



Chapter

6

Ageing and aged care

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6 Ageing and aged care

Key points

- Australians are living longer than ever before, with around one in seven persons being aged 65 years or over.
- Most older people live in private dwellings: only one in 20 persons aged 65 years or over, and one in four of those aged 85 years or over, live in cared accommodation.
- Many older Australians contribute to the community through voluntary work, as carers and as providers of regular informal child care.
- A range of government-funded programs assist older people living in the community. The largest of these is Home and Community Care (HACC), which provided services including domestic assistance, home maintenance, meals and transport to 688,000 older people in 2009–10.
- In June 2010, more than 47,000 older Australians were receiving community care packages to enable them to live in the community rather than enter residential aged care.
- The Australian Government also subsidises residential aged care services for people whose needs are such that they can no longer remain in their own homes. At 30 June 2010, there were over 156,000 permanent aged care residents aged 65 years or over.
- Over half of aged care residents have dementia. These residents are more likely than those without dementia to have high-care needs.
- Indigenous Australians have relatively high usage of aged care services compared with non-Indigenous Australians. They are also more likely to use these services at a younger age.

6.1 The policy context

Ongoing demographic and social trends in Australia are changing the circumstances of the older population. Today's older Australians are:

- living longer, and generally in better health, than ever before
- often highly skilled and with more formal qualifications than previous generations
- increasingly likely to continue working past the traditional 'retirement age'
- often participating in the community through volunteering
- major providers of informal care, especially to their spouse or partner
- a common source of regular informal child care
- highly likely to be home owners.

While population ageing has resulted in a large and growing group of older people who are generally well, living independently and participating in society in a variety of ways, other older Australians are unable to care for themselves at home or require support to do so.

Existing and emerging challenges

Supporting a growing and ageing population

As noted in 'Chapter 1 Australia's people', the ageing of the Australian population presents several challenges. These include the increased number of people requiring aged care services, the diversity and geographic distribution of this population, and the additional resources—in money, infrastructure and personnel—that will be needed to support older Australians in the future.

In addition, the projected changes in dependency ratios (discussed in Chapter 1) means that the pool of workers available to provide services and supports for older people—directly and through taxation—will fall as a proportion of the total population. The 2010 Intergenerational Report (Treasury 2010) suggests that improved productivity, increased labour force participation and more efficient use of resources will be important in tackling these problems.

One example of this is age-related pension expenditure. The pension system is designed to strike a balance between targeting of assistance and maintaining incentives for work and saving, and to ensure that those with the most need receive the highest rates of payment. The Australian Government's *Secure and Sustainable Pension Reform* package, which was part of the 2009 Federal Budget, included measures both to increase pension rates and also promote the sustainability of the system by increasing the pension income test taper (after it was reduced in 2000) and raising the Age Pension qualifying age to 67 years by 2023.

Seamlessly meeting varied needs of older Australians

The more efficient and effective use of resources underpins reforms proposed or underway in other key areas, most notably health and disability. In health, three recently issued reports—the National Preventative Health Strategy (Preventative Health Taskforce 2009), the National Primary Health Care Strategy (DoHA 2010a) and the final report of the National Health and Hospitals Reform Commission (NHHRC 2009)—outline the need for ensuring the health system better meets the needs of older Australians and is more effectively connected with other services, including aged care.

In the disability sector, the report of the Productivity Commission Inquiry into Long-term Care and Support recommends a National Disability Insurance Scheme (NDIS) and a National Injury Insurance Scheme be established to fund long-term care and support for people with disability or catastrophic injury (see 'Chapter 5 Disability and disability services'; PC 2011b). The proposed NDIS would reduce the difficulty that some people with disability face in accessing appropriate support as they age, allowing people to use the support system that best meets their needs. The Australian Government, together with States and Territories, are considering the recommendations.

Meeting the needs of older people in regional and remote areas

Chapter 1 showed that population age profiles vary between regions of Australia, with people aged 65 years or over making up 12% of the population in capital cities in 2010, compared to 15% outside the capital cities (Figure 1.15). Disability among older Australians is also unevenly distributed. Data from the 2006 Census shows that the burden of disability among older people is greatest in *Remote* areas (see AIHW 2009a, Fig 3.2).

The uneven distribution of potential need across Australia has implications for planning and delivery of health and aged care services. Transport, housing, and social and community facilities also need to be designed with the needs of older people in mind. The additional call for aged care services in regional and remote Australia is a key challenge for service delivery. Programs such as the Multi-Purpose Services program, the Remote and Indigenous Service Support (RISS) program, the National Aboriginal and Torres Strait Islander Flexible Aged Care program and Australian Government viability supplement payments all help to ensure the care needs of older people living outside of the major cities are met, while other developments such as the new front-end for aged care information and assessment and the Broadband for Seniors initiative will help to keep older Australians in regional and remote areas socially connected and able to access information they need.

Australia's aged care system

The Australian Government is committed to 'helping older people enjoy active, healthy, engaged and independent lives' and 'ensuring that all frail older people have timely access to appropriate care and support services' (DoHA 2010b). Numerous programs, policies and initiatives are in place to achieve these aims. Along with the provision of the Age Pension and contribution to funding of residential aged care facilities, the Australian Government provides funding and regulation for a wide range of supports for older people, including community and flexible aged care services, respite care services and a variety of concessions and allowances. These have been described in detail in previous editions of *Australia's welfare* (see, for example, Chapter 3 of the 2007 edition). The main features of the system and some recent major changes are summarised below, with additional detail provided in the following sections where appropriate.

The majority of Australian Government-subsidised aged care services in Australia operate within the legislative framework provided by the *Aged Care Act 1997* ('the Act') and related Aged Care Principles. This framework determines who can provide and receive care, and their responsibilities; the types of services that are available; and how aged care is funded. Australian Government programs under the Act include residential aged care, Community Aged Care Packages (CACAP), Extended Aged Care at Home (EACH) and EACH Dementia (EACHD) packages, and flexible aged care programs. These programs are described in detail in Chapter 6.6.

Major components of the system operating outside the Act include the Home and Community Care (HACC) program (described in Chapter 6.6) and the National Respite for Carers Program (discussed in 'Chapter 7 Informal care').

Under the Act, the following groups are identified as having special needs:

- people from Aboriginal and Torres Strait Islander communities
- people from non-English-speaking backgrounds
- people who live in rural or remote areas
- people who are financially or socially disadvantaged
- veterans, their spouse, widow or widower
- people who are homeless or at risk of becoming homeless
- care-leavers (people who, as children, were in institutional or other out-of-home care through the 20th century).

A range of specific programs aim to ensure that groups with special needs are well supported and aged care services are able to recognise, understand and meet their particular requirements. More detail about these programs is provided in the *Report on the operation of the Aged Care Act 1997* (DoHA 2010b).

A time of reform

This is a time of change and reform in several key areas, including aged care. In August 2011, the Australian Government released the findings of a Productivity Commission inquiry into aged care tasked with developing 'detailed options for redesigning Australia's aged care system to ensure it can meet the challenges facing it in coming decades' (PC 2010). The Commission found that while the aged care system has improved over the past decade, it suffers from key weaknesses, including difficulty in navigating the range of services available, limited consumer choice, variable quality, gaps in coverage, inconsistent pricing and workforce shortages.

Reforms proposed by the Commission to address these weaknesses include the establishment of a national platform for aged care information, assessment and referral; the creation of a single national care co-contribution regime, with the contribution rate set according to individual financial circumstances; the establishment of a Government-backed credit scheme to ensure that older Australians should not be required to sell their home to meet aged care costs, and a savings account scheme for pensioners who do wish to sell their residence; and a lifetime cap on care co-contributions to approved services, as protection against very high costs of care.

Other recommendations made by the Commission include strategies to build and maintain a well-skilled aged care workforce, and separation of the policy and regulation functions of the Australian Government Department of Health and Ageing via the establishment of a new independent Australian Aged Care Commission (PC 2011a).

The Australian Government is considering these issues and developing a response to the report, with input from the community and industry stakeholders.

Other recent changes affecting older Australians

In August 2011, the Council of Australian Governments (COAG) finalised a National Health Reform Agreement. Among a range of health reforms, the agreement sees the Commonwealth become directly responsible for funding basic community care under the HACC program in all states and territories (except Victoria and Western Australia) for people aged 65 years and over, and Indigenous Australians aged 50 years and over. This is in addition to its existing responsibility for funding and regulating packaged community and flexible aged care programs and residential aged care. The aim of these changes is to deliver a nationally consistent aged care system for all Australians.

A number of Federal Budget measures relating to ageing and aged care have been introduced in 2010 and 2011. These include the establishment of 'one-stop shops' to provide access to information, intake and assessment for aged care services; expanded access to Multi-Purpose Services providing flexible care in rural and remote areas; enhanced training for aged care workers; and incentives for health professionals to deliver bulk-billed services to residents in aged care facilities.

Box 6.1: Older Australians at a glance

- Over three million Australians (13% of the population) are aged 65 years or over; 54% are female.
- Less than 1% are of Aboriginal or Torres Strait Islander origin, and more than one-third were born overseas.
- More than 94% live in private homes or self-care accommodation, reducing to 77% of those aged 85 years or over.
- 25% of those in private homes live alone, rising to just over half of those aged 85 years or over; most are female.
- 1% are participating in formal education.
- 11% are employed, with 53% of these working part time.
- 27% participate in voluntary work.
- 19% are carers.
- Two-thirds of those living in private households rate their own health as good or better.
- 20% have a severe or profound disability.
- 78% receive the Age Pension or means-tested income support administered through the Department of Veterans' Affairs; around two-thirds receive a full-rate pension.

6.2 Australia's older population

Australia's older people are a far from homogeneous group. The population aged 65 years or over (see Box 6.2) spans a more than 40-year age range, with around one in every 6,000 Australians in 2010 aged 100 years or over. The people who are the focus of this chapter come from many different nations and cultural backgrounds; some are Indigenous Australians whereas others are recent immigrants. They live in all parts of the country as residents of many different communities, and their circumstances, abilities and resources differ, along with their needs.

Box 6.2: A note about age ranges

This chapter focuses for the most part on people aged 65 years or over, a conventional definition of 'older people' based on the original qualifying age for the Age Pension (for males). Governments do not use this age for making aged care service planning or funding decisions; nor does it reflect program eligibility. Information presented in this chapter, therefore, may relate to age groupings other than 65 years or over, depending on the particular service or data source, and this is made clear at the appropriate points.

A notable exception to the '65 years and over' focus is information about older Aboriginal and Torres Strait Islander people. Due to their generally lower life expectancy and poorer health status (see AIHW 2010a), Indigenous Australians may require care services at a younger age than other Australians. For this reason, the population of Indigenous Australians aged 50 years and over is considered in aged care planning.

Who are Australia's older people?

