House of Representatives
Standing Committee on Ageing

Inquiry into long-term strategies to address the ageing of the Australian population over the next 40 years.

Submission by:
Associate Professor Julie Byles
Director, Hunter Ageing Research
Hunter Medical Research Institute
and
Director, Centre for Clinical Epidemiology and Biostatistics
The University of Newcastle
Phone: 02 49236142
Fax: 02 49236148

Postal Address:
Level 3 DMB
Royal Newcastle Hospital
Newcastle NSW 2300

This submission is in response to the House of Representatives Committee on Ageing inquiry into issues surrounding the projected ageing of the Australian population. This inquiry is necessary and timely, and the tone and scope are appropriate. This submission highlights a number of themes already raised in the background documents available at www.aph.gov.au/house/committee/ageing.

In particular, this submission makes the following points:

- That ageing is a predictable, global and natural demographic phenomenon;
- That healthy ageing and aged care are separate issues, both necessary for the sustainability of an ageing population;
- That within these two differing paradigms and emphases, there is a need for a considerable increase in planning, training, resources and research.
- Also that equity is a key underlying principle and that inequity is an important consideration.

Ageing is a global predictable phenomenon

It has been said that population ageing "is the least debatable phenomenon, surest in progress, easiest to foresee, and most pregnant with consequences" (Sauvy, 1963). More recently, the World Health Organisation has declared ageing as one of the greatest challenges of this century and one that requires urgent action. Ageing is a global phenomenon and life expectancy is rising in virtually all regions of the world (except sub-Saharan Africa) and the fertility rate is falling. The world's population aged 60 years and over will double in

the next 20 years, and the majority of the world's older people will live in developing countries.

While this present inquiry focuses on the implications of Ageing for the Australian population, it cannot ignore the implications of ageing in other countries in our region and in other parts of the world. Unlike Australia where the rate of ageing has been relatively slow, the rate of change in developing countries has been far more rapid. These countries will have far less time to adapt to the demographic transition of population ageing, and often with less resources and infrastructure to cope with the economic and social needs of an ageing population

The global implications of ageing will affect Australia in many ways including economics and trade, foreign policy and aid. One major implication is the concurrent change in the major causes of morbidity and mortality. It is projected that by the year 2020 ageing will be associated with three-quarters of all deaths in developing countries. Moreover, there will be increasing burden of illness and disability due to non-fatal conditions such as dementia, blindness and arthritis.

In Australia, the rate of change is much slower and set against a reasonably well developed economic context. The demographic change of population ageing was first noted in Australia in the 1970's and the transition is expected to extend well into the first half of this century. However, as Dianne Gibson[1] points out, Australia's population projections lag well behind those of some other countries who have already reached the population profile that we expect in 20 years time, and that these countries are still economically and socially viable. Indeed Australia is in a highly interesting position where it can benefit from these international models, while having a high degree of economic and technological development on which to sustain the demographic change to come.

In Australia, population ageing could be considered to be very much a natural consequence of economic development, improved living conditions, improved health care technology and preventive strategies. In addition, one of the major drivers of the demographic transition is a reduced fertility rate that is partly related to the increased status of women and can also be considered to be ecologically desirable in terms of reduced global population.

No attempt to turn the demographic transition around is likely to have great impact in the short to medium term. Even more importantly however, one must really question whether such an attempt is necessary or desirable, or whether what we really need is a change of values and attitudes that is commensurate with our demographic evolution.

1 Gibson D and Gos J. The coming crisis of Australian aged care: fact or fiction. Australasian Journal on Ageing 1999;18(3) (suppl):19-25.

Healthy Ageing

One significant change in attitudes in recent times is the growth of the Healthy Ageing movement. Importantly Healthy Ageing is not a substitute for Aged Care, but rather affects individuals and populations at different points along the life course. In most cases, Aged Care is primarily required for people over the age of 80 years. In contrast, Healthy Ageing is strongly relevant to the current generation of retirees who are aged in their sixties and early seventies. Healthy Ageing represents the beginning of a change in social attitudes. This change recognises that most older people are highly independent and active, have an excellent quality of life, and contribute substantially to the quality of life of others and to the productivity of society as a whole.

