# Caring for older people in Australia

*Principles for nursing practice* | 2ND EDITION

*Edited by* AMANDA JOHNSON *and* ESTHER CHANG

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# Caring for older people in Australia: principles for nursing practice

SECOND EDITION

Edited by

Amanda Johnson

Esther Chang

WILEY

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# ABOUT THE EDITORS

## AMANDA JOHNSON

Associate Professor Amanda Johnson is State Head of School at the School of Nursing, Midwifery & Paramedicine, Australian Catholic University, NSW. She has worked in the tertiary sector since 1992. Dr Johnson's PhD thesis is in undergraduate palliative care education. She has been an active leader in the development of undergraduate curriculum in the areas of aged care, chronic illness and palliation. In 2011, Dr Johnson was the winner of the Vice-Chancellor's Excellence award in Leadership for the IRONE project and in 2010 was Highly Commended in these awards for her teaching of chronic illness and palliation. Dr Johnson's research over the last 12 years has been focused on aged care, dementia and palliation. She is committed to making a difference in the lives of older people through her teaching and research activities.

## ESTHER CHANG

Professor Esther Chang is Director for Higher Research Degree and Course Advisor for the Honours program in the School of Nursing and Midwifery, University of Western Sydney. She has worked in academia since 1986, with three tertiary institutions. She has been a Head of School, Dean of the Faculty of Health, and Acting Pro-Vice-Chancellor (Academic) at the University of Western Sydney, Hawkesbury. Professor Chang is committed to aged, dementia and palliative care; has received many large grants to investigate nursing and health needs in older people; and has developed models of care for acutely ill elderly patients and clients with end-stage dementia. Professor Chang's international links have generated collaborative research into aged care across several countries. This process has influenced her ideas and reflections on the approach that texts need to embrace for effective student learning.

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# PREFACE

Caring for older Australians should be of paramount concern to all in our community. Older people are from many walks of life, and deserve to be cared for in a manner that promotes their wellbeing and preserves their dignity to the end of their life. Nurses and other health professionals are pivotal in ensuring that their needs are met, at a time when they are most vulnerable. Importantly, nurses and other health professionals require knowledge and skills, informed by evidence, to provide care that is appropriate for the older person in their home, community, or acute care setting or residential aged-care facility. This text is developed to provide undergraduate students, students in the TAFE sector, newly registered nurses and other health professionals with contemporary knowledge and skills that enable them to practise effectively and competently across the continuum of care settings. Further, this text recognises that never before has Australia had to face such an ageing population in its history, necessitating that nurses and other health professionals have an increased awareness of the needs of the young-old, middle-old and the old-old specifically.

It was our intent in conceptualising this text that the reader would gain a deeper understanding of the importance of caring for older Australians in a way that would make a difference in their everyday lives. Underpinning our conceptualisation was our commitment to primary healthcare, on many levels, that would act as an overarching stimulus for us to encourage undergraduate nursing students and newly graduated nurses to also practise differently. We also hoped that those caring for older Australians would reflect on their practice, striving for excellence in the delivery of care, inform policy to better reflect the needs of the older person and promote change in how we see older people in practice. We also believe that competent practice is achieved by sound teaching, informed by international and Australian research. This text has been written with this in mind.

*Caring for older people in Australia* brings together contributors who are at the forefront of critical areas relevant to the needs of the older person and nurses who are required to provide contemporary practice. The contributors have constructed their chapters in an engaging manner, highlighting key issues well informed by research that supports evidence-based practice. Further, the way in which the contributors have constructed their chapters with innovative and interactive learning materials enables lecturers to easily provide effective teaching in this area. This ensures a scholarly approach in the delivery of learning materials, and the acquisition of core knowledge and skills by students and graduates capable of practising consistently in Australia and across the continuum of care settings.

We would like to thank those who have contributed to this text. Without their expert knowledge and commitment, this text would not have been possible. Contributors have come from a diverse range of academic and clinical settings and in themselves reflect a diversity which adds strength to this text. In particular, we would like to acknowledge the contributions of the following chapter authors:

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Finally we would also like to dedicate this text to all those undergraduate nursing students, students in the TAFE sector, newly registered nurses and other health professionals who share our commitment to providing quality care to older people. We hope you find this text helpful.

*Amanda Johnson*
*Esther Chang*
*August 2016*

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CHAPTER 1

DEBORAH HATCHER | KATHLEEN DIXON

# Healthy ageing and the older person

## LEARNING OBJECTIVES

After studying this chapter, you should be able to:

**1.1** describe the different perspectives on ageing and discuss the diverse characteristics of older people and how they impact on healthy ageing

**1.2** explain primary healthcare in terms of how its philosophical and strategic approaches support healthy ageing

**1.3** understand the concept of health and healthy ageing and discuss how the social determinants of health influence the health of older people

**1.4** describe how support and services available for older people enhance healthy ageing.

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# Introduction

The aim of this chapter is to develop an understanding of how older people age well and the factors that influence healthy ageing. Whilst the focus of this chapter is on older people living in Australia, we have also included some discussion on older people living in New Zealand. This is not a comprehensive exploration of ageing — rather, this chapter provides an examination of contemporary issues influencing the health of older people. Understanding healthy ageing is important because of the increasing ageing population in Australia and New Zealand. This chapter provides an overview of healthy ageing within a primary healthcare (PHC) context.

The chapter is divided into four sections. First, we discuss knowledge and attitudes about ageing. We then move on to explore how PHC supports healthy ageing. Following this, we look at societal factors that influence healthy ageing and finally we examine the importance of policy and service provision in maintaining and supporting the health of older people. Throughout this chapter, the term 'older person' is used to refer to all individuals over 65 years.

# 1.1 Knowledge and attitudes about ageing

**LEARNING OBJECTIVE 1.1** Describe the different perspectives on ageing and discuss the diverse characteristics of older people and how they impact on healthy ageing.

