4 Ageing and aged care

4.1 Introduction

Interest in the ageing of Australia's population has been growing steadily since the early 1990s when *Australia's Ageing Population – Policy Options* (Bureau of Immigration Research: Young 1990) was released. Government attention to the implications of population ageing was sharpened with the release of the first *Intergenerational Report* (Costello 2002). A succession of government inquiries and reports on the topic has followed, with the most recent being *Economic Implications of an Ageing Australia* (Productivity Commission 2005), a report prepared at the request of the Australian Treasurer on behalf of the Council of Australian Governments.

A key concern of these reports is that population ageing will lead to high levels of public expenditure on services for older people which will be borne by a relatively shrinking labour force. The concern is heightened because Australia experienced a lengthy postwar baby boom which resulted in a large cohort of people who, over the next couple of decades, will retire and contribute to a rapid increase in the number of older people eligible for government income support and other services.

The Productivity Commission's 2005 report had a particular focus on the implications for productivity, labour force and fiscal outcomes across the three tiers of government. The report argued for coordinated reforms in key human services areas such as health and aged care in response to growing demands placed on these sectors. It also argued that increasing labour force participation and productivity growth could partly offset the impacts of ageing. The importance of labour force participation in addressing some of the issues raised by population ageing underpins some recent policy initiatives by the Australian Government.

The broad policy framework of reports such as the *Intergenerational Report* stimulated renewed interest in improving the efficiency and effectiveness of aged care policy and program delivery, leading to a number of strategic reviews in the area. Reports from two major policy reviews were published in 2004: *Review of Pricing Arrangements in Residential Aged Care* (Hogan 2004), and *A New Strategy for Community Care – The Way Forward* (DoHA 2004c). In the following year the *National Aged Care Workforce Strategy* was released (Aged Care Workforce Committee 2005; see Section 4.3 for more detail). In broad terms, these reviews have focused on ways to meet the demand for aged care services in coordinated and cost-effective ways while ensuring that the services are directed to those most in need.

The other major prong of the policy response to population ageing involves initiatives to minimise demand for health and aged care services through the promotion of improved health among older people. This policy response is supported by a growing research effort. In December 2002, the Prime Minister announced the government's National Research Priorities, including as a priority goal *Ageing well, ageing productively* under the national priority of *Promoting and maintaining good health* (DEST 2002).

As part of this, Australia's peak research bodies, the National Health and Medical Research Council and the Australian Research Council, funded the Ageing Well Research Network in 2004 for 5 years (ARC/NHMRC Research Network in Ageing Well 2005; NHMRC 2004), and in June 2005, called for expressions of interest in the Ageing Well, Ageing Productively Research Program (up to $10 million is available over 5 years).

Improving the process of translating research evidence into policy and practice is one of the priorities of the Building Ageing Research Capacity project. Funded through the Office for an Ageing Australia and implemented jointly with the AIHW, this project aims to facilitate collaboration and coordination between Australian researchers and policy makers on ageing issues. Its activities have included developing a framework for an Australian ageing research agenda and implementing an interactive web-based directory of ageing-related research projects, courses of study and research grants (<www.aro.gov.au>).

Chapter outline

This chapter discusses the characteristics of Australia's older population and the care and services that they receive. The chapter has a primary focus on those aged 65 years and over, the age from which people can access the Age Pension. Other age groups are also sometimes relevant in discussions about ageing. For example, workers aged 45 and over—mature age workers—are the focus of research and policy designed to retain older workers in the labour force. Where relevant and useful, the chapter also includes data on age groups younger than 65.

Section 4.2 provides an overview of demographic changes resulting in population ageing. A focus on the problems caused by population ageing can result in a failure to appreciate that the majority of older Australians enjoy good health and lead active lives, making valuable contributions to the welfare of their communities. This section also reports on the health and disability levels of older Australians and on their contributions as volunteers and carers of people with disabilities.

There is also a risk that the debate about population ageing can encourage a view that all older people have the same needs for health and aged care. It is not possible here to examine the full diversity of the ageing experience. The chapter does, however, disaggregate data by age group wherever possible, revealing large differences between the 'younger' old and the very old in their health and disability status (Section 4.2) and use of aged care services (Sections 4.4 and 4.5).

Older people are eligible for, and make use of, a range of benefits and services that are available to the general population, such as housing (see Chapter 6), hospital care, medical care and pharmaceuticals (see AIHW 2004a). However, certain types of income support and care services are either targeted to, or primarily used by, older people. Section 4.3 provides an overview of the support and services available to older people. It should be noted that the population aged 65 years and over is not used by government as a planning or funding tool for the majority of the programs discussed, and that younger people can and do access these services. The use of services by younger disabled people is examined in Chapter 5.

Sections 4.4 to 4.7 present data on national aged care services and assistance, the clients of these services and the expenditure involved by both government and service users. Section 4.8 discusses outcomes for older people in relation to aged care services, and a brief summary follows in Section 4.9. Regionally-limited services (state, territory or local government) are not included in the chapter. Information on aged care services within states and territories can be found in the annual *Report on Government Services* (SCRCSSP 2005).

Presenting the picture

The analysis presented in this chapter draws on a number of data sources to present a picture of older people's welfare. New data sources used in this edition include the ABS Survey of Disability, Ageing and Carers conducted in 2003, and data from the Aged Care Assessment Program MDS version 2.0. Extensive use is made of data collections that are now well-established, notably on the residential aged care program and the Home and Community Care MDS version 1.0 which provides a comprehensive account of HACC clients and service use.

Reflecting the policy development activity in aged care, a number of recent national data development activities have occurred that will allow improved analysis of the aged care sector in the future (Box 4.1).

4.2 Ageing in Australia

As discussed in the last edition of *Australia's Welfare* (AIHW 2003a:279–82), the Australian population is ageing numerically in that the number of older people is increasing, and structurally in that the proportion of people who are aged at least 65 years is rising.

Population structure and change

On 30 June 2004, people aged 65 years and over represented 13% of Australia's total population, or 2.6 million people (ABS 2004b; Table 4.1). Fifty-three per cent were aged 65–74 years, 36% were aged 75–84, and a significant minority—over 298,000 people—were aged 85 and over (11%). Fifty-five per cent of older people (65+) were women. As age increases, this predominance becomes progressively more evident and by age 85 and over, there were more than twice as many women as men. In absolute numbers, in June 2004 there were 274,000 more women than men aged 65 and over in Australia.

In the 20 years to 2024, the number of people aged 65 and over is expected to increase by 92%, from 2.6 million to almost 5.0 million, and comprise 20% of the population by that time. This compares with a rise of 66% (or an increase of 1 million people) in the 20 years from 1984 when older people accounted for 10% of the population (ABS 2004b). The number of people aged 85 and over, among whom we find those most likely to be in need of services and assistance, is projected to expand more rapidly than other age groups: from 298,300 in 2004 to 725,300 in 2024, an increase of 143%. In addition, as a proportion of the total population, the number of people aged 85 and over is projected to rise from 1.5% in 2004 to 2.9% in 2024.

Box 4.1: Data development in aged care services

*The **ACAP Minimum Data Set version 2.0** was implemented progressively from 1 April 2003. By 30 June 2004 this version of the MDS was in use in all areas of Australia except Queensland and some parts of New South Wales.*

*An evaluation of the Home and Community Care Minimum Data Set version 1.0 (HACC MDS version 1.0) was concluded in 2003 (Alt Beatty Consulting & Australian Institute for Primary Care 2003). The HACC Data Reform Working Group examined a range of possible amendments based on the evaluation results. Its recommendations have been accepted by HACC Officials and are reflected in the **HACC MDS version 2.0** to be implemented from 1 January 2006. In version 2.0, information about the care recipient and their carer is recorded on the same client record. New data elements include those specifically related to the care recipient's need for assistance or dependency status, dates of entry into and exit from HACC service episodes and a range of carer characteristics. A new HACC MDS User Guide incorporating the HACC Data Dictionary and Guidelines to the HACC MDS is being developed.*

***HACC service standards:** Part of the HACC evaluation process included reporting on 'options for the future direction of managing compliance to the HACC Standards' (Australian Healthcare Associates 2005:6). Key recommendations included ensuring that in the future the process is nationally consistent, shifting the focus from compliance to quality improvement, and revising the National Service Standards Instrument to make it easier to use. There was general support, both from service providers and government, for a service standards appraisal program using an improved NSSI (Australian Healthcare Associates 2005:8–14, 46).*

*The **National Respite for Carers Program Minimum Data Set** has been developed. Analysis and assessment of initial data is currently being undertaken.*

*In 2003 and 2004, the need for a **national minimum data set for community-based palliative care** was examined (AIHW 2004e), and the resulting recommendations led to the decision to develop a national Data Set Specification. Final specifications are expected to be endorsed in 2006. At this stage, there is no commitment to implement a national data collection based on these specifications. Over the same period, performance indicators for palliative care were developed, with four indicators being endorsed by the Palliative Care Intergovernmental Forum. A trial national collection of data from regions and agencies to support the calculation of these four performance indicators was held in the second half of 2005.*

People born overseas

Past migration patterns have a significant impact on the mix of backgrounds found among the older population. On 30 June 2003, of people aged 65 and over, 518,100 (20% of older Australians) were originally from mainly non-English-speaking countries, 336,700 (13%) were from the main English-speaking countries and 1,691,600 (66%) were born in Australia (ABS 2005c).

Table 4.1: Persons aged 65 years and over, 30 June 2004[(a)] and 30 June 2024[(b)]

Age	Males	Females	Persons	Males	Females	Persons
2004		**Number**			**Per cent of people 65+**	
65–69	367,800	377,400	745,200	31.6	26.2	28.6
70–74	300,200	325,900	626,100	25.8	22.6	24.0
75–79	247,100	301,800	548,800	21.2	21.0	21.1
80–84	155,500	230,900	386,400	13.3	16.0	14.8
85+	94,800	203,500	298,300	8.1	14.1	11.5
Total	**1,165,500**	**1,439,400**	**2,604,900**	**100.0**	**100.0**	**100.0**
				Per cent of population aged 65+		
Total population	**9,994,500**	**10,116,800**	**20,111,300**	**11.7**	**14.2**	**13.0**
2024				**Per cent of people 65+**		
65–69	678,300	711,900	1,390,200	29.0	26.8	27.8
70–74	587,000	631,600	1,218,600	25.1	23.7	24.4
75–79	482,700	529,200	1,012,000	20.7	19.9	20.3
80–84	299,700	350,800	650,500	12.8	13.2	13.0
85+	289,500	435,800	725,300	12.4	16.4	14.5
Total	**2,337,300**	**2,659,300**	**4,996,600**	**100.0**	**100.0**	**100.0**
				Per cent of population aged 65+		
Total population	**12,257,500**	**12,413,300**	**24,670,800**	**19.1**	**21.4**	**20.3**

(a) Estimated resident population.

(b) Projected.

Note: Components may not add to total due to rounding.

Sources: ABS 2003b: series 8, 2004b.

A higher proportion of overseas-born Australians in 2003 were aged 65 or over compared with the rest of the population: 19% from mainly non-English-speaking countries and 18% from the main English-speaking countries compared with 11% of the Australian-born population. Much of this difference results from the under-representation of children among migrants: for people aged 45 and over, around 50% were aged 65 and over in all three birthplace groups. The age profile of older people from the non-English-speaking countries was younger than that of people from the main English-speaking countries and those born in Australia: only 7% of older people born in non-English-speaking countries were aged 85 or over, compared with 11% from the main English-speaking countries and 12% of those born in Australia (ABS 2005c).

As well as having a different age structure, Australians born overseas have a different mix of the sexes. In 2003, a relatively high proportion of older people born overseas were males: 49% from non-English-speaking countries and 47% born in English-speaking countries, compared with 43% of those born in Australian. This pattern was particularly noticeable for the 65–74 age group, among whom men outnumbered women among overseas-born people but not among those born in Australia. The ratio of women to men increased with age in both the overseas-born and Australian-born older populations (ABS 2005c).

The older population (65+) born in non-English-speaking countries is projected to increase more quickly and age more rapidly than the older Australian-born population (AIHW: Gibson et al. 2001). This more rapid ageing reflects both the waves of postwar immigration and the concentrated age profile of migrants, with large numbers of those from non-English-speaking countries now moving into the older age groups. In the 15 years between 1996 and 2011, the older population born in non-English-speaking countries is projected to increase by approximately 66%, compared with an increase of 23% among the older Australian-born population. In particular, the proportion of older people who are aged 80 or over is projected to grow faster among those born in non-English-speaking countries than among people born in Australia. Consequently, the proportion of people aged 80 and over who are from non-English-speaking countries is projected to increase from 13% to 22% (AIHW: Rowland & Karmel 2004). These changes will not be uniform across all countries of birth, with some communities expanding rapidly and others contracting, depending on the timing and strength of migration waves. The ageing of the older population born in non-English-speaking countries will impact considerably on service provision, both because people from different backgrounds prefer different types of services (see Section 4.6) and because people tend to revert to their mother tongue in their later years.

Aboriginal and Torres Strait Islander people

Indigenous Australians have a shorter life expectancy than other Australians. For the period 1996–2001, life expectancy at birth was 59.4 years for Indigenous men and 64.8 years for Indigenous women. In contrast, life expectancy at birth for all Australians was about 17 years longer (76.6 years for men and 82 years for women for the period 1998–2000) (ABS & AIHW 2005; also see Table 2.8 in Chapter 2).

Because of their different life expectancies, the age distributions of Indigenous and non-Indigenous Australians are quite different (see Figure 3.2). People aged 65 years and over were a relatively small proportion of all Indigenous Australians in 2004, accounting for just 2.8% of the population, compared with 13% for all Australians (ABS 2004b, 2004c). Aboriginal and Torres Strait Islander people aged 50 and over (51,700 people) accounted for 11% of Australia's total Indigenous population; among all Australians this age group made up 30% of the population.

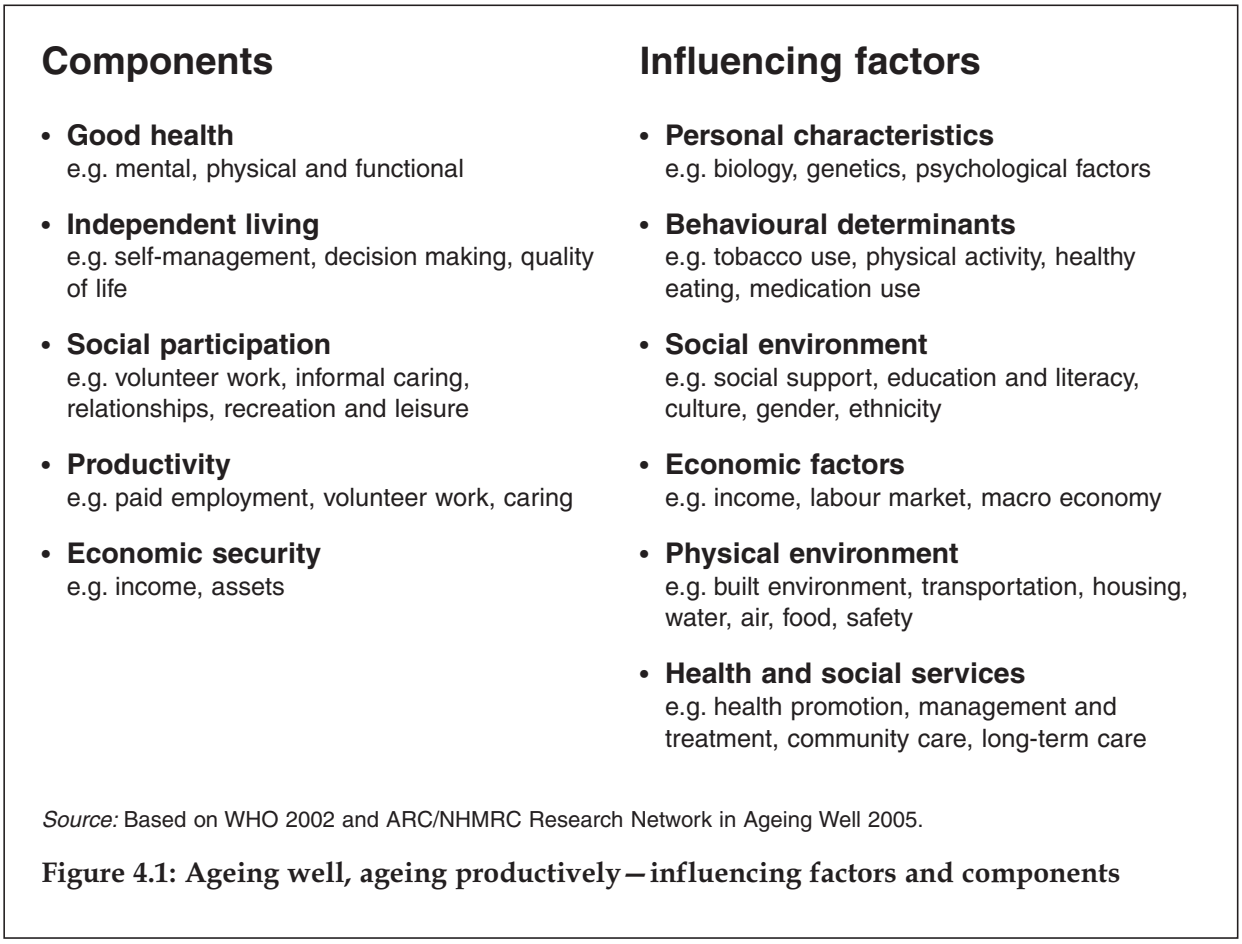
Of Indigenous Australians aged 50 and over, 74% were aged 50–64 years, 18% were aged 65–74 years, and 8% were aged 75 and over; 53% were women. The predominance of women becomes more evident as age increases, reaching a ratio of approximately three women for every two men in the oldest age group (75+). In absolute numbers, in June 2004 there were 3,000 more Indigenous women than Indigenous men aged 50 and over in Australia (ABS 2004c).

Like the total Australian population, the structure of the Aboriginal and Torres Strait Islander population is ageing but at a much slower pace than that of the general population. On 30 June 1996, 10% of the Indigenous population were aged 50 or over. By 2009, this group is expected to have increased to 12% (ABS 2004c).

Ageing well, ageing productively

The aim of the priority goal *Ageing well, ageing productively* research initiative is to reduce the risk of disease and disability, to maintain mental and physical function, and

to encourage active engagement with families, local communities and the broader society as people age. The ability of individuals and populations to age well and age productively is influenced by many factors. Figure 4.1 is a simple representation of some of the components of ageing well and productively, and the broad factors that influence them, together with some brief examples.



Source: Based on WHO 2002 and ARC/NHMRC Research Network in Ageing Well 2005.

Figure 4.1: Ageing well, ageing productively—influencing factors and components

Maintaining and improving good physical and mental health and functioning are central to notions of 'ageing well'. These are necessary conditions for older people to continue living independently in the community with relatively low demands on formal care and health systems. They also enhance the capacity of older people to remain productive as they age by being actively involved in their community, for example, through voluntary work, the provision of care to others or through paid employment activities.

A number of factors clearly influence older people's ability to maintain good health and to participate in their community. These include sufficient income, adequate and safe housing, and a physical environment which facilitates independence and mobility (see Chapter 2 for a discussion of these). Older people's own behaviour in respect of health risks and their individual social and genetic characteristics are also important influences on their health status. It is worth noting that these factors are not only pertinent to the ageing process, but also contribute to a person's experience of health and socioeconomic

participation throughout their lives. The impact of these factors through an individual's younger life may continue to affect their experience of ageing.

Ageing well

Health

Falling death rates in each of the age groups 65–74, 75–84, and 85 years and over are strong evidence that the health of older Australians has been improving. Much of the reduction has been due to large falls in death rates for cardiovascular diseases, attributed mainly to improvements in health behaviours and medical care. Death rates have also declined for cancer, with marked falls among smoking-related causes in men. This falling mortality has contributed to increasing life expectancy for older Australians. At age 65, men can expect to live for a further 17 years and women for 20 years. In addition, Australians experience about 90% of their life span in good health, without illness or disability. Australian males can expect to live for about 71 years without reduced functioning and Australian females about 74 years (AIHW 2004a).

Many older people have a positive view of their health even though older age is generally associated with increasing levels of disability and illness. Self-assessed health status is used as an indicator of general health and wellbeing, and has been found to be a strong indicator of future mortality (Idler & Benjamini 1997). By far the majority of older Australians consider themselves to be in good, very good or excellent health, although the proportion of older men and women reporting fair or poor health increases with age (Table 4.2). This pattern is similar to that observed in 1995 and 2001 (ABS 2002).

Table 4.2: Self-assessed health status of older Australians, 2002

Self-assessed health status[(a)]	Males			Females		
	55–64	65–74	75+	55–64	65–74	75+
Excellent/ very good	44.2	36.2	29.0	48.7	32.8	28.2
Good	30.3	31.3	34.7	27.9	33.3	32.3
Fair/ poor	25.5	32.5	36.3	23.5	33.9	39.5
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) The person's general assessment of their own health against a five point scale from excellent through to poor.

Note: Components may not add to total due to rounding.

Source: ABS 2003a.

Healthy behaviour

Healthy behaviour is an important determinant of health and is usually measured by behavioural risk factors that put an individual at increased risk of experiencing disease. Some risk factors have an accumulative effect over the life course and risk factor behaviour in middle age can lead to poorer health in later life. There is, however, potential for health gain at all stages of life through appropriate management of these risk behaviours in addition to early prevention. The prevalence of major preventable risk behaviours that can lead to ill-health in older Australians is shown in Table 4.3.

