



8 Aged care

8.1 Introduction

The past decade has seen substantial changes in the Australian aged care system, under the broad rubric of the Aged Care Reform Strategy. While the expansion in size and scope of home-based care services, and the reduction in levels of nursing home bed provision, were undoubtedly the most dramatic changes, the introduction of a national regulatory program for residential care, the emergence of a user rights focus, and the development and expansion of brokered forms of community care were also significant events in aged care policy during that time.¹ The decade to come promises to be one of further change and development, with a number of major policy developments already underway as part of the National Aged Care Strategy announced by the Coalition Government in 1996.

Foremost among the emerging directions have been a focus on funding, including user pays issues, the combination of the nursing home and hostel residential sectors into one residential care stream, and a shift in quality assurance mechanisms toward an accreditation-based system in residential care facilities. Other elements have remained largely unchanged, however. Community aged care packages continue to be a growing form of service delivery; there remains an emphasis on and preference for home-based rather than residential care and there is an ongoing concern with ensuring quality of care in both residential and home-based services.

In the midst of these policy developments, the structure and size of the older population continues to change. The period from 1986 to 1996 was one of pronounced population ageing for Australia, with a particular growth in the number and proportion of people aged 80 and over. From 1996 the rates of projected increase among the aged population slow somewhat, but are projected to regain momentum over the later part of the decade to 2006. Social change remains a relevant force, with the consequences of high rates of female work-force participation, high rates of divorce and the increase in single-person households affecting both the structure and functioning of informal support networks, and the availability of volunteer labour in the welfare service industry. The already complex task of identifying the need for formal aged care services is thus further complicated by a changing service framework, occurring in the context of a changing population structure, accompanied by the flow-on effects in successive age cohorts of changes in the fabric of contemporary family and social life.

1 For a more detailed account of changes under the Aged Care Reform Strategy, see AIHW (1993, Chapter 5) and AIHW (1995, Chapter 5).

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 1996a:117). Accordingly, this chapter on Australia's aged care services is focused on three sets of information essential to the task of reviewing progress towards the achievement of that goal:

- the need for services and assistance (Section 8.2);
- the amount and type of services and assistance being provided, and the characteristics of the clients to whom they are being provided (Section 8.3); and
- the outcomes of those services and assistance (Section 8.4).

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 such as those targeted at the healthy aged, income security, hospital care, medical benefits and services, pharmaceutical benefits and housing are not included. Although it is common to consider aged care only in terms of services and provisions targeted specifically at the aged, it is important to recognise at the outset that older people are also eligible for, and use, a range of services and benefits available to the general population.

This chapter takes as its focus those services put in place to provide ongoing care for frail and disabled older people, and the services and assistance available to those caring for them. In so doing, it includes within its scope services provided in domiciliary and residential contexts, and the assessment provisions and regulatory practices associated with those services. This necessarily involves the activities of Commonwealth, State or Territory, and local governments, the charitable sector and the private-for-profit sector. It also involves recognition of the extensive role played by family and friends in caring for frail older people in both residential and domiciliary settings.

8.2 The need for care

Determining the level of need for formal services is a difficult task (Doyal & Gough 1991). At the individual level, the decision as to whether one particular individual does or does not need help, and what kind of help, in relation to the competing needs of others can be a complex one. When the task is to establish indicators of need for the population at large, the definitions become even more complex and measurement more problematic.

A number of measures relevant to the likely need for formal assistance are included in this section. Traditionally in aged care services, age itself has been used, although in recent years there has been a growing recognition that the vast majority of people aged 65 and over neither need nor use services for frail or disabled older persons (Teshuva et al. 1994). At more advanced ages, however, the correlation between service use and age becomes higher, and so the proportion of the population aged 80 and over, or even 90 and over, becomes an important element in any appraisal of need in the aged population.

Another aspect which has gained recognition in recent years is the relationship between gender and likely need for and use of both formal and informal care (Gibson &

Allen 1993). Older women, for example, are more likely to enter residential care, even when age and level of handicap are taken into account (AIHW 1995). The usefulness of age and gender as predictors of need for formal services is, however, limited, without information on the level of dependency in the aged population. In the discussion which follows, data from the national surveys of disability conducted by the Australian Bureau of Statistics (ABS) are used to provide a detailed picture of levels of dependency, and the kinds of assistance required by older people with disabilities.

Finally, there is increasing recognition of the role played by informal carers in both substituting for and supplementing the formal service sector (ABS 1995b; DHFS 1996c). Thus, the characteristics and circumstances of carers are highly relevant variables in reviewing the need for assistance among frail and disabled older people.

Age and sex profiles

In 1986, there were 1.7 million people aged 65 and over in the Australian population (11%). By 1996, the number of people aged 65 and over had increased to 2.2 million (12%), and by 2006, according to ABS projections, will increase to 2.6 million (13%).² These growth patterns are even more evident among the population aged 70 and over, and that aged 80 and over. Indeed, these two decades will see the number of people aged 80 and over more than double, and their proportion in the population increase from 2% to 4% (Table 8.1).

Table 8.1: Estimated and projected resident populations, by age group, 1986–2006

Age group	1986		1996		2006	
	('000)	%	('000)	%	('000)	%
65–69	570.2	3.6	691.4	3.8	769.9	3.8
70–79	797.6	5.0	1,028.9	5.6	1,146.3	5.6
80+	314.3	2.0	485.2	2.7	707.4	3.5
<i>Total aged population</i>	<i>1,682.1</i>	<i>10.5</i>	<i>2,205.5</i>	<i>12.1</i>	<i>2,623.6</i>	<i>12.9</i>
Total population (all ages)	16,018.4	100.0	18,289.1	100.0	20,342.7	100.0

Sources: ABS 1987:22; ABS 1997b:19; ABS unpublished data.

The demographic profile of the older population itself has also changed, and will continue to change, over the period from 1986 to 2006 (Table 8.2). The proportion of women in the population aged 65 and over dropped from 58% in 1986 to 57% in 1996, and is expected to decrease to 55% by 2006. The proportion of older people aged 80 and over increased quite markedly, from 19% in 1986 to 22% in 1996, and is projected to increase to 27% by 2006.

² Demographic data presented in this section include estimated resident population data between 1986 and 1996 (as at 30 June in each year). Data thereafter are projections (series A) produced by the Australian Bureau of Statistics as at 30 June in each year.

Table 8.2: Estimated and projected resident populations for persons aged 65 and over, by sex and age group, 1986–2006

Sex and age group	1986		1996		2006	
	('000)	%	('000)	%	('000)	%
Males						
65–69	266.1	15.8	336.4	15.3	380.7	14.5
70–79	342.1	20.3	456.4	20.7	531.5	20.3
80+	101.1	6.0	167.4	7.6	259.2	9.9
<i>Total aged males</i>	<i>709.2</i>	<i>42.2</i>	<i>960.2</i>	<i>43.5</i>	<i>1,171.4</i>	<i>44.6</i>
Females						
65–69	304.1	18.1	355.0	16.1	389.2	14.8
70–79	455.6	27.1	572.5	26.0	614.8	23.4
80+	213.3	12.7	317.8	14.4	448.2	17.1
<i>Total aged females</i>	<i>972.9</i>	<i>57.8</i>	<i>1,245.3</i>	<i>56.5</i>	<i>1,452.2</i>	<i>55.4</i>

Sources: ABS 1987:20–21; ABS 1997b:14–17; ABS unpublished data.

Table 8.3 presents average annual rates of increase for the two 5-year periods just past, and the projected rates of increase for the two 5-year periods to come.³ Regardless of age group (65+, 70+ or 80+) or period, the rates of growth for the older population are markedly higher than those for the population as a whole.

A further important trend evident in Table 8.3 is that average annual rates of increase are consistently higher in the 80 and over age group than they are in the 65 and over or 70 and over categories. This pattern holds for the period 1986–2006, and for both men and women (although the rates of increase for men are higher than those for women). It is these different rates of increase which underpin both the general 'ageing' of the older population and the small increase in the proportion of men observed in relation to Table 8.2.

Table 8.3: Annual rates of increase of older populations, by sex and age group, 1986–2006 (%)

Year	Males				Females				Persons			
	65+	70+	80+	Total (all ages)	65+	70+	80+	Total (all ages)	65+	70+	80+	Total (all ages)
1986–1991	3.4	3.1	4.9	1.5	2.8	2.7	3.7	1.6	3.0	2.8	4.1	1.5
1991–1996	2.8	3.9	5.4	1.1	2.2	3.1	4.5	1.2	2.5	3.4	4.8	1.1
1996–2001	1.8	3.0	4.1	1.1	1.4	2.3	3.4	1.2	1.6	2.6	3.7	1.2
2001–2006	2.2	1.8	4.8	1.0	1.7	1.3	3.6	1.0	1.9	1.5	4.0	1.0

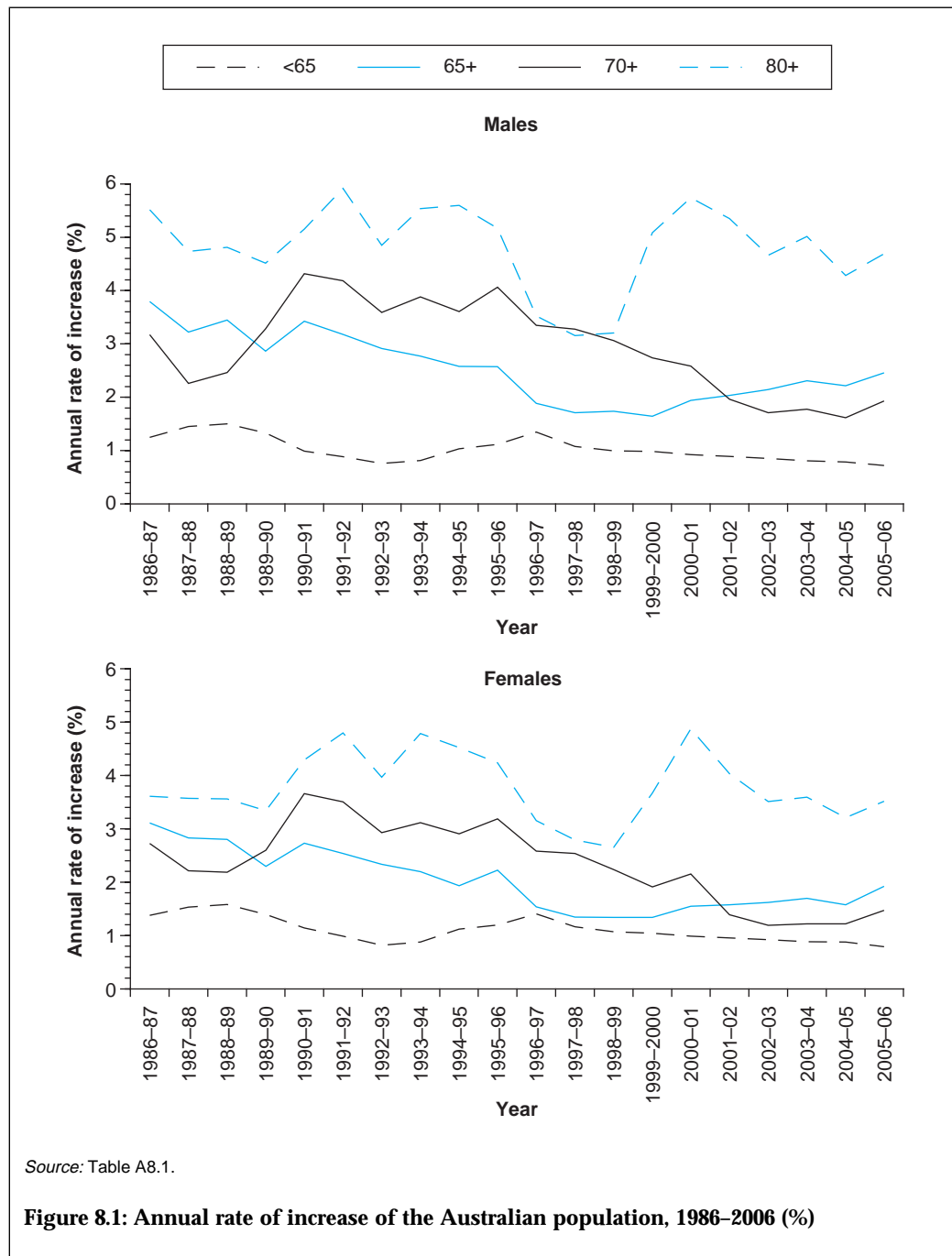
Sources: ABS 1987:20–22; ABS 1993c:28–32; ABS 1997b:15–19; ABS unpublished data.

³ Annual rates of increase are calculated using the rate of growth formula below:

$$r = \left(\left(P_t / P_0 \right)^{1/t} \right) - 1$$

where r = growth rate, t = number of years, P₀ = initial population, P_t = population after t years.

Interestingly, the past decade saw substantially higher growth rates for persons aged 65 and over than are projected for the decade to come (Figure 8.1). In the 5-year period to



1991, the population aged 65 and over grew by an average of 3.0% per annum, reducing to a 2.5% annual rate during 1991–96. The projected average annual growth rates for the next decade are lower again, at 1.6% for 1996–2001, and 1.9% for 2001–06. Growth rates are then, however, expected to increase again from 2006 onwards as the peak of the baby boom generations reaches retirement age. For the population aged 70 and over, the growth rates range between 2.6% and 3.4% for most of the 20-year period, but for 2001–06 they drop to only 1.5%. Among the 80 and over population, too, the decade to come has less rapid rates of increase than the decade past, with the current 5-year period (1996–2001) being characterised by the lowest average growth rate (3.7%) of the 20-year period.

Dependency

While age, particularly advanced old age, is a useful predictor of dependency, there are more direct measures available in Australia in the form of national survey data on levels of disability and handicap. The Australian Bureau of Statistics (ABS) has undertaken relevant surveys in 1981, 1988 and 1993, with another planned for 1998.⁴ For the population aged 65 and over, the rates of ‘handicap’ (as defined by the ABS) have proved to be quite consistent over the three surveys—particularly those for the most dependent category: ‘profound or severe handicap’, which identifies persons who always or sometimes require assistance with self-care, mobility or verbal communication.⁵

Table 8.4: Estimated and projected resident populations with a profound or severe handicap, by age group, 1986–2006

Age group	1986		1996		2006		1986–96 change		1996–2006 change	
	('000)	%	('000)	%	('000)	%	('000)	%	('000)	%
65–69	42.1	6.8	50.7	6.5	56.4	5.8	8.6	20.5	5.6	11.1
70–79	108.7	17.6	139.6	17.9	156.5	16.2	30.9	28.5	16.9	12.1
80+	132.4	21.5	203.8	26.1	301.2	31.2	71.4	53.9	97.3	47.8
<i>Total aged population</i>	<i>283.2</i>	<i>45.9</i>	<i>394.2</i>	<i>50.5</i>	<i>514.0</i>	<i>53.3</i>	<i>111.0</i>	<i>39.2</i>	<i>119.9</i>	<i>30.4</i>
Total population (all ages)	617.0	100.0	780.6	100.0	964.2	100.0	163.6	26.5	183.6	23.5

Note: The 1993 age- and sex-specific profound and severe handicap rates have been used to calculate the projected populations for the three time periods.

Sources: AIHW analysis of the ABS 1993 Survey of Disability, Ageing and Carers; ABS 1987:20–21; ABS 1997b:14–17; ABS unpublished data.

Table 8.4 presents data on the estimated numbers and projected rates of increase for persons with a profound or severe handicap for the period from 1986 to 2006. In 1986,

- 4 The surveys were the 1981 Handicapped Persons Survey, the 1988 Disabled and Aged Persons Survey, and the 1993 Disability, Ageing and Carers Survey. For further information, see ABS (1984, 1990 and 1993a). For further detail on the definitions of handicap employed by ABS, see also Chapter 9 of this volume.
- 5 For a discussion of these trends, see Wen et al. (1995), Mathers (1996) and Widdowson (1996).

of the 617,000 people in this category nationally, 46% were aged 65 and over; the majority (54%) were aged under 65. Ten years later, those who were aged 65 and over had increased as a proportion of all people with a profound or severe handicap (51%), and by 2006 on current trends 53% will be aged 65 and over.

