5

Healthy ageing

5.1 Healthy ageing is the normal experience of most Australians. As Professor Julie Byles informed the Committee: 'Ageing is not all downhill.'[1]

5.2 Australia rates highly by international health standards. Australians enjoy one of the highest life expectancies in the world, slightly higher than countries such as Canada, Norway and Spain, and well ahead of countries such as the USA, New Zealand and the United Kingdom. Australians also rate highly in terms of healthy life expectancy, or the expected number of years to be lived without reduced functioning due to ill health. Australia's levels of healthy life expectancy are 69.6 years for men (sixth in the world) and 73.3 years for women (third in the world).[2]

5.3 Most older Australians feel positive about their health, rating it as good, very good or excellent. Even though older age is generally associated with increasing levels of disability and illness, only 30% rate their health as fair or poor. Women tend to rate their health more positively then men. These 'self-ratings' of how people feel about their health are regarded as providing a reasonable measure of health status. They seem to reflect the complex nature of 'being healthy' including such factors as '…psychological wellbeing, aspects of health behaviour, social support and self confidence'.[3]

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1 Byles J, sub 103, p 3.

2 Department of Health and Ageing, *Chief Medical Officer's Report 2001-2002*, Canberra, 2003, pp 62, 64, viewed 3/05/2004, < http://www.health.gov.au/pubs/cmo/cmo0102/cmo2002.pdf >.

3 Australian Institute of Health and Welfare (AIHW), *Older Australians at a glance,* Third edition 2002, AIHW cat.no. AGE 25, p28; Bartlett H, transcript 20/05/2003, p 499.

5.4 While Australia's health levels are good, there are certainly areas in which their health could be improved:

> …one disturbing trend is that Australians are getting fatter, which has serious implications for the health of our population. In addition, statistics are now reflecting increasing numbers of tobacco-related deaths in women from lung cancer; youth suicides; deaths from drug overdoses; and higher mortality rates in Aboriginal and Torres Strait Islander people.[4]

5.5 The life expectancy of Indigenous Australians is around 20 years less than non-Indigenous people and mortality rates between two and four times higher. The low levels of health of many Indigenous people are exacerbated by poverty, unemployment, poor housing and education and incarceration.[5]

5.6 Evidence to the Committee shows additional reasons for the lower health levels of Australia's Indigenous population. Indigenous Australians are more likely to live in rural and remote communities than non-Indigenous Australians. Rural and remote communities struggle to maintain an adequate health infrastructure and there are few Indigenous health and allied health practitioners, leading to alienation for some Indigenous people. Indigenous people also have higher incidences of diseases which are largely controlled in the general population, and higher incidences of diseases caused by poor environmental health or poor nutrition.[6]

The top 10 health problems

5.7 Although there have been significant improvements in preventing and managing chronic diseases, their prevalence continues to increase with age so that older people are likely to be living with more than one chronic disease: 12% of people aged 59 years or younger have an impairment compared to 51% of people aged 60 and over. As shown

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4 Department of Health and Ageing, *Chief Medical Officer's Report 2001-2002*, Canberra, 2003, p 62, viewed 5/05/2004, <http://www.health.gov.au/pubs/cmo/cmo0102/cmo2002.pdf >.

5 Department of Health and Ageing, *National strategic framework for Aboriginal and Torres Strait Islander health*, 2003, p 1; Lester R, transcript 7/02/2003, p 47, Lipscombe J, transcript 7/03/2003, p 241; Gregory G, transcript 7/03/2003, pp 237-238.

6 Gregory G, transcript 7/03/2003, p 241; Emerson F, transcript 7/03/2003, pp 206, 208; Lester R, transcript 7/02/2003, p 47; Gooda M, transcript 7/03/2003, pp 203, 210.

in Table 5.1, for people 65 years and over the diseases most likely to affect their ability to lead healthy lives are dementia, adult hearing loss and stroke.