In 2010, there were an estimated three million Australians aged 65 years or over, 13% of Australia's total population (see Chapter 1.2). Of these, around two-thirds lived in *Major cities* and almost one-quarter in *Inner regional* areas. Fewer than 2% lived in *Remote* or *Very remote* areas. Females outnumbered males in all age groups, with the difference increasing with age (Figure 1.1).

As noted in Chapter 1, the Australian population is ageing. Life expectancy in Australia has increased almost continually over the past century (see AIHW 2010a), and this has resulted in growing numbers of people living healthy and productive lives beyond their working years, who may require services and other support during their older years. As the group most likely to require aged care services, the growth of the 85 and over population will have a large impact on government spending on such services in the future. Based on medium-level growth assumptions, the ABS has projected the number of people aged 85 years or over to double from 374,000 in 2010 to 764,000 in 2031.

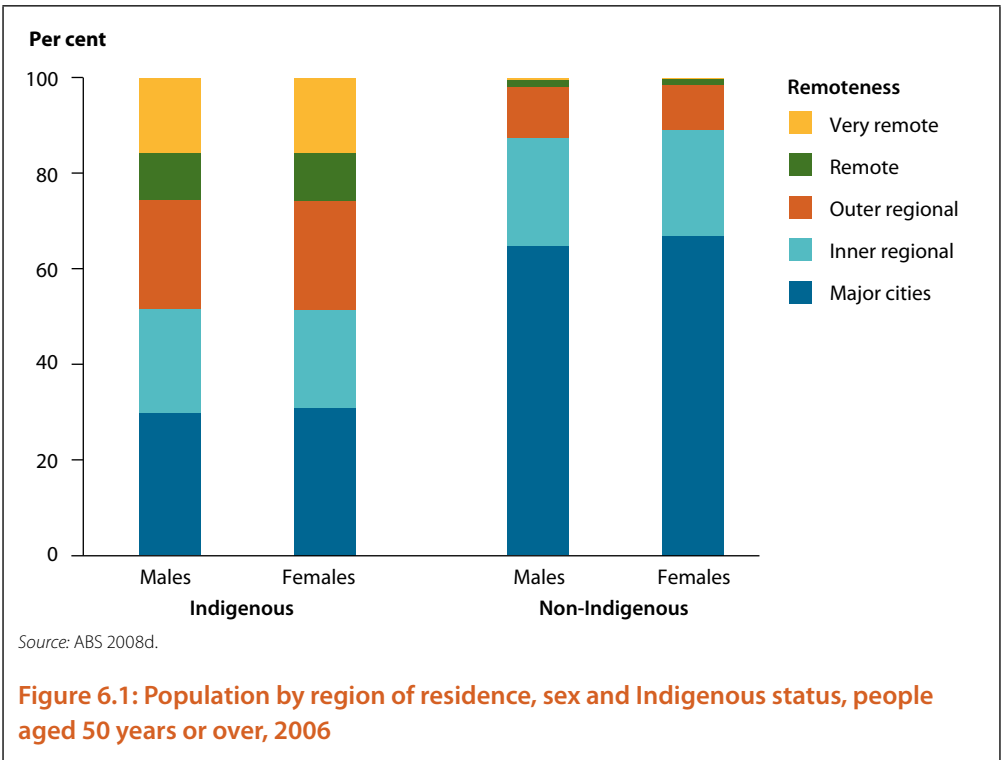
Women of all cultural backgrounds in Australia tend to live longer than men (AIHW 2007c). Women accounted for just over half of people aged 65–74 years in 2010, but comprised a larger share of the very old (65% of people aged 85 years and over). The predominance of women in older age groups is diminishing as recent life expectancy gains have been greater for males than for females, but is likely to continue for some time to come. The sex composition of the older population has implications for social and health policy—as a result of lifetime differences

in earnings and workforce participation, older women are more likely to have lower incomes (ABS 2008b), while their survival to more advanced ages means they have high rates of severe disability (AIHW 2007c: Table A17.1) and are less likely to have a spouse carer (AIHW 2007c:52).

Older Aboriginal and Torres Strait Islander people

The Indigenous Australian population has a younger age structure than the general Australian population, with only 3% of Australia's Indigenous population being aged 65 years or over, and 12% aged 50 years or over (see Chapter 1.2; Table A1.2; Box 6.2).

The geographic distribution of older Indigenous Australians differs considerably from that of their non-Indigenous counterparts, with less than one-third of Indigenous Australians aged 50 years or over living in *Major cities* and around one-quarter living in *Remote* or *Very remote* areas (Figure 6.1). As mentioned previously, this geographic spread is a key challenge for providing aged care services now and into the future.



As with the general population, the older Indigenous population has also been growing, at an average rate of approximately 4% per year between 1986 and 2006. Closing of the life expectancy gap between Indigenous and non-Indigenous Australians could see the rate of growth of the older Indigenous population increase further in the future.

This increase has important implications for the future planning of aged care services. With Indigenous Australians being more likely than non-Indigenous Australians to live in *Remote* and *Very remote* areas, additional services could be required in these areas over the next decade. Moreover, increased delivery of culturally appropriate services in all geographic

areas may be necessary to cope with greater demand. The differing overall health profile of Aboriginal and Torres Strait Islander people (for example, greater rates of Type 2 diabetes and chronic kidney disease, and younger age of onset of chronic conditions, compared with other Australians), though potentially changing due to the improvements resulting in increased life expectancy, also means that services may have to respond to a different pattern of medical needs. A corresponding increase to the aged care workforce, including additional workers of Aboriginal and Torres Strait Islander origin and workers fluent in Indigenous languages, would also be required.

Older overseas-born Australians

More than one-third of Australians aged 65 years or over in 2010 (36%, or over one million people) were born overseas (AIHW analysis of ABS 2011d). The most common countries of origin were the United Kingdom (the birthplace of 11% of older Australians), Italy (4.0%) and Greece (2.3%). Overseas-born older Australians are likely to be from European countries, having migrated in the years following World War II. More recently, younger migrants are more likely to have a non-European origin, coming from countries such as New Zealand, China, India and Vietnam.

Further information about migration patterns and ethnic diversity in the Australian population is provided in Chapter 1.4.

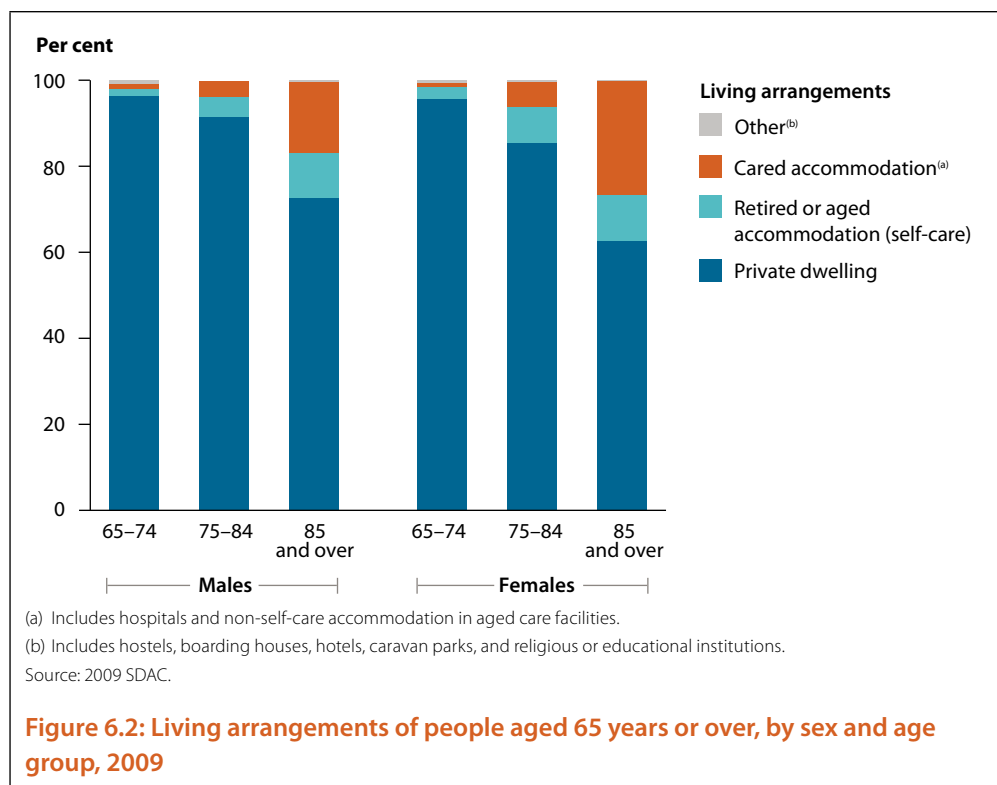
The diversity of cultural and language backgrounds within the Australian population—including the many Aboriginal and Torres Strait Islander cultural and language groups, as well as those born overseas—has implications for service provision, in terms of offering bilingual support and being sensitive to cultural traditions and beliefs. The shifts in migration patterns over the second half of the 20th century (see Chapter 1.4) will mean that aged care services will need to continue to adapt to varying cultural and language needs as the ethnic composition of the older population changes.

Family and living arrangements

Most older Australians live in private dwellings, with only around one in 20 people over 65 years being resident in cared accommodation (such as an aged care facility or hospital) (Figure 6.2). Although the use of cared accommodation increases sharply with age (to almost one in four among those aged 85 years or over), the majority of people live in private dwellings, even in the oldest age groups.

The majority (69%) of older people living in private dwellings lived in a single family household (AIHW analysis of the 2009 Survey of Disability, Ageing and Carers CURF). Around one-quarter lived alone, with the proportion increasing with age to be just over half (51%) of those aged 85 years or over, most of them women. Several factors influence this pattern, including higher numbers of widows and people with partners in cared accommodation among the older age groups, and the longer life expectancy of women compared with men leading to greater numbers of widowed females (among those aged 85 years or over in 2009, 78% of women were widowed compared with 38% of men). However, increasing life expectancy over the past 30–40 years, particularly among men, has meant that the proportion of older people who are widowed is gradually falling and, correspondingly, the proportion who are married is rising. Another change, currently being observed mainly in the younger cohort (aged 65–74 years), has been a gradual increase in the proportion who are divorced (AIHW 2007c).

These changes have consequences for the social and economic wellbeing of older people. On the one hand, increasing proportions of married couples may be accompanied by reductions in the proportions living alone and at risk of social isolation, an increase in the availability of spousal caregiving for older people with disability, and more secure financial and housing circumstances. On the other hand, the still considerable numbers of widows and increasing numbers of older people entering retirement as divorcees may bring higher risks of social, financial and emotional vulnerability for some.



On Census night 2006 there were an estimated 7,400 homeless older Australians, around 27 in every 10,000 people aged 65 years or over (ABS 2008c). Around two-thirds (64%) of these were males. Older people accounted for 7% of Australia's total homeless population in 2006.