The sub-group of the Australian population with a profound or severe handicap is thus (like the rest of the population) ageing. This trend is most evident in the 80 and over age group, which is projected to grow from 22% of all persons with a profound or severe handicap in 1986, to 31% by 2006. The rates of increase in the older population with a profound or severe handicap are consistently higher for men than for women, for older groups than for younger groups, and for the decade past (1986–96) rather than for the decade to come (1996–2006) (Table 8.5).

Table 8.5: Estimated and projected resident populations with a profound or severe handicap, by sex and age group, 1986–2006

Sex and age group	1986		1996		2006		1986–96 change		1996–2006 change	
	('000)	%	('000)	%	('000)	%	('000)	%	('000)	%
Males										
65–69	16.5	5.8	20.9	5.3	23.6	4.6	4.4	26.4	2.8	13.2
70–79	34.8	12.3	46.5	11.8	55.2	10.7	11.7	33.7	8.7	18.6
80+	34.5	12.2	58.0	14.7	91.7	17.8	23.4	67.9	33.7	58.2
<i>Total aged population</i>	<i>85.8</i>	<i>30.3</i>	<i>125.3</i>	<i>31.8</i>	<i>170.5</i>	<i>33.2</i>	<i>39.5</i>	<i>46.0</i>	<i>45.1</i>	<i>36.0</i>
Females										
65–69	25.6	9.0	29.9	7.6	32.7	6.4	4.3	16.7	2.9	9.6
70–79	73.9	26.1	93.1	23.6	101.3	19.7	19.2	26.0	8.2	8.8
80+	97.9	34.6	145.9	37.0	209.5	40.8	48.0	49.0	63.6	43.6
<i>Total aged population</i>	<i>197.4</i>	<i>69.7</i>	<i>268.8</i>	<i>68.2</i>	<i>343.5</i>	<i>66.8</i>	<i>71.5</i>	<i>36.2</i>	<i>74.7</i>	<i>27.8</i>

Note: The 1993 age- and sex-specific profound and severe handicap rates have been used to calculate the projected populations for the three time periods.

Sources: AIHW analysis of the ABS 1993 Survey of Disability, Ageing and Carers; ABS 1987:20–21; ABS 1997b:14–17; ABS unpublished data.

Among those older people with a profound or severe handicap, the proportion living by themselves increased over the period of the three surveys (1981–93) (Table 8.6).⁶ Living alone, for people with a profound or severe handicap, is an indicator of potential need for formal assistance. For men, the proportion living alone increased from 8% to 10%, while for women the increase was more substantial, from 22% to 27%. The increase is particularly evident among women aged 80 and over: from 41% in 1981 to 49% in 1993.

Among men aged 80 and over, there is an opposite trend with a decrease in the proportion living alone: from 25% in 1981 to 16% in 1993. This result may, however, be somewhat less reliable as a consequence of small cell sizes for this category, although it is consistent with the known demographic and social trends among older men.

⁶ See footnote 4.

Table 8.6: Living arrangements of persons with a severe handicap living in the community, by sex and age group, 1981–93 (%)

Sex and age group	Lives alone			Lives with relatives			Lives with non-relatives			Total (N)		
	1981	1988	1993	1981	1988	1993	1981	1988	1993	1981	1988	1993
Males												
<65	5.6	5.7	6.8	92.2	90.8	87.5	*2.2	3.6	5.7	123,764	144,228	191,369
65–79	10.2	11.8	18.2	86.7	86.3	80.6	*3.0	*1.9	*1.2	42,540	51,181	63,257
80+	24.5	*15.6	*15.5	72.0	81.9	84.5	*3.4	*2.5	0.0	12,993	21,146	34,951
<i>Total (all ages)</i>	<i>8.1</i>	<i>8.1</i>	<i>10.3</i>	<i>89.4</i>	<i>88.9</i>	<i>85.7</i>	<i>2.5</i>	<i>3.1</i>	<i>4.0</i>	<i>179,297</i>	<i>216,555</i>	<i>289,577</i>
Females												
<65	8.6	6.2	9.6	89.2	89.1	86.0	*2.3	4.8	4.4	120,387	158,262	181,946
65–79	32.7	32.3	36.9	63.9	64.7	62.3	*3.4	*3.0	*0.8	70,162	90,923	120,725
80+	41.3	47.5	49.4	54.7	49.4	49.3	*4.0	*3.1	*1.3	43,235	54,524	80,495
<i>Total (all ages)</i>	<i>21.9</i>	<i>21.4</i>	<i>26.6</i>	<i>75.2</i>	<i>74.7</i>	<i>70.8</i>	<i>2.9</i>	<i>3.9</i>	<i>2.6</i>	<i>233,784</i>	<i>303,709</i>	<i>383,166</i>

* Subject to relative standard error greater than 25%.

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

Sources: AIHW analysis of the ABS 1993 Survey of Disability, Ageing and Carers; ABS unpublished data from the 1981 Survey of Handicapped Persons and 1988 Survey of Disabled and Aged Persons.

What help is needed?

While the previous section focused on the ‘profound or severe’ category of handicap as defined by the ABS, the ‘moderate’ handicap category is also used for policy and planning purposes, particularly in the Home and Community Care (HACC) program. For HACC the target group has been operationalised in terms of the ABS definition of persons with a moderate, severe or profound handicap. Both categories (profound or severe, and moderate) are useful summary measures, and have the added advantages of their connection to the International Classification of Impairments, Disabilities and Handicaps and the comparability over time generated by their use in three successive surveys.⁷ It is also valuable, however, to consider the individual items which identify a potential need for service and assistance (formal or informal) among people living in the community. The ABS uses these items to construct the profound, severe and moderate handicap categories.⁸

7 There have been some slight changes in the disability and handicap definitions employed by the ABS over time, but it remains possible to adjust calculations to compare one survey with another.

8 The profound and severe handicap categories refer to persons who always or sometimes require personal help or supervision with at least one of the tasks of showering/bathing, dressing, eating/feeding, toileting, bladder/bowel control, moving about the house and away from the home, transferring between bed and chair and communicating with family/friends and strangers. The moderate handicap category refers to persons who have difficulty performing one of these tasks, but who do not require assistance.

According to the ABS 1993 Survey of Disability, Ageing and Carers, at least three-quarters of people aged 65 and over with a profound or severe handicap required assistance (either some or all of the time) with moving around places away from the home (76%), home help (76%), home maintenance (89%) or driving (78%). In addition, over one-half needed help with shopping (59%) and footcare (58%), and over a third with showering or bathing (35%) and financial management or writing letters (34%). Over a quarter required assistance with dressing (31%), meal preparation (33%) and taking medication or dressing wounds (28%). Less than a quarter needed help some or all of the time with activities such as eating or feeding, toileting, continence, moving about the house, transferring between bed and chair, communicating with family or friends, communicating with unfamiliar people, and using public transport (Table 8.7).

For people aged 65 and over with a moderate handicap, by definition, none required any assistance with showering or bathing, dressing, eating or feeding, toileting, continence, moving around the house, transferring between bed and chair, communicating with family or friends, or moving around places away from home.⁹ Assistance was mostly needed with home maintenance (61%), driving (37%), home help (35%), footcare (28%) and shopping (25%). A small proportion needed help with financial management or writing letters (10%) and public transport (8%), while less than 5% required assistance with meal preparation, communicating with unfamiliar people, and taking medication or dressing wounds.

Table 8.8 aggregates these data, by providing a summary score of all of the items from Table 8.7 for which help was needed. Only a very small proportion of the 65 and older group with a profound or severe handicap required help with two or fewer activities (6%), with a further 15% requiring assistance with three or four. Three-quarters needed help with five or more activities, including 21% who required help with 10 or more. For those with a moderate handicap, however, the profile was quite different. Almost two-thirds (64%) needed help with two or fewer activities, including 21% who required no assistance at all. Only 10% needed help with five or more activities.

Those aged under 65 showed a similar pattern to those aged 65 and over. On average, those under 65 with a profound or severe handicap required assistance with fewer activities, but were more likely to need help with personal care and verbal communication than their older counterparts. For those under 65 with a profound or severe handicap, around one-quarter required help with two or fewer activities, another quarter with three or four activities and around a half with five or more activities, including 11% who required help with 10 or more activities. For those with a moderate handicap, on the other hand, 85% required help with two or fewer activities (41% with none). Only 3% of persons aged 65 and under with a moderate handicap required help with five or more activities.

Table 8.9 provides estimates of the number of people aged 65 and over who required assistance with four groups of activities. Activity group 1, the most dependent, contained those who needed at least some help with one or more of the following tasks:

9 By the ABS definition, people with a moderate handicap have difficulty with self-care, mobility or verbal communication, but do not require any assistance to complete these tasks.

Table 8.7: Persons aged 5 years and over with a disability living in the community, by severity of handicap and assistance needed, 1993

Tasks for which assistance needed	Persons aged 5–64				Persons aged 65 and over			
	Profound/severe handicap		Moderate handicap		Profound/severe handicap		Moderate handicap	
	No.	%	No.	%	No.	%	No.	%
Showering/bathing	130,200	37.3	(a)	(a)	85,500	34.5	(a)	(a)
Dressing	139,300	39.9	(a)	(a)	77,400	31.2	(a)	(a)
Eating/feeding	83,800	24.0	(a)	(a)	48,400	19.5	(a)	(a)
Toileting	45,600	13.1	(a)	(a)	22,200	8.9	(a)	(a)
Bladder/bowel control	36,800	10.5	(a)	(a)	21,000	8.5	(a)	(a)
Moving about the house	78,600	22.5	(a)	(a)	39,200	15.8	(a)	(a)
Transfers between bed and chair	113,900	32.6	(a)	(a)	61,400	24.7	(a)	(a)
Communicating with family/friends	25,100	7.2	(a)	(a)	10,400	4.2	(a)	(a)
Moving around places away from the home	206,800	59.2	(a)	(a)	187,700	75.6	(a)	(a)
Communicating with unfamiliar people	59,000	16.9	18,700	7.3	25,900	10.4	*4,200	2.2
Home help	149,200	42.7	57,800	22.7	188,400	75.9	65,400	34.5
Meal preparation	57,800	16.6	9,900	3.9	81,100	32.7	*7,200	3.8
Taking medication/dressing wounds	56,500	16.2	8,600	3.4	68,200	27.5	*3,100	1.6
Financial management/writing letters	83,900	24.0	24,900	9.8	85,400	34.4	19,700	10.4
Shopping	88,900	25.5	22,100	8.7	145,700	58.7	47,700	25.2
Home maintenance	177,700	50.9	92,400	36.3	219,700	88.5	114,900	60.7
Public transport	87,600	25.1	14,700	5.8	57,800	23.3	14,500	7.6
Driving	106,800	30.6	29,500	11.6	192,700	77.6	69,200	36.6
Footcare	81,400	23.3	24,500	9.6	144,000	58.0	52,900	28.0
Total number of people (N)	349,100		254,800		248,200		189,300	

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

(a) People with a moderate handicap are defined in the 1993 Disability, Ageing and Carers Survey as having difficulty with these tasks, but not requiring assistance to complete these tasks.

Note: Total number of people may be less than the sum of components since persons may need assistance with more than one task.

Source: AIHW analysis of the ABS 1993 Survey of Disability, Ageing and Carers.

showering or bathing, dressing, eating or feeding, toileting, bladder or bowel control, moving about the house, transferring between bed and chair, and communicating with family or friends. Activity group 2 included those who did not require assistance with any of the activity group 1 tasks, but did with at least one of the following: moving around places away from home, communicating with people other than family or friends, home help, meal preparation, taking medication or dressing wounds, financial

Table 8.8: Persons aged 5 years and over with a disability living in the community, by severity of handicap and number of tasks for which assistance needed, 1993

Number of tasks for which assistance needed	Persons aged 5–64				Persons aged 65 and over			
	Profound/severe handicap		Moderate handicap		Profound/severe handicap		Moderate handicap	
	No.	%	No.	%	No.	%	No.	%
0	0	0.0	104,000	40.8	0	0.0	40,400	21.3
1	39,400	11.3	69,000	27.1	*6,400	2.6	34,600	18.3
2	46,200	13.2	42,500	16.7	9,400	3.8	45,200	23.9
3	55,700	15.9	19,700	7.7	14,700	5.9	31,500	16.6
4	42,000	12.0	11,800	4.6	22,500	9.1	18,500	9.8
5	31,700	9.1	*4,500	1.8	34,300	13.8	13,200	7.0
6	30,600	8.8	*2,000	0.8	40,100	16.1	*3,200	1.7
7	25,700	7.3	**1,100	0.4	26,800	10.8	**1,900	1.0
8	19,000	5.4	0	0.0	23,300	9.4	**800	0.4
9	20,400	5.8	0	0.0	18,400	7.4	0	0.0
10+	38,500	11.0	0	0.0	52,300	21.1	0	0.0
Total	349,100	100.0	254,800	100.0	248,200	100.0	189,300	100.0

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

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

Source: AIHW analysis of the ABS 1993 Survey of Disability, Ageing and Carers.

management and shopping. Activity group 3 consisted of those persons who did not need help with any of the tasks listed for activity groups 1 and 2, but did need help with at least one of the following: home maintenance, public transport, driving and footcare. Activity group 4 includes persons aged 65 and over classified by the ABS as having a disability, but who did not require assistance with any of the tasks described above.

Group 1 in this formulation is thus composed of people who needed help with activities of daily living, and group 2 of people who required assistance with instrumental activities of daily living.¹⁰ The profound and severe handicap category consists entirely of persons from groups 1 and 2, that is, of people aged 65 and over who required assistance with either activities of daily living or instrumental activities of daily living (from either formal or informal sources). The moderate handicap category, on the other hand, is almost evenly divided between group 2 (52%) and groups 3 and 4 (48%). Thus, a substantial proportion of those in the moderate handicap category did not require assistance with any of the tasks listed against activity groups 1 and 2. In other words, they required assistance only with activities such as home maintenance, public transport, driving and footcare. Not surprisingly, the proportions requiring various kinds of assistance decreased further in the 'mild' and 'not determined' handicap categories. Of some interest in exploring likely need for assistance, however, is the

10 See Rickwood (1994) for a review of these dependency measures.

substantial proportion of people requiring help with group 2 activities who were not captured by either the profound, severe or moderate categories—128,000 in the ‘mild’ handicap category; 12,700 in the ‘not determined’ category; and 10,600 in the ‘no handicap’ category.

The four group formulation developed here is not put forward as an alternative model for standard ABS purposes concerning the measurement of levels of disability and handicap in the community. It does, however, demonstrate the usefulness of the individual data items for undertaking more specific appraisals of the need for assistance (whether formal or informal) than was possible on the basis of the broader categorisations of profound, severe, moderate and mild handicap.

Table 8.9: Persons aged 65 years and over with a disability living in the community, by level of handicap and activity group, 1993

Activity groups*	Severity of handicap										Total with a disability	
	Profound/severe		Moderate		Mild		Not determined		No handicap			
	No. ('000)	%	No. ('000)	%	No. ('000)	%	No. ('000)	%	No. ('000)	%	No. ('000)	%
1	151.6	61.1	0	0.0	0	0.0	0	0.0	0	0.0	151.6	15.0
2	96.5	38.9	98.4	52.0	128.0	33.7	12.7	29.6	10.6	7.0	346.3	34.2
3	0	0.0	50.6	26.7	105.5	27.8	5.9	13.8	23.5	15.4	185.5	18.3
4	0	0.0	40.4	21.3	146.5	38.6	24.4	56.7	118.5	77.6	329.8	32.6
Total	248.2	100.0	189.3	100.0	380.0	100.0	43.0	100.0	152.7	100.0	1,013.2	100.0

* Activity groups are defined as follows:

- 1 = Needing assistance with showering/bathing, dressing, eating/feeding, toileting, bladder/bowel control, moving about the house, transfers between bed and chair, or communicating with family/friends.
- 2 = Needing assistance with moving around places away from the home, communicating with people does not know, home help, meal preparation, taking medication/dressing wounds, financial management/writing letters, or shopping.
- 3 = Needing assistance with home maintenance, public transport, driving, or footcare.
- 4 = Includes all persons not included in groups 1–3.

