

6 Aged care

6.1 Introduction

In the last decade of the twentieth century population ageing has been gaining increasing international attention: it is at the forefront of social and economic planning and policy agendas in many countries of the world. The subject has also attracted the attention of international organisations and resulted in a variety of reports by organisations such as the World Bank (1994) and the OECD (1992, 1994, 1996, 1999). Early in the 1990s, the United Nations General Assembly acknowledged the importance of population ageing by designating 1999 as the International Year of Older Persons. In Australia, the Commonwealth Government announced that its key policy response to the International Year of Older Persons would be the development of a National Strategy for an Ageing Australia. The Prime Minister appointed a Ministerial Reference Group to develop a National Strategy focusing on four themes:

Firstly, helping Australians to be independent and to provide for their later years through employment, life long learning and financial security. Secondly, delivering quality health care through new approaches to service delivery, co-ordinated care and independent living. Thirdly, improving attitudes to older people and ageing, lifestyle issues such as personal safety, housing, transport, recreation and community support. And fourthly, encouraging healthy ageing and the role of general practitioners in maintaining wellbeing of older people. (John Howard, quoted in Bishop 1999a:vi)

The emphasis of the National Strategy for an Ageing Australia is thus on a long term, whole-of-government approach, taking into account a range of policy areas, and the perspectives and experiences of individuals as well as programs and policies. The present chapter is more narrowly based, being concerned with the services and assistance provided to older people, and with what has occurred in the past, rather than what is planned for the future. In recent years there have been a number of quite significant changes in the aged care sector; these changes, together with pre-existing programs and policies, constitute the baseline against which future directions for aged care will be set.

In 1996 the Commonwealth Government announced a major restructuring of the Australian residential care system. The main elements of the National Aged Care Strategy were implemented during 1997–98: nursing homes and hostels were amalgamated into one single system of residential care; the eight-category Resident Classification Scale was introduced to determine the level of payment to which facilities were entitled for each resident (based on residents' levels of dependency); income- and asset-tested fees were introduced; and a pre-existing system of contributions to the capital cost of some aged care facilities (means tested) was modified and expanded to include all residential aged care facilities.¹ In addition, a new system of accreditation for

1 The single system of residential care and the Resident Classification Scale were implemented on 1 October 1997; the system of capital contributions was introduced on 1 October 1997 and revised in November 1997; and income and assets testing began on 1 March 1998.

residential aged care facilities was developed. Recent years have also been characterised by a marked expansion in coordinated forms of home-based care (particularly community aged care packages) and in respite services, both of which are central elements of the continuing policy emphasis on keeping older people at home in the community wherever possible.

In the midst of these policy developments, the structure and size of the older population in Australia continue to change. The two decades from 1981 to 2001 were periods of relatively rapid increase – averaging 4.1% a year – in the population aged 80 years and over. This rate of growth can be expected to slow considerably in the new millennium, particularly from 2011 to 2021, before regaining momentum in the decade beginning 2031. Other social changes also appear set to continue for the foreseeable future. High rates of female workforce participation, high rates of divorce, and an increasing number of single-person households will affect both the structure and functioning of informal support networks, and the availability of volunteer labour in the welfare services industry.

The already difficult task of identifying the need for formal aged care services is thus complicated by the changing nature of the service framework, the changing population structure, and the flow-on effects in successive age cohorts of changes in the fabric of family and social life.

The goal of the Australian aged care service delivery system is the ‘provision of a cohesive framework of high quality and cost-effective care services for frail older people and their carers’ (DHFS 1996:117). Accordingly, this chapter focuses on three sets of information that are essential to the task of reviewing progress toward the achievement of that goal:

- the need for services and assistance (Section 6.2, page 167);
- the amount and type of services and assistance being provided and the characteristics of the clients to whom they are being provided (Section 6.3, page 176); and
- the outcomes of those services and assistance (Section 6.4, page 203).

The range of services and assistance available to older people in Australia is extensive and by no means all such provisions are included in this chapter. For example, programs concerned with healthy ageing, hospital care, medical care, pharmaceuticals and housing are not included. Moreover, although it is common to view aged care only in terms of programs aimed specifically at older people, it must be remembered that older people are also eligible for, and make use of, various benefits and services that are available to the general population.

This chapter focuses on the services and assistance designed to provide continuing care for frail and disabled older people and the services and assistance available to those who care for them. This includes services and assistance provided in both domiciliary and residential care contexts, and the assessment programs and regulatory practices associated with those services. These services are funded and/or provided by Commonwealth, State and Territory, and local governments, the not-for-profit sector and the private for-profit sector. In addition, extensive informal assistance is provided by family and friends who care for older people in both residential and domiciliary settings.

6.2 The need for care

Age, sex and dependency

Traditionally, age itself is the most commonly used predictor of the need for assistance among older people. The proportion of people aged 65 and over has, for example, always been a key component of the labour force dependency ratio, one of the calculations commonly undertaken by economists to test the economic viability of different societies at different times.² In analysing income security, the proportion of the population aged 65 and over is a useful indicator of likely need for assistance. For analysts whose primary concern is aged care services, however, the population aged 80 and over is a better guide, given that rates of use, particularly for residential care, climb steeply from age 80 onward. The usefulness of age-based data is increased if the data are classified by sex: women are not only more likely than males to survive to more advanced ages, they are also more likely to be poor, disabled and living in residential care (Gibson 1998:Chapters 4, 7).

As at 30 June 1998 the Australian Bureau of Statistics estimated that there were 2.3 million people aged 65 years and over in Australia; this represents 12.2% of the total population. Of these, 30% were aged 65 to 69 years, 48% were aged 70 to 79, and 23% were aged 80 and over. Thus, while over three-quarters of older people are aged between 65 and 79, there is a significant minority (over half a million people) who are aged 80 and over. Fifty-six per cent of older people are women; this predominance becomes progressively more evident in the older age categories. In the 65–69 year age group the proportions of men and women are almost equal; by age 80 and over, however, there are almost twice as many women as men. In absolute numbers, there are 285,000 more women than men aged 65 and over in Australia (Table 6.1).

Table 6.1: Persons aged 65 years and over, by sex and age group, 30 June 1998

	65–69 years		70–79 years		80 years and over		Total aged population	
	'000	%	'000	%	'000	%	'000	%
Males	333.5	14.6	486.5	21.3	179.3	7.9	999.3	43.8
Females	348.3	15.3	597.5	26.2	338.2	14.8	1,284.0	56.2
Persons	681.8	29.9	1,084.0	47.5	517.5	22.7	2,283.4	100.0

Source: ABS 1999a:17.

While age and sex provide one indicator of the level of need for aged care services, direct measures of dependency are also useful. The Surveys of Disability, Ageing and Carers conducted by the Australian Bureau of Statistics provide direct information about dependency levels in the older population, as reported by older people themselves. The most recent data are drawn from the 1998 Survey, the fourth such survey by the Bureau since 1981.

2 The traditional dependency ratio is the proportion of the population aged 0–14 and 65 and over in relation to those aged 15–64 years.

In the 1998 Survey the Australian Bureau of Statistics modified its methodology and terminology. Two additional screening questions were added to those used in the 1993 Survey, one referring to difficulties with breathing and the other to pain. In the 1998 Survey, the term 'core activity restriction' replaces the previously used 'handicap'; the terminology used to describe levels of restriction (profound, severe, moderate and mild) does, however, remain the same.

The proportion of people aged 65 and over with any specific activity restriction (handicap in the 1993 Survey) increased slightly between 1993 (44.6%) and 1998 (45.5%), but is similar to that reported in 1988 (45.1%). The proportion of the population reporting a profound or severe core activity restriction (age-standardised) dropped marginally from 17.9% in 1988 to 17.1% in 1993, increasing to 19.6% in 1998. Over the three surveys, while the changes have been modest, the trend is for a drop from 1988 to 1993, and an increase from 1993 to 1998.

In comparing the three surveys, prevalence rates were age-standardised to the March 1998 Australian population and adjusted for differences between the surveys (ABS 1999b). However, it is not possible to control completely for the differences in survey design; the trends observed may be partly a result of these differences.³ In particular, as far as possible, only screening questions common to all four surveys were used.

Table 6.2: Persons aged 65 and over with core activity restrictions, age standardised prevalence rates, by sex and disability status, as a percentage of the Australian population for 1988, 1993 and 1998

	1988	1993	1998
Males			
Profound or severe core activity restriction	12.7	12.4	14.8
Moderate core activity restriction	13.3	8.6	7.5
Mild core activity restriction	17.6	23.3	22.7
All males with specific restrictions	43.6	44.3	45.0
Females			
Profound or severe core activity restriction	21.9	20.8	23.3
Moderate core activity restriction	10.9	7.7	7.7
Mild core activity restriction	13.5	16.4	15.0
All females with specific restrictions	46.2	44.9	45.9
Persons			
Profound or severe core activity restriction	17.9	17.1	19.6
Moderate core activity restriction	12.0	8.1	7.6
Mild core activity restriction	15.3	19.4	18.4
All persons with specific restrictions	45.1	44.6	45.5

Note: Only criteria common to the four collections have been used. Rates are age-standardised to the estimated resident population for March, 1998.

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

3 See Section 7.2, page 215, for further discussion of differences between the most recent surveys, and Appendix Table A7.1 for a comparison of activity restriction rates across all four ABS surveys.

However, it was not possible to control completely for the two screening questions added in 1998, because in both years there was a screening question asking for the existence of 'any other long-term condition', which in 1993 would pick-up some of the people included by the two extra questions in 1998.

The profound and severe core activity restriction categories are appropriate measures of need for assistance in relation to aged care services since they describe people who are unable to perform a core activity or always need assistance in doing so (profound core activity restriction), and people who sometimes need assistance (severe core activity restriction). Core activities are self care (bathing, showering, dressing, eating, using the toilet and managing incontinence), mobility (moving around at home and away from home, getting into or out of a bed or chair, and using public transport) and communication (understanding and being understood by others, including strangers, family and friends).

Table 6.3: Persons aged 65 years and over: disability status, by sex and age group, 1998 (per cent)

Core activity restriction	Males					Females				
	65-69	70-74	75-79	80-84	85+	65-69	70-74	75-79	80-84	85+
Profound or severe	7.8	11.8	19.0	24.2	56.0	9.2	15.1	24.9	35.5	68.8
Moderate	10.8	10.3	15.3	* 7.8	* 10.4	8.9	10.4	10.2	6.9	6.9
Mild	16.0	21.6	20.3	24.8	16.9	14.8	16.5	18.3	22.6	7.5
All with specific restrictions	34.6	43.7	54.6	56.9	83.3	32.8	41.9	53.3	65.0	83.2
All with disability	43.4	51.1	60.9	63.4	84.3	37.6	47.3	56.6	66.8	84.2

* Subject to a relative standard error greater than 25%.

Source: ABS 1999b:15.

Among older people, the rates of profound or severe core activity restriction are quite low until age 75 (Table 6.3). For those aged 65-69 years, for example, only 7.8% of men and 9.2% of women were so affected. The rates rise quite markedly with age, however, so that by ages 75-79 19% of men and 25% of women reported a profound or severe core activity restriction, while at ages 80-84 the rates had risen to 24% and 36% respectively. By age 85 and over, more than half the population reported a profound or severe core activity restriction. At these advanced ages, the degree of difference between the sexes lessens somewhat, although the rates reported by women are still substantially higher than those reported by men (69% for women and 56% for men).

The proportion of people with a disability (the last line of Table 6.3) is substantially higher than the proportion who report a profound or severe core activity restriction. Indeed, the overall disability rate for the population as a whole (at all ages) is 19%. Among older people, the proportion with a disability increases from 43% at ages 65-69 to 84% at 85 and over for men, and from 38% at ages 65-69 to 84% at 85 and over for women. It is important to understand the meaning of 'disability' as it is defined in these data drawn from the ABS Surveys, as it includes a significant proportion of the total population. Disability is defined as including people who have difficulties in any of 17 categories of health conditions. These 17 categories are set out in Box 7.1 (page 215); they range from 'loss of speech' to 'any ... long-term condition that restricts everyday activities'. Having a 'disability' as defined in these terms does not, therefore, necessarily imply a need among older people for either informal or formal assistance.

Changes over time

The primary policy trend in the provision of aged care services over the past 15 years has been the move away from residential services and towards home-based care. Table 6.4 presents data describing the changing living arrangements of people with a profound or severe core activity restriction over the decade from 1988 to 1998.

Among people aged 65–79 with a profound or severe core activity restriction, the proportion living in households increased from 79% in 1988 to 86% in 1993, then decreased slightly to 84% in 1998. For those aged 80 and over, a similar trend was evident, with 50% living in households in 1988, 61% in 1993 and 55% in 1998. The same trend is generally evident for both men and women, although the size of the decline in proportions living in the community between 1993 and 1998 does vary. In general, it appears that the strong trend towards living in the community that was evident between 1988 and 1993 reversed somewhat between 1993 and 1998. While the definitions used in the three ABS Surveys have been standardised for the purposes of this analysis, it is certainly possible that changes in survey design may account for some part of these trends. The broad trend for the 10-year period remains away from residential care and into the community, and this is particularly the case for people in the 65–79 age category with a profound or severe core activity restriction.

Similar proportions of men and women aged 65–79 years were living in the community but, from age 80 onward, men were significantly more likely to be living in the community than were women. While 61% of men aged 80 and over with a profound or severe core activity restriction lived in households in 1988, only 47% of women did so; for 1998, the comparable proportions were 61% for men and 53% for women. Women are thus substantially more likely than men to spend their later years in a health establishment.

Another interesting aspect of Table 6.4 is the proportion of older people with a profound or severe core activity restriction who lived alone in the community. Among those aged 65 to 79, almost 20% were living alone in the community in 1988; that proportion increased to 26% in 1993 and then dropped back somewhat to 22% in 1998. For those aged 80 and over, the proportion increased from 19% in 1988 to 24% in 1993, then dropped marginally to 23%. A particularly strong trend is evident among men aged 80 and over—10% lived alone in the community in 1988 and 11% in 1993, but this increased to 22% by 1998.

The future

From an estimated base of 2.3 million in 1998, the Australian Bureau of Statistics projects that the Australian population aged 65 and over will reach 4.0 million by the year 2021, and 5.8 million by 2041. The number of people aged 80 and over is projected to grow from an estimated 0.5 million in 1998 to 0.9 million in 2021, and to 1.9 million in 2041 (Table 6.5).

The rates of annual increase for the period 1981 to 2041 have been or are projected to be relatively high for the populations aged 65 and over and 80 and over. For the decades from 2001 to 2041 the rates of increase for the total Australian population are projected to be less than 1% per annum. For most of that time, the rates of increase for the population 65 and over are projected to be in the vicinity of 2–3% per annum (Table 6.6).