Our knowledge and attitudes about ageing influence the way we think about, promote and support the health of older people. Historically, ageing was viewed in a negative way, as a time of decline and dependence, and healthcare focused on providing care in residential aged-care settings (Hatcher, 2010). More recently, our ideas have changed to view ageing and the health of older people more positively, with the emphasis on healthy, positive and successful ageing; identification of factors to maximise independence and enhance quality of life (QoL); and the promotion of health of older people living in the community.

To understand how PHC can be implemented as a framework to support the health of older people, this section describes the demographics of the ageing population in Australia, classifications of older people, and the various perspectives on ageing.

## Classifying older people

There is no single agreement over what is meant by an **older person** (Hatcher, 2010). For centuries, old age has been defined chronologically. However, there are shortcomings to this approach — chronological ageing is not an accurate measure of ageing as it does not explain the differences in individual experiences of ageing. Despite these limitations, chronology is still used to define ageing, as it is considered to be a convenient and universally objective measure (Miller & Hunter, 2016).

Internationally, the United Nations (UN) refers to an older person as aged 60 and over. This takes account of the fact that ageing is often accelerated in developing countries in comparison to developed countries (Hatcher, 2010). However, it is common in contemporary Western societies (including Australia and New Zealand) to classify an older person as one who is aged 65 years and over (Australian Institute of Health and Welfare [AIHW], 2012a).

Increased longevity has, however, necessitated the use of subcategories — the most common being *young-old, middle-old, old-old* and *oldest-old*. The literature describes people aged 65–74 years as *young-old*, 75–84 years as *middle-old* and those 85 years and older as *old-old* (Miller & Hunter, 2016). The *oldest-old* are people over the age of 100 years.

Despite the convenience of using categories and classifications, the health and social needs of older individuals and communities differ (Hatcher, 2010). As the current categorisation of older people could extend across 40 years or more for some individuals, it is recognised in classifying older people as aged from 65 years and over that there is great diversity of background, lifestyle, and cultural, religious and social practices (AIHW, 2012a). These differences — particularly those regarding gender and ethnicity — impact on the health of older people.

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The following sections examine characteristics of the ageing population and how older people have been viewed through historical and theoretical perspectives on ageing. These views are important to consider because they influence understanding of the health of older people.

## Characteristics of the ageing population

Demographic studies show that Australians currently have one of the highest life expectancies compared to other countries (AIHW, 2010). The life expectancy for Australians born between 1901 and 1910 was 55 years for men and 59 years for women. Now, the average life expectancy for males has increased by approximately 24.5 years, and by 25 years for females. With these increases in life expectancy, those Australian men born between 2008 and 2010 can now expect to live to 79.5 years, whereas women can reach 84 years. Males and females currently aged 65 years can expect to live a further 18.9 and 21.9 years respectively (AIHW, 2012a).

Population growth is increasing at a much higher rate amongst the older age groups than younger age groups in Australia. This growth pattern is striking; between 1994 and 2014 the proportion of people aged 65 years and over increased from 11.8 per cent to 14.7 per cent, and those aged 85 years and over almost doubled for the same period, from 1.0 per cent of the total population in 1994 to 1.9 per cent in 2014. For people aged 85 and over this represents a staggering 153 per cent increase, compared with the total population growth of 32 per cent for the same 20-year period. In the 12 months to 30 June 2014 there was a 3.6 per cent increase in the number of people aged 65 years and over; this represented an increase of 118 700 people in this age group. For this same period there was a 4.4 per cent increase in the number of people aged 85 years and over, representing an increase of 19 200 people (ABS, 2014).

There is also a significant disparity in gender as the population ages, with twice as many females (291 600) as males (164 900) in the 85 and older age group. This growth in the population of people aged 65 years and over and 85 years and over is experienced across all states and territories, with the largest increases occurring in the Northern Territory. Even more striking is the increase in the population of people aged 100 years and over — over the last two decades this has increased by 263 per cent. In the 12 months to 30 June 2014 there was a 13.8 per cent increase in centenarians, representing 490 people, with four times as many females as males (ABS, 2014).

## Perspectives on ageing

There has been a major change in the way ageing has been represented and researched over time. Past representations encompassed a biological focus and were based on illness and decline, whereas the current emphasis is on healthy, active and positive ageing. At the turn of the twenty-first century, in response to changing societal perspectives, the focus of research, policies and practice shifted from ageing as a time of dependency and provision of residential care, to a PHC model of healthy ageing at home with the provision of services, informal care and community care when required (Hatcher, 2010).

These historical perspectives provide a context for the development of theoretical perspectives of ageing. Accompanying the shift in the way ageing has been viewed historically is the change in theoretical perspectives on ageing, where less importance is placed on biological models, in favour of a more social focus. Theories of ageing concentrate on what happens to people as they age and why it happens. There have been different schools of thought on ageing and each one has had some influence on current understandings of ageing. While some of these theories are no longer generally accepted, they have influenced debate and research about ageing (Hatcher, 2010). Drawing on theoretical knowledge assists in identifying factors contributing to the experience of ageing and the needs of the older person in the context of how they stay healthy.

The major theories applied to ageing are usually grouped according to their discipline. These include biological, psychological, sociological and gerontological theories (Hatcher, 2010). More recently, however, there has been a shift in focus to genetic factors, exploring the influence genes have on ageing and longevity (Miller & Hunter, 2016). Generally, biological perspectives focus on cellular processes and examine the effect of ageing on these processes. In contrast to biological theories, psychological theories focus on changes in human development, cognition, perception and personality. Sociological theories are oriented around the influence individuals and society have on each other, including social roles and

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relationships (Miller & Hunter, 2016). Gerontology — a multidisciplinary perspective — draws on the strengths of the biological, psychological, sociological and (more recently) spiritual perspectives on ageing. The emphasis now is on healthy, positive and successful ageing.

