COTA
For older Australians

COTA TASMANIA

Submission to the Parliament of Tasmania Joint Select Committee Preventative Health Care Inquiry

Prepared by
COTA Tasmania
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Introduction

COTA Tas is the peak body representing the needs and interests of older people in Tasmania. Our vision is for an inclusive society which values, supports and respects older people.

COTA welcomes the opportunity to comment on preventative health care. COTA recognises the key role played by primary and preventative care in the health system and supports a strong primary and community care system that is accessible, affordable and convenient for all Tasmanians. Consumers are an essential partner in preventative health care and the management of chronic disease. Investment in health literacy programs that target specific audiences will underpin efforts to manage health issues before they present in the tertiary care setting.

COTA's concern regarding preventative health focuses on the issues that are particularly important for older people. With people 60 and older making up a major group using health services and with their proportion of the population nearing 20 per cent and growing, it is important to ensure that this significant population group maintain their health and independence throughout most, if not all of their last decades of life.

COTA approaches preventative health policy through the framework of a commitment to active ageing and the promotion of healthy lifestyles and interventions that enable older Australians to age well and age in place. COTA recognises that the determinants of health are not only biological and behavioural but also social and environmental and consequently preventive action must focus not just on healthy lifestyles but also on healthy environments and social inclusion.

COTA supports the World Health Organisation's Active Ageing Framework[1] which provides a useful model for understanding how social, personal and behavioural determinants interact with the physical environment and access to health services to enable or prevent healthy ageing. COTA also endorses the social determinants of health as identified by the World Health Organisation:

- Social gradients
- Social exclusion
- Work
- Social support
- Food
- Stress
- Early life
- Unemployment
- Addiction
- Transport. [2]

[1] World Health Organisation, 2002, *Active Ageing: A Policy Framework,* http://whqlibdoc.who.int/hq/2002/WHO_NMH_NPH_02.8.pdf

[2] World Health Organisation, 2003, *Social Determinants of Health The Solid Facts,* http://www.euro.who.int/__data/assets/pdf_file/0005/98438/e81384.pdf

Terms of Reference 1

This submission does not address all aspects of all the Terms of Reference but highlights the major issues impacting on the health and wellbeing of older Tasmanians relevant in preventative health care and makes some comment on specific aspects of the Terms of Reference.

The current impact of inequalities in the major social determinants of health on the health outcomes, including mental health outcomes of Tasmanians and the capacity for health and community services to meet the needs of populations adversely affected by the social determinants of health

Inequalities in Health: Factors impacting on the health of older people

There are a myriad of factors impacting on the health and wellbeing of older people. In examining many of these factors it is evident that older people experience inequities in not only some of the key social determinants of health, but also in access to basic health care and other services.

The information below briefly highlights key factors and inequities impacting on the health and wellbeing of older Tasmanians.

Social inclusion

'The social inclusion agenda aims to give every Australian the help they need to access the support and opportunities our society has to offer'[3]. 'It's about the relationships in life that make us healthy, happy and productive'[4].

The opposite of social inclusion is social exclusion which can be interpreted as reduced capacity and opportunities to:

- Connect with productivity and economic growth (jobs and skills), manifesting in;
    - poverty and financial hardship
    - unemployment and/or casual and marginal attachment to employment
    - low literacy and numeracy skills
    - disengagement from education and training

- Connect with community (social and civic participation), as a result of;

[3] Social Inclusion Unit (Commonwealth), 2011, *What is Social Inclusion*?, viewed 13 July 2011 http://www.socialinclusion.gov.au/about/what-social-inclusion
[4] Adams, D., 2009, *A Social Inclusion Strategy for Tasmania*, Dept of Premier & Cabinet

- being unable to influence or engage in decisions that most affect them and the places in which they live
- barriers to volunteering
- barriers to meaningful cultural and recreational activities
- stigma and discrimination.

- Connect to services that support health and wellbeing, to address;
  - food insecurity
  - adequate and appropriate housing
  - exposure to and/or participation in risk behaviours
  - social isolation due to mental illness, disability, stigma and discrimination
  - weak support networks, including family, friends, professional and community services[5]

Social inclusion is considered a major factor in the personal, social and economic wellbeing of a local community and the nation as a whole. Adams in *A Social Inclusion Strategy for Tasmania* identifies older people living alone as one of the groups most at risk of social inclusion in our community. He further identifies that the places most at risk are the outer fringes of cities and towns that once were rural areas, rural towns in decline and older industrial areas[6], many locations in which older people live.

Adams also states that ageing is one of the new forms of exclusion in our society, along with mental illness, information communication technology (ICT), security of supply (food/water/energy) and violence[7], all factors that many older people in the Tasmanian community experience.

The publication, *Facing the Future: a Baseline Profile on Older Tasmanians*,[8] captured the following data that is relevant to the level of social exclusion being experienced by older Tasmanians.