Source: AIHW analysis of the ABS 1993 Survey of Disability, Ageing and Carers.

What is the likelihood of needing residential care?

While dependency and age are predictors of the need for services, current patterns of service use can also be employed for this purpose. At the present time, Australian nursing homes and hostels function under strict assessment procedures, with access determined by Aged Care Assessment Teams. The level of residential care provision has been progressively reduced in recent years, and is drawing closer to the proposed target of 40 nursing home beds and 50 hostel places per 1,000 persons aged 70 and over (see further discussion in Section 8.3). It seems useful, therefore, to employ data on current patterns of hostel and nursing home use to explore the likely future need of individuals for residential care.

At any one point in time, a relatively small proportion of Australians reside in hostels—in 1996, around 0.3% of the total population or 6% of those over 75. For nursing homes, the proportions are similar—0.4% and 7%, respectively. Statistics such as these can tend to suggest that the likelihood of any one individual entering a hostel or nursing home is

quite low, and, while this is indeed the case at any particular point in time, the likelihood of nursing home or hostel use over a lifetime is considerably higher.

Table 8.10 presents the results of a life table (double decrement) analysis to show the likelihood that a person will require residential care sometime in the future. The underlying assumption of this analysis is that current nursing home and hostel utilisation patterns (1994–95) will continue. At birth, the probability that at some time in the future a person will require permanent hostel care is 0.16, although it is substantially higher for women (0.22) than it is for men (0.09). For those who survive to age 65, the likelihood of requiring permanent care in a hostel at some point in the future increases to 0.20 (0.26 for women and 0.12 for men). The probability continues to grow with age, but accelerates particularly from age 80 onward. For persons aged 85, for example, it is 0.48 (0.57 for women and 0.31 for men).

Table 8.10: Probability of future hostel and nursing home use at various ages, by type of care and by sex, 1994–95

Type of care by sex	Age							
	0	65	70	75	80	85	90	95
Hostels								
Permanent care								
Males	0.09	0.12	0.14	0.17	0.22	0.31	0.39	0.38
Females	0.22	0.26	0.29	0.34	0.45	0.57	0.60	0.43
Persons	0.16	0.20	0.22	0.27	0.35	0.48	0.54	0.42
Permanent and respite care								
Males	0.13	0.17	0.19	0.22	0.27	0.36	0.44	0.41
Females	0.28	0.33	0.35	0.41	0.51	0.63	0.65	0.45
Persons	0.21	0.25	0.28	0.33	0.42	0.53	0.58	0.44
Nursing homes								
Permanent care								
Males	0.20	0.25	0.28	0.32	0.39	0.48	0.56	0.60
Females	0.34	0.39	0.42	0.48	0.59	0.76	0.95	0.94
Persons	0.27	0.33	0.36	0.41	0.51	0.66	0.83	0.85
Permanent and respite care								
Males	0.21	0.27	0.30	0.34	0.40	0.49	0.57	0.61
Females	0.35	0.41	0.44	0.50	0.61	0.78	0.97	0.95
Persons	0.28	0.34	0.37	0.43	0.53	0.67	0.85	0.86

Note: The data in this table are estimated using life table models based on 1994–95 hostel and nursing home use patterns. The analysis is based on the assumption that the current utilisation patterns will prevail in the future. These life tables are not included in this report but are available on request.

Sources: AIHW analysis of the DHFS Aged and Community Care Strategic Information System (ACCSIS) 1997; ABS 1996a:15; ABS 1997a:73–74.

For nursing homes, the probability at birth that a person will, during their lifetime, require permanent nursing home care is 0.27. Again, women have a higher likelihood of requiring such care (0.34) than men (0.20). By age 65, the probability is higher—0.33 (0.39 for women and 0.25 for men). The likelihood of requiring such care continues to grow with age, particularly from age 80 onward. For persons aged 85, the probability

that they will enter a nursing home for ongoing care before they die is 0.66 (0.76 for women and 0.48 for men). While women are generally more likely than men to enter a nursing home at some point, it is noteworthy that the magnitude of the difference increases substantially at older ages.

Informal care

While the frail and disabled older population has been growing over the last decade, so too has the proportion of these people being cared for in the community (AIHW 1995:190). This shift has been associated with the expansion of home-based care and (in relative terms) with the contraction of the residential care sector. The role played by informal carers is significant, as they provide the majority of assistance to frail and disabled older people living in the community.

At the time of the 1993 ABS Survey of Disability, Ageing and Carers, there were some 541,200 principal carers, of whom 267,500 were providing help to people aged 65 or over.

Much of the analysis in this section applies only to principal carers, who are defined by the ABS as the main informal providers of assistance to those with a profound or severe handicap in the activities of self-care, mobility and verbal communication. In the first table on this topic, however, data are presented on the main provider of assistance (both informal and formal) with specific activities, and these data are available for those with a moderate handicap as well as for those with a profound or severe handicap (Table 8.11).

The vast majority of assistance required by persons with a profound or severe handicap was provided by informal providers of assistance (to be referred to as informal carers). For activities such as personal care, mobility, communication, meals, financial management and transport, over 80% of recipients specified an informal carer as the main source of help. Formal providers of assistance were most commonly reported with regard to health care (40%), home help and home maintenance (25%) and personal care (13%), although even in these areas informal carers were providing the majority of assistance.

Among those with a moderate level of handicap, there was no need or receipt of assistance, by definition, in the activities of personal care and mobility. In the categories where help was needed and used, informal carers still predominated over formal providers of assistance, although not to quite the extent evident among people with a profound or severe handicap. 'No provider' was a more common category of response for those with a moderate level of handicap than for those with a profound or severe handicap. In general, people with a moderate handicap were more likely to receive help from formal services or to receive no help, and less likely to have an informal carer, than were those with a profound or severe handicap. While the higher rates of formal assistance received by those with a moderate handicap, in comparison with those with a profound or severe handicap, appears to be a counter-intuitive finding, it must be remembered that the data presented here only include main providers of assistance. In the case of people with a profound or severe handicap, it is more likely that the capacity to remain in the community is dependent on high levels of informal care. That is not to

Table 8.11: Persons aged 65 and over with a disability living in the community, by severity of handicap and type of main provider of assistance, 1993

Type of activity needs help with	Type of main provider of assistance						Total needing help	
	Informal provider		Formal provider		No provider		Profound /severe handicap	Moderate handicap
	Profound /severe handicap	Moderate handicap	Profound /severe handicap	Moderate handicap	Profound /severe handicap	Moderate handicap		
	Number							
Personal care	104,200	(a)	15,700	(a)	*4,900	(a)	124,800	(a)
Mobility	177,600	(a)	12,800	(a)	23,700	(a)	214,100	(a)
Communication	20,800	**1,300	0	0	*5,100	*2,900	25,900	*4,200
Health care	90,000	10,600	64,300	33,300	*7,700	10,600	161,900	54,500
Home help	136,700	28,700	47,100	21,000	*4,600	15,700	188,400	65,400
Home maintenance	161,700	69,700	54,100	33,500	*3,900	11,700	219,700	114,900
Meals	69,600	*4,800	*7,500	**1,300	4,000	**1,200	81,100	*7,200
Financial management	83,200	17,200	**900	**1,200	**1,400	**1,300	85,400	19,700
Transport	181,900	69,100	18,600	*5,500	8,800	*4,200	209,300	78,800
	Per cent							
Personal care	83.5	(a)	12.6	(a)	3.9	(a)	100.0	(a)
Mobility	83.0	(a)	6.0	(a)	11.1	(a)	100.0	(a)
Communication	80.1	30.7	0.0	0.0	19.9	69.3	100.0	100.0
Health care	55.6	19.5	39.7	61.1	4.7	19.4	100.0	100.0
Home help	72.6	43.9	25.0	32.1	2.5	24.0	100.0	100.0
Home maintenance	73.6	60.7	24.6	29.2	1.8	10.2	100.0	100.0
Meals	85.8	66.1	9.3	17.6	5.0	16.3	100.0	100.0
Financial management	97.4	87.3	1.0	6.2	1.6	6.6	100.0	100.0
Transport	86.9	87.7	8.9	7.0	4.2	5.3	100.0	100.0

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

(a) People with a moderate handicap are defined in the 1993 Disability, Ageing and Carers Survey as having difficulty with these activities, but not requiring assistance to complete these activities.

Source: AIHW analysis of the ABS 1993 Survey of Disability, Ageing and Carers.

say that they do not use formal assistance; in fact, over a third use a combination of informal and formal assistance (AIHW 1995:379).

While the important role played by carers has gained increasing recognition over the last decade, there has been less attention paid to the adequacy of the assistance which they receive in their caring role. Tables 8.12 and 8.13 provide information on the extent to which principal carers of older people indicated that they needed assistance in their caring role.¹¹

Overall, 42% of carers felt that they had no need for help in their caring role, another 42% were receiving the help which they needed, and 16% either needed help but were not receiving it, or needed more help than they were receiving. Younger carers

(under 65) were more likely than older carers to report an unmet need for assistance or a met need, and less likely to report 'no need'. Older carers (65 and over) were more likely to report 'no need' for assistance and less likely to report an 'unmet' need, although these trends were less marked in the 80 and over age category. When both age and sex are taken into account, men and women under 65 and men over 80 were considerably more likely to report a 'met need' for assistance (49%, 47% and 41%, respectively) than carers in any other age groups. The contrast in the 80 and over age group between men and women was particularly marked, with 41% of men over 80 reporting a 'met need' for assistance compared with 25% of women. This result is, however, somewhat unreliable given the small cell sizes for women aged 80 and over (Table 8.12).

Table 8.12: Principal carers providing care to persons aged 65 and over, by expressed need for assistance in caring role and by sex and age group of carer, 1993

Sex and age group	No need		Unmet need		Met need		Total	
	No.	%	No.	%	No.	%	No.	%
Males								
15-64	10,700	27.5	9,200	23.6	19,100	49.0	39,000	100.0
65-79	23,100	62.5	**1,100	3.1	12,700	34.4	37,000	100.0
80+	*4,600	43.6	**1,600	15.2	*4,300	41.2	10,600	100.0
<i>Total males (all ages)</i>	<i>38,400</i>	<i>44.4</i>	<i>11,900</i>	<i>13.8</i>	<i>36,200</i>	<i>41.8</i>	<i>86,500</i>	<i>100.0</i>
Females								
15-64	43,500	32.8	26,700	20.2	62,200	47.0	132,400	100.0
65-79	26,100	61.6	*3,900	9.2	12,400	29.2	42,400	100.0
80+	*4,400	69.9	**300	5.4	**1,500	24.7	*6,300	100.0
<i>Total females (all ages)</i>	<i>73,900</i>	<i>40.8</i>	<i>31,000</i>	<i>17.1</i>	<i>76,100</i>	<i>42.0</i>	<i>181,000</i>	<i>100.0</i>
Persons								
15-64	54,200	31.6	35,900	21.0	81,200	47.4	171,300	100.0
65-79	49,200	62.0	*5,100	6.4	25,100	31.6	79,400	100.0
80+	9,000	53.4	**1,900	11.6	*5,900	35.0	16,800	100.0
Total population (all ages)	112,300	42.0	42,900	16.0	112,200	42.0	267,500	100.0

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

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

Source: AIHW analysis of the ABS 1993 Survey of Disability, Ageing and Carers.

When these categories are examined with regard to the relationship between the carer and the care recipient, it is those providing help to a parent who are most likely to report 'unmet need' (24% compared with 9% of those caring for a spouse). Those providing help to a spouse are most likely to report 'no need' (66% compared with 28%

11 The analysis presented here is a simplified version of the expressed need component developed by the Australian Institute of Health and Welfare for the Respite Review conducted by the Department of Health and Family Services in 1996 (Gibson et al. 1996).

of those caring for a parent). There was no clear pattern relating to gender (Table A8.2). These findings are consistent with the age-related effects described above. The higher levels of 'unmet need' among children providing assistance to parents may be partly a cohort effect, with younger generations being more willing to demand or receive formal assistance than older generations.

These patterns are consistent with findings generated in the analysis of the need for respite care. In those analyses, non-co-resident carers (predominantly children caring for aged parents) emerged as a group who appeared to have less access to formal services, were often providing assistance to people with quite high dependency levels, and among whom a substantial proportion exhibited physical and emotional stress in their caring roles (Gibson et al. 1996:42, 164).

Table 8.13 profiles the number of tasks for which carers were providing assistance against their reported need for assistance. This gives an indication of the level of help which each of these groups of carers was providing. The distributions for those in the 'no need' and 'met need' groups were remarkably similar, suggesting that at least in terms of the number of tasks which carers were providing assistance with there is no obvious difference between the two groups. In contrast, those reporting an 'unmet need' were indeed more commonly helping with a greater number of tasks. So, for example, while over a third of carers reporting an 'unmet need' were providing help with 12 or more activities, only 10% of those reporting 'no need' and 13% of those reporting 'met need' were providing this level of assistance.

Table 8.13: Principal carers providing care to persons aged 65 and over, by expressed need for assistance in caring role and by number of tasks for which assistance provided, 1993

Number of tasks for which assistance provided	No need		Unmet need		Met need		Total	
	No.	%	No.	%	No.	%	No.	%
0	**600	0.5	0	0.0	0	0.0	**600	0.2
1-2	17,500	15.5	**1,300	2.9	*5,100	4.5	23,800	8.9
3-5	32,600	29.0	*6,200	14.5	34,400	30.6	73,200	27.3
6-8	31,200	27.7	12,900	30.0	39,400	35.1	83,400	31.2
9-11	19,100	17.0	*7,500	17.4	18,500	16.5	45,100	16.8
12 or more	11,400	10.2	15,100	35.2	15,000	13.3	41,500	15.5
Total	112,300	100.0	42,900	100.0	112,200	100.0	267,500	100.0

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

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

Source: AIHW analysis of the 1993 Survey of Disability, Ageing and Carers.

8.3 Service provision

As was noted in the introduction to this chapter, there are several new aged care policies set for implementation from 1997. Foremost amongst these is the Aged Care Structural Reform Package, announced in the 1996-97 Budget. In broad terms, the package removed the long-established distinction between nursing homes and hostels,

and introduced new income testing arrangements, a new accreditation and standards system, and an accommodation bonds scheme.

Prior to the 1996–97 Budget, the residential care sector in Australia consisted of two discrete tiers of service. Nursing homes were aimed at more highly dependent residents who required nursing care. Hostels were aimed at lower dependency residents, including those requiring help with personal care activities (referred to as ‘Personal Care’-level residents) and those who did not (referred to as ‘Hostel Care’ residents). Both nursing homes and hostels received Commonwealth government subsidies and were subject to outcome standards monitoring, but there were substantial differences between the two systems.

As a result of the changes brought about by the Aged Care Reform Strategy, a number of commentators have pointed to the increasing dependency of both hostel and nursing home residents, and to the increasing overlap in dependency level between the two populations.¹² Yet the financial reimbursement available to proprietors of hostels remained substantially below that for nursing homes. The increasing pressure on all facilities by residents in advanced stages of dementia had also led to concern in some sectors as to the adequacy of existing reimbursement arrangements. The new system is aimed at both simplifying administrative and funding procedures and removing some of the funding inequalities which had emerged as a consequence of the substantial overhaul of the residential care system during the decade to 1996.