Table 4.3: Prevalence of risk behaviours among older Australians, 2001 (per cent within age group)

	Males			Females		
Risk behaviour	**55–64**	**65–74**	**75+**	**55–64**	**65–74**	**75+**
Smoking[a]	21.7	12.4	7.4	15.8	9.4	4.8
Obesity[b]	17.8	14.6	8.9	21.8	20.1	10.5
Physical inactivity[c]	34.9	30.9	44.0	31.2	38.8	55.9
Poor diet						
Low fruit consumption[d]	46.9	39.6	38.1	29.4	30.8	31.7
Low vegetable consumption[e]	68.0	66.5	63.9	57.3	60.0	61.3
Usually add salt to food[f]	38.6	40.5	39.8	23.9	22.1	27.5
Risky alcohol consumption[g]	15.1	9.1	4.6	8.5	7.0	4.7

(a) Current regular (daily) smoker or current smoker not regular.

(b) A body mass index of 30 kg/m2 or more.

(c) Sedentary (exercise score less than 100, including no exercise) during previous 2 weeks. The exercise score was based on frequency, intensity and duration of exercise (for recreation, sport or fitness).

(d) Usual daily intake of 1 serve or less. Dietary guidelines recommend at least 2 serves of fruit per day (NHMRC 2003).

(e) Usual daily intake of 3 serves or less. Dietary guidelines recommend at least 5 serves of vegetables per day (NHMRC 2003).

(f) Dietary guidelines recommend choosing foods low in salt and using salt sparingly (NHMRC 2003).

(g) Based on the NHMRC risk levels for harm in the long term (NHMRC 2001).

Note: Estimates are based on self-reported data. Individuals may be engaged in more than one type of behaviour.

Source: ABS 2002.

Smoking levels have declined generally in Australia, but particularly among older Australians (ABS 2002). The lower rates among older Australians are likely to reflect a greater prevalence of smoking cessation in older age groups and greater mortality among smokers than non-smokers (AIHW 2004a). Smoking rates remain higher among older men than older women. Smoking is a major risk factor for coronary heart disease, stroke, peripheral vascular disease, cancer, chronic obstructive pulmonary diseases and a variety of other diseases and conditions. There is evidence that smoking cessation can have a substantial effect on subsequent mortality (Anthonisen et al. 2005).

Obesity rates in Australia have increased substantially over recent years, including for older Australians. Based on self-reported data, which are likely to underestimate the true prevalence, by 2001 obesity rates had reached 15% for men and 20% for women, aged 65–74. The likely health consequences for older Australians of increased body fatness are premature death from life-threatening diseases and debilitating conditions that impair quality of life (WHO 2000). This has implications for health care costs, for carers and their wellbeing, and for aged care services (AIHW: Bennett et al. 2004).

There has been little change in exercise levels among older Australians (AIHW 2004a). Physical inactivity is relatively more common in older age groups, perhaps reflecting reduced functioning and increased rates of disability in older age. Physical activity at all ages can help reduce the likelihood of obesity, and delay functional decline and the onset of chronic disease. It can also reduce the severity of disability associated with chronic diseases, improve mental health, promote social contacts, prolong independent living and reduce the risk of falls (Bauman & Smith 2000; WHO 2002).

Despite general concerns about the contribution of over-eating to the rising prevalence of obesity, many older Australians are not consuming adequate amounts of fruit and vegetables. Older men are more likely than older women to report low fruit intake and, to a lesser degree, low vegetable intake. For men, both low fruit intake and low vegetable intake are less common in older age groups. This is not the case for women. The prevalence of older Australians who reported that they usually add salt to food varied little by age but was higher among men than women.

The prevalence of alcohol consumption at levels that pose a risk to health in the longer term is lower in older age groups and less than 5% in Australians aged 75 years or older. Alcohol in sufficient levels over time increases the risk of developing some cancers, cirrhosis of the liver, alcohol dependence, cognitive problems, dementia, and sexual difficulties in men. Although there is evidence that low levels of alcohol may protect against heart disease and some types of stroke, heavy drinking has no additional benefits for heart disease and increases the risk of stroke. Although older people tend to drink less than people do in their younger or middle years, it remains an important part of social life that often expands in retirement. However, as people age their tolerance for alcohol tends to decrease; they are more likely to take medication, which may interact with alcohol; falls become a greater risk which is further increased with intoxication; and driving ability, which may be influenced by the effects of ageing, can be further impaired (NHMRC 2001).

Ageing and disability

Key factors affecting the ability of many people to take part in the daily activities of life—from workforce participation to independent living—include illness or injury and the related level of disability which arises. While many older Australians are free from a disability for which they require assistance, a proportion have more intensive care and assistance needs.

In 2003, the ABS conducted the fifth Survey of Disability, Ageing and Carers. This survey provides, among other things, information on the prevalence of disability in the Australian population, people's need for assistance, and the assistance they received (for more details about the survey, see Chapter 5 and Technical Appendix of this publication; ABS 2004a). The survey covered people in both private and non-private dwellings, including those in cared-accommodation establishments but excluding those in gaols and correctional institutions. Data from this survey were released in 2004, and are used in the following discussion.

In 2003, over half of all people aged 65 years and over (56% or 1.4 million) had at least one form of disability (see Tables 5.1; A5.2). While almost all older people with a disabling condition also reported a limitation or restriction in at least one of 10 specific and non-specific types of activities (see Table A5.2), having a disability does not necessarily imply a need for assistance. For example, while a person may have reduced mobility they may not require assistance undertaking the activities of daily living. Core activity limitation—which relates to difficulty or need for assistance with self-care, mobility or communication—provides a more useful indicator of the level of difficulty experienced or help needed in performing activities basic to living. Core activity limitations, as recorded in the 2003 survey, range from profound or severe, where assistance is always or sometimes needed, to moderate or mild, where assistance is not

required but difficulty in performing core activities may be experienced or aids and equipment may be used. The group of older people most likely to be in need of assistance from aged care programs providing relatively high levels of care are those with a profound or severe limitation. Therefore, the following discussion focuses on this group.

In 2003, almost one-quarter (23%) of older people (560,900) reported a profound or severe core activity limitation (Table 5.1). The rates of such limitation were quite low until age 75, remaining under 15%. The rates then rose markedly with age, increasing from 20% among people aged 75–79 to 58% among the very old (85+) (see Figure 5.3). Overall, a higher percentage of women (27%) than men (17%) had a profound or severe core activity limitation, and this was true for all age groups over 65.

Aids and equipments used by people with a disability to assist them with tasks can influence the level of impairment, limitation or restriction experienced. In addition, the use of equipment has been suggested as being more efficacious in the management of disability than personal assistance (see AIHW: Bricknell 2003: ch. 3 for literature review). In 2003, 923,400 people aged 65 or over with a disability reported using one or more aids. Overall, these people used over 2.4 million aids—an average of 2.6 aids per individual. This compares with an average number of between 1.4 and 1.7 aids used by people with a disability in younger age groups (see Table 5.9). The length of time that a person lives with a disability also affects their overall quality of life; age at onset of disability is discussed in Chapter 5.

Respondents to the 2003 Survey of Disability, Ageing and Carers provided detailed information on their health conditions, allowing the relationship between health conditions and level of disability to be examined. It should be noted that the survey relied on self-reporting by people or their carers to identify their health conditions. Self-identification of conditions in the absence of clinical assessment can result in mis-reporting, particularly in mild or moderate cases. Thus the estimated association between a condition and the experience of profound or severe core activity limitation may be biased for some conditions.

Overall, 87% of people aged 65 and over reported a long-term health condition, with many reporting more than one. The five most commonly reported conditions were hypertension (37%), arthritis and related disorders (36%), hearing disorders (29%), heart diseases (18%) and back problems (16%) (AIHW analysis of ABS 2003 SDAC data). Other health conditions affecting more than 10% of the older population were diabetes, high cholesterol and stroke.

Some conditions are more likely than others to be associated with profound or severe core activity limitation. Ninety-eight per cent of people reported with dementia and Alzheimer's disease had this level of limitation. Severe or profound disability was also high among people with paralysis (89% of older sufferers), problems with speech (87%), Parkinson's disease (79%), and schizophrenia (76%) (see Table A5.7).

The combination of the prevalence of a health condition and the extent of disability among those with the condition determines the overall burden of a disease on the population. Consequently, the prevalence of a certain condition among people with a profound or severe core activity limitation can be used to look broadly at the burden

that the particular disease places on the community. Twenty-three per cent of the older population had a profound or severe limitation. Among this older population, arthritis was the most commonly occurring health condition, affecting 50% of these people. Hearing disorders (43%), hypertension (38%), heart diseases (30%) and stroke (23%) were also commonly reported conditions among older people with a profound or severe disability. For all of these conditions, fewer than 50% of older sufferers had profound or severe core activity limitation, but the high prevalence of the condition in the older population generally—ranging from 10% of the older population having suffered from stroke to 37% with hypertension—leads to considerable burden on the community.

In contrast, although dementia and Alzheimer's disease together were reported by only 4% of the older population, 17% of older people with a profound or severe core activity limitation had this condition. Similarly 3% of older people reported speech problems, and 12% of older people with a profound or severe limitation had such problems. Detailed work on the burden of disease, which takes into account which condition is the main cause of disability, is currently being carried out by the AIHW and will be released within the next 12 months.

Ageing productively

Older people are actively involved in Australian society in a number of ways, making important contributions to the family, community and economy. Since the late 1990s there have been a number of policy initiatives aimed at giving people greater choices in their working lives before final retirement from the paid workforce. Some of these encourage older people to remain in the workforce while others remove the retiree/worker dichotomy, thereby taking away the necessity to choose between being either in or out of the workforce. Early initiatives aimed at supporting older people who would like to remain in the workforce at least part-time were the Pension Bonus Scheme (introduced on 1 July 1998) and the Senior Australians' Tax Offset (from July 2001) (see Box 4.4).

Since 2004, there have been several further changes that support older people in the workforce. In particular, the *Age Discrimination Act 2004* prohibits discrimination on the basis of age in key areas of public life, including employment. Other policy initiatives have included:

- The mature age worker tax offset (from 1 July 2004), which rewards workers aged 55 years or more who stay in the workforce by providing a tax offset of up to $500 a year, with the final value of the offset depending on the person's net income from working.
- The transition to retirement policy (from 1 July 2005) which gives older employees greater flexibility in arranging their working lives before final retirement by allowing people who have reached their preservation age to access their superannuation through a non-commutable income stream while continuing in the workforce. Previously, people had to retire completely from the workforce to access their superannuation benefits.
- Changes to job search requirements for job seekers aged over 50 years and the introduction of a new employment service, Employment Preparation, for mature age job seekers on income support (announced in the 2005 Budget).

In May 2005, 42% of people aged 60–64 and 7% of those aged 65 and over were in the workforce (ABS 2005b: table 1.2). The corresponding figures for December 2002 were 38% and 6% (AIHW 2003a:286).

Two other areas where older people make valuable contributions are through organised volunteer work and the provision of care to family and friends.

Older people as volunteers

Many Australians, including older people, provide support to the wider community by voluntary work through organisations. In the 2002 General Social Survey, voluntary work was defined as the provision of unpaid help—in the form of time, service or skills—through an organisation or group in the last 12 months. Around 32% of people aged 65–74 years and 24% of people aged 75 and over undertook voluntary work in 2002 (Table 4.4). This represents 634,000 people aged 65 and over.

These rates of volunteering are higher than equivalent estimates from the 2000 Survey of Voluntary Work: 30% for people aged 65–74 and 18% for those 75 years and over. Although the gap between the two surveys was less than 2 years, the General Social Survey results suggest a growing trend in volunteering that has been noticeable in older Australians since the mid-1990s; for example, from 24% in 1995 to 33% in 2000 for people aged 55–64 years (ABS 2001). Similarly, rates increased from 23% to 30% for people aged 65–74.

Table 4.4: Volunteering among older Australians, 2002

	Age group			Age group		
	55–64	65–74	75+	55–64	65–74	75+
	Number ('000)			Per cent within age group		
Males	347.2	175.0	100.0	36.5	28.3	24.6
Females	368.7	235.2	123.7	39.5	35.5	22.3
Total	**715.9**	**410.2**	**223.7**	**38.0**	**32.0**	**23.6**
Main types of voluntary work						
Sport/recreation/hobby	188.4	85.9	37.9	10.0	6.7	4.0
Welfare/community	310.9	232.0	117.6	16.5	18.1	12.4
Health	54.6	51.3	27.5	2.9	4.0	2.9
Education/training/youth development	75.4	25.6	22.8	4.0	2.0	2.4
Religious	201.6	128.2	81.5	10.7	10.0	8.6

Note: Estimates are based on self-reported data. Individuals may be engaged in more than one type of voluntary work.
Source: ABS 2003a.

The rates of volunteering differed little between men and women overall. On the other hand, they varied with age, with higher rates during middle age and lower rates among the older age groups. However, the median number of hours of voluntary work was highest in the 65–74 age group (2.5 hours per week in 2000) (ABS 2001).

Older Australians were most likely to volunteer to assist welfare and community organisations, and religious organisations. While volunteering to assist sport-, recreation- or hobby-related organisations also featured among people aged 65 years and over, rates were not as high as among younger Australians.

Older people as carers

Many older people provide care for family and friends who need assistance in their daily lives. They supply a substantial amount of informal care for children, and in almost 23,000 families, children are being raised by grandparents (see Chapter 3). In addition, older people play an active role in the community as carers of their ageing spouse. A number continue to provide care for adult children with disabilities, a role that a lot of them have been undertaking for many years.

In 2003, nearly 454,000 people aged 65 years and over provided assistance to people with a disability (ABS 2004a: table 27). Around one-quarter of these care providers (113,200) were a primary carer, that is, they provided the most assistance—in terms of help or supervision—to the care recipient. Overall, people aged 65 and over accounted for 24% of primary carers of people with a disability (Table 4.5).

Nearly one-fifth (17%) of older carers were aged at least 80. As with all primary carers in 2003, older carers were predominantly women. However, this preponderance was greater in the younger than older age groups: in 2003, 63% of primary carers aged 65–74 were female compared with just (50%) of carers aged 80 and over.

Table 4.5: Older primary carers (aged 65+), 2003

Age	Males	Females	Persons
		Number ('000)	
65–69	11.3	22.7	33.9
70–74	11.6	16.0	27.6
75–79	15.5	17.3	32.8
80–84	*8.1	*8.3	16.4
85+	**1.3	**1.2	*2.5
Total 65+	**47.7**	**65.4**	**113.2**
All primary carers	**135.4**	**337.1**	**472.5**
		Per cent	
65–69	23.6	34.6	30.0
70–74	24.3	24.4	24.4
75–79	32.5	26.4	28.9
80–84	*16.9	*12.7	14.5
85+	**2.7	**1.9	*2.2
Total 65+	**100.0**	**100.0**	**100.0**
		Carer rate within age–sex population (%)	
65–69	3.3	6.4	4.8
70–74	3.9	4.9	4.4
75–79	6.7	5.9	6.2
80–84	*5.5	*3.8	4.5
85+	**1.4	**0.6	*0.9
Total 65+	**4.3**	**4.7**	**4.5**

Notes

1. Table excludes people living in remote and sparsely settled parts of Australia.
2. Components may not add to total due to rounding.

Source: AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers confidentialised unit record file.

Overall, 4.5% of those aged 65 years and over were primary carers and this proportion increased with age, reaching a peak in the 75–79 age group among whom 6% were primary carers. By age 85 years few people were the primary carers of others (under 1%). Estimates suggest that while women aged 65–74 had higher carer rates than men of a similar age, the reverse was true for people aged 75 and over.

Primary carers aged 65 and over mainly care for their partner, and this is particularly true for men: in 2003, 92% of male carers compared with 76% of female carers (ABS 2004a: table 30). As a consequence, older carers generally lived with the care recipient. However, while 99% of older people caring for their partner lived in the same household as their partner, among those caring for another relative or friend around 40% were not co-resident with the care recipient. Around 9,000 older people were primary carers for people who were neither their partner, child nor parent.

4.3 Support and care for older people

In Australian society, support and care for older people are provided by the government in two ways: through income assistance to ensure financial security, and through the provision of services to people needing care and to those caring for their family and friends.l

Policy and program development

The last 2 years have been a period of considerable activity in relation to aged care policy (Box 4.2). The Review of Pricing Arrangements in Residential Aged Care examined current and alternative funding arrangements and long-term financing options for residential aged care (Hogan 2004). It made 20 recommendations to improve arrangements in the short to medium term, covering planning, place allocations, aged care assessment, funding supplements, workforce development and expansion, industry accountability and consumer financial contributions. The review also proposed six longer-term options for government consideration. A consultation process to progress this phase will commence in 2005–06 (DoHA 2005b).

The Australian Government's response to the review's recommendations has largely been put into effect through budget measures announced in 2004 and 2005 (Bishop 2004). The aged care provision ratio will increase from 100 to 108 operational places for every 1,000 persons aged 70 years and over, and the weighting for community care places within that ratio will double to 20 places (Community Aged Care Packages and Extended Aged Care at Home places combined). The allocation of places will be announced 3 years in advance with the intention that this will improve the ability of providers to plan for expansion.

In the 2004 Budget, the government announced that in 2006 the number of classification categories for basic subsidy funding in residential aged care would be reduced from eight to three and two supplements would be introduced covering dementia and nursing/palliative care to better target existing funding towards residents with high care needs. The new Aged Care Funding Instrument will replace the current Resident Classification Scale (RCS) and will focus on assessing resident care needs rather than care provided.

Box 4.2: Policy developments in aged care, 2003 to 2005

*On 5 April 2004, Professor Warren Hogan presented his **Final Report of the Review of Pricing Arrangements in Residential Aged Care** to the government, making 20 recommendations with respect to planning, assessment and funding systems, workforce training and user contribution arrangements (Hogan 2004).*

*The **2004 Budget** paper Investing in Aged Care: More Places, Better Care (Bishop 2004) outlined a range of initiatives in response to the review's recommendations, including:*

- *increased provision of places and funding supplements for special need care recipients such as those with dementia;*
- *from 1 July 2004, a new Medicare rebate was introduced for GPs to provide assessments for aged care residents. From the same date, the requirement to reassess residents moving between low and high care in the same facility was removed;*
- *a new taskforce to oversee delivery of budget initiatives designed to further protect residents' bonds (announced on 13 August 2004);*
- *improved training for the aged care workforce, including through the allocation of increased nursing places at universities; and*
- *a new program, the **Transition Care Program**, to provide support to older people immediately following a hospital stay, to allow them and their families time to assess their options for future care. The program will have up to 2,000 places to become operational over 3 years.*

*In 2004, the government released **A New Strategy for Community Care—The Way Forward** (DoHA 2004c). This strategy arose from the review of community care programs and is intended to ensure programs operate in a more consistent and coordinated way.*

*The 2005 Budget announced the creation of 2,000 new **dementia-specific Extended Aged Care at Home** places over the next 4 years. In addition, dementia was declared a National Health Priority in recognition of its impact among older people, and the growing number of people that will be affected as the population ages.*

From 1 July 2005, lump sum accommodation bonds paid by residents in aged care facilities are not included when applying the social security and Veterans' Affairs assets test. Also, an aged care resident who pays an accommodation bond wholly or partly by periodic payments can rent out their former home without the value of the home or the rental income affecting their rate of pension (DoHA 2005d).

*The **National Aged Care Workforce Strategy** was released in March 2005. It identifies the workforce profile of the residential aged care sector and its likely needs until 2010 (Aged Care Workforce Committee 2005).*

*A national trial of the new **Aged Care Funding Instrument** was conducted in all states and territories between May and October 2005 to test its usability by aged care providers and external assessors, including staff from Aged Care Assessment Teams in some states and territories (see DoHA 2005e).*

Community care programs are based on the premise that most people value being able to live in their own home, and the recognition that some older people and people with a disability may find this difficult without assistance. The growing complexity and diversity of the community care environment prompted the Community Care Review, begun in March 2003. The outcome of this review is outlined in *A New Strategy for Community Care – The Way Forward* (DoHA 2004c), which broadly describes the action that the Australian Government will take, in conjunction with state and territory governments, service providers and consumer representatives from the 2004–05 financial year. The aim is to improve coordination of community care through: addressing gaps and overlaps in service delivery; making services easier to access; enhancing service management; and streamlining Australian Government programs.

The Australian, state and territory governments met in 2004 to discuss the broad principles of the Community Care Review and, specifically, how they might apply to a new Home and Community Care Agreement. The most important issues were the development of consistent assessment processes and uniform reporting requirements across all similar programs, including standard approaches to financial reporting, quantity reporting (through a minimum data set) and quality reporting. The first 3-year reporting cycle for a combined quality reporting process for the Community Aged Care Packages and Extended Aged Care at Home programs and the National Respite for Carers Program began on 1 July 2005.

Improvement in the provision of care at the interface between aged care and other kinds of care, such as hospital care, is encouraged via funding of pilot services or projects through the Aged Care Innovative Pool (DoHA 2005f:16). This Pool allows the Australian Government, in partnership with other stakeholders, to allocate aged care places to services that will: provide aged care services in new ways; provide aged care services to client groups for whom current services are limited or to newly-emerging client groups; and provide aged care via new models of partnership and collaboration. Pilots that include services that are the responsibility of state or territory governments are jointly funded with those governments. At 30 June 2004, Innovative Pool projects had a total of 1,352 places available across five types of projects: Innovative Care Rehabilitation Services pilots (383 places); Intermittent Care Service pilots (396 places); Disability pilots (231 places); Dementia pilots (234 places); and High Needs pilots (107 places).

The interface between aged care and the acute/subacute care system has been recognised for some time as an important site for appropriate responses to older people's needs for rehabilitation, recovery and care needs assessment. Transition care is a new model of care located at this interface. Transition care is designed to provide care recipients who have completed their hospital episode with low-intensity therapy services and support to stabilise their care needs, optimise their independence and confidence, and give them time to decide on a suitable long-term care option. A new program based on these principles is currently being developed. The Transition Care Program will provide care in either a residential or community setting and will build upon the experiences of earlier initiatives under the Aged Care Innovative Pool, namely the Innovative Care Rehabilitation Service pilots and Intermittent Care Service pilots. The program will have up to 2,000 places for older people who are recovering after a stay in hospital under a cost-shared model with state and territory governments.