6.3 The health of older Australians

Today's older Australians have a longer life expectancy and are generally healthier than previous generations (Chapter 5; AIHW 2010a). Improving the health of older people is a national research priority in Australia (DIISR 2011), as good health not only promotes participation and good quality of life but reduces dependency on health and aged care services.

However, activity limitations and the presence of various long-term conditions do become more common with age. A substantial proportion of older Australians have several health conditions at once, which can greatly complicate their health care needs. The health of older Australians has been described in detail elsewhere (for example, see AIHW 2007a, 2007c, 2010a) but the following brief overview provides some context.

Life expectancy

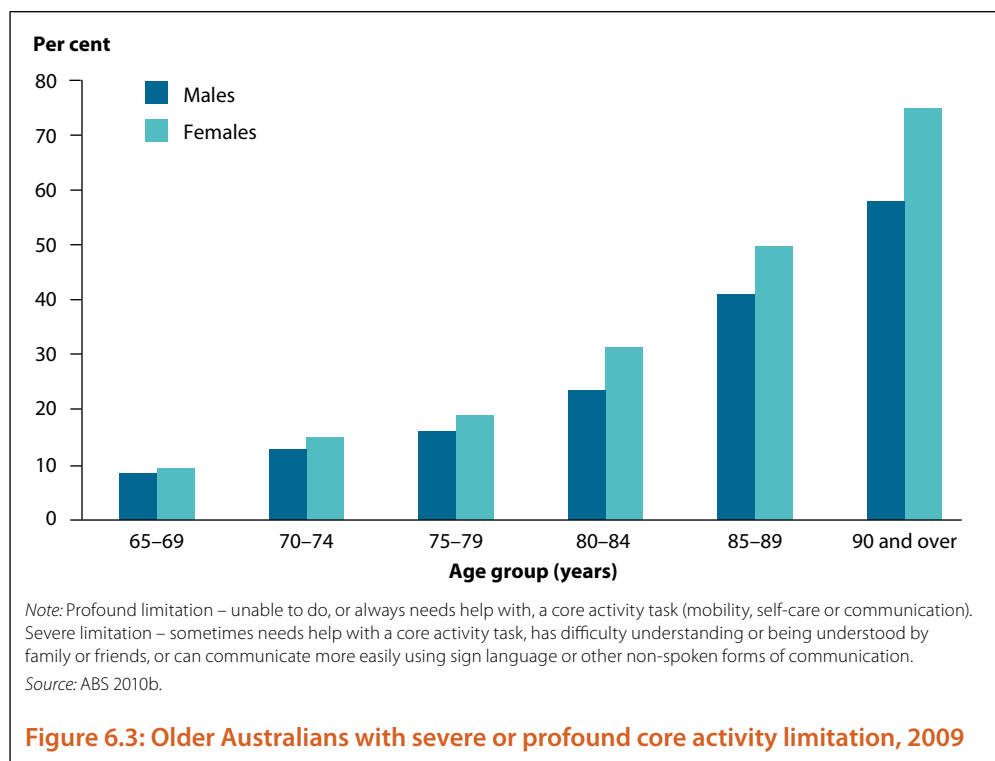
The majority of Australians enjoy good health and life expectancy among the highest in the world (AIHW 2010a). Since the 1970s, expectancies for older Australians have increased substantially. In 1970–1972, life expectancy for females and males aged 65 years was 80.9 and 77.2 years, respectively, whereas for those aged 85 years it was 90.0 and 89.1 years (ABS 2008a). By comparison, in 2007–2009, a 65-year-old Australian female could expect to live to the age of 86.8 years, and a male to 83.7. Females and males aged 85 years could look forward to living to the ages of 92.1 and 91.0 years, respectively (ABS 2010a).

Self-assessed health

According to the 2007–08 National Health Survey, two-thirds of older Australians living in households rated their own health as good, very good or excellent. This survey, however, does not include people living in institutions, such as hospitals and residential aged care facilities, and so excludes a large proportion of those who are more likely to have poor health.

Disability

Information from the 2009 Survey of Disability, Ageing and Carers (SDAC), which covers both the household and institutional populations, suggests that there are more than 1.5 million older Australians (53% of people aged 65 years or over) with some level of disability (ABS 2010b). One in five people of this age (590,000 people) have severe or profound disability, meaning that they sometimes or always need assistance with at least one core activity task (self-care, mobility or communication). The proportion of people with this level of disability increases with age, and is greater among women than men (Figure 6.3).



The most common conditions causing disability among older Australians are arthritis and related disorders (the main condition for 22% of older people with disability), back problems (12%), diseases of the ear and mastoid process (which affect hearing) (10%) and heart disease (6%). While less common, dementia and Alzheimer disease (discussed further below) are of significant concern in terms of disability severity. The large majority (95%) of older people with disability due to dementia or Alzheimer had severe or profound limitations. Other conditions associated with severe or profound limitations among older people include Parkinson disease (81%), Multiple Sclerosis (80%) and stroke (77%).

Assuming constant age-specific disability rates from 2003, the number of people aged 65 years and over with a profound or severe limitation was projected to almost double in the 20 years to 2023, to over a million people (see AIHW 2009a: Table 3.3). However, the latest estimates from the 2009 SDAC suggest that the overall disability rate among people aged 75–84 years has fallen by around five percentage points since 2003, and the proportion of females aged 80–84 years with a severe or profound limitation has fallen by nine percentage points (ABS 2011b). Disability rates in other adult age groups have also fallen, though not significantly so. If sustained, these falls are likely to substantially reduce projected estimates of the number of older people with disability in the future.

Long-term conditions

Three-quarters of Australians living in the community have at least one long-term condition (that is, a disease or health problem that has lasted, or is expected to last, for at least six months), and many have more than one (AIHW 2010a). The proportion of people with multiple long-term conditions increases with age; around half of those aged 65–74 years had five or more long-term conditions in 2007–08, increasing to seven in 10 of those aged 85 years or over.

Dementia is a significant health problem among older Australians. Although not often a direct cause of death, it is highly disabling and can result in a high need for care in the long term. Among Australians aged 75 years and over, dementia is estimated to be the leading cause of burden of disease for both females and males (AIHW 2010a).

Dementia is not a natural part of ageing, although the great majority of people with dementia are older people. In 2003 an estimated 175,000 Australians had dementia, with 95% being aged 65 years or over. While the majority of people with dementia lived in households (57%), almost two-thirds (63%) of those who were aged 85 years or over lived in cared accommodation (AIHW 2007b). Chapter 6.6 provides more detailed information about people with dementia living in residential aged care.

Assuming no change in underlying rates of dementia, in 2007 the AIHW projected that the number of Australians with dementia would have risen to 222,000 in 2011, due to population growth and ageing (AIHW 2007b). AIHW will publish revised estimates based on current data in 2012.

A range of other health conditions also disproportionately affect older Australians. These include arthritis (affecting 48% of people aged 65 years or over), complete or partial deafness (33%), cardiovascular disease (24%), osteoporosis (16%) and Type 2 diabetes (13%) (ABS 2010d). More information about these conditions and their impact on older Australians can be found in *Australia's health* (AIHW 2010a) and other AIHW reports (see <www.aihw.gov.au>).

6.4 Older Australians and participation

The Australian Government's Social Inclusion Agenda recognises the importance of social connectedness and participation in reducing disadvantage and social exclusion (Social Inclusion Unit 2009). Participation in social and other activities within the community has many benefits. It builds social capital—that is, the networks and relationships that facilitate cooperation, trust, support and the sharing of information. This helps to develop and maintain the informal support networks that many older people rely on for assistance, and can provide a source of information about formal support services. It may improve the mental and physical health of participants through increasing self-esteem, building a sense of belonging and enabling participation in physical activity (Caperchione et al. 2011; Ormsby et al. 2010). Further, there can be economic benefits for the individual through paid employment and for the community through volunteer work, informal caring and income tax. Each of these can promote individual wellbeing as well as contribute to reduced dependency on the welfare system.

Lifelong learning

Relatively few older Australians participate in mainstream formal education. In 2009, around 6,200 people aged 60 years or over (one in 1,000 people of this age) were enrolled in a higher education course (DEEWR 2010). Participation in vocational education was considerably more common, with almost 26,000 people aged 65 years or over (1%) enrolled in such courses in 2009 (NCVER 2010).

Other types of informal learning, such as participation in courses that the University of the Third Age (U3A) runs, are popular among older Australians. U3A is an international movement that encourages retired people to take part in lifelong learning activities for pleasure. In 2007, there were more than 200 U3A groups providing education and related social activities to over 60,000 retired people across Australia (Swindell 2007).

Staying at work

The labour force patterns of older Australians are changing, as discussed in 'Chapter 3 Economic participation'. Although most older Australians have retired, more than one in 10 (11%) people aged 65 years or over participated in the workforce in 2010–11, including 32% of males and 18% of females aged 65–69 years (ABS 2011c). Just over half (53%) of all older employees worked part time.

Helping out

Older Australians contribute greatly to the community through voluntary work, involvement in community activities and as carers (see Box 6.3). According to the 2006 General Social Survey, one in four Australians aged 65 years or over had participated in voluntary work in the previous 12 months (ABS 2007b). Volunteering rates were similar for men (27%) and women (28%). Older people who were volunteers were more likely to be carers than those who had not volunteered in the previous 12 months (30% compared with 18%).

Older people are more likely to volunteer for community or welfare organisations than for sporting or recreational organisations. The most common activities undertaken by older volunteers include fundraising/sales, preparing and serving food, and administration (ABS 2007b).

Box 6.3: Older Australians as care providers

Although this chapter provides a range of data about the support and services provided to older Australians, many older Australians themselves provide support and services to others. Apart from organised voluntary work, people aged 65 years or over make important contributions to Australian society as carers and as providers of informal child care.

In 2009, an estimated 520,000 older Australians (19%) were carers, providing unpaid support and assistance to relatives and friends who are aged, ill or living with disability (ABS 2010b). Almost 200,000 were primary carers: that is, the person providing the most care, including help with the core activities of communication, self-care and mobility, and who has been (or expects to be) doing so for at least six months. Care was most commonly being provided to a spouse (77%), with 9% caring for an adult child and a further 9% caring for a parent. Primary carers aged 65–74 years were more likely to be female (61%), however those aged 75 years and over were more likely to be male (57%).

More detailed information about carers and caring can be found in Chapter 7.

Older people are the main source of informal child care for Australian families. In 2008, grandparents provided care on a regular basis for 660,000 children (19%) aged 12 years or under (ABS 2009a). Grandparent care was most common at younger ages, with this being the usual child care arrangement for almost one in four children aged less than five years.

'Chapter 4 Children and young people' has more detailed information about child care and Australian families.

Staying in touch

As people age they may be at risk of social isolation. This may result from changes in personal circumstances; for example, retirement, reduced mobility, illness, widowhood or moving home. Maintaining contact with family and friends is important, and can be achieved through face-to-face contact at home or in the community, or remotely using communications technology.