Thus, while the move to contain the residential care sector and to expand community-based services continues, the actual structure of the residential care sector is set to change substantially, with the combination of nursing home and hostel care into one common residential care stream. Consequent on this change are other developments, including the implementation of a single classification instrument for both hostels and nursing homes, the development of a common database for program management purposes, and alterations to the funding arrangements for both capital and recurrent purposes.

Income testing arrangements for residential care

The new income testing arrangements are effective from 1 October 1997 and require residents to make an income-tested contribution to the cost of their accommodation and care. The basic daily fee is around \$21.10 per day (indexed) for pensioners and around \$26.40 per day (indexed) for non-pensioners. Part-pensioners and non-pensioners pay an additional amount of 25 cents in the dollar for private income above the pension free area (\$50 a week for single persons or \$88 for couples), up to a maximum total fee of around \$63.30 per day. The government subsidy payable for each resident is reduced by the amount of the additional income-tested fee paid; the service provider thus does not receive a higher amount for such residents.

12 More detailed accounts can be found in Duckett (1995), Gibson (1997) and Mathur (1996).

New resident classification scale

The single classification instrument has been developed to determine Commonwealth government subsidies payable for residents under the new system. It has eight care categories, with categories 1 to 4 representing the 'higher care' levels and 5 to 8 the 'lower care' levels. Level 8 has been designed to be broadly equivalent to the old 'Hostel Care' category; residents in this category will not attract a government subsidy. An Aged Care Assessment Team appraisal will be required before a resident can move from category 5 to category 4, but the new system is intended to facilitate 'ageing in place' by removing the necessity for residents to move from a hostel to a nursing home as their care needs increase.

The new single classification instrument has been designed to take better account of the care needs of residents with dementia, an area of ongoing concern with regard to both the Resident Classification Instrument (RCI) and the Personal Care Assessment Instrument (PCAI). The new funding system also includes a 'Concessional Resident Supplement', which will be paid by the Commonwealth Government on behalf of residents who do not have the financial resources to pay accommodation bonds.

Accommodation bonds

Accommodation bond arrangements have been used in hostels for around a decade; under the new arrangements, all residential aged care service providers who meet prescribed building and care standards will be required to charge accommodation bonds. The amount of the bond, and the timing of the payment, will be agreed at the time of entry. Bonds can be paid as lump sums or equivalent regular 'periodic' payments, or a combination of both. Service providers will be able to access up to \$2,600 per year for a maximum of 5 years; they also retain the interest earned on the principal during the resident's period of tenure in the facility. The pool of funds created by these payments is intended for use in upgrading or replacing building stock, thus ameliorating the shortage of capital funds which has been a major policy issue in the nursing home industry in recent years.

A number of protection mechanisms have been designed to minimise adverse effects, particularly for less financially well-off persons, under the new system. These include a quota of places which are set aside for financially disadvantaged residents (to be known as concessional residents), who cannot afford an accommodation bond. Residents must be left with a minimum of 2.5 times the annual age pension (currently \$22,500) after paying the bond, and for those who leave a spouse or dependent child in the family home, the home will be exempt from the assets test in establishing whether a bond is payable. If a carer or close family member has been living in the home for 5 years and is eligible for a pension or benefit, the home is also exempt.

Quality assurance

From 1 January 1998, the Aged Care Standards Agency will commence operation, replacing the system of standards monitoring which has been in place for the last decade. Nursing home outcome standards were introduced in 1987, and hostel outcome standards in 1991. Under the existing system, outcome standards monitoring teams visited nursing homes and hostels to assess their performance against the outcome standards. The new system is to be accreditation-based, administered by the

independent Aged Care Standards Authority, and oriented to four broad standards: management systems staffing and organisational development; health and personal care; resident lifestyle; and physical environment and safe systems.

National Carer Action Plan with carer support

Since 1995, a number of initiatives have emerged to increase the support and assistance provided to carers. The Respite Review, announced in the 1995–96 Budget, reported in 1997. It emphasised the substantial role played by informal carers in maintaining frail and disabled older people in the community, and the need for more responsive, flexible and accessible respite care services. Carer support focuses on three distinct elements identified in the Coalition's pre-election National Carer Action Plan—respite care, financial assistance, and carer needs-assessment, information and advice.

The National Respite for Carers program, announced by the Commonwealth Government in the 1996–97 Budget, included an additional \$6 million per year from 1 July 1996 for respite care services, the creation of Carer Resource Centres to provide information and support to carers, and improvements in access to emergency respite care. In the 1997–98 Budget the rate of payment for the Domiciliary Nursing Care Benefit was increased by 28%, or around \$16.60 per fortnight (to be implemented from July 1998). The eligibility criteria for the Carer Payment were extended to additional categories of carers, as were the number of days of respite care per year which could be used before carers lose their right to both the Carer Payment and the Domiciliary Nursing Care Benefit. An additional \$1 million in 1997–98, rising to \$2 million in 1998–99, was made available for carer information and support services.

National Action Plan for Dementia Care

The 5-year National Action Plan for Dementia Care concluded in June 1997. Dementia care continues to be a major concern in aged care policy development, with current estimates of the number of people aged 60 and over affected by dementia being around 135,000. This is expected to increase to 177,000 people by 2006 (DHFS 1996b). Under the plan, a variety of educational and training resources were made available to Aged Care Assessment Teams, residential care staff, community care workers and informal carers to improve their knowledge and skills relating to the care of people with dementia. A number of research activities were also funded. Related projects included the Scoping Study on Older People and Mental Health, conducted under the auspices of the Australian Health Ministers' Advisory Council National Mental Health Working Group, and a major research project on the care needs of people with dementia and challenging behaviour who live in Commonwealth-funded residential care facilities (Rosewarne et al. 1997).

Other developments

A number of other changes are underway or in their developmental stages. The Commonwealth Government has announced the implementation of a nationally consistent set of fees for HACC services, and a draft set of guidelines has been developed. In 1997, pilot testing of a quality appraisal process for these services, based on performance against the HACC national service standards first developed in 1989, was undertaken by the Australian Institute of Health and Welfare at the request of

HACC officials. The potential function of independent assessors within the HACC program is also under review, with a consultancy underway to develop an accreditation framework for assessors who would undertake holistic assessment of people with medium-high or complex needs. More broadly, the emphasis on home-based care continues, with the Commonwealth Government committed to retaining a growth rate of 6% per year in HACC funds in real terms (partially funded by increased user fees), and community aged care packages earmarked for ongoing expansion and development.

Level of supply

Home-based care

Before the mid-1980s, the Australian aged care system was generally perceived as heavily oriented towards residential care, with a poorly developed and fragmented home care system. Considerable emphasis was placed on the expansion of home-based care services, at first by drawing the existing services together under the umbrella of the HACC program, and subsequently in the implementation of innovative brokerage and intensive home care services (community options projects, hostel options, community aged care packages, and most recently the piloting of nursing home options).¹³ Expenditure (in real terms) on HACC services between 1985–86 and 1991–92 grew by 104%, and is testament to the substantial expansion of these services as a result of the policy direction established by the Aged Care Reform Strategy.

Some data are available on levels of service provision under HACC for 1989, but these are incomplete with regard to the range of service types and are not consistently available for all States and Territories. One clear trend was that respite care (both home and centre-based) expanded dramatically over the period, although growth patterns varied substantially from State to State.¹⁴ More complete and hence more representative data are available for 1993–94, and Table 8.14 provides a useful insight into recent trends within the HACC program. The data are presented for 1993–94 and 1996 in relation to both the total population aged 70 and over, and that aged 65 and over with a profound or severe handicap. (State and Territory breakdowns for 1996 can be seen in Table A8.3.)

Nationally, there has been a slight reduction over this period in the availability of home respite care (1%), with the reduction in home nursing being somewhat more substantial: in the vicinity of 16%. On the other hand, there was a modest increase in the supply of personal care, paramedical, centre-based day care and centre-based meals (all less than 19%), with home help, home maintenance and home meals also increasing slightly over this period.

13 Community options projects and community aged care packages (previously known as hostel options) are two brokerage or case management components of the community care sector, designed for highly dependent frail older people and people with complex care needs, with the overall intention of reducing inappropriate admissions to residential care. For a more detailed account of these programs, see Mathur et al. (1997).

14 See Mathur (1996) for a detailed analysis of these data.

Table 8.14: Hours of Home and Community Care (HACC) service provided per month per 1,000 target population, by type of service, 1993–94 and 1996

Type of service	Average hours per month per 1,000 persons			
	Aged 70 and over		With a profound/severe handicap aged 65 and over	
	1993–94	1996	1993–94	1996
Home help	426	429	1,639	1,648
Personal care	109	126	419	483
Home nursing	205	172	790	660
Paramedical	20	23	75	89
Respite care	154	153	593	587
Centre day care	418	452	1,611	1,736
Home maintenance	42	43	161	164
Home meals (N)	742	746	2,857	2,866
Centre meals (N)	101	115	387	440

Notes

1. In 1993–94 respite care refers to home respite.
2. Not all States and Territories have data for the same collection period. The 1993–94 service provision data for New South Wales, Victoria and Western Australia were from November 1993, and remaining States and Territories had data from May 1994. The most recent data from the 1996 data collection was November 1993 for Western Australia, May 1996 for Victoria, Queensland and South Australia, and November 1996 for the remaining States and Territories.
3. The national figure includes data from the most recent data collection in each State and Territory. The corresponding population data for each State and Territory have been used to derive the above ratios.
4. The Australian population estimates exclude the external territories (Jervis Bay, Cocos Island and Christmas Island).

Sources: AIHW analysis of the ABS 1993 Survey of Disability, Ageing and Carers and DHFS 1996 HACC Service Provision Data Collection; ABS 1995a:4–6; ABS 1996c:5–7; ABS 1997b:14–17; DSHS 1995b:Section 2:1–2.

Table 8.15: Hours of Home and Community Care (HACC) service provided per month and rates of increase, by type of service, 1993–94 and 1996

Type of service	Hours of service provision		Rate of increase (%)
	1993–94	1996	
Home help	596,874	644,537	8.0
Personal care	152,462	188,810	23.8
Home nursing	287,838	258,110	–10.3
Paramedical	27,421	34,694	26.5
Respite care	216,111	229,589	6.2
Centre day care	586,604	679,012	15.8
Home maintenance	58,603	64,245	9.6
Home meals (N)	1,040,599	1,120,744	7.7
Centre meals (N)	141,117	172,112	22.0

Notes

1. In 1993–94 respite care refers to home respite.
2. Not all States and Territories have data for the same collection period. The 1993–94 service provision data for New South Wales, Victoria and Western Australia were from November 1993, and remaining States and Territories had data from May 1994. The most recent data from the 1996 data collection was November 1993 for Western Australia, May 1996 for Victoria, Queensland and South Australia, and November 1996 for the remaining States and Territories.
3. The national figure includes data from the most recent data collection in each State and Territory.

Sources: AIHW analysis of the DHFS 1996 HACC Service Provision Data Collection; DSHS 1995b:Section 2:1–2.

In terms of absolute hours of service supplied, this translates into an actual decrease in the hours of home nursing (10%).¹⁵ For all other service categories the number of hours or occasions of service increased between 1993–94 and 1996, from 6% for home respite care, to 27% for paramedical services. Of particular interest, given the observed decrease in home nursing hours, is the increase of 24% for personal care services (Table 8.15).

In general, the increases in the availability of HACC services which characterised the early years of the Aged Care Reform Strategy did not continue into the later part of the decade. Nonetheless, growth in services has generally kept pace with increases in the numbers of frail and disabled older people, to produce a 'steady state' situation over recent years. This stability in the level of supply has occurred, however, in a context where the proportion of frail and disabled older people living in the community rather than in residential care has increased (AIHW 1995), as the supply of residential care is progressively reduced. Similarly, the supply of residential care for younger people with a disability (also part of the HACC client group) has reduced in recent years (see Figure 9.7, page 336). Taken together, this has almost certainly resulted in an increase in the number of potential clients competing for HACC resources. One countervailing force has been the emergence of community aged care packages, discussed in the next section, which have provided an additional source of support for those living in the community.

Residential care and community aged care packages

Community aged care packages deliver home-based care, and could, therefore, be discussed in the preceding section. However, the program is funded from the residential care program, and is seen as a direct alternative to and substitute for admission to a hostel as a 'Personal Care' resident. Care package clients receive a quantum of service up to and including the level of service provided to a 'Personal Care–Low' hostel resident, but delivered in the client's home. The expansion of community aged care packages is thus best analysed in the context of the reduction of residential care places, in order to gain an overview of the broader changes affecting the aged care system.

In 1985, there were 66.5 nursing home beds and 32.5 hostel places per 1,000 people aged 70 and over (total of 99 residential care places). By 1996, there were 49.5 nursing home beds and 41.4 hostel places per 1,000 people aged 70 and over (total of 91 residential care places), supplemented by three aged care packages per 1,000 people aged 70 and over (Table 8.16). If care packages are included as residential care equivalents, this represents a 5% reduction in the ratio of provision for the target population over the 11 years to 1996. In addition, and of equal importance, is the marked shift away from the more intensive nursing home level of provision towards the less intensive hostel care system. These changes are part of a deliberate plan by the government to achieve a level of provision of 40 nursing home beds, 50 hostel places and 10 community aged care packages (per 1,000 people aged 70 and over) by the year 2011.¹⁶

¹⁵ This national reduction in home nursing is largely attributed to the substantial drop in the provision of home nursing in New South Wales.

Table 8.16: Residential care places, by type of residential facility, 30 June 1985 and 1996

	1985			1996		
	Community aged care packages	Hostels	Nursing homes	Community aged care packages	Hostels	Nursing homes
Number of beds/places	0	34,885	71,503	4,441	62,645	75,008
Ratio of bed/places per 1,000 population						
Aged 70+	—	32.5	66.5	2.9	41.4	49.5
Aged 65+ with a profound/severe handicap	—	128.4	263.2	11.3	158.9	190.3

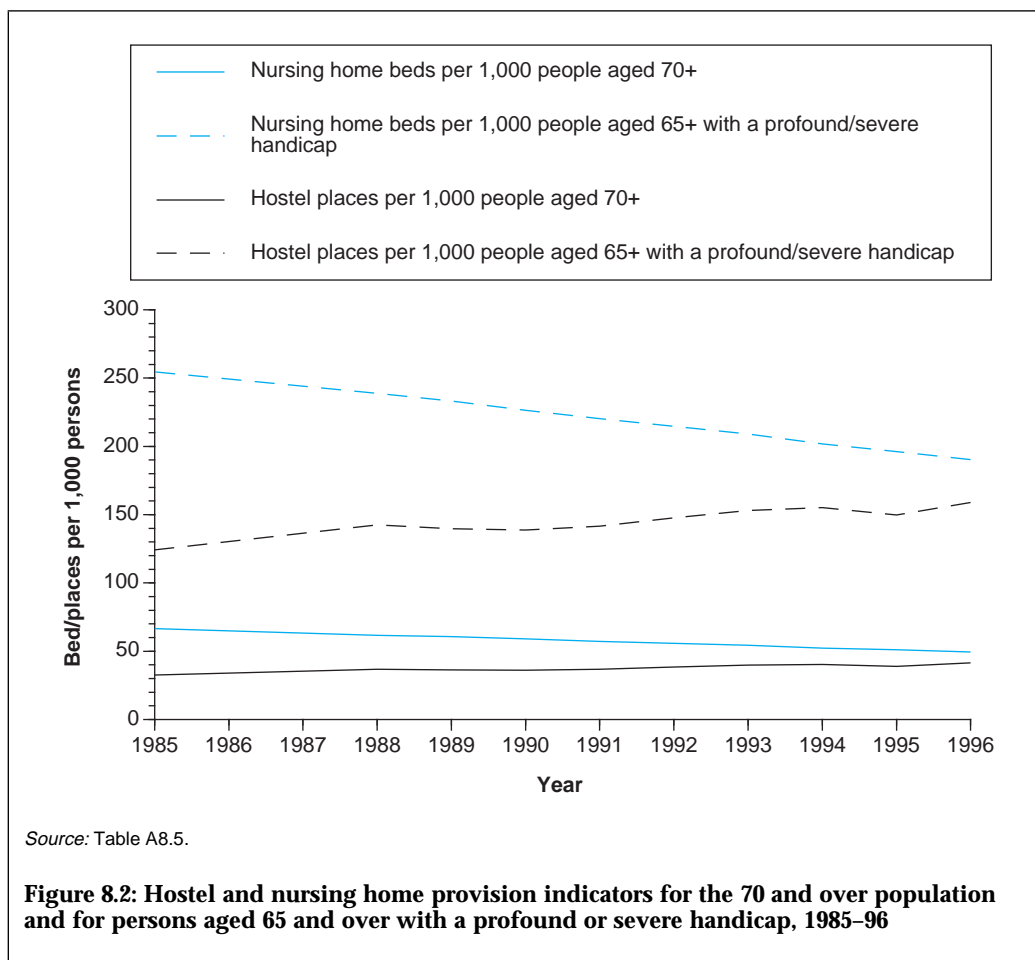
Sources: AIHW analysis of the ABS 1993 Survey of Disability, Ageing and Carers; ABS 1987:17–18; ABS 1997b:15–17; AIHW 1995:201; DHFS unpublished data.