The 2004 and 2005 federal budgets also contained a number of measures designed to provide support for carers (Box 4.3).

Box 4.3: Policy initiatives affecting carers

In 2003, the Australian Government commissioned a study by the COTA National Seniors Partnership to examine the financial, legal and social issues facing grandparents who are raising grandchildren (COTA National Seniors 2003).

From 1 November 2004, grandparents with primary care of their grandchildren may be eligible to access Child Care Benefit for up to 50 hours per week through a waiver of the work, training and study test. Grandparent carers who also receive an income support payment may be eligible for the Grandparent Child Care Benefit which covers the full cost of approved child care (Centrelink 2004a).

In June 2004 Carer Payment recipients were given a one-off payment of $1,000, and Carer Allowance recipients were given a one-off payment of $600 as part of the 2004 budget process (Treasury 2004:1). Similar one-off payments were included in the 2005 Budget.

From 1 September 2004, eligibility for the Carer Allowance was extended to carers who do not live with the people for whom they provide substantial levels of personal care in a home on a daily basis (at least 20 hours per week).

From 1 April 2005, the number of hours a week that a carer can work, train or study without losing eligibility for Carer Payment was increased from 20 to 25.

In the 2004 Budget, older carers were specifically targeted with the provision of up to 4 weeks a year respite for parents over 70 years of age who are caring for a son or daughter with a disability, and parents aged between 65 and 69 years who need to be hospitalised will be entitled to up to 2 weeks respite a year (to be cost-shared with state and territory governments) (Treasury 2004).

Income support

Australians today are living longer, and so spending longer in retirement, than those in preceding generations. Income security during these years is important if older people are to be able to participate in society as much as they can.

Pensions

Currently, the majority of older people are on publicly-funded income support (Box 4.4). The Age Pension and payments from the Department of Veterans' Affairs (DVA) are the two main sources of income support for older people. At the end of 2004, nearly 1,888,000 people were receiving either a full or part Age Pension and 363,700 were receiving DVA payments (Table 4.6). As a result, 80% of people aged 65 and over—and 63% of Australians aged 60 and over—received either the Age Pension (full and part pensions) or a DVA payment. The proportion of people receiving payments from either of these sources increased with age, ranging from 70% for 65–69 year olds to 88% of people aged 80–84. For both pension types, nearly 60% of pensioners were women.

Older people may also be eligible for the Senior Australians' Tax Offset. Had this offset not existed, it is estimated that the Australian Taxation Office would have collected an additional $1,630 million in tax in the 2003–04 financial year (Treasury 2005:54). For 2002–03, the latest year for which figures are available, the ATO recorded that 599,201 people who lodged tax returns received the tax offset (ATO 2005b:19).

The Pension Bonus Scheme provides an incentive for older Australians to defer claiming income support—that is, the Age Pension—and instead remain in the workforce. In June 2004, among those over Age Pension age who were working, 32% received some Age Pension while they worked and another 17% were registered in the Pension Bonus Scheme. As at 30 June 2004, 67,975 people were registered in the scheme, and during 2003–04 a total of $88 million was paid in bonuses to 7,416 people—an average of $11,868 per recipient (Centrelink unpublished data).

Table 4.6: Age and DVA pension recipients, December 2004/ January 2005

	Age group							
	[a]60–64	65–69	70–74	75–79	80–84	85–89	90+	Total
				Per cent of Age pensioners[b]				
Males	—	12.6	12.1	9.5	3.8	1.7	0.9	40.7
Females	6.7	14.6	13.0	10.3	7.3	4.5	2.9	59.3
Persons	**6.7**	**27.3**	**25.1**	**19.8**	**11.1**	**6.2**	**3.8**	**100.0**
Persons (number)	*126,289*	*515,176*	*474,472*	*374,648*	*209,453*	*117,008*	*70,940*	*1,887,986*
Per cent of age group population[c]	*13.7*	*68.0*	*75.9*	*68.2*	*53.2*	*61.1*	. .	*[d]66.9*
				Per cent of DVA pensioners[b]				
Males	2.6	2.1	2.2	7.3	18.6	7.1	1.6	41.4
Females	2.3	3.0	6.4	17.1	19.1	7.8	2.7	58.6
Persons	**5.0**	**5.1**	**8.6**	**24.4**	**37.8**	**14.9**	**4.3**	**100.0**
Persons (number)	*18,006*	*18,541*	*31,414*	*88,618*	*137,297*	*54,258*	*15,518*	*363,652*
Per cent of age group population[c]	*1.9*	*2.4*	*5.0*	*16.1*	*34.9*	*22.7*	. .	*[d]13.1*
Total as % of age group population[c]	**15.6**	**70.4**	**80.9**	**84.3**	**88.1**	**83.8**	. .	**[d]80.0**

(a) Eligibility for Age Pension in December 2004 was 62.5 years for women and 65 years for men.

(b) Age Pensions administered by DVA are included in the 'DVA pensioner' figures. Some of these pensioners were also in receipt of DVA payments. After allowing for people who received payments from more than one source, these added 2,676 to the DVA pensioner numbers (aged 60+).

(c) Age and DVA pension recipients aged 85–89 and 90+ have been combined to enable the percentage of age group to be calculated.

(d) As per cent of people aged 65+.

Notes

1. 37 DVA cases with unknown age have been excluded.
2. Table includes full and part pensioners.
3. DVA pensioners include any person in receipt of a Service Pension, Disability Pension, War Widow Pension or Orphan Pension.
4. Age pensioners as at December 2004; DVA pensioners as at 7 January 2005; population as at 31 December 2004 (preliminary estimates).
5. Components may not add to total due to rounding.

Sources: ABS 2005a; Centrelink unpublished data; DVA unpublished data.

Box 4.4: Income support

Age Pension: *The Age Pension is assets- and income- tested, and in December 2004 was available to men aged 65 years and over and women aged 62.5 years and over. The qualification age for women, which was 60 years until 1 July 1995, has been gradually increasing and will be raised to age 65 by 2014. The maximum single base rate of pension is set to at least 25% of male total average weekly earnings. Each member of a couple receives approximately 83% of the single rate of pension. The maximum single rate is adjusted every 6 months in line with the consumer price index. At the end of 2004, a single person on the maximum rate Age Pension received $235.35 per week, and a couple $393 per week. Age pensioners may also be entitled to a range of additional payments and benefits, depending on their circumstances, including the Pharmaceutical Allowance, Rent Assistance, Telephone Allowance, Remote Area Allowance, Utilities Allowance and a Pension Concession Card entitling the holder to reduced cost medicines as well as a range of state and local government concessions (Centrelink 2004d; private correspondence with FaCS).*

DVA pension and benefits: *The Service Pension is paid to veterans, eligible partners, widows and widowers. It is similar to the Age Pension, being paid at the same rate and subject to income and assets tests. In general, it is available 5 years earlier than the Age Pension; however, it may be granted at an earlier age to partners and in cases of invalidity. There are also forms of compensation available from DVA which are neither taxable nor subject to means testing. These include the war widow(er)'s pension, disability compensation, and ancillary benefits. Depending on their age, family circumstances and income and assets, people on the war widow(er)'s pension may also be eligible for the income support supplement (ISS). Allowances payable in association with the Service Pension and ISS include a pharmaceutical allowance, rent assistance, telephone allowance, annual utilities allowance and remote area allowance (DVA 2005).*

Senior Australians' Tax Offset: *Regardless of the source of their income, older Australians of Age Pension age are entitled to the income-tested Senior Australians' Tax Offset. The effect of the offset is to increase the non-taxable income threshold so that individuals who earn below $20,500 per year and couples who earn a combined amount of less than $33,612 per year do not pay income tax. As income rises, the amount of the tax offset is reduced by 12.5 cents per dollar earned above the tax-free income levels. In addition, people eligible for the tax offset pay no Medicare levy if their income is below $20,500 (ATO 2005a).*

Pension Bonus Scheme: *The Pension Bonus Scheme was introduced on 1 July 1998 to provide an incentive for older Australians to defer claiming the Age Pension and instead remain in the workforce. The scheme is voluntary and provides a tax-free lump sum to eligible scheme members who defer taking the Age Pension and continue to work at least 960 hours each year for a minimum of 1 year. Bonuses can be accrued for up to a maximum of 5 years, and cannot be accrued after age 75. The scheme pays a once-only, tax-free lump sum to registered members when they finally claim and receive the Age Pension. The amount of pension bonus is based on a multiple of the registrant's annual rate of Age Pension payable when the pension is granted. At the end of 2004, the maximum bonus payable to a person on the Age Pension varied between $1,150 and $28,760 for a single person and from $961 to $24,012 each for a person with a partner, depending on the number of bonus years the person had accrued. For those entitled to a part-pension, the bonus is reduced proportionately (Centrelink 2004c).*

Income support for older carers

In addition to general income support, depending on their circumstances, older people who are carers may be able to access two government payments: the Carer Payment and the Carer Allowance. People receiving these payments may be caring for more than one person (see Tables A4.1, A4.2).

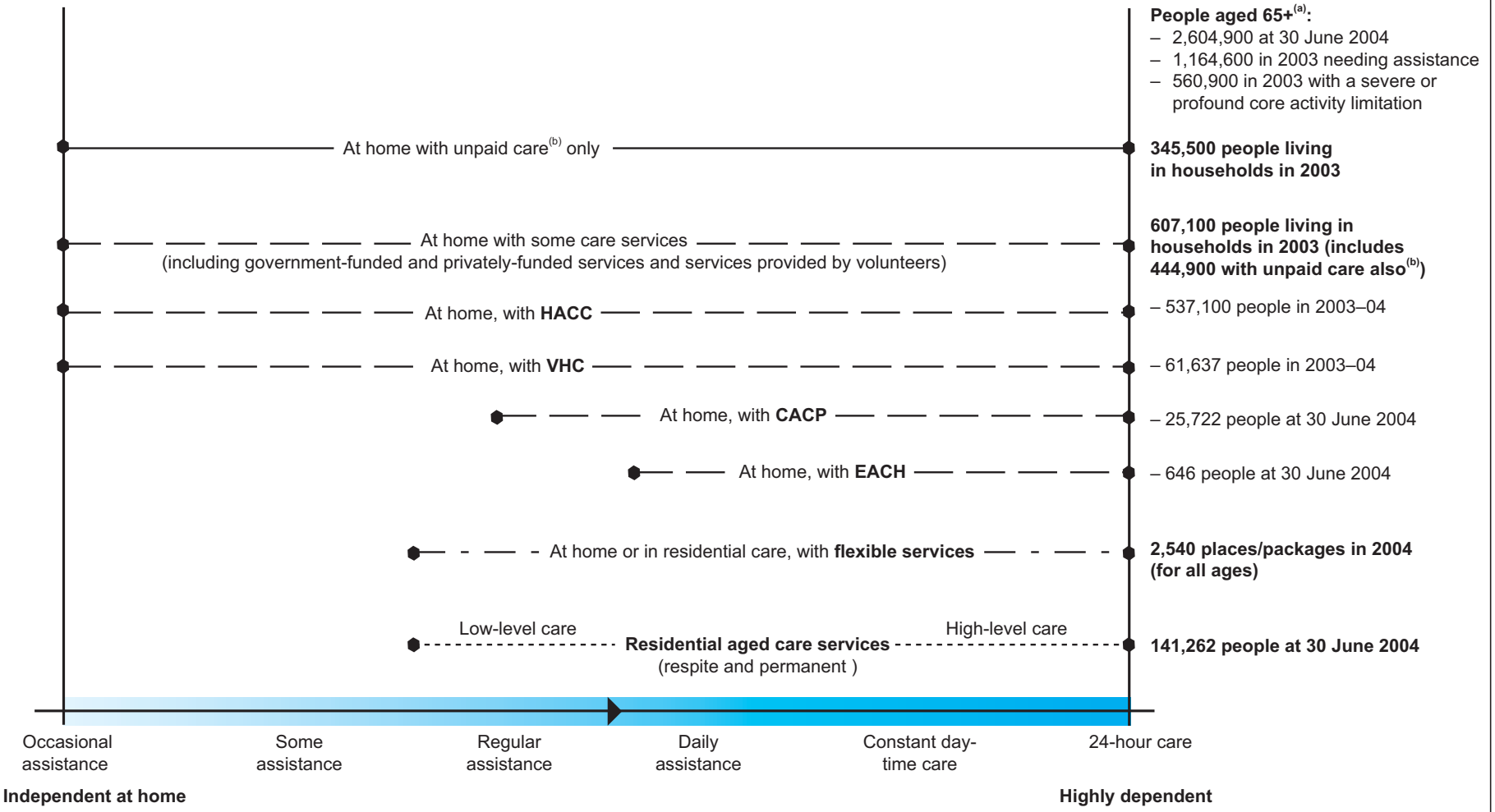
The Carer Payment is an income support benefit payable to people who, because of their caring responsibilities, are unable to support themselves (see Box 5.7). It is set at the same rate as the Age Pension and is subject to the same income and assets tests. Because it is for people forgoing paid work due to caring responsibilities, relatively few older people receive it. At the end of 2004, a total of 91,024 people were receiving the Carer Payment (see Table A4.1). People aged 65 and over accounted for just over 3% (2,863) of all recipients. A large majority (85%) of these older recipients were aged 65–74, and just over one-half were female.

The Carer Allowance is payable to carers who provide full-time daily care at home to people who need substantial amounts of care because of a disability or a severe medical condition or because they are frail older people (see Box 5.7). The allowance can be paid to carers whether or not they are in receipt of a government pension or benefit and is not income- or assets-tested. Since 1 April 2005, some non-co-resident carers have also been eligible for this allowance (see Box 4.3). It is adjusted on 1 January each year, and in 2005 was set at $92.40 per fortnight (Centrelink 2004b). In December 2004, 324,030 people were receiving the Carer Allowance (see Table A4.1). The majority (56%, or 66,610) of recipients looking after people aged 65 and over were themselves aged at least 65, while just 6% (12,696) of recipients caring for younger people were aged 65 and over. Older allowance recipients were more likely to be men than younger recipients: 40% compared with 18%for recipients aged under 65.

Care for older people

While many older people manage on their own at home, or with help from relatives and friends, others rely on a range of care services or a combination of services and informal help (Figure 4.2). In some cases, without these services people would not be able to remain living in the community, but would need to move into residential care.

There is evidence that in recent years there has been a shift in the mix of formal and informal care services that people access. In 1998 nearly 347,000 people aged 65 and over were living at home using only informal care services (that is, unpaid care), and 507,000 were living at home accessing formal care services. Seventy-two per cent of this second group were also assisted by unpaid carers (AIHW 2003a:294). By 2003, despite population growth, there had been virtually no change in the number of older people at home with only unpaid care (345,500), while the number using formal care services had increased by 20% to 607,100. Again, nearly three-quarters of those with formal care also had unpaid carers (73%). Over the same period, the number of people aged 65 and over grew by 10% while the number of older people with a severe or profound limitation grew by 17% (see Table 5.1; ABS 1999) These figures suggest that the use of formal care services increased in line with the number of people with a severe or profound core activity limitation. At the same time, relatively fewer people were remaining at home with only unpaid care.



(a) Due to data availability, numbers refer to different time periods.

(b) Excluding payments from government pensions and benefits.

Note: Figure includes selected government-funded programs only. Some services can be used concurrently. Hospital services are not included.

Sources: Tables 4.1, 4.7, 4.19, A5.1; AIHW analysis of ABS SDAC data; AIHW analysis of DoHA ACCMIS database.

Figure 4.2: Range of care arrangements for older people[a]

There are three main national programs which provide care to people living in their own homes: Home and Community Care, Community Aged Care Packages, and Veterans' Home Care and associated programs such as DVA nursing. A fourth program—the Extended Aged Care at Home Program—is still quite new and therefore provides services to a relatively small number of people. In addition, there are a number of smaller programs which also support people and their carers, including the National Respite for Carers Program. When people can no longer remain at home, either in the short term due to a temporary change in care needs, or for the longer term, they may access residential aged care services. States and territories may also provide a range of services independently of the Australian Government.

Care needs

A person's care needs and their personal resources (both social and economic) influence whether and how they access care. The assistance needed varies from person to person depending on the type and severity of the disability being experienced. In 2003, 47% of people aged 65 years or over (1,164,600 persons) reported needing assistance with at least one personal activity (for example, self-care or health care) or other daily activities (for example, paperwork, housework or meal preparation). People often required assistance in more than one area—on average, with three to four activities (Table 4.7).

Table 4.7: Need for assistance, 2003

	65–69	70–74	75–79	80–84	85–89	90+	Total	No. ('000)
Personal activities[a]				**Per cent within age group**				
Self-care	6.1	8.4	12.2	21.2	34.7	58.0	14.3	356.2
Mobility	7.2	11.6	17.8	31.1	46.6	69.4	19.3	482.9
Communication	1.7	2.2	3.4	8.7	17.1	34.2	5.6	139.9
Cognition or emotion	5.1	5.9	9.2	17.0	29.5	46.4	11.3	282.0
Health care	10.0	18.3	24.5	40.3	53.7	72.5	25.2	629.8
Total for personal activities[b]	*15.9*	*23.2*	*29.9*	*46.9*	*60.0*	*79.9*	*30.9*	*772.5*
Other activities								
Paperwork	3.7	5.4	10.8	19.1	34.9	49.3	11.9	298.5
Transport	8.6	15.8	22.6	33.4	43.3	36.7	20.7	516.5
Housework	9.7	15.1	20.5	30.0	34.6	29.8	18.9	473.2
Property maintenance	16.2	23.8	31.6	37.2	39.5	35.3	26.9	672.3
Meal preparation	2.2	4.2	7.8	10.6	18.2	15.5	6.8	170.3
Total for any activity[b]	**26.7**	**38.2**	**49.6**	**65.5**	**79.2**	**94.8**	**46.6**	**1,164.6**
Assistance not needed	**73.3**	**61.8**	**50.4**	**34.5**	**20.8**	***5.2**	**53.4**	**1,334.2**
Number ('000)	**701.6**	**622.0**	**525.2**	**366.3**	**191.5**	**92.1**	**. .**	**2,498.7**

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

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

Note: Table includes people living in both private and non-private dwellings.

Source: Derived from ABS 2004a: Table 21.

Overall, 31% of all older Australians needed assistance with personal activities. Health care was the most common area of personal need for all age groups, with 25% needing help in this area; this was followed by need for assistance with mobility (19%), self-care

(14%), and cognition or emotion (11%). At 6%, assistance with communication was required the least. Twenty-seven per cent of older Australians needed help with property maintenance, with other common areas of need including transport (21%) and housework (19%).

The proportion of older people needing assistance with at least one activity increased with age, rising from 27% among those aged 65–69 to 95% among those aged 90 or over. This pattern held generally for all activities examined, although a drop in need for assistance was observed among the very old for all the non-personal activities looked at, except paperwork.

Sources of care

The group of older people who could be considered as most in need of assistance are those with a profound or severe core activity limitation in the areas of self-care, mobility or communication. Informal care networks of family, friends and neighbours provided much of the help received by this group of older people living in the community in 2003 (Table 4.8). Over one-third relied solely on social networks, and 62% on a combination of both formal and informal care providers. Only 3% received only formal care assistance.

Table 4.8: Source of assistance received by people aged 65 years and older with profound or severe limitations living in households, 2003

	Source					
Assistance needed	**None**	**Informal only**	**Formal only**	**Informal and formal**	**Total needing assistance**	
Core activity		**Per cent**				**No. ('000)**
Self-care	9.6	64.3	9.8	16.2	100.0	207.9
Mobility	7.7	67.8	5.7	18.8	100.0	339.8
Communication	**2.5	91.5	**1.6	**4.4	100.0	35.7
Total core activity[(a)]	*7.4*	*65.2*	*6.7*	*20.7*	*100.0*	*400.5*
Other activity (in addition to core activity)						
Cognition or emotion	*4.1	73.2	*3.0	19.7	100.0	107.2
Health care	4.7	36.9	33.6	24.8	100.0	286.3
Housework	*2.7	53.7	19.4	24.1	100.0	281.9
Property maintenance	3.5	59.1	19.5	17.8	100.0	291.5
Paperwork	*3.2	90.8	*2.5	*3.5	100.0	129.5
Meal preparation	*2.8	74.4	10.9	11.9	100.0	146.9
Transport	5.5	79.3	4.6	10.6	100.0	298.3
Total with core activity limitation and limitation in another activity[(b)]	*1.2*	*33.2*	*5.0*	*60.5*	*100.0*	*383.7*
Total with core activity limitation and perhaps limitation in another activity	**1.3	**33.7**	**3.2**	**61.8**	**100.0**	**400.5**

(a) Includes people who need help sometimes or always with at least one core activity. As people may have different sources of care for different activities, these percentages are not simply the average of the percentages for the individual activities.

(b) Includes people who need help with one or more non-core activities and who sometimes or always need help with at least one core activity. As people may have different sources of care for different activities, the percentages are not simply the average of the percentages for the individual activities.

Note: Components may not add to total due to rounding.

Source: AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers confidentialised unit record file.

Assistance with communication (92%) and paperwork (91%) were most often provided through social networks alone, along with transport (79%) and meal preparation (74%). Such informal assistance was least likely to be the source of help with health care (37%), which was more likely than other types of assistance to be obtained only through formal providers (34%) (including government organisations, private agencies funded through government programs and privately purchased services). For most activities, 10–25% of those needing and receiving assistance were getting help from both formal and informal sources.

Unmet need for care

Unmet need occurs when a person receives insufficient or no assistance with activities when help is required. Figures on receipt of assistance show that relatively large numbers of older people with a profound or severe core activity limitation living in households reported receiving no assistance. Overall, 7% of such people reported receiving no assistance with these core activities. Between 3% and 6% of those needing assistance with another activity as well as a core activity had no assistance with that other activity. Within particular care needs, 10% of those needing assistance with self-care received no help; other needs which had relatively high levels of unmet need were mobility (8%) and transport (5.5%) (Table 4.8).