## Healthy, positive and successful ageing

As a consequence of the increase in the ageing population, many older people are living longer but with more complex health needs (Hatcher, 2010). To minimise the negative effects of health issues, **healthy ageing** has become an important focus for ageing populations (Hunter, 2016). Ageing in a healthy way results in benefits for individuals and their communities (O'Connor & Alde, 2011). The promotion of a healthy lifestyle prevents disease and disability, and extends quality of life for older people. In addition, being healthy reduces the demand for services and care from the family and community (AIHW, 2015b).

Generally, healthy ageing is referred to as the way older people actively maintain or restore their health and wellbeing. Wellbeing is related to health but is also influenced by other factors, such as social interaction, socioeconomic status and environment (McMurray & Clendon, 2011).

Health promotion facilitates healthy ageing as it enables older people to have control over the factors that influence their health. Health promotion for the older person is about using health information to make healthy decisions based upon sound health practices.

Healthy ageing can also be described as having a level of health that enables the older person to adapt to the ageing process in a way that best suits their needs. Healthy ageing, therefore, is about maximising independence and wellbeing, and so it encompasses what is required to enable older people to have quality of life and be active and independent.

Another perspective on ageing is known as positive ageing where the focus is on wellbeing rather than illness. This approach encompasses the older person's attitudes to ageing as well as community attitudes and interactions with older people. Furthermore, positive ageing recognises the contributions older people make to society. In terms of positive ageing, it is important to note that the majority of older people to whom this is applied live independently at home and provide assistance to their families and community (O'Connor & Alde, 2011).

In addition to healthy ageing and positive ageing, there is a substantial amount of literature on successful ageing. Much of the interest in this research can be attributed to increased longevity, the changing expectations of older people, and a greater interest in the promotion of healthy ageing. The focus of successful ageing is on maximising wellbeing through the promotion of activity and participation in society.

Each of these three perspectives on ageing can be seen to encompass principles of PHC, where the focus is on health, active participation in maintaining health and encouraging older people to continue to live and participate in their communities. These approaches to ageing highlight the shift in thinking from illness and cure to the promotion and maintenance of healthy ageing.

**CASE STUDY**

### Ageism in the workplace

Professor Jane Ambrose was retrenched from the position she had held for the past twenty years as a researcher with a large multinational company. Recently the company was taken over by an Asian conglomerate, which made it known that they wanted a young and energetic workforce. The company embarked on a major restructure, resulting in a number of positions — including Jane's — being made redundant.

Jane is a healthy 73-year-old woman who keeps fit by walking for an hour each day. She and her partner Sue, who works in hospitality, live in a townhouse in

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an inner-west suburb of Sydney. Jane has no family; however, she has two dogs and is an active member of the gay community. Jane is an enthusiastic member of the local theatre group and enjoys entertaining with friends. She was extremely upset when she was made redundant, as she had no intention of retiring from the workforce, believing she still had a lot to offer, both in terms of her knowledge as a researcher and particularly in regard to her strengths in supporting and mentoring younger researchers. Jane was a reliable employee who was held in high regard by her colleagues. She hardly ever took sick leave and she was always willing to stay back to support a colleague or ensure a job was completed on time. Jane suspects that her redundancy was related to her age. Since being made redundant, Jane has applied for a number of jobs for which she is highly qualified; however, to date, she has had no success in gaining employment.

**QUESTIONS**

1. What are the key limitations of classifying an older person according to their chronological age?
2. Drawing upon the perspectives on ageing, how is Professor Ambrose's current situation likely to impact upon her healthy ageing?

**CRITICAL THINKING**

1. What are some implications of an ageing population for health professionals and the healthcare system?
2. Describe how our attitudes towards older people ageing have changed.

# 1.2 Healthy ageing through primary healthcare (PHC)

**LEARNING OBJECTIVE 1.2** Explain primary healthcare in terms of how its philosophical and strategic approaches support healthy ageing.

**Primary healthcare** (PHC) is both a philosophy and strategy for healthcare provision for older people. Underpinning PHC as a philosophy are the fundamental principles of equity, participation and intersectoral collaboration. These principles provide an organising framework for approaches to health and healthcare delivery for older people. As a strategy, PHC supports approaches to delivery of healthcare services and promotion of healthy ageing.

## History of PHC

During the 1970s there was a growing awareness that previous approaches to health and healthcare provision — especially in the developing world — had failed. It was acknowledged that Western medicine was too expensive and of limited value in many communities. This led to the World Health Organization (WHO) adopting the goal of 'Health for all by the Year 2000' (WHO, 1978), with the intention that all people attain the highest possible level of health to enable them to lead socially and economically productive lives. Subsequently, in 1978 a conference in the former Union of Soviet Socialist Republics resulted in the Declaration of Alma-Ata, the intent of which was to provide a strategy for governments to build sustainable systems of healthcare and to redress inequities in healthcare provision (WHO, 1978). At the conference, PHC was adopted as the strategy to achieve health for all (Keleher & MacDougall, 2016) and was defined as:

> essential health care made universally accessible to families and individuals in the community by means acceptable to them through their full participation and at a cost that the community and country can afford (WHO, 1978, p. 2).

The declaration acknowledged health as a right for all people, and PHC was adopted as a global health strategy to reduce inequities in health. More recently, both the Australian and New Zealand governments

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adopted national PHC strategies. *Building a 21st century primary health care system* is Australia's first national PHC strategy, with a focus on community-based PHC services (Department of Health and Ageing [DoHA], 2010). The four key priority directions for change identified in the Australian national strategy are:

- improvement of access and reduction of inequality
- better management of chronic conditions
- an increased focus on prevention
- improvement of quality, safety, performance and accountability.

*Better, sooner, more convenient health care in the community* is New Zealand's strategy and has as its focus access to health services and preventive health care (Ministry of Health, 2011). The key priority directions identified in the New Zealand national strategy are:

- better services through health professionals working more collaboratively
- less waiting time for access to health care
- more convenient health care provision for the consumer.