In more recent years, the reduction in nursing home beds has continued (5 beds per 1,000 people aged 70 or over, or 9%, between 1993 and 1996), and the compensating expansion of hostel places slowed (2 places per 1,000 people aged 70 or over, or a 4% increase). In this same period, the number of community aged care packages has grown from 1 to 3 per 1,000 people aged 70 and over. Figure 8.2 illustrates these trends with regard to hostels and nursing homes. State and Territory breakdowns and time series data are presented in Tables A8.4 and A8.5.

While the discussion of these data has been undertaken in terms of people aged 70 and over, the tables and figures in this section also include the number of people aged 65 and over with a profound or severe handicap as a reference group. The target population for residential aged care services is those highly dependent older people who cannot be adequately supported by informal or formal services in the community. As has been discussed more fully elsewhere (AIHW 1995:180–2), the 70 and over age group is the basis of the formal planning ratio employed by the Department of Health and Family Services, and is used here for that reason. It is important to note that the formal planning ratio and the official target population for residential care are not the same. The planning ratio, based on the 70 and over age group, does not focus on only those highly dependent members of the 70 and over population who may be in need of residential care. In fact, only 22% of people aged 70 and over have a profound or severe handicap, and only a proportion of them utilise aged care services at a particular point in time. In addition, the changing structure of the aged population itself (as discussed in Section 8.2), coupled with the steep rise in levels of dependency at more advanced ages (80 and over, 85 and over, etc.), renders the 70 and over baseline an inconsistent predictor of need over time.

The use of the population aged 65 and over with a profound or severe handicap as a denominator has three main strengths. Firstly, it is a somewhat closer approximation of the target group, although again the majority of these people will be cared for in the community with the assistance of informal carers, rather than in a residential care

16 For a more detailed account of the changing patterns of residential care, see AIHW (1993, 1995).



context (or indeed by community-based services). Secondly, it reduces the lack of comparability over time introduced by the ageing of the population, as the nature of the population aged 65 and over shifts towards higher or lower levels of dependency as the proportion aged 80 and over, or even 85 and over, moves back and forth with successive cohorts of older people.¹⁷ Thirdly, it has the advantage of facilitating comparison with home-based aged care services (HACC and community options), where target groups are defined differently, by providing a common baseline denominator.

Regardless of the baseline employed, however, data on place and bed ratios provide only part of the picture concerning the availability of residential care. In particular, they do not provide any indication of how such resources are being used. For this purpose, measures of the movement of residents through the system are needed, trends which

¹⁷ This point is discussed in detail in AIHW (1995, Chapter 5).

are best represented by indicators such as length of stay, the number of admissions and turnover. Turnover (defined as the ratio of admissions to total number of beds) is particularly useful as it provides an indication of shifts in usage patterns distinct from changes associated simply with increases over time in the absolute numbers of beds and places available.

Table 8.17 provides time series data on admission and turnover for the last 5 years, the period for which it is generally agreed that the combined effects of reforms to the Australian aged care system began to be fully felt in the residential sector.¹⁸ Between 1991–92 and 1995–96, hostels experienced a substantial increase in the number of residents admitted for respite, rather than permanent, care. The total number of admissions also increased quite substantially over this period (from 28,943 to 41,400), with turnover increasing from 0.59 to 0.69. These increases are largely a result of the significant expansion in the absolute number of hostel places available during the period (see Table A8.4). While most of these changes were driven by increased respite admissions (and an increased turnover among respite residents), there was an actual increase in the number of residents admitted for permanent care in hostels: 4,680 more people were admitted in 1995–96 than in 1991–92.

Table 8.17: Hostel and nursing home admissions and turnover, by type of care, 1991–92 to 1995–96

	Hostels					Nursing homes				
	1991 –92	1992 –93	1993 –94	1994 –95	1995 –96	1991 –92	1992 –93	1993 –94	1994 –95	1995 –96
Permanent care										
Admissions	14,904	16,278	17,208	19,358	19,584	38,397	38,679	34,317	34,730	32,962
Turnover	0.30	0.31	0.31	0.34	0.33	0.52	0.52	0.46	0.47	0.44
Respite care										
Admissions	14,039	15,915	17,941	19,824	21,816	3,191	4,227	6,030	7,931	11,282
Turnover	0.29	0.30	0.32	0.35	0.36	0.04	0.06	0.08	0.11	0.15
Total										
Admissions (N)	28,943	32,193	35,149	39,182	41,400	41,588	42,906	40,347	42,661	44,244
Turnover	0.59	0.61	0.63	0.69	0.69	0.56	0.58	0.54	0.57	0.59

Notes

1. Whole-year bed numbers used by averaging consecutive years.
2. Turnover = (number of admissions/number of beds) in the financial year.

Sources: AIHW analysis of the DHFS ACCSIS system 1997; AIHW 1995:214–15, 380; DSHS 1995a:139.

¹⁸ Apart from the shift of resources towards home-based care and the reduction in the levels of residential care, Aged Care Assessment Teams were introduced to determine eligibility for residential care, and funding reforms provided nursing homes and hostels with incentives to take in more-dependent residents.

Table 8.18: Hostel and nursing home admissions, by length of stay and type of care, 1991–92 and 1995–96 (%)

Length of stay	Hostels				Nursing homes			
	Permanent care		Respite care		Permanent care		Respite care	
	1991–92	1995–96	1991–92	1995–96	1991–92	1995–96	1991–92	1995–96
Less than								
1 month	4.2	3.5	75.3	75.2	28.9	16.0	74.7	75.1
1–2 months	3.2	3.9	18.0	16.8	8.7	7.6	17.1	15.9
2–3 months	2.7	3.1	5.9	6.8	4.5	5.0	7.3	8.0
3–6 months	7.2	7.6	0.8	1.1	7.7	9.2	0.8	0.8
6 months+	82.6	81.9	0.0	0.1	50.2	62.1	0.0	0.1
Total (N)	14,904	19,584	14,039	21,816	38,397	32,962	3,191	11,282

Source: AIHW analysis of the DHFS ACCSIS system 1997.

The trend for nursing homes has been somewhat different. Like hostels, nursing homes experienced an increase in the total number of people admitted, with this trend again partly a result of growth in the absolute number of nursing home beds. The use of nursing homes for respite care grew rapidly over this period; the number of respite admissions more than tripled, and turnover increased from 0.04 to 0.15. For permanent care, the trend was in the reverse direction, with 5,435 fewer admissions in 1995–96 than in 1991–92. Turnover, too, declined sharply, from 0.52 to 0.44. Taken together, these findings suggest a decline in accessibility for those requiring permanent care in a nursing home, with those already admitted staying longer (i.e. lower turnover), and as a consequence fewer such people being admitted.

The growth in the use of residential respite care has been an important development in recent years. In 1991–92, 49% of hostel admissions and 8% of nursing home admissions were for respite care. By 1995–96, these proportions had increased to 53% for hostels and 26% for nursing homes. The number of bed days used for respite purposes also expanded quite dramatically over this period, although respite usage remains a small proportion (less than 5%) of all residential care bed days.¹⁹

There are marked differences between hostels and nursing homes in the length of stay of those admitted for permanent care during the 1991–92 and 1995–96 financial years (Table 8.18, above).²⁰

Of admissions to hostels for permanent care in 1995–96, 4% stayed less than 1 month, 15% between 1 and 6 months, and 82% for more than 6 months. For nursing homes, the comparable figures were 16%, 22% and 62%. As would be expected, the vast majority (75%) of hostel and nursing home residents admitted for respite care in 1995–96 stayed for less than 1 month. One of the more striking aspects of these data is the substantial

¹⁹ For further detail, see Gibson et al. (1996, Chapters 5 and 6).

²⁰ Note that the proportion of permanent nursing home admissions with a length of stay of less than 1 month is comparatively high in the 1991–92 financial year. While this appears to be a shift in usage patterns, it seems more likely in our view to represent poor data quality on the respite care indicator in the early years of the nursing home database.

proportion of both nursing home and hostel residents with really quite short lengths of stay. In hostels, this is almost entirely explained in terms of respite residents; only 7% of permanent hostel residents remained less than 2 months, and 82% remained more than 6 months. For nursing homes, while respite residents remain an important factor, 24% of permanent residents remained for less than 2 months, and only 62% for more than 6 months. Nursing homes thus differ quite significantly from hostels in having a larger proportion of people admitted for permanent care who remain for relatively short periods of time.

The data presented in Table 8.18 show the actual length of stay distributions of residents at a point in time. They do not show the final length of stay on departure from the nursing home or hostel.²¹ To obtain estimates of final length of stay, a life table methodology was used to give the expected length of stay for permanent residents of both hostels and nursing homes admitted in 1995–96, according to the proportion who had separated by a given month or year (Table 8.19).

Table 8.19: Cumulative expected length of stay distributions of permanent hostel and nursing home admissions, 1995–96 (%)

Length of stay	Hostels	Nursing homes
0	0.0	0.0
1 month	3.4	17.0
2 months	7.4	25.2
3 months	11.0	30.3
4 months	13.7	34.3
6 months	18.4	40.0
1 year	30.2	50.2
2 years	48.9	64.4
3 years	62.4	74.4
5 years	78.6	87.0
Total	100.0	100.0

Note: These figures are derived by using life table models based on hostel and nursing home data for 1995–96. These life tables are not provided in this report but are available on request.

Source: AIHW analysis of the DHFS ACCSIS system 1997.

In hostels only 3% of permanent admissions left in the first month, less than a third left within the first 12 months and approximately one-half within 2 years; the median length of stay was 746 days (a little over 2 years). In nursing homes, a different pattern emerged, with one in six permanent admissions leaving in the first month, a further third in the next 11 months and over one-half within the first year. The median length of

²¹ For residents admitted late in 1995–96, 6 months was the maximum possible length of stay at the point in time that the database was uploaded by the Australian Institute of Health and Welfare (January 1997). The problem of truncated length of stay is a standard problem in this type of analysis (Liu 1996).

stay for permanent nursing home admissions was 356 days (almost 12 months), substantially lower than that for hostels. In general, people entering nursing homes for permanent care stay for a considerably shorter period of time than those admitted for permanent care to aged persons hostels.

Expenditure

Tables 8.20 and 8.21 present expenditure data in current and constant prices on aged care services for the period from 1991–92 to 1995–96. Expenditure has not only grown in real terms in all aged care service categories during the period 1991–92 to 1995–96 (Table 8.20), but has also broadly continued to keep pace with the growth in the numbers of older people with a profound or severe handicap (Table 8.21).

Table 8.20: Aged care recurrent expenditure (Commonwealth and States and Territories) in current and constant (average 1989–90) prices, by program, 1991–92 to 1995–96 (\$m)

Program	Year				
	1991–92	1992–93	1993–94	1994–95	1995–96
Current prices (\$m)					
Assessment	29.0	31.9	34.5	35.1	35.7
HACC	521.1	564.5	611.4	657.4	697.8
Community aged care packages	1.9	3.3	7.4	17.9	33.1
Hostels	234.3	274.8	312.0	363.1	417.4
Nursing homes	1,605.5	1,680.9	1,704.0	1,804.7	2,001.7
Total	2,391.8	2,555.4	2,669.3	2,878.2	3,185.7
Constant (average 1989–90) prices (\$m)					
Assessment	26.5	28.3	30.3	30.9	30.8
HACC	475.6	501.6	536.7	577.9	601.9
Community aged care packages	1.7	2.9	6.5	15.7	28.6
Hostels	213.9	244.2	273.9	319.2	360.0
Nursing homes	1,465.4	1,493.5	1,495.8	1,586.5	1,726.5
Total	2,183.2	2,270.5	2,343.2	2,530.2	2,747.7

Notes

1. Deflated to constant prices using the Government Final Consumption Expenditure (GFCE) deflator.
2. Available data suggest that 20–25% of HACC clients are aged under 65, and that this has been constant over the period in question. A small proportion of expenditure in nursing homes and hostels involves younger residents. Total expenditure (i.e. all ages) is included in this table for all program areas.

Sources: ABS 1996b:74, 92; AIHW 1995:205; DHHLGCS 1993:57; DSHS 1995a:149; DHFS 1996a:150; DHFS unpublished data.

Nursing homes continue to dominate expenditure patterns, accounting for 67% of expenditure on aged care at the beginning of the period under scrutiny, and 63% at the end. Hostels increased their share somewhat, from 10% in 1991–92 to 13% in 1995–96. For total home-based care services (HACC plus community aged care packages), there was no net change over the period, remaining steady at 22–23% of total expenditure.

In terms of total recurrent government expenditure (in constant prices) per older person with a profound or severe handicap, annual growth rates varied from an increase of 0.5% early in the period, to an increase of 5% for the most recent year.

Table 8.21: Recurrent expenditure (Commonwealth and States and Territories) per person aged 65 and over with a profound or severe handicap, in constant (average 1989–90) prices, by program, 1991–92 to 1995–96

Program	Year				
	1991–92	1992–93	1993–94	1994–95	1995–96
Expenditure per person aged 65+ with profound/severe handicap (\$)					
Assessment	78	81	84	82	80
HACC	1,404	1,431	1,482	1,544	1,554
Community aged care packages	5	8	18	42	74
Hostels	631	696	756	853	929
Nursing homes	4,326	4,260	4,131	4,239	4,458
Total	6,445	6,476	6,472	6,761	7,094
Annual growth rates (%)					
Assessment	—	3.4	3.5	–1.4	–3.6
HACC	—	1.9	3.6	4.2	0.6
Community aged care packages	—	61.8	116.6	134.3	75.4
Hostels	—	10.3	8.6	12.7	9.0
Nursing homes	—	–1.5	–3.0	2.6	5.2
Total	—	0.5	–0.1	4.5	4.9

Notes

1. Deflated to constant prices using the Government Final Consumption Expenditure (GFCE) deflator.
2. Available data suggest that 20–25% of HACC clients are aged under 65, and that this has been constant over the period in question. A small proportion of expenditure in nursing homes and hostels involves younger residents. Total expenditure (i.e. all ages) is included in this table for all program areas.

Sources: AIHW analysis of the ABS 1993 Survey of Disability, Ageing and Carers; ABS 1993c:28–30; ABS 1994:4–6; ABS 1995a:4–6; ABS 1996b:74, 92; ABS 1996c:5–13; ABS 1997b:15–17; AIHW 1995:205; DHHLGCS 1993:57; DHSH 1995a:149; DHFS 1996a:150; DHFS unpublished data.