Table 6.4: Persons with a profound or severe core activity restriction: living arrangements, by age group and sex, 1988, 1993 and 1998 (per cent)

Living arrangements	1988			1993			1998		
	<65	65-79	80+ All ages	<65	65-79	80+ All ages	<65	65-79	80+ All ages
Males									
Households									
Alone	5.2	9.4	* 9.5	6.4	15.2	* 10.5	8.6	10.4	21.6
With relatives	83.4	68.5	50.0	82.9	67.6	57.4	85.1	72.1	37.8
With non-relatives	3.3	** 1.5	** 1.5	5.4	** 1.0	**0.0	3.1	** 1.7	n.p.
<i>Total</i>	<i>91.8</i>	<i>79.4</i>	<i>61.0</i>	<i>94.7</i>	<i>83.9</i>	<i>67.9</i>	<i>96.8</i>	<i>84.2</i>	<i>60.6</i>
Health establishment	8.2	20.6	39.0	5.3	16.1	32.1	3.2	15.8	39.4
<i>Total males (N)</i>	<i>157,000</i>	<i>64,500</i>	<i>34,600</i>	<i>202,000</i>	<i>75,400</i>	<i>51,500</i>	<i>338,100</i>	<i>104,500</i>	<i>69,500</i>
Females									
Households									
Alone	5.8	25.7	22.1	9.2	32.1	29.1	10.0	30.0	23.8
With relatives	83.1	51.4	23.0	82.2	54.2	29.0	82.8	51.0	25.6
With non-relatives	4.4	* 2.4	* 1.4	4.2	* 0.7	** 0.7	4.1	* 3.4	* 3.6
<i>Total</i>	<i>93.3</i>	<i>79.5</i>	<i>46.5</i>	<i>95.5</i>	<i>87.0</i>	<i>58.8</i>	<i>96.9</i>	<i>84.4</i>	<i>53.0</i>
Health establishment	6.7	20.5	53.5	4.5	13.0	41.2	* 3.1	15.6	47.0
<i>Total females (N)</i>	<i>169,600</i>	<i>114,400</i>	<i>117,300</i>	<i>190,500</i>	<i>138,700</i>	<i>136,800</i>	<i>277,800</i>	<i>156,300</i>	<i>179,900</i>
Persons									
Households									
Alone	5.5	19.8	19.2	7.8	26.2	24.0	9.2	22.2	23.2
With relatives	83.2	57.6	29.1	82.6	58.9	36.8	84.1	59.4	29.0
With non-relatives	3.9	* 2.1	* 1.5	4.8	** 0.8	** 0.5	3.6	* 2.7	* 2.9
<i>Total</i>	<i>92.6</i>	<i>79.4</i>	<i>49.8</i>	<i>95.1</i>	<i>85.9</i>	<i>61.3</i>	<i>96.8</i>	<i>84.3</i>	<i>55.1</i>
Health establishment	7.4	20.6	50.2	4.9	14.1	38.7	3.2	15.7	44.9
Total persons (N)	326,600	178,900	152,000	392,500	214,100	188,300	615,800	260,900	249,400
									1,126,100

n.p. Not published by the data source but included in totals.

* Subject to a relative standard error between 25% and 50%.

** Subject to a relative standard error greater than 50%.

Note: The 1988 and 1993 data are based on disability and handicap definitions used in the 1988 Survey.

Source: ABS 1988 Survey of Disabled and Aged Persons, unpublished data; ABS 1993 Survey of Disability, Ageing and Carers, unpublished data; ABS 1998 Survey of Disability, Ageing and Carers, unpublished data.

Table 6.5: Estimated and projected populations, by age group and disability status, 1981 to 2041

Year	All persons			Persons with a profound or severe core activity restriction		
	65+	80+	All ages	65+	80+	All ages
Males						
1981	612,205	79,840	7,448,267	89,655	29,167	369,650
1991	836,262	128,633	8,615,409	129,159	46,992	444,033
2001	1,050,852	203,063	9,616,490	177,039	74,183	537,415
2011	1,348,413	296,832	10,492,046	231,436	108,439	630,516
2021	1,866,135	365,313	11,239,570	311,412	133,456	726,256
2031	2,340,201	562,789	11,806,716	422,241	205,598	845,705
2041	2,644,228	739,695	12,121,750	505,195	270,225	932,471
Females						
1981	842,794	176,872	7,474,993	188,941	90,438	430,698
1991	1,114,453	255,442	8,668,627	261,311	130,612	540,969
2001	1,336,069	371,481	9,719,325	343,167	189,944	673,509
2011	1,617,524	486,250	10,609,512	419,506	248,628	797,580
2021	2,186,422	561,666	11,400,493	533,039	287,189	930,168
2031	2,777,747	826,254	12,047,565	728,240	422,477	1,132,018
2041	3,189,537	1,115,213	12,431,358	899,756	570,227	1,305,243
Persons						
1981	1,454,999	256,712	14,923,260	278,595	119,605	800,348
1991	1,950,715	384,075	17,284,036	390,470	177,604	985,002
2001	2,386,921	574,544	19,335,815	520,206	264,127	1,210,924
2011	2,965,937	783,082	21,101,558	650,942	357,066	1,428,097
2021	4,052,557	926,979	22,640,063	844,451	420,645	1,656,424
2031	5,117,948	1,389,043	23,854,281	1,150,481	628,075	1,977,723
2041	5,833,765	1,854,908	24,553,108	1,404,951	840,452	2,237,714

Source: ABS 1987:5–7; ABS 1993:27–32; ABS 1999 population projections (series K), unpublished data; ABS 1999b:15.

The current decade (1991 to 2001) and the one which follows (2001 to 2011) are characterised by relatively lower rates of increase among people aged 65 and over, at 2.0% and 2.2% a year respectively. From 2011 to 2021 the rate of increase in this age group rises to 3.2% a year as the baby boom generation moves into old age.

The picture is somewhat different for people aged 80 and over. For this group the two decades just concluding (1981–1991 and 1991–2001) were a period of particularly rapid increase, at 4.1% a year. For the decade from 2001 to 2011, this is projected to slow to 3.2% a year and then reduce even further in the following decade (2011 to 2021), to 1.7% per annum. The effect of the baby boom generation on the size of the 80 and over population will not be felt until the decade 2021 to 2031, when the rate of increase is projected to rise to 4.1% per annum.

A comparison of the rates of increase in the populations aged 65 years and over and 80 years and over makes it clear that in the 30 years from 1981 to 2011 the aged population itself has been undergoing an ageing process. In 1981 only 18% of older people (that is, people aged 65 and over) were aged over 80. This proportion is projected to increase to 24% by 2001 and 26% in 2011. From 2011 to 2021, this effect reverses—by 2021 the

Table 6.6: Annual rates of increase of older populations by disability status, age group and sex, 1981 to 2041 (per cent)

Decade	All persons			Persons with a profound or severe core activity restriction		
	65+	80+	All ages	65+	80+	All ages
Males						
1981–1991	3.2	4.9	1.5	3.7	4.9	1.9
1991–2001	2.3	4.7	1.1	3.2	4.7	1.9
2001–2011	2.5	3.9	0.9	2.7	3.9	1.6
2011–2021	3.3	2.1	0.7	3.0	2.1	1.4
2021–2031	2.3	4.4	0.5	3.1	4.4	1.5
2031–2041	1.2	2.8	0.3	1.8	2.8	1.0
Females						
1981–1991	2.8	3.7	1.5	3.3	3.7	2.3
1991–2001	1.8	3.8	1.2	2.8	3.8	2.2
2001–2011	1.9	2.7	0.9	2.0	2.7	1.7
2011–2021	3.1	1.5	0.7	2.4	1.5	1.5
2021–2031	2.4	3.9	0.6	3.2	3.9	2.0
2031–2041	1.4	3.0	0.3	2.1	3.0	1.4
Persons						
1981–1991	3.0	4.1	1.5	3.4	4.0	2.1
1991–2001	2.0	4.1	1.1	2.9	4.0	2.1
2001–2011	2.2	3.1	0.9	2.3	3.1	1.7
2011–2021	3.2	1.7	0.7	2.6	1.7	1.5
2021–2031	2.4	4.1	0.5	3.1	4.1	1.8
2031–2041	1.3	2.9	0.3	2.0	3.0	1.2

Note: Annual rates of increase were calculated using the exponential rate of growth formula: $r = ((p_2/p_1)^{1/t}) - 1$, where $t=10$.

Source: ABS 1987:5–7; ABS 1993:27–32; ABS 1999 population projections (series K), unpublished data; ABS 1999b:15.

proportion of older people who are aged 80 and over will drop to 23%. In the following two decades, however, the proportion will rise again; it is projected to reach 32% by 2041. Given that use of formal services is markedly higher in the 80 and over age group, this changing structure of the aged population is a useful indicator of the changing need for services and assistance over time.

Another noteworthy aspect of Table 6.6 is the higher rates of increase among males in comparison with females, in both age categories and for almost the entire time period. There will thus be a somewhat more even sex balance in future older populations, which may have implications for patterns of both formal and informal care.

Table 6.5 contains data on the increasing number of people with a profound or severe core activity restriction between 1981 and 2041.⁴ These data provide a measure of the number of people who are likely to need assistance (whether formal or informal) in the next 40 years (assuming that rates of serious disability remain reasonably stable among

4 The data were calculated using five-year age- and sex-specific profound or severe core activity restriction rates, and population data, including projections from the Australian Bureau of Statistics.

the 65 and over population). In 1981 the total number of people in this category numbered some 279,000; the figure increases to over half a million in 2001. By 2031 the number of older people likely to be in need of some assistance in their daily lives will have exceeded the one million mark on these calculations (1,150,000). Rates of growth in this population are high in the two decades from 1981 to 2001 (3.4% and 2.9% per annum), then drop back somewhat to 2.3% per annum from 2001 to 2011 and 2.6% from 2011 to 2021. From 2021 to 2031, the rate of growth is projected to increase to 3.1% (Table 6.6).

Calculating the number of people with a profound or severe core activity restriction has the advantage for planning purposes of 'adjusting' for the changing structure of the aged population over time, thus giving a better indication of the likely need for services than that obtained by simply using the number of people in an age category. That the measures are indeed different over time becomes evident from even a cursory examination of Table 6.5. In 1981 the population aged 80 and over was smaller than that aged 65 years and over with a profound or severe core activity restriction. By 1991 the two numbers were relatively similar, but from that time onward the number of people aged 80 and over draws substantially ahead of the number of people aged 65 years and over with a profound or severe core activity restriction. In planning for future service use, then, the proportions of people with a profound or severe core activity restriction provide a valuable additional source of information to that provided by age alone.

The need for informal care

According to the 1998 ABS Survey of Disability, Ageing and Carers, 447,900 primary carers were providing informal care in Australia in 1998. A 'primary carer' is defined as someone who provides the most assistance to a person with one or more disabilities, on an ongoing basis and in one of the three core activity areas of mobility, selfcare and communication (ABS 1999b).⁵

Over three-quarters of these carers (79%) were co-resident; thus a substantial minority did not live with the care recipient. Seventy per cent of the carers were women. Men were more likely than women to live with the person they were caring for: 87% of male carers were co-resident, compared with 75% of women. Around one in five carers (22%) were themselves aged 65 or over. Male carers were more likely to be aged 65 or over than were female carers (27% compared to 19%) (ABS 1999b:46).

Close to half the people identified as primary carers spent 40 or more hours each week providing care, and this proportion increased with age. Thus while 37% of carers aged 25–44 years provided 40 or more hours of assistance, the comparable proportion among carers aged 45–64 years was 48% and that for carers aged 65 and over was 53%. Only 27% of carers aged 65 and over provided less than 20 hours of care; this compares with 35% of those aged 45–64 and 43% of those aged 25–44. Caring thus takes up a larger proportion of old carers' time than it does for younger carers (ABS 1999b:49).

Contrary to common perceptions, only 45% of care recipients were aged 65 and over. Male and female carers were roughly similar in the proportions caring for people aged

5 The methodology used to identify 'primary carers' in the 1998 ABS Survey of Disability, Ageing and Carers differs from that used to identify 'principal carers' in the 1993 Survey, and results in a substantial drop in numbers between the two surveys. For further details of this change see Chapter 7, page 214.

65 and over: 46% of male carers and 42% of female carers were looking after someone aged 65 or over. Almost one in five of all caring dyads (18%) consisted of a carer and a care recipient who were both aged 65 and over. Among people aged 65 and over with a co-resident carer, over half (57%) were cared for by someone who was themselves over 65 (ABS 1999b:46).

For all age groups male carers were more likely to be caring for a spouse or partner: 67% of all male carers and 77% of all male co-resident carers were caring for a spouse or partner. This figure was even higher for male carers aged 65 and over, where 95% were caring for a spouse or partner. In contrast, only 34% of female carers were caring for a spouse or a partner, but this proportion is substantially higher among carers aged 65 and over: 77% of female carers aged 65 and over were caring for a spouse or partner (Table 6.7).

Table 6.7: Principal carers aged 25 years and over: age group, sex and living arrangements, by relationship of carer to care recipient, 1998 (per cent)

Relationship	Co-resident carer					Non-co-resident carer				
	25-44	45-64	65-74	75+	Total	25-44	45-64	65-74	75+	Total
Males caring for										
Partner	13	25	32	52	25	—	—	2	—	—
Child	4	5	—	—	3	10	18	—	—	13
Parent	4	4	—	3	3	—	1	—	—	1
Other	1	2	—	—	1	6	2	7	—	4
<i>Total male carers</i>	22	36	32	55	32	16	21	8	—	18
Females caring for										
Partner	21	30	48	35	31	1	—	5	—	1
Child	7	16	3	—	9	52	54	21	—	50
Parent	47	15	11	6	24	2	4	9	—	4
Other	3	4	6	4	4	29	21	56	—	27
<i>Total female carers</i>	78	64	68	45	68	84	79	92	—	82
Persons caring for										
Partner	34	56	80	87	56	1	—	7	—	1
Child	11	21	3	—	13	62	72	21	—	63
Parent	50	18	11	9	26	2	5	9	—	5
Other	5	6	6	4	5	35	23	63	—	31
Total carers (N)	109,200	143,900	53,900	33,500	340,600	35,100	49,600	9,300	—	93,900

Source: ABS 1998 Survey of Disability, Ageing and Carers, unpublished data.

Table 6.8 demonstrates the important role played by informal carers in providing assistance to older people living at home. In the areas of self care, mobility, communication, transport and paperwork over 90% of those receiving assistance were receiving it from informal carers. For meal preparation (83%), housework (73%) and property maintenance (71%), informal carers were also an important source of assistance to the vast majority of older people receiving help in these areas. Formal providers dominated in providing health care (67%) but also provided help to a substantial proportion of people receiving assistance with property maintenance (48%), housework (46%), meal preparation (28%), self care (25%) and mobility (20%). Although for most of these activities the bulk of formal assistance was provided by government or not-for-profit

providers, in the case of property maintenance and health care the majority of assistance was provided by the private for-profit sector (ABS 1999b:40).

Table 6.8 also provides information on the extent to which older people's need for help in each of these areas was being met. In the majority of cases older people reported that their need for assistance in each of the areas listed was being fully met. For paperwork and meal preparation, over 90% of older people reported that their need for assistance was fully met; for self care, mobility, communication, health care, transport and housework, over 80% of older people reported that their need was being fully met. Nonetheless, for a significant minority of older people their need for assistance remained either unmet or only partly met: for example, 13% of older people reported that their need for assistance with mobility was being only partly met and 6% reported that it was not being met at all.