According to the 2009 SDAC, an estimated 80% of people aged 65 years or over living in households had face-to-face contact with family or friends living outside their household in the previous week; 18% had such contact every day. Ninety per cent of people of this age had at least weekly contact with family and friends in other ways, such as by telephone, the internet or 'texting' (SMS). Females were slightly more likely than males to have had contact with family or friends living outside their household, and the proportion of people who had at least weekly contact decreased slightly with age in both sexes.

In 2008–09, almost one in three Australians aged 65 years or over had access to the internet, mostly in their own homes (ABS 2010c). (By comparison, in other age groups, between 63% and 94% of people had access to the internet.) Almost half of older Australians with internet access used it every day, with most using it at least once a week. The vast majority (96%) used the internet for private purposes, however 20% used it for work or business and 15% for voluntary or community purposes.

Social connections are an important source of support in times of crisis, and the ability to call on family and friends for assistance can reduce dependence on formal services, improve quality of life and reduce mental distress. Data from the 2009 SDAC suggest that most older Australians

living in households (95%) are able to get support from someone outside their household in times of crisis (ABS 2010b).

Opportunities for external social interaction among those in residential care can be limited. The Australian Government funds the Community Visitors Scheme to provide one-on-one volunteer visitors to residents of government-subsidised aged care services. Community-based organisations recruit, train and match volunteers to visit socially and culturally isolated residents whose quality of life would be improved by friendship and companionship to help them to maintain links to the community.

6.5 Financial resources of older people

A person's financial resources influence their living arrangements, the way they participate in the community and their ability to maintain their chosen lifestyle. For a household, financial resources generally comprise income (for example, wages from employment) and assets (possessions such as a house or car). On retirement, the main source of income shifts from employment or business income to superannuation, savings, investment income, and government pensions.

As with their younger counterparts, older Australians vary in their level of resources and the amount of disposable income they have. Households including people aged 65 years or over tend to have lower mean disposable incomes than other households, but greater wealth (see Chapter 3.4). This means older people are more likely than younger people to have assets that they can draw on if necessary. Older people also tend to have lower living expenses compared with other households. Estimates from the 2007–08 Survey of Income and Housing show that the mortgage-free home ownership rates among people aged 65 years or over were 86% for couples and 69% for single people (ABS 2009c).

Although the majority of older people rely at least in part on the Age Pension (or similar support from the Department of Veterans' Affairs), a smaller but substantial number are 'self-funded retirees'. People of pension age receive certain benefits and concessions—some means-tested and others not—that increase their economic security without necessarily providing additional cash income. Examples include the Commonwealth Seniors Health Card, the Seniors Supplement, the Seniors Card and various superannuation tax offsets. Concessions and discounts for pensioners or 'seniors' are also often available in the private sector.

Main sources of income

Employment

A relatively small proportion of older Australians receive the majority of their income from employment. According to the 2007–08 Survey of Income and Housing, 4% of couple households and 3% of single-person households where the reference person (see Chapter 2, Box 2.4) was aged 65 years or over had employment income as the main source of household income (ABS 2009c). The average gross household income for these households was \$916 and \$455 per week, respectively.

At 30 June 2010, 19% of workers over Age Pension age (64 years for women and 65 years for men in June 2010) were registered in the Pension Bonus Scheme. This scheme was intended to encourage older Australians to defer claiming the Age Pension, and continue working beyond the qualifying age. It provides a one-off tax-free lump sum to eligible registered people when

they later claim and receive the Age Pension. The Pension Bonus Scheme was closed to new entrants who did not qualify for the Age Pension before 20 September 2009. A new measure, the Work Bonus, was introduced in September 2009 as part of the Government's *Secure and Sustainable Pension Reform* package.

Australian Government pensions

As at 30 June 2010, around 78% of the Australian population aged 65 years or over received the Age Pension or a similar means-tested income support payment from the Department of Veterans' Affairs (DVA) (Table 6.1).

Over two million Australians received a full or partial Age Pension through Centrelink; three-fifths (60%) received a full-rate pension (Appendix Table A6.1). Around 56% of Age Pension recipients were women. A slightly higher proportion of women (62%) than men (58%) received a full pension.

In addition, over 272,000 people aged 60 years or over received income support from the Department of Veterans' Affairs (Age Pension, Service Pension or War Widow's/Widower's Pension) (Table 6.1). Almost two-thirds (65%) of DVA pensioners of this age are women, and more than half of these receive a War Widow's Pension (DVA unpublished data). By contrast, 96% of male DVA pensioners receive a Service Pension (DVA unpublished data). DVA pensions are particularly important for the cohort of older Australians aged 80 and over, many of whom served in World War II or are widows of those who served in the war.

Table 6.1: Age and DVA Pension recipients, 30 June 2010

	Age group (years)						Total
	60–64 ^(a)	65–69	70–74	75–79	80–84	85+	
Per cent of Age Pensioners ^(b)							
Males	..	11.9	12.1	9.6	6.8	3.0	43.5
Females	2.5	14.3	13.5	10.9	7.9	7.3	56.5
Persons	2.5	26.3	25.6	20.6	14.8	10.3	100.0
<i>Persons (number)</i>	53,688	565,471	550,211	442,592	318,418	222,795	2,153,175
<i>Per cent of age group population</i>	4.4	62.2	77.4	80.2	72.5	55.9	69.8 ^(c)
Per cent of DVA pensioners ^(b)							
Males	6.6	3.7	2.2	2.1	4.1	16.2	35.0
Females	5.0	3.5	4.0	7.3	18.5	26.6	65.0
Persons	11.7	7.2	6.2	9.5	22.6	42.9	100.0
<i>Persons (number)</i>	31,777	19,593	16,937	25,731	61,429	116,742	272,209
<i>Per cent of age group population</i>	2.6	2.2	2.4	4.7	14.0	29.3	8.0 ^(c)
Total as per cent of age group population	7.0	64.3	79.8	84.9	86.5	85.3	77.8^(c)

.. not applicable

(a) Eligibility for the Age Pension in June 2010 was 64 years (increasing to 65 by 2014) for women, and 65 years for men.

(b) Age pensions administered by DVA are included in the 'DVA pensioner' figures.

(c) Per cent of people aged 65 or over.

Notes

1. Table includes full and part-pension recipients (see Table A6.1 for a breakdown of part and full Age Pension recipients).

2. DVA pensioners include persons in receipt of a Service Pension or War Widow's Pension.

3. Components may not add to total due to rounding.

Sources: Centrelink pensions database; DVA unpublished data.

Age Pension recipients have relatively modest levels of assessable assets and income. The average value of assessable assets was just over \$40,000 for people receiving the full-rate pension in 2008–09 and almost \$145,000 for those receiving less than the full rate (FaHCSIA 2009). Similarly, the average assessable income was considerably lower for those receiving the full Age Pension than for those receiving a part-pension (\$907 per year compared with \$9,613). A person's principal home is not counted as an assessable asset, however the assets test limits are different for home owners and non-home owners.

Superannuation

Superannuation is money set aside over a person's lifetime to provide for their retirement. It can be accessed when a person reaches preservation age (between 55 and 60 years, depending on year of birth) and retires, or when they turn 65. New transition to retirement arrangements allow eligible people to reduce their working hours once they reach preservation age and top up their income using their superannuation savings.

In 2009–10, superannuation funds paid out more than \$60 billion in benefits (APRA 2011). This was divided evenly between lump sum and pension payments. The total value of superannuation payouts, and the average benefit, have been increasing—in 2003–04 funds paid out \$21 million in lump sums and \$13 million in pensions. Projections using Treasury models suggest that these increases will continue (Rothman & Tellis 2008).

Widespread superannuation coverage is a relatively recent phenomenon in Australia, emerging in the late 1980s and early 1990s. Lower rates of coverage combined with historically lower labour force participation, especially among older generations of women, means that many older Australians have never contributed to a superannuation scheme. In 2007, 79% of people aged 70 years or over had no superannuation coverage (ABS 2009b). One in five people aged 65–69 years were still contributing to a superannuation scheme, while one in four were already drawing on their funds. Males were more likely than females to have superannuation coverage, and also more likely to still be contributing to a scheme.

Financial stress

Measures of financial stress often show a general decline with increasing age. For example, the 2007–08 Survey of Income and Housing showed that housing costs were less than 26% of gross income for 89% of households where the reference person (that is, the person chosen to represent the household, see Box 2.4) was aged 65 years or over, compared with 66% of households where the reference person was aged under 35 years (ABS 2009d). The mean housing costs per week were also substantially lower for the older group than for most other groups. Some older people, however, do face high housing costs (see Chapter 2, Box 2.5).

In the 2006 General Social Survey, only 3% of couple households and 6% of lone-person households where the reference person was aged 65 years or over had a cash flow problem in the previous 12 months, compared with 17% of couple and 42% of lone person households where the reference person was aged under 35 years (ABS 2007a). Households with older people were also less likely than other households to have had difficulty paying bills or taken actions that reduced assets (such as selling assets or drawing on savings) in the previous 12 months.

6.6 Caring for older Australians

As noted earlier, although many older Australians are generally healthy and able to live independently, some require assistance. The Australian Government supports 'ageing in place', that is, providing sufficient support to enable older people to remain in their own homes rather than enter residential care. The need for such support generally increases with age.

Informal care underpins Australia's community services system, not least of all in aged care. Much of the care of older people with long-term health conditions and disability is provided on an unpaid basis by relatives and friends. Referred to in this report as 'carers', these people may provide help with a broad range of activities of daily living, including core activities (self-care, mobility and communication) and non-core activities (for example transportation, shopping, meal preparation, household chores and paperwork). Carers and caring are discussed in more detail in Chapter 7.

Australian Government-subsidised aged care is a feature of the care arrangements for significant numbers of frail older people, either supplementing informal care or providing a substitute for those without access to practical assistance from family and friends or for whom informal care is no longer able to meet all their critical needs.

Formal care can be delivered in two main settings: either at home in the community, or in a residential aged care facility. In addition, flexible care programs provide a combination of community and residential options. This section provides information about the use of these services and the users of such services.

Demand for aged care services

The 2009 SDAC collected data about the needs for assistance of survey participants living in private households. Information was collected about a range of activities, such as self-care, meal preparation, household chores and property maintenance. This provides an indication of the potential demand for aged care services in the community.

More than one in three older people (38%) needed assistance with at least one activity (Table 6.2). The proportion needing assistance increased with age, from around one in four of those aged 65–74 years to seven in 10 of those aged 85 years or over. Sixteen per cent needed assistance with one of the three core activities (self-care, mobility or communication). In each age group, mobility was the core activity with which the most people required assistance.

The need for assistance with non-core activities also increased with age. Help with property maintenance was the most common, with one in four older people requiring assistance in this area. Other activities with which people commonly needed assistance were household chores and health care.

