Australian Government
Australian Institute of Health and Welfare

# Older Australians

**Web report** | Last updated: **28 Jun 2023** | Topic: Older people

## About

Older people make up a considerable proportion of Australia's population – at 30 June 2020, over 1 in 6 people were aged 65 and over. The report details the demographic profile of older Australians, and adopts a person-centred model to report on their health and wellbeing across key domains. Feature articles further explore aspects of health and wellbeing for particular populations of older Australians. The report also identifies opportunities to address data gaps in our understanding of older Australians' experiences.

Older Australians was released 30 November 2021 and following sections were updated with more recent data (see Notes section): Health – status and functioning (last updated 7 July 2022) and Aged care (last updated 28 June 2023).

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**Findings from this report:**

- At 30 June 2020, 1 in 6 Australians were aged 65 and over
- In 2018–19, the average retirement age was 55 years, while the average intended retirement age was 66 years
- In 2016, over 1 in 3 older people were born overseas; the most common regions of birth were Europe and South-East Asia
- In 2016–18, Australian men aged 65 could expect to live another 20 years and women another 23 years

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# Summary

At 30 June 2020, approximately 4.2 million people (16% of Australia's total population) were aged 65 and over.

This report focuses on older Australians – generally those aged 65 and over, unless otherwise specified. For older Indigenous Australians, the age range 50 and over is used, reflecting the life expectancy gap between Indigenous and non-Indigenous Australians and the lower proportion of Indigenous people aged 65 and over.

Older Australians are a diverse group, with different ages, socioeconomic backgrounds, life experiences and lifestyles. These factors all influence the ageing process and affect Australians' health and wellbeing.

This new release provides insights into this group of older Australians, adopting a person-centred model to explore who they are, how they are changing, how healthy they are and the services they are using. It comprises a rolling series of pages that provide key statistics on the domains that made up the model, including health, income, social support and others. These pages are complemented by feature articles, which explore issues relevant to particular populations of older Australians. Both pages and feature articles will be updated over time, as more information becomes available. Given the diversity of content, we have used a mix of data sources. Hence, the date range available for reporting varies for the information presented for each topic.

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# Demographic profile

**On this page:**


- Australia's older population
- Age
- Sex
- Geographical distribution
- International comparison
- Where do I go for more information?


**Key findings**
1 in 6 Australians are aged 65 and over (16%).

**Key findings**
Over half (53%) of older Australians aged 65 and over are women.

This page presents an overview of the demographic characteristics of older Australians, including changes over time and population projections. Throughout this page, 'older people' refers to people aged 65 and over. Where this definition does not apply, the age group in focus is specified. The 'Older Aboriginal and Torres Strait Islander people' feature article defines older people as aged 50 and over. This definition does not apply to this article, with Indigenous Australians aged 50–64 not included in the information presented.

## Australia's older population

Australia's population is ageing due to increasing life expectancy and declining fertility rates. Both the number of people at the older ages is growing and older people are representing an increasing share of the total population (CEPAR 2021).

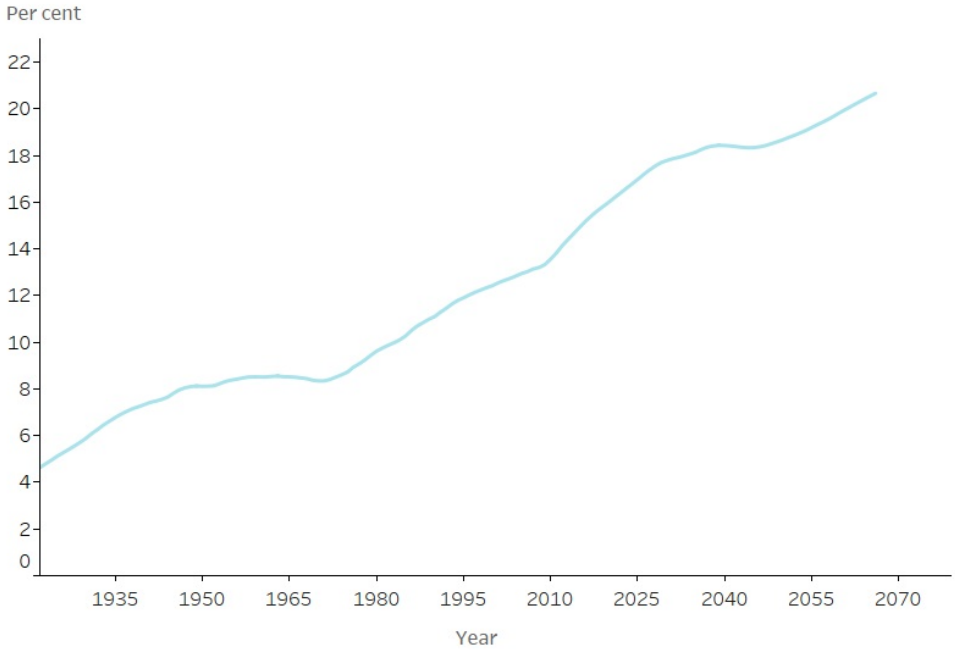
Recent data show that:

- At 30 June 2020, there were an estimated 4.2 million older Australians (aged 65 and over) with older people comprising 16% of the total Australian population (ABS 2020b).
- The number of older Australians has increased from 1.0 million (8.3% of the total population) in 1970 and 2.1 million (12%) in 1995 (Figure 1.1) (ABS 2019).
- The number and percentage of older Australians is expected to continue to grow. By 2066, it is projected that older people in Australia will make up between 21% and 23% of the total population (ABS 2018).
- For those aged 85 and over, the proportion has increased from 0.5% (63,200) in 1970, to 1.1% (190,400) in 1995, to 2.1% at 30 June 2020 (528,000). The proportion is expected to continue to rise to between 3.6% and 4.4% in 2066 (ABS 2018, 2020a).

Figure 1.1: Percentage of the Australian population aged 65 and over, at 30 June, over time

The line graph shows that the percentage of the Australian population aged 65 and over has increased, from 4.6% in 1922 to 16.2% in 2021. The percentage of older Australians in the population is set to continue increasing to approximately 20.7% in 2066, with particular growth between 2009 and 2029.

**Figure 1.1: Percentage of the Australian population aged 65 and over, at 30 June, over time**




*Notes*
1. Data for 1921 to 1970 are population estimates. Data from 1971 onwards are estimates of the resident population (ERP).
2. Population data from 1992 to 2011 are recast estimates following the rebasing of the 2011 Census. For more information, see the ABS explanatory notes.

*Sources:* ABS 2018, 2019.
http://www.aihw.gov.au/

## Age

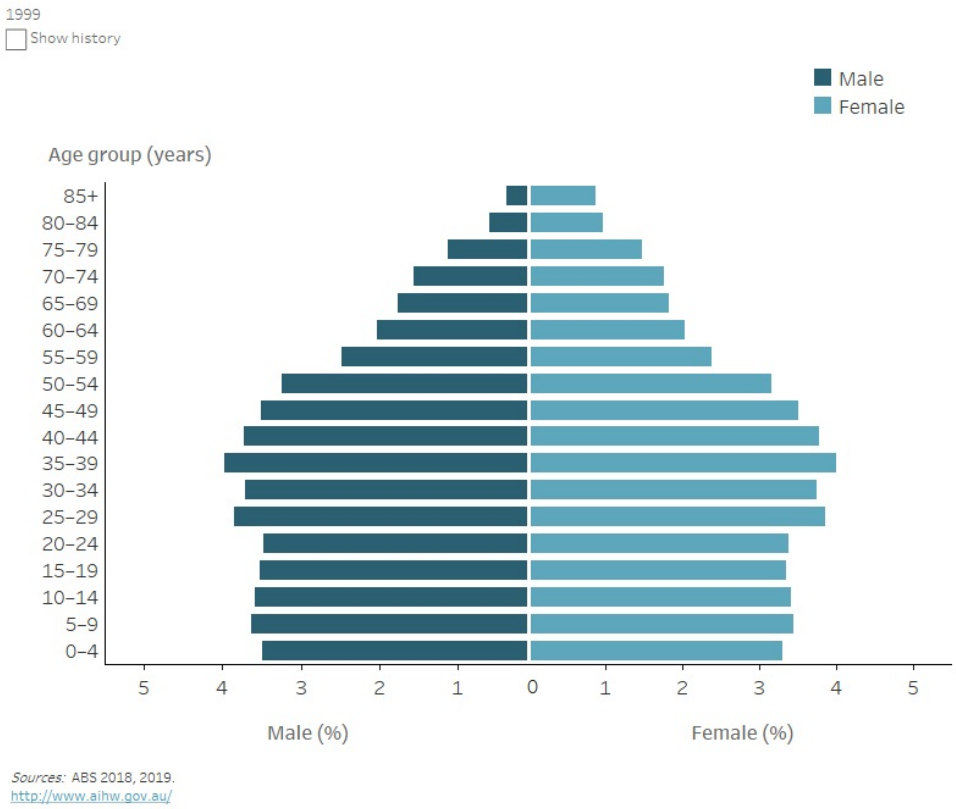
At 30 June 2020:

- More than half of older people were aged 65–74 (56%, 2.4 million people).
- 3 in 10 were aged 75–84 (31%, 1.3 million).
- Around 1 in 8 were aged 85 and over (13%, 528,000) (ABS 2020b) (Figure 1.2).

Figure 1.2: Population change by age group and sex, 1999, 2019 and 2066

The butterfly chart shows that the percentage of older men and women has increased between 1999 and 2019. In 1999, 5.4% of men were aged over 65, compared to 7.4% in 2019. The percentage of older females also increased from 6.9% to 8.4%. The percentage of older men and women is projected to increase to 9.8% and 10.8% in 2066 for men and women respectively.

Figure 1.2: Population change by age group and sex, 1999, 2019 and 2066




*Sources:* ABS 2018, 2019.
http://www.aihw.gov.au/

As Australia's population ages, the age profile of the older population is also projected to change. By 2066, it is projected:

- There will be just over 4.5 million people aged 65–74.
- People aged 75–84 will account for one-third (34%, 3.5 million) of the older population.
- 1 in 5 older people will be aged 85 and over (21%, 2.2 million) (ABS 2018).

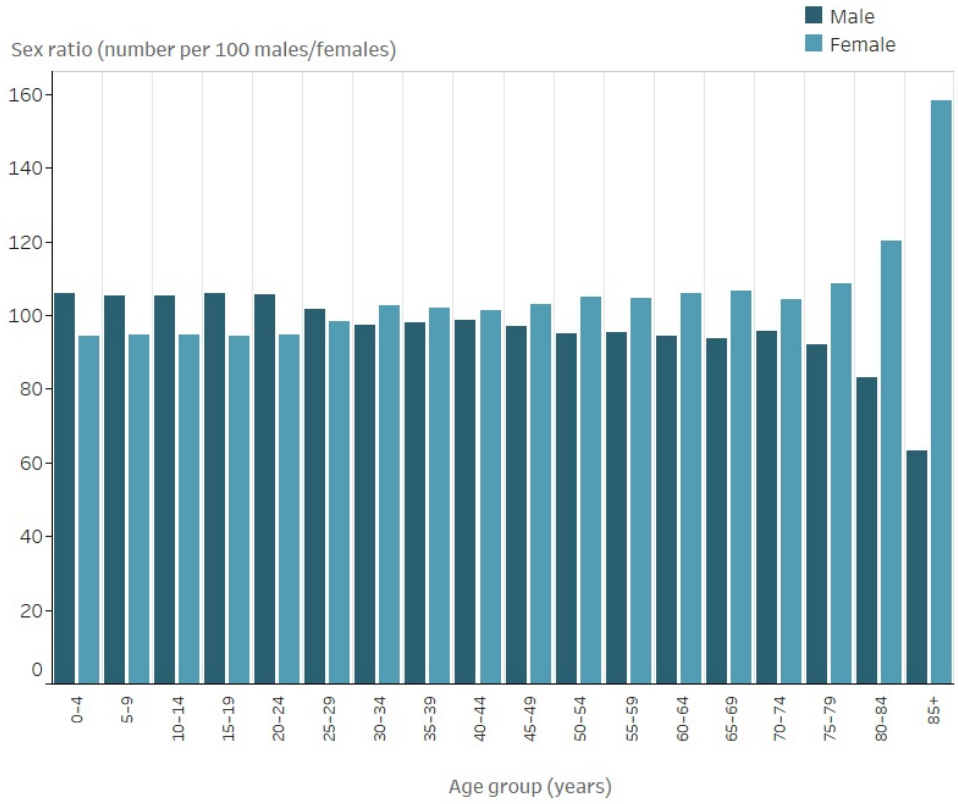
## Sex

At 30 June 2020, over half (53%) of older Australians (aged 65 and over) were women. There were an estimated 2.2 million women and almost 2.0 million men aged 65 and over (ABS 2020b).

Women tend to live longer than men. This is seen in the differences in life expectancy and is particularly apparent in the older age groups. The sex ratio at older ages reflects the higher male mortality of the older Australian population. At 30 June 2020, there were 88.1 older males (aged 65 and over) for every 100 older females (see Figure 1.3).
Figure 1.3: Sex ratio by age group, in 2020

The column graph shows there is a larger proportion of men than women in younger age groups (0 to 29 years) and a greater proportion of women in older age groups (30 years and over). The differences in proportion of females in each age group becomes more pronounced in older age groups, reflecting the longer life expectancy of women (there were 158.3 females per 100 males aged 85 and over in 2020).

Figure 1.3: Sex ratio by age group, 2020




*Source:* ABS 2020b.
http://www.aihw.gov.au/

The proportion of women in the older age groups peaked in 1968, when women made up 58% of all people aged 65 and over in Australia. This proportion has been declining since. The peak for women aged 65–74 was in 1965 (56%) and for those aged 75–84 in 1974 (63%); for women aged 85 and over, it peaked in 1982 (73%). These patterns relate in large part to the effects of World War II.

## Geographical distribution

At 30 June 2020, Tasmania (20%) had the highest proportion of its population aged 65 and over, followed by South Australia (19%) and New South Wales (17%). Considering older age groups, the state with the highest proportion of people aged 85 and over in its population was South Australia (2.6%). Similar proportions were reported for Tasmania (2.3%), New South Wales (2.2%) and Victoria (2.1%) (ABS 2020b).

Another way to consider the geographical distribution of older people is to look at the median age (the age at which half the population is older and half is younger) of smaller regions, such as Statistical Areas Level 4 (SA4s) within the Australian Statistical Geography Standard (ASGS). In 2019, the Hunter Valley (excluding Newcastle) in New South Wales had the highest median age (63.0), followed by the Mid North Coast in New South Wales (61.2) and Moreton Bay – North in Queensland (60.6) (ABS 2020c).

## International comparisons

Like many developed countries, Australia has a high median age, with a relatively large proportion of its population aged 65 and over. In 2020, the median age in Australia was estimated at 37.9. This was slightly lower than for the United States of America (38.3 years) and the United Kingdom (40.5 years). It was slightly higher than other Organisation for Economic Co-operation and Development (OECD) countries such as Turkey (31.5), Israel (30.5) and Mexico (29.2) (UN 2019).

The median age of the overseas-born population in Australia has decreased over the last 10 years, but increased slightly at 30 June 2020. The decrease before 30 June 2020 has slowed the ageing of the total Australian population (ABS 2021).

The estimated proportion of people aged 65 and over in these countries in 2020 was similar to Australia's (16%):

- 17% in the United States of America
- 19% in the United Kingdom.

This proportion was higher than a number of other OECD countries, including:

- 12% in Israel
- 9% in Turkey
- 7.6% in Mexico (UN 2019).

## Where do I go for more information?

For more information on the demographic profile of older Australians, see:

- ABS Census of Population and Housing: reflecting Australia – stories from the Census, 2016 Ageing population
- United Nations World population prospects 2019

Information about culturally and linguistically diverse, rural and remote and Aboriginal and Torres Strait Islander older Australians can be found in the feature articles, while information about deaths and life expectancy can be found in health status and functioning.

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# Feature articles

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# Feature articles

**On this page:**


- Demographic profile
- Health
- Aged care
- Social support
- Justice and safety
- Housing and living arrangements
- Education and skills
- Employment and work
- Income and finances
- Where do I go for more information?


**Key findings**
In 2016, around 1 in 6 Aboriginal and Torres Strait Islander people were aged 50 and over (16% or 124,000).

**Key findings**
By 2031, it is projected that 1 in 5 Aboriginal and Torres Strait Islander people will be aged 50 and over (20%).

**Key findings**
Around 2 in 3 (65%) Aboriginal and Torres Strait Islander people aged 50 and over receiving aged care services are women.

**Key findings**
In 2018–19, just over 1 in 5 (21%) Aboriginal and Torres Strait Islander people aged 50 and over owned their home without a mortgage, and a further 1 in 5 (20%) owned their home with a mortgage.

Aboriginal and Torres Strait Islander people are the Indigenous peoples of Australia. They are not one group, but rather comprise hundreds of groups that have their own distinct set of languages, histories and cultural traditions.

Aboriginal and Torres Strait Islander people continue to suffer from the consequences of European settlement, including the impact of 'new' infectious and chronic diseases. The interaction of other factors, including social dislocation and economic disadvantage, also contribute to poor health in many groups of Aboriginal and Torres Strait Islander people (AIHW 2015). Aboriginal and Torres Strait Islander people are more likely to develop serious medical conditions earlier in life and have a lower life expectancy than non-Indigenous Australians (AIHW 2017). In recognition of this, this feature article focuses on Aboriginal and Torres Strait Islander people aged 50 and over.

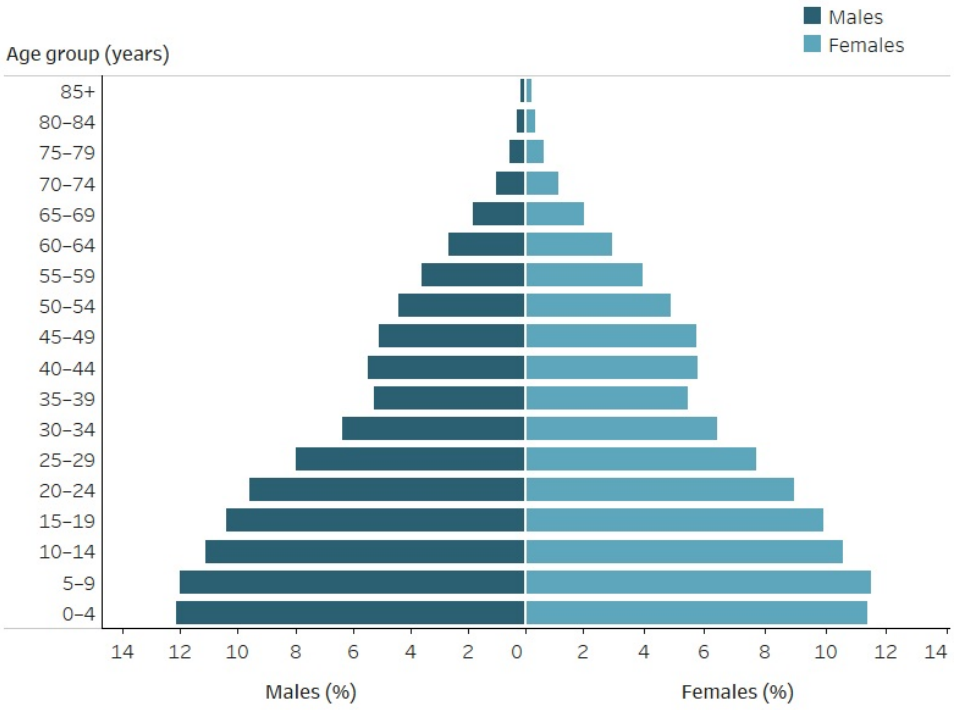
## Demographic profile

In 2016, an estimated 124,000 Australians aged 50 and over identified as being of Aboriginal and/or Torres Strait Islander origin. Older Indigenous Australians (aged 50 and over) comprise 1.5% of the total Australian population aged 50 and over and 16% of the total Indigenous population. The Indigenous population is ageing, with the proportion aged 50 and over increasing over recent years. This growth is projected to continue and by 2031 it is expected that 1 in 5 Indigenous people will be aged 50 or over (20%) (ABS 2019a). Due to higher rates of fertility and deaths occurring at younger ages, the Indigenous population has a much younger age structure than the non-Indigenous population (AIHW 2019).

One in 4 older Indigenous Australians (aged 50 and over) were aged 65 and over (27%) in 2016. This proportion was slightly higher for women (28%) than men (26%), reflecting the higher life expectancy of women (ABS 2019a) (Figure 2A.1).
Figure 2A.1: Estimated resident Indigenous Australian population by age group and sex, 2016

The butterfly chart shows that the population of Indigenous Australians is predominately young people. Approximately 15% of Indigenous men and 16% of Indigenous women were aged 50 and over in 2016. This is in comparison to 55% of Indigenous men and 52% of Indigenous women aged under 25.

Figure 2A.1: Estimated resident Indigenous Australian population by age group and sex, 2016



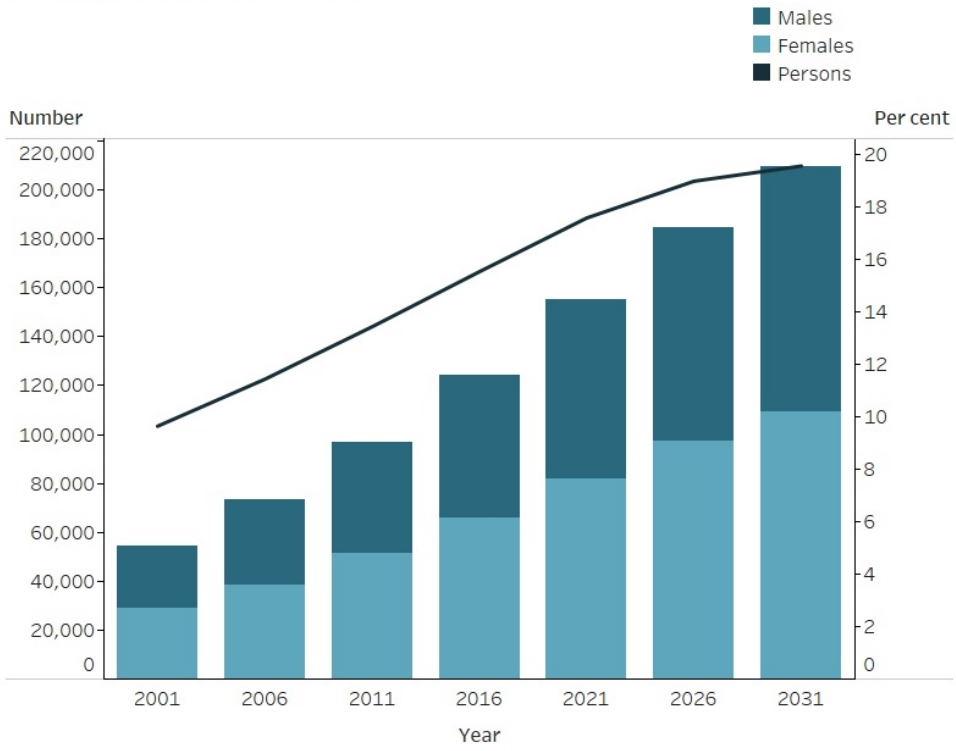

*Source:* ABS 2019a.
http://www.aihw.gov.au/

While the number of older Indigenous Australians has increased over recent years, and is projected to continue increasing, the split of men and women in the 50 and over age group has remained stable. Just over half (53%) of this population were women in 2001, 2006, 2011 and 2016 (ABS 2019a) (Figure 2A.2). For the 85 and over age group, women made up around two-thirds of the population in 2006, 2011 and 2016 (66%, 67% and 66%, respectively). This is an increase from 6 in 10 (60%) in 2001 (ABS 2019a).

Figure 2A.2: Estimated resident and projected older Indigenous population (50 and over) by sex, 2001 to 2031

The stacked column graph shows that the number of older Indigenous Australians (aged 50 and over) has grown and is projected to continue growing to 2031. The number of older Indigenous females is projected to be larger than the number of older Indigenous males. The line graph shows that the proportion of Indigenous people aged 50 and over is rising and is projected to continue to rise.

Figure 2A.2: Estimated resident and projected older Indigenous population (50 and over) by sex, 2001 to 2031




*Note:* 'Older Indigenous population' refers to people aged 50 and over.

*Source:* ABS 2019a.
http://www.aihw.gov.au/

Among the 124,000 older Indigenous Australians (aged 50 and over) in 2016:

- 91% (113,300) identified as being of Aboriginal origin only
- 6% (7,100) identified as being of Torres Strait Islander origin only
- 3% (3,600) identified as being of both Aboriginal and Torres Strait Islander origin (ABS 2018).

This is broadly consistent with the total Indigenous population in 2016, of which:

- 91% (727,500) identified as being of Aboriginal origin only
- 5% (38,700) identified as being of Torres Strait Islander origin only
- 4% (32,200) identified as being of both Aboriginal and Torres Strait Islander origin (ABS 2017).

In 2016:

- Around 1 in 3 older Indigenous Australians (aged 50 and over) lived in New South Wales (35%) and 1 in 4 lived in Queensland (26%).
- The highest proportion of older Indigenous Australians lived in *Major cities* (35%) and 1 in 5 (20%) lived in *Remote* or *Very remote* areas.
- Around half (51%) of older Indigenous Australians lived in 8 of the 37 Indigenous Regions (IREG) (ABS 2018; AIHW 2019).

## Health

The 2018–19 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) was conducted between July 2018 and April 2019 (ABS 2019c) and the following data are based on self-reporting by older Indigenous Australians (aged 50 and over) unless noted otherwise. While almost 1 in 5 older Indigenous survey respondents self-assessed their health as poor (19%, 26,100), more than half (58%, 78,800) self-assessed their health as good, very good or excellent.

### Health risk factors

A healthy diet can help to prevent and manage many chronic conditions, including type 2 diabetes, cardiovascular disease and some forms of cancer. The National Health and Medical Research Council (NHMRC 2013) recommends that adults have 2 servings of fruit and 5 servings of vegetables every day for a healthy lifestyle. In 2018–19:

- Around 1 in 25 (3.7%, 5,000) older Indigenous survey respondents met both the fruit and vegetable daily intake guidelines.
- More than a third (39%, 52,600) met the fruit guidelines only.
- 1 in 50 (2.2%, 3,000) met the vegetable guidelines only.
- More than half (56%, 75,900) did not meet either the fruit or vegetable intake guidelines (ABS 2019c).

More than half of older Indigenous Australians had a measured body mass index (BMI) range of obese (51%, 69,100) and a further 3 in 10 (31%, 41,500) had a measured BMI in the overweight range.

The consumption of alcohol, tobacco and other drugs is a major cause of preventable disease, illness and death in Australia. Based on responses about alcohol consumption in the last 12 months:

- Nearly 4 in 10 (39%, 52,800) Indigenous Australians aged 50 and over reported exceeding single occasion alcohol risk guidelines of more than 5 standard drinks.
- Around half (52%, 27,200) of those who had exceeded single occasion risk guidelines had exceeded 11 standard drinks on one occasion.
- Nearly 1 in 4 (23%, 30,600) had not consumed alcohol.

Tobacco is one of the leading risk factors contributing to the burden of disease for older Australians. Among older Indigenous Australians in 2018–19, around 1 in 3 (36%, 48,100) smoked daily and almost 1 in 10 (9.5%, 12,900) lived in a household where a daily smoker smoked at home indoors. Around 1 in 3 (35%, 48,000) were ex-smokers, and just over 1 in 4 (26%, 35,000) had never smoked.

### Health status

As noted earlier, Aboriginal and Torres Strait Islander Australians tend to develop chronic conditions earlier in life than non-Indigenous Australians. In 2018–19, more than 1 in 3 (35%, 47,400) older Indigenous Australians (aged 50 and over) self-reported they had been advised, by a doctor or nurse, of having diabetes or high sugar levels.

Of the 27% (37,000) of older Indigenous Australians who reported having asthma, only around 1 in 4 (28%, 10,200) had a written asthma action plan. More than 1 in 10 (12%, 4,300) had either never heard of or didn't know if they had a written asthma action plan.

### Cultural safety

Cultural safety is the practice of treating a person from another culture without any action that diminishes, demeans or disempowers them or their cultural identity. Improving cultural safety for Aboriginal and Torres Strait Islander health care users can improve access to, and the quality of, health care. This means a health system that respects Indigenous cultural values, strengths and differences, and also addresses racism and inequity (AIHW 2021a).

The Royal Commission into Aged Care Quality and Safety states that 'cultural safety must be embedded throughout aged care'. It proposes an Aboriginal and Torres Strait Islander aged care pathway that brings culturally safe and flexible aged care that meets the needs of Indigenous people wherever they live (RCACQS 2021).

For more information see Cultural safety in health care for Indigenous Australians: monitoring framework and RCACQS final report: care, dignity and respect.

## Aged care

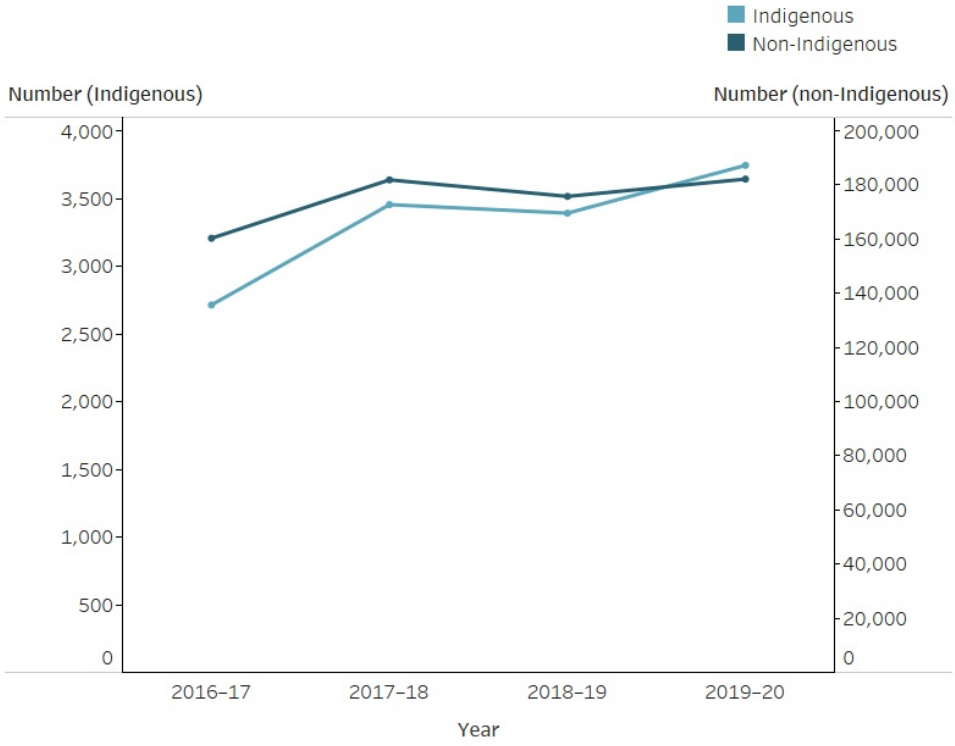
Access to aged care services in Australia is determined by need, rather than age. The *Aged Care Act 1997* designates some groups of people as 'people with special needs' (AIHW 2019). Indigenous Australians are one such group. Other groups designated as 'people with special needs' in the Aged Care Act include people from culturally and linguistically diverse (CALD) backgrounds, veterans, people who live in rural or remote areas, and lesbian, gay, bisexual, transgender and intersex (LGBTI) people.

Planning for aged care services takes into account the specific needs of the Indigenous population aged 50 and over and the non-Indigenous population aged 65 and over (Department of Health 2017). A broader age group is used for Indigenous Australians because of their greater need for care at a younger age compared with non-Indigenous Australians (AIHW 2019).

The aged care journey begins with an assessment process. In 2019–20, 3,745 aged care assessments for older Indigenous Australians were conducted, an increase from 3,392 in 2018–19. This continues an overall trend, in recent years, of increasing numbers of Indigenous Australians using aged care services (Figure 2A.3).
Figure 2A.3: Number of aged care assessments for older Australians (50 and over) by Indigenous status, 2016–17 to 2019–20

The line graphs show that the number of assessments for aged care services for older Indigenous Australians has increased in the last four years (from 2,700 in 2016–17 to 3,700 in 2019–20). The number of assessments for aged care services for older Indigenous and non-Indigenous Australians decreased in 2018–19, however increased to a 4-year peak in 2019–20.

**Figure 2A.3: Number of aged care assessments for older Australians (50 and over) by Indigenous status, 2016–17 to 2019–20**



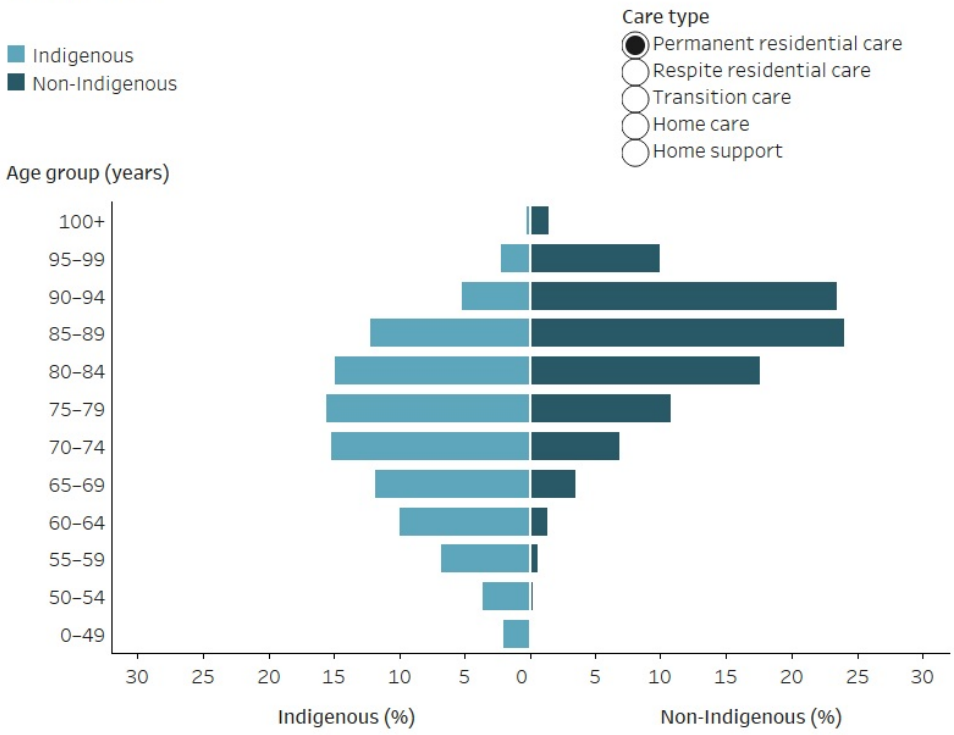

*Source:* Department of Health 2020.
http://www.aihw.gov.au/

Around 5,300 older Indigenous Australians were using aged care services (home, residential or transition care) at 30 June 2020. This represented 1.6% of all Australians aged 50 and over who were using aged care services. Around half of these older Indigenous Australians (48%, 2,600 people) were aged between 65 and 79 years. In addition, 50 Indigenous Australians aged under 50 were using aged care services (Figure 2A.4).

There is a considerable difference in the age profile of Indigenous Australians using aged care services, compared with non-Indigenous Australians (Figure 2A.4). While part of the reason is the broader age range at which Indigenous Australians can access aged care services, it also reflects the lower life expectancy of Indigenous Australians and the younger age at which services are needed (AIHW 2020b).
Figure 2A.4: People using aged care services by Indigenous status and age, 30 June 2020

The butterfly chart shows that the profile of Indigenous Australians differs across aged care services. Indigenous Australians in permanent residential care, home care and home support are often younger than non-Indigenous Australians (22% of Indigenous Australians in permanent residential care were aged under 65, compared with 2.4% of non-Indigenous Australians).

Figure 2A.4: People using aged care services by Indigenous status and age group, 30 June 2020




*Note:* Excludes unknown, not stated and inadequately described.

*Source:* AIHW 2020b.
http://www.aihw.gov.au/

Almost 2 in 3 (65%) older Indigenous Australians using aged care services were women and around 1 in 3 (35%) were men. Women made up 57% of the 50–54 age group and nearly three-quarters (73%) of the 85 and over age group.

### Service type

The three biggest aged care programs are residential aged care, home support and home care (see 'Types of aged care' in the Aged care article). At 30 June 2020, 5,400 Indigenous Australians were using residential aged care (permanent or respite), home care or transition care in Australia. In addition, during 2019–20, nearly 22,300 Indigenous Australians were assisted under the Commonwealth Home Support Programme.

At 30 June 2020, Indigenous Australians accounted for:

- 1.0% (2,000) of people living in residential aged care
- 2.4% (3,400) of people using home care
- 0.6% (20) of people using transition care
- 2.7% (22,300) of people using home support (during 2019–20) (AIHW 2021b).

The split between the use of home and residential care types contrasts markedly between Indigenous and non-Indigenous Australians. Around 1 in 3 (36%) older Indigenous Australians (aged 50 and over) using aged care services at 30 June 2020 were living in residential care, and 2 in 3 (64%) were using home care. In comparison, around 1 in 3 (32%) non-Indigenous Australians (aged 65 and over) using aged care services at 30 June 2020 were using home care, and around 2 in 3 (67%) were living in residential care. While residential care becomes more common with older age, differences in service type use remained between Indigenous and non-Indigenous Australians (Table 2A.1).

**Table 2A.1: Aged care service type by Indigenous status and age group, at 30 June 2020**

| Age group (years) | Permanent residential care (%) | | Respite residential care (%) | | Home care (%) | | Transition care (%) | |
|---|---|---|---|---|---|---|---|---|
| | Indigenous | Non-Indigenous | Indigenous | Non-Indigenous | Indigenous | Non-Indigenous | Indigenous | Non-Indigenous |
| 50-64 | 27 | 83 | 1.8 | 1.8 | 71 | 15 | 0.4 | 0.6 |
| 65-79 | 30 | 56 | 1.5 | 2.1 | 68 | 40 | 0.3 | 1.2 |
| 80 and over | 48 | 68 | 3.4 | 2.1 | 48 | 29 | 0.4 | 0.8 |

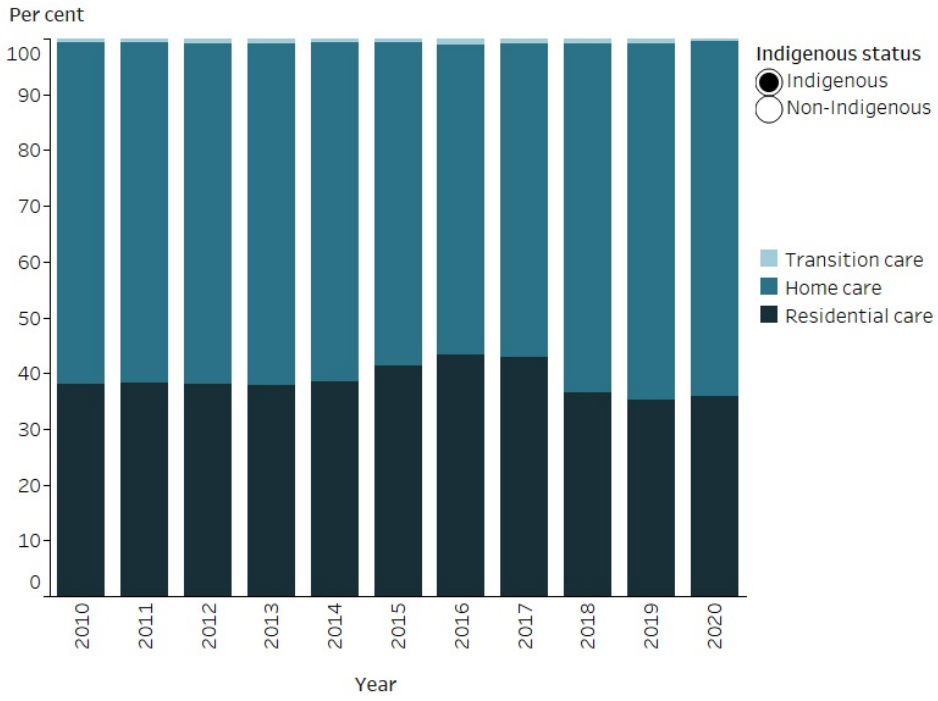
Source: AIHW 2021b.

In each year since June 2016, the proportion of older Indigenous Australians using home care has been increasing, while use of residential care has been generally decreasing (Figure 2A.5).

Figure 2A.5: Older Australians (50 and over) using aged care services by Indigenous status and care type, 30 June 2010–2020

The stacked column graph shows that the greatest proportion of older Indigenous people using aged care services since 2010 were using home care. This is in comparison to non-Indigenous Australians who most commonly used residential care. The proportion of older Indigenous Australians using home care has increased since 2016 (from 56% to 64%).

**Figure 2A.5: Older Australians (50 and over) using aged care services by Indigenous status and care type, 30 June 2010–2020**




*Note:* Excludes unknown, not stated and inadequately described.

*Source:* AIHW 2021b.
http://www.aihw.gov.au/

### Home care

At 30 June 2020, 3,400 older Indigenous Australians were using home care. Note that Indigenous identification for people using home care is relatively poor, with more than 1 in 3 people using home care having an Indigenous status of 'not stated' (36%, 51,900).

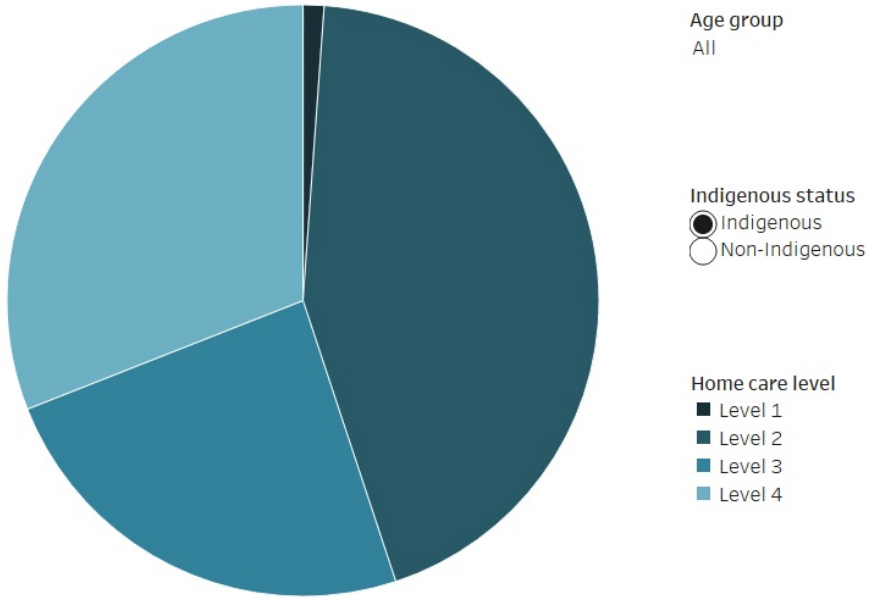
While home care is the most common service type for both Indigenous men and women aged 50 and over using aged care services, women are more likely to use home care services – 67% compared with 58% of men. At 30 June 2020, 44% of older Indigenous Australians using home care were receiving level 2 care (low care needs) and nearly 1 in 3 (31%) were receiving level 4 care (high care needs). Level 1 care (basic care needs) was the least common level of home care being received (1.1%) (Figure 2A.6).

The percentages of non-Indigenous older Australians receiving each level of home care are similar to those for Indigenous older Australians. Of the non-Indigenous Australians aged 65 and over using home care, around 4 in 10 (41%) were receiving level 2 care and 1 in 3 (33%) were receiving level 4 care. Level 1 care was the least common level of care being received (1.7%).

Figure 2A.6: Older Australians' (50 and over) home care level by age and Indigenous status, 2019–20

The pie chart shows the distribution of older Australians across home care levels in 2019–20. Both older Indigenous and non-Indigenous Australians predominantly used home care levels 2 and 4, 75% and 74% respectively.

Figure 2A.6: Older Australians' (50 and over) home care level by age and Indigenous status, 2019–20




*Source:* AIHW 2021b.
http://www.aihw.gov.au/

### Residential aged care

At 30 June 2020, 1,900 older Indigenous Australians were living in residential aged care. Most of these people were using permanent residential aged care services (1,800), with 100 using respite residential aged care services. At 30 June 2019, the most common medical conditions of all Indigenous Australians living in permanent residential aged care were:

- depression or other mood disorders, such as bipolar (40% of residents)
- dementia (34%)
- arthritis (30%)
- type 2 diabetes (25%).

In comparison, the most common medical conditions of all non-Indigenous Australians living in permanent residential aged care at 30 June 2019 were:

- depression or other mood disorders (49%)
- arthritis (44%)
- dementia (40%)
- anxiety disorders (27%) (AIHW 2020a).

### Aged Care Funding Instrument

The Aged Care Funding Instrument (ACFI) is used to assess residents' ongoing care needs to determine the amount of subsidy to be paid by the Australian Government. The ACFI is made up of 12 questions about a resident's assessed care needs and 2 diagnostic sections. It is not a comprehensive medical assessment. The medical conditions data reported above are from ACFI assessments and should be interpreted in context of this limitation.

Of the 1,700 times an older Indigenous Australian exited permanent residential aged care in 2019–20, 3 in 10 (30%) exits were due to death. The most common reason for discharge was an exit to home or community (37%).

On average, older Indigenous Australians stayed in residential aged care for nearly 12 months (376 days) and older non-Indigenous Australians for around 14 months (440 days). The average length of stay in residential aged care differed by reason of discharge (Table 2A.2).

### Table 2A.2: Average length of stay in residential aged care (days) by Indigenous status, sex and discharge reason, 2019–20

| Discharge reason | Indigenous (50 years and over) | | | Non-Indigenous (65 years and over) | | |
|---|---|---|---|---|---|---|
| | Men | Women | Total | Men | Women | Total |
| Home or community | 45 | 59 | 52 | 35 | 38 | 37 |
| Another residential service | 535 | 323 | 416 | 367 | 470 | 428 |
| Hospital | 107 | 154 | 133 | 88 | 118 | 104 |
| Death | 863 | 1,117 | 1,007 | 740 | 1,108 | 959 |

Source: AIHW 2021b.

### National Aboriginal and Torres Strait Islander Flexible Aged Care Program

Older Indigenous Australians (aged 50 and over) can also access aged care services through the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP). The NATSIFACP provides culturally safe aged care to Aboriginal and Torres Strait Islander people to remain close to home and community and is located mainly in remote areas. Services can be delivered in a residential or home setting. See 'Cultural safety' box above.

In 2019–20, 1,264 aged care places were provided through 42 aged care services under the NATSIFACP. Most of these places were for home care (770), followed by high care residential care (364) and low care residential care (130). Around half of these places were in the Northern Territory (614). There were no places in the Australian Capital Territory, and the next fewest were in New South Wales (27) (Department of Health 2020).

## Social support

In 2018–19 NATSIHS of the older Indigenous Australians (aged 50 and over) living in non-remote locations, almost 7 in 10 agreed (mildly, strongly or very strongly):

- They could count on their friends when things go wrong (69%).
- They could talk about their problems with their family (68%).
- They could talk about their problems with their friends (67%).
- They get the emotional support and help they need from their family (69%).
- Their family really tries to help them (68%) (AIHW analysis of ABS 2019b).