PHC is aimed at reducing reliance on medical intervention and enhancing health-creating environments (Keleher, 2012). There are many different meanings and interpretations of PHC; however, fundamentally PHC is both a philosophy and strategy for organising healthcare.

## PHC as a philosophy

To view PHC as a philosophy of care is to see it as a comprehensive approach to health. As a philosophy, PHC changes the emphasis in healthcare from cure (as in the traditional medical model), to addressing factors causing inequities in health. This approach acknowledges there are more than simply physical factors influencing an older person's health — there are also social, economic, environmental and political factors that impact on the health of older people.

Under a comprehensive PHC model, health professionals become a resource for older people, their families and communities because they take account of and endeavour to address these factors to facilitate the best health outcome for older people. This approach sees control over decisions about health remaining with the older person and/or their carer. In other words, health professionals work in partnership with older people and the community to make decisions about their health and healthcare through services such as those supporting prevention, **health promotion** and self-management of chronic illness (Keleher & MacDougall, 2016).

As a philosophy, PHC is underpinned by the following core principles aimed at improving the health of older people:

- participation
- equity
- intersectoral collaboration.

### Participation

According to the WHO (1978), all people should be able to participate individually and collectively in the planning and implementation of their healthcare. **Participation** implies that older people are not simply passive recipients of health information and healthcare; rather, they have the right to actively participate in decisions about their health.

For older people, the goal of community participation is empowerment and the extent to which they are able to participate enhances coping and resilience (McMurray & Clendon, 2015). Social aspects of ageing and aged-care policies — such as housing, income, pension entitlements and access to services — should reflect this, and health professionals have a role in providing support and services which enhance the capacity of older people to participate in their healthcare.

### Equity

**Equity** is an ethical principle where there is a commitment to fairness and social justice. It is not the same as equality. Equity reduces disadvantage through distribution of resources based on need. As

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people age, they are likely to experience inequities in access to healthcare due to age, gender, functional capacity, culture and language, education, socioeconomic status and living environments across urban, regional, rural or remote communities. PHC provides a framework to address inequities through access to support and services.

For example, the 2012 Australian federal government's *Living longer, living better* ten-year aged-care reform package is designed to provide a more flexible system of support to reduce inequities, reduce the fragmentation of services, increase services across a range of areas and better meet the needs of older people (DoHA, 2012a).

### Intersectoral collaboration

**Intersectoral collaboration** occurs when all sectors are working together to improve the health of older people. As an older person's health is influenced by many factors, the reliance on the health sector alone to optimise health is insufficient (WHO, 1978).

Maintenance of health for older people requires cooperation between government and non-government sectors. These sectors include the health, education, transport and housing sectors, and environmental and social services (McMurray & Clendon, 2015). Collaboration between these sectors enables efficient use of resources, helps reduce inequities and enables participation of older people. For example, policies designed to encourage more accessible and age-friendly transport will assist older people to have better access to healthcare and other services.

## PHC as a strategy

PHC is also a strategy used to address the factors influencing an older person's health. Through improving participation, equity and intersectoral collaboration, PHC provides a supportive environment that promotes personal capacity and independence. As a strategy, guided by these principles, PHC provides a framework for health professionals to deliver appropriate support and services for older people.

PHC can be implemented across different health settings, including general practice, acute care, rehabilitation, and in community and residential aged care. For example, PHC for older people in community settings includes support and services in the home — for example, shopping and provision of meals — and in the community, through senior citizen and day care centres.

In healthcare, the term 'primary healthcare' is often used interchangeably with primary care. However, there are distinct differences between PHC and primary care. PHC is a social model of health, and is referred to as comprehensive PHC, whereas primary care is a component of PHC, and is usually termed selective PHC. Primary care is the first point of contact an older person has with the health system, where they receive care relating to their everyday needs (usually this is via their general practitioner (GP)). Primary care focuses on early diagnosis, screening, treatment and chronic disease management, and may include referrals to specialists and diagnostic services such as laboratory tests or X-rays.

Historically, the failure of policy makers and health professionals, in some instances, to understand these differences or to distinguish between them has resulted in a failure of governments to fully adopt PHC as the way forward for healthcare in Australia.

**CRITICAL THINKING**

1. Using a PHC framework, provide examples of how equity impacts upon the health of older people.
2. Describe how older people can actively participate in planning and implementing their healthcare within a PHC framework.
3. Describe the importance of intersectoral collaboration in optimising the health of older people.

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# 1.3 Factors influencing healthy ageing

**LEARNING OBJECTIVE 1.3** Understand the concept of health and healthy ageing and discuss how the social determinants of health influence the health of older people.

Health is an individual and subjective concept. People understand and experience health differently — the way an older person understands health may be different to the way you view it. For example, an active 90-year-old person may consider themselves to be in better health than a 65-year-old person who is overweight and has diabetes. Health, as it relates to older people, can be thought of as a state where an older person can perform activities necessary for daily living.

## Definition of health

WHO defines **health** as a resource for everyday life, which assists people to lead socially and economically productive lives. Health is understood as a positive concept which emphasises social and personal resources as well as physical capacity (WHO, 1986).

Many factors have been identified as influencing health, not the least of which is access to:
- clean water
- good nutrition
- adequate sanitation
- housing
- healthy environmental conditions
- health-related information and education
- income
- participation in health-related decision making.

## Determinants of health

There are many factors or determinants that influence the health of older people. These can broadly be classified as social, economic and environmental. Here, we will concentrate more specifically on those **social determinants of health** that are most relevant to older people — including culture, income, employment and workforce participation, gender, education and social support. Individuals prevent illness and disease and promote their health through their health practices and coping skills. Older people who develop resilience and self-reliance make choices that lead to better health. Decisions about lifestyle choices are influenced by the social determinants of health.

