行政院及所屬各機關出國報告

(出國類別：研究)

# 臨床老人醫學

服務機關：國立台灣大學附設醫院家庭醫學部

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內容摘要: 澳洲人口總數爲19,786,600人(2002年)，國民所得約爲台灣國民的2倍，醫療照顧與社會福利體系健全。老人約有250萬人，佔人口總數之12.6 %，預估2050年，將佔人口總數之25 %，因此老人健康照護的問題，也是澳洲政府未來的一大挑戰。澳洲的老人照護系統可分成社區照護與院所照護兩大類，前者主要透過提供適當的服務內容，使其能在家庭及社區獨立生活，提高生活品質並減少住進護理院；後者主要由護士等專業工作人員提供老人在不同等級的院所中生活。澳洲的老人醫學專科是內科的次專科，需要6年以上的臨床專科訓練，但大多數的老年人生病時都會找家庭醫師，且老年人佔家庭醫師門診人數的約一半，因此訓練家庭醫師以提供老人完善的醫療照顧，是解決老人醫學專業照顧的最好方法。此外，透過不同醫療專業人員的整合服務，加上義工或慈善單位的協助，以及現有的社會福利與醫療照顧體系，提供了澳洲老人完善的照護制度。臺灣在已逐漸步入老化與已開發之國家，它山之石可以攻錯，澳洲的經驗可作爲不錯的參考。

## 摘要

澳洲人口總數為 19,786,600 人(2002 年)，國民所得約為台灣國民的 2 倍，醫療照顧與社會福利體系健全。老人約有 250 萬人，佔人口總數之 12.6 %，預估 2050 年，將佔人口總數之 25 %，因此老人健康照護的問題，也是澳洲政府未來的一大挑戰。澳洲的老人照護系統可分成社區照護與院所照護兩大類，前者主要透過提供適當的服務內容，使其能在家庭及社區獨立生活，提高生活品質並減少住進護理院；後者主要由護士等專業工作人員提供老人在不同等級的院所中生活。澳洲的老人醫學專科是內科的次專科，需要 6 年以上的臨床專科訓練，但大多數的老年人生病時都會找家庭醫師，且老年人佔家庭醫師門診人數的約一半，因此訓練家庭醫師以提供老人完善的醫療照顧，是解決老人醫學專業照顧的最好方法。此外，透過不同醫療專業人員的整合服務，加上義工或慈善單位的協助，以及現有的社會福利與醫療照顧體系，提供了澳洲老人完善的照護制度。臺灣在已逐漸步入老化與已開發之國家，它山之石可以攻錯，澳洲的經驗可作為不錯的參考。

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# 第一章 研究目的

台灣現有老人比率為 8.91% (2002 年)，約有 200 萬老人，此外台灣老年人口增加快速，根據內政部的統計預估 2030 年老人比率將達 20.07%，然而國內目前現有老人醫療照顧體系的架構與內容，以及醫療專業人員的訓練與能力，無法應付當前與未來的老人醫療照護，因此為了未來老人的健康維護，本人奉李院長及本部陳主任之命前往老人醫學與健康照護體系健全的國家—澳洲，進行為期一年的研究考查。

# 第二章 研究過程

## 一、澳洲簡介

澳洲，全稱澳大利亞聯邦，面積 768 萬平方公里(台灣為 3 萬 6 千平方公里)，是南半球最大的國家，但人口密度為每平方公里平均只有 2 人(台灣為 640 人)。2002 年底澳洲人口總數為 19,786,600 人，各州或領地之人口數目依次為 New South Wales (約 690 萬人)、Victoria (約 490 萬人)、Queensland (約 380 萬人)、Western Australia (約 200 萬人)、South Australia (約 150 萬人)、Tasmania (約 48 萬人)、Australian Capital Territory (約 32 萬人)及 Northern Territory (約 20 萬人)；而澳洲最大的城市為雪梨，人口超過 400 萬人。2002 年澳洲出生率為千分之 12.6 (total fertility rate 則為 1.75 per woman)，死亡率為千分之 6.8，自然增加率為千分之 5.9，但該年海外移民有 139,000 人，比自然增加的人口數 116,100 還多。此外，

根據 2001 年 6 月底的資料顯示，海外出生的澳洲住民約 450 萬人，佔人口總數之 23%，而其中 12 % 澳洲住民出生於歐洲及前蘇聯(6 %來自 UK 及 Ireland)，亞洲則佔 5.5 %；約 63 %的海外出生住民現在主要居住於 New South Wales 及 Victoria 內，而 Western Australia 住最多海外出生的住民(佔該洲人口數之 29 %)，而 Tasmania 最少(11 %)。2002 年底資料顯示，澳洲 65 歲以上的老人約有 250 萬人，佔人口總數之 12.6 %，而 85 歲以上的老人約 28 萬人，佔人口總數之 1.4 %。然而由於澳洲人生育率持續的降低以及其壽命逐年的延長，其老年人口比例將持續增加，根據專家預估在 2050 年時，65 歲以上老人將佔人口總數之 25 %，而 85 歲以上的老人則佔人口總數之 9 %。

圖 1. 澳洲人之年齡層分佈(2002 versus 1982)


根據資料指出，澳洲人在 1999-2001 年間，男性在其出生時的平均餘命為 77.0 歲，而女性則為 82.4 歲；但澳洲原住民的平均餘命約少 20 歲，男性其出生時的平均餘命為 56 歲，女性則為 63 歲，此外原住民的 infant mortality rate 為千分之

10.6，比全澳洲千分之 5.3 高出一倍。澳洲人死亡率有逐年下降的趨勢，而資料顯示其 2001 年死因前十名分別為癌症、ischemic heart diseases、stroke、COPD、accidents、DM、influenza and pneumonia、diseases of arteries, arterioles and capillaries、CHF 及 intentional self harm 等，男女前五大死因次序相同；其中死因第一位的癌症，進一步的分析發現，死因前三名的癌症在男性分別為支氣管及肺癌、攝護腺癌與大腸癌等，而女性則分別為乳癌、支氣管及肺癌與大腸癌等。然而根據盛行率的調查卻發現，常見的癌症在男性分別為 skin cancer、genital organ、GI 及 respiratory and intrathoracic organs 的 cancer 等，而在女性分別為 skin cancer、breast、genital organ 及 respiratory and intrathoracic organs 的 cancer 等。

表 1. 2001 年澳洲人常見死因

| Cause of death | Male | Female | Total | %Death |
|---|---|---|---|---|
| All Causes | 66,835 | 61,709 | 128,544 | 100.0 |
| Malignant neoplasm (cancer) (C00-C97) | 20,753 | 15,997 | 36,750 | 28.5 |
| Ischaemic heart diseases (I20-I25) | 13,906 | 12,328 | 26,234 | 20.4 |
| Cerebrovascular diseases (stroke) (I60-I69) | 4,852 | 7,294 | 12,146 | 9.4 |
| Chronic lower respiratory disease (including asthma, emphysema and bronchitis) (J40-J47) | 3,419 | 2,497 | 5,916 | 4.6 |
| Accidents (V01-X59) | 3,155 | 1,685 | 4,840 | 3.8 |
| Diabetes mellitus (E10-E14) | 1,639 | 1,439 | 3,078 | 2.4 |
| Influenza and pneumonia (J10-J18) | 1,184 | 1,518 | 2,702 | 2.1 |
| Diseases of arteries, arterioles and capillaries (including atherosclerosis and aortic aneurysm) (I70-I79) | 1,381 | 1,244 | 2,625 | 2.0 |
| Heart failure (I50) | 982 | 1,630 | 2,612 | 2.0 |
| Intentional self harm (X60-X84) | 1,935 | 519 | 2,454 | 1.9 |
| All other causes | 13,629 | 15,558 | 29,187 | 22.7 |

表 2. 2001 年澳洲人之腫瘤盛行率

| | Males | | Females | | Total | |
|---|---|---|---|---|---|---|
| Malignant neoplasms | '000 | % | '000 | % | '000 | % |
| Digestive organs | 21.4 | 0.23 | 7.0 | 0.07 | 28.4 | 0.15 |
| Respiratory and intrathoracic organs | 12.0 | 0.13 | 2.8 | 0.03 | 14.8 | 0.08 |
| Skin | 62.7 | 0.67 | 31.6 | 0.33 | 94.3 | 0.50 |
| Breast | - | - | 25.3 | 0.26 | - | - |
| Genital organs | 37.4 | 0.40 | 10.3 | 0.11 | 47.7 | 0.25 |
| Other and site unknown | 40.6 | 0.43 | 23.3 | 0.24 | 64.0 | 0.34 |
| Benign neoplasms and neoplasms of an uncertain nature | 12.1 | 0.13 | 39.2 | 0.41 | 51.3 | 0.27 |
| **All malignant neoplasms** | **176.1** | **1.88** | **135.2** | **1.42** | **311.3** | **1.65** |

## 二、澳洲的健康保險系統(Medicare)

澳洲的健康保險系統屬於 national health service model，其特色為範圍普及，財務來自一般稅收，醫療服務機構的所有權及控制權為政府所有。2000 年澳洲每人的 GDP 為 26,523 美元，而每人的健康醫療支出為 2,213 美元，約佔 GDP 之 8.3%。澳洲於 1984 年開始實施 Medicare，能夠享有該保險者的資格包括永久居民、已申請永久居民並有工作簽證、已申請永久居民，且其父母、配偶或子女為澳洲公民或永久居民等；保險涵蓋的範圍包括醫師診查費、檢驗費、驗光師費、大部份的手術與治療費及特殊的牙醫師費等醫院外服務(out-of-hospital services)，而 Medicare 給付公定價格之 85 %或公定價格減 57.10 元(取較高者)。

若其一年內醫院外服務差額已達319.7元時，Medicare安全網(Medicare Safety Net)則會使其給付 100 %的公定價格。醫院內服務(in-hospital services)分成 public patient 身份，即於公立醫院接受其指定的醫師看診，而 Medicare 會給付所有費用；或是 private patient 身份，可在公立或私人醫院自己選擇醫師看診，但 Medicare 只給付公定價格之 75 %，且並不給付手術、住院、護理及藥物等費用。除已在公立醫院時有些項目會給付外，Medicare 並不涵蓋牙齒檢查與治療、居家護理、針灸、義肢、助聽器、藥物福利計劃(Pharmaceutical Benefit Scheme，簡稱 PBS)不涵蓋的藥物、物理及職能治療、語言治療、心理治療及足部治療等，此外美容手術及應由其他人所負責的醫療費用，例如保險公司、雇主或政府機構等，Medicare 也不予給付。