Table 5.1: Top 10 causes of healthy years of life lost due to disability for females and males aged 65 and over, 1996[10]

Disease category	Females	Males	Persons	
	Years of life lost due to disability (*YLD)s*			*Per cent*[a]
Dementia	33, 976	20, 232	54, 208	16.7
Adult-onset hearing loss	10, 871	15, 404	26, 275	8.1
Stroke	10, 160	13, 587	23, 747	7.3
Vision disorders	15, 591	4, 343	19, 934	6.2
Osteoarthritis	11, 942	7, 691	19, 633	6.1
Coronary heart disease	9, 593	9, 734	19, 327	6.0
Parkinson's disease	9, 969	5, 392	15, 360	4.7
Diabetes mellitus[b]	4, 288	5, 541	9, 829	3.0
Benign prostatic hypertrophy	..	9, 690	9, 690	3.0
Chronic Obstructive Pulmonary Disease	3, 698	4, 506	8, 204	2.5
Top 10 Disorders	*110, 088*	*96, 120*	*206, 207*	*63.6*
Total	170, 730	152, 995	323, 725	100.0

a) Per cent refers to percentage of total YLD for persons. b) Includes Type 1 and Type 2 diabetes

Source: AIHW Older Australia at a glance p 32.

5.8 The causes and means of preventing dementia are still unclear. While many acute illnesses may be cured and chronic diseases managed over time, the effects of dementia are irreversible. Alzheimer's Australia suggested that the rate of neuro-degenerative disease is likely to increase over the next forty years to the point where it may become the primary disease of ageing. There are some promising medications that may slow progress of dementia but there are no miracle cures in view.[7] (See further, chapter 8).

5.9 Associate Professor Linda Worrall informed the Committee that loss of hearing is of major concern to older people as it affects their ability to communicate effectively and to participate in their communities. If this loss of hearing occurs in conjunction with a visual impairment,

7 Alzheimer's Australia, *Promoting healthy ageing in Australia*, p 13; Bruen W, transcript 7/02/2003, p 8; Pollard D, transcript 20/05/2003, p 523; Alzheimer's Australia, sub 79, pp 6-7; Woodward M, 'Prevention and cure of dementia', Public Lecture, September 2002 (accessed at http://alzheimers.org.au/content.cmf?infopageid=940).

such as cataracts, then communication becomes progressively more difficult and social isolation more likely.[8]

5.10 The number of people living with disability who reach 70 years or more is increasing. However, increasing age can mean that they are also affected by the diseases common among older people generally, which can further impact on their capacity to manage daily living.[9]

5.11 The extent to which the various behavioural and biomedical risk factors are linked to the common chronic diseases is shown in Table 5.2.

Table 5.2: Relationships between various chronic diseases, conditions and risk factors

Condition	Behavioural				Biomedical		
	Poor diet	Physical inactivity	Tobacco use	Alcohol misuse	Excess weight	High blood pressure	High blood cholesterol
Coronary heart disease	✓	✓	✓	✓	✓	✓	✓
Stroke	✓	✓	✓	✓	✓	✓	✓
Lung cancer			✓				
Colorectal cancer	✓	✓			✓		
Depression		✓	✓	✓	✓		
Diabetes	✓	✓			✓		
Asthma			✓		✓		
Chronic obstructive pulmonary disease			✓				
Chronic renal diseases	✓				✓	✓	
Oral diseases	✓		✓				
Osteoarthritis		✓			✓		
Osteoporosis	✓	✓	✓	✓			

Source: AIHW Chronic diseases and associated risk factors, Canberra, AIHW, 2002

Prevention, not reaction

5.12 While acknowledging the prevalence of chronic disease, the Department of Health and Ageing advised the Committee that such diseases are in many instances preventable:

> Modifiable risk factors such as smoking, alcohol misuse, poor diet, physical inactivity, overweight and obesity and chronic stress have been shown to account for up to a third of the total disease burden in Australia. Hence preventive action that targets a particular risk factor or condition can provide

8 Worrall L, transcript 20/05/2003, p 506.

9 COTA NSW, sub 157, p 2; Disability Information Australia Pty Ltd, sub 8, p 2.

> benefits in terms of prevention of a range of conditions simultaneously.[10]

5.13 The Committee heard that a number of preventive actions can contribute to healthy ageing such as regular physical activity and maintenance of functioning,[11] good nutrition,[12] adequate support for daily living, adequate financial resources,[13] reducing the adverse effects of air pollution,[14] access to appropriate infrastructure,[15] social connectedness,[16] and 'training' for old age.[17] An approach focusing on smoking, nutrition, alcohol, and physical activity (known as SNAP) has produced positive results in increasing health and well being across the Australian population.[18]

