Health Needs Assessment – Fact sheet

phn BRISBANE NORTH

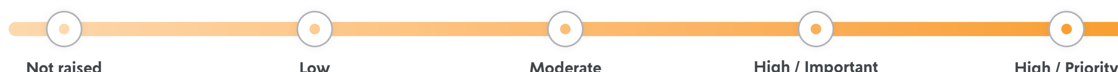
An Australian Government Initiative

Older Persons Needs

The 2021/22 – 2023/24 Health Needs Assessment has identified numerous health and service issues in the Brisbane North community that relate to older persons who are aged 65 years and above. These needs are listed below:

Health Issues	Service Issues
✓ Chronic disease	✓ Coordination and integration of health and age care
✓ Dementia	✓ Navigation and appropriate care
✓ Frailty	✓ Specialist and geriatric services
✓ Mental health	✓ Support for families and carers
✓ Social isolation	✓ Workforce
✓ Ageism	

LEGEND:
Relative rank for prioritised needs:



Health Issues — Overall Prioritisation Rank

Chronic disease

In 2016 the Coordination of Health Care Study found that approximately 74.1% (or 239,334 people) of the Brisbane North population aged 45 years and above had a long term health condition. Of chronic conditions hypertension (31.9%), arthritis (28.6%), other conditions or injuries (22.3%) and moderate or severe pain (19.7%) were the most frequently reported among the cohort.

Dementia

Dementia is the second leading cause of death in the region, having caused a total of 2,754 deaths in 2015–19. This equates to 9.5% of all causes of death in the region, and an age-standardised rate of 46.1 deaths per 100,000 people. This is on contrast to Queensland and Australian rates which are comparably lower at 41.9 and 41.5 deaths per 100,000 people.

- Females are at higher risk of dying due to dementia.
- Of people using permanent residential care in Brisbane North in June 2020, 52.9% had a diagnosis of dementia. This equates to approximately 4,000 people in residential care.

Mental health

- **Medicare subsidised services:** In 2018–19 there were 6,943 and 3,455 patients aged 65 years and above who access Medicare-subsidised GP and allied mental health services, respectively. Among these patients, a total of 28,636 services were accessed, majority (55.4%) of which were through allied health professions.
- **Medicare subsidised prescriptions:** In 2019–20 there were 50,710 patients aged above 65 years with mental health-related prescriptions. These patients accounted for 27.5% of prescriptions dispensed in the region.
- **Emergency department presentations:** Between 2014–15 to 2019–20, mental health-related emergency department presentations for people aged 65 years and above by 52.2%. In 2019–20, this age cohort of patients accounted for 12.6% of total mental health-related presentations.
- **Admitted hospital patients:** In 2019–20, over 6,000 people aged 65 years and above were hospitalised for mental and behavioural disorders. Hospitalisations declined with age, whereby 35.1% of hospitalisations were in the 65–69 year age cohort and gradually decreased down to 13.8% in the 85 years and above age group.

Social isolation

Several risk factors have been identified as contributors to social isolation, including living in a lone person household or not having the transport or means to travel to places for social engagement.

The use of the *Adult Social Care Outcomes Toolkit* (ASCOT) in a sample of 732 CHSP clients (serviced by the healthy@home consortium) in 2019–20 found that 29.7% of respondents reported they had adequate social contact with people, while 14.2% had some social contact with people but not enough, and a further 4% had little contact with people and feel socially isolated.

Ageism (stigma and discrimination)

A recent report by the Australian Human Rights Commission found that only 13% of people believed ageism was a problem when directed towards older people and that older Australian's were perceived to lack competence and have declining skills. These perceptions or attitudes towards older people can be prohibitive in a person fairly achieving employment, housing, healthcare and receiving goods and services, ultimately impacting on their wellbeing.

Health Issues	Overall Prioritisation Rank
Frailty	

Home support: To be eligible for CHSP, clients must be considered a frail person, aged at least 65 years and has difficulty in performing activities of daily living and must live in the community.

- Home support is accessed at a rate of 382.2 recipients per 1,000 people aged 70 years and above. This is equivalent to approximately 40,000* people or 38% of the population aged 70 years and above.

Accidental falls: Death, injury and hospitalisation due to accidental falls are associated with frailty.

- In 2017–18 there were over 9,500 hospitalisations in for people aged 65 years and above due to falls. Females accounted for majority (62.6%) of these. Hospitalisations for those aged 85 years and above were also higher and accounted for 42.7% of hospitalisations in this cohort.

Highlight – Frailty

2017–18

9,500

hospitalisations due to falls

2019–20

10,000

hospitalisations due to falls

In 2017–18 there were over 9,500 hospitalisations in Brisbane North for people aged 65 years and above due to falls. Females accounted for majority (62.6%) of these hospitalisations. Hospitalisations for those aged 85 years and above were also higher and accounted for 42.7% of hospitalisations in this cohort. In 2019–20 total hospitalisations due to falls in this age cohort increased to over 10,000. While females continued to account for majority of these hospitalisations, the distribution of hospitalisations has slightly shifted to younger age groups, indicating the falls injuries or risk of frailty are developing sooner.

