care services should be particularly targeted towards rural and remote areas of Western Australia including the South West, and towards the South Metropolitan, Peel, Swan and Wanneroo districts of the Perth metropolitan area.

NEW MODELS OF SERVICE DELIVERY

It could be argued that there is now a need to move beyond a program-based approach to one of service provision which is consumer based, thereby enabling available funding to be associated with individuals in need of care and support, rather than directed to programs and provider systems. This approach would encourage services to develop in response to clients’ needs rather than institutional pressures.

Often the older person’s complex health conditions require a comprehensive assessment and the involvement of more than one service provider. A system is required whereby older people, people with disabilities, their Carers and families participate in one streamlined assessment to access a range of health and related aged care services. The HDWA will look to promote this by continuing to expand current comprehensive assessment processes and encouraging all service providers to be involved. The aim is to ensure equitable provision of services which
meet the full range of the individual’s health and support needs.

Many older people require management of their complex and/or chronic health conditions from different types of service providers. A number of initiatives are beginning to emerge which examine ways in which care, support and other services can be integrated more effectively, such as the model of integrated aged care service delivery which the Health Department of Western Australia is currently introducing in country regional areas as discussed in an earlier section of this Paper.

Another initiative is that of the Commonwealth Government, supported by the State, to integrate general practice services with other health care services by enhancing the participation and involvement of GPs with multidisciplinary case management and coordinated care planning. These initiatives, announced in the 1999/2000 Commonwealth Budget, are expected to assist older people in particular to receive care which is better coordinated with community health care providers.

There is also a need for greater collaboration of general practice with the acute care setting to allow the locus of treatment of low-level acute care for older people to shift from the hospital setting, to the community and the person’s home. To fully develop this, not only does general practice need to become better integrated with community care, but the community care sector needs to be able to support older people to continue living in their own homes during periods of mild illness.

This integration could be within programs which attempt to provide complete medical care to people at home or in the community, and which avoids the need for older people to present themselves to hospital emergency departments for care. As indicated earlier in this Paper, the Health Department is currently developing a model of care in which acute care services can be better integrated with primary health and community care services. This proposed model is expected to reduce the number of hospitalisations of older patients following a minor acute event.

Rehabilitation strategies to assist older people to regain their independence after a period of illness may also be managed effectively in the community. The Health Department of Western Australia has recently approved an initiative to promote the development of a statewide community-based rehabilitation service for older people, the aim of which is to introduce a systematic rehabilitation ethos into government-funded home and community care and post-acute care.

Promotion of a healthy lifestyle, through diet, exercise, protection from the sun, and avoiding alcohol and tobacco, needs to start at an early age to avoid or lessen the impact of disease and disability in later life. However as indicated earlier in this Paper, there are a number of active measures older people can be encouraged to take to reduce the risk of developing conditions common in old age. For example, annual influenza immunisation, cancer screening programs, and reducing the risk of falls are key strategies that will help older people avoid illness or injury which may require treatment in hospital.

To date, however, there have been few health promotion strategies which specifically target older people. More needs to be done to ensure older people recognise
that health promotion strategies are as important in later life as they are in early life and that, for example, a good diet and low to moderate exercise can assist older people with chronic health conditions such as cardiovascular disease improve their state of health.

The success of any new strategies or models for service delivery may well depend in part upon the abilities and availability of Carers to support older people who are frail, disabled or ill. As indicated earlier in this Paper, the growing numbers of older people living on their own and the decreasing numbers of older people with spouses and daughters, may lead to a reduction in the availability of unpaid Carers. This eventuality needs to be incorporated into the planning of health and related aged care service delivery approaches for the future, and growth in service provision in the community care sector will need to be supplemented by continued support for the Carers of older people.

However, while health promotion and community-based strategies are important in helping older people remain living independently in the community, there will continue to be a need for appropriate acute (hospital) care for older people with the concomitant support requirements of infrastructure, capital and recurrent funding. Consideration needs to be given to the actual distribution of acute care beds including the possibility of realigning their location to more closely match the geographic spread and concentrations of the State’s older population.

All these anticipated changes provide the opportunity to analyse the current structure of the health and aged care system and develop new models of service delivery. This needs to be done on a whole-of-sector or cross-jurisdictional basis for, as indicated in earlier sections of this Paper, the appropriate care and management of older people often require the involvement of more than one type of health and aged care service provider. Too often there is a lack of coordination, communication and integration which can have a negative impact on the very people for whom the care and services are intended.

Examples mentioned in earlier sections of this Paper, show that attempts are already being made to overcome these problems and include the primary care initiatives of the Commonwealth Government; the State Government’s inter-agency working party which is currently developing a Carers’ Strategy, the intended outcome of which is to ensure government programs are more oriented towards the needs of Carers; and the State’s SOYFWA Program which is a collaborative program bringing together community groups, government and non-government agencies, health professionals and individuals already working to maintain, restore and promote positive ageing.

