Older Australia *at a glance*

Third edition
2002

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Contents

Foreword

Australia, like many other countries, is experiencing the start of an unprecedented ageing of the population that will continue over several decades. Significant changes will flow to all aspects of social and economic life as the proportion of older people in the community increases. The magnitude of the demographic change requires a proactive approach in order to ensure quality of life for older people, inter-generational equity and investment, and positive outcomes for the whole population.

A sound and broadly accepted evidence base is essential to inform policy development for an older Australia. This third edition of *Older Australia at a Glance* has been revised to reflect the continuing advances in Australia's data and policies on ageing and aged care. The presentation of the information has also been revised to reflect the priorities identified in the National Strategy for an Ageing Australia and the International Plan of Action on Ageing 2002, adopted at the Second World Assembly on Ageing in Madrid this year.

The National Strategy recognises the breadth and complexity of issues related to demographic ageing, and the importance of effective and coordinated action in making the necessary adjustments over time. It is intended to encourage organisations and people to reflect on the possible implications and options, and to be a catalyst for cooperation and discussion to ensure Australia's continued prosperity.

Changes that have taken place in Australia in recent years, which reflect the goals of the National Strategy, include:

- the continuous improvement and targeting of aged and community care programs to reflect the choices and needs of frail, older Australians;
- innovative projects to improve the health system's interface with aged and community care;
- the introduction of preservation rules for superannuation;
- removal of the formal retirement age for Commonwealth public servants;
- industrial relations reforms which prohibit age discrimination in certified agreements; and
- the Pension Bonus Scheme and other retirement income reforms.

The Government is also in the process of developing a strategy to support the important contribution that mature age workers will make to Australia's workforce in the years ahead. This will be essential as the supply of younger workers begins to decline as part of the consequences of an ageing Australia. Legislation to prohibit discrimination on the grounds of age will also be introduced into the Federal Parliament in 2003.

Older Australia at a Glance is a joint venture undertaken by the Australian Institute of Health and Welfare and the Ageing and Aged Care Division in the Commonwealth Department of Health and Ageing. It is a reference document that will be useful to academics, journalists, policy makers and others in our community interested in the facts about the demographic health and welfare status of older Australians and the services available to them.

It is with pleasure that I recommend this document as an essential reference on older Australia.

Kevin Andrews

Minister for Ageing

October 2002

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Valuable comments on the report were provided by staff of the Aged and Community Care Division in the Department of Health and Ageing and by staff of Health Research and Development in the Department of Veterans' Affairs. Their input is greatly appreciated.

Abbreviations and symbols

Abbreviations

ABS	Australian Bureau of Statistics
ACAT	Aged Care Assessment Team
AIHW	Australian Institute of Health and Welfare
CACP	Community Aged Care Package
COP	Community Options Program
DoHA	Commonwealth Department of Health and Ageing
DVA	Commonwealth Department of Veterans' Affairs
GDP	Gross domestic product
HACC	Home and Community Care
UK	United Kingdom
USA	United States of America

Symbols in tables

N	number
$	Australian dollars
%	per cent
n.a.	not available
. .	not applicable
n.p.	not published by the data source but included in totals where applicable
—	nil or rounded to zero (including null cells)
*	when used in front of a numerical value means the value is subject to sampling variability too high for most practical purposes and/or the relative standard error is 25% to 50%
**	when used in front of a numerical value means the value is subject to sampling variability too high for most practical purposes and/or the relative standard error is more than 50%

Demographic profile

1 Age, sex and cultural diversity

On Census Night, 7 August 2001, there were 2,370,878 people in Australia aged 65 and over, among the total population of 18,769,249, excluding overseas visitors and people travelling abroad (ABS 2002d:89). Throughout this publication, the term 'older people' is generally used to refer to people aged 65 and over. Of course, people included in this group are far from homogenous. A wide range of ages and diversity of backgrounds is evident and there exist a variety of lifestyles, living arrangements, family circumstances and cultural, social and religious practices. Additionally, the health levels, activity and interaction with social and government systems that contribute to the health and welfare of Australians vary widely among older Australians.

Age

Australians enjoy one of the highest life expectancies in the world. Significant gains over the twentieth century have led to a life expectancy at birth of 81.9 years for females and 76.5 years for males (see Topic 13: *Life expectancy and causes of death*). This means that a significant proportion of people in Australia are now aged 75 or older. The last two columns of Table 1.1 show the proportion of older people in three age groups, and the total number for women, men and persons. Just over half (54%) of all older people in 2001 were aged between 65 and 74. About one-third (35%) were aged between 75 and 84 and 11% were aged 85 years and over. On Census Night, 7 August 2001, there were 2,503 people in Australia aged 100 and over.

Grouping all Australians aged 65 years and over into one category contains an age range of almost 40 years—equivalent to grouping the population aged 20 to 60 together. The family circumstances, physical abilities, economic circumstances and service needs of an average 65 year old are likely to be very different to those of a 90 year old. These differences emerge very clearly in many sections of this publication.

Table 1.1: Estimated resident population aged 65 and over, by cultural diversity, age and sex, 30 June 2001[a] (per cent)

	Australian-born		Overseas-born[c]		Total	
Age/sex	Indigenous[b]	Non-Indigenous	CLDB	English-speaking background	Per cent	Number
Females						
65–74	0.2	18.8	5.8	3.2	28.0	682,400
75–84	0.1	14.4	3.4	2.4	20.3	495,700
85+	—	5.6	0.9	1.0	7.5	184,200
Total	*0.3*	*38.7*	*10.1*	*6.7*	*55.8*	*1,362,300*
Males						
65–74	0.2	16.5	6.1	3.3	26.2	639,300
75–84	0.1	9.8	2.8	2.0	14.6	357,100
85+	—	2.3	0.6	0.5	3.4	82,000
Total	*0.2*	*28.6*	*9.5*	*5.8*	*44.2*	*1,078,400*
Persons						
65–74	0.4	35.3	11.9	6.6	54.2	1,321,700
75–84	0.1	24.2	6.2	4.4	34.9	852,700
85+	—	7.8	1.5	1.5	10.9	266,200
Total	*0.5*	*67.3*	*19.6*	*12.5*	*100.0*	
Total (number)	**13,100**	**1,643,000**	**479,400**	**305,200**		**2,440,600**

(a) Estimated resident population figures are not yet available from the Population Census of 7 August 2001. The total presented here (2,440,600) covers all residents, including those temporarily overseas.

(b) The figures for Indigenous Australians are estimated resident population preliminary figures based on the 2001 Census.

(c) The cultural diversity classification for overseas-born people is based on country of birth. The English-speaking background category comprises people whose country of birth was New Zealand, United Kingdom, Ireland, United States of America, Canada and South Africa. The culturally and linguistically diverse background (CLDB) category comprises people born in other countries.

Sources: ABS 2002e; ABS 2002a; Gibson et al. 2001.

Sex

Women of all cultural backgrounds in Australia tend to live longer than do men (ABS 2002a:8). Consequently, women make up a greater proportion (56%) of older Australians, and their predominance increases with age. In 2001 the proportions of women in the 65–74, 75–84 and 85 and over age categories were 52%, 58% and 69% respectively.

Cultural diversity

The cultural diversity of the older population has recently begun to grow, reflecting the immigration policies of the post-war period (see Topic 2: *The changing demographic profile: 1991–2021*). The mix varies from cohort to cohort and is largely a reflection of the immigration policies of past governments. In 2001, for those older people born overseas, the main countries of birth other than English-speaking countries were Italy, Greece, Germany and the Netherlands (Table A1.1). However, different birthplaces predominated among the different age groups (Figure 1.1). Of older overseas-born people from culturally and linguistically diverse backgrounds, males were estimated to account for 49% in 2001. This was more than in the Australian-born older population, of which 42% were males.

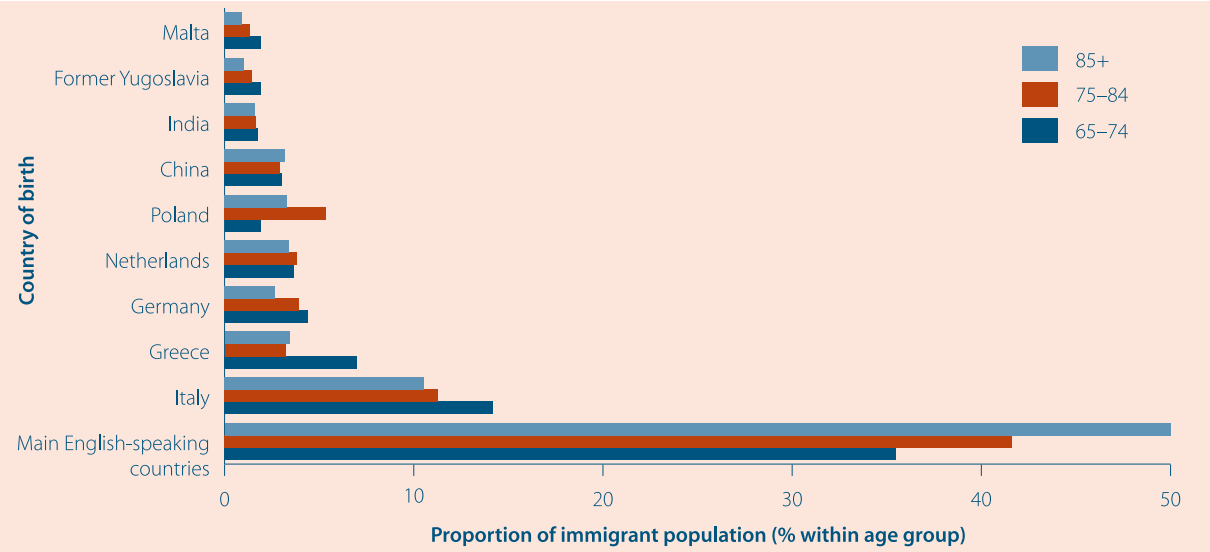
In 2001, the proportion of older people who had been born overseas was 33% (784,600 people). Older people from English-speaking countries constituted 39% of older people born overseas, with the remaining 61% coming from culturally and linguistically diverse backgrounds. The age structure of older people from culturally and linguistically diverse backgrounds was somewhat younger than that for the non-Indigenous Australian-born population. Among older people from culturally and linguistically diverse backgrounds, 8% were aged 85 and over, compared with 12% among the non-Indigenous Australian-born population.

People from culturally and linguistically diverse backgrounds in the 65–74 age group made up 12% of the total population of older people in 2001, whereas the same group aged 85 and over represented less than 2% of the total population of older people. By comparison, Australian-born non-Indigenous people aged 85 and over constituted approximately 8% of all older people (Table 1.1). This pattern will change over the next two decades, as post-war immigrants reach these age groups.

Indigenous Australians

In 2001, older Indigenous Australians were estimated to comprise only a small proportion of older people (0.5%), much smaller than their representation among the population generally (2.6%), owing to a much lower life expectancy—approximately 20 years lower than for the total population (see Topic 20: *Indigenous people*). Of the population aged under 65 years, 2.9% are Indigenous. Unlike the non-Indigenous population, in which life expectancy has been increasing, there is no evidence for a similar improvement for the Indigenous population.

Figure 1.1: Selected countries of birth of overseas-born Australians, by age, 2001



Source: Table A1.1.

2 The changing demographic profile: 1991–2021

The Australian population is ageing, meaning that the proportion of older people in the population is increasing. The growth rate of the older population is also changing. The annual rate of increase for the population of older people has been higher than for the entire population and substantially higher for very old people in recent years. The growth rate of the older population is projected to continue to increase into the future. These changes within the age structure of the older population will shape the character of Australian society into the future. They are of relevance to government, business, communities and individuals in planning for their continued health and wellbeing.

Ageing across the population

There has been a more or less persistent ageing of the Australian population since the beginning of the 20th century, except for a reversal during the post-war baby boom. This baby boom effect forms part of the phenomenon of the cyclical nature of population ageing. At 30 June 2001, there were an estimated 2.4 million Australians aged 65 and over, or 12.5% of the total population of 19.4 million. This represents 22% growth since 1991 when there were 2.0 million older Australians (Table 2.1). This is a slower increase than that experienced during the previous decade (1981–1991), when the older population increased by 34%. In the decade just begun (2001–2011), the older population is projected to increase by 26%—more than in the last decade but less than in 1981–1991.
The older population is expected to continue to grow over the next 50 years to reach around 6.5 million, or around one-quarter of the total population (ABS 2000:16). According to projections published by the ABS (2000), the 10-year growth rate of the population aged 65 and over will reach a peak at 39% between 2011 and 2021 as the Australian baby boom generation reaches retirement age. Thereafter growth rates are expected to decline to under 30% for the following decade.

Table 2.1 shows the projected size of the growth in the older population in absolute terms from 1991 to 2021. As the growth in the older population outpaces the growth in the younger population, an overall ageing of the Australian population is projected to occur.

Table 2.1: Population aged 65 and over, by age and sex, 1991, 2001, 2011 and 2021 (projected from 2001)

Age/sex	1991	2001	2011	2021
Females				
65–74	633,500	676,900	847,000	1,243,200
75–84	370,900	486,600	544,300	705,800
85+	110,000	179,400	256,000	300,800
Total females 65+	*1,114,500*	*1,343,000*	*1,647,300*	*2,249,800*
Total females	*8,668,600*	*9,754,100*	*10,688,800*	*11,512,100*
Males				
65–74	548,600	628,400	820,200	1,184,500
75–84	243,400	350,800	435,400	608,400
85+	44,200	80,900	133,100	177,800
Total males 65+	*836,300*	*1,060,100*	*1,388,700*	*1,970,700*
Total males	*8,615,400*	*9,667,200*	*10,600,000*	*11,414,300*
Persons				
65–74	1,182,100	1,305,300	1,667,200	2,427,700
75–84	614,300	837,500	979,600	1,314,100
85+	154,200	260,300	389,200	478,600
Total 65+	**1,950,700**	**2,403,100**	**3,036,000**	**4,220,400**
Total	**17,284,000**	**19,421,300**	**21,288,800**	**22,926,400**

Sources: ABS 2002a; ABS 2000, estimated resident population Series II.

In 1991, 11% of the population were aged 65 and over (2.0 million) and by 2021 this is projected to increase to 18% (4.2 million). This change in the proportion of the Australian population who are aged 65 and over is as important a change as the increase in absolute numbers described in the preceding paragraph.

The changing older population

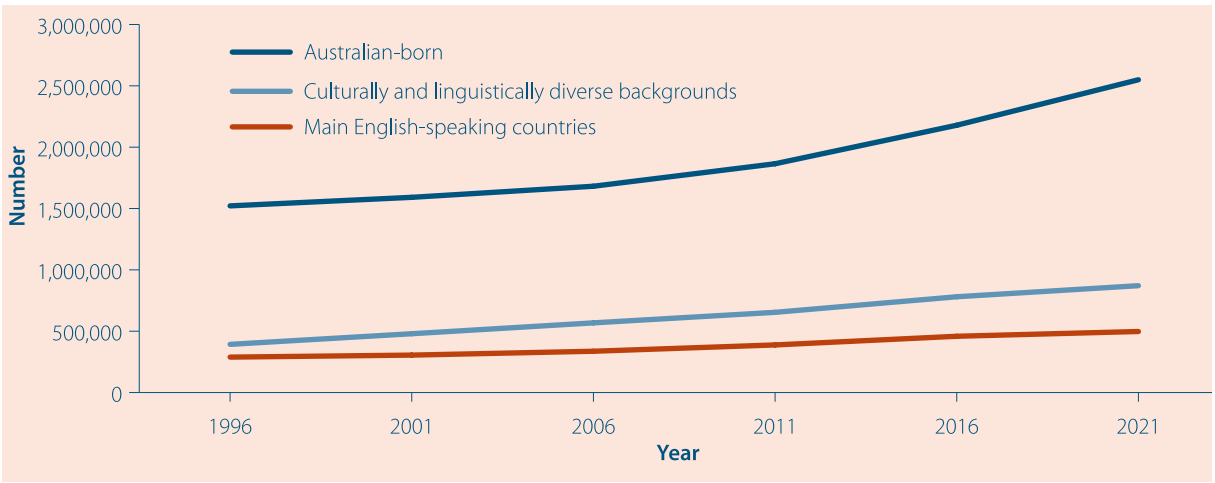
As well as increasing in absolute numbers, and as a proportion of the total population, the older population is also changing in its internal age structure. In 1991, the proportion of older people who were aged 85 and over was 8%; in 2001 it was 11%. Between 1991 and 2001, the 85 and over population increased more rapidly than other groups (10% for those aged 65–74, 36% for those aged 75–84 and 69% for those aged 85 and over). Between 2011 and 2021 this will begin to change, as the baby boom generation enters the 65 and over age groups. In that decade, the rates of increase are projected to be 28% for those aged 65–74, 17% for 75–84 and 50% for those aged 85 and over. In this decade, the ageing of the aged population which has been strongly evident since 1981 will begin to reverse, giving way in the cycle of population change to a 'younging' of the aged population.

The ratio of men to women in the older population is also projected to increase, although older women will still outnumber men. It is anticipated that the proportion of women in the 65 and over age group will decrease from 57% in 1991 to 53% in 2021.

Another interesting feature of the ageing population is changing cultural diversity. Figure 2.1 shows how the number of overseas-born older Australians from culturally and linguistically diverse backgrounds has increased since 1996 and will continue to do so over the coming 20 years. This reflects high levels of migration from non-English-speaking countries in Europe after World War II until the early 1970s. In 1996, people from culturally and linguistically diverse backgrounds made up 18% of the older population. This proportion has been projected to increase to 23% of the older population by 2011 (Table A2.1). The population of older people from culturally and linguistically diverse backgrounds is also expected to age more rapidly than the Australian-born population. Between 1996 and 2011, a 165% increase in those aged 80 and over from culturally and linguistically diverse backgrounds is projected, compared with a 47% increase in the Australian-born (Gibson et al. 2001:4–5).

Other changes to Australia's population can also be expected in the future. The number of veterans in the older population is expected to decline substantially. With some exceptions, the population in rural and remote areas is expected to age at a greater rate than the population in metropolitan areas.

Figure 2.1: Population aged 65 and over, by cultural and linguistic background, 1996 to 2021 (projected)



Source: Table A2.1.

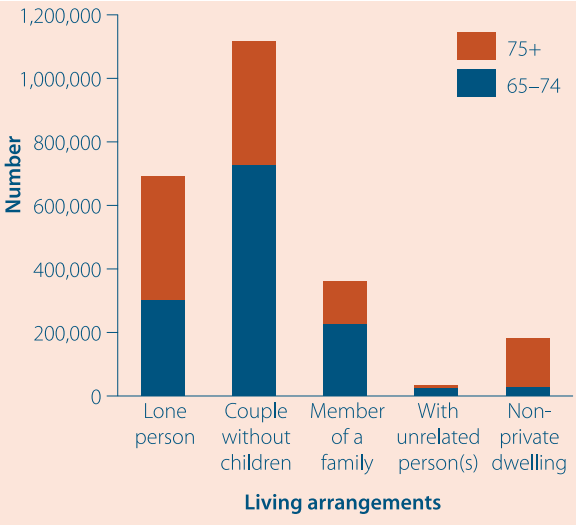
3 Living arrangements

Living arrangements are an important factor in the general health and wellbeing of older people, as they are for Australians generally. Older people live in a variety of arrangements, mostly in private dwellings. This reality challenges the common myth of older people predominantly living in retirement homes and residential aged care services.

Living arrangements of the older population

Of those older people who lived in a private dwelling, the ABS projected in 1999 (ABS 1999b) that by June 2001 approximately 1,513,500 (69%) would be living with others—the majority of these with a spouse or partner (Figure 3.1). Of those living alone, by far the greatest proportion were females (73%). The proportions living alone also increased with age (ABS 1999b:56). Projections indicate that there will be a substantial increase in the number of older people living alone over the coming years. For example, the number of older females living alone is projected to increase by 22%, from 438,800 in 1996 to 536,900 in 2006. For men aged 65 and over, the comparable increase is projected to be 35%, from 160,400 in 1996 to 217,200 in 2006 (AIHW 1997:85–6).

Figure 3.1: Living arrangements of older people, by age, 2001



Source: Table A3.1.

Only 8% (181,400) of older people were estimated to live in non-private dwellings, including residential aged care. This follows a trend away from institutional care and towards community care, dating from the mid-1980s. Without these policies it is estimated that there would have been an extra 34,100 people aged 65 and over in health and welfare institutions in 1996, if the 1981 rates of institutionalisation had continued (AIHW 2001:112). Of those in a non-private dwelling, the majority were aged over 75, reflecting the increased care needs and reduced carer availability experienced by this group. Indeed, the proportion in the 75 and over age group living in a non-private dwelling was seven times as high as the proportion aged 65 and over.

Older people tend to prefer to 'age in place' rather than move, which is recognised in government policy. One of the specified objectives of the 1997 Commonwealth *Aged Care Act* was the promotion of desirable living arrangements through 'ageing in place'. This policy aims to link care and support services to the places where older people prefer to live, rather than disrupt their lives by moving them. For that proportion of older people living in residential aged care, this has been facilitated by the 1997 aged care reforms (Gibson et al. 2002; see Topic 35: *Residential aged care: patterns of use*).

Overall, older people are much less likely to change their address than the rest of the population, although some sub-groups of people aged 65 and over are more likely to move than others. There is some evidence that small but significant numbers of older people are choosing to relocate to coastal or other non-urban areas due to retirement and accumulated finances (Stimson et al. 1997). In 1996, 32% of all older people lived within 5 km of the coast compared with 25% of the rest of the population (ABS 1999d:16–17). Among the very old, however, mobility rates increase as this group move closer to family or into accommodation more appropriate to their needs. When the very old do move, it is usually only within the immediate local area.

Living arrangements of older people with a disability

Table 3.1 shows the living arrangements of older people with various degrees of restriction as a result of disability. The majority (83%) of older people with a core activity restriction (that is, people who sometimes or always need assistance with activities of self-care, mobility and communication; see Topic 17: *Disability levels*) lived in a private dwelling (55% with other people). The proportion living in cared accommodation (such as aged care homes and hospitals) increases dramatically if the disability results in a severe or profound core activity restriction, reflecting the high level of need for assistance. While 1 per cent of older people with a mild or moderate core activity restriction lived in cared accommodation, 32% of those with a severe or profound core activity restriction lived in such accommodation.

The proportion of older people living in a non-private dwelling who have a severe or profound activity restriction increases steadily with age, rising sharply after age 84 (Table A3.2). There are also substantial differences between men and women. Older women predominate among older people with a severe or profound restriction who live alone (78%), and among those in aged care accommodation and other non-private dwellings (73%). However, there is a more even split between the sexes among older people with a severe or profound restriction who live with others (56% female). This is only partly a result of the greater number of women in older age groups, and in general a greater proportion of women with a severe and profound restriction live alone than men. Among those aged 65 and over, 24% of women with a severe or profound restriction lived alone, compared with 14% of men. The differences are particularly marked for the 75–84 age group, with 29% of women and 12% of men with a severe or profound restriction living alone.

Table 3.1: People aged 65 and over with core activity restrictions, living arrangements by severity of restriction, 1998 (per cent)

	Core activity restriction			
Living arrangements	**Severe or profound**	**Moderate**	**Mild**	**Total**
Private dwelling				
Alone	20.3	38.3	31.2	27.9
With at least one other person	45.5	58.2	65.5	55.3
Total private	*65.8*	*96.6*	*96.7*	*83.2*
Non-private dwelling				
Cared accommodation	32.1	1.1	0.9	14.5
Other non-private dwelling	2.0	2.4	2.5	2.2
Total non-private	*34.2*	*3.5*	*3.3*	*16.8*
Total	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**481,200**	**226,400**	**399,600**	**1,107,200**

Notes

1 Core activities comprise communication, mobility and self-care.

2 Table excludes 59,500 people living in retirement villages which can include private and non-private dwellings (including cared accommodation).

Source: ABS 1999b:20.

4 The international context: population and expenditure

Population ageing was a defining characteristic of all developed and many developing nations in the latter part of the 20th century. It is a trend that is set to continue into the 21st century, and Australia is no exception. Associated with these population changes is another projected international trend, that of increasing expenditure on older people as a proportion of each nation's wealth (as measured by gross domestic product (GDP)).

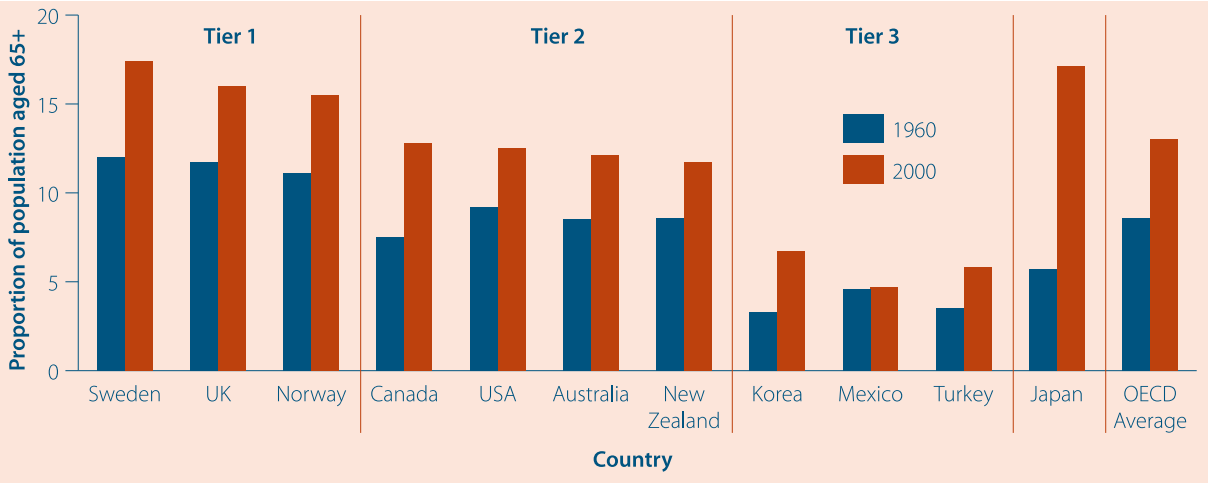
The age of the population

Australia continues to have a relatively young population among developed nations. The 11-country comparison provided in Figure 4.1 shows three broad tiers in terms of population structure for the years 1960 and 2000. The first tier includes most European countries, which have a relatively large proportion of their population aged 65 and over: 15–17% in 2000 for countries presented in Figure 4.1. The second tier, which includes Australia, the United States of America, Canada and New Zealand, comprises a predominantly 'younger' group of countries. In 2000 about 12–13% of the populations of this second tier were older people. The third tier comprises the so-called 'late initiation' countries, such as Korea, Mexico and Turkey, where the decline in fertility that precedes population ageing has only recently occurred. These countries have a much younger population, with only 5–7% aged 65 and over in 2000. Japan does not easily fit into any of the three categories. Its current age structure is the result of a particularly rapidly ageing population. In 1960 its age structure was more like that of a Tier 3 country, but by 2000 its age profile was similar to that of the first tier.

Growth of the older population

As is the case in many countries in the Organisation for Economic Co-operation and Development (OECD), Australia's population is ageing. Declining fertility and mortality rates are driving this change. In Australia, the increase in the proportion of the population that is aged 65 and over will be larger in the decade just begun than in the previous decade (Topic 2: *The changing demographic profile:1991–2021*). These changes are not, however, unprecedented: Australia's older population is projected to grow at a similar rate over the next 20 years as it did in the 20 years prior to 2000, averaging 3.2% per annum over both periods (Table 4.1). These rates of increase are above the OECD average for both periods (2.0% and 2.2%).

Figure 4.1: International comparison of the proportion of populations aged 65 and over, 1960 and 2000 (per cent)



Source: Table A4.1.

Table 4.1: International comparison of the average annual growth rate of the population aged 65 and over (per cent)

Country	1980–2000	2000–2020
Mexico	4.1	5.6
Korea	5.8	5.1
Turkey	4.2	4.1
Canada	3.6	3.4
Australia	*3.2*	*3.2*
New Zealand	2.3	2.9
USA	1.8	2.6
Japan	5.2	2.5
OECD average	**2.0**	**2.2**
Norway	0.7	1.8
Sweden	0.7	1.8
UK	0.6	1.3

Source: AIHW analysis of OECD 2000.

Age-related expenditure

Expenditure on a wide range of programs is affected by changes in the demographic profile of a country. As the proportion of the population aged under 25 years decreases and the proportion aged over 65 increases it can be expected that, in relative terms, expenditure in areas aimed primarily at youth, such as education, will fall while expenditure on programs commonly used by older people, such as health services and old-age pensions, will increase. A recent OECD study compared age-related public expenditure in 21 countries. In this report age-related expenditure was defined as public expenditure on: old-age pensions, 'early retirement' programs, health care, long-term care, child and family benefits, and education. In 2000 Australia's overall age-related expenditure was around the average for the countries included in the study—16.7% of GDP compared with an average of 16.9% (Table A4.2). The rises in expenditure on health care and old-age pensions projected for the next 20 years will be counterbalanced to varying degrees in different countries by falls in expenditure on education and child and family benefits (Dang et al. 2001:48–51). As a result, the overall OECD expenditure on age-related sectors was projected to increase to 18.7% of GDP by 2020, while such expenditure for Australia was projected to reach 17.6% of GDP over the same period.

The final impact of population changes on expenditure will depend not only on population patterns and steps taken by government to address issues arising as a consequence, but also on the economic environment of the time. The Intergenerational Report recently released by the Federal Treasurer, reported that, as a result of declining fertility rates and an ageing population, over the next decade all OECD countries are expected to experience similar downward pressure on the growth rate of the labour force and consequently on real economic growth per person. Australia's GDP growth rate per person is projected to be stronger than that for countries such as New Zealand and Japan, but slightly lower than that for the United Kingdom and the United States (Treasury 2002:31–32; UN 1998). The significant demographic changes expected will present economic and social challenges and opportunities. How the changes are managed will influence the resulting fiscal impact.

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Social context

5 Leisure and lifestyle

The choices older people make regarding the use of their time has implications for both their health and their wellbeing. The importance of an active and healthy lifestyle is particularly recognised in recent Australian initiatives on healthy ageing outlined in the Commonwealth and State and Territory Healthy Ageing Strategy (HATF 2000:17). The World Health Organization (WHO) has also identified the importance of 'active ageing', which includes participation in physical activities (such as sport) as well as in social, economic, cultural, spiritual and civic affairs. Active ageing is purported to help to address some of the challenges associated with an ageing population (see Topic 2: *The changing demographic profile: 1991–2021*) leading to increased longevity, reduced disability, a more positive quality of life and lower costs of medical and care services (WHO 2002:16).

Time use of older people

The ABS Time Use Survey (ABS 1998b) provides a means of comparing the daily activities of older people with the general Australian population. The average amount of time dedicated to various activities is shown in Figure 5.1. Half of the day of an older person is dedicated to essential activities such as sleeping, eating and personal hygiene (Table A5.1). The two next biggest categories include recreation and leisure (27%) and domestic activities such as cooking, laundry and cleaning (13%).

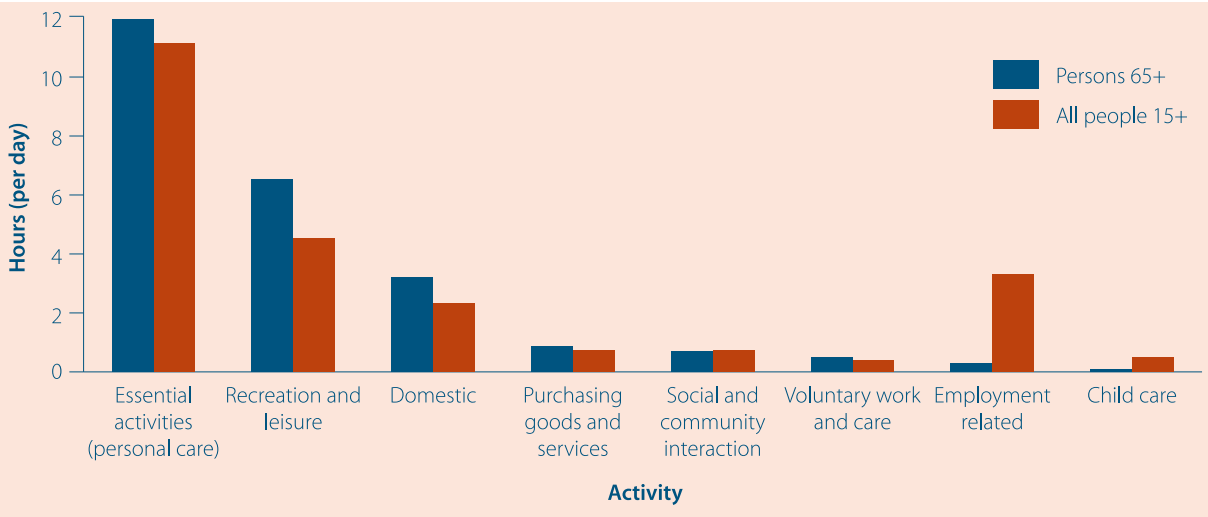
The time use of older people is somewhat different to that of other Australians, but there are similarities. The average time spent in essential activities such as eating and sleeping, for example, is almost 12 hours per day for an older person and just over 11 hours for all people aged 15 and over. Major differences in time use are in the areas of employment, leisure and child care. Older people dedicate much less time to employment than others (15 minutes a day on average compared with 3.25 hours for all people aged 15 or more) and to child care (under 5 minutes compared with 31 minutes). On the other hand, older people spend more time on recreation and leisure (6.5 hours compared with 4.5 hours).

The differences in time use between older women and men are similar to those for the rest of the population. For example, on average older men spend much more time in employment-related activities than older women (almost half an hour a day compared with 5 minutes), but they spend less time on domestic activities (2.75 hours compared with 3.5 hours) (Table A5.1). On the other hand, the average time spent on domestic activities was 1.25 hours a day more for older men than for all men aged 15 or more.

Learning

Life long learning is becoming increasingly popular among older people. For example, as at April 2002 at least 46,000 older people participated in courses

Figure 5.1: Main activities of people, by age, 1997



Source: Table A5.1.

provided by the University of the Third Age (U3A) through 153 providers (U3A 2002). U3A is an organisation providing low-cost educational opportunities for people in active retirement. Older people also participate in mainstream education. In 2001, there were 866 people aged 60 and over commencing university courses. Of the course completions by people aged 60 and over in 2000, 56% were for postgraduate and 44% were for undergraduate awards. About 3% of all course completions were by people aged 50 or more (4,985 people; DEST 2002).

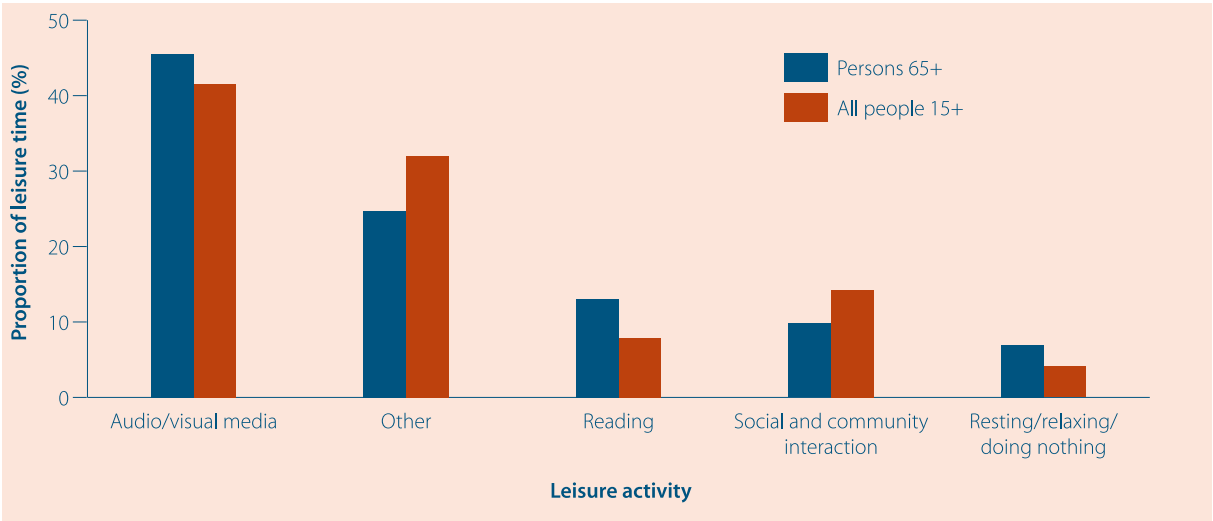
Leisure activities of older people

Older people have almost 2 hours more free time per day (defined as the time dedicated to social and community interaction and recreation and leisure) than the general population (Table A5.2). In particular, older people spend more time on 'passive' leisure activities—which involve little, if any, physical activity—such as reading, watching television, and relaxing. Older people spend half an hour more time reading per day than the general population. They also read more often. For example, in 1997 approximately one-third of 15–24 year olds read on an average day, compared with two-thirds of older people (ABS 1998a:10). Figure 5.2 shows that this is not just an artefact of the extra free time; older people also spend a greater proportion of their free time reading (13% compared with 8% for the population as a whole).

Older people also dedicate more time to watching or listening to audio-visual media. This activity takes up by far the greatest proportion of free time available to older people (46%), and most of this time is dedicated to watching television (Table A5.2). On average, older people watch television for about 1 hour a day more than the general population. Much of this difference can be attributed to older people watching more television during the day, as well as beginning their viewing earlier at night (see ABS 1998a:10).

Older people spend 10% of their time on social and community interaction. This includes activities such as socialising, visiting entertainment and cultural venues, attendance at sports events, religious activities and community participation. A 1997 study (Howe & Donath 1997) found that older people are often members of sporting clubs and a majority had engaged in some form of exercise in a given week, mostly walking (DHAC 2000).