Table 6.2: Need for assistance with broad activities, by age group, people aged 65 years or over living in households, 2009 (per cent)

Activity type	Age group (years)			Total 65 and over
	65–74	75–84	85 and over	
Core activities				
Self-care	5.8	9.3	20.1	8.5
Mobility	8.1	16.3	37.4	13.9
Communication	0.8	1.8	5.1	1.6
At least one core activity	10.2	18.3	40.7	16.1
Non-core activities				
Meal preparation	2.7	6.5	19.6	5.7
Cognitive/emotional tasks ^(a)	4.5	4.9	10.3	5.2
Reading/writing tasks	2.6	5.8	18.2	5.3
Transport	0.8	1.6	5.5	1.5
Property maintenance	17.2	31.3	47.7	25.2
Household chores	11.9	23.4	47.8	19.6
Health care ^(a)	12.5	23.6	45.9	19.7
At least one activity	27.1	44.7	71.9	37.7

(a) These items relate only to people with disability.

Source: ABS 2009 Survey of Disability, Ageing and Carers.

Where are services located?

Aged care services are located all over Australia in order to meet the needs of our widespread population.

In total, more than 234,000 operational aged care places (excluding Transition Care places) were available nationwide in June 2010, with more than three-quarters of these (almost 183,000) being residential places (Table 6.3). More than 51,000 community care places were available, with the majority being low-care places. The distribution of services among remoteness areas was broadly consistent with the distribution of the population aged 70 years and over (the population used in aged care service planning).

Table 6.3: Number of operational aged care places by geographic region, as at 30 June 2010

Service type	Major cities	Inner regional	Outer regional	Remote	Very remote	Total
Residential care						
Residential aged care	123,883	40,111	14,353	1,071	331	179,749
Multi-Purpose Services, residential	0	419	1,509	544	235	2,707
NATSIFACP, residential	87	0	68	69	170	394
Total residential care	123,970	40,530	15,930	1,684	736	182,850
Per cent of places	67.8	22.2	8.7	0.9	0.4	100.0
Community care						
EACH	3,669	1,380	471	57	9	5,587
EACH Dementia	1,778	565	222	18	0	2,583
<i>Subtotal community high care</i>	<i>5,447</i>	<i>1,945</i>	<i>693</i>	<i>75</i>	<i>9</i>	<i>8,170</i>
CACP	28,823	9,311	3,339	646	515	42,634
Multi-Purpose Services, non-residential	0	35	230	104	44	413
NATSIFACP, non-residential	78	36	10	28	107	259
<i>Subtotal community low care</i>	<i>28,901</i>	<i>9,382</i>	<i>3,579</i>	<i>778</i>	<i>666</i>	<i>43,306</i>
Total community care	34,348	11,327	4,272	853	675	51,476
Per cent of places	66.7	22.0	8.3	1.7	1.3	100.0
Grand total	158,318	51,857	20,202	2,537	1,411	234,326
Per cent of places	67.6	22.1	8.6	1.1	0.6	100.0
Per cent of 70+ population	66.1	22.9	9.7	1.0	0.3	100.0

CACP Community Aged Care Package

EACH Extended Aged Care at Home

NATSIFACP National Aboriginal and Torres Strait Islander Flexible Aged Care Program

Source: DoHA unpublished data.

How many places are available?

Government planning and allocation processes influence the supply of aged care places, which determines the number of places available, as well as take-up and delivery of place allocations by service providers. The level of supply in turn affects consumers' ability to access services. Examining the number of aged care places relative to the population at risk of needing care provides a useful indirect measure of accessibility for individuals. For the purposes of reporting on provision outcomes, aged care places and packages include CACP, EACH, EACHD, Transition Care and residential aged care. Operational packages or places in these programs can be measured against planning targets. It is not possible to provide a similar analysis for HACC or Veterans' Home Care (VHC) as discrete packages and places for individuals do not exist.

Historically, the population aged 70 years or over has been used for planning purposes, being considered to reflect the population 'at risk' of needing aged care services. More recently, however, the Health and Hospitals Reform Commission (NHHRC 2009) has proposed that the population aged 85 years and over be used for planning, on the basis that this better reflects usage patterns as the population has aged. Table 6.4 presents data based on both of these age groups, but also considers the population with profound or severe core activity limitations, as a potential indicator of high need.

Table 6.4: Operational residential aged care places, community care packages and Transition Care places at 30 June, 2000–2010

	Number of places/packages	Places/packages per 1,000 persons			
		Aged 70+	Aged 85+	Aged 70+ with severe or profound core activity limitation	Aged 85+ with severe or profound core activity limitation
2000	160,650	94.4	635.8	350.0	978.4
2002	172,983	96.9	629.6	353.5	969.5
2004	186,503	101.2	645.6	369.3	1104.1
2006	205,450	107.5	637.8	385.1	1094.7
2008	223,955	111.9	617.9	443.6	1149.9
2010	237,024	112.5	595.2	441.8	1096.2

Note: The number of places/packages includes residential aged care, CACP, EACH, EACHD and Transition Care programs combined. Places provided by Multi-Purpose Services and services receiving flexible care subsidy under the National Aboriginal and Torres Strait Islander Aged Care Program are also included. Data on the number of places available in individual programs is presented in Appendix Table A6.2.

Sources: AIHW analysis of ACCMIS database as at October 2010; AIHW analysis of ABS 2003 SDAC CURF; ABS 2010b.

Community and flexible aged care

There is a continuing strong emphasis on the provision of innovative and flexible community care to help people stay in their own homes. Community care services offer packaged care at different levels of assistance, depending on the needs of the client. Most programs offer services that can be received over variable periods of time. Services such as domestic assistance and personal care may be provided on an ongoing basis, whereas other services such as home maintenance may be required less often.

HACC

In terms of client numbers, HACC, administered under the *Home and Community Care Act 1985*, is the largest of the community care programs. The HACC program delivers 'a comprehensive coordinated and integrated range of basic maintenance and support services for frail aged people, people with disability and their carers' (DoHA 2011). Assistance available through HACC includes domestic assistance, personal care, transport, home maintenance, nursing and allied health care.

Service use

As at 30 June 2010, there were more than 3,300 active agencies registered in the HACC Minimum Data Set Agency Register. During 2009–10, reporting agencies provided services and assistance to about 688,000 people aged 65 and over (Appendix Table A6.3), 77% of the total HACC client population in 2009–10. The HACC services usage rate among older people has increased since 2004–05, from 211 per 1,000 to 229 per 1,000 persons aged 65 and over in 2009–10. Two-thirds of older service users were female, and one-quarter were aged 80–84 years.

In 2009–10, the major types of assistance which HACC program clients received were domestic assistance (33% of clients), home or garden maintenance (19%), and meals and transport (each 17%) (Appendix Table A6.4). Specialist services such as nursing (21% of clients) and allied health or therapy (20%) were also commonly used. Note that in the reporting of HACC services, use of respite services is recorded against the carer and not the care recipient, leading to an artificially low proportion of 'clients' reported as receiving this type of assistance.

Programs administered by the Department of Veterans' Affairs

Eligible veterans, war widows and widowers can receive assistance from a number of DVA funded community care programs. Veterans' Home Care (VHC) delivers in-home support services including domestic assistance, personal care, safety-related home and garden maintenance, and respite care. VHC is the second largest provider of community aged care services after HACC, providing services to almost 77,000 clients in 2009–10 (Appendix Table A6.3). Eligible people needing more than 1.5 hours per week of personal care or nursing may be referred to the DVA Community Nursing program, which served almost 33,000 clients in 2009–10 (Appendix Table A6.3).

Other DVA programs that provide support to older people include the DVA Rehabilitation Appliances Program for the supply of aids and equipment; HomeFront, a falls and accident prevention program; and the Home Maintenance Line, a telephone service for advice with property maintenance and emergency repairs. Clients of DVA programs may also be eligible for assistance through other programs, on the basis of an assessment of care needs.

The most common services provided to VHC clients are domestic assistance (93%) and home or garden maintenance (23%) (Appendix Table A6.4).

CACP

Community care in a person's home is also provided as tailored packages through the Community Aged Care Packages (CACP) program. These packages are designed to meet the daily care needs of frail older people, allowing them to stay in their own homes and community without having to enter low-level residential care. Care planning and case management are provided, including assistance with personal care, meals, and domestic duties, such as cleaning (DoHA 2009a). Nursing and allied health are not available through CACP.

Since 1998, the number of operational CACP packages has increased substantially. At 30 June 2010, 1,300 service outlets managed more than 43,000 packages and delivered CACP services to over 40,000 clients (Appendix Table A6.2), 96% of whom were aged 65 years or over (Appendix Table A6.3).

The majority of CACP clients received domestic assistance (Appendix Table A6.4). Assistance with personal care (39%) and social support (36%) were also common. The median duration of support for people who stopped receiving CACP assistance during 2009–10 was between one and two years (AIHW 2011a).

The AIHW publishes more detailed information about CACP program use annually (see, for example, AIHW 2011a).

EACH and EACHD

CACPs are complemented by Extended Aged Care at Home (EACH) and EACH Dementia (EACHD) packages, which aim to deliver care at home that is equivalent to high-level residential care. EACH packages may include clinical care (nursing services), personal assistance, meal preparation, continence management, therapy services, home safety and medication management. The EACHD package offers the same type of assistance as the EACH package, but is specific to the needs of people with dementia (DoHA 2009a).

While still relatively small in size, the growth in these programs has been rapid. At 30 June 2010 there were almost 400 outlets providing EACH packages to more than 5,000 clients, and over 250 outlets providing EACHD services to almost 2,300 clients (Appendix Table A6.2).

Personal care services were provided to a large proportion of people in the EACH (83%) and EACHD (74%) programs, reflecting their higher care needs. Use of domestic assistance and respite care was also common (Appendix Table A6.4). The median duration of support was shorter for EACH and EACHD than for CACP, at 6–12 months for those who stopped receiving care in 2009–10 (AIHW 2011a).

The AIHW publishes more detailed information about EACH and EACHD program use annually (see, for example, AIHW 2011a).

Transition Care

The Transition Care Program is a relatively new program which the Australian Government and the state and territory governments fund jointly. It provides time-limited, goal-oriented and therapy-focused care for older people who have been assessed as eligible for residential aged care during a hospital stay. The program provides a package of services that include low-intensity therapy (such as physiotherapy), care management, nursing support and personal care. Transition care can be provided for up to 12 weeks (with a possible extension of another six weeks), either in a home-like residential setting or in a person's home. This gives care recipients, their families and carers time to consider long-term care arrangements. It also aims to optimise the independence level of those older people prior to their making longer term arrangements.

At 30 June 2010, there were 84 service outlets providing transition care with almost 2,700 operational places (Appendix Table A6.2). Including people who used the program more than once, there were over 11,000 admissions to the program in 2009–10.