The economic and social development that has preceded population ageing in Australia means that each subsequent cohort of older people has more financial, personal and social resources than the previous cohort. This effect is partly due to improved standards of living, greater educational opportunities, health promotion activities and risk reduction, and greater and more interesting leisure opportunities. One of the challenges in economic planning for Australia's future will be to prevent an inversion of this situation, where older people have increasing power (including voting power due to strength of numbers) and wealth at the disadvantage of younger people.

In vernacular terms, the brief message of Healthy Ageing is that ageing is "not all downhill". Most people report a wide range of positive aspects of growing old. Further, research has found that older people deliver substantial benefits to their families and communities.[2] Between one-third to a half of older people are engaged in volunteer work - they commonly provide goods and services to family members including childcare, and much of the care-giving for older people is done by older people. Indeed a woman in her seventies is twice as likely to be caring for someone else than to be cared for herself.[3] It is important to acknowledge that while being very old puts a person at greater risk of frailty and illness, these needs do not equal the entire experience of ageing.

A positive implication of Healthy Ageing with respect to population ageing is the continued productivity of older people. This productivity needs to be valued and encouraged whether it is in the form of paid or unpaid (volunteer) work or informal contribution to families and friends. There is an urgent need to consider the barriers to continued employment for older workers, attitudes and retirement intentions of mid-aged workers, and attitudes and practices of employers. There also needs to be a redesign of work to account for changing needs of older workers, and to accommodate appropriate evolution

[2] Kendig H, Helme R, Teshuva K, Osborne D, Flicker L, Browning C. Health status of older people project: preliminary findings from a survey of the health and lifestyle of older Australians. Melbourne: Victorian Health Foundation, 1996.

3 Byles JE, for the Australian Longitudinal Study on Women's Health. Over the hill and picking up speed: A profile of older women of the Australian Longitudinal Study on Women's Health. Australasian Journal on Ageing 1999;18(3 suppl):55-62.

in worklife rather than terminations and retirement. There is also a need for greater understanding and valuing of post-retirement labour and productivity.

Volunteering is already a mainstay of our present community and could become an increasingly important resource as the population ages. There is a need to consider current financing, accreditation and liability issues as they impact on the quality and quantity of volunteer resources across the community.

All forms of participation, and independence, will need to be facilitated and enhanced by adequate attention to design of communities, housing and technologies.

Ageing, Disease and Disability, and Health Promotion

To expand the reality of Healthy Ageing, there is a great need to consider ways in which to prevent and mitigate against common mental and physical conditions that increase in prevalence with ageing. In the past, health promotion has focussed on those conditions that are the most common causes of death, but with population ageing there is an increasing urgency to consider ways to prevent conditions that are major causes of morbidity. Ideally our efforts should focus on those conditions and situations that contribute more to healthy life than they do to long life. According to an analysis undertaken in the Netherlands[4] conditions where the improvement in healthy life expectancy exceeds the improvement in life expectancy by a factor of 2 include:

- Arthritis
- Back problems, other musculoskeletal conditions
- Eye and ear complaints
- Depression, and other mental illness
- Respiratory conditions
- Injury, including fractures
- Poisoning

This list reflects not only the seriousness of each condition, but also its prevalence. Arthritis, for instance, has a very small risk of functional decline for each individual with the condition. However, because so many individuals are affected the impact at a population level is substantial.[5] Also, as well as the direct effects of pain and stiffness, arthritis has indirect effects by limiting physical activity and thereby increasing the risk of other conditions.

4 Metz D. Can the impact of ageing on health care costs be avoided? J Health Service Res Policy 1999; 4(4): 249-252.
5 Yelin EH,Katz PP. Transitions in health status among community-dwelling elderly people with arthritis. Arthritis and Rheumatism 1990; 33:1205-15.