Similarly, in the 2014–15 National Aboriginal and Torres Strait Islander Social Survey (NATSISS) (the most recent data available), around 8 in 10 (81%) older Indigenous Australians (aged 50 and over) reported they could confide in family or friends outside the household. More than half (57%) had daily contact with friends or family outside the household, and a further third (37%) had contact at least once a week (AIHW analysis of ABS 2016).

## Justice and safety

As reported in the 2014–15 NATSISS:

- Around 1 in 10 (11%, 10,900) older Indigenous Australians (aged 50 and over) had been imprisoned at least once in their lifetime.
- Around 1 in 15 (6.5%, 6,400) had experienced physical violence in the previous 12 months.
- Almost 1 in 10 (9.5%, 9,400) had experienced threatened physical violence in the previous 12 months (AIHW analysis of ABS 2016).

In the 2014–15 NATSISS, more than 1 in 4 (28%) older Indigenous Australians reported they had received unfair treatment in the previous 12 months because they were of Aboriginal and/or Torres Strait Islander origin. In the previous 12 months, around 1 in 8 (13%) older Indigenous Australians reported avoiding situations due to unfair past treatment that was because they were of Aboriginal and/or Torres Strait Islander origin (AIHW analysis of ABS 2016).

More than 2 in 3 (68%) older Indigenous Australians who walked alone after dark felt safe or very safe walking alone in the local area at night – more than 1 in 5 (23%) felt unsafe or very unsafe. Seven in 10 (70%) older Indigenous Australians were aware of at least one local neighbourhood or community problem. The most commonly reported problems were:

- dangerous and noisy driving (44%)
- theft (43%)
- illegal drugs (37%)
- alcohol (36%) (AIHW analysis of ABS 2016).

## Housing and living arrangements

As reported in the 2018–19 NATSIHS, older Indigenous Australians (aged 50 and over) most commonly lived in one-family households (58%), followed by lone-person households (31%). Just over 1 in 5 (21%) older Indigenous Australians in 2018–19 lived in a home that was owned without a mortgage, and a further 1 in 5 (20%) lived in a home that was owned with a mortgage.

The most common landlord types for older Indigenous Australians were:

- state or territory housing authority (39% of renters)
- Indigenous housing organisation or community housing (22%)
- real estate agents (20%).

Around 1 in 12 (8.3%) older Indigenous Australians lived in a household where cooking facilities were either not available or did not work. Just over three-quarters (78%) of older Indigenous Australians lived in a household of an acceptable standard; this is similar to Indigenous Australians aged under 50 (78%) (AIHW analysis of ABS 2019b). An 'acceptable standard' means a dwelling with working health hardware (facilities for washing people, clothes and bedding, for safely storing and preparing food, and for removing waste) and no more than 2 major structural problems.

### Homelessness

In the 2014–15 NATSISS, nearly 1 in 4 (23%) older Indigenous Australians (aged 50 and over) reported they had experienced homelessness during their lifetime. This proportion was higher in non-remote areas (25%) than remote areas (18%) (AIHW 2019).

On Census night in 2016, nearly 3% of Aboriginal and Torres Strait Islander people aged 50 and over were homeless. More than half (57%) of this group lived in severely crowded dwellings (requiring 4 or more additional bedrooms) and around 1 in 6 (17%) lived in improvised dwellings or tents, or were sleeping out (AIHW 2019).

Less than 1% of non-Indigenous older Australians (aged 65 and over) were homeless on Census night in 2016 (0.4%). Of this group, more than 1 in 4 (28%) were housed in caravan parks, and around 1 in 6 (16%) were staying temporarily with other households (AIHW 2019).

## Education and skills

As reported in the 2018–19 NATSIHS, more than half (56%) of older Indigenous Australians (aged 50 and over) had completed at least year 10 or equivalent. Around 1 in 4 (27%) of this group had completed year 12 or equivalent.

Almost half (48%) of older Indigenous Australians had completed a qualification other than pre-primary, primary or secondary education – also known as a non-school qualification. The most commonly reported non-school qualifications of this group were:

- certificates III or IV (43%)
- advanced diploma/diploma (22%)
- certificates I or II (13%)
- bachelor degree (12%) (AIHW analysis of ABS 2019b).

## Employment and work

In 2018–19, 1 in 3 (33%) older Indigenous Australians (aged 50 and over) were employed full-time or part-time. This increased to 45% when focusing on those aged 50–64. Half of those aged 50–64 (50%) were not in the labour force (AIHW analysis of ABS 2019b).

## Income and finances

In 2018–19, most older Indigenous Australians (aged 50 and over) received a government pension, benefit or allowance as their main source of personal income (62%). About 1 in 4 (26%) received a wage or salary as their main source of personal income. Of those receiving a government pension or allowance, the most commonly received government pension or allowance was:

- Age Pension, for Indigenous Australians aged 65 and over (89%)
- Disability Pension, for Indigenous Australians aged 50–64 (51%), followed by Newstart allowance (28%).

In 2018–19, around 1 in 3 (35%) older Indigenous Australians had days without money for basic living expenses in the last 12 months. More than 1 in 5 (22%) older Indigenous Australians ran out of food in the last 12 months and couldn't afford to buy more (AIHW analysis of ABS 2019b).

## Where do I go for more information?

For more information on Aboriginal and Torres Strait Islander people aged 50 and over, see:

- ABS National Aboriginal and Torres Strait Islander Health Survey
- AIHW GEN Aged Care Data website
- AIHW Insights into vulnerabilities of Aboriginal and Torres Strait Islander people aged 50 and over: 2019 – In brief.

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# Feature articles

**On this page:**


- Demographic profile
- Health
- Aged care
- Social support
- Housing and living arrangements
- Education and skills
- Employment and work
- Income and finances
- Where do I go for more information?


**Key findings**
Over one-third (37%) of older Australians were born overseas.

**Key findings**
Over 1 in 6 (18%) older Australians spoke a language other than English at home.

**Key findings**
Almost 6% of older Australians spoke English either not well or not at all.

Australia's older people (aged 65 and over) come from all corners of the world and there is no single way to define what it means to be from a culturally and linguistically diverse (CALD) background. For example, it can refer to people who were not born in Australia, whose preferred language or the language they speak at home is a language other than English, or those who do not speak English well (referred to as English language proficiency). It can also include Aboriginal or Torres Strait Islander people – or can comprise a mix of these elements. People's experiences and circumstances can also vary considerably even within a particular group.

Throughout this feature article, 'older people' refers to people aged 65 and over. Where this definition does not apply, the age group in focus is specified. The 'Older Aboriginal and Torres Strait Islander people' feature article defines older people as aged 50 and over. This definition does not apply to this article, with Indigenous Australians aged 50–64 not included in the information presented.

### Measuring cultural and linguistic diversity

In addition to country of birth, preferred language, English language proficiency and Indigenous status, CALD measures can include factors such as the following (individually, or in combination with others):

- non-English-speaking country of birth – where countries re classified based on the main language spoken (English or another language) by the population. For the purpose of this report, non-English-speaking countries of birth comprise those other than the main English-speaking countries of New Zealand, United Kingdom, Ireland, United States of America, Canada and South Africa
- people's ancestry and their parents' country of birth
- first language spoken or other languages spoken
- religious affiliation
- year people arrived in Australia (or the time they have lived in Australia)
- migration pathways (for example, whether people moved to Australia as children, as refugees or as skilled migrants).

This article considers this diverse population from multiple perspectives and presents an overview of what key data sources tell us about CALD older Australians. Due to data availability, it primarily focuses on country of birth and English language proficiency as measures of cultural and linguistic diversity.

For information on older Aboriginal and Torres Strait Islander Australians, see Older Aboriginal and Torres Strait Islander people.

## Demographic profile

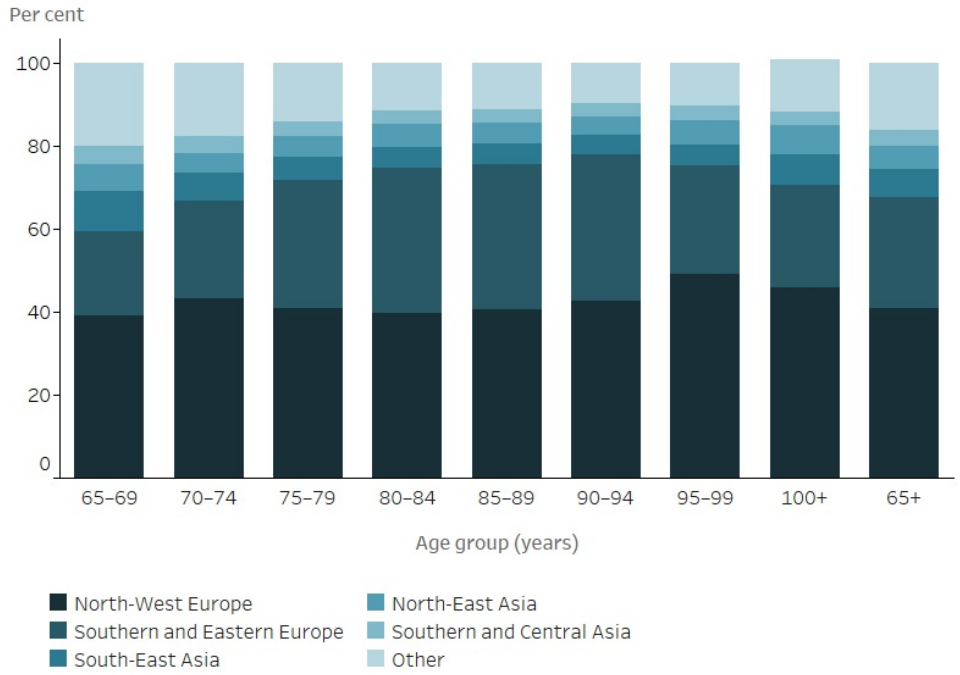
### Country of birth

According to the 2016 Australian Bureau of Statistics (ABS) Census, 1.2 million older Australians had been born overseas, representing over one-third (37%) of all people aged 65 and over.

Among those who were born overseas, the most common regions of birth were North-West Europe, Southern and Eastern Europe and South-East Asia. However, a somewhat smaller proportion were from Europe in the younger age groups compared with the older ages, and a somewhat higher proportion were from Asia and other regions (Figure 2B.1).
Figure 2B.1: Region of birth for older Australians born overseas by age group, 2016

The stacked column graph shows that, among older Australians born overseas, the most common region of birth was North-West Europe (41% of overseas-born Australians aged over 65 and 46% of overseas-born Australians aged over 100).

**Figure 2B.1: Region of birth for older Australians born overseas by age group, 2016**




*Notes*
1. 'Other' includes Americas, Sub-Saharan Africa, North Africa and the Middle East, and Oceania and Antarctica (excluding Australia).
2. Data exclude supplementary codes 'not stated' and 'overseas visitor'.
3. 'Older Australians' refers to people aged 65 and over.

*Source:* AIHW analysis of ABS Census of Population and Housing, 2016, TableBuilder.
http://www.aihw.gov.au/

This trend can be expected to increase over time as it reflects broader migration patterns in the period following World War II. For example, the proportion of migrants from Europe has been declining in recent years, falling from 52% in 2001 to 34% in 2016 (ABS 2017). In contrast, there has been an increase in migration from Asian countries over the last few decades, and older Australians born overseas who have arrived in Australia since the 1970s are more likely to have migrated from Asia than Europe (ABS 2017).

### Year of arrival

Many overseas-born older Australians migrated to Australia in their youth or middle age: 28% arrived before 1960, 65% in the 4 decades between 1960 and 1999, and only 6.9% since 2000 (Table 2B.1).

Table 2B.1: Year of arrival for older Australians born overseas by age group (%), 2016

| Age group (years) | Before 1960 | Between 1960 and 1999 | 2000 or later |
|---|---|---|---|
| 65–69 | 21.7 | 69.8 | 8.5 |
| 70–74 | 22.4 | 70.4 | 7.2 |
| 75–79 | 25.8 | 67.7 | 6.4 |
| 80–84 | 36.6 | 58.1 | 5.2 |
| 85–89 | 46.7 | 49.2 | 4.1 |
| 90–94 | 56.4 | 40.1 | 3.4 |
| 95–99 | 56.5 | 38.2 | 5.0 |
| 100+ | 50.8 | 39.2 | 7.2 |

| | | | |
|---|---|---|---|
| **Total** | **27.8** | **65.4** | **6.9** |

Note: 'Older Australians' refers to people aged 65 and over.

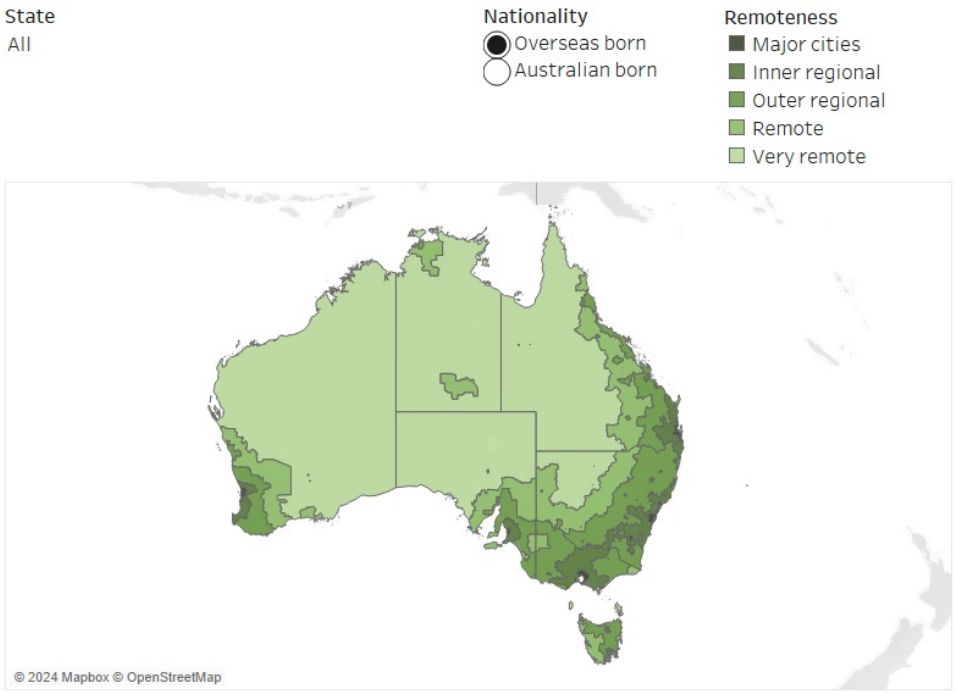
Source: AIHW analysis of ABS 2016a.

### Geographical distribution

The cultural and linguistic diversity of older Australians varies between geographies; for example, when measured by where people were born and the state or territory and remoteness area where they were living on Census night in 2016. In *Major cities* in New South Wales, Victoria and Western Australia, around half of older Australians were born overseas (46%, 51% and 51%, respectively) compared with 34% in Queensland (Figure 2B.2) (AIHW analysis of ABS 2016a). Note that this does not take into account details of people's cultural or linguistic background or other contextual information that may be relevant to diversity.
Figure 2B.2: Older Australians born overseas by state and territory and remoteness, 2016

The map shows the geographical distribution of overseas- and Australian-born older Australians across state and territory and remoteness areas. The proportion of overseas-born older Australians was highest in major cities (approximately half of older Australians in New South Wales, Victoria and Western Australia).

**Figure 2B.2: Older Australians born overseas by state and territory and remoteness, 2016**




*Notes*
1. Data exclude supplementary codes 'not stated', 'overseas visitor', and 'migratory and offshore '.
2. ACT regional numbers are small and should be treated with caution.
3. 'Older Australians' refers to people aged 65 and over.

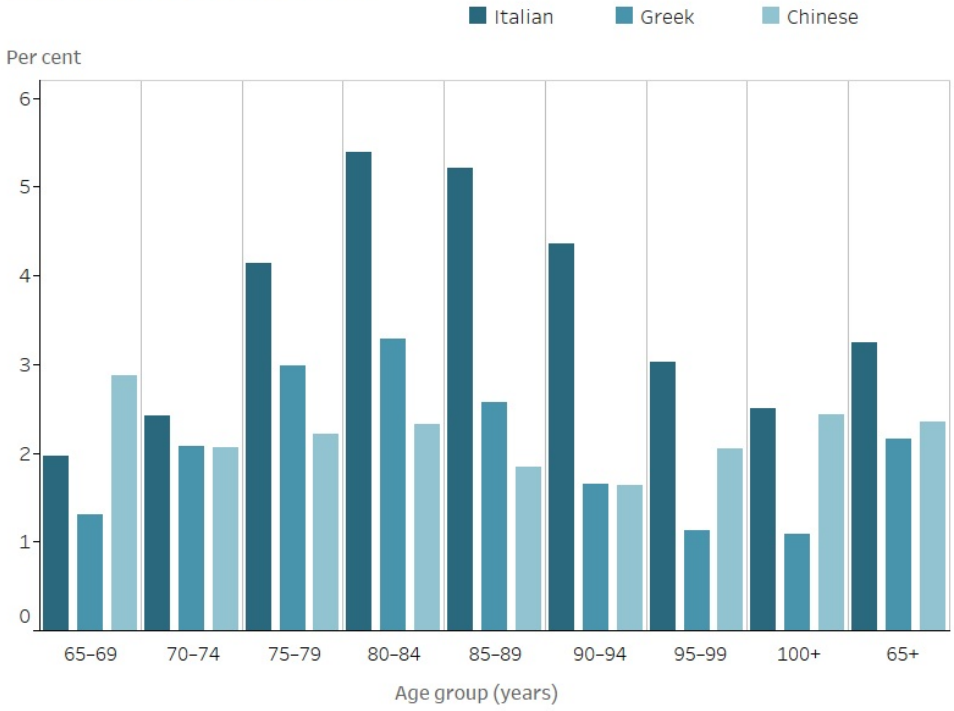
*Source:* AIHW analysis of ABS Census of Population and Housing, 2016, TableBuilder.
http://www.aihw.gov.au/

### Language

One in 5 (20%) older Australians (aged 65 and over) were born in non-English speaking countries, and 18% spoke a language other than English at home, according to the 2016 Census. The most common individual languages were Italian, Chinese (including both Cantonese and Mandarin) and Greek (Figure 2B.3). These patterns were similar for both men and women (AIHW analysis of ABS 2016a).
Figure 2B.3: Most common languages other than English spoken at home for older Australians by age group, 2016

The column graph shows that, of older Australians speaking the most common languages other than English, people aged 80–84 had the greatest proportion of other languages spoken (11% spoke Italian, Greek or Chinese). The proportion of people speaking Italian was higher than the proportion of people speaking Greek and Chinese in older age groups, with the exception of people aged 65–69 for whom the highest proportion spoke Chinese.

**Figure 2B.3: Most common languages other than English spoken at home for older Australians by age group, 2016**




*Notes*
1. Data exclude supplementary codes 'not stated' and 'overseas visitor'.
2. 'Older Australians' refers to people aged 65 and over.

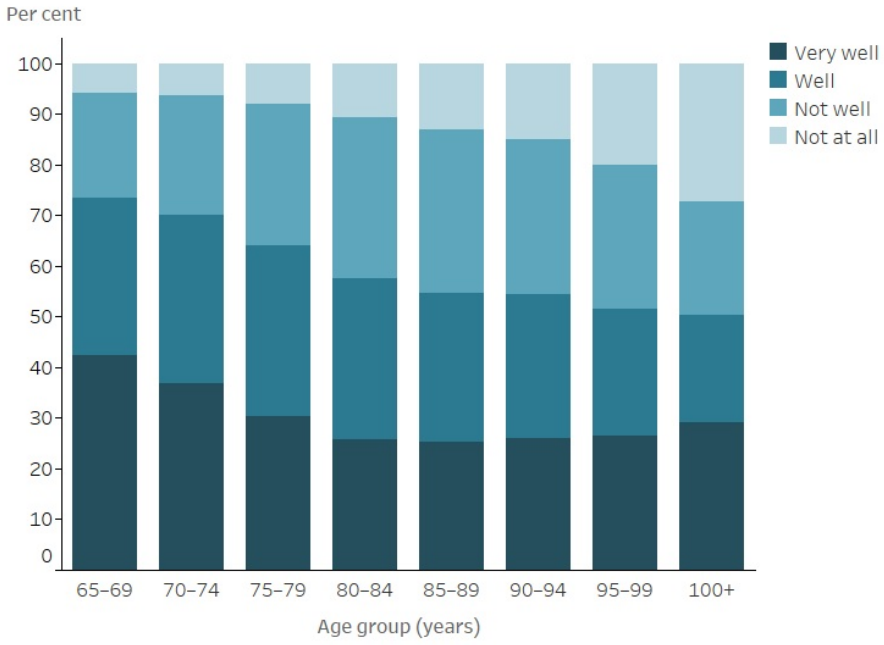
*Source:* AIHW analysis of ABS Census of Population and Housing, 2016, TableBuilder.
http://www.aihw.gov.au/

According to the 2016 Census, around 4 in 5 (82%) older Australians only spoke English. This can be connected with where people were born: 99% of those born in Australia only spoke English, compared with 54% of those born overseas. Of those born overseas who did not only speak English, 29% spoke English either well or very well.

Of all older Australians, 12% spoke another language other than English and spoke English well or very well, and 6% spoke another language other than English and spoke English not well or not at all. Looking only at this group of older people (those who spoke another language other than English), the proportion who spoke English well or very well decreased with age (Figure 2B.4) (AIHW analysis of ABS 2016a).
Figure 2B.4: English language proficiency for older Australians who spoke another language other than English by age group, 2016

The stacked column graph shows that the majority of older Australians who spoke another language other than English could speak English 'well' or 'very well'. The proportion of people who spoke English 'well' or 'very well' decreased with increasing age (73% of people aged 65-69 compared to 50% of people aged over 100).

Figure 2B.4: English language proficiency for older Australians who spoke another language other than English by age group, 2016




*Notes*
1. Data exclude 'not stated – both language and proficiency not stated', 'not stated – language stated, proficiency not stated' and 'overseas visitor'.
2. 'Older Australians' refers to people aged 65 and over.

*Source:* AIHW analysis of ABS Census of Population and Housing, 2016, TableBuilder.
http://www.aihw.gov.au/

### Religious affiliation

Almost 4 in 5 (78%) older Australians identified their religious background as Christian (commonly Catholic or Anglican), according to the 2016 Census. Other religions represented 3.7% (of these, the most common religious affiliation was Buddhism at 1.5%), while secular beliefs, other spiritual beliefs and no religious affiliation collectively accounted for 18% of older Australians. This last proportion was generally higher in the younger age groups (ABS 2017) (Table 2B.2). Note that questions around religious affiliation in the 2016 Census were voluntary and this section excludes not stated or inadequately described responses.

Table 2B.2: Religious affiliation for older Australians (%), 2016

| Age group (years) | Christianity | Other religions | Other beliefs or no belief |
|---|---|---|---|
| 65-69 | 72.8 | 4.7 | 22.4 |
| 70-74 | 77.8 | 3.7 | 18.5 |
| 75-79 | 81.6 | 3.2 | 15.3 |
| 80-84 | 83.3 | 2.8 | 13.8 |
| 85-89 | 84.1 | 2.7 | 13.2 |
| 90-94 | 84.5 | 2.8 | 12.7 |
| 95-99 | 82.6 | 3.5 | 14.0 |
| 100+ | 81.3 | 4.4 | 14.3 |
| **Total** | **78.3** | **3.7** | **18.0** |

Note: 'Older Australians' refers to people aged 65 and over.

Source: ABS 2017.

## Health and functional status

People's circumstances can influence their health status, what they need from health services, and how they access these. However, as the previous section has shown, older Australians from CALD backgrounds are not a homogenous group. As a result, the personal experiences, health status and health needs of individuals within any given group can vary greatly. The subgroups that make up the CALD population can

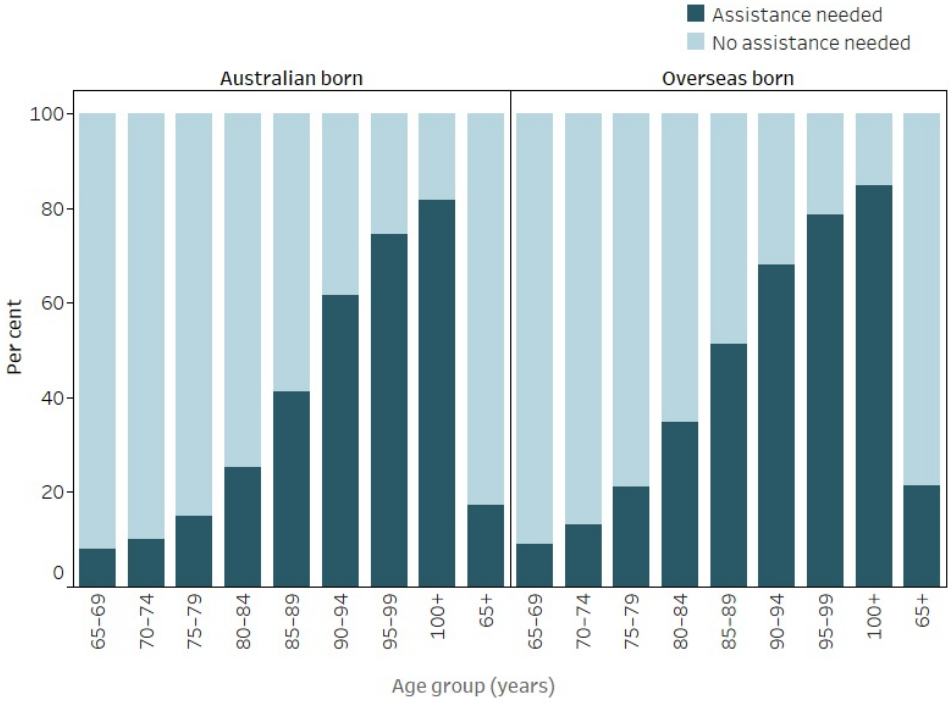
also change over time (see ‘Demographic profile’ above).

As with all older people, the proportion of older people (aged 65 and over) from CALD backgrounds who need assistance with core activities (communications, self-care and mobility) increased with age (Figure 2B.5). For more information on older people with disability, see Health status and functioning.

Figure 2B.5: Older Australians with need for assistance in core activities whether born overseas or in Australia, by age group, 2016

Two stacked bar charts show that the proportion of older Australians needing assistance in core activities increases with age. The proportion of people requiring assistance was slightly higher in overseas born older Australians. The greatest difference in need for assistance was in older Australians aged 80–84 and 85–89 (proportion of people needing assistance was 10% higher among people born overseas compared to Australian born).

**Figure 2B.5: Older Australians with need for assistance in core activities whether born overseas or in Australia, by age group, 2016**




*Notes*
1. Data excludes supplementary codes ‘not stated’ and ‘overseas visitor’.
2. ‘Older Australians’ refers to people aged 65 and over.

*Source:* AIHW analysis of ABS Census of Population and Housing, 2016, TableBuilder.
http://www.aihw.gov.au/

According to self-reported data in the 2017–18 ABS National Health Survey (NHS), of older Australians born overseas:

- 13% had exceeded lifetime alcohol risk guidelines (7-day average 2009 guidelines; NHMRC 2009)
- 7.1% were current daily smokers
- 68% had not met 2014 physical activity guidelines (see ABS 2019c for information on how the NHS derives the physical activity guidelines as being met)
- 1.7% met the recommended serves of vegetables only (see NHMRC 2013 for recommended serves)
- 57% met the recommended serves of fruit only (see NHMRC 2013 for recommended serves)
- 7.4% met the recommended serves of both fruit and vegetables (AIHW analysis of ABS 2019a; see NHMRC 2013 for recommended serves).

Around 4 in 10 (41%) older Australians born overseas reported their health as excellent or very good, and almost 1 in 2 (45%) reported experiencing no pain or very mild pain in the past 4 weeks (AIHW analysis of ABS 2019a). Considering selected measures of health service use, almost all (97%) older Australians born overseas had seen a general practitioner in the last 12 months, and around half (48%) had seen a dentist (AIHW analysis of ABS 2019b).

## Aged care

As with health care, it can be difficult for some groups of older Australians to access aged care services. For example, they may face language barriers, and available services may not be culturally appropriate or they may fail to meet people’s needs. Cultural practices and family culture can also influence what a person needs from aged care services and how they access them. For example, where informal, family-centred care is available, people may not seek formal aged care.

Around 28% of people using home care, 20% of people using permanent residential aged care and 20% of people using respite or transition care at 30 June 2020 were from a CALD background (Department of Health 2020). (In this case, CALD background refers to the proportion of people who were born overseas in countries other than the main English-speaking countries. This may underestimate the proportion of

people from a CALD background as it is only one marker of cultural and linguistic diversity.) For all older Australians, information is presented on aged care and related information is available in housing and living arrangements.

Varying slightly between programs, around 1 in 8 (12%) aged care users at 30 June 2020 had a preferred language other than English (AIHW 2020). The aged care workforce commonly includes many people from non-English-speaking backgrounds, but from different backgrounds to those common among aged care users. For example, in residential aged care facilities where at least one-third of personal care attendants spoke a language other than English, facilities commonly identified Indian and Filipino as the workers' background (Mavromaras et al. 2017). This is an important consideration in terms of language barriers, for which currently no data exist to allow a more detailed study. The Department of Health's 2020 Aged Care Workforce Census found that 36% of personal care attendants in residential aged care identified as being from a CALD background, increasing to 58% in facilities with a higher proportion of CALD residents (Department of Health 2021). However, these figures provide no indication of overlap between the CALD background of staff and that of residents. Similar issues may be present in other sectors, such as disability support.

### Social support

According to the 2016 Census, around 1 in 8 overseas-born older Australians provided support to someone with disability (13%), took part in voluntary work (15%) or provided unpaid child care (14%). Similarly, around 1 in 7 Australian-born older people provided support to someone with disability (14%) or provided unpaid child care (14%). Almost 1 in 4 (24%) Australian-born older people took part in voluntary work.

Proficiency in the local language may influence people's sense of social connectedness. The 2016 ABS Personal Safety Survey indicated that nearly all (95%) older people who mainly spoke another language at home but spoke English well or very well had visited (or had been visited by) friends in the last 3 months (AIHW analysis of ABS 2016b).

For more information on social support for all older Australians, see Social support.

### Housing and living arrangements

In 2016, older Australians who were born overseas were somewhat less likely to own their home outright, and somewhat more likely to be either mortgaged or renting, compared with those born in Australia (Table 2B.3).

**Table 2B.3: Housing tenure type of older Australians, by whether born overseas or in Australia, 2016**

| Place of birth | Owned outright | Mortgaged or being purchased | Rented | Other |
|---|---|---|---|---|
| Overseas | 68.0% | 14.5% | 14.9% | 2.6% |
| In Australia | 74.3% | 10.5% | 11.9% | 3.3% |

Note: 'Older Australians' refers to people aged 65 and over.

Source: AIHW analysis of ABS 2016a.

Around 5.2% of overseas-born older Australians reported living in a multi-family household in 2016 compared with 1.9% of those born in Australia. This suggests that intergenerational living may be more common for some older people from CALD backgrounds. This may also account for some of the variation in housing arrangements seen above; for example, living with family, people may be less likely to need to move into residential aged care.

Around 1.2% of overseas-born older people were experiencing some form of homelessness on Census night in 2016 (defined as living in caravan parks, boarding houses, supported accommodation or similar, or in temporary, improvised or crowded dwellings). This compared with 2.3% of Australian-born older people (AIHW analysis of ABS 2016a).

### Education and skills

More than 1 in 2 (52%) older Australians aged 65–74 who were born overseas had a highest educational attainment of year 12 or below. More than 1 in 5 had a bachelor degree or a higher qualification (22%), and another 1 in 5 had a certificate (III or IV) or diploma (21%) (AIHW analysis of ABS 2020).

For people aged 65–74 born overseas, whose highest level of education was a bachelor degree or higher, 1 in 5 had a main field of study of management and commerce (20%) and another 14% in engineering and related technologies (AIHW analysis of ABS 2020). These patterns may have been influenced by skilled migration pathways into Australia and may be different for different cohorts of older people. The fields people study also vary by sex; for more information on this for all older Australians, see Education and skills.

### Employment and work

In 2020, more than 1 in 6 (18%) overseas-born people aged 65–74 were still working. The most common occupations of work were professionals and managers (38% for those born overseas who continued to work) (AIHW analysis of ABS 2020). However, 'professionals and managers' refers to a broad group, and people from particular backgrounds – such as those who have migrated more recently, or who come from non-English-speaking countries – may have very different experiences.

Around two-thirds (63%) of overseas-born people aged 65–74 indicated that they were permanently not intending to work (AIHW analysis of ABS 2020).

## Income and finances

Many older Australians receive the Age Pension and/or are able to access superannuation (for more information on this, see Income and finance). In addition to supports available through Australia (or instead of these), some people born overseas may also be able to access similar supports from their birth country. No information is available on income source by people's CALD background.

Cultural and linguistic diversity is a broad concept and this can mask specific issues, such as those relating to socioeconomic disadvantage. For example, the 2016 ABS Personal Safety Survey indicated that nearly 9 in 10 (86%) older people who mainly speak another language at home and speak English well or very well could raise $2,000 within a week in an emergency. Around 7 in 10 (74%) of those who speak English not well or not at all could raise $2,000 within a week in an emergency (AIHW analysis of ABS 2016b).

This was also reflected in the 2016 Census. Where income was reported, overseas-born older Australians were more likely to have a personal weekly income below $500 compared with those born in Australia (61% and 55%, respectively) (AIHW analysis of ABS 2016a).

## Where do I go for more information?

For more information on older people from culturally and linguistically diverse backgrounds, see:

- ABS Cultural diversity in Australia, 2016
- AIHW Dementia in Australia 2021: Cultural and linguistic diversity among Australians who died with dementia.

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# Feature articles

**On this page:**


- Demographic profile
- Health
- Aged care
- Housing and living arrangements
- Where do I go for more information?


**Key findings**
In 2017–18, almost half (47%) of males aged 55–64 who had ever served in the Australian Defence Force (ADF) considered themselves to be in excellent or very good health; however, this dropped to 36% for those aged 75 and over.

**Key findings**
In 2019–20, of older Department of Veterans' Affairs (DVA) clients (aged 65 and over), 30% were approved for Veterans' Home Care services and 11% received community nursing services respectively.

**Key findings**
At 30 June 2020, over half of all DVA clients (55%, or over 181,500 permanent, reserve and ex-serving ADF members and their dependants) were aged 65 and over.

## Demographic profile

People who served in the ADF, as well as the spouse, widow or widower of a serving or ex-serving ADF member, form an important minority of older Australians. This population may experience ageing differently due to factors associated with ADF service, and many experience health and welfare challenges over and above those of the Australian population.

### Data considerations

- Within this article, each section references findings from a variety of data sources. This means that subpopulations of veterans and their families will often differ between sections, depending on the data source used. As such, findings across different sections of this article should not be compared.
- While the older Australian population is generally defined as 65 years and over, data on older veterans in this article are presented in differing age ranges due to differences in the data sources.
- For some sections of this article, data are only presented for males due to female population sizes being too small to report.

### Who are veterans?

In 2017, the Veterans Ministers' Roundtable responsible for veterans' issues agreed that all jurisdictions would define a veteran as 'a person who is serving or has served in the ADF' (Tehan 2017). The *Australian Veterans' Recognition (Putting Veterans and their Families First) Act 2019* (Cth) defined a veteran as 'a person who has served, or is serving, as a member of the Permanent Forces or as a member of the Reserves'.

The subpopulations of veterans covered in this article are:

- **DVA clients** – eligible permanent, reserve and ex-serving ADF members and their eligible family members who are supported by the DVA. These may be permanent, reserve or ex-serving members of the ADF, or the family, partner or dependant of a permanent, reserve or ex-serving ADF member. DVA clients may be identified in survey data through a question asking whether they are a card holder or payment recipient, or in administrative data where a service was funded by the DVA. In some cases, DVA clients are separated into DVA benefit or payment recipients, and DVA card holders (noting it is possible for a person to fit both categories) (AIHW 2018).
- **ADF members** – people who have had at least one day of permanent or reserve service in the ADF, as reported in the Defence Census and DVA annual reports. This includes both members who are still serving in a permanent regular capacity or in the reserve forces, as well as those who have separated from the ADF.
- **Contemporary ex-serving ADF members** – ADF members who have had at least one day of permanent or reserve service on or after 1 January 2001, and have since separated from the ADF. This subpopulation was used in previous AIHW studies on veterans, and is based on the current ADF personnel system (AIHW 2020).
- **Ever served in the ADF** – respondents who answered 'yes' when asked 'Have you ever served in the Australian Defence Force?' in the 2017–18 National Health Survey. This is self-reported by respondents, and may include permanent, reserve and/or ex-serving ADF members.

### How many serving and ex-serving ADF members are there in Australia?

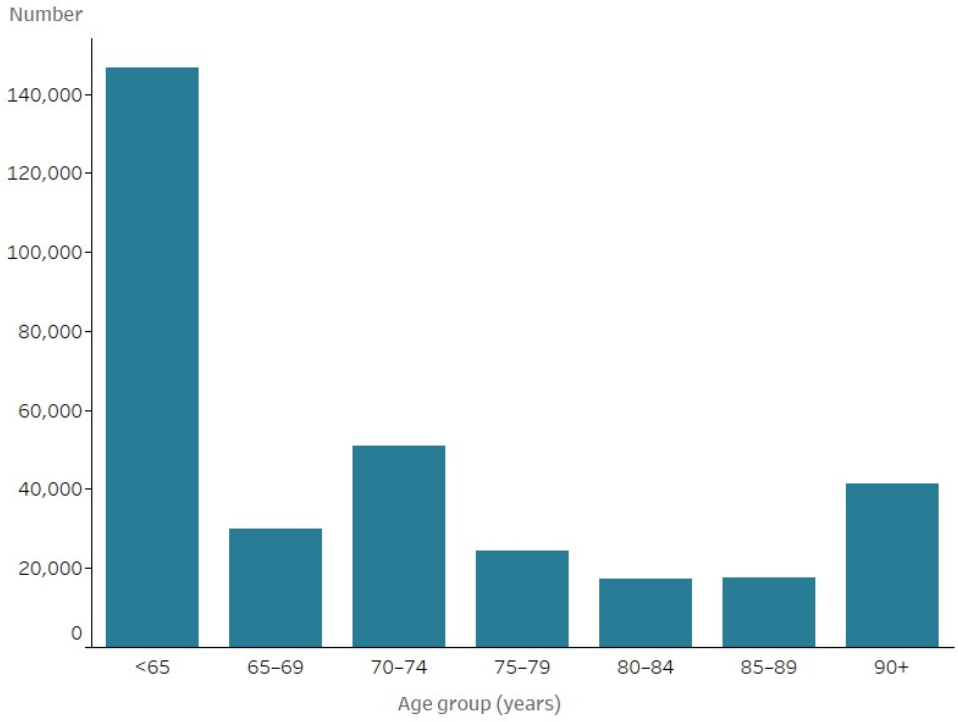
While the number of permanent and reserve ADF members is known, the exact number and characteristics of ex-serving ADF members in Australia is unknown and veterans are not readily identifiable in many general population health and welfare data sets. At 30 June 2020, the ADF comprised about 59,000 permanent (48,000 males and 11,000 females) and over 28,800 active ADF reserve members across the Royal Australian Navy, the Australian Army and the Royal Australian Air Force (Department of Defence 2019a).

According to the 2019 Department of Defence Census, around 9% of permanent ADF members were aged 50 and over, compared with 35% of ADF reserve members (Department of Defence 2019b).

At 30 June 2020, more than half of all DVA clients (55%, or over 181,500 permanent, reserve and ex-serving ADF members and their dependants) were aged 65 and over. Of DVA clients overall, around 1 in 8 (13%) were aged 90 and over (DVA 2020b) (Figure 2C.1).
Figure 2C.1: Number of DVA clients by age group, 30 June 2020

The column graph shows the number of DVA clients amongst older Australians was greatest in the 70–74 age group as well as those 90 and over. Around 147,000 DVA clients were aged 65 and over as at 30 June 2020.

**Figure 2C.1: Number of DVA clients by age group, 30 June 2020**




*Note:* The total number of DVA clients includes any person in receipt of a pension or allowance from DVA or eligible for treatment or pharmaceuticals paid for by the DVA. Clients of unknown age are included in the total but not reported separately. Some clients are both serving or ex-serving ADF members and dependants; therefore, the total number of clients supported does not equal the total number of serving and ex-serving ADF members plus the total number of dependants.

*Source:* DVA 2020b.
http://www.aihw.gov.au/

## Health

### Health status

According to the Australian Bureau of Statistics (ABS) 2017–18 National Health Survey, almost half (47%) of males aged 55–64 who had ever served in the ADF considered themselves to be in excellent or very good health; however, this dropped to 36% among males who had ever served in the ADF aged 75 and over. This was similar for males who had never served in the ADF (52% and 36%, respectively) (ABS 2019).

Nearly 2 in 5 (39%) males aged 75 and over who had ever served in the ADF considered their health to be fair or poor, compared with 31% of males of the same age who had never served in the ADF (ABS 2019).

### Chronic diseases

In 2017–18, males aged 55 and over who had ever served in the ADF generally reported similar rates of chronic diseases as the non-serving population, including arthritis, back pain and problems, and diabetes. However, males aged 65–74 who had ever served in the ADF reported mental and behavioural conditions at a rate 10 percentage points higher than males aged 65–74 who had never served in the ADF (27% and 17%, respectively) (ABS 2019).

### Dispensed medication

In 2017–18, over 1 million medications were dispensed to around 70,000 contemporary ex-serving ADF members of all ages (AIHW 2019a). Consistent with the increased likelihood of developing chronic diseases with age (ABS 2018), the rate of medication dispensing per member was found to increase with age:

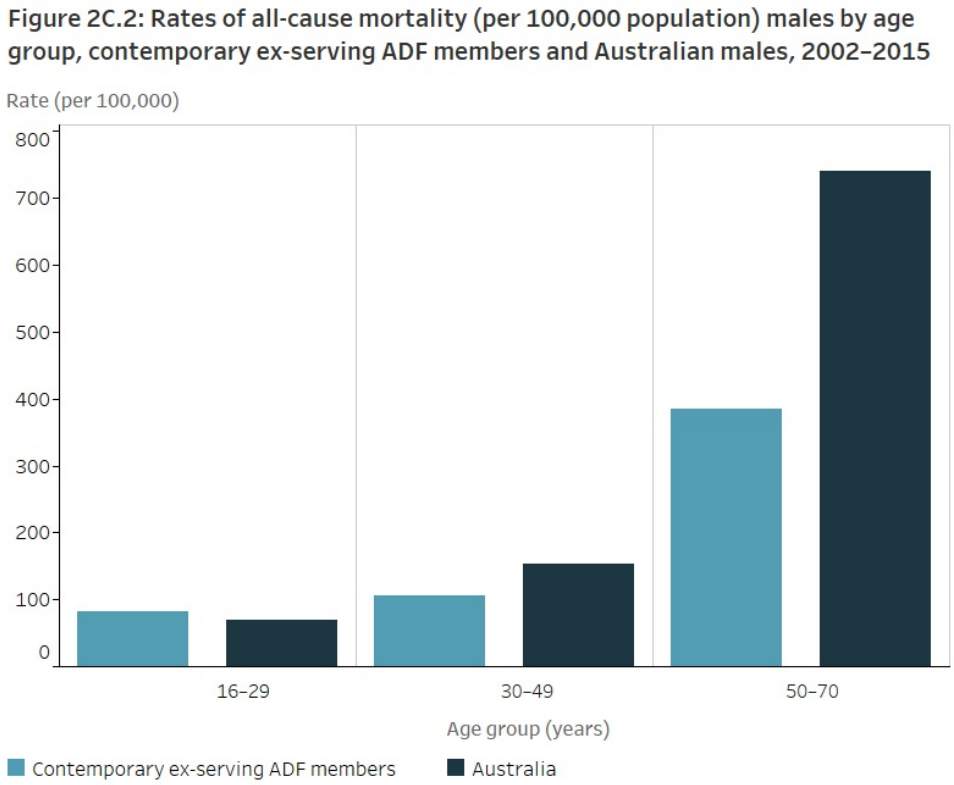
- Contemporary ex-serving ADF members in older age-groups were dispensed more medications than younger age groups, with almost half (47%) of all medications dispensed to members aged 50–69. For males in this age group, medications relating to the cardiovascular system were the most commonly dispensed, accounting for over one-third (39%) of all dispensing for males aged 50-69 (AIHW 2019a).
- The rate of dispensing for contemporary ex-serving ADF members increased with age, with the rate for those aged 70 and over being 35 per person. This was nearly twice as high as the rate for those aged 50–69 (19 per person) and around 10 times the rate for those aged 17–30 (4 per person). This pattern is similar in age-matched rates within the Australian population (AIHW 2019a).

### Deaths

Between 2002 and 2015, rates of deaths due to any cause (all-cause mortality) for contemporary ex-serving ADF males aged 50–70 were almost half those of Australian males of the same age. In contrast, rates of all-cause mortality for contemporary ex-serving ADF males aged 16–29 were similar to those of Australian males of the same age. As expected, all-cause mortality rates increased with age (AIHW 2020) (Figure 2C.2).

Figure 2C.2: Rates of all-cause mortality (per 100,000 population) males by age group, contemporary ex-serving ADF members and Australian males, 2002–2015

The column graph shows that the all-cause mortality rate for males was greater amongst Australian males compared to contemporary ex-serving ADF members between the ages of 30–70 in 2002–2015. However contemporary ex-serving males aged 16–29 had a greater all-cause mortality rate than Australian males (81.6 and 69.0 per 100,000, respectively).




*Note:* All differences in age-specific rates between the contemporary ex-serving population and the Australian population were statistically significant. The exception was the contemporary ex-serving 16–29 year age group; the difference with the Australian population was not statistically significant.

*Sources:* AIHW analysis of linked PMKeyS-NDI data 2002–2015; AIHW NMD 2002–2015.
http://www.aihw.gov.au/

The leading causes of death for male contemporary ex-serving ADF members for 2002–2015, aged 50 and over, included coronary heart disease, lung cancer, prostate cancer, colorectal cancer and cerebrovascular disease. This is similar to the Australian population for males aged 50 and over, whose leading causes of death included coronary heart disease, lung cancer, cerebrovascular disease, chronic obstructive pulmonary disease and prostate cancer. While suicide is a leading cause of death for those contemporary ex-serving ADF members aged under 50, this is not the case among contemporary ex-serving ADF members aged 50 and over (AIHW 2020).

## Aged care

The DVA provides two main services to assist older permanent, reserve and ex-serving ADF members, and war widow(er)s:

- Veterans' Home Care (providing domestic assistance, personal care, safety-related home and garden maintenance and respite care for those with low care needs)
- community nursing services (providing clinical and personal care).

Those ADF members and war widow(er)s who are aged 65 and over needing assistance may also access mainstream aged care services, either exclusively or in addition to DVA services, as long as the services are not duplicated. These services include the Commonwealth Home Support Programme, Home Care Packages and residential aged care. While it is possible to identify DVA clients in residential aged care, at this stage it is not possible to identify how many ex-serving ADF members are accessing these mainstream community-based services.

In 2019–20, 37,700 older DVA clients (aged 65 and over) were approved for Veteran's Home Care services and 13,800 older DVA clients received community nursing services, representing 30% and 11% of older DVA clients, respectively (SCRGSP 2021).

### Who is eligible for Veterans' Home Care services?

Serving and ex-serving ADF members eligible for Veterans' Home Care services are those with an assessed need who hold a Veteran Gold Card, or a Veteran White Card for an accepted service-related injury or condition. Carers and family members of Gold Card and White Card holders with an accepted service-related condition may be eligible for an assessment (DVA 2019).