Figure 5.2: Proportion of free time dedicated to specific activities, by age, 1997



Source: Table A5.2.

6 Retirement

The changing profile of Australia's population has implications for its workforce. Over the next 40 years, the proportion of older people will grow and the proportion of those of traditionally labour force age will decrease. As the supply of younger workers declines, the need to retain older workers will become an issue of increasing importance. By understanding the reasons for retirement and the barriers to employment for older workers, it is possible to open greater opportunities for their continued contribution to society and the economy.

Labour force participation

There have been major changes in labour force participation patterns. In recent decades there has been a general rise in the participation rate for women, and the time spent in education by young people is increasing. With respect to older people, over recent years labour force participation rates for women have increased substantially. Between 1988 and 2001, the participation rate for women aged 55–59 increased from 33% to 49%, while that for women aged 60–64 increased from 16% to 25% (Table 6.1). The increase was more pronounced in more recent years. For older men, the general picture was more stable, remaining at 73% for men aged 55–59, declining somewhat during the mid-1990s but increasing again in more recent years for those aged 60–64. In both sexes, a small proportion aged 65 and over remain in the labour force, and this has been quite constant over the period, edging up marginally in recent years.

Table 6.1: Labour force participation rates by age and sex, December 1988, 1993, 1998 and 2001 (per cent)

Age/sex	1988	1993	1998	2001
Females				
45–54	58.2	65.7	69.8	70.6
55–59	33.0	37.4	44.0	48.7
60–64	15.7	15.5	18.0	24.7
65+	2.7	2.8	2.9	3.4
Males				
45–54	89.3	88.5	87.8	87.6
55–59	73.3	73.0	72.8	72.8
60–64	47.8	50.6	45.8	47.4
65+	9.7	9.2	9.7	10.4
Persons				
45–54	74.1	77.3	78.8	79.1
55–59	53.3	55.4	58.7	60.9
60–64	31.5	33.1	31.9	36.1
65+	5.6	5.6	5.9	6.5

Sources: ABS 1989:24; ABS 1994:19; ABS 1999a:26; ABS 2002b:22.

The working age ratio (the proportion of people aged 65 and over to the people of traditional labour force age, 15 to 64) provides an indication of the size of the population potentially to be supported by those of working age. In June 2002 there were 19 people aged 65 and over for every 100 people aged 15 to 64. By 2042 this is predicted to rise to a ratio of 41 to 100 (Treasury 2002:23–4). Over the same period the proportion of the population aged under 15 is expected to fall. Overall, it is projected that the dependency ratio, that is the number of people not of working age (aged under 15 or 65 and over) compared with the number of people of working age (aged 15 to 64), will fall to a minimum in 2009 and then rise, reaching around 65 per 100 in 2042. Similarly high levels of dependency have been experienced before in Australia, in the early 1970s. However, at that time children accounted for the major part of the dependency ratio whereas in the future older people will contribute the greater proportion.

Given the projected rise in the ratio of older people and children to working-age people, policies aimed at changing patterns of participation in the labour force, as well as those aimed at changing patterns for saving for retirement (see Topic 8: *Income sources*), will have increasing prominence. Currently there are initiatives to encourage older people to stay in the workforce and delay their decision to retire. For example, the Pension Bonus Scheme provides a lump sum payment upon retirement for those who defer their choice to take up the Age Pension and continue to work (DFaCS 2002).

Timing of retirement

In line with the principle of encouraging continued workforce participation among older people, there is no statutory retirement age in Australia. There is, however, a minimum age that must be attained before qualifying for the Age Pension. For men, this is reached at the age of 65. Before 1995 the eligible age for women was 60. Owing to a change in government policy, the age for women is gradually being increased to that for men, reaching age 65 in 2014 (see Topic 9: *Pensions*).

The most recent detailed data concerning retirement are from the 1997 ABS Survey of Retirement and Retirement Intentions. Currently, relatively few men and women wait until qualifying for the Age Pension before retiring. The ABS survey found that, among people aged 45 and over who had retired from full-time work after the age of 45, around three-quarters retired before qualifying for the Age Pension: 76% of the men had retired before age 65 and 73% of the women had retired before age 60 (Table 6.2). Only a very small percentage of retirees had retired from full-time work after the age of 70. In addition, women tend to retire before men: almost half (47%) of retired women aged 45 and over had retired before the age of 55 compared with only 19% of the men. However, the effect of the increasing participation by older women in the workforce since the early 1990s may gradually bring the retirement age patterns of men and women closer together. In addition, the notion of formal 'retirement' may have decreasing salience for older workers, as some leave full-time work to move into part-time work, and others face redundancy and increased difficulty in obtaining access to the labour market. There was little change in the pattern of age of retirement between 1994 and 1997 (ABS 1998b:11).

Table 6.2: Persons aged 45 and over retired from full-time work at age 45 or more: age at retirement from full-time work, 1997

Age at retirement	Number	Per cent
Females		
45–54	414,100	47.4
55–59	220,900	25.3
60–64	182,800	20.9
65–69	49,700	5.7
70 and over	6,200	0.7
Total	*873,700*	*100.0*
Males		
45–54	225,500	18.7
55–59	288,800	24.0
60–64	401,900	33.3
65–69	253,300	21.0
70 and over	36,300	3.0
Total	*1,205,800*	*100.0*

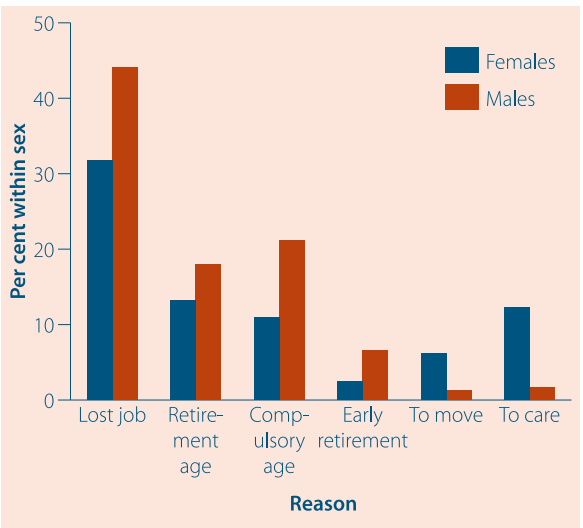
Note: Persons retired from full-time work were defined as those who had had a full-time job at some time and who had ceased full-time labour force activity (i.e. were not working full-time, were not looking for full-time work and did not intend to work full-time at any time in the future). Unpaid voluntary work was not considered full-time work.

Source: ABS 1998b:11.

Reasons for retirement

The three main reasons given for retiring in the ABS survey were the same for men and women: losing a job, reaching the appropriate age for retirement and reaching the compulsory retirement age for that job (see Figure 6.1). Nearly half (44%) of the men and one-third of the women (32%) who had retired from full-time work by the end of 1997 did so because they had lost their job. For both men and women in the majority of cases, job loss was caused by ill health or injury (ABS 1998b:13–14). Women were more likely than men to retire for family reasons (to care or move with family), while men were more likely than women to retire because of reaching the age of either voluntary or compulsory retirement, or to take up early retirement.

Figure 6.1: Common reasons for retirement for persons aged 45 and over retired from full-time work at age 45 or more, by sex, November 1997



Source: Table A6.1.

7 Voluntary work

While many older people retire from formal work, most continue to contribute actively to their family, community and society. Many engage in voluntary work, contributing to the economic, political, social and cultural life of the country. People aged 55 and over provide more than a third of the volunteer hours worked in Australia. In economic terms, this contribution can be difficult to measure but its value is expressed in a strong and cohesive Australian society. Voluntary work provides a reciprocal benefit to those who engage in it, contributing to the growth and maintenance of personal wellbeing.

Participation in voluntary work

Volunteer activity includes providing informal assistance to family members, to friends and neighbours, and more formally to others through an organisation or group. The definition of volunteer activity used here is consistent with its frequent usage, however, referring more narrowly to unpaid activities undertaken through a formal organisation or group.

Approximately 25% of older people in Australia participated in some form of voluntary work during the 12 months to June 2000. This contrasts with 32% of the total Australian population aged 18 years and over. While these simple statistics suggest a lower rate of participation by older people, the overall picture is more complicated.

The overall figures for voluntary work among older people are skewed because, past the age of 65, the rate of participation declines dramatically with age. To illustrate, the participation rate for the 55–64 age group is 33%, which is similar to that for the 65–74 age group (30%). It then falls to 18% after the age of 75 (ABS 2001c:13).

Moreover, older people tend to contribute more hours to voluntary work than their younger counterparts. While contributing 12% of the total number of volunteers, older people (encompassing the 65–74 and 75 and over age groups) contributed 17% of the total hours worked. There is further evidence of this in the increase in the median number of hours contributed after the age of 65. If the 55–64 age group is added in, the proportions are 24% of participants and 37% of total hours (see Table 7.1).

The number of older volunteers has increased considerably over the 5 years to 2000. The main growth has been among those aged 55–64 and 75 and over, with increases of around 50% being observed in these groups. For the 55–64 age group, the number increased from 356,400 in 1995 to 545,500 volunteers in 2000. The number of volunteers in the 65–74 age group expanded from 309,200 to 381,400 and the number of volunteers aged 75 or over went from 97,700 to 146,700 over the 5 years (ABS 2001d:12).

Reasons for taking up voluntary work

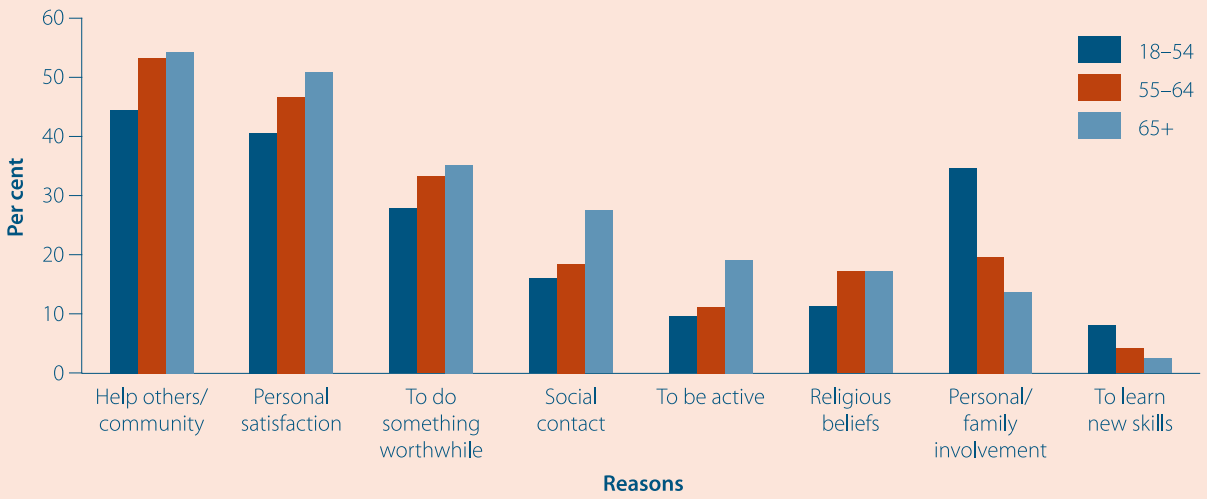
The reasons for taking up volunteer work appear to be different for older Australians than for the rest of the population (Figure 7.1). They are less likely to be involved for reasons associated with personal involvement in an organisation and learning new skills than are their younger counterparts, and more likely to nominate personal satisfaction, social contact and helping others (ABS 2000). In 2000, the most commonly nominated reason for becoming a volunteer by Australians aged 65 and over was to help others in the community, which was chosen by 54% of those surveyed (Table A7.1). This was about the same as for the 55–64 age group (53%), but higher than for the 18–54 age group (45%).

Table 7.1: Participation in voluntary work, by age, 2000

Age	Number of participants	Per cent	Total hours (annual)	Per cent	Median hours per week
18–54	3,322,200	75.6	442,700,000	62.9	n.a.
55–64	545,500	12.4	139,300,000	19.8	1.9
65–74	381,400	8.7	90,100,000	12.8	2.5
75+	146,700	3.3	32,000,000	4.5	2.3
Total	**4,395,600**	**100.0**	**704,100,000**	**100.0**	**1.4**

Source: ABS 2001c:12, 14, 15.

Figure 7.1: Common reasons for volunteering, by age group, 2000



Source: Table A7.1.

Types of voluntary work

Table 7.2 shows the type of voluntary work performed by older people compared with younger age groups. In 2000, voluntary work by older people commonly included fundraising (carried out by 52% of older volunteers), administration and management or committee work (each 39%). The type of voluntary work performed by older people varies depending on their age and sex. For example, females aged 65 and over were more likely to volunteer for fundraising and sales activities or the preparation and serving of food. Males were more likely to be involved in administrative and clerical or management and committee type work. The activity of teaching, instructing or providing information showed the greatest difference in participation rates between those under and over age 65.

Table 7.2: Participation in volunteer activity, by type of activity, age and sex, 2000 (per cent of volunteers)

	Females			Males			Persons		
Voluntary activity	**18–54**	**55–64**	**65+**	**18–54**	**55–64**	**65+**	**18–54**	**55–64**	**65+**
Fundrasing/sales	60.5	53.2	63.2	50.5	50.5	39.5	55.9	51.8	51.9
Administration/clerical/recruitment	39.5	47.5	27.6	38.9	49.8	51.3	39.3	48.7	38.9
Management/committee work/ co-ordination	40.3	43.3	26.0	47.9	54.3	53.1	43.9	49.0	38.9
Preparing/serving food	44.8	49.9	41.8	22.6	18.4	23.0	34.5	33.7	32.9
Befriending/supportive listening/ counselling	25.6	34.9	35.8	17.3	23.8	28.0	21.7	29.2	32.1
Teaching/instruction/providing information	52.5	42.7	23.9	41.9	40.3	28.6	47.5	41.5	26.1
Personal care/assistance	15.4	14.2	13.5	13.4	16.1	14.3	14.4	15.2	13.9
Transporting people/goods	24.1	17.4	25.3	26.9	33.6	26.3	25.4	29.3	25.8

Note: Volunteers may participate in more than one activity for up to three organisations. Therefore, figures from individual categories will not add up to 100%.
Source: ABS 2001d:29.

8 Income sources

The living standards of older people are supported not only through government pensions and benefits but through continued participation in the workforce and through the retirement benefits provided by superannuation. Over the past two decades there have been considerable changes in superannuation arrangements and contributions, and changes in workforce participation among older people. Change continues to occur as these issues gain prominence in the face of increasing debate about the future costs associated with Australia's ageing population.

To examine the income of people, income units are often used rather than individuals, simply because income often tends to be shared among more than one person. An income unit is a person or a group of people related in some way who share both source of income and control over how it is spent. Pensions and government allowances are by far the biggest source of income for people aged 65 and over (see Topic 9: *Pensions*). In 1999–00 pensions and allowances were the main source of income for around three-quarters of all income units with the reference person aged 65 or over (Table A8.1). Superannuation was the main source of income for a further 8% of these income units, with earned income being the main source for 5%. Other sources of income, including income from property, shares and other sources of wealth, predominated in the remaining 11% of older income units.

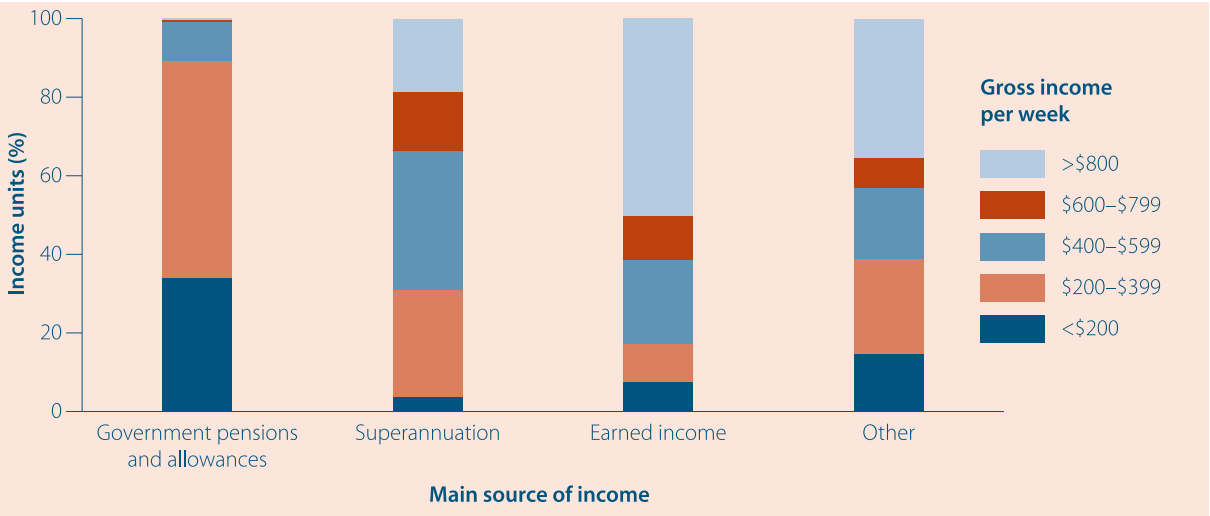
Income units whose main source of income is through government payments tend to have lower incomes than others, as can be seen in Figure 8.1. In 1999–00, only 11% of income units relying on government payments had gross income greater than $400 per week; the corresponding proportions for those reliant on superannuation and earned income were 69% and 83%, respectively. To put these amounts into perspective, at the time of the survey a single person income unit receiving the full Age Pension and no additional income was receiving just under $200 a week, while the equivalent amount for a couple income unit was slightly over $300 per week.

Income units whose main source of income is paid work tend to have higher incomes than others. In 1999–00, this group had the largest proportion of income units with incomes greater than $800 per week, at 50% of income units with the reference person aged 65 or over compared with 8% for all income groups (Table A8.1).

Superannuation

The importance of superannuation as an income source in old age has been growing since the mid-1980s. The development of the national contributory system in the 1980s, followed in 1993 by the introduction of the Superannuation Guarantee Charge (requiring employer contributions), has driven change

Figure 8.1: Source of income, by income range for income units with reference person aged 65 and over, 1999–00



Source: Table A8.1.

towards the accumulation of private savings for retirement in addition to the publicly provided Age Pension. Thus, while in 1988 over half (55%) of employees aged 15 to 64 had superannuation, by the year 2000 the vast majority (91%) of employees aged 15 to 64 were covered by superannuation (ABS 1999b:81; ABS 2002a:175).

Given the relatively recent nature of the superannuation initiative, its full effects on the income of people moving through retirement and into old age have yet to be seen. Assuming an average working career spanning 40 years, for example, the full impact of the superannuation guarantee implemented in 1993 will not come into play for a retiring cohort until 2033. At present, however, superannuation is already a significant contributor to the wealth and incomes of older people. In 2000, about 13% of retired people aged under 70 were receiving at least part of their income from superannuation or annuities. However, men were much more likely to be getting income from this source, with 22% of retired men aged under 70 getting income from superannuation compared with 8% of women. Over 33% of these younger retired people had received a lump sum payment (ABS 2001b:14, 38).

Paid work

In 1999–00 only 5% of income units with the reference person aged 65 or more obtained income primarily through paid work. Given that the eligible age for the Age Pension is between 60 and 65 (61.5 in 2000 for women and 65 for men—see also Topic 9: *Pensions*), it is not surprising that only a small proportion of older people participate in the workforce. In general, labour force participation among older people decreases as age increases: in 2001, among people aged 65 and over, around 7% of people were in the labour force—10% of men and 3% of women—compared with 61% of those aged 55 to 59 (see Topic 6: *Retirement*). Among those who are employed, there is also an increasing propensity for people to work part-time as age increases (Table 8.1). Thus, in 2001 just under 90% of employed men aged 55 to 59 worked full-time, but only 55% of those aged 65 or more did so. The corresponding figures for employed women were 51% and 35%.

As part of the development of the National Strategy for an Ageing Australia, research was commissioned by the Department of Health and Ageing on the interrelationships between population ageing and the economy. This research confirmed the increasing value to the economy of older workers as the entry rate of young workers declines over the next few decades (DoHA 2001).

Table 8.1: Employed persons by age and sex, December 2001

Age/sex	Full-time	Part-time	Total	Total
Females		**Per cent**		**Number**
55–59	50.5	49.5	100.0	239,000
60–64	40.9	59.0	100.0	98,300
65+	35.1	65.1	100.0	45,900
Males				
55–59	87.5	12.5	100.0	362,700
60–64	80.5	19.5	100.0	184,600
65+	55.0	45.0	100.0	111,400
Persons				
55–59	72.8	27.2	100.0	601,700
60–64	66.8	33.2	100.0	282,900
65+	49.2	50.8	100.0	157,300

Source: derived from ABS 2002b:25.

9 Pensions

There are a number of benefits made available by the Australian Government that are provided to maintain the living standards of people as they move through their older years, including the Age Pension and the Service Pension. The Government also provides support for the informal care *of* older people and informal care *by* older people through the Carer Payment and the Carer Allowance. Together, these provide income support in retirement and old age and provide support to individuals caring for older people in the community.

The Australian Age Pension

The Age Pension is the Commonwealth Government's largest single program of income support. The aim of the Age Pension is to provide an adequate safety net payment to older people who are financially unable to support themselves following retirement. As such, it is not linked to previous labour force participation. However, to target those in financial need, it is both income and assets tested. From March 2002, the maximum single rate of pension was $421.80 a fortnight. The equivalent for each member of a couple was $352.10 a fortnight.

Currently, the Age Pension is payable to men at age 65 years and women at age 62 years, who are Australian residents. The qualification age for women began to increase from 1 July 1995. It will reach 63 years in 2006, 64 years in 2010 and 65 in 2014. Table A9.1 shows the changes to the eligibility age for women depending on their date of birth.

Of the 1.8 million people receiving the Age Pension in March 2002, almost 1.1 million (61%) were women. Over a third of pensioners were aged between 60 and 69. Although a much smaller proportion were aged 85 and over (11%), this represented 71% of the population in that age group (Table 9.1).

There are also a range of benefits available to war veterans and their dependants through the Department of Veterans' Affairs (DVA), and these are discussed in Topic 23: *Veterans*. Overall, some 2,068,000 people aged 65 and over received at least a part pension (Age or DVA), comprising 85% of that age group. The proportion was higher at older ages, increasing from 78% among those aged 65–74, to 93% among those aged 85 and over.

The Carer Payment

The Carer Payment (previously the Carer Pension) is an income-support benefit payable to people who (regardless of their age) are unable to engage in a substantial level of paid work because of their caring responsibilities. The Carer Payment is income and assets tested and it has the same rate of payment as the Age Pension. In March 2002, there were 64,913 people caring for another person and receiving the Payment (Table 9.2). The majority of these recipients (62%) were women and a large proportion were aged 45–64 years (64% of men and 66% of women). Over a third of carers (41%) were caring for people aged 65 and over.

The Carer Allowance

The Carer Allowance (previously the Domiciliary Nursing Care Benefit) is paid to people caring for a person, in his or her own home, who requires extensive care due to a disability or severe medical condition. As at March 2002, the Carer Allowance was $85.30 per fortnight. It is not means tested, nor is it treated as income for social security or taxation purposes.

In April 2002, there were 275,444 people receiving the Carer Allowance for caring for another person (Figure 9.1). Of these, 81% were women. Around 20% were aged 65 and over, while 9% were aged 75 and over.

Table 9.1: Age Pension recipients, by age and sex, 30 March 2002 (per cent)

Sex	60–64	65–69	70–74	75–79	80–84	85–89	90–94	95+	Total
Females	8.6	14.3	13.0	9.9	7.3	5.0	2.2	0.6	60.9
Males	..	12.9	12.9	7.2	3.4	2.0	0.7	0.1	39.1
Persons	**8.6**	**27.2**	**25.9**	**17.0**	**10.7**	**7.0**	**2.8**	**0.7**	**100.0**
Total (number)	**154,341**	**489,566**	**465,706**	**306,655**	**192,834**	**126,269**	**51,177**	**12,672**	**1,799,220**

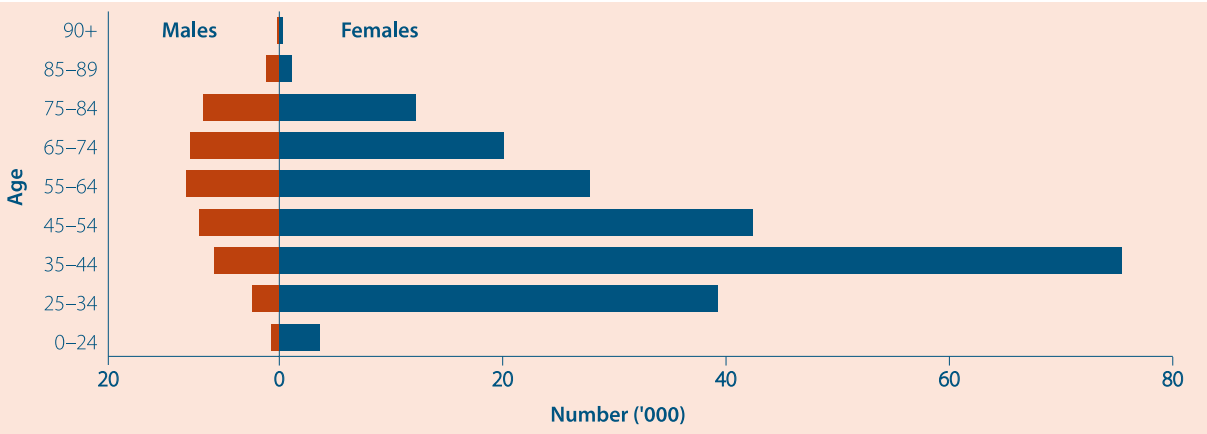
Source: Centrelink unpublished data.

Table 9.2: Persons receiving the Carer Payment, by age and sex, 8 March 2002

	Females		Males		Persons	
Age	Number	Per cent	Number	Per cent	Number	Per cent
0–24	1,488	2.3	920	1.4	2,408	3.7
25–34	3,384	5.2	2,331	3.6	5,715	8.8
35–44	8,108	12.5	4,858	7.5	12,966	20.0
45–54	14,546	22.4	7,019	10.8	21,565	33.2
55–64	12,042	18.6	8,657	13.3	20,699	31.9
65–74	727	1.1	579	0.9	1,306	2.0
75+	162	0.2	92	0.1	254	0.4
Total	**40,457**	**62.3**	**24,456**	**37.7**	**64,913**	**100.0**

Source: Centrelink unpublished data.

Figure 9.1: Persons receiving the Carer Allowance, by age and sex, 5 April 2002



Source: Table A9.3.

Some of these people may have been caring for more than one person. Among those being cared for by someone receiving the Allowance, almost one-third (30%) were aged 65 and over, with 20% aged 75 or more (Table A9.2).

Future outlays on pensions

The superannuation policies introduced in the 1990s have been directed at improving and diversifying the retirement income system to encourage greater self-provision and less reliance on the public pension.

The Intergenerational Report (Treasury 2002) anticipates that an increased proportion of retirees drawing on their superannuation savings will lower the proportion receiving a full Age Pension, in this way reducing the fiscal pressures on the government. Age and Service Pension payments are nonetheless projected in that report to rise from 2.9% to 4.6% of GDP in 2041–42.

10 Housing

Australia's rates of home ownership are among the highest of any of the advanced industrial countries (Kendig & Pynoos 1996). However, since 1981 the overall rate of home ownership has fallen slightly, from 73% in 1981 to 71% in 1996. Such falls were not across all population groups, and among lone-person and couple-only households with the reference person aged 65 or over ownership rates in 1996 were marginally higher than those in 1981 (Mudd et al. 2001:6–11).

The 1999 housing survey by the Australian Bureau of Statistics is the most recent source of detailed data on housing in Australia. This survey showed that, among people living in private dwellings, 70% of households were home owners. Older Australians are particularly characterised by very high rates of home ownership: 91% of couple-only households with the reference person aged 65 or over were home owners compared with 52% of couple-only households with the reference person aged under 35. For lone-person households the corresponding figures were 76% and 32% (ABS 2001a:173–180).

Among those living in private dwellings, overall 81% of households with a reference person aged 65 or more were home owners in 1999 (78% outright owners and 4% with a mortgage; Table 10.1). Housing therefore constitutes a significant financial resource for many older people, as well as a personal and social resource: long-term residence in their own homes provides people with a sense of security and continuity.

While the majority of older households own their home, 6% of households were public renters, 7% of households were private renters and 4% were living rent-free.

There were no substantial differences in home ownership rates by age for older households with a male reference person. However, there were some differences for households with a female reference person. In age groups 65–69 and 70–74, similar proportions of households with a female reference person owned their own homes: 84% and 82%, respectively. In contrast, in the 75 and over age group,

Table 10.1: Households where the reference person is aged 65 or over, by tenure, age and sex, 1999 (per cent)

	Owners			Renters						
Age/sex	Without a mortgage	With a mortgage	Total owners	Public housing	Private landlord	Total renters[a]	Rent-free	Other tenure[b]	Total	Number
Females										
65–69	78.5	5.5	84.0	6.1	5.7	12.5	2.0	1.4	100.0	348,700
70–74	78.1	4.1	82.2	5.4	4.9	11.4	5.0	1.4	100.0	332,700
75+	71.5	2.4	73.9	7.3	8.1	16.6	6.6	2.9	100.0	517,600
Total	*75.4*	*3.8*	*79.1*	*6.4*	*6.5*	*14.0*	*4.8*	*2.1*	*100.0*	*1,198,900*
Males										
65–69	80.2	5.4	85.7	5.4	5.8	12.2	2.1	0.1	100.0	316,700
70–74	78.7	4.9	83.6	4.0	7.6	12.1	2.6	1.6	100.0	292,000
75+	81.2	2.4	83.6	5.3	7.0	12.8	2.7	0.9	100.0	368,000
Total	*80.2*	*4.1*	*84.3*	*4.9*	*6.8*	*12.4*	*2.5*	*0.8*	*100.0*	*976,700*
Persons										
65–69	79.3	5.5	84.8	5.7	5.8	12.3	2.1	0.8	100.0	665,300
70–74	78.4	4.5	82.9	4.7	6.2	11.7	3.9	1.5	100.0	624,600
75+	75.5	2.4	77.9	6.5	7.7	15.1	5.0	2.1	100.0	885,600
Total	**77.5**	**3.9**	**81.4**	**5.7**	**6.6**	**13.3**	**3.8**	**1.5**	**100.0**	**2,175,600**

(a) Includes 'other renter'.

(b) Includes life tenure and rent/buy (or shared equity) schemes.

Note: Table includes households living in private dwellings only, and therefore excludes people living in residential aged care services.

Source: AIHW analysis of ABS 1999 Australian Housing Survey.

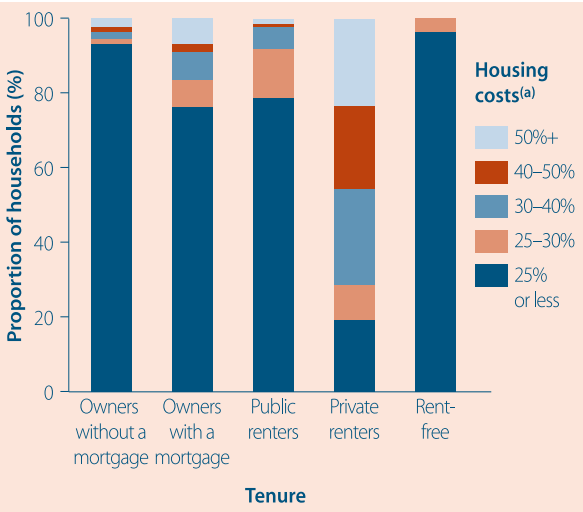
the home ownership rate was relatively low at 74% of households with a female reference person. At age 75 and over, women were somewhat more likely to be renting (17% compared with 11% at ages 70–74) or to be living rent-free (7% compared with 5% at ages 70–74, and 2% at ages 65–69).

Older lone-person households had smaller houses than couple-only households, with an average of 2.4 bedrooms per dwelling compared with 2.9 bedrooms for older couple-only households. Furthermore, only 65% of older lone-person households lived in separate dwellings (i.e. a detached house), while 87% of older couple-only households lived in separate dwellings (ABS 2001a:181).

Housing affordability

Figure 10.1 shows the affordability of housing for older households. Affordability is measured here as the proportion of household income spent on housing costs, where housing costs include mortgage or rental payments, water and general council rates, land tax and body corporate payments, and expenditure on repairs and maintenance. For public renters, State Housing Authorities consider that housing costs taking up more than 25% of household income may cause affordability problems for low-income households (SCRCSSP 2002:870).

Figure 10.1: Housing costs of older households, by tenure, 1999



(a) Housing costs as a proportion of household income.

Source: Table A10.1.

Housing tends to be more affordable for home owners (Figure 10.1). About 93% of older households who owned their dwelling without a mortgage paid 25% or less of their income on housing costs, compared with 79% of households renting publicly and only 19% of private renters. Over 71% of older households renting privately paid more than 30% of their income on housing costs, with nearly one-quarter paying more than 50%.

In 1999, average weekly housing costs for older households were $44 for couple-only households and $40 for lone-person households. The amount varied with home ownership. Among older people without a mortgage, couple-only households paid $38 a week, while lone-person households paid $31. For those with a mortgage, the figures were substantially higher at $91 and $62 for couple-only households and lone-person households, respectively. For older people who were renting, housing costs were higher again, at $103 a week for couple-only households and $70 for lone-person households (ABS 2001a:180).

In old age the cumulative effects of housing choices and opportunities (including government housing policies) interact with health and welfare services. With the current strong trend towards providing services to frail or disabled older people in their own homes, access to secure, affordable and appropriate housing is being recognised as a critical component in a 'home-based' system of service delivery. Housing, in combination with the accessibility and availability of services, strongly influences the extent to which individual needs for health and welfare assistance are met, and the ways in which they are met. The majority of older people who own their own home have an asset which can be used to obtain entry to a range of accommodation types, including retirement villages, self-contained accommodation within a supported environment, and residential aged care. A key theme in current debates in Australia concerning housing policies for older people is the need to achieve more flexible models of housing provision which encompass a wide range of settings whilst fostering supportive environments and facilitating the delivery of appropriate care services.

11 Older people's organisations

In virtually every local community in Australia there are many older people's organisations, with varying purposes, membership and activities. They provide a focus for the engagement of people in the activities of importance to them throughout life and into old age, spanning social, economic, political, spiritual, cultural, and physical interests. Many other organisations, although not exclusive to, cater mostly for older people. Examples include older membership of many ethnic organisations (reflecting the pattern of post-war migration to Australia) and many self-help, church and leisure interest groups. While many organisations are locally based, most are affiliated with State umbrella organisations, which are often, in turn, members of a national group or network. A brief description of some selected major national groups follows.

The **Council on the Ageing** (COTA) began with the incorporation in 1992 of the Old People's Welfare Councils (established 1951) and the Australian Council on the Ageing (1970). It has around 40,000 members over 50 years of age, with branches in each State and Territory. It also represents several hundred thousand people through affiliated consumer organisations, service providers and professional and industry associations. COTA seeks to protect and promote the wellbeing of all older people through advocacy, information provision, referral and advice, and publications. It conducts research, policy analysis and seminars, liaises with governments and engages in consultation. Policy development in the areas of health, housing, transport, residential care, retirement income, mature age employment, community services, age discrimination and attitudes toward ageing are of particular focus.

Publications produced by COTA at the State, Territory and national level include newsletters (e.g. *ReportAge*), directories, reports and policy papers.

Contact: Council on the Ageing (Australia), Level 2, 3 Bowen Crescent, Melbourne Vic 3004, Ph (03) 9820 2655, Web site: http://www.cota.org.au, E-mail: cota@cota.org.au

The **National Seniors Association** (NSA, originally Later Years) was formed in 1976 in Queensland. The association aims to create an image of 'conservative positive responsibility' in which seniors of Australia have equality with the rest of the community. Its major activities include representation of its members to government and donating funds to assist older people. It also offers discounts to members on accommodation, insurance and other services and runs a travel company and financial advisory service. Its membership is open to people over 50 years of age. The association has about 220,000 members. One-third of its members are in the workforce, a third receive a social security or veterans pension and the remaining third have independent incomes. It publishes a bimonthly magazine, *50 Something*.

Contact: National Seniors Association Ltd, GPO Box 1450, Brisbane Qld 4001, Ph (07) 3221 2977, Web site: http://www.nationalseniors.com.au, E-mail: general@nationalseniors.com.au

In July 2002, COTA and NSA formed a strategic partnership to present a unified view on policy, enhance the political representation of older people and provide better membership benefits. The partnership will result in a joint membership of about 270,000 people aged over 50 years, comprising over 1,500 organisations.

The **Association of Independent Retirees** was established in Queensland in 1990. Its membership is open to retired or semi-retired people who depend wholly or partly on independent income—that is, whose level of independent income or assets disqualifies them from receiving a maximum-rate age or veterans pension. Its objectives include lobbying governments on behalf of independent retired people, a reduction in the taxation they pay, gaining access to benefits at present available only to social security or veterans pensioners and providing advice.

Membership currently includes 18,000 self-funded retirees. The association has local branches in all States, with 83 branches across Australia. It is a non-profit organisation staffed entirely by its volunteer members. It publishes a national quarterly magazine, *Independent Retiree*.

Contact: Association of Independent Retirees Inc., PO Box 12, Keilor Vic 3036, Ph 1800 777 324, Web site: http://www.independentretirees.com, E-mail: info@independentretirees.com.au

The **Australian Pensioners' and Superannuants' Federation** (AP&SF, originally the Australian Pensioners' Federation) was established nationally in 1956. The federation is a network of affiliated autonomous State, regional and national consumer organisations run by an elected executive of older people. It represents 70,000 pensioners, state superannuants, retired unionists and older women.