Health promotion for old age should start at conception and continue until death. This lifecourse approach underpins the very useful three stage approach to promoting healthy old age described by Kaleche.[6] The first stage is to build resources that may affect later capacity including maternal nutrition, and development of vital organs such as brain, muscle, bone and blood vessels during childhood and early adulthood. The second stage occurs in adult life and involves strategies to reduce damage (such as avoiding smoking), to protect against damage (such as anti-oxidants), or to prevent loss through lack of use (such as physical activity). The third stage is in late life and involves minimising the progress of disease and disability, protecting against increased demands or stresses, and compensating for lost capacity. Examples of these approaches to health promotion include secondary prevention of stroke, rehabilitation, exercise and strength training, social support, and correction of deficits in vision and hearing.

Applying this model, many of the health promotion efforts aimed at younger people would be expected to be instrumental in improving the health of these cohorts as they age. There is also evidence that the benefits of healthy behaviours such as physical activity, quitting smoking, good nutrition and vaccination also apply to people at older ages. Quality care for chronic diseases to prevent complications and to compensate for functional impairment is also a pillar in optimising health and quality of life for older people. In providing this care we need to challenge and overcome ageist attitudes in delivery of care and recognise that the average 70 year old seeking treatment, prevention or rehabilitation has around twenty more years of life in which to enjoy the benefits of that intervention.

One limitation to understanding the potential impact of health promotion on the ageing population is the lack of reliable robust disability data. Current disability surveys do not include sufficient numbers of people in the oldest age groups to get precise data on disability levels. Consequently it is impossible to reliably project and plan for future needs, nor to measure trends in disability and gains in terms of prevention.

Another important population dimension to health promotion and illness prevention, however, is the impact of socioeconomic status. Many of the determinants of health are social rather than physiological. The World Health Organisation identifies ten social determinants of health and these include:

- Poor social and economic circumstances;
- Social exclusion and relative deprivation;
- Social and psychological circumstances and stress;
- Early childhood development;
- Stress at work;
- Unemployment and threats to employment;
- Social support and good social relations improve health;
- Drug use (as a response to social breakdown);
- Diet and adequate food supply;

6 Kaleche A, Pandya SM. Chapter 6: Health Promotion and Ageing. In Ratnaike R (Ed). Practical Guide to Geriatric Medicine. Roseville: McGraw Hill, 2002.

- Transport.

There is good evidence that the relationship between health and ageing is strongly affected by social factors reflected in markers such as gender, marital status, education, income, occupation and employment, country of birth and ethnic background, as well as other measures of socio-economic status.[7] People living in areas with a high index of socio-economic disadvantage have higher rates of mortality at all ages for both genders, have more health risks such as smoking, alcohol, physical inactivity and obesity, and report poorer self-rated health.[8] There is some evidence to suggest that these inequalities diminish at older ages.[9] It is also suggested that health service subsidies for older people may reduce differential in access to medical care in later life.[10] However other studies contradict this evidence.[11] Recent analyses of data from the Australian Longitudinal Study of Women's Health suggest that for Australian women, the impact of Socioeconomic status on physical health-related quality of life may attenuate with age, but the impact on emotional health, health service use and mortality persists into older age.[12,13]

Gender differentials in health and ageing have been poorly studied, but are important because of the gender imbalance in the population at older age groups due to women's longer life expectancy. In Britain, research has shown that while there are few differences on self-rated health and long-standing illness, older women have higher rates of functional disability than men. Single older men, however, are more likely to be admitted to residential care than single older women, and married men are more likely to remain living in the community than married women.[14]

Of course another major differential of considerable importance to Australia is the premature death of people in Aboriginal populations. While, this contributor is not sufficiently informed to make detailed comments on this situation and need, I urge the Inquiry to make special consideration and attention to this issue, gathering data from informed and relevant sources.