Multi-Purpose Services

Multi-Purpose Services are a joint initiative between the Australian Government and those states and territories that need such services. They deliver a mix of aged care, health and community services in rural and remote communities that cannot otherwise sustain separate services (DoHA 2010b). The services may be delivered at central locations or out in the community. At 30 June 2010 there were 3,120 operational Multi-Purpose Service places across 129 service outlets (DoHA 2010b). Almost 1,700 of these places were for high-level residential care.

Services for Indigenous Australians

Flexible models of care are also provided under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. The services funded under this program provide culturally appropriate residential and community aged care, mainly in rural and remote areas close to Indigenous communities. At 30 June 2010 there were 29 service outlets funded under the program, delivering over 650 places (DoHA 2010b), of which almost 400 were for residential care.

Ensuring quality community care

A multi-jurisdictional community care reform process has been underway since 2004, aiming to streamline service delivery and administration. As part of this process a set of nationally consistent standards has been developed, which apply to HACC, CACP, EACH, EACHD and the National Respite for Carers Program (each of which previously functioned under separate standards).

The Community Care Common Standards came into effect on 1 March 2011. They cover three broad areas: effective management; appropriate access and service delivery; and service user rights and responsibilities. As part of enacting the standards, a self-assessment tool and an on-site visit by quality reviewers will facilitate the implementation of quality reviews, including service provider reviews of practices relating to the standards.

Residential aged care

The Australian Government funds aged care facilities to provide residential aged care to older Australians whose care needs are such that they can no longer remain in their own homes. Facilities provide suitable accommodation and related services (such as laundry, meals and cleaning) as well as personal care services (such as assistance with the activities of daily living). Nursing care and equipment are provided to residents requiring such assistance. The residential aged care program is provided on a permanent or respite basis.

Permanent care is offered at two levels—low care and high care—depending on a person's assessed needs. Permanent residents receiving low-level care require accommodation and personal care, and residents receiving high-level care require 24-hour nursing in addition to their low-care needs (DoHA 2009b).

Residential respite gives short-term care (either low- or high-care) in aged care facilities on a planned or emergency basis to elderly people who need temporary care, but intend to return to their own home. It supports elderly people in transition stages of health, and carers use respite to provide them with a break from their caring duties (DoHA 2009b).

Service use

At 30 June 2010, 2,772 service providers provided 179,749 Australian Government-subsidised residential aged care places (excluding places that flexible programs provided) (AIHW 2011e). The majority (60%) of providers were in the not-for-profit sector, such as religious and community organisations. A further 29% of providers were private for-profit establishments, while the remaining 11% were state and local government facilities. The average facility size has grown from 46 places in 1998 to 65 in 2010.

At 30 June 2010, there were 159,728 permanent and respite residents aged 65 years or over in Australian Government-funded aged care homes. Over 156,000 were permanent residents, with almost 58,000 new admissions for permanent care during 2009–10 (AIHW 2011e). Seventy per cent of these permanent residents were female and 59% were aged 85 years or over. The median length of stay among people in permanent residential care at 30 June 2010 was 2–3 years; however, one in five (21%) people had been in care for five years or more.

The AIHW publishes more detailed information about residential aged care services and clients annually (see, for example, AIHW 2011e).

Are the available places being used?

Occupancy levels in residential aged care were very high over the period 2000–2006 (mostly around 95–96%), but have since declined to average 92% in 2009–10 (Table 6.5). This decline reflects higher annual allocations of new places. Occupancy rates remain higher in South Australia and Tasmania than in other jurisdictions. High occupancy rates may create lengthy waiting times for entry to care in some parts of the country and for some groups of people

(Hogan 2004, PC 2008). Conversely, low occupancy rates may affect the financial viability of services with flow-on effects for service availability over time (Senate Standing Committee on Finance and Public Administration 2009).

Table 6.5: Average occupancy in residential aged care 2000–01 to 2009–10

State/territory	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
2000–01	95.9	94.8	96.6	94.7	97.6	97.5	95.6	93.5	95.9
2001–02	95.3	94.9	96.4	92.9	97.7	97.7	97.7	91.9	95.5
2002–03	96.4	94.7	96.4	95.6	97.3	97.8	97.7	94.7	96.0
2003–04	96.1	94.4	96.5	95.7	97.2	97.5	98.0	90.9	95.9
2004–05	95.2	94.1	96.2	94.8	97.5	96.9	98.3	93.9	95.3
2005–06	95.4	93.0	96.0	94.9	97.6	96.0	97.9	95.1	95.1
2006–07	94.3	92.5	94.9	94.6	97.6	95.9	96.3	94.9	94.3
2007–08	93.4	92.2	93.5	94.2	96.8	95.1	93.2	92.2	93.5
2008–09	92.6	91.4	92.3	94.1	96.0	93.8	92.4	89.0	92.7
2009–10	92.3	91.2	91.1	93.9	95.8	96.0	91.5	89.0	92.3

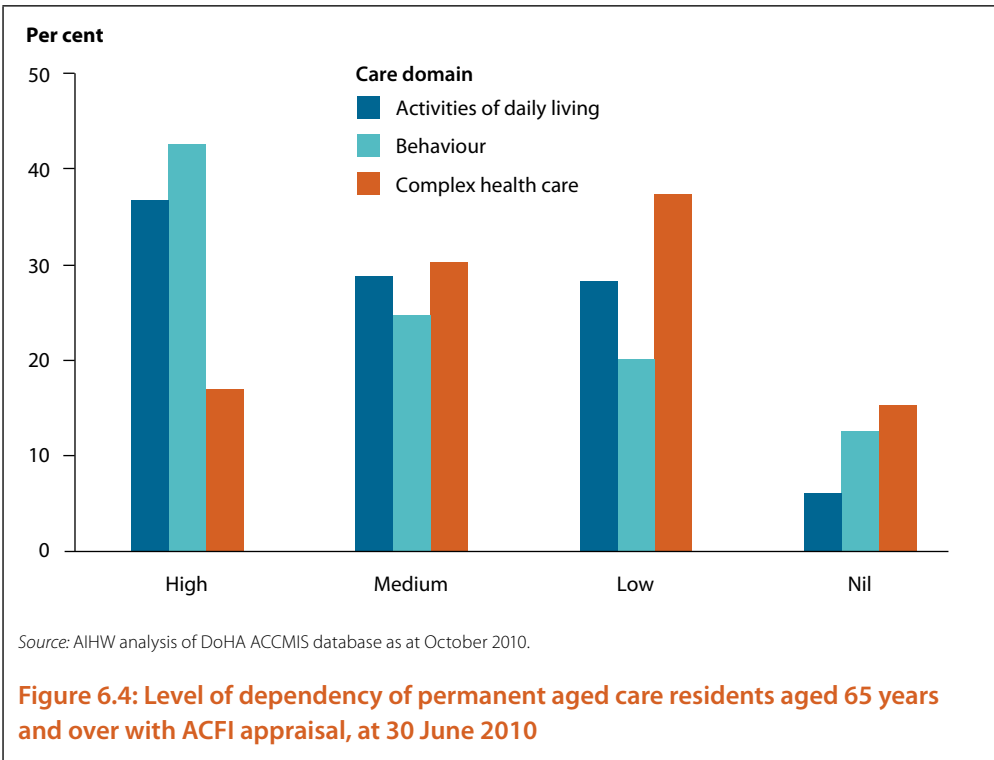
Note: The average occupancy over a year is calculated by dividing total occupied resident days over the year by total available place days over the year. This gives an underestimate of true occupancy because some places may be offline for upgrading etc. over the period.

Source: AIHW 2011e.

Dependency of clients in residential care

At 30 June 2010 more than 155,000 permanent aged care residents had been appraised using the Aged Care Funding Instrument (ACFI; see Box 6.4). More than one-third were assessed as having high dependency with regard to activities of daily living, and over two-fifths had high dependency in terms of behaviour (Figure 6.4). The high and medium categories combined accounted for almost half of residents with complex health care needs, along with two-thirds of those assessed for behaviour and activities of daily living.

Data collected using the ACFI suggests that over half of all permanent residents in Australian Government-subsidised aged care facilities have a diagnosis of dementia. In 2008–09, 70% of those with dementia were female, and 79% were aged 85 years or more (AIHW 2011b). Most residents with dementia (87%) had high-care needs, particularly in the areas of behaviour and activities of daily living. By comparison, 68% of residents without a diagnosis of dementia had high-care needs.



Box 6.4: Measuring dependency of permanent residents in aged care homes

From 20 March 2008, the Aged Care Funding Instrument (ACFI) was introduced as the determinant within a new funding model for residential aged care. Detailed analysis of the first capture of data has been published in *Dementia among aged care residents: first information from the Aged Care Funding Instrument* (AIHW 2011b).

The ACFI attempts to separate and measure only those care elements that most contribute to the cost of individual care. Each resident is appraised in respect of three domains: Activities of Daily Living, Behaviour Characteristics and Complex Health Care Needs. Scores in each of these domains determine the level of care required (high, medium or low) for that domain, and the overall level of resident subsidy is derived from this. The concepts of ACFI high care and ACFI low care are defined through various combinations of scores in the three domains.

All new permanent admissions after 20 March 2008 are appraised using the ACFI. From 20 March 2008, assessors will use the ACFI to appraise existing residents if and when they require a review of their current classification.

Ensuring quality residential aged care

Accreditation of services

The *Aged Care Act 1997* sets out a process of accreditation of residential aged care homes as an eligibility requirement for Australian Government funding. Accreditation by an independent authority, the Aged Care Standards and Accreditation Agency, is designed to assure both the government and the community that services provided to consumers meet recognised standards. The agency assesses homes against standards in four areas: management systems, staffing and organisational development; health and personal care; resident lifestyle; and physical environment and safe systems. At 30 June 2010, 92% of homes were accredited for at least three years and 98% of all homes were compliant with all 44 Accreditation Standards Outcomes (DoHA 2010b).

In addition, the Aged Care Standards and Accreditation Agency undertakes a program of unannounced visits to ensure proper care of residents, including nutrition and hydration. In 2009–10, the agency conducted 6,119 visits to homes and all homes received at least one unannounced visit during this period (DoHA 2010b).

Promoting best practice

The Australian Government-funded Encouraging Best Practice in Residential Care program aims to improve the level of clinical care for residents in aged care homes. The program supports the uptake of existing evidence-based guidelines by funding organisations to translate the best available evidence into effective approaches for staff to use in their everyday practice. The focus of the program is to implement cost-effective and sustainable strategies for evidence-based care for residents, using existing knowledge and tools. The University of Wollongong, Centre for Health Service Development (CHSD), is undertaking a national evaluation of the program.

Respite care

Respite care offers support to older people and their carers who may need a break or who require some extra care for a short period—for example, during or while recovering from illness. Care may be provided for a few hours on a one-off or regular basis, for a couple of days, or for a few weeks. Programs that deliver care services typically offer respite care services in the community and may also help clients to access residential respite care. For example, HACC provides respite care in the form of a substitute carer in the home, centre-based respite, host-family respite and peer-support respite. VHC provides in-home respite care, while DVA separately funds residential respite care for eligible clients.