Table 6.8: Older people living at home: extent to which need for assistance is met, and provider of assistance, 1998 (per cent)

Activity	Extent to which need for assistance is met				Provider of assistance			
	Fully	Partly	Not at all	Total (N)	Informal	Formal	Both	Total (N)
Self care	86	* 5	9	155,000	90	25	15	141,100
Mobility	81	13	6	275,000	95	20	15	258,600
Communication	86	n.p.	* 11	28,300	100	n.p.	—	25,200
Health care	85	9	6	376,000	49	67	16	354,100
Transport	81	8	12	453,900	93	16	9	400,500
Paperwork	91	* 5	* 4	144,300	97	8	5	138,200
Housework	83	13	4	403,900	73	46	19	386,700
Property maintenance	78	17	5	626,100	71	48	19	592,900
Meal preparation	92	* 6	* 2	142,200	83	28	11	139,200
Any activity	67	29	4	887,900	83	59	43	853,300

n.p. Not published by the data source but included in totals.

Source: ABS 1999b:39–40.

6.3 Service provision

As noted in the introduction to this chapter, the period since 1997 has seen a number of important changes to aged care programs, particularly in the residential care sector. Among these changes were the restructuring of the two tiers of residential care (hostels and nursing homes) into one single system (residential aged care facilities), the introduction of the new Resident Classification Scale, the modification and expansion of the system of contribution to the capital costs of aged care facilities, and the introduction of means-tested fees.

Alongside these changes, some trends have continued unabated; in particular, the move to contain the residential care sector and expand the range and extent of home-based care services. Community aged care packages and respite care services continue to be important areas of growth. The development and implementation of quality appraisal and accreditation procedures also remain important. Boxes 6.1 and 6.2 summarise recent policy initiatives in aged care; Box 6.3 briefly describes national activities for the International Year of Older Persons.

Box 6.1: Policy changes 1997 to 1999: residential care

The Resident Classification Scale

The Resident Classification Scale, a new funding tool for residential aged care services, was introduced on 1 October 1997 to allow the unification of the nursing home and hostel sectors and to facilitate the goal of 'ageing in place'.

Income-tested fees in residential aged care facilities

Income tested fees were introduced for all residential aged care facilities from 1 March 1998. The standard fee is set at 85% of the full rate of the Age Pension (\$21.52 in 1999) for pensioners and part-pensioners, and \$26.91 per day for non-pensioners. In addition, new residents entering care from 1 March 1998 and with an income in excess of the pension-free area (\$50 per week in 1999) pay an income-tested fee of 25 cents in the dollar, to a maximum of three times the pensioner daily rate or the cost of care, whichever is the lower.

Accommodation charges and bonds

From 1 March 1998 residents entering nursing home level care (RCS level 1–4) can be asked to pay an accommodation charge of up to \$12 a day. The maximum of \$12 is payable if the resident's assets are over \$44,900. For hostel level care residents (RCS 5–8), eligible residents may be asked to pay an accommodation bond (to be agreed between the resident and service provider). Service providers are able to draw down \$2,600 per year for a maximum of five years and retain the interest earned on the principal for the duration of the resident's stay. Accommodation payment arrangements require that a resident be left with a minimum equivalent to 2.5 times the Age Pension (currently \$23,000) in assets after paying.

Aged Care Standards and Accreditation Agency

An Aged Care Standards and Accreditation Agency has been established to monitor care standards, oversee new accreditation arrangements, and provide education and training in residential aged care facilities. The new system replaces the Outcome Standards Monitoring Program implemented in 1987.

Best practice grants for dementia specific facilities (1997–98 Budget)

This initiative provided \$0.6 million to facilities that specialise in dementia care to assist them in the transition to the new unified residential system in 1997–98.

Two-year review of the aged care reform policy

In 1998 the Commonwealth Government commissioned a two-year review of the aged care reform policy and its implementation. The purpose of the review is to evaluate the impact of the reforms and the extent to which their objectives are being achieved, particularly in overcoming acknowledged deficiencies of the former system. The review's terms of reference cover a broad range of matters of interest to stakeholders, among them access, affordability, quality, choice and appropriateness, and industry viability. Professor Len Gray was appointed to chair the Review.

(continued)

Box 6.1 (continued): Policy changes 1997 to 1999: residential care

Residential Aged Care Grants

In 1998 the Commonwealth Government approved some 100 Residential Care Grants totalling \$20 million to help residential aged care services build, rebuild, or upgrade their facilities. The purpose of the grants was to provide special, targeted assistance to services that provide care to concessional residents, particularly where those services are in rural and remote locations and where there is an urgent need for improvement in the physical quality of the facility and a need for financial assistance.

Box 6.2: Policy changes 1997 to 1999: Home- and community-based care

Staying at Home – Care and Support for Older Australians (1998–99 Budget)

Announced by the Prime Minister on 2 April 1998, this package of measures is to cost \$280 million over four years. It has been designed to enhance the care of older people in the community and provide greater recognition and support for carers within Australian society. The measures will help older Australians remain in their homes for as long as possible and provide further support for carers. Areas of particular focus are

- ageing carers
- respite care for families of people with dementia
- continence management
- new carer allowance

Carer Payment and Domiciliary Nursing Care Benefit to continue when care recipient is in hospital (1998–99 Budget)

The measure extends eligibility for the Carer Payment and the Domiciliary Nursing Care Benefit to provide for the payment of benefits to carers when the care recipient is hospitalised for up to 63 days in a calendar year. The 63-day period applies provided that the treatment plan involves returning the care recipient to the carer in the private home of the care recipient or where the care recipient is terminally ill.

Revised arrangements for carers of adults and children with disabilities (1997–98 Budget)

From July 1998 the rate of the Domiciliary Nursing Care Benefit was increased to bring it into alignment with the Child Disability Allowance.

Carers' support and information (1997–98 Budget)

Funding of \$8.1 million was allocated over four years for the Carer Support Strategy, to provide support programs and information to carers of frail older people and people with disabilities.

(continued)

Box 6.2 (continued): Policy changes 1997 to 1999: Home- and community-based care

Specific support for people with dementia and their carers (1997–98 Budget)

This allocation of \$10 million over a four-year period is aimed at providing more accurate diagnosis and assessment of people with dementia (particularly those living in country areas) and of their care needs. It also aims to provide more appropriate and timely treatment, care and support services for these people.

Multipurpose Services in Rural & Remote Australia (1998–99 Budget)

Federal Aged Care Minister the Hon. Bronwyn Bishop announced the expanded funding of multipurpose services in rural and remote regions of Australia, with total funding of \$17.48 million over five years. Multipurpose services provide a mix of Commonwealth- and State-funded services best suited to the needs of each community.

Carelink

Carelink is an initiative announced in the 1999–2000 Budget; its purpose is to simplify access to community care services through the establishment of single contact points for community care across Australia. A single phone call will provide information about community care services in the local area. \$41.2 million has been allocated over four years to this initiative.

Box 6.3: National activities for the International Year of Older Persons

The International Year of Older Persons

Additional funding (\$5–6 million) was allocated in the 1999 International Year of Older Persons to help recognise the significant contribution of older people to communities and families to encourage a sharing of responsibility between the community and older people for creating a society for all ages, and to ensure a positive cultural change in attitude towards ageing.

National Strategy for an Ageing Australia

In response to the celebration of the International Year of Older Persons, the Commonwealth government is developing a National Strategy for an Ageing Australia. The Strategy will develop a broad-ranging framework to identify challenges and possible responses by government, business, the community and individuals to meet the needs of Australians as they age. A background paper and a discussion paper have been released by the Minister for Aged Care (Bishop 1999a, 1999b).

The Active Australia International Year of Older Persons campaign

Launched in February 1999 by the Prime Minister, the campaign encourages older people to become more involved in physical activity and urges community groups to create more opportunities for older people to be physically active.

The very recency of some of the policy changes that have been introduced makes it difficult to assess their impact; the situation is further complicated by discontinuities in the national data sets that constitute the main resource for time-series analyses. Such analyses rely on administrative data; thus, when the programs undergo substantial change, so too do the associated databases. In particular, the restructuring of the two tiers of residential care (hostels and nursing homes) into one single system (residential aged care facilities) has made it difficult to track dependency levels (the measures of dependency having changed) and to analyse data on admissions and separations. This latter problem arises because some residents who would previously have 'separated' from a hostel on 'admission' to a nursing home are now simply transferring from one level of care to another within the same system. Not only does this affect the number of admissions and separations; it also affects other derived measures such as length of stay and turnover.

Some of these data issues will become evident in the statistical information provided later in this section. First, some basic data are presented on patterns of income support in old age. This is followed by discussions of recent trends in assessment, home-based care, community aged care packages, residential care, and expenditure.

Income support

Australia has 1.7 million people receiving the Age Pension and a further 0.4 million people aged 60 and over receiving pensions from the Department of Veterans' Affairs (DVA). The Age Pension is income and assets tested, as is the Income Support Pension paid by the Department of Veterans' Affairs. Compensation pensions⁶ paid for by the Department of Veterans' Affairs are neither taxable nor subject to means testing. In February 1999 the single rate for the Service Pension was \$366.80 a fortnight, while the couple rate was \$304.30 each per fortnight. For the Age Pension the rate was \$357.30 for single pensioners or \$298.10 for each member of a couple.

Women made up 64% of age pensioners and 53% of DVA pensioners (that is, those aged 60 and over). While over a third of age pensioners were aged between 60 and 69, a substantial minority (10%) were aged 85 and over. There were 53,000 age pensioners in Australia aged 90 and over. The profile of DVA pensioners is substantially older: only 12% were aged between 60 and 69; 64% were aged between 70 and 79; less than 10% were aged 85 and over (Table 6.9).

According to the 1997 ABS Survey of Retirement and Retirement Intentions, 71% of retired people aged 65 and over were dependent on a pension or benefit (predominantly the Age Pension) as their main source of income. Superannuation—either a superannuation pension or a pension or annuity bought with superannuation lump-sum or rollover money—was the main source of income for only 10% of this age group. This pattern is likely to change in the future because the introduction of superannuation provisions into award entitlements in 1986 and of the superannuation guarantee in 1992 has substantially increased superannuation coverage in all age groups. In 1988, 9% of women and 34% of men aged between 55 and 64 had some superannuation coverage; by 1995 the figures were 22% and 43% respectively. If coverage is examined only for people in the labour force, the change in recent years is even more marked. In 1988,

6 Includes the Disability Pension, the War or Defence Widow's/Widower's Pension, and the Orphan's Pension.

among people in the labour force aged 55 to 64, 37% of women and 55% of men were covered by superannuation; by 1995 the comparable figure was 68% for both men and women (Office of the Status of Women 1999). It must, however, be remembered that increased coverage will take some time to translate into substantial retirement benefits since entitlements are determined by the length of time during which superannuation has been accrued.

Table 6.9: Recipients of Age Pension and DVA pensions, by age group and sex, 1999 (per cent)

Sex	60–64	65–69	70–74	75–79	80–84	85–89	90–94	95+	Total
Age Pension									
Males	—	13.9	10.8	5.3	3.7	2.0	0.6	0.1	36.5
Females	11.1	14.6	12.3	10.1	8.0	5.0	2.0	0.5	63.5
Persons	11.1	28.5	23.1	15.4	11.7	7.0	2.6	0.6	100.0
Total (N)	187,256	479,884	388,474	258,756	196,415	118,520	43,076	10,237	1,682,618
DVA pensions									
Males	1.3	2.0	10.2	21.0	9.3	2.6	0.5	0.1	46.8
Females	2.3	6.2	16.2	16.7	7.8	2.9	0.8	0.2	53.2
Persons	3.6	8.2	26.4	37.7	17.0	5.5	1.2	0.3	100.0
Total (N)	15,580	35,063	113,335	161,872	73,077	23,671	5,320	1,297	429,215

Source: Centrelink 1999, unpublished data; Department of Veterans' Affairs information system, March 1999, unpublished data.

The Carer Payment (previously known as the Carer Pension) is an income-support benefit payable to people who, because of their caring responsibilities, are unable to engage in a substantial level of paid work. It is income and assets tested. A total of 12,590 people who were caring for someone aged 65 or over received the Carer Payment in 1999 (Table 6.10). Two-thirds (67%) of these carers were women. The majority of both male and female carers receiving this benefit were aged between 45 and 64 (71% of men and 73% of women). Among care recipients, 75% were female and 25% male. Among female care recipients, 56% were aged 80 and over, while 42% of male care recipients were in this age group. The full rate for the Carer Payment as at June 1999 was \$361.40 a fortnight for a single recipient or \$301.60 for each member of a couple.

The Domiciliary Nursing Care Benefit was previously paid to people caring for someone at home who would otherwise require nursing home level care in a residential aged care facility. From July 1999 the Domiciliary Nursing Care Benefit (and the Child Disability Allowance) was replaced by the Carers Allowance. The payment is not means tested, nor is it treated as income for social security or taxation purposes.

In January 1999 some 49,000 people were receiving the Domiciliary Nursing Care Benefit. Three-quarters of beneficiaries were receiving assistance for the care of people aged 65 and over (Table 6.11). Among those caring for people aged 65 and over, 75% of carers were themselves over 60. Among these beneficiaries there were 4,776 people aged 80 to 89, and 309 people aged 90 and over who were providing care to a person aged 65 or over.

Among people receiving the Domiciliary Nursing Care Benefit to assist in the care of a person aged less than 65 years, 60% were aged between 50 and 69. There were 227 people aged 80 and over who were receiving the Domiciliary Nursing Care Benefit to support them in caring for a younger person with a disability (Table 6.11).

Table 6.10: Recipients of the Carer Payment who care for people aged 65 years and over, by age group and sex of carer and age group and sex of care recipient, 1999

Care recipients	Male carers					Female carers				
	<25	25-44	45-64	65+	Total	<25	25-44	45-64	65+	Total
Females										
65-69	18	165	302	41	526	15	318	113	3	449
70-79	12	405	639	46	1,102	64	762	1,219	10	2,055
80-89	21	160	1,121	38	1,340	40	353	2,597	39	3,029
90+	5	19	215	18	257	2	58	613	59	732
Total	56	749	2,277	143	3,225	121	1,491	4,542	111	6,265
Males										
65-69	5	111	38	1	155	12	138	445	12	607
70-79	15	199	131	3	348	18	271	356	50	695
80-89	6	85	266	1	358	10	105	536	17	668
90+	5	9	74	4	92	—	10	157	10	177
Total	31	404	509	9	953	40	524	1,494	89	2,147

Source: Centrelink 1999, unpublished data.

Table 6.11: Recipients of Domiciliary Nursing Care Benefit, 1999

Age of carer	Males		Females		Persons	
	N	%	N	%	N	%
Care recipient aged 0-64 years						
15-19	15	—	15	—	30	—
20-29	65	1	182	2	247	2
30-39	222	2	551	5	773	7
40-49	504	5	1,625	15	2,129	19
50-59	953	9	2,608	24	3,561	32
60-69	1,442	13	1,704	15	3,146	29
70-79	347	3	579	5	926	8
80-89	40	—	166	2	206	2
90-99	6	—	15	—	21	—
Total	3,594	33	7,445	67	11,039	100
Care recipient aged 65 years and over						
15-19	3	—	6	—	9	—
20-29	31	—	117	—	148	—
30-39	178	1	574	2	752	2
40-49	525	2	1,956	6	2,481	8
50-59	808	3	3,830	12	4,638	14
60-69	1,412	4	6,337	19	7,749	24
70-79	4,312	13	7,539	23	11,851	36
80-89	2,374	7	2,402	7	4,776	15
90-99	194	1	115	—	309	1
Total	9,837	30	22,876	70	32,713	100

Note: A further 5,167 persons receiving the Benefit are not included in this table because there was no information on their age and/or sex.