### Culture

Customs and beliefs affect the health of older people. Dominant cultural values can lead to marginalisation, stigmatisation and reduced access to culturally appropriate services for some older people (Keleher & MacDougall, 2011). This section will focus on two important groups in society: older people from culturally and linguistically diverse backgrounds and Indigenous older people.

Many older people in Australia are migrants from non–English-speaking backgrounds. In 2011, 36 per cent of people aged 65 years and over in Australia were born overseas (AIHW, 2014b). It is believed as a result of post–World War II immigration, the number of culturally and linguistically diverse (CALD) older people will increase (ABS, 2014). Furthermore, it is recognised that the different migrant groups of older people will turn 65 in the same order that they migrated to Australia. As the profiles of these groups change, they will have different health and social service needs.

The older population in New Zealand is largely comprised of New Zealand Europeans; however, there is increasing ethnic diversity with growing Asian, Maori and Pacific populations. It is anticipated that in the next 10 years there will be a significant increase in those aged 65 and over, with a 50 per cent growth expected in the population of New Zealand Europeans, 115 per cent in Maori, 203 per cent in Asian people and 110 per cent in Pacific peoples (Office for Senior Citizens, 2015).

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Language, communication, education and the location of migrant communities affect the health and social needs of CALD older people, particularly when accessing services. Difficulty with communication, cultural differences and attitudes to ageing (especially in terms of support from services) can lead to social isolation and impact on the ability of the older person to stay healthy. As the needs of older people from a CALD background may be more varied, healthcare policies and services need to be flexible in order to support them. Issues arising from language barriers and cultural expectations also relate to care and family support, and can impact upon the care and assistance provided to older people from a CALD background.

Despite the fact older people from CALD backgrounds have lower mortality rates and higher self-reported levels of disability, they are less likely to move to residential care, and are more likely to remain living at home with a higher use of community services (AIHW, 2014b). This suggests support and services need to be culturally sensitive to prevent isolation and enable the older person to optimise their health. It is thought older people from a CALD background in future will be concentrated in cities as they tend to age in place near family (ABS, 2012b). In this way, close proximity to family provides support for older people's health.

Whilst recognising that there is no single culture for Indigenous older people, culture is a significant determinant of health. It is important to note that only some Aboriginal and Torres Strait Islanders live to 65 years. Indigenous Australians have a lower life expectancy — living 9.5–10.6 years less than non–Indigenous Australians — and they have a younger population profile than the nation as a whole (AIHW, 2015a). Only 4 per cent of Aboriginal and Torres Strait Islanders were aged 65 or over in 2010–2012 (Wall et al., 2013), and life expectancy was 69 years for males and 73 years for females (AIHW, 2015a). Therefore, the current marker of 65 years and over, used to classify older people in Australia, is not appropriate for Indigenous Australians. Indigenous Australians are defined as an older person at age 50 years or over (O'Connor & Alde, 2011).

Indigenous communities are disadvantaged across a wide range of socioeconomic indicators, which accounts for their poorer health status (AIHW, 2015b). There is a higher incidence of chronic illness and higher rates of hospital admission compared with non-Indigenous people. Poverty and other social and economic circumstances — such as poor housing, low levels of education and employment, inadequate nutrition and substance misuse — underlie the health issues of cardiovascular and respiratory disease, cancer, diabetes and renal failure (AIHW, 2010).

There is great cultural and linguistic diversity amongst older Indigenous people. In terms of service provision and support, there are some culturally specific services available, including housing for older Indigenous Australians, Home Care Packages, Aboriginal health workers and traditional healers. In Australia and New Zealand there is recognition of the need for increased provision of culturally appropriate services (DoHA, 2012a; Office for Senior Citizens, 2015). For Indigenous Australians, in acknowledgement of their poorer health and lower life expectancy, it is recommended these services be available at age 50, as distinct to age 65 for non–Aboriginal Australians. The aim of these services is to enable older Indigenous Australians to participate in their community (AIHW, 2015b; Wall et al., 2013).

## Income

Health is associated with economic and social conditions and these appear to be key determinants of health (Keleher & MacDougall, 2016). Older people who have low incomes generally have poorer health and higher levels of disability and chronic illness. Older people with low incomes often postpone obtaining medical assistance and use less preventive and after-care services. At the same time, they have poorer nutrition and housing, and higher rates of hospitalisation. Income, therefore, has implications for the health of older people — in particular, the ability to afford food, healthcare, adequate housing and other services.

Income influences the capacity of older people to purchase services and have supportive accommodation. The income levels of older people vary greatly. For some people, income inequalities increase as they age. In particular, women acquire less wealth and retirement provision through their working lives, and therefore have less as they age (Hatcher, 2010).

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The Age Pension and home ownership provide a minimum standard of wellbeing for older people in Australia and New Zealand. Currently, in Australia the major source of income for people over 65 years is the government pension. According to the AIHW (2012a), 78 per cent of people over 65 years received the Age Pension. However, a shift in social policy has seen a promotion of individual responsibility and the push for superannuation (Hatcher, 2010). New Zealanders aged 65 years and over are entitled to government pension known as New Zealand superannuation (Office for Senior Citizens, 2013).

### Employment and workforce participation

Employment and health are related. Paid work provides income, gives identity and provides a social network. Lower life expectancy is linked to unemployment and poorer health. Unemployment and stressful or high-risk/unsafe workplaces or conditions are linked to poorer health (Keleher & MacDougall, 2016).

Changes in workforce patterns affect older people. In the general population, over the past 50 years, the workforce participation rate for males has decreased, whereas women's participation has increased (ABS, 2012a). Other trends include an increase in part-time work and early retirement.

Older people are encouraged to remain in the workforce longer and there has been an increase in the number of those over 65 years staying in the workforce. In 2014, in Australia, the percentage of employed people aged 65 years and over was 12.6. These rates have increased by more than 5 per cent in the last decade (AIHW, 2015b). In New Zealand, 22 per cent of people aged 65 and over are in paid work and this figure is projected to grow to 30 per cent by 2036 (Office for Senior Citizens, 2015). Retirement has a significant impact on the ageing experience — currently there is no compulsory retirement age in Australia or New Zealand, so the transition to retirement is a more gradual process (Office for Senior Citizens, 2015).