The AP&SF's primary goal is social justice and a 'fair deal' for all (irrespective of age) affected by low income, ill-health or prejudice. It specifically promotes the independence and opportunities and choices of older people. It does so through research, disseminating information, making representations to governments, businesses and services. It adopts a national perspective on issues of retirement income, taxation, banking, aged care, health and housing. A number of affiliated groups offer information, advocacy and other services from staffed offices. Others operate on a volunteer basis. It publishes a bimonthly newspaper, *Action Network*, as well as discussion papers and a range of other resources.

Contact: Australian Pensioners' and Superannuants' Federation, Macgregor Hall, Childers Street, Canberra ACT 2601, Ph (02) 6262 5393, Web site: http://www.apsfnational.org, E-mail: apsf@funnelwebinternet.com.au

Carers Australia began in 1993 as a non-profit organisation dedicated to improving the lives of carers. The association is the national peak carer organisation with eight member organisations—the Carers Associations in each State and Territory. Carers Australia works to promote the recognition of the important role of carers in our community and to empower carers so that they will be better informed and resourced. Carers Australia represents and maintains a strong policy voice in developing and evaluating government policy and service arrangements for income support, aged care, community care, disability services and related legislative program reviews, as well as through annual budget submissions. Advice from Carers Australia is widely sought by a range of government agencies, politicians, service providers, disability and other community groups and carers themselves.

Contact: Carers Australia, PO Box 73, Deakin West ACT 2600, Ph (02) 6282 7886, Web site: http://www.carers.asn.au, E-mail: caa@carersaustralia.com.au

The **Alzheimer's Association Australia** was established as a state-based organisation by carers of people with dementia in the early 1980s, becoming national in 1990. Current membership is approximately 11,000 people. The goal of the association is to promote the development of a society committed to the prevention of dementia, while valuing and supporting people living with dementia. The association aims to provide leadership in policy and services for people living with dementia, their families and their carers. The national body engages in policy development and review, advocacy, research and coordination. State and Territory associations provide information, support, advocacy and education to people with dementia, their families and carers, and education to professionals who work with people living with dementia. Information and support are provided through the association's web site and Helpline.

Contact: Alzheimer's Association Australia, PO Box 108, Higgins ACT 2615, Ph (02) 6254 4233, Web site: http://www.alzheimers.org.au, E-mail: secretariat@alzheimers.org.au, Helpline: 1800 639 331.

Some **other organisations** with substantial older membership include:

ARPA Over 50s Association, Ph 1800 555 150

Arthritis Foundation of Australia, Ph (02) 9552 6085

Country Women's Association of Australia (CWAA), Ph (02) 9358 2923

Older Women's Network (OWN), Ph (02) 9247 7046

Returned and Services League of Australia (RSL), Ph (02) 6248 7199

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Health

12 Self-rated health

Apart from being a good measure of current physical health, people's self-assessment of their own health has been shown to be a powerful, independent predictor of their future health care use and survival (Idler & Benjamini 1997). In particular, Australian studies have demonstrated a link between self-rated health and subsequent health outcomes for older Australians (McCallum et al. 1994).

Self-rated health and age

Many older people have a positive view of their health even though older age is generally associated with increasing levels of disability and illness. This is supported by data from the 1997 National Survey of Mental Health and Wellbeing of Adults conducted by the Australian Bureau of Statistics. Self-assessed health was recorded with a question that asked respondents to rate their health according to a 5-point scale (excellent, very good, good, fair, poor). The majority of Australians aged 65 years or older (70%) rated their health as either good, very good or excellent while 30% reported their health as fair or poor.

Self-assessed health status is strongly related to age. In the 1997 survey the proportion reporting excellent, very good or good health was slightly over 90% up to ages 35–44 years. Thereafter, the proportion reporting their health as good or better, while remaining in the majority, declined with increasing age, from approximately 84% at ages 45–54 to 67% at ages 75 and over, for both men and women. The corresponding proportion reporting fair or poor health increased from around 15% to 33% (Figure 12.1).

Although the proportion rating their health as good or better was marginally higher among women than men at each age group, overall the general pattern by age group in self-rated health was quite similar for men and women.

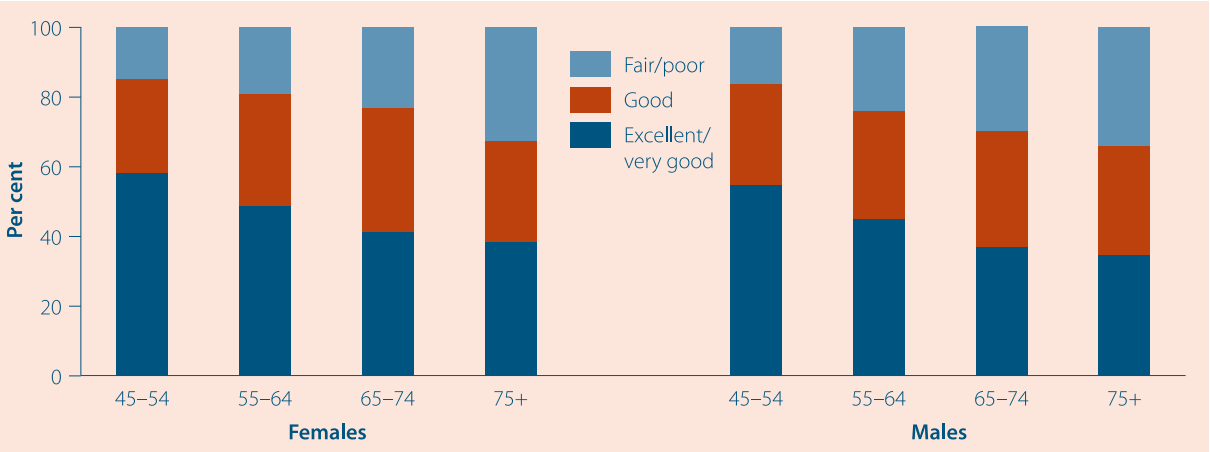
Self-rated health appears to work well as a measure of health status, in part because it measures more than just 'objective health'. It may reflect the complex nature of health by including factors such as psychological wellbeing, aspects of health behaviour, social support and self-confidence, which individuals may emphasise depending on perceived importance. Research shows that, while the prevalence of disability and chronic illness rises sharply with age, older people appear to adapt to these limitations or perhaps adjust their expectations (Walker-Birckhead 1996).

Self-rated health and socioeconomic status

The link between health and socioeconomic status has been demonstrated in many studies, with lower socioeconomic status generally being associated with poorer overall health (Wilkinson & Marmot 1998). Within Australia, it has been shown that the inequalities in the health of younger and middle-aged Australians persist into older ages, and that there is a consistent relationship between socioeconomic status and health among people aged 65 and over, although it is less marked than for younger people (Mathers 1994).

Analysis of the ABS National Health Survey (1995) shows that this relationship holds for self-reported

Figure 12.1: Self-rated health status, by age and sex, 1997



Source: Table A12.1.

Table 12.1: People living in households: proportion of people aged 65 and over reporting their health as good, very good or excellent, by socioeconomic status, 1995 (per cent)

Socioeconomic group	Females	Males	Persons
Education		**Per cent**	
Tertiary	73.0	85.1	80.6
Post-secondary	68.8	68.3	68.5
Secondary	64.8	59.5	62.9
Household income[(a)]			
High	74.4	67.0	70.7
Medium	62.3	57.3	60.1
Low	60.0	59.1	59.7

(a) Low-income is defined here as equivalent household income in the lowest 2 deciles; medium is defined as deciles 3 and 4; high is defined as the highest 6 deciles. Deciles are based on all households.

Source: AIHW analysis of 1995 ABS National Health Survey.

health status of older people (aged 65 or more) using educational attainment and family income level as indicators of socioeconomic status (Table 12.1). Older people with tertiary qualifications were more likely to report their health as good, very good or excellent (81%) than those with post-secondary (69%) or secondary qualifications (63%). This relationship was true for both older women and older men. Also, relatively more older people living in high income households (71%) reported their health as good or better compared with those living in medium and lower income households (both 60%).

Many factors determine and influence the health of individuals and populations. Disease, disability and death are the result of the interaction of human biology, lifestyle and environmental (including social) factors, modified by health care interventions (AIHW 2002). The socioeconomic differentials in self-reported health status described here are the result of this complex interplay of factors over the life course.

13 Life expectancy and causes of death

Life expectancy

Life expectancy has risen throughout the 20th century and most Australians can now expect to live an average of 80 years. Life expectancy at birth has risen from 58.8 years for women and 55.2 years for men at the turn of last century to 81.9 and 76.5 years respectively in 2001 (Figure 13.1). Life expectancy at age 65 has also increased. Women aged 65 years in 2001 could expect to live to 85.2 years and men to 81.6 years, about 6 years more than in the early 1900s. Much of this growth in life expectancy at age 65 occurred over the last three decades.

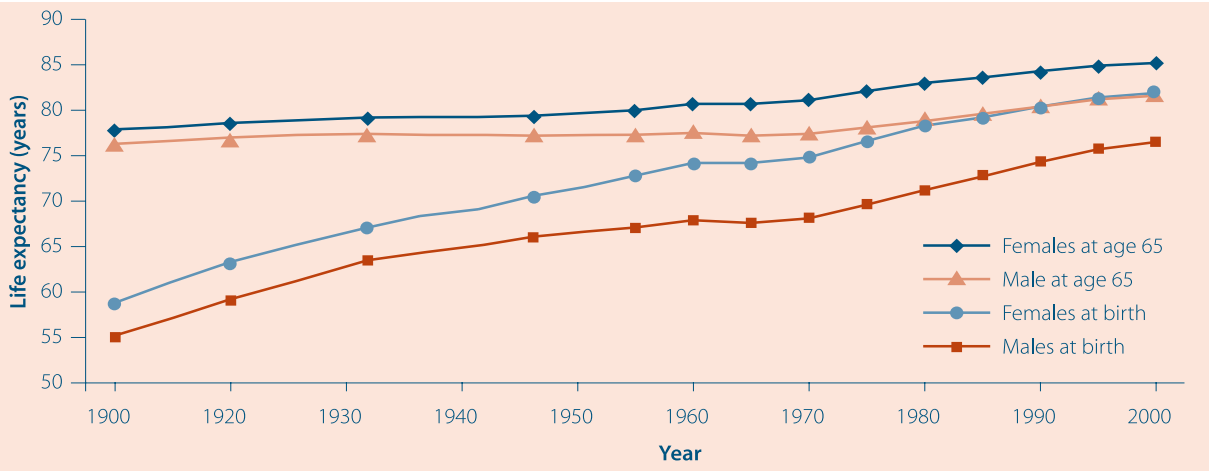
The increases in life expectancy during the first half of the century were predominantly the result of a rapid decline in infant and maternal mortality rates, particularly due to improved control of infectious diseases associated with childhood and early adulthood. More recently, significant gains in life expectancy have occurred as the result of reductions in death rates among older Australians, especially for diseases such as coronary heart disease and stroke where death rates have fallen by almost 70% since the late 1960s. These trends lead to a greater number of Australians reaching older ages and have important consequences for patterns of health, disease and disability in the community.

Main causes of death

The main causes of death for both women and men aged 65 and over are diseases of the circulatory system, cancers and diseases of the respiratory system, with these accounting for over three-quarters of all deaths among people in this age group. In 2000, the proportion of deaths for women aged 65 and over dying from circulatory diseases (48%) was higher than that for men (41%), while deaths from cancer were fewer (21% compared with 30%) and deaths from respiratory diseases differed only slightly (9% and 11% respectively). Deaths from accidental falls, which are more common among older people, are included in the category 'injury and poisoning' which accounted for 2% of deaths (Table 13.1).

Looking within these broad groupings at more specific causes of death among older people, coronary heart disease, stroke, breast cancer, prostate cancer, emphysema and falls each accounts for a high proportion of deaths. Among people aged 65–74, women have lower death rates from coronary heart disease, stroke, emphysema and accidental falls compared with men. In people aged 75 and over, females have a higher death rate from stroke than men (Table 13.2).

Figure 13.1: Life expectancy at birth and at age 65, by sex, 1901–2001



Source: Table A13.1.

Table 13.1: Deaths for selected major causes in people aged 65 and over, 2000

Cause of death	Females	Males	Females	Males
	Number		Per cent	
Circulatory	24,466	19,960	47.5	40.7
Cancer	11,003	14,874	21.4	30.3
Respiratory	4,509	5,276	8.8	10.8
Injury and poisoning	1,162	1,128	2.3	2.3
All causes	**51,462**	**49,012**	**100.0**	**100.0**

Source: AIHW 2002:191.

Death rates from coronary heart disease and stroke among older people have decreased markedly since 1991 (Table 13.2). The death rate from breast cancer in older women has also dropped, while that from prostate cancer in men has changed little. Death rates from emphysema have changed marginally in women, while those for older men have declined.

The death rate from accidental falls is substantially higher in people aged 75 and older compared with the 65–74 age group, for both men and women. These rates have changed little over the period from 1991 to 2000.

Table 13.2: Age-specific death rates for selected causes of death in people aged 65 years and over, 1991 and 2000 (deaths per 100,000 population)

	Females		Males	
Cause of death	**65–74**	**75+**	**65–74**	**75+**
1991				
Coronary heart disease	466	2,267	1,017	3,029
Stroke	142	1,140	199	1,021
Breast cancer	96	143	1	1
Prostate cancer	..	..	113	435
Emphysema	10	21	30	82
Accidental falls	5	27	9	35
2000				
Coronary heart disease	234	1,586	530	1,975
Stroke	96	987	149	853
Breast cancer	74	132	—	2
Prostate cancer	..	..	110	435
Emphysema	11	19	23	73
Accidental falls	4	29	7	32

Source: AIHW National Mortality database.

14 Burden of disease

In order to encourage individual behaviours and treatment practices that lead to healthy ageing of the Australian population, it is advantageous to have an understanding of the size and impact of health problems in the population, including information on how sub-groups of the population are differently affected and the causes of loss of health. This knowledge is important in optimising opportunities for people to have physical, social and mental wellbeing throughout their lives.

Life lost due to disability

One way in which the burden of disease is measured is by Years of Life lost due to Disability (YLD). YLD measures both the incidence of illness and the severity or level of impact on functioning due to that illness (AIHW 2000:50). In 1996, of all the years of life lost due to disability across the population, 28% occurred in the older population, who accounted for 12% of the total population.

The 10 leading causes of years of life lost due to disability for people aged 65 years and over represented 64% of the total YLD burden for this age group in 1996 (Table 14.1). Dementia was the leading cause of non-fatal disease burden, accounting for 17% of the YLD burden. The next most significant were adult-onset hearing loss (8%) and stroke (7%). Vision disorders, osteoarthritis and coronary heart disease also caused considerable disability burden, accounting for 6% each. The pattern of disability for older people was quite different to the pattern for younger people. The most important causes of non-fatal disease burden for people under 65 were depression, asthma and substance abuse, which are not as common in the older population (see Topic 16: *Mental health*).

Loss of life among older people

As well as high morbidity, older people also suffer from premature mortality. Premature mortality is captured by the Years of Life Lost (YLL) measure. This estimates the years lost when people die earlier than the average expected for the age group in question. Thus, if a woman dies at age 65, and the average life expectancy for 65 year olds is 85.2,

Table 14.1: Top 10 causes of years of life lost due to disability (YLD), by age and sex, 1996

Aged 65 years and over					Aged under 65 years		
Disease category	Females	Males	Persons		Disease category	Persons	
		YLDs		Per cent[a]		YLDs	Per cent[a]
Dementia	33,976	20,232	54,208	16.7	Depression	89,273	10.6
Adult-onset hearing loss	10,871	15,404	26,275	8.1	Asthma	54,083	6.5
Stroke	10,160	13,587	23,747	7.3	Alcohol dependence & harmful use	40,648	4.8
Vision disorders	15,591	4,343	19,934	6.2	Osteoarthritis	36,105	4.3
Osteoarthritis	11,942	7,691	19,633	6.1	Diabetes mellitus[b]	33,993	4.1
Coronary heart disease	9,593	9,734	19,327	6.0	COPD[c]	30,690	3.7
Parkinson's disease	9,969	5,392	15,360	4.7	Generalised anxiety disorder	30,355	3.6
Diabetes mellitus[b]	4,288	5,541	9,829	3.0	Adult-onset hearing loss	21,895	2.6
Benign prostatic hypertrophy	..	9,690	9,690	3.0	Social phobia	18,318	2.2
COPD[c]	3,698	4,506	8,204	2.5	Bipolar affective disorder	17,661	2.1
Top 10 disorders	*110,088*	*96,120*	*206,207*	*63.6*	*Top 10 disorders*	*373,021*	*44.5*
Total	**170,730**	**152,995**	**323,725**	**100.0**	**Total**	**838,316**	**100.0**

(a) Per cent refers to percentage of total YLD for persons.

(b) Includes Type 1 and Type 2 diabetes.

(c) COPD = Chronic Obstructive Pulmonary Disease.

Source: AIHW Australian Burden of Disease database.

the YLL is 20.2 years. Older age groups bear 56% of the YLL burden. The leading causes of premature death among older Australians are cardiovascular diseases and cancers (Mathers et al. 1999:218–224).

Overall burden of disease on older people

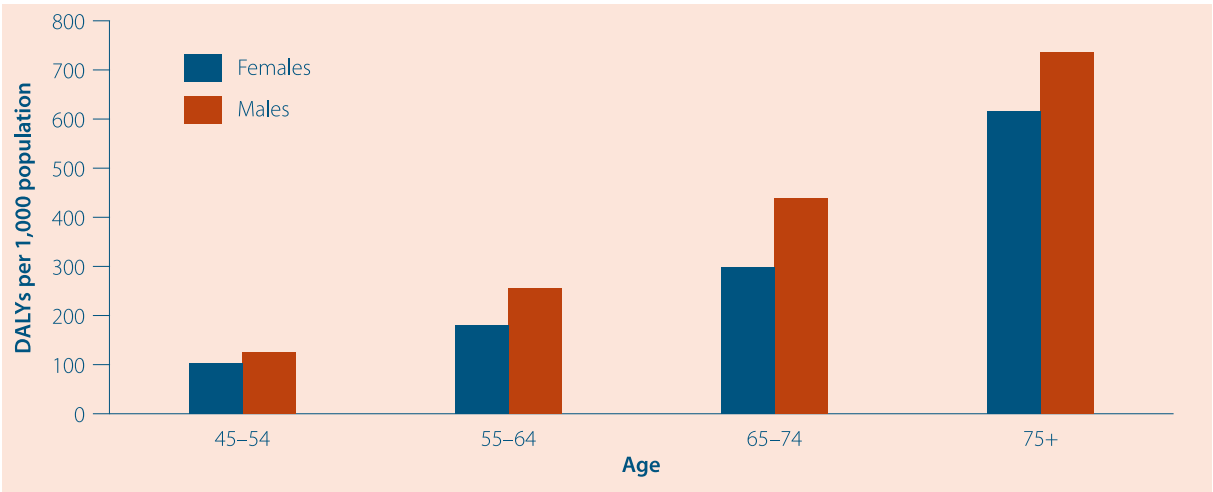
Overall, the impact of disability and premature mortality can be represented using a combination of both the YLD and YLL measures. The result is the Disability-Adjusted Life Year (DALY). One DALY represents one lost year of life in full health, whether that year is lost due to disability or premature mortality.

There is an increase in DALY rates with age. For women there is an increase from 102 DALYs per 1,000 women aged 45–54 years to 615 DALYs per 1,000 women aged over 75 years. For men, the rate increases from 125 for the 45–54 year age group to 736 DALYs per 1,000 for the 75 years and over age group (Figure 14.1).

Impact of selected risk factors

There are a number of contributors to loss of healthy life years among older people (see also Topic 15: *Risk factors*). Tobacco smoking is the risk factor responsible for the greatest burden of disease in older Australians, accounting for 9% of DALYs lost for older women and 16% for older men. High blood pressure is the next most important risk factor, causing about 10% of the DALY burden. Other important risk factors are physical inactivity (8% of DALYs), high blood cholesterol (4%) and inadequate intake of fruit and vegetables (2%). Excessive alcohol consumption negatively affects health. However, alcohol taken in small or moderate amounts can reduce the risk of coronary heart disease, stroke and other conditions. The benefits from small or moderate alcohol consumption are significant, lowering the total disease burden for older men by 4% and by 6% for older women.

Figure 14.1: Burden of disease (DALYs per 1,000) among older people, by age, 1996



Source: Table A14.1.

15 Risk factors

A risk factor is an attribute or exposure that is associated with an increased probability of a specified outcome, such as the occurrence of a disease. Thus, while risk factors are not necessarily causes of disease, they may put an individual at risk of experiencing disease. Many risk factors accumulate as a result of risk exposure over the life course; however, the levels of a number of risk factors increase for people aged 45 and over. Established risk factors in middle age can lead to poorer health in later life. There is, however, potential for health gain at all life stages through appropriate management of risk factors in addition to early prevention. Although risk factors are discussed here individually these factors often co-exist and interact.

Body weight

People who are overweight have higher mortality and morbidity rates for Type 2 diabetes, coronary heart disease, respiratory disease, some types of cancers, gall bladder disease, osteoporosis and ischaemic stroke. In general the prevalence of overweight people is higher among older than younger Australians. For women rates are highest between 55 and 74 years (around 69%); however, for men the proportion who are overweight varies little between the ages of 45 and 74 (around 73%; Table 15.1). Weight loss among those who are overweight reduces the incidence and severity of high blood pressure, high blood cholesterol, diabetes, osteoarthritis and some types of cancers (NHLBI 1998).

Blood pressure

High blood pressure is a major risk factor for coronary heart disease, stroke, heart failure, peripheral vascular disease and renal failure. The risk of disease increases as the level of blood pressure increases. The proportion of people with high blood pressure is greater at older ages, with levels greater than 75% in people 75 years or older.

High blood pressure is more likely to develop among people who are overweight or physically inactive, or have high dietary salt intakes. When high blood pressure is controlled by medication, the risk of disease is reduced, but not to the levels of unaffected people (Kannel 1991).

Blood cholesterol

High blood cholesterol is a major risk factor for coronary heart disease and possibly for some types of stroke. Saturated fat in the diet is a major factor in raising blood cholesterol levels for most people. However, genetic factors can affect blood cholesterol—some people have high cholesterol levels regardless of their saturated fat and cholesterol dietary intake. For women, the prevalence of high blood cholesterol is highest among 65 to 74 year-olds (74%), while for men prevalence is highest among those aged 45–64 years (around 61%). The prevalence of high blood cholesterol is lower in people aged 75 years or more but remains common (65% of women and 49% of men).

Table 15.1: Risk factors for illness and disease (per cent of population group)

	Females				Males			
Risk factor	**45–54**	**55–64**	**65–74**	**75+**	**45–54**	**55–64**	**65–74**	**75+**
Overweight	58.1	67.2	70.7	56.4	72.5	74.0	73.7	64.3
High blood pressure	22.8	42.3	66.7	77.2	30.5	46.5	69.7	75.1
High blood cholesterol	54.7	71.6	74.0	65.2	60.7	61.8	54.1	49.2
Impaired glucose tolerance	11.2	15.2	22.9	20.7	8.4	14.8	20.4	25.5
Tobacco smoking	17.5	13.5	6.6	4.4	22.0	15.2	11.0	4.8
Risky alcohol consumption	11.6	4.9	2.5	0.9	18.6	13.6	7.7	3.3
Physical inactivity	52.0	46.9	[a]46.1	n.a.	47.6	50.1	[a]45.8	n.a.

(a) Data for ages 65–75.

Note: see Table A15.1 for definitions of risk factors.

Sources: AIHW 2002:132, 383; 2001 National Drug Strategy Household Survey.

Impaired glucose tolerance

Impaired glucose tolerance (IGT) is common in people who are physically inactive and overweight, and is more common in older people because such risk factors are more widespread. In people with IGT, blood glucose levels are higher than normal but less than the level required for a diagnosis of diabetes. As well as being a risk factor for Type 2 diabetes, IGT is linked to a greater risk of heart disease.

With increasing age, the cells in the pancreas that make insulin—the hormone that enables the body to convert glucose to energy—become less efficient. This, combined with decreased physical activity and increased body weight, contributes to the higher prevalence of IGT (and Type 2 diabetes) among older people. IGT is most prevalent among older Australians, with over 20% of people aged 65 years and over having the condition.

Tobacco smoking

Of all risk factors for disease, tobacco smoking has the greatest effect on the health of Australians. Smoking increases the risk of lung cancer, chronic obstructive pulmonary disease, ischaemic heart disease and other diseases, and there are benefits to stopping smoking at all ages. The prevalence of people who smoke daily is highest in early adulthood and declines with increasing age to about 5% in people 75 years or older. The current prevalence of smoking among older Australians is not, however, a good indicator of the associated disease burden because of the long time lag between exposure to tobacco smoke and some of its subsequent ill-effects. The disease burden caused by tobacco smoking, measured in terms of disability and premature death, increases markedly at ages 45–54 and remains high for all older ages (see also Topic 14: *Burden of disease*).

Alcohol consumption

Excessive alcohol consumption in the long term is associated with liver disease, pancreatitis, diabetes, epilepsy and some cancers. In addition, it is also a significant factor for short-term harm at all ages, and especially among older people because the body's tolerance for alcohol decreases with age. Of particular relevance to older people are the increased risks from driving and the risk of alcohol interacting with medications. Self-reported data collected in 2001 showed that the prevalence of people who put their health at risk of alcohol-related harm in the short term on a monthly basis was less among older than younger Australians, at 1% and 3% among women and men aged 75 years or older.

On the other hand, low to moderate levels of alcohol consumption can protect against hypertension, ischaemic heart disease, stroke and other conditions. The distribution of harm and benefit varies with age. The largest protective effect is realised in persons over 65 years of age because of the increased risk of cardiovascular disease in this age group.

Physical inactivity

Physical inactivity is an independent risk factor for cardiovascular disease, and is also associated with other risk factors such as high blood pressure, high blood cholesterol and excess body weight (Bauman & Owen 1999). Physical inactivity levels among older Australians (65–75 years) are marginally lower than those at younger ages (45–64). In 2000, 46% of older Australians did not undertake physical activity at the level recommended to achieve health benefits.

Participation in physical activity by older people has benefits in relation to falls prevention, musculoskeletal health, continence, mental health and arthritis. Physically active people are less likely to develop colon cancer, and women of all ages are less likely to develop breast cancer (Colditz et al. 1997; Thune & Furgerg 2001). Physical activity can also help in the prevention and treatment of Type 2 diabetes, especially among people already at risk.

16 Mental health

The majority of older people enjoy good mental health; it is estimated that only 6% have a mental disorder over a 12 month period compared with 18% of all people aged 18 and over (ABS 1998:5). Mental disorders cover a range of cognitive, emotional and behavioural disorders impacting on the lives and productivity of people. These include disorders such as depression, anxiety, substance use disorders, psychosis and dementia (DHAC 2000). These affect the general population, including older people who have been identified by the second National Mental Health Plan as a target group for improved mental health services (AHM 1998:10). Dementia in particular is a major health problem among older people.

Dementia

Dementia, which may also be considered as a neurological disorder, is a syndrome caused by a range of illnesses, most of them currently incurable. It is most commonly associated with Alzheimer's disease, but is also related to vascular disease, frontal lobe dementia, diffuse Lewy body dementia, AIDS-related dementia, Pick's disease, progressive supra-nuclear palsy, alcohol-related dementia, Huntington's disease, Parkinson's disease, and Down's syndrome (AANSW 1999). Dementia is characterised by memory impairment, increasing difficulties with everyday tasks, by personality changes and by a later progression to the loss of the capacity to act independently. Approximately half of those diagnosed with dementia live in the community, higher levels of cognitive loss being associated with greater use of residential care.

Dementia is already an important health issue and is expected to increase in line with Australia's ageing population (Jorm 2001). Estimates of prevalence vary depending on definition. Using prevalence rates published by Jorm et al (1987), who combined information from 22 studies throughout the world, the number of older people with dementia in 2001 has been estimated at 153,800 (6% of the population aged 65 years and over; see Table 16.1). Although prevalence rates differ greatly from study to study, the underlying pattern was for dementia to increase exponentially with age. Consequently, the prevalence of dementia is highest among people 85 years and over, with an estimated prevalence of up to one in four. Almost two-thirds of older people with dementia were estimated to be 80 years or over, with around 40% being aged 85 years or over. In 2001, the estimated number of women with dementia was much higher than for men (94,800 compared with 58,900).

Table 16.1: People with dementia (estimated), by age and sex, 30 June 2001

Age	Females	Males	Persons
		Number	
65–69	4,800	4,600	9,400
70–74	9,300	8,300	17,600
75–79	16,300	12,500	28,800
80–84	21,800	14,100	36,000
85+	42,600	19,400	62,000
Total 65+	**94,800**	**58,900**	**153,800**
		Per cent of population group	
65–69	1.4	1.4	1.4
70–74	2.8	2.8	2.8
75–79	5.6	5.6	5.6
80–84	11.1	11.2	11.2
85+	23.7	24.0	23.8
Total 65+	**7.1**	**5.6**	**6.4**

Source: AIHW analysis based on prevalence estimates derived by Jorm et al. 1987.

The number of older people with dementia is projected to rise by about 60% by 2020 to reach 242,600 (Table A16.1). The most significant increase in people with dementia will be among those aged 85 and over, mostly due to the ageing of the older population: nearly half of the increase will be in this oldest age group, with the number aged 85 and over with dementia estimated to increase from 62,000 in the year 2001 to 102,800 in 2020. However, it should be noted that a recent review of the literature has outlined possibilities, such as pharmaceuticals and changing lifestyle factors, for the prevention or postponement of dementia, suggesting that prevalence may not increase as rapidly as it has previously (Jorm 2002).

In the year 2000 there were 3,655 deaths from dementia, which equates to a crude mortality rate of 19.1 per 100,000 population (AIHW National Mortality Database). Deaths from an underlying cause of dementia were more common among women than men. Overall,

the crude death rate from dementia was 26.3 per 100,000 for women, and 11.8 for men. This large difference was caused by a combination of the greater longevity of women compared with men and higher crude death rates from dementia for women aged 80 and over (see Topic 13: *Life expectancy and causes of death*). After allowing for the different age distributions of men and women, the death rates from dementia are much closer: the age-standardised death rate for women in 2000 was 15.4 per 100,000 population compared with 12.4 per 100,000 for men (Australian 1991 population standard). Age-specific death rates from dementia were greatest in people 85 and over (641.2 and 981.9 per 100,000 among men and women respectively in 2000).

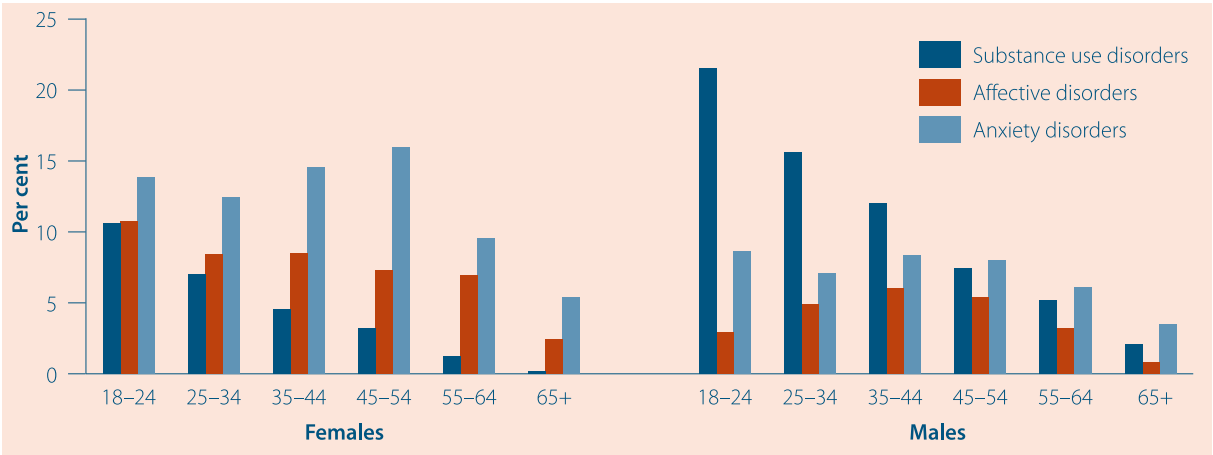
Other mental disorders and suicide

The available data for other mental disorders among older people are marked by problems with respect to reliability (Snowdon et al. 1998). In general, older people are generally happier and report fewer worries than do their younger counterparts (Byles 1999; Headey 1999). Using the 1997 ABS Survey of Mental Health and Wellbeing, it is estimated that in a 12 month period affective disorders such as depression, bipolar disorder and dysthymia affect slightly less than 2% of older people compared with 5% to 7% of their younger counterparts (Table A16.2). However, this is probably somewhat understated, in part due to problems with diagnosis of depression which is often misinterpreted as part of the ageing process (Draper 2000; DHAC 2000:101). Similarly, the reported prevalence of anxiety (5%) and substance abuse (1%) disorders are lower than for other age groups (Figure 16.1).

The 1997 ABS Survey of Mental Health and Wellbeing compared all older people aged 65 and over with those in younger age groups. Figure 16.1 shows that in all age groups women are reported as more likely than men to suffer from anxiety disorders and from affective disorders. However, men are more likely to suffer from substance abuse than women—a pattern found at both younger and older ages.

Despite more women than men reporting affective disorders, analysis of 1998 suicide data by the Australian Institute of Health and Welfare has shown that the suicide rate for women is considerably lower than that for men at all ages (Steenkamp & Harrison 2000:80). The rate of suicide among older men increases with age, peaking at a rate of 39.8 per 100,000 at age 85 years and over. Only young men aged 20 to 29 had a higher rate of suicide (over 40 per 100,000). Among older women the suicide rate peaks at ages 75 to 79 years (8.2 per 100,000 in this age group). Older men in particular are being targeted for prevention strategies to reduce depression such as may follow retirement or the loss of a partner (AHM 1998:14).

Figure 16.1: Prevalence of mental disorders in a 12 month period, by age and sex, 1997 (per cent)



Source: Table A16.2.

17 Disability levels

The majority of older people are free from a disability for which they require assistance (61%). The 1998 Survey of Disability, Ageing and Carers (ABS 1999) provides the most recent data available on disability levels. It measured dependency in terms of 'impairment', 'disability' and 'activity restriction'. These definitions are based on the 1980 International Classification of Impairments, Disabilities and Handicaps. It also drew on draft material prepared for the 2001 revision of the classification (WHO 1997).

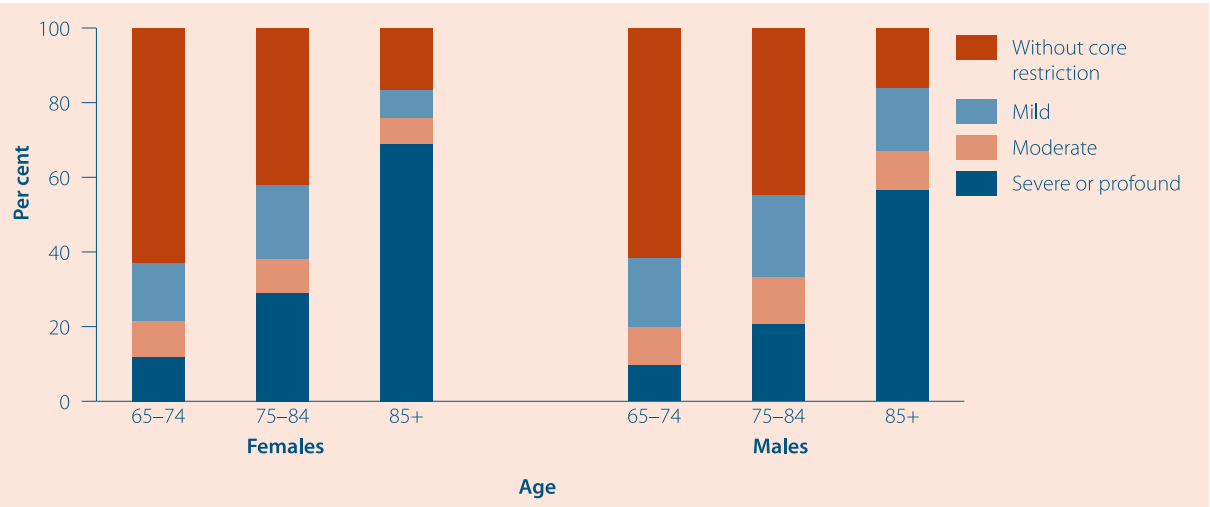
Core activity restriction

Core activity restriction—which relates to self-care, mobility or communication—is a useful indicator of levels of dependency among older people. These restrictions range from mild or moderate to severe and profound restrictions on ability to perform core activities. This latter group includes those who sometimes or always need assistance with activities such as self-care, mobility and communication. Data on this subgroup are used for establishing need for assistance and hence demand for services (although it is important to recognise that only a relatively small proportion will actually use such services at any one time).

One in five older people report a profound or severe core activity restriction. As can be seen in Figure 17.1, both the proportions of older people with, and the severity of, disability increases markedly with age. Differences between males and females are mainly in the form of the severity of disability, with women aged 85 or over more likely than similarly aged men to suffer from a severe or profound disability (70% compared with 56%; see Table A17.1).

Any increase in numbers with a profound or severe core activity restriction has important implications for service providers, planners and policy analysts. The number of older people in this category is projected to rise by almost 100% over the next two decades—from an estimated 524,900 in 2001 to 1,083,600 in 2022. However, these calculations are based on a constant age- and sex-specific activity restriction rate, about which there is considerable debate. While international research tends to point to declining disability rates, particularly among the low-level disability groups, there is no evidence of such a decline in Australia (AIHW 2001:204).

