CHAPTER 2

WHAT ARE THE PRIORITY ISSUES FOR IMPROVING AUSTRALIA'S HEALTH? (*continued*)

- **groups experiencing health inequities**
- **research and analyse Aboriginal and Torres Strait Islander peoples and ONE other group experiencing health inequities by investigating:**

– the nature and extent of the health inequities

– the sociocultural, socioeconomic and environmental determinants

– the roles of individuals, communities and governments in addressing the health inequities

– the elderly

ACTIVITY 1

The percentage of people aged 65 years and older will increase from 13.6% in 2006 to around 20% in 2026. Generally, older people are living longer and healthier lives than in previous generations. This is reflected by 32% of older Australians who report their health as being good and 36% who report their health as being very good or excellent.

– the nature and extent of the health inequities

Nevertheless, with increasing life expectancy and high prevalence rates for chronic diseases, it follows that the impact of chronic disease will rise with age. For example, diseases such as coronary heart disease, diabetes and some cancers increase significantly in prevalence and as causes of death with advancing age.

Almost 100% of Australians aged above 65 years report having some type of long-term health condition. Elderly Australians report higher levels of psychological distress and disabilities that restrict core daily activities than younger Australians.

In 2005, the most common long-term conditions experienced by elderly Australians included eye sight problems, arthritis, hypertension and deafness.

Accidental falls also represent a major health problem for elderly people. Death rates for accidental falls rise very significantly from 75 years of age upwards.

Dementia affects more elderly females in particular, increases in prevalence with advancing age and contributes more to the burden of disability for the aged than any other cause.

The main causes of death for elderly people were:

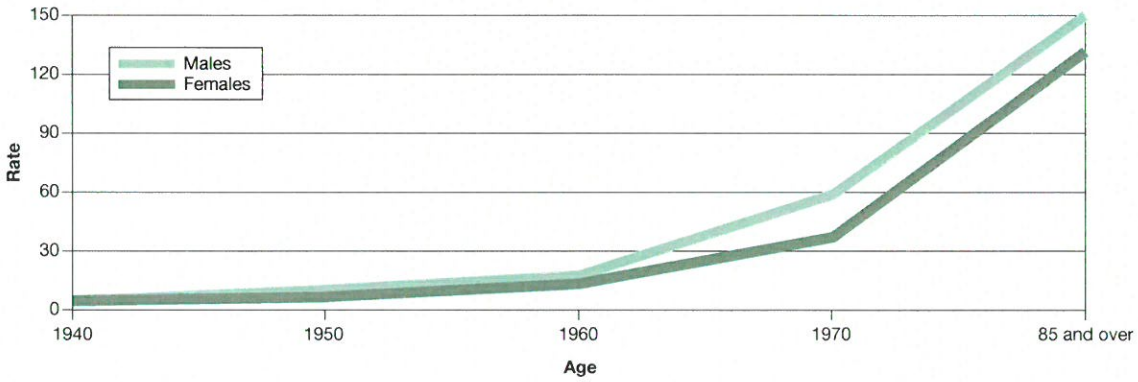
- coronary heart disease
- cerebrovascular disease

24-64 YEARS	%	65-74 YEARS	%	75 YEARS AND OVER	%
Long sightedness	32	Long sightedness	64	Long sightedness	59
Short sightedness	27	Arthritis	49	Arthritis	50
Back pain/problems neck, disc disorders	21	Hypertension	38	Deafness (complete/partial)	42
Hayfever and allergic rhinitis	19	Short sightedness	36	Hypertension	41
Arthritis	17	Deafness (complete/partial)	26	Short sightedness	34

TABLE CD1 ▲
Most common reported conditions, by selected age group, 2005

SOURCE: NATIONAL HEALTH SURVEY, 2004–2005

FIGURE CD1 ▶
Deaths from accidental falls



SOURCE: ABS, CAUSES OF DEATH COLLECTION

- cancers (especially lung, prostate, breast and colorectal)
- chronic pulmonary obstructive disease.