Table 8.22: Aged care capital funding in current and constant (average 1989–90) prices, by program, 1991–92 to 1995–96

Program	Year				
	1991–92	1992–93	1993–94	1994–95	1995–96
Current prices (\$m)					
HACC	19.5	19.1	22.8	25.4	15.0
Nursing homes and hostels	220.0	196.9	134.8	106.8	68.9
Constant (average 1989–90) prices (\$m)					
HACC	17.8	17.0	20.0	22.3	12.9
Nursing homes and hostels	200.8	174.9	118.3	93.9	59.4
Expenditure (in constant prices) per person aged 65+ with profound/severe handicap (\$)					
HACC	53	48	55	60	33
Nursing homes and hostels	593	499	327	251	153

Notes

1. Deflated to constant prices using the Government Final Consumption Expenditure (GFCE) deflator.
2. Available data suggest that 20–25% of HACC clients are aged under 65, and that this has been constant over the period in question. A small proportion of expenditure in nursing homes and hostels involves younger residents. Total expenditure (i.e. all ages) is included in this table for all program areas.

Sources: AIHW analysis of the ABS 1993 Survey of Disability, Ageing and Carers; ABS 1993c:28–30; ABS 1994:4–6; ABS 1995a:4–6; ABS 1996b:74, 92; ABS 1996c:5–13; ABS 1997b:15–17; DHFS unpublished data.

This higher rate of growth for 1995–96 was largely the result of an increase of 5% in nursing home expenditure, where previously rates had ranged between –3% and 3%. For hostels, the rate of growth in per person expenditure has remained broadly constant (between 9% and 13%), with substantial growth (albeit from a very low base) evident in the expanding community aged care package program throughout the period. Per person expenditure on assessment appears to be reducing, with a decline in the last 2 years. For HACC, while per person expenditure continued to increase over the 4-year period, the rate of increase declined quite sharply in 1995–96, to only 0.6%.

There was a decline in capital expenditure on nursing homes and hostels over the period. For HACC, capital expenditure grew in real terms until 1994–95, but fell in 1995–96 (Table 8.22).

Client profiles

Age and sex

Table 8.23 presents data on the age and sex profiles of community care, hostel and nursing home residents. For hostels and nursing homes, the profiles reflect dependency levels: for hostels, separate calculations are presented for Personal Care (higher dependency) and Hostel Care (lower dependency) residents; and for nursing homes, for RCI 1–2 (higher dependency) and RCI 3–5 (lower dependency) residents. Perhaps the most striking finding to emerge from this mode of presentation for the residential care profiles is one of remarkable similarity, with few age-based distinctions between the lower and higher dependency categories in each of the residential settings. The sex ratios, too, are quite similar, although women predominate to a slightly more marked extent in the higher dependency categories for both nursing homes and hostels.

For all groups, women constituted the majority of clients, ranging from 65% of community options clients to 76% of Personal Care hostel residents. Hostel and nursing home residents were clearly older than community care clients, with the vast majority aged 80 and over (72% of hostel residents and 68% of nursing home residents), and a sizeable number being 90 or over (19% and 22% respectively). For care package clients, the proportions aged 80 and over were lower (59%), while only 40% of HACC and 37% of community options clients fell into this category. These differences are partly associated with the target groups: both HACC and community options programs are aimed at younger people with disabilities as well as at the aged. However, the comparatively small proportions in the 90 and over age groups in the community care sector suggest that home-based care is much less frequently an option for these age groups, a salient point given the progressive increases in the numbers and proportion of older people reaching these more advanced ages.

Indigenous peoples

Indigenous and non-Indigenous Australians vary in their use of aged care services (Figure 8.3).²² Overall, Indigenous people comprised 3% of HACC clients, 4% of care package clients, 6% of community options clients, 1% of hostel residents, 1% of nursing home residents, and an estimated 1.7% of the Australian population. Indigenous clients thus appear to make more use of community-based than residential care services, a finding which is in keeping with reported preferences of Indigenous people to remain on the land and with their families in old age (Woenne-Green 1995).

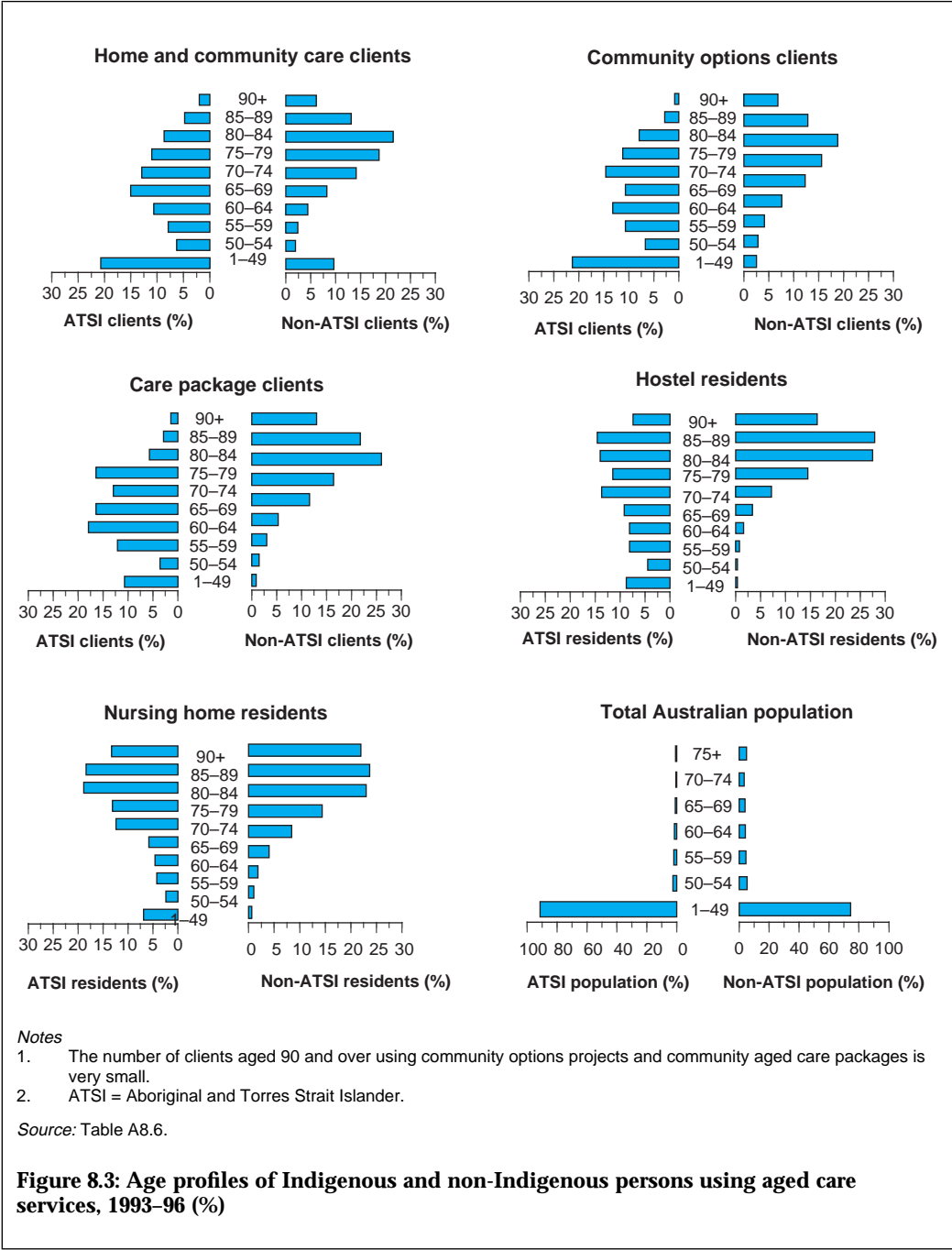
Table 8.23: Persons using aged care services, by sex and age group, 1993–96 (%)

Sex and age group	Community care clients			Hostel residents (1996)			Nursing home residents (1996)		
	HACC (1993–94)	Community options (1994)	Care packages (1996)	Hostel care	Personal care	Total	RCI 3–5	RCI 1–2	Total
Males									
1–54	4.8	9.2	0.9	0.6	0.5	0.5	0.9	1.1	1.0
55–64	2.6	3.0	2.4	1.4	1.3	1.4	1.8	1.2	1.5
65–69	2.9	3.2	2.2	1.6	1.7	1.7	2.4	1.6	2.1
70–79	9.6	8.5	8.6	8.0	6.0	6.6	9.7	8.1	8.9
80–89	9.6	9.6	13.7	14.1	10.7	11.6	12.0	11.1	11.6
90+	1.6	1.3	3.1	4.2	3.4	3.6	3.6	3.0	3.3
<i>Total males (all ages)</i>	<i>31.2</i>	<i>34.7</i>	<i>30.9</i>	<i>29.8</i>	<i>23.7</i>	<i>25.4</i>	<i>30.4</i>	<i>26.2</i>	<i>28.4</i>
Females									
1–54	7.1	10.5	1.0	0.4	0.5	0.5	0.8	1.0	0.9
55–64	4.4	5.0	3.1	0.9	1.2	1.1	1.5	1.4	1.5
65–69	5.5	4.7	3.5	1.5	1.9	1.8	2.3	1.8	2.1
70–79	22.8	19.3	19.5	13.9	14.2	14.1	14.2	13.7	14.0
80–89	24.5	20.7	32.6	41.3	41.5	41.5	33.6	35.3	34.4
90+	4.4	5.2	9.5	12.2	16.9	15.6	17.2	20.6	18.8
<i>Total females (all ages)</i>	<i>68.8</i>	<i>65.3</i>	<i>69.1</i>	<i>70.2</i>	<i>76.3</i>	<i>74.6</i>	<i>69.6</i>	<i>73.8</i>	<i>71.6</i>
Persons									
1–54	12.0	19.7	1.9	0.9	1.0	1.0	1.7	2.1	1.9
55–64	7.1	7.9	5.5	2.3	2.6	2.5	3.3	2.6	3.0
65–69	8.4	7.9	5.7	3.1	3.6	3.5	4.7	3.5	4.2
70–79	32.5	27.8	28.1	21.9	20.2	20.7	23.9	21.8	22.9
80–89	34.1	30.3	46.3	55.4	52.2	53.1	45.6	46.4	46.0
90+	6.0	6.4	12.6	16.4	20.4	19.3	20.8	23.5	22.1
Total (N)	41,643	6,033	3,766	15,871	42,306	58,177	37,598	33,369	70,967

Sources: AIHW analysis of the DHFS ACCSIS system 1997, DHFS 1994 Community Options Project Client Characteristics Census, and DHFS 1993–94 HACC User Characteristics Survey; Mathur et al. 1997:21.

22 The item indicating whether residents are of Aboriginal or Torres Strait Islander origin is not a mandatory field in the residential care databases, and hence the extent of missing data is quite high (e.g. 50% for Personal Care hostel residents). In contrast, the level of missing data in community care databases is very low. Missing data were excluded from these analyses.

This pattern is, however, substantially affected by age profiles. As was observed earlier, higher usage of residential care occurs at very advanced ages, and the shorter life span of Indigenous Australians could in its own right be expected to be associated with a lower relative use of residential as opposed to home-based care. On the other hand, it is



also the case that the shorter average life span of Indigenous peoples (by some 15–20 years) is associated with the use of aged care services at younger ages than for non-Indigenous peoples. The very different age profiles of Indigenous and non-Indigenous peoples are thus likely to be a confounding factor in comparing patterns of service use between the two population groups. Like non-Indigenous people, there was a markedly higher proportion of very old Indigenous people in residential care than there was among community care clients. For example, where 13% of Indigenous nursing home residents were aged 90 or over, only 1% of community options clients fell into this age group (Table A8.6).

When age-specific service usage rates are calculated for Indigenous and non-Indigenous peoples, some interesting findings emerge (Table 8.24). These rates control for the very different age profiles of the two population groups, and allow a more accurate comparison of usage patterns. Within any given age group, and for all service types, Indigenous Australians were at least twice as likely as non-Indigenous Australians to be service recipients. Among those aged 75 and over, for example, 169 in every 1,000 Indigenous people were resident in a nursing home in contrast to 53 per 1,000 for non-Indigenous people. The strong preference for home-based rather than residential care remains evident, with the emphasis much more marked among Indigenous than non-Indigenous Australians. For Indigenous people aged 75 and over, however, the usage rate for nursing homes (169 per 1,000) was higher than that for HACC services (112 per 1,000), or indeed for HACC and community options combined (145 per 1,000).

Table 8.24: Rates of usage of aged care services by Indigenous and non-Indigenous Australians, by age group, 1994

Aged care services	Number of Indigenous residents/ clients per 1,000 Indigenous persons in the population					Number of non-Indigenous residents/ clients per 1,000 non-Indigenous persons in the population				
	1–49	50–64	65–74	75+	All ages	1–49	50–64	65–74	75+	All ages
HACC clients	0.8	13.7	53.6	111.6	3.4	0.3	1.3	6.4	25.7	2.1
Community options clients	0.3	5.8	16.9	33.3	1.2	0.1	0.2	0.9	3.7	0.3
Hostel residents	0.1	3.5	14.1	69.2	1.1	0.0	0.2	1.8	22.6	1.2
Nursing home residents	0.2	2.9	22.1	169.2	2.1	0.1	0.8	6.4	52.8	3.1

Sources: AIHW analysis of the DHFS 1993–94 HACC User Characteristics Survey; Jenkins 1996:33, 36; Mathur et al. 1997:30; ABS unpublished data.

The picture which emerges from the comparison of these age-specific usage rates is thus somewhat different from that which emerges when the two populations of service users are compared in totality. The former pointed to quite substantial levels of use by Indigenous Australians of both residential and home-based care, whereas the latter suggested relatively low rates of use of residential care in contrast to non-Indigenous Australians, and a relatively higher use of home-based care services.

People from a non-English-speaking background

The age profiles of clients and users of aged care services who are from a non-English-speaking background were generally similar to those of users from an English-speaking

background (Table 8.25).²³ Nursing home and hostel residents from an English-speaking background tended to be somewhat older, however—for example, among residents from an English-speaking background there was a greater proportion aged 90 and over (23% and 18%, respectively) than there was among those from a non-English-speaking background (16% and 13%, respectively). There was also a higher proportion of people aged 90 and over among HACC, community options and care package clients from an English-speaking background than was the case for clients from a non-English-speaking background. In addition, for community options clients, there were comparatively few people from a non-English-speaking background (7%) in the youngest age category (i.e. aged under 54), compared with those from an English-speaking background (23%).

Table 8.25: Use of aged care services by persons from English-speaking and non-English-speaking backgrounds, by age group, 1993–96 (%)

Age group	Community care clients			Hostel residents (1996)			Nursing home residents (1996)		
	HACC (1993–94)	Community options (1994)	Care packages (1996)	Hostel care	Personal care	Total	RCI 3–5	RCI 1–2	Total
Non-English-speaking background									
1–54	8.2	7.4	0.6	1.0	1.0	1.0	1.1	1.7	1.4
55–64	9.1	7.4	6.9	2.9	2.8	2.9	3.5	3.4	3.5
65–69	12.7	10.4	7.4	4.3	4.2	4.2	5.4	5.3	5.3
70–79	36.5	36.2	32.9	29.5	26.5	27.3	29.3	26.3	27.8
80–89	29.6	34.6	42.8	52.5	51.9	52.1	44.5	47.5	46.0
90+	3.9	4.0	9.5	9.8	13.6	12.6	16.3	15.8	16.0
All ages (N)	4,842	1,149	828	926	2,658	3,584	3,256	3,203	6,459
English-speaking background									
1–54	12.6	22.7	2.2	0.8	0.9	0.9	1.7	2.2	1.9
55–64	6.7	8.0	5.1	2.2	2.4	2.3	3.3	2.6	3.0
65–69	7.7	7.2	5.4	3.0	3.5	3.3	4.7	3.3	4.0
70–79	31.9	25.8	26.7	21.7	20.2	20.6	23.4	21.3	22.4
80–89	34.9	29.3	47.2	56.8	54.0	54.7	45.7	46.3	46.0
90+	6.3	7.0	13.5	15.4	19.0	18.1	21.2	24.4	22.7
All ages (N)	34,377	4,944	2,898	10,833	30,882	41,715	34,177	30,044	64,221

Note: An individual is defined as being from an English-speaking background if they were born in Australia (including Christmas Island and Cocos Island), Canada, Ireland, United Kingdom, New Zealand, United States of America or South Africa.