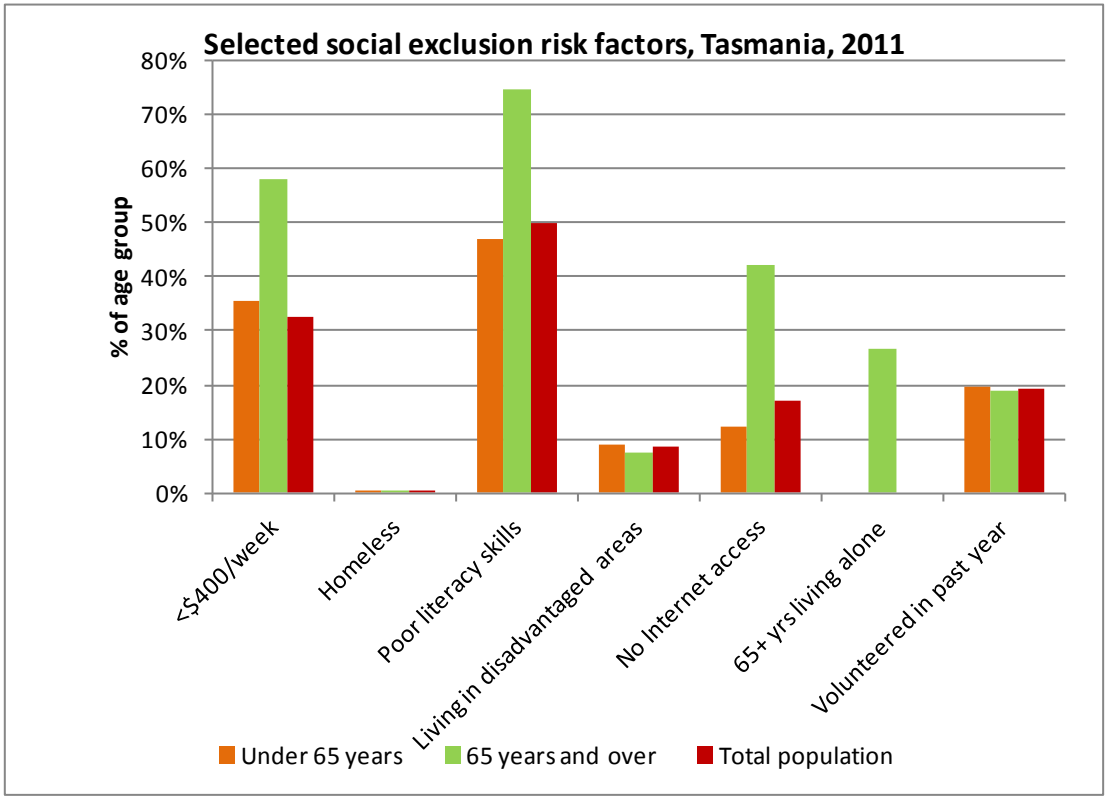
- Regular social contact with others is a central element of social inclusion. In 2010, 26% of Tasmanians reported that they had daily face to face contact with family or friends living outside the household. The proportion increased to 86% for face to face contact within the past week. Daily face to face contact tended to decrease with age, from a high of 38% for 18-34 year olds to 20% of the 65-74 year age group and 21% for those aged 75+ years (Figure 75). The likelihood of contact within the past week was highest for 25-34 year age group (91%), and lowest for 65-74 year age group (81%), increasing for those aged 75+ years to 88%.

[5] Social Inclusion Unit, 2013, *Social Exclusion Risk Factors*, Department of Premier and Cabinet, unpublished report
[6] Adams, D., 2009, *A Social Inclusion Strategy for Tasmania*, Department of Premier and Cabinet
[7] Ibid
[8] *COTA Tasmania, 2013, Facing the Future: A Baseline Profile on Older Tasmanians*

- For Tasmanians aged 60+ years, just over half (51%) felt there were 'opportunities to have a real say on issues that are important'. The proportion was slightly higher in the North West (53%) and slightly lower in the South (50%).

- The majority of older Tasmanians aged 60+ years indicated that they felt valued by society (52%), with another 26% feeling valued sometimes. Just over 15% of older Tasmanians did not feel valued by society often; if at all.

- ***Figure 1 Selected social exclusion risk factors - % of age group, Tasmania***



Data sources: refer to

Table *2* in appendix

- The percentages shown in Figure 1 are drawn from Table 1 and 2 shown as appendices. The Tables, which include a range of variables and data from multiple sources, contain condensed information regarding the key risk factors for social exclusion (by actual numbers as at the 2011 Census), some population estimates and the data sources from which the information is drawn.

- The social inclusion risk factor '*poverty and financial hardship*' refers to individuals earning less than $400 per week. Both the ABS and the definitions used by the Tasmanian Government's Social Exclusion Risk Factors use this earnings figure as the benchmark for the poverty line.

- In the following discussion, please note that the percentages are calculated for **all** Tasmanians aged 65+, including those who did not report their income.

- According to the 2011 Census data, 58.2% of all Tasmanians aged 65+ years live under the poverty line of $400 per week. Approximately 35% of all younger Tasmanians live below this agreed poverty and financial hardship benchmark with just over 30% of all Tasmanians living on or below the poverty line.

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- Adult literacy is key to people's access to social and economic participation and according to an assessment of literacy, numeracy and problem solving skills for Australians aged 15 – 74 years, conducted in 2012, 45% of all adult Tasmanians were judged as having poor literacy.

The social gradient: Socioeconomic status

Socioeconomic status (SES) is a combined economic and sociological measure of a person's work experience and social position in relation to others based on income, education and occupation. When analysing SES, an individual's income as well as the combined household income, earners' education and occupation are also examined.[9]

A simpler definition of socioeconomic status refers to a person's access to material and social resources as well as their ability to participate in society. Access and participation are key concepts that underpin the Tasmanian Government's *Inclusive Ageing: Tasmania 2012 – 2014 Strategy*.