Many older people undertake unpaid work — including volunteer and voluntary work, caring for grandchildren and other older people, (the majority caring for a partner at home) (AIHW, 2015b). While this unpaid work contributes to the economy, unfortunately it is only valued to a small extent.

### Gender

Gender has particular significance for ageing as the majority of older people are women. This results in an even greater number of women aged over 85 years (AIHW, 2015b; Statistics New Zealand, 2015). The implication for women is that there are a greater number of older women living alone with less financial security and support. Furthermore, as more women are living longer, women become the major recipients of aged care.

It is predicted that the number of older men will increase in the future. This is largely because life expectancy for men in Australia is increasing faster than women (AIHW, 2012a), possibly because of increased awareness of health issues. Consequently, the impact of an increased number of older men will need to be understood in terms of the provision of health and social services.

### Education

Low literacy levels are linked to low levels of education and poor health (Keleher & MacDougall, 2016). Childhood education and lifelong learning contribute to the health of older people as education gives people knowledge and skills and more opportunities for employment and income. It also enables greater access to information on keeping healthy. Older people with low levels of literacy are more likely to have poorer health and lower life expectancy. Therefore, current interest is focused on the health literacy needs of older people.

### Social support

Socialising is highly valued by many older people. Having a social network prevents isolation and gives older people somewhere to go, to engage in activities and spend time in the company of others. By giving them resources to draw on, it enhances health and assists older people to age successfully.

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**CASE STUDY**

### Struggling to manage alone

Lucia is an 85-year-old migrant woman who lives on her own. She has been depressed since her husband died three years ago. Her house is old and somewhat neglected, and it is extremely cold in winter. There is no heating because Lucia feels she cannot afford the cost of electricity. Each fortnight, after she receives her Age Pension, Lucia carefully allocates money for her expenses. Lucia is physically frail; at times, she becomes unsteady on her feet and consequently has experienced a number of falls. She appears to have no other health issues except for hypertension, which is controlled by medication.

Lucia's doctor is concerned that she appears sleepy, morose, withdrawn and lacking in emotional expression despite the antidepressants and sleeping pills she has been prescribed. Although she considers herself to be a 'good cook', Lucia cannot be bothered to cook a meal for herself every day. She has one daughter who is married and living in another state; she lives too far away to provide support for Lucia.

Lucia has a very strong faith and attends her place of worship regularly. However, she has no friends in her religious community as she thinks they gossip too much. She does not feel part of her community and considers herself to be an 'outsider'. In short, she is socially isolated. Recently, Lucia has been talking about moving into an independent living aged care facility, as she feels lonely and is not coping on her own. She stated 'my only disease is my loneliness'.

**QUESTIONS**

1. Using the definition of health, identify and discuss the factors impacting on Lucia's health status.
2. Drawing upon your reading of the determinants of health, do you consider Lucia to be healthy? Explain the rationale behind your answer.

**CRITICAL THINKING**

1. How do the social determinants of health as they apply to healthy ageing relate to PHC?

## 1.4 Maintaining health for older people through policy and service provision

**LEARNING OBJECTIVE 1.4** Describe how support and services available for older people enhance healthy ageing.

Increasingly, policies in Australia and New Zealand based on economic and social implications of an ageing population are directed towards assisting older people to remain healthy and continue to live at home. These policies turn the focus to the community setting where there is heavy reliance on informal support by family, friends or neighbours, and the older person is seen in the context of their family and community.

As people age, there is a need for more targeted approaches to supporting optimal health. Supporting older people to age well requires the implementation of a PHC approach across all sectors of the community. In Australia and New Zealand services and support are delivered through a selective PHC

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or primary care framework in all settings. The *Living longer, living better* aged-care reform package (DoSS, 2016) in Australia and the *Better, sooner, more convenient health care in the community* strategy (Ministry of Health, 2011) in New Zealand move closer to a comprehensive PHC model. These strategies attempt to address the needs of older people by including the principles of participation, equity and intersectoral collaboration.

## Health, disability and chronic illness

Increasing life expectancy has impacted on levels of health and disability in older people. Generally, older people view their health positively and, despite many older people experiencing a chronic illness, most report they are content with their level of health (AIHW, 2015b).

Chronic health conditions, however, can limit personal satisfaction and social participation. If older people are healthy, there are benefits for individuals and society. Older people with good health have less chronic illness and disability, better quality of life, remain independent and require less health service support (AIHW, 2015b). As people age, they experience increased frailty and functional decline (Statistics New Zealand, 2013). The risk of co-morbidities, both disease and disability, also increases (AIHW, 2015b). There is very little difference between the rates of disability among males and females, although rates are higher in females (AIHW, 2014b). Disability here is defined as impairment in functioning, limitation in activities and restriction in participation in major areas of life (AIHW, 2014a).

With increasing life expectancy, there is evidence that the additional years of life are not likely to be disability free. However, there is a view that morbidity will be condensed into fewer years at the end of life. Australian data shows the rate of disability increases with age, with nine in ten people aged 90 years and over having a disability (ABS, 2012c). In New Zealand a disproportionate rate of disability is experienced in people aged 65 and over; with 59 per cent of older people experiencing disability compared with 21 per cent of adults under 65. Maori and Pacific people are the older adults most likely to experience disability (Office for Senior Citizens, 2015). A particular concern is the increase in dementia prevalence, with a projected increase to approximately 1.13 million sufferers by 2050 (Warburton & Savy, 2012). Between 2011and 2013, the main causes of death for older people in Australia were coronary heart disease, dementia and Alzheimer’s disease, cerebrovascular disease, lung cancer and chronic obstructive pulmonary disease (AIHW, 2015c).