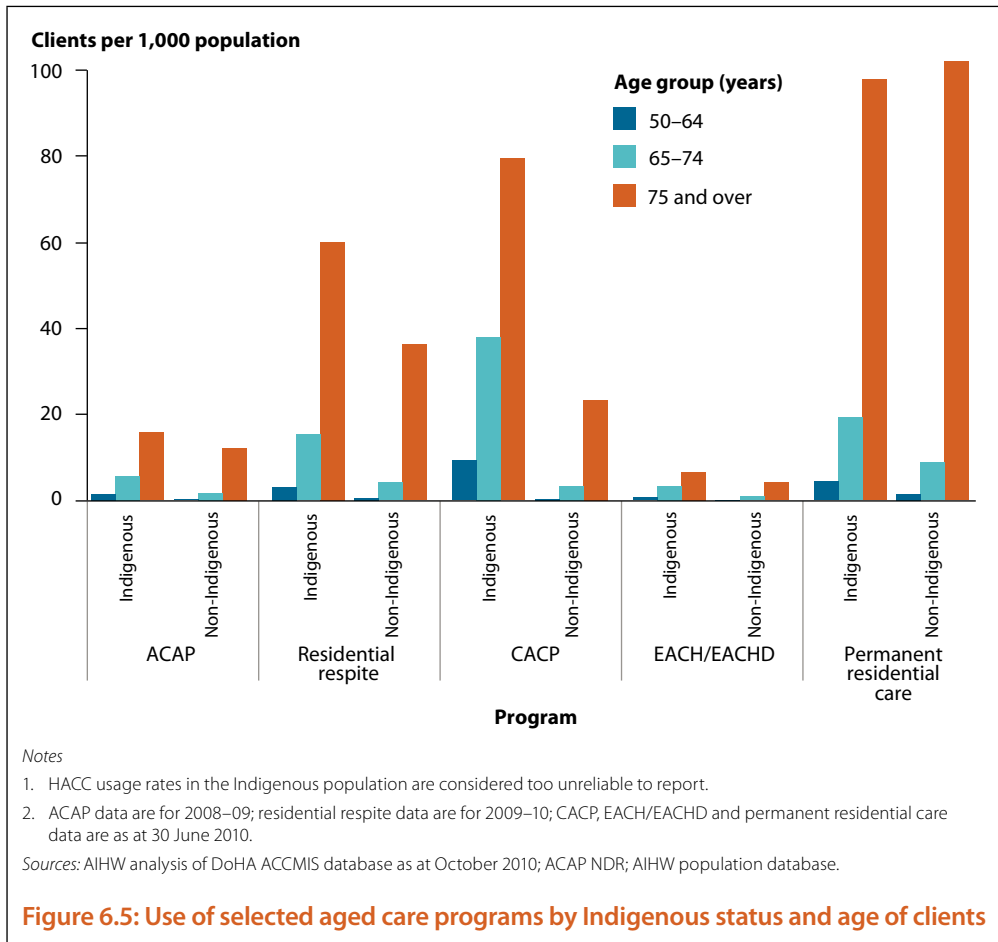
The National Respite for Carers Program is dedicated to the provision of respite care and other forms of support for carers. The program provides direct respite care in a number of settings, as well as indirect respite such as domestic assistance, social support and personal care for the care recipient, intended to relieve carers of some of the tasks of daily living (see Chapter 7 for more detail). During a census in 2008 that captured data over 1 week for each individual, around 8,500 carers received a total of 97,000 hours of program-funded respite care (DoHA unpublished data).

Residential respite care provides emergency or planned care in a residential aged care home on a short-term basis. An Aged Care Assessment Team (ACAT) approval is required to access residential respite care, and, up until 1 July 2009, an approval remained valid for 12 months (see the following section, 'How do people access aged care services?'). A person with a valid

approval may use up to 63 days of respite care in a financial year, which may be taken in ‘blocks’. The numbers of people using residential respite care is small at any point in time—almost 3,800 people, or 2% of aged care residents, at 30 June 2010 (AIHW 2011e). The short length of stay (an average of 3.4 weeks in 2009–10) means that the total number of people using respite care during the year is much higher. In 2009–10, there were about 57,500 admissions to residential respite care, which accounted for 50% of all residential care admissions during that financial year.

Use of aged care services by Indigenous Australians

As expected, aged care program usage rates increase with age for both Indigenous and non-Indigenous Australians (Figure 6.5). For some programs, however, Indigenous Australians have relatively high usage compared with their non-Indigenous counterparts. For example, Indigenous Australians aged 75 years or over use CACPs at a rate of almost 80 per 1,000 population—more than three times the rate among non-Indigenous Australians of this age. Younger Indigenous Australians also have relatively high usage of permanent residential care. Although to some extent this does reflect the poorer health of Indigenous Australians, the substantially different age distributions of the two populations also affects the comparison (see Chapter 1, Figure 1.1).



How do people access aged care services?

Assessment of care needs is an integral step in accessing Australian Government-subsidised aged care services, and mandatory for certain types of services. These assessments not only determine eligibility for various programs but also try to ensure the services recommended are appropriate to the client's needs and wishes. Aged Care Assessment Teams (ACATs) operate under the Aged Care Assessment Program (ACAP), funded by the Australian Government and managed by the states and territories. Following a detailed assessment that considers physical, psychological, medical, cultural and social needs, ACATs approve clients to receive the types of services and/or accommodation deemed to best meet their needs for care and support in the long term (see Box 6.5). The target population for ACAP services is people aged 70 years or over, or Indigenous Australians aged 50 years or over. Younger people with disability may receive an ACAT assessment if their needs cannot be met through other sources.

ACAT assessments are not required for HACC, the National Respite for Carers Program, VHC or DVA Community Nursing; however, ACATs can refer clients to these programs when they are more appropriate for meeting individual needs.

Box 6.5: ACAT recommendations and approvals for care and support

A completed ACAT assessment results in recommendations for long-term care and program support (including an appropriate setting) as part of a care plan. However, clients can be approved to receive more than one type of care. For example, a client may be recommended for high-level residential care, but be approved to receive high-level permanent residential care as well as an EACH package and/or residential respite care.

Differences between recommendations and approvals may arise because:

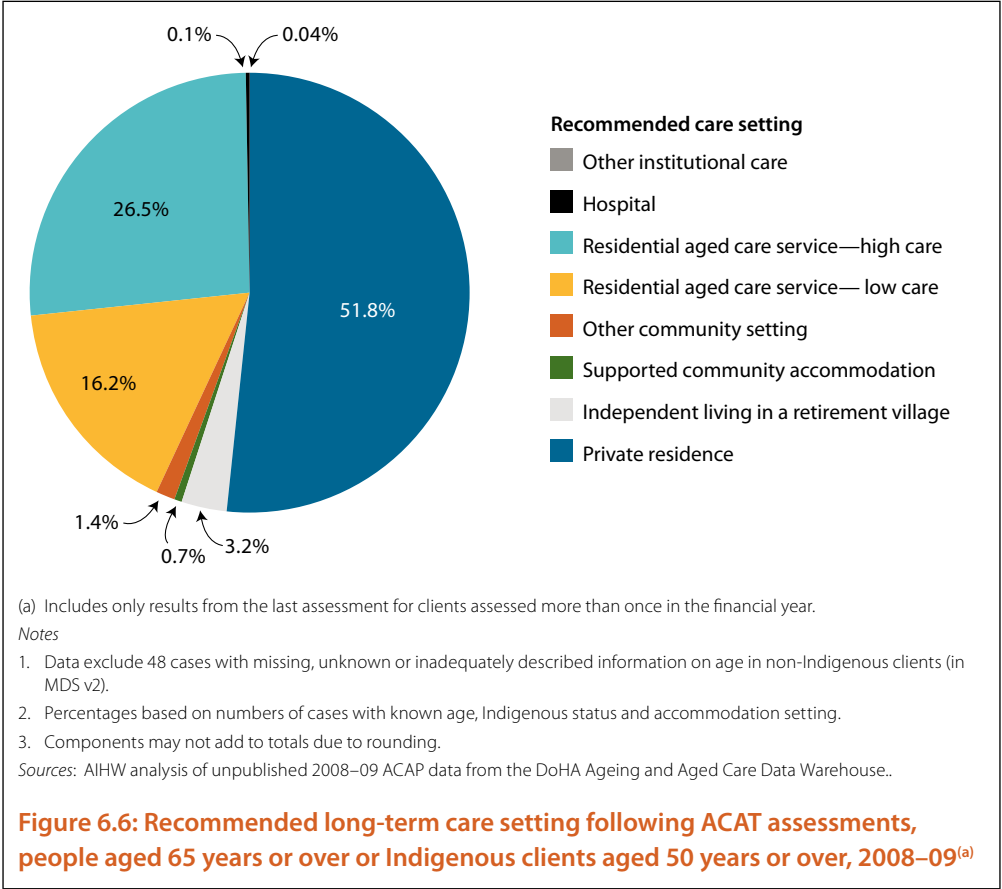
- some approvals are 'just in case', where a client may be recommended to live in the community but is eligible for low-level residential care and approved for this care in case it is required
- some approvals are for support that is 'interim until entry to residential care', such as for the client in the example above who is recommended to live in residential care but packaged care and residential respite care may be provided in the interim.

In cases where the assessor and the client do not agree on the outcome of the assessment, approvals reflect the care the client is eligible to receive, and the recommendation reflects the assessor's view. The client's wishes are reflected in the types of care for which he or she applies. Under the *Aged Care Act 1997*, a client can be recommended and approved for a type of care whether or not he or she has applied for that type of care.

Once a type of care is approved, the client's receipt of services is subject to the availability of places and other considerations. Clients can be reassessed if their care needs change to the extent that a different level or type of care is required.