### Who is eligible to receive community nursing services?

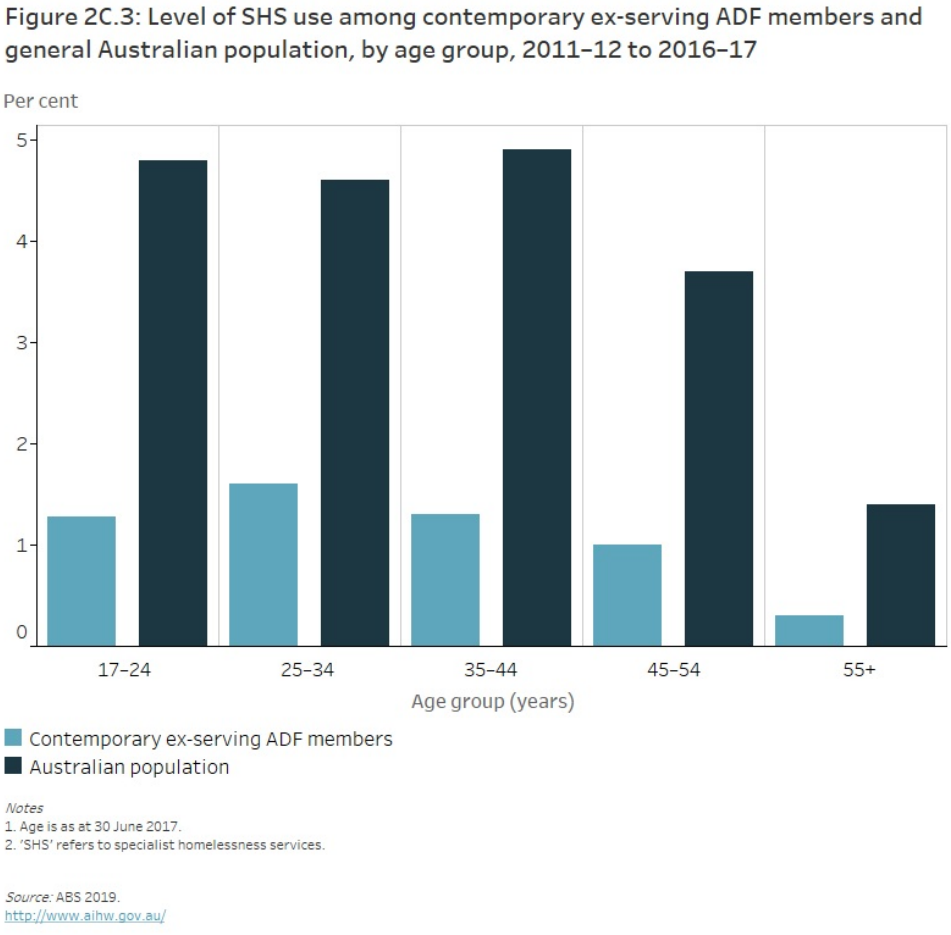
To receive community nursing services for an assessed clinical need, a client must have either a Gold Card or a White Card. Where a client holds a White Card, the need for community nursing services must be related to an accepted service-related injury or condition (DVA 2020a).

## Housing and living arrangements

Between 1 July 2011 and 30 June 2017, 1,200 contemporary ex-serving ADF members used specialist homelessness services (SHS), representing 1.1% of contemporary ex-serving ADF members, compared with 3.4% of the Australian population. Across all age groups, the level of SHS use among contemporary ex-serving ADF members was lower than among the Australian population. For both contemporary ex-serving ADF members and the Australian population, the proportion of SHS use was lowest among those aged 55 and over (0.3% and 1.4%, respectively) (AIHW 2019b) (Figure 2C.3).

Figure 2C.3: Level of SHS use among contemporary ex-serving ADF members and general Australian population, by age group, 2011–12 to 2016–17

The column graph shows that the level of use of specialised homelessness services (SHS) was greater amongst the general Australian population compared with contemporary ex-serving ADF members, across all age groups. In the Australian population, the percentage of those using SHS was highest in those aged 35–44, at 4.9% of people in this age group. Amongst contemporary ex-serving ADF members, this percentage was highest in those aged 25–34, with 1.6% of members in this age group using SHS.




## Where do I go for more information?

For more information on serving and ex-serving ADF members:

- AIHW A profile of Australia's veterans 2018

- AIHW Health of veterans
- AIHW Medications dispensed to contemporary ex-serving Australian Defence Force members, 2017–18
- AIHW National suicide monitoring of serving and ex-serving Australian Defence Force personnel: 2020 update
- AIHW Serving and ex-serving Australian Defence Force members who have served since 1985: population characteristics 2019
- AIHW Use of homelessness services by contemporary ex-serving Australian Defence Force members 2011–17

### What support is available?

Open Arms – Veterans & Families Counselling

Provides 24-hour free counselling and support to you and your family, including the Safe Zone Support – a 24-hour free anonymous counselling line.

ADF Mental Health All-hours Support Line

A confidential 24-hour telephone service for ADF members and their families.

Lifeline Australia

Provides free support services if you are in crisis and need to talk to someone.

1800RESPECT

Provides 24-hour counselling services to help you cope with sexual assault or violence.

Ex-service organisations

Connect with an ex-service organisation in your local area. These organisations may be able to provide you with support and resources.

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# Feature articles

**On this page:**


- Demographic profile
- Health
- Aged care
- Social support
- Justice and safety
- Housing and living arrangements
- Education and skills
- Employment and work
- Income and finances
- Where do I go for more information?


**Key findings**
1 in 3 (34%) older Australians (aged 65 and over) live in rural and remote areas of Australia.

**Key findings**
1 in 5 (22% or 13,400) older Australians who live in Remote and Very remote areas were receiving assistance from aged care home support programs.

**Key findings**
1 in 3 (34%) older Australians with disability lived in rural and remote areas.

This feature article reports on the health and wellbeing of older people (aged 65 and over) living in rural and remote areas, which encompass many diverse locations and communities. The geographical isolation of some rural and remote communities can impact the experience of ageing due to the availability of services, transport, infrastructure, employment opportunities, housing and living arrangements, and community resources (AIHW 2019b; Davis and Bartlett 2008).

Throughout this feature article, 'older people' refers to people aged 65 and over. Where this definition does not apply, the age group in focus will be specified. The 'Older Aboriginal and Torres Strait Islander people' feature article defines older people as aged 50 and over. This definition does not apply to this feature article, with Indigenous Australians aged 50–64 not included in the information presented unless specified.

### Regions of Australia

The regions within Australia can be broadly divided into *Major cities, Inner regional, Outer regional, Remote* and *Very remote*. These areas are based on the Accessibility/Remoteness Index of Australia, which takes into consideration the road distances people have to travel for services (ABS 2020d). The majority of Australia's total population lives in *Major cities* (72%), with a further 26% in *Inner regional* and *Outer regional* and 1.9% in *Remote* and *Very remote* areas (AIHW 2020a).

The term 'rural and remote' covers the areas outside Australia's *Major cities*. Due to small population sizes, data for *Outer regional, Remote* and *Very remote* are sometimes combined for reporting.

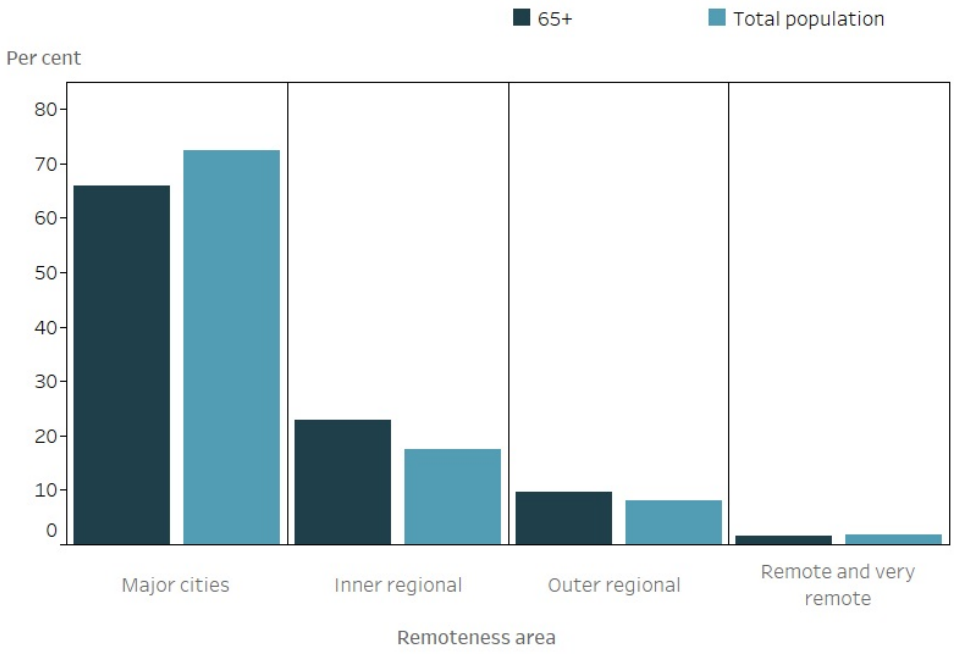
## Demographic profile

At 30 June 2020, there were an estimated 4.1 million older people (aged 65 and over) living in Australia. Two-thirds lived in *Major cities* (66%, 2.7 million), nearly 1 in 4 in *Inner regional* areas (23%, 0.9 million) and the remaining 11% lived in *Outer regional* and *Remote and very remote* areas combined (0.5 million, Figure 2D.1). Compared with the total Australian population, a higher proportion of older people lived in *Inner regional* areas and a lower proportion in *Major cities*. Nearly 3 in 4 (72%) of the total Australian population lived in *Major cities*, 18% in *Inner regional* areas and the remaining 9.9% lived in *Outer regional* and *Remote and very remote* areas combined (AIHW 2020a) (Figure 2D.1).

Younger people are more likely to live in, and migrate to, *Major cities* because of education and job opportunities, and to easily access social activities. However, older people may also move to *Major cities* for better access to services (Davis and Bartlett 2008).
Figure 2D.1: Profile of older Australians and total population by remoteness, at 30 June 2020

The column graph shows that a higher proportion of older Australians live in Inner regional and Outer regional areas in comparison to the total population (66% of older Australians live in Major cities, 23% in Inner regional areas, 9.7% in Outer regional areas and 1.5% in Remote and very remote areas).

**Figure 2D.1: Profile of older Australians and total population by remoteness, at 30 June 2020**




*Notes*
1. Remoteness Areas are based on the ABS Australian Statistical Geograpy Standard ('ASGS 2016'). See ABS cat. no. 1270.0.55.005 for more information.
2. *Remote and very remote* field calculated by combining the two remoteness areas.
3. 'Older Australians' refers to people aged 65 and over.

*Source:* AIHW 2020a.
http://www.aihw.gov.au/

## Health

Rural and remote areas tend to overlap with areas identified as the most disadvantaged in Australia (ABS 2018a). Australians living in rural and remote areas, on average, have shorter lives, higher death rates, higher levels of disease and injury, and poorer health outcomes compared with people living in metropolitan areas (AIHW 2019b, 2020b). This can be linked to multiple factors including lifestyle risk factors, socioeconomic disadvantages and poorer access to health services (NRHA 2011).

The health disadvantages of communities in rural and remote Australia can also be impacted by the availability of health care services. Accessibility issues, such as access to dental, general practitioner and community services, and higher prevalence of health risk factors, such as higher rates of smoking, disability and physical inactivity, can all contribute to poorer health outcomes (NRHA 2011).

For more information, see Rural & remote health.

### Chronic conditions

In Australia, chronic conditions and diseases are the leading cause of ill health, disability and death, having a significant impact on the health sector in all regions. Although the prevalence of many health conditions does not vary between people living in areas of increasing remoteness, some conditions are reported more frequently among people living outside of *Major cities*. These include mental and behavioural conditions, arthritis, back pain and asthma (AIHW 2019b). Alongside the factors identified above, differences in the rates of these chronic conditions may contribute to the poorer health outcomes of Australians living in rural and remote communities.

Similar patterns in health conditions and remoteness are observed among older Australians (aged 65 and over) specifically. For example, compared with older people living in *Major cities*, older people living in rural and remote areas have a higher prevalence of chronic conditions such as arthritis, asthma and chronic obstructive pulmonary disease (ABS 2018c). Although differences exist in these specific conditions, no differences were detected between remoteness categories in the presence of multiple chronic conditions more generally in 2017–18: around 1 in 2 older people reported having 2 or more chronic conditions in *Major cities* (50%), *Inner regional* (51%) and *Outer regional, remote and very remote* areas (50%). In comparison, around 1 in 6 (17%) older people in *Inner regional* areas, and around 1 in 5 in *Major cities* (21%) and *Outer regional, remote and very remote* areas (23%), reported having no chronic conditions (ABS 2018c).

The differing sociodemographic profiles of urban and remote communities also likely explain some of the divergence in health conditions and outcomes between these regions. For instance, there are differences in age composition and other demographic characteristics associated with health and wellbeing. At 30 June 2020, around 1 in 10 (9%) people living in *Very remote* areas were aged 65 and over, compared with 1 in 7 (15%) in *Major cities*. Moreover, at 30 June 2016, around 1 in 5 (22%) older people living in *Very remote* areas were Aboriginal and/or Torres Strait Islander people, compared with only 0.5% in *Major cities* (ABS 2018b). Indigenous Australians tend to develop chronic conditions earlier in life and are more likely to have higher rates of hospitalisations and poorer health outcomes than non-Indigenous Australians (AIHW 2019b).

For more information on Aboriginal and Torres Strait Islander health by remoteness, see Aboriginal and Torres Strait Islander Health Performance Framework (HPF) report and Older Aboriginal and Torres Strait Islander people.

### Disability

The prevalence of disability among older Australians has remained stable over recent years. Based on data from the 2018 Australian Bureau of Statistics (ABS) Survey of Disability, Ageing and Carers (SDAC), 1 in 2 (50%) older people had disability in 2018. This was similar in 2015 (51%) and 2012 (53%) (ABS 2019a; AIHW analysis of ABS 2019c). Even though the proportion of older people with disability has been stable, the number of older people with disability has increased:

- 1.94 million in 2018
- 1.80 million in 2015
- 1.72 million in 2012 (AIHW analysis of ABS 2013, 2016, 2019c).

Of these older Australians with disability, 1 in 3 (34%) lived in rural and remote areas (AIHW analysis of ABS 2019c). Overall, the prevalence of disability among older Australians did not vary systematically by level of remoteness, with a slightly lower prevalence of older Australians with disability in *Major cities* (49%) and *Outer regional* areas (49%), and a slightly higher prevalence in *Inner regional* (52%) and *Remote* areas (55%) (AIHW analysis of ABS 2019c). However, looking solely at those older Australians with disability who report mild limitations in core activities, a step-wise relationship between prevalence of disability and level of remoteness was observed: lowest in *Major cities* (19%), followed by *Inner regional* (21%), *Outer regional* (22%) and *Remote* (27%) areas. This relationship does not extend to those older Australians with disability who report other levels of limitation in core activities; for example, moderate limitations were most prevalent in *Inner regional* areas (8.7%), whereas severe limitations were most prevalent in *Remote* areas (9.1%).

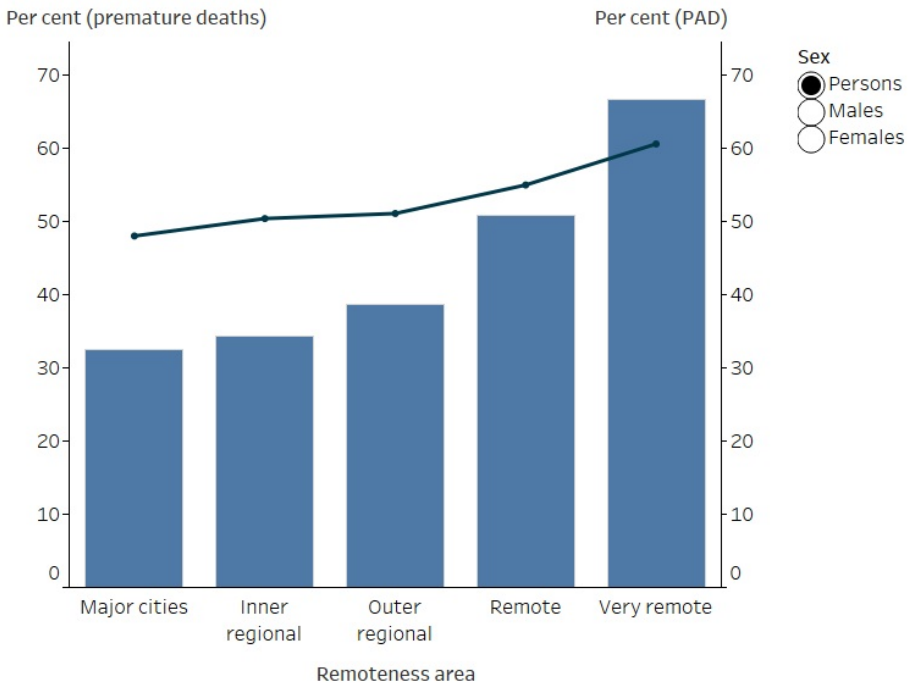
### Deaths

People living in rural and remote areas are more likely to die at a younger age than their counterparts living in *Major cities* among both men and women. They have higher mortality rates and higher rates of potentially avoidable deaths – deaths under the age of 75 from conditions that are potentially preventable through primary or hospital care – than those living in *Major cities (*Figure 2D.2*)*.

Across Australia in 2018, the median age at death decreased as remoteness increased for both sexes and the overall population. Men had the lowest median age at death across the remoteness areas: 68 years in *Very remote* areas compared with 79 years in *Major cities* (Table 2D.1). Of the total number of deaths that occurred in *Very remote* areas in 2018, 2 in 3 (67%) were premature deaths – people aged under 75. Around 3 in 5 (61%) of these premature deaths were considered to be potentially avoidable. In contrast, 33% of all deaths were premature deaths in *Major cities,* of which nearly half (48%) were considered potentially avoidable (AIHW 2020c) (Figure 2D.2). As discussed in 'Chronic conditions' below, the differences between remoteness areas may be due to the characteristics of the population. Figure 2D.2: All causes of premature death by sex and remoteness area, 2018

The column and line graph shows that the proportion of people who died prematurely and the proportion of potentially avoidable premature deaths in Australians aged under 75 increased with increasing remoteness. The proportion of premature deaths was highest among males in very remote areas (71% of men died prematurely with 61% of these premature deaths being potentially avoidable).

Figure 2D.2: All causes of premature death by sex and remoteness area, 2018




*Notes*
1. Premature deaths are deaths of people under the age of 75.
2. Potentially avoidable deaths (PAD) are percentages of deaths under the age of 75 (premature deaths) from conditions that are potentially preventable through primary or hospital care.

*Source:* AIHW 2020b.
http://www.aihw.gov.au/

Table 2D.1: Median age at death, by sex and remoteness area, 2018

| Sex | Major cities | Inner regional | Outer regional | Remote | Very remote |
|---|---|---|---|---|---|
| Men | 79 | 78 | 76 | 73 | 68 |
| Women | 85 | 84 | 83 | 80 | 70 |
| People | 82 | 81 | 79 | 76 | 69 |

Source: AIHW 2020c.

### Burden of disease

The impact of disease, injury and dying early can be measured as the burden of disease on a population. A summary measure of health, called disability-adjusted life years, combines the estimates of years of life lost due to premature death and years lived in ill health or with disability to account for the total years of healthy life lost from disease and injury (AIHW 2019a).

In Australia, the total burden of disease rates increased as remoteness increased. Each remoteness area showed a similar pattern of increasing rates of burden in older age groups, with *Remote* and *Very remote* areas having the highest rates across all age groups. In 2015, the rates of total burden of disease were around twice as high for people aged 85 and over compared with those aged 65–84 (AIHW 2019a).

### Risk factors

Health risk factors are characteristics or exposures that increase the likelihood of a person developing a disease or health disorder.

Based on the 2017–18 ABS National Health Survey, there was little difference in the prevalence of common health risk factors across remoteness areas. Across all remoteness areas, around 3 in 4 older people were overweight or obese based on measured body mass index, and more than 7 in 10 had high blood pressure (AIHW analysis of ABS 2019b) (Table 2D.2).

Table 2D.2: Percentage of older people with selected health risk factors by remoteness area, 2018

| | Major cities | Inner regional | Outer regional and Remote |
|---|---|---|---|
| Exceeded lifetime alcohol risk guideline[(a)] | 15 | 16 | 17 |
| Overweight or obese[(b)] | 75 | 78 | 78 |

| | | | |
|---|---|---|---|
| High blood pressure[(c)] | 74 | 71 | 73 |
| Did not meet physical activity guidelines[(d)] | 72 | 72 | 74 |
| Current daily smoker | 7.1 | 6.5 | 7.1 |
| Did not meet either fruit or vegetable guidelines[(e)] | 36 | 33 | 36 |

(a) National Health and Medical Research Council (NHMRC) 2009 Guideline 1: Reducing the risk of alcohol-related harm over a lifetime, which recommends no more than 2 standard drinks per day.

(b) Based on measured height and weight and includes a body mass index of 25 and above.

(c) High blood pressure includes all persons with a high, very high or severe (from 140/90 mmHg) measured or imputed blood pressure (regardless of whether taking hypertension medication) as well as persons with normal/low (<140/90 mmHg) measured or imputed blood pressure who reported they were taking hypertension medication.

(d) The 2014 NHMRC Guidelines recommend that older Australians aged 65 and over should accumulate at least 30 minutes of moderate intensity physical activity on most, preferably all, days. This guideline is met where physical activity is completed 7 days in the last week and at least 30 minutes of physical activity is completed on at least 5 days in the last week. Data capture older Australians who did not meet this guideline and do not include people for whom this measure was not known or not applicable. Physical activity includes exercise at work, walking for fitness, recreation, or sport; walking to get to or from places; moderate exercise; and vigorous exercise (multiplied by 2) in the week prior to interview.

(e) Whether vegetable and fruit consumption met the recommended guidelines based on recommendations from the NHMRC Australian Dietary Guidelines (2013).

Notes:

1. The above data are survey data and as such have a level of error attached to each estimate. Comparisons should be made with caution. Please refer to ABS 2019b for further information and relevant estimates of error.
2. Data for *Very remote* areas are not included.
3. 'Older people' refers to people aged 65 and over.

Source: AIHW analysis of ABS 2019b.

For more information see Risk factors and Rural and remote health.

## Aged care

Older people who live in *Remote* and *Very remote* areas can face more barriers to accessing aged care services than older people living in *Major cities* and regional areas. A range of demographic, geographical, climatic, cultural and socioeconomic factors contribute to the complexity of providing high-quality aged care services, especially in rural and remote communities (RDAA 2017).

The proportion of older Australians using mainstream higher level aged care services (that is, residential aged care and home care) tends to decrease as people live more remotely. This may reflect people in rural and remote areas moving to access higher level services that are not available in their community. Mainstream services tend to be concentrated in more densely populated areas, with almost two-thirds (62%) of permanent residential aged care facilities located in metropolitan areas and only 21% located in rural or remote areas (AIHW 2021a). By contrast, as people live more remotely, they tend to use more basic support services, such as home support assistance under the Commonwealth Home Support Programme. Additional care types, such as Multi-Purpose Services and the National Aboriginal and Torres Strait Islander Flexible Aged Care Program also cater to older Australians living in remote areas. At 30 June 2020, 89% of older Australians living in *Very remote* areas used home support services, compared with 70% living in *Major cities* (Table 2D.3) (AIHW 2020a).

**Table 2D.3. Percentage of older people using aged care services by remoteness area, 30 June 2020**

| | Home support | Residential aged care | Home care |
|---|---|---|---|
| Major cities | 70 | 17 | 13 |
| Inner regional | 74 | 14 | 12 |
| Outer regional | 79 | 12 | 9.0 |
| Remote | 86 | 6.9 | 6.8 |
| Very remote | 89 | 3.8 | 7.4 |

Note: 'Older people' refers to people aged 65 and over.

Source: AIHW 2020a.

**Availability of aged care services by remoteness**

The availability of aged care services differs by remoteness area. Most aged care services are located in *Major cities*, reflective of the proportion of older Australians (66%) living in these areas.

Compared with *Major cities*, the number of available places differ significantly for older people living remotely. In residential aged care, at 30 June 2020, 7 in 10 (71%) places were available in *Major cities*, followed by 21% in *Inner regional* areas, 7.6% in *Outer regional* areas and 0.6% in *Remote* and *Very remote* areas.

At 30 June 2020, the number of operational aged care services available in *Remote* and *Very remote* areas included:

- 43 residential aged care services, 1.6% of the national total
- 109 home care programs, 4% of the national total
- no transition care programs (AIHW 2020a).

For information on aged care services and places in Australia, see GEN Aged Care Data.

## Social support

Social support can be formal or informal and includes emotional, personal and domestic support to individuals or groups. Informal social support is commonly provided by people close to the individual, such as friends, family and community. Formal social support refers to government and non-government services and programs. Unpaid care provided by family, friends and the community is invaluable, especially in regional and remote areas (Edwards et al. 2009).

### Carers

In the 2018 ABS SDAC, an estimated 647,300 (17%) people aged 65 and over provided informal care and assistance within their household (18% of older men and 17% of older women were primary or secondary carers). Around 2 in 3 older Australians who identified as a carer during this period lived in *Major cities* (66%), 1 in 4 lived in *Inner regional* areas (25%) and 1 in 10 lived in *Outer regional, remote and very remote* areas (10%) (ABS 2019a).

Across remoteness areas, a similar proportion of older people identified as a carer:

- 17% in *Major cities*
- 17% in *Outer regional, remote and very remote*
- 19% in *Inner regional* (ABS 2019a).

### Family and community support

Providing assistance and social support is significant to maintaining and supporting the health and independent functioning of older Australians. Broad activities such as mobility, self-care, oral communication, health care, cognitive or emotional tasks, household maintenance, meal preparation, reading or writing and private transport are recognised as activities where assistance or supervision may be required for older Australians (ABS 2019a). Assistance may be provided formally through services or informally through existing relationships, such as family members, friends or neighbours.

Based on the 2018 ABS SDAC:

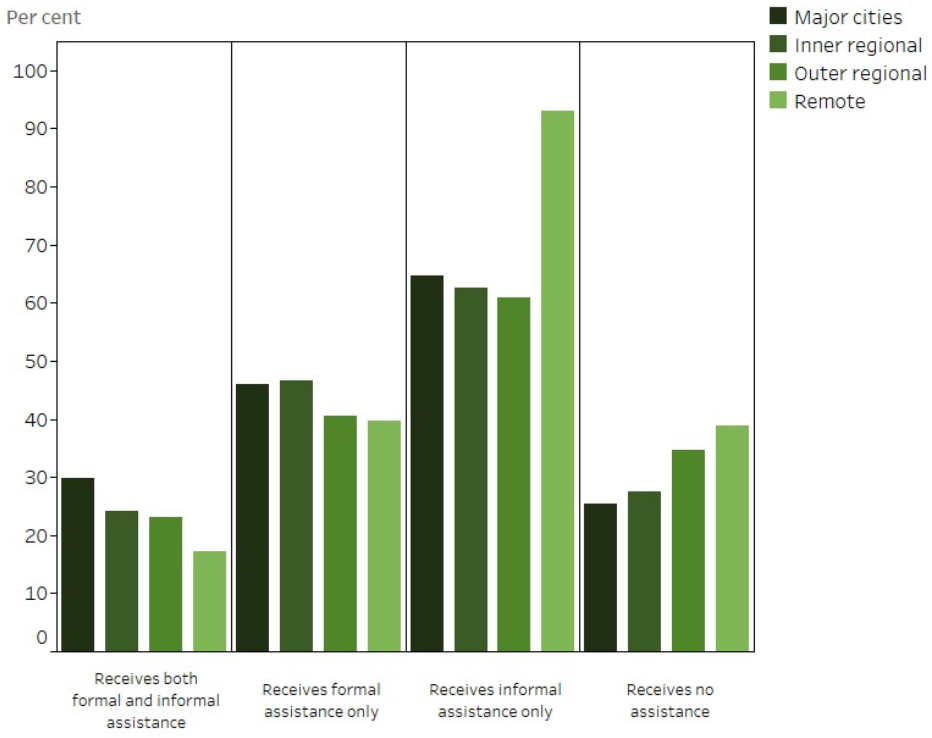
- Around 2 in 7 (28%) older Australians (aged 65 and over) received both formal and informal assistance. However, as remoteness levels increased, older Australians were less likely to receive both kinds of support. Almost 1 in 3 (30%) older Australians in *Major cities* received both formal and informal assistance, compared with under 1 in 4 in both *Inner regional* (24%) and *Outer regional, remote and very remote* (23%*) areas.
- Almost 2 in 3 (64%) older Australians received only informal assistance. This did not differ substantially across *Major cities* (65%), *Inner regional* (63%) and *Outer regional* (61%) areas. However, in *Remote and very remote* areas, 9 in 10 (93%*) older Australians relied on only informal assistance.
- Nearly 1 in 2 older Australians (46%) received only formal assistance. Older Australians in *Outer regional, remote and very remote* areas were less likely to receive only formal assistance (41%*) compared with in *Major cities* (46%) and *Inner regional areas* (47%).
- Over 1 in 4 (27%) older Australians received no assistance. The proportion of those receiving no assistance varied by remoteness, with 1 in 3 (35%*) older Australians in *Outer regional, remote and very remote* areas, 2 in 7 in *Inner regional* areas (28%) and 1 in 4 in *Major cities* (25%) receiving no assistance (AIHW analysis of ABS 2019c) (Figure 2D.3).

In these points, asterisks (*) indicate that the estimate has a relative standard error of 25% to 50% and should be used with caution. Also note that proportions within regional areas do not add to 100%. For further information, see ABS 2019c.

Figure 2D.3: Proportion of older Australians whether received formal or informal assistance with broad activities by remoteness, 2018

The column graph shows, across all remoteness areas, the greatest proportion of older Australians receive informal assistance only. Older Australians in remote areas had the highest proportion of people receiving informal assistance only (93%). The proportion of people receiving no assistance was also highest in remote areas followed by outer regional areas (39% and 35%, respectively).

Figure 2D.3: Percentage of older Australians whether received formal or informal assistance with broad activities by remoteness, 2018




*Note:* 'Older Australians' refers to people aged 65 and over.

*Source:* AIHW analysis of ABS Survey of Disability, Ageing and Carers, June 2018, Tablebuilder.
http://www.aihw.gov.au/

### Volunteering

Volunteering provides a substantial benefit to communities and organisations. Volunteers bring new insights, enhance the image of an organisation and increase efficiencies, operations and effectiveness (AIHW 2021b). According to the 2014 ABS General Social Survey (GSS) (the most recent GSS data available that include age and remoteness breakdowns), an estimated 566,600 (30%) people aged 65 and over participated in unpaid voluntary work through an organisation in the last 12 months. Older people in more remote areas were more likely than their more urban counterparts to participate in volunteering: around 1 in 2 (49%*) older people living in *Remote and very remote* areas participated, 4 in 10 (41%) in *Outer regional* areas, 1 in 3 (32%) in *Inner regional* areas and 1 in 4 (27%) in *Major cities* (AIHW analysis of ABS 2015). (Note that estimate marked with asterisk (*) has a relative standard error of 25% to 50% and should be used with caution).

For more information on the social support of older Australians, see Social support.

## Justice and safety

Elder abuse is a serious public health issue that can cause a range of physical, psychological and financial harms to older people. The prevalence of abuse among older Australians is largely unknown and there is a lack of information about the justice and safety of older Australians living in rural and remote communities. For information on the justice and safety of older Australians, see Justice and safety.

## Housing and living arrangements

The housing and living arrangements of older people can have an impact on their health, economic status and overall wellbeing. Many older people live with family members; however, with changing circumstances – such as the loss of a spouse or a decline in health and functioning – living arrangements can change. According to the 2016 ABS Census:

- Around half (49%) of older people (aged 65 and over) in both *Major cities* and *Remote and very remote* locations lived with their spouse, compared with 55% of those in *Inner regional* areas and 54% in *Outer regional* areas.
- 2 in 7 (28%) older people in *Remote and very remote* areas lived alone, similar to 28% in *Outer regional* areas and 26% in both *Inner regional* areas and *Major cities,* respectively (AIHW analysis of ABS 2017).
- In 2016, older people aged 85 and over were more likely to live alone than their younger counterparts. The more remote the population, the greater the prevalence of people aged 85 years and over living alone: 44% of people lived alone in Major cities, 46% in *Inner regional* areas, 50% in *Outer regional* areas and 43% in *Remote and very remote* areas (AIHW analysis of ABS 2017).

For more information on the housing and living arrangements of older Australians see Housing and living arrangements.

## Education and skills

The highest level of educational attainment of older Australians differs by remoteness. In *Remote and very remote* areas, 5 in 7 (72%) people aged 65 and over had an equivalent of year 12 or below as their highest education attainment, compared with 66% in *Outer regional* areas, 62% in *Inner regional* areas and 57% in *Major cities* (AIHW analysis of ABS 2017).

Older Australians in *Major cities* were more likely to have a bachelor degree or postgraduate qualification as their highest educational attainment compared with older Australians in *Remote and very remote* areas (16% and 5.6%, respectively) (AIHW analysis of ABS 2017).

For more information on the education and skills of older Australians, see Education and skills page.

## Employment and work

Some older Australians (aged 65 and over) participate in the workforce, with those in more remote areas more likely to do so. Around 1 in 6 (17%) older men were employed and participated in the workforce compared with 1 in 10 (9.2%) women in 2016.

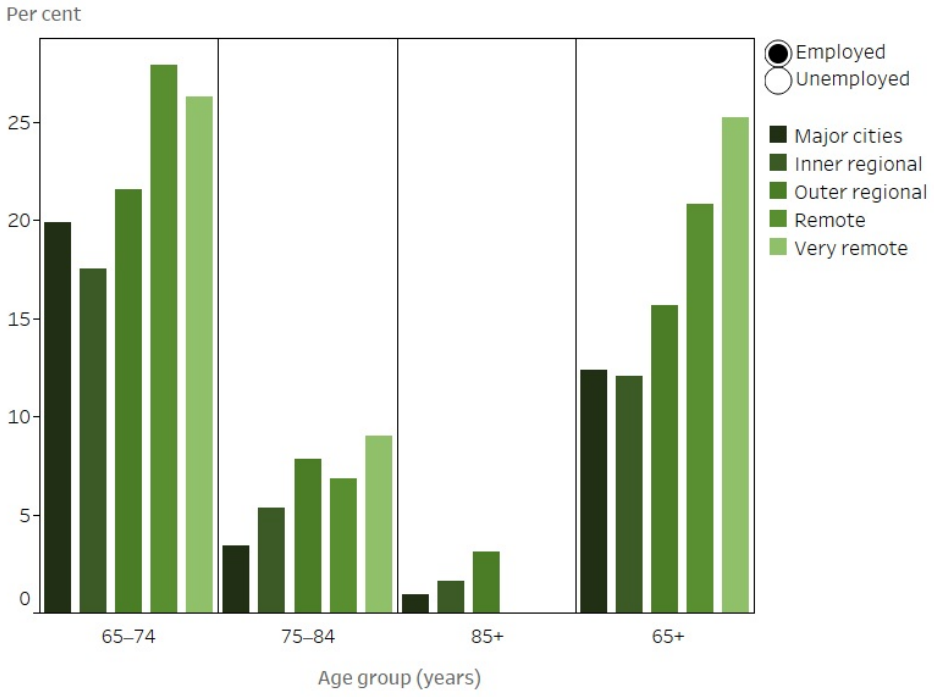
According to the 2016 ABS Census:

- 1 in 4 (25%) people aged 65 and over in *Very remote* Australia were employed, compared with 12% in *Major cities.*
- The proportion of older people who were employed and worked full-time hours also increased with remoteness – 5% in *Major cities*, 4.6% in *Inner regional* areas, 7.2% in *Outer regional* areas, 11% in *Remote* and 15% in *Very remote* areas.
- Compared with those in *Major cities,* older Australians in *Remote* and *Very remote* areas were more than twice as likely to be employed on a full-time basis.
- Most (87%) older Australians in *Major cities* were not in the labour force compared with almost three-quarters (75%) of older people in *Very remote* areas (AIHW analysis of ABS 2017).

Across all remoteness areas, as age increased the proportion of people not participating in the workforce increased. In *Major cities*, 4 in 5 (80%) people aged 65–74 were not in the labour force compared with 96% aged 75–84 and 99% of those 85 and over. In *Remote* and *Very remote* areas, all people aged 85 and over were not participating in the workforce (Figure 2D.4).
Figure 2D.4: Proportion of older Australians whether employed or unemployed by age and remoteness, 2016

The column graph shows that the proportion of older Australians employed is highest in Remote and Very remote areas (21% and 25% respectively). The proportion of unemployed older Australians was highest in Major cities and Inner regional areas (both 88%).

**Figure 2D.4: Percentage of older Australians whether employed or unemployed by age group and remoteness, 2016**




*Notes*
1. 'Older Australians' refers to people aged 65 and over
2.'Employed' category includes employed, worked full-time, employed, worked part-time and employed, away from work and 'unemployed' includes data for those who were not in the labour force, unemployed, looking for full-time and unemployed, looking for part-time work.
3. Data excludes not stated and non applicable responses from labour status and migratory and no place of residence from remoteness.

*Source:* AIHW analysis of ABS Census, 2016, TableBuilder.
http://www.aihw.gov.au/

For more information about the work and employment of older Australians see Employment and work.

## Income and finances

Generally, the main sources of income for older people (aged 65 and over) are government pension or allowance, followed by superannuation and wages or salary. According to the 2018 ABS SDAC, nearly 2 in 3 (63%) older Australians in *Outer regional* and *Remote and very remote* areas received a pension or allowance as their main source of income, 15% received superannuation and 7.5% received wages or salary (AIHW analysis of ABS 2019c).

For more information on the income and finances of older Australians, see Income and finances.

### Where do I go for more information?

For more information on older Australians living in regional and remote communities, see:

- AIHW GEN Aged care data snapshot 2020 – third release
- AIHW Mortality Over Regions and Time (MORT) books
- AIHW Rural and remote health

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# Feature articles

**On this page:**


- Demographic profile
- Health
- Aged care
- Social support
- Housing and living arrangements
- Employment and work
- Income and finances
- Where do I go for more information?


**Key findings**
Almost 4,800 older people are part of a cohabiting same-sex couple.

**Key findings**
1 in 4 older partners in same-sex couples are in the labour force.

**Key findings**
7 in 10 older partners in same-sex couples own their house outright.

The LGBTI communities include individuals who identify as lesbian, gay, bisexual, transgender, intersex or otherwise diverse in gender, sex or sexuality. Each community may have its own experiences and needs, and so too will the individuals in these groups. Older LGBTI Australians have lived through many periods of social and cultural transition. While such experiences may be shared among some in this older age group, the older LGBTI population is diverse. What being part of the community means to each older person may be unique.

Data about LGBTI communities in Australia are slowly developing but are currently limited. This feature article presents the national information currently available about older same-sex couples, recognising that this is a limited picture of the experiences of LGBTI communities. Comparisons throughout this article are made to the most appropriate comparison group for which data are available.

Throughout this feature article, 'older people' refers to people aged 65 and over. Where this definition does not apply, the age group in focus is specified. The 'Older Aboriginal and Torres Strait Islander people' feature article defines older people as aged 50 and over. This definition does not apply to this feature article, with Indigenous Australians aged 50–64 not included in the information presented.

### Sources of information about LGBTI older Australians

There are very little data available regarding the older Australian LGBTI community. The Australian Bureau of Statistics (ABS) has been collecting data on sexual orientation since 2007 when a question was included in the National Survey of Mental Health and Wellbeing. Questions on sexual orientation have also been asked in the General Social Survey since 2014. The Melbourne Institute's Household, Income and Labour Dynamics Australia (HILDA) longitudinal survey of Australian households included a question on sexual identity in waves 12 (2012) and 16 (2016) as part of the self-completion questionnaire (Wooden 2014). For more information, see HILDA Survey.

While sex and/or gender orientation and identity may be captured in some surveys and administrative collections, it is not necessarily the case that the data can be published due to issues of reliability and confidentiality, particularly for subgroups such as those aged 65 and over. The Census, enumerating all persons in Australia on Census night, has been able to capture and publish considerable information about partners in same-sex couples, and older partners.

### Australian Bureau of Statistics Census

Data about same-sex couples (both male and female) from the Census have been available since 1996 (ABS 2013). More recently, data have included sexual orientation and gender identity. The 2016 online Census had an opt-in question for people to more fully identify their sex or gender. This allowed the choice of 'Other', coupled with a response box to provide further detail. This was part of an initiative to make it possible for Australians to report their sex in a way not limited to 'male' or 'female' in the Census (ABS 2017).

The 2021 Census did not include and questions on sexual orientation or gender identity. Through testing, the ABS assessed that there was not sufficient confidence in the quality of the data that would be obtained. For sexual orientation, testing revealed a range of sensitivities, including privacy concerns, discomfort or a lack of comprehension of the question. For more information, see the ABS 2021 Census topics and data release plan.

For information about the limited availability and reporting of data about older people, see Key data gaps.

## Demographic profile

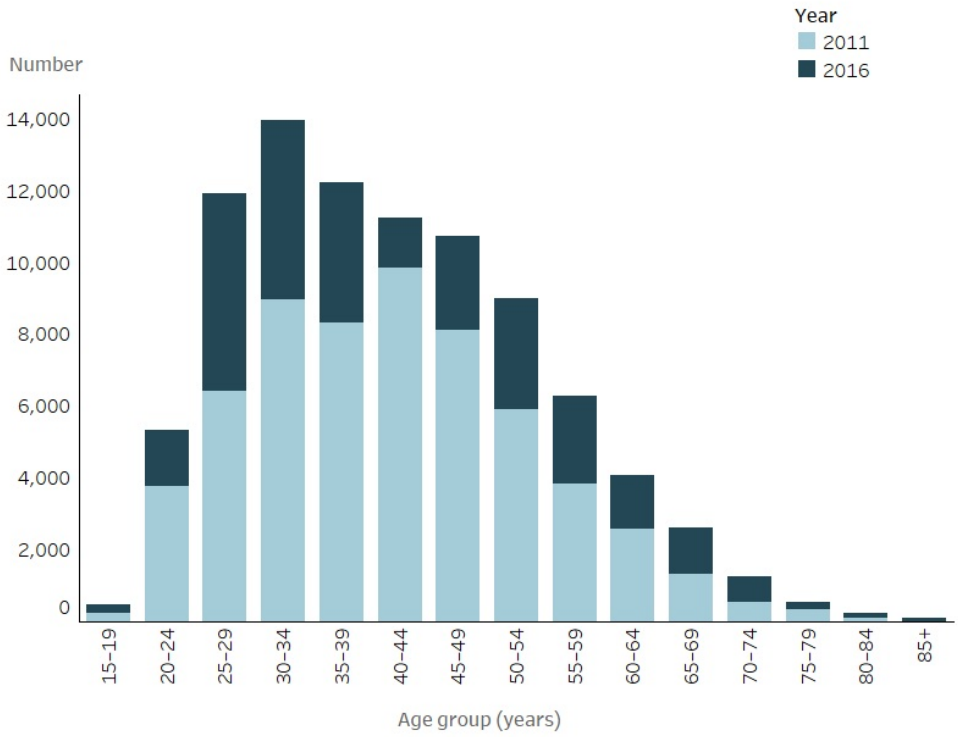
In the 2016 Census, there were almost 4,800 cohabiting older partners (aged 65 and over) in same-sex couples. Nearly 3 in 5 were male partners in same-sex couples (59%, or 2,800), while 2 in 5 were female (41%, or 2,000) (ABS 2018a).

Overall, 5.3% of people in same-sex couples were aged 65 or over, compared with 20% of people in opposite-sex couples (ABS 2018a). This is higher than reported in the 2011 Census, when 3.8% of people in same-sex couples were aged 65 or over (ABS 2013). As the Census only captures information about relationships within each household, non-cohabiting couples, both same-sex and opposite-sex, are not included in Census figures.

While more older people are reporting being in same-sex couples, it is to a far smaller extent than among younger age groups (Figure 2E.1). This might indicate less of a willingness by people of older ages to identify in this way (ABS 2018a).
Figure 2E.1: Number of people in same-sex couples by age group, 2011 and 2016

The overlapping column chart shows the proportion of same-sex couples by age groups in 2011 and 2016. In 2011 the greatest proportion of same-sex couples were aged 40–44 (16%), whereas in 2016 the greatest proportion of same-sex couples were aged 30–34 (16%).

**Figure 2E.1: Number of people in same-sex couples by age group, 2011 and 2016**




*Note:* For the 2011 Census, age has been adjusted so that it is the expected age at the time of the 2016 Census, to enable comparisons of the same age cohort between Censuses.

*Sources:* AIHW analysis of ABS Census of Population and Housing, 2016 & 2012, Tablebuilder.
http://www.aihw.gov.au/

### Older people with diverse sex and/or gender identity

According to the 2016 Census, older people made up a smaller proportion of the 1,260 people who reported a diverse sex and/or gender identity (including intersex/indeterminate, transgender, non-binary, another gender and 'other' (not further defined)) compared with younger Australians. As this was a new question, introduced on an opt-in basis, it is likely the 2016 Census did not capture all sex and gender-diverse individuals.

1 in 17 (5.9%) people who reported a diverse sex and/or gender identity were older Australians (aged 65 and over). This is likely an underrepresentation due to the decreasing preference for online forms with age (ABS 2017). This question was not included in the 2021 Census.

Population surveys are another source of information about older LGBTI Australians. Estimates from the 2019 ABS General Social Survey show that 1 in 10 (10%) of those who identified as gay, lesbian or bisexual were aged 55 and over (Table 1). Note that these estimates have a relative standard error of 25% to 50% and should be used with caution (ABS 2020).

Population estimates suggest that a higher proportion of younger Australians identify as lesbian, gay, bisexual or another sexual minority orientation (for example, queer, pansexual) than older Australians (Wilson et al. 2020). In parallel with older Australians' lower reported rates of being in a same-sex couple, these data might reflect changing societal attitudes and younger people's greater willingness to report

their sexual orientation.

Table 2E.1: Sexual orientation, by age estimates, 2019

| Age group | Heterosexual Number ('000) | Gay, Lesbian or Bisexual Number ('000) | Total persons Number ('000) |
|---|---|---|---|
| <55 | 12,306.5 | 481.1* | 13,354.2 |
| 55–69 | 3,899.3 | 44.8* | 4,081.5 |
| 70+ | 2,543.2 | 9.0** | 2,602.0 |
| **Total** | **18,737.7** | **539.2** | **20,010.8** |

* Estimates have a relative standard error of 25% to 50% and should be used with caution.

** Estimates have a relative standard error greater than 50% and are considered too unreliable for general use.

Notes:

1. Estimates have a high margin of error and should be used with caution.
2. Cells in this table have been randomly adjusted to avoid the release of confidential data. As a result cells do not add to the totals.

Source: ABS 2020.

**A new way to collect information**

Recently, the ABS developed the Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables, 2020. This standard forms part of the demographic set of items for use in surveys and administrative collections. It standardises the collection and dissemination of data relating to sex, gender, variations of sex characteristics and sexual orientation (ABS 2021).