## 三、澳洲的老人照護系統 (Aged care in Australia)

澳洲的老人照護系統大致可分成社區照護與院所照護兩大類(圖 2)。2002 年聯邦政府在老人照護的總支出約為 55 億元，其中在院所照護中支出約 40 億。

### 1. 社區照護 (community care)

*居家及社區照護 (Home and community care，簡稱 HACC)*

此類服務的對象包括虛弱的老人，殘障者及其照護者，透過提供護理及其他醫療專業照護、餐飲服務、在宅服務、個人照護、居家環境改善、交通運輸、喘息照護(respite care)、照會及健康評估等服務內容，使其能在家庭及社區獨立生活,提

高生活品質並避免其住進護理院。此類服務由聯邦政府補助百分之六十，其於由州政府及地方政府負擔，因此只需少許費用就能得到此類服務，2002 年聯邦政府約支出 10 億元。此外不同種族語言的族群，包括原住民及 Torres Strait Islanders、老年痴呆症患者、偏遠離島的國民及經濟困難者會另有特別的優惠服務。根據 2001 年資料顯示，任一時間約有 31 萬 5 千人，一年約 60 萬人接受此類服務。68 %接受服務者為女性，72 %的人年齡超過 70 歲，94 %者為接受政府老年或其它津貼，24 %為出生在其它國家者，9%在家說其它語言，而 58%有一位照護者，全國共約有 4000 機構提供此類服務。

*社區老人照護套裝服務 (Community Aged Care Packages，簡稱 CACPs)*

在老人照護評估小組評估其需求後，提供洗澡、如廁、洗衣、餐飲、購物、逛街、修剪花草及交通運輸等個別化的服務，使老人能繼續在家中生活。聯邦政府補助 CACPs 的提供者，因此老人只需少許費用就能得到此類服務，2002 年聯邦政府約支出 2 億 5 千萬元。另外有老人居家延展照護(Extended aged care at home,簡稱 EACH)，主要讓虛弱的老人能在家中接受高等級的照護，目前共有 19 家機構提供 450 人的服務，其成效仍在評估中。

*日間治療中心 (Day Therapy Centers，簡稱 DTCs)*

全澳洲有 155 個聯邦政府資助的日間治療中心，所提供的服務包括物理治療(physiotherapy)、職能治療(occupational therapy)、語言治療(speech therapy)及足科治療(podiatry)，目地是能幫助老人維持或恢復一定程度獨立生活的能力,使他們

能繼續在家中或低等級的護理院，2002 年聯邦政府約支出 3 千萬元。

*喘息照護 (Respite care)*

若照護者想要休息一段或長或短的時間，但希望讓受照護者能持續生活，喘息照護即可符合需求。喘息照護可在家中、日間照護中心或護理院進行。此外，醫院對於照護者也有一系列的訓練活動，舉例來說 Royal North Shore Hospital 的 Aged Care & Rehabilitation Department 一年有三次，每班 10~12 人，名為 Care for carers programme，每次有 6 天的課程(每星期一天)，課程內容包括 impact of caring、relaxation exercise、coping with changes、family stress and conflicts、various ways of taking breaks/respite care、loss and grief、looking after yourself、nurse "managing dementia & difficult behaviour、physio & OT "practical help with daily tasks、dietitian、stress management & relaxation 及其實習課程等，這些課程全部免費，也有免費停車的優待。

這些服務可由政府補助或民間公益及宗教團體所提供，也可由私人公司提供部份或綜合的服務內容。舉例來說，Silver Circle 是提供這類服務的機構，包括 (1) home assist-cleaning, cooking, shopping, laundry, making beds, paying bills 之 domestic help、help with showering, dressing, personal hygiene and attending appointments 之 personal care、taking care when family carers are unavailable or need a break 之 respite care、sharing time at home or on an outing 之 companionship 以及 Security, company and assistance at home 之 24 hour and overnight care；(2) home

safe-improve safety, security, independence and access at home with simple home adaptations, modifications and maintenance, and with inexpensive independent living aids and equipment；(3) home alert-safety, reassurance and emergency response at the touch of button；(4) information and advice 等四類服務。

**2. 院所照護 (Residential care)**

院所照護又可分成高等級(high level)院所照護、低等級(low level)院所照護及支持性照護(supported)院所照護(簡稱 SRC)等三種，在護士等專業工作人員的照護下，受照護者可以在不同等級的院所中生活。高等級的院所照護一般需要 24 小時的照護，可提供住宿、支持性服務(清潔、洗衣及餐食等)、個人照護服務(協助穿衣、就餐、如廁、洗澡及行動等)、聯合保健服務(物理治療、職能治療、休閒治療及足部治療等)及其它必要的護理照護；低等級的院所照護重點則在於個人照護服務(協助穿衣、就餐、如廁、洗澡及行動等)及某些聯合保健服務(物理治療、職能治療、休閒治療及足部治療等)等照護服務；而在支持性照護院所內，主要是由非護士提供服務，但提供的照護方式是相似的。

高等級與低等級的院所照護都從政府獲得資金補助，相對的這些院所必需確保其能夠提供優質的管理、包括滿足不同生活方式與心靈層次的個人照料、安全性以及適當的硬體建築。支持性照護院所則無法獲得政府資助，主要由私人經營，即使是私人事業，不過這些機構仍需提供適當的照護給其服務的對象。

| | High care | Low care | Supported Residential Services (SRS) |
|---|---|---|---|
| *Do we need an Aged Care Assessment Service (ACAS)?* | Yes | Yes | No |
| *What sorts of fees are charged?* | Daily fees and accommodation charges decided by the Commonwealth Government. | Daily fees and accommodation bonds decided by the Commonwealth Government. | Daily fees set by the owner. |
| *What is the level of care?* | For people who need 24-hour high level care. | For people who need 24-hour low level care. | For people who want to live in a place that can support them, or who need help some of the time. |
| *Who works there?* | A Director of Nursing usually, other nurses and personal care workers. | A supervisor or manager who may be a nurse, and personal care workers. | A manager or the owner who may be a nurse, and personal care workers. |

| | **High care** | **Low care** | **Supported Residential Services (SRS)** |
|---|---|---|---|
| *Are there facilities for people who have migrated from different countries?* | Most high care places care for all people. Some facilities specifically target particular ethnic groups—see the list at the end. | Most low care places care for all people. Some facilities specifically target particular ethnic groups—see the list at the end. | Most Supported Residential Services (SRS) care for all people. Some facilities specifically target particular ethnic groups—see the list at the end. |
| *Do these facilities care for people with dementia?* | Some facilities are specifically designed to ensure that people who are likely to wander off are safe and secure. | Some facilities are specifically designed to ensure that people who are likely to wander off are safe and secure. | Some facilities are specifically designed to ensure that people who are likely to wander off are safe and secure. |

有關 70 歲以上老人接受院所照護及 CACPs 的情形如下表，以 2002 年的資料顯示，1,000 位老人中有 81.6 人接受院所照護，而有 14.7 人接受 CACPs。

Table 1: Number of operational residential aged care places and Community Aged Care Packages and the provision ratio per 1,000 persons aged 70 years and over, [a] 30 June 1995 to 30 June 2002

| Year | Residential places | Community Aged Care Packages | Total | Places per 1,000 persons aged 70 and over | Packages per 1,000 persons aged 70 and over | Ratio per 1,000 persons aged 70 years and over[a] |
|---|---|---|---|---|---|---|
| 1995 | 134,810.0 | 2,542.0 | 137,352 | 92.2 | 1.7 | 93.9 |
| 1996 | 136,851.0 | 4,431.0 | 141,282 | 90.6 | 2.9 | 93.5 |
| 1997 | 139,058.0 | 6,124.0 | 145,182 | 89.2 | 3.9 | 93.1 |
| 1998 | 139,917.0 | 10,046.0 | 149,963 | 87.1 | 6.3 | 93.3 |
| 1999 | 141,697.5 | 13,896.5 | 155,594 | 85.6 | 8.4 | 94.0 |
| 2000 | 142,341.5 | 18,308.5 | 160,650 | 83.6 | 10.8 | 94.4 |
| 2001 | 144,012.5 | 24,629.5 | 168,642 | 82.2 | 14.0 | 96.2 |
| 2002 | 146,268.0 | 26,425.0 | 172,693 | 81.6 | 14.7 | 96.4 |

(a) The ratios are based on Australian Bureau of Statistics (ABS) population estimates released in March 2003, cat. no. 3101.0, and are recalculated back to 1997.

Note: From 1999, the data in this table include places and packages provided by Multi-Purpose Services and flexible funding under the Aboriginal and Torres Strait Islander Aged Care Strategy. In 1998 there were a total of 143.5 packages and 1,046.5 places.

## 四、老人醫學專科醫師(Geriatrians)

澳洲的老人醫學專科是 RACP (Royal Australasian College of Physicians)成人內科(Adult Medicine)的次專科，通常需要 6 年以上的臨床訓練。所有接受完 basic and advanced training 並通過考試者，即可以在他(她)的名字後面加上 FRACP (Fellow of the Royal Australasian College of Physicians)。RACP (次專科包括 cardiology、clinical genetics、clinical pharmacology、community child health、pediatric emergency medicine、endocrinology、gastroenterology and hepatology、general medicine、geriatric medicine、general pediatrics、hematology、immunology and allergy、infectious diseases、intensive care medicine、neonatal/perinatal medicine、nephrology、nuclear medicine、oncology、pediatrics and child and adolescent psychiatry、pediatric rehabilitation medicine、palliative medicine、rheumatology、sleep medicine、thoracic medicine 等)主要分成 Adult Medicine 及 Pediatrics & Child Health 兩大專科，而老人醫學專科屬 Adult Medicine 的次專科。