It is also worth considering that currently in Australia, around 31% of the total population aged over 65 years was born overseas, and 61% of these people

---

7 Gibson D, Benham C and Racic L. Older Australia at a Glance (2nd Ed). Canberra: Australian Institute of Heath and Welfare, 1999.
8 Mathers C. Health differentials among older Australians. Health Monitoring Series No.2. Canberra: AGPS 1999.
9 Beckett M. Converging health inequalities in later life – an artifact of mortality selection. J Health Soc Behav 2000; 4(1):106-119.
10 Young AF, Dobson AJ, Byles JE. Access and equity in the provision of general practitioner services for women in Australia. Aust & New Zealand J Pub Health 2000; 24(5):474-480.
11 Berkman CS, Gurland BJ. The relationship among income, other socioeconomic indicators, and functional level in older persons. J Aging Health 1998;10(1): 81-98.
12 Mishra GD, Ball K, Dobson AJ, Byles JE. Do socioeconomic gradients in women's health widen over time with age? 2002 unpublished manuscript.
13 Mishra GD, Ball K, Dobson AJ, Warner-Smith, P Byles JE. The Measurement of Socio-Economic Status: Investigation of Gender-and Age-Specific Indicators in Australia: National Health Survey '95. Social Indicators Research 2001;56:73-89.
14 Arber S, Cooper H. Gender differences in health in later life: the new paradox. Soc Sci Med 1999; 48: 61-76.

came from non-English speaking backgrounds (NESB). In 2001 over 660,000 people (25% of the older population) were NESB[15] and the usage of particular services, including residential care, can be markedly different for some of these NESB groups.

Aged care

Regardless of all effort and success in healthy ageing it is a reality that there will be an ongoing and increasing need for aged care services. This increasing need provides a challenge to identify new and better ways to deliver and finance the level of aged care required.

Currently there is very little and inadequate data to understand and interpret the needs for aged care. There are no clear overall data to quantify or qualify the health conditions and needs of those people in residential care, with the possible exception of cognitive impairment.[16] Residential care facility providers express a view that people in residential care facilities are relatively disadvantaged in getting access to standard medical care that is more readily available to those living in the community. There has also been very little research that accounts for the views and experiences of the recipients of care; there has been very little research into the desires and expectations of those who will need aged care into the future.

There is also a need for much greater understanding of mechanisms to enhance ageing in place. Some pilot studies and evaluations have taken place, such as the EACH project, but there needs to be a much more intensive, integrated and powerful program of research for policy in this area. This program should include properly conducted robust community trials, not just post hoc evaluations.

There are also issues regarding the development of a more evolved understanding of the rights and responsibilities relating to aged care. How do we empower older people and respect their individuality within an aged care setting, while still maintaining safety, standards and efficiencies? What is the correct balance between individual and institutional responsibilities? How can older people take amore active and informed role in decision-making?

The Myer Foundation recently sponsored and facilitated the development of a "2020 Vision for Aged Care". The full outcome of this project is available at www.myerfoundation.org.au. The major recommendations in relation to the future of Aged Care include:

- Clearer administrative lines between Commonwealth, State and local Governments
- An industry plan to achieve economies of scale and coordination of a diversity of services

15 Gibson D, Benham C and Racic L. Older Australia at a Glance. (2nd Ed). Canberra: Australian Institute of Heath and Welfare, 1999.
16 Julie E Byles, Leon Flicker MB BS, for Sydney Myer Foundation. Population Ageing and Trends in Health and Disease. www.myerfoundation.org.au, 2002.

- The need for a expanded, robust and effective community care to assist the vast majority of older people in need
- Adequate housing that is innovative, accessible and supported by community infrastructure and well designed urban environments
- Adequate funding with significantly greater resources than currently awarded to aged care – with funds to be released from a mixture of private capital and public budgets. It is estimated that by 2020 the cost of providing the current level of services to an expanded aged population will require an additional $4.8 billion per annum on top of the current $7.3 billion annual expenditure.

A major issue is the adequacy of the Aged Care workforce. There is a workforce shortage, lack of training, and poor remuneration. Moreover, those working in the industry are further undervalued in that they subsidise the industry through contribution of additional unpaid time to ensure they can come someway towards providing the care they know is required. Financial projections undervalue this true cost of care.

Importantly, however, projections provided by the Allen Consulting Group and available at www.myerfoundation.org.au indicate that the economic impact of increasing wages for aged care nurses (as one component of the workforce) would have a very small impact on the projected costs and these would be offset by changing the mix of residential and community care.