The 2020 standard is intended to improve the comparability and quality of data collected in Australia. It can be used by not only government but also academic and private-sector organisations in their own statistical collections. This standard will be applied to future ABS social surveys.

For more information, see the ABS Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables, 2020.

## Health

Evidence from small-scale LGBTI targeted studies, and some larger population-based surveys, indicate that, overall, LGBTI people face disparities in terms of their mental health (ABS 2008), sexual health (Kirby Institute 2018) and rates of substance use (AIHW 2018). The lack of data sources with information about people in LGBTI communities limits reporting on their health. Some information about health-based need for assistance by older people is collected in the Census.

Older people may need assistance with one of the core activity areas of self-care, communication or mobility because of a disability, long-term health condition or the effects of old age. According to the 2016 Census, 7.1% of older partners in same-sex couples aged 65–74 reported having a need for assistance with core activities, increasing to 22% among partners in same-sex couples aged 75 and over. This was similar for older partners in opposite-sex couples: 8.7% of those aged 65–74 reported having a need for assistance with core activities, increasing to 25% for those aged 75 and over (AIHW analysis of ABS 2016).

### Drug use

The AIHW's National Drug Strategy Household Survey is the only national data source that specifically collects information by sexual identity. However, it does not include estimates for people identifying as transgender, intersex or queer. In 2019, 2 in 5 (40%) people who identified as gay, lesbian or bisexual had used an illicit drug in the last 12 months, and almost 2 in 5 (38%) had exceeded the lifetime risk guidelines for use of alcohol (AIHW 2020). This information is not separately available for older people identifying as gay, lesbian or bisexual.

## Aged care

The Royal Commission into Aged Care Quality and Safety recognised that LGBTI people, and others from diverse backgrounds, may have varied life experiences and face challenges accessing aged care services that meet their particular needs. It heard about the important role LGBTI volunteers play in helping reduce LGBTI residents' isolation and maintaining connection to their LGBTI identity and communities (RCACQS 2021).

To help ensure aged care services are appropriate to the needs of all clients, the *Aged Care Act 1997* designates some groups of people as 'people with special needs'. Australians who identify as LGBTI are one such group. Other groups designated as 'people with special needs' in the Aged Care Act include people from culturally and linguistically diverse (CALD) backgrounds, veterans, people who live in rural or remote areas, and older Aboriginal and Torres Strait Islander people.

There is currently no way to identify LGBTI older Australians accessing aged care services. For those older people starting their journey into aged care, some information may be collected as part of the screening and assessment process.

## Social support

Social support can be formal or informal and includes emotional, personal and domestic support to individuals or groups. Informal social support is commonly provided by people close to the individual, such as friends, family and community. Formal social support refers to government and non-government services and programs. This section focuses on informal social support.

Older LGBTI people may receive social support from others, but also provide it in the form of volunteering or caring. According to the 2016 Census results, 7.7% of older partners in same-sex couples reported providing unpaid child care (to their own and/or other children) compared with 17% of older partners in opposite-sex couples. Just under 700 older partners in same-sex couples provided unpaid assistance to a person with disability (14%), similar to the proportion of older partners in opposite-sex couples (16%) (AIHW analysis of ABS 2016).

## Housing and living arrangements

In 2016, most older partners in same-sex couples owned their house outright (70%, 3,300 people), with a further 17% (820 people) owning with a mortgage. Renting was less common (10%) (Table 2). In comparison, older partners in opposite-sex couples were more likely to own their house outright (76%), less likely to own their house with a mortgage (11%) and less likely to be renting (8%).

Table 2E.2: Tenure type of older partners by age group, 2016

| | Older same-sex couples (%) | | | | Older opposite-sex couples (%) | | | |
|---|---|---|---|---|---|---|---|---|
| | **65-69** | **70-74** | **75+** | **Total** | **65-69** | **70-74** | **75+** | **Total** |
| Owned outright | 66.3 | 74.4 | 73.5 | 69.5 | 71.7 | 78.0 | 78.5 | 75.8 |
| Owned with mortgage | 22.1 | 13.4 | 7.6 | 17.2 | 17.1 | 10.3 | 5.9 | 11.4 |
| Rented | 8.7 | 9.0 | 13.0 | 9.6 | 8.4 | 7.7 | 7.7 | 7.9 |
| Other | 1.3 | 1.3 | 1.7 | 1.7 | 1.3 | 2.1 | 4.1 | 2.5 |
| Not stated | 1.6 | 1.9 | 4.2 | 2.0 | 1.5 | 1.9 | 3.8 | 2.4 |
| **Total** | **100.0** | **100.0** | **100.0** | **100.0** | **100.0** | **100.0** | **100.0** | **100.0** |

Notes:

1. 'Older partners' refers to people aged 65 and over.
2. 'Other' includes being occupied rent-free, being occupied under a life tenure scheme, being purchased under a shared equity scheme and other tenure type.

Source: AIHW analysis of ABS 2016.

A higher proportion of same-sex couples reported living in a separate house (69%), compared with townhouses (16%) and flats or apartments (14%) (Table 2E.3).

Table 2E.3: Dwelling structure of older partners in same-sex couples by age group, 2016

| **Type of dwelling** | **65-69** | **70-74** | **75+** | **Total** |
|---|---|---|---|---|
| Separate house | 69.3 | 69.0 | 71.6 | 69.0 |
| Semi-detached, row or terrace house, townhouse | 16.4 | 14.3 | 15.3 | 15.8 |
| Flat or apartment | 13.6 | 15.3 | 13.1 | 14.2 |
| Other | 0.8 | 1.5 | 0.0 | 0.9 |
| **Total** | **100.0** | **100.0** | **100.0** | **100.0** |

Notes:

1. 'Older partners' refers to people aged 65 and over.
2. 'Other' includes ‘not stated’.

Source: AIHW analysis of ABS 2016.

Older LGBTI people may be more vulnerable to homelessness than the rest of the population. This may be due to discrimination and individual vulnerabilities because of family rejection, trauma and mental health problems (McNair and Andrews 2020). The risk of homelessness for some may be exacerbated by a lack of support from family (McNair and Andrews 2020). There is currently no available national information about this.

## Employment and work

People in same-sex couples, overall, tend to be more highly educated and have higher labour force participation rates than people in opposite-sex couples (ABS 2018).

In 2016, around 1 in 4 older partners in same-sex couples (27%, 1,300 people) were in the labour force; that is, either employed or unemployed.

Of all older partners in same-sex couples (aged 65 and over):

- 73% were not in the labour force
- 26% were employed
- 0.9% were unemployed.

In comparison, 83% of partners in opposite-sex couples were not in the labour force, 17% were employed and 0.4% were unemployed (ABS 2018).

Over one-third (35%) of partners in same-sex couples aged 65–69 were in the labour force, and this declined with age (20% of those aged 70–74 and 12% of those 75 and over) (ABS 2018).

### Income and finances

In 2016, older people in same-sex couples were more likely to earn higher incomes than people in opposite-sex couples, with 7.8% earning $2,000 or more per week compared with 3.6%, respectively. The majority of older partners in same-sex couples (89%) reported incomes of less than $2,000 per week which is similar to, but somewhat lower than, opposite-sex couples (92%) (Table 2E.4).

Table 2E.4: Older couple relationships by income and age group, 2016

| | Partners in same-sex couples | | | Partners in opposite-sex couples | | |
|---|---|---|---|---|---|---|
| | Less than $2,000 per week | $2,000 or more per week | Total | Less than $2,000 per week | $2,000 or more per week | Total |
| **Age group (years)** | **Number** | | | | | |
| 65–69 | 2,344 | 248 | 2,631 | 665,115 | 36,646 | 722,477 |
| 70–74 | 1,132 | 75 | 1,252 | 483,269 | 17,120 | 520,334 |
| 75–79 | 479 | 32 | 537 | 322,598 | 8,526 | 348,972 |
| 80+ | 295 | 18 | 349 | 284,889 | 7,237 | 315,275 |
| Total | 4,250 | 373 | 4,769 | 1,755,871 | 69,529 | 1,907,058 |
| | **%** | | | | | |
| 65–69 | 89.1 | 9.4 | 100.0 | 92.1 | 5.1 | 100.0 |
| 70–74 | 90.4 | 6.0 | 100.0 | 92.9 | 3.3 | 100.0 |
| 75–79 | 89.2 | 6.0 | 100.0 | 92.4 | 2.4 | 100.0 |
| 80+ | 84.5 | 5.2 | 100.0 | 90.4 | 2.3 | 100.0 |
| **Total** | **89.1** | **7.8** | **100.0** | **92.1** | **3.6** | **100.0** |

Notes:

1. 'Older couples' refers to people aged 65 and over.
2. Total includes Income not stated.
3. This table is based on place of enumeration.

Source: ABS 2018.

### Where do I go for more information?

For more information on older Australians who identify as lesbian, gay, bisexual, transgender or intersex see:

- ABS Census
- AIHW Australia's health 2018 snapshot: Lesbian, gay, bisexual, transgender and intersex people

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# Health

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# Health

**Health of older people** is an Australia's health topic

- Dementia | 28 Mar 2024
- Stroke | 14 Dec 2023

**On this page:**


- Self-assessed health
- Disability
- Life expectancy
- Causes of death
- Burden of disease
- Injuries
- Where do I go for more information?


**Key findings**
3 in 4 older Australians (aged 65 and over) report they have good, very good or excellent health.

**Key findings**
1 in 5 older people have severe or profound disability.

**Key findings**
The median age at death for men is 79 and for women is 85.

**Key findings**
Coronary heart disease is the leading cause of death among older Australians.

As the number of older people in Australia continues to grow, supporting their health and wellbeing is becoming even more important. While understanding health conditions is one way to measure how older people are faring, so too is understanding their overall health status, functioning, life expectancy and death. The burden of disease on the lives of older people is also important.

Throughout this page, 'older people' refers to people aged 65 and over. Where this definition does not apply, the age group in focus is specified. The 'Older Aboriginal and Torres Strait Islander people' feature article defines older people as aged 50 and over. This definition does not apply to this page, with Indigenous Australians aged 50–64 not included in the information presented.

## Self-assessed health

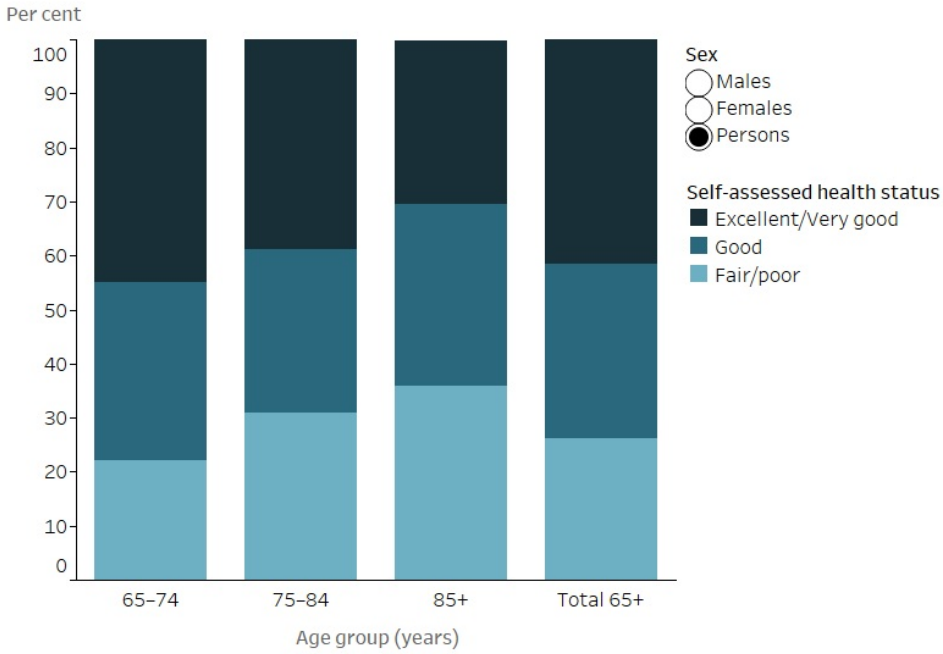
According to the 2017–18 Australian Bureau of Statistics (ABS) National Health Survey (NHS), an estimated 3 in 4 (74%) older Australians (aged 65 and over) reported their health as good, very good or excellent including:

- 42% who reported their health as being very good or excellent
- 32% who reported their health as being good (ABS 2018).

Older men and women self-assessed their health similarly. Around 2 in 5 older men (41%) and older women (43%) reported their health as very good or excellent, and 1 in 4 older men (27%) and women (26%) reported their health as being fair or poor (ABS 2018). Older people aged 65–74 were more likely to report their health as very good or excellent than older people aged 75 and over, and less likely to report their health as fair or poor (ABS 2018) (Figure 3A.1).
Figure 3A.1: Older Australians' self-assessed health status by sex and age group, 2017–18

The stacked column graph shows the percentage of people with a self-assessed health status as fair or poor increased with age. 22% of people aged 65–74 assessed their health status as fair or poor compared with 36% of people aged 85 and over in 2017–18. However, on average people aged 65 and over were more likely to have an excellent or very good self-assessed health status (42%).

**Figure 3A.1: Older Australians' self-assessed health status by sex and age group, 2017–18**




*Notes*
1. Percentage may not add to 100 due to rounding.
2. 'Older Australians' refers to people aged 65 and over.

*Source:* ABS 2018.
http://www.aihw.gov.au/

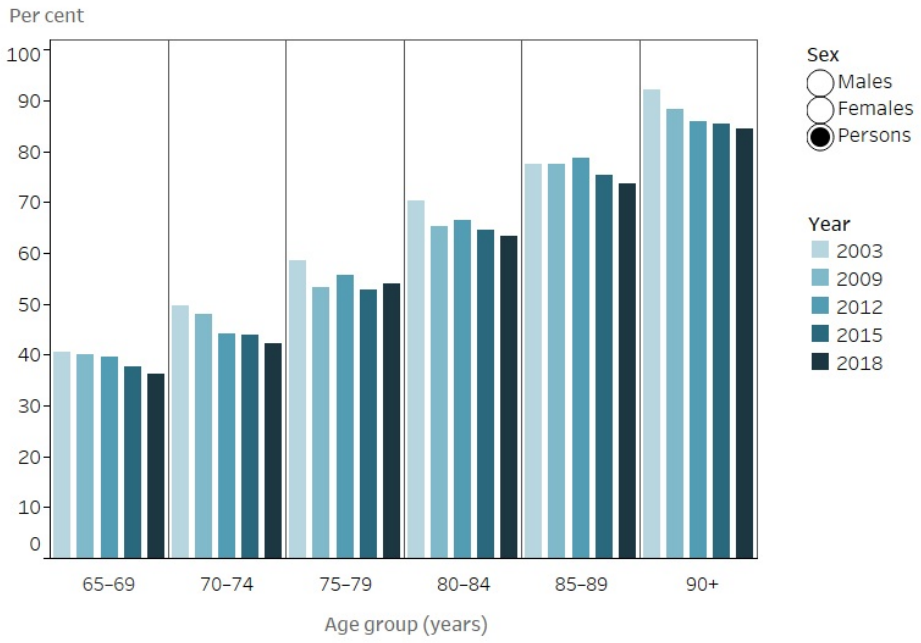
## Disability

According to the 2018 ABS Survey of Disability, Ageing and Carers (SDAC), half (50%) of older Australians (aged 65 and over) had disability. In the SDAC, a person is considered to have disability if they have at least one of a list of limitations, restrictions or impairments, which has lasted, or is likely to last, for at least six months. The prevalence of disability among older Australians has remained relatively stable in recent years, at 51% in 2015 (ABS 2019).

The rate of disability increased with age in 2018, rising from 36% of people aged 65–69 to 85% of those 90 and over (Figure 3A.2). The need for assistance at older ages is likely a trigger for needing formal support services such as aged care. See Aged care for more information.
Figure 3A.2: Percentage of older Australians with disability by sex and age group, 2003–2018

The column graph shows the percentage of people with disability increased with age across all of the years. However, these percentages decreased in each of the age groups across the years and amongst men and women. The percentage of people aged 90 and over who had a disability decreased from 92% in 2003 to 85% in 2018, these percentages being similar amongst both men and women.

Figure 3A.2: Percentage of older Australians with disability by sex and age group, 2003–2018




*Note:* 'Older Australians' refers to people aged 65 and over.

*Source:* ABS 2018.
http://www.aihw.gov.au/

Older people experience different levels of disability. The severity of disability is defined by whether a person needs help, has difficulty, or uses aids or equipment with 3 core activities of communication, mobility or self-care, and is grouped for mild, moderate, severe and profound limitation. In 2018, nearly 1 in 5 (18%) older Australians (aged 65 and over) had severe or profound disability (that is, they sometimes or always needed help with self-care, mobility or communication) (AIHW 2020).

In 2018, 49% of older men and 50% of older women had disability, and 15% of older men and 20% of older women had severe or profound disability (ABS 2019; AIHW 2020).

## Life expectancy

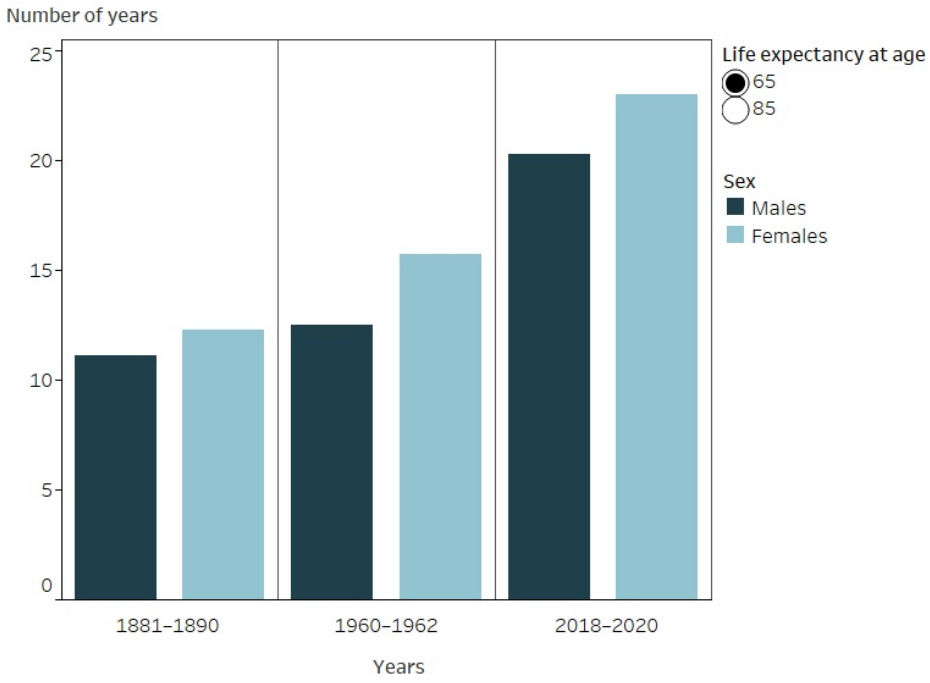
Life expectancy is one way to understand how long, on average, people can be expected to live based on current mortality rates. The measure is not a prediction, rather it is useful for comparisons between population groups and for considering changes over time. It is a common way to assess a population's overall health.

Life expectancy in Australia has improved dramatically for both sexes in the last century. This is particularly the case for life expectancy at birth. Compared with children born in 1881–1890, both boys and girls born in 2018–2020 can expect to live around 34 years longer.

Another way to measure life expectancy is through the remaining life expectancy at a given age. Men aged 65 in 2018–20 could expect to live another 20.3 years (an expected age at death of 85.3 years), and women aged 65 in 2018–20 could expect to live another 23.0 years (an expected age at death of 88.0 years) (Figure 3A.3).
Figure 3A.3: Life expectancy at age 65 and 85 by sex, 1881–1890, 1960–1962 and 2018–2020

The column graph shows the number of years' men and women were expected to live for when they are aged 65 and 85 in 1881–1890 1960-1962 and 2018–2020. From 1881 the life expectancy of both men and women increased, however women had the greatest life expectancy across all the years. In 2018-2020 men who were aged 65 were expected to live for another 20 years compared with women aged 65 who were expected to live for another 23 years.

Figure 3A.3: Life expectancy at age 65 and 85 by sex, 1881–1890, 1960–1962 and 2018–2020




*Source:* AIHW 2022a.
http://www.aihw.gov.au/

### Health-adjusted life expectancy

Health-adjusted life expectancy extends the concept of life expectancy by considering the time spent living with ill health due to disease and injury. It reflects the length of time an individual at a specific age could, on average, expect to live in full health. It is most meaningful when compared with life expectancy.

Health-adjusted life expectancy for males and females born in 2018 was 71.5 and 74.1 years, respectively. Between 2003 and 2018, increases in health-adjusted life expectancy for people aged 65 were slightly smaller than those seen for life expectancy alone: health-adjusted life expectancy increased by 1.7 years for men aged 65 (as life expectancy increased by 2.1) and by 0.9 years for women (as life expectancy increased by 1.4 years). There was a small decrease in the proportion of life expectancy as healthy years over time for women (from 75% in 2003 to 74% in 2018), whereas for men there was a small increase (from 75% in 2003 to 76% in 2018) (AIHW 2021a).

### Disability-free life expectancy

Increases in life expectancy hopefully accompany an increase in the number of healthy years people live. Disability-free life expectancy is a measure that provides the estimated number of years people can expect to live without disability.

It is important to note that disability does not necessarily equate to poor health or illness. Expected years living with disability should not be considered as being of less value than years without disability (AIHW 2020).

In Australia, the overall disability-free life expectancy has increased in recent years.

Men aged 65 in 2018 can expect to live, on average, another:

- 9 years without disability
- 11 years with some level of disability, including around 3.5 years with severe or profound disability.

Women aged 65 in 2018 can expect to live, on average, another:

- 10 years without disability
- 12 years with some level of disability, including around 5.5 years with severe or profound disability.

For people aged 65 in 2018, this equates to living just over half of their remaining lives with some level of disability (53% for men and 54% for women).

Over time, the number of estimated years living without disability at any age has increased for both men and women. Between 2003 and 2018, the gender gap in the expected years living without disability narrowed in most age groups. The gap for years living without severe or profound disability remained stable for most age groups. In the older age groups, however, the gap for years living without disability and

living without severe or profound disability remained relatively stable, changing by no more than 0.2 years across the 65–69, 70–74, 75–79, 80–84 and 85 and over age groups (AIHW 2020).

For more information, see People with disability in Australia 2020.

## Causes of death

In Australia in 2020, there were around 132,500 deaths of people aged 65 and over (82% of all deaths) (Table 3A.1). The median age at death was 79 for males and 85 for females (AIHW 2022a).

Table 3A.1: Deaths of older people by sex and age group, 2020

| Age group (years) | Men | Women | People | % of total |
|---|---|---|---|---|
| 65–69 | 6,518 | 4,084 | 10,602 | 8.0 |
| 70–74 | 9,424 | 6,099 | 15,523 | 11.7 |
| 75–79 | 10,870 | 7,618 | 18,488 | 14.0 |
| 80–84 | 12,692 | 10,721 | 23,413 | 17.7 |
| 85–89 | 13,063 | 13,777 | 26,840 | 20.3 |
| 90–94 | 10,065 | 14,556 | 24,621 | 18.6 |
| 95–99 | 3,446 | 7,608 | 11,054 | 8.3 |
| 100+ | 420 | 1,530 | 1,950 | 1.5 |
| **Total 65+** | **66,498** | **65,993** | **132,491** | **100.0** |

Notes

1. Year refers to year of registration of death. Deaths registered in 2020 are based on preliminary data and are subject to further revision by the Australian Bureau of Statistics (ABS).
2. 'Older Australians' refers to people aged 65 and over.

Source: AIHW 2022a.

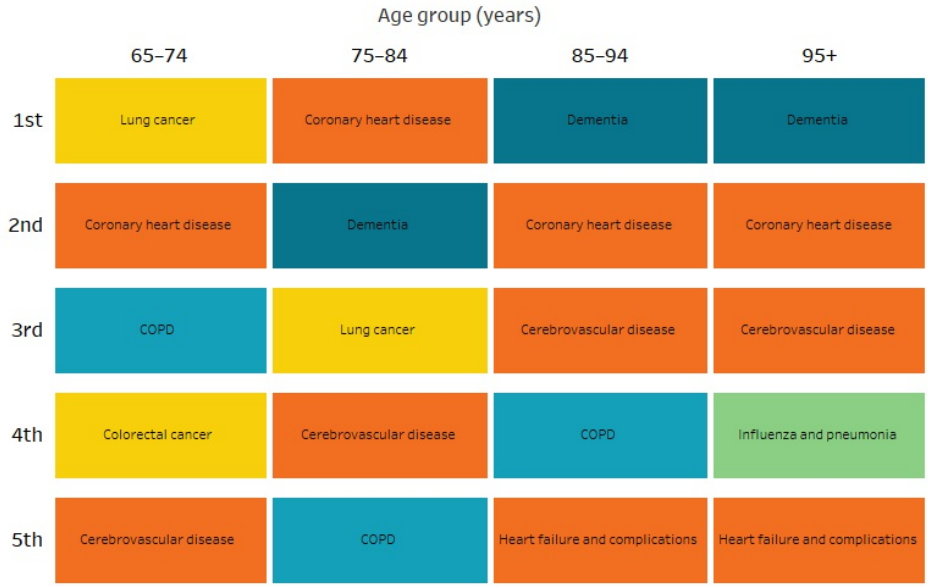
Coronary heart disease is the overall leading cause of death among older Australians. However, there were differences in the leading cause of death across the older age groups (Figure 3A.4). During 2018–20, the leading cause of death for people aged 65–74 was lung cancer (8,000), followed by coronary heart disease (7,500). Coronary heart disease was the leading cause of death for people aged 75–84 (12,600). For people aged 85 and over, dementia including Alzheimer's disease was the leading cause of death (30,700), followed by coronary heart disease (25,000) (AIHW 2022a).

Men and women also had different leading causes of death. For men, coronary heart disease was the leading cause across all older age groups. For women aged 65–74, the leading cause was lung cancer and for all other older age groups, it was dementia including Alzheimer’s disease (AIHW 2022a).

Figure 3A.4: Five leading causes of death for older Australians by age group, 2016–18

The ranked box chart shows the five leading causes of death for older Australians by age groups in 2016–2018. The top three leading causes of death moved from chronic obstructive pulmonary disease, coronary heart disease and lung cancer in those aged 65–74 to cerebrovascular disease, coronary heart disease and dementia in all age groups 75 and over.

Figure 3A.4: Five leading causes of death for older Australians by age group, 2018–20




*Notes*
1. 'Older Australians' refers to people aged 65 and over.
2. 'COPD' refers to chronic obstructive pulmonary disease.

*Source:* AIHW 2022a.
http://www.aihw.gov.au/

### COVID-19 deaths

Australia's older population has been disproportionately impacted by the spread of the COVID-19 virus throughout the country. The risk of serious illness as a result of contracting COVID-19, resulting in hospitalisation, intensive care admission, or death, is much higher in older people in general, and particularly in those with underlying health conditions. This has had devastating consequences in residential aged care settings, as the close proximity between residents increased the risk of virus transmission among people who were already in poorer health than the general population. Although vaccination rollout and improved infection prevention and control methods have reduced the impact of COVID-19 in residential aged care over time, approximately one-third of COVID-19-related deaths in Australia to date have occurred in people living in residential aged care facilities.

For further information related to older Australians and COVID-19, including access to advice and support resources, see the Australian Government's My Aged Care website. For more information regarding COVID-19 outbreaks in Australian residential aged care facilities, see the latest weekly report.

### Suicide

Suicide can affect anyone, regardless of age, personal characteristics or family background. Although it is a relatively rare cause of death, it can have devastating and long-lasting effects on those left behind. The numbers and rates of deaths by suicide change over time as social, economic and environmental factors influence suicide risk.

The AIHW recognises that each of the numbers reported here represents an individual.

In 2020, there were 516 deaths from intentional self-harm for people aged 65 and over. Three in 4 of these deaths were among older men (76%, 392 deaths), and 1 in 4 (24%, 124 deaths) were among older females (ABS 2021). The deaths among older people represented 16% of total deaths from intentional self-harm (across all ages) (Table 3A.2).

Table 3A.2: Deaths of older people (65 and over) from intentional self-harm by sex and age group, 2020

| Age group (years) | Men | Women | Total |
|---|---|---|---|
| 65–69 | 106 | 30 | 136 |
| 70–74 | 89 | 31 | 120 |
| 75–79 | 71 | 24 | 95 |
| 80–84 | 52 | 19 | 71 |

| | | | |
|---|---|---|---|
| 85+ | 74 | 20 | 94 |
| **Total (all age groups)** | **2,384** | **755** | **3,139** |

Source: ABS 2021.

The proportion of deaths by suicide is highest among people of young or middle age, and decreases progressively in older age groups. While the counts are lower in older age groups, deaths by suicide have a significant impact on older age groups. Taking into account the underlying population structure, the highest rates of deaths by suicide were among men aged 85 and over (36.2 deaths per 100,000 population) (ABS 2021).

For more information, see Suicide & self-harm monitoring.

## Burden of disease

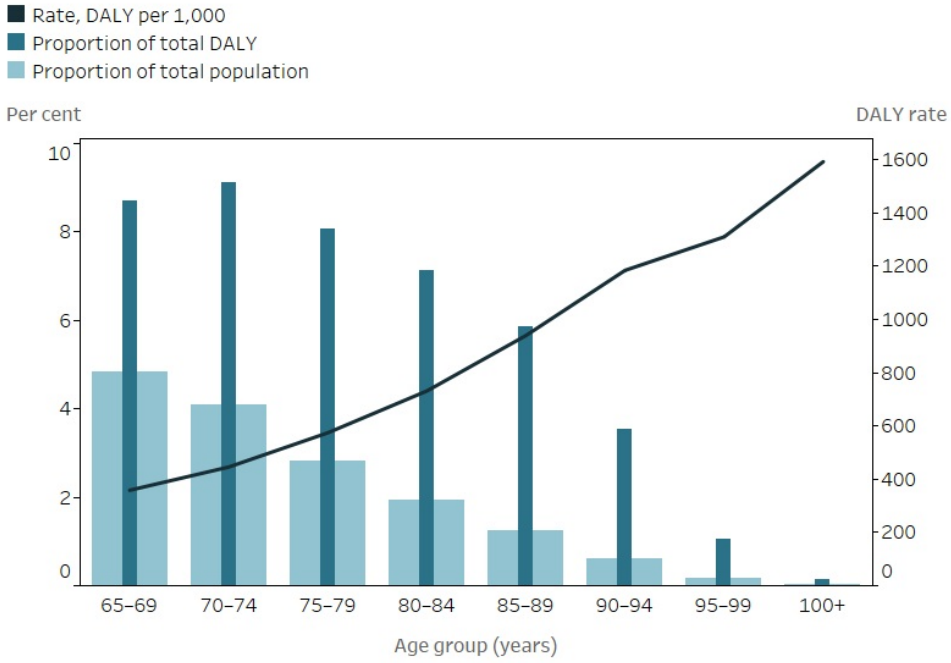
Burden of disease combines the years of healthy life lost due to living with ill health (YLD or non-fatal burden) with the years of life lost due to dying prematurely (YLL or fatal burden). Total burden is reported using disability-adjusted life years (DALY).

In 2018, older people (aged 65 and over) lost more than 2.1 million years of healthy life (DALY) due to illness or premature death. This has increased since 2003, from 1.7 million DALY. However, in 2018, the Australian population had a higher proportion of older people (16%) than in 2003 (13%). Age-standardised rates of DALY for older people have gone down from 84.3 per 1,000 in 2003, to 69.1 per 1,000 in 2018. In 2018, the years of healthy life lost for older people represented 44% of total DALY in Australia. The YLL accounted for 58% of DALY (1.3 million YLL), with YLD contributing 42% (904,000 YLD) (AIHW 2021a). To learn more about the methodology applied in burden of disease analysis, please refer to *Australian Burden of Disease Study 2018: methods and supplementary material* (AIHW 2021b).

Older Australians contribute to a large share of the total burden of disease and this increases with age (Figure 3A.6). For example, people aged 65–69 made up 5% of the population, but contributed to 9% of the total burden, while people aged 70 and over made up 11% of the population, but contributed to 35% of the total burden.
Figure 3A.6: Older Australians' age distribution of the Australian population and contribution to total burden (DALY), 2018

The column and line graph shows the proportion of the total population of people aged 65 and over decreases as people get older, similar to the proportion of total burden (DALY), however this peaked in those aged 70–74 where the proportion of total DALY was 9.1%. In 2018 the DALY rate per 1,000 increased with age with people aged 100 and over having a DALY rate of 1,592 per 1,000.

**Figure 3A.6: Older Australians' age distribution of the Australian population and contribution to total burden (DALY), 2018**




*Notes*
1. DALY rate is expressed as DALY per 1,000 population.
2. 'Older Australians' refers to people aged 65 and over.

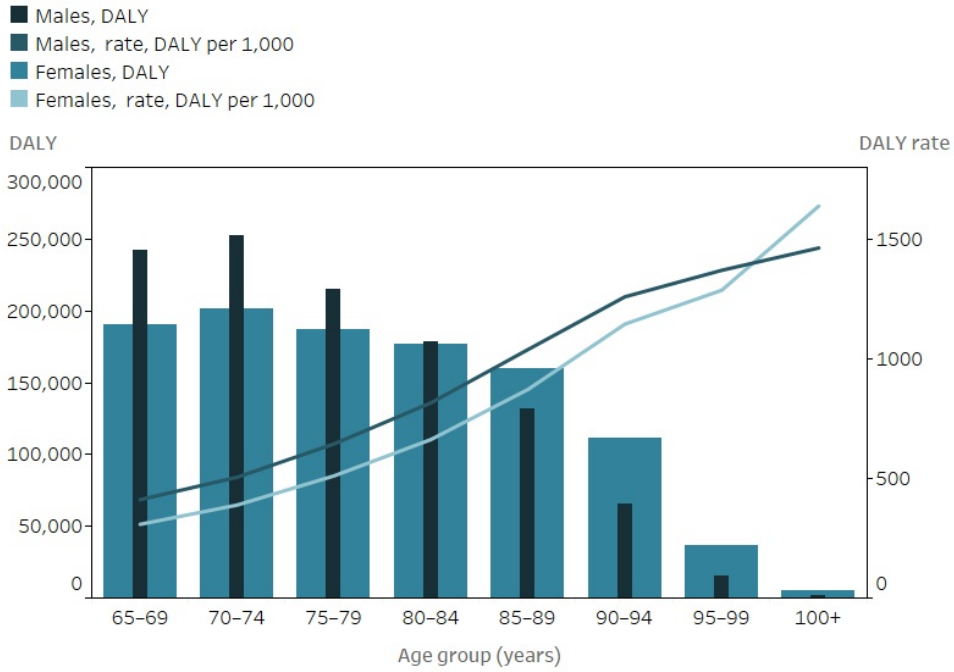
*Source:* AIHW 2021a.
http://www.aihw.gov.au/

In 2018, the burden was spread relatively evenly between the sexes. Older men (aged 65 and over) accounted for just over half (51%) of the burden, while older women accounted for 49%. Men contributed to more burden than women between the ages of 65 and 84 (around 888,000 DALY compared with 755,000 DALY, respectively), whereas women contributed to more burden than men from the age of 85

(313,000 DALY compared with 214,000 DALY, respectively) (AIHW 2021a) (Figure 3A.7).
Figure 3A.7: Older Australians' total DALY and rates of total burden (DALY per 1,000) by age group and sex, 2018

The column and line graph shows that men aged 65–84 had a higher DALY compared with women in these age groups, however in the 85 and over age groups women had a higher DALY compared with men. DALY decreased as ages increased in both men and women, however the DALY rate increased with age for both men and women.

**Figure 3A.7: Older Australians' total DALY and rates of total burden (DALY per 1,000) by age group and sex, 2018**




*Notes*
1. DALY rate expressed as DALY per 1,000 population.
2. 'Older Australians' refers to people aged 65 and over.

*Source:* AIHW 2021a.
http://www.aihw.gov.au/

**Leading causes of burden of disease (groups)**

In 2018, cancer and other neoplasms, cardiovascular diseases, and neurological conditions were the leading disease groups causing total burden (fatal and non-fatal combined) for older Australians, followed by musculoskeletal conditions, and respiratory diseases (Figure 3A.8). Among these top disease groups, the rate of burden per 1,000 people increased with age – except for cancer and other neoplasms where the rate was highest for 80–84 year olds and musculoskeletal conditions where the rate was highest for 75-79 year olds (AIHW 2021a).
Figure 3A.8: Older Australians' leading causes of total burden (DALY '000, proportion of age group) by sex and age group, 2018

The ranked box chart shows the top five leading causes of total burden for men and women. The leading cause of total burden amongst men across all age groups was coronary heart disease. However, the leading cause of total burden in women changed from other musculoskeletal and chronic obstructive pulmonary disease amongst those aged 65–79 to dementia amongst women aged 80 and over.

Figure 3A.8: Older Australians' leading causes of total burden (DALY '000, proportion of age group) by sex and age group, 2018

*Note:* 'Older Australians' refers to people aged 65 and over.

*Source:* AIHW 2021.
http://www.aihw.gov.au/

## Injuries

Most injuries, whether unintentional or intentional, are preventable (WHO 2014). Injuries can be minor with full recovery, or more serious and causing lasting health problems. While some more serious injuries lead to hospital admittance or emergency department visits, others lead to death.

Injuries can happen to anyone, but older people are at particularly high risk of hospitalisation and death for certain injuries. As a result, overall injury hospitalisation and death rates are higher for older people than younger people. In 2019–20, 1 in 3 (33%) hospitalised injury cases involved older Australians (aged 65 and over). There were 173,000 cases of hospitalised injury for older people. This included 103,300 cases of hospitalised injury for women and 69,700 for men, noting that sex is not reported in the remainder of cases. From about the age of 65, injury hospitalisation rates rise considerably from 2,027 per 100,000 for the 65–69 age group to 16,280 per 100,000 for the 95-and-over age group (AIHW 2022b).

For both males and females, rates of hospitalised injury were highest in older people (aged 65 and over), compared with other life-stage age groups. Males had higher rates of hospitalised injury than females in all age groups from 0–64, and were similar for those aged 65–69 (2,037 and 2,017 per 100,000 population, respectively). From ages 70–74 and over, women had higher rates (AIHW 2022b).

In 2019–20, injury death rates were highest for older Australians (aged 65 and over), compared with other life-stage age groups. In 2019–20, there were 7,122 injury deaths among older Australians, 71% of which were due to falls. Almost all (97%) female deaths due to falls involved those aged 65 and over (AIHW 2022b).

## Where do I go for more information?

For more information on health status and functioning, see:

- ABS Life tables
- AIHW Australian Burden of Disease Study 2018: interactive data on disease burden

Elsewhere in this report, information about older people's health is available on health risk factors, health service use and selected health conditions.

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# Health

**On this page:**


- Cardiovascular disease
- Arthritis and other musculoskeletal conditions
- Chronic kidney disease
- Respiratory conditions
- Dementia
- Diabetes
- Mental health
- Oral health and disease
- Ear health and hearing
- Eye health and sight
- Chronic pain
- Where do I go for more information?


**Key findings**
Most (80%) older Australians (aged 65 and over) have at least one selected chronic health condition – and 28% had 3 or more.

**Key findings**
Arthritis is the most common chronic condition among older people, with half (49%), or 1.8 million people, reporting they have it.

**Key findings**
1 in 5 (20%) people aged 65–74 report having chronic pain, increasing to 22% of those aged 75–84 and 24% of those 85 and over.

Today's older Australians (aged 65 and over) are generally living longer and healthier lives than those in previous generations. However, many older people live with chronic health conditions. The Australian Bureau of Statistics' (ABS) National Health Survey (NHS) estimated that, in 2017–18, 1.1 million (29%) older people had one chronic condition, just over 831,000 (23%) had 2 and 1.0 million (28%) had 3 or more. The minority of older people had no chronic conditions (730,000, 20%) (ABS 2018a).

This page presents key information about selected health conditions and how they affect older Australians. The information is presented by individual condition or group of conditions. As noted above, many older Australians have several different conditions, and the impact on people's health care use or wellbeing may be compounded by the number of conditions people have, or the interactions between particular conditions (often referred to as comorbidities). More information on chronic conditions can be found in Chronic disease.

Throughout this page, 'older people' refers to people aged 65 and over. Where this definition does not apply, the age group in focus is specified. The 'Older Aboriginal and Torres Strait Islander people' feature article defines older people as aged 50 and over. This definition does not apply to this page, with Indigenous Australians aged 50–64 not included in the information presented.

### Chronic conditions

Chronic conditions generally have long-lasting and persistent effects. The statistics reported here are based on a selected group of chronic conditions that commonly affect older people, and for which robust data are available. The analysis on chronic conditions does not include all possible chronic conditions. The chronic conditions statistics reported above from the NHS include:

- arthritis
- asthma
- back pain and problems
- cancer
- cardiovascular disease (selected heart, stroke and vascular disease, excluding hypertension)
- chronic kidney disease
- chronic obstructive pulmonary disease (COPD)
- diabetes
- mental and behavioural conditions
- osteoporosis.

## Cardiovascular disease

Cardiovascular disease is a term used to describe a range of conditions related to heart, stroke and vascular disease. Cardiovascular disease remains a major health concern in Australia, and it generally has a greater impact on older people (AIHW 2020c).

An estimated 717,800 people aged 65 and over had one or more conditions related to heart, stroke or vascular disease, based on self-reported data from the 2017–18 NHS (AIHW 2020c). The proportion increased with age, with an estimated 16% of people aged 65–74 having heart, stroke and vascular disease, compared with 26% of those aged 75 and over.

A higher proportion of men and a higher proportion of people 75 and over had one or more conditions related to cardiovascular disease (Table 3B.1).

Table 3B.1: Prevalence of heart, stroke and vascular disease by age group and sex, 2017–18

| Age group (years) | Males (%) | Females (%) |
|---|---|---|
| 65–74 | 20 | 12 |
| 75 and over | 32 | 20 |

Source: AIHW 2020c.

Common cardiovascular diseases are coronary heart disease (affecting an estimated 380,000 older people in 2017–18) and stroke (affecting an estimated 276,000 older people) (AIHW 2020c). Again, the prevalence of these diseases was higher for older men compared with women, and increased with age for both men and women (AIHW 2020c).

Cardiovascular disease was a major cause of total burden of disease in older Australians. In 2015, coronary heart disease was the leading cause of disease burden for men aged 65 and over, while for women it was the second leading cause for those aged 75 and over (AIHW 2019).

Cardiovascular disease is also a common cause of hospitalisations. In 2017–18, cardiovascular disease was the principal diagnosis in 387,500 hospitalisations for older Australians, accounting for 66% of all cardiovascular hospitalisations. Hospitalisation rates increased with age, with the highest rates among people aged 85 and over (17,900 hospitalisations per 100,000 population) (AIHW 2020c).

Cardiovascular disease is also a common cause of death. In 2018, there were around 37,400 deaths where cardiovascular disease was the underlying cause among older people (aged 65 and over) (89% of all cardiovascular deaths).

Further information on cardiovascular disease is contained in Heart, stroke and vascular diseases.

### Arthritis and other musculoskeletal conditions

The musculoskeletal system refers to bones, muscles and joints. As people age, conditions such as arthritis, back problems and osteoporosis become increasingly more common; these can have a profound impact on people's quality of life and wellbeing.

Arthritis is the most common chronic condition among older Australians. In 2017–18, almost half (49% or 1.8 million) of older people (aged 65 and over) reported arthritis, commonly:

- osteoarthritis (1.2 million people)
- rheumatoid arthritis (193,400 people).

Some 955,000 (26%) older Australians reported back problems (AIHW 2020b).

According to 2015 Australian Burden of Disease Study results, musculoskeletal conditions are a leading cause of non-fatal burden for older people (AIHW 2019). More information about this can be found in Health—status and functioning.

### Chronic kidney disease

Chronic kidney disease (CKD) refers to dysfunctional or damaged kidneys. At the earlier stages of the disease, people may not feel ill, but in the end stages of the disease, people require dialysis or transplants to stay alive. For various reasons, not all people with end-stage kidney disease receive dialysis or transplant, particularly in the older age groups (AIHW 2020a).

Measured data from the 2011–12 Australian Health Survey – which takes into account biomedical signs as well as self-reporting – showed that the prevalence of biomedical signs of CKD increased rapidly in older ages. The prevalence of CKD was twice as high for people aged 75 and over as for those aged 65–74 (42% and 21%, respectively) and around 7 times as high as for those aged 18–44 (5.5%) and 45–54 (5.6%) (AIHW 2020d). The incidence rate (meaning newly diagnosed cases) similarly increased with age.

In 2017–18, 7 in 10 (70%) of hospitalisations where kidney disease was identified as the principal or additional diagnosis were for people aged 65 and over (AIHW 2020d). The rates of hospitalisations also increased with age. This can reflect the repeated nature of dialysis treatment: older people are more likely to have kidney disease, and people with kidney disease may visit hospital very regularly. The rates of CKD-related hospitalisations for both men and women were highest in those aged 85 and over (19,100 and 11,000 per 100,000 population, respectively) – at least 1.6 times as high as for those aged 75–84 (11,100 and 6,900 per 100,000, respectively) (AIHW 2020d).

### Respiratory conditions

Older people are often more vulnerable to respiratory conditions. This broad umbrella term includes both chronic conditions and acute infections (see section on COVID-19 in box below).

A chronic respiratory condition common among older Australians is COPD. This lung disease develops over many years and therefore affects mainly people from middle age onwards. It is characterised by the chronic obstruction of airflow. People with COPD may experience coughing, sputum production, or difficult or laboured breathing. The disease can interrupt daily activities, sleep patterns and the ability to exercise (AIHW 2020f).

According to 2017–18 NHS estimates, 252,000 older Australians reported COPD (including emphysema) as a long-term health condition, representing 7.0% of all older people (7.5% of older men and 6.4% of older women) (ABS 2018b).

The proportion of people with COPD across older age groups was:

- 7.1% of those aged 65–74 (153,000 people)
- 6.6% of those aged 75–84 (74,400 people)
- 6.6% of those aged 85 and over (22,000 people).

Asthma is another common chronic respiratory condition, and its symptoms can overlap with those seen in COPD. According to the 2017–18 NHS, asthma was reported as a long-term health condition by around 1 in 8 (12%, 433,700) older people (9.5% of older men and 14% of older women) (ABS 2018b).

The proportion of older people with asthma across older age groups was:

- 12.6% of those aged 65–74 (274,000 people)
- 12.0% of those aged 75–84 (129,000 people)
- 9.5% of those aged 85 and over (31,600 people) (ABS 2018b).

### Acute respiratory conditions

#### Coronavirus disease 2019 (COVID-19)

COVID-19 can have a considerable impact on the health of older people because of their weaker immune systems and greater likelihood of having a chronic condition such as dementia, heart disease, diabetes, lung disease and cancer (Wu 2020).

To 14 October 2021, there were just under 15,700 confirmed cases of COVID-19 among people aged 60 and over and just under 1,400 deaths (Department of Health 2021a). From 1 January to 26 September 2021, age groups 60 and over had the lowest rates of COVID-19 cases per 100,000 population:

- 60–69 – 132
- 70–79 – 89
- 80–89 – 96
- 90 and over – 99 (Department of Health 2021b).

For information on the use of health services during COVID-19, see Health—service use. For information on how the COVID-19 pandemic affected older Australia's social engagement, see Social support. For further information on COVID-19 in Australia, see The first year of COVID-19 in Australia: direct and indirect health effects.