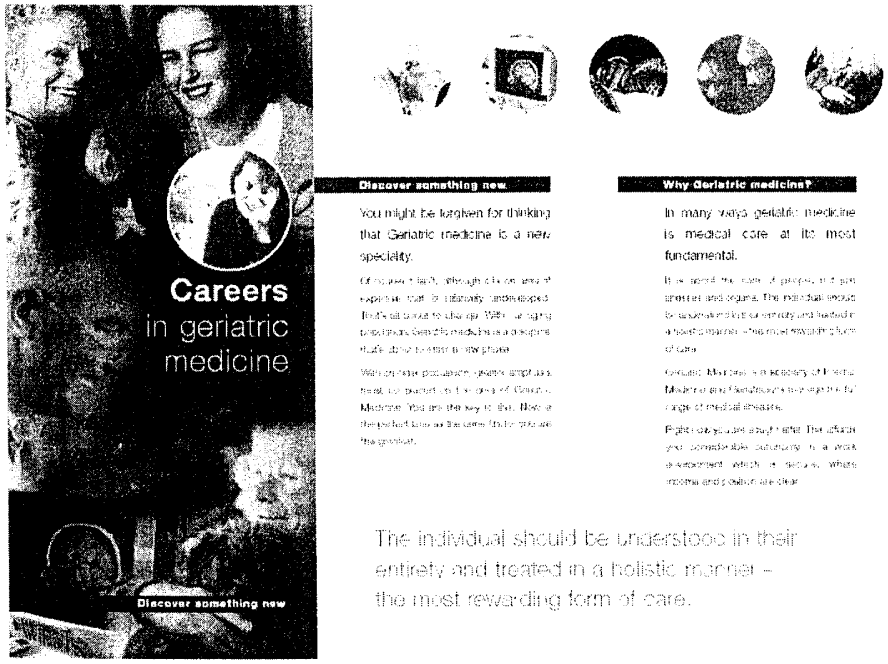
要成為澳洲的老人醫學次專科醫師，必需先在醫學系畢業後經過一年的internship (PGY1)及 RMO (resident medical officer)1 和 RMO2 的住院醫師訓練後，通過在其 RMO3 或 Registrar 時所進行筆試與口試後(如此便成為 advanced trainee)，之後進入 vocational training，當完成符合老人醫學專科之訓練後，通過專科考試後才能成為老人醫學專科醫師。Vocational training in geriatric medicine 的原則主要讓訓練完後的老人醫學專科醫師，能夠具備以下的知識與技能：

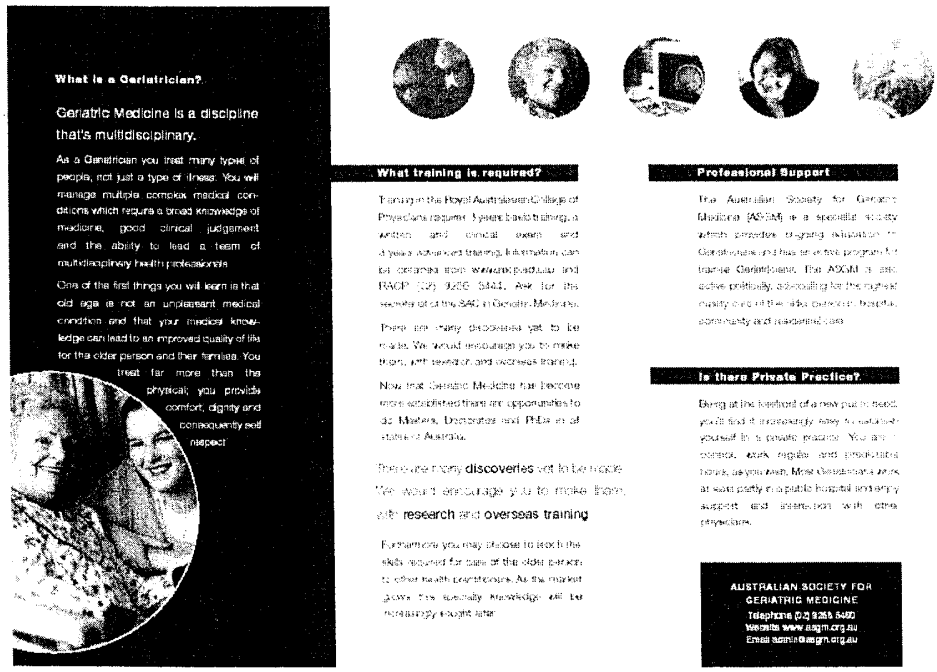
1. a knowledge of the normal ageing processes;
2. an understanding that geriatric medicine focuses on the chronic and acute diseases associated with ageing;
3. an understanding of the management of complex, often multiple, medical problems which often requires a coordinated interdisciplinary approach;
4. an ability to assess impairment, disability and handicap, and devise appropriate management strategies;
5. an ability to use appropriate resources for rehabilitation;
6. an understanding of the effect of physical illness, psychological illness, social and environmental factors on the health of an older person;
7. judgment in the application of investigations and therapeutic procedures in the care of older patients;

8. an understanding of the role of preventative approaches for older people, including health promotion;

9. an understanding of principles of palliative care.

其訓練內容包括：(1) core training-至少 2 年，包括 acute, evaluation and management care、rehabilitative care、geriatric medical consultative care、domiciliary consultations、day and ambulatory (outpatient) care、respite care 及 long term care 的訓練經驗；(2) non core advanced training-指 1 年與老人醫學相關的領域，包括 clinical epidemiology, neurology, clinical pharmacology, rheumatology, rehabilitation medicine, palliative care, psychogeriatrics or age-related research 等。此外，在次專科訓練期間，必需有以下至少 3 項的成果，包含 published research paper (aim for at least one during advanced training)、published literature review (aim for at least one during advanced training)、case report and review、lecture/platform presentation, e.g. to the Annual Scientific Meeting (ASM) of the Australian Society for Geriatric Medicine (ASGM)、research proposal、audit/QA 及 computer interactive educational program 等，且必需通過 2 位 SAC (specialist Advisory committee)的考評。而如果想拿兩種次專科者，通常可以接受 2 年的老人醫學專科 core training 及另外 2 年的其它次專科的 core training programs，而其中一般醫學(general medicine)最受歡迎，其次為 rheumatology、oncology 及 gastroenterology 等。




根據 2001 年針對 advanced trainee 所做的調查發現，當其在接受 basic training 時或 internship 時較會影響將來選擇成為老人醫學專科醫師，醫學生時期受到影

響而想走老人醫學專科倒是很少。此外，正面影響其意願最重要的因素為其認定老人醫學專科是全人醫學、團隊工作及一般醫學，且其工作內容有變化，喜歡未來成為老人醫學專科醫師後的生活方式等，而負面的因素包括其專業不受其它專科重視、經費補助少、缺乏工作人員、收入不佳、過去沒有標準專科模式、治療病人成果有限及研究機會不多等，例如 NHMRC 對其它專科在老化的研究，即可能對某些想在進行學術研究者產生負面影響，減低其選擇老人醫學專科的意願。

五、一般科醫師**(General practitioner)**在老人照護上的角色

由於老年人口的增加及老年醫學專科醫師的不足，一般科醫師(家庭醫師)的角色更顯得十分重要。據統計，老年人佔一般科醫師門診就診人數的比例接近一半左右。老人的健康問題，有以下幾個特色：(1)多重病變(multiple pathologies and multi-system disease)，(2)非典型的疾病表現，(3)溝通困難，(4)很多找不出病因的健康問題，(5)功能性評估的重要，(6)服用多種藥物(polypharmacy)，(7)較差的生理、心理及經濟能力的應付能力，(8)需要親友或其他醫療專業人員的協助，(9)必需瞭解社區資源，(10)更需持續性的照顧。此外，某些疾病也比較常發生在老年人。因此，一般科醫師在老年人，必需應用自己的專業，提供更為持續性的健康照護，使其能在老年人自己的生活環境中，維持最佳的健康狀況。

自從 1999 年以來，澳洲推行 Enhanced Primary Care，其目的即是在提供老

年人更多的預防保健服務，並改善一般科醫師與其他醫療專業人員對有慢性病及有複雜需求的病人，提供更具協調性的醫療照護。例如定期健康評估的服務，主要對象為 75 歲以上老人或 55 歲以上澳洲原住民及 Torres Strait Island 之島民，在非住院期間(包括醫院、日間醫院及院所照護機構等)，每年皆可在家或在門診，接受由政府補助的健康評估，由一般科醫師及其他醫療專業人員執行，包括完整的身體、心理及社會功能之評估；提供有需要一位一般科醫師及兩位以上專業醫療人員照護的出院病人(discharge care plan)或社區的病人(community care plan)，團隊的醫療照護服務(multidisciplinary care plan)。

**1. 定期健康評估(Health assessment)**

75歲以上老人或55歲以上原住民及Torres Strait Island島民，每年可在家或門診接受由政府補助的健康評估，由一般科醫師及其他醫療專業人員執行，包括約60~90分鐘之身體、心理及社會功能的評估，以確定是否提供其預防性健康照護及教育。 檢查項目包括血壓、脈博、藥物史、失禁、疫苗注射、生活功能(如transfer between bed, chair & toilet, bathing, dress, shop等)、 過去三個月內的跌倒史、心理功能(如cognition 及mood)、社會功能(如availability and adequacy of paid and unpaid help)及是否正在照護別人。其它如是否能開車、聽力、視力、口腔衛生、飲食與營養狀況、抽菸與飲酒史、足部照護、睡眠、居家安全、心血管危險因子及社區服務的需要性等。

2. 一般科門診老人疾病統計

此資料來源乃源自於Bettering the Evaluation and Care of Health (BEACH)計劃的分析統計。BEACH是政府對一般科門診服務內容所進行的持續性調查研究，每年收集1,000位一般科醫師門診中100個就醫病人的資料共100,000筆，其中有49,647人為大於65歲者，65~74歲佔其48.3%，75歲以上佔51.7%。96.3%至門診就醫，年齡越大者較需家訪；診查時間平均為15.4分鐘(65歲以下為14.9分鐘)，75歲以上為15.6分鐘。多數老年病人為女性(59%)，就診的原因依次為General and unspecified(37.6%)、circulatory system (25.1 %)、musculoskeletal system (19.4 %)、respiratory system (18.7 %)及skin (15.1 %)等，而requests for prescription (16.8 %)是最常就診的理由，其次為要求心臟檢查(11.9 %)及注射疫苗(6.0 %)。