Sources: AIHW analysis of the DHFS ACCSIS system 1997, DHFS 1996 Community Aged Care Packages Client Characteristics Survey, DHFS 1994 Community Options Project Client Characteristics Census and DHFS 1993–94 HACC User Characteristics Survey.

²³ An individual is defined as being from an English-speaking background if they were born in Australia (including Christmas Island and Cocos Island), Canada, Ireland, United Kingdom, New Zealand, United States of America or South Africa.

Pension status

The increased emphasis under the National Aged Care Strategy on means testing and user contributions with regard to residential aged care services renders information on pension status of some policy significance. In the absence of detailed data on income and assets, pension status provides the best available indication of financial status.

Table 8.26 presents data on persons admitted to hostels and nursing homes during the 1995–96 financial year.²⁴ While the focus on admissions (or persons admitted within a specified time period) is of particular relevance to the payment of entry contributions, it also provides a useful basis from which to examine the likely future profile of residents with regard to the ongoing payment of fees. In addition, it has the advantage of substantially reducing the proportion of residents for whom pension data are missing from the database.

Table 8.26: Pension status of permanent residents admitted to hostels and nursing homes in 1995–96, by sex (%)

Sex and pension status	Hostels				Nursing homes			
	65–69	70–79	80+	Total aged	65–69	70–79	80+	Total aged
Males								
Receives pension	85.9	85.0	83.2	83.9	93.2	93.6	92.0	92.6
Does not receive pension	0.0	0.0	0.0	0.0	4.7	4.4	5.9	5.3
Missing data	14.1	15.0	16.8	16.1	2.1	2.1	2.1	2.1
<i>Total males (N)</i>	<i>355</i>	<i>1,605</i>	<i>3,349</i>	<i>5,309</i>	<i>746</i>	<i>3,516</i>	<i>6,713</i>	<i>10,975</i>
Females								
Receives pension	87.7	85.5	84.7	85.0	92.2	93.0	92.9	92.9
Does not receive pension	0.0	0.0	0.0	0.0	5.9	4.9	5.1	5.1
Missing data	12.3	14.5	15.3	15.0	2.0	2.1	2.0	2.0
<i>Total females (N)</i>	<i>390</i>	<i>3,187</i>	<i>9,769</i>	<i>13,346</i>	<i>614</i>	<i>4,253</i>	<i>14,600</i>	<i>19,467</i>
Persons								
Receives pension	86.8	85.4	84.3	84.7	92.7	93.2	92.7	92.8
Does not receive pension	0.0	0.0	0.0	0.0	5.2	4.7	5.3	5.2
Missing data	13.2	14.6	15.7	15.3	2.1	2.1	2.0	2.0
Total (N)	745	4,792	13,118	18,655	1,360	7,769	21,313	30,442

Note: Multiple admissions are excluded from this analysis by selecting the most recent admission in 1995–96 for each resident.

Source: AIHW analysis of the DHFS ACCSIS system 1997.

²⁴ No data on pension status were collected in the 1996 Community Aged Care Packages Client Characteristics Survey. For HACC and community options, the available pensions data are for 1993 and 1994, respectively, making them somewhat outdated.

Overall, 85% of people aged 65 and over admitted to hostels in 1995–96 were receiving either a full or part pension, while in nursing homes the corresponding figure was 93%. Interestingly, there do not appear to be the expected age- or sex-related trends; that is, women were not more likely than men to be in receipt of a pension, nor were older residents more likely than younger ones to be pensioners. While the level of missing data for hostels is somewhat high (15%), it is consistent across age and sex categories. Moreover, even if the majority of those for whom no pension status data are available were assumed to be non-pensioners, the general conclusion from the table remains unequivocal—the vast majority of people admitted to hostels or nursing homes for permanent care in 1995–96 were in receipt of a pension.

Unfortunately, the residential care databases do not indicate whether these people were receiving a full or part pension; this more finely tuned information would provide a better indication of the likely level of income and assets held by incoming nursing home and hostel residents. These breakdowns are available from the Department of Social Security and the Department of Veterans' Affairs for the population at large, but not specifically for those in hostels and nursing homes. In order to gain some indication of the likely ratio of full to part pensioners among hostel and nursing home residents, age- and sex-specific pension rates were calculated from these national data and applied to the hostel and nursing home populations (Table A8.7). These estimates suggest that, overall, over two-thirds (70%) of those admitted for permanent care in 1995–96 would be receiving a full pension. In other words, approximately two in three would have met the means and assets test which determines eligibility for the full pension.

Two differences between the estimates presented in Table A8.7 and the frequencies obtained from the national residential care databases (Table 8.26) should be noted. First, the estimates yield a somewhat lower proportion of residents in receipt of either a full or part pension than those derived from the databases (80% compared with 85% for hostels, and 81% compared with 93% for nursing homes). Second, for the estimates based on pension data, pension rates are higher among older residents and among women. These trends, although expected, were not found in the residential care databases on pension status.

Two alternative explanations for these anomalies present themselves. First, there is the question of data quality; income data are notoriously sensitive to collect, and it may simply be that the pension data recorded by nursing home and hostel staff on admission contain some inaccuracies. Alternatively, the differences may reflect real differences between the population at large and those who enter nursing homes. If older people with limited financial resources (that is, pensioners) are more likely to enter residential care than better-off older people, then one would expect to find a higher proportion of pensioners actually in residential care than would be estimated by applying age- and sex-specific pension rates calculated from the general aged population. This higher rate of entry could occur as a result of poorer health status among those on lower incomes, and thus reflect a greater need for residential care, or it could mean that those with less disposable income are not as well placed to remain in their own homes at a given dependency level, as they are less able to purchase extra assistance on the private market. If these income effects were less marked at older ages (as increasing dependency levels reduce the effect of income differences), then the

difference in age- and sex-specific patterns between the two sets of calculations would also be readily explained.

8.4 Outcomes

Outcome measures for aged care services, and indeed for all chronic care services, remain something of a vexed issue, despite the contemporary emphasis on and enthusiasm for outcome-based funding and performance appraisal. Outcome measurement lends itself more easily to acute care contexts, where desired outcomes can be clearly specified, and agreed measures employed to determine whether or not the proposed benchmark has been met. Aged care, with its varied client mix, combining a range of chronic and acute conditions, receiving varied services from the formal sectors supported by a myriad of informal sector activities, does not readily yield clearly specified outcomes. In a care context where successful management may still result in death or deterioration in health status, such measures are problematic.

Having introduced such caveats, it is still possible to report measures relevant to program achievement. In this section, indicators of appropriateness, accessibility and quality of care are reported. Appropriateness is explored by reviewing the dependency levels of clients in a range of service categories, each linked to particular levels of government expenditure. So, for example, if hostel clients were found to be on average more dependent than nursing home clients, and armed with the knowledge that hostels are allocated significantly fewer resources per resident than nursing homes, there would be some basis to suggest that care was being inappropriately allocated. To review accessibility, measures of turnover and service use discussed in the previous section are examined, as well as more specific analyses of accessibility and gross utilisation. Finally, data derived from the outcome standards appraisal process are presented for nursing homes and hostels, to allow the tracking of performance information for the residential care sector in recent years. These latter two analyses (accessibility and quality appraisal) are limited to the residential care sector, as such data are not available for the community care sector. Developments are underway, however, to improve the breadth and quality of data collected for the Home and Community Care (HACC) program (see Box 8.1).

Appropriateness of care

Data on dependency are collected on clients of all aged care services, and thus provide a useful basis from which to examine appropriateness of care across the spectrum of service provision. There are, however, significant differences in the exact nature of the items collected, which reduce the number of comparable items available for analysis (see Rickwood (1994) for further details and discussion of these measures). Nonetheless, comparisons of dependency levels among care package clients, community options clients, Personal Care hostel residents and nursing home residents can be undertaken on three common items—washing and dressing, eating, and mobility and transfers.

Figure 8.4 (and Table A8.8) illustrates that nursing home residents are markedly more dependent than all other groups. Virtually 100% of nursing home residents required at least some help with washing and dressing (90% required total help), 90% required at least some help with eating (33% total help) and 95% required at least some help with mobility and transfers (63% total help). When this population is broken down into the more dependent RCI 1–2 categories and the less dependent RCI 3–5 categories, the

Box 8.1: Recent data development activities for the HACC program

Implementing the HACC Service Standards

In 1989, after 2 years of community consultations, the national HACC Service Standards were formally agreed to and adopted by HACC officials as the basis for quality appraisal among HACC agencies. However, no method for implementing a regulatory or quality appraisal process focusing on the standards was developed. In 1994, HACC officials appointed a subcommittee, the Standards Working Group, to develop an instrument which could be used to measure agency performance against the standards. In 1996, the Australian Institute of Health and Welfare (AIHW) was asked to undertake development and refinement of the HACC Service Standards Instrument, including the completion of a pilot test.

The aim of the project was to devise a cost-effective and nationally consistent method for appraising the quality of services received by consumers of HACC services, as defined by the nationally agreed standards. The method included the collection of information from both agencies and consumers. The AIHW assumed responsibility for field testing the instrument, and examining its practicality, reliability and validity for quality appraisal purposes.

After a series of pre-tests, a national pilot was undertaken in all States and Territories excluding Tasmania. Preliminary results from the pilot are encouraging, suggesting that the instrument can be employed to gather reliable and valid information concerning performance against the HACC Service Standards. As part of the study design, several different approaches to assessment were trialled, although all used the nationally agreed Service Standards instrument. The methods trialled included self-assessment, self-assessment with verification, joint appraisal and peer review. Final results from the project are not yet available.

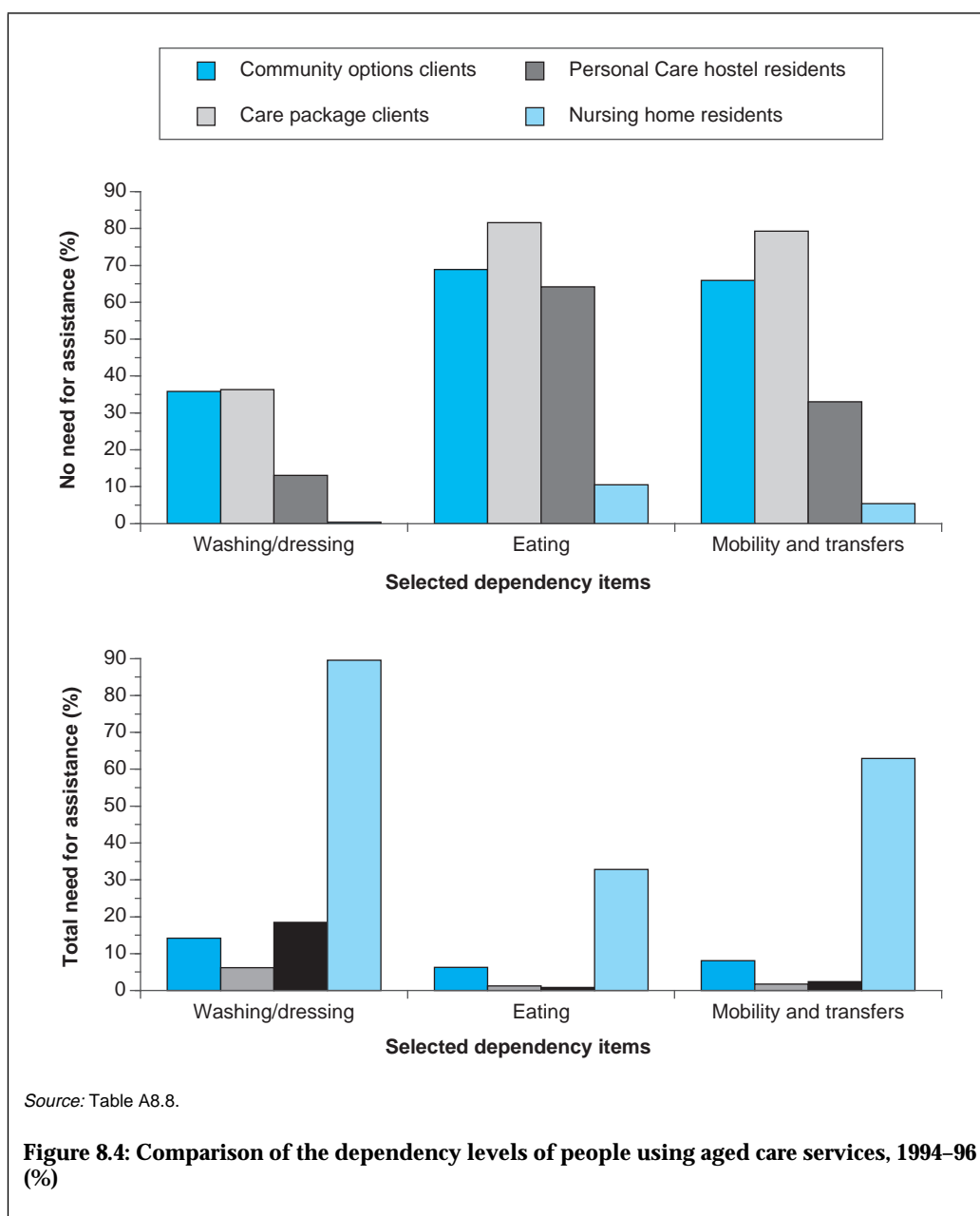
Further development of the HACC Minimum Data Set

In late 1996, the AIHW agreed to undertake under the direction of HACC officials the redevelopment of the HACC national Minimum Data Set (HACC MDS). This project builds on the National Review of HACC Data Requirements undertaken by Brian Elton & Associates.

The project comprises the following elements:

- *A review of all data items in the draft MDS and a comparison of these items with those in other relevant data collections.*
- *The pre-testing of data items.*
- *Recommendations concerning the feasibility of a unique linkage key which does not identify individuals but enables statistical linkage.*
- *A draft HACC MDS Data Dictionary.*

Work on the project commenced early in 1997 and is to be completed by December 1997.



highly dependent nature of the RCI 1–2 client group emerges very clearly—100% required total assistance with washing and dressing, 60% total assistance with eating and 90% total assistance with mobility and transfers.

The dependency levels of hostel residents were generally between those of nursing home residents and community-based clients. There was quite a substantial difference between those in the Personal Care–High dependency category and those in the Inter-

mediate and Low categories, with the Personal Care–High hostel residents being quite similar (albeit still somewhat less dependent) to nursing home RCI 3–5 residents.

On the three items for which comparisons are possible, care package and community options clients were either similar to or somewhat less dependent than hostel residents in the Personal Care–Intermediate category. The exception was the small group of community options clients who reported ‘total need’ for assistance with eating (6%) and mobility and transfers (8%), for whom the comparable group among hostel residents in the Personal Care–Intermediate category was extremely small (less than 0.4%). Community options clients were somewhat more likely to require assistance in the three areas than were care package clients.

While the validity of these findings is limited by the number of items available for comparison, the results do suggest that Personal Care hostel residents remain on average more dependent than those clients being cared for in the community by intensive home-based care services, whether these be care package or community options clients. A somewhat more detailed comparison, undertaken on five items which were common to the hostel, care package and community options data collections, revealed similar trends (Mathur et al. 1997). The expanded intensive home-based care services may thus be targeting a somewhat less dependent population than that currently cared for in a hostel context.

