Health Ageing and Elderly Wellbeing

Background

The Australian Medical Students’ Association (AMSA) is the peak representative body of Australia’s medical students. AMSA believes that all communities should have the right to the highest attainable level of health and quality of life. Accordingly, AMSA advocates for a holistic approach to address the biopsychosocial issues impacting the health and wellbeing of the growing ageing population.

The elderly population, aged 65 years and above, is considered by the World Health Organisation (WHO) to be a ‘powerful and transforming demographic force’, and plays a significantly increasing role in shaping healthcare nationally and globally.[1] The proportion of elderly Australians is predicted to increase to 25% by 2042.[2] Contributing factors include declining fertility rates and increased life expectancy associated with developments in medical technology.[3] Given the foreseeable increasing need for geriatric care, it is vital that policy and frameworks be created and reviewed frequently to ensure that the healthcare system can cater for this highly growing population effectively.

Australian Demographics

There is notable diversity in the older Australian population; 36% were born overseas and 25% had a non-English speaking background, with the most common languages spoken including Italian, Greek and various Chinese dialects. Of the Indigenous Australian population, 15% are 50 or older, 4% are 65 or older and less than 1% were older than 85.[2] Currently, there is an approximate 10-year life expectancy gap between Indigenous and non-Indigenous Australians.[4] Diverse sexuality is also prevalent. In 2011, 3% of all same-sex couples were aged 65 and over, though this figure is expected to have increased, as stigma surrounding LGBTIQ issues is reduced.[2] Notably, there is currently no way of identifying these older Australians due to limited relevant epidemiological data being available.

Economic Impact

Despite the growing ageing population, there is insufficient growth in the Australian workforce to accommodate for the increasing need of aged care services.[5] Over 3.5 million elderly Australians are expected to require access to at home or residential aged care services by 2050, and existing infrastructure is inadequate to accommodate the forthcoming influx of elderly Australians.[6,7,8] In 2002, there were 5 working people to support each elderly individual. By 2042, this ratio is predicted to fall to 2.5.[5] As Commonwealth spending on age pensions and aged care related costs continue to increase, there is a need to generate more jobs.[3,5]

Barriers to employment of older Australians seeking occupation include concerns related to workplace injury, adaptability and training. Research suggests that there is little decline in productivity with age, and the quality of work in skilled jobs increases with experience in the workforce. [4,9,10] A shift in community attitudes to value individuals of all ages for their skills and ability is vital, and may be facilitated through education and acknowledgement of existing elderly discrimination.[3,5]

Challenges affecting recruitment in the aged care sector include the regard of such work as being low status, poorly paid and physically and emotionally challenging.[6] Migrants currently make up 32% of the aged care workforce.[11] While linguistic and culturally appropriate support can be beneficial, associated challenges such as language and cultural barriers can
lead to tension between carers and older people.[6] It has been difficult to collect accurate data regarding the skill status of migrant workers due to potential misrepresentation of skillset caused by employment in positions below their skill level.[6]

Accessibility to quality healthcare is a key factor to maintaining a high quality of life. Amongst older Australians, healthcare is primarily delivered via general practitioners (GPs).[12] The medicare benefits schedule (MBS) allows older Australians to undertake comprehensive health assessments. Furthermore, the current MBS allows longer consultations (up to 30 minutes) to set up and review the management plans (Refer to Appendix A).[13,14] Currently, the ongoing MBS rebate freeze creates a disparity between the MBS rebate for GPs and the true cost of providing a service to older Australians.[12,15] The current rebate system does not include many clinically significant items necessary for the care of older Australians such as liaising with other specialist consultants over the phone[12], thus calling for a need to upgrade the existing MBS.

**Burden of disease**

**Overall Disease**

In 2011 the elderly population made up 41% of the overall burden of disease in Australia, of which 63% is attributable to premature loss of years of life. The remaining 37% accounts for the disability presented by living with a condition.[16] Chronic diseases are responsible for most of the disease burden in the Australian elderly population. Cardiovascular disease, cancer, neurological, musculoskeletal and respiratory conditions constituted 71% of the disease burden in the elderly.[3]

**Distribution of Disease Burden**

There is an uneven distribution of disease burden amongst the elderly population:

- Elderly people in remote communities experience a disproportionately high burden of disease. This is likely attributable to poor access to healthcare, increased prevalence of smoking and alcohol consumption and reduced availability of aged care services.[3]
- Indigenous Australians have a shorter life expectancy and tend to experience health complications at a younger age despite numerous health initiatives, which is suggestive of a gap in healthcare that needs to be addressed. Likely causes include disadvantages in access to healthcare, education, income, employment and housing. [3]
- Veterans of war are generally older Australians, as 80% of all DVA pension recipients were over 65 and are prone to experiencing social isolation, mental health issues and substance abuse disorders at a disproportionately high rate.[3]

The ten most significant diseases together account for 51% of disease burden in the elderly (see Appendix B). Some of the non-communicable diseases and their sequelae are chronic in nature, which contributes to significant comorbidity, disability and premature death. Important modifiable risk factors include exercise, diet, smoking, alcohol intake and obesity. Currently only 35% of elderly individuals report adequate exercise, 8% meet dietary guidelines and 7% are current smokers. 72% are obese, a condition especially difficult to treat among the elderly due to associated morbidity with weight loss. [17] Refer to AMSA Non-Communicable Diseases (2018) policy for more detail. Continued mental and social engagement are also important throughout old age. Social integration is correlated with 50% increase in survival. [3]

**Other Conditions**

Prevention of infectious diseases is especially important in elderly populations due to their higher susceptibility and weakened responses to treatment. 84% of infectious disease burden is fatal. [3]

In 2015, 22.7% of elderly people suffered a fall.[16] Falls can result in serious complications including hip fractures, cranial injuries and death. In NSW, there were 3126.1 fall-related hospitalisations (per 100 000) among the elderly from 2016- 2017. [18,19]
Disability is a major barrier to healthy ageing. People with disabilities are vulnerable to social exclusion among other mental health issues. The prevalence of disability in the elderly has decreased slightly – from 52.7% in 2012 to 50.7% in 2015. Nevertheless, as the population ages there is a proportionally higher propensity for developing severe disabilities. Two thirds of Australians with disabilities reported that their need for assistance had not been fully met. Additionally, over a third of primary carers live with a disability themselves (37.8%).

The most common disabilities in the elderly include physical impairment (40%) and sensory and speech difficulties (25%). These statistics further heighten concerns regarding already vulnerable Indigenous communities. In 2014-2015, 14% of Indigenous Australians aged 55 and over stated that they have a profound or severe core activity limitation (requiring supervision most, or all, of the time) - twice as likely compared to non-Indigenous people.

Additionally, abuse is an emerging issue known to be detrimental to the physical and mental health of older Australians. To date, there is little data on the prevalence of elder abuse, which may be attributed to the lack of awareness and research on this issue. Elder abuse can manifest in various forms, such as financial abuse, psychological abuse, physical and sexual abuse or neglect. Some risk factors include cognitive impairment and disability, social isolation, carer stress and traumatic life events. Other factors include misalignment of social and individual values which can perpetuate the onset of elder abuse.

Prevention and Management

With the growing ageing population, there will be a substantial increase in the burden of managing their medical conditions. Efficient management and care of the elderly involves formulating individualised care considering their functional abilities, comorbidities, and weighing the risks and benefits for therapies and interventions in addition to offering support services.

A potential hindrance to effective disease prevention and management is the lack of representation of the elderly population in current research. Older Australians are often excluded from clinical trials, therefore, guidelines extrapolated from appropriate evidence-based studies are scarce. The elderly also tend to have a lesser degree of health literacy, and often lack assertiveness in decision making. As such, a multi-disciplinary, holistic approach to the evaluation and treatment of older patients produces the best health outcomes (refer to Appendix C). With this, a consideration of non-fatal disabilities is also important.

The National Standards for Disability Services are a key framework in support of older Australians with disabilities. These standards apply to all Australian disability service providers and promote a nationally consistent approach for patient-centred service.

Geriatrics Evaluation and Management (GEM) provides a framework for healthcare by providing a multidisciplinary team focused on assessing, managing and negotiating healthcare goals with the patient. GEM strategies have been shown to be effective in slowing down functional decline as well as addressing the individualised needs of patients. It has been implemented in a wide variety of settings and produces greater satisfaction of care.