Figure 17.1: Proportion with activity restriction, by age and sex, 2001



Source: Table A17.1.

Nature of dependency and demand for services

Those with disabilities often require some sort of assistance. Understanding the nature of this dependency is important for planning adequate and appropriate aged care services. In 1998, the majority of older people (54%) had at least one disability lasting (or anticipated to last) at least 6 months; 52% of these needed at least some help with the activities of self-care, mobility, communication, or health care (ABS 1999:38). However, over one quarter (28%) did not need any assistance despite their disability.

The types of formal services required by older people reflect the range of conditions that result in disability and activity restrictions. In 1998, 707,600 older people had a profound or severe core activity restriction (Table A17.2). The most common condition was arthritis (23%), followed by other musculoskeletal conditions (13%), circulatory conditions other than stroke (10%), dementia and Alzheimer's disease (9%), diseases of the eye (6%), stroke (6%) and respiratory conditions (5%).

The rate of dependency among older people on all types of assistance is higher at older ages (Table 17.1). Overall, in 1998 the proportion of people needing assistance with at least one activity, both those with and without a long-term disability, rose from 28% among those aged 65–69 to 77% among those aged 80 and over. This increase is consistent with the rise in core activity restriction shown in Figure 17.1. Need for assistance with self-care is illustrative of this. Only 5% of people aged 65–69 required assistance with self-care activities; this rises to 10% among those aged 70–79, and 31% among those aged 80 and over. Need for assistance with mobility was the most common need among the core activities for all age groups. Need for assistance with communication rises particularly sharply between the 70–79 and 80 and over age groups (from 4% to 17%; see Table 17.1).

Table 17.1: Need for assistance with particular activities among older people, by age, 1998 (per cent)

Activity	65–69	70–79	80+	Total
Core activities				
Self-care	5.2	9.9	31.4	13.3
Mobility	6.7	13.8	42.1	18.1
Communication	1.1	3.5	17.3	5.9
Total needing assistance with core activities	*13.7*	*25.1*	*53.8*	*28.2*
Other activities				
Health care	10.4	20.3	46.8	23.4
Transport	8.8	18.7	37.5	20.0
Paperwork	3.2	7.7	30.7	11.6
Housework	10.0	17.7	28.4	17.8
Property maintenance	19.4	28.3	36.8	27.6
Meal preparation	2.3	5.8	12.5	6.3
Total needing assistance with at least one activity	*27.9*	*42.9*	*77.0*	*46.2*
No assistance needed	*72.1*	*57.1*	*23.0*	*53.8*
All persons (N)	**681,900**	**1,075,300**	**514,100**	**2,271,200**

Note: Only persons with a disability were asked about need for assistance with core activities.

Source: AIHW analysis of ABS 1998 Survey of Disability, Ageing and Carers.

18 Need for assistance

Understanding the level of need for assistance among older people requires consideration of a range of factors. Estimates of need for assistance generally consider the changing age structure of the population and the level of disability at various ages. This can then be compared with the provision of services designed to meet these needs. An alternative approach is to look at how need for assistance is reported by older people, and how this expressed need is reported to have been met.

Expressed level of need

The Survey of Disability, Ageing and Carers conducted by the ABS in 1998 (ABS 1999) found that 42% of the 2.1 million people aged 65 and over living in households (887,900 persons) expressed a need for some form of assistance to help them stay at home (Table A18.1). The most common area of need reported was property maintenance, followed by transport and housework (Figure 18.1). Approximately 15% needed some assistance with personal care, such as health care, mobility, self-care and communication. A higher proportion of women than men aged 65 years and older required assistance of all types except communication, a result which is consistent with their older age profile.

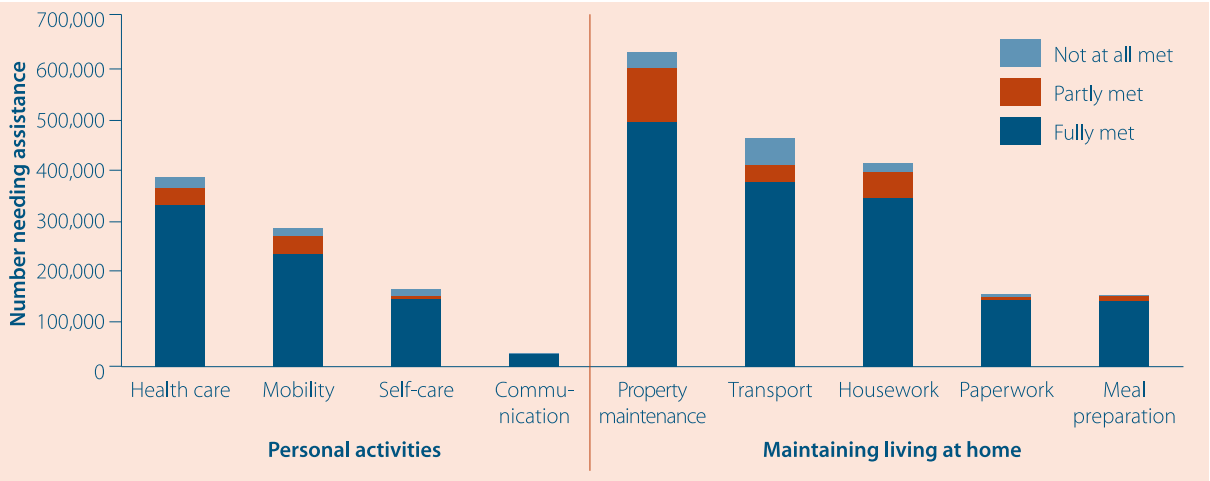
There was a gap between reported need for assistance and the level to which this was met. Two-thirds of older people needing assistance with at least one activity (67%, or 594,600) reported that their needs were fully met, over one-quarter (29% or 258,600) reported that their needs were partly met, and 4% (34,600) reported that they received no assistance whatsoever.

Providers of assistance

Informal care networks of friends and family provide most of the assistance received by older people in the community. Among those receiving assistance, 83% received help from informal providers, 59% received help from formal providers (including government organisations as well as private for-profit and private not-for-profit agencies), so that 43% received assistance from both informal and formal sources (Table 18.1). The highest levels of help from informal providers were for personal care activities: over 90% of those receiving assistance in self-care, mobility and communication were being helped by informal providers. The lowest proportions receiving assistance from informal providers were in the area of health care (49% of recipients). For most activities, between 10% and 20% of those needing and receiving assistance were getting help from both formal and informal sources.

Among informal providers, there are clear gender and relationship differences. Informal carers are predominantly female partners and daughters across most activities—the one exception being property maintenance. There are also clear gender differences in the types of assistance provided by informal carers. This is true for informal carers who are partners but is more pronounced between daughters and sons. In 1998, daughters were from two to six times more likely than sons to provide assistance for all activities except property maintenance. Interestingly, male partners were more commonly recorded as providing assistance with housework than female partners, though this probably reflects dominant gender roles and the

Figure 18.1: People aged 65 and older living in households, whether need for assistance was met, by type of assistance required, 1998



Source: Table A18.1.

expectation that, for women, performing the bulk of household duties is part of their routine responsibilities.

Among formal providers, data from the 1998 Survey of Disability, Ageing and Carers indicate that government-owned agencies predominate across most activities. However, these figures may overstate the use of government providers as people may not be able to distinguish between government and non-government services, and the estimates rely on service users for the information. For example, most Home and Community Care services are provided by non-government agencies even though the program is funded by government. Areas where a greater proportion of people reported using non-government rather than government services were health care (the only area where more people received help from a formal rather than an informal provider) and property maintenance, both of which showed a clear majority of people who received this type of service getting assistance from a private for-profit source.

It should be noted that these figures do not convey the total amount or frequency of help provided to older Australians living in the community. For instance, the greatest number of older people in the community need and receive assistance with property maintenance, yet the nature of property maintenance tasks means that this assistance is likely to be single episodes of short duration. By contrast, activities such as meal preparation or personal care typically occur on a sustained daily basis.

The expression of need for services is shaped by the experiences, attitudes and beliefs of people, and therefore can be affected by what is known to be available or the perceived adequacy or accessibility of what is available. In addition, social and cultural norms can influence the likelihood of someone expressing a need for assistance, and interpersonal dynamics, such as between a carer and a care recipient, can affect the way need for assistance is experienced and expressed (Braithwaite 1996; Cooper and Jenkins 1999). Bearing these cautions in mind, reported need for assistance provides a valuable point-in-time account of need and unmet need.

Table 18.1: People aged 65 and older living in households and receiving assistance, activities by provider type, 1998 (per cent)

	Personal activities				Activities to maintain living at home					
Provider type	**Self-care**	**Mobility**	**Com-munic-ation**	**Health care**	**Trans-port**	**Paper-work**	**House-work**	**Property mainten-ance**	**Meal prepara-tion**	**Any activity**
Informal providers										
Female partner	32.8	19.7	37.7	18.6	10.2	26.4	15.4	11.3	24.1	16.8
Male partner	24.0	18.4	12.3	8.4	15.8	14.0	22.2	15.5	18.3	17.8
Daughter	27.9	32.7	44.8	14.1	33.2	35.6	23.3	13.1	27.5	26.1
Son	5.3	15.2	7.1	4.7	15.5	12.9	9.8	19.7	7.7	20.0
Other	9.3	33.8	25.4	6.2	37.1	16.4	11.8	25.6	11.6	40.1
Total informal	*90.3*	*95.3*	*100.0*	*48.7*	*93.1*	*96.7*	*72.7*	*71.2*	*83.1*	*83.3*
Formal providers										
Government	16.4	12.6	n.p.	29.9	9.6	3.2	28.0	7.2	14.4	27.8
Private non-profit	5.3	4.4	—	4.1	4.6	1.5	3.5	4.1	8.8	8.7
Private for-profit	4.5	3.6	—	37.3	3.0	3.3	15.5	39.6	5.5	41.0
Total formal	*25.0*	*19.8*	*n.p.*	*67.4*	*16.2*	*8.0*	*45.9*	*48.1*	*28.2*	*59.4*
Both informal and formal providers	**15.3**	**15.0**	**—**	**16.1**	**9.3**	**4.7**	**18.6**	**19.3**	**11.3**	**42.7**
Total (number)	**141,100**	**258,600**	**25,200**	**354,100**	**400,500**	**138,200**	**386,700**	**592,900**	**139,200**	**853,300**

Notes

1 Not all informal providers are listed.

2 'Other' informal provider includes other female relative, other male relative, female friend and male friend.

Source: ABS 1999:40.

19 Carers

With the growing emphasis on home-based care, informal care by family, friends and neighbours is increasingly being recognised as an important source of support to people of all ages. Carers play a key role in assisting older people to remain in the community and the need for this support is expected to increase. While informal care is important in helping older people with disabilities to remain living in the community, it is important to recognise that older people themselves provide a lot of informal care. According to the ABS Survey of Disability, Ageing and Carers, in 1998 there were some 450,900 primary carers, where a primary carer is defined as the person who provides the most informal assistance to a person with one or more disabilities lasting at least 6 months and which restrict everyday activities. Of these, over 200,000 were providing assistance to persons aged 65 and over, and 176,000 were themselves aged 55 or more (ABS 1999:43, 46).

Characteristics of carers

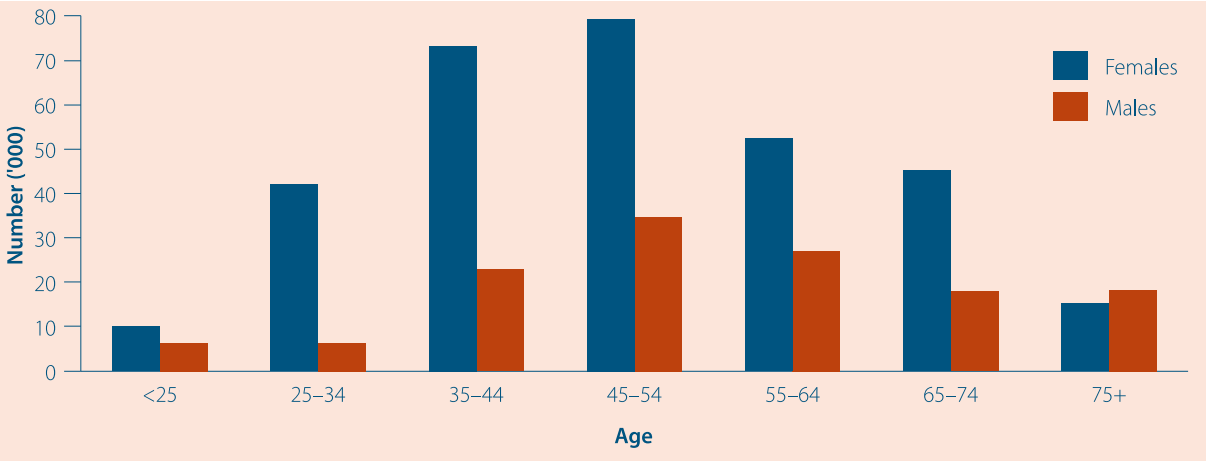
Many primary carers of older people are also over the age of 65, with 39% of such carers being aged at least 65 and 82% being aged 45 or more in 1998. Women comprised over two-thirds (72%) of primary carers of older people (ABS 1999:46). Older men were most likely to be cared for by a female carer aged 65 and over (AIHW 2001:205–6). The predominance of older female carers was more marked among men aged 75 and over than among men aged 65–74. Women aged 65–74 were most commonly cared for by an older male, while women aged 75 and older were most likely to be cared for by a female carer aged 25–64 years, although older male carers were also important in this age group.

Looking at primary carers of people of any age with disabilities, women comprised over two-thirds (70%) of all primary carers and outnumbered men in all but the oldest age group (aged 75 and over), where men outnumbered women (Figure 19.1). Twenty-one per cent of all primary carers were aged 65 and over, and 39% were aged 55 and over. Most, however, were aged between 35 and 64 (63% of male primary carers and 65% of female primary carers; see Table A19.1).

Women take on the caring role at a younger age than men and are more likely to provide care for people other than their own partners (ABS 1999:46–7). While in 1998 almost two-thirds (65%) of all male primary carers provided care to their partner, female carers more frequently took on care of other family members. Thirty-four per cent of all female primary carers provided care to their partner and over half provided care to either children or parents (both 27%). This trend continues for carers over 65 years of age. Among older carers, 95% of male carers were caring for a partner compared with only 63% of female carers; 6% of older female carers were looking after their son or daughter and 15% were caring for a parent.

The caring role can often be with people for an extended period in their lives. The Survey of Disability, Ageing and Carers found that 13% of primary carers had spent 25 or more years in caring for a person with a disability (ABS 1999:48). Just over one-quarter (27%) of primary carers had spent between 10 and 24 years

Figure 19.1: Primary carers, by age and sex, 1998



Source: Table A19.1.

in the caring role, with a further 29% having spent between 5 and 9 years.

Health and disability status of carers

Most primary carers reported their health as good (40%), very good (27%), or excellent (13%), although almost one-quarter reported their health as either fair (17%) or poor (6%). Overall, female carers reported better health than their male counterparts, with only 21% of women reporting their health as fair or poor compared with 29% of men. Perhaps not surprisingly, younger carers reported better health than older carers, with 47% of carers aged 15 to 44 reporting their health as either very good or excellent compared with 37% of those aged 45 to 64 and 27% of those aged 65 and over (AIHW 1999).

While most primary carers in 1998 reported relatively good health, a significant proportion (39%) were found to have a disability themselves (Table 19.1). Largely reflecting the predominance of female carers, of those carers with a disability 66% were women and 34% were men. The majority of carers with a disability had a specific restriction (33% out of 39%), and overall 9% of primary carers had a profound or severe core activity restriction. There were almost four times as many women with a profound or severe disability providing care than there were male carers with a severe or profound disability. This disparity was much more marked among those under 65, with women accounting for 86% of primary carers aged under 65 with a severe or profound restriction compared with 64% of such primary carers aged 65 and over.

Table 19.1: Disability status of primary carers, by sex and age group, 1998

Age/sex	Core activity restriction: Profound or severe	Core activity restriction: Moderate	Core activity restriction: Mild	All with specific restrictions	All with disability	No disability	All carers
Females				Number			
Under 65	24,500	15,000	28,100	67,600	84,800	172,200	257,000
65 and over	*8,500	11,100	*9,300	28,900	32,000	28,400	60,400
Total	*33,000*	*26,100*	*37,400*	*96,400*	*116,800*	*200,600*	*317,400*
Males							
Under 65	*4,100	15,000	11,900	31,000	39,200	58,100	97,300
65 and over	*4,800	*7,300	*7,300	19,400	21,500	14,700	36,200
Total	*8,900*	*22,300*	*19,200*	*50,400*	*60,800*	*72,700*	*133,500*
Persons							
Under 65	28,600	30,000	40,000	98,600	124,000	230,300	354,300
65 and over	13,300	18,400	16,600	48,300	53,500	43,100	96,600
Total	**41,900**	**48,400**	**56,600**	**146,800**	**177,600**	**273,300**	**450,900**
Females				Per cent			
Under 65	7.7	4.7	8.9	21.3	26.7	54.3	81.0
65 and over	*2.7	3.5	*2.9	9.1	10.1	8.9	19.0
Total	*10.4*	*8.2*	*11.8*	*30.4*	*36.8*	*63.2*	*100.0*
Males							
Under 65	*3.1	11.2	8.9	23.2	29.4	43.5	72.9
65 and over	*3.6	*5.5	*5.5	14.5	16.1	11.0	27.1
Total	*6.7*	*16.7*	*14.4*	*37.8*	*45.5*	*54.5*	*100.0*
Persons							
Under 65	6.3	6.7	8.9	21.9	27.5	51.1	78.6
65 and over	2.9	4.1	3.7	10.7	11.9	9.6	21.4
Total	**9.3**	**10.7**	**12.6**	**32.6**	**39.4**	**60.6**	**100.0**

*The estimate has a relative standard error greater than 25%. These estimates should be interpreted accordingly.

Source: AIHW 2002:189, Table A19.1.

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Special groups

20 Indigenous people

Based on preliminary estimates from the 2001 census, at 30 June 2001 there were an estimated 460,100 Indigenous Australians—430,800 of Aboriginal descent and 49,000 of Torres Strait Islander descent—accounting for 2.4% of the total Australian population (ABS 2002c:24). It has been estimated that among these groups, over 31,200 were aged 55 and over (0.7% of the total population aged 55 years and over). Indigenous Australians aged 65 and over are a relatively small proportion of all Indigenous Australians, much smaller than the same age group for non-Indigenous Australians—2.8% of Indigenous Australians compared with 12.8% of non-Indigenous Australians (ABS 2002a; ABS 2002d).

Population profile

The age distribution of Indigenous Australians is quite different to that of non-Indigenous Australians, and the number of Indigenous people declines more sharply beyond the age of 45 than does the number of non-Indigenous people (Figure 20.1). These differences are associated with lower life expectancies among the Indigenous Australian population. Indigenous males born during the period from 1998 to 2000 have a life expectancy of 56 years, 21 years less than for the total male population. Life expectancy for Indigenous females at birth is 63 years, which is 20 years less than the life expectancy of the total female population (ABS 2002c:86).

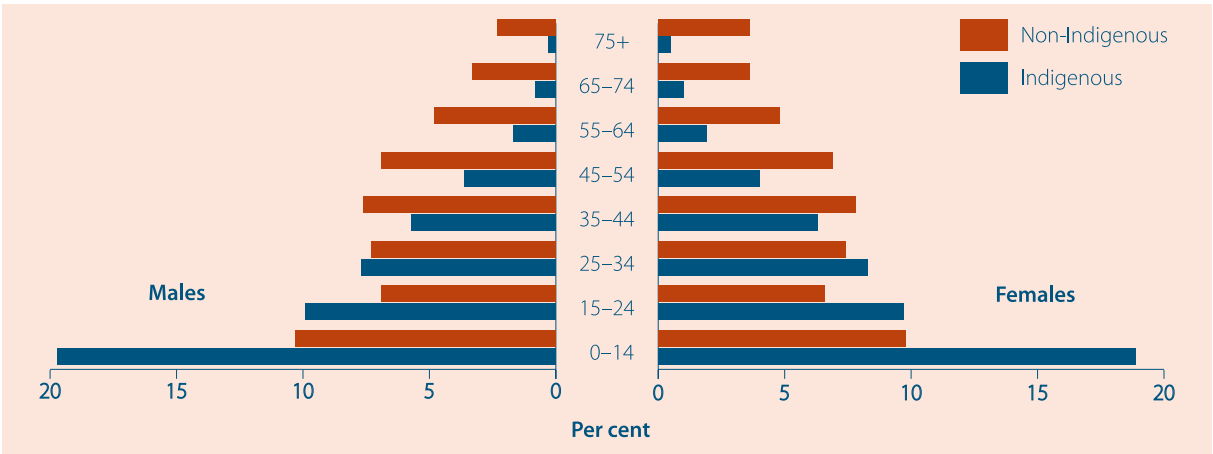
Health status

Indigenous people experience substantially higher death rates than non-Indigenous people. For example, in 1997–99, death rates per 100,000 population for people aged 65–74 were more than twice as high for Indigenous males than for the general male population (5,686 compared with 2,636 per 100,000) and around three times as high for females (4,242 compared with 1,436 per 100,000). Indigenous people were twice as likely to be hospitalised as people in the general population in 1998–99, with injury, respiratory and digestive diseases among the most common causes. Indigenous peoples are at a higher risk of poor health due to factors such as poor nutrition, obesity, substance abuse, exposure to violence, and inadequate housing and education. The prevalence of diabetes in the Indigenous population is considerably higher than in the Australian population as a whole (ABS & AIHW 2001). Dialysis is the most frequent cause of hospitalisation among Indigenous people.

Aged care services for Indigenous people

The *Aged Care Act 1997* recognises the implications of these differences in health status and life expectancy for Indigenous service users. In planning for services for older Indigenous people, the Federal Government uses the number of people aged 50 and over, instead of 70 years and over which is used for the non-Indigenous population.

Figure 20.1: Age and sex profile of Indigenous and non-Indigenous Australians, 30 June 2001



Source: Table A20.1.

Indigenous Australians have particular aged care needs. For example, the strict conditions within which residential aged care services operate are often unworkable for the care needs of Indigenous communities in regional areas. It has also been documented that it is the overwhelming preference of many Indigenous people to remain in their community rather than enter residential care. In view of these needs, in 1994 a series of consultations with Indigenous communities and organisations involved in aged care services resulted in the Aboriginal and Torres Strait Islander Aged Care Strategy. This process allowed Indigenous communities to identify their own needs and made available more flexible aged care services, as well as support and financial assistance to provide for these and other aged care related services. This strategy seeks to address issues of access to services, including those related to the rural and remote location of many Indigenous communities.

The Aboriginal and Torres Strait Islander Aged Care Strategy also allows for the provision of flexible care, that is care provided outside the usual residential and community care settings in a flexible manner. In general, the rates of use by Indigenous Australians of community-based care are higher than those by non-Indigenous Australians (Table 20.1). Indigenous Australians constitute 2.4% of Community Aged Care Package clients and only 0.5% of permanent residential aged care residents.

When age-specific usage rates are considered, Indigenous Australians make relatively high use of aged care services in both service types in all age categories, with the exception of residential care for women aged 70 and over. At 30 June 2001, 12 per 1,000 Indigenous persons aged 60–69 were using a Community Aged Care Package compared with 1 per 1,000 non-Indigenous people in the same age group. For residential care, 11 people per 1,000 Indigenous Australians aged 60–69 were residents compared with 4 per 1,000 non-Indigenous Australians.

Table 20.1: Age- and sex-specific usage rates of Community Aged Care Packages and residential aged care services (permanent residents), by Indigenous status, 30 June 2001 (per 1,000 population)

	Indigenous			Non-Indigenous		
Age	**Females**	**Males**	**Persons**	**Females**	**Males**	**Persons**
Community Aged Care Packages						
50–59	2.8	2.5	2.6	0.2	0.2	0.2
60–69	14.8	7.9	11.6	1.2	0.9	1.0
70+	40.7	24.2	33.7	12.9	6.8	10.3
Residential aged care						
50–59	3.9	3.6	3.7	1.0	1.0	1.0
60–69	9.4	11.8	10.5	4.3	4.5	4.4
70+	73.5	50.8	63.8	90.9	42.6	70.5

Note: Recipients with unknown status have been pro rated.

Source: ABS 2002a; ABS 2002d; AIHW analysis of DoHA data.

21 People from culturally and linguistically diverse backgrounds

Older people from culturally and linguistically diverse backgrounds (that is, those born overseas in non-English-speaking countries), while generally healthier than the rest of the older population, can face barriers to access to appropriate aged care services. An important principle of government is that its services are provided on an equitable basis to all Australians. Consequently, older people from culturally and linguistically diverse backgrounds are one of a number of groups given special consideration in the planning and allocation of government-funded aged care services.

Demographics of older people from culturally and linguistically diverse backgrounds

People from culturally and linguistically diverse backgrounds comprise one in five older Australians. At 30 June 2001, older people from culturally and linguistically diverse backgrounds numbered over 479,400, compared with 305,200 from the main English-speaking countries and 1,591,200 Australian-born. In 2001, the most common countries of birth for non-English-speaking older people were estimated to be Italy (101,000) and Greece (42,400) (Gibson et al. 2001).

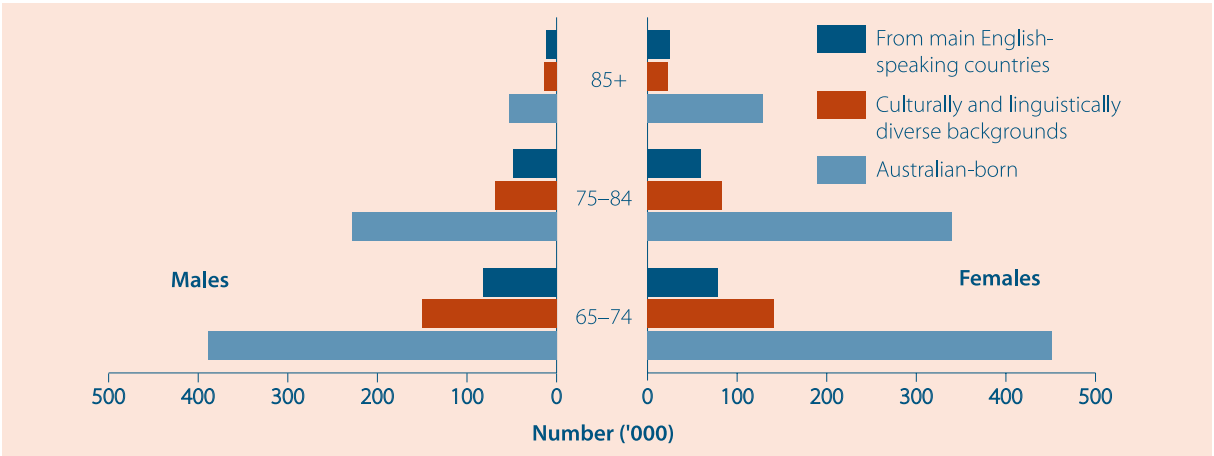
Figure 21.1 shows a younger age pattern for older people from culturally and linguistically diverse backgrounds compared with older people from the main English-speaking countries and those born in Australia. The greatest difference is in the 85 and over age group, where only 14% are from culturally and linguistically diverse backgrounds, compared with 18% of people aged 75–84 and 23% of people aged 65–74. However, this is set to change. Over the coming decades, immigrants from non-English-speaking European countries, who arrived in Australia during the peak of post-war immigration up to 1971, will populate these older age groups (ABS 2002b:17).

A higher proportion of people of culturally and linguistically diverse backgrounds are males than in the rest of the older population. This is particularly the case for the 65–74 age group, where males outnumber females: 52% are males, compared with the older population in general where 48% are males (Table A21.1). This may reflect lower levels of marriage at earlier life stages among certain immigration groups (particularly from Eastern Europe) (Jackson 2001:28).

Health and life expectancy

People from culturally and linguistically diverse backgrounds are, by definition, a diverse group, and generalisations covering the whole group are often not appropriate. Because of variations within the group, the evidence is unclear as to whether immigrants from culturally and linguistically diverse backgrounds have better health than the Australian-born population. Better health tends to be reported among immigrants generally, which may result from Australian immigration being partially determined by their health status, but the evidence among different countries is mixed (ABS 2002c). One factor militating against good

Figure 21.1: Older people by age, sex and cultural and linguistic background, 30 June 2001



Source: Table A21.1.

health is the problem of access to health services by older people who do not speak English well (VandenHeuvel & Wooden 1999). Despite this, immigrants from culturally and linguistically diverse backgrounds tend to have higher life expectancies than those from English-speaking countries, and higher than that in their country of origin (ABS 2002a:9). Women from countries such as Vietnam and China have particularly high life expectancies (ABS 2002a:8–9)

Use of aged care services

Improving the access of people from culturally and linguistically diverse backgrounds to aged care has been a key policy objective over the past 10 years. Strategies have included providing residential aged care services for specific ethnic groups, promoting cultural sensitivity in mainstream services, and culturally appropriate assessment and referral. Another initiative is a flexible service model called clustering that brings together people of a particular ethnic background in a single facility.

Representing just over 20% of the older population, older people from culturally and linguistically diverse backgrounds make up 16% of older Home and Community Care (HACC) clients, 24% of older Community Aged Care Package recipients, and around 7% of older permanent residential aged care residents. These data suggest that people from culturally and linguistically diverse backgrounds are more likely to make use of home-based rather than residential services. This may be partially explained by their younger age structure, but even so there is a general pattern of lower use of residential care.

The rate of people from culturally and linguistically diverse backgrounds receiving permanent residential care at 30 June 2001 was estimated to be 26 per 1,000 persons aged 75–84 and 115 per 1,000 persons aged 85 and over. The comparable figures for people from an English-speaking background were 62 and 279, respectively (AIHW 2002c:50; Table 21.1). By contrast, rates of use of Community Aged Care Packages are higher among people from culturally and linguistically diverse backgrounds than among English-speaking groups, at 15 per 1,000 persons aged 75–84, and 43 per 1,000 persons aged 85 and over, compared with 9 and 26 respectively. Overall, there is a relatively low level of use among older people from culturally and linguistically diverse backgrounds of Home and Community Care services (136 per 1,000 aged 75–84 compared with 150 for people from English-speaking backgrounds, and 221 per 1,000 aged 85 and over compared with 266). Thus, Community Aged Care Packages, a more intensive form of community support, appear to have been particularly successful in targeting services to people from culturally and linguistically diverse backgrounds.

Table 21.1: Use of aged care services, by age and cultural and linguistic background,[(a)] 30 June 2001

	Residential aged care services		Community Aged Care Packages		Home and Community Care	
Age	English-speaking background	CLDB	English-speaking background	CLDB	English-speaking background	CLDB
			Number			
65–74	12,386	1,219	2,382	842	50,756	12,439
75–84	43,352	3,697	6,519	2,177	104,466	19,432
85+	63,235	4,167	5,866	1,576	60,200	8,047
Total 65+	**118,973**	**9,083**	**15,686**	**4,843**	**215,422**	**39,918**
			Rate (per 1,000)			
65–74	12.2	4.3	2.3	3.0	49.9	43.8
75–84	62.4	25.9	9.4	15.2	150.3	136.0
85+	279.4	114.6	25.9	43.3	266.0	221.4
Total 65+	**61.4**	**19.6**	**8.1**	**10.5**	**111.1**	**86.2**

(a) The cultural diversity classification is based on country of birth. The English-speaking background category comprises people whose country of birth was Australia, New Zealand, United Kingdom, Ireland, United States of America, Canada or South Africa. The culturally and linguistically diverse background (CLDB) category comprises people born in other countries.

Sources: ABS 2000; ABS 2002a; AIHW 2002b; AIHW 2002c; AIHW analysis of HACC minimum data set.

22 People in rural and remote communities

Almost one-third of people aged 65 and over live in rural and remote areas (an estimated 30% at 30 June 2000—see Table A22.1). This is slightly higher than the proportion of the total population of Australia living in these areas (28%). The movement of younger age groups to metropolitan areas for employment and other opportunities, and the tendency among some older people to relocate to coastal and other non-urban areas in retirement are some of the factors that contribute to this difference.

Distribution of older people

Figure 22.1 shows the number of older people living in rural and remote areas compared with capital cities and other metropolitan areas. At 30 June 2000, there were an estimated 717,200 people aged 65 and over living in rural and remote communities. Of these, 94% were living in rural communities. There were an estimated 1,642,900 older people in capital cities and other metropolitan areas.

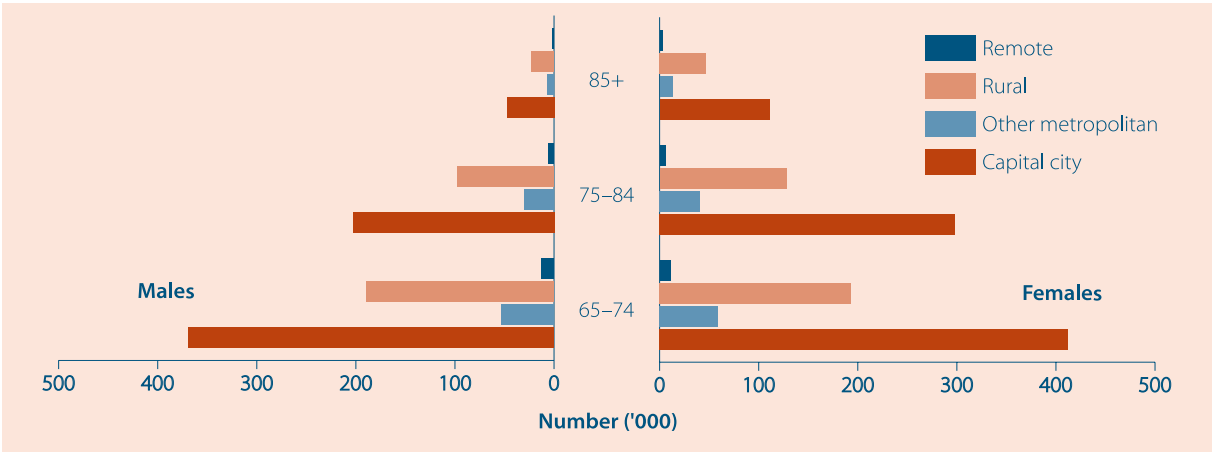
Health of older people in rural and remote communities

The health of older people living in rural and remote areas generally compares poorly with that of older people living in metropolitan centres, although there are differences between different groups across regions. The characteristics of these groups explain or provide better insight into many of the apparent health differences. For example, people who live in rural and remote areas are more likely to be Indigenous, with just under one-quarter of the remote area population being Indigenous compared with 1% in capital cities.

Life expectancy is relatively low among people who live in remote areas. Calculations of life expectancy at birth show that metropolitan area males and females are expected to outlive their counterparts in remote areas by 3 years and those in rural areas by less than a year (AIHW 2002a:218). In general, average death rates in rural and remote areas are higher than in metropolitan areas. There are, however, differences in certain age groups. Figure 22.2 shows that death rates for people over the age of 80 in remote areas are generally lower than for their counterparts in other geographical regions. The overall death rate for older males is 4,848 per 100,000 in remote areas, compared with 4,997 per 100,000 in rural areas. For females these rates are 3,991 and 3,966 per 100,000 respectively. It may be that, with declining health, older people move to larger population centres which have more facilities and eventually die there, affecting death rates in both areas.

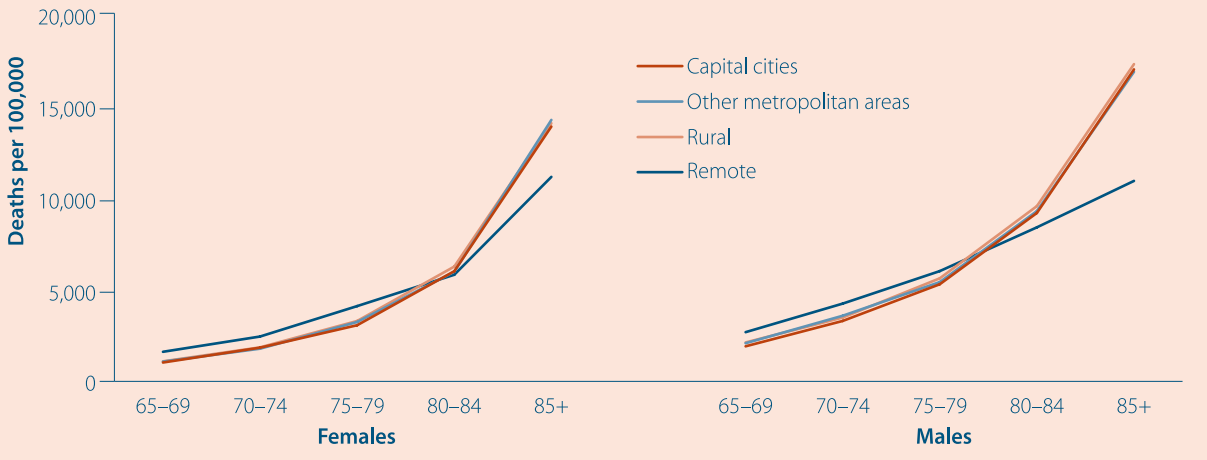
The rural and remote location of some communities can be associated with barriers to access to health and aged care services. In many areas the viability of services is problematic. A number of programs have been put in place to address these difficulties and to improve services and the health of people in rural and remote areas generally. In particular, the Bush Nursing, Small Community and Regional Private Hospitals Program announced in the 2000–01 Budget, provides an opportunity for these areas to review their operations to meet the needs of the local community.

Figure 22.1: Older people, by age, sex and geographic area, 30 June 2000



Source: Table A22.1.