Economies of scale have to be achieved to enable a properly trained and paid workforce to deliver care efficiently and effectively. One way of achieving these economies is to have larger residential care facilities allowing a critical mass of specialist staff. However, in the past, the large facilities known as "old people's homes" were seen to be "huge, hidden and hideous" and highly undesirable. An alternative way of achieving integration is for facilities to provide care for older people which is independent of whether they are residents of the facility or live in their own homes in the community. What is required are large organisations providing appropriate care across a variety of settings, rather than large institutions providing "homes". This separation of care from hotel and accommodation services has other benefits for aged care financing. These benefits are well articulated in the Myer Foundation's Vision.

Buildings are a fundamental feature and major capital cost of residential care facilities. The long-term nature of this capital investment means that many years of service may be required in order to yield financial return (or break even). It is problematic however, that the demographic demands for services change at a much faster pace meaning that frequently buildings and institutions are not geographically situated in localities with greatest demand. This reality poses a challenge for planning, and for the design of more adaptable, transportable facilities that can change purpose and function in response to changing demographic needs (eg. From high care to low care, residential to day stay).

Aged care also needs to be reoriented to better bridge the gap between acute care and aged care. Many people are admitted to long-term residential care

following acute admission to hospital. There needs to be effective programs for enabling people to rehabilitate and return to their own homes. Transitional Care projects are beginning to shed light on these opportunities and indicate that such approaches can be effective and cost-effective.

Another issue for aged care is in achieving an appropriate balance between formal and informal care that allows for equity between generations and equity within the generation of "older people". Informal carers are a strength of the current aged care system and can provide care that is expressive as well as instrumental. Formal services are required to ensure that the full range of needs are met, to prevent undue burden on carers, and to provide for those who do not have strong social supports.

Aged care need not be simply physical care. The issues that are most likely to make people want to leave their homes are gardening and housework. In a substudy of widows involved in the Australian Longitudinal Study on women's health, gardening, housework and minor repairs rated most highly on their list of needs.[17]

Finally, it is worth remembering that death and dying are an important part of aged care and there is a need to better understand the influence of instruments such as advanced care directives and their role in aged care in general.

Implications for women

The ageing of the population has substantial implications for women of all generations. Older women are affected because they currently live longer than men, and they provide a substantial proportion of formal and informal care. In the Australian Longitudinal Study on Women's Health 10% of women aged 70 to 75 years were providing care for husbands (69% of carers), adult children (15%), and mothers (aged in their 90's) (8%). Of these carers, 9% were caring for two or more people simultaneously, and many of the older people being cared for have multiple conditions and disabilities and highly complex care needs. [18]

The Australian Longitudinal Study on Women's Health has also substantially documented the needs and experiences of widowed women. Being widowed is a natural life transition for women, they live longer than men and tend to be slightly younger on average than their husbands. This transition is associated with significant distress associated with bereavement, but can also be associated with ongoing health, social and financial issues. In terms of health, it appears that the differentials associated with being widowed may be transient, with "recovery" for most women occurring within 12-24 months,

17 Feldman S, Byles JE, Mishra G, Powers J. The health and social needs of recently widowed older women. Australasian Journal of Ageing 2002; 21(1):135-140.
18 Lee C. Family Caregiving: Women Care. In: Women's Health Australia: What do we know; what do we need to know? Progress on the ACSWH 1995-2000. By Women's Health Australia Research Team. C Lee (Ed). Australian Academic Press 2001.

however the financial implications and disadvantages are more enduring.[19] The needs of these widowed women are substantial and broad and have direct implications for planning of community services to underpin aged care. While 81% of the widowed women studied still lived in their own homes, 19% had moved house since being widowed for financial or social reasons. There were prevalent needs for legal services (44%), and home maintenance (55%). Assistance from medical practitioners included understanding (54%), support (32%) and information (20%). Thirty percent said they had received medication to assist their bereavement, and 30% had taken medication to help them sleep or "for their nerves" within the four weeks prior to survey. Most women (85%) felt they had maintained or increased their level of social contact since becoming widowed.[20]