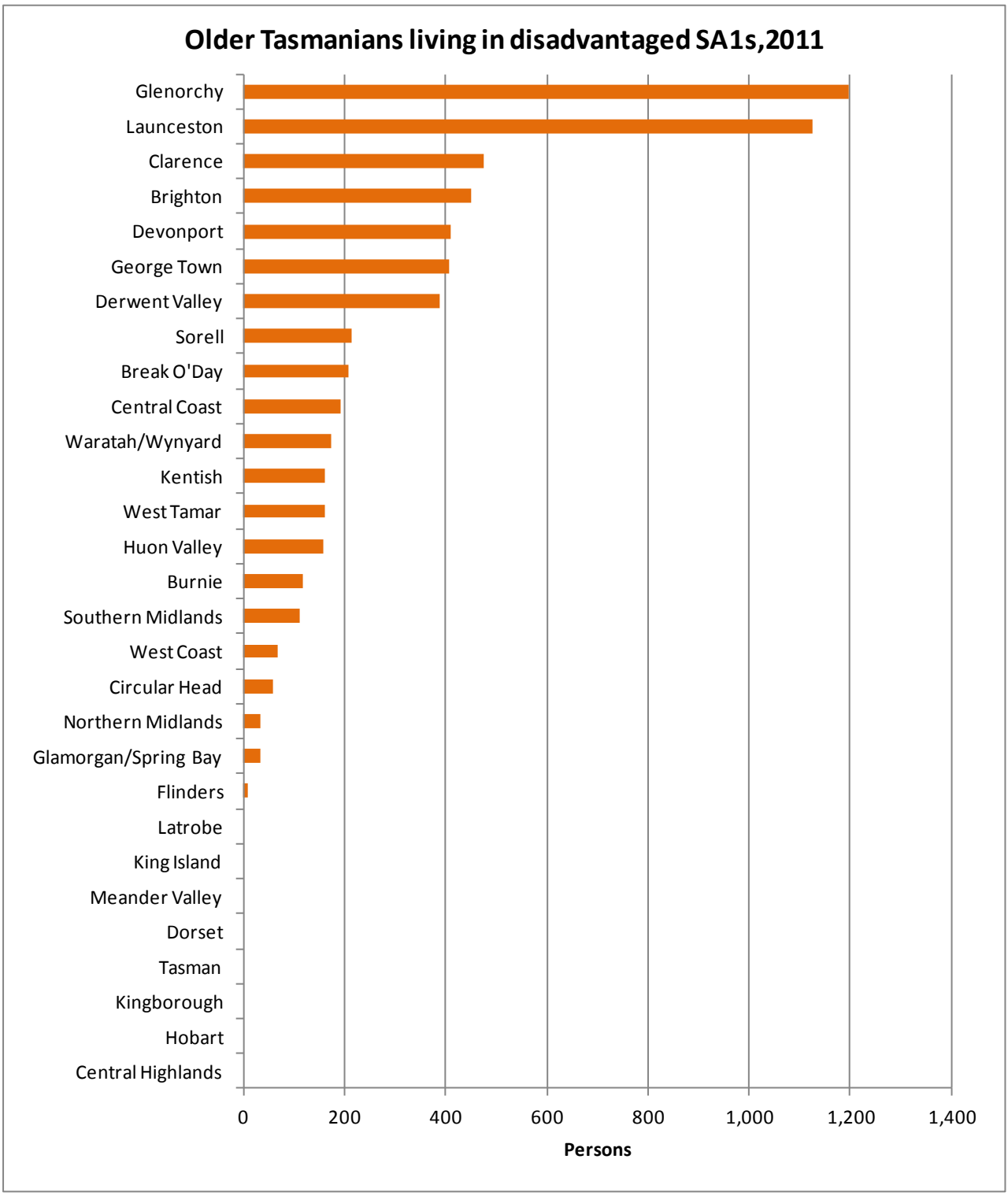
In looking at older Tasmanians' access to material and social resources, and by definition SES, it is important to measure and compare key attributes such as:

- income as well as financial security;
- the level and type of education attained and literacy levels;
- type of labour and labour force participation;
- housing location, type of housing and security of tenure; and
- access to social services (medical, transport, legal, advocacy, information) and cultural events.

The following table shows the numbers of older Tasmanians living in disadvantaged areas (SA1's) as at the 2011 Census. There is significant variation across the state and Glenorchy and Launceston clearly significant numbers of Tasmanians over the age of 65 years.

[9] National Center for Educational Statistics. 31 March 2008. http://nces.ed.gov/programs/coe/glossary/s.asp

Figure 2 Older Tasmanians (65+ years) living in disadvantaged areas (SA1s), 2011



Data source: ABS *Census of Population and Housing*, 2011 and ABS *SEIFA* 2011

Social support and connections

Interpersonal relations and social networks are a central component for health ageing. Social support is strongly correlated with a healthy diet, physical activity, good mental health and overall wellbeing.[10]

The importance of social connections was highlighted in a study by COTA Tas with many older people indicating that personal and social connections were important in making them feel connected to their local community. The social connections they described were both formal including belonging to community groups and participating in specific social, recreational or physical activities and informal including maintaining friendships, exchanging pleasantries at the local shop, having neighbours say "hi" to and exchange a cuppa with.[11]

Our ability to remain socially connected is challenged as we age by factors such as reduced mobility, access to transport, the availability of information, where we live and how we live.

As the State's older population increases, so too does the number of older people living alone. In 2011, 12% of Tasmanians lived alone whereas the proportion of older Tasmanians living alone aged 65+ years is more than double at 27%. For people aged 85+ years, this figure increased to 38%, higher than the Australian average of 34%.[12] This trend is likely to increase over time and as more people continue to live at home in their later years with the support of aged care services. Considerable care will need to be taken to ensure that older people living at home as they age are not further isolated from the community.

The three major municipalities of Glenorchy, Clarence and Hobart have the greatest number of people living alone but have better access to services and support, potentially limiting their risk of social isolation.[13]

Nutrition

Studies on the nutritional status of the Australian population indicate that a number of older people have poor diets, and do not eat enough fibre, or enough of some vitamins and minerals. When the diet does not provide the body with the nutrients it needs, health can suffer.

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[10] The Physical Activity Nutrition and Obesity Research Group, 2012, *Reducing the risk of chronic disease in older adults; A summary report to support obesity prevention planning in NSW* http://sydney.edu.au/medicine/public-health/prevention-research/news/reports/PANORG_Reducing%20the%20risk%20of%20chronic%20disease%20in%20older%20adults.pdf. Viewed 21 February 2013

[11] COTA, 2011, *A Sense of Belonging: Social Inclusion Issues for Older People in Tasmania*

[12] *COTA Tasmania, 2013, Facing the Future: A Baseline Profile on Older Tasmanians*

[13] ibid

Ageing can be associated with changes in lifestyle that affect the types of foods eaten. Loneliness, boredom, depression and worrying about the future can lead some to neglect their diets. Unfortunately this can result in skipping meals and generally poor eating habits.

Malnutrition in older people is common, frequently overlooked and results in many negative health outcomes. The prevalence of malnutrition increases with escalating frailty and physical dependence. Factors that can lead to malnutrition amongst older people include: social factors such as poverty, an inability to shop, an inability or lack of motivation to prepare and cook meals, social isolation and living alone; psychological factors such as bereavement, depression, alcoholism; and health factors such as dementia, arthritis, cancer and poor dental health.

Obesity

The number of obese older Australians is now approaching one million, which represents more than one in five older people.

Older Tasmanians are caught up in the national obesity epidemic. The number of obese older Australians is now approaching 1 million, which represents more than one in five older people. Their number has trebled over the past 20 years, due to the combined effect of an ageing population and the obesity epidemic.[14] These older Australians are about 6–7 kg heavier on average than their counterparts were 20 years ago. Obese older Australians are at greater risk of ill health from chronic diseases, disability and social impairment. Their increasing number has implications for health care costs, for carers and their wellbeing and for aged care services.