表 3. 一般科門診老人就診的原因

| | 65–74 (*n* = 24,003) | | | 75+ (*n* = 25,644) | | | Total 65+ (*n* = 49,647) | | |
|---|---|---|---|---|---|---|---|---|---|
| ICPC–2 chapter | Rate per 100 encs[a] | 95% LCL | 95% UCL | Rate per 100 encs[a] | 95% LCL | 95% UCL | Rate per 100 encs[a] | 95% LCL | 95% UCL |
| General & unspecified | 34.7 | 33.6 | 35.8 | 40.3 | 39.0 | 41.6 | 37.6 | 36.5 | 38.6 |
| Circulatory | 25.3 | 24.4 | 26.1 | 25.0 | 24.0 | 26.1 | 25.1 | 24.3 | 26.0 |
| Musculoskeletal | 20.6 | 19.8 | 21.4 | 18.3 | 17.7 | 19.0 | 19.4 | 18.9 | 20.0 |
| Respiratory | 20.3 | 19.5 | 21.2 | 17.2 | 16.3 | 18.0 | 18.7 | 18.0 | 19.4 |
| Skin | 14.1 | 13.4 | 14.8 | 16.0 | 15.3 | 16.8 | 15.1 | 14.6 | 15.6 |
| Endocrine & metabolic | 11.2 | 10.5 | 11.9 | 7.1 | 6.5 | 7.7 | 9.1 | 8.6 | 9.5 |
| Digestive | 9.1 | 8.5 | 9.6 | 8.3 | 7.8 | 8.8 | 8.7 | 8.3 | 9.0 |
| Psychological | 6.2 | 5.8 | 6.6 | 7.3 | 6.7 | 7.9 | 6.8 | 6.4 | 7.2 |
| Neurological | 5.1 | 4.6 | 5.6 | 4.9 | 4.4 | 5.3 | 5.0 | 4.7 | 5.2 |
| Urology | 3.3 | 2.7 | 3.9 | 3.6 | 3.2 | 4.1 | 3.5 | 3.2 | 3.7 |
| Ear | 3.1 | 2.6 | 3.7 | 3.1 | 2.7 | 3.6 | 3.1 | 2.9 | 3.4 |
| Eye | 2.9 | 2.3 | 3.4 | 3.0 | 2.6 | 3.5 | 3.0 | 2.7 | 3.2 |
| Blood | 2.6 | 1.8 | 3.4 | 2.6 | 1.9 | 3.3 | 2.6 | 2.2 | 3.0 |
| Female genital system | 2.8 | 2.0 | 3.6 | 1.3 | 0.6 | 2.1 | 2.1 | 1.7 | 2.4 |
| Male genital system | 1.4 | 0.5 | 2.2 | 1.0 | 0.3 | 1.8 | 1.2 | 0.8 | 1.6 |
| Social problems | 0.8 | 0.0 | 1.9 | 0.9 | 0.0 | 1.7 | 0.8 | 0.4 | 1.3 |
| Total RFEs | 163.5 | 161.8 | 165.2 | 160.1 | 158.2 | 162.0 | 161.7 | 160.1 | 163.4 |

表 4. 一般科門診老人就診的理由

| Patient reasons for encounter | 65–74 (n = 24,003) Rate per 100 encs[a] | 95% LCL | 95% UCL | 75+ (n = 25,644) Rate per 100 encs[a] | 95% LCL | 95% UCL | Total 65+ (n = 49,647) Rate per 100 encs[a] | 95% LCL | 95% UCL |
|---|---|---|---|---|---|---|---|---|---|
| Prescription all* | 17.1 | 16.2 | 18.1 | 16.5 | 15.6 | 17.4 | 16.8 | 16.0 | 17.6 |
| Cardiac check-up* | 12.3 | 11.5 | 13.1 | 11.5 | 10.5 | 12.5 | 11.9 | 11.2 | 12.6 |
| Immunisation/vaccination (all)* | 6.7 | 4.7 | 8.7 | 5.5 | 3.0 | 7.5 | 6.0 | 4.4 | 7.5 |
| Test results* | 6.7 | 6.0 | 7.3 | 4.4 | 3.8 | 5.1 | 5.5 | 5.1 | 5.9 |
| General check-up* | 3.8 | 2.9 | 4.6 | 7.1 | 6.3 | 7.9 | 5.5 | 4.9 | 6.0 |
| Hypertension | 4.8 | 3.6 | 6.0 | 4.2 | 3.1 | 5.2 | 4.5 | 3.7 | 5.2 |
| Cough | 4.5 | 3.9 | 5.1 | 3.7 | 3.2 | 4.2 | 4.1 | 3.8 | 4.4 |
| Back complaint* | 3.6 | 2.9 | 4.2 | 3.3 | 2.8 | 3.8 | 3.5 | 3.1 | 3.8 |
| Rash* | 2.0 | 1.3 | 2.6 | 2.0 | 1.5 | 2.5 | 2.0 | 1.7 | 2.3 |
| Skin symptom/complaint | 1.9 | 0.8 | 3.0 | 2.0 | 1.3 | 2.7 | 1.9 | 1.5 | 2.4 |
| Shortness of breath/ dyspnoea | 1.5 | 0.6 | 2.4 | 2.3 | 1.8 | 2.9 | 1.9 | 1.6 | 2.3 |
| Diabetes* | 2.3 | 1.4 | 3.2 | 1.6 | 0.9 | 2.3 | 1.9 | 1.5 | 2.4 |
| Vertigo/dizziness | 1.8 | 1.1 | 2.6 | 2.0 | 1.5 | 2.5 | 1.9 | 1.6 | 2.2 |
| Leg/thigh symptom/complaint | 1.8 | 1.1 | 2.6 | 1.6 | 1.0 | 2.1 | 1.7 | 1.4 | 2.0 |
| Knee symptom/complaint | 1.9 | 1.1 | 2.6 | 1.5 | 0.9 | 2.1 | 1.7 | 1.4 | 2.0 |
| Sleep disturbance | 1.4 | 0.5 | 2.2 | 1.7 | 0.9 | 2.4 | 1.5 | 1.1 | 1.9 |
| Subtotal (% [b]) | 17,746 | 45.2% | — | 18,105 | 44.1% | — | 35,851 | 44.6% | — |
| Total RFEs | 39,244 | — | — | 41,052 | — | — | 80,296 | — | — |

以疾病別來看，常處理的疾病依序為hypertension (19.9 %)、osteoarthritis (6.2%)、diabetes (5.9 %)、lipid disorders (4.8 %)、ischemic heart disease (3.8 %)、sleep disturbance (3.0 %)、depression (2.8%)、esophageal disease (2.7 %)、heart failure (2.7 %)及acute bronchitis (2.7 %)等，這些統計乃使用ICPC (International Classification of Primary Care) -2 plus的歸類方法所計算得之。然而在其中的調查發現有93.2%的老人有慢性病，其中最多為hypertension佔45.6%，其次為osteoarthritis佔20.9%及lipid disorders佔17.5%；危險因子的盛行率分別為酗酒16.3%、抽菸7.5%、肥胖19.1%及體重過輕7.9%。

老人用藥平均為1.3種，常用的藥依次為心血管藥物、中樞神經藥物(包括simple analgesics 及compound analgesics、narcotics與止吐藥)、抗生素、安眠鎮定劑、骨骼肌肉藥物(包括NSAIDs)等，其中31.6 %的老人使用心血管藥物，而有6.7%

的老人使用NSAIDs。

非藥物治療包括臨床治療(clinical treatment)佔30.8%及procedural treatment佔15.3%，前者包括營養與體重諮詢(最多，佔5.1%)、用藥諮詢、心理治療及戒菸等，後者包括切除、電燒、引流及局部注射等。

轉診至其它專科醫師比率為8.1%，而轉介至其它醫療專業人員為2.7%。血液檢查佔33.5%，檢查項目依次為blood count(4.7%)、lipids(2.4%)及liver function(2.3%)等；而影像檢查(包括X光、乳房攝影、骨密度及超音波等)與心電圖佔8.1%，其中胸部X光最多佔1.4%。

表 5. 一般科門診老人疾病別分佈

| | 65–74 (n = 24,003) | | | 75+ (n = 25,644) | | | Total 65+ (n = 49,647) | | |
|---|---|---|---|---|---|---|---|---|---|
| Problem managed | Rate per 100 encs[3] | 95% LCL | 95% UCL | Rate per 100 encs[3] | 95% LCL | 95% UCL | Rate per 100 encs[3] | 95% LCL | 95% UCL |
| Hypertension* | 20.7 | 19.9 | 21.4 | 19.2 | 18.3 | 20.0 | 19.9 | 19.2 | 20.6 |
| Osteoarthritis* | 6.1 | 5.5 | 6.6 | 6.4 | 5.8 | 6.9 | 6.2 | 5.9 | 6.6 |
| Immunisation/vaccination (all)* | 6.9 | 5.0 | 8.9 | 5.5 | 3.3 | 7.6 | 6.2 | 4.7 | 7.7 |
| Diabetes* | 7.0 | 6.4 | 7.6 | 4.9 | 4.5 | 5.4 | 5.9 | 5.6 | 6.3 |
| Lipid disorder | 6.7 | 6.1 | 7.3 | 3.1 | 2.5 | 3.7 | 4.8 | 4.5 | 5.2 |
| Ischaemic heart disease* | 3.3 | 2.7 | 3.9 | 4.3 | 3.8 | 4.8 | 3.8 | 3.5 | 4.1 |
| Prescription all* | 3.2 | 2.1 | 4.2 | 3.3 | 2.3 | 4.4 | 3.2 | 2.6 | 3.9 |
| Sleep disturbance | 2.4 | 1.7 | 3.2 | 3.5 | 2.9 | 4.2 | 3.0 | 2.6 | 3.4 |
| Depression* | 2.9 | 2.3 | 3.6 | 2.7 | 2.2 | 3.2 | 2.8 | 2.5 | 3.1 |
| Oesophageal disease | 2.9 | 2.3 | 3.5 | 2.5 | 2.0 | 3.0 | 2.7 | 2.4 | 3.0 |
| Heart failure | 1.5 | 0.8 | 2.4 | 3.8 | 3.2 | 4.2 | 2.7 | 2.4 | 3.0 |
| Acute bronchitis/ bronchiolitis | 2.5 | 1.7 | 3.3 | 2.6 | 2.0 | 3.1 | 2.5 | 2.2 | 2.9 |
| Cardiac check-up* | 2.4 | 1.2 | 3.6 | 2.3 | 1.3 | 3.2 | 2.3 | 1.7 | 3.0 |
| General check-up* | 1.6 | 0.7 | 2.4 | 2.9 | 2.3 | 3.6 | 2.3 | 1.9 | 2.6 |
| Chronic obstructive pulmonary disease | 2.2 | 1.4 | 2.9 | 2.3 | 1.8 | 2.8 | 2.2 | 1.9 | 2.5 |
| Back complaint* | 2.4 | 1.7 | 3.1 | 2.0 | 1.4 | 2.6 | 2.2 | 1.9 | 2.5 |
| Atrial fibrillation/flutter | 1.6 | 0.8 | 2.5 | 2.6 | 2.1 | 3.2 | 2.2 | 1.8 | 2.5 |
| Asthma | 2.6 | 2.0 | 3.2 | 1.7 | 1.1 | 2.4 | 2.2 | 1.9 | 2.4 |
| Solar keratosis/sunburn | 2.1 | 1.1 | 3.1 | 2.2 | 1.5 | 2.8 | 2.1 | 1.7 | 2.5 |
| UTI* | 1.8 | 1.1 | 2.4 | 2.5 | 2.0 | 2.9 | 2.1 | 1.9 | 2.3 |
| Upper respiratory infection, acute | 2.5 | 1.7 | 3.2 | 1.7 | 1.1 | 2.3 | 2.1 | 1.7 | 2.4 |
| Osteoporosis | 1.8 | 1.1 | 2.5 | 2.2 | 1.6 | 2.7 | 2.0 | 1.7 | 2.3 |
| Malignant neoplasm, skin | 1.8 | 0.9 | 2.8 | 2.0 | 1.4 | 2.6 | 1.9 | 1.5 | 2.3 |
| Anxiety* | 1.8 | 1.1 | 2.5 | 1.7 | 1.1 | 2.4 | 1.8 | 1.4 | 2.1 |
| Contact/allergic dermatitis | 1.6 | 0.9 | 2.3 | 1.9 | 1.4 | 2.4 | 1.7 | 1.5 | 2.0 |
| Chronic ulcer, skin | 0.9 | 0.0 | 1.9 | 2.5 | 1.8 | 3.2 | 1.7 | 1.4 | 2.1 |
| Arthritis* | 1.5 | 0.5 | 2.5 | 1.6 | 0.7 | 2.5 | 1.5 | 1.0 | 2.0 |
| Success* (n, %) | 22,481 | 51.3% | — | 25,182 | 57.4% | — | 47,591 | 66.0% | — |
| Total problems (n) | 43,829 | — | — | 43,829 | — | — | 85,005 | — | — |