These figures do not tell the full story as having a source of assistance does not imply that a person's needs are fully met: a person's need for assistance in one or more areas may still only be partially met. Also, people with care needs do not all have a severe or profound core activity limitation. Looking at the broader population, among all people aged 60 years or over who were living in households in 2003 and who needed some assistance, either with core activities or other activities, 64.5% (788,100 out of 1,221,500 people) had all their needs fully met and 29.7% (363,400) had their needs partly met; 5.7% (70,000) reported that none of their needs were met, even partially. The areas with the highest proportions of older people reporting that their need for assistance was completely unmet were transport (11%) and self care (10%) (ABS 2004a: Table 22).

The above figures give an indication of the level of unmet need in 2003. If the provision of help by either informal or formal care providers changes relative to the number of people requiring assistance, then the level of unmet need will also change. Analysis of the likely availability of primary carers over the next few years indicates that, on the basis of demographic changes alone, the ratio of primary carers to persons with a severe or profound core activity limitation is expected to fall— by an estimated 7% between 1998 and 2013 (AIHW 2004b:xiv, 41–3). This is despite a projected 27% increase in the absolute number of primary carers (AIHW 2003a:108). A general decline in propensity to become a carer, due to other social or economic factors, will aggravate this situation. For highly dependent people, reduced assistance from family and friends (especially co-resident carers) will place increased demands on formal care services to provide assistance that enables the person to remain in their own home. For people with relatively few care needs, lower availability of informal care may result in their accessing formal care services earlier than is currently the case.

Accessing aged care services

While access to most community care services can be gained directly through providers, there are two key programs which provide information on available services and which assist people in accessing residential and community care: the Commonwealth Carelink Centres and the Aged Care Assessment Program.

Commonwealth Carelink Centres

To help people find appropriate services, in 2001 the Australian Government set up a network of Commonwealth Carelink Centres. These centres provide a single point of contact for obtaining comprehensive information on community aged care, residential care, and disability and other support services available in any region within Australia. The centres are operated by a wide range of organisations, including not-for-profit and for-profit non-government organisations, and government agencies, with a total of 65 shopfronts and over 90 access points such as free phones in rural and remote localities (Centrelink 2005). During 2004–05, the centres had 235,000 contacts, including phone calls, visits, emails and facsimiles, up from almost 200,000 the year before (DoHA unpublished data; SCRCSSP 2005: table 12A.59).

Aged Care Assessment Program

The Aged Care Assessment Program (ACAP) funds Aged Care Assessment Teams (ACATs) across Australia. These teams play a crucial role in the aged care system as they determine eligibility for Community Aged Care Packages, Extended Aged Care at Home places, and residential aged care. They also function as a source of advice and referral concerning Home and Community Care services but do not determine eligibility for these services.

Implementation of the revised ACAP minimum data set (MDS v2.0), begun in April 2003, has improved the information available on assessments undertaken, on the people seeking assessment and the resulting ACAT recommendations. While recommendations are valid for up to 12 months, people may have multiple assessments in a year if their situation changes; data from the last assessment in the financial year were used in the following analysis. Data on assessments undertaken in Queensland and some parts of New South Wales (for about one-third of clients) were not available in the MDS v2.0 format, and are therefore not included in the analysis.[1]

In 2003–04, 158,988 people had 176,955 assessments completed by an ACAT, an average of 1.1 per client over the year. Close to 95% of clients were aged 65 and over (see Table 4.19). The proportion of the population having an assessment during the year increased substantially with age, from 14 per 1,000 people aged 65–74 up to 220 per 1,000 aged 85 and over (see Table 4.22). When compared with the number of people with a severe or profound core activity limitation, for every 1,000 people aged 65 and over with such a limitation 261 had an assessment some time during the year (Table A4.5).

1. Data for this analysis were provided by the Lincoln Centre for Ageing and Community Care Research (Lincoln Centre).

Up until 30 June 2004, all aged care residents needed an assessment in order to change from low care to high care (or vice versa). Consequently, at the time of assessment, although nearly three-quarters of ACAP clients aged 65 and over were living in a private residence, 13% were in institutional settings, predominantly residential aged care (Table 4.9). Of those still living in the community, 37% were already receiving services through Home and Community Care (HACC) and 10% through Community Aged Care Packages (CACPs) (Table 4.10). Smaller numbers were getting help through Veterans' Home Care, Extended Aged Care at Home (EACH) places and other programs. Thirty-five per cent of those assessed while still living at home were not receiving any assistance through government programs at the time of their assessment.

Table 4.9: ACAP clients: accommodation at assessment and as recommended, [(a)] 2003–04 (per cent)

	Usual accommodation at assessment			Recommended long-term care setting at assessment		
	<65	65+	Total	<65	65+	Total
Community setting						
Private residence	76.1	74.0	74.1	51.5	43.3	43.7
Independent living within a retirement village	1.1	6.9	6.6	1.1	2.9	2.8
Supported community accommodation	5.5	1.6	1.8	5.3	0.9	1.1
Other	9.4	4.3	4.6	2.8	0.8	0.9
Total	*92.1*	*86.8*	*87.0*	*60.8*	*47.9*	*48.5*
Institutional setting						
Residential aged care service—low-level care	4.4	11.5	11.2	13.9	22.1	21.7
Residential aged care service—high-level care	1.5	1.1	1.1	24.0	29.5	29.2
Hospital	0.8	0.3	0.3	0.4	0.4	0.4
Other institutional care	1.2	0.3	0.4	0.9	0.1	0.1
Total	*7.8*	*13.2*	*13.0*	*39.2*	*52.1*	*51.5*
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**5,117**	**97,257**	**102,374**	**5,264**	**99,750**	**105,014**

(a) Qld and some parts of NSW have not yet adopted the MDS v2 format for reporting data on usual accommodation setting; 51,974 clients assessed in these regions are therefore not included in this table.

Notes

1. Table excludes cases with missing, unknown or inadequately described information on accommodation setting: 4,592 cases at assessment (including all assessments in the ACT), and 1,952 recommendations; 48 cases with missing age are also excluded.
2. Components may not add to total due to rounding.

Source: Lincoln Centre and AIHW analysis of ACAP MDS v2.

Permanent residential aged care was recommended for over half of older ACAP clients (52%), mostly for high care (Table 4.9). Among those with recommendations to stay living in the community, HACC services were recommended for 40% and a CACP or EACH place was recommended for 40% (Table 4.10). No continuing program support was recommended for a relatively small number of people (15%).

Table 4.10: ACAP clients: community program support at assessment and as recommended,[(a)] 2003–04 (per cent)

	Program support at time of assessment received by clients living in the community			Program support recommended at assessment for clients with a recommendation to live in the community		
	<65	65+	Total	<65	65+	Total
CACP	6.0	9.8	9.6	26.3	36.9	36.3
EACH	0.7	0.4	0.4	2.8	1.9	2.0
HACC	33.8	36.5	36.4	37.5	39.6	39.5
Veterans' Home Care	0.4	6.5	6.2	0.5	7.5	7.0
Day Therapy Centre	2.3	2.4	2.3	4.1	4.7	4.6
National Respite for Carers Program	5.7	4.3	4.4	16.5	17.0	17.0
Other	13.0	6.2	6.6	13.2	7.7	8.0
None	39.3	35.1	35.3	21.7	15.1	15.5
Total (number)	**4,552**	**82,209**	**86,761**	**3,040**	**45,716**	**48,756**

(a) Qld and some parts of NSW have not yet adopted the MDS v2 format for reporting data on program support; 51,974 clients assessed in these regions are therefore not included in this table.

Notes

1. 'At time of assessment' figures exclude clients living permanently in residential aged care, hospitals or other institutional settings. 'Recommended at assessment' figures exclude clients recommended to living permanently in residential aged care or other institutional settings.
2. Table excludes cases with missing, unknown or inadequately described information on program support: 2,325 cases at assessment, and 2,187 recommendations.
3. As clients can receive assistance from/be recommended for more than one program, percentages do not sum to 100.

Source: Lincoln Centre and AIHW analysis of ACAP MDS v2.

Among older people living at home at the time of assessment, over two-thirds were receiving help in the areas of domestic assistance, meals and transport, with around half receiving assistance with health-care tasks, home maintenance and self-care; only 8% were not already getting some kind of assistance (Table 4.11). For many activities, the assistance was provided most commonly by unpaid carers. The exceptions to this were self-care, health-care tasks and domestic assistance: for these three activities the majority of assistance was provided either by paid helpers or through a combination of paid and unpaid carers.

For the clients with an ACAT recommendation to live in the community, domestic assistance was the most commonly recommended formal assistance (recommended for 68% of older clients). Recommendations for between 35% and 45% of clients were also made for formal assistance with meals, transport, social activities, health-care tasks and self-care. Around 11% received no recommendation for formal assistance with particular tasks. At 5%, communication was the activity least likely to get a recommendation for formal assistance, followed by movement activities (8%).

In addition to continuing program support, ACATs may recommend respite care. Among people assessed in 2003–04, a large majority of those living in the community at the time of assessment had not used respite care in the previous 12 months (82% of older clients).

In contrast, respite care was recommended for 69% of clients aged 65 and over with a recommendation to live in the community (Lincoln Centre unpublished data). Most of the respite recommendations involved residential respite care, with non-residential respite care alone being recommended for a small number of clients (2%); both residential and non-residential respite care were recommended for 12%.

Table 4.11: Older ACAP clients (65+): assistance with activities,[(a)(b)] 2003–04 (per cent)

	Source of assistance for clients living in the community						Formal assistance recommended for clients with a recommendation to live in the community
Assistance	Formal	Informal	Both	Not stated	Total	All	
Self-care	39.6	42.2	13.1	5.0	100.0	46.4	36.2
Movement activities	20.5	62.1	11.3	6.1	100.0	17.6	7.6
Moving around places at or away from home	13.0	70.9	11.1	5.0	100.0	38.2	20.5
Communication	10.9	73.4	10.9	4.8	100.0	12.5	4.6
Health-care tasks	35.1	48.5	12.0	4.4	100.0	55.4	38.5
Transport	13.1	69.3	13.5	4.1	100.0	70.3	44.4
Activities involved in social and community participation	16.9	64.9	13.8	4.4	100.0	55.1	42.4
Domestic assistance	40.0	41.7	13.9	4.4	100.0	82.6	68.5
Meals	29.1	57.8	8.9	4.3	100.0	71.1	44.7
Home maintenance	23.5	64.9	7.3	4.3	100.0	53.7	33.3
Other	37.6	48.8	3.5	10.1	100.0	4.0	7.5
None	. .	. .	. .	. .	. .	7.5	11.1
Total (number)	**. .**	**. .**	**. .**	**. .**	**. .**	**77,875**	**44,260**

(a) Qld and some parts of NSW have not yet adopted the MDS v2 format for reporting data on assistance; 51,974 clients assessed in these regions are therefore not included in this table.

(b) Formal assistance involves payment for services; informal assistance is unpaid.

Notes

1. 'Source of assistance for clients living in the community' figures exclude clients living permanently in residential aged care, hospitals or other institutional settings. 'Clients with a recommendation to live in the community' figures exclude clients recommended to living permanently in residential aged care or other institutional settings.
2. Table excludes cases with missing or inadequately described data on assistance: 5,955 cases at assessment and 2,122 recommendations, as recorded on MDS v2.
3. Components may not add to total due to rounding.

Source: Lincoln Centre and AIHW analysis of ACAP MDS v2.

4.4 Use of community care

In general, aged care programs are targeted at frail or disabled older people with care needs related to activities of daily living (personal care, mobility and communication), and their carers. The following discussion examines the use of services from the main community care programs by all people aged 65 years and over. It also examines the services provided relative to the number of people defined in the 2003 ABS Survey of

Disability, Ageing and Carers as having a severe or profound core activity restriction—the categories of people identified by the survey as sometimes or always needing assistance with core activities of daily living (see Technical Appendix).

Home and Community Care

The bulk of home- and community-based services for older people are provided under the auspices of the HACC program. While it is important to recognise that the HACC target population is people of all ages requiring assistance due to disability and/or frailty (and their carers), older people account for the great majority of clients. During the 12 months between 1 July 2003 and 30 June 2004, at least 707,000 clients received services through HACC (see Table 4.19). Of these, just over three-quarters (76%, or 537,100) were aged 65 years or more. Information on services provided to people aged under 65 with a disability are discussed in Chapter 5.

The aim of the program is to enhance the independence of people and avoid premature or inappropriate admission to long-term residential care. The program is jointly funded by the Australian (60%) and state and territory governments (40%); clients can be asked to contribute to the cost of services provided.

An ACAT assessment is not a prerequisite to accessing the program. However, many clients assessed by ACATs are recommended for HACC services, which include home nursing services, delivered meals, home help and home maintenance services, transport and shopping assistance, allied health services, home- and centre-based respite care, and advice and assistance of various kinds. HACC also provides brokered or coordinated care for some clients, through community options or linkages projects.

The HACC program commenced in 1985, and since then both the quantity and variety of service types have increased substantially, as has government expenditure (see Table 4.24 and AIHW 2001:243). As at 30 June 2003, there were around 3,100 service providers across the country who were part of this program, and throughout 2003–04 approximately 3,500 organisations provided HACC-funded services (DoHA 2004b:4, 13). In the following discussion, data from the HACC minimum data set quarterly collections—begun in January 2001—are used to describe the services provided. Not all agencies participate in the collection, and, as for 2002–03, it is estimated that 83% of funded service providers submitted data for 2003–04. Using these data, the demographic profile of service users, and the services they received, are examined.

Patterns of service use (HACC)

During 2003–04, among every 1,000 people aged 65 years and over in the population at least 210 used HACC services (see Table A4.5). In general, people are increasingly more likely to access these services as they get older, with at least 100 per 1,000 people aged 65–74 doing so in 2003–04, compared with at least 480 per 1,000 aged 85 and over (see Table 4.22). For every 1,000 people aged 65 and over with a severe or profound core activity limitation there were at least 930 who used HACC services at some time during the year.[2]

In 2003–04, assessment and associated services were the service types reported for the largest number of older HACC clients (44%) (Table 4.12). Other services commonly reported were assistance with domestic chores (31% of older clients), and meals, nursing and transport services (all around 20%). Centre-based day care and personal

care were used by around 10% of older HACC clients, while respite care was reported for 1%. Based on reported service use, during 2003–04 older HACC clients used an average of 2.1 of the service groups listed in the table.

Table 4.12: Services received by Home and Community Care clients, 2003–04

	<65	65–74	75–84	85+	Total 65+
	Per cent of clients within age group				
Assessment, case management and case planning/review[(a)]	40.1	42.2	43.9	45.0	43.6
Domestic assistance	19.8	26.9	31.5	33.6	30.7
Meals (at home and/or at a centre)[(a)]	11.1	15.9	22.7	28.4	22.4
Nursing (home and/or centre-based)[(a)]	24.6	20.5	19.7	23.8	20.9
Transport services	13.3	15.7	17.7	16.5	17.0
Allied health (at home and/or at a centre)[(a)]	14.0	19.0	15.3	14.4	16.0
Home maintenance	8.5	15.3	16.1	13.6	15.1
Counselling and/or social support[(a)]	18.9	14.4	14.4	15.5	14.8
Centre-based day care	11.5	10.7	10.6	11.2	10.8
Personal care	7.1	6.5	8.1	12.7	8.8
Goods and equipment[(a)]	4.4	5.3	5.2	5.5	5.3
Home modification	2.1	3.5	3.5	3.3	3.4
Respite care[(b)]	6.5	1.6	0.8	0.5	1.0
Other food services	0.5	0.3	0.4	0.5	0.4
Linen services	0.3	0.2	0.2	0.2	0.2
Average number of services per client	**1.8**	**2.0**	**2.1**	**2.2**	**2.1**
Total clients (number)	**170,100**	**139,200**	**257,600**	**140,300**	**537,100**

(a) Service type includes more than one service category.

(b) For respite care, the carer is considered the HACC client. Anecdotal evidence indicates that the provision of respite care may be under-reported.

Notes

1. Age is as at 30 June 2004. Age was missing (date of birth reported as 1 January 1900 or 1901 (see AIHW: Karmel 2005)) or greater than 110 for 3,243 clients. These clients are assumed to be aged 65 and over, and have been pro-rated accordingly.
2. Not all HACC agencies submitted data to the HACC MDS. For 2003–04, the proportion of HACC-funded agencies that submitted HACC MDS data differed across jurisdictions, and ranged from 77% to 99%. Actual client numbers will therefore be higher than those reported here. Because of this incomplete coverage, and because of cases with missing age, numbers have been rounded to the nearest 100.

Source: AIHW analysis of the HACC MDS.

Overall, the average number of services used by clients increased with age, from 1.8 services for clients aged under 65 to 2.2 for those aged 85 and over. However, use did not increase with age for all service types. While older clients were more likely than younger clients to receive services involving assessment and associated services, domestic assistance, nursing, transport and personal care, for most other services there

2. Note that this is a ratio of clients to potential users and not a usage rate, as disability status is not available in the HACC MDS and not all HACC clients will necessarily have a profound or severe core activity restriction as defined by the ABS.

was no strong relationship between age and service provision. In contrast, use of respite services declined with age, from almost 7% of clients aged under 65 to 1.6% of those aged 65–74 and 0.5% of clients aged 85 and over.

Table 4.13: Volume of services received by Home and Community Care clients, 2003–04

		65–74	75–84	85+	Total 65+	Total 65+	<65
Time-based services		**Column per cent**				**Volume ('000)**	**Per cent**
Centre-based day care	Care hours	40.4	42.1	40.3	41.1	8,161.7	32.2
Domestic assistance	Care hours	24.4	26.6	25.4	25.7	5,096.6	16.7
Personal care	Care hours	10.2	9.4	13.7	10.8	2,144.3	18.1
Nursing (home and/or centre-based)	Care hours	8.5	8.6	9.8	8.9	1,769.1	6.5
Assessment, case management and/or case planning/review	Care hours	5.6	5.6	5.5	5.5	1,102.0	5.4
Home maintenance	Care hours	3.2	3.2	2.4	3.0	593.6	2.0
Allied health (at home and/or at a centre)	Care hours	2.5	1.9	1.5	2.0	387.9	2.4
Respite care	Care hours	3.8	1.5	0.6	1.9	370.5	14.4
Counselling and/or social support	Care hours	1.2	0.8	0.6	0.8	168.5	1.8
Other food services	Care hours	0.3	0.3	0.4	0.3	65.5	0.5
Total	**Care hours**	**100.0**	**100.0**	**100.0**	**100.0**	**. .**	**100.0**
Total volume (row % and '000)	**Care hours**	**24.4**	**46.4**	**29.2**	**100.0**	**19,859.5**	**8,521.9**
Unit-based services			**Row per cent**			**Volume ('000)**	
Meals (at home and/or at a centre)	Number	14.9	47.1	38.0	100.0	10,297.1	1,410.2
Linen services	Deliveries	26.1	43.1	30.8	100.0	18.0	9.9
Transport	One-way trips	22.1	49.5	28.4	100.0	3,196.4	932.5
Goods and equipment	Number	39.0	46.8	14.3	100.0	16.6	5.2
Home modification	$	30.6	45.7	23.8	100.0	4,643.6	2,574.2

Notes

1. Age is as at 30 June 2004. Age was missing or greater than 110 for 3,243 clients. These clients are assumed to be aged 65 and over, and are included in the Total 65+.
2. Not all HACC agencies submitted data to the HACC MDS. For 2003–04, the proportion of HACC-funded agencies that submitted HACC MDS data differed across jurisdictions, and ranged from 77% to 99%. Actual volume will therefore be greater than reported here.
3. Components may not add to total due to rounding.

Source: AIHW analysis of the HACC MDS.

HACC provided 19.9 million hours of service to older clients during 2003–04 (Table 4.13). Because some services by their very nature take longer to deliver than others, higher use of one service than another by clients does not necessarily translate into greater numbers of service hours. For example, while only 11% of older HACC clients used centre-based day care, the time involved in providing a single instance of this service meant that it accounted for the greatest number of hours of service: 8.2 million hours, or 41% of hours of timed services. The next most time-consuming service was domestic assistance which used 26% of total hours of service, with personal care and

nursing accounting for around 10% of service hours each. The distribution of volume of service provision was very similar among the three older age groups examined, with a slightly higher percentage of hours of service to very old clients (aged 85+) being used for personal care and fewer being expended on respite care compared with younger clients. The distribution of service hours was quite different for clients aged under 65.

In addition to hour-based services, over the year older HACC clients received between them a total of 10.3 million meals, and went on 3.2 million one-way trips. In addition, just over $4.6 million was used to fund home modifications. Formal linen services were rarely provided to HACC clients, with only 0.2% of older HACC clients (920 people) using this service. Consequently, in 2003–04 only 18,000 deliveries were made by HACC providers.

Veterans' Home Care and in-home respite for veterans

Begun in January 2001, Veterans' Home Care (VHC) is similar in purpose and content to the HACC program, and is designed to help veterans, war widows and widowers with low-level care needs to enjoy a healthier lifestyle and remain living in their own homes longer. The program has a preventive focus and, through the early intervention of home support services, aims to reduce the use of formal medical services and delay entry to residential aged care services. While available generally to eligible veterans and war widow(er)s, the program targets those aged 70 years and over.

Provision of services is based on assessed need. Assessments are undertaken by designated regional assessment agencies, which also arrange for the services to be provided. Services include domestic assistance, personal care and safety-related home and garden maintenance (the latter limited to 15 hours in a financial year). Although funded separately, respite care is also arranged through Veterans' Home Care, up to a limit of 28 days (196 hours) of in-home or residential respite, or a combination of both, in any one financial year (7 hours in-home respite is deemed equivalent to 1 day in residential respite care). Except for respite care, clients are required to make a co-payment for VHC services.