Transport

Having access to private or public transport was identified in Tasmania as a key issue that makes older people feel connected to their local community

As people age, their mobility may decline, but their need for transport does not. Access to transport has a significant impact on the health and wellbeing of older people as they need to access social, cultural and recreational activities, health care and other service providers,

[14] Australian Institute of Health and Welfare, 2004, *Obesity Trends in Older Australians*.

shopping and a range of other activities. Lack of access to transport due to problems of affordability, safety, availability, convenience, lack of confidence and information and appropriateness of the type of transport available can act as a barrier to older people's participation in the community. Health can affect desirability to use, afford and access transport.

When both access and mobility are constrained, transport disadvantage occurs. People on low incomes and pensions are more likely to experience transport disadvantage. With Tasmania's rapidly ageing population, there will be a significant increase in the proportion of the community who are transport disadvantaged. It is important that transport is accessible, reliable and affordable and that older people feel safe and comfortable using it.

Having access to private or public transport was recently identified in Tasmania as a key issue that makes older people feel connected to their local community and also limitations to transport prevents older people from feeling connected to their local community. Comments such as "being able to keep my driver's licence", "accessibility to my car in order to keep up with my normal habits", "frequent reasonably priced public transport", "buses are too infrequent outside of commuter times", "lack of public transport in rural area", poor "pedestrian access" and "buses are too expensive" are examples of comments from older Tasmanians[15] in relation to transport.

Maintaining a driver's licence is of incredible importance to people as they age. 46,017 or 95% of Tasmanians aged 65 to 74 years currently hold a driver's licence, with the number decreasing to 3,899 or 37% of people aged 85+ years. The gap between males and females increases beyond 74 years, with men retaining their drivers' licences for significantly more years. Figure 3 illustrates the declining proportion of people holding a driver's licence with an increase in age.

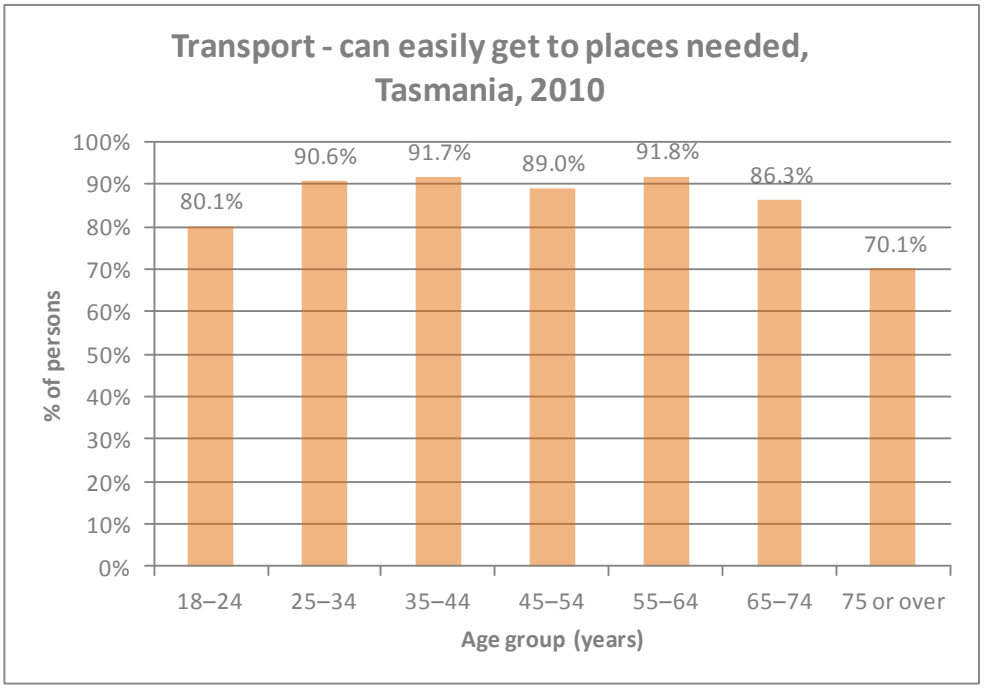
Available services and activities may not be readily accessible by those with limited transport options. Public transport is limited in many, mainly rural, areas of Tasmania. If households do not own a motor vehicle this may be a major barrier to their ability to participate in their community or to access services and activities.

While only 5% of Tasmanians aged 65-74 years lived in a household without access to a motor vehicle, for those aged 85+ years the proportion increased to 35%. [16]

[15] COTA, 2011, Op Cit
[16] ABS Census of Population and Housing, 2011

COTA Tas supports the recent changes to licensing arrangements that mean older drivers without medical conditions are no longer required to undergo annual medical checks as a condition of their licence.

Figure 3 Transport – can easily get to places needed, by age group, Tasmania, 2010



Data source: ABS *General Social Survey, 2010*

Unemployment

Mature aged people, those aged over 45 years, make up 34% of the unemployed and 46% of the long-term unemployed

In 2010-2011 33% of unemployed people aged 55-64 were long term unemployed.[17]

One out of five people aged between 45 and 64 in 2008 were not working because they had either been forced out, confined by disabilities or by carer duties. Over half of all 60-64 year old Australians are not in jobs[18.]

Australia's labour force participation rate for older workers is less than many OECD countries – reflecting both voluntary early retirement and involuntary exit. Discrimination by employers is a key factor impacting on older people's ability to secure and retain work.

[17] Fowkes, L, 2011 *Long term unemployment in Australia,* Australian Policy On Line http://apo.org.au/guide/long-term-unemployment-australia, viewed 21 February 2013

[18] Ryan, S, 2012 *Demography is not Destiny*, Australian Human Rights Commission, http://humanrights.gov.au/about/media/speeches/age/2012/20120308_destiny.html, viewed 25 February 2013

Poor education levels, outdated skills, or skills associated with declining industries or occupations reduce employment prospects for mature aged job seekers. Mature aged workers are less likely to participate in vocational training and generally respond to different approaches to training.

In Tasmania the labour force participation rate for those aged 65+ years in 2011 was 9.1% compared to 11% for older Australians.

In Tasmania the labour force participation rate for those aged 65+ years in 2011 was 9.1% compared to 11% for older Australians.