表 6. 一般科門診老人接受的檢驗項目內容

| Pathology test type | 65–74 (*n* = 24,003) | | | 75+ (*n* = 25,644) | | | Total 65+ (*n* = 49,647) | | |
|---|---|---|---|---|---|---|---|---|---|
| | Rate per 100 encs | 95% LCL | 95% UCL | Rate per 100 encs | 95% LCL | 95% UCL | Rate per 100 encs | 95% LCL | 95% UCL |
| Full blood count | 4.7 | 4.1 | 6.4 | 4.7 | 4.1 | 5.3 | 4.7 | 4.4 | 6.1 |
| Lipids | 3.2 | 2.4 | 4.0 | 1.7 | 0.8 | 2.5 | 2.4 | 1.9 | 2.8 |
| Liver function | 2.6 | 1.8 | 3.4 | 1.9 | 1.1 | 2.7 | 2.3 | 1.8 | 2.7 |
| EUC | 1.9 | 0.7 | 3.2 | 2.0 | 0.9 | 3.0 | 2.0 | 1.3 | 2.7 |
| Urine MC&S | 1.6 | 0.8 | 2.4 | 2.0 | 1.4 | 2.6 | 1.8 | 1.5 | 2.1 |
| INR | 1.7 | 0.7 | 2.7 | 1.7 | 1.0 | 2.5 | 1.7 | 1.3 | 2.2 |
| Glucose | 2.1 | 1.2 | 3.1 | 1.2 | 0.3 | 2.0 | 1.6 | 1.1 | 2.1 |
| HbA1c | 1.4 | 0.5 | 2.3 | 1.0 | 0.3 | 1.7 | 1.2 | 0.9 | 1.6 |
| ESR | 1.3 | 0.2 | 2.3 | 1.2 | 0.3 | 2.1 | 1.2 | 0.8 | 1.7 |
| U&E | 1.1 | 0.0 | 2.6 | 1.1 | 0.0 | 2.6 | 1.1 | 0.2 | 1.9 |
| *Subtotal (n, %)* | 9,925 | 59.7 | — | 5,198 | 58.6 | — | 4,729 | 60.9 | — |
| Total pathology tests (*n*, %) | 8,858 | 100.0 | — | 7,766 | 100.0 | — | 16,634 | 100.0 | — |

*Note.* Encs—encounters; LCL—lower confidence limit; UCL—upper confidence limit; EUC—electrolytes, urea and creatinine; MC&S—microscopy culture & sensitivity; INR—international normalised ratio; HbA1c glycosated haemoglobin; ESR—erythrocyte sedimentation rate; U&E—urea and electrolytes

六、雪梨大學與其建教合作醫院

雪梨大學是澳洲最好的學校之一，該大學共包含 3 個 college，亦即 The College of Health Sciences、The College of Humanities and Social Sciences 及 The College of Sciences and Technology，其中 The College of Health Sciences 再分成 5 個 faculty (**Medicine**、Dentistry、Pharmacy、Nursing 及 Health Sciences)，The College of Humanities and Social Sciences 再分成 7 個 faculty，而 The College of Sciences and Technology 再分成 6 個 faculty (**Science**、Engineering、Architecture、Rural Management、Veterinary Science 及 Agriculture, Food and Natural Resources)。Faculty of Science 再細分成 Department of Agricultural Chemistry & Soil Science、Department of Anatomy & Histology、School of Biological Sciences、School of

Chemistry、School of Geosciences、Unit for History & Philosophy of Science、School of Information Technologies、School of Mathematics & Statistics、**School of Molecular & Microbial Biosciences**、Department of Pathology、Department of Pharmacology、School of Physics、Department of Physiology 及 school of Psychology，而筆者所在單位 **Human Nutrition Unit** 即屬 School of Molecular & Microbial Biosciences (MMB)中，有趣的是，MMB 也屬 Faculty of Medicine 科系之一，主要是因為兩個 faculty 之間教學與研究關係十分密切。Human Nutrition Unit 中的第 1 號人物就是 Professor Ian Caterson，除了本身是 endocrinologist 外，他同時也是 Faculty of Medicine 的 associate dean，因此在他的團隊中進修，對於筆者在澳洲一年內多元的學習助益頗大。Faculty of Medicine 與 40 餘家醫院有建教關係，其中以 Royal Prince Alfred Hospital 規模最大，也是澳洲歷史優久(1882 年)、規模最大(850 床)的教學及研究醫學中心。不過有關老人醫學的教學、服務及研究，卻以離校區約 15 公里的 Concord Repatriation General Hospital (500 床)中的 The Centre for Education and Research on Ageing (CERA)最為有名。此外，Balmain Hospital (93 床的社區醫院，主要提供 General Medicine, Geriatric and Rehabilitation services，也提供急診服務)也提供 Royal Prince Alfred Hospital 老人科的轉介病房，亦即當完成住院初期的檢查處置之後，可再由 Royal Prince Alfred Hospital 轉至 Balmain Hospital 繼續其醫療照護。因此這兩家醫院老人醫學科的主任皆為同一人 Dr. George Szonyi，以便於處理相關事務，此模式類似台大與公

館分院的關係，可作為本院老人醫學科發展的參考。而同屬雪黎大學教學醫院的 Royal North Shore Hospital (660 床)之老人醫學科，其社區老人照護與 fall clinics 也頗負盛名，除此之外，老人的健康問題常與復健醫學有很大的交集，因此筆者也至 Rehabilitation Research Center 參觀學習。當然，社區老人照護的瞭解，也必需親至前往觀摩，包括診所、院所照護機構、社區健康中心(包括 day care、meals on wheels 等)及退休村(retirement village)等，而在像澳洲有許多來至不同國家的公民，專屬華人的社團機構也有參訪學習的價值。

圖 6.1 Hip protector for patients with high risk of falling and fracture.

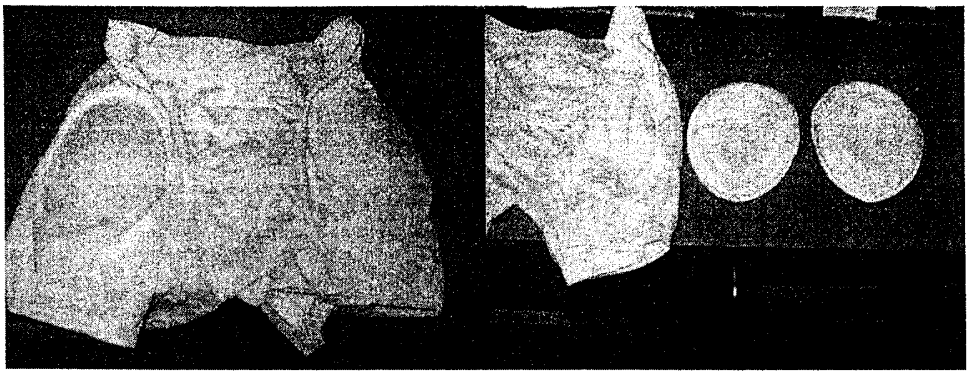


圖 6.2 The Center for Education and Research on Aging at the Concord Repatriation General Hospital.

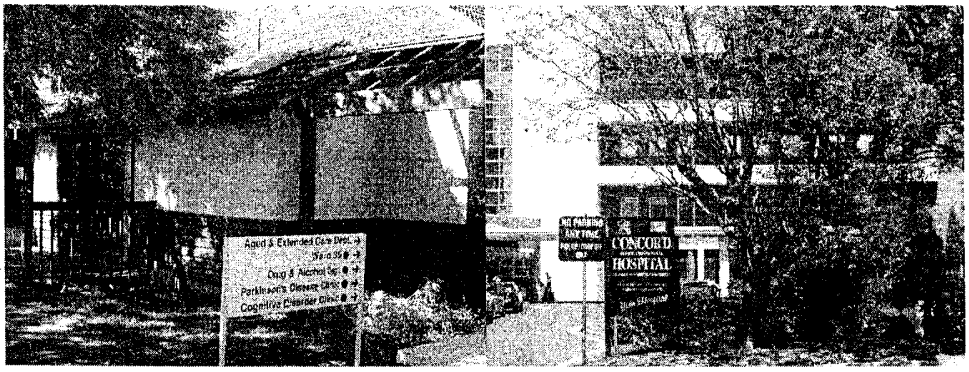



圖 6.3 Acute and psychogeriatric ward at the Aged & Extended Care Department in the Concord Repatriation General Hospital.

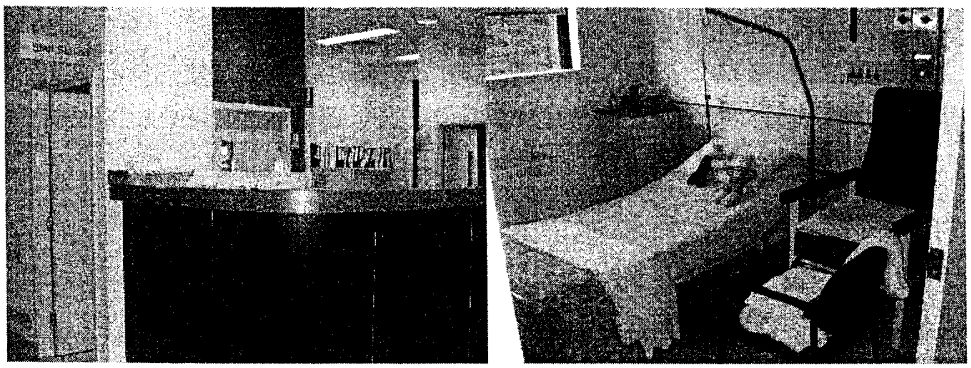


圖 6.4 The Fall clinic at the Royal North Shore Hospital (1).