Veterans and war widow(er)s continue to be eligible to be assessed for the full range of services provided under HACC through arrangements with state and territory governments. Veterans and war widow(er)s currently receiving HACC services are able to transfer to Veterans' Home Care. However, clients can access different services from both programs at the same time.

Patterns of service use (VHC)

During 2003–04, just over 62,700 people received services through Veterans' Home Care. Of these, just over 61,600 (98%) were aged 65 years and over. Domestic assistance (90% of clients) and safety-related maintenance (18%) were the services received by the most clients some time during the year (Table 4.14). Similar proportions of clients in the three age groups examined used domestic assistance. However, older clients were more likely than younger clients to receive in-home respite care and personal care, while the reverse was true for home and garden maintenance.

Table 4.14: Services received by Veterans' Home Care clients, 2003–04

	65–74	75–84	85+	Total 65+	
Clients	**Per cent within client age group**				**[a]Number**
Domestic assistance	91.0	89.3	91.7	90.1	55,506
Home and garden maintenance	26.5	19.0	13.7	18.0	11,119
Respite care (excluding residential respite)	7.8	12.0	17.4	13.2	8,144
Personal care	2.3	3.3	6.2	4.0	2,492
Total (number)	**3,663**	**41,266**	**16,708**	**. .**	**61,639**
Volume of assistance		**Per cent**			**Total ('000 hours)**
Domestic assistance	79.7	73.9	65.6	71.7	1,698.1
Home and garden maintenance	3.7	2.4	1.4	2.1	50.2
Respite care (excluding residential respite)	14.8	21.1	28.8	23.1	548.0
Personal care	1.8	2.6	4.2	3.1	72.7
Total (all types)	**100.0**	**100.0**	**100.0**	**100.0**	**2,369.1**
Total volume ('000s)	**113.1**	**1,538.2**	**717.8**	**2,369.1**	**. .**

(a) Total number of recipients will be less than the sum for all service types, as one recipient may receive more than one service type during the financial year. Table totals include services provided to two people of unknown age.

Note: Components may not add to total due to rounding.

Source: DVA unpublished data (DVA database as at 15 April 2005).

During 2003–04, nearly 2.4 million hours of assistance were provided to people aged 65 and over through Veterans' Home Care—around 12% of the volume of hours provided through the HACC program. Reflecting the time-consuming nature of respite care, this type of assistance accounted for 23% of the total hours of assistance although it was used by only 13% of clients. Conversely, although 18% of clients received home and garden maintenance, this type of help accounted for only 2% of all hours of assistance. Over two-thirds of hours of assistance related to domestic assistance. The proportion of hours of service expended on respite care and personal care increased with age, while younger clients used more hours for domestic assistance and maintenance than their older counterparts.

Community Aged Care Packages

Community Aged Care Packages (CACPs) provide support services for older people with complex needs living at home who would otherwise be eligible for admission to 'low-level' residential care. They provide a range of home-based services, excluding home nursing assistance (which may, however, be provided through HACC), with care being coordinated by the package provider. To receive a package, an ACAT approval specifically for a CACP is required. On 30 June 2004 there were 27,657 people in receipt of a Community Aged Care Package; 25,722 of these recipients were aged 65 and over (see Table 4.19). These figures do not include supplementary clients or recipients of flexible care and Multi-purpose Service packages.[3]

Unlike the HACC program which is jointly funded by the Australian and state and territory governments, the CACP program is solely Commonwealth funded. On 1 July 2004, the daily subsidy paid by the Australian Government for a Community Aged Care

Package was $32.04, which is in the middle of the subsidy range for low-level residential aged care (DoHA 2004d). Clients may be asked to contribute towards the cost of their care (see Section 4.7). Begun in 1992, the program has expanded rapidly, and reached 29,048 operational packages as at 30 June 2004 (including flexible care and Multi-purpose Service packages, discussed separately later).

Patterns of service use (CACP)

On 30 June 2004, nearly 10 out of every 1,000 people aged 65 years and over were receiving a Community Aged Care Package (not including supplementary clients or recipients of flexible care and Multi-purpose Service packages). This equates to 44 CACP recipients for every 1,000 people aged 65 and over with a severe or profound core activity limitation (see Table A4.5). As with HACC services, use of a package increased with age, from 3 per 1,000 people aged 65–74 to 33 per 1,000 people aged 85 and over (see Table 4.22).

At the time of the 2002 CACP census, more than half of older CACP recipients had a carer, with the percentage increasing with age (from 50% among recipients aged 65–69 to 60% among those aged 90 and over). However, carers were more likely to be co-resident for younger than older package recipients: for recipients aged 60–64, 73% of people with a carer lived with their carer compared with 40% for those aged 90 and over (AIHW 2004c:44–5).

A range of services can be included in a Community Aged Care Package, including domestic assistance, personal care, social support, rehabilitation, respite care, meals and food preparation, home maintenance, transport and linen services. In 2002, data on the type and quantity of services people received were collected for the first time, via the CACP census (AIHW 2004c). The collection reported information on services provided to package recipients within the census week. Since not all services used by a CACP recipient are provided each week, the census underestimates the total number of services provided to an individual as part of the package. Four service types were received by more than half the package recipients aged 65 and over during the census week: domestic assistance (received by 83% of recipients aged 65 or more), case management and care coordination (73%), social support (60%) and personal care (54%) (Table 4.15). Transport services (36% of older clients), meal preparation and other food services (29%), and delivered meals (21%) were also commonly received.

The percentage of clients receiving the service increased with age for personal care, domestic assistance, social support, and other food services. For delivered meals there was no clear relationship between service provision and client age. For all other service types the proportion of clients in a particular age group receiving the service decreased with age.

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3. Package recipients are permitted to take leave from their packaged care for a number of reasons (e.g. for a holiday, residential respite care, or a stay in hospital). In these situations, the subsidy paid for these packages may be used to fund care for other recipients who are eligible for placement in a package. These recipients are called 'supplementary care recipients'.

Older CACP clients receiving assistance during the census received an average of 3.8 service types each. The amount of assistance provided varied by type (Table 4.16). Although provided to only 4% of clients, respite care involved the most time per client, entailing at least 2½ hours per week for half of the older people using this service. Other services commonly involving more than 1 hour of help per week were domestic assistance (median of 2 hours), meal preparation and other food services (1¼ hours), personal care (2 hours) and social support (1¾ hours).

Table 4.15: Services received by CACP recipients, census week 2002

	<65	65–74	75–84	85+	Total 65+
	Per cent of clients within age group				
Domestic assistance	74.8	81.3	83.2	83.9	83.1
Case management/care coordination	73.4	72.5	73.1	73.0	73.0
Social support[(a)]	53.0	57.1	60.7	60.7	60.1
Personal care	42.2	48.4	52.0	59.2	54.2
Transport trips	38.8	38.3	36.7	32.9	35.5
Other food services	21.6	24.7	27.8	33.2	29.4
Delivered meals	21.3	17.9	20.1	23.4	21.0
Home maintenance	19.9	17.2	15.6	14.9	15.6
Respite care	6.4	6.3	4.3	3.5	4.3
Rehabilitation	3.8	3.0	2.4	1.7	2.2
Linen deliveries	1.7	1.2	0.8	0.9	0.9
No service recorded in census week	2.8	3.3	2.6	2.6	2.7
Total clients (number)	**1,743**	**3,896**	**10,494**	**9,117**	**23,507**
Average number of services for people receiving any services	**3.6**	**3.7**	**3.8**	**3.9**	**3.8**

(a) Includes services to assist people with their personal affairs, such as letter writing, managing paperwork and making telephone-based contacts; shopping, bill paying and banking (when the person is accompanied by the care worker); keeping the person company; and, accompanying the person to social activities. Also includes attending centre-based day care where attendance at the centre is paid for by the CACP provider, or the care recipient is accompanied by a CACP care worker.

Notes

1. Age is as at end of the census period.
2. Table excludes 189 cases with missing age.
3. Not all CACP service outlets submitted data; an estimated that 94% of CACP service outlets responded to the census.
4. Table includes clients of Multi-purpose and flexible service places or packages.

Source: AIHW analysis of 2002 CACP census.

Overall, the median number of hours of assistance given to people aged 65 years and over receiving timed assistance during the census week was 5½. While there were some differences between the age groups in the amount of assistance being provided, there was not a strong relationship between age and amount. Because of the large number of people receiving domestic assistance, overall this service accounted for the greatest number of hours of services (32%) provided under Community Aged Care Packages during the census week. Personal care and social support each accounted for just over one-fifth of all hours of service provided.

Table 4.16: Volume of services received by CACP recipients, census week 2002 (median)

	<65	65–74	75–84	85+	Total 65+	Total volume 65+	
Time-based services			**Median volume**				**Unit**
Personal care	2	2	2	2	2	29,592	hours
Domestic assistance	2	2	2	2	2	43,833	hours
Social support[(a)]	2	2	1¾	1½	1¾	30,250	hours
Other food services	1¼	1	1¼	1¼	1¼	11,592	hours
Respite care	3	2¾	2½	2½	2½	3,322	hours
Rehabilitation	1¼	1	1	1	1	685	hours
Home maintenance	1	1	1	¾	1	3,725	hours
Case management/care co-ordination	1	¾	¾	½	¾	16,107	hours
All hour-based services	**5¼**	**5¼**	**5½**	**5½**	**5½**	**139,105**	**hours**
Unit-based services							
Delivered meals	5	5	5	5	5	29,834	meals
Linen deliveries	2	1	1	1	1	380	deliveries
Transport trips	2	2	2	2	2	24,094	one-way trips
Total volume			**Total volume**				
All hour-based services	10,654	23,030	61,111	54,965	139,105	. .	hours
Total volume–delivered meals	2,393	4,198	12,567	13,069	29,834	. .	meals
Total volume–linen deliveries	81	70	134	176	380	. .	deliveries
Total volume–transport trips	2,424	4,588	11,145	8,361	24,094	. .	one-way trips

(a) Includes services to assist people with their personal affairs, such as letter writing, managing paperwork and making telephone-based contacts; shopping, bill paying and banking (when the person is accompanied by the care worker); keeping the person company; and, accompanying the person to social activities. Also includes attending centre-based day care where attendance at the centre is paid for by the CACP provider, or the care recipient is accompanied by a CACP care worker.

Notes

1. Age is as at end of the census period.
2. Table excludes 189 cases with missing age.
3. Median hours for a service are based on people receiving some of the service. Amounts of service were reported to the nearest 15 minutes.
4. Not all CACP service outlets submitted data; an estimated that 94% of CACP service outlets responded to the census.
5. Table includes clients of Multi-purpose and flexible service places or packages.
6. Components may not add to total due to rounding.

Source: AIHW analysis of 2002 CACP census.

For the 21% of clients receiving delivered meals, at least half received 5 meals a week. The median number of one-way trips provided to CACP recipients was 2 per week, and the small number of people using formal linen services in general received 1 delivery a week.

In 2003–04, there were nearly 12,800 separations from packages by people aged 65 and over (see Table A4.4). Of these, nearly half of the recipients had been receiving the package for more than 1 year, with one-fifth having been in receipt of one for between 2 and 4 years. The most common reasons for the cessation of a package were clients moving into residential aged care, or death: in 2003–04, nearly half (48%) of all separations—including those for younger people—were to residential aged care, while 19% were the result of the death of the care recipient (AIHW 2005a:48). In addition, 8% of separations related to a recipient leaving one care package to take up another.

Extended Aged Care at Home

The Extended Aged Care at Home (EACH) program aims to deliver care at home that is equivalent to high-level residential care. Begun as a pilot in 2000 with 300 clients in 10 areas, EACH was established in 2002 by the Australian Government as an ongoing program. As with CACPs, access to a place is through assessment and approval by an ACAT. The daily subsidy for a place is aligned with that for the second highest care-need category in high-level residential aged care, with supplements for use of oxygen and enteral feeding. On 1 July 2004, the daily subsidy was set at $107.10 ($109.25 in Victoria), with care service supplements of up to $23.24 (DoHA 2004d). As with the other community care programs, clients may be asked to contribute to the cost of their care (see Section 4.7).

As at 30 June 2004, there were 858 EACH operational places (see Table 4.25). Because of small delays in converting operational places into occupied places, at that time there were 707 people living at home with the support of EACH, including 646 aged 65 and over. Illustrating the rapid growth of the program, by the end of June 2005 the number of operational places had grown to 1,672 and the number of recipients had reached 1,125 (DoHA unpublished). It is planned that by 2006 there will be over 3,224 places available (DoHA 2004c:14).

Many of the services available to EACH recipients are similar to those provided to CACP recipients. In addition, nursing and allied health care services can be provided as part of an EACH place. Information on the characteristics of recipients, and the services they received, was collected for the pilot project in the 2002 EACH one-week census (AIHW 2004d:28). At that time, nearly 90% of EACH clients received personal care and 65% were provided with domestic assistance. In addition, nursing was provided to 54% of recipients, and social support to 47%. At 13% and 9% of recipients, allied health services and home maintenance, respectively, were the services least likely to be provided. Three-quarters of EACH recipients had a co-resident carer and a further 15% had a non-resident carer (AIHW 2004d:22). While administrative by-product data on people accessing EACH places are available on an ongoing basis, data on services provided to recipients have not been collected since EACH was established as an ongoing program.

Respite care and National Respite for Carers Program

With the trend towards increasing home-based care and reduced rates of residential care, respite care has emerged as an important area of service provision. This has been evident in a number of government policy initiatives, in particular in the development of the National Respite for Carers Program.

Respite care may be provided in the home, at a centre during the day, or in a residential service. In 2003–04, 11% (57,800) of older HACC clients used centre-based day care and 1% (5,200) used in-home respite care services (see Table 4.12).[4] In

4. In the case of respite care, the carer is considered the HACC client. Anecdotal evidence suggests that the provision of respite care may be under-reported.

addition, 13% (8,100) of Veterans' Home Care clients aged 65 years and over received in-home or emergency respite care during 2003–04 (see Table 4.14). Among older CACP recipients, 4%(about 1,000 people) accessed respite assistance during the 2002 census week (see Table 4.15).

In addition to the above respite services, nearly half of all admissions into residential aged care are for respite care. Among the 95,322 admissions for older people into residential care in 2003–04, nearly 44,100 were for respite care—an increase of 8% since 2001–02 (AIHW 2003a:466, 2005b:52, 54). In addition, while the average length of stay in respite care fell slightly between 2001–02 and 2003–04 (from 3.2 to 3.1 weeks for respite care residents of all ages), the increase in respite admissions resulted in the total number of respite bed-days rising by over 4%, from 960,300 occupied place-days to over 1 million (1,002,200) (AIHW 2003b:24, 2005b:15).

Respite services can also be accessed through the National Respite for Carers Program, which provides information and support for carers as well as respite care. The program funds respite services, Commonwealth Carer Respite Centres (which provide information on respite services and arrange respite), Commonwealth Carer Resource Centres (which provide carers with information about their caring role and the services available to them), and the National Carer Counselling Program. An ACAT assessment is not required for people accessing respite through the National Respite for Carers Program; there are, however, assessment procedures within the program with the focus being on primary carers and the relative need of clients. An ACAT assessment is necessary for people wanting respite care in aged care facilities.

In 2003–04, the program funded the eight state- and territory-based and one national Commonwealth Carer Resource Centres, over 90 regional Commonwealth Carer Respite Centres and outlets, and more than 430 community-based respite service providers. During 2003–04, the Respite Centres assisted an estimated 47,800 carers providing 110,100 occasions of service, and the Resource Centres helped 42,600 carers. In addition, an estimated 2,000 carers received counselling under the National Carer Counselling Program delivered through Commonwealth Carer Resource Centres (DoHA 2004a: carer support, 2005c:139).

Other programs

In addition to the main national services, there are many smaller programs—at Australian, state/territory and local government levels—targeting older people. Given the importance of dementia in an ageing population (as reflected in its becoming a National Health Priority—see Box 4.2), a number of national programs focus on people with dementia and their carers, including the National Dementia Helpline (through Alzheimer's Australia), the Early Stage Dementia Support Program and Psychogeriatric Care Units. Other programs include the Day Therapy Centre Program, which provides therapy services to people to maintain or recover a level of independence, the Continence Aids Assistance Scheme, and the Assistance with Care and Housing for the Aged program which assists frail low-income older people who are renting, are in insecure or inappropriate housing, or are homeless, to remain in the community by accessing suitable housing linked to community care.

4.5 Use of residential care

Residential aged care services provide accommodation and support for older people who can no longer live at home. Two levels of care are available: low-level care (Resident Classification Scale (RCS) categories 5 to 8, see later), and high-level care (RCS categories 1 to 4). Short-term respite care services are also available. All residential care services are required to meet a number of national standards (see Section 4.8). To enter residential care, people must have an assessment and approval for such care by an ACAT. In addition, up to 30 June 2004 an ACAT approval was also required for people moving between low and high permanent residential aged care. However, from 1 July 2004, this requirement was lifted if the person remained within the same facility.

Residential aged care is mainly funded by the Australian Government, via daily subsidies. In addition, all residents pay fees, including an income-tested component, and government subsidies for individual permanent residents are reduced in line with the income-tested fees paid by residents (see Section 4.7). The daily subsidy paid by the government varies with the type of care provided and the situation of the residential aged care service, including the number of concessional residents it has and the viability of the facility (due, for example, to operating in a remote area). Subsidies increase with the care-needs category of the resident, with permanent residents in the lowest care-needs category (RCS8) attracting no daily subsidy. Excluding all supplements, for 2004–05 basic subsidies for permanent residents in other RCS groups ranged from $25.27 per day for RCS7 up to $118.12 for RCS1 (Table 4.17). The basic subsidy for respite residents has two levels, and during 2004–05 these were $32.92 for low-care residents and $92.27 for high-care residents.

Table 4.17: Australian Government residential care basic daily subsidy rates, 2004–05

	High care				Low care			
Care type	**RCS1**	**RCS2**	**RCS3**	**RCS4**	**RCS5**	**RCS6**	**RCS7**	**RCS8**
Permanent	$118.12	$107.10	$92.27	$65.22	$39.73	$32.92	$25.27	$0.00
Respite	$92.27				$32.92			

Notes

1. Amounts do not include any supplements that may be applicable. Supplements depend on the type of care provided and the situation of the residential aged care service.
2. Rates vary marginally across states and territories.

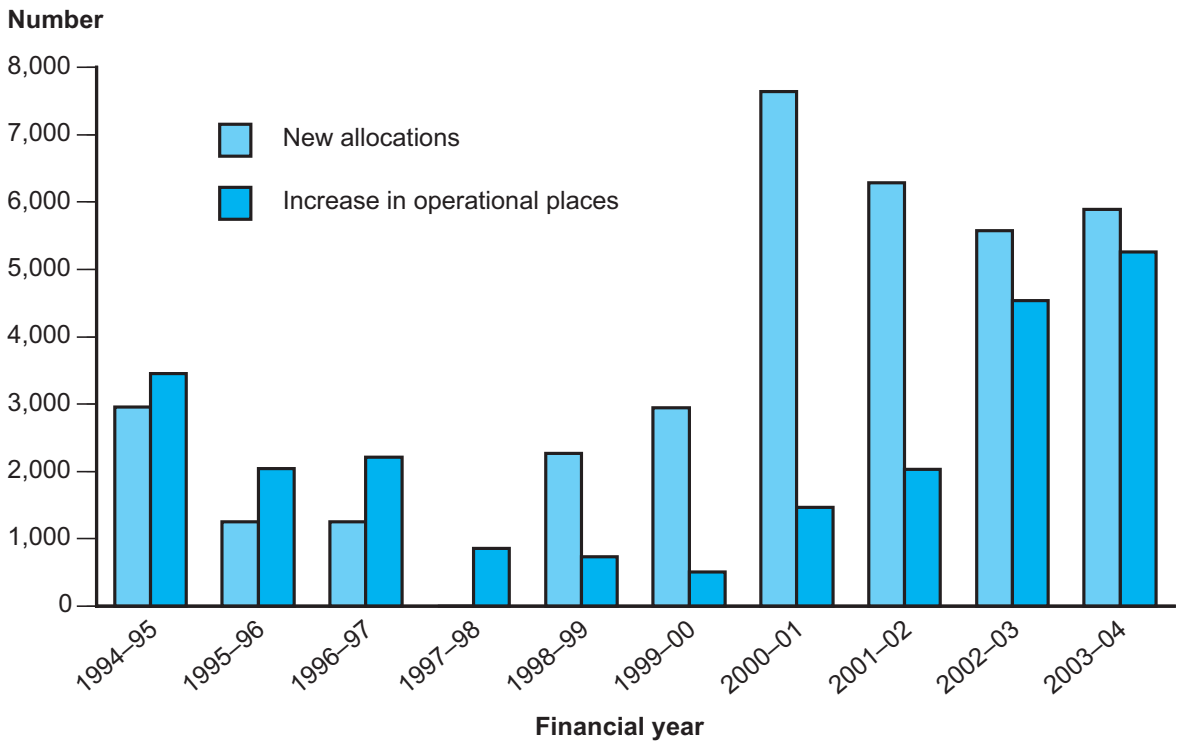
Source: DoHA 2004d.

Growth in provision of residential care

Between 30 June 1998 and 30 June 2002, the number of operational residential aged care places grew by an average of 1% a year (including flexible and Multi-purpose Service places) (AIHW 2003a:307). However, after 2002 the growth rate increased, with the number of operational places rising by 3.4% and then 3.6% in the 2 years from June 2002 (see Table 4.25). At 30 June 2004, there were 2,961 residential aged care services in Australia providing 156,580 operational places. By 30 June 2005, there were 161,165 operational places (DoHA provisional estimate).

Given the time lags between residential places being approved and allocated and then becoming operational, consideration of operational places alone does not give the complete picture of aged care provision. The development of residential aged care places (and similarly new CACPs and EACH places) can only occur when they have been formally allocated to a provider by the Australian Government, usually through an Approvals Round.