According to the ABS General Social Survey 2010, almost 21% of Tasmanians aged 55-64 years were living in households reliant on government pensions and allowances as the main source of income. The proportion rose dramatically to 66% for Tasmanians aged 65-74 years; and to 81% for Tasmanians aged 75+ years.

Reliance on a fixed, low income makes these older Tasmanians particularly vulnerable to increasing costs in goods, services and utilities.

Long-term unemployment is associated with poor physical and mental health, social isolation and poverty. Workers who remain outside the workforce for some time find it much harder to re-enter – their skills lose currency and employers tend to screen them in favour of people with more recent experience.

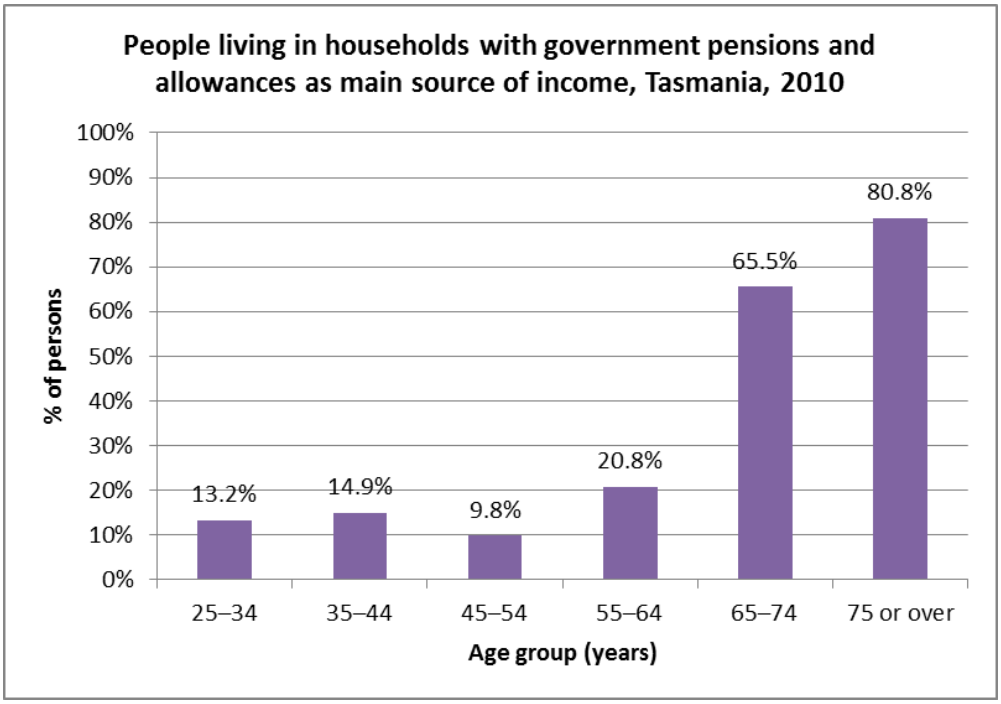
Furthermore, in a recent report released by the Australian Human Rights Commission entitled *'Fact or fiction? Stereotypes of older Australians'* 2013; the researchers identified that most community and business respondents feel that age discrimination is likely to occur in the workplace (88% of community respondents and 92% of business respondents).[19] In the same report it was shown that more than one third of Australians aged 55 years and older have experienced age related discrimination, with 67% of Australians aged between 54-65 and 50% of those aged 65+ years being turned down for a position.

The Age Discrimination Commissioner has launched a new campaign in 2014 – *The Power of Oldness* – designed to raise awareness about age discrimination in the workplace and start to address the issue. http://www.powerofoldness.com/

[19] Australian Human Rights Commission, 2013, *Fact or fiction? Stereotypes of older Australians*

The factors outlined above all have a major impact on the health and wellbeing of older Tasmanians.

Figure 4 Tasmanians (by age group) living in households with government pensions & allowances as main source of income, 2010



Data source: ABS *General Social Survey* 2010

Depression and anxiety

While the precise rates of depression and anxiety in older people are not yet known, research conducted by *beyondblue* suggests between 10-15% of older people living in the community experience depression symptoms and approximately 10% experience anxiety. Rates of depression in residential aged care facilities are thought to be much higher, with a recent Australian study showing 34.7% of aged care residents suffering from depression.

beyondblue identified groups of older people most at risk of depression and anxiety, including older people in residential aged care, older people with multiple physical co-morbidities, older people with dementia, older people who are carers, older people in hospital, older women, older Indigenous people and older people from CALD backgrounds. They also report that older people with depression and anxiety have a much higher risk of suicide than the general population.[20]

[20] Beyondblue, http://www.beyondblue.org.au/index.aspx?link_id=101#depression. Viewed 21 February 2013

Age discrimination

> ***Age discrimination does much more than make older people feel uncomfortable; it effectively limits their life chances***

Ageist attitudes in the community mean that older people are perceived to be less deserving or, alternatively, are incapacitated and in need of protection. Ageism is discrimination based on age and especially prejudice against older people. Ageism is endemic in our society. It is experienced by older people in the forms of speech by which they are addressed, evident in the media where negative and ageist stereotypes are promulgated, and in the health system where organisational and process bias tends to give older people and their illnesses a lower priority.[21]

The Australian Human Rights Commission highlights the impact of age discrimination in our society in stating "age discrimination does much more than make older people feel uncomfortable; it effectively limits their life chances. Age discrimination can erode one's economic status and one's ability to participate in society"[22,] hence one's health and wellbeing and quality of life.

Dental health

Dental and oral health care is a national health issue and is a fundamental necessity for an individual's healthy ageing. Many older people are now missing out on dental care with public dental hospitals and clinics either not accepting any new cases or reporting waiting lists of well over 12 months.

The financial and health costs of poor and neglected oral health are well documented and highlight the significant impact on all areas of a persons' wellbeing. Poor dental health can indirectly lead to chronic conditions that prevent people from normal activities such as chewing and speaking. Periodontal disease can lead to a range of medical conditions including coronary heart disease, stroke, peripheral vascular disease and pancreatic cancer.