5.14 The value of preventing poor health rather than treating it is stressed in evidence to the Committee. Preventing poor health ensures better quality of life and reduces health costs.[19]

5.15 Catholic Health Australia noted that preventative approaches are being adopted internationally:

> 'Healthy ageing' – at the lowest cost while ensuring quality – is becoming an international catch-cry, resulting in public policy campaigns for injury prevention, healthy eating, smoking cessation and physical activity. Multi-faceted approaches to enable healthy ageing include re-orientations within the health care system (emphasising self-help strategies), translation of information into action by creating supportive psycho-social environments, involvement of

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10 Department of Health and Ageing, sub 119, p 24.

11 Australian Physiotherapy Association, sub 118, p 6; Hunter Health, sub 46, p 2; National Private Rehabilitation Group, sub 53, pp 14-15; Lake Macquarie City Council, sub 68, p.2; Lgov NSW, sub 89, p 19; Dunn L, transcript 25/02/2003, p181; Bartlett H, transcript 20/05/2003, p 499; Telford B, transcript 7/02/2003, pp 29-30.

12 CSIRO, sub 35, p 3; Head R, transcript 28/04/2003, pp 361-66; Smith M, transcript 2/02/2004, p 744; Byles J, transcript 24/02/2003, p 160.

13 Central Australian Aboriginal Congress Inc, sub 176, p 7.

14 CSIRO, sub 35, pp 7-8.

15 McCullough T, transcript 31/03/2003, p 339; Worrall L, transcript 20/05/2003, p 502.

16 Australian Institute of Family Studies, sub 115, p 5; Department of Health and Ageing, sub 119, p 14; Waverley Council, sub 73, p 5.

17 Isaacs Health and Aged Care Round Table, sub 105, p 5; Cheah V, transcript 23/02/2004, p 835.

18 O'Donoghue R, transcript 7/02/2003, p 3.

19 Catholic Health Australia, sub 94, p16; Older Women's Network, sub 58, p 3; Council of the Ageing, sub 91, p 20; Hunter Area Health Service, sub 46, p 3.

> seniors at all levels, emphasis on diversity and sustainability and policies that combat age discrimination.[20]

5.16 This evidence indicates that healthy ageing requires not only a pro-active attitude from individuals but also a supportive infrastructure that promotes preventative health measures.

Obesity

5.17 Obesity is a significant risk factor in preventable health problems such as Type II diabetes, cardiovascular diseases, stroke and hypertension. An 'alarming rise' in the prevalence of overweight and obesity across all socio-demographic groups is shown by data from the 1989-90, 1995 and 2001 National Health Surveys with around a 25% increase in just over 10 years. If this trend continues, by 2010 least 60% of adults will be overweight or obese, and this could increase to 65% by 2020.[21] As the surveys are based on self reporting they are likely to under estimate the problem.

5.18 While the tendency to be overweight is inherited, lifestyle factors, in particular nutrition (diet) and the level of daily physical activity, influence the tendency. Ms Maxine Smith, from the Yuendumu Old People's Project, told the Committee of some of the factors contributing to the poor health status (including diabetes) and high mortality rate of Indigenous young people and people in their middle years.

> We see lots of young people buying Coca-cola and iceblocks for breakfast …The cost of food … is very exorbitant in community stores … Things like fruit and fresh vegetables are often beyond what people can afford.[22]

5.19 Some Indigenous communities in remote areas have, or would prefer to have, stores with more healthy food but transport costs can undercut their intentions.

5.20 Apart from the effects on people's health, there are significant economic costs relating to obesity. The Pharmacy Guild of Australia noted that increasing obesity contributes to Pharmaceutical Benefits

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20 Catholic Health Australia, sub 94, p 16.

21 O'Donoghue R, transcript 7/02/2003 p 3; NHMRC, *Acting on Australia's weight: A strategic plan for the prevention of overweight and obesity*, summary report, 1997, p.2; AIHW, *Are all Australians gaining weight?* AIHW Bulletin No 11, 2003. These studies are based on self-reporting. The AIHW considers that the data are likely to under-report prevalence. See also *About overweight and obesity*, viewed 9/05/2004, <http://www.health.gov.au/pubhlth strateg/hlthwt/ obesity.htm#prevalence>.