While the majority of CACPs and EACH places become available for use reasonably quickly, residential aged care places may take longer to come on line, especially where capital works are involved. The time lag between allocation of residential places and their becoming operational is apparent in Figure 4.3 which shows that, while allocations began to increase from 1998–99, the number of new operational places in a year did not start to increase until 2 years later. As can be seen, between 1998–99 and 2001–02 there were substantially more approvals than new places coming on line. However, the number of new operational places in 2002–03 was over 4,500—more than double the number for 2001–02—and in both 2002–03 and 2003–04 the increase in new places was higher than it had been at any time in the preceding decade. In addition, a further 8,860 places were approved for allocation in the 2004 Aged Care Approvals Round (DoHA 2005a). Since the majority of allocated places do generally become operational, and because 30,600 new places have been allocated since 1997–98 and only 15,400 have as yet become newly operational, such growth is likely to continue over the next few years.



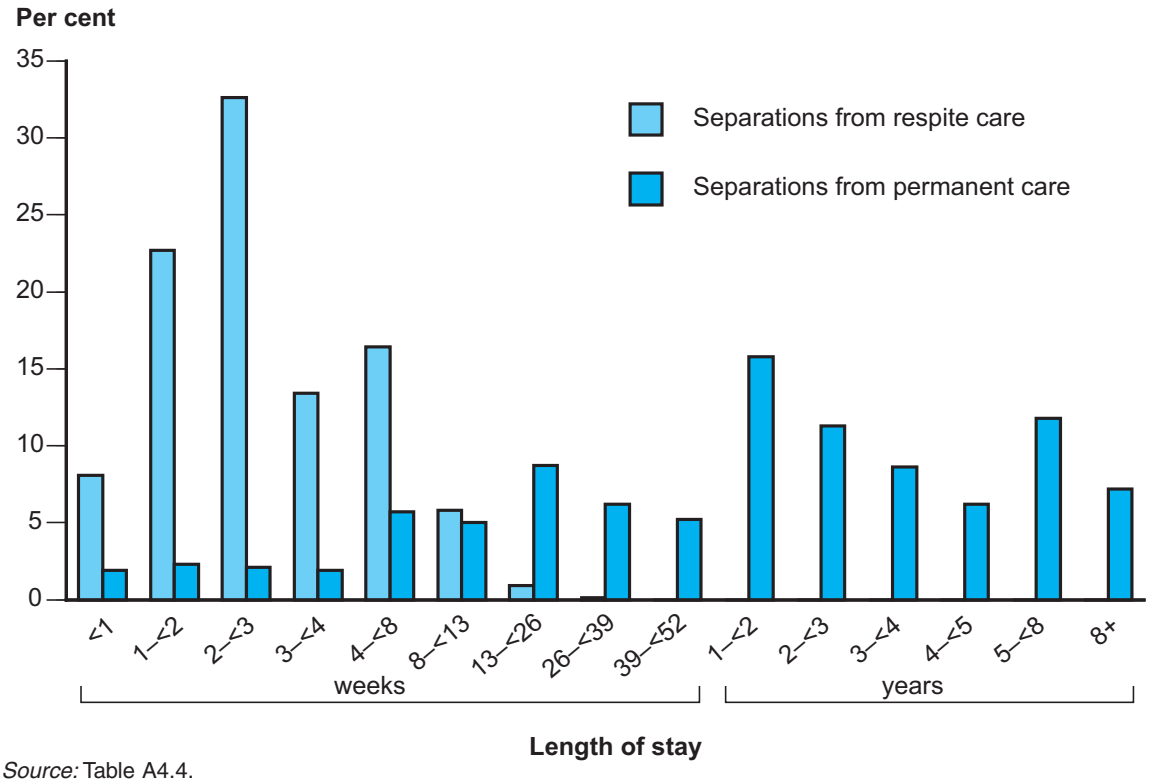
Source: Table A4.3.

Figure 4.3: New residential aged care allocations and operational places, 1994–95 to 2003–04

Mix of respite and permanent care

People may use residential care either as their permanent place of residence, or for the short-term accommodation and care associated with respite care. Residential respite care is important both for people who need a higher level of care just for the short term and as a component of the carer support system, whether for emergency care or to provide a 'break' while carers attend to other affairs or take a holiday. On 30 June 2004, respite residents made up just under 2% (2,508) of the 141,262 aged care service residents aged 65 years and over (AIHW 2005b:35–7). However, because it provides short-term care, respite accounted for over half (54%) of the 95,332 admissions for older people during 2003–04. Just over 60% of respite care episodes lasted 3 weeks or less compared with a similar proportion of permanent care episodes lasting at least 9 months (Figure 4.4).

As the name 'respite' suggests, most of the people who are admitted for respite care return to the community: 69% in 2003–04 (AIHW 2005b:27–8). In only 1% of episodes the person died while in residential respite care, with the remainder either going to another residential aged care service or to hospital (13% and 5%, respectively). The story for permanent residents is quite different, with 84% of separations resulting from the death of the resident, and just 4% involving a return to the community. The remainder of people who left a permanent residential aged care service were fairly evenly split between going to hospital and moving to another aged care service (following 6% and 5% of separations, respectively).



Source: Table A4.4.

Figure 4.4: Length of stay of older clients (65+) who left residential aged care during 2003–04

Patterns of service use

Currently, residential aged care is the second most commonly used aged care program after HACC. While there has been some fluctuation, there has been little change in the use of residential aged care since 2000: on 30 June 2004, 53 out of every 1,000 people aged 65 years and over (or 5%) were permanent aged care residents, compared with 54 per 1,000 in 2000. Just 1 additional person per 1,000 was in residential respite care on 30 June 2004 (see Table A4.5; AIHW 2001:247, 2005b:37). Use of residential care increases substantially with age, from 10 permanent residents per 1,000 people aged 65–74 to 249 per 1,000 people aged 85 and over (see Table 4.22). Comparing use with the number of people with a disability, on 30 June 2004 for every 1,000 people aged 65 and over with a severe or profound core activity limitation, there were 237 people in permanent residential aged care and 4 people in residential respite care.

Overall, during the 12 months to 30 June 2004, there were 17 respite admissions into residential services per 1,000 people aged 65 and over (see Table A4.5). As with permanent residential care, residential respite care is accessed more by older than younger people: there were 4 respite admissions over the year per 1,000 people aged 65–74, 21 per 1,000 aged 75–84 and 64 per 1,000 aged 85 and over (see Table 4.22).

Use of permanent residential care by younger people

While the vast majority of permanent residents of residential aged care services are aged at least 65 (96% in 2004; see Table 4.19), age per se is not a criterion for admission and younger people also use these services. On 30 June 2004, there were around 6,200 people aged under 65 living permanently in residential aged care, and of these the great majority were aged 50–64 with one-sixth (almost 1,000) aged under 50 (Table 4.18). In comparison, nearly 33,200 people used CSTDA-funded accommodation support in 2003–04, comprising 5,300 people using institutional accommodation, 11,300 using group homes and 17,300 using other types of accommodation support (see Table 5.13).

Table 4.18: Younger permanent residents of residential aged care, 30 June 2004

	High care					Low care					
Age	**RCS1**	**RCS2**	**RCS3**	**RCS4**	***RCS1–4***	**RCS5**	**RCS6**	**RCS7**	**RCS8**	***RCS5–8***	**Total**
					Number						
Under 50	381	280	130	26	*817*	58	59	48	5	*170*	987
50–64	1,396	1,274	739	251	*3,660*	592	488	444	28	*1,552*	5,212
65+	29,692	33,680	19,973	6,577	*89,922*	16,630	14,653	15,450	1,052	*47,785*	137,707
Total	**31,469**	**35,234**	**20,842**	**6,854**	***94,399***	**17,280**	**15,200**	**15,942**	**1,085**	***49,507***	**143,906**
					Per cent						
Under 50	38.6	28.4	13.2	2.6	*82.8*	5.9	6.0	4.9	0.5	*17.2*	100.0
50–64	26.8	24.4	14.2	4.8	*70.2*	11.4	9.4	8.5	0.5	*29.8*	100.0
65+	21.6	24.5	14.5	4.8	*65.3*	12.1	10.6	11.2	0.8	*34.7*	100.0
Total	**21.9**	**24.5**	**14.5**	**4.8**	***65.6***	**12.0**	**10.6**	**11.1**	**0.8**	***34.4***	**100.0**

Notes

1. Table excludes 1,088 residents whose dependency was not reported.
2. Components may not add to total due to rounding.

Source: AIHW 2005b: table 4.27.

While permanent residents aged 50–64 have a dependency profile which is similar to that of older residents, younger residents have greater levels of dependency. Men were more common among younger than older clients: 53% of clients aged under 50 compared with 28% of those aged 65 and over (AIHW 2005b:66).

Flexible aged care services

The Australian Government also provides flexible aged care services through Multi-purpose Services in rural and remote communities, and through services under the National Aboriginal and Torres Strait Islander Aged Care Strategy. Multi-purpose Services were trialled in 1990 and expanded in 1994. As at June 2004, there were 95 of these services providing 1,757 residential care places and 204 Community Aged Care Packages. Flexible services provided under the strategy began operating in 1996. In June 2004, there were 29 operational flexible services providing 336 residential care places and 243 packages (AIHW 2005a:4).

Data on clients of these flexible aged care services are not currently included on the national database (ACCMIS) for residential aged care and Community Aged Care Packages. Consequently, there is no information available on the precise number and characteristics of people using these services.

Support services for residential care

A number of programs support residential care providers and their clients, such as: the Community Visitors Scheme,a national program that provides companionship to socially isolated people living in Australian Government-funded aged care facilities; resident advocacy services, including the Complaints Resolution Scheme which seeks to resolve complaints about the health, safety and/or welfare of people receiving aged care; and aged care workforce support which includes funding to train staff, for example, to ensure they are able to meet the diverse cultural needs of older Australians as overseas-born people make up an increasing proportion of people using residential aged care (Bishop 2005; DoHA 2004a).

4.6 Client profiles

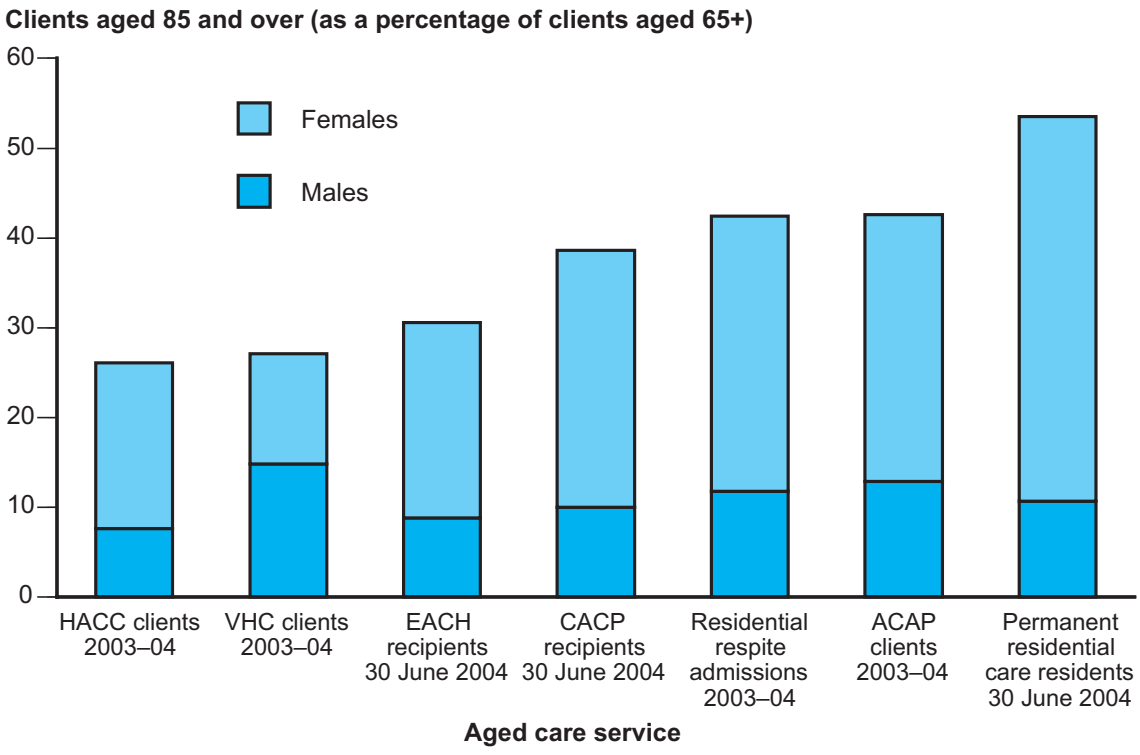
The programs included in this section are the Aged Care Assessment Program, Home and Community Care, Veterans' Home Care, Community Aged Care Packages, Extended Aged Care at Home and residential aged care. For most programs, care (or assessment) is long-term, and so the characteristics of individuals using a service are of interest. However, respite care is generally for short periods and a client may have multiple care episodes in a year. In this case, client profiles across all respite admissions in a year are examined. Data limitations have meant that some client characteristics for particular programs could not be assessed.

Age and sex

In all the aged care services examined, except Veterans' Home Care, the clients were predominantly women (Table 4.19). In 2004, 49% of VHC clients were women; for other

services, the proportion ranged from 62% of EACH recipients to 73% of permanent aged care residents. Reflecting their greater longevity, the predominance of women in aged care services generally increases with age (again, with the exception of VHC). This effect is particularly noticeable in permanent residential aged care: in June 2004 in the 65–74 year age group, there were similar numbers of male and female residents, while among residents aged 90 and over there were nearly five times as many women as men.

A greater proportion of people in residential aged care than in community care is very old (aged 85+) (Figure 4.5). On 30 June 2004, over half (54%) of older permanent residents were aged 85 and over, and, during 2003–04, 42% of respite admissions were for very old people. Of the community care programs examined, Community Aged Care Packages had the oldest age profile, with two-fifths of older recipients being aged 85 and over. HACC and VHC had the youngest age profiles, and around one-quarter of their older clients were aged 85 and over. Although Extended Aged Care at Home places provide a higher level of care than Community Aged Care Packages, EACH recipients had an age profile between those of HACC and CACP clients, with 31% of older recipients being aged 85 and older. People being assessed for aged care services—that is, ACAP clients—had a slightly older profile than CACP clients (43% aged 85+).



Source: Table 4.19.

Figure 4.5: Use of aged care services by clients aged 85 and over, 2003–04

Table 4.19: Use of selected aged care services, 2004 (per cent)

Sex/age	VHC 2003–04	HACC 2003–04	ACAP 2003–04	CACP 30 June 2004	EACH 30 June 2004	Permanent residential care 30 June 2004	Residential respite 2003–04
Males	**Clients**	**Clients**	**Clients**	**Recipients**	**Recipients**	**Residents**	**Admissions**
65–69	0.5	3.6	2.1	2.4	4.3	1.6	2.4
70–74	1.1	5.6	3.8	3.2	7.1	2.8	4.3
75–79	9.9	7.8	7.0	5.4	9.8	4.9	7.9
80–84	24.8	7.9	9.6	6.8	8.2	6.7	10.0
85–89	11.9	5.0	7.9	6.0	5.6	6.0	7.6
90+	2.9	2.6	5.0	4.0	3.3	4.8	4.2
Total males	*51.1*	*32.5*	*35.4*	*27.8*	*38.2*	*26.7*	*36.4*
Females							
65–69	0.8	6.5	2.3	3.6	5.6	1.6	2.1
70–74	3.6	10.2	4.9	7.2	8.2	3.4	4.2
75–79	13.7	15.0	10.4	13.1	13.6	8.4	10.1
80–84	18.6	17.3	17.4	19.6	12.5	17.0	16.6
85–89	9.4	11.8	16.9	17.3	12.5	20.5	17.9
90+	2.9	6.7	12.8	11.3	9.3	22.2	12.6
Total females	*48.9*	*67.5*	*64.6*	*72.2*	*61.8*	*73.3*	*63.6*
Persons							
65–69	1.3	10.1	4.3	6.0	9.9	3.2	4.5
70–74	4.7	15.8	8.7	10.4	15.3	6.3	8.5
75–79	23.6	22.8	17.3	18.5	23.4	13.3	18.0
80–84	43.3	25.2	27.0	26.4	20.7	23.7	26.7
85–89	21.3	16.8	24.8	23.3	18.1	26.5	25.5
90+	5.8	9.3	17.8	15.3	12.5	27.0	16.9
Total persons	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total persons 65+ (number)	**61,637**	**537,100**	**150,672**	**25,722**	**646**	**138,754**	**44,068**
Clients aged <65 (number)	**1,082**	**170,100**	**8,172**	**1,935**	**61**	**6,240**	**2,564**
Clients aged <65 (% clients all ages)	**1.7**	**24.0**	**5.1**	**7.0**	**8.6**	**4.3**	**5.5**

Notes

1. For point in time estimates, age is as at the point in time. For ACAP clients age is as at the time of the last assessment in the financial year. For residential respite, age is as at the end of the respite period. For HACC and VHC clients, age is as at 30 June 2004.
2. Residential respite care annual figures exclude transfers between service providers for care of the same type (that is, respite care).
3. For ACAP, 144 clients with missing age and/or sex have been excluded; for VHC, 2 cases with both sex and age missing have been excluded from the table. There were no cases with missing age and/or sex for CACP, EACH or residential aged care.
4. In the HACC MDS, age was unknown (date of birth reported as 1 January 1900 or 1901 (see AIHW: Karmel 2005), or age greater than 110) for 3,243 clients. These clients are assumed to be aged 65 and over, and have been pro-rated accordingly. Sex was missing for 1,224 and 3,386 records for people aged under 65 and aged 65 and over, respectively; 342 records had both missing age and sex. Percentages are based on cases with known sex after pro-rating for unknown age.
5. Not all HACC agencies submitted data to the HACC MDS. For 2003–04, the proportion of HACC-funded agencies that submitted HACC MDS data differed across jurisdictions, and ranged from 77% to 99%. Actual client numbers will therefore be higher than those reported here. Because of this incomplete coverage, and because of cases with missing age and sex, numbers have been rounded to the nearest 100.
6. Table does not include clients of Multi-purpose and flexible service places or packages.
7. Components may not add to total due to rounding.

Sources: AIHW analysis of DoHA ACCMIS database (as at November 2004), AIHW analysis of HACC MDS; DVA unpublished data (DVA database as at 15 April 2005); Lincoln Centre analysis of ACAP MDS v1 and v2.

Dependency

No dependency information is available from the administrative by-product data collected regularly for CACP recipients. Using data from the 2002 CACP 1-week census, at that time around two-thirds of older CACP recipients had care needs related to self-care and mobility (64% and 70%, respectively) (Table 4.20). Only 15% of recipients needed assistance or support with communication. Overall, 85% of CACP clients had care needs with one or more of self-care, mobility and communication. The proportion of clients with dependency needs in self-care increased with age, while dependency rates in communication decreased with age.

Recent years have seen a continuing rise in the profile of care needs of permanent aged care residents (AIHW 1999:205; Table 4.21). This trend has been in evidence at least since the early 1990s (DHAC: Gray 2001:44–6), and reflects both the increased availability of community care and greater targeting of residential aged care to people with high-level needs. In June 1999, 60% of older residents had high-care needs; by June 2004, this had risen to 65%. In addition, the greatest increase in the eight categories was in the highest care group (RCS1): from 12% of older permanent residents in 1999 to 22% in 2002. A shift towards higher care needs was also seen among low-care residents: in 1999, one-fifth (21%) were in the lowest two care groups (RSC7 and RCS8), compared with 12% in 2004.

As is to be expected given the CACP target group—that is, those requiring care equivalent to low-level residential care—the care needs of people in permanent residential care with respect to core activities are considerably more than those of CACP recipients. In June 2004, 98% of older permanent residents had needs in at least one of eating, bathing, dressing, toileting and managing incontinence (i.e. with self-care), and 97% required some assistance with communication (i.e. with understanding others or being understood) (Table 4.20). A large majority also had problems related to mobility (85%).[5] Furthermore, nearly all had care needs related to their behaviour (96%) or other needs such as particular medical or social needs (99.9%). From this it can be seen that an overwhelming majority of aged care residents have multiple care requirements. Of the dependency items examined, only the prevalence of mobility problems appeared to increase with the age of residents: 81% of residents aged 65–74 had mobility-related care needs compared with 86% of those aged 85 and over.

Service use by people born overseas

People born overseas are an increasing proportion of the older population (see Section 4.2). The use of particular aged care services varies across birthplace groups. Programs providing community care have relatively more clients born in non-English-speaking countries compared with residential care services, and community care services providing packages of care (CACP and EACH) have even higher use by this group compared with the services provided through the HACC program. In 2004, between 18% and 25% of older community care recipients were born in non-English-speaking

5. In the CACP census, the measure of mobility needs included moving or manipulating objects, an aspect not included in the residential aged care measure.

countries, compared with around 13% of people in residential aged care and 20% of all people aged 65 and over (see Table A4.5; Section 4.2). A relatively low proportion of older people getting ACAT assessments (14%) were born in non-English-speaking countries.

Table 4.20: Type of dependency (per cent within each age group)

Dependency item	65–74	75–84	85+	Total	Number
Permanent residential aged care (30 June 2004)					
Self-care[a]	98.1	98.0	98.1	98.0	135,007
Mobility[b]	81.3	83.7	86.0	84.7	116,671
Communication[c]	96.8	96.7	97.6	97.2	133,813
Total with at least one of the above	*99.4*	*99.4*	*99.6*	*99.5*	*137,034*
Behaviour[d]	97.4	96.3	95.4	96.0	131,935
Other[e]	99.9	99.9	99.9	99.9	131,041
Total with at least one of all of the above	*99.9*	*100.0*	*100.0*	*100.0*	*137,113*
Total	**9.5**	**37.0**	**53.5**	**100.0**	**. .**
Total (number)	**13,062**	**50,970**	**73,675**	**137,707**	**137,707**
Community Aged Care Packages (2002)					
Self-care[f]	61.0	62.0	68.4	64.3	14,884
Mobility[g]	68.7	68.9	70.6	69.5	16,087
Communication[h]	16.8	15.0	13.7	14.8	3,423
Total with at least one of the above	*82.7*	*83.9*	*87.2*	*85.0*	*19,659*
Total with none of the above	*17.3*	*16.1*	*12.8*	*15.0*	*3,479*
Total	**16.5**	**44.7**	**38.8**	**100.0**	**. .**
Total (number)	**3,820**	**10,332**	**8,986**	**23,138**	**23,138**

(a) Includes at least some assistance or support required in any of the following areas: meals and drinks, personal hygiene, toileting, bladder management and bowel management (RCS questions 3 to 7).