圖 6.5 The Fall clinic and a rehabilitation specialist, Dr. Mark Haran, at the Royal North Shore Hospital (2).

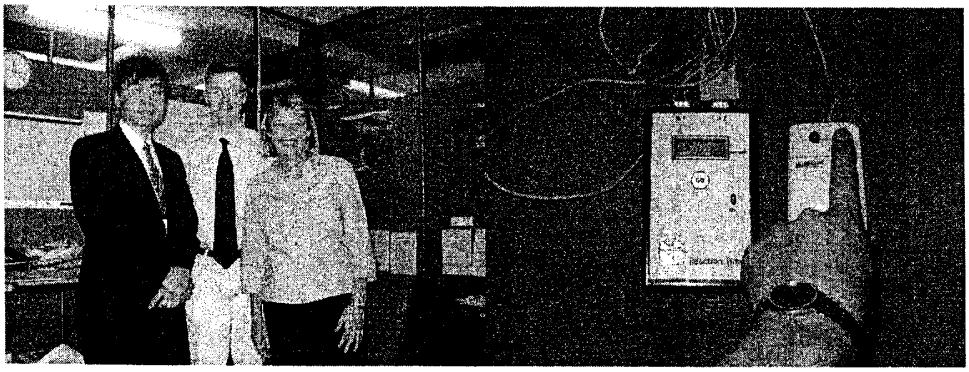


圖 6.6 The Rehabilitation Research Center and a senior geriatrician, Dr. Ernest Tam in Sydney.

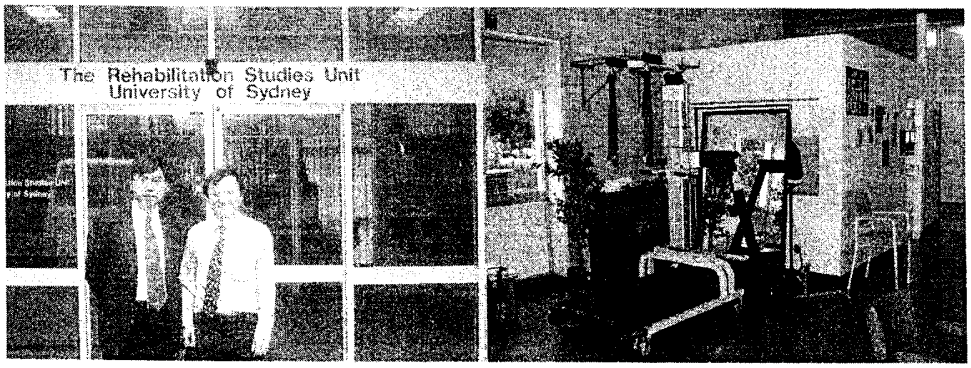


圖 6.7 The Aged Care and Rehabilitation and head of the department, Dr. Sue Ogle at the Royal North Shore Hospital.

圖 6.8 The daily activity for me at Human Nutrition Unit in University of Sydney.

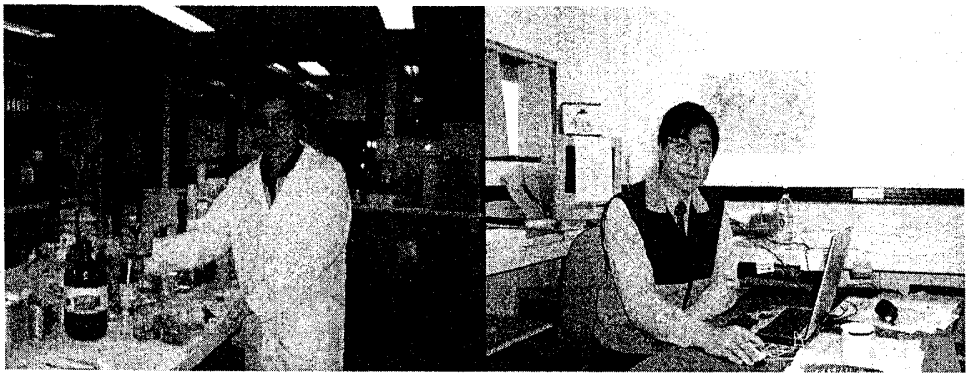
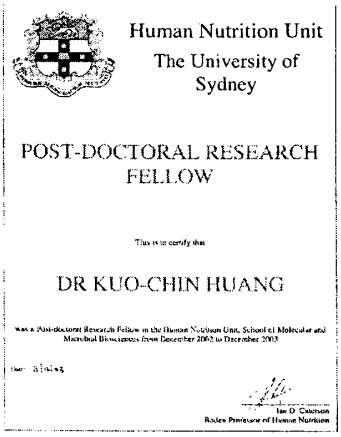


圖 6.9 Two of my colleagues, Dr. Vera Terry and Dr. Marjaana Lahti-Koski from Finland, in the same office at Human Nutrition Unit in University of Sydney.



Human Nutrition Unit
The University of Sydney

POST-DOCTORAL RESEARCH FELLOW

This is to certify that

DR KUO-CHIN HUANG

was a Post-doctoral Research Fellow in the Human Nutrition Unit, School of Molecular and Microbial Biosciences from December 2002 to December 2003

Ian D. Caterson
Boden Professor of Human Nutrition

# 第三章 研究心得

澳洲擁有完善的老人照護系統，除了一般性主流的健康照護體系外(如Medicare、PBS 及社會福利等)，大致還包括社區照護與院所照護兩大類。此外，每年政府在老人照護的支出逐漸增加，以 2002 年來說聯邦政府約支出 55 億，佔 GDP 之 0.8 %。然而以老人照護服務的提供者而言，政府佔整體包括宗教慈善團體及私人機構的支出是保持穩定的比率，以 2001 年的統計僅佔 9.4 %，而宗教慈善團體佔 63.6 %，私人機構則佔 27 %。因此，國內有關老人照護經費的開拓，可以參考澳洲的模式。

在社區照護方面，2002 年間澳洲共有 24,100 位老年人接受 CACPs (相當於低等級院所照護)，資料顯示，約 5 %目前接受低等級院所照護的老年人可轉換成接收 CACPs 的服務。而約 583,000 位老年人，接受共計 2530 萬小時、840 萬個餐飲服務的 HACC，其平均年齡為 71.6 歲，期中 66 %為女性，93 %領福利金，52 %有自己的照護者。在院所照護方面，70 歲以上的澳洲人，有 36 %的機會需要高等級之院所照護。目前院所照護可提供 144,100 床的照護服務，而這些院所的佔床率約為 97 %，住民平均年齡為 83.2 歲，平均入住時間為 36 個月(35 %少於 1 年，22 %超過 5 年)。接受高等級之院所照護者 64 %來自醫院，26 %來自低等級照護之院所，而 10 %來自社區；接受低等級之院所照護者 30%來自醫院，而 70 %則來自社區。綜言之，70 歲以上的澳洲老年人，有 21 %者正使用上述的

老人照護資源，其中 7.9 %是接受院所照護，0.7 %接受 CACPs，而 12.2 %接受 HACC。以經費補助而言，聯邦政府每年在院所照護每床的支出為 30,000 元，而 CACPs 的支出為 10,000，因此 CACPs 不僅經費支出遠低於院所照護，同時也符合多數老人留在家中的意願，此經驗亦可為國內政府有關單位之參考。

老人醫學專科醫師是內科底下的一個次專科，至少 6 年完整的訓練，培養出許多面臨老化人口的澳洲之老人醫療照護團隊的領導人，但老人醫學專科醫師相對的還是嚴重不足。歸究其原因，除需求層面外，醫師選科的負面的因素包括其專業不受其它專科重視、經費補助少、缺乏工作人員、收入不佳、過去沒有標準專科模式、治療病人成果有限及研究機會不多等，其它專科在老化的研究，也可能降低其選擇老人醫學專科的意願。不過選擇老人醫學專科者，通常認定其為全人的醫學，並喜歡與其他專業人員的團隊工作。此外，雙次專科特別是一般醫學專科是其重要的選擇，此經驗也可作為目前國內正推動的老人醫學專科制度之參考。

由於老年人口的增加及老年醫學專科醫師的不足，一般科醫師(家庭醫師)的角色更顯得十分重要。自從 1999 年以來，澳洲推行 Enhanced Primary Care，其目地即是提供老年人更多的預防保健服務，及改善一般科醫師與其它專業者對有慢性病及複雜需要的人具協調性的醫療照護。例如包括 75 歲以上老人或 55 歲以上原住民及 Torres Strait Island 島民，每年可在家或門診接受由政府補助的健康

評估，由一般科醫師及其他醫療專業人員執行，包括完整的身體、心理及社會功能之評估；提供有需要一位一般科醫師及兩位以上專業醫療人員照護的出院病人(discharge care plan)或社區的病人(community care plan)，團隊的醫療照護服務(multidisciplinary care plan)。這些澳洲的經驗，也可供國人參考。

## 第四章 建 議

1. 臺灣為因應老人時代的來臨，應儘速建立適合國人的老人照護模式，包括初級、次級與三級預防醫學領域的健康照護。
2. 積極培養老人照護的專業人員，包括老年醫學專科醫師、老年復健師、營養師、藥師與護理師等，可採認證方式，制度面鼓勵參與，並加強在職教育。
3. 政策鼓勵醫師加入老年醫學專科醫師的訓練，包括現有的醫師或醫學生，例如公費醫師或獎金制度等。
4. 老年人的健康問題複雜，為鼓勵醫療專業人員的辛勞，有關老人的健保給付應依需要適時提高。
5. 建立流暢的老人生活輔具之供應體系與回收系統，並鼓勵該類產業之研發與推廣，使有需要的老人可享受到價廉物美的輔具。
6. 目前健保老人建檢項目不足反應老人的需要，必需加上生活功能評估、居家安全與家庭社會支持資源等之評估，並調升其健保給付。
7. 規劃、結合與鼓勵社福團體與宗教的力量，以減輕政府的負擔，並可提升社

會參與公益的風氣。

8. 整合政府從中央到地方單位有關老人福利、健康照護及相關服務機關的行政單位，提供老人全方位健康照護服務的單一窗口。

9. 加強基層醫師與家庭醫師有關老人醫學的知識與醫療照護之繼續教育，並設計相關的服務獎勵制度，並提供基層醫師與家庭醫師可給與民眾服務的資源介紹，並建立良好的周邊服務體系。