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[21] COTA Australia, 2012, *COTA Australia Policy & Position Statements, http://www.cota.org.au/lib/pdf/COTA_Australia/public_policy/policy_compendium_dec_2012.pdf.*

[22] Australian Human Rights Commission, 2012, *Demography is not Destiny,* http://humanrights.gov.au/about/media/speeches/age/2012/20120308_destiny.html, Viewed 21 February 2013

Physical activity

Physical activity improves health and wellbeing, helping reduce the likelihood of obesity and delaying functional decline and onset of chronic disease. It also reduces the severity of disability associated with chronic diseases, improves mental health, promotes social contact, prolongs independent living and reduces the risk of falls.[23] Low physical activity in postmenopausal women contribute to the increased risk of metabolic syndrome, diabetes, cardiovascular disease, low cardio respiratory fitness and all-cause mortality.

Despite the recognised benefits from regular physical activity, the ABS data of 2004-05 indicated that over 40% of men and 40.5% of women aged 64-75 years and 51.5% of women aged 75 years and over were classified as being sedentary. [24]

Life-stage changes impact older adults' health directly or indirectly through their effect on the underlying behaviours contributing to disease. Retirement is a major life change that can affect activity and sedentary behaviours. Also older adults are often involved as carers, providing care for grandchildren, a partner or elderly family member which may reduce their time for self-care, such as exercising. Additionally older adults living in disadvantaged areas are less likely to meet physical activity recommendations compared to those living in more advantaged areas.

An age-friendly environment, highlighted below, is crucial in encouraging and supporting older people to pursue an active lifestyle, including regular physical activity.

Health literacy

Health literacy refers to an individual's capacity to seek, understand and use health information to make informed decisions about their own health. A Victorian government report indicates that older people are at a high risk of low health literacy with approximately 80% of older Australians reporting having poor health literacy.[25] Older people who have English as a second language or minimal English would no doubt be highly represented in this 80%.

This Victorian report states that factors effecting lower health literacy levels include lower education levels, lower income and poor mental and physical health[26,] all of which are prevalent factors amongst older Tasmanians.

[23] State of Victoria Department of Health, 2012, *Healthy ageing literature review.*
[24] ABS Data - Physical Activity in Australia: A Snapshot, 2004-05
[25] State of Victoria Department of Health, 2012, *Healthy ageing literature review.*
[26] Ibid

Prevalence of chronic disease

According to data from the ABS quoted in a recent study by National Seniors, almost all older Australians have a least one long term chronic health condition and over 80% have three or more long term chronic health conditions.[27] Such health conditions include cancer, high blood pressure, heart disease, diabetes, stoke, arthritis, depression and anxiety and asthma.

Diversity of older people

Older adults are not a homogeneous population

Older adults are not a homogeneous population, they experience different life stages and circumstances that need to be taken into consideration when planning and implementing any preventative health care initiatives. Any approaches to prevention need to take into account the fact that disadvantaged groups bear the highest burden of disease and are often least able to respond to health promotion messages.

Specifically older people in rural and remote areas, socioeconomically disadvantaged, older Indigenous Australians, older people from culturally and linguistically diverse backgrounds, and people ageing with a longstanding disability, all experience additional social and economic barriers that need to be considered in preventative health care strategies.

For example a person living in less than ideal housing, who is struggling financially, who has moderate arthritis and lives a long way from shops that sell vegetables, has far less chance of responding to promotion messages such as those about physical activity and healthy eating, than a retired, well educated, well motivated middle class person with discretionary disposable time and money, good transport, and broad social networks.[28]

Preventative health care in CALD communities in Tasmania is impacted by tradition, culture and beliefs of community members who bring with them various understandings of health care depending on the culture and traditions of their background. The following aspects are examples of the importance to certain CALD communities:

- Use of traditional herbal remedies and other practices such as acupuncture in the Chinese community
- Use of medicine man/witch doctor in the African communities
- Holistic approach to health care in the European communities

[27] National Seniors, 2012, *The Health of Senior Australians and the Out-of-Pocket Healthcare Costs They Face,* National Seniors Productive Ageing Centre.
[28] The Physical Activity Nutrition and Obesity Research Group, 2012, Op Cit

- Spiritual approach to health care in the Asian communities
- Superstition as to the origins of specific diseases and to western health care outcomes in various communities, and
- the reliance on health care information from community members, friends and family in various communities [29]

Aboriginal Tasmanians experience significant disadvantage in their health and wellbeing. On average, Indigenous Australians experience a higher burden of disease than non-Indigenous Australians, through kidney disease, diabetes, eye and hearing issues, as well as accidents and external injury. Indigenous Australians also experience higher rates of mortality than non-Indigenous Australians.

Life expectancy for Aboriginal and Torres Strait Islander men is estimated to be 11.5 years less than for non-Indigenous men (67.2 years and 78.7 years respectively). For Aboriginal and Torres Strait Islander women, the difference is 9.7 years (72.9 years for Aboriginal and Torres Strait Islander women and 82.6 years for non-Indigenous women).[30]

Access to health services

Older people's ability to access health and community services was highlighted as a major issue in a recent study by COTA asking people "What are key issues for you as you age?" Access issues included the geographical barriers to facilities and services and insufficient provision of facilities and services. Other older people highlighted factors such as prohibitive distances, lack of public transport to gain access, centralised rather than community based facilities and services and apprehension about the quality and availability of health services, especially dental services.[31]

A recent study by the National Seniors found that on average older Australians expend $353 per quarter on health related goods and services with the median expenditure of $150 per quarter. Those with five or more chronic conditions were estimated to expend $882 per quarter on average. The likelihood of facing a substantial financial burden was higher for each additional chronic disease experienced and estimated to be roughly ten times as high for those with five or more chronic conditions than for those with no chronic conditions.[32]

The National Seniors report concludes that "for sicker older Australians, even with the protection of Medicare, costs can be significant and are associated with a substantial

[29] Feike, S, 2013 Migrant Resource Centre, Information provided for this submission.
[30] Australian Bureau of Statistics, 2010, *Measures of Australia's Progress*, http://www.abs.gov.au/ausstats/abs@.nsf/2f762f95845417aeca25706c00834efa/f1452ed1b3b2c77aca25779e001c4758!OpenDocument. Viewed 21 February 2013.
[31] COTA Tas, 2013 *Key Issues for Older Tasmanians*
[32] National Seniors, 2012, Op cit

financial burden ... such financial burdens can themselves lead to reduced use of medical services and hence overall poorer health".[33]

Terms of Reference 2

The challenges to, and benefits of, the provision of an integrated and collaborative preventative health care model which focuses on the prevention and early detection of, and intervention for, chronic disease.