– the sociocultural, socioeconomic and environmental determinants

The cumulative effects of risky health behaviours, such as smoking tobacco, drinking alcohol and patterns of diet and exercise over many years are likely to have an influence on the health of elderly people. Though a lower percentage of elderly people are regular smokers when compared to younger people.

Australians over 65 years of age experience rates of overweight and obesity very similar to those under the age of 65 years. From 65 years onwards, the proportion of people who are overweight or obese declines progressively.

Physical inactivity and sedentary lifestyle also increase with age, contributing to problems associated with body weight or musculoskeletal strength.

Elderly people visit doctors more frequently, are hospitalised more often and take more prescription drugs than their younger counterparts.

Loss of mobility can have a detrimental effect on the quality of life of elderly people. The inability to travel reduces social interaction, ability to access health services and a general sense of freedom and wellbeing.

Social support also affects health significantly. Elderly people with consistent family or professional support report higher levels of psychological health and wellbeing than those with limited or no social support.

– the roles of individuals, communities and governments in addressing the health inequities

Elderly Australians are the fastest growing age group in the population, presenting governments and communities with a significant challenge to provide adequate health services for an increasing number of people aged over 65 years and indeed 85 years old.

Governments

Funding and general policy are the main responsibilities of the Australian Government in addressing the needs of older Australians. Medicare, the Pharmaceutical Benefits Scheme (PBS) and the aged pension are major government programs that contribute significantly to the health of older Australians. Aged care, housing and disability services are also provided.

The federal government is the main source of income support for people with disability and for their carers. These include: the Disability Support Pension, Mobility Allowance, Sickness Allowance, Carer Allowance, Carer Payment, Wife Pension, Disability Pension, and other allowances, all of which are accessed predominantly by older people.

Policies and support programs that improve outcomes relating to dementia, falls, transport and mobility, the welfare of carers and that reduce confusion and improve clarity of information about access to health services are all important government responsibilities.

Communities

The non-government sector has a long history for providing aged care and continues to sustain the majority of residential and community-care services. However, only 6% of Australians aged over 65 years live in non-private dwellings. The remaining 94% live in their own homes and rely greatly on the people and services within their local community.

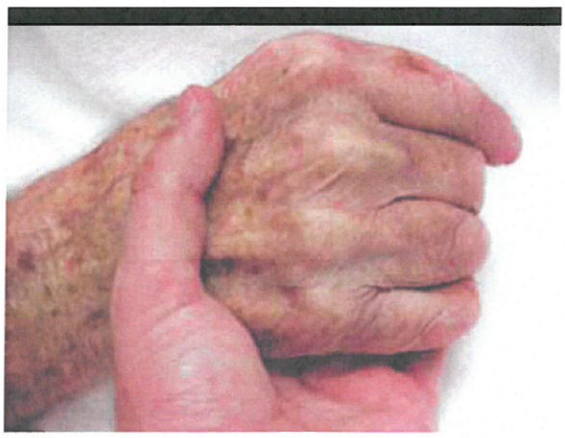
The importance of community in taking responsibility for the health of its older people is best demonstrated by indicators relating to 'social capital' such as:

- having attended a community event at least once in the last six months
- helping out any local group or organisation at least once in the last three months
- being an active member of a local organisation, church or club
- feeling that most people can be trusted
- feeling safe walking down their street after dark
- knowing the area has a reputation for being a safe place
- visiting neighbours
- running into friends and acquaintances when shopping in the local area
- feeling sad to leave the neighbourhood.

The more traditional contribution of communities comes from primary healthcare services provided in the home or in residential care settings by a variety of government and non-government agencies. Care packages can be delivered at 'high level' or 'low level'. Aged Care Assessment Teams (ACATs) determine the eligibility of older people for specific aged care services including:

- Home and Community Care (HACC) Programs: These programs include home nursing services, delivered meals, home help and home maintenance services, transport and shopping assistance, allied health services, home- and centre-based respite care, and advice and assistance.