10. 獎勵興建機構服務(院所照護)的軟硬體設備，並建立定期評估考核、獎勵制度與服務人員的在職教育。

11. 鼓勵醫藥界、其它專業人員與學術界等進行有關老人健康照護與政策制定等相關的研究，此外其它有關老化、營養及藥物等相關的基礎研究也應多予獎勵。

12. 同時亦結合產官學界，將有利於老人的相關行業之研究發展，實際應用於社會上，除造福老人外，亦可帶動國家社會經濟發展。

13. 特殊族群如失智症、殘障與原住民等，應有特殊的照護計劃與機構，以維護特殊族群老人的健康。

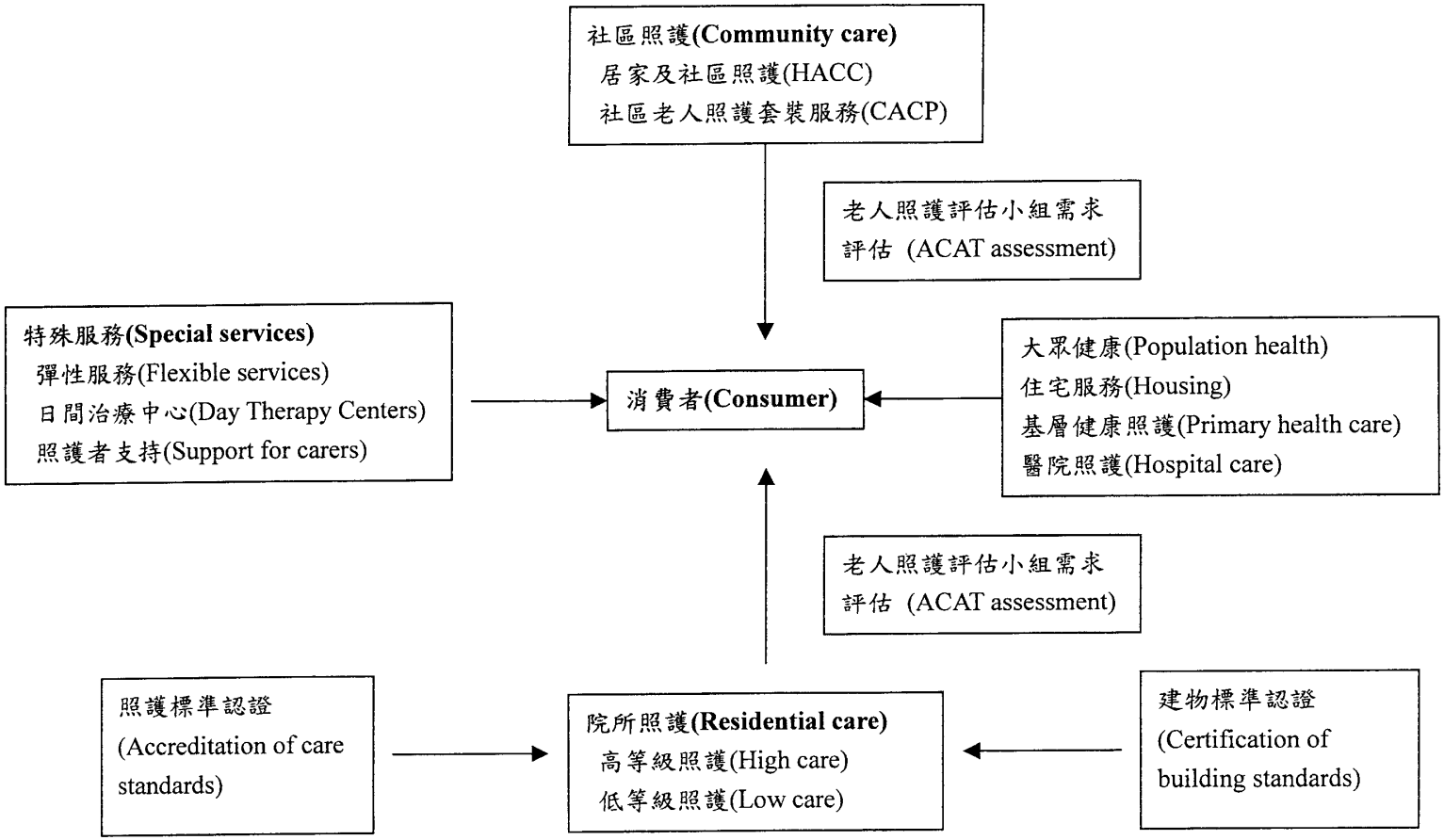



圖 2. 澳洲老人照護之架構圖

# HEALTH ASSESSMENT

Aged 75+ Aboriginal & Torres Strait Islander 55+
(to be conducted by the patient's usual GP)

| All | | Aboriginal & Torres Strait Islander | |
|---|---|---|---|
| Practice | Home | Practice | Home |
| Item 700 ☐ | Item 702 ☐ | Item 704 ☐ | Item 706 ☐ |

PATIENT NAME _____

DOB _____ Male ☐ Female ☐

Name & contact details of carer _____

Medical Practitioner

Medical record/file No. 19/03/01

Is this patient a carer? Yes ☐ No ☐

This is the only health assessment the patient has undertaken in the last 12 months Yes ☐ No ☐

This is a review of a Health Assessment undertaken: ___/___/___

Health Assessment at Practice ☐

Home Visit ☐

## CURRENT HEALTH / RELEVANT FAMILY HISTORY

**1 Ask the patient "in general, would you say your health is..."**

| | |
|---|---|
| Excellent | ☐ |
| Very good | ☐ |
| Good | ☐ |
| Fair | ☐ |
| Poor | ☐ |

**2 Current health problems / relevant family history**

## COMMUNITY / ALLIED HEALTH SERVICES

**3 Ask the patient "Are you seeing or have you seen any other GP/specialist/other health worker in the last 6 months?"**

eg

- ☐ Aboriginal health worker
- ☐ Audiologist
- ☐ Community nursing
- ☐ Continence Adviser
- ☐ Daycare
- ☐ Dental
- ☐ Dietician
- ☐ Education providers
- ☐ HACC – home help
- ☐ Meals on wheels
- ☐ Occupational therapist
- ☐ Optometrist
- ☐ Orthoptist
- ☐ Orthotist
- ☐ Pharmacist
- ☐ Physiotherapy
- ☐ Podiatry
- ☐ Prosthetist
- ☐ Psychologist
- ☐ Registered nurse
- ☐ Respite care
- ☐ Self help provider
- ☐ Social worker
- ☐ Specialist
- ☐ Speech therapist

| other services/specialists in last 6 months | reason |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

# HEALTH ASSESSMENT

Aged 75+ Aboriginal & Torres Strait Islander 55+
(to be conducted by the patient's usual GP)

## SMOKING / ALCOHOL

**4 Smoking**

Never smoked ☐
Has quit smoking (when) ☐
Currently smokes ☐
Wishes to quit ☐

*Comments*

**5 Alcohol Consumption**

*Comments*

*Consider AUDIT, CAGE or other scales* Y ☐ N ☐

## PHYSICAL ACTIVITY

6 Do you **exercise** at least 30 minutes a day, most days Y ☐ N ☐

## EXAMINATION

**7 Weight** _____ kg

**8 Height** _____ m

**9 BMI** _____

**10 BP/Pulses**

Systolic BP _____ mm/Hg
Diastolic BP _____ mm/Hg
Pulse regular ☐
Pulse irregular ☐
Pulse rate _____

*Comments*

*Consider check for postural hypotension* Y ☐ N ☐

## GENERAL

**11 Comments**

## OTHER

**12 Oral Health**

*Comments eg teeth, gums, dentures*

**13 Feet**
Problems with one or both feet? Y ☐ N ☐

*Comments*

**14 Vision**
Acuity (with glasses) _____

*Comments*

**15 Hearing**
a Whisper test — Heard ☐ Not heard ☐

*Comments*

b Hearing aid — N/A ☐ Adequate ☐ Poor ☐

c Check ear canals — Normal ☐ Abnormal ☐

**16 Fit to drive** Y ☐ N ☐
*Comments*

*Refer AustRoads Guidelines*

# HEALTH ASSESSMENT

Aged 75+ Aboriginal & Torres Strait Islander 55+
(to be conducted by the patient's usual GP)

## NUTRITION

**17 Nutrition**

*These questions may not apply to all eg those with particular conditions or lifestyles*

| | | score |
|---|---|---|
| Do you have an illness or condition that made you change the kind and/or amount of food you eat? | *yes 2 no 0* | |
| Do you eat at least 3 meals per day? | *yes 0 no 3* | |
| Do you eat fruit or vegetables most days? | *yes 0 no 2* | |
| Do you eat dairy products most days? | *yes 0 no 2* | |
| Do you have 3 or more glasses of beer, wine or spirits almost every day? | *yes 3 no 0* | |
| Do you have 6-8 cups of fluids most days? | *yes 0 no 1* | |
| Do you have teeth, mouth or swallowing problems that make it hard to eat? | *yes 4 no 0* | |
| Do you always have enough money to buy food? | *yes 0 no 3* | |
| Do you eat alone most of the time? | *yes 2 no 0* | |
| Do you take 3 or more prescribed or over the counter medicines every day? | *yes 3 no 0* | |
| Without wanting to, have you lost or gained 5kg in the last 6 months? | *yes 2 no 0* | |
| Are you always able to shop, cook and/or feed yourself? | *yes 0 no 2* | |

**Total score**

*0-3 'good', 4-5 'moderate', 6-29 'high risk'*

*Comments*

## MENTAL STATUS

**18** *Any problems with memory, thinking, planning, motivation?*

*Consider Folstein, MMSE, AMT* Y☐ N☐

## INDEPENDENCE / SOCIAL SUPPORT

**19 Are you living**

Alone ☐
As a couple ☐
With others ☐

*Comments*

**20 Social support**

a During the last 4 weeks... was someone available to help you if you needed and wanted help? For example if you:
- Felt very nervous, lonely or blue
- Got sick and had to stay in bed
- Needed someone to talk to
- Needed help with daily chores
- Needed help just taking care of yourself

Yes as much as I wanted ☐
Yes, quite a bit ☐
Yes, some ☐
Yes, a little ☐
No, not at all ☐

b Does this person have a carer? Y☐ N☐

c Are you responsible for the care of someone else? If yes: who/relationship Y☐ N☐

d Consider Dukes Scale Y☐ N☐

e Referral to Allied health required? Y☐ N☐

## MOOD / SLEEP

**21 Mood (affect)**

a During the last 4 weeks... How much have you been bothered by emotional problems such as feeling anxious, depressed, irritable or downhearted or blue?