Figure 22.2: Death rates per 100,000 people, by age, sex and geographic area, 1997–1999



Source: Table A22.2.

Use of aged care services

To address the special needs of people living in rural and remote areas, multi-functional models have been developed to improve access to services. In communities too small to support standard models, single function services, a more flexible solution is provided by Multipurpose Centres and Multipurpose Services. Multipurpose Services provide a range of health and aged care services. At 31 August 2001 there were 58 operational Multipurpose Service Centre sites with 1,269 flexible places. Another 21 proposed Multipurpose Services had received a provisional allocation of flexible care places.

A recent AIHW analysis of the equity of supply of aged care services concluded that the overall supply was reasonably equitable across States, Territories and regions (Gibson et al. 2000). Table 22.1 shows the level of service usage in each geographic region for Home and Community Care (HACC), Community Aged Care Packages and residential aged care. While remote areas have considerably fewer people in residential care per 1,000 people aged 65 and over than other regions (33 residents per 1,000 people aged 65 and over compared with 57 in capital cities), more people in remote areas access Community Aged Care Packages (12 recipients per 1,000 people aged 65 and over compared with 8 in capital cities) and HACC services (153 clients per 1,000 people aged 65 and over compared with 102 in capital cities).

Table 22.1: Usage rates of aged care services, by age and geographic area, 30 June 2001 (per 1,000 population)

Age	Capital cities	Other metro. centres	Rural	Remote
Residential aged care service residents				
65–74	11.4	10.5	9.4	10.6
75–84	58.8	56.2	54.6	46.0
85+	258.5	263.9	253.1	114.9
Total	**56.5**	**52.2**	**50.6**	**33.1**
Community Aged Care Package recipients				
65–74	2.4	2.6	2.2	7.1
75–84	10.5	10.2	9.6	17.2
85+	27.2	36.5	26.7	23.8
Total	**8.1**	**8.7**	**7.3**	**12.0**
Home and Community Care clients				
65–74	44.1	35.0	50.6	88.2
75–84	135.1	120.6	156.8	221.0
85+	240.7	216.2	261.7	255.9
Total	**98.8**	**83.7**	**108.9**	**147.2**

Note: Table excludes a small number of cases with missing age.

Sources: ABS 2002a; AIHW 2002b; AIHW 2002c; AIHW analysis of HACC minimum data set; AIHW analysis of ABS Statistical Local Area population estimates, 2000.

23 Veterans

There is a range of health and welfare benefits and services available to war veterans and their dependants through the Department of Veterans' Affairs (DVA). These are provided in recognition of the need for care, compensation and income support that arises as a result of war service. Veterans are also eligible for residential aged care services and Community Aged Care Packages. At 30 June 2002, an estimated 285,600 ex-servicemen and women were potentially eligible to receive a DVA service pension. Around 95% of these people were male. The majority (53%) were aged 75–84, having served in World War II and Korean conflicts, with the next largest group aged under 55 (14%). Including veterans, their dependants, war widows and widowers, it is estimated that 18% of men and 8% of women aged 65 years and over in the Australian population are DVA clients.

Health and health care

A survey of veterans and war widows found that the most common medical condition reported was vision problems, alleviated by glasses or contact lenses (85%). Other prevalent medical conditions included arthritis or rheumatism (59%), complete or partial deafness (49%), and back trouble (40%) (DVA 1998). When compared with people of the same age in the general community, veterans and war widows were more likely to have had a recent illness, taken health-related action, and consulted a health professional. Both males and females were more likely than those in the general community to experience respiratory diseases. In addition, male veterans were more likely than males generally to experience arthritis, neoplasms, and diseases of the circulatory, digestive and musculoskeletal systems (Covance & DVA 1999).

Specific health care benefits and services available to eligible veterans and dependants include one of three health benefit cards. These entitle holders to health services (Gold and White Cards) and pharmaceuticals (Orange Card). General practitioner and specialist medical services, dental care, hospital care and psychological services are available. Holders of a Gold Card are entitled to the full range of health care services at no cost to them, while White Card holders are entitled to health services for service-related disabilities or illnesses.

Mental health

Veterans are more likely to experience mental disorders than the rest of the community (Covance & DVA 1999). They and their families have been found to access mental health services more often. This is evidenced by a recent DVA report that revealed 22% (or 73,000) out of a DVA treatment population of 350,000 people received some form of mental health treatment (DVA 2001:6). A special service catering for the mental health of veterans of all conflicts is the Vietnam Veterans Counselling Service. The service is free, providing direct counselling and referral services, specialist programs and a telephone crisis service (Veterans Line). There were 69,393 counselling sessions conducted and 6,562 telephone calls made to Veterans Line in 2001–02.

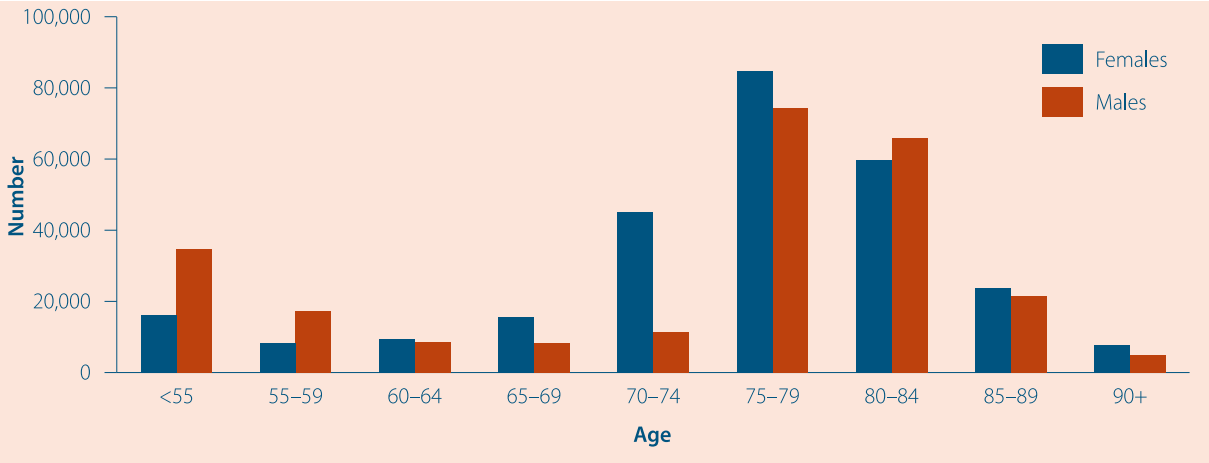
Service Pension and income support

The Service Pension is similar in many ways to the Age Pension (see Topic 9: *Pensions*). It is paid at the same single and couple rates—from March 2002, a maximum of $421.80 a fortnight for a single and $352.10 a fortnight for each member of a couple. It is also subject to income and assets tests. However, an important difference is that the Service Pension is available 5 years earlier than the Age Pension. Currently the qualifying age stands at 60 years for males and 57 years for females (the qualifying age for females is being progressively increased from 55 to 60 in a similar way to the increase in the Age Pension eligibility age for women).

There are also other forms of income support available from DVA. These include the widow's/widower's pension, income support supplement, disability compensation and various other allowances. None of these are taxable or subject to means testing. The Disability Pension, which is a payment for injuries or disease caused or aggravated by war or defence service, was being paid to 159,425 veterans at 30 June 2002.

At 30 June 2002, 517,963 people were receiving payments from DVA, with the largest number being in the 75–79 age group (31%). Females (generally war widows) accounted for 52% of DVA pension recipients. Figure 23.1 shows that there are more female than male recipients in the age groups between 60 and 80 years and 85 years and over, with the 70–74 group showing the greatest difference.

Figure 23.1: DVA pension recipients, by age and sex, 30 June 2002



Source: Table A23.1.

Veterans' Home Care

The Veterans' Home Care (VHC) program began in January 2001 to assist veterans and war widows or widowers to remain resident in their own homes for as long as possible. It provides services including domestic assistance, personal care, home and garden maintenance and respite care to eligible members of the veteran community. Other services such as delivered meals and community transport are provided through special arrangements with State and Territory governments. Veterans and war widows and widowers are required to make a co-payment for VHC services, except for respite care. Between January 2001 and July 2002 there were 60,098 veterans assessed under Veterans' Home Care and, of these, approximately 95% (or 56,803) were approved to receive VHC services.

Table 23.1 shows a June 2002 snapshot of veterans approved for services, indicating that domestic assistance was the most common service approved (84%), followed by home and garden maintenance (29%).

Other services

Other DVA services are available to veterans and their families. These include a free financial information service and housing assistance through the Defence Service Homes Scheme, as well as home loans and insurance. Less direct, but still important, services include commemoration activities. In particular, there is the Their Service—Our Heritage Program which provides an avenue for educating the community about and acknowledging the service and sacrifice of Australia's veterans.

Table 23.1: Veterans approved for Veterans' Home Care services, by service type, snapshot June 2002

Service type	Number of veterans	Per cent
Domestic assistance	35,738	84
Home and garden maintenance	12,275	29
Personal care	2,030	5
Respite care	5,111	12
Total (veterans)	**42,317**	**100**

Note: A veteran may receive more than one service type; therefore the total number will always exceed the actual number of veterans approved for services. Likewise, the percentages will sum to more than 100% as a veteran receiving more than one service type will be included in the percentage for each service type.

Source: DVA unpublished Veterans' Home Care administrative data.

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Health and welfare system

24 The Australian health and welfare system

Australia's welfare system

The welfare system comprises social programs that are designed to enhance the welfare of individuals or communities, and to provide more equal opportunities for participation in the social and economic life of the Australian community. It has two major components. The first is the provision of welfare services, described as assistance delivered to clients with special needs such as the young, people with disability and older people. Important welfare services for older people include assistance with housing, residential care and care provided in the community. The second component of the welfare system concerns certain types of social security benefits (or income support) such as the Disability Pension, Age Pension and Carer Payment, all of which are relevant to older people (AIHW 1997:19–20).

In 1999–00, approximately $13.7 billion (2.2% of GDP) was spent on welfare services by both the government ($8.6 billion) and non-government sectors ($5.1 billion) (AIHW 2001c:1). Examples of specific services provided by Commonwealth, State and Territory Governments include home and community support and transport services for both frail older people and younger people with disabilities. An Australian Bureau of Statistics survey of employing businesses and private sector organisations involved in community services found that, in 1999–00, there were over 340,000 people employed in community services (ABS 2001). Importantly, formal provision of welfare is only part of the story, accounting for only 33% of a total estimated $41.7 billion of resources devoted to welfare (AIHW 2001a:13). The majority of other contributions come from unpaid family members, carers and volunteers.

The Commonwealth Government's involvement in social security began with the introduction of federal old age and invalid pensions in 1909 and maternity allowances in 1912, both of which gained Australia a reputation as a pioneer in public welfare. The contemporary Australian social security system provides income support to people and families who are without an adequate income because of age, disability, unemployment or sole parenthood. Total Commonwealth expenditure on income support in 2000–01 amounted to $51.7 billion (DFaCS 2001). In 2000, about six million Australians (approximately one-third of the population) received social security entitlements. The proportion was highest among people aged 65 years and over of whom 78% received income support, compared with 23% of the population aged between 15 and 65 (Whiteford & Bond 2000:1–2).

Changes to the welfare system were introduced in May 2001 by the *Australians Working Together* initiative (Commonwealth Government of Australia 2002) with the objective of 'striking the right balance between incentives, obligations and assistance'. These followed a review by the Reference Group on Welfare Reform (2000), whose terms of reference included provision of advice on reducing 'welfare dependency'. New measures included increased assistance for parents and older people and emphasis on programs to facilitate the transition to paid work for those able to work.

Australia's health care system

The Australian health care system is designed to ensure universal access to adequate health care at an affordable or no cost. It also seeks to provide choices through private sector involvement (DHAC 2000:5). In achieving its goal, Australia's system is considered as being world-class in its efficiency and objectiveness (AIHW 2002a:6). It is a complex system, comprising many types and providers of services and a range of funding and regulatory mechanisms.

The Australian health care system is a blend of public and private sector involvement: private medical practitioners provide primary and specialist care in the community, and a mixed public (State-controlled) and private hospital system provides comprehensive acute services. Funding for the health care system in 2000–01 amounted to approximately $60.8 billion (9.0% of GDP; AIHW 2002b). Before amendments to the Constitution in 1946, Commonwealth involvement in health was limited to quarantine matters. It now takes a leadership role in national policy issues, with the States and Territories responsible for delivery and management of health services (DHAC 2000:1). By 2000–01 about half (47%) of all health funding was provided by the Commonwealth Government ($28.8 billion), the remainder by State and Territory and local governments ($13.7 billion) and non-government sources such as health insurers and individuals ($18.3 billion) (AIHW 2002b:18). Commonwealth funding includes two universal national subsidy schemes—Medicare (partly funded by a 1.5%

levy on taxable income), which subsidises payments for private medical services, and the Pharmaceutical Benefits Scheme, which subsidises a high proportion of private prescription medications. In addition to these direct subsidies of health care, the Commonwealth subsidises private health insurance through a 30% rebate on premiums. The Commonwealth and State and Territory Governments also jointly fund universal public hospital services.

Many patients' first contact with the health care system is through a general medical practitioner (GP), which is covered at least in part by Medicare, depending on billing arrangements. Patients needing specialised care can be referred to specialist medical practitioners or other health service providers. Others, such as dentists are generally met by the patients themselves, sometimes with the support of private health insurance. Patients can access public hospitals through emergency departments, where they may present on their own initiative, or via the ambulance services, or after referral from a medical practitioner. Unless they choose private treatment, patients in public hospitals are charged nothing for their treatment, food or accommodation. Emergency department and outpatient services are free.

In addition to the services outlined above, the Commonwealth, State and Territory Governments and local governments provide public health services, community health services and ambulance services. Public health services include activities to ensure food quality, immunisation services and other communicable disease control, public health education campaigns, environmental monitoring and control, and screening programs for diseases such as breast cancer. Community health services include domiciliary nursing, general medical practitioners, dental services, community-based mental health care, community-based drug and alcohol treatment, and a range of allied health services (for example, physiotherapy).

25 Government expenditure on older people

In Australia, assistance is provided to older people in a variety of cash and non-cash forms, by the Commonwealth, State and Territory Governments, local governments, the not-for-profit and for-profit sectors, volunteers, family members and friends. While a full accounting of the costs of the diverse array of services and assistance provided by these various groups must await further developments in our national data systems, it is possible to report on expenditure by Commonwealth and State and Territory Governments across key areas of provision.

Expenditure on older people

Table 25.1 provides a broad estimate of government expenditure on older Australians, taking into account expenditure on income support (including both the Service Pension and the Age Pension), residential care, home-based care, and medical, hospital and pharmaceutical services. Total government funding for these items was $29,000 million in 1998–99, which equates to around $12,500 per person aged 65 and over.

Table 25.1: Government funding for people aged 65 and over, by service type, 1998–99

Service type	$million	Average annual real growth, 1988–89 to 1998–99[a]
Pension[b]	16,611	2.7
Public hospitals	5,228	4.9
Medical services	1,874	7.5
Pharmaceutical services	959	8.6
Residential aged care	3,423	5.0
Home-based care[c]	905	8.6
Total	**28,999**	**3.8**

(a) Real growth calculated from expenditure deflated using the GDP deflator.

(b) Includes Age Pension and Service Pension.

(c) Includes Community Aged Care Packages, Commonwealth-funded respite services, the Aged Care Assessment Program, HACC and Carer Allowance.

Sources: Revised from AIHW 2001a:245; AIHW 2001b:62; Choi 1998.

The Age Pension, funded by the Commonwealth Government, is currently paid to men aged 65 and over and women aged 62 and over (see Topic 9: *Pensions*), subject to a means test applied to both income and assets. A similar pension is paid to returned service men and women (the Service Pension). Pensions paid to the dependent wives of aged pensioners (the Wife Pension and Widow Pension) are being phased out to become the Age Pension. In total, pension payments to older people amounted to $16,611 million in 1998–99; this represented an average real growth rate for the 10 years to 1998–99 of 2.7% per annum.

Public hospitals are administered by State and Territory Governments, but funded jointly by the Commonwealth and State and Territory Governments. Private hospitals, which handle about 31% of hospital patients, are not funded directly by government. Patients are either insured by private health insurance or make independent out-of-pocket payments or are funded through the Department of Veterans' Affairs, workers' compensation or other insurance arrangements. In 1998–99, public hospitals received around $5,228 million of public funding for services to older people. This estimate is derived as a proportion of expenditure on public hospitals. The proportion of funding consumed by those aged 65 and over was initially estimated through analysis of the situation in 1993–94 (34.7%; Mathers et al. 1998). Since then the proportion is projected to have increased slightly each year, and for 1998–99 it is estimated that those aged 65 and over consumed 36.7% of hospital expenditure.

Medical services include expenditure on consultations with general practitioners and specialists, pathology tests, screening and diagnostic imaging services. Public funding is provided through Medicare, which pays 85% of the scheduled fee set by Medicare for services provided outside of hospitals. The remaining 15%, and any amount charged by individual practitioners above the scheduled fee, is the responsibility of the patient. In 1998–99, it is calculated that $1,874 million in public funds were expended on medical services for older people. This is estimated on the basis that in 1998–99 approximately 25.4% of medical services expenditure was for people aged 65 and over (Mathers et al. 1998, adjusted for small annual increases in the proportion of medical services expenditure attributable to people aged 65 and over).

Government expenditure on pharmaceutical services includes the cost of drugs and other therapeutic non-durables dispensed to patients either with or without a prescription by a doctor. The Pharmaceutical Benefits Scheme (PBS) subsidises the cost of a wide range of

necessary medications. Concessional beneficiaries (e.g. holders of Pensioner Health Benefit Cards or Department of Veterans' Affairs treatment card holders) pay a set contribution for each item listed under the PBS, currently $3.60. General beneficiaries (i.e. all others) pay a higher contribution, currently a maximum of $22.40. The Pharmaceutical Benefits Scheme also provides a safety net that sets separate upper boundaries for both concessional and general beneficiaries, beyond which all costs for drugs for the rest of the year are met. The items that do or do not attract benefits under the PBS, the basic price and the benefit level are reviewed regularly. In 1998–99, it is estimated that $959 million were expended under the Pharmaceutical Benefits Scheme on behalf of persons aged 65 and over (estimated on the basis that approximately 31% of pharmaceutical services are used by people aged 65 and over (Mathers et al. 1998)).

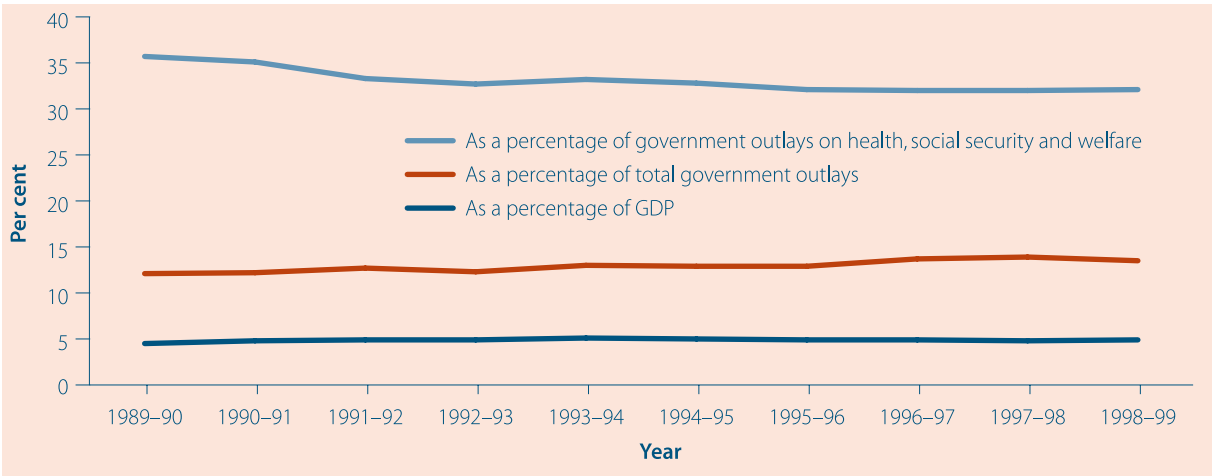
Residential care services are funded by the Commonwealth Government, but the services are provided by for-profit and not-for-profit organisations, and, in a small number of cases, by local and State Governments. In 1998–99, the Commonwealth paid some $3,423 million for residential care services to older people. This represents a real average annual increase of 5% over the decade to 1998–99.

Home-based care services include services provided under the jointly funded (Commonwealth and State) Home and Community Care Program (HACC), Commonwealth-funded Community Aged Care Packages and other Commonwealth-funded respite services. For the purposes of this overview, expenditure under the Aged Care Assessment Program has also been included in the home-based care category. Home-based care has seen the largest growth in government expenditure over the decade (8.6% real average annual growth), reflecting the shift in government policy towards community care and away from residential care. In total, this amounted to $905 million expended on home-based care services for older people in 1998–99.

Expenditure as a proportion of GDP and government outlays

As a proportion of GDP, government expenditure on older Australians remained relatively unchanged over the 10 years from 1989–90 to 1998–99 (at around 4.9%). As a proportion of total Commonwealth, State and local government outlays, expenditure has remained relatively stable, moving from 12.1% in 1989–90 to 13.5% in 1998–99. As a proportion of government outlays on health, welfare and social security, expenditure on older Australians declined from 35.7% in 1989–90 to 32.1% in 1995–96, and since then has largely stabilised (also 32.1% in 1998–99; see Figure 25.1).

Figure 25.1: Government funding for people aged 65 and over, 1989–90 to 1998–99



Source: Table A25.1.

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Health services

26 Hospital use

Hospitals are a key component of the health care system. Access to hospital care is gained through the referral of a medical practitioner undertaking primary or specialist care, at outpatient departments, or through the emergency department. Information collected by hospitals includes number of admissions, length of stay, reasons for which older people are hospitalised and procedures that they undergo during their stay. While this information may not necessarily reflect the health of all older people, it provides insight into the health of those who attend hospital.

Number of visits

A common measure of hospital use is the number of separations from hospital that occur in a particular period. In 2000–01 there were 6,138,398 hospital separations for people of all ages, giving rise to a rate of 318 hospital separations per 1,000 persons (AIHW 2002a:9, 112). Older people have a higher rate of admission to hospital than the general population. Older Australians account for 33% of all hospital separations (2.0 million), while comprising only 12% of the total population (AIHW 2002a:112). In terms of usage rates, the number of separations per 1,000 persons aged 65 and over in 2000–01 was 844. Hospital utilisation may not be simply a function of the health and needs of older people compared with younger people. Other factors such as the availability of and access to other medical services and care may influence hospital utilisation.

While separation rates are higher for women than for men in the general population, the reverse is true for older people (Table 26.1). In 2000–01, older men averaged 955 hospital separations per 1,000 people compared with 756 for women. However, due to the higher numbers of older women, overall, older men and older women accounted for similar numbers of separations (1,014,884 and 1,017,838). Separation rates tended to increase with age for both women and men. Men were also more likely to be admitted and separated from hospital on the same day (50% of visits compared with 45% for women).

Number of days and length of stay

Not only does frequency of hospitalisation increase with age, so too does the duration of the stay (see Table A26.1). In 2000–01, patients aged 65 and over accounted for 10.8 million patient days (48% of all

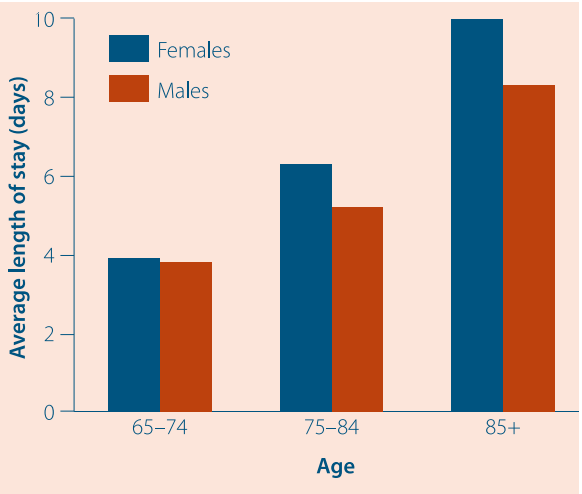
Table 26.1: Hospital separations of older people, by age and sex, 2000–01

	Separations				
Age/sex	>1 day	Same day	Total	Total	Per 1,000 population
Females		**Per cent**		**Number**	
65–74	42.9	57.1	100.0	442,795	650
75–84	58.0	42.0	100.0	411,795	846
85+	78.4	21.6	100.0	163,248	915
Total	*54.7*	*45.3*	*100.0*	*1,017,838*	*756*
Males					
65–74	43.9	56.1	100.0	507,951	798
75–84	52.6	47.4	100.0	411,394	1,184
85+	73.0	27.0	100.0	95,539	1,210
Total	*50.2*	*49.8*	*100.0*	*1,014,884*	*955*
Persons					
65–74	43.5	56.5	100.0	950,746	722
75–84	55.3	44.7	100.0	823,189	987
85+	76.4	23.6	100.0	258,787	1,005
Total	**52.4**	**47.6**	**100.0**	**2,032,722**	**844**

Sources: AIHW National Morbidity Database; ABS 2002.

patient days; AIHW 2002a). The proportion of same-day hospital separations decreases with increasing age for both men and women (Table 26.1). Patients aged 65 and over stayed 5.3 days on average compared with 3.7 days across all age groups. When same-day separations are excluded, hospital episodes were, on average, 9.2 days for people aged 65 and over, whereas across all age groups the figure is 6.4. Women had longer average lengths of stay in hospital than men in all age groups over 65 years (Figure 26.1).

Figure 26.1: Average length of stay in hospital including same-day separations, by age and sex, 2000–01



Source: Table A26.1.

Length of stay in hospital is not necessarily an indicator of the severity of the patient's illness. Several clinical (for example, diagnoses, procedures, re-admissions) and non-clinical factors (for example, social background, geographic isolation, patient classification, medical care alternatives and mode of separation) can affect a patient's length of stay.

Changes in hospital use

There has been a discernible change in hospital usage over time. Between 1996–97 and 2000–01, overall the proportion of hospital stays that were a same-day separation rose from 45% to 51% (see AIHW 2002a:17). Reflecting these changes, the average length of hospitalisation for older people declined between 1996–97 and 2000–01, from 9.8 days for stays excluding same-day separations to 9.2 days. This fall was observed in nearly all the older age groups for both men and women.

These changes are the result of both government policy and changes in the technologies used in medical procedures (AIHW 2001b:130; Duckett 2000:110–14). Developments in other health care services also affect hospital utilisation patterns. For example, patient care provided in the community with support from a hospital is becoming more common. Sub-acute care services are increasingly being provided in settings other than acute hospitals. Rehabilitation in the home is one example of this. At present, a number of States and Territories are undertaking trials of new step-down care arrangements. Step-down facilities offer short-term convalescent support for people making the transition from hospital to home.

27 Major diagnoses and procedures

When people attend hospitals, information is recorded about the diagnoses and procedures performed on them while they are there. Given the central role of hospitals in the provision of health care, information about people attending these institutions can provide some insight into the diseases and conditions affecting the community. It is important to remember, however, that factors such as the availability of and access to other medical services may influence the extent to which certain conditions present at hospitals or the extent to which certain procedures are conducted. Some groups of people or people with particular conditions may not use hospital services at all.

Principal diagnoses

Principal diagnosis is defined as 'the diagnosis established, after study, to be chiefly responsible for occasioning the admitted patient's episode of care in hospital' (AIHW 2001a:94). The principal diagnosis is coded from patient's medical records according to the International Classification of Diseases 10th revision Australian Modification (ICD-10-AM).

Table 27.1 shows the number and the percentage of total hospital separations of people aged 65 and over in 2001–01 for each of the principal diagnosis chapters of the ICD-10-AM. The diagnoses for older people who have visited a hospital most commonly fall into the categories of cardiovascular disease (13% of all separations of patients aged 65 and over), neoplasms, more commonly known as tumours (11%), diagnoses associated with the digestive system (10%), and diagnoses associated with the eye and adnexa (i.e. parts attached to the eye such as eyelids; 6%).

Cardiovascular disease refers to any disease that affects the heart and blood vessels. Within this category, angina pectoris (in which the patient suffers severe pain over the heart) is associated with the highest number of separations among older people (53,611 separations in

Table 27.1: Patients aged 65 and over: separation statistics for principal diagnoses (ICD-10-AM chapter), 2000–01

Principal diagnosis (ICD-10-AM chapter)	Same-day admissions and separations	Other	Total	Same-day admissions and separations	Other	Total
	Number			Per cent		
Certain infectious & parasitic diseases (A00–B99)	2,185	12,673	14,858	0.2	1.2	0.7
Neoplasms (C00–D48)	99,139	115,338	214,477	10.3	10.8	10.6
Blood & blood forming organs (D50–D89)	12,813	13,852	26,665	1.3	1.3	1.3
Endocrine, nutritional, metabolic & immunity (E00–E90)	11,114	25,521	36,635	1.1	2.4	1.8
Mental disorders (F00–F99)	11,166	24,561	35,727	1.2	2.3	1.8
Nervous system & sense organs (G00–G99)	10,753	28,545	39,298	1.1	2.7	1.9
Eye and adnexa (H00–H59)	100,911	23,616	124,527	10.4	2.2	6.1
Ear and mastoid process (H60–H95)	2,502	3,888	6,390	0.3	0.4	0.3
Cardiovascular disease (I00–I99)	40,919	214,501	255,420	4.2	20.1	12.6
Respiratory system (J00–J99)	9,915	96,196	106,111	1.0	9.0	5.2
Digestive system (K00–K93)	111,476	100,262	211,738	11.5	9.4	10.4
Skin & subcutaneous tissue (L00–L99)	13,580	19,277	32,857	1.4	1.8	1.6
Musculoskeletal system (M00–M99)	29,407	76,929	106,336	3.0	7.2	5.2
Genitourinary system (N00–N99)	26,742	59,263	86,005	2.8	5.6	4.2
Congenital anomalies (Q00–Q99)	525	634	1,159	0.1	0.1	0.1
Symptoms, signs & ill–defined conditions (R00–R99)	43,549	72,991	116,540	4.5	6.8	5.7
Injury & poisoning (S00–T98)	16,021	88,003	104,024	1.7	8.3	5.1
Other reason for contact with health services (Z00–Z99)	421,953	88,677	510,630	43.6	8.3	25.1
No principal diagnosis	2,090	1,239	3,329	0.2	0.1	0.2
Total	**966,762**	**1,065,967**	**2,032,729**	**100.0**	**100.0**	**100.0**

Source: AIHW National Hospital Morbidity database.

2000–01), although heart failure and myocardial infarction (heart attack) are also frequently diagnosed for older people admitted to hospital and result in longer average length of stay in hospital. In 2000–01 there were 35,632 separations for heart failure and 22,849 for heart attack. The average length of stay was 8.4 days and 7.0 days respectively. For angina pectoris the average length of stay was 4.3 days.

A neoplasm (or tumour) is any new and abnormal tissue growth, often forming a lump. This growth is uncontrolled and progressive. Tumours can occur throughout the body but among older people the tumours associated with the highest number of hospital admissions are those occurring on the skin. Melanoma and other malignant neoplasms of the skin were diagnosed for 44,694 separations in 2000–01 and patients with diagnoses in this category had an average length of stay in hospital of just over 2 days (2.1 days).

Principal diagnoses associated with the digestive system occurred for 211,738 separations in 2000–01. The most common diagnosis in this category for older people was diverticular disease of the intestine for which there were 24,279 separations for older people. Diverticular disease is a condition of the large intestine (colon) in which small sacs or pouches (diverticula) form at weak points in the wall of the intestine. This weakness is thought to be caused by genetic factors or a diet which is low in fibre. Diverticula can cause pain and become infected and result in life-threatening complications (DoHA 2002).

The most frequently occurring diagnosed disorders of the eye and adnexa for older people admitted to hospital in 2000–01 were disorders of the lens and, in particular, senile and other cataracts. The total number of separations for those diagnosed with these cataracts was 105,785. Both diagnoses were associated with a same-day separation from hospital.

Procedures

In 2000–01 the principal procedures carried out on older people who visited a hospital most commonly fell into the categories of procedures on the urinary system (16% of all separations of patients aged 65 and over), procedures on the digestive system (14%), and procedures on the eye (6%) (Table A27.1). The most common procedure on the urinary system was haemodialysis with a total of 261,369 separations for older people being associated with this procedure. Haemodialysis is frequently associated with a same-day separation from hospital. This blood purification and enrichment procedure is conducted on patients whose kidneys no longer function adequately. Diabetes and hypertension (high blood pressure) are among the leading causes of kidney failure.

The most common procedure on the digestive system was fibre-optic colonoscopy and fibre-optic colonoscopy with excision. These procedures were conducted for a total of 127,550 separations for older people. The associated average length of stay in hospital was 2.5 days. A fibre-optic colonoscopy is an examination of the large intestine. This investigative technique is often associated with diverticular disease of the intestine and other disorders such as colonic cancer.

In 2000–01 there were 128,796 separations for older people in which procedures had been conducted on the eye. The majority of these procedures were for the treatment of cataracts using the specific procedure described as extracapsular crystalline lens extraction by phacoemulsification. This procedure occurred for 104,272 older patients admitted to hospital. Of separations in which procedures were conducted on the eye, 81% were same-day admissions and separations.

External causes

Many admissions to hospital come about as the result of factors other than illness or pre-existing physical conditions. The two most common external causes of admission to hospital for older people were complications of medical and surgical care (116,900 separations) and falls (80,300 separations). Across all ages, hospital admission caused by complications of medical and surgical care occurred most frequently for people between the ages of 65 and 84 years. Hospital admission caused by falls occurred frequently in the 75–84 year age group but, for males, falls were equally common among 5 to14 year olds. The most common injury diagnosed was fracture of the lower limb including fractured neck of femur and other unspecified fractures of the femur. The most common principal diagnosis associated with falls was care involving the use of rehabilitation procedure.

28 General practitioner services

General practice is recognised as the first point of entry for most patients into the Australian health care system. General practitioners (GPs) perform a gatekeeper role in that they diagnose and refer people to other appropriate services in the health care system. They are heavily used by people of all ages; the majority of Australians (82%) attended a GP at least once during the year 2000 (Britt et al. 2001).

Use of GPs by older people

In 1999–00, almost 105 million non-hospital GP services were provided to Australians (Table 28.1). Approximately 24% of these were provided to older people. Given that people aged 65 and over represent 12% of the total population, clearly older people use the services of non-hospital GPs more frequently than younger people.

Table 28.1 shows how this rate of use increases with age. Rates and numbers of consultations or services received are shown for users of general practitioners and local medical officers (LMOs). War veterans, war widows or widowers and their dependants who hold a Gold or White health card issued by the Department of Veterans' Affairs (DVA) mostly use LMOs for their GP services but sometimes use Medicare funded GP services. The rate of use for a person aged 65 or over is more than double that for someone aged under 65 (9,654 services per 1,000 persons aged 65 and over, compared with 4,732 per 1,000 persons aged under 65).

Table 28.1 also shows that, overall, women are more likely than men to use the services of a GP. This is true for all age groups in the older population; for example, there were over 10,800 non-hospital GP services per 1,000 women aged 75 to 84 compared with 8,800 for their male counterparts.

Table 28.1: Non-hospital general practice services, by patient age and sex, 1999–00

Age/sex	Number of services	Rate (per 1,000)
Females		
Under 65	33,888,819	5,502
65–74	5,580,058	9,424
75–84	4,049,828	10,834
85+	1,014,068	13,039
Total 65+	*10,643,954*	*10,414*
Total	**44,532,773**	**6,220**
Males		
Under 65	45,478,267	3,984
65–74	6,674,632	8,457
75–84	5,701,753	8,760
85+	2,382,706	11,031
Total 65+	*14,759,091*	*8,767*
Total	**60,237,358**	**4,581**
Persons		
Under 65	79,367,086	4,732
65–74	12,254,690	8,958
75–84	9,751,581	9,864
85+	3,396,774	12,367
Total 65+	*25,403,045*	*9,654*
Total	**104,770,131**	**5,399**

Note: Data relate to unreferred general practice attendances outside hospital, including those by war veterans, war widows or widowers and their dependants who hold a Gold or White health card issued by DVA.

Sources: ABS 2002; AIHW analysis of DoHA unpublished Medicare statistics and DVA data.

Characteristics of GP services

Since 1998 Australia has had ongoing national data available on the types of services provided by GPs, obtained through the Bettering the Evaluation And Care of Health (BEACH) survey. The BEACH survey is part of a continuous study of general practice activity in Australia. It takes a random sample of 1,000 GPs per year and analyses the record details of 100,000 consecutive patient encounters (100 per GP). Details recorded include GP and patient characteristics, encounter details, problems managed and action taken such as referrals, procedures and medications prescribed. The data presented below relate to consultations between April 2000 and March 2001.

Most of the older people seeking GP services did so in relation to recurring problems. On average, 35 new problems were raised per 100 encounters compared with 137 old problems, and, overall, 80% of the problems being managed by GPs in patient encounters related to continuing problems. As can be seen in Figure 28.1, the most common problem managed by general practitioners for both older men and women was hypertension which accounted for 13% of all problems managed for older women and 10% for older men, and was addressed at a rate of 22 per 100 encounters with older women and 17 per 100 encounters with older men (Table A28.1). For women, osteoarthritis was the next most common problem, being managed at a rate of 7 per 100 encounters, while for men diabetes was the second most common problem, also managed at a rate of 7 per 100 encounters. Diseases such as some forms of diabetes and heart disease are preventable. Indeed, 80% of health problems associated with older age are considered to be able to be prevented or postponed, primarily through lifestyle changes (Andrews 2002:15; see also Topic 15: *Risk factors*).