#### Influenza and pneumonia

Influenza and pneumonia also commonly affect older people more than those at younger ages – particularly those who live in permanent residential aged care and who may have dementia. For more information, see Interfaces between the aged care and health systems in Australia – where do older Australians die?.

## Dementia

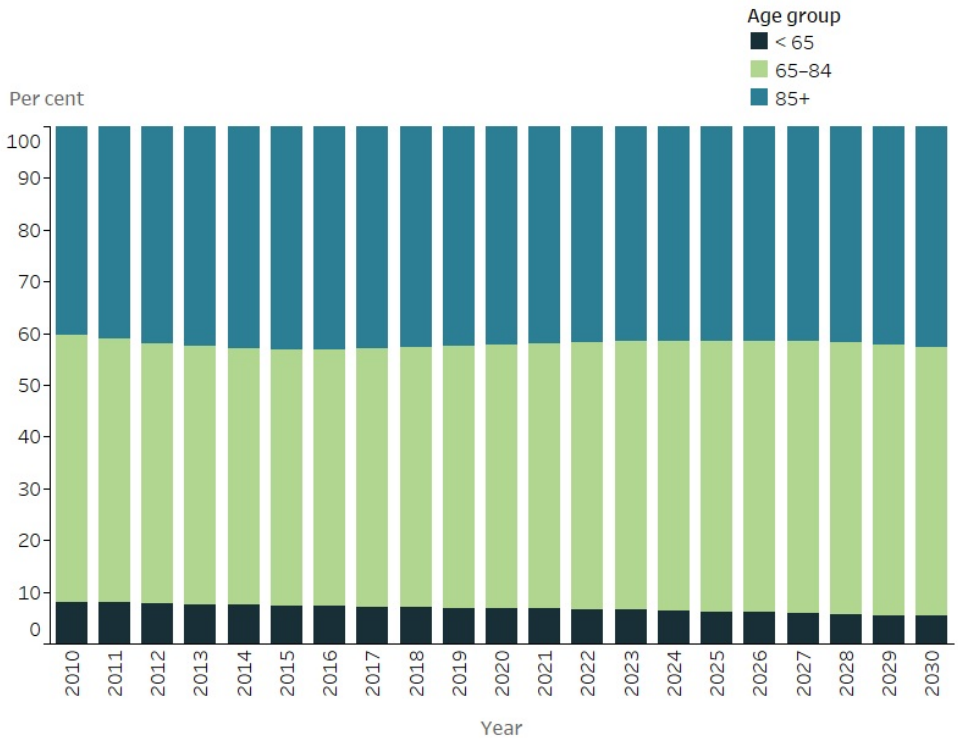
As a term, dementia describes a group of conditions characterised by the gradual impairment of brain function. It is commonly associated with memory loss, but it is not limited to this: people's ability to speak, think and move can be affected, their behaviour or personality may change. Generally, people's health and functional abilities decline as the condition progresses. There are many forms of dementia and it is common to have multiple types of dementia at once – known as 'mixed dementia'. Dementia is more common with advancing age and mainly occurs among people aged 65 and over – but it is not a normal part of ageing.

The number of Australians of all ages living with dementia was estimated to be between 400,000 and 459,000 in 2020, but the exact number is unknown (AIHW 2018, 2020a). Some international studies suggest that the incidence of dementia may be decreasing, but the continued growth and ageing of Australia's population will lead to an increase in the number of people with dementia over time. By 2030, the number of people with dementia is expected to increase to 550,000 (AIHW 2018), with people aged 65–84 making up slightly more than half (52%) of this number (Figure 3B.1).

Figure 3B.1: Historical and projected dementia prevalence by age group, 2010–2030

The stacked column graph shows the proportion of people with dementia is predominately among people aged 65–84 years. Projections suggest that dementia prevalence is likely to remain highest in older age groups, and decrease among people aged under 65 (in 2010 92% of people with dementia were aged over 65, compared to the projected 95% in 2030).

Figure 3B.1: Historical and projected dementia prevalence by age group, 2010–2030




*Source:* AIHW 2018.
http://www.aihw.gov.au/

For more information, see Dementia in Australia.

## Diabetes

Diabetes is a chronic condition characterised by high levels of glucose (sugar) in the blood. It is caused either by the body's inability to produce insulin (a hormone produced by the pancreas to control blood glucose levels) or by the body not being able to use insulin effectively. These estimates include people with the following types of diabetes:

- type 1 (non-preventable autoimmune disease mainly developing in childhood)
- type 2 (largely associated with modifiable risk factors but also genetic and family related risk factors)
- type unknown (AIHW 2020h).

The prevalence of diabetes (based on self-reporting) among older people (aged 65 and over) has doubled over the last 2 decades – from 8.5% in 1995 to 16.8% in 2017–18. This increase is likely due to several factors, including an increased prevalence of risk factors, improved public awareness, better detection techniques and improved survival through management strategies.

In 2017–18, 607,700 Australians aged 65 and over self-reported diabetes as a long-term health condition (ABS 2018a). The prevalence of diabetes for those aged 65–74 was more than 3 times as high as for those aged 45–54. Older men aged 65–74 were more likely than women of the same age to report having diabetes (19% compared with 12%, respectively) (AIHW 2020h).

While the self-reported rate of diabetes for Australians aged up to 64 has remained relatively stable since 2001, it has increased for older Australians. In 2017–18, 15% of Australians aged 65–74 self-reported having diabetes, an increase from 13% in 2001. Similarly, in 2017–18, 19% of Australians aged 75 and over self-reported diabetes, an increase from 11% in 2001 (ABS 2018a).

More information about diabetes is available in Health—service use (see 'Pharmaceutical use' and 'Hospitals'), and Health—status and functioning (see 'Burden of disease').

## Mental health

Mental health is influenced by a combination of psychological, biological and socioeconomic or cultural factors (such as income levels and living conditions) (Slade et al. 2009). Good mental health can support healthy behaviours in old age. In turn, poor mental health can be associated with poor physical health.

Poor mental health can be defined in different ways but commonly it includes mental illnesses such as anxiety disorders, affective disorders (such as depression), psychotic disorders and substance use disorders (AIHW 2020a). People may have experienced poor mental health over their lifetime, or they may have experienced a recent onset; for example, due to stressors such as loss, bereavement or health issues (AIHW 2015).

Mental illness may be more common among particular groups of older Australians, such as older carers, people in hospital and people with dementia (RANZCP 2016; Rickwood 2005). People living in residential aged care are another subgroup at higher risk of poor mental health. At 30 June 2019, of those people living in permanent residential aged care, the majority (87%) were diagnosed with at least one mental health or behavioural condition and 49% had a diagnosis of depression (AIHW 2020l).

For more information on diversity in older Australians, see Culturally and linguistically diverse older people; for more information on their financial and housing situations, see Income and finances and Housing and living arrangements; for more information on older Australians' experiences of abuse and discrimination, see Justice and safety.

The prevalence of mental illness decreases with age. Using the Kessler Psychological Distress Scale (K10)—which includes questions about people's level of nervousness, agitation, psychological fatigue and depression—the 2017–18 ABS NHS showed that:

- almost 7 in 10 (68%) people aged 65 and over reported low levels of psychological distress in the past 4 weeks
- 1 in 5 (19%) reported moderate distress levels
- 10% reported high or very high levels (ABS 2019).

### COVID-19 and mental health

Older Australians have been shown to have generally lower levels of anxiety and worry over the course of 2020 than younger Australians. Australian National University research found this in May, August and October 2020. However, between May and August 2020, older people aged 65–74 years had the largest increase in anxiety and worry, up to 57% from 47%. Similarly, older people aged 75 and over were the only age group that saw a significant worsening in psychological distress between May and August 2020 (Biddle et al. 2020).

The ABS Household Impacts of COVID-19 Survey showed that, in June 2021, around 1 in 10 (10%) older people (aged 65 and over) reported high or very high distress. However, the majority of older people reported low distress levels (66%). Around 1 in 6 (16%) older people reported feeling nervous at least some of the time in the last 4 weeks (ABS 2021).

For more information, see Household Impacts of COVID-19 survey.

For information on how older Australians use mental health services, see Health—service use. For more information about suicide and self-harm among older people, see Health—status and functioning and Suicide & self-harm monitoring.

## Oral health and disease

Oral health relates to the ability to eat, speak and socialise without discomfort or active disease in the teeth, mouth or gums. Oral health generally deteriorates over a person's lifetime: it can be affected by biomedical risks, as well as clinical conditions and age-related functional impairments, such as increased difficulty with personal care.

Oral disease can in turn have an impact on people's health and wellbeing more broadly. The 2 main forms of oral disease affect the teeth (dental caries or decay) and gums (periodontal disease). Oral disease also includes conditions such as mouth ulcers, oral cancers, tooth impactions and misaligned teeth, and traumatic injuries to the teeth and mouth (AIHW 2020j).

The proportions of older people with at least one natural tooth who report fair or poor oral health have increased over time (capturing different cohorts of older people):

- For those aged 65–74, the proportion with fair or poor oral health increased from 18% in 2004–06 to 26% in 2017–18.
- For those aged 75 and over, it increased from 18% to 23% (AIHW 2020j).

Among older Australians, the proportion with at least one tooth with untreated decay increased from 22% in 2004–06 to 27% in 2017–18.

Between 2013 and 2017–18, the proportion of older people who had experienced toothache in the past 12 months also increased, from 8.9% to 13%. The proportion of older people who reported feeling uncomfortable with the appearance of their teeth, mouth or dentures in the past 12 months increased from 21.7% in 2013 to 29.1% in 2017–18. Compared with other age groups at both of these time points, older people were the least likely to report feeling uncomfortable with the appearance of their teeth, mouth or dentures (AIHW 2020i).

In 2017–18, the average number of missing teeth for older Australians (aged 65 and over) was 13.7, higher than the 2.5 for young people aged 15–24 (the full adult set is 32). Other selected aspects of oral health and disease were also high for older people (Table 3B.2).

Table 3B.2: Selected aspects of oral health and disease for older Australians, 2017–18

| | % |
|---|---|
| Experienced toothache | 13 |
| Lost all natural teeth | 15 |
| Has periodontitis | 59 |
| Avoided eating some foods due to problems with teeth | 27 |

Note: 'Older Australians' refers to people aged 65 and over.

Source: AIHW 2020i.

Many of these oral health issues and disease have also increased over time. For more information about progress against key performance indicators used to monitor performance of the strategies in Australia's National Oral Health Plan 2015–2024, see AIHW (2020i).

## Ear health and hearing

Poor ear health and poor hearing can have implications for communication, social participation, independent living and employment (AIHW 2016). Middle-age hearing loss can also be linked to an increased risk of later developing dementia (Livingston et al. 2017). Ear disease and the associated hearing loss can develop over time for many reasons (such as injury, infection or genetic causes) but, for the most part, these are preventable (AIHW 2018).

In 2017–18, an estimated 1 in 3 (34%) people aged 65 and over reported complete or partial deafness as a long-term health condition (ABS 2018b). The 2018 ABS Survey of Disability Ageing and Carers also estimated that among older people, 7.7% (300,000 people) had a main long-term health condition of the ear (diseases of the ear and mastoid process), with a higher proportion of older men affected (11%) than older women (4.7%) (ABS 2019).

## Eye health and sight

Chronic eye conditions vary in their presentation, treatment and consequences, but many are commonly experienced by older people. In 2017–18, the majority of people aged 65 and over reported a chronic eye condition (93%, 3.4 million people). The most common chronic eye condition was long-sightedness (62%), followed by short-sightedness (41%), presbyopia (9.6%) – a type of long-sightedness – and cataracts (9.1%) (ABS 2018b).

The prevalence of long-term eye conditions was broadly similar for both older men and women (AIHW 2021b). Looking at selected eye conditions among older Australians between 2007–08 and 2017–18, the prevalence by sex remained relatively stable (Table 3B.3).

Table 3B.3: Percentage of older Australians with selected eye conditions, 2007–08 and 2017–18

| | 2007-08 | | 2017-18 | |
|---|---|---|---|---|
| | Men | Women | Men | Women |
| Cataracts | 9.0 | 10.2 | 7.4 | 10.6 |
| Macular degeneration | 4.2 | 6.8 | 4.1 | 4.9 |
| Glaucoma | 5.2 | 5.0 | 3.5 | 3.8 |

Note: 'Older Australians' refers to people aged 65 and over.

Source: AIHW 2021b.

## Chronic pain

Chronic pain is pain that lasts beyond normal healing time after injury or illness. It is a common and complex condition, and the pain experienced may be anything from a mild niggle to debilitating. Older people with chronic pain can be at an increased risk of falling, reduced mobility and disability. In turn, people who experience falls, reduced mobility or disability may be at an increased risk of pain. Pain can also affect people's ability to look after themselves and remain independent in older age (AIHW 2020e; Eggermont et al. 2014; Stubbs et al. 2014).

Chronic pain is more likely to affect women and older people. In 2016:

- 1 in 5 (20%) people aged 65–74 reported having chronic pain, increasing to 22% of those aged 75–84 and 24% of those 85 and over.
- Among women, chronic pain was 1.8 times as high in those aged 85 and over (28%) as in those aged 45–54 (16%).
- Among men, chronic pain was 1.3 times as high in those aged 85 and over (18%) as in those aged 45–54 (13%) (AIHW 2020e).

For more information, such as hospitalisation for chronic pain, see Chronic pain in Australia.

## Where do I find more information?

For more information on health conditions among older Australians, see:

- AIHW Australia's health 2020

Information about health and aged care service use associated with specific health conditions is located in Health—service use, while information about deaths and burden of disease is located in Health—status and functioning.

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# Health

**On this page:**


- Physical activity
- Nutrition
- Obesity
- Tobacco smoking
- Alcohol consumption
- Illicit drugs
- Stress
- Vaccination
- High blood pressure
- High cholesterol
- Self-harm
- Where do I go for more information?


**Key findings**
3 in 4 older Australians (65 and over) are overweight or obese.

**Key findings**
1 in 10 older people experienced high levels of psychological distress.

**Key findings**
1 in 3 older people had high cholesterol.

**Key findings**
Since 2001, there has been little improvement in the rates of daily smoking by older people (aged 50 and over), and there has been increases in risky drinking and recent cannabis use (AIHW 2020f).

Some behaviours and risk factors (attributes, characteristics or exposures) can increase the likelihood of developing a disease or health condition. They include behavioural risk factors (which are those that individuals have the most ability to modify) and biomedical risk factors (bodily states). Behavioural and biomedical risk factors can increase each other's effects when they occur together in an individual (AIHW 2016a). People can also experience other risk factors that affect their health and wellbeing, such as social isolation, poor engagement and exclusion. For information on these topics, see Social support.

Throughout this page, 'older people' refers to people aged 65 and over. Where this definition does not apply, the age group in focus is specified. The 'Older Aboriginal and Torres Strait Islander people' feature article defines older people as aged 50 and over. This definition does not apply to this page, with Indigenous Australians aged 50–64 not included in the information presented.

Many serious health issues, including some chronic diseases (such as cardiovascular disease, chronic kidney disease, certain types of cancer, type 2 diabetes, influenza and high blood pressure) can relate to these behaviours and risk factors (Table 3C.1).

Table 3C.1. Percentage of people who meet selected indicators of healthy lifestyles, by age group, 2017–18

| | 18-64 | 64+ |
|---|---|---|
| Met guidelines for physical activity [(a)] | 17.0 | 18.3 |
| Not a current smoker | 83.0 | 92.6 |
| Vaccinated against influenza | 22.8 | 74.6 |
| Did not exceed guidelines for alcohol consumption[(b)] | 51.1 | 79.9 |
| Met recommendation for fruit and vegetables[(c)] | 4.7 | 8.2 |
| Normal weight range[(d)] | 33.7 | 23.5 |
| Did not experience high levels of psychological distress[(e)] | 81.9 | 86.2 |

Notes:

(a) Met the 2014 Physical activity guidelines based on Australia's Physical Activity and Sedentary Behaviour Guidelines for any physical activity.

(b) Refers to single-occasion risk on any occasion in the last 12 months. See 'Risky drinking levels' box below for more information.

(c) Met the National Health and Medical Research Council (NHMRC) 2013 Australian Dietary Guidelines recommendation for daily consumption of fruit and vegetables.

(d) Based on measured height and weight and includes a body mass index (BMI) of 18.5 to less than 25.

(e) Did not experience high/very high psychological distress. Denominator includes level of distress unable to be determined.

Sources: ABS 2018c; AIHW 2011.

## Physical activity

Regular physical activity has important benefits for both physical and mental health, including:

- reducing the risk of many health problems, such as cardiovascular disease, diabetes, anxiety, depression and musculoskeletal problems
- enhancing social and community connectedness by providing opportunities for social engagement (AIHW 2020e).

According to the 2017–18 Australian Bureau of Statistics (ABS) National Health Survey (NHS), 7 in 10 (73%) people aged 65 years and over engaged in some form of exercise in the last week, but many older people (82%) did not meet the guidelines for physical activity (defined as accumulating at least 30 minutes of moderate intensity physical activity on most, preferably all, days; see box below for more information). Similarly, 83% of people aged 18–64 did not meet the guidelines (ABS 2018c).

Around one quarter (26%) of older people (aged 65 and over) engaged in 30 minutes or more of exercise on 5 or more days in the last week (28% of older men and 25% of older women), with:

- 30% of those aged 65–74
- 23% of those aged 75–84
- 11% of those aged 85 and over (ABS 2018c).

**Not meeting the physical activity guidelines**

Some 82% of older Australians (aged 65 and over) did not meet the physical activity guidelines. However, within this group, a range of behaviours are represented, with some falling further below the recommended level of physical activity than others:

- 4 in 10 (42%) men and almost half (47%) of women completed less than 30 minutes of exercise in the last week.
- At the other end of the spectrum, 47% of men and 38% of women completed 150 minutes or more of exercise in the last week.

Some of the people who did not meet the physical activity guidelines reported no physical activity at all. In all, an estimated 983,000 people aged 65 and over did no physical activity in the last week, representing 38% of older Australians who did not meet the physical activity guidelines. For people aged 18–64 who did not meet the physical activity guidelines in the last week, 23% did no physical activity in the last week (AIHW 2020e).

## Nutrition

A healthy diet can help to prevent and manage many chronic conditions, including type 2 diabetes, cardiovascular disease and some forms of cancer. The National Health and Medical Research Council (NHMRC 2013) recommends a minimum number of serves of fruit and vegetable every day for a healthy lifestyle, with the number of serves based on a person's age and sex.

Based on data from the 2017–18 NHS, across all age groups, most Australians (95%) reported not eating enough fruit and vegetables to meet these recommended guidelines. Around 1 in 12 older Australians (8.2%) met both the fruit and vegetable guidelines (10% of older women and 6.1% of older men). Over 3 in 5 (63%) older Australians met the recommended fruit intake, while few (11%) met this for vegetables (ABS 2018c).

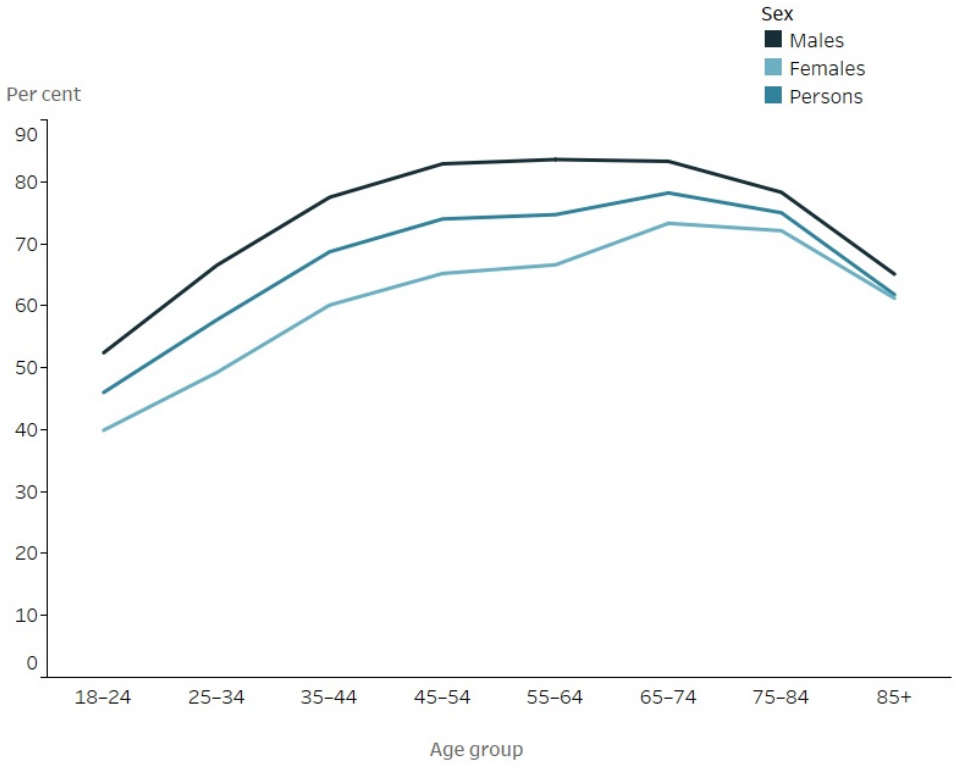
## Obesity

Obesity is a key health issue for older Australians and can increase the risk of developing long-term health conditions such as heart disease, type 2 diabetes and certain cancers. Based on estimates from the 2017–18 NHS, 3 in 4 (76%) older Australians (aged 65 and over) were overweight or obese. The prevalence of overweight or obesity increases with age up to the 65–74 age group. In 2017–18, 78% of people in this age group were overweight or obese, compared with 65% of those aged 18–64 years (AIHW 2020g) (Figure 3C.1).

Figure 3C.1: Percentage of overweight or obese persons by age group and sex, 2017–18

The line graph shows that the percentage of overweight and obese men peaked in those aged 55–64, compared with women who peaked in the 65–74 age group (84% and 73%, respectively). The percentage of overweight and obese persons was greater in men across all age groups compared with women.

Figure 3C.1: Percentage of overweight or obese persons by age group and sex, 2017–18




*Source:* ABS 2018c.
http://www.aihw.gov.au/

## Tobacco smoking

Tobacco is one of the leading risk factors contributing to the burden of disease for older Australians. Specifically, tobacco is the leading risk factor for the burden of disease for males and females aged 65–74 and 75–84, and males aged 45–64 (AIHW 2020a). It is the leading risk factor for coronary heart disease and lung disease and contributes to cancer deaths (see Australia's health 2020: Tobacco smoking snapshot).

According to the 2017–18 NHS, an estimated 251,700 (7%) older Australians (aged 65 and over) were current daily smokers. Almost half of older people had never smoked (49%) and around 2 in 5 (44%) were ex-smokers (ABS 2018c).

Improved awareness of the negative health effects of tobacco, and a range of control measures aimed at reducing smoking rates, may be influencing overall declines in smoking rates. The National Drug Strategy Household Survey (NDSHS) estimated that the daily smoking rate across all ages (14 and over) has declined from just over 12% in 2016 to 11% in 2019, and halving since 1991 (24%). However, the move away from smoking is not consistent across all age groups. According to the NDSHS, older people were some of the most likely to smoke daily. Of all daily smokers aged 14 and above in 2019, 2 in 5 (39%) were aged 50 and over. This was an increase from 2001 where people aged 50 and over made up nearly 1 in 4 (23%) of all daily smokers aged 14 and above. People aged 60 and over made up 8.9% of all daily smokers in 2001, doubling in 2019 to 18% (AIHW 2020f).

**Older people in the NDSHS**

Most population data define 'old' as persons aged 65 and over to align with the qualifying age for the Age pension. However, AIHW reporting on the NDSHS generally refers to older people as those aged 50 and over. This wider age range is to capture people who may be ageing prematurely due to alcohol and other drug use, and to include the 'baby boomer' cohort (AIHW 2016b). On this page, people in their 50s are included in some sections where the NDSHS is being referenced. The age cohort relevant to the information presented has been specified to make this clear.

In 2019, the proportion of daily smokers who were aged:

- in their 50s was 16%
- in their 60s was 11%
- 70 and over was 4.6% (decreasing from 6.0% in 2016) (AIHW 2020f).

Compared with younger smokers, older smokers were:

- more likely to report smoking more cigarettes. People in their 60s smoked 16.5 cigarettes per day on average, and those aged 70 and over smoked 15.5 cigarettes. This was around double the number of cigarettes smoked by people aged 18–24 (8.1 cigarettes)

- less likely to have intentions to quit smoking. The proportion of current smokers who were not planning to quit smoking was higher among people in their 50s (33%), 60s (40%) and aged 70 and over (46%) compared with all current smokers (30%). The main reason older smokers gave for not wanting to quit was because they enjoyed it (AIHW 2020f).

### Alcohol consumption

In Australia, alcohol plays a prominent role in society and is associated with many social and cultural activities. While fewer people are drinking daily and most Australians drink at light to moderate levels, it is excessive drinking that is of most concern. Consuming excessive amounts of alcohol is a health risk. It can contribute to long-term health issues such as liver disease, some cancers and brain damage. In 2019, people aged 55 and over had the highest age-specific rates of alcohol-induced and alcohol-related deaths. Alcohol-induced deaths per 100,00 population were:

- 12.2 for those 55–59
- 13.4 for those aged 60–64
- 11.4 for those aged 65 and over.

The lowest rates of alcohol-induced deaths were for young people aged 15–19 with no alcohol-induced deaths, followed by 0.3 per 100,00 population for people aged 20–24 and 25–29.

The rate of alcohol-related deaths (per 100,000 population) increased with increasing age up to ages 60–64, where it peaked and then dropped for people aged 65 and over:

- 34.3 for those 55–59
- 37.7 for those aged 60–64
- 32.2 for those aged 65 and over.

The lowest rate of 4.2 per 100,000 population was for people aged 15–19 (AIHW 2021a).

#### Risky drinking levels

New Australian guidelines to reduce health risks from drinking alcohol were released in December 2020 (NHMRC 2020). Data for alcohol risk on this page are measured against the 2009 guidelines (NHMRC 2009).

Based on the 2009 Australian Guidelines to Reduce Health Risks from Drinking Alcohol, these 2 guidelines are used to measure risk among adults:

- **Lifetime risk** – for healthy men and women, drinking no more than 2 standard drinks on any day reduces the lifetime risk of harm from alcohol-related disease or injury.
- **Single occasion risk** – for healthy men and women, drinking no more than 4 standard drinks on any one occasion.

See National Drug Strategy Household Survey 2019 for more information. NDSHS data relating to the updated guidelines are available.

According to 2017–18 NHS estimates, almost 1 in 5 (18%) older Australians (aged 65 and over) exceeded the single occasion risk guideline for alcohol consumption for any occasion in the last 12 months (ABS 2018c).

Data from the 2019 NDSHS indicated that the proportion of people in their 50s giving up alcohol has not changed; 9.1% were ex-drinkers in 2001 and a similar proportion (9.6%) were ex-drinkers in 2019. People aged 60 and over were slightly more likely to have given up alcohol in 2019 (14%) than in 2001 (12%) (AIHW 2020f).

Estimates from the NDSHS showed that, in 2019:

- Among people in their 50s, there has been no change in the proportion of people exceeding the lifetime risk guideline – 22% in 2001 and 21% in 2019. The proportion exceeding the single occasion risk guidelines at least monthly increased from 22% in 2001 to 27% in 2019.
- Around 1 in 6 (17%) people in their 60s exceeded single occasion risk guidelines at least monthly in 2019.
- People aged 70 and over continued to be the most likely to drink daily (13%), followed by people in their 60s (9.6%). While those 70 and over were the least likely age group to exceed single occasion risk guidelines at least monthly (8.8%), this figure increased since 2016 (7.2%) (AIHW 2020f).

## Illicit drugs

Illicit drug use includes the use of illegal drugs, use of pharmaceuticals for non-medical purposes and volatile substances used inappropriately (for example, petrol as an inhalant). The most common illicit drugs used are cannabis and non-medical use of pharmaceuticals (AIHW 2020f).

There is an ageing cohort of people who use illicit drugs. Data from the 2019 NDSHS indicate that a greater proportion of older Australians reported illicit drug use than in previous years (AIHW 2020f). Recent (in the previous 12 months) illicit drug use increased among those aged 60 and over, from 3.9% in 2001 to 7.2% in 2019.

The proportion of people aged 60 or over who had used illicit drugs in their lifetime increased between 2016 (26%) and 2019 (29%). There were increases for both men (from 30% to 34%) and women (22% to 24%) (AIHW 2020f).

Recent cannabis use has increased for older people. Between 2016 and 2019, recent use of cannabis significantly increased among people in their 50s (from 7.2% to 9.2%) and those aged 60 and over (from 1.9% to 2.9%). Older people are more likely to use cannabis for medical purposes. In 2019, 43.1% of people who had recently used cannabis for medical purposes only were aged 50 and over, compared with 16.0% of people who had recently used cannabis for non-medical purposes aged 50 and over (AIHW 2020f).

## Stress

Chronic stress can potentially lead to anxiety and depression, as well as to physical health issues such as high blood pressure. Chronic stress may be precipitated by experiencing personal stressors, including serious illness or accident, death of a family member or friend, and exposure to abuse. While chronic stress is an independent health risk factor, it may result in psychological distress, which can produce further symptoms (AIHW 2020d).

The 2020 ABS General Social Survey estimated that over half (56%, 1.5 million) of older Australians aged 70 and over had experienced at least one personal stressor in the last 12 months (ABS 2021).

The 2017–18 NHS also provided a measure of stress, using the Kessler Psychological Distress Scale (K10). The K10 is a scale of non-specific distress. Just under 10% (357,100) of people aged 65 and over reported high or very high levels of psychological distress. Around 1 in 10 older women (11%) and older men (8.9%) reported having high or very high levels of psychological distress (ABS 2018c). For information on mental health conditions among older people, see Health—selected conditions.

## Vaccination

Vaccination is the process of receiving a vaccine. It is a safe and effective way to protect individuals against harmful communicable diseases, while also preventing the spread of these diseases in the community. Vaccine-preventable illnesses that can seriously affect the health of older Australians include influenza, pneumonia and coronavirus disease 2019 (COVID-19). These vaccines are free for people aged 65 and over to ensure high coverage. The influenza vaccine is recommended annually; the pneumonia vaccine is administered less often.

It is difficult to estimate the number of Australians vaccinated against influenza because vaccinations can also be purchased by workplaces or individuals, in addition to programs funded by governments; see Key data gaps.

### Preventing influenza and COVID-19

Influenza is a contagious respiratory disease that causes seasonal epidemics in Australia. It spreads from person to person through droplets made when an infected person coughs, sneezes or speaks.

Between 1997 and 2019, influenza caused just over 4,800 deaths in Australia, of which 85% (4,100 deaths) were in people aged 65 and over (AIHW 2021c). These data may underestimate the real impact of influenza on deaths in Australia, as many of the people who die will not have been tested for influenza (AIHW 2020c).

During the first year of the COVID-19 pandemic, there was a reduction in influenza cases. It could be that the reduction was the result of social distancing measures taken to reduce COVID-19. It is also possible that the increased uptake of influenza immunisation played a role (AIHW 2020b).

In March 2021, Australia's COVID-19 vaccine rollout began. Vaccines were rolled out in phases, being made available first to those most in need of protection. These priority groups were identified based on expert medical advice. Residential aged care residents and workers could receive a COVID-19 vaccine from the first phase of the rollout (Phase 1a) (Department of Health 2021b). At 13 October 2021, nearly 32 million vaccine doses had been administered Australia wide. Around 2,600 residential aged care facilities had been visited. In total, just over 1 million doses had been administered in aged care and disability facilities (Department of Health 2021a).

For more information, see The first year of COVID-19 in Australia: direct and indirect health effects.

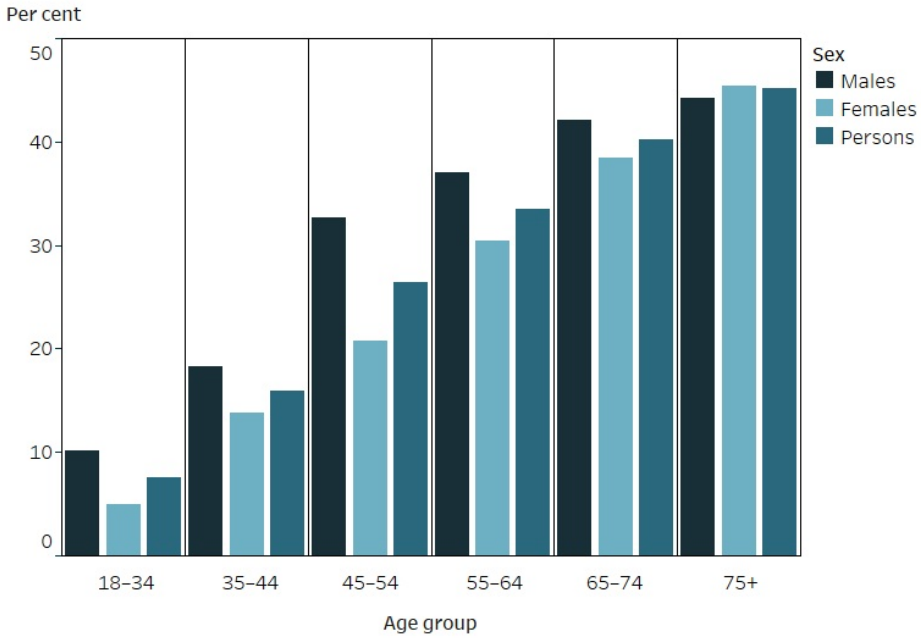
## High blood pressure

High blood pressure – also known as hypertension – is a major risk factor for cardiovascular diseases, including stroke, coronary heart disease, heart failure, peripheral vascular disease, as well as chronic kidney disease. When high blood pressure is controlled by medication and lifestyle measures, the risk of developing chronic conditions is reduced (AIHW 2019).

The proportion of adults with measured high blood pressure increases with age. In 2017–18, the proportion was lowest among people aged 18–44 (5.5%) and reaching 45% for those aged 75 and over (44% for men and 45% for women) (AIHW 2019) (Figure 3C.2).
Figure 3C.2: Percentage of Australians with measured high blood pressure by age group and sex, 2017–18

The column graph shows that the percentage of people with measured high blood pressure increased with age in both men and women. Between ages 18–74, the percentage of men with measured high blood pressure was higher than the percentage of women with measured high blood pressure. However, in the 75 and over age group, a higher percentage of women had measured high blood pressure than did men (45% and 44%, respectively).

Figure 3C.2: Percentage of Australians with measured high blood pressure by age group and sex, 2017–18




*Notes*
1. 'Measured high blood pressure' is defined as measured systolic blood pressure of 140 mmHg or more, or diastolic blood pressure of 90 mmHg or more, whether or not they were taking blood pressure medication.
2. 'Older Australians' refers to people aged 65 and over.

*Source:* ABS 2018b.
http://www.aihw.gov.au/

## High cholesterol

High cholesterol – or abnormal levels of blood lipids – is a risk factor for chronic diseases such as coronary heart disease and for some types of stroke. Blood lipids are fats in the blood and include cholesterol (a fatty substance that is an essential part of cell walls) and triglycerides (fat in the blood that assists in transporting and supplying metabolic energy throughout the body).

As with many health conditions, the prevalence of high cholesterol increases sharply with age, with a sharp increase from age 45. In 2017–18, the proportion of people with high cholesterol doubled from 6.8% for people aged 45–54 to 14% for those aged 55–64. One in 5 (21%) people aged 65 and over had high cholesterol (ABS 2018a).

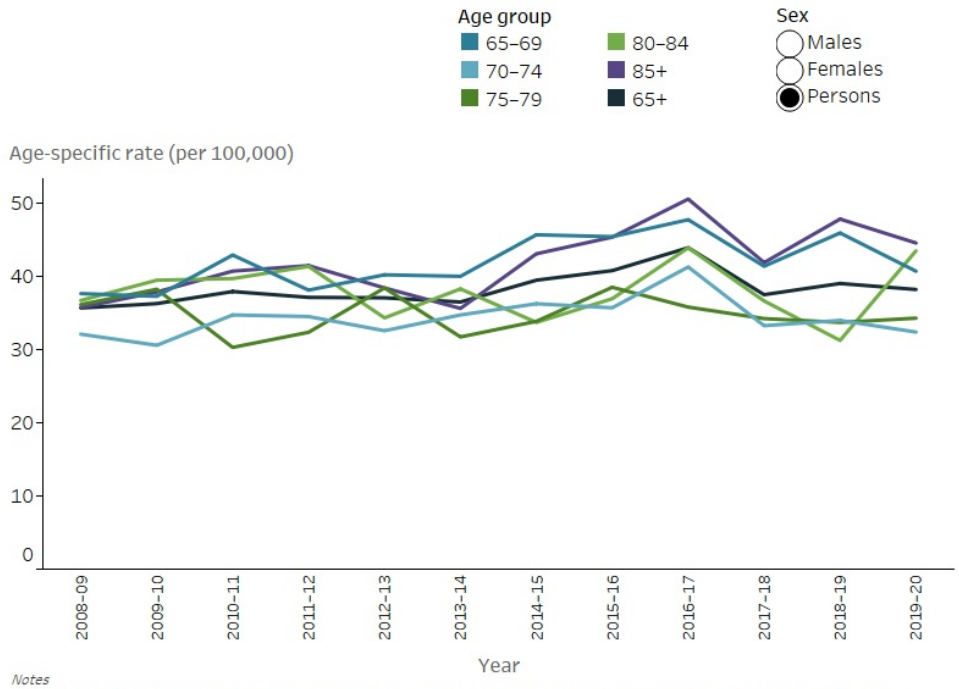
## Self-harm

Intentional self-harm is the act of deliberately causing physical harm to oneself. Current international coding practices for intentional self-harm are not able to distinguish between self-harm with suicidal intent and self-harm without the intent to die. Self-harm is a serious public health issue of concern to governments and communities across Australia and around the world. The number of people who intentionally self-harmed but were not hospitalised is largely unknown. Hospitalisations data for patients with intentional self-harm injuries include those with and without suicidal intent.

In 2019–20, the age-specific rate of intentional self-harm hospitalisation for people aged 65 years and over was 38.2 per 100,000 population. There was a peak at 44.0 in 2016–17, but it has been relatively steady since 2008–09 (AIHW 2021c). There were differences for men and women that changed with increasing age. In 2019–20, women had higher rates of intentional self-harm hospitalisations than men for ages 65–69 and ages 70–74; for ages 75–79, 80–84 and 85 and over, men had higher rates (AIHW 2021c) (Figure 3C.3).
Figure 3C.3: Age-specific rates of intentional self-harm hospitalisations among older Australians, 2008–09 to 2019–20

The line graph shows that the age-specific rates of intentional self-harm hospitalisations per 100,000 had variable differences across the time period. Men aged 85 and over had a greater age-specific rate between 2008–09 and 2019–20 compared to other age groups, with the rate peaking in 2016–17 (69.6 per 100,000).

**Figure 3C.3: Age-specific rates of intentional self-harm hospitalisations among older Australians, 2008–09 to 2019–20**




*Notes*
1. Rates (per 100,000 population) for specific age groups, sex and jurisdictions are crude rates based on the 2011 Census estimated resident populations as at 30 June of the year prior to the reference year. For example, the estimated resident population at 30 June 2018 was used to calculate the rate of hospitalisations for the reference period 2018–19.
2. 'Persons' includes separations for which the sex of the patient was missing or not reported.
3. 'Older Australians' refers to people aged 65 and over.

*Source:* AIHW 2021b.
http://www.aihw.gov.au/

Of deaths registered in 2019, 15% of deaths due to intentional self-harm were older Australians (aged 65 and over). This proportion was similar for men (15%) and women (16%) (ABS 2020a). See also Suicide & self-harm monitoring.

**If this has raised any issues for you, these services can help:**

Lifeline 13 11 14

Suicide Call Back Service 1300 659 467

Kids Helpline 1800 55 1800

MensLine Australia 1300 78 99 78

Beyond Blue 1300 22 4636.

Crisis support services can be reached 24 hours a day.

## Where do I go for more information?

For more information on behaviours and risk factors among older people, see:

- ABS General Social Survey: summary results, Australia
- AIHW Alcohol and other drug treatment services in Australia annual report
- AIHW Alcohol, tobacco and other drugs in Australia
- AIHW Australian Burden of Disease
- AIHW Australia's health 2020: snapshots
- AIHW Diabetes
- Department of Health Physical activity guidelines for all Australians: for older Australians (65 years and over)
- NHMRC Australian Dietary Guidelines

Information is also available about selected health conditions and health service use among older Australians. For information on behaviours and risk factors among older Aboriginal and/or Torres Strait Islander people, see Older Aboriginal and Torres Strait Islander people.

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# Health

**On this page:**


- Primary care
- Allied health professionals
- Mental health services
- Dental services
- Hospitals
- Pharmaceutical use
- Palliative care
- Where do I go for more information?


**Key findings**
Most (95%) older Australians see a general practitioner.

**Key findings**
In 2019–20, 241,200 older people accessed Medicare- subsidised mental health-specific services, with older people using services at relatively low rates compared with younger people.

**Key findings**
Older people account for 16% of the population but more than 1 in 5 (22%) emergency department visits.

**Key findings**
People aged 85 and over have the highest rate of Pharmaceutical Benefits Scheme prescriptions dispensed.

**Key findings**
Older people account for 3 in 4 of total palliative care hospitalisations.

There are many programs and services available to support the health of older Australians. Health services include those provided by medical practitioners, specialists and other health professionals in hospitals and clinics. Older people's access to these services may vary according to where they live, their access to transport, their health and cultural background, as well as socioeconomic factors (AIHW 2020e; van Gaans and Dent 2018).

Cancer screening programs are an important component of health service use. In Australia, there are three national screening programs:

- BreastScreen Australia
- National Bowel Cancer Screening Program (NBCSP)
- National Cervical Screening Program (NCSP).

These programs test for signs of cancer or pre-cancerous conditions in populations without obvious symptoms. They target specific populations and/or age groups where evidence shows screening to be most effective. Cancer screening is not included in this page; for more information on cancer screening in Australia, see Cancer screening.

Throughout this page, 'older people' refers to people aged 65 and over. Where this definition does not apply, the age group in focus is specified. The Older Aboriginal and Torres Strait Islander people feature article defines older people as aged 50 and over. This definition does not apply to this page, with Indigenous Australians aged 50–64 not included in the information presented.

## Primary care

### General practitioners

General practitioners (GPs) are part of the front line of Australia's health care system. GPs treat a broad range of health issues and are often the first point of contact many people have with the health system. They can be critical in reducing the number of potentially avoidable hospital visits and improving the health of the population (AIHW 2020k).

Most older Australians see a GP. The 2019–20 Australian Bureau of Statistics (ABS) Patient Experience Survey estimated that, in 2019–20, 3.7 million older people (aged 65 and over) saw a GP at least once (95% of all older people). Over half (58%) of these older people were aged 65–74. An estimated 8 in 10 (80%) people aged 15–64 saw a GP at least once (ABS 2020).

In 2019–20, there were 43 million Medicare claims for unreferred GP attendances for people aged 65 and over – 30% of the total 141 million claims for unreferred GP attendances.

Unreferred GP usage was greater for those of older ages. The rates of service use per 100,000 population were:

- 1.5 million by people aged 85 and over
- 1.1 million by those aged 75–84
- 0.8 million by those aged 65–74.

In comparison, the service use for those aged 45–54 was 0.5 million per 100,000 (Services Australia 2021).

ABS data for 2018–19 show that the majority of older people self-reported that they had acceptable waiting times to get an appointment with a GP. For those accessing GP services in the last 12 months, this included:

- 86% of those aged 65–74
- 90% of those aged 75–84
- 89% of those aged 85 and over (AIHW 2020k).

#### GP visits during COVID-19

During the coronavirus disease 2019 (COVID-19) pandemic, the Australian Government expanded Medicare-subsidised telehealth (telephone and videoconference) services for all Australians and increased Practice Incentive Payments. The new Medicare Benefits Schedule (MBS) items allowed Australians to access essential primary health services, such as GP visits from home, to limit the potential exposure of patients, practice staff and medical practitioners to the virus (AIHW 2020b).

### Specialists

Specialists provide diagnostic and treatment services in a specific area of medicine, generally for a particular disease or body system. They also support patients in managing health conditions. Commonly referred specialties across all age groups include: dermatology, cardiology, gynaecology, neurology, oncology and rheumatology.

#### Medicare-subsidised specialist consultations

There were 14.6 million specialist attendances processed through Medicare in 2019–20 for people aged 65 and over. Almost 1 in 2 specialist attendance claims (46%) were for these older people (Services Australia 2021).

Older people received more Medicare-subsidised specialist consultations outside hospital than younger people. In 2017–18, a higher percentage of older people had at least one Medicare-subsidised referred specialist consultation outside hospital (64% compared with 26% of those under 65) (AIHW 2020g).

Estimates from the 2019–20 ABS Patient Experience Survey showed that older people (aged 65 and over) are more likely to see a medical specialist than younger people. In 2019–20, people aged 85 and over were more than twice as likely to have seen a medical specialist in the last 12 months as those aged 15–24 (59% compared with 20%, respectively) (ABS 2020).

Older people who report seeing a medical specialist, across both age and sex comprised:

- 57% of men and 53% of women aged 65–74
- 61% of men and 61% of women aged 75–84
- 61% of men and 58% of women aged 85 and over (ABS 2020).

Older people were less likely to delay seeing or to not see a medical specialist compared with younger people – 1 in 10 people aged 65 and over (11%) compared with 1 in 4 people aged 15–24 (27%).

Most older people reported that a medical specialist:

- always listened carefully to them (85%)
- always showed them respect (88%)
- always spent enough time with them (86%) (ABS 2020).

## Allied health professionals

Allied health services include those delivered by audiologists, chiropractors, diabetes educators, dietitians, exercise physiologists, occupational therapists, optometrists, orthoptists, osteopaths, physiotherapists, podiatrists, psychologists, social workers and speech pathologists.

Overall, older people (aged 65 and over) use allied health services more than younger people. In 2018–19, 65% of Australians aged 65–79 and 72% of people aged 80 and over received an allied health service, whereas 32% of Australians aged 64 or under received a service (AIHW 2020g). For more information on older Australians' health, see Health – selected conditions.

There were around 10 million non-admitted patient service events provided to people aged 65 and over in 2019–20; that is, allied health services provided to public patients in public hospital outpatient clinics. While people aged 65 and over accounted for 16% of the total population, they represented 34% of these non-admitted patient service events (AIHW 2020i).

For more information, see Medicare-subsidised GP, allied health and specialist health care across local areas: 2013–14 to 2017–18.

## Mental health services

As for all Australians, older people may access mental health services through various pathways, including hospital, residential and community-based services, emergency departments, GPs, medical specialists and/or allied health professionals. Due to the diversity of mental health support services available, there is no single, overarching data collection that can be used to report on the mental health care being accessed by older Australians.

In 2019–20, 241,200 older people (aged 65 and over) accessed over 1.0 million Medicare-subsidised mental health-specific services. These services represented 8.3% of the total 12.4 million mental health-related services subsidised by Medicare in that year (AIHW 2021a). Compared with younger people, a relatively low percentage of older people received Medicare-subsidised mental health-specific services (Table 3D.1).