22 Smith M, transcript 2/02/2004, p 744.

Scheme (PBS) expenditure which is projected by the *Intergenerational Report* to rise from around 0.6% of GDP in 2001-02 to 3.4% by 2041-42 unless there are changes in utilisation rates.[23]

5.21 In the Committee's view, reducing the incidence of obesity is a priority area in supporting healthy ageing. The children, adolescents and young adults of 2004 are the adults and older adults of 2042. They must be encouraged to adopt good nutrition and patterns of physical activity now, to give themselves the best opportunity for healthy ageing in the future.

5.22 The Committee notes that all levels of government have recognised the need for action. A National Obesity Taskforce was established by the Australian Health Ministers' Conference (AHMC) to consider what should be done to tackle obesity, including in the Aboriginal and Torres Strait Islander population.[24]

5.23 The work of the Taskforce resulted in the AHMC agreeing to the need for a long term, whole of government approach. The AHMC stated:

> …families, schools, child care centres, general practitioners, food manufacturers, retailers, sporting groups, urban planners, the media, community health centres, workplaces and many other groups all have a role to play and should be the focus of sustained programs to reduce overweight and obesity and the harm it causes.[25]

5.24 A National Action Agenda for Children and Young People and their Families, *Healthy weight 2008 – Australia's future*, has been developed and the Taskforce is to lead implementation of the strategies it sets out. Cathy Freeman has been named patron and ambassador.[26]

5.25 Although implementation is yet to formally commence, some stakeholder groups (such as the advertising industry) are already making changes within their own responsibilities relating to obesity. AHMC has also requested the Taskforce to undertake further consultation to develop similar action agendas designed for adults and older people. Complementary initiatives include the publication

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23 Department of the Treasury, *Intergenerational Report 2002-03,* Budget Paper No 5, pp 8-9.

24 National Obesity Taskforce, *Aboriginal and Torres Strait Islander Workshop: Outcomes*, September 2003, pp 10-11, viewed 13/05/2004, < http://www.healthyactive.gov.au/docs/ indigenous_obesity.pdf>.

25 Australian Health Ministers' Conference, Joint Communiqué, *Obesity a national epidemic*, 28 November 2003, viewed 7/05/2004, <http://www.health.gov.au/mediarel/yr2003/jointcom/jc002.htm >.

26 The Herald Sun, 5/05/2004.

of *Clinical practice guidelines for the management of overweight and obesity* by the National Health and Medical Research Council.[27]

5.26 The Committee commends the significant attention that is being focussed on the issue of obesity and agrees with Mr Ross O'Donoghue that, in addition to wide stakeholder involvement:

> …we very much have to ask people to take some responsibility as well for taking the initiative to have an influence on their own health.[28]

5.27 The Committee considers that the success of these strategies will depend on their effectiveness in gaining the active support of diverse stakeholders so that there is a multi-faceted and cohesive attack on the problem. Active encouragement and close monitoring of the outcomes will be necessary.

5.28 As the effectiveness of these initiatives will be not be demonstrated for many years, a commitment to longitudinal studies will be necessary. Critical to this will be establishing more reliable baseline data than provided by self reporting. The Committee notes that the National Obesity Taskforce recommended a program of evidence and performance monitoring and that the Australian Government is yet to respond to this recommendation.[29]

Physical activity and falls prevention

5.29 Evidence from local governments and communities also stressed the importance of physical activity and recreation. Input to the community consultations conducted for the Western Subregional Organisation of Councils (WESROC) Regional Seniors' Needs Study suggested a vision for recreation in an age-friendly society, one which has affordable recreation facilities open to everyone to encourage participation as a community, and which also recognises the need for some age-specific facilities and activities (see Box 5.1).[30]

5.30 The Committee recognises the growing importance of exercise and strength programs specifically designed for older people. These help

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27 Australian Health Ministers' Conference, Joint Communique, *Obesity a national epidemic*, 28 November 2003, viewed 12/05/2004, <http://www.health.gov.au/mediarel/yr2003/jointcom/jc002.htm>.