As the general population of Australia and New Zealand is ageing, it is important to recognise that the older population is ageing concurrently, which presents challenges for maintaining health. It is believed that an increase in the number of people aged over 85 years will have significant economic and health service impacts (AIHW, 2015b). This category of older people is the group most likely to experience dementia (O’Connor & Alde, 2011; Office for Senior Citizens, 2013), with one in four people over the age of 85 already diagnosed with dementia. This is a major challenge for Australia and New Zealand’s healthcare systems as these people will require additional support to sustain their health (AIHW, 2015b; Office for Senior Citizens, 2013). Overall, the need for support and services for older people is greatest in the last few years of life.

## Community settings

Maintaining the health of older people is a cost-effective measure for older people, services and governments. To achieve this, the majority of older people receive support informally from their family, friends and neighbours. Most older people live independently and can continue to do so if they know how to access services and can access them when needed. To complement informal support, the community care system provides additional support and services for older people (Productivity Commission, 2011).

The aims of community care include:

- early detection of health problems
- prevention and self-management
- delayed entry into residential care.

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However, older people are major users of health services and the demand for services currently exceeds capacity. Given that the population is ageing at an increased rate, it is anticipated demand for health and social services will also continue to increase (AIHW, 2015b). The Australian government, through the Department of Health and Ageing, and the New Zealand government, through the Ministry of Health, fund and provide health services and aged care (Hatcher & Dixon, 2016). Within the community setting, the first point of contact for older people to access health services is usually their GP. If it is identified that there is a need for more support and service provision, the **Aged Care Assessment Program (ACAP)** is the avenue for access to services and programs for community care. Older people who require a higher level of care and service provision may be referred to an acute care setting or a residential care setting.

## Role of the general practitioner

Many older people in Australia receive healthcare from their GP, as general practice is the entry and navigation point of the health system for most Australians (AIHW, 2012a). General practice is funded nationally and Australians have access to GPs through the Commonwealth Medicare Benefits Scheme (MBS) (AIHW, 2012a). The use of GP services increases with age and the most common reasons for appointments with GPs are to get prescriptions, test results or to have a check-up (AIHW, 2012a).

General practitioners are now responsible for the implementation of management programs for chronic disease, and education for self-management of chronic conditions such as diabetes and cardiovascular disease. As the incidence of chronic disease increases with the ageing population and there is a requirement for more support and services (AIHW, 2015b), the role of the GP in assisting the older person to stay healthy will continue to be very important. Currently, GPs in Australia are responsible for referral to secondary and tertiary health services. This includes referral of older people to the ACAP.

## Aged Care Assessment Program

The increasing numbers of older people living in the community has led to many requiring assistance to maintain their health. In 1987 under the ACAP, multidisciplinary Aged Care Assessment Teams (ACAT) were developed to assess and advise on the provision of services and the requirement for health and social support (Hatcher, 2010). These teams assess carer stress, social support, the ability for self-care, and determine the amount of care required as well as needs relating to equipment and home modification. Prior to the introduction of this program, GPs were responsible for the assessment of older people and determination of the services or care required.

Besides organising support and care at home, multidisciplinary teams made up of health professionals also determine whether relocation to residential care is required. The ACAP has assisted in keeping older people out of residential care and supporting them at home with the provision of home and community care (Warburton & Savy, 2012).

However, it is important to recognise that although multidisciplinary healthcare teams have been successful in reducing residential care placement, there is inconsistency in referral patterns amongst ACAT teams (DoHA, 2012a). Inconsistencies lead to differences in the amount and type of community care received by older people at home, and these impact on their ability to remain living at home. A PHC model may provide more holistic assessments, better communication and continuity of care across different settings.

## Community care

The Home and Community Care (HACC) program, implemented in 1985 and funded by the Commonwealth, provides a range of assistance to older people living in the community (Productivity Commission, 2011). HACC is the main provider of community care in Australia. Some of their services include home help, personal care, 'meals on wheels' and centre-based meals, shopping, respite care, home maintenance and modification, transport and community nursing (DoHA, 2012b).

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A component of community care, day care centres provide care during weekdays. Services that might be provided at day care centres include physiotherapy, occupational therapy, podiatry, diversional therapy, social work and nursing services. Day care centres also provide a meal and an opportunity for older people to socialise.

The current system of low-level and high-level community care is currently undergoing major changes and is being replaced with Home Care Packages. Since 1992, Community Aged Care Packages (CACPs) have been available for older people with complex care needs so they can remain at home (AIHW, 2015b). Within this package is the provision of 2–6 hours of care per week, including personal care, cleaning, cooking and shopping. High-level care packages, known as Extended Aged Care at Home (EACH) packages, assist older people requiring greater support to stay living at home (AIHW, 2015b). These packages are for older people who need 8–22 hours of care per week. High-level care packages became available for older people with dementia; these are known as Extended Aged Care at Home Dementia (EACHD) packages (AIHW, 2015b). Home Care Packages will provide a level of support from basic to high care.

As the preference of most older people is to stay living at home with support, it is therefore not surprising that the demand for services in the community has continued to increase.

## Acute care setting

Older people are major consumers of hospital-based care and the average length of a hospital stay is 7–8 days. In Australia in 2010–2011, 38 per cent of all hospital admissions were over 65 years of age (AIHW, 2012b). Longer hospital stays are related to complex physical, functional, cognitive and psychosocial problems and this highlights the importance of self-management of conditions by the older person, the prevention of ill health and the promotion of good health.

An effective interface between acute care and the community is essential for the optimisation of health in older people. In the event of an older person requiring acute hospital care, the transition from hospital back to home is one that is managed currently through the liaison nurse or case manager to ensure a level of functional capacity and a reduction of risk of readmission to the acute care setting.