COTA supports an integrated and collaborative preventative health care model and endorses the WHO's definition that integrated service delivery is "the organisation and management of health services so that people get the care they need, where the need it, in ways that are user friendly, achieve the desired results and provide value for money".[34]

A prime example of such an integrated health model was the Living Longer Living Stronger program run through COTA for nearly six years from 2002 - 2008

The highly successful Living Longer Living Stronger (LLLS) program focused on strength and resistance training for older Tasmanians and relied on the integration and collaboration of numerous government departments, non-government and community organisations and local businesses. Such organisations included COTA, the Department of Health and Human Services, Department of Veterans Affairs, Office of Sport and Recreation, local councils, Fitness Tasmania, private gyms and older people's organisations.

The LLLS Program aimed to increase the quantity and quality of strength training available for people over 50 years by creating pathways for older people to access mainstream gyms, offering reduced fees for strength training classes, providing training and support to local gyms to involve older people in their services and to promote the program to older people. There was significant enthusiasm for the LLLS Program in Tasmania, as evidenced by the fact that after just nine months of implementation, 417 older people had joined the program through 15 service providers.[35]

Anecdotal evidence from participants of the program highlighted the significant benefits of strength training in the quality of life of older people. One of the keys to the program's existence was the collaboration and partnerships between a significant range of

[33] Ibid
[34] World Health Organisation, 2008, *Integrated health services: what and why*, http://www.who.int/healthsystems/technical_brief_final.pdf. Viewed 28 February 2013.
[35] COTA, 2010, *A Review of the Living Longer Living Stronger Program in Tasmania*, Unpublished document.

stakeholders within the community. Unfortunately, despite the enthusiasm of participants, the program no longer exists as ongoing funding was not able to be sourced.

It is interesting to note that the three government departments involved in the program, namely the Department of Health and Human Services, Department of Veterans Affairs and Office of Sport and Recreation, all extensively promoted the outcomes of the program in terms of the ongoing benefits to the health and wellbeing of participants but none were able to commit ongoing funding.

Terms of Reference 3

Structural and economic reforms that may be required to promote and facilitate the integration of a preventative approach to health and wellbeing, including the consideration of funding models.

COTA consider it essential that there are both structural and economic reforms that promote the integration of a preventative approach to health and wellbeing that focus broadly on the social determinants of health. Currently the focus and attention of hospital, illness and disease is still far too prominent in the Tasmanian community to the detriment of preventative health and the social determinants of health. Focusing on these key aspects of health will lessen the need for the distorted focus on illness and disease.

An example of a very effective health preventative program for older people is COTA's Peer Education initiative. COTA Peer Educators are trained to have knowledge of particular subjects and then share this knowledge by connecting with older Tasmanians in a range of community-based presentations with established organisations.

Over the nine years of this service COTA has educated more than 6,000 older people through approximately 250 older people's organisations

COTA currently has 20 Peer Educators who deliver presentations on health and wellbeing to senior's organisations across Tasmania. COTA has provided these highly successful and well-regarded education and information sessions to older Tasmanians for more than eight years and annually more than 600 seniors are educated by COTA. Over the eight years of this service COTA has educated more than 6,000 older people through approximately 250 older people's organisations.

This highly successful model could be broadened to other preventative health topics such as falls prevention, physical activity, sleep issues, nutrition and transport options, just to name a few.

COTA would also like to see preventative health resources allocated to educating health professionals on the rights of, and attitudes to older people. As stated previously, older people frequently experience discrimination in accessing health services and in having their health needs addressed, often a result of ageism and ageist attitudes of health professionals. Additionally preventative health resources are also required to address health literacy issues highlighted previously.

COTA Tas would encourage health systems in Tasmania to not only understand the needs and attitudes of older people but to actively partner with older people. According to the Australian Commission of Health and Safety, "Partnering with consumers is about healthcare organisations, healthcare providers and policy-makers actively working with consumers to ensure that health information, systems and services meet their needs."[36]

Examples of ways this can happen for better patient outcomes include models such as patient-centred care, consumer engagement, patient participation and citizen engagement. They are underpinned by the following principles:

- consumers are treated with dignity and respect
- information is shared with consumers
- participation and collaboration in healthcare processes are encouraged and supported to the extent that consumers choose (there is good evidence that patient-centred approaches to care can lead to improvements in safety, quality and cost effectiveness, as well as improvements in patient and staff satisfaction.)

Some examples of how healthcare providers can partner with consumers include:

- asking consumers about their needs and preferences and working to meet them
- using shared decision-making tools to help consumers make decisions about their health and care
- ensuring that consumers have the option of support people or translators during consultations if they need them, and
- using communication strategies that are tailored to the needs[37]

[36] http://www.safetyandquality.gov.au/our-work/patient-and-consumer-centred-care/ accessed 27/2/2015

[37] http://www.safetyandquality.gov.au/our-work/patient-and-consumer-centred-care/ accessed 27/2/2015

Terms of Reference 4

The extent to which experience and expertise in the social determinants of health is appropriately represented on whole of government committees or advisory groups.

COTA is unable to comment specifically on the extent to which experience and expertise in the social determinants of health is appropriately represented on whole of government committees or advisory bodies in Tasmania. We do however consider it mandatory that such experience and expertise is evident in any planning of services, activities and programs that affect the health and wellbeing of Tasmanians.

In accepting the social determinants of health as key to influencing the quality of life of Tasmanians, the government needs to be advised and influenced by those with expertise in this field. The Social Determinants of Health Advocacy Network in Tasmania, of which COTA is a member, has a significant membership of stakeholders with experience and expertise in the social determinants of health. Representation from this Network on government committees and advisory groups is recommended.

Terms of Reference 5

The level of government and other funding provided for research into the social determinants of health

COTA is not familiar with the current level of funding from government and other sources into research on addressing the social determinants of health. COTA believes however that significant evidence and research already exists proving the significance of the social determinants in the health and wellbeing of the population.

This evidence is available at:

- An international level as evident by the support, attendance and papers from the World Health Organisations global conference on the determinants in October 2011.[38]
- At a national level with the recently established Social Determinants of Health Alliance.
- And at a state level with the significant body of work promoted through the Social Determinants of Health Advocacy Network.