Source: Centrelink 1999, unpublished data.

Assessment

Aged care assessment teams play a crucial role in the Australian aged care system. They determine eligibility for community aged care packages and for admission to residential aged care facilities. They also function as a source of advice and referral concerning Home and Community Care (HACC) services; they do not, however, determine eligibility for HACC services. The desirability and practicality of establishing a central assessment strategy for HACC services has been a subject of ongoing policy discussions in recent years, including a government sponsored consultancy on the topic (Lincoln Gerontology Centre 1998b).

In the 13 years since their inception, aged care assessment teams have become an established part of the aged care system. In the process of determining eligibility, the teams generate data on the clients they assess – their age and sex, their dependency levels, and their assessed level of need for services. While these data provide some information about the flow of clients into the aged care system, the current 22-item national minimum data set has some limitations (particularly in relation to the measurement of dependency and the availability of informal care). A review of the national minimum data set for the Aged Care Assessment Program is under way. It should be noted that while the data are reported here as national data, there are some interstate differences in the data collections; in particular, there have been historical differences in what is and is not defined as an ‘assessment’ in different jurisdictions.⁷

From January to June 1998 aged care assessment teams carried out 79,796 assessments, equivalent to 3.5% of the Australian population aged 65 and over (Table 6.12). This is just over 24,000 more assessments than were carried out during the same period in 1994 (55,746 assessments, or 2.6% of the population aged 65 and over). This is a 43% increase; the percentage increase was much higher in the older age groups (36% among those aged 70 to 79, and 51% among those aged 80 and over) than among those aged 65 to 69 (only 15%). The rate of assessment (that is, the proportion of the age group assessed) was highest in the 80 and over age group (9.4%, compared with 2.4% of those aged 70 to 79 and 0.8% of those aged 65 to 69), and marginally higher among women than men in all age groups.

One contributing factor in this increased rate of assessment could be re-assessments associated with the amalgamation of hostels and nursing homes into single-stream residential aged care facilities. As a consequence of this amalgamation, residents in what were formerly hostels can now be classified as requiring high-level care (RCS levels 1–4) without moving to a high-care institution. This reclassification requires, however, an assessment by aged care assessment teams to determine residents’ eligibility to move from the low care (RCS levels 5–8) to the high care (RCS levels 1–4). While a short-term ‘catch-up’ increase in assessment rates therefore seems plausible, and may have occurred, there is no supporting evidence for such a trend in the pattern of recommendations for care made by the assessment teams.

The proportion of people assessed who were deemed to require residential care remained largely unchanged in recent years, ranging from 24.1% in 1994 to 23.9% in 1998 for nursing homes and from 22.2% in 1994 to 21.0% in 1998 for hostels. The

7 This is discussed in more detail in *Australia's Welfare 1995* (AIHW 1995:183-185).

proportion who received a recommendation for community aged care packages increased substantially, however, from 3.3% in 1994 to 8.5% in 1998. This latter result reflects the large increase in the number of community aged care packages available during the period.

Table 6.12: Aged care assessment team clients aged 65 years and over: recommendations and assessments by age group and sex, January–June 1994 and January–June 1998

	January–June 1994				January–June 1998			
	65–69	70–79	80+	Total	65–69	70–79	80+	Total
Males								
% nursing homes	20	24	28	26	17	22	27	25
% hostels	16	17	21	19	16	16	21	18
% CACPs/COPs	3	3	4	3	6	7	9	8
Total assessments	2,145	7,372	9,930	19,447	2,488	10,531	15,193	28,345
All males	332,441	427,089	151,823	911,353	333,511	486,517	179,290	999,318
% assessed	0.6	1.7	6.5	2.1	0.7	2.2	8.5	2.8
Females								
% nursing homes	16	19	26	23	16	18	27	24
% hostels	16	21	27	24	14	19	25	23
% CACPs/COPs	3	3	3	3	9	9	9	9
Total assessments	2,421	11,601	22,277	36,299	2,707	15,318	33,280	51,451
All females	354,471	545,101	294,675	1,194,247	348,319	597,494	338,226	1,284,039
% assessed	0.7	2.1	7.6	3.0	0.8	2.6	9.8	4.0
Persons								
% nursing homes	18	21	27	24	17	20	27	24
% hostels	16	19	25	22	15	18	24	21
% CACPs/COPs	3	3	3	3	8	8	9	9
Total assessments	4,566	18,973	32,207	55,746	5,195	25,849	48,473	79,796
All persons	686,912	972,190	446,498	2,105,600	681,830	1,084,011	517,516	2,283,357
% assessed	0.7	2.0	7.2	2.6	0.8	2.4	9.4	3.5

Source: AIHW 1995:186–7; ACAP evaluation units, 1998 unpublished data; ABS 1999a:17.

The Aged Care Assessment Program national minimum data set contains three items on client dependency: mobility, continence and orientation. For much of the period from 1994–95 to 1997–98 there was no change at all in the dependency profile of aged care assessment team clients as measured by these three items (Table 6.13). In 1997–98, however, the proportion who could walk independently declined from 63% to 58% and the proportion who were fully continent declined slightly, from 61% to 58%. The proportion of clients who were aware of time and place increased marginally, from 62% to 64%. The changes suggest a modest trend toward increasing dependency of aged care assessment team clients; the trend is consistent with the significant increases in dependency levels observed in recent years among both nursing home and hostel residents. Access to community aged care packages has also increased substantially, perhaps changing the profile of clients seen by assessment teams. Finally, this increase in dependency may reflect the re-assessment of (former) hostel residents, referred to in the preceding discussion.

More detailed dependency data recorded in Western Australia and Queensland provide further evidence that the dependency levels of assessment from clients may be increasing. The level of client dependency showed a modest increase from 1994 to 1998 in both States, supporting the hypothesis that although the proportion of older people seen by aged care assessment teams has increased, so too have the dependency levels of those assessed (see Tables A6.1, page 344, and A6.2, page 344).

Table 6.13: Aged care assessment team clients: mobility, continence and orientation, 1994–95 to 1997–98 (per cent)

	1994–95	1995–96	1996–97	1997–98
Mobility				
Walks independently	63	63	63	58
Does not walk independently	33	33	33	36
Unknown	4	4	4	6
Total (N)	132,957	164,862	166,410	171,660
Continence				
Fully continent	61	61	61	58
Not fully continent	33	32	33	36
Unknown	7	6	6	6
Total (N)	132,957	164,862	166,410	171,660
Orientation				
Aware, time and place	62	62	62	64
Not aware	32	32	33	29
Unknown	6	6	5	7
Total (N)	132,957	164,862	166,410	171,660

Source: Lincoln Gerontology Centre (LGC) 1998a:Tables 9, 10, 11; LGC 1997:29; LGC 1996:28; LGC 1995:22; Queensland Aged Care Evaluation Unit (QACEU) 1999:29; QACEU 1995a:34–6; QACEU 1995b:24–7; QACEU 1996:26–7; QACEU 1997:11; University of Western Australia (UWA) 1995:42–4, UWA 1996a:40–4; UWA 1996b:42–6; UWA 1997:43–7.

Home-based care

The Home and Community Care Program is jointly funded by the Commonwealth and State and Territory governments. The bulk of home- and community-based services are provided under the auspices of this program. It includes home nursing services, delivered meals, home help and home maintenance services, transport and shopping assistance, paramedical 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. Community aged care packages, an alternative source of coordinated home-based care, are discussed later in this section.

Table 6.14 provides data on the hours of services provided under the HACC Program in relation to the number of people aged 70 and over and the number of people aged 65 and over with a profound or severe core activity restriction. These ratios of HACC service provision to the potential client group allow changes in the level of provision of HACC services to be examined in the context of the increasing size of the aged population between 1993–94 and 1997–98.

In 1997–98 HACC agencies provided 1,465 hours of home help (per month) per 1,000 people aged 65 and over with a profound or severe core activity restriction. They also provided (again per month) 1,682 hours of centre-based respite care and 2,317 meals per 1,000 people aged aged 65 and over with a profound or severe core activity restriction. The levels of provision were lower in the more intensive service types—for home-based respite care, 653 hours; for personal care, 477 hours; and for home nursing, 423 hours.

Table 6.14: Ratio of HACC hours of service provision, average hours per month, 1993–94 to 1997–98

Service type	Per 1,000 persons aged 70 and over			Per 1,000 persons aged 65 and over with a profound or severe core activity restriction		
	1993–94	1997–98	% change	1993–94	1997–98	% change
Home help (hours)	428	441	3.0	1,423	1,465	3.0
Personal care (hours)	109	143	31.2	364	477	31.0
Home nursing (hours) ^(a)	206	127	-38.3	686	423	-38.3
Paramedical (hours)	20	23	15.0	65	77	18.5
Home respite care (hours)	155	196	26.5	515	653	26.8
Centre day care (hours)	421	506	20.2	1,399	1,682	20.2
Home meals (number)	746	697	-6.6	2,481	2,317	-6.6
Centre meals (number)	101	100	-1.0	337	333	-1.2
Home maintenance/modification (hours)	42	45	7.1	140	151	7.9

(a) Excludes the Northern Territory: home nursing is not HACC funded in the Northern Territory.

Source: DSHS 1995, Section 2:1–2; DHAC unpublished data, 1998; ABS 1997, 1998, 1999b:15.

Four categories of HACC service showed a substantial increase in relation to the population aged 70 and over since 1993–94: personal care (a 31% increase), paramedical services (15%), respite care services (27%) and centre day care (20%). There was a substantial reduction in the level of service provision in home nursing (a 38% decrease).

To some extent the increase in personal care services and the decrease in home nursing may constitute a changing pattern of service delivery as services previously provided by nurses become the province of personal care assistants. Although the percentages involved are roughly similar, the two changes do not in fact offset each other because of the very different percentage bases for the two categories of care. The decrease of 79 hours per 1,000 people aged 70 and over for home nursing is thus not matched by the increase of 34 hours per 1,000 people aged 70 and over for personal care assistance.

Home help has shown little change, as have home-delivered and centre-based meals and home maintenance or modifications. When these patterns are reviewed using the ratio of HACC service provision to the number of people aged 65 and over with a profound or severe core activity restriction the findings are similar to those reported in relation to the population aged 70 and over.

There are quite interesting State- and Territory-based variations in these patterns of service delivery (see Table A6.3). The Northern Territory has a comparatively high level of provision for all HACC services (except centre-based day care) in relation to both the number of people aged 70 and over and the number of people aged 65 and over with a profound or severe core activity restriction. This pattern is to be expected given the

high proportion of Indigenous Australians in the Northern Territory, their higher levels of morbidity and lower life expectancy, and their consequent need for both home-based and residential aged care services at (on average) younger ages than non-Indigenous Australians.

There are considerable variations among the other States and the Australian Capital Territory, and there is no clear evidence that these different patterns are converging over time. For home help in 1997–98, Victoria was a relatively high provider, at 2,715 hours per 1,000 people aged 65 and over with a profound or severe core activity restriction. The corresponding figure for the Australian Capital Territory was 647, for South Australia it was 978 and for Queensland it was 981. For personal care services, New South Wales, the Australian Capital Territory and Western Australia were relatively high providers (respectively, 680, 600 and 556 hours per 1,000 people aged 65 and over with a profound or severe core activity restriction), while Queensland was a relatively low provider (148). For home-based respite care, the Australian Capital Territory, New South Wales and South Australia were comparatively high providers (respectively, 1,306, 848 and 827 hours per 1,000 people aged 65 and over with a profound or severe core activity restriction).

It may be that these variations are partly artificial, deriving from State- and Territory-based differences in how forms of care are defined – for example, whether assistance is defined as personal care rather than home help or as home nursing rather than respite care. Another possible contributing factor is that these differences represent a ‘trade-off’ among service types. These explanations do not, however, fully account for the observed differences. If the hours of assistance provided in home help, home nursing, personal care and home-based respite care are added together, there remains a clear difference in the level of supply across the States and Territories. The Northern Territory undoubtedly has the highest level of service provision (but note the earlier caveat about its population profile), although hours of home nursing are not available because that is not a HACC-funded service in the Northern Territory. Next is Victoria (with 4,107 hours of these four service types per 1,000 people aged 65 and over with a profound or severe core activity restriction), followed by New South Wales (3,008), the Australian Capital Territory (2,841), Tasmania (2,747), South Australia (2,685), Western Australia (2,664) and finally Queensland (2,078). As can be seen, the level of service provision in Queensland is around half that in Victoria.

The HACC program has undergone a substantial amount of review and development work in recent years. The Australian Institute of Health and Welfare has played a central role in two such projects, both aimed at improving the amount and quality of information available concerning the HACC program. These AIHW projects involved the development of an Instrument for monitoring quality of care using the HACC National Service Standards and the development of a national minimum data set for the HACC program. HACC officials have agreed to implement both the HACC National Service Standards Instrument (from 1 July 1999) and the HACC national minimum data set (from 1 July 2000). Boxes 6.4 and 6.5 provide a summary of each project.

Box 6.4 The HACC Service Standards quality appraisal projects

The HACC Service Standards Instrument Project (1996–1997)

In June 1996 the AIHW was asked by HACC Officials to develop a way of measuring quality of service in Australia's HACC-funded agencies. A draft assessment tool, provided by the HACC Officials Standards Working Group, was refined in preliminary interviews with service providers, revised, and then trialed in a national pilot that tested five different methods of assessment. Close to 200 HACC agencies, from all States (except Tasmania) and the Territories, participated in the pilot.

HACC Officials accepted the refined Instrument for national implementation from July 1999. The assessment tool, known as the HACC National Service Standards Instrument, provides a means of assessing HACC agencies compliance with the 27 HACC National Service Standards. The Standards are organised under seven Objectives: access to services; information and consultation; efficient and effective management; coordinated, planned and reliable service delivery; privacy; confidentiality and access to personal information, complaints and disputes; and advocacy. The National Service Standards were originally released by Commonwealth, State and Territory Ministers in 1991. Compliance with these Standards is now part of agencies' funding agreements with their State or Territory government. With the successful implementation of the Instrument, Australia will have its first nationally consistent measure of service quality in home care agencies.

The result of the pilot test showed the Instrument to be a reliable and valid means of assessing agencies against the Standards. It could be applied across the range of HACC agencies, the only exceptions being agencies providing advocacy, information and education services. The pilot was also successful in establishing that agency ratings against the Standards could be added to assess overall agency performance against the Standards and to compare agency performance against each of the seven Objectives. For further details of this project see Jenkins et al. (1998).

A means of incorporating consumer input into this process was also investigated by AIHW, as was a comparison of the HACC assessment tool with other accreditation and standards appraisal systems. The latter was published in an AIHW working paper (Butkus 1997).

The Consumer Appraisal Data Development Project (1998–1999)

Client appraisal of agency performance is an important component of the assessment of quality of service in HACC agencies. Some developmental work on methods and tools for gathering consumer input occurred during the development of the HACC National Service Standards Instrument. At the request of the HACC Officials Standards Working Group, the AIHW is doing further work in this area.