It is evident that regardless of the nature of the chronic illness, elderly patient care and management ultimately includes a combination of: Mitigating complications from comorbidities and/or disabilities by encouraging positive lifestyle changes; Promoting quality of life, safety and overall wellbeing by addressing any limitations in their activities of daily living and mental health; Providing individual consultation and devising a personalised management plan in aspects including medication, choice of therapy and/or surgical treatment; Discussing the implications of their diagnosis and/or prognosis and assisting them with providing resources, support and information for future decision-making in regards to medical, legal and financial aspects, and; Giving continuing multidisciplinary care from health professionals as well as support from caregivers and family.

Moreover, elderly individuals are susceptible to abuse in healthcare settings. Current prevention and intervention strategies for elder abuse include education, emphasis on
effective listening, counselling and thorough research on effective ways to prevent abuse and empower victims of elder abuse. Education is an effective tool to address age-based and sexist assumptions and attitudes towards the elderly. Counselling services provided by elder abuse helplines also greatly assist in empowering victims through effective listening.[37,38] To date, there is limited evidence on the efficacy of elder abuse prevention, warranting more research into appropriate strategies to prevent this issue.[37-39]

An important aspect of addressing the burden of illness in the elderly population is preventative healthcare. There is limited data on the efficacy of lifestyle intervention for primary prevention of chronic disease, acute illness and injury in the elderly. In contrast, it is well established that preventative measures implemented early in life can decrease the burden of diseases common to the elderly. The adoption of “lifestyle clinics” tailored specifically to the elderly has been postulated as a solution in the prevention of chronic disease by delivering preventative interventions to address the burden of a range of chronic diseases. Implementation in tandem with streamlined referral pathways and services would optimise this system’s efficacy.[40]

Non-lifestyle-related preventative interventions are also effective in curbing the burden of disease. Significant injuries to the elderly population can be mitigated by falls prevention strategies. These have been shown to confer modest benefit in alleviating the burden of falls in the elderly.[41, 42] Exercises such as tai chi, Zumba, and balance classes have led to a 16% reduction in falls and a 57% decrease in fall-related injuries.[43] Furthermore, treatment of visual impairments, withdrawal of certain medications that could prove a risk-factor in a fall, and assessment of cognitive impairments, function most effectively when used in collaboration.[44-46] Other preventative measures to improve the overall health of elderly citizens include park design and effective use of local public commodities. Public and community transport have been emphasised as a pivotal factor to improve the social wellbeing of the elderly and to facilitate connectedness amongst this demographic group.[47]

There is significant evidence for vaccination being the most effective intervention for preventing pneumonia and infective complications of chronic respiratory disease. Current vaccinations exhibit diminished immunogenicity in the elderly population. Future vaccine development should focus on higher antigen dosages, different routes of administration and different adjuvants. Respiratory pathogens commonly affecting the elderly which currently lack a vaccine should also be targeted, such as respiratory syncytial virus (RSV) and various hospital-acquired pathogens.[48]

Long-term care

Long-term care (LTC) services are required by elderly people with reduced functional capacity necessitating support with basic daily activities.[47] LTC may be provided informally as support from family and friends, or formally from health and social services either at home in the community or within institutions outside hospitals.[49,50] In Australia, there is an increasing demand for the delivery of formal aged care services in the community setting, with expected reductions in informal family care.[11] Nevertheless, family caregivers need additional support such as further education, allied healthcare services, assistive devices, and assistance with financial and housing arrangements. [50]

Residential Aged Care and Home Care

Demand for LTC provision in Australia is rising due to the increasing elderly population and associated increase in patients with chronic health conditions.[51] To date, there is insufficient evidence on appropriate alternatives to residential LTC such as day-care or shared accommodation.[52] More information is also required regarding the risk factors for entry and determinants of duration of stay, to assist in planning necessary services.[52] Additionally, there is an increasing proportion of deaths occurring in residential aged care, indicating a need to optimise palliative care in this setting.[53]

The Australian Government provides support for elderly individuals to maintain independent living at home through the Commonwealth Home Support Programme, and the higher level individualised Home Care Packages (HCP).[54] Currently, increasing demand and high waiting times for HCPs indicate a need for more efficient fund allocation to reduce preventable hospitalisations and premature entry into residential aged care. [55]

Polypharmacy
Elderly individuals living in LTC facilities often have multimorbidity, with over 38% of residents taking five or more medications.[56] In elderly people, polypharmacy is associated with hospitalisations due to unintentional poisoning from medication, adverse drug interactions, falls, and functional and cognitive impairment.[56,57] Deprescribing medications as a management method has been associated with reduced mortality rates and referral to acute care, as well as improved health and quality of life.[56] Current barriers to deprescribing include: lack of standardised procedures for GPs regarding communication of the need to deprescribe to patients and their specialist physicians; lack of awareness about evidence, fear of negative consequences to patient health; and lack of detailed medication and prescriber history.[56]