Table 3D.1: Australians accessing Medicare-subsidised mental health-specific services by age, 2019–20

| Age group (years) | Number of services | Number of patients | Rate (% of the population) |
|---|---|---|---|
| **18–24** | 1,641,488 | 361,634 | 15.3 |
| **25–34** | 2,497,812 | 553,374 | 14.5 |
| **35–44** | 2,224,281 | 483,525 | 14.1 |
| **45–54** | 1,906,883 | 403,860 | 12.5 |
| **55–64** | 1,429,588 | 294,977 | 10.0 |
| **65–74** | 714,261 | 157,596 | 6.8 |
| **75–84** | 261,029 | 65,965 | 5.2 |
| **85 and over** | 60,253 | 17,650 | 3.4 |

Note: In the last 12 months.

Source: AIHW 2021a.

Of the 241,200 older people accessing Medicare-subsidised mental health-specific services, most accessed these services provided by GPs (186,300 people). Psychiatrists were the next most common provider (50,900), followed by psychologists –other psychologist services (44,800) and clinical psychologist services (35,100) (AIHW 2021a). Note people can receive services from multiple providers but are counted only once in the total number of patients. As such, the total number of patients will not be a sum of the provider types.

Some older people (aged 65 and over) seeking help for their mental health are admitted for overnight care. In 2018–19, 54,300 older people had a separation from an overnight admitted mental health service. Most of these were without specialised psychiatric care (70%, 38,200). Over time, there has been an increase in the percentage of separations without specialised psychiatric care, particularly for people aged 85 and over (average annual change of 9.3% from 2008–09 to 2018–19). In contrast, separations with specialised psychiatric care for people aged 85 and over had an average annual decrease of 0.8% from 2008–09 to 2018–19 (AIHW 2021a).

For more details about older people with mental health conditions, see Health – selected conditions, and for more information on mental health services in general see Mental health services in Australia.

## Dental services

Dental services are provided to improve oral health and reduce disease. Dental services are commonly delivered by dental practitioners (such as dentists and dental surgeons). Services range from routine and preventive care to treatment of dental problems and emergencies. Services can be accessed privately or through public dental clinics or the Department of Veterans Affairs (based on eligibility). As more people are retaining more of their teeth into old age, this is also likely to increase older people's need for dental services. For more about older Australians' dental health, see Health – selected conditions.

According to the 2017–18 National Survey of Adult and Oral Health, almost 3 in 5 older people saw a dentist in the last 12 months (AIHW 2021b) (Table 3D.2).

Table 3D.2: Older Australians who saw a dentist by age and sex, 2017–18

| | 55–74 | 75 and over |
|---|---|---|
| **Males** | 57.4% | 54.8% |
| **Females** | 61.3% | 56.9% |
| **Total** | **59.4%** | **56.0%** |

Notes

1. In the last 12 months.
2. `Older Australians' refers to people aged 55 and over.

According to the 2019–20 ABS Patient Experience Survey, over half of older Australians who visited a dental professional in the last 12 months had between 2 to 3 dental visits (52%), with 35% having one visit and 13% having 4 or more (ABS 2020).

Publicly funded dental care is targeted towards low-income groups, with aged pensioners and unemployed people eligible for services at minimal or no cost to the patient. Waiting times for services, and their availability, can be problematic and lead to poorer outcomes for people reliant on these services. According to the 2019–20 ABS Patient Experience Survey:

- 1 in 7 (14%) older people aged 65 and over received public dental care.
- 1 in 12 (8.3%) older people were placed on a public dentistry waiting list (ABS 2020).

The cost of dental services is often reported as a barrier to accessing services. In 2017–18, of people aged 75 and over:

- 22% avoided or delayed dental care due to cost.
- 18% reported they would have difficulty paying a $200 dental bill.
- 9.8% reported cost prevented dental treatment (AIHW 2021b).

For more information, such as to compare with younger age groups or explore financial barriers to dental care by selected characteristics, see Oral health and dental care use in Australia.

## Hospitals

### Emergency departments

Emergency departments (EDs) are an essential component of Australia's health care system. Many of Australia's public hospitals have purpose-built EDs, staffed 24 hours a day, providing care for patients who require urgent medical, surgical or other attention. Between February and June 2020, a number of travel, business, social interaction and border control restrictions were introduced to prevent and reduce the spread of COVID-19. A number of other changes during this time may have impacted ED health care, and the provision of health-care services more generally. Compared with 2018–19, ED presentations in 2019–20 decreased by 1.4% (AIHW 2020d).

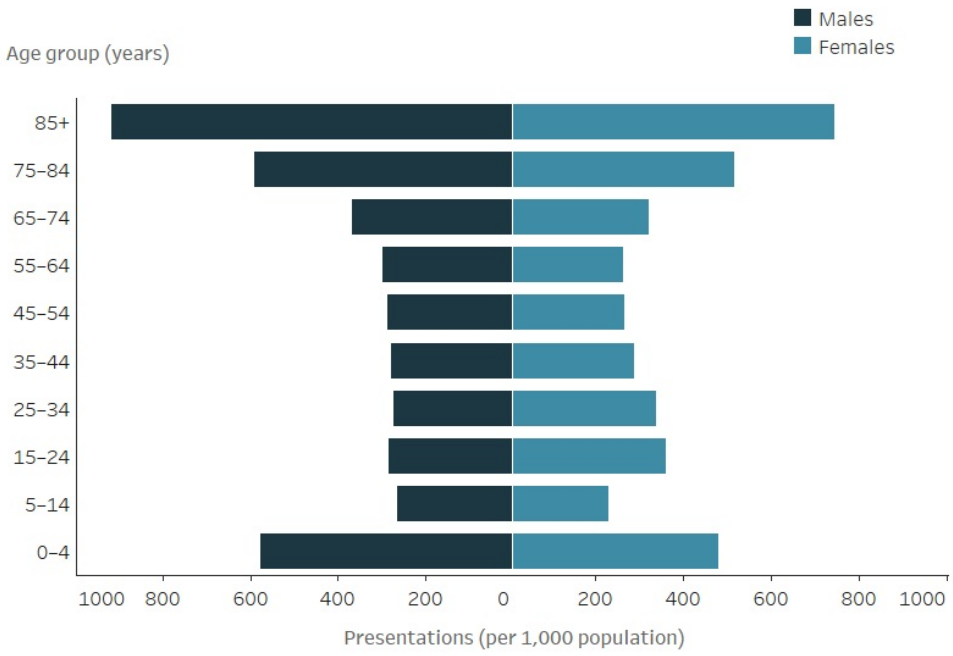
In 2019–20, older people – who made up about 16% of the population – accounted for 22% (1.8 million ED presentations) of the 8.2 million ED presentations over the year. Across the older age groups, men had higher rates of presentation than women, with ED presentations per 1,000 population, respectively, of:

- 366.2 compared with 320.3 for those aged 65–74
- 589.8 compared with 516.1 for those aged 75–84
- 918.7 compared with 744.7 for those aged 85 and over (AIHW 2020d).

Taking account of the size of the population, presentations were highest for men and women aged 85 and over (Figure 3D.1).
Figure 3D.1: Emergency department presentations per 1,000 population by age group and sex, 2019–20

The butterfly chart shows that emergency department presentations are highest among older age groups. The highest numbers of emergency department presentations for men and women were in older people aged 85 and over (918.7 presentations per 1,000 men and 744.7 presentations per 1,000 women).

**Figure 3D.1: Emergency department presentations per 1,000 population by age group and sex, 2019–20**




*Notes*
1. Excludes presentations for which the age group or sex was not reported.
2. Crude rates are calculated based on the number of presentations within a specific population and should be interpreted with caution.

*Source:* AIHW 2020d
http://www.aihw.gov.au/

Patients presenting at EDs are triaged into 1 of 5 categories on the Australasian Triage Scale. For older people, most ED presentations in 2019–20 were of an urgent or semi-urgent nature:

- 44% (808,800 presentations) were assigned to the urgent triage category
- 29% (532,100) were semi-urgent
- 19% (354,600) were emergency
- 5.7% (104,100) were non-urgent
- 1.3% (23,800) were resuscitation (AIHW 2020d).

While a similar percentage of ED presentations in 2019–20 for people aged 45–64 was of an urgent or semi-urgent nature (72% compared with 74% for older people), the split between urgent and semi-urgent presentations differed:

- 37% (624,700 presentations) were assigned to the urgent triage category
- 35% (583,600) were semi-urgent
- 17% (294,900) were emergency
- 10% (168,000) were non-urgent
- 0.9% (15,500) were resuscitation (AIHW 2020d).

In 2019–20, the top 3 reasons for people aged 65 and over presenting to an ED were:

- symptoms, signs and abnormal findings
- injury and poisoning
- cardiovascular diseases (such as heart disease and stroke) (AIHW 2020d).

Following an ED presentation in a public hospital, 1 in 2 of those aged 65 and over (54% or almost 1.0 million people) were admitted to hospital (AIHW 2020d).

### COVID-19 and hospitalisations

In 2019–20, there were 2,600 hospitalisations involving a COVID-19 diagnosis. Around 1 in 3 (33%) of these hospitalisations were for an older person (aged 65 and over). Of hospitalisations for an older person involving a COVID-19 diagnosis:

- More than 1 in 8 (13%) involved an intensive care unit (ICU) stay.
- Around 1 in 9 (11%) had a separation mode indicating the patient died in hospital.
- Around 1 in 10 (9.4%) involved continuous ventilatory support.

In comparison, of hospitalisations for a person aged 25–64 involving a COVID-19 diagnosis:

- Around 1 in 13 (7.5%) involved an ICU stay.
- Around 1 in 25 (3.7%) involved continuous ventilatory support.
- Around 1 in 200 (0.6%) had a separation mode indicating the patient died in hospital.

For more information, see Admitted patient activity (AIHW 2020a).

## Hospitalisations

In 2019–20, older people (aged 65 and over) were more likely to be hospitalised than younger age groups. For older people, the rate of hospitalisations per 1,000 population ranged from 981 to 1,469, compared with hospitalisation rates for age groups 0–64 ranging from 84 to 598 per 1,000 population (AIHW 2020a). Older men were more likely to be hospitalised than older women, with hospitalisation rates per 1,000 population, respectively, of:

- 1,089 compared with 878 for those aged 65–74
- 1,689 compared with 1,241 for those aged 75–84
- 1,814 compared with 1,255 for those aged 85 and over.

During 2019–20, older people had:

- 4.8 million hospitalisations with over half (56%) in public hospitals (39% of the total 11.1 million)
- 2.7 million same-day hospitalisations (43% of the total 6.4 million)
- 1.6 million overnight hospitalisations (41% of the total 3.8 million) (AIHW 2020a).

In 2018–19, the main reason older people went to hospital was other factors influencing their health status (this includes examinations, investigations, observation, evaluation and other health management), followed by cancer and musculoskeletal conditions (AIHW 2020b) (Table 3D.3).

Table 3D.3: Top 3 main reasons for hospitalisation of older people by sex

| | **Males** | **Females** | **Total** |
|---|---|---|---|
| 1 | Other factors influencing health status | Other factors influencing health status | Other factors influencing health status |
| 2 | Cancer | Musculoskeletal system diseases | Cancer |
| 3 | Diseases of the circulatory system | Symptoms, signs and abnormal findings | Musculoskeletal conditions |

Note: `Older people' refers to people aged 65 and over.

Source: AIHW 2020b.

Between 2015–16 and 2019–20, hospitalisations for people:

- aged 65–74 increased by 11% – an average increase of 2.7% each year
- aged 75–84 increased by 12% – an average increase of 3.0% each year
- aged 85 and over increased by 5.1% – an average increase of 1.3% each year (AIHW 2020a).

The increase for older people aged 75–84 was the largest across all age groups. All age groups under 25 saw a decrease in hospitalisations between 2015–16 and 2019–20 (AIHW 2020a).

At the end of a hospitalisation, most older people are discharged to their place of usual residence, while some enter residential aged care. Excluding those whose usual place of residence was residential aged care, less than 2% of hospital separations (76,200 in 2016–17) for older people were to residential aged care (AIHW 2019).

### Hospitals and aged care

Using a linked data set for Queensland and Victoria, in 2016–17, 1 in 10 (10%) overnight hospital stays for older people involved higher levels of aged care use after hospital than before it, and the percentage increased regardless of what aged care program had been used before the hospital stay (AIHW 2020f).

Overall, hospital stays that originated for those already using aged care (community-based aged care, transition care and residential aged care) were more likely to be somewhat longer than hospital stays without preceding aged care use. The median length of stay for overnight hospital stays was under one week for all but those hospital stays that were preceded by transition care (AIHW 2020f).

For more information, see Interfaces between the aged care and health: movements between aged care and hospital 2016–17 and GEN Aged Care Data website.

## Potentially preventable hospitalisations

Potentially preventable hospitalisations (PPHs) can be used as a measure to assess the effectiveness of primary care such as GPs. PPHs are specific hospital admissions that potentially could have been prevented by timely and adequate health care in the community. Older people, along with Indigenous Australians and people who live in remote or disadvantaged areas, are more likely to be hospitalised for

potentially preventable reasons; for more information see Disparities in potentially preventable hospitalisations across Australia: exploring the data.

In 2017–18, nearly half (46%) of PPHs were for people aged 65 and over. Among this age group, the most common reasons for hospitalisation included chronic obstructive pulmonary disease (COPD), congestive cardiac failure and urinary tract infections (AIHW 2020c).

For more information on hospital use, see MyHospitals.

## Pharmaceutical use

In 2017–18, Pharmaceutical Benefits Scheme (PBS) prescriptions were dispensed to 17.0 million Australians of all ages (69% of the population). Population dispensing rates increased with age:

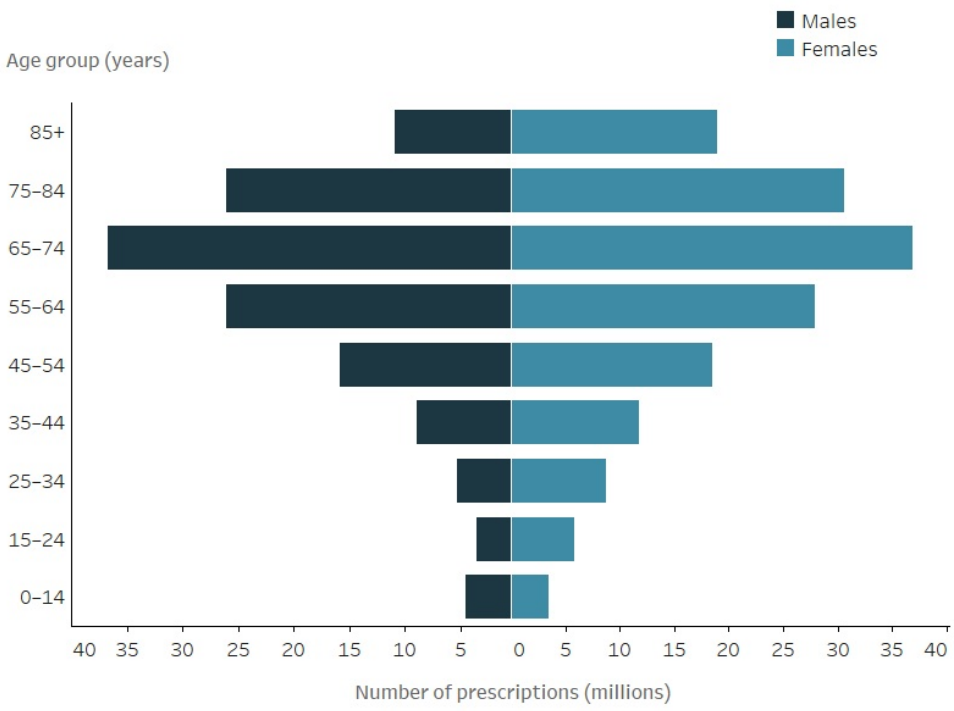
- Young people aged 0–14 had the lowest rates of dispensed prescriptions (173 per 100 people).
- The highest rates were among those aged 85 and over (6,077 prescriptions per 100 people).

Among older Australians (aged 65 and over), similar prescription patterns were seen for both men and women (Figure 3D.2).

Over half of PBS and Repatriation Schedule of Pharmaceutical Benefits medicines were dispensed to people aged 65 and over (53%). Within specific age groups, people aged 65–74 had the highest number of dispensed prescriptions and accounted for the highest Australian Government expenditure on subsidised prescription pharmaceuticals (AIHW 2020h).
Figure 3D.2: Total prescriptions used by the Australian population by age group and sex, 2017–18

The butterfly chart shows that a large number of dispensed prescriptions are for older Australians aged 65 and over. The greatest number of prescriptions for men and women was for people aged 65–74 (approximately 74 million prescriptions in total).

**Figure 3D.2: Total prescriptions used by the Australian population by age group and sex, 2017–18**




*Source:* AIHW analysis of Department of Health PBS and RPBS data, ABS 2011 and ABS 2018; AIHW 2020h.
http://www.aihw.gov.au/

### Antipsychotic medicines

Antipsychotic medicines are used to manage psychotic disorders such as schizophrenia, and the psychotic symptoms of mood disorders. While these medicines may be appropriate for adults with severe mental health issues or long-term mental illness, there is concern that they are being prescribed inappropriately for people aged 65 and over for their sedative effects; that is, as a form of chemical restraint for people with psychological and behavioural symptoms of dementia or delirium (ACSQHC 2018).

Analysis of data from 2013–14 to 2016–17 suggests there has been little change in the overall use of antipsychotic medications by older people during those 4 years. Whilst prescriptions have decreased over these 4 years, the volume of these medicines supplied on any given day has remained relatively stable (ACSQHC 2018). Whether parts of the older population are more at risk of such medication is still to be seen.

For more information, see Fourth Australian Atlas of Healthcare Variation.

## Palliative care

The World Health Organization (WHO) describes palliative care as an approach that improves the quality of life of patients and their families facing the problems associated with life-limiting illness, through the prevention and relief of suffering (WHO 2020). This involves early identification and correct assessment and treatment of pain and other problems, physical, psychosocial and spiritual (AIHW 2021c).

In 2018–19, there were 64,100 palliative care-related hospitalisations reported from public acute and private hospitals in Australia for people aged 65 and over. Almost 3 in 5 (57%, 36,800 hospitalisations) of these were palliative care and 27,300 were other end-of-life care hospitalisations. Older people accounted for 3 in 4 of the total palliative care hospitalisations (77%) and of the total other end-of-life care hospitalisations (77%). The average patient age at admission was 73.9 for palliative care hospitalisations and 74.1 for other end-of-life care hospitalisations. This was considerably older than the average age at admission of 56.0 for hospitalisations for all reasons (AIHW 2021c).

Palliative care-related services provided by palliative medicine specialists are included in the MBS. Of these MBS-subsidised services processed in 2019–20 (services may have been provided in a different year), 3 in 4 (74%) patients were older people (aged 65 and over) and 3 in 4 services (75%) were to older people. People aged 65–74 had the highest number of services per person (5.5) (AIHW 2021c).

Palliative care can be provided in other settings, such as at home and in hospices outside of the hospital system. Based on Palliative Care Outcomes Collaboration data from 2019, 3 in 4 (77%) palliative care episodes in community settings were for older people (aged 65 and over) (AIHW 2021).

Palliative care can also be provided in residential aged care. Data on palliative care in residential aged care comes from claims using the Aged Care Funding Instrument (ACFI). The ACFI is used to determine Australian Government subsidies for people living in permanent residential aged care and there are limitations in using these data. It is accepted that the number of ACFI claims involving palliative care is lower than the number of recipients in residential aged care that require palliative care (AIHW 2021c). For more information on the context for interpreting palliative care data from the ACFI, see Palliative care services in Australia.

In 2019–20, 1 in 77 aged care residents had an ACFI appraisal indicating a need for palliative care (1.3%). This need increased with age; 1 in 15 appraisals indicating a need for palliative care were for people aged under 70 (6.7%), and around 1 in 2 were for people aged 85 and over (55%). While around 1 in 3 people in residential aged care were male (35%), 1 in 2 appraised needs for palliative care were for males (51%) (AIHW 2021c).

### Health service use by older people with dementia in their last year of life

A recent AIHW study provides a greater understanding of health service use by people with dementia in their final year of life (12 months before 2013). It found that in the last year of life of people who died aged 65 or over, GP services were the most common health service type, used by 90% of people with and without dementia. Other than GP services, people with dementia who died aged 65 or over used health services less in their last year of life than people without dementia. The greatest difference was seen in the use of specialist services. Women with dementia were found to have used health services the least (AIHW 2020j).

The report also showed that in their last year of life, for people with dementia who died aged 65 or over:

- 66% had a hospital admission
- an average of 21 GP services were used
- an average of 59 prescriptions were dispensed (AIHW 2020j).

For more information, see Patterns of health service use by people with dementia in their last year of life: New South Wales and Victoria.

## Where do I go for more information?

For more information on older people's health service use, see:

- AIHW Australia's health
- AIHW Australia's welfare
- AIHW Cancer screening
- AIHW Dementia in Australia compendium
- AIHW Palliative care services in Australia

Information about health conditions can be found on the page Health – selected conditions.

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# Aged care

**Aged care** is an Australia's welfare topic

**On this page:**


- Aged care assessments
- Entering aged care
- People using aged care
- Impact of COVID-19 on people in aged care
- Assessment of care needs
- Leaving aged care
- Where do I go for more information?
- References


**Key findings**
Most people aged 65 and over using aged care services receive it in their homes – around 800,000 people used home support in 2021–22 and 213,000 were using home care at 30 June 2022.

**Key findings**
At 30 June 2022, around 185,000 people aged 65 and over were using residential aged care (permanent or respite).

**Key findings**
59% of people aged 65 and over using residential aged care were aged 85 and over, compared with 41% in home care and 30% in home support.

**Key findings**
There were more women than men in each aged care service type.

Australia's aged care system delivers services through a range of care types to cater for the diverse needs of the ageing population. Services range from supports to remain living largely independently at home, through to full-time care in a residential setting. Access to government-subsidised aged care services does not involve a minimum age of eligibility (with the exception of home support) – rather, access is determined based on assessed need. Although the majority of people using aged care services are aged 65 and over, younger people also access these services (AIHW 2023d).

This page explores the use of mainstream residential and community-based aged care programs by people aged 65 years and over. It provides information about how people are assessed for, and enter, aged care, the types of care they use, and how they leave aged care. It is important to note that a person may use multiple programs during the year, and may be counted more than once as an admission or exit. For more information on aged care in Australia, including younger people using aged care, see GEN aged care data.

### Types of aged care

There are 3 mainstream types of care:

- **Residential aged care** provides accommodation and care at a facility on a permanent or respite (temporary) basis. Permanent care is intended for those who can no longer live at home due to increased care needs, while respite provides a break from normal living arrangements.
- **Home support** (Commonwealth Home Support Programme) provides entry-level support at home for people as well as their carers. Services available through home support include domestic assistance, personal care, social support, allied health and respite services.
- **Home care** (Home Care Packages Program) provides different levels of aged care services for people in their own homes. It is targeted towards people with needs that go beyond what home support can provide. Ongoing services are available to keep people well and independent (such as nursing care), stay in their home (through help with cleaning, cooking and home maintenance) and remain connected to their community through transport and social support.

There are also several types of flexible care available that extend across the spectrum from home support to residential aged care, including:

- **Transition care**, which provides short-term care to restore independent living after a hospital stay.
- **Short-term restorative care**, which provides early intervention services to reduce difficulty with everyday tasks and maintain or restore independence.

- **Multi-Purpose Services Program**, which provides integrated health and aged care services in small regional and remote communities that cannot support both a separate aged care facility and a hospital.
- **National Aboriginal and Torres Strait Islander Flexible Aged Care Program**, which delivers a mix of care types in a culturally appropriate way for older Aboriginal and Torres Strait Islander people.
- **Department of Veterans' Affairs community nursing** and **Veterans' Home Care services** for eligible veterans and their families, which provides support to help people stay in their own home.

## Aged care assessments

To access government-funded aged care services, people undergo an assessment of need. These processes assess people's circumstances and care needs and, where appropriate, approve them for particular aged care services. They also refer people to service providers.

My Aged Care is a contact centre and website which serves as the starting point for access to government-subsidised aged care services. Access to My Aged Care can be gained by self-referral, or requests from carers or health and aged care professionals.

Following an initial screening through the My Aged Care platform, people are directed to one of 2 types of assessment:

- Aged Care Assessment Teams (ACATs) conduct comprehensive assessments and approve people for entry into residential aged care (permanent or respite), home care and transition care programs.
- Regional Assessment Services assess eligibility for entry-level home support services, known as the Commonwealth Home Support Programme.

In 2021–22 there were around 273,000 home support assessments and 201,000 comprehensive assessments completed (Department of Health and Aged Care 2022). The number of completed comprehensive aged care assessments increased by 13% between 2012–13 and 2021–22, however trends tend to fluctuate generally from year to year (SCRGSP 2023).

## Entering aged care

The time between an individual's ACAT approval and access to an aged care service can be influenced by a range of factors, including availability of places and packages of care, and a person's individual preferences about entering care.

In 2021–22:

- 41% of new entrants to permanent residential care entered permanent care within 3 months of their ACAT assessment (Department of Health and Aged Care 2022)
- the median time elapsed for access to a Home Care Package ranged from 1 month for a Level 4 package, 5 months for a Level 1 package and 8 months for a Level 2 or Level 3 package (SCRGSP 2023).

In 2021–22, 245,000 people aged 65 and over entered residential care and home care. Around 3 in 5 (62%) admissions were for residential aged care, including approximately 68,400 for permanent care and 82,300 for respite care (AIHW 2023a).

Characteristics of people entering aged care in 2021–22 include:

- Over half (54%) of people aged 65 and over entering permanent residential aged care were aged 85 and over.
- Almost 3 in 5 (59%) people aged 65 and over entering permanent residential care for the first time were women. This proportion increased with age. This is partly driven by the fact that women's life expectancy exceeds men's, so there are more women than men at older ages entering and using aged care.
- Almost 2 in 5 (37%) people aged 65 and over entering home care were aged 85 and over (AIHW 2023a).

Of all people entering residential and home care in 2021–22, 1.0% were aged under 65 (AIHW 2023a).

## People using aged care

People tend to use different aged care programs at different stages of their life. As people get older, it is likely they will experience escalating care needs that require different care types. However, people's journey through aged care can vary. Some people may start using lower-level care services, then progress to using increasing levels of care as their needs change. For others, their first experience with aged care services may be when they require higher level care after a sudden event, such as the loss of a carer or a health crisis.

### Home support

In 2021–22, around 800,000 people aged 65 and over used home support services. Of these:

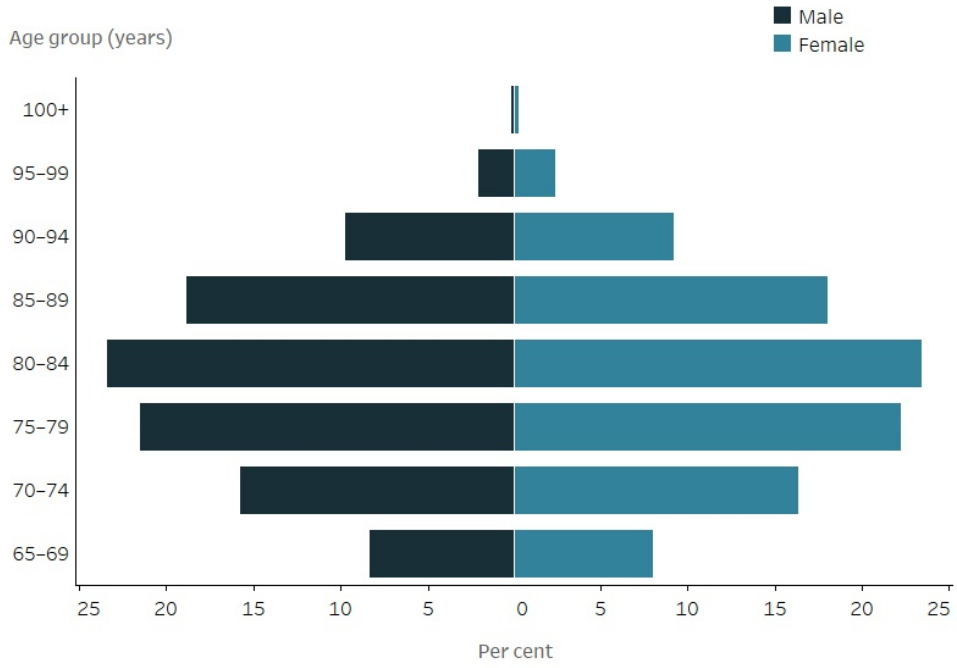
- 2 in 3 (65%) were female
- the highest proportion of people were aged 80–84 (23%) (AIHW 2023d) (Figure 4.1).

In 2021–22, including people whose sex is unknown, 30% of people aged 65 and over using home support were aged 85 and over. This is lower than home care (41%) and residential aged care (59%).

### Figure 4.1 Home support recipients by age group and sex, 2021-22

Figure 4.1: Home support recipients by age group and sex, 2021–22

The butterfly chart shows that the highest percentage of people using home support were aged 80–84 years (approximately 23% of men and 23% women using home support were aged 80–84). The age distribution of home support use by Australians aged 65 years and over was similar among men and women.




Notes

1. Excludes unknown age and sex.
2. Proportions sum to 100% for males and females separately.

Source: AIHW 2023d – GEN aged care data.

http://www.aihw.gov.au/

### Home care

At 30 June 2022, almost 213,000 people using home care were aged 65 and over. This is more than triple the 69,500 people aged 65 and over who were accessing home care services at 30 June 2017 (AIHW 2023d). The growth in home care follows the introduction of the *Increasing Choice in Home Care* reforms in February 2017 which changed the way home care services were delivered. Under these reforms, funding for home care packages were assigned to the recipient rather than the provider, giving recipients more choice and flexibility (Department of Health and Aged Care 2021).

#### Levels of home care

Home care provides varying levels of care to individuals based on their assessed care needs. A coordinated package of care is available at 4 levels, from Level 1 (basic care – for example, shopping assistance, transportation, and meal preparation), through to Level 4 (high-level care – for example, assistance with bathing, dressing, and getting out of bed, including support for additional care needs such as dementia, or vision and hearing impairment).

At 30 June 2022, of all home care recipients:

- 5.4% were receiving care at Level 1
- 41% were receiving care at Level 2
- 31% were receiving care at Level 3
- 22% were receiving care at Level 4 (AIHW 2023d).

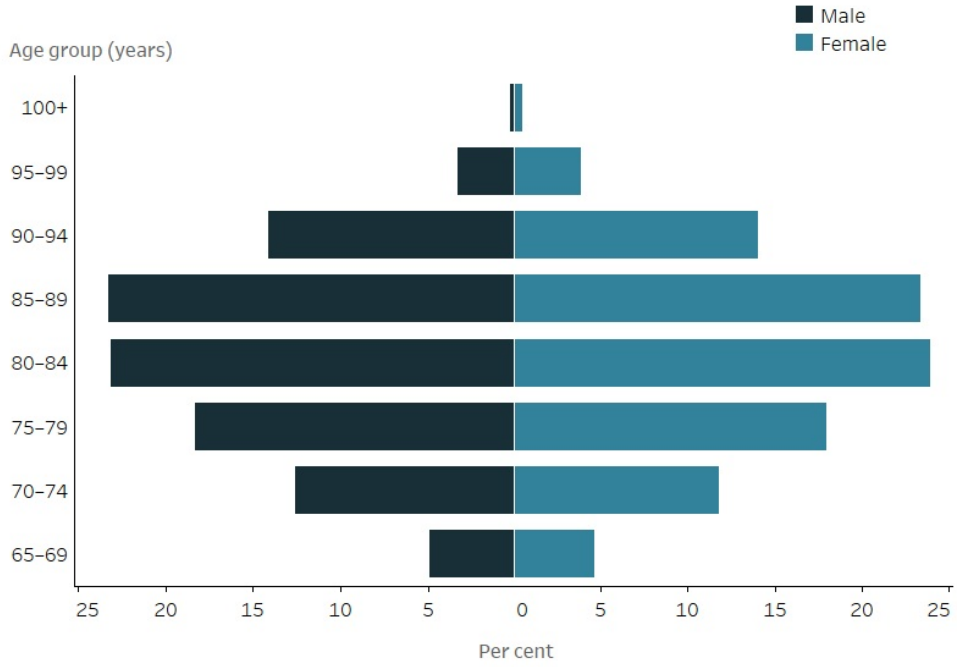
At 30 June 2022, of people aged 65 and over using home care (including where sex is unknown):

- 2 in 3 (65%) were women (139,000 people)
- the highest proportion were aged 85 and over (41%, 88,300 people) (Figure 4.2).

### Figure 4.2 Home care recipients by age group and sex, 30 June 2022

Figure 4.2: Home care recipients by age group and sex, 30 June 2022

The butterfly chart shows that the highest percentage of people using home care were aged 80–84 and 85–89 years (46% of men and 47% of women using home care were aged 80–89 years). The age distribution of home care use by Australians aged 65 years and over was similar among men and women.




Notes

1. Excludes unknown age and sex.
2. Proportions sum to 100% for males and females separately.

Source: AIHW 2023d – GEN aged care data.

http://www.aihw.gov.au/

### Residential aged care

At 30 June 2022:

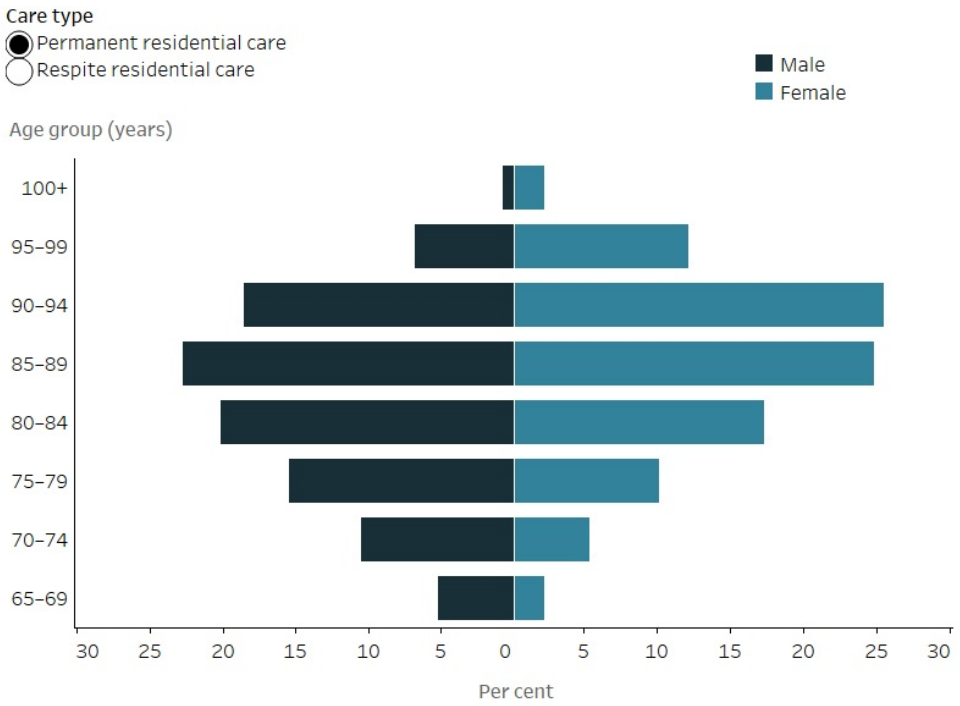
- 185,000 people using residential care were aged 65 years and over, with:
  - 178,000 living in permanent residential care
  - 7,400 using respite care.
- Among people aged 65 and over in permanent residential care:
  - the number of women was almost double the number of men
  - people were most commonly aged 85–89 (Figure 4.3) (AIHW 2023d).
- The number of people aged 65 and over living in permanent residential aged care increased by 3.1% over the last 5 years (from 172,000 at 30 June 2017 to 178,000 at 30 June 2022) (AIHW 2023d). This change may be partially attributed to the growth in the Australian population aged 65 and over, which increased 17% over the same period (from 3.8 million to 4.4 million people) (ABS 2023).

Compared with other aged care programs, people generally use residential aged care at older ages. For all admissions to permanent residential aged care in 2021–22, the average age at admission was 83 years for men and 85 years for women (Department of Health and Aged Care 2022).

### Figure 4.3 Residential aged care recipients by age group and sex, 30 June 2022

Figure 4.3: Residential aged care recipients by age group and sex, 30 June 2022

The butterfly chart shows that the highest percentage of men using permanent residential care were aged 85–89 years (23%), while among women, the age group with the highest percentage using permanent residential care was slightly older (26% of women using residential care were aged 90–94 years). The highest percentage of people using respite residential care were aged 85–89 years (approximately 25% of men and 27% of women using respite residential care were aged 85–89 years). The age distribution of permanent and respite residential care use among Australians aged 65 years and over differed by sex, with greater percentages of men in relatively younger age groups (65–84) using residential aged care compared with women.




Notes

1. Excludes unknown age and sex.
2. Proportions sum to 100% for males and females separately.

Source: AIHW 2023d – GEN aged care data.

http://www.aihw.gov.au/

## Impact of COVID-19 on older people in aged care

The COVID-19 pandemic impacted the health and wellbeing of people using aged care, particularly those in residential aged care. Compared to the general community, people in residential aged care were disproportionately affected by COVID-19 infection in terms of risk of serious illness and related mortality (Department of Health and Aged Care 2023a). Three-quarters (75%) of all COVID-19 related deaths in the first year of the COVID-19 pandemic (to 5 March 2021) were among people living in residential aged care (Department of Health and Aged Care 2023b).

The 2021–22 financial year saw an increased COVID-19 case load on the aged care sector. Most of Australia's residential aged care homes experienced a COVID-19 outbreak during 2021–22 (2,570 facilities experienced one or more outbreaks in 2021–22). During the 12-month period, there were over 56,000 resident cases and almost 2,200 resident deaths in aged care (Department of Health and Aged Care 2022). As at 30 June 2022, 29% of all COVID-19 related deaths in Australia were among people living in residential aged care (Department of Health and Aged Care 2023b).

Across all types of aged care, the lockdowns and social restrictions may have affected access to formal and informal support. For example, older people living in the community were encouraged to seek health services remotely through telehealth, and a number of temporary Medicare items were added. Additionally, measures introduced in the aged care sector meant that people in residential aged care could temporarily return to community-living through 'emergency leave' that provided up to eight weeks of home support.

The restrictions imposed may also have affected people's physical, mental and emotional wellbeing. The isolation and social disconnection experienced by permanent residential aged care residents as a result of visitor restrictions and lockdowns at many facilities, placed older people at greater risk of health problems including anxiety and neurocognitive conditions.

## Assessment of care needs

Until recently, the Aged Care Funding Instrument (ACFI) has been used to assess the care needs of people living in permanent residential aged care to determine the government funding provided to care providers. Residents may be reappraised in the same year if their needs change. The ACFI measures care needs across 3 different areas of care:

- activities of daily living
- cognition and behaviour
- complex health care.

On 30 June 2022, among people aged 65 and over living in permanent residential aged care, almost 2 in 5 (37%) had high care ratings across all 3 ACFI assessment areas (AIHW 2023b).

### Australian National Aged Care Classification

On 1 October 2022, the Australian National Aged Care Classification (AN-ACC) residential care funding model replaced the ACFI. The AN-ACC Assessment Tool focuses on the characteristics of residents that drive care costs in residential care. AN-ACC data are not currently reported on this page.

For more information about AN-ACC, see the AN-ACC Reference Manual and AN-ACC Assessment Tool on the Department of Health and Aged Care website.

### Health of people in aged care

People using aged care continue to interact with the health system through General Practitioners (GPs), specialists and the hospital system. For example, GPs are an important part of the health care of people living in residential aged care. Among people living in permanent residential aged care in 2016–17, some 92% had at least one Medicare Benefits Scheme claim for a GP visit, and almost all of the remaining would have seen a doctor through some other interface with the health or aged care system, such as hospitals or through Department of Veterans' Affairs arrangements (AIHW 2020).

For more information on use of health services, see the Health – service use chapter.

## Leaving aged care

Many people use aged care in their final years of life. For deaths among people aged 50 and over in 2016–17, over two thirds (67%) had used at least one aged care service in the last 2 years of life. For people over the age of 85 in 2016–17, 50% of deaths were in residential care, compared with 40% in hospital (AIHW 2021).

People may also leave care to move back home, to enter other aged care, or to be admitted to hospital. The following information covers exits from aged care services in 2021–22. A person may be counted twice if they exited aged care services more than once over the 12-month period.

In 2021–22, for people aged 65 years and over:

- there were almost 201,000 exits from residential aged care and home care
- the majority of exits were by people leaving respite residential care (82,000, 41%), followed by permanent residential care (71,200, 35%) and home care (47,700, 24%)
- most (86%) exits from permanent residential care were due to death, compared with 38% from home care. The majority of exits from home care were to residential care (51%).

Of all people who exited permanent residential aged care, those who died in care had the longest median length of stay (approximately 25 months) (AIHW 2023c).

Among people aged 65 and over exiting aged care, those in permanent residential care had the longest median length of stay (22 months), followed by home care (17 months) and respite residential care (21 days). Women stayed longer in permanent residential care than men, while this difference was less pronounced in respite care.

## Where do I go for more information?

For more information on Australians' use of aged care services, see the AIHW's aged care data website, GEN aged care data.

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# Social support

**On this page:**


- Social participation
- Social engagement and isolation
- Where do I go for more information?


**Key findings**
In 2018, an estimated 647,000 older people (aged 65 and over) were carers.

**Key findings**
More than 1 in 3 (35%) older people who were carers were primary carers, and 6 in 10 primary carers were women (61%).

**Key findings**
The majority of older people living in households had participated in social activities at home (97%) or outside their home (94%) in the previous 3 months.

**Key findings**
During the COVID-19 pandemic, people aged over 70 were more than twice as likely as people under 40 to have less-than-weekly contact with family living elsewhere (10% compared with 4%, respectively). (Hand et al 2020)

Social support can come in different forms such as:

- instrumental support (help with personal care, household chores, transport or finances)
- emotional support (offering empathy and affection)
- informational support (providing advice and guidance).

Social support is not a one-way relationship; it is built on the ties people have with other individuals, groups, and the broader community (Lin et al. 1979). In addition to receiving support from others, people often provide support to others.

Measures such as social participation and social engagement are commonly used to examine social support. These factors may influence the nature of the social support networks available to older people. Continuing engagement in social and community life is also an important factor in active ageing (WHO 2002).

This page looks at social participation, social engagement and isolation. Throughout this page, ‘older people’ refers to people aged 65 and over. Where this definition does not apply, the age group in focus is specified. The ‘Older Aboriginal and Torres Strait Islander people’ feature article defines older people as aged 50 and over. This definition does not apply to this page, with Indigenous Australians aged 50–64 not included in the information presented.

## Social participation

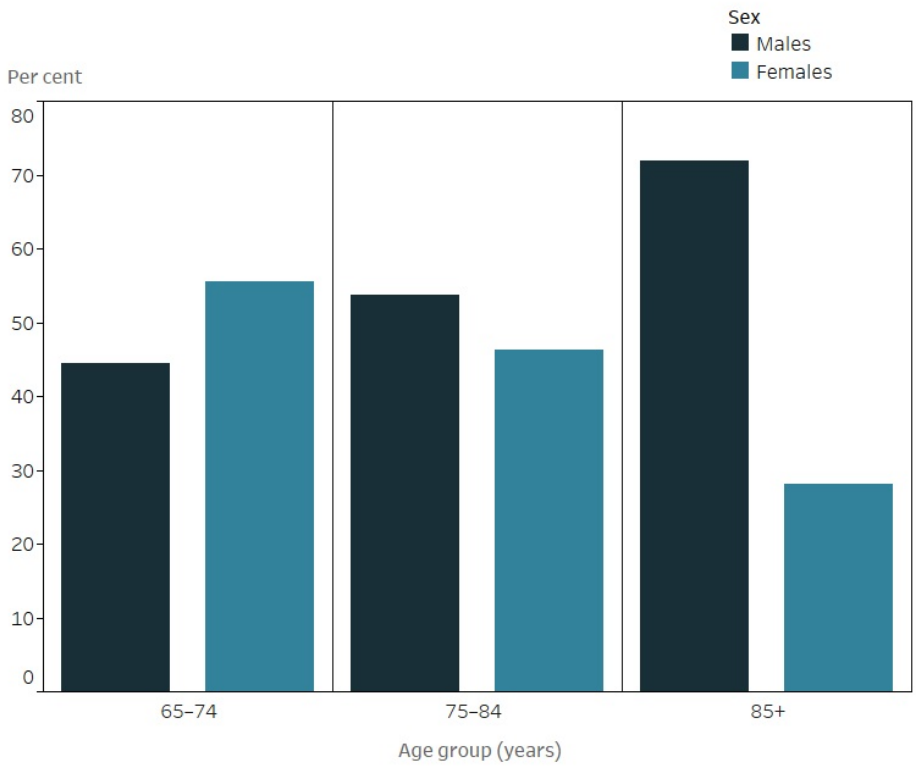
### Unpaid informal care provision

Some older people are carers, providing informal assistance (help or supervision) to other people, such as those with disability or older people. The 2018 Australian Bureau of Statistics (ABS) Survey of Disability, Ageing and Carers (SDAC) estimated there were 647,000 older people (aged 65 and over) providing care. Older carers represented around 1 in 6 (17%) of the total older population and just over half (51%) of older carers had disability (ABS 2019a).

Of carers aged 75–84, 54% (105,000) were men and 45% (88,600) were women. Around 7 in 10 carers aged 85 and over were men (72%, 27,400) and 30% (11,300) were women (AIHW analysis of ABS 2019b) (Figure 5.1). Note this data has been randomly adjusted to avoid the release of confidential data and discrepancies may occur between sums of the component items and totals.
Figure 5.1: Informal carers aged 65 and over by age group and sex, 2018

The column graph shows that in 2018 females constituted a greater proportion of informal carers in Australians aged 65–74 (56%), while males constituted a greater proportion of informal carers in Australians aged 75–84 (54%) and aged over 85 (72%).

Figure 5.1: Informal carers aged 65 and over by age group and sex, 2018




*Source:* ABS 2019b.
http://www.aihw.gov.au/

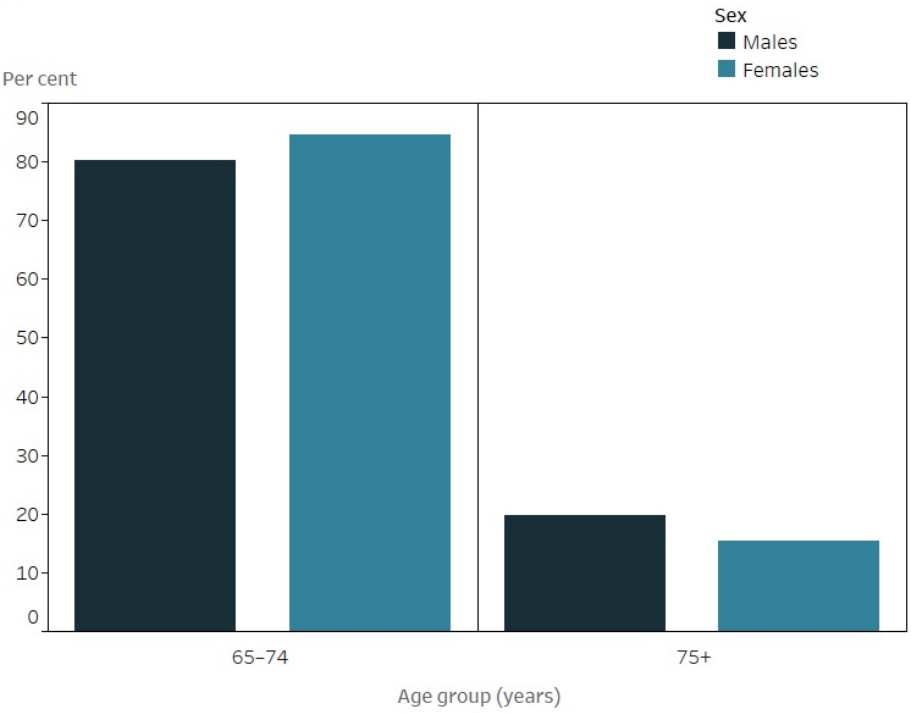
Of all older informal carers, over 1 in 3 (35%, 229,000) were primary carers (that is, the carer providing the most informal assistance to a person). Around 6 in 10 (61%) older primary carers were women. Of these older women that were primary carers, 7 in 10 (71%) provided care to their partner, 13% provided care to their child and 11% provided care to their parent (ABS 2019a).