The first stage of the project involved a review of current literature concerning consumer involvement in the appraisal of a range of health and welfare services. This review aimed to examine the best methods for obtaining consumer feedback, particularly from consumers represented by the HACC target group: frail or disabled older people, younger people with disabilities, and carers. It also examined special problems in obtaining consumer feedback that arise for people from diverse cultural backgrounds and Indigenous people. The literature review is available as a Welfare Division working paper (Cooper & Jenkins 1998).

(continued)

Box 6.4 (continued): The HACC Service Standards quality appraisal projects

A field trial, scheduled for completion in late 1999, will test strategies for obtaining consumer input to the HACC quality appraisal process. The project aims are the refinement of an appropriate tool and development of an appropriate methodology for collecting consumers' views about service quality.

Box 6.5: The HACC National Minimum Data Set Project, 1997–1998

In February 1997, the Australian Institute of Health and Welfare was commissioned by Commonwealth and State and Territory HACC officials to refine and further develop a national minimum data set (MDS) for use across the HACC program. The HACC MDS is a central plank in data reforms aimed at enhancing the quality, consistency and client focus of HACC data and improving access to data required for program management, planning and accountability.

The HACC National Minimum Data Set Project ran from February 1997 to May 1998 and was overseen by a national steering committee consisting of Commonwealth and State and Territory government officers (HACC officials or their representatives) and service provider representatives. Building on initial data specifications from the National Review of HACC Data Requirements (Elton & Associates 1996), the Project developed a framework for a national client-centred data collection to improve on and supersede existing collections (the HACC Service Provision, HACC User Characteristics, and Community Options Project Collections).

In completing the Project, the Institute undertook extensive data development work using information modelling techniques and targeted consultations with HACC agencies, government officials and service provider representatives. In contrast with previous collections, the HACC National Minimum Data Set is structured around an ongoing data-collection process, widespread client coverage, and data recording and reporting at the individual client level.

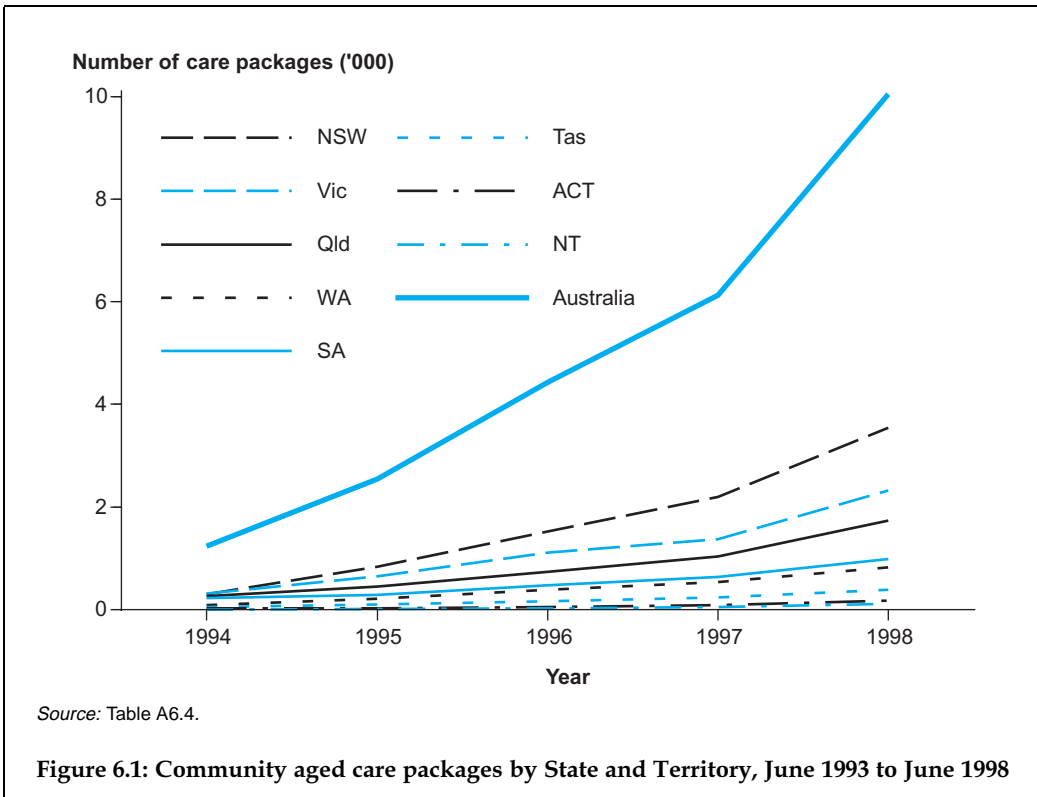
The final products of the Project included

- a set of data elements to assist HACC agencies enhance their internal management of HACC-funded service delivery, and capable of meeting key program planning, evaluation and accountability requirements across different levels of government;*
- a comprehensive data dictionary produced in line with national and international data standards to support the HACC MDS collection;*
- recommendations as to the implementation of a statistical linkage key based on standard client information; and*
- a final report detailing the process of developing the HACC MDS and the conceptual and analytical decisions which underscore the collection.*

Due for implementation from July 2000, the HACC MDS collection will provide data about the characteristics and circumstances of people assisted through the HACC program, and the extent and nature of assistance they receive. In the lead-up to full implementation, the AIHW has been asked to act as an interim national data repository for the purposes of the HACC MDS pilot test. The HACC MDS pilot collection was conducted during September and October 1999 to trial data collection and transfer processes prior to full implementation. The HACC Data Dictionary Version 1.0 was published by the Department of Health and Aged Care in 1998. An AIHW report on the project is also available (Ryan, Holmes & Gibson 1999).

Community aged care packages

Community aged care packages, first implemented in 1993, provide personal care services for people living at home who would otherwise be eligible for admission to what was previously Personal Care level in a hostel. They provide a full range of home-based services, with care being coordinated by the care package provider. From a small beginning of some 470 operational community aged care packages in 1993, the program has grown to reach 10,046 operational care packages by 1998. As Figure 6.1 demonstrates, the bulk of this growth occurred in the past two years, with an increase from 4,441 places in 1996 to 10,046 in 1998. This growth rate is higher than that of the potential client base, with the consequence that care packages are providing care to an increasing proportion of older people in need of formal assistance. In 1996 there were 2.9 packages per 1,000 people aged 70 and over (or 10 packages per 1,000 people aged 65 and over with a profound or severe core activity restriction); by 1998 this figure had increased to 6.3 packages per 1,000 people aged 70 and over (or 21 packages per 1,000 people aged 65 and over with a profound or severe core activity restriction) (Table 6.15, Figure 6.1). The numerical increase has been particularly strong in New South Wales, but all States and Territories more than doubled the number of operational care packages between 1996 and 1998 (see Table A6.4).



Residential care

Supply

Between 1994 and 1997 the number of hostel places increased from 57,104 to 64,825 (Table 6.15). The ratio of places to the potential client population also increased. Using the official planning ratio, provision increased from 40 hostel places per 1,000 people aged 70 and over in 1994 to 42 per 1,000 people aged 70 and over in 1997. If these figures are considered in relation to the population aged 65 and over with a profound or severe core activity restriction, the ratio changes from 134 per 1,000 to 138 per 1,000.

During the same period the number of nursing home beds decreased marginally, from 74,247 in 1994 to 74,233 in 1997. The ratio of provision of nursing home beds to people aged 70 and over (and to people aged 65 and over with a profound or severe core activity restriction) decreased between 1994 and 1997, from 52 to 48 beds per 1,000 people aged 70 and over (or from 174 to 158 beds per 1,000 people aged 65 and over with a profound or severe core activity restriction).

As noted, from 1 October 1997 nursing homes and hostels were integrated into a single residential aged care system. Time-series comparisons from this point onward must therefore be made in terms of the total number of residential care places. On 30 June 1998 there were 139,917 residential aged care places in Australia, up from a total of 139,058 (nursing home beds and hostel places combined) on 30 June 1997. The total number of residential care places available has been consistently increasing in recent years—the comparable figure in 1994 was 131,351.

While the number of residential aged care places has increased, so too has the number of people in need of assistance. The ratio of places to people aged 70 and over and the ratio of places to people aged 65 and over with a profound or severe core activity restriction provide two measures of the availability of residential aged care. Both measures have declined in recent years. On 30 June 1994 there were 93 places (nursing home beds and hostel places combined) per 1,000 people aged 70 and over; by 30 June 1997 the ratio was 89 per 1,000 people aged 70 and over, and by 30 June 1998 it had dropped again, to 87 per 1,000 people aged 70 and over. Using the ratio of residential care provision to the population aged 65 and over with a profound or severe core activity restriction, supply drops from 308 places per 1,000 people in 1994 to 296 places per 1,000 people in 1997 and 289 places per 1,000 people in 1998.

Much of the decline in the ratio of residential places to people is counter balanced by an increase in the provision of community aged care packages. Community aged care packages are an alternative source of assistance for people who may otherwise require residential care, and Table 6.15 provides information on changes in the total number of residential care places and care packages during the period under scrutiny. In 1994 there were 93.5 residential care places and care packages per 1,000 people aged 70 and over; in 1998 the comparable figure was 93.7 per 1,000. In relation to the number of people aged 65 and over with a profound or severe handicap, the ratio of provision changed from 311.3 places per 1,000 people in 1994 to 309.5 in 1998.

In addition, the Commonwealth Government provides assistance through multi-purpose services in rural and remote communities, and flexible services provided under the Aboriginal and Torres Strait Islander Aged Care Strategy. In 1999, there were

38 multipurpose services providing 876 operational places, and 18 flexible services set up under the Aboriginal and Torres Strait Islander Aged Care Strategy providing 314 operational places.

Table 6.15: Community aged care packages and residential care places, 30 June 1994 to 30 June 1998

Year	Residential care type	No. of places	Ratio of places per 1,000 population	
			Aged 70+	Aged 65+ with a severe or profound core activity restriction
1994	Care Packages	1,227	0.9	2.9
	Hostels	57,104	40.3	134.1
	Nursing homes	74,247	52.3	174.3
	Residential aged care ^(a)	131,351	92.6	308.4
	<i>Total residential aged care and care packages</i>	<i>132,578</i>	<i>93.5</i>	<i>311.3</i>
1995	Care Packages	2,542	1.7	5.8
	Hostels	56,950	39.0	129.5
	Nursing homes	74,695	51.1	169.8
	Residential aged care ^(a)	131,645	90.0	299.3
	<i>Total residential aged care and care packages</i>	<i>134,187</i>	<i>91.7</i>	<i>305.1</i>
1996	Care Packages	4,431	2.9	9.7
	Hostels	62,645	41.5	137.6
	Nursing homes	75,008	49.6	164.8
	Residential aged care ^(a)	137,653	91.1	302.5
	<i>Total residential aged care and care packages</i>	<i>142,084</i>	<i>94</i>	<i>312.2</i>
1997	Care Packages	6,124	3.9	13.1
	Hostels	64,825	41.7	138.2
	Nursing homes	74,233	47.7	158.2
	Residential aged care	139,058	89.4	296.4
	<i>Total residential aged care and care packages</i>	<i>145,182</i>	<i>93.3</i>	<i>309.5</i>
1998	Care Packages	10,046	6.3	20.7
	Residential aged care ^(a)	139,917	87.4	288.8
	<i>Total residential aged care and care packages</i>	<i>149,963</i>	<i>93.7</i>	<i>309.5</i>

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

Source: AIHW 1997a:384; 1999, unpublished data; AIHW 1998a:15; AIHW 1998b:15; AIHW 1999:20; ABS 1997:29, 35, 41, 47; ABS 1999a:20; ABS 1999b:15.

There are some noteworthy differences in the levels of supply of residential care among the States and Territories (see Table A6.4). The Northern Territory had the highest ratio of provision, at 328 residential care places per 1,000 people aged 65 and over with a profound or severe core activity restriction. While quite high in relation to the national average of 289 places, this level of provision must be understood in the context of the comparatively high proportion of Indigenous Australians in the Northern Territory, the poorer health status of these people, their shorter life expectancy, and their use of aged care services at younger ages. Queensland – at 305 places per 1,000 people aged 65 and over with a profound or severe core activity restriction – has a comparatively high level

of provision; it is followed by the Australian Capital Territory (295 places). South Australia, Western Australia and New South Wales—with 293, 291 and 291 places respectively—all lie closer to the national average. Tasmania and Victoria had the lowest levels of residential care provision—with 282 and 274 places respectively. Although these differences remained significant in 1998, it is evident from the time-series data presented in Table A6.4 that the difference in the supply of residential care places between States and Territories is decreasing over time.

Changing patterns of use

Data on the number of residential care places and ratios of provision are static measures of the availability of residential care. The way these services are used—that is, the movement of people through the residential care system—is also important. Here, measures such as admissions, separations, turnover, occupancy rates and length of stay are of particular value. As foreshadowed, however, the merging of hostels and nursing homes into one system of care (and the consequent creation of a single residential care database) has made comparisons between 1997–98 and previous years difficult. Data for the period 1 July 1997 to 31 December 1997, during which the new residential care system was introduced and the new database established, are unreliable. Thus, for admissions and separations, only data for the half-year from 1 January 1998 to 30 June 1998 are reported here.

Another source of discontinuity between the ‘old’ and ‘new’ systems has to do with transfers between nursing homes and hostels. Under the ‘old’ system, such transfers counted as admissions and separations; under the ‘new’ system they are internal transfers within a single system. Length of stay is thus also affected: under the ‘old’ system residents who moved from hostels to nursing homes had two separate lengths of stay; under the ‘new’ system residents who move from low-level to high-level care have one continuous length of stay.⁸

Admissions to nursing homes for permanent care declined, from 34,317 in 1993–94 to 32,252 in 1996–97. Turnover (the average number of admissions per bed) for permanent admissions also declined, from 0.46 in 1993–94 to 0.43 in 1996–97. In contrast, the number of respite admissions to nursing homes more than doubled from 6,030 in 1993–94 to 12,612 in 1996–97 (Table 6.16).

Admissions to hostels, on the other hand, increased in both permanent and respite categories. There were 17,208 admissions to hostels for permanent care in 1993–94 and 19,900 in 1996–97; the comparable figures for respite admissions are 17,941 and 23,507 respectively. Turnover for permanent admissions was 0.31 in 1993–94, after which it rose slightly before returning to 0.31 in 1996–97. The increase in admissions is thus essentially a reflection of the increase in hostel places, rather than a reflection of a changing pattern of use (as would be the case had turnover increased).

The figure for permanent admissions to all residential aged care facilities for the six months to June 98 is 21,165; that for respite admissions is 18,487.

Figure 6.2 presents quarterly data on occupancy rates for nursing homes, hostels and the two systems combined for the period from July 1993 to June 1997 and for the six months from January 1998 for the new single stream residential care system. One striking aspect of Figure 6.2 is the consistency of the data: for hostels, occupancy rates remained between 92.1% and 93.2%; for nursing homes the range was from 97.0% to

8 For a more detailed discussion of these data issues see AIHW (1999).

98.2% (with some evidence of a slight dip in the winter months). The combined occupancy rate was similarly stable, ranging from 95.2% to 95.8%. These data suggest that occupancy rates have been unaffected by the changes to the residential care system in October 1997.