Not at all ☐
Slightly ☐
Moderately ☐
Quite a bit ☐
Extremely ☐

b Have you had any difficulty sleeping? Y☐ N☐

*Details:*

*Consider Geriatric Depression Scale* Y☐ N☐

*Comment*

# HEALTH ASSESSMENT

Aged 75+ Aboriginal & Torres Strait Islander 55+
(to be conducted by the patient's usual GP)

## CONTINENCE

**22 Continence**

Leaking urine? Never ☐ Sometimes ☐ Often ☐

Is this related to coughing or sneezing? Y ☐ N ☐

Faecal soiling/change of bowel habit Never ☐ Sometimes ☐ Often ☐

*Comment*

## HOME SAFETY / HOME VISIT

*Consider home visit*
*(See Appendix for checklist)*

**23 Home Safety**

Can you get down to up from your lounge chair easily and safely? Y ☐ N ☐

Can you get in and out of bed easily and safely? Y ☐ N ☐

Can you switch on a light easily from your bed? Y ☐ N ☐

Can you get on an off the toilet easily and safely? Y ☐ N ☐

Are all loose mats and floor coverings securely fixed to the floor? Y ☐ N ☐

Do you use slip resistant mats or self-adhesive non slip strips in the bath/bathroom/shower recess? Y ☐ N ☐

Can you carry meals easily and safely from the kitchen to your dining area? Y ☐ N ☐

Are you able to grip and use utensils efficiently and safely? Y ☐ N ☐

Are the edges of the steps/stairs easily identifiable? Y ☐ N ☐

*Actions Suggested eg fitting of hand rails, removal of hazards, improving access*

## FUNCTIONAL ACTIVITIES

**24 Mobility**

Can you get around without a mobility aid indoors? Y ☐ N ☐

Outdoors? Y ☐ N ☐

Can you bath/shower easily and safely? Y ☐ N ☐

Can you bend, kneel and stoop easily and safely? Y ☐ N ☐

Can you walk 100 metres easily? Y ☐ N ☐

Can you go up and down access steps to your home or internal stairs easily and safely? Y ☐ N ☐

Can you easily keep your balance when you reach overhead? Y ☐ N ☐

Are your walkways inside and outside the house free of cords and clutter? Y ☐ N ☐

Is all the household lighting adequate for you to see clearly? Y ☐ N ☐

Have you been free of falls in the home in the past 3 months? Y ☐ N ☐

*Actions suggested*

## MEDICATION REVIEW

**25 Complete the separate Medication Review Sheet**
*Comment*

## RELEVANT PREVENTIVE CARE CHECKLIST

**26 Vaccinations** **date**

Influenza ☐
Pneumococcus ☐
Tetanus ☐
Other ☐

*Comments*

**27 Other areas for examination and or follow up**
*eg Pap smears, weight bearing exercise*

# HEALTH ASSESSMENT

Aged 75+ Aboriginal & Torres Strait Islander 55+
(to be conducted by the patient's usual GP)

PATIENT NAME _____ DOB _____ Carer _____

## HEALTH ASSESSMENT HISTORY

Is this the only health assessment the patient has undertaken in the last 12 months Y☐ N☐ If so, by whom _____

Is patient eligible under Veterans' Affairs Y☐ N☐ If yes, please ensure this form is available on request from DVA

## GOALS OF PATIENT AND CARERS

_____

_____

_____

## CURRENT MEDICAL SITUATION (complete Medication Review sheet separately)

Principal diagnoses

_____

_____

_____

_____

Planned investigation, care, medication (including over the counter complementary and prescriptions from other doctors)

_____

_____

_____

_____

Other significant health problems

_____

_____

_____

_____

_____

_____

_____

_____

## OTHER RECOMMENDATIONS

I believe that the patient would benefit from

Care Plan Y☐ N☐ Case Conference Y☐ N☐ Other service to be recommended _____

## PATIENT'S AGREEMENT

I have agreed / my carer has agreed to this Health Assessment and understand the recommendations above.

Signed by Patient / Carer _____ *date* / /

Signed by GP _____ *date* / /

A review date has been set for: / /
(*MBS rebate available for repeat health assessment after 12 months*)

Agency Identifier

Agency Name

Data Collection Identifier

## Client Information

The details entered below are used to determine the Statistical Linkage Key and are not transmitted in the final data file.

First Given Name

Family Name

# Client Details

## Data Linkage Key

**Letters of Name** Refer to instructions provided to Agencies on how to derive Letters of Name

[ ] Selected Letters from Family Name

[ ] Selected Letters from First Given Name

**Date of Birth** [ ] DD/MM/YYYY

**Sex** [ ] 1 Male 2 Female

## Area of Residence

**State** [ ]

1 New South Wales
2 Victoria
3 Queensland
4 South Australia
5 Western Australia
6 Tasmania
7 Northern Territory
8 Australian Capital Territory
9 Other Territories

**Suburb / Town / Locality** [ ]

**Post Code** [ ]

## Background

**Country of Birth** [ ] eg Australia 1101

**Main Language Spoken at Home** [ ] eg English 02

**Indigenous Status**

**Is the Client of Aboriginal or Torres Strait Islander Origin ?**

Tick one or more boxes

- [ ] No
- [ ] Yes, Aboriginal
- [ ] Yes, Torres Strait Islander

# Client Details

## Client Circumstances

### Reason for HACC Client Status

Select code for Client

1 Care Recipient

2 Carer

### Living Arrangements

Select code for Client

1 Lives Alone

2 Lives with Family

3 Lives with Others

### Government Pension / Benefit

Select code for Client

Refers to principal Australian Government pension/benefits only

1 Aged Pension

2 Veterans' Affairs Pension

3 Disability Support Pension

4 Carer Payment (Pension)

5 Unemployment Related Benefits

6 Other Gov't Pension/Benefit

7 No Gov't Pension/Benefit

### Accommodation Setting

Select code for Client

1 Private - Owned/Purchasing

2 Private - Private Rental

3 Private - Public Rental

4 Private - Mobile Home

5 Independent unit within retirement village

6 Boarding House/Private Hotel

7 Emergency/Transitional Accommodation

8 Domestic-scale supported living facility

9 Supported accommodation facility

10 Residential Aged Care Facility

11 Mental Health Community Care Facility

12 Public Place/Temporary Shelter

13 Private home rented from Aboriginal Community

14 Temporary Shelter within an Aboriginal Community

19 Other

# Client Details

## Carer Support Detail

### Carer - Existence of

**Is the Client a Care Recipient ?**
If **YES** select a code for the client → [ ]

2 Has No Carer →

1 Has Carer

If **NO, the client is a Carer**, move to next Question ↓

### Carer Residency Status

This Question is answered for both Carer and Care Recipients

**Does the Carer live with the Care Recipient ?** [ ]

1 (Yes) Co-Resident Carer

2 (No) Non-Resident Carer

### Relationship of Carer to Care Recipient

This Question is answered whether the client is a Carer or a Care Recipient

**What is the relationship of the Carer to the Care Recipient ?** [ ]

eg the Carer is the DAUGHTER of the Care Recipient.
eg the Carer is the HUSBAND of the Care Recipient.

1 Wife/Female Partner
2 Husband/Male Partner
3 Mother
4 Father
5 Daughter
6 Son
7 Daughter-in-Law
8 Son-in-Law
9 Other Relative - Female
10 Other Relative - Male
11 Friend/Neighbour - Female
12 Friend/Neighbour - Male

# Client Details

## Start of Current or Most Recent Service Episode

**Is the Client currently receiving services ?**

**YES** - respond in respect of current service episode

**NO** - respond in respect of most recent service episode

**Source of Referral** [ ]

| | |
|---|---|
| 1 Self | 12 Aboriginal Health Service |
| 2 Family, Significant other, Friend | 13 Carelink Centre |
| 3 GP/Medical Practitioner | 14 Other Community based Government Medical/Health Service |
| 4 Aged/Disability Specialist Team | 15 Other Government Medical/Health |
| 5 HACC Assessment Authority | 16 Other Government Community based |
| 6 Community Nursing Service | 17 Hospital - Private |
| 7 Hospital - Public | 18 Non Government Residential Aged Care Facility |
| 8 Psychiatric/Mental Health Care | 19 Other Non Government Medical/Health |
| 9 Extended Care/Rehabilitation Facility | 20 Other Non Government Community based |
| 10 Palliative Care Facility/Hospice | 21 Law Enforcement Agency |
| 11 Government Residential Aged Care Facility | 22 Other |

**Date of Last Assessment** [ ] Record Date of Most Recent Client Assessment

# Service Totals

## Total Amount of Assistance - by Hours

| | Hours at Home | Total Hours / Hours at Centre |
|---|---|---|
| Domestic Assistance | | |
| Social Support | | |
| Nursing Care | | |
| Allied Health Care | | |
| Personal Care | | |
| Centre-based Day Care | | |
| Other Food Services | | |
| Respite Care | | |
| Assessment | | |
| Case Management | | |
| Case Planning, Review & Coordination | | |
| Home Maintenance | | |
| Counselling/Information/Advocacy | | |

## Total Amount of Assistance - by Quantity

| | Meals at Home | Meals at Centre |
|---|---|---|
| Meals | | |

| | Total Collection/Deliveries |
|---|---|
| Formal Linen Service | |

| | Total One-Way Trips |
|---|---|
| Transport | |

## Total Amount of Assistance - Cost

| | Total Cost |
|---|---|
| Home Modification | $ |

## Provision of Goods and Equipment

List the 2 digit codes which indicate Goods or Equipment provided during the reporting period. Up to 10 codes may be listed.

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |

# Cessation Details

## Exit from Most Recent Service Episode

**Has the Client ceased to receive services during the reporting period ?**

**Main Reason for Cessation of** ☐

1. Client no longer needs assistance from Agency
2. Client moved to residential, institutional or supported accommodation setting
3. Needs Increased - Other Service Provider Required
4. Services ended due to Budget/Staffing Constraints
5. Services Terminated due to OH&S reasons
6. Client Moved Out of Area
7. Client Died
8. Client Terminated Service
9. Other

## Accommodation Setting After Cessation of Services

**Is the Client a Care Recipient?**

If **YES**, Select a code for Client ☐

1. Private - Owned/Purchasing
2. Private - Private Rental
3. Private - Public Rental
4. Private - Mobile Home
5. Independent unit within retirement village
6. Boarding House/Private Hotel
7. Emergency/Transitional Accommodation
8. Domestic-scale supported living facility
9. Supported accommodation facility
10. Residential Aged Care Facility
11. Mental Health Community Care Facility
12. Public Place/Temporary Shelter
13. Private home rented from Aboriginal Community
14. Temporary Shelter within an Aboriginal Community
15. Hospital
16. Extended Care/Rehabilitation Facility
17. Palliative Care Facility/Hospice
18. Not applicable - client died
19. Other
20. Not Known

**Please provide an estimate of the time taken to complete this form.**
Include the time actually spent reading the instructions, working on the data items and obtaining the information, and the time spent by all employees in collecting and obtaining this information.

**Hours** ☐ **Minutes** ☐