Figure 28.1: Common problems managed for older people by GPs, April 2000 to March 2001

Source: Table A28.1.

29 Use of pharmaceuticals

A national health survey revealed that about 59% of the population had used some form of medication, or medicine used for health or medical reasons, in the fortnight before the survey (ABS 1999:3). The Pharmaceutical Benefits Scheme (PBS), funded by the Commonwealth Government, subsidises the cost of a wide range of drugs. Expenditure under the PBS for people of all ages was $3,522 million in 1999–00 (AIHW 2002b:255; see also Topic 25: *Government expenditure on older people*).

Level of use by older people

The level of use of medications increases with age. Approximately 86% of people aged 65 or over use medications, compared with 59% for the general population. The level of use is slightly higher for older females than for males (87% compared with 84%)—as is the case for the general population (ABS 1999:16–18).

Table 29.1 shows the percentages of older people using one or more types of medication in a fortnight. Only about half of the general population who used medications used more than one type of medication, and about three-quarters used one or two. By contrast, only 17% of those over the age of 85 who used medication only used one type, so that 83% of this population used two or more simultaneously.

Table 29.1: People using medications: number of medications used in a fortnight, by age, 1995 (per cent)

Number of medications	65–74	75–84	85 +	Total (all ages)
One	24.8	23.6	16.6	47.4
Two	24.1	19.8	24.3	25.6
Three	17.9	15.9	20.9	12.4
Four or five	20.1	23.7	22.0	9.9
Six or more	13.1	17.0	16.2	4.6
Total	**100.0**	**100.0**	**100.0**	**100.0**

Source: ABS 1999:5.

Types of medications used by older people

As with use of medications, so too the type of medication used varies with age. Respondents in the health survey were asked to name any medications taken in the past 2 weeks. Most notable is the dramatic increase in use of medications for heart problems beyond the 25–44 age group (2%), reaching almost 50% among people aged 65 and over. Similar though less dramatic increases occur for medication for arthritis, stomach conditions, cholesterol and diabetes, as well as the use of diuretics. Interestingly, while pain relievers were the most commonly used medication across the population (24%), their use declined with age, dropping from 30% in the 25–44 age group, to 19% in people aged 65 and over (ABS 1999:18).

Recent data from the BEACH survey on doctors' prescriptions for older people permit a more detailed look at their use of medications. These data show that older women and men were prescribed medications at similar rates (125 and 118 per 100 encounters, respectively). Moreover, the most common types of medications prescribed to women and men were quite similar, as shown in Table 29.2. For example, antihypertensives were the most frequently prescribed medications for both sexes, and women and men had similar prescription rates (18 and 16 per 100 encounters). Other common medications prescribed to older people included non-steroidal anti-inflammatory drugs, often used for arthritis, and simple analgesics for relieving pain and fever. The prescription rates for antihypertensives were more than double that of the next most common category for both women and men (simple analgesics for women and non-steroidal anti-inflammatory drugs for men).

Anti-depressants and anti-anxiety medications were among the top 15 prescribed medicines for women but not men (see Topic 16: *Mental health*). By contrast, men were more likely to be prescribed bronchodilator or spasm relaxant drugs. Both older women and men had immunisations in the top 10 medications with 4 out of every 100 encounters resulting in a prescription or provision of an immunisation. The majority of these are for protection against influenza, with around 3 per 100 encounters involving prescription or provision of this vaccine. This increase is in keeping with government policy to promote vaccination among older people by providing free flu vaccines through the National Influenza Vaccine Program for Older Australians.

Penicillin and 'other antibiotics' were in the top 15 medications for older men and women, both being prescribed by a GP in around 3 per 100 encounters. In addition, broad spectrum penicillin, although not in the top 15 prescribed medication groups, was prescribed in 2 per 100 encounters for older women and 3 per 100 encounters for older men.

Table 29.2: Top 15 groups of medications prescribed for people aged 65 and over, by sex, April 2000 to March 2001

Medication group	Per 100 encounters
Females	
Antihypertensive	17.6
Simple analgesic	7.6
Non-steroidal anti-inflammatory drugs (NSAIDs)	7.3
Other cardiovascular system drugs[a]	4.7
Diuretic	4.6
Sedative/hypnotics	4.1
Beta-blockers (for cardiovascular problems)	4.0
Immunisation	3.9
Anti-depressant	3.7
Anti-ulcerants	3.6
Hypoglycaemic	3.5
Penicillin/cephalosporins	3.5
Anti-anxiety	3.3
Antiangina	3.1
Other antibiotics[b]	3.1
Total prescribed (all medication groups)	*124.7*
Males	
Antihypertensive	16.2
Non-steroidal anti-inflammatory drugs (NSAIDs)	6.6
Simple analgesic	6.4
Other cardiovascular system drugs[a]	6.2
Hypoglycaemic	4.7
Bronchodilator/spasm relaxant	4.0
Immunisation	3.9
Beta-blockers (for cardiovascular problems)	3.8
Anti-ulcerants	3.7
Diuretic	3.6
Other blood drug[c]	3.5
Antiangina	3.5
Penicillin/cephalosporins	3.0
Sedative/hypnotics	2.9
Other antibiotics[b]	2.8
Total prescribed (all medication groups)	*118.3*

(a) Cardiovascular system drugs other than antihypertensive, antiarrythmic, antiangina, cardiac glycoside, beta-blocker, adrenergic stimulant, peripheral vasodilator, antimigraine and hypolipidaemic agents.

(b) Antibiotics other than penicillin/cephalosporin, broad spectrum penicillin, tetracycline, antifungal, sulphonamide and anti infective.

(c) Blood drugs other than haemopoietic.

Source: Analysis of BEACH data by AIHW General Practice Statistics and Classification Unit.

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Aged care system

30 The Australian aged care system

The aged care system covers services that support people living both in the community and in formal residential aged care. It is underpinned by quality assurance mechanisms and guided by access strategies that are coordinated at the national level and aimed at ensuring appropriate services are available to all older people in need of assistance.

Access and equity

An important consideration in aged care is access to and equity in services. With regard to accessibility in financial terms, residents of aged care services contribute to their accommodation and other living costs according to their capacity to pay. To assist affordability, the maximum fee for pensioners for basic daily care is set at 85% of the Age Pension (DoHA 2002d). In addition, since 1 March 1998, new residents who are part-pensioners or non-pensioners can be asked to pay an additional income tested fee. Services deemed to meet set standards of care and accommodation have the option to charge additional accommodation payments to those residents who have sufficient assets to be able to afford to pay (see Topic 37: *Financing the Australian aged care system*). However, service providers are required to set aside a proportion of places for residents with low assets, for whom the government pays an additional subsidy.

Provision of aged care

Box 30.1 outlines some of the key, government-funded aged care services. Planning of residential care places sets a target of 90 places per 1,000 people aged 70 and over. This is further broken down into 40 high care and 50 low care places per 1,000 people aged 70 and over. In addition, the provision target for Community Aged Care Packages has been set for some years at 10 packages per 1,000 people aged 70 and over. In the 2002–03 Budget the Federal Government committed itself to providing 18 Community Aged Care Packages per 1,000 people aged 70 and over by 2006. Access to residential aged care and to Community Aged Care Packages is determined by Aged Care Assessment Teams (ACATs) which assess medical, physical, psychological and social needs.

Carers of frail or disabled older people (that is, the family members and friends of older people who help them stay at home) are another focus in the aged care system. Current government policy is to support primary carers through information services, respite services and financial assistance. A national network of Commonwealth Carer Resource Centres has been established to provide information and advice to carers. This complements a national network of Commonwealth Carer Respite Centres which assist carers to access the wide range of respite services provided through different programs and by different levels of government. In addition, the Commonwealth Government provides financial support to carers of older people through the Carer Payment (a pension paid to full-time carers) and the Carer Allowance (see Topic 9: *Pensions*).

Commonwealth Carelink Centres have recently been established across Australia to provide information about community and aged care services available in the local region.

Contributors to the aged care system

The success of the Australian aged care system depends on, and is characterised by, a mix of types of provision and a high degree of cooperation between all levels of government, service providers and the community. Much of the residential service provision is undertaken by the non-government sector (88%). State and local governments provide the remaining 12% of aged care services. The roles of each level of government are complementary and delineated to avoid duplication of effort and resources, and the relationship with, and role of, the non-government sector is clearly established.

The non-government sector has a long history in the provision of aged care services. Religious and charitable organisations provided care and accommodation to older people for many years before the introduction of government subsidies for these services. These 'not-for-profit' organisations maintain a strong presence in aged care service provision today. The majority (63%) of all residential care places are provided by not-for-profit organisations, as are many community care services. Private sector involvement in aged care is mostly through high care residential services (formerly known as nursing homes). About 46% of places in these high care facilities are managed by for-profit organisations.

Box 30.1: Elements of the aged care system

Residential aged care provides accommodation and other support services, such as domestic services (laundry, cleaning), help with performing daily tasks (moving around, dressing, personal hygiene, eating) and medical care (various levels of nursing care and therapy services). Residential aged care is for older people with physical, medical, psychological or social care needs which cannot be met in the community. There were approximately 144,000 residential aged care places at 30 June 2001.

Community Aged Care Packages (CACPs) support people who prefer to remain at home but who require care equivalent to low level care provided in residential aged care. A total of 859 organisations provide over 24,000 packages at any one point in time.

The Home and Community Care (HACC) Program provides community-based support services, such as home nursing, personal care, respite, domestic help, meals and transport, to people who can be appropriately cared for in the community and can remain at home. There are about 2,900 organisations providing community care services to some 250,000 older clients over any 3-month period.

Day therapy centres provide a range of services, such as physiotherapy and occupational therapy, to residents of aged care services and people living in the community.

Flexible care services are intended for people whose needs are not easily met in mainstream services. These include **Multipurpose Services** which operate in small rural communities lacking the population to support stand-alone services, and which provide a range of aged care services, including health care.

Extended Aged Care at Home (EACH) Packages support people who prefer to remain at home but who require care equivalent to high level care provided in residential aged care. This fledgling program began as a pilot in 2000, offering care to 300 clients at ten sites across Australia. The Government has recently committed funds to the further development of this program in which EACH places are substituted for residential care places.

Aged Care Assessment Teams (ACATs) are responsible for determining eligibility for residential aged care, CACPs and EACH Packages. They also recommend HACC services. There are 127 ACATs providing services across Australia.

The links between each level of government and the non-government sector are through formal agreements (such as the Home and Community Care Agreements), joint setting of strategic directions and joint planning processes, and consultative mechanisms. Service providers are subject to legally enforceable conditions of grant.

The Commonwealth Government has the major role in funding residential aged care services and Community Aged Care Packages. It establishes the policy directions, in consultation with State and Territory Governments and the aged care industry and consumers, and provides the bulk of the administrative support. The Commonwealth Government is responsible for defining outcome measures and monitoring performance in residential aged care services.

State and Territory Governments have a regulatory role in the residential aged care sector, in areas such as building compliance and fire safety regulations, occupational health and safety requirements and industrial awards. State and Territory Governments administer the Home and Community Care (HACC) program through an agreement with the Commonwealth and directly operate some residential aged care services. State, Territory and Commonwealth Governments jointly fund the HACC program.

Local governments provide some residential aged care services and community care services, as well as having a regulatory role.

31 Assessment

Policy initiatives during the late 1980s led to the creation of a national assessment program for aged care services. The program was to ensure that older people in need of a substantial level of care and support could gain access to the available residential care and community services appropriate to their needs.

Aged Care Assessment Teams

There is currently a network of 127 regionally based multidisciplinary Aged Care Assessment Teams (often referred to as ACATs) providing services across the entire continent (AIHW 2001:214). Some work out of large metropolitan teaching hospitals, others work in rural areas where the 'team' comprises only the community nurse and a part-time clerical assistant. Aged Care Assessment Teams are responsible for determining eligibility for admission to residential aged care and for Community Aged Care Packages (CACPs) and Extended Aged Care at Home (EACH) Packages. They may also recommend a range of Home and Community Care (HACC) services, including the Community Options Program (COP), although they do not determine eligibility for these services. The clients seen by these teams thus include a number of people requiring general advice, referral or some form of assistance in managing their ongoing care in the community.

Assessments and recommendations

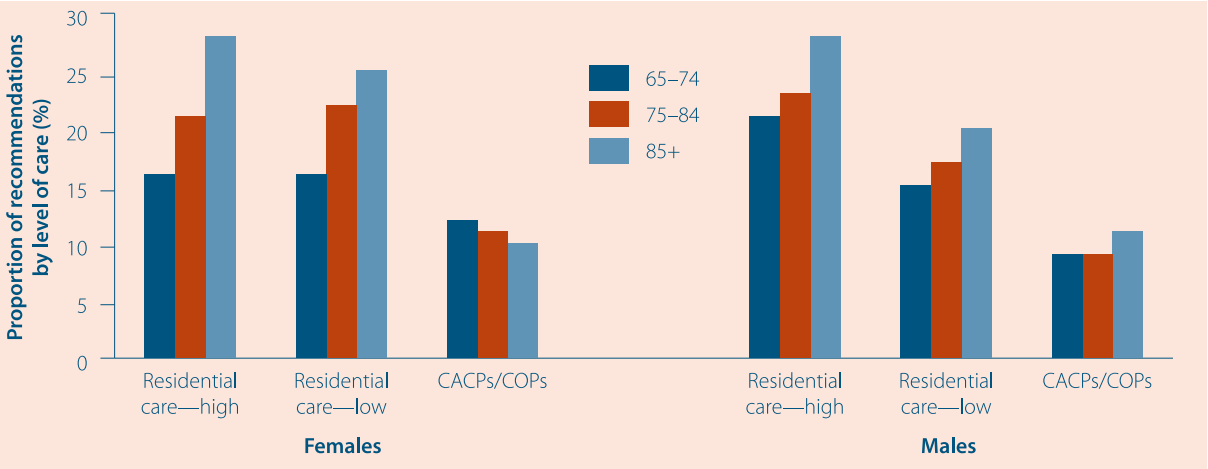
The outcomes of assessments by Assessment Teams during the period January to June 2000 can be seen in Figure 31.1. During this period, 85,444 assessments were undertaken, equivalent to 36 assessments per 1,000 persons aged 65 and over in the Australian population. Just under half (44%) of the clients assessed were recommended for long-term residential care, with slightly more being recommended for high-level care than for low-level care—23% versus 21% (Table A31.1; AIHW 2001:216).

As can be seen from Figure 31.1, the likelihood that some form of residential care would be recommended rose steadily across the three age groups. For women, the proportions needing high-level care were 16%, 21% and 28% for the age groups 65–74, 75–84 and 85+ respectively. The equivalent levels for low-level care were 16%, 22% and 25%. For men, the comparable figures across these age groups were 21%, 23% and 28% for high-level care, and 15%, 17% and 20% for low-level care.

Women were less likely than men to be assessed as requiring high-level care in all except the 85+ age group, where the proportions were similar. Women were more likely than men to be assessed as requiring low-level care in the older two age groups (see Figure 31.1).

Both need and availability of high-care services guide recommendations by ACAT teams. Because of limited availability, only a small proportion of assessments by ACAT teams lead to recommendations for intensive community-based care. Both the availability of, and the number of recommendations for, CACPs have increased over time. Between 1994 and 2000 the proportion of ACAT recommendations for CACPs moved from 2% to 10% of assessments. During this period the proportion of recommendations for residential care remained relatively stable.

Figure 31.1: ACAT assessment recommendations, by age and sex, January–June 2000 (per cent within age-sex group)



Source: Table A31.1.

Not all people assessed by an ACAT and recommended for residential aged care enter a residential service. Some receive recommendations for both residential aged care and a Community Aged Care Package, and take up the latter. Whatever the case, the option to take up the recommendations for residential care remains active for 12 months.

Entry period

If an individual wishes to take up the recommendations by an ACAT team for residential aged care, the number of days between the assessment and when they take up the recommendation is known as the 'entry period'. Entry period differs from waiting time because it can include the period during which the individual is either using other care options or making a decision on their preferred place of care, or indeed on their decision to enter care. In 1999–00 the median entry period was 34 days, but it varied substantially between people admitted for low care (55 days) and those admitted for high care (24 days).

In recent years entry period has been increasing. Analytical work undertaken by the AIHW has shown that a longer entry period was strongly related to whether the resident had used a Community Aged Care Package or residential respite care prior to admission (programs which have been increasing in availability in recent years) (AIHW 2002b). One of the main determinants of a short entry period was whether the resident had an ACAT assessment performed while they were in hospital rather than when they were living at home. Also, the presence of a carer tended to lengthen the entry period. Provision ratios in the region had a negligible effect on length of entry period.

Assessment of disabilities and care needs

Clients suffering from disabilities relating to mobility, continence or orientation were more likely than others to be recommended for residential care. Almost half of the clients who had any one of these disabilities were recommended for high-level residential care (LGC 2000). Table 31.1 shows disability trends in older people assessed by ACATs. In 1999–00 about one-third of those assessed were found to be dependent with respect to mobility, continence or orientation difficulties. For the period 1994–95 to 1999–00, there was no clear change in the dependency profile of ACAT clients as measured by these three items, although there was a modest increase in the proportion who were not fully continent.

Table 31.1: Disability levels in ACAT clients, 1994–95 to 1999–00

Dependency	1994–95	1995–96	1996–97	1997–98	1998–99	1999–00
Mobility						
Walks independently	65.7	65.8	65.6	61.5	64.4	63.9
Does not walk independently	34.3	34.2	34.4	38.5	35.6	36.1
Number assessed	*127,419*	*158,011*	*160,501*	*160,897*	*173,011*	*179,341*
Continence						
Fully continent	65.1	65.5	64.8	61.5	61.5	61.4
Not fully continent	34.9	34.5	35.2	38.5	38.5	38.6
Number assessed	*124,293*	*154,337*	*157,228*	*160,897*	*170,148*	*176,276*
Orientation						
Aware, time & place	66.0	66.2	65.5	68.9	65.7	67.1
Not aware	34.0	33.8	34.5	31.1	34.3	32.9
Number assessed	*125,621*	*154,731*	*158,467*	*160,043*	*169,075*	*174,740*
Total number assessed	**132,957**	**164,862**	**166,410**	**171,660**	**178,915**	**183,572**

Note: Totals for each category exclude unknowns.

Source: AIHW 2001:217.

32 Home and Community Care (HACC) Program

The Home and Community Care (HACC) Program provides a range of community-based care services to people in their homes, and, despite the rapid growth in Community Aged Care Packages in recent years, remains the main provider of home-based care services in Australia. It is funded jointly by the Commonwealth and State and Territory Governments. The HACC program was created via the *HACC Act 1985* following a report of the House of Representatives Standing Committee on Expenditure in 1982 (HRSCE 1982), and brought together into one system a range of separately funded programs.

Since the inception of the HACC program, both the quantity and variety of services have increased substantially, as has government expenditure. Between 1995–96 and 2001–02, expenditure on this program has increased by 45% to $1,012 million. There are now approximately 2,900 service providers across the country who are part of this program (DoHA 2002c).

Client profile

The most recent data on usage of the HACC program come from the new national minimum data set developed by the AIHW, and implemented by HACC officials in June 2001. The HACC program includes as part of its target group younger people with disabilities as well as older people and their carers. In the months July–September 2001, 21% of HACC clients were people aged under 65, including 41,100 females and 26,300 males.

Over the 3-month period, HACC provided services to around 252,700 people aged 65 and over. Among these older clients, over two-thirds were women, with the single biggest group being women aged between 75 and 84 (35% of all older clients) (Table A32.1). People using HACC services have a younger profile than those in either residential aged care or the Community Aged Care Packages. Looking at clients aged 65 and over, only 27% of HACC clients were aged 85 or more,

Table 32.1: Clients aged 65 and over using Home and Community Care services, by age and service type, July–September 2001

	65–74		75–84		85+		Total 65+	
Service type	Clients	Rate per 1,000[a]	Clients	Rate per 1,000[a]	Clients	Rate per 1,000[a]	Clients	Rate per 1,000[a]
Domestic assistance	23,156	17.5	51,497	60.4	27,295	102.5	101,948	41.8
Assessment, case management and case planning[b]	15,872	12.0	29,306	34.4	16,635	62.5	61,813	25.3
Meals[b]	9,771	7.4	26,081	30.6	17,502	65.8	53,354	21.9
Transport services	9,955	7.5	19,851	23.3	10,184	38.3	39,990	16.4
Nursing (home and centre-based)[b]	8,659	6.6	15,630	18.3	10,509	39.5	34,798	14.3
Home maintenance and modification[b]	8,000	6.1	14,936	17.5	6,544	24.6	29,480	12.1
Counselling and social support[b]	6,704	5.1	11,810	13.8	7,048	26.5	25,562	10.5
Centre-based day care	6,168	4.7	10,586	12.4	6,288	23.6	23,042	9.4
Personal care	4,577	3.5	9,767	11.5	8,361	31.4	22,705	9.3
Allied health (home and centre-based)[b]	6,625	5.0	9,643	11.3	5,022	18.9	21,290	8.7
Provision of aids/car modifications[b]	2,029	1.5	3,751	4.4	2,276	8.6	8,056	3.3
Respite care	886	0.7	840	1.0	409	1.5	2,135	0.9
Other services (other food services and linen services)[b]	288	0.2	609	0.7	396	1.5	1,293	0.5
Total	**62,618**	**47.4**	**122,955**	**144.2**	**67,805**	**254.7**	**253,378**	**103.8**

(a) Usage rate per 1,000 people in the population in the age group.

(b) Service type includes more than one service category. Clients are only counted once per service type.

Notes

1 For the July–September 2001 quarter, 75% of agencies submitted data.

2 Excludes a small number of cases with age missing.

Source: AIHW analysis of HACC minimum data set.

compared with 36% of people using Community Aged Care Packages and 50% of those in permanent residential aged care (see Topics 33 and 34, *Community Aged Care Packages* and *Residential aged care: resident profiles*).

Service provision

Table 32.1 shows that, during July–September 2001, assistance with domestic chores was the service used by the largest number of older HACC clients and that the rate of usage of all services increased substantially with age. So too did the range of services, with older people much more likely than younger people to require assessment, management and planning of their requirements, assistance with meals, transport, nursing, home maintenance, counselling, and personal care. Overall, out of every 1,000 people aged 85 and over, 255 were using HACC services. The corresponding usage rate for people aged 65–74 and 75–84 were 47 and 144 per 1,000 people, respectively.

While domestic assistance is the most commonly used service it does not involve the most hours of assistance. Among the 102,000 HACC clients aged 65 and over who used this service, half received 9 hours or less of domestic assistance during the 3 months from July to September 2001. Centre-based day care, which was used by only 9% (23,000) of clients, involved the most time per client among the services offered by the program: 50% of those older HACC clients using the centres did so for 46 hours or more during the 3 months.

Half of all 53,400 older HACC clients receiving meals were provided with 36 meals or more over the 3 months of the collection. Transport services were used by 40,000 clients with a median of 10 one-way trips every 3 months. While services classified as assessment, case management and case planning were used by 61,800 clients aged 65 and over, in 50% of cases this involved 2 hours or less over the 3-month period (see Table 32.1 and Table 32.2).

For most service types the amount of service provided did not vary much with the age of the client. However, the hours of service provided for centre-based day care, and counselling and social support increased with age. So too did the number of meals and transport services provided. In contrast, the median number of hours of respite care decreased with the increasing age of the client, noting that for respite care the usual carer is considered the recipient of the HACC service (Table 32.2).

Table 32.2: Median volume of Home and Community Care services used, by age and type of service, July–September 2001

Type of service (unit of measure)	65–74	75–84	85+	Total 65+
Home modification ($)	75	80	65	75
Meals (meals)[a]	25	35	39	36
Linen services (deliveries)	13	13	12	13
Transport services (one-way trips)	9	10	12	10
Provision of aids/car modifications (number)[a]	1	1	1	1
Centre-based day care (hours)	40	48	50	46
Respite care (hours)	24	20	18	21
Personal care (hours)	12	12	12	12
Domestic assistance (hours)	9	9	9	9
Other food services (hours)	10	8	8	8
Counselling and social support (hours)[a]	4	5	6	5
Nursing (home and centre-based) (hours)[a]	4	5	5	5
Assessment, case management and case planning (hours)[a]	2	2	2	2
Home maintenance (hours)	2	2	2	2
Allied health (home and centre-based) (hours)[a]	1	1	1	1

(a) Service type includes more than one service category. Amount of service provided is the sum of all contributing service categories.

Notes

1 For the July–September 2001 quarter, 75% of agencies submitted data.

2 'Median' is the value of an item such that half the clients are below this value and half are above it. Median measures refer only to those clients who used that particular type of service in the 3-month period.

3 Table includes a small proportion of clients with very heavy reported use. These are unlikely to affect the median value.

Source: AIHW analysis of HACC minimum data set.

33 Community Aged Care Packages

Community Aged Care Packages (CACPs) is a Commonwealth-funded program. The program began in 1992 as an alternative to low-level residential aged care. It provides home-based care to frail or disabled older people living in the community.

Growth in demand for CACP

The CACP program has grown rapidly since its inception, from 235 packages in 1992 to 4,431 in 1996, and to 24,630 at 30 June 2001 (Figure 33.1). This last figure equates to 14.2 packages per 1,000 persons aged 70 and over. There were 859 service outlets providing these packages throughout Australia as at 30 June 2001.

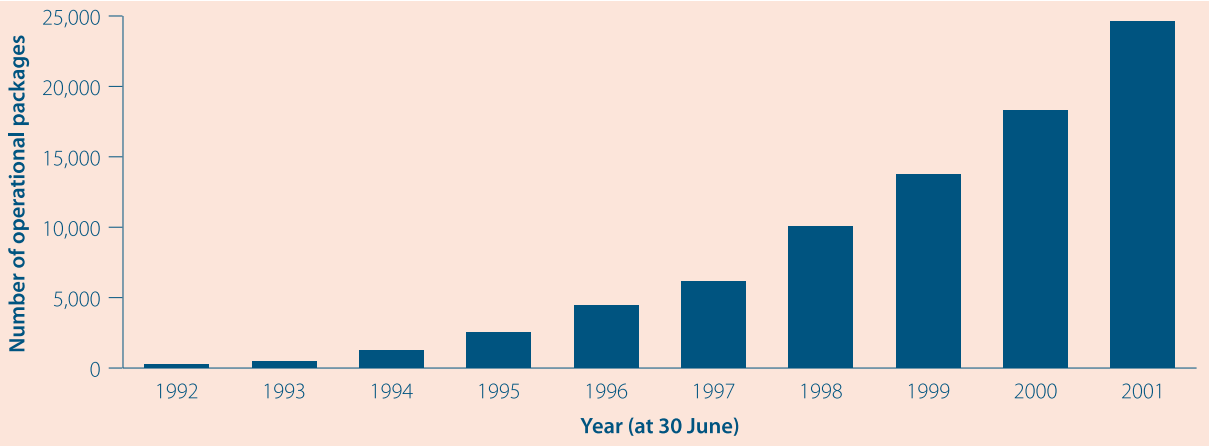
In the 2002–03 Budget it was announced that the Federal Government will provide $68.8 million for an additional 6,000 CACPs over the next 4 years, increasing the number of packages to 18 packages per 1,000 persons aged 70 and over by 2006.

Profile of CACP recipients

At 30 June 2001, a large proportion of CACP program recipients were aged 85 years and over (36%), with 2.3% aged 95 years or more. Around 7% of package recipients were aged under the age of 65, while only 1% were under the age of 50. Female recipients predominated in all age groups, varying from 55% of all recipients aged under 50 years to 73% of all recipients aged 85 years and over. Over half (57%) of all package recipients were women aged 75 years or over (Table 33.1).

The majority of CACP recipients lived alone (56% of cases with known living arrangements) or with their spouse only (27%). A further 8% lived with their child, or child and child's family. Almost three-quarters of care recipients owned their own home (73% of those with housing circumstances reported), while 14% lived in public rental housing. The remainder lived in a private rental property (8%) or were boarding or lodging (5%) (AIHW 2002a:6).

Figure 33.1: Number of Community Aged Care Packages, 1992–2001



Source: Table A33.1.

Table 33.1: Community Aged Care Package recipients, by age and sex, 30 June 2001

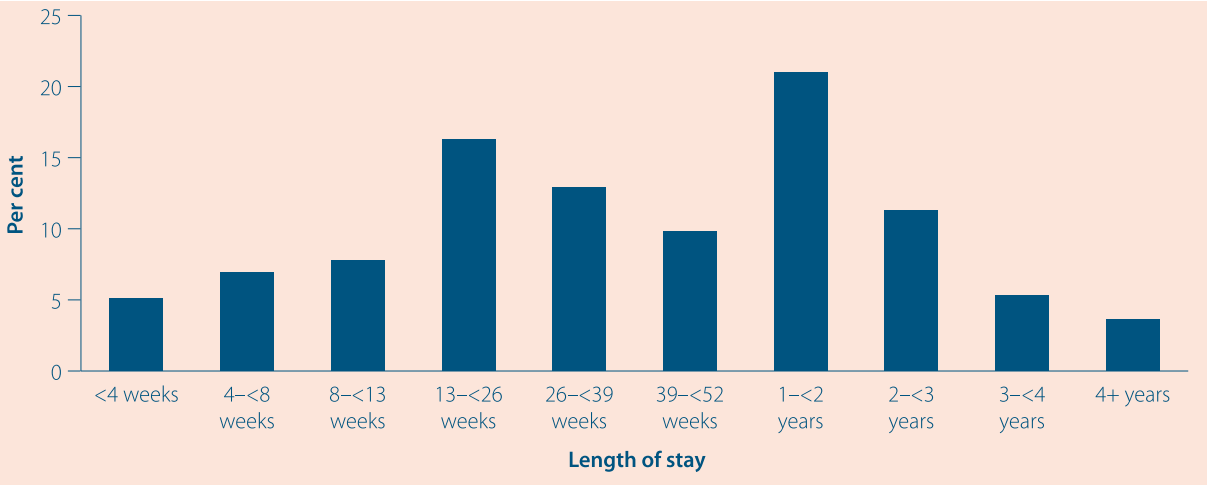
	Females		Males		Persons	
Age	Number	Per cent	Number	Per cent	Number	Per cent
0–49	109	0.7	90	1.5	199	1.0
50–54	101	0.7	88	1.4	189	0.9
55–59	187	1.3	147	2.4	334	1.6
60–64	360	2.5	284	4.6	644	3.1
65–69	679	4.7	396	6.5	1,075	5.2
70–74	1,418	9.7	731	11.9	2,149	10.4
75–79	2,681	18.4	1,054	17.2	3,735	18.0
80–84	3,624	24.8	1,337	21.8	4,961	23.9
85–89	3,527	24.2	1,250	20.4	4,777	23.0
90–94	1,562	10.7	635	10.4	2,197	10.6
95+	354	2.4	114	1.9	468	2.3
Total	**14,602**	**100.0**	**6,126**	**100.0**	**20,728**	**100.0**

Source: AIHW 2002a:19–20.

CACP separations

Of those care recipients who left the program in 2000–01, 46% entered a residential aged care service, while 21% died. The proportion of men who ceased receiving the service and entered a residential aged care service was lower (40% of male care recipients) than that for women (48%). Conversely, there was a higher proportion of deaths among men (27%) than among women (17%). Many of the care recipients leaving the program had been clients for more than 1 year (41%); 9% had used a package for 3 years or more (Figure 33.2).

Figure 33.2: Length of time with a Community Aged Care Package, 30 June 2001



Source: Table A33.2.

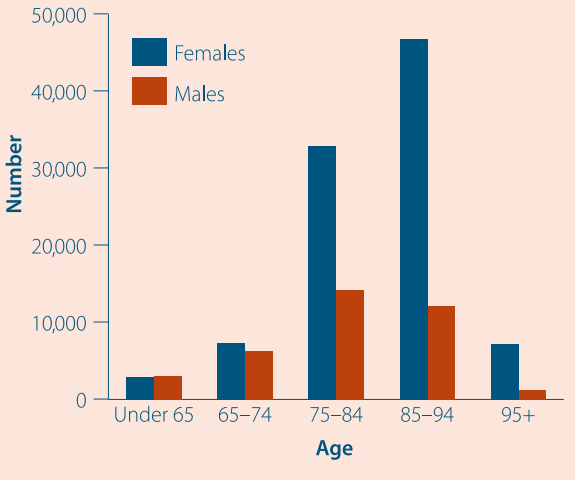
34 Residential aged care: resident profiles

Prior to 1 October 1997, the Australian system of residential aged care consisted of two discrete systems of care—hostels (for lower dependency residents) and nursing homes (for higher dependency residents). As part of the Federal Government's 1997 aged care reforms, hostels and nursing homes were amalgamated into one residential care system.

Residents

At 30 June 2001, there were 134,004 permanent residents and 2,604 respite residents in residential aged care. Around 72% of permanent residents were women. By far the majority of permanent residents were aged 75 years or over (85%); indeed, 50% were aged 85 and over, and 6% were 95 and over. The numbers in the 65–74 age group were similar for both sexes, with the proportion who were women increasing substantially in the 75–84 and 85 and over age categories. At 30 June 2001 there were 5,948 residents of aged care services who were under age 65. This equates to 4% of all permanent residents. Of these, just under one half (48%) were women (Figure 34.1).

Figure 34.1: Permanent residents in residential aged care, by age, 2001



Source: Table A34.1.

Most residents in aged care were widowed at the time they entered the aged care service (57%). However, this was due to the predominance of widows among female residents (67% of women were widows while only 30% of men were widowers). By contrast, relatively more men than women in residential aged care were married or in a de facto relationship (39% of men, 16% of women), single (16% of men, 9% of women) or divorced (7% of men, 3% of women) (AIHW 2002c:31).

A large majority of residents in aged care were born in Australia (75%), with much of the remainder comprising those born in the United Kingdom and Ireland (11%) and the rest of Europe (8%) (AIHW 2002c:37–8). Given the increasing diversity in the origins of older people, these proportions could be expected to change over the coming decade (see Topic 2: *The changing demographic profile*: 1991–2021).

There were also 681 Indigenous Australians in mainstream permanent residential aged care. This may be an underestimate, however, as 9.1% of residents (12,198 people) did not report their Indigenous status (AIHW 2002c:33). At 30 June 2001, there were 23 services receiving flexible funding under the Aboriginal and Torres Strait Islander Aged Care Strategy, providing 297 places. There were also 56 Multipurpose Services providing 1,089 residential care places to people in rural and remote communities (AIHW 2002b:1).

Needs of residents in aged care

The Resident Classification Scale (RCS) provides a measure of resident dependency. The level of Commonwealth care subsidy to services is based on the level of care need indicated by each resident's score on this scale. Table 34.1 shows that, at 30 June 2001, the proportion of permanent residents classified as high care (RCS 1 to 4) was 63%, with the remainder in the low-care category. The lowest level of care needs (RCS 8) contained less than 2% of residents on 30 June 2001.

Younger residents demonstrated a slightly higher level of dependency than older residents. For example, 71% of those under 65 were in RCS categories 1 to 4 compared with 63% overall. Among older residents, those aged 95 years and over were most likely to be in the high-dependency category; 69% of those in this age group were in RCS categories 1 to 4. There were few differences between male and female residents in relation to dependency levels.

Table 34.1. Permanent residents, by age and level of dependency, 30 June 2001

Age	High dependency (RCS 1–RCS 4)	Low dependency (RCS 5–RCS 8)	Total (RCS 1–RCS 8)
		Number	
Under 65	4,150	1,727	5,877
65–69	2,735	1,428	4,163
70–74	6,101	3,116	9,217
75–79	11,897	6,229	18,126
80–84	17,384	10,666	28,050
85–89	20,891	14,134	35,025
90–94	14,052	8,867	22,919
95+	5,679	2,603	8,282
Total	**82,889**	**48,770**	**131,659**
		Per cent	
Under 65	70.6	29.4	100.0
65–69	65.7	34.3	100.0
70–74	66.2	33.8	100.0
75–79	65.6	34.4	100.0
80–84	62.0	38.0	100.0
85–89	59.6	40.4	100.0
90–94	61.3	38.7	100.0
95+	68.6	31.4	100.0
Total	**63.0**	**37.0**	**100.0**

Source: AIHW 2002c:77.

Residents' need for different types of assistance over the past 3 years is shown in Table 34.2. Assistance with personal hygiene and communication were both reported as being needed by over 90% of permanent residents over the 1999 to 2001 period. There has also been an increase in the proportion of residents needing assistance for bowel management, from 68% in 1999 to 77% in 2001. There have been slight, but steady, increases in the proportions of residents needing assistance in the remaining categories.

Table 34.2: Permanent aged care residents: need for at least some assistance with selected dependency items, 30 June 1999 to 2001

Type of assistance	1999	2000	2001
Personal hygiene	92.2	92.8	93.2
Communication	90.8	91.6	93.0
Understanding and undertaking living activities	83.2	85.1	86.3
Mobility	82.8	82.9	83.5
Bowel management	67.5	73.1	77.2
Meals and drinks	75.9	75.5	76.5
Bladder management	64.5	65.9	67.2

Note: Percentages include individuals who require any level of assistance for a particular function.

Source: AIHW analysis of DoHA database.

35 Residential aged care: patterns of use

Only a small proportion of the older population of Australia is in residential aged care at any time, and this proportion has decreased over time. In 1992 it was 5.6% of the population aged 65 and over; in 2001 it was 5.2%. However, the absolute number is growing. In 1998, there were 125,402 older people in permanent residential aged care. By June 2001, this had grown to 128,056 older people (AIHW 1999; AIHW 2002c). These measures refer to a particular point in time; however, over an individual lifetime, the probability of using residential aged care is much higher. The probability of someone in the community aged 65 entering permanent residential aged care is 28% for men and 46% for women. These probabilities increase with age (Mason et al. 2001).