28 O'Donoughue R, transcript 7/02/2003, p 4.

29 *Healthy Weight 2008 – Australia's Future,* The National Agenda for Children and Young People and their Families, p 10, Evidence and performance monitoring, viewed 8/05/2004, <http://www.healthyandactive.health.gov.au/docs/healthy_weight08.pdf>.

30 Western Suburbs Regional Organisation of Councils, *Building Strong Communities through positive ageing*, pp 139-44.

tackle osteoporosis and arthritis through maintaining flexibility and mobility. They also assist in preventing falls which can result in older people being hospitalised, entering aged care or even death. [31]

Box 5.1: Facilities for recreation in an age-friendly community

In my vision of an age-friendly community …

… space and facilities for all ages – recreation within easy access.

- Has easy-access, low-cost social facilities for entertainment, sport, hobbies for all income groups.
- There would be a sports and gym complex with gentle activities for the aged and a swimming pool, spa etc.
- Facilities for a variety of recreational activities ranging from various kinds of sports and hobbies to more passive activities would be available at low cost in local centres, parks and sports grounds.

…

- More participation and occupation in keeping fit and well i.e. programs in hostels, retirement villages and even community gyms.
- Affordable recreational activities. Many people in their own home are receiving pension, so cannot afford club fees etc…[32]

5.31 The Department of Health and Ageing drew the Committee's attention to the National Falls Prevention for Older People Initiative. This initiative aims to increase understanding of the causes and prevention of falls, and to encourage individual, professional and community action to decrease the incidence and costs of falls. Research, information, training and community demonstration projects are funded under the initiative.[33]

5.32 The Committee commends this initiative but considers that sustained investment and effort over time will be necessary before falls prevention is seen not just as a medical issue but also a workplace, housing and community responsibility. Local government authorities, such as the Kingston City Council, already see it as their

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31 Australian Physiotherapy Association, sub 118, p 6; Department of Health and Ageing, sub 119, p 30; Malone D, transcript 31/03/2003, p 322.

32 Western Suburbs Regional Organisation of Councils, *Building Strong Communities through positive ageing*, p 139.

33 Department of Health and Ageing, sub 119, p 30; Moller J, *Projected costs of fall related injury to older persons due to demographic change in* Australia, 2003, p 4; National Falls Prevention for Older People Initiative, viewed 16/05/2004, <http://www.health.gov.au/pubhlth/strateg/ injury/falls/index.htm>.

responsibility to ensure that are no tripping points in their footpaths.'[34]

The role of community Pharmacists

5.33 An important aspect of support for healthy living is the network of community pharmacies throughout Australia.

5.34 Community pharmacists provide a wide range advisory and preventative services including cholesterol testing and early detection and prevention of conditions such as diabetes and asthma. They also advise patients on issues such as effects of medication, and refer them to expert medical attention where necessary.[35]

5.35 Given their close relationship with the community, pharmacists play a significant role in provision of health services in rural and remote regions, facilitating wider delivery of health services.[36] Community pharmacies have been prominent in providing health services in predominantly Indigenous communities such as the Tiwi Islands by utilising methods such as telepharmacy to dispense prescriptions remotely.[37]

5.36 Many older people take multiple medications and may need help to ensure that they use them safely and effectively. Community Pharmacists advise and assist them through programs such as the Quality Care Pharmacy Program and the Home Medicine Review in relation to the National Strategy for Quality Use of Medicines. This includes such practical help as safely disposing of outdated or unrequired medicines, assisting older people to use dose administration aids and to know how to store medicines safely.[38]

5.37 Evidence from the Pharmacy Guild shows that services provided by community pharmacists:

> …lead to improved patient compliance, reduced inappropriate medication use, fewer preventable adverse drug effects and interaction, reduced hospitalisation, reduced

34 McCullough T, transcript 31/03/2003, p 339.

35 Pharmacy Guild of Australia, sub 75, p 10.

36 Pharmacy Guild of Australia, sub 75, p 6; Crockett J, sub 165, p 37.

37 Crockett J, sub 165, p 37.

38 Pharmacy Guild of Australia , sub 75, p 4, attachment 2; Department of Health, The National Strategy for Quality Use of Medicines, Canberra, 2002, 36 p.; Department of Health, Checklist for using medications wisely, viewed 8/08/2004, <http://www.health.gov.au/pbs/general/check_wise.htm>.