As well as the caring roles described above, older people play an important role in providing unpaid childcare. Data from the 2016 ABS Census showed that 425,000 (13%) older people had spent time in the last 2 weeks caring for a child or children aged under 15 years without being paid. People aged 65–74 (83%) were most likely to provide this care (AIHW analysis of ABS 2016).

Women more commonly provided unpaid child care (61%). However, similar to the provision of other informal care, this differed with increasing age - a higher percentage of men aged 75 and over provided unpaid child care than women (20% compared with 15%, respectively) (AIHW analysis of ABS 2016) (Figure 5.2).
Figure 5.2: Older Australians providing unpaid childcare by age group and sex, 2016

The column graph shows that in 2016 a large proportion of Australians aged 65–74 provided unpaid childcare. While a greater proportion of women aged 65–74 provided unpaid childcare than men (85% and 80% respectively), a greater proportion of men aged over 75 provided unpaid childcare than women (20% and 15% respectively).

**Figure 5.2: Older Australians providing unpaid childcare by age group and sex, 2016**




*Note:* 'Older Australians' refers to people aged 65 and over.

*Source:* AIHW analysis of ABS 2016.
http://www.aihw.gov.au/

### Volunteering

Many older people volunteer formally through an organisation or group, or participate in other informal volunteering. Volunteering may offer an opportunity for activity, social connection and personal satisfaction.

According to the 2019 ABS General Social Survey (GSS), there were an estimated 638,000 (25%) people aged 70 and over who participated in unpaid voluntary work through an organisation in the last 12 months (26% of older women and 23% of older men). Around 1 in 2 (51%) people aged 70 and over who volunteered, volunteered for 100 hours or more in the last 12 months (ABS 2020a).

Many older people also participate in informal volunteering. Just under half (45%) of people aged 70 and over reported having provided unpaid work or support to non-household members in the last 4 weeks (ABS 2020a).

## Social engagement and isolation

Many factors may affect people's ability to participate in society and social activities, such as their health, living arrangements and access to a licence or a vehicle. According to the 2018 SDAC, the majority of older people (aged 65 and over) who were living in households had participated in social activities at home (97%) or outside their home (94%) in the previous 3 months.

In 2018, in the last 3 months:

- Almost 9 in 10 (87%) older people reported visiting relatives or friends away from home.
- 3 in 4 (74%) reported going out with relatives or friends.
- 1 in 3 (33%) reported participating in sport or physical recreation with others.
- Over 1 in 4 (28%) reported going on holiday or camping with others (ABS 2019a).

In 2018, over 3 in 4 older people (77%) living in households had participated in activities in the community in the last 12 months. In particular:

- Around half (49%) of older people had participated in physical activities for exercise or recreation.
- Around half (49%) had attended a movie, concert, theatre or other performing arts event.
- 3 in 10 (30%) had visited a public library.
- 1 in 4 (24%) had visited a museum or art gallery (ABS 2019a).

### Family and community support

According to the 2019 GSS, nearly 3 in 4 (73%) people aged 70 and over had face-to-face contact with family or friends living outside the household at least once a week in the last 3 months. Many (84%) had other forms of contact with family or friends living elsewhere. The majority (95%) were able to get support in times of crisis from persons living outside the household (ABS 2020a).

### Impact of COVID-19 on social isolation and loneliness

## Impact of COVID-19 on social isolation and loneliness

During the coronavirus disease 2019 (COVID-19) pandemic in Australia, physical distancing has been in place to reduce the risk of the virus spreading. This has impacted on social gatherings. At times during the pandemic, all Australians were advised to stay at home, affecting their social engagement and connections with family and friends. Social isolation and loneliness also had major impacts on older people living in residential aged care facilities (see Royal Commission into Aged Care Quality and Safety 2020. Aged care and COVID-19: a special report).

### Social connectedness

According to the Families in Australia Survey, conducted in 2020 by the Australian Institute of Family Studies – during the COVID-19 pandemic, older people struggled to stay connected with family and friends. For example:

- 23% of those aged over 70 reported having daily contact with family living outside the household, compared with 40% of people aged under 40.
- People aged over 70 were more than twice as likely as people under 40 to have less-than-weekly contact with family living elsewhere (10% compared with 4%, respectively) (Hand et al 2020).

### Attendance at social gatherings

The ABS Household Impacts of COVID-19 survey in January 2021 asked whether people had attended one or more social gatherings since 1 December 2020, when many of the restrictions had been eased or lifted. Around 3 in 10 (31%) older people chose not to attend any social gatherings. The majority were comfortable or very comfortable attending social gatherings at their own residence (85%), or at a friend or family member's residence (85%) (ABS 2021a).

In February 2021, 14% of older people reported having participated in social gatherings of more than 10 people at least once a week in the last 4 weeks. In March 2020, before COVID-19 restrictions began, 1 in 4 (26%) older people reported having participated (ABS 2021b).

### Loneliness

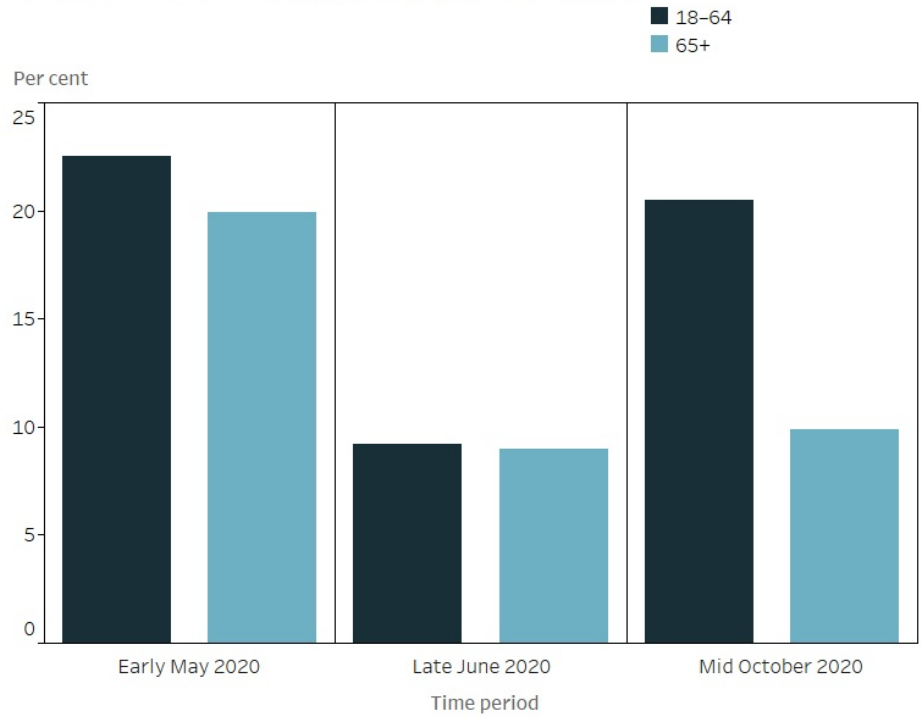
Loneliness is a feeling of distress people experience when their social relationships are not the way they would like (APS 2018), and may affect health and wellbeing. Studies investigating loneliness across age groups can have contradictory findings (AIHW 2021). While some studies find higher levels of loneliness among older people (Relationships Australia 2018), others find lower levels (Relationships Australia 2011).

Before the COVID-19 pandemic, compared with younger people (aged 18–64), older people were less lonely (APS 2018). During the pandemic, loneliness remained the most commonly reported personal stressor due to COVID-19. In May 2020, not long after the social distancing requirements had been in place, loneliness was reported as a personal stressor experienced in the last 4 weeks due to COVID-19 for around 1 in 5 (20%) older people and 1 in 4 (23%) younger people (ABS 2020b). Later in the pandemic in October 2020, 1 in 10 (10%) older people reported loneliness and 1 in 5 (21%) younger people reported loneliness (ABS 2020c) (Figure 5.3).

Figure 5.3: Proportion of persons reporting suffering loneliness as a personal stressor due to COVID-19 by age, May–October 2020

The column graph shows that the proportion of older Australians who reported experiencing loneliness fluctuated throughout 2020 as a consequence of the COVID-19 pandemic. Reports of loneliness in the last four weeks among older Australians was highest in May (20%). Although the proportion of older Australians reporting loneliness decreased in June and October, loneliness reports remained at 9% and 10% respectively.

Figure 5.3: Percentage of people reporting suffering loneliness as a personal stressor due to COVID-19 by age group, May–October 2020




*Notes*
1. 'Early May 2020' results refers to personal stressors experienced in the week before the interview in early May
2. 'Late June 2020' results refers to personal stressors experienced in the week before the interview in late June
3. 'Mid October 2020' results refers to personal stressors experienced in mid October

*Source:* ABS 2020c.
http://www.aihw.gov.au/

## Where do I go for more information?

For more information on social support, see:

- ABS COVID-19: measuring the impacts of COVID-19
- AIHW Australia's welfare 2021: social isolation and loneliness snapshot

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# Justice and safety

**On this page:**


- Discrimination against older people
- Abuse of older people
- Older prisoners
- Where do I go for more information?


**Key findings**
1 in 5 (20%) older Australians (aged 65 and over) experienced age discrimination in the workplace between 2012 and 2014.

**Key findings**
In 2017–18, more than 10,900 calls were made to elder abuse helplines across Australia.

**Key findings**
From 2010 to 2020, the number of older prisoners (aged 45 and over) in Australia grew from around 5,600 to 9,300, up 68%. The highest growth was among those aged 65 and over (increasing from 530 to 1,200 prisoners, up 133%).

Older Australians can face ageism, discrimination, abuse and other forms of violence, and they may have encounters with the justice system - as either a victim or perpetrator. As for all Australians, older people may be concerned about their safety. For example, age-related factors such as increasing frailty, cognitive impairment or dependence on others can make some older people more vulnerable to abuse (ALRC 2017).

This page presents information relating to issues around justice and safety. Throughout this page, 'older people' refers to people aged 65 and over. Where this definition does not apply, the age group in focus is specified. The 'Older Aboriginal and Torres Strait Islander people' feature article defines older people as aged 50 and over. This definition does not apply to this page, with Indigenous Australians aged 50–64 not included in the information presented.

For more information on the health status and social support of older Australians see Health—status and functioning and Social support.

## Discrimination against older people

Discrimination can make participating in activities difficult for people, including older Australians (aged 65 and over). Age discrimination refers to treating a person less favourably, or not giving them the same opportunities as others, due to judgements about their age (AHRC 2014). It can restrict older people's participation and inclusion in all aspects of life. Perceptions of older people being less deserving, incapacitated or in need of protection, can affect the ways in which services are accessed and delivered, particularly in the workplace, healthcare and aged care, and within families and local communities (Benevolent Society 2017; COTA 2021).

### Age discrimination in the workplace

In Australian workplaces, age discrimination can be an ongoing barrier and occurrence for some older people. In 2015, the first National Prevalence Survey of age discrimination in the workplace was conducted across Australia. More than 1 in 4 (27%) Australians aged 50 and over reported experiencing some form of age discrimination in the workplace in the last 2 years (AHRC 2015).

Based on the survey data in 2015:

- 1 in 5 (20%) older Australians (aged 65 and over) experienced age discrimination on at least one occasion in the workplace in the last 2 years
- Australians aged 55–64 were more likely to experience age discrimination, with around 1 in 3 people aged 55–59 (32%) and 3 in 10 people aged 60–64 (31%)
- Men and women experienced age discrimination at similar rates in the last 2 years (28% and 26%, respectively) (AHRC 2015).

However, as people get older, they are less likely to remain employed to experience discrimination in the workplace. For more information on older Australians and retirement, see Employment and work.

## Abuse of older people

Elder abuse is commonly defined as the 'single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person' (WHO 2020). Within this definition, elder abuse can take various forms, including physical, psychological, financial and sexual abuse, as well as neglect.

The risk factors associated with elder abuse include, but are not limited to:

- isolation

- functional dependency and disability
- poor physical and mental health
- changes in living arrangements
- financial pressures on or from children
- mistreatment by adult children
- ageist attitudes within the community (Joosten et al. 2017; WHO 2020).

The mistreatment and abuse of older Australians can occur in both formal and informal relationships, and it can involve close, loved and trusted family members. Currently the prevalence of elder abuse in Australia is not known. Neither is the type of abuse, the perpetrator or in what context the abuse may be more likely to occur (AIHW 2019a).

Worldwide, an estimated 1 in 6 (16%) people aged 60 and over have experienced elder abuse in the past year (WHO 2020). In 2016, the estimated prevalence of older Australians experiencing elder abuse was likely to be between 2% and 14% in any given year, with neglect possibly occurring at higher rates (Kaspiew et al.2016).

Across Australia in 2017–18, more than 10,900 calls were made to elder abuse helplines, where emotional and financial abuse were the most common types reported (AIHW 2019b).

### Financial abuse

Financial abuse can be defined as the misuse or theft of a person's assets or money. This can include behaviours such as using a person's finances without their permission, power of attorney privileges outside their intended purposes, withholding care for financial gain, or selling and transferring property against a person's wishes (CAG 2020).

Most older Australians (aged 65 and over) wish to remain independent and active within the community. However, there are those who experience the challenges of ageing and require support and assistance from families and professional service providers. In some instances, older Australians who have a dependence on someone's care, may require a power of attorney to act and make decisions on their behalf. Unfortunately, there is a potential for the appointed person or organisation to misuse this power (AIFS 2020).

Financial abuse is a form of elder abuse that is most likely committed by a family member, a trusted friend and/or caregiver. Analysis of data from Seniors Rights Victoria showed that the majority (92%) of abuse was committed by a family member and most often (67%) by an adult child (AIHW 2019a; Joosten et al. 2015). There is currently no national data available on the prevalence of financial abuse (AIFS 2020; CAG 2020).

#### Older Australians as targets for scammers

Scams seek to obtain money or other goods from vulnerable and unsuspecting individuals through dishonest means.

In June 2019, the Australian Competition and Consumer Commission (ACCC) reported that almost 1 in 5 Australians experienced a scam in the past 5 years, with 1 in 4 being affected more than once. However, while people aged 65 and over made the most reports to Scamwatch (25,100) in 2019, the age group that reported the highest financial loss was those aged 55–64 (nearly $30 million). This age group may have the highest financial loss due to the accumulated wealth at these ages, along with interest in investment opportunities (ACCC 2020).

Older Australians can also experience door-to-door, home maintenance, and telemarketing scams. However, the most common scams reported by the ACCC for people aged 65 and over related to investments, dating and romance, and remote access. In 2019, scam phone calls claiming to be from NBN Co. for remote access affected people aged 65 and over more than any other age group. It was estimated that these scams alone cost older Australians more than $2.5 million (ACCC 2020).

### Sexual assault

According to the ABS 2016 Personal Safety Survey, sexual assault is defined as any act of a sexual nature carried out against a person's will using physical force, intimidation or coercion. Sexual assault can also involve a broad range of behaviours including sexual harassment and sexualised bullying (ABS 2017; Tarczon and Quadara 2012).

According to the ABS 2016 Personal Safety Survey, acts of sexual harassment include:

- indecent phone calls, text, emails or posts (internet social networking sites or mail)
- indecent exposure
- inappropriate comments
- unwanted touching, grabbing and kissing or fondling
- distribution or posting of pictures or videos without consent, that are sexual in nature
- exposure to pictures, videos, or materials that are sexual in nature (ABS 2017; AIHW 2019b).

In 2016, an estimated 4.7% of older women (aged 65 and over) and 3.7% of older men (aged 65 and over) had experienced sexual harassment in the last 12 months, and 0.3% of both older women and men experienced sexual assault in the last 12 months (ABS 2017).

### Substandard care in residential aged care services

Substandard care and abuse are problems that affect some people living in residential aged care services. Substandard care can occur in both routine and complex areas of care for residents. It can involve deliberate acts of harm and forms of abuse - including physical and sexual violence. This can include restrictive practices, such as restraining people to their bed or administering medication with the intent to

manage people's behaviour (RCACQS 2021).

The Royal Commission into Aged Care Quality and Safety found that many older Australians living in residential aged care services experienced substandard care and abuse (including neglect). Estimates reported indicate that:

- In 2019–20, around 5,700 allegations of assault were made through mandatory reporting under the *Aged Care Act 1997*. A further 27,000 to 39,000 alleged assaults were reported that were exempt from mandatory reporting, as they were resident-on-resident incidents.
- Across Australia, residential aged care services made around 24,700 reports of intent to restrain and 62,800 reports of physical restraint devices, in the last quarter of 2019–20 (RCACQS 2021).

At 30 June 2019, just over half (53%) of the people living in permanent residential aged care had a diagnosis of dementia. People with dementia can be particularly vulnerable to abuse, and this can be increased in residential aged care settings (AIHW 2019a, AIHW 2020a). Elder abuse incidents can go undetected, especially where an older person is not in a position to report the abuse (AIHW 2019a).

### The effects of COVID-19 on the safety of older Australians

Individuals at greater risk of developing a severe illness, being hospitalised or dying from coronavirus disease 2019 (COVID-19) are older people and those with underlying comorbidities. To August 2020, the highest number of COVID-19 deaths occurred among those aged 80–89 (294) (ABS 2020a). The greater health impact on older people was reported as contributing to negative attitudes and stereotypes about the health and functioning of older Australians (Holt et al. 2020).

During the pandemic, the protections put around older people may have also put them at risk of harm. The social restrictions may have resulted in social disconnection and isolation among older Australians. This may have affected their overall safety and health (Holt et al. 2020; Patterson 2020).

Although health policies aimed to reduce the transmission of COVID-19 to vulnerable populations in aged care facilities, social isolation and visitor restrictions may have contributed to declines in the health and wellbeing of residents. The potential harms caused include reduced mobility, pressure injuries, loneliness, anxiety, depression and feelings of fear and boredom (ACQSC 2021).

For more information on the effects of isolation and social support for older Australians, see Social support.

## Older prisoners

A prisoner is commonly considered 'older' around the age of 45, this being 10 to 20 years younger than an older person in the community. Their social and lifestyle characteristics, before and during incarceration, means prisoners experience early onset of age-related conditions. This is referred to as accelerated ageing (AIHW 2020b).

At 30 June 2020, older prisoners (aged 45 and over) represented just over 1 in 5 (22%) of the Australian prisoner population. The population aged 65 and over made up 1 in 8 (13%) of the older prisoner population and 3% of overall Australian prisoners (ABS 2020b).

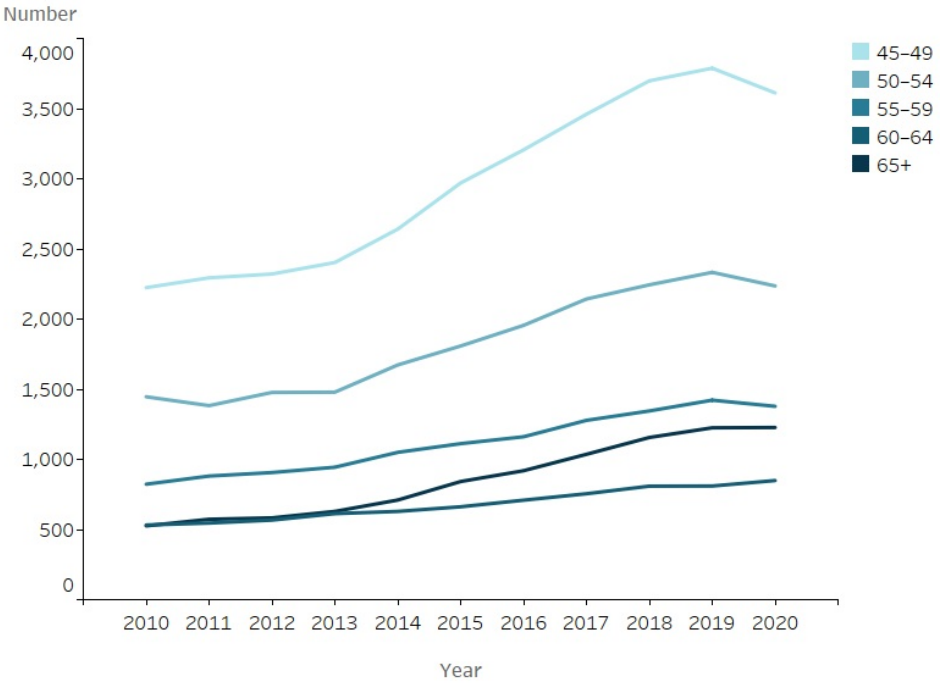
Over the long term, the population of older prisoners in Australia has grown more than the population of younger prisoners. Between 2010 and 2020, the number of older prisoners (aged 45 and over) in Australia grew from around 5,600 to 9,300 - a growth of 68%. Conversely, the overall older prisoner population decreased by 2.9% between 30 June 2019 and 30 June 2020 (AIHW 2020b; ABS 2020b).

Prisoners aged 65 and over increased the most over the 2010-2020 period, from 530 to 1,200 prisoners, up 133%. Between 30 June 2019 and 30 June 2020 the population aged 60–64 showed the greatest increase at 4.8%, from 810 to 850 prisoners (ABS 2020b; AIHW 2020c) (Figure 6.1).

Figure 6.1: Older prisoners by age group, 2010–2020

The line graph shows that the number of older prisoners has increased across the decade from 2010–2020. The greatest increase in prisoners was in Australians aged 45–49 (2,224 prisoners in 2010 compared to 3,612 in 2020). Between 2019 and 2020 the number of prisoners aged 45–59 decreased by between 3.1% and 4.6%.

Figure 6.1: Older prisoners (aged 45 and over) by age group, 2010–2020




*Notes*
1. Numbers are based on 30 June counts for each respective year.
2. 'Older prisoners' refers to people aged 45 and over.

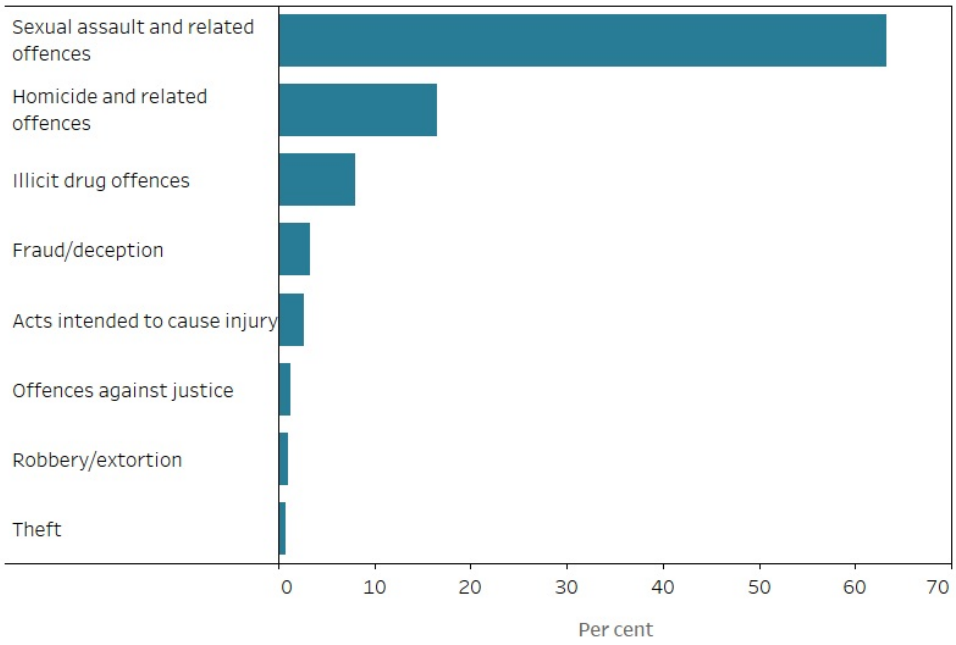
*Sources:* ABS 2020b; AIHW2020c
http://www.aihw.gov.au/

The Australian prisoner population was predominantly male (92%) in 2020, and 3.2% of all male prisoners were aged 65 and over. Australia's population is ageing both in prison and in the community generally because people are living longer. In 2020, nearly 2 in 3 (63%) prisoners aged 65 and over had a most serious offence or charge of sexual assault and related offences, while 1 in 6 (17%) had a most serious offence or charge of homicide and related offences. (ABS 2020b) (Figure 6.2).

Figure 6.2: Rank of most serious offence or charge by prisoners aged 65 and over, 2020

The bar graph shows that in 2020 the largest proportion of serious offences or charges for older Australians was for sexual assault and related offences (63%). Other common offences were for homicide and related offences (17%) and illicit drug offences (8%).

Figure 6.2: Rank of most serious offence or charge by prisoners aged 65 and over, 2020




*Source:* ABS 2020b.
http://www.aihw.gov.au/

For more information on older Australian prisoners, see Health and ageing of Australia's prisoners 2018.

### Where do I go for more information?

For more information on the justice and safety of older Australians, see:

- AIHW Elder abuse: context, concepts and challenges
- Attorney-General's Department National Plan to Respond to the Abuse of Older Australians (Elder Abuse) 2019–2023
- Compass Guiding action on elder abuse
- RCACQS Royal Commission into Aged Care Quality and Safety
- Scamwatch Advice for older Australians

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# Housing and living arrangements

**On this page:**


- Housing tenure
- Homelessness and insecure housing
- Types of dwellings
- Living arrangements
- Housing suitability
- Where do I find more information?


**Key findings**
In 2016, 1 in 4 older people (aged 65 and over) living in private dwellings lived alone.

**Key findings**
Older people (aged 65 and over) made up 1 in 5 of those living in public housing in 2019–20.

**Key findings**
1 in 6 homeless people on Census night in 2016 were aged 55 and over.

**Key findings**
In 2019–20, over 24,400 older people (55 years and over) received services from specialist homelessness support agencies.

Housing plays a critical role in the health and wellbeing of older Australians (SCRGSP 2020). It serves the basic human need for physical shelter and contributes to physical, psychological, health and emotional security. Home ownership in particular, provides older people with security of housing tenure and long-term social and economic benefits (AIHW 2019). It can be a key determinant of wealth and financial security in retirement (PC 2015).

Many older Australians prefer to age in place, meaning they wish to stay in their local home or community (PC 2015). However, their capacity to do so can be influenced by:

- the appropriateness and quality of their home (for example, size, layout)
- their ability to modify their home to suit their functional requirements
- the cost and availability of suitable housing
- their need for formal care and assistance
- their proximity to services and social support.

Throughout this page, ‘older people’ refers to people aged 65 and over. Where this definition does not apply, the age group in focus is specified. The ‘Older Aboriginal and Torres Strait Islander people’ feature article defines older people as aged 50 and over. This definition does not apply to this page, with Indigenous Australians aged 50–64 not included in the information presented.

## Housing tenure

### Home ownership

Older Australians have traditionally had high rates of home ownership. This has often provided a key financial asset on retirement. In more recent years, the rate of home ownership among older people has decreased, consistent with decreases in home ownership seen in the broader population (people aged 15 and over). In 2017–18, three-quarters (74%) of households with a reference person aged 65 or over were owners without a mortgage, compared with around 8 in 10 (79%) in in 2003–04 (ABS 2006, 2019).

Home ownership patterns for older people vary according to their living arrangements. In 2017–18, 9 in 10 (92%) older couple households owned a home (92%), with around 8 in 10 (81%) owning their home without a mortgage and 1 in 10 (11%) with a mortgage. Around 3 in 4 older lone person households (75%) owned a home, with around 7 in 10 (69%) owning without a mortgage and 1 in 17 (6%) owning their home with a mortgage (ABS 2019).

In 2017–18, 2.3% of recent first home buyers were aged 65 and over (age of household reference person), with a further 21% being changeover buyers - that is, they had previously owned a home (ABS 2019).

### Renting in the private market

Often older Australians rent out of necessity rather than choice (PC 2015). Renting at an older age can be associated with the risk of poverty and adverse impacts on health and wellbeing (AHURI 2018). Older people renting can be disproportionately affected by insecure tenures and as such, be at an increased risk of homelessness (AIHW 2019). Furthermore, older households who rent can be more likely to move than those owning their homes outright (AIHW 2020).

In 2017–18, 1 in 7 (14%) households with a reference person aged 65 or over were renters. Most rented from a private landlord (64%) and around 1 in 4 (24%) rented from a state or territory housing authority.

In 2017–18 older lone persons were more likely to rent (22%) than older people in couple only households (6.2%). Of older lone persons renting:

- 13% rented from private landlords
- 6.4% from state or territory housing authorities.

Of older people in couple only households renting:

- 4.8% rented from private landlords
- 1.3% from state or territory housing authorities (ABS 2019).

For further information on housing tenure of older Australians see Older clients on Specialist homelessness services and Housing occupancy and costs.

### Social housing

Older people having difficulty meeting the costs of housing can be supported by housing assistance programs such as financial assistance and social housing (such as public and community housing). Whether it is managed by state and territory governments or community-based organisations, social housing can play a critical role in reducing financial and housing stress and improving physical and mental wellbeing.

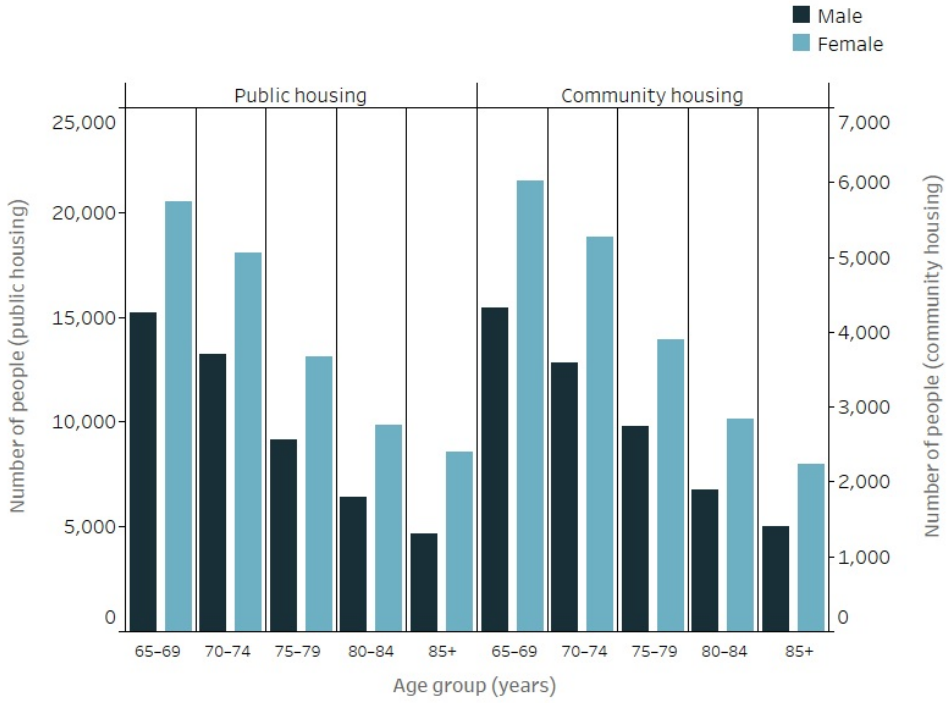
During 2019–20, older people (aged 65 and over) represented:

- 1 in 5 public housing household members (21%, 121,900)
- 1 in 5 community housing household members (19%, 34,300) (AIHW 2021).

Women make up the majority of all occupants, and older occupants, in public and community housing. During 2019–20, females accounted for 59% of public housing and 59% of community housing occupants aged 65 and over (AIHW 2021) (see Figure 7.1).
Figure 7.1: Older public and community housing occupants by age group and sex, 2019–20

The column graph shows that in 2019–20 the number of older Australians in public and community housing was smaller for those who were older. In each age group, the number of females using public and community housing was larger than the number of males.

**Figure 7.1: Older public and community housing occupants by age group and sex, 2019–20**




*Notes*
1. Excludes unknown age and sex.
2. 'Older public and community housing occupants' refers to people aged 65 and over.

*Source:* AIHW 2021.
http://www.aihw.gov.au/

Social housing is generally allocated according to groups deemed to have priority needs. Older people aged 75 and over are one special needs group for housing allocation (AIHW 2021). In 2019–20, of the 10,300 newly allocated public housing households to people with special needs, 6.0% (around 600 households) had a main tenant aged 75 or over (AIHW 2021). More broadly, 12% of newly allocated public housing went to main tenants aged 65 and over.

## Homelessness and insecure housing

The pathways into homelessness for older Australians are varied. Some may have had a conventional housing history earlier in life, but have experienced financial trouble, divorce or other disruptions later in life, that have placed them at risk of homelessness. Others may have experienced homelessness or insecure housing throughout life, sometimes with repeated attempts to achieve housing stability (AIHW 2020; Petersen et al. 2014).

For people who are homeless or at risk of homelessness (generally due to living in insecure housing), 'older people' can refer to people who are aged under 65. The disadvantages associated with homelessness or insecure housing are many, and people who are homeless or living in insecure housing may be experiencing poor physical and mental health or substance misuse. They can also experience earlier onset of health problems usually associated with older age. To capture elements of this, people aged 55 and over are considered 'older people' in this context.

The Australian Bureau of Statistics defines homelessness as a situation where someone does not have suitable accommodation, and their current living arrangement:

- is in a dwelling that is inadequate (is unfit for human habitation and lacks basic facilities such as kitchen and bathroom facilities)
- has no tenure, or if their initial tenure is short and not extendable
- does not allow them to have control of, and access to space for social relations (including personal or household living space, ability to maintain privacy and exclusive access to kitchen and bathroom facilities).

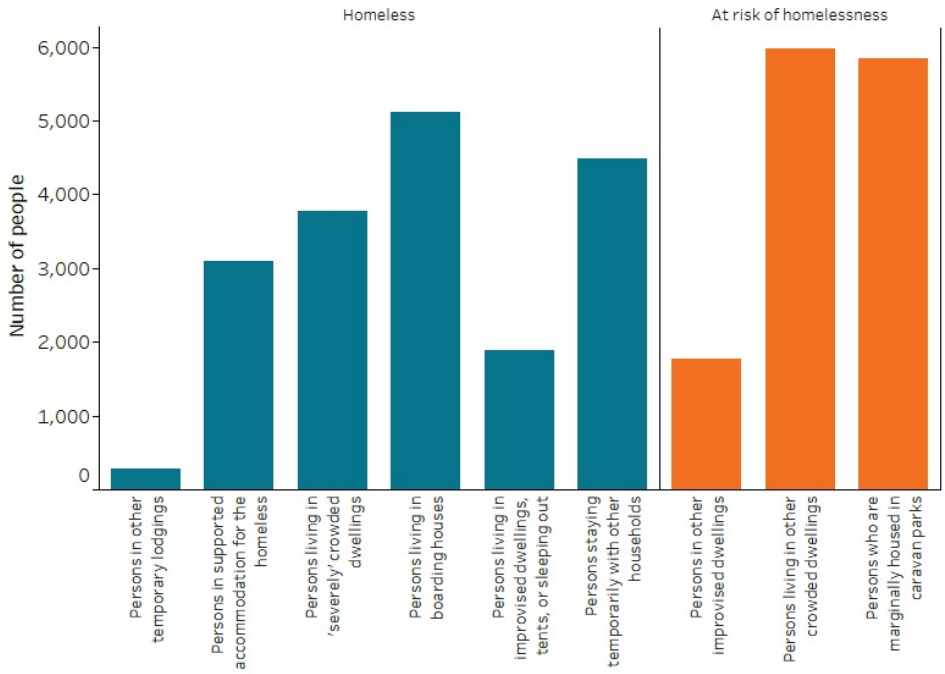
On Census night in 2016, 18,600 people aged 55 and over were homeless (representing 16% of all homeless people in Australia). There were a further 13,600 older people living in marginal housing (such as caravan parks and crowded or improvised dwellings) who were potentially at risk of homelessness.

The majority of older homeless people were aged 55–64 (57%), with those aged 65–74 accounting for 30% and those aged 75 and over, 12%.The patterns were broadly similar for those at risk of homelessness, with a small shift towards older age (the percentages were 51%, 33% and 17%, respectively) (ABS 2018).

Most commonly, older people experiencing homelessness were living in boarding houses (27%) or staying temporarily with other households (24%) (Figure 7.2).
Figure 7.2: Older people (aged 55 and over) experiencing homelessness or at risk of homelessness by type of dwelling, 2016

The column graph shows that in 2016 older Australians experiencing homelessness were most commonly living in boarding houses or staying temporarily with other households (28% and 24% respectively). Older Australians at risk of homelessness were most commonly living in other crowded dwellings or marginally housed in caravan parks (44% and 43% respectively).

**Figure 7.2: Older people (aged 55 and over) experiencing homelessness or at risk of homelessness by type of dwelling, 2016**




*Note:* 'Older people' refers to people aged 55 and over.

*Source:* ABS 2018.
http://www.aihw.gov.au/

The overall rate of older people (aged 55 and over) experiencing homelessness increased from 25.8 to 29.0 per 10,000 people between 2006 and 2016 (ABS 2018). Homelessness is a growing problem for older Australians, and may continue to increase over time due to the increase in the ageing population and the decrease in the rate of home ownership among older people.

In addition, particular groups of older people may be at a higher risk of homelessness, such as veterans, Indigenous people and people from culturally and linguistically diverse backgrounds (Parliament of Australia 2020). For example, around 8% of older homeless people were Aboriginal or Torres Strait Islander people (ABS 2018). Also, although older women do not account for the majority of homeless people, they represent a rapidly growing demographic in the homeless population - increasing by 31% between 2011 and 2016 (ABS 2018). Factors such as domestic violence, relationship breakdown, financial difficulty and limited superannuation can put people at risk of homelessness (ABS 2018).

**Older people sleeping out or staying in supported accommodation on Census night**

While definitions of homelessness and being at risk of homelessness cover broader territory, in layman terms, 'homeless' is commonly thought of as living on the streets or accessing homelessness shelters. The Census also provides a snapshot of this population. On Census night 2016, there were almost 1,900 people aged 55 and over sleeping out or staying in a tent or other improvised dwelling and 3,100 people aged 55 and over staying in supported accommodation for the homeless (ABS 2018).

Some people at risk of, or experiencing homelessness, may seek help from specialist homelessness services (SHS). In 2019–20, there were over 24,400 older clients (55 and over) who received services from SHS agencies. Of these older clients:

- around 60% were living alone
- 55% were returning clients
- 30% were currently experiencing a mental health issue
- 15% were Indigenous
- 5.0% had a disability (AIHW 2020).

At the start of support, older clients are much more likely to be at risk of homelessness (66%) than experiencing homelessness (35%). This profile is different to the total SHS client group where 43% of clients are experiencing homelessness and 57% are at risk of homelessness (AIHW 2020).

The main reasons older people who were experiencing homelessness sought assistance were due to a housing crisis (such as eviction) (24%) or inadequate dwelling conditions (23%). At the same time, the main reasons older people who were a risk of homelessness sought assistance were due to financial difficulties (20%) and family and domestic violence (18%).

More information is reported in the Specialist homelessness services annual report, which summarises data from the Specialist Homelessness Services Collection, and in the Older clients of specialist homelessness services report.

## Types of dwellings

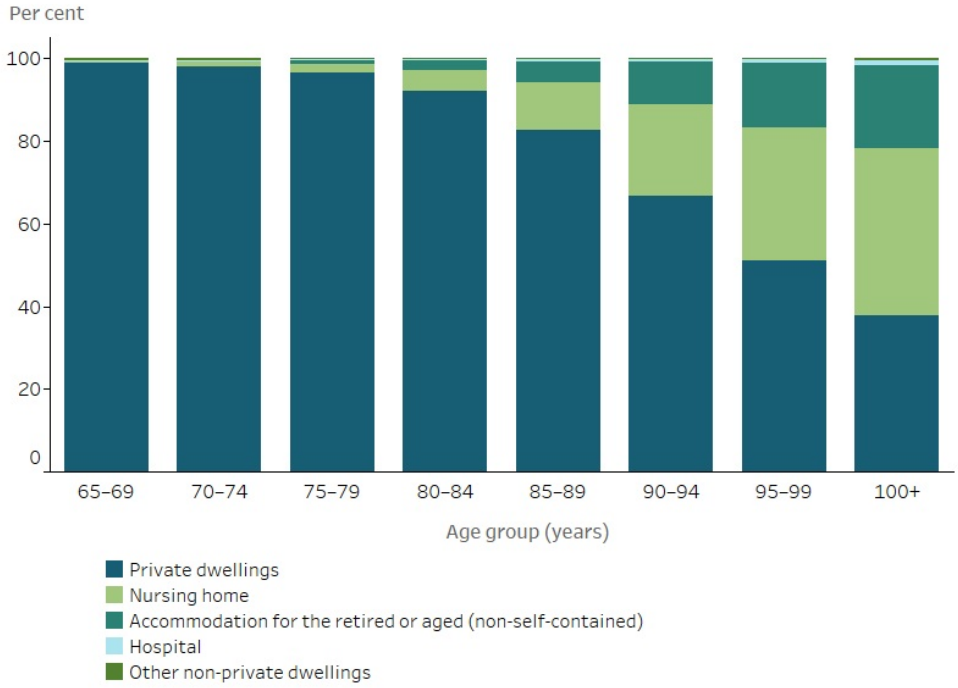
According to the 2016 Census, most older Australians lived in private dwellings:

- 99% of people aged 65–74 years
- 75% of those aged 85 and over (see Figure 7.3).

Figure 7.3: Older people in private and non-private dwellings by age group and sex, 2016

The stacked column graph shows that in 2016 the majority of older Australians occupied private dwellings. However, the proportion of older Australians occupying private dwellings decreased as age increased (99% of people aged 65–69 lived in private dwellings compared to 38% of those aged 100 and over).

**Figure 7.3: Older people in private and non-private dwellings by age group, 2016**




*Notes*
1. Hospitals include private hospitals, public hospitals and psychiatric hospitals.
2. Total includes people with a usual residence in migratory, offshore and shipping areas.
3. 'Older people' refers to people aged 65 and over.

*Source:* ABS 2017.
http://www.aihw.gov.au/

There were differences between men and women with women aged 75 and over less likely than men to live in a private dwelling. This difference was most noticeable for the 85 and over group, where 71% of women and 82% of men lived in private dwellings.

In contrast, a small percentage of older people (5.7%) lived in a non-private dwelling which often provide communal or short-term accommodation. In 2016, of the older people who lived in non-private dwellings, most (91%) were in cared accommodation (nursing homes or accommodation for the aged with common living and eating facilities). The percentage of all older people living in cared accommodation increased sharply with age from 1.0% of people aged 65–74 to 24% of those aged 85 and over. For people aged 85 and over, women were more likely than men to live in cared accommodation (28% compared with 17%, respectively) (ABS 2017).

For information about older people living in aged care settings or receiving care in their home, see Aged care.

### Dwelling structure

In 2017–18, for couple-only households where the reference person was 65 and over:

- 89% were living in a separate house
- 7.3% in a semi-detached house or townhouse
- 3.4% in a flat or apartment.

For older people in lone-person households:

- 67% were living in a separate house
- 19% in a semi-detached house or townhouse
- 14% in a flat or apartment (ABS 2019).

## Living arrangements

In 2016, more than half (58%) of all older people (aged 65 and over) lived with a spouse or partner in a private dwelling, with a further 25% living alone.

Older people who lived with a spouse or partner included those who lived:

- with no children in the dwelling (48% of all older people)
- with children (7.7%)
- in a multi-family household (2.6%).

Older people aged 65–74 were most likely to live with a spouse or partner (68%), and older people aged 85 and over were more likely to live alone (35%) than other age groups.

The likelihood of a person living alone increases with age, with a sharper increase for older women than older men. Nearly 1 in 3 (31%) older women lived in a lone person household compared with almost 1 in 5 older men (18%). The difference was greatest for the 85 years and over group (41% of women compared with 25% of men) (ABS 2017).

**Housing preferences**

Around 1 in 3 (35%) older Australians (aged 55 and over) surveyed in an Australian Housing Aspirations survey wanted to live in a home in the middle to outer suburbs of capital cities. This preference increased with age. More than 2 in 3 (69%) preferred a detached dwelling with 3 bedrooms (50%) the most common choice. Most older Australians surveyed did not want to be in the private rental market with 4 in 5 (80%) choosing home ownership as the preferred tenure. Results indicated that many older people currently renting had previously been in home ownership, moving into renting due to relationship breakdown or financial hardship (James et al 2019).

## Housing suitability

One measure of housing suitability is based on considering the appropriate number of bedrooms in a dwelling in relation to the household size and composition (for example, couple only, or family with children).

Results from the 2016 Census showed that 76% of older people who were a spouse or partner and 65% of older people in a lone-person household lived in a dwelling with 2 or more spare bedrooms (ABS 2018).

Living in a dwelling with more bedrooms than the number of people who usually live there may reflect a choice or that some people may be discouraged from downsizing due to financial or other disincentives.

Accessibility is another key aspect of housing suitability. The suitability of a dwelling can depend on its physical characteristics in relation to the needs of an older person (such as mobility limitations and restrictions). The arrangement, design and facilities within the home are of great importance with increasing age and frailty. For more information, see 'Disability' in Health – status and functioning.

## Where do I find more information?

For more information on older Australia's housing and living arrangements, see:

- Australian Human Rights Commission Older women's risk of homelessness: background paper
- My Aged Care Support for people facing homelessness

For information about older people living in aged care settings or receiving care in their home, see Aged care. Information about government financial support for housing expenses can be found in Income and finances.

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# Education and skills

**On this page:**


- Highest level of educational attainment
- Participation in education and training
- Where do I go for more information?


**Key findings**
Almost half (47%) of older Australians have a qualification equivalent to year 12 or below.

**Key findings**
Of the 12% of older Australians whose highest qualification is a bachelor degree or higher, the most common fields of study were education and health (with variation by sex).

Healthy ageing can involve both physical health and social and mental wellbeing. People's education and skill levels can help maintain mental activity and cognitive functioning in older age. They also impact a person's life course: the circumstances associated with higher education in mid-life, for example, can continue to offer a protective element into older age. This may be through health literacy and healthy behaviours, or through the employment opportunities and higher incomes associated with higher levels of education (for more information, see Employment and skills and Income and finances).

Older Australians (aged 65 and over) are a diverse population. This diversity is also reflected in the life experiences and skills people have accumulated throughout life.

Throughout this page, 'older people' refers to people aged 65 and over. Where this definition does not apply, the age group in focus is specified. The 'Older Aboriginal and Torres Strait Islander people' feature article defines older people as aged 50 and over. This definition does not apply to this page, with Indigenous Australians aged 50–64 not included in the information presented.