**Position Statement**

AMSA believes that:

1. The health and wellbeing of the growing ageing population is a significant issue that requires urgent attention.
2. Prevention and management of disease in the elderly should be personalised and culturally appropriate.
3. Frequent and comprehensive research of the geriatric population is vital to identify the health issues they face and to cater to their needs.
4. Preventative interventions such as lifestyle modification and vaccination are essential to offsetting the burden of both non-communicable and communicable diseases in the elderly.
5. Management of disease and disability in the elderly requires a multidisciplinary approach including active engagement from the patient, health professionals, family and the wider community.
6. Changing demand for long-term care services requires further research and development of programs to deal with issues related to recruitment of the aged care workforce, polypharmacy in residential aged care institutions and provision of care.

**Policy**

AMSA calls upon:

1. The Australian State, Territory and Federal Governments to:

   **In relation to the economic impact of an ageing population:**
   
   a. Increase the participation of elderly in population in society and the workforce where desired through:
      
      i. Nationwide campaigns to address employer and community attitudes about mature aged people in order to reduce age based discrimination in the work space and community.
      
      ii. Increased use of existing Australian immigration programs to upskill qualified migrants
      
      iii. Development of initiatives to attract and retain migrant care workers.
   
   b. Continually monitor, review and reform existing infrastructure, policy and aged care services accordingly, to accommodate for the increasing numbers of elderly people.
   
   c. Address and rectify the current inadequate MBS rebate by:
      
      i. improving funding models.
      
      ii. addition of necessary and appropriate MBS rebate items to encourage and enable GPs to provide the best healthcare possible to elderly Australians.

   **In relation to prevention and management of diseases:**
   
   d. Grant funding for:
      
      i. The National Health and Medical Research Council (NHMRC) to formulate clinical trials with a focus on elderly models where such studies can be leveraged as a precedent for future treatment and management approaches.
      
      ii. The NHMRC to work towards expanding and optimising the current range of vaccinations in the elderly.
      
      iii. Research into geriatric concerns specific to various minority groups including, but not limited to:
1. Aboriginal and Torres Strait Islanders;
2. Culturally and linguistically diverse populations;
3. Lesbian, gay, bisexual, transgender, intersex and queer groups;
4. Elderly individuals in rural or remote locations;
5. War veterans.

iv. Research into appropriate management methods for obese elderly patients.

v. Research into the efficacy of current intervention and prevention strategies for elder abuse.

vi. Improvement of public transport to promote social connectedness and engagement with health services among the elderly.

e. Expand workforce numbers such as that of Aged Care Assessment Team (ACAT) or the Aged Care Assessment Services (ACAS in Victoria) and other government services for older Australians in aspects such as advanced care planning.

f. Create national frameworks surrounding elder abuse to generate greater awareness of an emerging issue.

In relation to long-term care:

g. Increase skilled staff and financial resource allocation towards the aged care sector.

h. Continue to provide (and where possible improve):
   i. Support services for informal carers in the community;
   ii. The Commonwealth Home Support Programme and Home Care Package subsidies provided to eligible elderly individuals.

i. Improve how aged care work is regarded amongst the population to increase the ability to recruit and retain employees by:
   i. Campaigning and promotion of geriatric care careers.
   ii. Addressing issues such as pay, workload and emotional demands on staff.

j. Establish targets for the provision of new aged care places for the growing population in accordance with the demonstrated needs of different regions and number of elderly.

k. Promote employment in the aged care sector to the younger age group and provide them with opportunities for up-skilling and specialised training.

l. Increase provision of palliative care medical services in the residential aged care setting, in addition to the policy points covered in AMSA End of Life Care (2017) policy.

