Fall Injury Prevention in Older People

Policy Position Statement

Key messages:

The Australian population is ageing, with projections estimating that in the year 2066 approximately 21% of the population will be over 65. Falls and fall risk increase with age, and fall-related injuries are both predictable and preventable.

Effective action requires a nationally coordinated response, with activity in a wide range of health care settings, and community-based and population-focused initiatives.

Key policy positions:

1. A national strategy involving a whole of system approach to falls prevention that addresses the complex risk factors for falls is needed.
2. Increased funding for researching, developing, implementing, and evaluating fall prevention strategies is required.
3. Ensure that researchers, health professionals, educators, policy makers, and community workers work collaboratively to translate evidence into practical strategies and interventions to prevent falls in older age.
4. Implementation of interventions in accordance with the Australian Commission on Safety and Quality in Health Care Falls Guidelines (2025).

Audience: Federal, State and Territory Governments, policymakers and program managers, PHAA members, media.

Responsibility: PHAA Injury Prevention Special Interest Group

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PHAA affirms the following principles:

1. "Population ageing is one of humanity's greatest triumphs".[1] Older people are an important component of the societal patchwork, and although population ageing comes with some complex health challenges, older people ultimately have the right to independence and freedom from preventable injury, including access to multidisciplinary health care and necessary social services.[2]
2. Intrinsic, age-related factors such as reduced muscle strength, postural instability, and impaired vision and cognition can increase the likelihood of falls, as can extrinsic factors like polypharmacy and hazardous household environments.[3,4]
3. Falls are complex and largely preventable. Appropriately designed intervention programmes that target exercise, visual deficits, environmental modification, medication reviews, and multifactorial assessment have been clinically proven to reduce the risk of falls in older adults.[4,5,6,7]
4. Effective fall prevention programs contribute economic and social benefits to individuals, communities, and governments through increased autonomy and productivity of older persons,and reduced costs and demand on aged and acute care services.[8]
5. Social determinants, including culture, gender, alcohol consumption, risk-taking behaviours, attitudes towards ageing, social isolation and loneliness, physical environments and socioeconomicstatus, need to be addressed in falls prevention strategies.[9]
6. Culturally appropriate interventions are required for specific groups, such as Aboriginal and TorresStrait Islander people, acknowledging differing health priorities and cultural beliefs.[10]

PHAA notes the following evidence:

7. The World Health Organization defines a fall as "an event which results in a person coming to rest inadvertently on the ground or floor or other lower level."[11]
8. Australia's population is ageing, with 4.2 million Australians or 16% of the total population aged 65 and over. This number is expected to increase to 21-23% of the population by 2066.[12]
9. With each year above the age of 65, the incidence of fall-related hospitalisations significantly increase for both men and women, with one in three in this age group experiencing at least one fall per year.[13,14]
10. Fall-related injuries in Australia cost an estimated $4.3 billion annually,[15] comprising of 37% of reported external causes of injury or poisoning in hospitals.[16] Falls are the leading cause of injury-related hospitalisation and fall related injury is a leading cause of morbidity and mortality in older people.[15]
11. Hip fractures are of significant concern in older adults[10] due to a threefold increased risk of mortality within three months of the injury and a threefold increase in requiring functional dependency.
12. Half of all hospitalised fall injuries in people over 65 occur in the home and 21% in residential care.Those in residential care homes are up to 5 times more likely to fall,[17] of which 37% cause injury, and almost 10% result in hospitalisation.[18]

13. The Royal Commission into Aged Care Quality and Safety identified that residents in aged care facilities have limited access to allied health (e.g., physiotherapists, occupational therapists and podiatrists) who assist in maintaining mobility and preventing falls. Moreover, it revealed that aged care providers provide very limited support to assist residents with their mobility.[19] The report does, however, recommend the integration of allied health into residential care.[19]

14. Older Australians are over-represented in hospital and health care settings. In 2022-23, people aged 65 and over accounted for 44% of hospitalisations and 51% of patient days.[20] Theestimated average length of stay for fall injury cases is 10 days.[13]

15. Falls in-hospital are highly prevalent, with 3.6% of all admitted patients experiencing at least one fall, a third of which result in injury.[21] Those who have an in-hospital fall remain inpatients for nearly twice the length of stay and costs of non-fallers, which is a high cost burden to hospitals.[21]

16. Falls were the leading cause of injury-related hospitalisations among Aboriginal and Torres Strait Islander people in 2020-21 accounting for 21% of injury-related hospitalisations.[22] Aboriginal and Torres Strait Islander people over 65 have a higher risk of fall-related injury compared to non-Indigenous people by amargin of 10.9%.[13] Factors linked to falls in Aboriginal and Torres Strait Islander people populations include impaired mobility, a history of stroke, poor hearing, urinary incontinence, and excessive alcohol consumption.[10]