▼ FIGURE CD2
Helping hands



- The Extended Aged Care at Home (EACH) and EACH Dementia programs: These aim at delivering care at home that is equivalent to high-level residential care.
- Community Aged Care Packages (CACPs): Provide support services to older people with complex needs living at home who would otherwise be eligible for admission to at least 'low-level' residential care.

Most health services for older Australians, including residential and non-residential care, are provided in a local community setting via a partnership between government and non-government agencies. Most community service providers have to comply with the standards of government regulators in order to deliver their services.

Many older people rely on family members and even partners who are old themselves to provide the necessary support to maintain their health status and quality of life. Respite care can be provided to assist in situations where older people or their carers need rest or relief.

ACTIVITIES 2 AND 3

– people with disabilities

A disability is an impairment, limitation or restriction that lasts six months or more and restricts everyday activities. A reported 20% of Australians had a disability in 2003. While many people deal with disability from birth or early in life, disability can result from any number of events throughout life and becomes more prevalent with age.

– the nature and extent of the health inequities

Australians suffer a broad range of disabilities with a subsequent wide variety of health inequities. Over a million Australians require assistance or supervision to carry out core activities like mobility, communication, self-care, schooling or employment.

The most commonly reported disabilities are restrictions to physical activity, chronic pain and difficulty gripping things. Other disabilities include sight and hearing impairments, learning and developmental disabilities and restrictions associated with the effects of chronic illness. People with disabilities:

- experience lower life expectancy than people of similar age without a disability
- are less likely to describe their general health as very good or excellent
- suffer poorer levels of wellbeing, quality of life and participation in society
- are more likely to suffer psychological stress from social isolation
- suffer from accidental falls at a higher rate than people of similar age without a disability.

The level of disadvantage suffered by the disabled increases with the level of disability. Health inequities for Australia's disabled people result from restricted capacity to communicate, access services and support, go where they want to and participate fully in society.

– the sociocultural, socioeconomic and environmental determinants

Disabled people are affected by many of the same determinants that affect the health of others. The magnitude of risk factors is often reduced by the support of family and community to improve their access to services, level of care and participation in society. A higher level of support will have a more protective effect.

Many disabilities restrict capacity to join the workforce, leading to socioeconomic disadvantage, unemployment and poverty. These determinants are common problems that are harmful to the health status of many disabled people.

Physical disabilities reduce mobility and participation levels, increasing the likelihood of overweight, obesity and physical inactivity. With increased exposure to these determinants there is an increased risk of CHD, hypertension, some respiratory conditions and diabetes.

Disabilities that lead to difficulty learning and understanding can have wide ranging effects. The sufferer may struggle to develop the necessary skills and knowledge to protect their own health and may even engage in high-risk behaviours without understanding the cost.

Any disability that limits communication and mobility will reduce the individual's capacity to participate in society. This can lead to social isolation and limit the individual's capacity for self-determination. Exposure to these determinants increases the likelihood of depression and psychological stress.

	NO DISABILITY	DISABILITY	SPECIFIC LIMITATION OR RESTRICTION	PROFOUND /SEVERE CORE ACTIVITY LIMITATION
	%	%	%	%
Self-assessed health status very good/ excellent	75.9	33.8	21.8	13.7
Has a non-school qualification	45.3	36.9	33.9	25.9
Employed (of all aged 18–64 years)	80.4	62.0	48.9	34.4
Middle to high household income[c]	71.0	47.7	39.4	33.2
Can easily get to the places needed	87.7	79.2	69.9	54.1
At least one social activity in past three months	94.6	88.5	85.1	77.7
Feels safe/very safe at home alone after dark	85.9	78.5	73.7	68.2

(a) Aged 18 years and over.
(b) Disability or long-term health condition.
(c) In the top 60% of all persons when ranked according to their equivalised gross household income.