GP visitation and a better quality of life for the Australian community.[39]

Nutrition

5.38 For older people, good nutrition is important in relation to both obesity and malnutrition. Evidence to the Committee indicated that 30% to 50% of older people entering hospital are undernourished and that older people's nutrition is under-researched. Malnourishment is also a factor in older people entering residential aged care. Malnourishment may be associated with poor dentition, forgetfulness because of advancing dementia, nausea related to drugs, depression, poor mobility and social isolation.[40]

5.39 The Committee also notes that the role of Aged Care Assessment Teams is to be expanded to include case management. The Committee considers that this means Aged Care Assessment Teams will be well placed to identify people who are at risk of malnutrition and assist them to access practical help.[41]

Summing up

5.40 Ageing healthily requires that individuals take an active role in keeping themselves healthy, but just as importantly, communities and the health care system have a responsibility to provide appropriate infrastructure and encouragement.

5.41 The Committee is concerned that despite the fact that most Australians age healthily, there continue to be high levels of preventable diseases, including what is now an obesity epidemic affecting all age groups.

5.42 The Committee concludes that support by the Australian Health Obesity Taskforce for action agendas involving responsibilities for all stakeholders is a creative and promising approach. As the full

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39 Pharmacy Guild of Australia, sub 75, p 7.

40 Byles J, transcript 25/02/2003, p 160; Head R, transcript 28/04/2003, p 363; Malnutrition and hip fractures, research project being undertaken by Hunter Health, viewed 9/05/2004, <http://www.newcastle.edu.au/faculty/health/nletter/archive/2002_12/p6.pdf>; Whitehead C, 'Malnutrition in elderly people', in Ashford Community Hospital, *Clinical Practice Bulletin,* No 3, viewed 8/05/2004, <http://www.joannabriggs.edu.au/services/ durdin/ashdec98.htm#anchor142909>.

41 Department of the Treasury, Budget Paper No 2, <http://www.aph.gov.au/budget/2004-05/bp2/html/ expense-12.htm>; In Victoria assessment is the responsibility of Aged Care Assessment Services.

effectiveness of these initiatives will not be demonstrated for many years, the Committee concludes that the Australian Health Ministers' Conference should commit to jointly funding research to establish reliable baseline data on obesity and longitudinal studies to track changes over time and the impact on health status.

5.43 The Committee also concludes that the Australian Health Ministers' Conference should direct that the next agenda to be developed by the National Obesity Taskforce should be that for older Australians. Where necessary the Australian Health Ministers' Conference should commission research to fill the gaps in knowledge of nutrition for older people and the medical and social reasons for malnutrition. This research should include specific consideration of older Indigenous people, and older people from culturally and linguistically diverse backgrounds.

5.44 The Committee considers that the success of these strategies will depend on their effectiveness in gaining the active support of diverse stakeholders so that there is a multi-faceted and cohesive attack on the problem. Active encouragement and close monitoring of the outcomes will be necessary.

5.45 As the effectiveness of these initiatives will be not be demonstrated for many years, a commitment to longitudinal studies will be necessary. Critical to this will be establishing more reliable baseline data than provided by self reporting.

Conclusion 7

5.46 **The Committee concludes that the Australian Government fund research to establish reliable baseline data on obesity and longitudinal studies to track changes over time and the impact of changes on health status.**

5.47 For older people, good nutrition is important in relation to both obesity and malnutrition. The Committee is concerned that 30% to 50% of older people entering hospital, are undernourished and that older people's nutrition is under-researched. The Committee concludes with the proposed expansion of their role to include case management, Aged Care Assessment Teams will be well placed to

identify people who are at risk of malnutrition and assist them to access practical help. [42]

Conclusion 8

5.48 **The Committee concludes that the Department of Health and Ageing ensure that the expanded role of Aged Care Assessment Teams in case management include early identification and management of nutritional problems.**

Nutritional problems should be included in the Aged Care Assessment Program National Minimum Data Set and reported against annually.

42 Budget Measures 2004-05, Budget paper no. 2, p 188; In Victoria assessment is the responsibility of Aged Care Assessment Services.