"Early identification of deterioration in function and timely referral/access to health services that are aimed at preventing injuries and issues. Too often people in this age group soldier on and make do until they have a fall and then their capacity to return to home is reduced because they have not made changes to their environment, how they do activities or implemented AT in their homes to support them to be safe and independent." — **Social Worker**

"Availability / accessibility of geriatric specialists. Better home support for patients and carers. Better funding for adequate primary care services for these complex patients." — **General Practitioner**

"For those with complex care needs, additional allied health services are needed to keep people well and out of hospital. The current chronic disease management plan system is not working. Too many people are accessing this funding who do not meet the criteria and who do not need the care while those who need help are restricted to 5 visits across all allied health. Care for this group needs to be needs based, not visit based." — **Occupational Therapist**

Service Issues	Overall Prioritisation Rank
Navigation and appropriate care	

Movement between aged care types (2019–20):

- 5,412 people were admitted into residential aged care. In the same period there were a total of 5,198 people who were discharged from residential aged care mostly due to death (44.3%) or return to community (26.9%).
- 2,326 people received a home care package in Brisbane North. Of home care package recipients in the region 26.7% where on level 1 packages, 47.3% were on level 2 packages, 17.6% were on level 3 packages, and 8.2% were on level 4 packages. Of those who were discharged from home care, most (57%) were discharge to residential care.
- 1,016 people were recovering from a hospital stay and received transition care. Notably, a higher proportion of people receiving transition care were below the age of 60 years. Of those who were discharged from transition care, most (56%) were discharged to return home or the community.

Workforce	

The royal commission found that the workforce is understaffed, undertrained, and underpaid, particularly for in home and residential care. The number of staff employed and providing direct care are not sufficient to provide quality and safe care, and that the skills mix are not suited to the diversity of people needing care. It highlights the need for increased efforts in workforce planning and development, in addition to improving the working conditions in the sector and attracting more employees into roles.

Consultation: Some respondents noted that GPs required improvement in providing older persons care, in addition to an increased GP workforce that performed in-reach services to RACFs.

Service Issues	Overall Prioritisation Rank
Service capacity	

Across the region there were 6,844 people accessing home care, 7,662 people accessing residential care, and 126 people receiving transition care. In total 14,632 people were accessing a form of aged care, not including home support. This reflects a 12.8% annual growth, since 2016.

Rates of age care use is as follows:

- 81.7 places in residential care per 1,000 people aged 70 years and older in 2017–20
- 42.7 home care recipients per 1,000 people aged 70 years and above
- 382.2 home support recipients per 1,000 people aged 70 years and above.

Older persons in Brisbane North access residential care and home support at higher rates than Queensland or Nationally.

Specialist and geriatric services

In Brisbane North, 59% and 60% of people aged 65–79 years and 80 years and above accessed specialist services in 2018–19. This equates to over 110 services per 100 people for both age cohorts. In comparison to national rates, older persons aged 65 years and over in Brisbane North access specialists less frequently.

Nationally, only 32% of residential care recipients attended a specialist, in comparison to 74%, 65% and 58% of home support, home care and no aged care users, respectively. However, of residential care recipients those living in larger facilities had a higher median number of specialist attendances.

Support for families and carers

Support for carers and families of older people was mostly raised by GPs in consultation. GPs noted that the reason for chronic disease among older people is identified as a priority is because patients have no support network or person, which is presumed to negatively impacts on their ability to stay healthy.

Other practitioners alternatively offered that carers required better communication with service providers and assistance in also navigating the aged care space. Specific support was particularly mentioned for those who are frail or diagnosed with dementia.

Coordination and integration

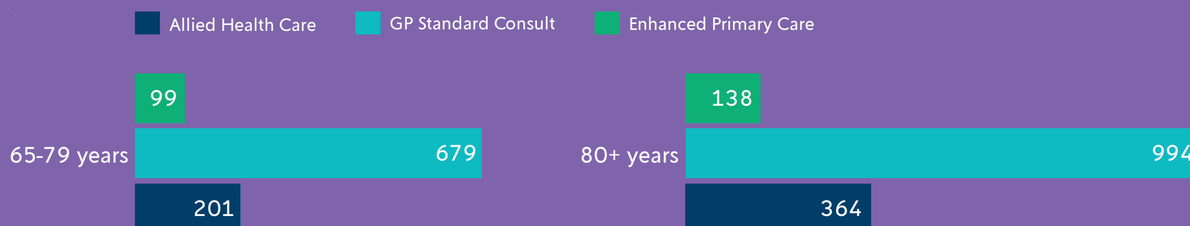
Interface between aged care and health system:

- Nationally, people living in residential care had more GP attendances per person in 2016–17, than people using community-based care or no aged care.
- Only 32% of residential care recipients attended a specialist, in comparison to 74%, 65% and 58% of home support, home care and no aged care users, respectively.
- Across all aged care types, people had a similar number of different medicines dispensed, except for non-aged care users.
- People using community-based aged care had a higher likelihood of presenting to ED or have a hospital separation, in comparison to people who used residential care.

Primary care: Older persons access GP services, particularly enhanced primary care, at higher rates than the general population. As cohorts age the rate of service use also increase. This pattern is also observed for allied healthcare services.

Highlight – Coordination and integration

Types of aged care services provided per 100 people



The narrative around the integration between health and aged care therefore predominantly focussed on in-home care or support and the need to have better healthcare available to older persons in their respective care setting, but more pointedly in the community.

"Community Geriatrician supportive by allied health and community nursing to prevent hospital admissions. GPs able to refer patients to a GEM PACS type service." — **Practitioner**