Table 6.16: Hostel and nursing home admissions and turnover, by type of care, 1993-94 to 1997-98

	Hostels				Nursing homes				Residential care
	1993-94	1994-95	1995-96	1996-97	1993-94	1994-95	1995-96	1996-97	Jan-Jun 98 ^(a)
Permanent									
Admissions	17,208	19,358	19,584	19,900	34,317	34,730	32,962	32,252	21,165
Turnover	0.31	0.34	0.33	0.31	0.46	0.47	0.44	0.43	0.15
Respite									
Admissions	17,941	19,824	21,816	23,507	6,030	7,931	11,282	12,612	18,487
Turnover	0.32	0.35	0.36	0.37	0.08	0.11	0.15	0.17	0.13
Total	35,149	39,182	41,400	43,407	40,347	42,661	44,244	44,864	39,652
Turnover	0.63	0.69	0.69	0.68	0.54	0.57	0.59	0.60	0.28

(a) Reliable data are available only for the six-month period to June 1998.

Note: Turnover = (number of admissions/average number of beds) in the financial year.

Source: AIHW 1998a:15, 40; AIHW 1998b:15, 42; AIHW 1999:20, 52; AIHW 1997a:264; AIHW 1999 analysis of residential aged care services data (SPARC).

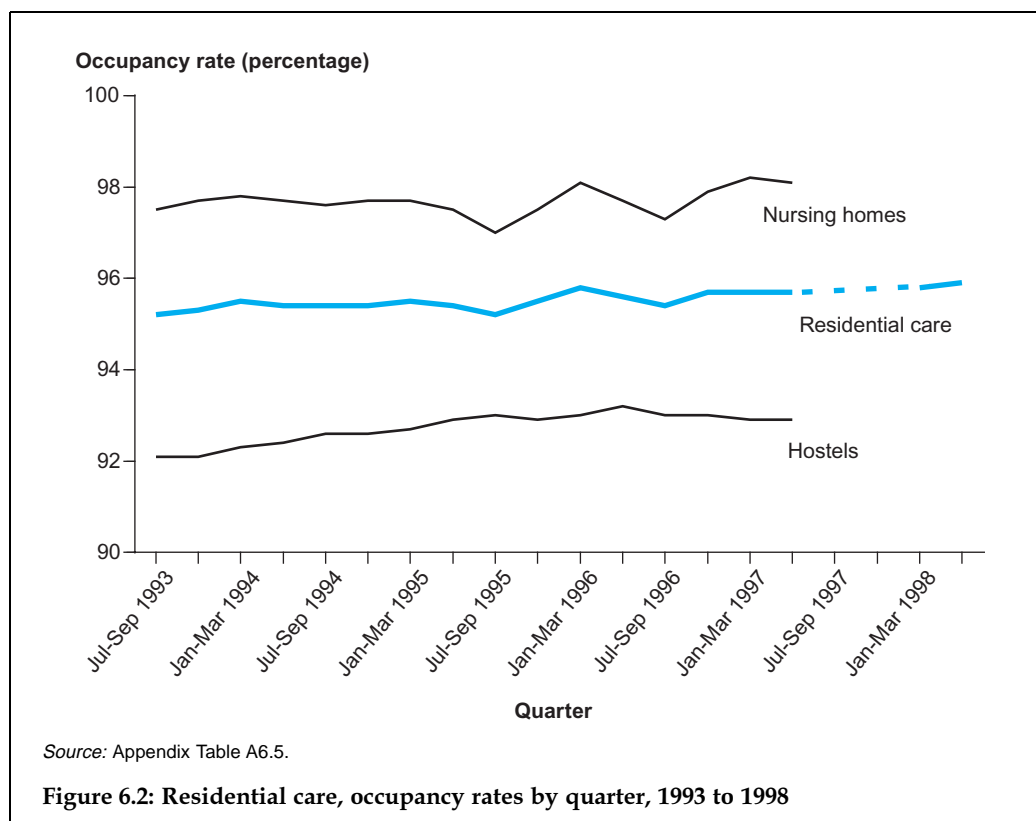


Table 6.17 presents data for 1993–94 to 1996–97 on length of stay for permanent residents of hostels and nursing homes. The data refer to people who left the hostel or nursing home during each 12-month period. Because client records are not linked between nursing homes and hostels, it is not possible to calculate a combined length of stay for clients who move between the two. As a result, the data conclude at 1996–97. The table shows a stable pattern among hostel residents, but a modest trend toward longer periods of stay for nursing home residents. The trend is mainly evident in the reduction in the proportion of very short stay residents: in 1993–94, 18% of residents stayed for less than four weeks; by 1996–97 the proportion had dropped to 12%.

Table 6.17: Hostel and nursing home separations from permanent care, by length of stay, 1993–94 to 1996–97 (per cent)

Length of stay	1993–94	1994–95	1995–96	1996–97
Hostel residents: permanent				
<4 weeks	3.5	3.9	3.5	3.6
4–<13 weeks	8.0	8.5	8.6	8.1
1–<26 weeks	8.9	8.6	8.6	8.6
26–<52 weeks	13.6	13.1	13.5	13.5
1–2 years	19.4	19.0	20.1	19.5
2–3 years	46.5 ^(a)	13.0	13.2	13.9
3–5 years	n.a.	33.8 ^(b)	32.5 ^(b)	15.5
5 years or more	n.a.	n.a.	n.a.	17.3
<i>Total (N)</i>	<i>14,783</i>	<i>16,063</i>	<i>16,838</i>	<i>17,599</i>
Nursing home residents: permanent				
<4 weeks	18.0	17.5	13.7	12.4
4–<13 weeks	14.1	14.3	13.8	13.2
13–<26 weeks	8.9	9.2	9.4	9.6
26–<52 weeks	10.6	11.0	11.2	11.7
1–<2 years	13.5	13.6	14.4	14.9
2–<3 years	9.9	9.4	10.0	10.2
3–<5 years	12.5	12.2	12.3	12.9
5 years or more	12.6	12.8	15.3	14.9
<i>Total (N)</i>	<i>32,281</i>	<i>33,040</i>	<i>32,049</i>	<i>31,554</i>

(a) Residents with a length of stay of at least 2 years.

(b) Residents with a length of stay of at least 3 years.

Notes

1. Each resident is counted only once, regardless of the number of admissions the resident had during the period.
2. Table includes permanent residents only.

Source: AIHW 1999 analysis of nursing home and hostel data (ACCSIS).

Expected length of stay in residential care over a lifetime

Table 6.18 presents data on the expected length of stay for both men and women at specific ages for both hostels and nursing homes. The data have been calculated using a life-table methodology in order to provide estimates of completed length of stay for current residents of nursing homes and hostels.⁹

9 These estimates are useful for planning purposes since they give an indirect measure of completed length of stay until separation from residential care for all persons resident in the facility during that period, rather than truncated length of stay of current residents who have not completed their stay, or completed length of stay only for those residents who have separated during that period.

For comparative purposes, data on life expectancy are also included in the table. Thus, at age 65 women have a life expectancy of 20 years and can expect to spend 0.9 years in a hostel and 1 year in a nursing home (a total of 1.9 years, on average, in residential aged care). For men aged 65, life expectancy is 16 years, their likely length of stay in a hostel is 0.3 years and that in a nursing home 0.4 years (or a total of 0.7 years, on average, in residential care).

By age 80 women have a life expectancy of 9 years, and can expect to live 1 year in a hostel and 1.2 years in a nursing home (2.2 years in total). At this age men have a life expectancy of 7 years and can expect to live 0.4 years in a hostel and 0.5 years in a nursing home (0.9 years in total). Liu (1999) provides a more detailed account of these analyses.

Table 6.18: Life expectancy and expected length of stay in residential care at specific ages, by sex

Age	Life expectancy (years)	Expected length of stay (years)		
		Hostels	Nursing homes	Residential care
Males				
65	16.1	0.3	0.4	0.7
70	12.7	0.3	0.4	0.8
75	9.7	0.4	0.4	0.8
80	7.2	0.4	0.5	0.9
85	5.3	0.5	0.6	1.0
90	4.0	0.5	0.6	1.1
95	3.3	0.4	0.5	0.8
Females				
65	19.8	0.9	1.0	1.9
70	15.8	0.9	1.1	1.9
75	12.2	0.9	1.1	2.1
80	9.0	1.0	1.2	2.2
85	6.4	1.0	1.2	2.2
90	4.6	0.8	1.2	2.1
95	3.4	0.5	1.0	1.5

Note: The table uses a life-table methodology to estimate expected length of stay in hostels and nursing homes over the remaining lifetime. See Liu (1999) for details.

Source: Liu 1999.

Client profiles

Age and sex

Table 6.19 presents the most recent available data on the age and sex profiles of clients of community and residential services. Both HACC and community options services were more likely to be used by people under age 65 than were care packages or residential care. This is consistent with the target populations of these services, since HACC (and community options) includes in its client group younger people with a disability as well as frail and disabled older people. Between 1% and 2% of clients of care package or residential services were aged under 55; a further 6% of care package clients and 3% of residential care clients were aged 55 to 64. In general, residential care services catered to more very old clients, with two-thirds being aged 80 and over. Care packages had a marginally younger clientele: 59% of their clients were aged 80 and over. For HACC and community options clients, the proportions aged 80 and over were 42% and 37% respectively.

Table 6.19: Persons using aged care services, by sex and age group (per cent)

Sex and age group	Community care clients			Residential care clients		
	HACC (1998)	Community options (1994) ^(a)	Care packages (1998)	High-level care (1998)	Low-level care (1998)	Total (1998)
Males						
1–54	6	9	1	1	1	1
55–64	3	3	2	2	2	2
65–69	3	3	2	2	2	2
70–79	10	9	8	9	7	9
80–89	10	10	13	11	12	11
90+	2	1	3	3	3	3
Total males	32	35	30	28	26	27
Females						
1–54	7	11	1	1	1	1
55–64	4	5	3	2	1	2
65–69	5	5	4	2	2	2
70–79	21	19	20	16	16	16
80–89	25	21	33	36	41	38
90+	5	5	8	16	13	15
Total females	68	65	70	72	74	73
Persons						
1–54	13	20	2	2	1	2
55–64	7	8	6	3	3	3
65–69	7	8	6	5	4	4
70–79	31	28	29	25	23	24
80–89	35	30	46	47	53	50
90+	7	6	11	18	16	17
Total (N)	74,926	6,033	9,574	74,795	54,608	129,403

(a) These are the most recent national data available on community options clients.

Note: Due to varying sample selection mechanisms across the States and Territories, HACC data have been weighted using the 1996–97 recurrent expenditure by States and Territories in order to derive a national profile.

Source: AIHW 1999 analysis of nursing home and hostel data (ACCSIS); DHAC, unpublished data.

Women predominated in all service categories, although the proportions tended to be higher for residential care services (73%) than for care packages (69%), community options services (65%) or HACC services (68%).

Table 6.20 shows the proportions of Indigenous and non-Indigenous Australians using aged care services. A larger proportion of Indigenous than non-Indigenous Australians were using residential aged care services in 1998 at ages 50–59 and 60–69; this was not, however, the case for Indigenous people aged 70 and over. If only high-level residential care is considered, however, then Indigenous people are higher users across all age categories. For HACC services, the only data suitable for this calculation come from Western Australia, where a census of clients of all agencies was conducted in 1988. Rates of HACC service use among Western Australian Indigenous people are substantially higher than those for non-Indigenous people in all age categories. These findings are consistent with the recognised poorer health status of Indigenous Australians compared with non-Indigenous Australians.

Table 6.21 shows rates of use of residential care services by people from culturally and linguistically diverse backgrounds in comparison with Australians from English-speaking backgrounds. There is a substantially lower rate of use of residential care services by people from culturally and linguistically diverse backgrounds, for all service types and in all age categories.

Table 6.20: Proportion of Indigenous and non-Indigenous Australians using aged care services, 1998 (per cent)

Age group	HACC ^(a)		Residential low care		Residential high care		Residential care total	
	Indi- genous	Non-Indi- genous	Indi- genous	Non-Indi- genous	Indi- genous	Non-Indi- genous	Indi- genous	Non-Indi- genous
1-49	0.3	0.2	0.0	0.0	0.0	0.0	0.0	0.0
50-59	5.1	0.7	0.1	0.0	0.2	0.1	0.3	0.1
60-69	20.8	2.6	0.2	0.2	0.7	0.3	0.9	0.5
70+	34.8	16.5	0.8	3.1	5.4	3.5	6.2	6.6
50+	14.8	5.9	0.2	1.0	1.2	1.2	1.4	2.3

(a) HACC data are for Western Australia only. While WA conducted a census of its HACC clients, other States and Territories used a range of different sampling techniques, precluding the use of a national figure.

Source: AIHW 1999 analysis of Department of Health and Aged Care HACC client data and residential aged care service data (SPARC); ABS, unpublished data.

Table 6.21: Proportion of people from culturally and linguistically diverse backgrounds and from English-speaking backgrounds using residential aged care services, 1998 (per cent)

Age group	Residential low care		Residential high care		Residential care total	
	Culturally & linguistically diverse	English- speaking background	Culturally & linguistically diverse	English- speaking background	Culturally & linguistically diverse	English- speaking background
65-69	0.1	0.3	0.3	0.5	0.5	0.9
70-74	0.4	0.7	0.9	1.2	1.3	1.9
75-79	0.9	1.8	1.8	2.6	2.7	4.4
80-84	2.8	5.0	5.3	6.1	8.2	11.1
85+	4.6	10.2	9.9	14.2	14.5	24.4
65+	0.5	1.5	1.1	2.1	1.6	3.6

Note: The English-speaking background category comprises people whose country of birth was Australia, New Zealand, the United Kingdom, Ireland, the United States of America, Canada or South Africa. The culturally and linguistically diverse background category comprises people born in countries other than those previously stated.

Source: AIHW 1999 analysis of HACC client data and residential aged care service data (SPARC); ABS 1999, unpublished data.

Pension status

Table 6.22 shows the pension status of hostel and nursing home residents from 1994-95 to 1997-98.¹⁰ The most obvious trend is the reduction in the proportion of missing data among nursing home residents. Taking this into account, it appears that the pension status profile of both hostel and nursing home residents remains largely unchanged, the vast majority of both sets of residents receiving either a part or full pension.

¹⁰ While data on pension status were collected in the HACC User Characteristics Surveys of 1993-94 and 1996-97, variations in the sampling frames adopted in the two Surveys make comparisons insufficiently reliable for this purpose.