Use by age and sex

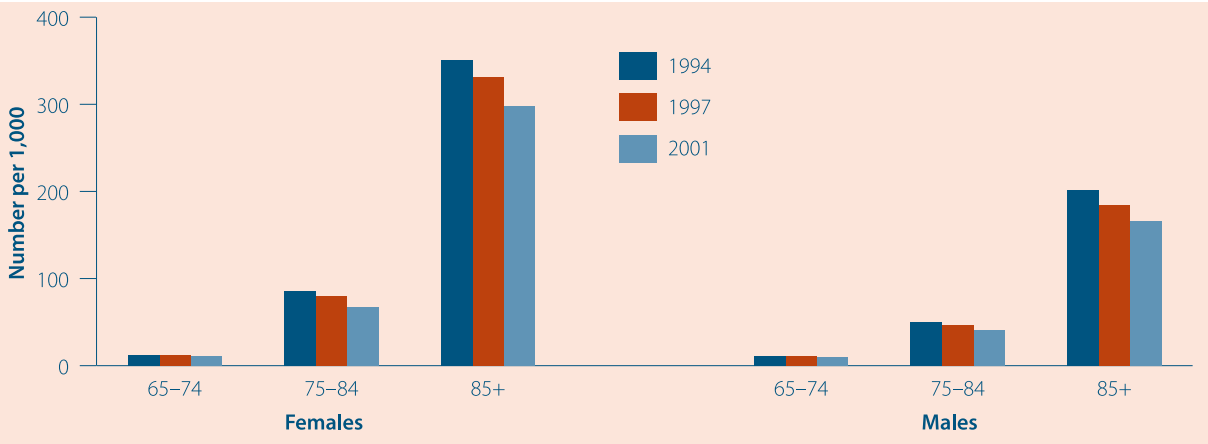
Rates of use of residential aged care are relatively high at older ages, with 166 per 1,000 men and 298 per 1,000 women aged 85 and over being residents, compared with 10 per 1,000 men and 11 per 1,000 women aged 65–74, in 2001. The usage of residential aged care is higher for women than men, as shown in Figure 35.1. The figure shows similar patterns of usage of residential aged care in the 65–74 age group for both men and women. However, at older ages the use by women is substantially higher than that by men. There has been a major change in the pattern of use of residential aged care since 1994, particularly in the older groups. In the 85 and over age group, rates of use have declined by 15% for women and 17% for men.

Patterns of use by dependency

A review of the aged care reforms published in 2001 found that, in the 2 years following the 1997 reforms, access to residential aged care appeared to increase for those needing high levels of care. Access for middle levels of care remained stable, while access for lower levels of care has changed variably (Gray 2001:46). Due to the lack of comparable data prior to and following the reforms, assessing the impact of the changes across this period is difficult. Nevertheless, since the 1997 reforms, the increasing rates of dependency of those in residential aged care appears to be confirmed using the Resident Classification Scale (RCS) data (AIHW 2001:240).

Table 35.1 shows the changes in the distribution of residents across the eight RCS categories between 1998 and 2001. The most dramatic change in usage can be seen in the RCS 1 category, requiring greatest levels of care, which has more than doubled between 1998 and 2001, from 7% to 17%. At the other end of the scale, those categories needing least care (RCS 7 and RCS 8) have declined from 20% to 15% and from 5% to 2%, respectively.

Figure 35.1: Age- and sex-specific usage rates for residents of residential aged care, 30 June 1994, 1997 and 2000



Source: Table A35.1.

Table 35.1: Permanent aged care residents, by level of dependency at 30 June 1998 to 2001 (per cent)

Year	RCS 1	RCS 2	RCS 3	RCS 4	RCS 5	RCS 6	RCS 7	RCS 8	Total
1998	6.9	24.9	20.3	5.7	7.7	9.7	20.3	4.5	100.0
1999	12.4	25.9	17.9	4.6	8.6	10.1	17.4	3.1	100.0
2000	14.4	26.0	16.7	4.7	8.9	10.3	16.8	2.3	100.0
2001	17.3	25.5	15.6	4.7	9.9	10.6	14.9	1.7	100.0

Notes

1 RCS is the Resident Classification Scale (dependency increases with decreasing RCS classification).

2 In 1998, 1999, 2000 and 2001, there were 1,767, 3,865, 3,071 and 2,345 residents respectively whose dependency levels were not recorded in the databases.

3 The 1998 data only covered half a year, from 1 January to 30 June 1998.

Sources: AIHW 2001:240; AIHW 2002c:76.

Length of stay

Since the reform of the aged care system in 1997 there has been an increase in average length of stay in residential aged care (AIHW 2001:228). The number of residents staying in residential aged care for 5 years or more has increased, from 17% in 1999 to 23% in 2001. The proportion of shorter stays has decreased over the same period (Table 35.2). These changes in patterns of use have moved the length of stay towards the longer end of the spectrum. As at 30 June 2001, close to one-quarter of permanent residents had already stayed 5 years or more (23%) and almost three-quarters had stayed 1 year or more (74%).

Table 35.2: Length of stay to date by people in permanent residential aged care as at 30 June 1999, 2000 and 2001 (per cent)

Length of stay	1999	2000	2001
<4 weeks	3.0	2.5	2.7
4–13 weeks	5.8	4.8	4.8
13–26 weeks	7.8	6.1	6.4
26–52 weeks	13.8	11.9	12.1
1–2 years	20.5	18.2	18.0
2–3 years	14.6	14.5	13.6
3–5 years	17.7	20.1	19.6
5 years or more	16.8	21.9	22.7
Total (number)	**132,420**	**133,387**	**134,004**

Sources: AIHW 1999; AIHW 2000; AIHW 2002c.

Supply of residential aged care

At 30 June 2001, there were 2,977 residential aged care services providing 144,013 aged care places. This equates to 83.3 places per 1,000 persons aged 70 and over. Although the absolute number of places has been steadily increasing over recent years, the ratio of places per 1,000 persons aged 70 and over has been decreasing. Table 35.3 shows that places have increased by 5% since 1996, from 136,851 places to 144,013 places, while over the same period the ratio of supply has declined from 90.6 to 83.3 places per 1,000 people aged 70 and over.

Table 35.3: Operational aged care places, at 30 June 1996 to 2001

Year	Aged care type	Number of places	Places per 1,000 persons aged 70+
1996	Hostels	62,471	41.4
	Nursing homes	74,380	49.2
	Residential aged care [a]	*136,851*	*90.6*
1997	Hostels	64,825	41.7
	Nursing homes	74,233	47.7
	Residential aged care [a]	*139,058*	*89.4*
1998	Residential aged care	139,917	87.4
1999	Residential aged care[b]	141,698	86.3
2000	Residential aged care[b]	142,342	84.5
2001	Residential aged care[b]	144,013	83.3

(a) Residential aged care combines nursing homes and hostels; from 1 October 1997 nursing homes and hostels were combined into one residential care system.

(b) Includes places provided by Multipurpose Services and services receiving flexible funding under the Aboriginal and Torres Strait Islander Aged Care Strategy.

Sources: AIHW 2001:223; AIHW 2002c:2, 21.

36 Respite care

With the increasing trend towards home-based care and away from residential care, respite care has emerged as an important area of service provision. This has been evident in a number of government policy initiatives, such as the announcement of the National Respite for Carers Program in the 1996–97 Budget, and with respite care being a key component of the Staying at Home measures announced in the 1998–99 and 2002–03 Budgets.

Respite care provides carers and care recipients with a break from usual care arrangements. Residential aged care services offer short-term care in a residential setting. Community-based respite care includes a range of services such as day care centres, in-home respite, activity programs and flexible residential respite in community-based facilities. Under the National Respite for Carers Program, Commonwealth Carer Respite Centres and Commonwealth Carer Resource Centres have been established which provide carers with information, support, and assistance in finding respite services in their local area. It was announced in the Federal 2002–03 Budget that an extra $30 million will be spent on support for carers of older people, including respite care, over the next 4 years.

Residential respite care

Residential respite care is recognised as an important component of the carer support system, whether for emergency care, to provide a 'break' while carers attend to other affairs or take a holiday, or for instances where carers themselves encounter health, personal or family problems. There were 43,606 admissions to residential respite care during the period from 1 July 2000 to 30 June 2001. Of these admissions, 27,382 (63%) were for women. Around 6% of all persons admitted for respite care were aged under 65. The age group 75–84 accounted for the largest number of admissions (42%) during the year (Table 36.1).

The number of days of residential respite supplied has steadily increased over the last decade, as has the proportion of residential care days used for respite care. Total respite days increased from 337,020 in the year ending 30 June 1991 to 985,905 in the year ending 30 June 2001; this is an average annual percentage increase of 11.3%. The increase was most pronounced during the period from 1991 to 1996 (averaging 19% per annum), but since then growth in the program has slowed (the average increase between 1996 and 2001 was 4.2% per annum) and was even seen to reverse between 1999 and 2000. The number of residential respite bed-days provided fell marginally (the only time this decade) between 1999 and 2000: from 980,545 to 978,408 (0.2% decrease in total days), then increased to 985,905 in 2001. As a percentage of total residential care bed-days, respite care increased from 0.8% in 1991 to 1.7% in 1996, and then to 2.0% in 1999, remaining at that figure in 2000 and 2001 (AIHW 2001; AIHW 2002c).

Table 36.1: Respite admissions to residential aged care, by sex and age at admission, 1 July 2000 to 30 June 2001

Age	Females	Males	Persons
		Number	
Under 65	1,264	1,374	2,638
65–74	3,070	3,249	6,319
75–84	11,132	6,990	18,122
85–94	11,065	4,362	15,427
95+	851	249	1,100
Total	**27,382**	**16,224**	**43,606**
		Per cent	
Under 65	4.6	8.5	6.0
65–74	11.2	20.0	14.5
75–84	40.7	43.1	41.6
85–94	40.4	26.9	35.4
95+	3.1	1.5	2.5
Total	**100.0**	**100.0**	**100.0**

Source: AIHW analysis of DoHA data.

The policy target for residential respite is generally regarded as the equivalent of 2 places per 1,000 persons aged 70 and over. Converting place days used to places at the rate of 365 days per annum gives a usage figure of 0.72 places per 1,000 people aged 70 and over in 1991, rising to 1.64 places in 1999, then falling to 1.56 places in 2001.

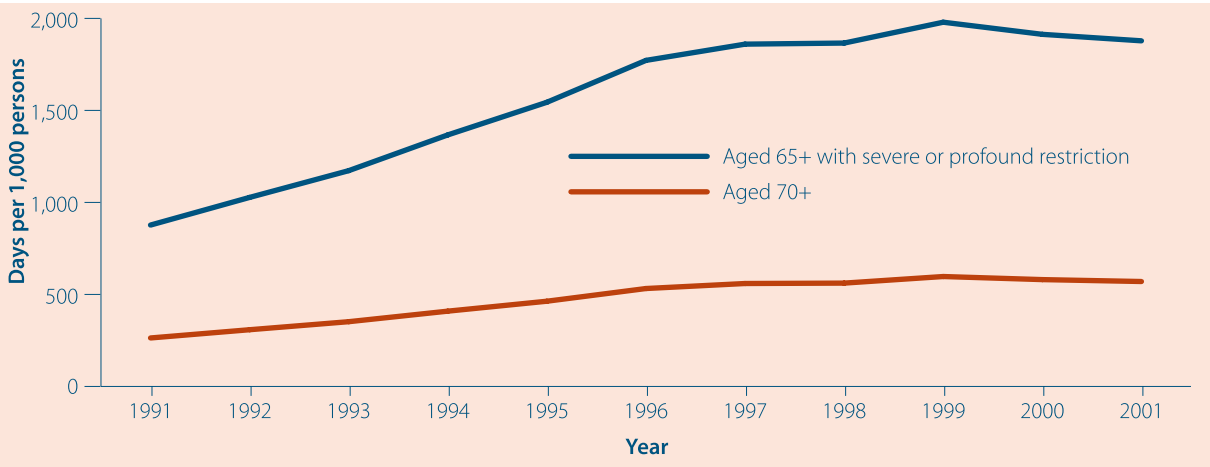
These data on available respite can also be considered in relation to the population aged 70 years and over and the population aged 65 years and over with a severe or profound restriction. In 1990–91, 877 days of residential respite were provided per 1,000 people aged 65 and over with a severe or profound restriction.

By 2000–01 this figure had increased to 1,878 days of residential respite per 1,000 people aged 65 and over with a severe or profound restriction. Comparing provision with the population aged 70 and over, the ratio of residential respite provision increased from 263 days per 1,000 people aged 70 and over in 1990–91 to 570 days per 1,000 people aged 70 and over in 2000–01 (Figure 36.1).

Community-based respite care

Respite care in the community is largely provided through the Home and Community Care (HACC) Program and the Community Aged Care Package Program, although the Federal Government also funds, through the National Respite for Carers Program, some 400 respite services targeted at carers. Over the last decade there has been substantial growth in the provision of in-home respite care under the HACC program. There has been a 23% increase in respite provision in the home in relation to the population aged 65 and over with a profound or severe restriction since 1993–94. Indeed, in-home respite and centre-based day care are the only areas of HACC where growth in program hours has outpaced growth in the population aged 65 and over with a profound or severe restriction in recent years. During July–September 2001, HACC provided respite services to 2,100 people aged 65 years and over, with half of these people receiving at least 21 hours of respite care over the 3 month period. HACC also provided centre-based day care (which is often called centre-based respite care) to 23,000 clients, and half of these people had at least 46 hours of such care over the 3 months. These HACC data provide for the first time an indication of the number of clients using services, so historical comparisons are not yet possible (AIHW 2002c; see Topic 32: *Home and Community Care (HACC) Program*). Although respite care is provided under the Community Aged Care Package program, currently no data are available about the level of specific services received by care package recipients. The ratio of care package provision, however, has increased substantially from its beginnings in 1992, and has continued to expand rapidly in recent years in line with policy (see Topic 33: *Community Aged Care Packages*).

Figure 36.1: Occupied residential aged care respite days, per 1,000 persons in population, 30 June 1991 to 2001



Source: Table A36.1.

37 Financing the Australian aged care system

Overall sources of funding

Overall, the largest source of funds for the aged care system is the Commonwealth Government, which has primary responsibility for funding residential aged care. It also provides funding for a number of programs, including Community Aged Care Packages, Multipurpose Services, Aged Care Assessment Teams, and the Home and Community Care (HACC) Program. The latter program is cost-shared with State and Territory Governments with contributions from local government. State and Territory Governments also provide some funding for other areas of aged care, including residential aged care and assessment services.

Governments are not the only source of funding in the aged care system. The users themselves meet some of the cost. For example, residents of aged care services, who can afford to do so, contribute to the cost of their care through a daily care fee. User charges also contribute to the funding of community care services. Importantly, the charitable sector also provides a substantial contribution to the aged care system and includes the active participation of a large volunteer labour force, augmenting the services provided by paid staff.

Residential aged care services

The cost of the residential aged care system is met by a combination of Commonwealth funding and resident contributions. Specifically, the Commonwealth Government pays a subsidy to service providers for each day that a bed is occupied.

Recurrent Commonwealth payments to residential aged care services are calculated on the basis of the level of care needs of each resident. After assessment, each resident's level of care need is recorded using the Resident Classification Scale. Residents classified as having greater care needs according to this scale attract a larger government subsidy.

The maximum basic daily care fee for residents who are pensioners or part-pensioners is 85 per cent of the full rate Age Pension ($24.63 per day as at 1 July 2002). The maximum basic daily care fee for non-pensioners was $30.76 per day on 1 July 2002. Residents may also pay additional income-tested fees, based on their private income. Residents with a private income in excess of the income test free area for the pension (currently $56 per week for a single pensioner) can be asked to pay an income-tested fee of 25 cents in the dollar up to a maximum of three times the pensioner daily rate less their basic daily care fee, or the cost of care, whichever is the lower (DoHA 2002a).

Residential aged care service providers who meet prescribed building and care standards are able to charge accommodation payments. Residents who enter residential care at a low level of care or at an extra service basis may be asked to pay an accommodation bond. The quantum and timing of the bond is agreed between the service provider and the resident at the time of entry. Service providers are able to draw down up to $2,952 per year from the bond for a maximum of 5 years and they retain interest earned on the principal for the duration of the resident's stay (DoHA 2002b).

Residents who enter permanent care for high-level care pay an accommodation charge, which is payable for up to 5 years, of up to $13.45 per day on a means-tested basis. Residents can only be asked to pay the maximum of $13.45 per day if their assets are over $51,000 (DoHA 2002a).

Not all residents of aged care are required to pay accommodation payments. Services are required to set aside a proportion of places for concessional (financially disadvantaged) residents, for whom the Commonwealth Government pays a higher subsidy. Further, accommodation payment arrangements require that a resident be left with at least the equivalent of 2.5 times the Age Pension (currently $26,500) in assets after paying. If an incoming resident leaves either a partner or dependent child in the family home, the home is exempt from consideration as an asset. The home may also be exempt in certain situations for residents who leave close relatives or a carer in the family home.

Community care

As discussed above, funding of the Home and Community Care Program (HACC) is shared by the Commonwealth and State and Territory Governments. To provide an additional source of funding and to address inter- and intrastate inequities in HACC user charges, the Commonwealth Government announced

in 1996 that a national fees policy would be implemented in consultation with State and Territory Governments. This policy is intended to ensure the fair and consistent treatment of HACC clients across Australia and to protect people on low incomes and those who need a number of services. Future growth in the program funding will be maintained at 6%, taking into account the expected increased level of user charges.

Community Aged Care Packages are funded on a flat amount per client per day ($29.79 as at 1 July 2002), which is approximately $10,900 per year for each occupied care package. Clients are charged depending on income, with people on the full pension paying no more than 17.5% of their income. There are requirements for providers to allocate packages to financially disadvantaged clients, and these currently make up approximately 35% of clients.

Expenditure in respect of carers has grown significantly in the last few years under programs that have a specific carers focus. Financial support through the Carer Allowance for older people has grown from $144.2 million in 1998–99 to $268.9 million in 1999–00 due to an increase in the rate of the allowance (AIHW 2001:244).

38 Expenditure on aged care

Changes in the allocation of resources among residential aged care and community care are an important measure of changing patterns of service provision. In current prices, expenditure on aged care and related services in 1999–00 was $4,839.9 million. Residential aged care services attracted by far the largest component of aged care funding, at $3,741.3 million (77%).

Increases in aged care expenditure

Total recurrent expenditure on aged care services in constant price terms increased from $3,572.8 million in 1995–96 to $4,735.7 million in 1999–00, an increase of 33% (Table 38.1).

Residential care expenditure continues to dominate overall expenditure on aged care programs. Between 1995–96 and 1999–00, recurrent expenditure on residential care increased by 28% in constant price terms (Table 38.1). However, the proportion of total aged care expenditure directed to residential care decreased from 80% to 77%, consistent with government policy to support people in their own homes by directing additional resources to the community care sector. Over the same period, expenditure on Community Aged Care Packages increased more than fourfold, but the increase was from a relatively small base, so that this program accounted for only 3% of the total expenditure on aged care programs in 1999–00. Similarly, while expenditure on the Carer Allowance (previously the Domiciliary Nursing Care Benefit) increased by almost 180% in constant terms over the period, it also remained at less than 3% of total expenditure. The proportion of aged care expenditure allocated to aged care assessment remained relatively constant over the period (1%), while that for Home and Community Care (HACC) dropped marginally from 16% to 15%.

Table 38.1: Recurrent aged care expenditure in current and constant (1998–99) dollars, by program, 1995–96 to 1999–00

Program	1995–96	1996–97	1997–98	1998–99	1999–00
			Current prices ($million)		
Residential aged care services	2,695.0	2,997.0	3,381.0	3,584.0	3,741.3
Home and Community Care[a]	554.0	615.6	630.2	673.4	722.4
Assessment	38.2	38.4	39.8	38.6	40.1
Community Aged Care Packages	33.1	51.6	84.1	121.8	148.9
Multi-purpose flexible services	12.8	17.7	25.3	29.4	38.7
DNCB[b]/Carer Allowance[c]	46.7	51.9	52.9	71.6	140.8
Accreditation	—	—	5.1	5.9	7.8
Total	**3,379.8**	**3,772.2**	**4,218.3**	**4,524.7**	**4,839.9**
			Constant prices ($million)[d]		
Residential aged care services	2,848.8	3,112.1	3,460.6	3,584.0	3,660.7
Home and Community Care[a]	585.7	639.3	645.0	673.4	706.8
Assessment	40.4	39.9	40.7	38.6	39.2
Community Aged Care Packages	35.0	53.6	86.1	121.8	145.7
Multi-purpose flexible services	13.5	18.4	25.8	29.4	37.9
DNCB[b]/Carer Allowance[c]	49.4	53.9	54.1	71.6	137.8
Accreditation	—	—	5.2	5.9	7.6
Total	**3,572.8**	**3,917.2**	**4,317.6**	**4,524.7**	**4,735.7**
Annual increase (%)	**..**	**9.6**	**10.2**	**4.8**	**4.7**

(a) Includes expenditure on the National Respite for Carers Program.

(b) Domiciliary Nursing Care Benefit.

(c) Carer Allowance estimated according to the proportion of recipients aged 65 or more years.

(d) The 1998–99 Government Final Consumption Expenditure (GFCE) deflator has been used to calculate constant prices.

Source: AIHW 2001:243.

Per person expenditure

Expenditure on a per capita basis provides an indication of levels of service provision in relation to the size of the aged population. In Australia, both the number of older people, and the proportion who are aged 85 and over, have been growing quite rapidly in recent years. Indeed, the last decade has seen the fastest rates of growth since 1900 in the population aged 85 and over (among whom aged care service use is concentrated); this rate of growth will not be equalled until 2021 (see Topic 2: *The changing demographic profile: 1991–2021*).

Between 1995–96 and 1999–00, in constant terms, aged care expenditure per person aged 65 and over with a profound or severe handicap increased by 18% (Table 38.2). However, most of this rise occurred between 1995–96 and 1997–98, with the increases being relatively small in 1998–99 and 1999–00. In constant prices, aged care expenditure per person aged 65 and over with a profound or severe handicap in 1999–00 was $9,244—an increase of 1.4% from 1998–99.

Table 38.2: Recurrent aged care expenditure per person with a profound or severe core activity restriction, by program, 1995–96 to 1999–00 (in constant 1998–99 dollars)

Program	1995–96	1996–97	1997–98	1998–99	1999–00
Residential aged care services	6,266	6,639	7,179	7,220	7,145
Home and Community Care[a]	1,288	1,364	1,338	1,357	1,380
Assessment	89	85	85	78	77
Community Aged Care Packages	77	114	179	245	284
Multi-purpose flexible services	30	39	54	59	74
DNCB[b]/Carer Allowance[c]	109	115	112	144	269
Accreditation	—	—	11	12	15
Total	**7,858**	**8,357**	**8,956**	**9,115**	**9,244**
Annual increase (%)	**..**	**6.4**	**7.2**	**1.8**	**1.4**

(a) Includes expenditure on the National Respite for Carers Program.

(b) Domiciliary Nursing Care Benefit.

(c) Carer Allowance estimated according to the proportion of recipients aged 65 or more years.

Source: Revised from AIHW 2001:244.

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Appendix tables

Appendix tables

Table A1.1: Selected countries of birth of overseas-born Australians, by age, 2001

Country of birth	65–74	75–84	85+	65–74	75–84	85+	Total
	Proportion of immigrant age group (%)			Number of migrants			
Main English-speaking countries	35.5	41.6	50.2	160,200	107,900	37,100	305,200
Italy	14.2	11.3	10.5	64,000	29,300	7,800	101,000
Greece	7.0	3.2	3.4	31,500	8,400	2,500	42,400
Germany	4.4	3.9	2.7	20,000	10,200	2,000	32,100
Netherlands	3.7	3.8	3.4	16,600	10,000	2,500	29,000
Poland	1.9	5.4	3.3	8,600	13,900	2,400	24,900
China	3.0	2.9	3.2	13,600	7,500	2,400	23,600
India	1.7	1.7	1.6	7,900	4,300	1,200	13,400
Former Yugoslavia (nfd)	1.9	1.5	1.0	8,800	3,800	700	13,300
Malta	1.9	1.3	0.9	8,600	3,500	700	12,800
Other	24.7	23.4	19.8	111,500	60,700	14,600	186,800
Total overseas-born	**100.0**	**100.0**	**100.0**	**451,200**	**259,400**	**73,900**	**784,600**

Notes

1 'nfd' means not further defined.

2 Main English-speaking countries include New Zealand, United Kingdom, Ireland, United States of America, Canada and South Africa.

Source: Gibson et al. 2001.

Table A2.1: Population aged 65 and over, by cultural and linguistic background, 1996 to 2021 (projected)

Cultural and linguistic background	1996	2001	2006	2011	2016	2021
Culturally and linguistically diverse backgrounds	392,800	479,400	567,900	653,800	780,700	871,000
Main English–speaking countries	288,700	305,200	336,600	388,100	458,700	497,700
Australian born	1,521,400	1,591,200	1,681,600	1,864,900	2,178,800	2,549,600
Total	**2,203,000**	**2,375,800**	**2,586,100**	**2,906,700**	**3,418,200**	**3,918,200**

Note: Main English-speaking countries include New Zealand, United Kingdom, Ireland, United States of America, Canada and South Africa.

Source: Gibson et al. 2001.

Table A3.1: Living arrangements of older people, by age, 2001 (projected)

Living arrangement	65–74	75+	Total
Lone person	301,200	390,900	692,000
Couple without children	725,800	390,800	1,116,600
Member of a family	225,200	136,700	361,900
With unrelated person(s)	22,700	12,300	35,000
Non-private dwelling	26,300	155,100	181,400
Total	**1,301,200**	**1,085,800**	**2,386,900**

Source: AIHW analysis of ABS household and family projections (see also Series B ABS 1999b:56).

Table A3.2: Persons aged 65 and over with a severe or profound core activity restriction, by sex, age and living arrangements, 1998

Age/sex	Live in a non-private dwelling	Live in households		Total
		With others	Alone	
		Number		
Females				
65–74	13,800	47,100	20,600	81,500
75–84	42,900	49,400	37,100	129,400
85+	62,800	27,000	18,200	108,000
Total	*119,500*	*123,400*	*75,900*	*318,900*
Males				
65–74	9,200	44,800	5,500	59,600
75–84	18,700	37,500	7,900	64,000
85+	17,000	13,100	8,600	38,700
Total	*44,900*	*95,500*	*22,000*	*162,300*
Persons				
65–74	23,000	91,900	26,200	141,000
75–84	61,600	86,900	45,000	193,500
85+	79,800	40,100	26,800	146,700
Total	**164,400**	**218,900**	**97,900**	**481,200**
		Per cent		
Females				
65–74	16.9	57.8	25.3	100.0
75–84	33.2	38.2	28.7	100.0
85+	58.2	25.0	16.8	100.0
Total	*37.5*	*38.7*	*23.8*	*100.0*
Males				
65–74	15.4	75.2	9.3	100.0
75–84	29.2	58.5	12.3	100.0
85+	43.9	34.0	22.1	100.0
Total	*27.6*	*58.8*	*13.5*	*100.0*
Persons				
65–74	16.3	65.2	18.6	100.0
75–84	31.9	44.9	23.2	100.0
85+	54.4	27.4	18.2	100.0
Total	**34.2**	**45.5**	**20.3**	**100.0**

Source: AIHW analysis of ABS 1998 Survey of Disability, Ageing and Carers.

Table A4.1: Proportion of population aged 65 and over, by selected OECD country, 1960 to 2000 (per cent)

Country	1960	1980	2000
Sweden	12.0	16.3	17.4
United Kingdom	11.7	15.1	16.0
Norway	11.1	14.8	15.5
Canada	7.5	9.4	12.8
United States	9.2	11.2	12.5
Australia	*8.5*	*9.6*	*12.1*
New Zealand	8.6	10.0	11.7
Korea	3.3	3.8	6.7
Mexico	4.6	3.8	4.7
Turkey	3.5	4.7	5.8
Japan	5.7	9.0	17.1
OECD average	**8.6**	**10.8**	**13.0**

Source: OECD 2000 Tables 2 and 4.

Table A4.2: Age-related public expenditure as a percentage of GDP, by OECD country, 2000 and 2020[a]

Country	2000	2020
Australia	16.7	17.6
Austria[b]	10.4	12.5
Belgium	22.1	23.9
Canada	17.9	20.6
Czech Republic	23.1	23.4
Denmark[c]	29.3	34.5
Finland	19.4	22.8
France	n.a.	n.a.
Germany	n.a.	n.a.
Hungary[d]	7.1	5.7
Italy	n.a.	n.a.
Japan	13.7	16.0
Korea	3.1	5.7
Netherlands[e]	19.1	23.0
New Zealand	18.7	20.4
Norway	17.9	24.0
Poland[d]	12.2	9.3
Portugal[f]	15.6	20.4
Spain	n.a.	n.a.
Sweden	29.0	29.4
United Kingdom	15.6	15.4
United States	11.2	13.3
Average[g]	**16.9**	**18.7**

(a) Table includes public expenditure on old-age pensions, 'early retirement' programs, health care, long-term care, child/family benefits, and education. Countries presenting data on old-age pension spending only, including Mexico and Turkey, are not included.

(b) Total pension spending includes other age-related spending which does not fall within the definitions. This represents 0.9 per cent of GDP in 2000 and is projected to rise by 0.1 percentage point in the period to 2050.

(c) Total includes other age-related spending not classifiable under the other headings. This represents 6.3 per cent of GDP in 2000 and is projected to increase by 0.2 percentage points from 2000 to 2050.

(d) Total includes old-age pension spending and 'early retirement' programs only.

(e) "Early retirement" programs only include spending on persons 55+.

(f) Portugal provided an estimate for total age-related spending but did not provide expenditure on individual spending components other than old-age pensions.

(g) OECD average excludes countries where information is not available and Portugal which is less comparable than other countries.

Source: Dang et al. 2001:48.

Table A5.1: Main activities[a] of people, by sex, 1997

	Hours:minutes per day		Proportion of day (%)	
Purpose of activities (major level)	**65+**	**All 15+**	**65+**	**All 15+**
Females				
Personal care	11:51	11:11	49.4	46.6
Employment related	*0:05	2:12	*0.3	9.2
Education	—	0:28	—	1.9
Domestic	3:34	2:57	14.9	12.3
Child care	0:05	0:45	0.3	3.1
Purchasing goods and services	0:48	0:54	3.3	3.8
Voluntary work and care	0:28	0:24	1.9	1.7
Social and community interaction	0:43	0:48	3.0	3.3
Recreation and leisure[a]	6:17	4:17	26.2	17.8
Undescribed	0:07	0:05	0.5	0.3
Total	*24:00*	*24:00*	*100.0*	*100.0*
Males				
Personal care	11:55	10:58	49.7	45.7
Employment related	0:28	4:21	1.9	18.1
Education	—	0:24	—	1.7
Domestic	2:45	1:34	11.5	6.5
Child care	0:03	0:16	0.2	1.1
Purchasing goods and services	0:49	0:35	3.4	2.4
Voluntary work and care	0:30	0:19	2.1	1.3
Social and community interaction	0:41	0:43	2.8	3.0
Recreation and leisure[a]	6:40	4:46	27.8	19.9
Undescribed	0:07	0:05	0.5	0.3
Total	*24:00*	*24:00*	*100.0*	*100.0*
Persons				
Personal care	11:53	11:05	49.5	46.2
Employment related	0:15	3:16	1.0	13.6
Education	—	0:26	—	1.8
Domestic	3:13	2:16	13.4	9.4
Child care	0:04	0:31	0.3	2.2
Purchasing goods and services	0:49	0:45	3.4	3.1
Voluntary work and care	0:29	0:22	2.0	1.5
Social and community interaction	0:42	0:45	2.9	3.1
Recreation and leisure[a]	6:27	4:31	26.9	18.8
Undescribed	0:07	0:05	0.5	0.3
Total	**24:00**	**24:00**	**100.0**	**100.0**

(a) Includes interaction with pets.

*Subject to a relative standard error greater than 25%. These estimates should be interpreted accordingly.

Source: ABS 1998a:55.

Table A5.2: Leisure time dedicated to specific activities, by age and sex, 1997

Purpose of activities	Females		Males		Persons	
	65+	All 15+	65+	All 15+	65+	All 15+
	Free time (hours:minutes per day)[a]					
Reading	0:54	0:26	0:59	0:24	0:56	0:25
Audio/visual media	*3:04*	*1:58*	*3:29*	*2:25*	*3:15*	*2:11*
Watching TV	2:40	1:42	3:03	2:06	2:50	1:54
Other audio/visual	0:24	0:16	0:26	0:19	0:25	0:17
Resting/ relaxing/ doing nothing	0:31	0:14	0:29	0:12	0:30	0:13
Social and community interaction	0:43	0:48	0:41	0:43	0:42	0:45
Other	1:48	1:37	1:43	1:44	1:46	1:41
Total free time[b]	**7:00**	**5:04**	**7:21**	**5:28**	**7:09**	**5:16**
	Free time (per cent)					
Reading	12.9	8.6	13.4	7.3	13.1	7.9
Audio/visual media	*43.8*	*38.8*	*47.4*	*44.2*	*45.5*	*41.5*
Watching TV	38.1	33.6	41.5	38.4	39.6	36.1
Other audio/visual	5.7	5.3	5.9	5.8	5.8	5.4
Resting/relaxing/doing nothing	7.4	4.6	6.6	3.7	7.0	4.1
Social and community interaction	10.2	15.8	9.3	13.1	9.8	14.2
Other	25.7	31.9	23.4	31.7	24.7	32.0
Total free time[b]	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Average time estimates include time spent on communication for the specific activity.

(b) Includes interaction with pets.

Source: ABS 1998b: 41, 55.

Table A6.1: Persons aged 45 and over retired from full-time work at age 45 or more: reason for retirement, by sex, November 1997

Reason for retirement	Females	Males	Persons	Females	Males	Persons
	Number			Per cent		
Lost job	277,700	531,800	809,500	31.8	44.1	38.9
Unsatisfactory work arrangements/pay/hours	14,700	10,500	25,200	1.7	0.9	1.2
Reached appropriate age for retirement/too old	114,900	215,700	330,600	13.2	17.9	15.9
Reached compulsory retirement age (in that job)	96,100	256,200	352,300	11.0	21.2	16.9
Wanted to work part-time or full-time work too stressful	48,500	13,900	62,400	5.6	1.2	3.0
Early retirement package/eligible for superannuation	20,600	80,000	100,600	2.4	6.6	4.8
To pursue leisure activities	36,600	21,700	58,300	4.2	1.8	2.8
To get married	13,000	—	13,000	1.5	—	0.6
Pregnancy/to have children	9,400	—	9,400	1.1	—	0.5
To coincide with partner's retirement	36,900	1,600	38,500	4.2	0.1	1.9
To look after family, house or someone else	106,900	19,500	126,400	12.2	1.6	6.1
To have holiday/move house/spouse transferred	54,100	16,200	70,300	6.2	1.3	3.4
Business closed or sold for other than economic reasons	28,300	20,100	48,400	3.2	1.7	2.3
Other	28,700	18,400	47,100	3.3	1.5	2.3
Total	**873,700**	**1,205,800**	**2,079,500**	**100.0**	**100.0**	**100.0**

Source: ABS 1998c.

Table A7.1: Reasons for volunteering, major categories by age group, 2000 (per cent of volunteers)

Reason	18–54	55–64	65+
Help others/community	44.5	53.2	54.2
Personal satisfaction	40.6	46.6	50.9
To do something worthwhile	27.8	33.2	35.1
Social contact	16.0	18.5	27.5
To be active	9.6	11.2	19.1
Religious beliefs	11.3	17.2	17.2
Personal/family involvement	34.7	19.6	13.7
To learn new skills	8.1	*4.2	*2.5

*Subject to a relative standard error greater than 25%. These estimates should be interpreted accordingly.

Note: Volunteers may give more than one reason. Therefore figures for individual categories will not add to 100%.

Source: ABS 2001:12, 20.

Table A8.1: Main source of income, by income range for income units with reference person aged 65 years and over, 1999–00 (income units)

Gross weekly income ($)	Government pensions and allowances	Superannuation	Earned income[a]	Other[b]	Total
<200	406,200	*5,000	*5,800	26,300	[c]457,200
200–399	662,300	36,700	*7,600	43,000	749,600
400–599	116,900	47,700	*16,800	32,600	214,000
600–799	*7,200	*20,000	*8,800	*13,500	49,500
800 or more	*5,200	25,400	39,600	63,900	134,100
Total	**1,197,800**	**134,700**	**78,700**	**179,400**	**1,604,500**
Total (%)	**74.7**	**8.4**	**4.9**	**11.2**	**100.0**

(a) Includes wage and salary and income from own business.

(b) Includes investments, property and other sources of income.

(c) Includes zero and negative incomes.

*Subject to a relative standard error greater than 25%. These estimates should be interpreted accordingly.

Source: Unpublished data from the ABS Survey of Income and Housing Costs 1999–00.

Table A9.1: Qualification ages for the Age Pension for females

Date of birth		
From	To	Qualification age
July 1935	December 1936	60.5
January 1937	June 1938	61.0
July 1938	December 1939	61.5
January 1940	June 1941	62.0
July 1941	December 1942	62.5
January 1943	June 1944	63.0
July 1944	December 1945	63.5
January 1946	June 1947	64.0
July 1947	December 1948	64.5

Note: A decimal of .5 denotes 6 months.

Source: DFaCS 2002.