(b) Includes at least some assistance or support required in the area of walking and transfers (RCS question 2).

(c) Includes at least some assistance or support required in any of the following areas: communicating with staff, relatives, friends and others, and in understanding and undertaking living activities (RCS questions 1 and 8).

(d) Includes at least some assistance or support required in any of the following areas: problem wandering or intrusive behaviour, verbally disruptive or noisy, physically aggressive, emotional dependence, danger to self and others, and other behaviour (RCS questions 9 to 14).

(e) Includes at least some assistance or support required in any of the following areas: social and human care needs (either for the care recipients or for family and friends), medication, technical and complex nursing procedures, therapy and 'other' services (RCS questions 15 to 20).

(f) Recipient sometimes or always needs assistance/supervision with: eating; showering/bathing; dressing; toileting; or managing incontinence.

(g) Recipient sometimes or always needs assistance/supervision with: maintaining or changing body position; carrying, moving or manipulating objects related to the tasks of daily living; getting in or out of bed or chair; or walking and related activities.

(h) Recipient sometimes or always needs assistance/supervision with: understanding others or making oneself understood by others.

Notes

1. Table does not include clients of Multi-purpose and flexible service places or packages.
2. RCS assessments were unavailable for 1,047 permanent residents aged 65 and over in 2004; table also excludes 588 cases with missing age and/or dependency information in the 2002 CACP census.

Sources: AIHW analysis of DoHA ACCMIS database as at November 2004, AIHW analysis of 2002 CACP census.

Table 4.21: Level of dependency of permanent aged care residents aged 65 and over, at 30 June 1999,[(a)] 2000, 2002 and 2004

	High care					Low care					
	RCS1	RCS2	RCS3	RCS4	RCS1–4	RCS5	RCS6	RCS7	RCS8	RCS5–8	Total
						Number					
1999	15,005	31,925	22,170	5,644	*74,744*	10,762	12,650	21,882	3,869	*49,163*	**123,907**
2000	17,618	32,205	20,818	5,820	*76,461*	11,071	12,933	21,153	2,978	*48,135*	**124,596**
2002	24,010	32,455	19,016	5,964	*81,445*	13,643	14,057	17,989	1,781	*47,470*	**128,915**
2004	29,692	33,680	19,973	6,577	*89,922*	16,630	14,653	15,450	1,052	*47,785*	**137,707**
						Per cent					
1999	12.1	25.8	17.9	4.6	*60.3*	8.7	10.2	17.7	3.1	*39.7*	**100.0**
2000	14.1	25.8	16.7	4.7	*61.4*	8.9	10.4	17.0	2.4	*38.6*	**100.0**
2002	18.6	25.2	14.8	4.6	*63.2*	10.6	10.9	14.0	1.4	*36.8*	**100.0**
2004	21.6	24.5	14.5	4.8	*65.3*	12.1	10.6	11.2	0.8	*34.7*	**100.0**

(a) Reliable data for 30 June 1998 are not available.

Notes

1. Assessments were unavailable for 2,722 residents in 1999, 2,821 residents in 2000, 1,591 residents in 2002, and 1,047 residents in 2004.
2. Table does not include clients of Multi-purpose and flexible services.
3. Components may not add to total due to rounding.

Source: AIHW analysis of DoHA ACCMIS database as at November 2004.

In the general community, the age and sex profiles of different population groups vary (see Section 4.2). Some of these differences are apparent in the observed usage patterns of the groups. For example, for all programs examined, the median age of older clients born in non-English-speaking countries was lower than that for those born elsewhere, and the ratio of female to male clients was lower among clients born overseas than among those born in Australia.

The pattern of increased use with age was evident for both Australian-born and overseas-born people for all services (Table 4.22). However, people born in Australia had higher usage rates than others in all age groups for all services except Community Aged Care Packages. For CACPs, people born in non-English-speaking countries had the highest usage rates among those aged at least 75.

Service use by Aboriginal and Torres Strait Islander people

As a result of their poorer health status, Aboriginal and Torres Strait Islander people tend to need and use aged care services at a relatively young age. Consequently, the examination here of their use of these services includes people aged 50 and over.

Like other groups in the population, Indigenous Australians access some services in preference to others. A relatively high percentage of CACP recipients are Indigenous: 4%as at 30 June 2004 compared with less than 1% of aged care residents (0.6% of permanent residents and 1% of respite admissions) and 0.9% of all people aged 50 and over (see Table A4.6; ABS 2004b, 2004c). In comparison, it is estimated that Aboriginal and Torres Strait Islander people made up around 2% of HACC and EACH clients aged 50 and over.

The differences in the age profiles of Indigenous and other Australians are reflected in the client profiles of these two groups for all aged care services. For all services examined, Aboriginal and Torres Strait Islander clients had a younger median age than other clients: between 9 and 13 years less in 2004. However, although the sex ratio among older Indigenous and other Australians is very similar (on 30 June 2004, 47% and 48% of people aged 50 and over were male for the two groups, respectively), Indigenous clients of services have a lower female to male ratio than other clients.

Among people aged 50–74 years, Indigenous Australians had much higher usage rates than other people for all services examined. For example, Indigenous Australians aged 65–74 used HACC services at a rate of 393 per 1,000, compared with 99 per 1,000 for all other Australians and 73 per 1,000 for people born in the main English-speaking countries (Tables 4.22, 4.23). In the oldest age group for which population data were available for Indigenous Australians (75+), data given in Table 4.23 suggest that while they use community care and respite services at higher rates than other people, both groups use permanent residential aged care at the same rate. However, the comparison between usage rates is affected significantly by the different age structures of the two populations, that is, by the relatively low percentage of Indigenous Australians aged 75 and over.

Table 4.22: Usage rates and country of birth of clients of selected aged care services, 2004

Age	HACC 2003–04	ACAP 2003–04	CACP 30 June 2004	Permanent residential care 30 June 2004	Residential respite 2003–04
	Clients	Clients	Recipients	Residents	Admissions
Australian-born			Number per 1,000		
65–74	111.1	16.2	3.4	11.0	4.8
75–84	290.8	78.5	11.6	57.8	22.4
85+	506.3	234.1	32.7	257.8	65.8
Overseas-born: main English-speaking countries					
65–74	72.8	10.1	2.0	7.1	3.7
75–84	233.1	57.0	11.0	50.3	21.8
85+	396.3	187.5	31.3	253.8	69.1
Overseas-born: non-English-speaking countries					
65–74	94.6	12.0	3.0	7.0	2.9
75–84	275.0	63.1	16.2	47.6	17.5
85+	426.4	176.9	38.3	195.1	49.7
All					
65–74	102.2	14.4	3.1	9.6	4.2
75–84	280.2	72.8	12.4	54.9	21.4
85+	481.1	220.3	33.3	248.8	64.0

Note: See notes to Table A4.5 concerning derivation of statistics and caveats, including allowing for missing values.

Sources: ABS 2005c; AIHW analysis of DoHA ACCMIS database (as at 30 November 2004), AIHW analysis of HACC MDS; Lincoln Centre and AIHW analysis of ACAP MDS v1 and v2.

Table 4.23: Usage rates and Indigenous status of clients of selected aged care services, 2004

Age	HACC 2003–04	CACP 30 June 2004	Permanent residential care 30 June 2004	Residential respite 2003–04
	Clients	Recipients	Residents	Admissions
Indigenous Australians		Number per 1,000		
50–64	132.7	9.5	5.1	2.9
65–74	393.5	41.9	23.6	14.8
75+	772.6	71.1	100.4	53.6
Non-Indigenous Australians				
50–64	23.7	0.4	1.5	0.6
65–74	99.5	2.8	9.5	4.1
75+	321.1	17.2	101.8	31.0
All Australians				
50–64	24.9	0.5	1.5	0.6
65–74	101.5	3.1	9.6	4.2
75+	322.5	17.4	101.8	31.1

Note: See also notes to Table A4.6 concerning derivation of statistics and caveats, including allowing for missing values.

Sources: AIHW analysis of DoHA ACCMIS database; ABS 2004b, 2004c.

4.7 Expenditure

Overall, because it has primary responsibility for funding residential aged care, the largest source of funds for the aged care system is the Australian Government. It also provides funding for a number of other programs, including Community Aged Care Packages, Extended Aged Care at Home, Multi-purpose and flexible services, Aged Care Assessment Teams, and the Home and Community Care and Veterans' Home Care programs. The HACC program is cost-shared with state and territory governments, which also provide some funding for other areas of aged care, including residential aged care and assessment services. Governments are not, however, the only source of funding in the aged care system. Users of programs meet part of the costs, and non-government community services organisations contribute funds to some services (see Chapter 8). In addition, volunteers contribute to the sector.

Government expenditure on aged care

Aged care expenditure is spread across both health and welfare services. When classifying expenditure to either health or welfare, expenditure on residents in high-level care in residential aged care services is generally included in health while expenditure on low-level residential care and community-based programs is allocated to welfare. In the following discussion, expenditure on both levels of residential care is included, along with that for a range of community care programs, to give an overall picture of expenditure on aged care. For this reason, the figures presented here differ from those in Chapter 8 for expenditure on older people. In addition, due to data

availability, expenditure by local government and non-government organisations has not been included. Government concessions (such as concessional land and water rates) and welfare-related social expenditures (for example, the Age Pension) that can be accessed by older people are discussed in Chapter 8.

Total Australian, state and territory recurrent government expenditure on aged care services increased from $5,339.7 million in 2000–01 to $7,321.7 million in 2003–04 (see Table A4.7). As has been historically the case, in 2003–04 the largest area of expenditure was in residential aged care ($5,356.5 million), representing 73% of expenditure, compared with 75% in 2000–01 (Table 4.24).[6] The overwhelming majority of these funds—over 99%—was spent on residential care subsidies. Expenditure on older people in the Home and Community Care Program was the second largest area of expenditure. Overall, around $1.2 billion in capital and recurrent funds were provided for the HACC program in 2003–04; of this, an estimated $917.1 million was used to deliver services to people aged 65 and over. Consequently, in 2003–04 HACC accounted for just under 13% of recurrent expenditure on aged care, slightly down from the 13–14% observed for the 3 previous years. Community care places and packages are the other main area of expenditure, and in 2003–04 EACH places and CACP packages together accounted for 4.4% of government expenditure on aged care services ($15.5 and $307.9 million, respectively). At $326.9 million, expenditure on the Carer Allowance, where the care recipient was aged 65 and over, accounted for 4.5% of expenditure. This was up slightly on previous years due to the one-off payment of $600 made to allowance recipients in June 2004. Other programs which accounted for more than 1% of expenditure in 2003–04 were the National Respite for Carers program ($101.5 million, or 1.4%), and Veterans' Home Care including in-home respite ($91.1 million, or 1.2%).

Comparisons of program expenditure as expressed in constant prices show whether there has been growth in real terms; that is, in terms of what the programs would have cost had the same prices operated in each of the years being compared. As such, changes in constant prices reflect changes in the actual quantity of goods and services used to produce welfare services (that is, real growth) rather than simply showing the amount of dollars used each year. For example, given a fixed amount of money, the 60% increase that occurred in average weekly earnings of carers and aides between 2002 and 2004 would have resulted in a substantial reduction in the capacity to produce welfare services, simply because each dollar could purchase fewer resources (see Table 8.24 and AIHW 2003a:145). The constant price estimates remove the effect of such distortions due to inflation and show whether more or fewer physical resources were being used.

In real terms, total government expenditure on aged care services increased by 23% over the years examined, from $5,747.8 million in 2000–01 to $7,067.3 million in 2003–04 (expressed in 2002–03 prices, Table 4.24). Overall expenditure on largest program, residential aged care, rose 20% in the same period. This growth was driven by both the increasing provision of residential aged care and the rising care needs of residents

6. Figures do not include some state and territory expenditure, see note (a) to Appendix Table 4.24.

(see Sections 4.6, 4.8). Between 2000–01 and 2003–04 the number of high-care bed-days occupied by permanent residents increased by nearly 12%, while the number of low-care days declined by 0.5% (AIHW analysis of ACCMIS database). In addition, more of those receiving high care were in the top care-need category (RCS1) which attracts the highest subsidies: among residents aged 65 and over, between June 2002 and June 2004 there was a 24% increase in the number of people in RCS1 but only a 7% increase in the number of permanent residents overall (see Table 4.21). The effect that these two trends have on expenditure on subsidies is clear when noting that on 1 July 2004 the RCS1 basic subsidy was 10% higher than that for RCS2 and 38% higher than that for RCS3 (DoHA 2004d).

Table 4.24: Recurrent government expenditure on aged care services, 2000–01 to 2003–04[(a)] ($m)

Program[(b)]	2000–01	2001–02	2002–03	2003–04	2003–04
	Constant 2002–03 prices				Current prices
Residential aged care–subsidies	4,291.7	4,375.7	4,506.7	5,150.6	5,336.0
Residential aged care–resident and provider support	9.3	9.9	15.5	19.7	20.4
Community Aged Care Packages	209.5	255.0	287.9	297.2	307.9
Home and Community Care	780.5	814.0	853.0	885.2	917.1
Veterans' Home Care and DVA in-home respite	25.1	64.1	93.5	87.9	91.1
Extended Aged Care at Home	9.1	9.3	10.5	14.9	15.5
Day Therapy Centres	30.7	30.3	31.0	30.5	31.6
Multi-purpose and flexible services	36.6	41.7	51.4	58.6	60.7
National Respite for Carers	73.9	70.9	94.0	98.0	101.5
Carer Allowance	193.3	197.2	228.0	315.5	326.9
Assessment	42.2	42.4	42.9	46.7	48.4
Commonwealth Carelink Centres	13.0	11.9	12.1	13.4	13.9
Accreditation	11.2	13.0	11.9	6.3	6.5
Flexible care pilot projects	. .	. .	4.6	16.9	17.6
Other	21.8	30.5	27.7	25.7	26.6
Total	**5,747.8**	**5,965.9**	**6,270.6**	**7,067.3**	**7,321.7**
Amount per person aged 65 and over with a profound or severe core activity limitation (dollars)	**10,682**	**10,763**	**11,008**	**12,057**	**12,491**
GFCE deflator	92.9	96.6	100	103.6	. .

(a) Expenditure excludes departmental program administration and running costs. Only state and territory funding for high-level residential aged care subsidies and HACC have been included. Comparisons with ABS welfare expenditure estimates on older people (see AIHW 2003c:5, 9; excludes expenditure on high-level residential care) indicate that including other state/territory expenditure would have resulted in an increase in the estimate of expenditure for 2000–01 of about 7%.

(b) To improve coverage, the programs included here have changed slightly from those in the corresponding table in the previous edition of this publication (AIHW 2003a: table 7.13). Consequently, the numbers in the two publications are not strictly comparable.

Notes

1. See notes to Appendix Table A4.7 for information on expenditure derivation and comparability with previous editions. Constant dollar values were calculated using the GFCE deflator, referenced to 2002–03.
2. Components may not add to total due to rounding.

Sources: Tables A4.7, A4.8.

Expenditure in real terms on HACC services (provided to people aged 65+) increased by 13%. VHC and HACC provide similar services, and if the expenditures on these programs are amalgamated, the combined rise for these home-based services was 21%.

The emphasis on developing community support programs is demonstrated in expenditure on the CACP and the National Respite for Carers programs, which rose by 42% and 33%, respectively, over the 3 years. Expenditure on Carer Allowance also increased—by 63%. In contrast, expenditure on the accreditation of residential aged care providers dropped by 44%, reflecting the cyclic nature of residential aged care facility accreditation, with the second round of accreditation being completed mid 2003–04.

While the above analysis shows that expenditure on aged care services has been increasing in real terms, it does not indicate whether expenditure has been keeping pace with the growing need for services caused by the ageing of the population. As stated earlier, the segment of the older population most likely to be in need of assistance from aged care programs in general is people aged 65 and over with a severe or profound core activity limitation. Over the 3 years since 2000–01, estimates indicate that the number of such people grew by 9%, compared with a 23% growth in real expenditure (AIHW estimates). Consequently, real (constant price) program expenditure has been more than keeping pace with the increasing number of people in this group (see Table A4.8). In 2000–01, total aged care expenditure in real terms broadly equated to $10,682 for every person aged 65 and over with a profound or severe limitation (in 2002–03 prices). By 2003–04, this figure is estimated to have risen by 13% to $12,057. More than half of this growth occurred in the last year (10% between 2002–03 and 2003–04).

Per person growth was not consistent either over time or across programs. Relative to the number of people aged 65 and over with a profound or severe core activity limitation, expenditure on residential aged care subsidies rose by 10% to $8,787 (in 2002–03 prices) between 2000–01 and 2003–04, with nearly all of this growth occurring in the last year. Relative expenditure on the Carer Allowance rose by around 50%; again most of this growth happened in the last year and was partly due to the one-off lump sum paid to allowance recipients in June 2004. On the other hand, while CACP expenditure grew by 30% over the period to $507 for every person aged 65 years and over with a profound or severe limitation, nearly all of this growth occurred before 2003–04. Taken together, the HACC and VHC programs increased by 11% over the 3 years, and reached $1,660 per person by 2003–04. However, the two programs had quite different growth patterns.

User contributions to cost of aged care

Users of many aged care services pay a contribution towards the provision of the service. However, in both residential and community care, government-set limits are placed on fees chargeable by providers.

Clients of the HACC program may be asked to pay a service fee in accordance with the relevant state or territory government's fees policy (which are based on the draft HACC Fees Policy (DoHA 2002:28–33)). The amount charged varies across service types and between states and territories. However, if such a contribution causes financial difficulty for the user, the provider is obliged to reduce or waive charges. Veterans' Home Care clients are required to make a co-payment for all services except respite care. As at July 2005, contributions for VHC services were $5 per hour of assistance, with the contribution for personal care capped at $10 a week.

CACP and EACH recipients may also be required to make a contribution. Full pensioners can be asked to pay up to 17.5% of their pension (excluding the GST supplement), and at 30 June 2004 this equated to $5.67 per day, or 18% and 5% of the basic daily CACP and EACH subsidies, respectively. Those on higher incomes can be asked to pay more, up to a maximum of 50% of their income above the pension. As for HACC services, people cannot be denied services they need based on an inability to pay fees. Data are not generally collected on user payments for community care; however, estimates for the above three programs were derived for the Review of Pricing Arrangements in Residential Aged Care. For 2002–03, user payments by HACC clients were estimated at $43 million, and CACP and EACH recipients contributed an estimated $50 million towards service provision (Hogan 2004:108).

Care fees payable by people in residential aged care depend on both the person's resident status and pensioner status. For all respite residents and pensioner permanent residents (both full and part-pensioner), the maximum standard daily care fee is set at 85% of the Age Pension ($27.54 at 1 January 2005). Non-pensioner permanent residents can be charged a higher standard daily fee—up to $34.76 as at 1 January 2005 (DoHA 2005g). In addition to these maximum basic daily care fees, part-pensioner and non-pensioner permanent residents who are on higher incomes may pay income-tested fees (reviewed quarterly). Such fees are capped at 25 cents for every additional dollar of income over the relevant pension income test free area, and cannot exceed three times the daily standard pensioner rate or the cost of care, whichever is the lower (DoHA 2001: section 7.3.4.1). In 2002–03, the basic daily care fees yielded $1,274.8 million in basic user charges, and income-tested fees amounted to an additional $92.9 million (AIHW and DoHA analysis of ACCMIS database). Basic daily care fees raised $1,411.8 million in 2003–04, while the income-tested contributions provided $119.2 million. These fees were in addition to the $5,336.0 million spent in 2003–04 on residential aged care subsidies by the Australian, state and territory governments (Table 4.24), and, similar to previous years, accounted for just over one-fifth of the $6,867 million spent in total on care in residential aged services.

In addition to the basic and income-tested care fees, people entering permanent residential aged care may contract, on entry, to make accommodation payments to contribute to the cost of their accommodation. These payments are assets-tested, and can only be charged to people who have assets exceeding a prescribed minimum level and who entered into an accommodation payment agreement on entry into their current permanent care. Payments may be either in the form of an accommodation bond or accommodation charge. An accommodation bond is an amount payable by people who enter residential care at low-level care, and by those who receive care on an extra service basis (with either high- or low-level care needs). Residents can choose to pay an accommodation bond as a lump sum, as a regular periodic payment, or a combination of both. The service provider can retain part of the accommodation bond, with the balance of the bond being refunded to the resident (or their estate) on departure. An accommodation charge is an additional daily amount which is payable by people who enter permanent residential care at a high level of care; it is payable for up to 5 years.

The amount of the accommodation bond or charge is agreed by the resident and the aged care provider, and may vary widely between residents, both within a residential

aged care service and between services. The Australian Government does not dictate the amount of bonds for residents at different assets levels, but provides a number of legislative protections, including the requirement that residents be left with a minimum level of assets after payment of the accommodation bond; as at 1 July 2004 this minimum was set at $29,000, indexed to $29,500 on 20 September 2004 and $30,000 on 20 March 2005. Other than meeting the minimum assets requirement, there is no upper limit for an accommodation bond. Unlike accommodation bonds, maximum daily accommodation charges are set by the Australian Government, with annual indexation. However, the daily rate for existing residents does not change when these indexations occur. For 2004–05, the maximum daily accommodation charge for new residents was $16.25 (DoHA 2001: ch. 8, 2005g). In addition, residents may choose to pay for additional services not funded through care fees.