2. Government Health Departments across Australia to:

In relation to prevention and management:

a. Liaise to develop comprehensive guidelines and establish clinical targets for chronic illness prevention and management in the elderly, and allowing ease of access to relevant resources in addition to the policy points covered in AMSA Non-Communicable Diseases (2018) policy.

b. Increase access to:
   i. Aged care services within rural and remote communities.
   ii. Culturally appropriate aged care for Aboriginal and Torres Strait Islanders.
   iii. Relevant medical information for elderly LGBTQI patients.

c. Implement improved professional training programs in chronic illness care recommended for health professionals in relation to methods and strategies for meeting the needs for an elderly patient’s wellbeing, including raising awareness of drug-drug interactions.

d. Increase awareness through appropriate mass media campaigns targeted to the elderly to receive the annual influenza and pneumococcal vaccines.

e. Incorporate effective, evidence-based falls prevention strategies in geriatric care.

In relation to long-term care:

f. Improve monitoring of the utilisation of residential aged care services through data collection with regards to:
   i. Reasons for entry to the residential aged care service.
ii. Determinants of length of stay.

g. Develop evidence-based strategies for:
   i. Dealing with large amounts of hospitalisation of the elderly.
   ii. Improving provision of palliative care in residential facilities.
   iii. Future provision of evidence-based alternative residential services.

h. Develop interventions to facilitate deprescribing including:
   i. Provision of GPs with access to available evidence and education regarding deprescribing.
   ii. Development of evidence-based guidelines to standardise and assist communication with long-term care facility residents, their families and specialist physicians regarding deprescribing.

3. Medical schools, universities and educational institutions to:
   a. Provide opportunities for medical students to engage with current geriatric research projects.
   b. Increase courses and opportunities for professional development in geriatric medicine.
   c. Develop curriculum objectives relating to social determinants that affect the elderly with regards to the needs of vulnerable subgroups within this population.
   d. Offer placements within geriatric care facilities to allow students to develop an interdisciplinary understanding of this population, challenges and community resources that both the patient and their carers may access.

   In relation to prevention and management of diseases:
   e. Provide education for medical students about the multidisciplinary nature of prevention and management of disease for older patients living with chronic illness and/or comorbidities.
   f. Encourage academics to pursue research into vaccine development and assessing the efficacy of preventative interventions.
   g. Implement comprehensive education about disability in the elderly population – particularly multifactorial management strategies (e.g. Geriatrics Evaluation and Management).

   In relation to long-term care:
   h. Provide evidence-based education and training for medical students and young doctors with regards to:
      i. The risks of polypharmacy in the elderly.
      ii. The importance of reviewing patient medication with ageing.

4. Medical professionals to:
   a. Deliver holistic and multidisciplinary care in cooperation with allied healthcare providers.

   In relation to prevention and management of diseases:
   b. Practise individual consultations and formulate personalised management plans, as well as addressing their mental health as part of integrated patient care.
   c. Provide comprehensive patient education on the usage of medical equipment for treatment and adherence to number and frequency of medications.
   d. Implement individualised treatment goals for patients in aged care homes ensuring that preferred and effective communication tools are utilised.
   e. Promote lifestyle modification to offset the burden of chronic disease that affect the elderly.
   f. Review research relevant to geriatric patients to maintain an understanding of this dynamic population.
   g. Ensure potential clients, carers and the general public are aware of the services accessible via the National Disability Insurance scheme (NDIS) as well as potential developments and changes that may impact upon their service in addition to the policy points covered in AMSA Disability Care and Support (2014) policy.
   h. Utilise fall prevention strategies to optimise clinical outcomes for patients.

   In relation to long-term care:
i. Reduce polypharmacy and review previously prescribed medications to identify those that may have become inappropriate with age.

5. Local communities and health organisations to:

In relation to prevention and management of diseases:

a. Increase social events, activities and programs for older Australians with an inadequate social support network.

b. Optimise parks and recreation spaces in terms of accessibility to promote social connectedness amongst the elderly.

c. Generate further awareness of volunteering opportunities and community initiatives that campaign for better outcomes for disability in the elderly.

6. Health research institutions to:

a. Collect thorough and frequent data relating to the geriatric population, in order to identify gaps in the healthcare provided to older Australians, evaluate the efficacy of initiatives put in place and to cater to their specific needs.

b. Encourage research into:

i. Factors associated with the increasing migrant aged care workforce and any challenges to patient care and health workforce planning due to the increasing demand for workers.

ii. The risk factors for entry into and prolonged stay in residential aged care.

iii. Larger randomised controlled clinical trials further investigating the effectiveness of reducing polypharmacy in relation to patient safety and health outcomes.

iv. Effective protocols to reduce polypharmacy in the community and in residential aged care.

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