Table 6.22: Permanent admissions to hostels and nursing homes: pension status by sex 1994–95 to 1997–98 (per cent)

Pension status	Hostels					Nursing homes					Residential aged care				
	1993–94	1994–95	1995–96	1996–97	1997–98	1993–94	1994–95	1995–96	1996–97	1997–98	1993–94	1994–95	1995–96	1996–97	1997–98
Males															
Receives pension	81.9	82.4	84.1	84.4	84.4	77.5	79.1	84.7	88.1	88.1	78.8	80.1	84.5	86.1	83.8
Does not receive pension	—	—	—	—	—	5.4	4.7	5.4	5.4	5.4	3.8	3.2	3.6	2.5	8.1
Missing data	18.1	17.6	15.9	15.6	17.1	16.2	9.9	6.5	6.5	17.4	16.7	11.8	11.4	11.4	8.1
Total males (N)	5,030	5,716	5,713	13,849	12,088	12,475	11,734	11,733	11,733	17,118	18,191	17,447	25,582	13,190	
Females															
Receives pension	82.3	83.3	85.2	83.3	78.8	80.9	86.3	86.0	86.0	80.1	81.9	85.9	85.4	80.4	80.4
Does not receive pension	—	—	—	—	5.5	4.1	5.2	7.9	7.9	3.5	2.4	3.1	6.1	8.4	8.4
Missing data	17.7	16.7	14.8	16.7	15.6	15.0	8.5	6.0	6.0	16.4	15.7	11.0	8.5	11.1	11.1
Total females (N)	11,967	13,403	13,622	5,829	19,983	20,352	20,023	19,783	31,950	33,755	33,645	25,612	7,748		
Persons															
Receives pension	82.2	83.1	84.9	84.1	78.3	80.2	85.7	86.8	86.8	79.7	81.3	85.4	85.8	82.5	82.5
Does not receive pension	—	—	—	—	5.5	4.3	5.2	7.0	7.0	3.6	2.7	3.3	4.3	8.2	8.2
Missing data	17.8	16.9	15.1	15.9	16.2	15.5	9.0	6.2	6.2	16.8	16.0	11.3	9.9	9.2	9.2
Total (N)	16,997	19,119	19,335	19,678	32,071	32,827	31,757	31,516	49,068	51,946	51,092	51,194	20,938		

Notes

1. Each resident is counted only once, regardless of the number of admissions they had during a period.
 2. 'Missing data' represents unknowns plus not reported.
- Source: AIHW 1999 analysis of nursing home and hostel data (ACCIS) and residential care service data (SPARC).

Expenditure

Table 6.23 presents data on aged care recurrent expenditure in both current and constant (1996–97) prices for the years from 1993–94 to 1997–98. Total expenditure on aged care services—assessment, HACC, community aged care packages, the Domiciliary Nursing Care Benefit, hostels and nursing homes—increased from \$2,728.7 million in 1993–94 to \$3,849.8 million in 1997–98 (current prices). This represents an increase of 33% in real terms over the past four years. The relative allocation of funds during the period remained remarkably stable, in contrast with earlier years, when expenditure on nursing homes was declining somewhat and that on hostels increasing (AIHW 1997a:267–8).

Table 6.23: Aged care recurrent expenditure in current and constant prices, 1993–94 to 1997–98

Program	1993–94	1994–95	1995–96	1996–97	1997–98
Current prices (\$m)					
Assessment	34.5	35.1	35.7	35.8	36.1
HACC ^(a)	620.9	671.3	716.2	764.6	810.6
Care packages	7.4	17.7	33.1	51.6	84.1
Domiciliary Nursing Care Benefit	49.9	54.0	59.0	65.0	71.7
Hostels	312.0	363.1	417.4	478.1	2,847.3 ^(b)
Nursing homes	1,704.0	1,804.7	2,001.7	2,170.9	
Total	2,728.7	2,946.0	3,263.2	3,566.2	3,849.8
Constant prices (\$m)					
Assessment	36.1	36.5	36.4	35.8	35.6
HACC ^(a)	650.2	698.5	730.1	764.6	798.6
Care packages	7.7	18.4	33.7	51.6	82.9
Domiciliary Nursing Care Benefit	52.3	56.2	60.1	65.0	70.6
Hostels	326.7	377.8	425.5	478.1	2,805.2 ^(b)
Nursing homes	1,784.3	1,877.9	2,040.5	2,170.9	
Total	2,857.3	3,065.6	3,326.4	3,566.2	3,792.9

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

(b) Expenditure on nursing homes and hostels; from 1 October 1997 nursing homes and hostels were combined into one residential aged care system.

Notes

1. Includes Commonwealth and State and Territory government expenditure.

2. Constant prices were calculated using the 1996–97 Government Final Consumption Expenditure (GFCE) deflator.

Source: AIHW 1997a:267; Gibson et al. 1999, sheet 34; ABS 1998.

From 1993–94 to 1996–97 (the last year for which data are available on nursing homes as a separate program), nursing homes continued to dominate aged care expenditure, accounting for 62% of total expenditure at the beginning of the period and 61% at the end. When expenditure on the combined residential care system is considered, the proportion remains constant, at 74% in both 1993–94 and 1997–98. The relative share of expenditure on HACC also remained fairly constant, at 22% at the beginning of the period and 21% at the end. Expenditure on care packages accounts for only a small proportion of aged care expenditure—less than 1% until 1995–96, and only 2% in 1997–98. Nonetheless, it has increased rapidly in real terms, from \$7.7 million in 1993–94 to \$33.7 million in 1995–96, and then to \$82.9 million in 1997–98. The Domiciliary

Nursing Care Benefit accounted for just under 2% of expenditure in 1993–94 and 2% in 1997–98. Expenditure on assessment continued to account for about 1% of aged care expenditure throughout the period, although it declined marginally in real terms, from \$36.5 million in 1994–95 to \$35.6 million in 1997–98.

The increase in expenditure on aged care services overall has kept pace with the growth in the number of older people needing some assistance; indeed, the amount of expenditure per person aged 65 and over with a profound or severe core activity restriction increased during the last four years in real terms (Table 6.24). In 1993–94, aged care expenditure (in constant 1996–97 prices) amounted to \$6,507 per year per person aged 65 and over with a profound or severe core activity restriction. In 1997–98 the figure had increased to \$8,074. Annual growth varied between 4.6% (in 1994–95 and 1997–98) and 7.2% (in 1995–96).

Between 1994–95 and 1997–98 the aged care assessment program recorded negative expenditure growth in relation to the number of people aged 65 and over with a profound or severe core activity restriction; all other program areas showed increases. The annual rate of increase in HACC expenditure in relation to the number of people aged 65 and over with a profound or severe core activity restriction declined from 4.7% in 1994–95 to 2.8% in 1997–98. Care packages have, of course, recorded extremely high growth rates in expenditure in relation to the population but this must be interpreted in the light of the very small base from which the program started in the early 1990s.

Table 6.24: Aged care and recurrent aged care expenditure per person aged 65 with a profound or severe core activity restriction, in constant prices, 1993–94 to 1997–98

Program	1993–94	1994–95	1995–96	1996–97	1997–98
Expenditure per person aged 65+ with a severe or profound core activity restriction (\$)					
Assessment	82	81	80	77	76
HACC ^(a)	1,481	1,551	1,601	1,654	1,700
Care packages	18	41	74	112	176
Domiciliary nursing care benefit	119	125	132	141	150
Hostels	744	839	933	1,035	5,971 ^(b)
Nursing homes	4,063	4,169	4,473	4,697	
Total	6,507	6,805	7,293	7,717	8,074
Annual growth rates (%)					
Assessment	—	–1.4	–1.6	–2.9	–2.3
HACC ^(a)	—	4.7	3.2	3.4	2.8
Care packages	—	131.7	80.9	50.9	58.0
Domiciliary nursing care benefit	—	4.8	5.7	6.7	6.9
Hostels	—	12.7	11.2	10.9	4.2 ^(b)
Nursing homes	—	2.6	7.3	5.0	
Total	—	4.6	7.2	5.8	4.6

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

(b) Expenditure on nursing homes and hostels; from 1 October 1997 nursing homes and hostels were combined into one residential aged care system.

Notes

1. Includes Commonwealth and State and Territory government expenditure.

2. Constant prices were calculated using the 1996–97 Government Final Consumption Expenditure deflator.

Source: AIHW 1997a:267; Gibson et al. 1999, sheet 34; ABS 1999a:20.

Table 6.25 presents data on government capital expenditure on aged care services in current and constant (1996–97) prices for 1993–94 to 1997–98. Capital expenditure on HACC declined quite substantially in real terms from 1993–94 to 1996–97 but increased again in 1997–98. For nursing homes and hostels, capital expenditure generally declined in real terms.

Table 6.25: Aged care capital expenditure in current and constant prices, 1993–94 to 1997–98

Program	1993–94	1994–95	1995–96	1996–97	1997–98
Current prices (\$m)					
HACC	22.8	25.4	15.0	9.3	21.4
Nursing homes and hostels	135.2	109.0	73.1	105.2	39.8
Constant prices (\$m)					
HACC	23.9	26.4	15.2	9.3	21.1
Nursing homes and hostels	141.6	113.4	74.5	105.2	39.2

Note: Constant prices were calculated using the 1996–97 Government Final Consumption Expenditure deflator.

Sources: DHAC, unpublished data; AIHW 1997a:268; DHFS 1997, Section 1,2; DHAC 1998a, Section 1,2; ABS 1997:47; ABS 1999a:20.

Table 6.26: Government expenditure on Age and Veterans' pensions, Carer Pensions, DNCB, hospitals, pharmaceuticals and general practitioner visits

Program	Average annual growth from 1990–91 to 1995–96	\$m
Age Pension ^(a)	3.5	15,700
Public hospitals	3.6	3,900
Medical services	8.5	1,600
Pharmaceutical services	13.1	780
Residential care	2.9	2,600
Home-based care ^(b)	7.8	650

(a) Includes Age Pension, Veteran's Pension, Widow's Pension and Wife's Pension.

(b) Includes community aged care packages, Commonwealth-funded respite services, aged care assessment program and HACC.

Source: Choi 1998:2–8.

Table 6.26 provides a more broadly based picture of expenditure on older Australians, taking into account expenditure on income support as well as medical, hospital and pharmaceutical services. Quite clearly, income support is the largest item of expenditure (\$15,700 million); it is followed at some distance by hospital services (\$3,900 million) and residential care (\$2,600 million). Between 1990–91 and 1995–96, by far the fastest growing area of government expenditure on older Australians was pharmaceutical services (13.1% per annum); this is followed by medical services (8.5% per annum) and home-based care (7.8% per annum). Residential care was the slowest growing area of expenditure, at 2.9% per annum.

As a proportion of GDP, government expenditure on older Australians remained relatively unchanged over the 15 years from 1980–81 (5.1%) to 1995–96 (5.1%), despite the relatively rapid ageing of the Australian population. As a proportion of total government outlays, expenditure on older Australians declined in this period from 14.1% to 13.4%; as a proportion of total outlays on health, welfare and social security, expenditure on older Australians declined from 43% in 1980–81 to 32.8% in 1995–96 (Choi 1998).

6.4 Outcomes

Deriving outcome measures for aged care services—and indeed for all chronic care services—remains problematic, despite the contemporary enthusiasm for outcome-based funding and performance indicators. Outcome measurement lends itself more readily to the acute care context, where desired outcomes can be more clearly specified and appropriate measures agreed, and to areas such as education, where there can be a reasonable level of agreement on literacy and numeracy standards and the levels to be achieved at various points in the education system. Aged care—with its varied client mix, combining a range of chronic and acute conditions, receiving varied services from the formal sector and supported by a myriad of informal sector activities—does not readily lend itself to clearly specified outcome measures (Gibson 1998:Chapter 8). In a care context where successful management may still result in death or a deterioration in health status, such measures are problematic. These caveats aside, it is still possible to report on measures relevant to program achievements. This section presents data on the appropriateness and the accessibility of aged care services.

Appropriateness

Data on dependency are collected for all clients of aged care services, albeit in different ways and using different measures.¹¹ Dependency, of course, is not the only indicator of the level of need for assistance—in particular, the availability of differing levels of informal care may significantly alter the degree of formal assistance required by clients with quite similar levels of dependency. Nonetheless, if, for example, low care residential clients were found to have on average a higher dependency profile than high care residential clients, this would suggest that resources were being inappropriately allocated. Similarly, if home-based care clients were found to be on average considerably more dependent than high care residential clients, this may well raise questions about the allocation of resources within the Australian aged care system.

Table 6.27 provides some measure of the relative dependency of clients of community options, community aged care packages and residential care services. Overall, it is evident that on these three measures, for which comparable data are available, residential care clients were considerably more dependent than were clients of home-based care services, and high care residential clients were more dependent than low care residential clients. For washing and dressing, 14% of community options clients and 6% of care package clients were totally dependent; this compares with 41% of low care residential clients and 80% of high care residential clients. For eating, less than 10% of community options, care package and low care residential clients were totally dependent, in contrast to 47% of high care residential clients. A similar pattern is apparent for mobility and transfers. Although the home-based care data (the most recent available) are somewhat older than the data for residential care clients, the differences are so marked that it is unlikely they would disappear even if more recent data were available.

Residential care clients are more dependent on average than clients receiving home-based care, and their dependency profile has been increasing. Dependency levels rose

11 See Rickwood (1994) for a review of some of these measures

Table 6.27: Persons using aged care services: need for assistance

Dependency items	Community care clients				Residential care clients				Total (1998)	
	Community options (1994)		Care packages (1996)		Low level care (1998)		High level care (1998)			
	Number	%	Number	%	Number	%	Number	%	Number	%
Washing and dressing										
No need	2,184	36	1,370	36	11,765	22	12,536	17	24,301	19
Some need	3,044	50	2,174	58	20,227	37	2,375	3	22,602	17
Total need	868	14	234	6	22,609	41	59,880	80	82,489	64
Total	6,096	100	3,778	100	54,601	100	74,791	100	129,392	100
Eating										
No need	4,200	69	3,094	82	30,476	56	13,103	18	43,579	34
Some need	1,511	25	653	17	21,224	39	26,486	35	47,710	37
Total need	387	6	46	1	2,867	5	35,202	47	38,069	29
Total	6,098	100	3,793	100	54,567	100	74,791	100	129,358	100
Mobility and transfers										
No need	4,019	66	3,006	79	22,336	41	2,461	3	24,797	19
Some need	1,588	26	722	19	22,774	42	12,743	17	35,517	27
Total need	491	8	63	2	9,491	17	59,587	80	69,078	53
Total	6,098	100	3,791	100	54,601	100	74,791	100	129,392	100

Note: 'Major' and 'extensive' assistance were combined into residential aged care data to create the 'total need' category for comparability with the community options and care package data.

Source: Unpublished data from the 1996 Community Aged Care Packages Survey, the 1994 Community Options Census and from the DHAC residential care data (SPARC).

steadily among both nursing home and hostel populations in the years preceding the introduction of the single residential care system in October 1997. It was expected that this trend towards increasing dependency would continue with the integration of the two systems. The main force behind the trend was the decreasing level of residential care places available in relation to the number of frail and disabled older people: the available residential care places have thus been restricted to a progressively more dependent group of people. This pattern is in keeping with government policy, which aims to provide a greater proportion of care for frail and disabled older people in their homes rather than in a residential context.

While dependency levels have been increasing in both nursing homes and hostels (AIHW 1997b, 1998a, 1998b, 1998c), the relative increase in the number of hostel places has meant that, with time, an increasing proportion of the residential care population was accommodated in hostels rather than nursing homes (Table 6.28, Figure 6.3). Thus, at 30 June 1994, 42% of residents were located in hostels; by 30 June 1997 this proportion had increased to 45%. With the introduction of the single classification scale in October 1997, all residents were subsequently reclassified using the same scale, rather than the two separate scales that had previously operated for hostels and nursing homes.