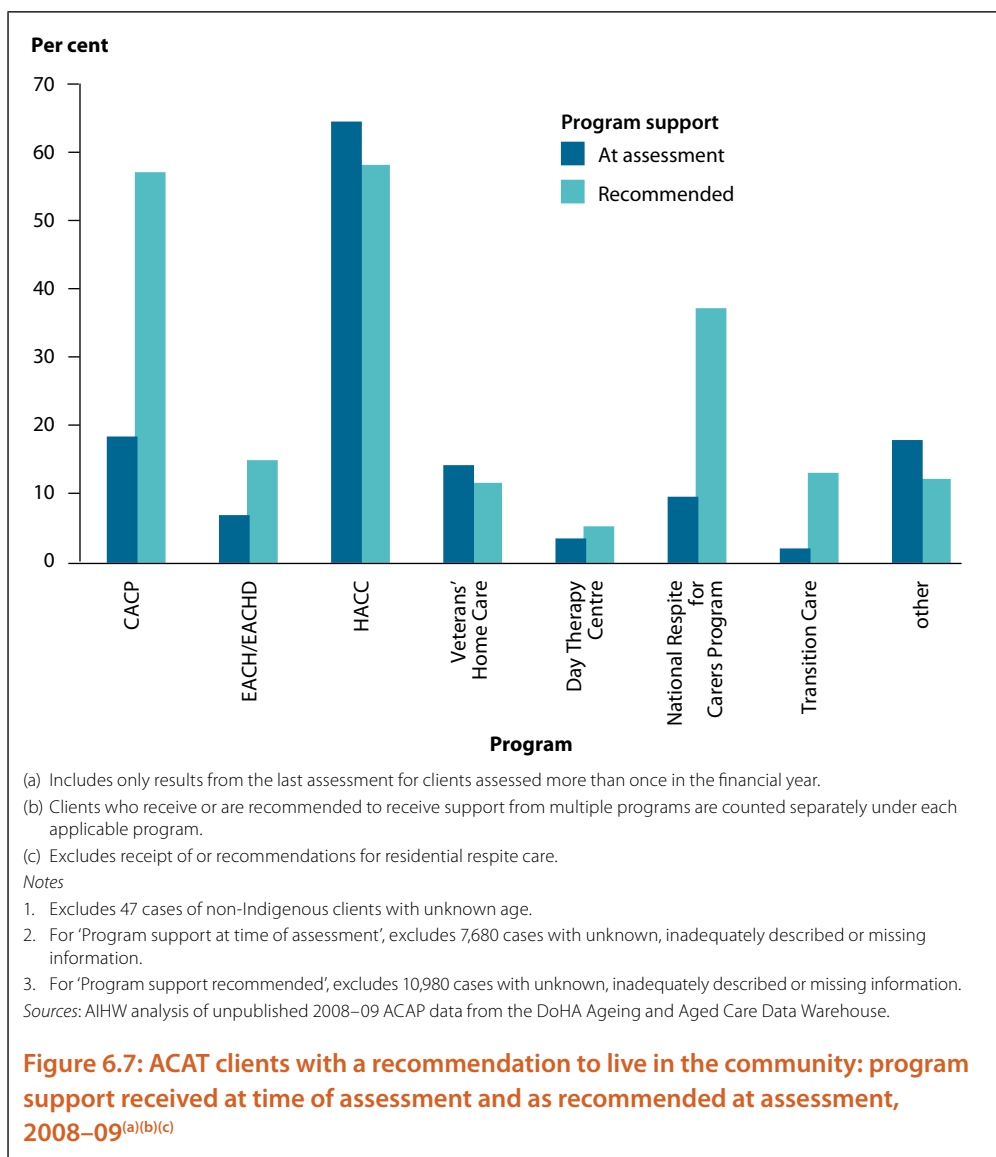
Sources: ACAP NDR 2009; AIHW 2007a.

In 2008–09, ACATs undertook assessments for 191,087 clients aged 65 years or over (or Indigenous clients aged 50 years or over). Most clients (92%) were living in the community at the time of assessment. Long-term care in the community was recommended in more than half of cases (57%), with the majority of recommendations being for accommodation in private residences (Figure 6.6). High-level residential aged care was recommended for just over one-quarter of clients.



Half of ACAT clients with a recommendation for care services in the community were receiving formal assistance at the time of assessment. HACC was the most commonly used program (64%), followed by CACP (18%) and Veterans’ Home Care (14%). Following assessment, ACATs recommended a CACP for 57% of clients and EACH or EACHD for 15%. Over one-third of clients (37%) were recommended to access the National Respite for Carers Program (Figure 6.7).

Analysis of linked data from the Pathways in Aged Care project has shown that the recommendations made by ACATs are not always followed by clients (AIHW 2011d). Although program use varied with recommended care setting and client characteristics, one-quarter of clients assessed in 2003–04 did not use aged care services in the 2 years after assessment. The results also suggested that use of community care delays entry into permanent residential care, and that the timing of the use of community care is an important factor in this.



The majority (78%) of ACAT assessments in 2008–09 were performed in a non-hospital setting (Appendix Table A6.5). There is a marked difference in relation to recommended long-term care arrangements depending on the assessment settings. Overall, hospital-based assessments were most likely (52%) to result in recommendations for high-level residential care, with fewer than one in three (29%) resulting in recommendations for community care. In contrast, only 17% of assessments carried out in a non-hospital setting resulted in recommendations for high-level residential care, with around two-thirds (65%) being recommended for community care.

Among those assessed in hospital, having a main health condition of dementia, stroke or Parkinson Disease were most likely to result in a recommendation for high-level residential care (recommended setting in 60%–70% of cases). By contrast, non-hospital assessments for people with these conditions resulted in recommendations for community accommodation in more than half of cases.

Needs of community-living ACAT clients

ACAT assessments record the care needs of clients across a range of areas in order to recommend appropriate assistance. In 2008–09, the largest area of need for clients living in the community at assessment was for domestic assistance (88% of clients) (DoHA Ageing and Aged Care Data Warehouse 2008–09, AIHW analysis of unpublished ACAP data). High proportions of clients also needed assistance with transport (84%), meals (78%), social support (77%) and health care (72%). Almost two-thirds of community-living ACAT clients needed assistance with self-care (63%). Unsupported needs for assistance in these areas may jeopardise the ability of older people to remain living in the community, as well as their social participation.

How long do people wait?

Accessing care services involves a number of processes including assessment, finding suitable care providers and making necessary arrangements to receive care. In 2007–08 the median time from referral to ‘first face-to-face contact’ with an ACAT was 10 days, ranging from 7 days in South Australia, Tasmania and the Australian Capital Territory to 15 days in Queensland (ACAP NDR 2009). The median time varied little over the previous few years, however the mean increased, suggesting that overall waiting times remained similar but there was an increased number of clients waiting longer for assessment.

Factors including the death of the potential client; the availability of services; perceptions and concerns about quality of care that influence client choice of preferred service; and unwillingness to accept particular residential placement offers may affect the period of time between the ACAT approval and use of care services (elapsed time) (SCRGSP 2011: boxes 13.11 and 13.12). It may also reflect the degree to which existing or other service provision results in outcomes that the assessed person and their family find acceptable. Elapsed time is different from waiting time—ideally, a measure of waiting time would exclude such factors and measure the time between a client’s dedicated intention to obtain a service and receipt of the service. However, the practical problems of measuring this concept of waiting time at a population level are still being addressed.

One measure of ‘elapsed time’ between ACAT approval and entry to high-level residential care or receipt of a CACP appears in the *Report on government services 2011* (SCRGSP 2011). This measure reveals that 25% of people entering high-level residential care during 2009–10 did so within 7 days of their ACAT approval and 51% within 1 month (SCRGSP 2011: Table 13A.66). The comparable figures for starting a CACP were 11% and 39%.

6.7 Data development

Population surveys and studies

Over the past decade, substantial progress has been made in terms of collecting and reporting data about older Australians. Increased and targeted sampling and reporting of ABS population survey data means that more options exist to disaggregate data by age groups to at least 85 years and over, thus permitting improved reporting about the diversity of needs and circumstances among Australia’s older people.

For example, the **2009 ABS Survey of Disability, Ageing and Carers** had a greatly increased sample size compared with previous surveys, and should provide more accurate estimates relating to the health and functioning of people in residential care as well as those in the

community. This latest survey also provides more detailed information than previously about the need for and receipt of assistance, the need for more assistance and social and community participation.

The **Australian Health Survey**, in the field at the time of publication, will also provide valuable information about the health and health-related behaviours of older Indigenous and non-Indigenous Australians. The survey will include blood and urine tests to measure biomarkers such as cholesterol levels, blood glucose levels and various nutrient measures, which will provide detailed information about diabetes status, kidney and liver function, vitamin D deficiency and cardiovascular disease risk (ABS 2011a). This information will provide insight into not only the health of today's older Australians but the potential health of and health risks for the older Australians of the future.

Other useful sources of information about the health and lives of older Australians include the Australian Women's Health Study, the Australian Longitudinal Study of Ageing, the 45 and Up Study, the Melbourne Longitudinal Studies on Healthy Ageing Program and the Dubbo Study of the Health of the Elderly. Although none of these sources provide national pictures of the whole older population, they nevertheless provide valuable insights into certain subgroups or geographic areas which can be used as building blocks to form a detailed view of older Australians and their experiences.

Service data

Data relating to aged care provision and use have also improved considerably over the past decade or so. This has been particularly notable in the community care sector with the development of the **HACC Minimum Data Set** (now in its second version) and in improvements to the **ACAP Minimum Data Set**. Ongoing developments using data linkage methods are also increasing the ability to report on the operation of the aged care system as a whole rather than only on a program basis; the previous edition of *Australia's welfare* (AIHW 2009a) drew heavily on linked data from the Pathways In Aged Care cohort study, and several reports on this cohort have been published (for example, see AIHW 2009b, 2010b, 2011c, 2011d).

The newly implemented **ACFI** provides enriched information about permanent aged care residents, particularly in relation to their physical and cognitive health. Over time this will provide valuable data on the functional status of aged care residents, in particular providing previously unavailable information about people with dementia. The recently published report *Dementia among aged care residents: first information from the Aged Care Funding Instrument* (AIHW 2011b) provides a first look at these data.

Recipients of pensions and other benefits

The ABS received increased funding in the May 2009 Federal Budget to implement a new **Pensioner and Beneficiary Living Costs Index** (PBLCI; see Chapter 11) for indexing pensions. The weighting component of the new index required a 44% increase in the size of the **2009–10 Household Expenditure Survey**, using a new sample design targeted at pensioner and beneficiary households. This increase will result in data on an additional 3,000 households whose main source of income was from government pensions, benefits and allowances. This will enable in-depth analysis of households on aged pensions including their income, wealth, expenditure, housing situation, financial stress and disability. The results of the survey are expected to be released in September 2011. The PBLCI is currently released quarterly.

Data gaps

Despite these improvements, some important limitations and key data gaps remain. Although data from ACAT assessments provide valuable information about the needs of clients at assessment and the types of services recommended for them, information about the needs of clients taking up particular programs and the types of assistance actually received is a significant knowledge gap. Some of this information was collected through two special purpose data collections (the Community Care Census) in 2002 and 2008, and has been reported in previous editions of *Australia's welfare* and elsewhere. Most routine community care data collections, however, do not include this information. Although reporting coverage has improved, the HACC Functional Screen (see AIHW 2009a:116) is not yet able to provide a national picture of the care needs of HACC clients, as reporting practices differ among jurisdictions.

Perhaps the most substantial data gap at present is the lack of data relating to client outcomes. Although there is considerable effort being devoted to appraising the quality of care provided to aged care clients in the community and residential care sector, there is limited data currently available for reporting about these processes or outcomes for clients. This is not a problem limited to the aged care sector; the lack of outcome data for evaluating quality and effectiveness has also been noted as a substantial gap in our knowledge about, for example, primary health care (AIHW 2008).

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