**FURTHERING THE DISCUSSION**

The Health Department of Western Australia is looking to further progress this move towards whole-of-sector and cross-jurisdictional cooperation in the planning and provision of a comprehensive range of services which will meet the health and community support needs of the older population of Western Australia.

This Paper aims to provide the foundation for the development of such an approach and has described:
The current form of the health and related aged care systems for older people

Some of the factors which affect quality of life for older people

Factors which directly or indirectly impact on issues of service demand for health and community care services in Western Australia both currently and in the future

Some of the initiatives currently under way or under development.

The provision of health and related aged care services for older West Australians lies in determining their needs, planning for those needs, and then ensuring that there are adequate and appropriate services available to meet them. The Health Department is therefore keen to seek responses and comment from agencies, organisations and individuals interested in the issue of health and related aged care services in Western Australia.

The responses, information and advice will assist the development of a comprehensive, integrated system of health and related aged care services for older West Australians in general, and for specific groups, particularly older Aboriginal people, older people with disabilities and older people from a non-English speaking background.

Please forward your comments to:

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Phone: (08) 9222 2365
Fax: (08) 9222 2192
## ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
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<tr>
<td>ACAT</td>
<td>Aged Care Assessment Team</td>
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<td>ACCB</td>
<td>Aged and Continuing Care Branch</td>
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<td>ADR</td>
<td>Adverse Drug Reaction</td>
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<td>AMWAC</td>
<td>Australian Medical Workforce Advisory Committee</td>
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<td>ASGM</td>
<td>Australian Society of Geriatric Medicine</td>
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<tr>
<td>ATSI</td>
<td>Aboriginal and Torres Strait Islander</td>
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<tr>
<td>CAEP</td>
<td>Community Aids and Equipment Program</td>
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<tr>
<td>CAP</td>
<td>Care Awaiting Placement</td>
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<td>CCP</td>
<td>Community Care Package</td>
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<tr>
<td>DHAC</td>
<td>Commonwealth Department of Health and Aged Care</td>
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<tr>
<td>DSC</td>
<td>Disability Services Commission</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<td>GPD</td>
<td>General Practice Division</td>
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<td>HACC</td>
<td>Home and Community Care</td>
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<td>HDWA</td>
<td>Health Department of Western Australia</td>
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<td>IYOP</td>
<td>International Year of Older Persons</td>
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<td>MBS</td>
<td>Medical Benefits Scheme</td>
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<td>MPS</td>
<td>Multi-Purpose Service</td>
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<td>NESB</td>
<td>Non-English Speaking Background</td>
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<td>NHTP</td>
<td>Nursing Home Type Patient</td>
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<tr>
<td>OAH</td>
<td>Office of Aboriginal Health</td>
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<td>OSI</td>
<td>Office of Seniors Interests</td>
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<tr>
<td>PADP</td>
<td>Program of Aids for Disabled People</td>
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<tr>
<td>SCNA</td>
<td>Silver Chain Nursing Association</td>
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<td>SGNH</td>
<td>State Government Nursing Homes</td>
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<td>SMHWB</td>
<td>Survey of Mental Health and Wellbeing</td>
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<tr>
<td>SOYFWA</td>
<td>Stay on Your Feet WA</td>
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<td>YPINH</td>
<td>Young People in Nursing Homes</td>
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RESOURCES FOR FURTHER INFORMATION

Information and Support
Many of these organisations are listed in the ‘Living in Your Community Age Page’ of the Perth metropolitan White Pages.

HACC Services
The HACC Services Directory 1998 provides full information regarding HACC-funded services, the Agencies that provide them and their location and contact details throughout the whole State. It is available from the Central HACC Unit in the Health Department of Western Australia.

Residential Aged Care Facilities
A ‘Seniors Accommodation Guide’ provides comprehensive information on residential aged care facilities and independent living units/retirement villages in Western Australia. It is available through a number of sources including Aged Care WA, the Office of Seniors Interests, and the Council on the Ageing.

Ageing of People with Longstanding Disabilities
Gething L (1999) We’re growing old too: Quality of life for people with long standing disabilities who are ageing. Community Disability and Ageing Program, University of Sydney.

Useful Internet Sites:
- Aged Care WA http://www.acwa.com.au
- Aged Care Australia http://www.agedcare.org.au
- AdvoCare http://www.iinet.net.au/~advocare
- Aged Care Standards and Accreditation Agency http://www.accreditation.aust.com
- DHAC http://www.health.gov.au
- DSC http://www.dsc.wa.gov.au
- HDWA http://www.health.wa.gov.au
- OSI http://www.osi.wa.gov.au

Most of the above sites have useful links to other sites.
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