Table A9.2: Care recipients being cared for by a person receiving the Carer Allowance, by age and sex, 30 March 2002

Age	Females	Males	Persons	Females	Males	Persons
		Number			Per cent all of care recipients	
0–24	52,310	93,418	145,728	18.2	32.4	50.6
25–34	3,810	4,405	8,215	1.3	1.5	2.9
35–44	5,001	5,470	10,471	1.7	1.9	3.6
45–54	6,809	8,585	15,394	2.4	3.0	5.3
55–64	9,527	13,897	23,424	3.3	4.8	8.1
65–74	12,679	16,191	28,870	4.4	5.6	10.0
75–84	18,455	18,878	37,333	6.4	6.6	13.0
85–89	7,384	4,710	12,094	2.6	1.6	4.2
90+	4,718	1,936	6,654	1.6	0.7	2.3
Total	**120,693**	**167,490**	**288,183**	**41.9**	**58.1**	**100.0**

Source: Centrelink unpublished data.

Table A9.3: Carer Allowance recipients, by age and sex, 5 April 2002

Age	Females	Males	Persons
0–24	3,613	961	4,574
25–34	39,312	3,205	42,517
35–44	75,422	7,612	83,034
45–54	42,375	9,359	51,734
55–64	27,801	10,938	38,739
65–74	20,125	10,413	30,538
75–84	12,235	8,904	21,139
85–89	1,057	1,456	2,513
90+	335	321	656
Total	**222,275**	**53,169**	**275,444**

Source: Centrelink unpublished data.

Table A10.1: Households where the reference person is aged 65 or over, by tenure and housing costs as a proportion of income, 1999 (per cent)

Housing costs as a proportion of income	Owners			Renters					
	Without a mortgage	With a mortgage	Total owners	Public housing	Private landlord	Total renters[a]	Rent-free	Other tenure[b]	Total
25% or less	93.1	76.2	92.0	78.7	19.1	53.6	96.4	91.2	86.7
From 25% to 30%	1.3	7.4	1.7	12.9	9.5	11.0	3.6	1.4	3.0
From 30% to 40%	1.9	7.5	2.2	5.9	25.7	13.8	—	4.6	3.9
From 40% to 50%	1.4	2.0	1.5	0.9	22.3	10.8	—	0.8	2.7
50% or more	2.3	6.9	2.6	1.5	23.3	10.8	—	2.0	3.7
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**1,186,700**	**82,900**	**1,269,700**	**103,900**	**88,300**	**210,300**	**15,400**	**26,000**	**1,521,300**

(a) Includes 'other renter'.

(b) Includes life tenure and rent/buy (or shared equity) schemes.

Source: AIHW analysis of ABS 1999 Australian Housing Survey.

Table A12.1: Self-rated health, by age and sex, 1997 (per cent)

	Females				Males			
Rating	**45–54**	**55–64**	**65–74**	**75+**	**45–54**	**55–64**	**65–74**	**75+**
Excellent/very good	58.2	48.7	41.2	38.2	54.7	45.0	36.8	34.6
Good	26.7	31.9	35.5	29.0	28.9	30.7	33.3	31.2
Fair/poor	15.2	19.4	23.3	32.8	16.4	24.2	30.0	34.2
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Source: AIHW analysis of ABS 1997 National Survey of Mental Health & Wellbeing; AIHW 2002a:13.

Table A13.1: Life expectancy at birth and at age 65, by sex, 1901 to 2001 (years)

	Females		Males	
Year	**At birth**	**At age 65**	**At birth**	**At age 65**
1901–10	58.8	77.9	55.2	76.3
1920–22	63.3	78.6	59.2	77.0
1932–34	67.1	79.2	63.5	77.4
1946–48	70.6	79.4	66.1	77.2
1953–55	72.8	80.0	67.1	77.3
1960–62	74.2	80.7	67.9	77.5
1965–67	74.2	80.7	67.6	77.2
1970–72	74.8	81.1	68.1	77.4
1975–77	76.6	82.1	69.6	78.1
1980–82	78.3	83.0	71.2	78.8
1985–87	79.2	83.6	72.7	79.6
1990–92	80.4	84.3	74.3	80.4
1995–97	81.4	84.9	75.7	81.2
2001	81.9	85.2	76.5	81.6

Source: Australian Government Actuary Life Tables 1995–97.

Table A14.1: Age-specific DALYs,[a] 1996 (per 1,000 population)

Age group	Females	Males
0–4	90.4	121.0
5–14	27.8	30.0
15–24	75.0	84.9
25–34	59.9	72.1
35–44	72.2	87.5
45–54	102.1	125.4
55–64	179.8	256.2
65–74	298.4	439.0
75+	615.3	735.9

(a) Disability-Adjusted Life Year.

Source: AIHW Burden of Disease database.

Table A15.1: Definitions of health risk factors

Risk factor	Definition
Overweight	Body mass index (BMI) greater than or equal to 25 where BMI is calculated as weight (kg) divided by height squared (m^2).
High blood pressure	Systolic blood pressure greater than or equal to 140 mmHg and/or diastolic blood pressure greater than or equal to 90 mmHg and/or receiving treatment for high blood pressure.
High blood cholesterol	Above 5.5 mmol/L.
Impaired glucose tolerance	Fasting plasma glucose concentration of less than 7.0 mmol/L, and between 7.8 and 11.1 mmol/L 2 hours after an oral glucose load (75g).
Tobacco smoking	The daily smoking of tobacco products, including packet cigarettes, roll-your-own cigarettes, pipes and cigars.
Risky alcohol consumption	Alcohol consumption on at least a monthly basis that is risky or high risk for short-term harm. Such consumption is defined as at least 5 (women) or 7 (men) standard drinks per drinking occasion.
Physical inactivity	Less than 150 minutes of physical activity for recreation or exercise in the previous week.

Table A16.1: People with dementia, by age, 30 June 2000 to 2020 (projected)

Age	2000	2005	2010	2015	2020
65–69	9,500	10,500	12,600	16,200	17,500
70–74	17,500	17,300	19,200	23,200	29,900
75–79	28,100	29,900	29,900	33,400	40,600
80–84	33,400	42,400	45,500	45,900	51,900
85+	58,400	67,600	83,900	96,200	102,800
Total	**146,800**	**167,600**	**191,100**	**214,900**	**242,600**

Source: AIHW analysis based on prevalence estimates derived by Jorm et al. 1987.

Table A16.2: Prevalence of mental disorders,[a] by age and sex, 1997 (per cent)

Age/sex	Anxiety disorders[b]	Affective disorders[c]	Substance use disorders[d]	Total population
Females				
18–24	13.8	10.7	10.6	896,500
25–34	12.4	8.4	7.0	1,427,900
35–44	14.5	8.5	4.5	1,423,000
45–54	15.9	7.3	3.2	1,168,500
55–64	9.5	6.9	*1.2	777,500
65+	5.4	2.4	**0.2	1,144,300
Total	*12.1*	*7.4*	*4.5*	*6,837,700*
Males				
18–24	8.6	2.9	21.5	921,900
25–34	7.1	4.9	15.6	1,405,800
35–44	8.3	6.0	12.0	1,401,100
45–54	8.0	5.4	7.4	1,189,300
55–64	6.1	3.2	5.2	781,200
65+	3.5	*0.8	2.1	927,800
Total	*7.1*	*4.2*	*11.1*	*6,627,100*
Persons				
18–24	11.2	6.7	16.1	1,818,300
25–34	9.8	6.6	11.3	2,833,800
35–44	11.4	7.2	8.2	2,824,100
45–54	11.9	6.4	5.3	2,357,800
55–64	7.8	5.0	3.2	1,558,600
65+	4.5	1.7	1.1	2,072,100
Total	**9.7**	**5.8**	**7.7**	**13,464,800**

(a) During 12 months prior to interview.

(b) Includes panic disorder, agoraphobia, social phobia, generalised anxiety disorder, obsessive-compulsive disorder and post-traumatic stress disorder.

(c) Includes depression, dysthymia, mania, hypomania and bipolar affective disorder.

(d) Includes alcohol harmful use, alcohol dependence, harmful drug harmful use and drug dependence.

* Subject to a relative standard error between 25% and 50%. These estimates should be interpreted accordingly.

** Subject to a relative standard error greater than 50%. These estimates should be interpreted accordingly.

Note: A person may have more than one mental disorder.

Source: ABS 1998b:19.

Table A17.1: Disability status of older people, by age and sex, 2001

Age/sex	Activity restriction				Without specific activity restriction	Total disabled	Total population
	Mild	Moderate	Severe or profound	Total			
				Number			
Females							
65–74	104,900	63,900	80,200	248,900	34,100	283,000	674,600
75–84	96,500	43,600	141,500	281,600	12,700	294,400	487,100
85+	13,300	12,400	124,400	150,200	1,700	151,900	180,400
Total	*214,700*	*119,900*	*346,100*	*680,700*	*48,600*	*729,300*	*1,342,200*
Males							
65–74	114,700	64,600	60,200	239,600	51,200	290,800	626,900
75–84	76,600	44,500	72,200	193,300	21,500	214,900	350,900
85+	14,000	8,600	46,400	69,000	800	69,800	82,200
Total	*205,300*	*117,800*	*178,800*	*501,900*	*73,600*	*575,500*	*1,060,000*
Persons							
65–74	219,600	128,500	140,400	488,500	85,200	573,800	1,301,500
75–84	173,100	88,000	213,800	474,900	34,300	509,200	838,000
85+	27,300	21,100	170,800	219,200	2,600	221,800	262,700
Total	**420,000**	**237,700**	**524,900**	**1,182,600**	**122,100**	**1,304,700**	**2,402,100**
				Per cent			
Females							
65–74	15.5	9.5	11.9	36.9	5.1	42.0	100.0
75–84	19.8	9.0	29.0	57.8	2.6	60.4	100.0
85+	7.4	6.9	69.0	83.3	0.9	84.2	100.0
Total	*16.0*	*8.9*	*25.8*	*50.7*	*3.6*	*54.3*	*100.0*
Males							
65–74	18.3	10.3	9.6	38.2	8.2	46.4	100.0
75–84	21.8	12.7	20.6	55.1	6.1	61.2	100.0
85+	17.0	10.5	56.4	83.9	1.0	84.9	100.0
Total	*19.4*	*11.1*	*16.9*	*47.3*	*6.9*	*54.3*	*100.0*
Persons							
65–74	16.9	9.9	10.8	37.5	6.5	44.1	100.0
75–84	20.7	10.5	25.5	56.7	4.1	60.8	100.0
85+	10.4	8.0	65.0	83.4	1.0	84.4	100.0
Total	**17.5**	**9.9**	**21.9**	**49.2**	**5.1**	**54.3**	**100.0**

Note: Based on 1998 disability rates.

Sources: AIHW analysis of ABS 1998 Survey of Disability, Ageing and Carers; ABS 2002a:18.

Table A17.2: Causes of disability in older people with a profound or severe core activity restriction, 1998

Condition	Females	Males	Persons
		Number	
Arthritis	118,600	43,300	161,900
All other diseases and conditions	59,900	55,100	115,000
Other musculoskeletal	59,000	32,200	91,200
Other circulatory	42,700	31,000	73,800
Dementia and Alzheimer's	44,200	19,000	63,200
Disease of eye	25,300	15,900	41,200
Stroke	25,700	14,200	40,000
Respiratory	15,200	22,500	37,700
Nervous system	13,200	16,900	30,100
Disease of ear	10,600	13,000	23,500
Other psychiatric	14,700	6,600	21,400
Intellectual and 'Other mental'	2,700	2,600	5,300
Head or brain injury	2,200	1,000	3,300
Total	**434,200**	**273,400**	**707,600**
		Per cent	
Arthritis	27.3	15.8	22.9
All other diseases and conditions	13.8	20.2	16.3
Other musculoskeletal	13.6	11.8	12.9
Other circulatory	9.8	11.3	10.4
Dementia and Alzheimer's	10.2	6.9	8.9
Disease of eye	5.8	5.8	5.8
Stroke	5.9	5.2	5.7
Respiratory	3.5	8.2	5.3
Nervous system	3.0	6.2	4.3
Disease of ear	2.4	4.8	3.3
Other psychiatric	3.4	2.4	3.0
Intellectual and 'Other mental'	0.6	1.0	0.7
Head or brain injury	0.5	0.4	0.5
Total	**100.0**	**100.0**	**100.0**

Source: AIHW analysis of ABS 1998 Survey of Disability, Ageing and Carers.

Table A18.1: People aged 65 and over needing assistance and living in households, whether need for assistance was met, by type of assistance required and sex, 1998

Assistance required	Extent to which need met				Per cent of older people				
	Fully	Partly	Not at all	Total		Fully	Partly	Not at all	Total
Females			Number					Per cent (row)	
Personal activities[a]									
Self-care	80,900	*3,100	10,300	94,300	8.1	85.8	*3.3	10.9	100.0
Mobility	148,400	26,500	*8,200	183,100	15.8	81.1	14.5	*4.5	100.0
Communication	12,000	n.p.	**1,600	14,500	1.3	82.8	n.p.	**11.0	100.0
Health care	193,000	23,100	11,800	227,900	19.7	84.7	10.1	5.2	100.0
All needing assistance with personal activities[b]	*162,200*	*31,600*	*13,000*	*206,800*	*17.8*	*78.4*	*15.3*	*6.3*	*100.0*
Transport	243,500	25,000	37,500	306,000	26.4	79.6	8.2	12.3	100.0
Paperwork	82,700	*3,300	**1,700	87,700	7.6	94.3	*3.8	**1.9	100.0
Housework	239,900	39,800	10,800	290,500	25.1	82.6	13.7	3.7	100.0
Property maintenance	331,800	64,400	19,600	415,800	35.9	79.8	15.5	4.7	100.0
Meal preparation	83,800	*6,300	**2,000	92,100	7.9	91.0	*6.8	**2.2	100.0
All needing assistance with at least one activity[b]	*390,300*	*170,000*	*18,500*	*578,800*	*49.9*	*67.4*	*29.4*	*3.2*	*100.0*
Males									
Personal activities[a]									
Self-care	52,400	*4,700	*3,600	60,600	6.4	86.5	*7.8	*5.9	100.0
Mobility	75,400	*8,400	*8,100	91,900	9.7	82.1	*9.1	*8.8	100.0
Communication	12,300	n.p.	**1,500	13,800	1.5	89.1	n.p.	**10.9	100.0
Health care	127,100	10,900	10,100	148,100	15.7	85.8	7.4	6.8	100.0
All needing assistance with personal activities[b]	*86,900*	*14,500*	*10,400*	*111,800*	*11.8*	*77.7*	*13.0*	*9.3*	*100.0*
Transport	122,500	9,400	15,900	147,900	15.7	82.8	6.4	10.8	100.0
Paperwork	48,700	*3,500	*4,300	56,500	6.0	86.2	*6.2	*7.6	100.0
Housework	96,000	11,000	*6,400	113,400	12.0	84.7	*9.7	5.6	100.0
Property maintenance	153,700	43,000	13,700	210,300	22.3	73.1	20.5	6.5	100.0
Meal preparation	47,300	**1,800	**1,000	50,100	5.3	94.4	**3.6	**2.0	100.0
All needing assistance with at least one activity[b]	*204,300*	*88,600*	*16,200*	*309,000*	*32.7*	*66.1*	*28.7*	*5.2*	*100.0*
Persons									
Personal activities[a]									
Self-care	133,300	*7,800	13,900	155,000	7.4	86.0	*5.0	9.0	100.0
Mobility	223,800	34,800	16,300	275,000	13.1	81.4	12.7	5.9	100.0
Communication	24,400	n.p.	*3,100	28,300	1.3	86.2	n.p.	*11.0	100.0
Health care	320,100	34,000	21,900	376,000	17.9	85.1	9.0	5.8	100.0
All needing assistance with personal activities[b]	*249,000*	*46,200*	*23,400*	*318,600*	*15.1*	*78.2*	*14.5*	*7.3*	*100.0*

/ continued

Table A18.1 (continued)

	Extent to which need met								
Assistance required	Fully	Partly	Not at all	Total	Per cent of older people	Fully	Partly	Not at all	Total
Transport	366,000	34,500	53,400	453,900	21.6	80.6	7.6	11.8	100.0
Paperwork	131,400	*6,800	*6,100	144,300	6.9	91.1	*4.7	4.2	100.0
Housework	335,900	50,800	17,200	403,900	19.2	83.2	12.6	4.3	100.0
Property maintenance	485,500	107,400	33,200	626,100	29.8	77.5	17.2	5.3	100.0
Meal preparation	131,100	*8,100	*3,000	142,200	6.8	92.2	*5.7	*2.1	100.0
Total needing assistance with at least one activity	**594,600**	**258,600**	**34,600**	**887,900**	**42.2**	**67.0**	**29.1**	**3.9**	**100.0**

(a) These activities were only asked of persons with a disability.

(b) Total may be less than the sum of components as persons may need assistance with more than one activity.

* Subject to a relative standard error between 25% and 50%. These estimates should be interpreted accordingly.

** Subject to a relative standard error greater than 50%. These estimates should be interpreted accordingly.

Source: ABS 1999a:39.

Table A19.1: Primary carers in households, by age and sex, 1998

Age	Females	Males	Persons
<25	10,100	*6,300	16,300
25–34	42,000	*6,300	48,300
35–44	73,200	22,900	96,000
45–54	79,300	34,700	114,000
55–64	52,400	27,100	79,500
65–74	45,200	17,900	63,200
75+	15,200	18,300	33,500
Total	**317,300**	**133,500**	**450,900**

* Subject to a relative standard error greater than 25%. These estimates should be interpreted accordingly.

Source: ABS 1999a:43.

Table A20.1: Australians, by age, sex and Indigenous status, 30 June 2001

Age/sex	Indigenous	Non-Indigenous
Females		
0–14	87,200	1,862,700
15–24	42,000	1,265,900
25–34	37,900	1,414,900
35–44	29,400	1,474,700
45–54	18,600	1,318,900
55–64	9,600	902,800
65–74	4,900	677,500
75+	2,300	677,600
Total	*231,800*	*9,594,900*
Males		
0–14	92,000	1,960,900
15–24	42,300	1,316,500
25–34	34,700	1,397,000
35–44	27,100	1,451,500
45–54	17,600	1,315,300
55–64	8,700	916,600
65–74	4,000	635,400
75+	1,700	437,300
Total	*228,100*	*9,430,500*

Source: ABS 2002a; ABS 2002b.

Table A21.1: Older people by age, sex and cultural and linguistic background,[a] 30 June 2001

	Overseas-born			
Age/sex	CLDB	English-speaking background	Australian-born	Total
Females				
65–74	141,100	78,600	452,000	671,600
75–84	82,800	59,200	340,400	482,300
85+	22,900	25,100	128,900	176,900
Total	*246,800*	*162,800*	*921,200*	*1,330,900*
Males				
65–74	150,000	81,600	389,100	620,700
75–84	68,700	48,800	228,200	345,700
85+	13,900	12,000	52,700	78,500
Total	*232,600*	*142,300*	*670,000*	*1,044,900*
Persons				
65–74	291,000	160,200	841,100	1,292,300
75–84	151,500	107,900	568,600	828,000
85+	36,800	37,100	181,500	255,500
Total	**479,400**	**305,200**	**1,591,200**	**2,375,800**

(a) The cultural diversity classification for overseas-born people is based on country of birth. The English-speaking background category comprises people whose country of birth was New Zealand, United Kingdom, Ireland, United States of America, Canada and South Africa. The culturally and linguistically diverse background (CLDB) category comprises people born in other countries.

Source: Gibson et al. 2001.

Table A22.1: Older people, by age, sex and geographic area, 30 June 2000

Age/sex	Capital cities	Other metropolitan areas	Rural	Remote
Females				
65–74	412,000	59,200	193,400	10,800
75–84	298,000	40,700	127,700	6,200
85+	111,400	13,300	46,600	2,600
Total	*821,400*	*113,100*	*367,700*	*19,500*
Males				
65–74	368,700	53,000	189,300	12,900
75–84	202,900	30,100	97,500	5,600
85+	47,500	6,300	22,800	1,800
Total	*619,000*	*89,400*	*309,600*	*20,400*
Persons				
65–74	780,700	112,100	382,800	23,700
75–84	500,900	70,800	225,200	11,800
85+	158,800	19,600	69,400	4,400
Total	**1,440,400**	**202,500**	**677,300**	**39,900**

Source: AIHW, derived from ABS Statistical Local Area population estimates.

Table A22.2: Death rates, by age, sex and geographic area, 1997–1999 (per 100,000 people)

Age/sex	Capital cities	Other metropolitan areas	Rural	Remote
Females				
65–69	1,024	1,074	1,087	1,607
70–74	1,831	1,777	1,848	2,436
75–79	3,050	3,227	3,281	4,090
80–84	5,986	5,955	6,237	5,793
85+	13,845	14,206	14,024	11,111
Total	*3,976*	*3,792*	*3,966*	*3,991*
Males				
65–69	1,904	2,074	2,114	2,673
70–74	3,283	3,565	3,468	4,225
75–79	5,278	5,394	5,599	5,992
80–84	9,150	9,252	9,522	8,369
85+	16,952	16,820	17,238	10,892
Total	*4,839*	*4,918*	*4,997*	*4,848*

Source: AIHW National Mortality Database.

Table A23.1: Department of Veterans' Affairs pension recipients, by age and sex, 30 June 2002

Sex	<55	55–59	60–64	65–69	70–74	75–79	80–84	85–89	90+	Total
Females	16,145	8,260	9,465	15,508	45,260	84,922	59,850	23,820	7,807	271,037
Males	34,824	17,326	8,597	8,208	11,318	74,341	66,017	21,486	4,811	246,926
Persons	**50,968**	**25,585**	**18,062**	**23,716**	**56,577**	**159,263**	**125,867**	**45,306**	**12,618**	**517,963**

Source: DVA unpublished data.

Table A25.1: Government funding for people aged 65 and over,[a] 1989–90 to 1998–99

Year	As per cent of: Government outlays on health, social security and welfare	Total government outlays	GDP
1989–90	35.7	12.1	4.5
1990–91	35.1	12.2	4.8
1991–92	33.3	12.7	4.9
1992–93	32.7	12.3	4.9
1993–94	33.2	13.0	5.1
1994–95	32.8	12.9	5.0
1995–96	32.1	12.9	4.9
1996–97	32.0	13.7	4.9
1997–98	32.0	13.9	4.8
1998–99	32.1	13.5	4.9

(a) Includes Commonwealth and State and Territory expenditure on income support, residential care, home-based care, and medical, public hospital and pharmaceutical services.

Source: AIHW 2001:439.

Table A26.1: Number of days in hospital and usage rates, by age and sex, 2000–01

Age/sex	Length of stay >1 day	Length of stay Same day	Length of stay Total	Length of stay >1 day	Length of stay All separations	Patient days per 1,000 population
Females		Patient days		Average length of stay (days)		
65–74	1,481,052	252,806	1,733,858	7.8	3.9	2,547
75–84	2,400,657	173,095	2,573,752	10.1	6.3	5,286
85+	1,603,558	35,221	1,638,779	12.5	10.0	9,183
Total	*5,485,267*	*461,122*	*5,946,389*	*9.9*	*5.8*	*4,417*
Males						
65–74	1,632,214	284,719	1,916,933	7.3	3.8	3,013
75–84	1,938,815	195,105	2,133,920	9.0	5.2	6,140
85+	770,526	25,810	796,336	11.1	8.3	10,083
Total	*4,341,555*	*505,634*	*4,847,189*	*8.5*	*4.8*	*4,561*
Persons						
65–74	3,113,266	537,525	3,650,791	7.5	3.8	2,772
75–84	4,339,472	368,200	4,707,672	9.5	5.7	5,642
85+	2,374,084	61,031	2,435,115	12.0	9.4	9,459
Total	**9,826,822**	**966,756**	**10,793,578**	**9.2**	**5.3**	**4,481**

Source: AIHW National Hospital Morbidity database.

Table A27.1: Patients aged 65 and over: separation statistics for principal procedures (ICD-10-AM block), 2000–01

Principal procedure (ICD-10-AM block number)	Same-day admissions and separations	Other	Total	Same-day admissions and separations	Other	Total
	Number			Per cent		
No procedure	82,446	271,743	354,189	8.5	25.5	17.4
Non–invasive, cognitive and interventions, not elsewhere classified (1820–1916)	76,964	258,995	335,959	8.0	24.3	16.5
The urinary system (1040–1128)	299,557	33,161	332,718	31.0	3.1	16.4
The digestive system (850–1011)	174,600	101,332	275,932	18.1	9.5	13.6
The eye (160–256)	104,225	24,571	128,796	10.8	2.3	6.3
Imaging services (1940–2016)	10,255	94,555	104,810	1.1	8.9	5.2
The musculoskeletal system (1360–1579)	18,439	83,995	102,434	1.9	7.9	5.0
Chemotherapeutic & radiation oncology (1780–1799)	85,177	11,835	97,012	8.8	1.1	4.8
The cardiovascular system (600–767)	19,233	74,433	93,666	2.0	7.0	4.6
Dermatological & plastic (1600–1718)	52,291	26,982	79,273	5.4	2.5	3.9
The nervous system (1–86)	15,311	14,484	29,795	1.6	1.4	1.5
The respiratory system (520–569)	7,552	20,402	27,954	0.8	1.9	1.4
The male genital organs (1160–1203)	2,781	18,812	21,593	0.3	1.8	1.1
Gynaecological (1230–1299)	6,433	11,084	17,517	0.7	1.0	0.9
The nose, mouth & pharynx (370–422)	2,610	5,741	8,351	0.3	0.5	0.4
Blood & blood forming organs (800–817)	3,290	4,136	7,426	0.3	0.4	0.4
Breast (1740–1759)	1,902	5,524	7,426	0.2	0.5	0.4
The ear (300–333)	1,876	1,207	3,083	0.2	0.1	0.2
Dental services (450–490)	1,787	882	2,669	0.2	0.1	0.1
The endocrine system (110–129)	33	2,093	2,126	—	0.2	0.1
Total	**966,762**	**1,065,967**	**2,032,729**	**100.0**	**100.0**	**100.0**

Source: AIHW National Hospital Morbidity database.

Table A28.1: Encounters with general practitioners: top 10 problems managed for older people, by sex, April 2000 to March 2001

Females			Males		
Problem	Per cent of total problems	Per 100 encounters	Problem	Per cent of total problems	Per 100 encounters
Hypertension[a]	12.5	22.0	Hypertension[a]	10.4	17.4
Osteoarthritis[a]	4.1	7.1	Diabetes[a]	4.0	6.7
Immunisations[a]	3.1	5.5	Immunisations[a]	3.3	5.4
Diabetes[a]	3.0	5.3	Ischaemic heart disease[a]	3.2	5.4
Lipid disorder	2.7	4.8	Lipid disorder	3.1	5.1
Depression[a]	2.1	3.8	Osteoarthritis[a]	3.0	5.1
Prescriptions[a]	2.0	3.6	Chronic obstructive pulmonary disease	2.0	3.3
Sleep disturbance	2.0	3.5	Prescriptions[a]	1.8	3.1
Ischaemic heart disease[a]	1.8	3.1	Acute bronchitis/bronchiolitis	1.7	2.8
Urinary tract infection[a]	1.7	3.0	Solar kertosis/sunburn	1.6	2.7

(a) Indicates multiple ICPC–2 or ICPC–2 PLUS rubrics (see Britt et al. 2001).

Source: Analysis of BEACH data by AIHW General Practice Statistics and Classification Unit.

Table A31.1: ACAT[a] assessment rates and recommendations, by age and sex, January–June 1994, 1997 and 2000 (per cent)

	1994				1997				2000			
Sex/recommendations	**65–74**	**75–84**	**85+**	**Total**	**65–74**	**75–84**	**85+**	**Total**	**65–74**	**75–84**	**85+**	**Total**
Females												
Residential care:												
High care/Nursing home	16	19	28	22	16	18	27	21	16	21	28	23
Low care/Hostel	16	23	25	23	16	23	25	23	16	22	25	22
CACPs/COPs	2	2	2	2	5	5	4	5	12	11	10	11
Total assessments	*7,950*	*20,088*	*15,162*	*43,200*	*7,785*	*22,173*	*18,021*	*47,979*	*8,148*	*24,958*	*22,311*	*55,417*
Per cent assessed[b]	*1.2*	*5.1*	*11.9*	*3.6*	*1.1*	*5.1*	*12.1*	*3.8*	*1.2*	*5.3*	*12.8*	*4.2*
Males												
Residential care:												
High care/Nursing home	20	24	29	24	20	23	28	24	21	23	28	24
Low care/Hostel	14	18	21	18	15	18	21	18	15	17	20	18
CACPs/COPs	2	2	2	2	4	4	5	4	9	9	11	10
Total assessments	*5,992*	*10,851*	*6,073*	*22,916*	*6,604*	*12,430*	*7,352*	*26,386*	*6,471*	*14,076*	*9,193*	*29,740*
Per cent assessed[b]	*1.0*	*4.1*	*11.4*	*2.5*	*1.1*	*4.2*	*11.5*	*2.7*	*1.0*	*4.2*	*11.7*	*2.9*
Persons												
Residential care:												
High care/Nursing home	17	21	29	23	18	20	27	22	18	21	28	23
Low care/Hostel	15	21	25	21	15	21	24	21	15	20	24	21
CACPs/COPs	2	2	2	2	5	5	5	5	10	10	10	10
Total assessments	**13,957**	**30,969**	**20,492**	**65,418**	**14,405**	**34,629**	**25,429**	**74,463**	**14,663**	**39,166**	**31,615**	**85,444**
Per cent assessed[b]	**1.1**	**4.7**	**11.3**	**3.1**	**1.1**	**4.7**	**11.9**	**3.3**	**1.1**	**4.8**	**12.5**	**3.6**

(a) Aged Care Assessment Teams.

(b) Per cent of population in the age/sex group.

Notes

1 In addition to the recommendations listed above, ACATs may also recommend a continuation of living in the community either alone or with a spouse, with others such as relatives, or in a boarding house.

2 The table shows the proportion of ACAT clients who are recommended for residential care or coordinated community care (CACPs or COPs). The remaining clients generally receive a recommendation to continue living in the community, some with the assistance of HACC-funded services.

Source: AIHW 2001:216.

Table A32.1: HACC clients, by age and sex, July–September 2001

Sex	Under 65	65–74	75–84	85+	Total 65+	Total
Females	41,061	42,031	87,527	49,118	178,676	219,737
Males	26,274	20,443	35,081	18,489	74,013	100,287
Total	**67,335**	**62,474**	**122,608**	**67,607**	**252,689**	**320,024**

Note: This table draws on data over a 3-month period and is intended only to be indicative of use.

Source: AIHW analysis of HACC minimum data set.

Table A33.1: Number of operational Community Aged Care Packages, by State/Territory,[a] 30 June 1992 to 30 June 2001

Year	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
1992	68	25	10	12	120	—	—	—	235
1993	138	82	54	26	150	20	—	—	470
1994	291	313	253	81	224	43	20	2	1,227
1995	834	640	443	210	285	98	25	7	2,542
1996	1,517	1,104	731	383	468	160	47	21	4,431
1997	2,199	1,369	1,027	538	634	228	84	45	6,124
1998	3,538	2,314	1,728	822	989	378	168	109	10,046
1999	4,685	3,323	2,440	1,161	1,258	450	266	170	13,753
2000[b]	6,337	4,517	3,163	1,571	1,636	584	308	193	18,309
2001[b]	8,626	5,974	4,155	2,278	2,270	679	336	312	24,630

(a) 'State/Territory' refers to the location of the outlet.

(b) Packages provided by Multipurpose Services and services receiving flexible funding under the Aboriginal and Torres Strait Islander Aged Care Strategy are included.

Source: AIHW 2002b:14.

Table A33.2: Length of time with a Community Aged Care Package, separations from 1 July 2000 to 30 June 2001 (per cent)

Length of time	Per cent
<4 weeks	5.1
4–<8 weeks	6.9
8–<13 weeks	7.8
13–<26 weeks	16.3
26–<39 weeks	12.9
39–<52 weeks	9.8
1–<2 years	21.0
2–<3 years	11.3
3–<4 years	5.3
4+ years	3.6
Total	**100.0**

Source: AIHW 2002b:46.

Table A34.1: Permanent residents in aged care, by age and sex, 30 June 2001

Age	Females	Males	Persons
Under 65	2,862	3,086	5,948
65–69	2,132	2,105	4,237
70–74	5,211	4,157	9,368
75–79	11,950	6,500	18,450
80–84	20,908	7,691	28,599
85–89	27,817	7,888	35,705
90–94	19,016	4,285	23,301
95+	7,218	1,178	8,396
Total	**97,114**	**36,890**	**134,004**

Source: AIHW 2002c:29.

Table A35.1: Age- and sex-specific usage rates for residents of residential aged care, 30 June 1994, 1997 and 2001

Age/sex	1994	1997	2001
Females			
65–74	12.5	12.2	11.0
75–84	85.1	80.1	67.7
85+	351.1	331.1	297.5
Total	*72.7*	*73.2*	*70.4*
Males			
65–74	11.0	10.8	10.0
75–84	50.0	46.3	40.8
85+	200.9	183.9	166.0
Total	*33.3*	*32.9*	*32.1*

Source: AIHW 2001:247; AIHW 2002c:28; ABS 2002a.

Table A36.1: Occupied residential aged care respite days, per 1,000 persons in population, years ending 30 June 1991 to 2001

Year	Per 1,000 people aged 70 and over	Per 1,000 people aged 65 and over with a severe or profound restriction
1991	263.4	877.0
1992	308.2	1,027.2
1993	351.9	1,172.6
1994	409.1	1,366.9
1995	463.1	1,544.2
1996	532.1	1,771.8
1997	559.4	1,860.1
1998	561.5	1,866.0
1999	597.3	1,979.2
2000	580.6	1,913.4
2001	570.2	1,878.1

Source: AIHW 2001:438; AIHW analysis of DoHA database and ABS 1998 Survey of Disability, Ageing and Carers; ABS 2002a.

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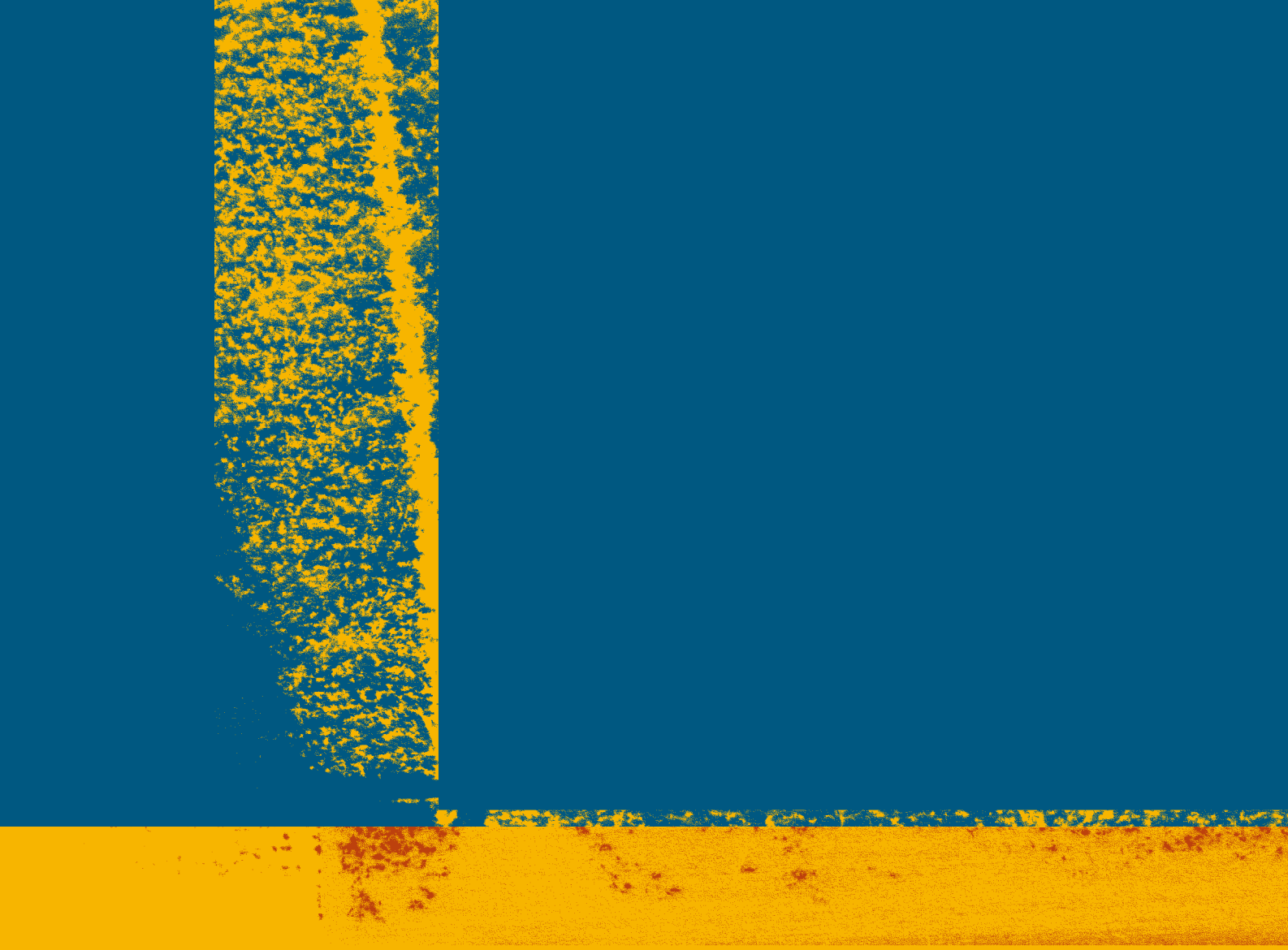
Notes



Australia's population is ageing and as baby boomers move into old age this trend is set to gather greater momentum over the next three decades. Significant changes will flow to all aspects of social and economic life as both the number and proportion of older people in the community increase. This third edition of *Older Australia at a Glance* provides insights into the diversity of the older population of Australia at the beginning of the 21st century, where they are living, what they are doing, how healthy they are and the services they are using.