Analysis of qualitative data collected from these women also reflected these needs, and provided a greater breadth of understanding of the women's circumstances and experiences. Women described the importance of health care providers and other community services in assisting them through the transition from married to single life, as well as the need to keep busy and active within their communities.[21]

Middle aged women are affected because of their increasing levels of labour force participation, and changing retirement patterns; as well as their roles in caring for parents and older spouses. Labour force participation by these women is important in two regards. Firstly, increasing workforce participation will be necessary to sustain national productivity against an ageing population. Secondly, there is evidence to support that employed women have better health than non-employed women.[20] Presently, around 70% of women aged 45-50 years are in the paid workforce. It is important to understand the factors that influence these women's continued participation in the work force, the impact on their health, and the impact on the availability of informal care giving over the next 20 years.

Young women are affected because they are the focus of policy aimed at increasing fertility rates. What are the implications for these young women for education and work, and for achieving equal social standing with men? At present, many women in Australia delay child bearing until they have established themselves financially and vocationally, and may have fewer children as a result of this delay. In contrast, other countries where social policies promote a combination of work and parenthood, fertility rates have been maintained at higher levels.[22]

---

19 Byles JE, Feldman S. For Richer, for poorer, in sickness and in health: Older widowed women's health, relationships and financial security. Women and Health 1999; 29 (1):15-30.
20 Feldman S, Byles JE, Mishra G, Powers J. The health and social needs of recently widowed older women in Australia Australasian Journal of Ageing 2002 21(3): 135-140.
21 Feldman S, Byles JE, Beaumont R. 'Is anybody listening?' The experiences of widowhood for older Australian women. Journal of Women & Aging 2000; 12(3-4):155-176.
22 Bryson L, Warner-Smith P. Paid Work and Women's Health. In: Women's Health Australia: What do we know; what do we need to know? Progress on the ACSWH 1995-2000. By Women's Health Australia Research Team. C Lee (Ed). Australian Academic Press 2001.

Analysis of young women's life aspirations shows that the vast majority (92%) of young women do want to have children at some time before the age of 35: 8% want no children, 65% want up to two children, 27% would like three or more children. However before having children, they want to gain educational qualifications, establish themselves in work, and enjoy their independence.[23]

Women are also affected by increasing reliance on private financing of retirement and aged care: women commonly have had less full-time employment, and less superannuation than their male counterparts.

These issues are to receive fuller exploration using data from the Australian Longitudinal Study on Women's Health, which is a large scale longitudinal study of three cohorts of women funded by the Commonwealth Department of Human Services and Health. The results of the exploration of issues related to ageing are due to be reported to the Commonwealth Department of Human Services and Health in March 2003

Research

There is an urgent need for more research to underpin planning and action for the ageing population. Ageing is a complex biological, psychological, and social phenomenon. Research into ageing must necessarily be transdisciplinary, focussing a variety of biological, clinical and social perspectives for greater understanding of issues limiting health in older age and effective means to intervene.

NHMRC Strategic Research Development Committee Working Party on Ageing

The NHMRC Strategic Research Development Committee recognises the need for more focussed research into ageing and has appropriately established a working party to promote research into ageing. However, the terms of reference of this working party may need to be expanded to take a more population-based approach and to give greater emphasis to aged care.

Research into ageing must recognise that ageing occurs across the lifespan, and factors in earlier life influence health well into old age. The current emphasis on genetics, oxidative stress and mitochondrial dysfunction prescribed by the NHMRC Strategic Working Group on Ageing is therefore appropriate, but physical and social environmental influences in early life should also be considered as part of this life course approach. This emphasis on early life however, must not detract from a greater emphasis on maintenance and promotion of health in old age. There is a necessity to apply some focus within the Ageing research agenda to ensure that adequate attention is also given to address those conditions and issues that are

23 Wicks D, and Mishra G. Aspirations: What do young Australian women want? In: Women's Health Australia: What do we know; what do we need to know? Progress on the ACSWH 1995-2000. By Women's Health Australia Research Team. C Lee (Ed). Australian Academic Press 2001.

particular to the health and well-being of older people (especially those that contribute to healthy life expectancy).