The restructuring thus removed the 'barrier' between hostel and nursing home care, facilitating the government policy commitment to 'ageing in place'. Another factor contributing to this policy change was the perception that a significant proportion of

hostel residents were actually as dependent as some clients being cared for in nursing homes. At 30 June 1998, 58% of residents were classified in the RCS categories 1–4 (roughly equivalent to the ‘old’ nursing home care). During the preceding four years the proportion of all residents accommodated in nursing homes had been progressively falling, from 58% at 30 June 1994 to 55% at 30 June 1997; the 58% recorded in 1998 is a reversal of that trend. For RCS categories 5–8 (roughly equivalent to the ‘old’ hostels), the reverse pattern is evident: the proportion of residents accommodated in hostels increased from 42% at 30 June 1994 to 45% at 30 June 1997 then dropped back to 42% at 30 June 1998.

Table 6.28: Residents of residential aged care facilities, by dependency level, 30 June 1994 to 30 June 1998 (per cent)

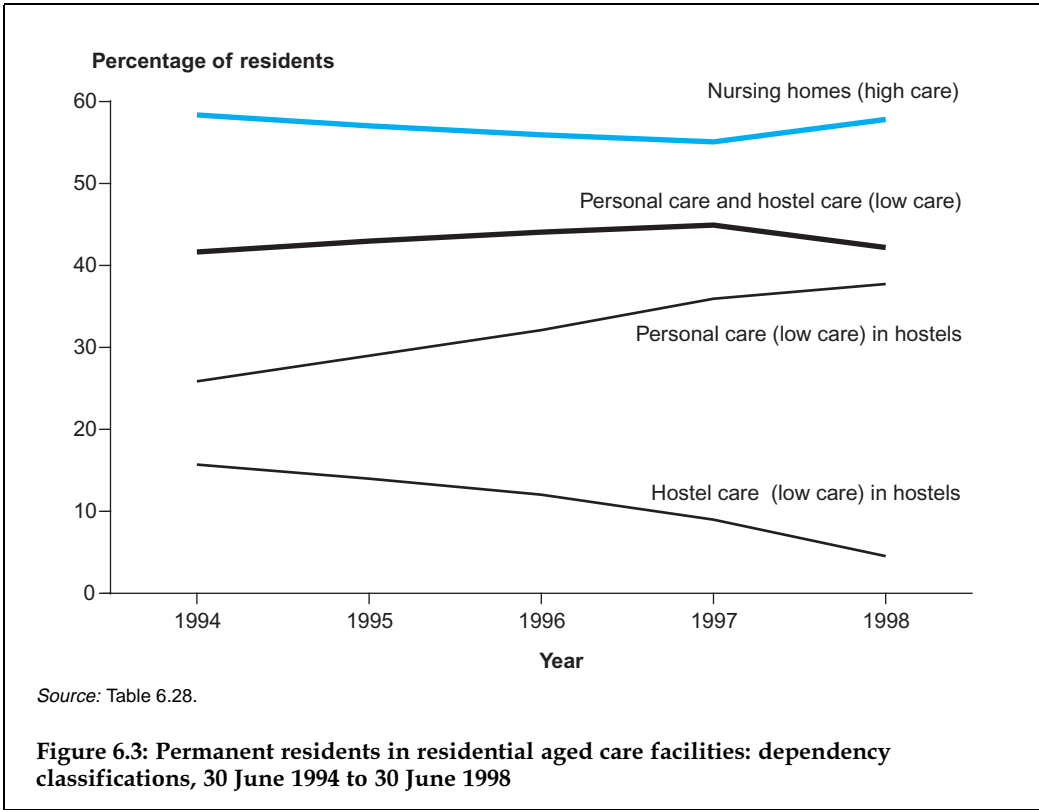
Year	Personal care in hostels	Hostel care in hostels	Hostels (low care)	Nursing homes (high care)
Females				
1994	27.3	15.3	42.5	57.5
1995	30.5	13.6	44.1	55.9
1996	33.6	11.6	45.2	54.8
1997	37.5	8.6	46.1	53.9
1998 ^(a)	38.4	4.5	42.9	57.1
Males				
1994	22.1	17.0	39.1	60.9
1995	25.1	15.0	40.2	59.8
1996	27.9	13.1	41.0	59.0
1997	31.7	9.9	41.6	58.4
1998 ^(a)	35.7	4.6	40.4	59.6
Persons				
1994	25.9	15.7	41.6	58.4
1995	29.0	14.0	43.0	57.0
1996	32.1	12.0	44.1	55.9
1997	35.9	8.9	44.9	55.1
1998 ^(a)	37.7	4.5	42.2	57.8

(a) Nursing homes are taken to be equivalent to RCS levels 1–4, Personal Care in a hostel to RCS levels 5–7, and Hostel Care in a hostel to RCS level 8.

Source: AIHW 1999 analysis of residential aged care data (SPARC).

The proportion of residents in the lowest care category – Hostel Care hostel residents under the previous system; RCS level 8 under the current system – has changed quite dramatically in the past five years. At 30 June 1994, 16% of residents in the aged care system (nursing homes plus hostels) were categorised as Hostel Care hostel residents. By 30 June 1996 this proportion had dropped to 12%; it fell further, to 9% at 30 June 1997 and then, following the restructure, to 5% at 30 June 1998.

Table 6.28 provides no clear evidence that the impact of the restructuring on dependency profiles was experienced differently by men and women. The decrease in the proportion of residents accommodated in nursing homes that had occurred until 1997 was, however, more pronounced among women than among men, as was the increase that occurred in 1998. On the other hand, the decrease in the proportions



accommodated in hostels at the Hostel Care level (or RCS 8) was slightly more pronounced among male than female residents.

The data just reported are for current residents of aged care facilities. 'Current residents' includes people admitted into a facility either before or after the restructure of the residential care system. The dependency profile of newly admitted residents provides a useful indication of the most recent trends in residential care and the dependency levels of permanent residents admitted between 1 January and 30 June 1998 suggest that a continuing trend towards higher levels of care can be expected in the future.

Among newly admitted residents, 59% were classified as high care and 41% as low care. These proportions are very similar to those for existing residents, yet newly admitted residents are, by definition, at the beginning of their stay in a residential aged care facility – many will progress to higher levels of dependency in the course of their stay. A situation where the dependency profile of newly admitted residents is similar to or more dependent than that of current residents thus suggests that the recent trend toward increasing dependency levels is likely to continue.

Accessibility

Section 6.3 presents data on changes in the number of permanent and respite residents in the last five years and on changes in turnover. These data were reported for both

hostels and nursing homes from 1993–94 to 1996–97. The restructuring of residential care into a single residential care system in late 1997 precludes the inclusion of data for 1997–98. Until 1996–97, the data show that the number of permanent admissions increased in hostels (from 17,208 to 19,900) and decreased in nursing homes (from 34,317 to 32,252), while the number of respite admissions increased substantially in both. For permanent care, turnover was relatively stable in hostels but decreased for nursing homes. For respite care, turnover increased in both nursing homes and hostels.

The data suggest that access to respite care places has increased since 1993–94, while access to permanent places in nursing homes has been declining. Those data do not, however, take account of the growing size of the aged population during this period. Table 6.29 presents two further measures of access to residential care, which take the changing size of the aged population into account. The first measure, accessibility, describes the number of admissions for both permanent and respite care in relation to the population aged 65 and over with a profound or severe core activity restriction. The second, gross utilisation, is a measure of admissions plus the number of residents already in the hostel, nursing home or residential aged care facility at the beginning of the financial year. This measure, when considered in relation to the total number of people aged 65 and over with a profound or severe core activity restriction in the population, gives the gross utilisation rate.

Access to permanent places in hostels increased from 41 admissions per 1,000 people aged 65 and over with a profound or severe core activity restriction in 1993–94 to

Table 6.29: Accessibility and gross utilisation: hostels and nursing homes, 1993–94 to 1996–97

	1993–94	1994–95	1995–96	1996–97
Hostels				
Accessibility				
Permanent	41.0	44.7	43.8	43.1
Respite	42.8	45.8	48.8	50.9
All admissions	83.8	90.5	92.5	93.9
Gross utilisation	85,320	91,732	97,080	101,584
Gross utilisation rate	203.5	211.9	217.0	219.8
Nursing homes				
Accessibility				
Permanent	82.0	80.5	73.7	69.8
Respite	14.4	18.3	25.2	27.3
All admissions	96.4	98.8	98.9	97.1
Gross utilisation	112,725	115,246	116,736	117,546
Gross utilisation rate	268.8	266.2	260.9	254.3

Notes

1. Accessibility = (number of admissions/number of people with a severe or profound core activity restriction aged 65 and over)*1,000.
2. Gross utilisation = sum of number of residents at start of financial year plus number of admissions in financial year.
3. Gross utilisation rate = (gross utilisation/number of people with a severe or profound core activity restriction aged 65 and over)*1,000.

Source: AIHW 1999 analysis of nursing home and hostel data (ACCSIS) and residential aged care service data (SPARC); ABS 1997; ABS 1999a.

45 admissions per 1,000 such people in 1994–95; it then dropped to 43 admissions per 1,000 such people in 1996–97. For nursing homes, access to permanent places fell from 82 admissions per 1,000 people aged 65 and over with a profound or severe core activity restriction in 1993–94, to 70 admissions per 1,000 such people in 1996–97. Taken together, hostels and nursing homes show a net reduction in accessibility over the period for admissions to permanent care. For respite care admissions, accessibility increased for both hostels and nursing homes.

In relation to gross utilisation rates, access increased for hostels but declined for nursing homes between 1993–94 and 1996–97.

6.5 Summary

Increases in demand

In June 1998 there were 2.3 million people aged 65 and over in Australia, representing some 12% of the total population. The figure was 1.5 million in 1981, and it is projected to reach 2.4 million by the year 2001 and 5.1 million by 2031. Quite a small proportion of these people, however, are in need of or will be in need of aged care services. Of the 2.3 million people aged 65 and over in 1998, for example, 30% were aged 65 to 69 and only 9% of people in the 65–69 age group required assistance with basic activities of daily living—self care, mobility and communication.

The number of people aged 65 and over who require at least some assistance with the basic activities of daily living is increasing, from just over a quarter of a million in 1981 to a projected half a million by 2001, and over 1 million by 2031. The actual rates of growth in this population are slowing, however: they were higher in the two decades from 1981 to 2001 than they will be in the two decades from 2001 to 2021. Nevertheless, in absolute numbers, there is projected to be an increase of 242,000 people in this category between 1981 and 2001 and an increase of 324,000 people from 2001 to 2021.

The continuing role of informal care

With the continuing emphasis on ‘ageing in place’ and the provision of care to older people in their homes rather than in institutions, the important role played by informal care seems set to continue. According to the 1998 ABS Survey of Disability, Ageing and Carers, some 434,527 people were primary carers for a person with one or more disabilities and needing assistance on a continuing basis; 46% of those receiving care were aged 65 or older. The majority of carers were women (71%) and around one in five carers were themselves aged 65 or older. Among older carers, 53% spent 40 or more hours a week helping the care recipient. Among people aged 65 and over with a co-resident carer, over half (57%) were cared for by a person who was themselves aged 65 or more. In thinking about informal care, then, it must be recognised that older people are themselves carers as well as care recipients.

The changing system of residential care

Australia has entered a new era in the provision of residential aged care. The bringing together of nursing homes and hostels into a single residential aged care system, the introduction of a new single instrument for the classification of residents according to

their care needs, the extended use of accommodation bonds and charges, and the introduction of means-tested fees all combine to produce a system that is very different from that which operated prior to 1997. The new quality appraisal system for the accreditation of residential aged care facilities is in its implementation phase while the outcome standards monitoring system it replaces is already a thing of the past. Although it is too early to assess the impact of these policy developments, there are some preliminary indications of the changes and continuities we are likely to see.

The number of residential care places continues to increase, up from 131,351 in 1994 to 139,058 in 1997 and 139,917 in 1998. The ratio of residential care places to people aged 70 and over has decreased, from 93 places per 1,000 people aged 70 and over in 1994 to 87 places in 1998. This trend has been counterbalanced by the increasing availability of community aged care packages—the combined residential care and care package ratio has been relatively stable during the period, at 94 places and packages per 1,000 people aged 70 and over.

There was a modest decrease in accessibility (that is admissions per 1,000 people aged 65 and over with a severe or profound core activity restriction) to permanent nursing home care, and a modest increase in accessibility to permanent hostel care, between 1993–94 and 1996–97. Accessibility in terms of respite admissions continued to increase. Occupancy rates remained quite stable, there being no suggestion that demand for residential care services has reduced to the point where occupancy rates are affected. The recent structural changes to the aged care system appear to have left these trends unaffected.

Increasing dependency levels in residential care

Dependency levels have continued to increase in both hostels and nursing homes between 1994 and 1998, although the discontinuities in the data, as a result of the structural reforms, make accurate assessment of more recent trends difficult. The available evidence suggests that the proportion of residents in the lowest level of care (formerly Hostel Care residents in hostels, now RCS level 8) has decreased and that the rate of decrease is accelerating. In 1994, 16% of residents fell into this category; by 1996 the proportion had fallen to 12% and in 1998 it was 4.5%. Although these trends are consistent with government policies of using the residential care system for those most in need, the question of what housing and care options are available to people who were formerly accommodated as Hostel Care residents in hostels is emerging as something that warrants further scrutiny.

Home-based care

Home-based care services continue to expand. Services provided under the HACC program have generally kept pace with the increasing size of the population likely to be needing such services. Community aged care packages, a coordinated and intensive form of home-based care, have expanded quite dramatically in the last two years, from 4,441 places in 1996 to 10,046 places in 1998. In relation to the size of the aged population, this represents a doubling of supply, from three places per 1,000 people aged 70 and over in 1996 to six places in 1998. Despite this expansion, HACC remains by far the major supplier of home-based care services for older Australians.

Considerable effort is being devoted to implementing a national quality appraisal process for HACC, the first appraisals being conducted in the second half of 1999. Another important initiative is the development of a national minimum data set for HACC, which should substantially improve the quality of data available on the HACC program and its clients. The HACC national minimum data set is scheduled for implementation from 1 July 2000; a pilot test was conducted in September–October 1999.

Trends in expenditure on older Australians

Total expenditure on aged care services—assessment, HACC, community aged care packages, the Domiciliary Nursing Care Benefit, hostels and nursing homes—was \$3,849.8 million in 1997–98, an increase of 33% in real terms from 1994. This increase in expenditure kept pace with the increase in the number of older people needing some assistance; indeed, the amount of expenditure per person aged 65 and over with a profound or severe core activity restriction increased over the last four years in real terms.

A more broadly based picture of government expenditure on older Australians takes into account expenditure on income support, medical services, hospital services and pharmaceutical services as well as expenditure on aged care services. This more broadly defined measure provides a useful indication of the sustainability of government services for older Australians. In the 15 years since 1980–81 government expenditure on older Australians has remained relatively unchanged as a proportion of GDP (5.1% in 1995–96), despite the relatively rapid ageing of the Australian population during this time. As a percentage of total government outlays, and of total government outlays on health, welfare and social security, expenditure on older Australians declined over the period from 1980–81 to 1995–96.

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