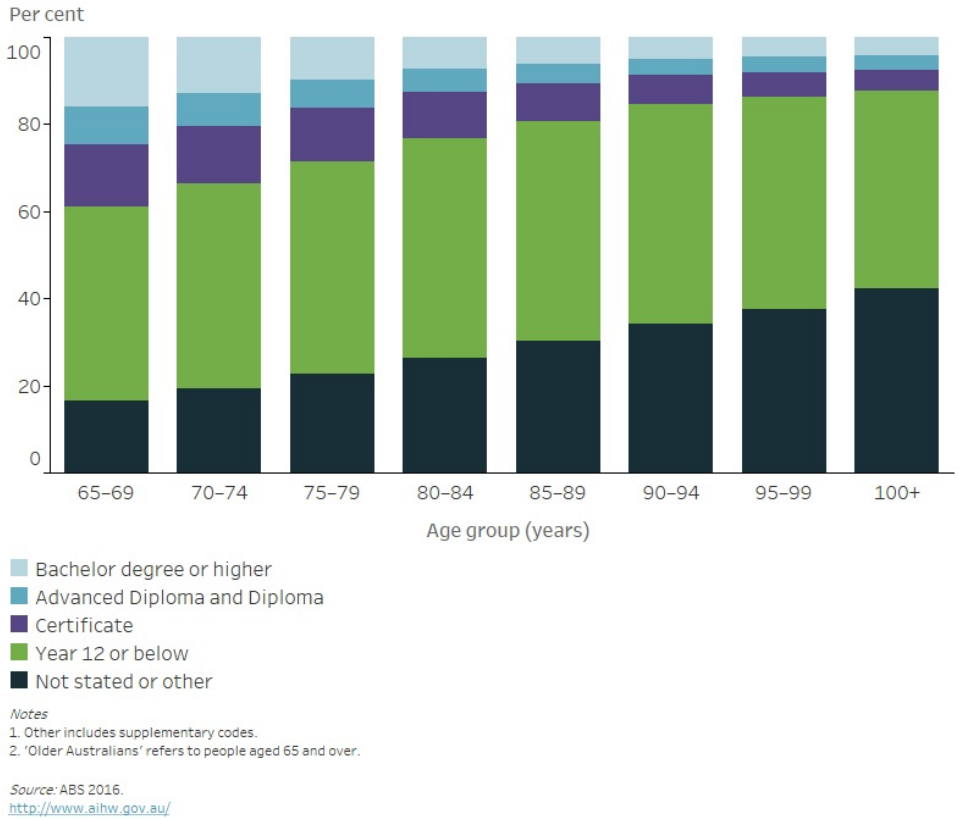
## Highest level of educational attainment

In 2016, almost half (47%) of older Australians had a highest educational qualification of year 12 (or equivalent) or below, while 1 in 5 (19%) had completed a certificate or diploma-level qualification and 1 in 8 (12%) a bachelor degree or higher (ABS 2016).

While the percentage of older Australians whose highest level of educational attainment was Year 12 or below was somewhat similar across age groups, the percentages with higher levels of education varied with age. Generally, those in the younger age groups were more likely to have a qualification at certificate, diploma or degree level than those in the older age groups (Figure 8.1).
Figure 8.1: Highest level of educational attainment for older Australians by age group, 2016

The stacked column graph shows that in 2016 the proportion of older Australians whose highest level of educational attainment was Year 12 or below was somewhat similar across age groups. However, the proportion of people with higher levels of educational attainment, such as a degree, diploma or certificate, decreased with age.

Figure 8.1: Highest level of educational attainment for older Australians by age group, 2016




*Notes*
1. Other includes supplementary codes.
2. 'Older Australians' refers to people aged 65 and over.

*Source:* ABS 2016.
http://www.aihw.gov.au/

Older Australians' educational attainment may in part reflect how education would have changed over their lifetime, with degree studies becoming increasingly more common over time. Other factors may also influence what and when people study. For example, of those older women whose highest level of education was a bachelor degree or higher, 30% had studied education and 29% had studied health (compared with 14% and 11% of men, respectively) (Table 8.1).

**Table 8.1: Most common fields of study for older Australians whose highest level of education was a bachelor degree or higher, by sex, 2016**

| Sex | Education % | Health % | Society and culture % | Management and commerce % | Engineering and related technologies % |
|---|---|---|---|---|---|
| Men | 13.9 | 11.0 | 20.2 | 18.0 | 15.8 |
| Women | 30.4 | 29.3 | 21.7 | 6.0 | 0.9 |
| **Total** | **21.8** | **19.7** | **20.9** | **12.3** | **8.7** |

Note: 'Older Australians' refers to people aged 65 and over.

Source: AIHW analysis of ABS 2016.

## Participation in education and training

In 2016, less than 0.6% of older Australians (almost 21,100) were enrolled in an educational course. Of these, almost one-third (some 6,600) were studying at university or other tertiary institution (AIHW analysis of ABS 2016).

## Where do I go for more information?

The page on social support provides information on some other ways that older people participate in Australia's society.

The ABS publishes information on the education and skills of Australia's older people through the Census of Population and Housing and the Survey of Education and Work.

## References

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# Employment and work

**On this page:**


- Introduction
- Participating in the workforce
- Working arrangements
- Underemployment and unemployment
- Retirement
- Where do I go for more information?


**Key findings**
In April 2021, older Australians (aged 65 and over) had a workforce participation rate of 15% (19% for men, 11% for women).

**Key findings**
The unemployment rate among older Australians was 3% at April 2021.

**Key findings**
In 2018–19, the average retirement age was 55.4, while the average intended retirement age was 66.

Older Australians are important contributors to Australia's labour force. Studies have demonstrated that for older people who are able to and wish to continue working, employment can provide a variety of benefits (Waddell and Burton 2006). Employment can assist in maintaining good health, promoting diversity in work environments and reducing demand on publicly-funded pensions. This page explores the workforce participation and retirement patterns of older Australians (aged 65 and over).

Throughout this page, 'older people' refers to people aged 65 and over. Where this definition does not apply, the age group in focus is specified. The 'Older Aboriginal and Torres Strait Islander people' feature article defines older people as aged 50 and over. This definition does not apply to this page, with Indigenous Australians aged 50–64 not included in the information presented.

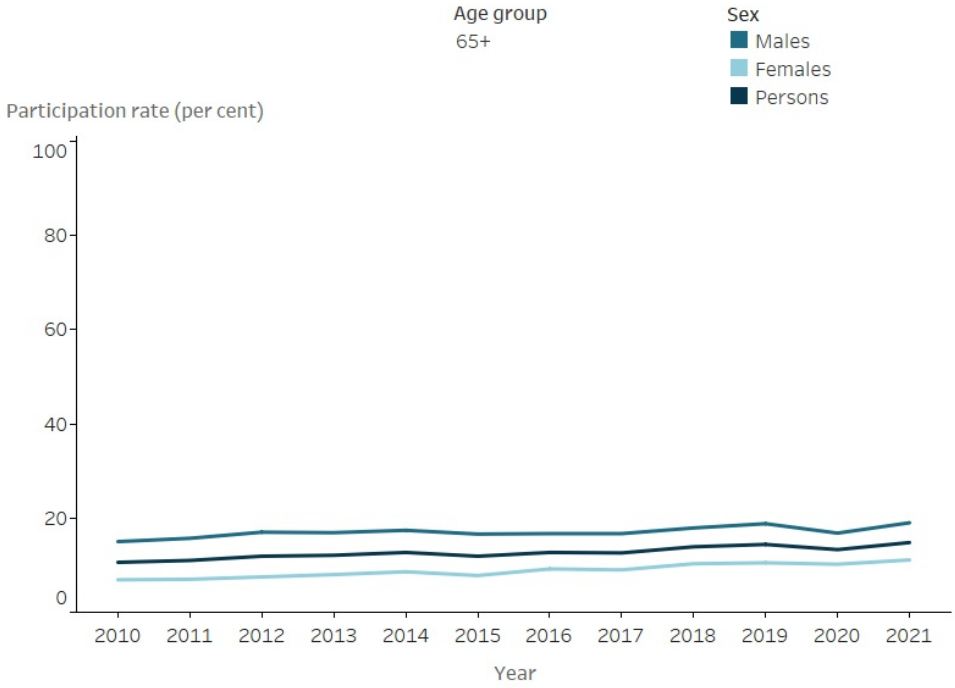
## Participating in the workforce

In April 2021, approximately 619,000 older Australians (aged 65 and over) were employed in the labour force. Of these older workers, 3 in 5 (61%) were men and 2 in 5 were women (39%) (ABS 2021b).

Australians are increasingly working to older ages. In the 20 years leading up to April 2021, the workforce participation rate of older Australians more than doubled (from 6.1% in 2001 to 15% in 2021) (ABS 2021b). Increases in labour force participation for men and women over this period have been substantial – the participation rate for older men almost doubled (from 10% to 19%), while older women's participation almost quadrupled (from 3.0% to 11%) (Figure 9.1) (ABS 2021b).
Figure 9.1: Australian workforce participation rate by age group and sex over time, 2010–2021

The line graph shows that the workforce participation rate among older Australians has increased (11% in April 2010 to 15% in April 2021). Workforce participation in older females was lower than for older males.

**Figure 9.1: Australian workforce participation rate by age group and sex over time, 2010–2021**




*Note:* Data at April each year.

*Source:* ABS 2021b.
http://www.aihw.gov.au/

Older Australians may remain in or return to the workforce for many reasons. These reasons may differ between individuals, as people take into consideration their health and economic circumstances, as well as job availability, working arrangements and family commitments. The type of work being undertaken, informal caring commitments, the presence of an employed spouse or partner, and presence of additional supporting income are also likely to contribute to individual decision making around employment. These decisions have flow-on effects to workforce participation rates. Older Australians today also have an increased life expectancy and increased years of disability-free life (for more information, see 'Life expectancy' in Health—status and functioning). As such, individuals may have both an increased need and an increased capacity to work longer. Furthermore, changing eligibility criteria for access to superannuation and the Age Pension may see an increasing number of people aged 65 and over remain in the workforce (for more information, see Income and finance).

## Working arrangements

In May 2021, employed older people were most commonly working as professionals, managers, and clerical and administrative workers (ABS 2021c). Older people were most commonly employed in the industries of health care and social assistance, agriculture, forestry and fisheries, and education and training. Their roles were most likely to be as professionals, managers or clerical and administrative workers (ABS 2021c) (Table 9.1).

Table 9.1: Most common form of employment for older Australians by sex, May 2021

| Rank | Males | Females | Total |
|---|---|---|---|
| 1 | Managers | Clerical and administrative workers | Professionals |
| 2 | Professionals | Professionals | Managers |
| 3 | Technicians and trades workers | Managers | Clerical and administrative workers |
| 4 | Machinery operators and drivers | Community and personal service workers | Technicians and trades workers |
| 5 | Labourers | Labourers | Labourers |

Notes:

1. Employment data taken at May 2021.
2. ‘Labourers’ includes, but is not limited to, occupations such as cleaners, laundry workers, construction and mining labourers, farm, forestry and garden workers.
3. 'Older Australians’ refers to people aged 65 and over.

Source: ABS 2021c.

In April 2021, 49% of older employed persons were employed full-time (301,200 people), and 51% were employed part-time (317,800 people) (ABS 2021b). In younger age groups (those aged 25–54), around 3 in 4 employed people worked full-time. For those aged 55–64, this reduced to 2 in 3, and for those aged 65 and over, 1 in 2 (ABS 2021b) (see Table 9.2).

Table 9.2: Proportion of people employed full- and part-time by age group, 2021

| | 15-24 | 25-34 | 35-44 | 45-54 | 55-64 | 65+ |
|---|---|---|---|---|---|---|
| **Full-time** | 41.7% | 75.7% | 74.0% | 75.4% | 68.0% | 48.7% |
| **Part-time** | 58.3% | 24.3% | 26.0% | 24.6% | 32.0% | 51.3% |

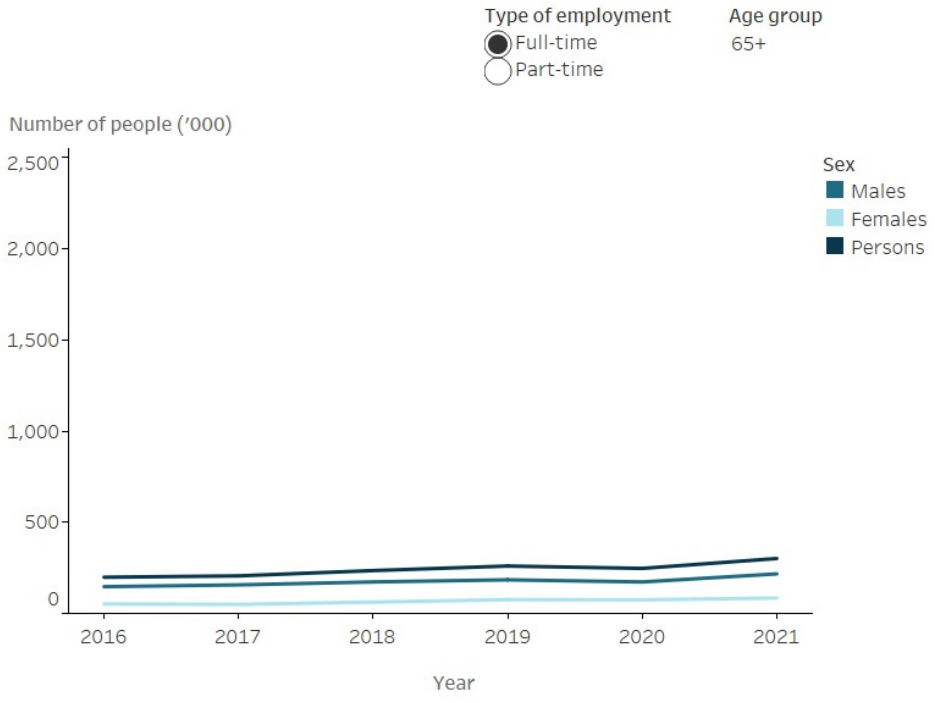
Note: Proportion of people data taken at April 2021.

Source: ABS 2021b.

In April 2021, almost 2 in 5 (58%) employed older men worked on a full-time basis, and over 1 in 3 (35%) employed women. Almost 3 in 4 (72%) older Australians employed on a full-time basis were men. The split of older men and women in part-time employment was almost equal (50%) (Figure 9.2) (ABS 2021b).
Figure 9.2: Australian employment participation by age group and sex over time, 2016–2021

The line graph shows that the number of older Australians in full-time and part-time employment has increased since 2016. In April 2021, there were a similar number of older males and females employed part-time (158,000 and 160,000 respectively), while there were more males than females employed full-time (217,000 and 84,300 respectively).

**Figure 9.2: Australian employment participation by age group and sex over time, 2016–2021**




*Note:* Data at April each year.

*Source:* ABS 2021b.
http://www.aihw.gov.au/

The proportions of older Australians employed full-time and part-time have remained relatively consistent over the past 6 years for both men and women (ABS 2021b). Since April 2016, over 7 in 10 older full-time workers have been men (74% in 2016, 72% in 2021) (ABS 2021b). For older part-time employees, the proportions of men and women have remained at approximately 50% each (ABS 2021b).

### Impact of COVID-19 on older people’s work

The significant health challenges resulting from the coronavirus disease 2019 (COVID-19) pandemic have had substantial impacts on the Australian labour force. Declines in employment were largest among the youngest (18–24) and oldest (65–74) age groups in the workforce (Biddle et al. 2020). COVID-19 is likely to have impacted the trend data on employment and work, as well as those relating to income support.

For more information on older Australians receiving government assistance, see Income and finance.

## Underemployment and unemployment

Some older people are either working less than they would like to or are looking for work (also referred to as underemployment and unemployment, respectively; see 'Key terms' box below). For older Australians (aged 65 and over) in April 2021:

- 6.1% of employed people were underemployed.
- The unemployment rate was 2.9% compared with 1.1% in April 2011 (Figure 9.3) and 2.1% in April 2001. Of the 18,400 older Australians who were unemployed, approximately half (52% or 9,500 people) were looking for part-time work only, while the remainder (48% or 8,900 people) were looking for full-time work.
- The underutilisation rate was 8.8%, 5.7% in April 2011 and 5.1% in April 2001 (ABS 2021a).

### Key terms

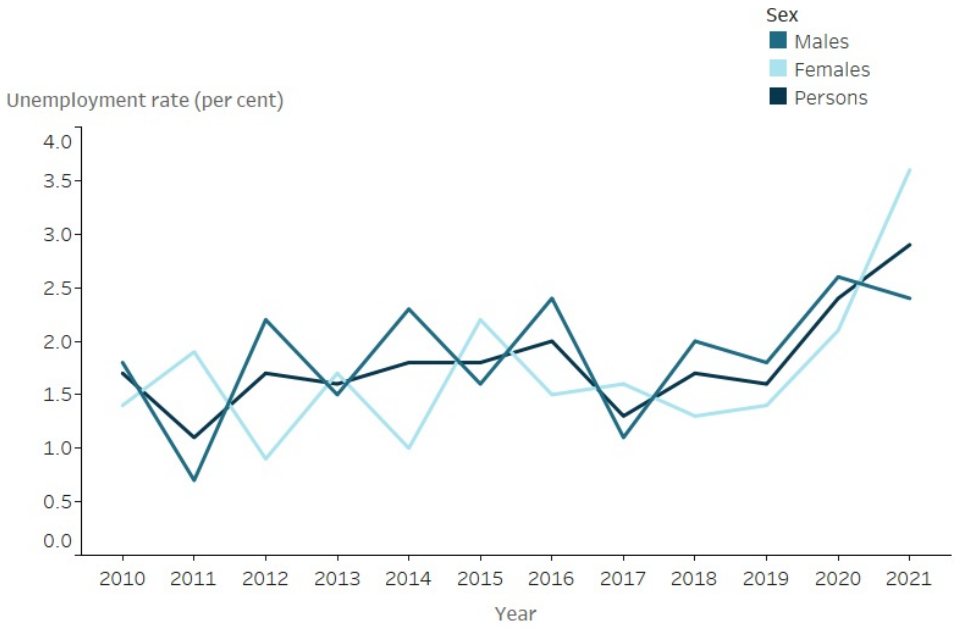
According to Australian Bureau of Statistics (ABS) definitions:

- **Underemployed** workers are employed people aged 15 and over who want, and are available for, more hours of work than they currently have.
- **Unemployed** people are those aged 15 and over who were not employed during the reference week, and either
  - had actively looked for full-time or part-time work at any time in the 4 weeks up to the end of the reference week, or
  - were waiting to start a new job within 4 weeks from the end of the reference week, and were available to work during the reference week.
- The **unemployment rate** is the number of unemployed people as a percentage of the labour force.
- The **underutilisation rate** is the sum of the number of people unemployed and the number of people in underemployment, expressed as a percentage of the labour force (ABS 2021d).

Figure 9.3: Older Australians' unemployment rate by sex over time, 2010–2021

The line graph shows that there has been fluctuation in the unemployment rate among older Australians since 2010. Increases in the unemployment rate for older Australians were substantial between April 2019 to April 2020, and again to April 2021. As of April 2021 the unemployment rate for older females was higher than males (3.6% and 2.4% respectively).

**Figure 9.3: Older Australians' unemployment rate by sex over time, 2010–2021**




*Notes*
1. Data at April each year.
2. 'Older Australians' refers to people aged 65 and over.

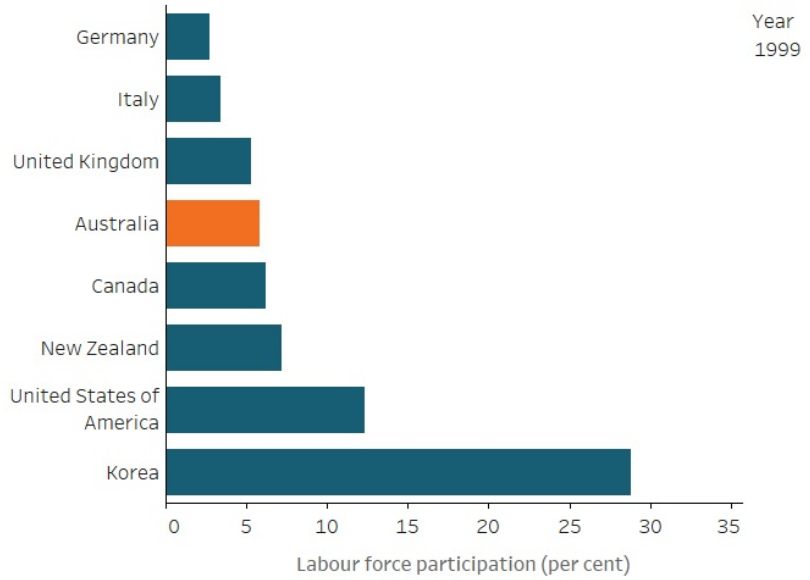
*Source:* ABS 2021b.
http://www.aihw.gov.au/

Labour force participation rates among older people (aged 65 and over) have increased over time, and vary between countries. Australia and Canada have very similar rates (both 15% in 2019) (OECD 2021). Western European countries have lower rates (for example, 5.1% in Italy in 2019), while some other Pacific countries have much higher rates (for example, 24% in New Zealand) (OECD 2021) (OECD 2021). These differences may reflect the global variation in both the longevity of the older population and the availability of social supports, such as government-funded pensions.

Figure 9.4: Labour force participation rate for older populations in selected countries, 1999, 2009 and 2019

The bar chart shows that the labour force participation of older people in Australia is similar to other selected countries such Canada (both 15% in 2019). Labour force participation of older people in Australia remains higher than in countries such as Italy, Germany and the United Kingdom, but lower than New Zealand and Korea.

**Figure 9.4: Labour force participation rate for older populations in selected countries, 1999, 2009 and 2019**




*Note:* 'Older populations' refers to people aged 65 and over.

*Source:* OECD 2021.
http://www.aihw.gov.au/

## Retirement

The ABS defines retirement as requiring people to have previously worked in a job for any duration, including jobs that lasted for less than 2 weeks, and have retired from work or looking for work, and did not intend to look for or take up work in the future (ABS 2020).

In 2018–19, there were 3.9 million retirees in Australia aged 45 and over, with the average retirement age being 55.4. Men were more likely to retire at older ages than women (the average age at retirement was 60 for men and 52 for women) (ABS 2020).

The most common reasons for retirement in 2018–19 were:

- reaching the retirement age or eligible for superannuation or pension
- having a sickness, injury or disability
- being retrenched or dismissed or there was no work available (ABS 2020).

In 2018–19, just under 1 in 5 (18%) people aged 45–64 reported that they intended to retire before age 65, 1 in 3 (33%) intended to retire at between 65 and 69, and 1 in 10 (11%) after age 70. A further 2 in 5 (38%) reported that they did not know when they intended to retire. The average intended retirement age was 66 (66 for men and 65 for women) (ABS 2020) (Table 9.3).

Table 9.3: Intended age of retirement, 2008–09 to 2018–19

| | 2008-09 | 2010-11 | 2012-13 | 2014-15 | 2016-17 | 2018-19 |
|---|---|---|---|---|---|---|
| Persons aged 45–64: **Before 65** | 28% | 25% | 23% | 20% | 19% | 18% |
| Persons aged 45–64: **65–69** | 30% | 29% | 31% | 32% | 31% | 33% |
| Persons aged 45–64: **70+** | 6% | 7% | 9% | 12% | 10% | 11% |
| Persons aged 45–64: **Did not know** | 37% | 39% | 37% | 35% | 40% | 38% |
| Persons aged 45 and over: **Average age intends to retire** | 63.4 | 62.9 | 63.4 | 65.1 | 65.0 | 65.5 |

Source: ABS 2020, various releases.

Experiences after retirement can potentially lead to people returning to the workforce. In 2018–19, approximately 143,500 people in the labour force had previously retired (ABS 2020). Reasons for returning to work included financial need, boredom, and other reasons (that they no longer needed to care for a partner or family member, the death of a partner, or separation or divorce from a partner) (ABS 2020). For information about income during retirement, see Income and finance.

### Where do I go for more information?

For more information on older Australians' employment and work, see:

- ABS Labour force, Australia.

Information about volunteering and informal care can be found in the Social support.

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# Income and finances

**On this page:**


- Introduction
- Sources of income
- Income and wealth
- Income support payments
- Income during retirement
- Superannuation and other assets
- Where do I go for more information?


**Key findings**
At 30 June 2021, 2 in 3 (67%) people aged 65 and over received the Age Pension, Carer Payment, Disability Support Payment or JobSeeker Payment.

**Key findings**
At 30 June 2020, 1 in 5 (20%) people receiving Commonwealth Rent Assistance were aged 65 and over.

**Key findings**
Almost half of Older Australians had a government pension or allowance as their main source of income.

**Key findings**
Of the 3.9 million retirees in Australia in 2018–19 aged 45 and over, the average age of retirement was 55.4.

Exploring the income of a population group can provide insights into their economic security. Generally, a person's resources are accumulated over the course of their working lives and income levels can diminish during retirement, even as wealth or assets may not.

Many older Australians (aged 65 and over) receive government assistance through a range of payments to help support them financially. This page investigates the types and levels of income received by older people. Throughout this page, 'older people' refers to people aged 65 and over. Where this definition does not apply, the age group in focus is specified. The 'Older Aboriginal and Torres Strait Islander people' feature article defines older people as aged 50 and over. This definition does not apply to this page, with Indigenous Australians aged 50–64 not included in the information presented.

### Economic security

Economic security is having a stable income or other resources to support a standard of living and cover essential needs, both now and in the immediate future. Essential needs might include food, basic shelter, clothing, hygiene, health care and education (ICRC 2015).

## Sources of income

People can receive income from multiple sources. To simplify this, the main source or sources of income that make up the largest proportion of an individual's total income can be reported. This can be associated with people's economic security and their socioeconomic circumstances.

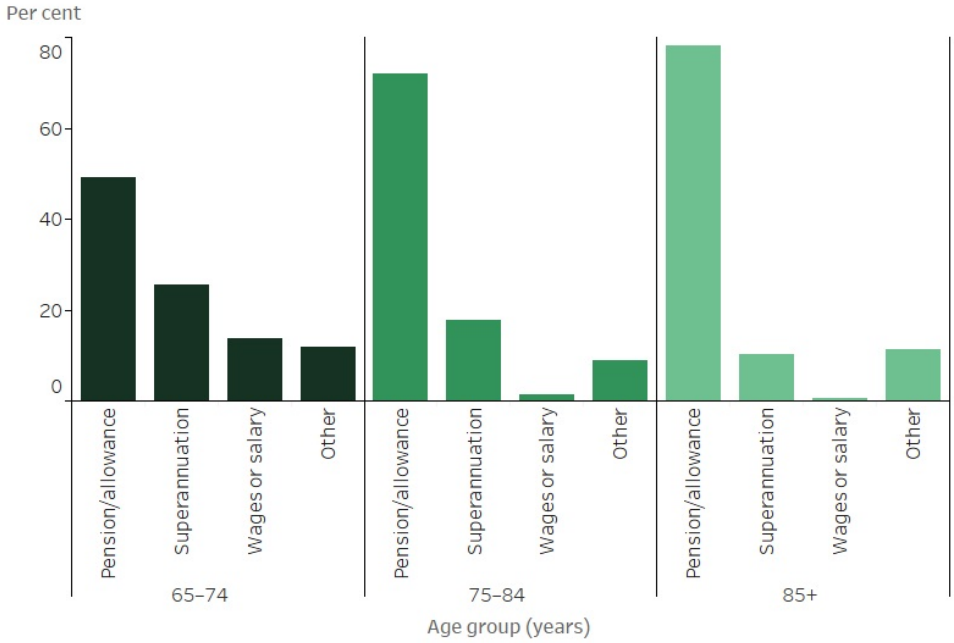
The 2018 ABS Survey of Disability, Ageing and Carers reported that for older Australians (aged 65 and over) with an income source, the main source of income was:

- government pension or allowance (57%), decreasing from 63% in 2015
- superannuation, annuity or private pension (21%), increasing from 18% in 2015
- wages or salary (8%), increasing from 7% in 2015 (ABS 2019) (see Figure 10.1).

Figure 10.1: Older Australians' main source of income by age group, 2018

The column chart shows that in 2018 the main source of income across all age groups 65 and over was by receiving a government pension or allowance. 49% of people aged 65–74 received a government pension or allowance as their main source of income and this increased to 78% for people aged 85 and over

Figure 10.1: Older Australians' main source of income by age group, 2018




*Notes*
1. 'Other' includes rental property, unincorporated business or share in a partnership, dividends and/or interest and other source of income.
2. Data exclude those with no income, not stated/known and not applicable.
3. 'Older Australians' refers to people aged 65 and over

*Estimate has a relative standard error of 25% to 50% and should be used with caution
**Estimate has a relative standard error greater than 50% and is considered too unreliable for general use

*Source:* AIHW analysis of ABS 2019.
http://www.aihw.gov.au/

## Income and wealth

Income and wealth are 2 important concepts in determining a person's economic resources. Income can be used to purchase goods and services, or saved and invested to increase wealth (ABS 2019). Wealth includes assets such as housing, superannuation, shares, savings and non-financial assets such as cars (Davidson et al. 2020). Generally speaking, incomes increase until around middle age, and wealth gradually increases during working years and is used during retirement (ABS 2019). As a result, in the older years in particular, people can have low incomes but high wealth.

During 2017–18, older people were more likely than younger people to be in low-income households, with 2 in 3 (66%) households with a reference person aged 65 years or over being in the lowest 40% of households as ranked by equivalised disposable income. The average wealth of these older households, however, was 1.5 times that of younger age group households ($1.4 million compared with $0.9 million, respectively). The main reason for this wealth difference is home ownership, with older people having houses of an average value of $597,000 compared with $328,000 for households with a reference person under 65 years (Davidson et al. 2020).

### Key terms

Gross income (or total income) is the sum of income received from all sources before any deductions are removed. Equivalised disposable income refers to income whereby the following adjustments are made:

- Income tax is removed resulting in after-tax income (disposable).
- This disposable income is adjusted down based on the size of the household (equivalised). Note no adjustment is made for lone person households (Davidson et al 2020).

## Income support payments

There are a range of government assistance payments available to support older Australians. The most common is the Age Pension – an income support payment for people who have reached Age Pension age (65.5 in 2017, 66.5 in July 2021, increasing to 67 in 2023), are under the income and assets test limits, and are an Australian resident (for at least 10 years). Among older Australians, recipient numbers for Jobseeker Payment, Disability Support Pension and Carer Payment have risen steeply in recent years as the qualifying age for Age Pension continues to increase (AIHW 2021b).

At June 2021, 2.8 million people aged 65 and over received an income support payment, equating to 2 in 3 (67%) of the population aged 65 and over (DSS 2021). Of these older people:

- The majority received the Age Pension (93%, 2.6 million).
- 1 in 29 received the Disability Support Pension (3.7%, 101,800).
- 1 in 50 received the Carer Payment (2.0%, 56,400).

- 1 in 83 received the JobSeeker Payment (1.1%, 30,300) (DSS 2021).

At June 2018, there were 2.6 million older people receiving an income support payment. Of these older people:

- The majority received the Age Pension (95%, 2.5 million).
- 2.8% received the Disability Support Pension (72,600).
- 1.8% received Carer Payment (46,400).
- 0.4% received Newstart Allowance (an unemployment-related payment) (10,600 people) (DSS 2018).

Between March 2018 and March 2021, the number of older people receiving the Disability Support Pension increased by 43% and recipients of the JobSeeker Payment and Newstart Allowance tripled, as the qualifying age for the Age Pension continued to rise. At March 2021, the proportion of the population aged 65 and over who received the Age Pension increased with age, up to age group 80–84:

- 38% for those aged 65–69
- 64% for those aged 70–74
- 82% for those aged 80–84.

For those 85 and over, the proportion dropped to 77% (AIHW 2021b).

### Housing assistance

Sometimes people need help to meet the cost of housing. Government assistance is available to people on lower incomes, for example those who are renting or saving a deposit for a home purchase.

At 26 June 2020:

- 1 in 5 (20%) income units receiving Commonwealth Rent Assistance had a reference person aged 65 and over, compared with more than 1 in 4 where the reference person was aged 45–64 (27%)*
- 1 in 20 (5.1%) households receiving Private Rent Assistance had a main applicant 65 years and over compared with nearly 1 in 4 aged 45–64 (23%)
- 1 in 10 (11%) households receiving Home Purchase Assistance had a main applicant aged 65 years and over compared with 1 in 3 aged 45–64 (34%) (AIHW 2021a).

### Income units

An income unit refers to a grouping of one or more people who are in receipt of a social security or family assistance payment, and are assumed to share income with one another. The grouping could comprise a single individual, or a couple, with or without dependent children. As an income unit may be in receipt of more than one payment, one non-dependent member of the unit is designated as its reference person, according to a hierarchy of payment types, with pensions outranking other payments (and the Disability Support Pension and Carer Payment outranking the Age Pension). As a result, the number of income units with reference persons aged 65 and over would be smaller than the number of income units containing members aged 65 and over.

For more information on older Australians' housing situation, see Housing and living arrangements.

## Income during retirement

The age at which a person can access Australia's Age Pension or superannuation is often referred to as 'retirement age' (depending on circumstances, between ages 55 and 67). While people can choose to retire at any age for any reason, the most common reason retirees left their previous job in 2018–19 was reaching 'retirement age' or being eligible for superannuation (46%) (ABS 2020).

The Survey of Retirement and Retirement Intentions reported that, in 2018–19, for people aged 45 and over:

- 36% of retired women relied on their partner's income to meet their living costs at retirement (compared with 7% of retired men).
- For people who were intending to retire, financial security was the main factor that influenced their decision about when to retire (ABS 2020).

Of the 3.9 million retirees in Australia in 2018–19 aged 45 and over, the average age of retirement was 55.4. Around 2 in 5 (44%) women and 1 in 2 (49%) men had a government pension or allowance as their main source of income. Superannuation was the main source of income for a considerable proportion of retirees, especially men (30% for men and 17% for women). Women were far more likely than men to report no personal income (30% for women and 7% for men) (ABS 2020; AIHW 2021b).

## Superannuation and other assets

Access to superannuation to supplement the Age Pension is important for older people's economic security. In 2018–19, around two-thirds (67%) of retirees reported that they had made contributions to a superannuation scheme (76% of men and 59% of women) (ABS 2020). In 1997, 12% of retired Australians aged 45 and over stated that superannuation was their main source of income, compared with 23% in 2018–19 (ABS 2020; AIHW 2015). It is likely that many older Australians were working before superannuation schemes (like those that align with the *Superannuation Guarantee (Administration) Act 1992*) became mandatory and nationwide.

Older people's most significant asset is often their home. For more information on older Australians and home ownership, see Housing and living arrangements.

## Where do I go for more information?

For more information on the income and finances of older Australians, see:

- Australia's welfare 2021
- Older Australian clients of Specialist Homelessness Services

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# Key data gaps

**On this page:**


- Existing data sources for reporting on older people
- What are the main challenges with the existing data?
- What are the impacts of these issues?
- What can be done?


This report applied a person-centred model to facilitate consistent, comprehensive and structured reporting on the health and wellbeing of older Australians (Figure 11.1). This model is based on social-ecological frameworks of the determinants of health and wellbeing and was developed by the Australian Institute of Health and Welfare (AIHW) to measure and report on health and welfare of the general population. The approach identifies 7 information domains needed to understand the experiences of the population and its various cohorts. It reflects that a person's health and welfare result from a complex interplay between biological, lifestyle, socioeconomic, societal and environmental factors, many of which can be modified to some extent by health care, financial support and other interventions. The person-centred model provides a way to understand these factors and their interactions.

While much is known about the health and wellbeing issues that affect older Australians, there are still notable gaps. This section explores some of the main data gaps, highlighting those where timely and valuable improvements and developments could be made.

**Figure 11.1: Person-centred model**

## Existing data sources for reporting on older people

Using the 7 domains as a framework, there is a range of elements that can be explored to build an understanding of each domain. These elements can be categorised as:

- **Current status:** How are older people currently faring relative to this domain? How can their experience or situation be described?
- **Determinants:** What factors related to this domain may positively or negatively affect older people's health and welfare? How many older people are exposed to such factors, and how can they be described?
- **Services:** What services related to this domain are available to older people and how are they being used? What are the outcomes of these services and what additional services are needed?

Table 11.1 outlines the elements within each category and for each domain that have been used in this report on the health and wellbeing of older Australians. The elements largely reflect the information currently available; that is, what is known about the current status, determinants and relevant services. The domains of the model provide a structure for organising the elements to enable systematic analysis, as well as identify areas where information on older people is sparse and could be filled to provide a more comprehensive picture. These elements can change over time, as analysis progresses and the evidence base grows.

Table 11.1: Person-centred model of health and welfare: domains and elements currently reported

| Domain | Status | Determinants | Services (use, need, outcomes) |
|---|---|---|---|

| | | | |
|---|---|---|---|
| Health | Self-assessed health<br>Disability<br>Mortality<br>Causes of death<br>Burden of disease<br>Injuries<br>Selected health conditions<br>Multimorbidity | Behavioural<br>Biomedical | Primary care<br>Allied health care<br>Mental health services<br>Dental services<br>Hospitals<br>Pharmaceutical use<br>Aged care<br>Integration of health and aged care |
| Housing | Housing (tenure, dwelling type, suitability)<br>Living arrangements<br>Homelessness and insecure housing | Housing (tenure, dwelling type, suitability)<br>Homelessness and insecure housing | Homelessness and insecure housing |
| Social support | | Social participation<br>Social engagement and isolation | |
| Education and skills | Highest level of educational attainment | Highest level of educational attainment<br>Participation in education and training | |
| Employment | Participating in the workforce<br>Working arrangements<br>Retirement | Underemployment and unemployment<br>Retirement | |
| Income and finance | Sources of income<br>Level of income<br>Income during retirement<br>Superannuation and other assets | Income during retirement<br>Superannuation and other assets | Income support payments |
| Justice and safety | | Discrimination<br>Abuse<br>Older prisoners | |

Note: Where a cell is empty, this indicates that information about the relevant domain's current status, determinants or services is not yet available.

### What are the main challenges with the existing data?

Building a comprehensive picture of the health and wellbeing of older Australians requires information to be drawn from many different data sources, including administrative and survey data. The overarching challenge with much of the data used in this publication, and data available on older Australians in general, is that the data sources have been designed for other and/or wider purposes than exploring the health and wellbeing experiences of older Australians. It is not an issue of the underlying data quality of these data sources. As such, there are many improvement and development opportunities that can be easily implemented to achieve quick gains in building a comprehensive picture of older Australians.

It should also be noted that some of the challenges with existing data sources are not specific to data on older Australians and can occur when focusing on any specific population group (for example, limited disaggregation due to small cell sizes or high standard errors in survey data).

The main limitations identified with existing data include:

- **domain coverage** – incomplete coverage of health and wellbeing issues affecting older people
- **population groups** – fragmented and incomplete coverage of issues affecting population groups of interest
- **data presentation** – need for more disaggregation for older age groups, particularly at local geographical levels.

### Domain coverage

While much is known about older Australians across the 7 domains of the person-centred model discussed above, there continue to be notable data gaps and opportunities. While not exhaustive, key gaps exist in the domains of 'Income and finance' and 'Justice and safety'. Data on the prevalence of financial stress experienced by older Australians, as well as the reasons for financial stress, are not readily available. A critical data gap exists around abuse experienced by older Australians, although a prevalence study by researchers at the Australian Institute of Family Studies (AIFS) is currently underway. For more information, see AIFS Elder Abuse Prevalence Study.

Much of the data available is also not person-centred – that is, showing the combination and clustering of factors within an individual – but rather population-wide, showing the prevalence of different variables. This results in an incomplete picture of the range of factors affecting people's health and wellbeing, and the concentration of many factors within the same individual. Even considering health alone, data on the prevalence of different diseases are often presented without considering the common coexistence of multiple conditions within the same individual. In turn, health care for this person can be fragmented and unmanageable, with management approaches for different conditions competing for the person's time, Medicare-funded services and other resources.

### Population groups

This report has illustrated that older Australians are not a homogenous group. There is great diversity within the older population, and data are needed to inform what we know about their health and wellbeing. For example, information is needed to identify what are the health-care needs of particular population groups, what are the barriers for accessing care and services, what interactions take place between the domains and how these affect pathways and outcomes.

Data from national surveys play an important role in providing information on the health and wellbeing of older Australians. Challenges exist in collecting data on population subgroups, including data quality and coverage. It can be difficult, for example, to obtain a large representative sample of some populations in national surveys – for example, culturally and linguistically diverse (CALD) or lesbian, gay, bisexual, transgender and intersex (LGBTI) communities – and data become less reliable and robust as sample size decreases.

Further, some surveys exclude certain geographical regions and, in doing so, decrease visibility of these population groups. For example, some surveys do not include populations living in very remote locations; this impacts the ability to comprehensively report on both population groups of older Indigenous Australians and older Australians living in rural and remote communities. Another example is that people living in residential aged care facilities may not be in scope for, or identified, in data collections such as surveys. People in such care settings can have very different needs compared with those living in private homes in the community. Similarly, people living with cognitive decline or dementia may face barriers to participating in data collections, and may have specific needs distinct from older people without these conditions.

While not specific to data related to older Australians, identification of specific older population groups of interest also needs improvement. As described in Older people from CALD backgrounds, there are various ways to describe cultural and linguistic diversity but available data sources only capture some of these concepts. For other population groups, such as older people who identify as LGBTI or otherwise diverse in gender, sex or sexuality, several data sources lack the option for older people to identify as such. Identification of sex and gender-diverse populations are particularly limited. Without standard ways of identifying people, there can be a lack of data quality and limited comparability across collections.

Many of the older populations of interest are designated as people with special needs in the *Aged Care Act 1997*. This designation adds further importance to improving both identification and coverage of these population groups across various data sources.

### Data presentation

Often publicly available data on older Australians are presented with limited age disaggregation, sometimes as a single 65 and over age group. This is sometimes a result of the data that are collected. In other cases, the data exist, but are not published or available. Additional disaggregation of these age groups is important in understanding how the health and wellbeing of older people can differ at different ages. For example, the health and wellbeing of people aged 90 and over may be substantially different from people aged 65.

Further disaggregation by geographical areas is an additional area for improvement. Additional disaggregation by local areas would be particularly valuable. However, further disaggregation may raise concerns (as mentioned above) in relation to population groups, as well as concerns of confidentiality and statistical validity due to small population groups. The quality and consistency of geographical units also varies between data sources.

## What are the impacts of these issues?

As well as summarising currently reported information, Table 11.1 illustrates gaps in the information available across the 7 health and wellbeing domains; in particular, in the social support, education and skills, employment, and justice and safety domains. There are also substantial gaps in information on service use, needs and outcomes across the majority of domains, including a lack of information on how multiple service sectors (for example, health and aged care) work together. Within individual domains there are also gaps relating to, for example, selected health conditions (such as dementia, mental health), use of health services (such as private dental practices/providers, palliative care), the cultural appropriateness or safety of aged care services and elder abuse. These data gaps limit the ability to fully understand the factors (and their interactions) that influence the health and wellbeing of older Australians.

There is great diversity within the older population and being able to report on ageing-related issues for population groups is important for building an understanding of their needs and how their life experiences differ. This analysis relies on the variables collected in the underlying data and, in many instances, this is missing, not comprehensive or inconsistent across the data sets. This is particularly the case

in relation to data on Australians who identify as LGBTI or otherwise diverse in gender, sex or sexuality, and CALD populations. Similar data quality issues have also been reported in relation to older Aboriginal and Torres Strait Islander people.

## What can be done?

Work can be done to not only improve what data are collected about older people, but what is reported. The existing data can also be harnessed in different ways to provide insights into pathways and outcomes.

### Maximise existing sources

For existing data sources, where the available data are reliable and robust, thought needs to be given to presenting as much detail as possible to describe the diversity within the older population, for example:

- by 5- or 10-year age groups for ages 65 and over
- including specific characteristics, such as socioeconomic status and remoteness.

### Add to existing data sources to deal with priority gap areas

In the longer term, consideration of data improvements could include:

- enhancing existing data sets where information about older people is not collected comprehensively. For example, many population surveys are limited to people living in private dwellings. They thus fail to account for the 1 in 20 (4.5%) people aged 65 and over, or 185,000 people, who live in residential aged care (AIHW 2020). The health and wellbeing of this population group differ considerably to that of the population of older Australians living in private dwellings
- improving data capture to support analysis of population groups that may experience ageing differently – for example, incorporating the Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables, released by the Australian Bureau of Statistics in 2021 (ABS 2021), into data collections
- integrating data to better understand pathways and outcomes across domains and elements – for example, accessibility and availability of health services (particularly primary health care) data for older Australians in regional and remote areas. This could also include integration with non-government data sources, such as data collected by advocacy services
- filling gaps where there are limited or no data, which could include developing targeted surveys or modules to explore the health and wellbeing of older Australians, specific components and lifecourse impacts. The development of an older person survey module could build on a number of excellent national survey data sources that already exist. Such a module could be specifically designed to capture several gaps; for example, data about dental services and mental health, and conditions particularly pertinent to older Australians, such as dementia
- improving the timeliness of data collection and reporting, so that data can provide rapid indications of any emerging issues, and reflect the impacts of any changes to aged care policy and service delivery.

### New developments and data improvement activities

- The AIHW is currently working with governments to develop a number of Multi-source Enduring Linked Data Assets (MELDAs) to meet an increasing demand for access to linked data, including the National Primary Health Care Data Asset, National Disability Data Asset and the National Aged Care Data Asset. These MELDAs will facilitate use of person-centred data to construct a more detailed picture of the population of interest, and to explore relationships between multiple elements of health and welfare.
- In response to the Royal Commission into Aged Care Quality and Safety, data improvement activities are taking place within the aged care data system. The AIHW is leading the development of a National Aged Care Data Strategy. This includes undertaking a comprehensive review of the available data and identifying information gaps, limitations and opportunities. In addition to establishing the linked data asset noted above, a national minimum data set is being developed to standardise the collection and reporting of a core set of aged care data. New data governance and stakeholder engagement arrangements will inform these developments. These activities will provide a path forward for understanding in more detail this aspect of some older people's lives.
- The AIHW is undertaking a program of work for the Department of Health focused on monitoring dementia in Australia. The work includes providing advice on how to direct efforts to build sustainable data collections and monitoring programs for dementia in Australia.
- The AIHW and the Department of Veterans' Affairs (DVA) continue to increase the range of data available about serving and ex-serving Australian Defence Force (ADF) members, and collaborate on how best to describe the information. Work is also underway to build a more comprehensive profile of the welfare of Australia's serving and ex-serving ADF members, as well as their families. With the AIHW and DVA collaboration broadening its scope on wellbeing, research will also look to address key information gaps in the areas of education, employment, justice, housing, safety, finance and social support.
- More broadly, new questions included in the 2021 Census on long-term health conditions and Australian ADF service will enable the collection of data on health conditions, such as arthritis and diabetes, and provide a better understanding of the circumstances of Australia's veteran community, including older veterans.

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# Notes

## Amendments

**10 May 2022**

References and COVID-19 content updated.

## Data updates

**30 November 2021**

Older Australians released – all sections updated with latest data.

**7 July 2022**

Health – status and functioning updated with latest data for Australia's health 2022 topic summary.

**28 June 2023**

Aged care updated with latest data for Australia's welfare 2023 topic summary.

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# Report editions

## This release

Older Australians | 28 Jun 2023

## Previous releases

- Older Australia at a glance (fourth edition) |
  **Publication** | 22 Nov 2007
- Older Australia at a glance (third edition) |
  **Publication** | 29 Oct 2002
- Older Australia at a glance (second edition) |
  **Publication** | 23 Dec 1999
- Older Australia at a glance |
  **Publication** | 01 Jul 1997

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# Related material

## Resources

## Related topics

- Aged care
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