17. Fall-related psychological concerns, such as fear of falling, have deleterious effects on the health and well-being of an older adult, including a loss of autonomy, isolation, and a decrease in physical condition, which can in turn increase the risk of falls.[23]

18. People living in 'very remote areas' are 1.4 times more likely to be hospitalised for a fall-related injury compared to people living in inner regional areas.[24]

19. The ageing Australian population contributes to a projected increase in fall-related mortality from 5,034 annual incidents in 2020 to 6,594 in 2030.[24]

20. Risk factors for falls in older people can be broken into four broad categories:[9,25]
    - Behavioural (polypharmacy, excessive alcohol, physical inactivity, poor footwear, inattention)
    - Biological (demographic, chronic illness and comorbidities, gait, visual and cognitive deficits)
    - Socioeconomic (social interaction, access to resources, malnourishment,[26] socioeconomic status)
    - Environmental (physical hazards, lighting, building design).

21. Evidence-based fall prevention interventions that address these risk factors include exercise that challenges balance and strengthens muscles[27,28] (including group and home-based exercise programmes),[29] reactive and volitional step training,[27] occupational therapy interventions,[30] withdrawal or minimising use of psychoactive and other falls risk increasing medications,[28,29] visualrisk factor assessment and interventions,[31] home modifications,[32]and alleviating foot problems.[33]

22. Fall prevention strategies need to consider behaviour change principles such as whether changing behaviour to reduce the risk of falls for individuals is within their ability to do so and if the benefitof changing behaviour outweighs the cost or effort in overcoming barriers.[9]

23. The Falls Guidelines (2025) provide the evidence base for fall injury prevention in hospitals,community care and residential aged care.[15] Despite the lack of an implementation plan, preventing falls and harm from falls is an agreed-upon national safety and quality health service standard.[4,34]

24. Universal fall precautions apply to all patients in care regardless of fall risk and include having sturdy handrails in bathrooms, bedrooms and hallways; supplemental lighting, especially at night; clean, clutter-

free, and dry floors; and nonslip, comfortable, well-fitting footwear for the patient.[35]

25. The Reducing Harm from Falls programme in New Zealand has demonstrated that a multi-prongedand multidisciplinary approach is effective in reducing falls and fall-related injuries.[36]
26. Lack of continuity of care post-discharge from fall-related hospitalisations is a major source of readmission.[37]
27. Implementing this policy would contribute towards the achievement of UN Sustainable Development Goal 3 – Good Health and Wellbeing.

PHAA seeks the following actions:

28. A National Injury Prevention Strategy with resourced implementation plans, with older people as a priority group, incorporating the ACSQHC *Falls Guidelines (2025)*, contemporary evidence- based practice and recommendations from the Royal Commission into Aged Care Quality and Safety.
29. A National Strategy must include strategies for culturally and linguistically diverse people andAboriginal and Torres Strait Islander people that suit their health beliefs, behaviours, and needs.
30. The Commonwealth Department of Health, Disability and Ageing and state/territory jurisdictions should collaboratively implement an integrated falls prevention approach across acute, residential aged, community and home care settings, involving primary, secondary, and tertiary strategies.
31. Workforce development should be targeted at public and private health services in best practice fallprevention, accounting for changing injury profiles associated with ageing.
32. Criteria for unplanned or unexpected readmissions should be amended to include falls within a specified timeframe to increase the accountability and measurement of readmissions due to falls.
33. Local governments should create age-friendly communities that recognise the wide diversity of older people; promote their inclusion and contribution in all areas of community life; respect theirdecisions and choices; and anticipate and respond to age-related needs and preferences.[37]
34. Services such as the Home Medicine Review should be adequately funded and promoted in communities to ensure older people are taking appropriate medication in a safe manner, reducing adverse side effects of medication which increase falls risk.
35. Implementation of evidence-based falls prevention initiatives should be in line with broader public health policy, such as Closing the Gap with Aboriginal and Torres Strait Islander people.
36. Introduction of healthy ageing campaigns to educate the community about healthy ageing and falls prevention.

PHAA resolves to:

37. Advocate for the above actions based on the evidence and principles outlined in this statement including support for the Falls Prevention Alliance Australia.
38. Support the development of a United Nations convention into the rights of older persons to provide an explicit universal statement that reaffirms the essential human rights of older people. This will provide an international obligation to protect, respect, promote and fulfil human rights ofolder people.[35]
39. Support recommendations flowing from the Royal Commission into Aged Care Quality and Safetyand consider providing effective and dignifying care and prevention interventions to older people.

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