## Residential care setting

Older people assessed by the ACAP as unable to continue to live at home are admitted to residential care. The use of residential care increases with age and is higher for women (Productivity Commission, 2011). Currently, only 6 per cent of older people in Australia and in New Zealand live in residential care (Miller & Hunter, 2016). They have a high-level dependency. In Australia and New Zealand residential care settings include dementia-specific sections, some secured for those requiring greater dementia care. Generally, older people try to avoid relocation to a residential care facility and prefer to remain at home with high levels of support (Hatcher, 2010).

It is essential for residential care to provide an environment that is homelike. There has been a shift away from the hospital environment appearance to an environment that mimics a home setting. As the residential care facility becomes an older person's home, it needs to be an environment that is safe and supportive, matches the needs of the resident and ensures opportunities for the older person, their family or carer and facility staff to make decisions together. As socialising is important for healthy ageing, residential care settings should promote participation and foster relationships to avoid loneliness, isolation and prevent depression.

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**CRITICAL THINKING**

1. What is likely to be the impact on the ageing population from disability and chronic illness?
2. How do community services support older people to remain in the community?
3. To what extent does the current level of health service provision meet the needs of an ageing population?

## SUMMARY

**1.1 Describe the different perspectives on ageing and discuss the diverse characteristics of older people and how they impact on healthy ageing.**

Present-day perspectives focusing on healthy, positive and successful ageing now influence the way we view ageing and the health of older people. It is generally recognised that older people are not a homogenous group, and the health and social needs of individuals and communities differ. Despite this diversity, the marker used for older people in Australia is 65 years. There are many perspectives influencing the complex and multidimensional nature of ageing and the health of older people. The experience of ageing is influenced by historical and theoretical perspectives and the context in which older people live their ageing years. The health of an older person is influenced by these perspectives and the biological, psychological and social factors within the economic and political context in which they live.

**1.2 Explain primary healthcare in terms of how its philosophical and strategic approaches support healthy ageing.**

Primary healthcare is both a philosophy of care and a strategy for healthcare provision for older people. It focuses on health rather than illness; older people, their families and communities; and self-reliance, where older people take responsibility for their health. Underpinning PHC as a philosophy are the fundamental principles of equity, participation and intersectoral collaboration. These principles provide an organising framework for approaches to health and healthcare delivery for older people.

**1.3 Understand the concept of health and healthy ageing and discuss how the social determinants of health influence the health of older people.**

There are many definitions of health; it is a concept that is individual and subjective. People perceive health differently and the way an older person sees health may be different to the perspective of others. The demographic characteristics and health and social experiences of older people demonstrate they are varied and influenced by many factors. Social determinants of health are of particular significance to a PHC approach.

**1.4 Describe how support and services available for older people enhance healthy ageing.**

As older people are living longer and the population is ageing, Australia and New Zealand have made some positive attempts to address requirements for health services and social support. PHC as a strategy, underpinned by the principles embedded in its philosophy, provides a framework for health professionals to provide support and services for older people in all settings.

## KEY TERMS

**Aged care assessment program (ACAP)** a cooperative working arrangement comprising multidisciplinary teams designed to assess and advise older people and their families about the provision of services and available support

**Equity** the redistribution of resources to address the determinants of health and enhance the health and wellbeing of all older people

**Health** a resource used for everyday living

**Health promotion** an approach designed to enable older people to positively maintain and improve their health individually or at a community level

**Healthy ageing** the ability of the older person to develop, maintain or adapt in order to function optimally mentally, physically, socially and economically

**Intersectoral collaboration** the collective action of all sectors — not just the healthcare sector — to enhance the health of older people

**Older people** people aged 65 and older in developed countries, or 60 and older in developing countries

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**Participation** the active involvement of older people, in conjunction with health professionals and service providers, in decisions about their health

**Primary healthcare** essential healthcare based on 'the practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community' (WHO, 1978, p. 3)

**Social determinants of health** the social conditions that influence the health of older people and their communities

## EXERCISES

1. Mr Charlie Malbong is a 70-year-old Indigenous man who was recently admitted to your ward for management of type 2 diabetes. You are the registered nurse on shift. Mr Malbong expresses concern about being away from his community. The physician plans for Mr Malbong to remain in hospital until his diabetes is stabilised. However, Mr Malbong has told you he does not want to remain in hospital as he wishes to return to his community. What information will you provide to Mr Malbong to enable him to actively participate in decisions that will optimise his health?
2. Mrs Duff lives at home with her daughter and grandchildren. She has recently been diagnosed with dementia but remains independent although she is a little forgetful and repeats information frequently. The family are anxious about the progression of the disease and that she might need to be admitted to a residential facility. They are prepared to provide support and care for her at home but as her daughter works and the grandchildren are at school, they are worried about leaving her on her own for extended periods of time. In your capacity as a practice nurse at the local general practice, how would you respond to the concerns of the family?
3. You are coordinating a local community seniors centre. Some of the older people who regularly come to the centre have told you that the timetable for the bus service has changed and the bus no longer stops outside the centre. They are upset as this will prevent them from attending and participating in the centre's activities. Outline how you would respond to this situation and identify what PHC principles will underpin your actions.
4. In your capacity as a primary healthcare nurse in a regional area in New Zealand, you are aware that many healthcare services are not easily accessible to the local population. You have particular concerns about the level of access for the local Maori population. You have the opportunity to submit a proposal for funding for additional services. Draw on your knowledge of healthy ageing and PHC to inform your proposal.
5. You are working in the independent living section of a residential facility for older people and are responsible for planning and coordinating activities for residents. Based on your knowledge of the health and social needs of older people, use a PHC framework to develop a weekly schedule of activities to maximise healthy ageing.

## PROJECT ACTIVITY

Identify the services available to older people in your community. Organise to visit one of these services and spend time conversing with some of the older people who use this service. The type of issues you could consider discussing include:

- information about the older person and the strategies they use to maintain their health and wellbeing
- their current health status and the factors that they consider influence their health
- their needs for service provision
- any issues they have relating to access and affordability of services
- the types of informal support they have in place.

Critically reflect upon the issues raised in your conversations with these older people.

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