SOURCE: ABS, GENERAL SOCIAL SURVEY, 2002

▲ TABLE CD2
Selected indicators of wellbeing: proportion of population[a] by disability[b] status, 2002

– roles of individuals, communities and governments in addressing the health inequities

In a 2008 discussion paper the NSW Council of Social Service identified a number of barriers that people with disability face to participating fully within the community. These include:

- supported living
- financial security
- participating in society
- support services
- education
- equipment, aids and appliances
- transport
- employment
- communication
- physical community infrastructure
- inadequate healthcare for people with intellectual disability.

The challenge for governments and communities is to provide services that help overcome these barriers in order to improve the health status of the disabled.

Government

In New South Wales, the government department responsible for providing services to the disabled is the Department of Ageing, Disability and Home Care. It describes its main responsibilities as providing:

- accommodation and respite
- community access
- Home Care service of NSW.

www.dadhc.nsw.gov.au/dadhc

In particular the move away from large institutional accommodation to supported community housing has been a major feature of disabled care in recent years. There are also critical programs that provide disabled people with devices, equipment and adaptations to housing, like ramps and handrails, to improve mobility, access and quality of life.

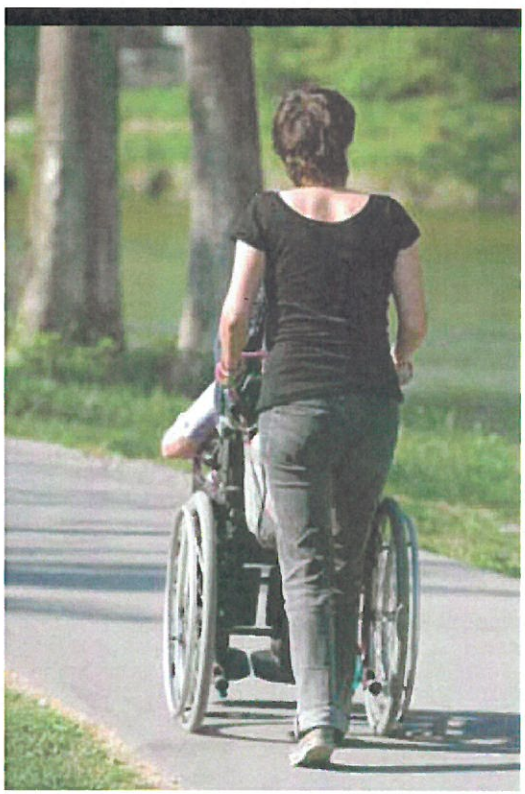
Communities

The Council of Social Service of New South Wales (NCOSS) is the peak body for the social and community services sector in New South Wales. It is a non-government organisation, and its members range from the smallest community-based services to the largest welfare organisations. They include refuges, charities, church groups, local councils, consumer organisations, hospitals, and aged, disability and childcare services. They also include peak support and advocacy groups that represent services at a regional and statewide level.

NCOSS plays a coordination, advocacy, policy development, leadership and information role for the social and community services sector in New South Wales. Many of the member services of NCOSS provide services to the disabled, such as:

- day programs
- transition to work programs
- disability action planning
- behaviour intervention services
- services for families
- attendant care
- community support teams
- post-school programs
- accommodation
- respite.

FIGURE CD3 ▼
Carer with disabled person in wheelchair



www.ncoss.org.au

The Disability Council of NSW is another peak body. It is a hybrid organisation that works in partnership with governments to advocate for the needs and rights of disabled people. Its role is to:

- advise government on disability matters
- raise community awareness about people with disability and their aspirations
- promote participation by people with disability.

www.disabilitycouncil.nsw.gov.au

Individuals

Carers provide invaluable support for people with disabilities. There are many carers employed by government and non-government agencies, but the vast majority of carers are family members who provide support and assistance to children and adults with a disability. Sometimes, the quality of their own lives often deteriorates as a result of their responsibilities.

Carers can receive support from a variety of sources, including family, friends, non-government agencies and government departments. Respite care is one of the most vital services to allow carers time for themselves to rest and recover from their demanding roles. Carers NSW is one organisation devoted to the support and education of carers in our community.