[38] World Health Organisation, 2011 *Rio Political Declaration on Social Determinants of Health* http://www.who.int/sdhconference/en/index.html

With so much evidence available on the impact of the social determinants of health and with limited state funding available, COTA strongly supports the allocation of funding to the actual delivery of services and programs at a grass roots level. Additionally COTA requests that this funding is offered on a long term basis to successful initiatives, not as one-off project funding that is not effective in establishing sustainable outcomes.

Conclusion

COTA welcomes the Government's Inquiry into Preventative Health Care and appreciates the opportunity to have input into the Inquiry.

COTA requests that the Inquiry take particular consideration of the needs and issues of older Tasmanians who currently equate to over a fifth of Tasmania's population. Older people experience significant inequities in their health and wellbeing, in their access to health services and in the social determinants of health. It is imperative that the Inquiry give significant attention to their needs.

COTA looks forward to meeting with the Committee to further discuss this submission.

- ***Table 1 Selected social exclusion risk factors – persons, Tasmania***

Social exclusion risk factor	Indicator (from DPAC)	Year	Indicator used here	Under 65 years	65+ years	Total population	Data source
Poverty and financial hardship	People living below the poverty line	2011	People living below the poverty line			48,000	DPAC Social Exclusion Risk Factors
		2011	People with individual income <$400/week	113,618	46,987	160,603	ABS Census 2011
	Households with government pensions and allowances as main source of income	2010	People living in households where principal source of income was Government pensions and allowances		*29,318 (65-74 yrs)* *29,045 (75+ yrs)*	*106,794*	ABS General Social Survey 2010
Housing and homelessness	People who are homeless	2011	People who are homeless	1,477	104	1,581	ABS Estimating homelessness
	People waiting for public housing	2012		n/a	305	2,670	DPAC Social Exclusion Risk Factors
Exclusion from jobs and skills	Adults with poor literacy skills (prose literacy scale)	2006	Adults with poor literacy skills (prose literacy scale)	146,500 (15-64 yrs)	27,900 (65-74 yrs)	174,400 (15-74 yrs)	ABS Adult Literacy and Life Skills Survey 2006
Locational disadvantage, service and transport exclusion	People living in disadvantaged areas	2011	People living in disadvantaged areas	36,887	6,155	43,042	ABS Census 2011 and SEIFA 2011
	Tasmanians who cannot easily access transport	2010	People who cannot easily access trsnport		*1,701 (65-74 yrs)* *4,565 (75+ yrs)*	*17,665 (15+ yrs)*	ABS General Social Survey 2010
	Adults who have difficulty in accessing services they need	2010	Adults who have difficulty in accessing services they need		*12,667 (65-74 yrs)* *8,160 (75+ yrs)*	*149,752*	ABS General Social Survey 2010
	Households who do not have access to the Internet	2011	People living in households without an Internet connection	50,347	33,868	84,211	ABS Census 2011
Population groups at risk	Extent to which people with disability had a need for assistance and the need was only partly met	2009	Extent to which people with disability had a need for assistance and the need was only partly met	n/a	n/a	20,100	DPAC Social Exclusion Risk Factors
		2009	People with a disability needing more assistance with *core* activities than currently received	4,500	2,500	7,000	ABS Disability, Ageing and Carers Survey 2009
	Older Tasmanians living alone	2011	People aged 65+ living in lone person households	n/a	21,514		ABS Census 2011
Volunteering	Number of volunteers	2011	People who volunteered in past year	62,713	15,360	78,073	ABS Census 2011

Table 2 Selected social exclusion risk factors – % of age group, Tasmania

Social exclusion risk factor	Indicator (from DPAC)	Year	Indicator used here	Under 65 years	65+ years	Total population	Data source
Poverty and financial hardship	People living below the poverty line	2011	People living below the poverty line			10.7%	DPAC Social Exclusion Risk Factors
		2011	People with individual income <$400/week	*35.4%*	*58.2%*	*32.4% (15+ yrs)*	ABS Census 2011
	Households with government pensions and allowances as main source of income	2010	People living in households where principal source of income was Government pensions and allowances		65.5% (65-74 yrs) 80.8% (75+ yrs)	26.6%	ABS General Social Survey 2010
Housing and homelessness	People who are homeless	2011	People who are homeless	*0.4%*	*0.1%*	*0.3%*	ABS Estimating homelessness
	People waiting for public housing	2012		n/a	*0.3%* (60+ yrs)	0.5%	DPAC Social Exclusion Risk Factors
Exclusion from jobs and skills	Adults with poor literacy skills (prose literacy scale)	2006	Adults with poor literacy skills (prose literacy scale)	47.1%	74.5%	50.0% (15-74 yrs)	ABS Adult Literacy and Life Skills Survey 2006
Locational disadvantage, service and transport exclusion	People living in disadvantaged areas	2011	People living in disadvantaged areas	*8.9%*	*7.6%*	*8.7%*	ABS Census 2011 and SEIFA 2011
	Tasmanians who cannot easily access transport	2010	People who cannot easily access trsnport		3.8%* (65-74 yrs) 12.7% (75+ yrs)	4.4% (15+ yrs)	ABS General Social Survey 2010
	Adults who have difficulty in accessing services they need	2010	Adults who have difficulty in accessing services they need		28.3% (65-74 yrs) 22.7% (75+ yrs)	37.3% (15+ yrs)	ABS General Social Survey 2010
	Households who do not have access to the Internet	2011	People living in households without an Internet connection	*12.1%*	*42.0%*	*17.0%*	ABS Census 2011
Population groups at risk	Extent to which people with disability had a need for assistance and the need was only partly met	2009	Extent to which people with disability had a need for assistance and the need was only partly met			not determined	DPAC Social Exclusion Risk Factors
		2009	People with a disability needing more assistance with *core* activities than currently received	not determined	not determined	not determined	ABS Disability, Ageing and Carers Survey 2009
	Older Tasmanians living alone	2011	People aged 65+ living in lone person households		26.7%		ABS Census 2011
Volunteering	Number of volunteers	2011	People who volunteered in past year	*19.6%*	*19.0%*	*19.4% (15+ yrs)*	ABS Census 2011