4.8 Outcomes

As with other welfare services, the measurement of outcomes for aged care services is an important tool for examining the delivery and quality of the services provided. However, outcome measurement lends itself more readily to the acute care context, where desired outcomes can be more clearly specified, than to aged care services. In care contexts where successful management may be followed by death or deterioration in health status, determining and then measuring desired outcomes is problematic. However, it is still possible to report on measures relevant to program achievements. This section presents data on the accessibility and quality of aged care services.

Accessibility

Accessibility is examined below by considering the provision of residential and community care places and packages, and their use over time. It is currently not possible to provide similar analysis of the HACC program—the other key aged care program—as the provision of HACC services is not bundled into countable packages, and much of the large increase in client numbers seen in the recent HACC MDS collections is more likely the result of increasing participation in the collection than the result of large increases in client numbers.

Supply of residential aged care places and community packages

One of the tools used to plan the provision of residential aged care places and community care places and packages is the planning ratio; this ratio is based on achieving a desired number of places and packages for the number of people likely to need these services. Residential aged care places, Extended Aged Care at Home places and Community Aged Care Packages are intrinsically linked because CACPs aim to provide care equivalent to low care in residential aged care, and EACH places are intended to provide care equivalent to high care in residential aged care. All three are included in the planning ratio, and so are combined to present a comparison of the provision of aged care services against the planning ratio. At the same time, an individual's circumstances may affect whether or not the person can take up a CACP or EACH place, so there is not a strict substitution effect.

As part of the Australian Government's response to the 2004 Review of Pricing Arrangements in Residential Aged Care (Australian Government 2004; Hogan 2004), the planning ratio will be increased from the long-standing 100 operational places and packages per 1,000 persons aged 70 years and over (including places in flexible care) to 108 over 4 years from July 2004. The new provision ratio will be divided into 88 residential aged care places and 20 community care places and packages per 1,000 people aged 70 and over; 55 of the residential places are assigned to high-level care.

In 1999, the total provision of places and packages stood at 94.0 per 1000 people aged 70 and over (AIHW 2003a:321). However, as a result of continued growth in the CACP program and large increases in aged care places since 2001–02, this ratio had reached 100.3 places and packages by 30 June 2004 (Table 4.25). An additional 7,252 places and packages became operational during 2004–05 (DoHA provisional estimate).

While the overall ratio has been increasing since 1996, the provision of residential aged care places declined steadily during the 1990s relative to the number of people aged 70 and over (AIHW 1999:192, 2003a:321). However, this trend has been reversed, with the provision ratio for residential aged care places increasing since 2002. On 30 June 2004, the ratio stood at 84.2 per 1,000 people aged 70 and over, up from its low of 81.7 places in June 2002.

Since the program's inception, CACP provision has grown from year to year relative to the older (70+) population, although in recent years this growth has been slowing. By June 2004 there were 15.6 Community Aged Care Packages per 1,000 people aged 70 and over, up from 14.0 in 2001, and 10.8 in 2000 (AIHW 2003a:321). In addition to these places, the nascent EACH program provided 0.5 community care places per 1,000 in June 2004.

In terms of the more closely targeted supply measure of places and/or packages per 1,000 people aged 65 and over with a severe or profound core activity limitation, between 2001 and 2004 provision changed from 45.8 to 51.0 community care places and packages, and from 267.6 to 267.1 residential aged care places. Consequently, on this measure over the 4 years the number of places and packages per 1,000 people aged 65 and over with a severe or profound limitation rose from 313.4 to 318.2. This equates to an increase of 1.5%, compared with an increase of 7% in places per 1,000 people aged 70 and over. The difference in growth for these two measures is a consequence of the ageing of the population: because disability rates increase with age, as greater proportions reach very old age so too are larger proportions of the older population affected by severe or profound core activity limitations.

Use of residential aged care places and community packages

The use of places and packages by older people reflects the growth patterns in their provision discussed above. Between 2001 and 2004, the rates of use of packages grew for both men and women in all age groups (Table 4.26): by between 14% (among men aged 85 and older) and 33% (among women aged 65–74). On the other hand, within age and sex groups, the use of residential aged care places remained stable or decreased slightly over the period. Taken together, the use of residential aged care places and community care packages rose for women in all age groups, and for men aged 75–84; for men in the other age groups, small declines in use were observed.

Table 4.25: Operational residential aged care places and community care places and packages, 30 June 2001 to 30 June 2005

		Number of places/ packages	Places/packages per 1,000 persons	
			Aged 70+	Aged 65+ with a severe or profound core activity limitation
2001	Community Aged Care Packages	24,629	14.0	45.8
	Residential aged care places	144,013	82.2	267.6
	Total	**168,642**	**96.2**	**313.4**
2002	Community Aged Care Packages	26,425	14.8	47.7
	Extended Aged Care at Home places[(a)]	290	0.2	0.5
	Residential aged care places	146,268	81.7	263.9
	Total	**172,983**	**96.6**	**312.1**
2003	Community Aged Care Packages	27,881	15.3	48.9
	Extended Aged Care at Home places	255	0.1	0.4
	Residential aged care places	151,181	82.8	265.4
	Total	**179,317**	**98.3**	**314.8**
2004	Community Aged Care Packages	29,063	15.6	49.6
	Extended Aged Care at Home places[(a)]	858	0.5	1.5
	Residential aged care places	156,580	84.2	267.1
	Total	**186,501**	**100.3**	**318.2**
2005[(b)]	Community Aged Care Packages	30,916	n.a.	n.a.
	Extended Aged Care at Home places	1,672	n.a.	n.a.
	Residential aged care places	161,165	n.a.	n.a.
	Total	**193,753**	**n.a.**	**n.a.**

(a) In June 2002, EACH places were still formally provided under pilot projects.

(b) 2005 data supplied by DoHA are provisional figures. Places/packages per 1,000 people can be derived once ABS population estimates for June 2005 become available.

Notes

1. Table includes places and packages provided by Multi-purpose Services and flexible funding under the Aboriginal and Torres Strait Islander Aged Care Strategy.
2. Resident population estimates used to derive provision rates are from those released by the ABS in December 2004.
3. Population estimates by disability status are obtained using age/sex disability rates from the ABS 1998 Survey of Disability, Ageing and Carers in conjunction with the estimated resident population. The estimates assume constant disability rates over time within age/sex groups.

Sources: ABS 2004b; AIHW 2005b:3; AIHW analysis of DoHA ACCMIS database (as at 30 November 2004), AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers; DoHA unpublished data.

While the use of residential care within all age and sex groups examined dropped over the 3-year period, the overall usage rate among people aged 65 and over increased. This apparently contradictory result arises directly from the ageing of the population: although use within groups dropped, the ageing of the population meant that a greater proportion of people fell into the older age groups, which had higher use of residential care than younger groups, so that the overall effect was a rise in the usage rate among

those aged 65 and over. The effect is also seen in the usage rates for places and packages combined: the growth in use among those aged 65 and over is greater than would be expected on simple inspection of the changes in the rates within age groups. This phenomenon illustrates the importance of looking more deeply into use patterns when the structure of a population is changing, as a simple total population usage rate may not provide a true indication of whether provision of services is keeping pace with population growth and change.

The high occupancy rate seen recently in residential care services—averaging around 96% since 2000—indicates continuing high demand for residential places (AIHW 2005b:17, and earlier editions). While the overall provision of aged care places and packages has been keeping pace with the growth in the population aged 70 and over, the ageing of the older population, combined with the greater use of services at older ages, is likely to place increasing pressure on the accessibility of aged care. The announced changes in the planning ratio and rising new annual allocations are both aimed at addressing this issue. Whether these measures will be effective is yet to be seen. However, to obtain a broader picture of the accessibility of aged care, and to examine how general access is changing as the population ages, time-series data on age-specific usage rates of HACC services and unmet demand for all programs would be required. Such data are not currently available.

Table 4.26: Usage rates of residential and community care, 30 June 2001 to 2004 (per 1,000 population)

	Males				Females				Persons			
	65–74	75–84	85+	*65+*	65–74	75–84	85+	*65+*	65–74	75–84	85+	*65+*
CACP and EACH												
2001	1.8	6.7	24.5	*5.1*	3.1	12.8	29.8	*10.2*	2.5	10.3	28.1	*8.0*
2004	2.3	8.1	27.8	*6.4*	4.1	16.1	36.8	*13.2*	3.2	12.7	33.9	*10.1*
3-year growth (%)	**27.9**	**19.9**	**13.5**	***23.5***	**32.7**	**26.1**	**23.8**	***29.0***	**30.8**	**23.5**	**20.7**	***27.0***
Residential aged care												
2001	10.1	41.0	166.1	*32.1*	11.0	68.0	299.0	*70.6*	10.6	56.7	257.9	*53.6*
2004	9.5	41.0	160.1	*32.6*	10.1	67.6	295.6	*71.7*	9.8	56.1	252.5	*54.2*
3-year growth (%)	**–5.9**	**–0.1**	**–3.6**	***1.4***	**–8.1**	**–0.6**	**–1.1**	***1.7***	**–7.1**	**–1.0**	**–2.1**	***1.2***
Total												
2001	11.8	47.7	190.6	*37.3*	14.1	80.8	328.7	*80.8*	13.0	67.0	286.0	*61.6*
2004	11.7	49.0	187.9	*38.9*	14.2	83.7	332.4	*84.9*	13.0	68.8	286.5	*64.4*
3-year growth (%)	**–0.8**	**2.7**	**–1.4**	***4.5***	**0.8**	**3.6**	**1.1**	***5.1***	**0.1**	**2.7**	**0.1**	***4.5***

Notes

1. Until June 2002, EACH places were provided under pilot projects. EACH recipients recorded on ACCMIS as at 30 November 2004 were: 51 in 2001, 82 in 2002, 138 in 2003 and 707 in 2004.
2. Residential care includes permanent and respite residents.
3. Table does not include clients of Multi-purpose and flexible service places or packages.
4. Resident population estimates used to derived usage rates are from those released by the ABS in December 2004.
5. Components may not add to total due to rounding.

Sources: ABS 2004b; AIHW analysis of DoHA ACCMIS database as at November 2004.

Standards and quality of care

Previously data on national standards and quality of care have only been available for residential aged care services. However, the completion in June 2004 of a 3-year appraisal program for HACC agencies means that data on quality of care are now also available for the HACC program.

The HACC National Service Standards were introduced by the Australian Government in 1991 'as part of a commitment to providing high quality services to consumers of community care' (Australian Healthcare Associates 2005:15). The HACC National Service Standards Instrument and Guidelines were developed in 1998 to provide a nationally consistent and reliable means of measuring and monitoring agency compliance with the standards (Box 4.5).

Box 4.5: HACC National Service Standards Instrument (NSSI)

The NSSI addresses the seven objectives of the HACC National Service Standards:

1. *Access to services*
2. *Information and consultation*
3. *Efficient and effective management*
4. *Coordinated, planned and reliable service delivery*
5. *Privacy, confidentiality and access to personal information*
6. *Complaints and disputes*
7. *Advocacy.*

The NSSI comprises 25 performance questions and the Consumer Survey Instrument, and is designed to identify whether agencies are meeting the standards. (HACC Officials 1998; DoHA 2000; see AIHW 1999 and AIHW 2001 for discussion of instrument development).

Between 2000–01 and 2003–04, HACC-funded agencies underwent their first external appraisal using the HACC National Service Standards Instrument (NSSI). In the absence of detailed implementation guidelines, each state and territory adopted individual approaches when assessing agencies against the NSSI. As a consequence, the results for each state and territory from the first 3-year assessment cycle are not directly comparable. During the evaluation cycle, 2,709 out of 3,335 HACC agencies were assessed using the HACC NSSI; of these, 46% had an overall rating of 'High', 29% rated 'Good', 18% rated 'Basic' and 7% rated 'Poor'. The level of compliance varied across the states and territories, both in terms of their overall rating and within the seven service standard objectives for individual jurisdictions (Australian Healthcare Associates 2005:22–3).

Unlike HACC, national data on standards and quality of care for residential aged care have been available for a number of years. Two processes are in place to ensure quality of residential aged care: certification and accreditation (Box 4.6).

Box 4.6: Residential aged care service certification and accreditation processes

Certification

Certification is managed by the Department of Health and Ageing. New services, and extensions and modifications to existing services, are assessed for certification either prior to occupancy or once residents have moved in. To achieve certification a service is assessed in an on-site building inspection. The building assessments focus on seven areas, with the following weightings: fire safety (25%); hazards (12%); privacy (26%); access, mobility and occupational health and safety (13%); heating and cooling (6%); lighting and ventilation (6%); and security (12%) (DoHA 2001: ch. 13). Residential aged care services are required to achieve a safety score of at least 19 out of 25, and an overall score of 60 out of 100. If the service is new, compliance with the 1999 privacy and space standards is also assessed; these include a mandatory maximum average of 1.5 residents per room, with no room accommodating more than two people.

Accreditation

Service accreditation is undertaken by the Aged Care Standards and Accreditation Agency Ltd. Accreditation is based on assessment against the residential aged care Accreditation Standards. These standards include 44 expected outcomes relating to four matters: management systems, staffing and organisational development; health and personal care; residents' lifestyle; and physical environment and safe systems (for details, see AIHW 2001:442–3).

The agency makes accreditation decisions based on audits by registered aged care quality assessors, other site visits, and other relevant information. It is currently funded for an average of 1.25 visits per residential aged care facility per year, with most services getting one visit per year and a few getting multiple visits, depending on the risk profile (ACS&AA 2004b:2).

Generally, residential aged care services that satisfy all of the Accreditation Standards receive 3 years accreditation. Services accredited for periods of less than 3 years may have areas of current non-compliance or a recent history of non-compliance, and the agency may refuse to accredit a service altogether. Before new residential aged care services can claim residential care subsidies they must be accredited. Such commencing services can only receive 12 months accreditation (ACS&AA 2003:24–5, 2005). The agency regularly reviews all residential aged care services through planned accreditation rounds.

Certification aims to ensure the physical quality of the residential aged care service. A service must be certified for it to be able to charge accommodation payments or to receive concessional resident supplements. While there is no mandatory review mechanism for certification, the certification status of an established residential aged care service can be re-assessed at any time. Many of the issues that could lead to a review of certification are covered in the accreditation process, and consequently the need for review of a service's certification may be indicated by poor performance in one or more of the areas (including the physical environment) examined in the accreditation process.

Because services are certified when they are new, or when building modifications are made, data on the certification status relate to the date of its certification, and so, as these dates differ for each service, it is not possible to provide data on the physical quality of all services at any one time.

While certification ensures the quality of the building when a residential aged care service is established, regular accreditation ensures the ongoing quality of care for aged care residents. Established in 1997, the Aged Care Standards and Accreditation Agency Ltd manages the accreditation process and promotes high-quality care. Residential aged care services must be accredited in order to receive residential care subsidies from the Department of Health and Ageing (ACS&AA 2004a:16).

During 2003–04 the agency completed its second round of accreditation, round one having been completed at the end of 2000. It conducted 879 accreditation site visits, 86 review audits and 553 spot checks. In addition, its assessors carried out 2,815 on-site support contacts (ACS&AA 2004a:22). The previous year 1,965 site audits, 68 review audits, 242 spot checks and 1,310 on-site support contacts were conducted (ACS&AA 2003:15). The difference in activity mix between the 2 years resulted from the cyclic nature of accreditation.

In the 2 years up to 30 June 2004, two services were refused accreditation (Table 4.27), and as at 30 June 2004, 91% of the 2,898 accredited residential aged care services (not including 51 commencing facilities) had been given 3 years accreditation. In addition, 'of those that did have some non-compliance, about half were non-compliant in only one expected outcome' (ACS&AA 2004a:4). Excluding the 51 commencing services, 91% of accredited services were accredited for at least 3 years, and 6% were accredited for between 2 and 3 years. Just 1% were accredited for 1 year or less. Similar results were observed for the previous year, although a higher proportion of services had 3 years accreditation (96%).

4.9 Summary

Policy developments

The last 2 years have witnessed a continuing strong interest in population ageing and its implications for the social and economic future of Australia. Reflecting this, there has been a considerable amount of activity in respect of aged care policy. The Review of Pricing Arrangements in Residential Aged Care was completed, and the 2004 and 2005 federal budgets included a number of initiatives which responded to its recommendations. These include increasing the provision ratio for aged care places, introducing funding supplements for residents with complex care needs and declaring dementia a National Health Priority. The Community Care Review resulted in the 2004 release of *A New Strategy for Community Care – The Way Forward* which establishes a framework to progress work on improving accessibility to and coordination of community care programs.

The establishment of the Ageing Well Research Network and the funding available through the Ageing Well, Ageing Productively Research Program confirm the importance of building ageing research capacity and provide new opportunities to strengthen the evidence base for future policy.

Table 4.27: Accreditation status of residential aged care services as at 30 June 2003 and 2004

Length of accreditation	2003	2004
Existing residential aged care services		
<1 year	—	0.1
1 year	0.5	0.9
>1 and <2 years	0.2	1.2
2 years	2.1	3.7
>2 and <3 years	1.7	2.7
3 years	95.5	91.1
4 years[(a)]	—	0.2
Total	*100.0*	*100.0*
Total number	*2,887*	*2,898*
Commencing residential aged care services		
1 year[(b)]	57	51
Total accredited residential aged care services	**2,944**	**2,949**
Accreditations undertaken in the year		
Accreditation granted	1,655	294
Accreditation refused	2	—
Total	**1,657**	**294**

(a) Prior to July 2005, a service could be awarded 4 years accreditation after showing consistent and exceptional performance against the Accreditation Standards. From 1 July 2005, the maximum period of accreditation was limited to 3 years, with higher ratings being replaced with Better Practice in Aged Care awards.

(b) Legally, commencing services can be accredited for 1 year only.

Note: Components may not add to total due to rounding.

Sources: ACS&AA 2003:24–5, 2004a:16–17.

Ageing in Australia

In the 20 years from 2004, the number of people aged 65 years and over is expected to increase by 92% to reach almost 5 million by 2024. The number of very old people (85+) is expected to grow even faster and is projected to reach 725,300 in 2024; by then this group of people will make up nearly 15% of the population aged 65 and over, up from 12% in 2004.

Like the total Australian population, the Aboriginal and Torres Strait Islander population is ageing both numerically and structurally, albeit at a much slower pace. The older population (65+) born in non-English-speaking countries is projected to increase more quickly and age more rapidly than the older Australian-born population.

Ageing of the population is one of the most important issues facing Australia over the coming decades, with significant implications for the health sector, the economy, and the social and physical environments. A range of strategies and policies have been and are being developed to address these issues, and there is increasing emphasis on facilitating healthy and productive ageing.

Older Australians are experiencing falling death rates and greater life expectancy, most of which is lived without reduced functioning, and most rate their health as good or better. While many older people live with some disability, the rates of profound or severe limitation are quite low until age 75 (under 15% in 2003). Only around 5% of people aged over 65 live permanently in residential aged care.

Older people contribute to society in a variety of ways, including through volunteer work and caring. In 2002, 634,000 people aged 65 and over (28%) undertook volunteer work through an organisation or group. Many older people also provide care for family and friends. In 2003, nearly 454,000 people aged 65 and over provided assistance to people with a disability—113,200 as the primary carer of the care recipient (equating to 4.5% of older people).

Aged care services

Increasing emphasis on community care and decreasing emphasis on residential care has continued. For all aged care services, the proportion of people using a service increases with age.

The bulk of home- and community-based services for older people is provided under the auspices of the Home and Community Care program. In 2003–04, at least 537,100 people aged 65 and over received HACC services—or 210 people per 1,000. In the same year, Veterans' Home Care assisted 61,600 older people, and as at 30 June 2004, 25,700 people aged 65 and over were on a Community Aged Care Package.

Respite services continue to play an important role in supporting home-based care. In 2003–04, 57,800 older HACC clients used centre-based respite care and 5,200 used in-home respite. In addition, 8,100 VHC clients aged 65 and over received in-home or emergency respite. Furthermore, 46% (or 44,100) of admissions into residential aged care for older people during 2003–04 were for respite care.

Residential aged care is the second most commonly used aged care service after HACC. At 30 June 2004, 141,300 people aged 65 and over were in residential aged care, either permanently or for respite care, so that out of every 1,000 people aged 65 and over, 53 were in permanent residential aged care, with just 1 additional person being in residential respite care. The profile of care needs of permanent residents has continued to shift towards higher care, and 65% of older permanent residents had high care needs, with nearly all having multiple care needs. There were 161,165 operational residential aged care places, including flexible and Multi-purpose Service places, by 30 June 2005.

Aboriginal and Torres Strait Islander peoples have a shorter life expectancy than other Australians, and use aged care services at a younger age: among people aged 50–74 years, Indigenous people had much higher usage rates than other people for all services examined.

Programs providing community care have relatively more clients born in non-English-speaking countries compared with residential care services. However, people born in Australia had higher usage rates than others in all age groups for all services except Community Aged Care Packages.

The provision of residential aged care places and community places and packages would appear to be keeping pace with growth in the population aged 65 and over with a severe or profound limitation. However, growth in the population of very old people aged 85 and above would appear to be driving increased demand for care and a rise in the overall usage rate for the population aged 65 and over.

Expenditure

Total government expenditure on aged care services was $7,321.7 million in 2003–04, an increase of 23% in real terms since 2000–01. Overall, the increase in expenditure on aged care services kept pace with the growth in the number of older people likely to need some assistance.

Users of aged care services also contribute to the cost of their care. In 2003–04, residents of residential aged care services contributed just over $1,500 million in basic and income-tested fees. Clients of community care programs also make contributions, and for 2002–03 it is estimated that HACC clients contributed $43 million and CACP and EACH recipients together paid $50 million towards the cost of their care.

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