There are a number of conditions that are increasingly common in old age, and that dramatically reduce quality of life and opportunity for independence. One of the most outstanding of these is dementia and there is need for further research into prevention and management and care for people with this condition. This emphasis intersects with another NHMRC SRDC priority area "systems of care for chronic disease".

There is also a need to better understand and capitalise on opportunities for health promotion in old age: nutrition, exercise, falls prevention, sensory loss, continence maintenance, social support, psychological well-being etc. The emphases on geriatric nutrition, musculoskeletal health and mental disorder are consistent with this need. However there is inadequate recognition of the importance of hearing and vision in maintaining mental health and general well being. Research into these areas requires the adequate funding of large scale prospective epidemiological studies, as well as sufficiently powered clinical and community trials.

There is a tremendous lack of evidence to underpin clinical decision-making and care in older age. It is not sufficient to extrapolate from research involving younger adults. Research is needed to derive an evidence-base that is particular to older people. The emphasis on geriatric pharmacology is consistent with this need, but the research must be clinical as well as laboratory-based. For example there should be an emphasis on rational use of pharmaceuticals by older people, not just greater understanding of in vivo mechanisms of action.

Likewise the NHMRC SRDC Working Party's emphasis on wound healing targets a problem that is prevalent and problematic in old age, particularly the prevention and treatment of chronic leg ulcers. Again this research needs to be both basic and clinically applied. There is currently no evidence-base to enable decisions about best practice for leg ulcer management or for wound management for older people.

Community Views

During 2000, Hunter Ageing Research (a network of researchers from the University of Newcastle and service providers from across the Hunter Area) sought to determine the community priorities for research and service in ageing in the Hunter area, by surveying a random sample of Hunter households. Participants were asked to rate the importance of researching the various aspects of health for people aged 70 years and over. The survey was sent by mail to addresses randomly selected from the electronic white pages and one adult household member was asked to complete the survey. Mail surveys were returned by 694 people from throughout the Hunter (40% males, 60% females).

Factor analysis of the survey results revealed four meaningful relatively independent factors which described issues people thought were important to research for those aged 70 years and over. These were:

Diseases of Ageing (eg, Stroke, heart disease, prostate/breast/bowel cancer, diabetes, asthma and airways disease)
Symptoms and problems of Ageing (eg, Depression, Hearing Loss, Alcohol Problems, Falls, Sleep Difficulties)
Lifestyle Factors (eg, Healthy eating, keeping active, access to shops and services, home safety, quitting smoking, Social Interaction)
Mental and Social Issues of Ageing (eg, Dementia, Arthritis, Looking after the ill/disabled, Mental Health, Residential Care)

Optimising the Research Workforce for Ageing

It is well recognised that Australia has a small research workforce with which to address many issues in relation to ageing. In response to this need the Commonwealth Department of Health and Ageing has established the Building Ageing Research Capacity (BARC) Expert Forum to assist in mapping out the major themes and areas of critical research endeavour needed to support the broad policy agenda articulated in the National Strategy for an Ageing Australia and other government strategy documents such as the Commonwealth, State and Territory Strategy on Healthy Ageing and the Federal Treasury's Intergenerational Report. This Forum will enable the release of a research strategy document describing Research Priorities for an Ageing Australia which will be designed to facilitate investments in research that are useful for making informed policy decisions regarding of Australia's ageing population.

To meet this research agenda, Australia needs better networking across researchers enabling more powerful collaborations and contributions. Consultation with researchers throughout Australia undertaken for the Review of Healthy Ageing Research in Australia (2000) identified a need for a more strategic approach the development of health and social policy related research on ageing. Probably, the most efficient mechanism to achieve the critical mass of researchers needed, from a geographically dispersed base of expertise, is to establish a fully funded and well-resourced Virtual Centre for Ageing Research. With the right infrastructure, this Centre could help shape and respond to the research agenda, monitor developments in research, focus on under-researched areas of need, and facilitate the dissemination of research findings and the conversion of these findings into policy and action.