Accessibility

In Section 8.3, data were reported on changes in the number of permanent and respite admissions over the last 5 years, and on changes in turnover, in relation to both hostels and nursing homes. For nursing homes, respite admissions had increased threefold, but the number of permanent admissions had dropped. Turnover, which measures the number of admissions in relation to bed numbers, also declined. For hostels, while there was a similar increase in respite admissions, the number of permanent admissions also increased, and turnover among permanent residents remained essentially stable. The co-existence of these two trends (an increase in respite admissions without a corresponding drop in permanent admissions) was made possible by the significant expansion in the number of hostel places which occurred during this period.

These findings suggest that access to permanent places in hostels may have remained stable, while access to nursing home beds fell. These data do not, however, take into account the growing size of the aged population over the period. To examine changes in accessibility over time, this latter aspect also needs to be taken into account. Table 8.27 presents two further measures of access to residential care. The first, termed simply accessibility, describes the number of admissions for both permanent and respite care in relation to the total aged population with a profound or severe handicap. The second, gross utilisation, is a measure of admissions plus the number of residents already in the hostel or nursing home 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 handicap in the population, gives the gross utilisation rate.

Access to permanent places in hostels increased slightly between 1991–92 and 1995–96, from 44 to 51 admissions per 1,000 people aged 65 and over with a profound or severe handicap. Access to respite places also increased, from 41 to 56 admissions. Overall, this led to an increase in accessibility to hostels, moving from 85 admissions per 1,000 people aged 65 and over with a profound or severe handicap in 1991–92 to 107 in

Table 8.27: Accessibility and gross utilisation, hostels and nursing homes, 1991–92 to 1995–96

	Year				
	1991–92	1992–93	1993–94	1994–95	1995–96
Hostels					
Accessibility					
Permanent	44.0	46.4	47.5	51.7	50.6
Respite	41.4	45.4	49.6	53.0	56.3
All admissions	85.4	91.8	97.1	104.7	106.9
Gross utilisation	71,351	77,094	82,952	91,732	97,080
Gross utilisation rate	210.6	219.9	229.1	245.1	250.7
Nursing homes					
Accessibility					
Permanent	113.4	110.3	94.8	92.8	85.1
Respite	9.4	12.1	16.7	21.2	29.1
All admissions	122.8	122.4	111.4	114.0	114.2
Gross utilisation	111,479	113,426	115,064	115,137	116,708
Gross utilisation rate	329.1	323.5	317.8	307.6	301.3

Notes

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

Sources: AIHW analysis of the ABS 1993 Survey of Disability, Ageing and Carers and DHFS ACCSIS system 1997; ABS 1993c:28–30; ABS 1994:4–6; ABS 1995a:4–6; ABS 1996b:74, 92; ABS 1996c:5–13; ABS 1997b:15–17; AIHW 1995:216–217.

1995–96. The gross utilisation rate, which incorporates into the measure those already using hostel places, also increased (from 211 to 251).

Accessibility declined over the same period for permanent nursing home beds, from 113 admissions per 1,000 people aged 65 and over with a profound or severe handicap in 1991–92 to 85 in 1995–96. Access to respite beds increased, however, from 9 to 29 admissions. Taken together, this represents a decline in overall accessibility, from 123 to 114 admissions per 1,000 people aged 65 and over with a profound or severe handicap. The gross utilisation rate also declined, from 329 to 301. If the two forms of residential care (hostels and nursing homes) are taken together, the gross utilisation rate increased slightly over the period, moving from 540 in 1991–92 to 552 in 1995–96.

Quality of care

In 1987, outcome standards were introduced into Australian nursing homes as the basis for assessment of compliance with legislative requirements. The process was extended to hostels in 1991, with a related but different set of standards employed. The process involves visits to nursing homes and hostels by a team of standards monitors, and the subsequent tendering of a report appraising the nursing home or hostel against the relevant standards.²⁵ Until 1993–94, all nursing homes and hostels were visited on an approximately biennial cycle. At that point, a decision was taken by the Department of Health and Family Services to implement a risk management strategy, whereby only homes or hostels which were judged to be at risk were included in the inspection cycle.

Between the baseline year (1990–91 for nursing homes and 1991–92 for hostels) and the ‘end’ of the phase in which all homes were monitored (1993–94), both hostels and nursing homes showed an improvement against all standards, with a significant improvement on a number of standards (see Tables A8.9 and A8.10; and Hostel and Nursing Home Outcome Standards, page 391; for a list of the individual standards for both hostels and nursing homes). From 1993–94 to 1995–96, with the risk management strategy targeting homes and hostels which were deemed to be at risk, the scores against the outcome standards declined (as would be expected) for both hostels and nursing homes.

This decline was more pronounced for nursing homes than for hostels, and more marked with regard to certain standards than for others. For hostels, performance generally remained above the baseline measures, whereas for nursing homes the proportion meeting each standard fell below the baseline (although not substantially below) in the majority of cases. Given that the risk management strategy targets those facilities believed to be performing poorly against the standards or, due to changes in ownership or management, deemed to be potentially at risk of performing less well against the standards than previously, it is somewhat pleasing to find that ratings against the standards have not declined below the baseline year for hostels, and only to a limited extent in nursing homes. This comparison of current ratings with the baseline year is essentially a comparison of nursing homes or hostels deemed to be at risk of poor performance (the 1995–96 data) with those which happened to be visited in the earlier years. Prior to the implementation of the risk management strategy, nursing homes and hostels were visited on a strict rotational basis, with only very limited numbers targeted for a standards monitoring visit on the basis of complaints or previous poor performance. This suggests that the ‘at risk’ nursing homes and hostels are now performing in a manner approximately similar to that for the industry as a whole at the time of the implementation of the standards monitoring process.

8.5 Summary

In 1997, the Australian aged care system stands poised for the implementation of a number of substantial changes. The past decade was characterised by a re-orienting of the system, away from nursing home care and towards expanded hostel and home-based care services. The new policy directions involve substantial changes to funding arrangements, with an increased emphasis on user pays elements, including the introduction of accommodation bonds for nursing homes. There is also to be a new quality appraisal system for residential care, and an ongoing commitment to increased flexibility of provision to meet the varying and often complex needs of older people, in both rural and urban settings. This chapter has focused on the need for services and assistance, the amount and type of services being provided and the characteristics of the recipients of those services, and, where possible, the outcome of those services.

25 For further details of the standards monitoring program, see AIHW (1995:226–31) and Braithwaite et al. (1993).

Likely increases in demand

The size of the aged population continues to expand, with the population aged 65 and over projected to increase from 11% to 13% of the total Australian population between 1986 and 2006. Growth is particularly marked among the very old population—people aged 80 and over are projected to comprise 4% of the total population by 2006, compared with only 2% in 1986. The decade just past, however, has seen more rapid rates of increase in the older population than will the decade to come; rates of increase in both the 65 and over and 80 and over population are slower for the period from 1996 to 2006 than was the case for the previous decade.

Over the period 1986–96, the number of people aged 65 and over with a profound or severe handicap increased by 39%, with a projected increase from 1996 to 2006 of 30%. Among those with a profound or severe handicap living in the community, the proportion living alone increased substantially from 1981 to 1993. In general, rates of increase for older people with a profound or severe handicap were consistently higher for men than for women, for older (80+) than for younger age groups, and for the decade past than for the decade to come.

Likely need for residential care

At any one point in time, a relatively small proportion of Australians reside in hostels—in 1996 around 0.3% of the total population or 6% of the population aged 75 plus. Similarly, for nursing homes, the corresponding proportions are 0.4% and 7%. While such statistics suggest that the probability of any one individual requiring hostel or nursing home care is quite low, the likelihood of requiring residential care over a lifetime is considerably higher. At birth, the likelihood of requiring permanent care in a hostel is 0.16, although it is substantially higher for women (0.22) than for men (0.09). By age 65, the likelihood of requiring such care some time in the future is 0.20 (0.26 for women and 0.12 for men). For nursing home care, the comparable probabilities are 0.27 at birth (0.34 for women and 0.20 for men) and 0.33 at age 65 (0.39 for women and 0.25 for men). The likelihood of requiring an admission to residential care at some time in the future continues to increase with age, reaching 0.57 for women aged 85 with regard to hostel care, and 0.76 with regard to nursing home care.

Carers' need for help

While the important role played by carers has gained increasing recognition over the last decade, there has been less attention paid to the adequacy of assistance which they receive in their caring role. Overall, 42% of carers felt that they had no need for help, another 42% were receiving the help they needed, and 16% either needed help but were not receiving it, or needed more help than they were receiving. Younger carers (under 65) were more likely than older carers to report an unmet need for assistance or a met need, and less likely to report 'no need'. Older carers (65 and over) were more likely to report 'no need' for assistance and less likely to report an 'unmet' need, although these trends were less marked in the 80 and over age category.

When these categories were examined with regard to the relationship between the carer and the care recipient, it was those providing help to a parent who were most likely to report 'unmet need', and those providing help to a spouse who were most likely to report 'no need'. The higher levels of 'unmet need' among children providing assistance

to parents may be partly a cohort effect, with younger generations being more willing to request or receive formal assistance than older generations.

The changing balance of care

In 1985, there were 66.5 nursing home beds and 32.5 hostel places per 1,000 people aged 70 and over (total of 99 residential care places). By 1996, there were 49.5 nursing home beds and 41.4 hostel places per 1,000 people aged 70 and over (total of 91 residential care places), supplemented by three aged care packages per 1,000 people aged 70 and over. Taking care packages as residential care equivalents, this represents a 5% reduction in the ratio of provision for the target population over the 11 years to 1996. In addition, there has also been a shift away from the more intensive nursing home level of provision towards the less intensive hostel care system, in keeping with policy directions set by the Commonwealth Government.

For hostels, access to permanent and respite places has increased over recent years (1991–92 to 1995–96), leading to an increase in accessibility from 85 admissions per 1,000 people aged 65 and over with a profound or severe handicap in 1991–92, to 107 in 1995–96. For nursing homes, access to permanent beds has declined since 1991–92, while that for respite beds has increased. Taken together, this represents a decline in overall accessibility for nursing homes, from 123 to 114 admissions per 1,000 people aged 65 and over with a profound or severe handicap.

Appropriateness of care

Nursing home residents were markedly more dependent than all other client groups of aged care services. Virtually 100% of nursing home residents required at least some help with washing and dressing (90% required total help), 90% required at least some help with eating (33% total help), and 95% required at least some help with mobility and transfers (63% total help). The dependency levels of hostel residents were generally somewhat lower, being between those of nursing home residents and community-based clients. There was, however, quite a substantial difference between those in the Personal Care–High dependency category and those in the Intermediate and Low categories, with the Personal Care–High hostel residents being quite similar to (albeit still somewhat less dependent than) lower dependency nursing home residents.

Personal Care hostel residents remain on average more dependent than those being cared for in the community by intensive home-based care services, whether these be care package or community options clients. The expanded intensive home-based care services may thus be targeting a somewhat less dependent population than that currently cared for in a hostel context.

Quality of care

Data from the standards monitoring program in place in nursing homes and hostels were reviewed at three points in time—a baseline year (1990–91 for nursing homes and 1991–92 for hostels), the end of the phase in which all nursing homes and hostels were monitored (1993–94), and the most recent data (1995–96) after 2 years of a risk management approach to standards monitoring. Between the baseline year and 1993–94, both nursing homes and hostels showed an improvement against all standards, with a significant improvement on a number of standards. From 1993–94 to

1995–96, under the risk management strategy, the scores against the outcome standards declined (as would be expected) for both hostels and nursing homes.

For hostels, performance generally remained above the baseline measures, whereas for nursing homes the proportion meeting each standard fell below the baseline (although not substantially below) in the majority of cases. The risk management strategy targets homes or hostels believed to be performing poorly against the standards or, due to changes in ownership or management deemed to be potentially at risk of performing less well against the standards than previously. These data suggest that the ‘at risk’ homes and hostels are now performing in a manner approximately similar to that for the industry as a whole at the time of the implementation of the standards monitoring process.

References

- Australian Bureau of Statistics (ABS) 1984. Handicapped persons Australia, 1981. Cat. No. 4343.0. Canberra: AGPS.
- Australian Bureau of Statistics (ABS) 1987. Estimated resident population by sex and age: States and Territories of Australia, June 1981 to June 1987. Cat. No. 3201.0. Canberra: AGPS.
- Australian Bureau of Statistics (ABS) 1990. Disability and handicap Australia, 1988. Cat. No. 4120.0. Canberra: AGPS.
- Australian Bureau of Statistics (ABS) 1993a. Disability, ageing and carers Australia, 1993: summary of findings. Cat. No. 4430.0. Canberra: AGPS.
- Australian Bureau of Statistics (ABS) 1993b. Disability, ageing and carers Australia, 1993: users guide. Cat. No. 4431.0. Canberra: AGPS.
- Australian Bureau of Statistics (ABS) 1993c. Estimated resident population by sex and age: States and Territories of Australia, June 1987 and June 1992. Cat. No. 3201.0. Canberra: AGPS.
- Australian Bureau of Statistics (ABS) 1994. Estimated resident population by sex and age: States and Territories of Australia, preliminary June 1992 and June 1993. Cat. No. 3201.0. Canberra: AGPS.
- Australian Bureau of Statistics (ABS) 1995a. Estimated resident population by sex and age: States and Territories of Australia, June 1993 and preliminary June 1994. Cat. No. 3201.0. Canberra: AGPS.
- Australian Bureau of Statistics (ABS) 1995b. Focus on families. Caring in families: support for persons who are older or have disabilities. Cat. No. 4423.0. Canberra: AGPS.
- Australian Bureau of Statistics (ABS) 1996a. Australian demographic statistics, June quarter 1996. Cat. No. 3101.0. Canberra: AGPS.
- Australian Bureau of Statistics (ABS) 1996b. Australian national accounts: national income, expenditure and product. Cat. No. 5206.0. Canberra: AGPS.
- Australian Bureau of Statistics (ABS) 1996c. Estimated resident population by sex and age: States and Territories of Australia, June 1994 and preliminary June 1995. Cat. No. 3201.0. Canberra: AGPS.
- Australian Bureau of Statistics (ABS) 1997a. Deaths in Australia. Cat. No. 3302.0. Canberra: AGPS.
- Australian Bureau of Statistics (ABS) 1997b. Estimated resident population by sex and age: States and Territories of Australia, June 1995 and preliminary June 1996. Cat. No. 3201.0. Canberra: AGPS.
- Australian Institute of Health and Welfare (AIHW) 1993. Australia's welfare 1993: services and assistance. Canberra: AGPS.
- Australian Institute of Health and Welfare (AIHW) 1995. Australia's welfare 1995: services and assistance. Canberra: AGPS.

- Braithwaite J, Makkai T, Braithwaite V & Gibson D 1993. Raising the standard: resident centred nursing home regulation in Australia. Aged and Community Care Service Development and Evaluation Reports No. 10. Canberra: AGPS.
- Commonwealth/State Working Party 1987. Living in a nursing home. Canberra: AGPS.
- Department of Health and Family Services (DHFS) 1996a. Annual report 1995–96. Canberra: DHFS.
- Department of Health and Family Services (DHFS) 1996b. National action plan for dementia care: mid plan report. Aged and Community Care Service Development and Evaluation Reports (DHFS). Canberra: AGPS.
- Department of Health and Family Services (DHFS) 1996c. The respite review report. Canberra: AGPS.
- Department of Health and Family Services (DHFS) 1997. Community care statistics 1995–96. Canberra: DHFS.
- Department of Health, Housing and Community Services (DHHCS) 1991. Aged care reform strategy, mid-term review 1990–91 report. Canberra: AGPS.
- Department of Health, Housing, Local Government and Community Services (DHHLGCS) 1990. Keeping the quality in hostel life. Canberra: DHHLGCS.
- Department of Health, Housing, Local Government and Community Services (DHHLGCS) 1993. Annual report statistical supplement 1992–93. Canberra: DHHLGCS.
- Department of Human Services and Health (DHS) 1995a. Annual report 1994–95. Canberra: DHS.
- Department of Human Services and Health (DHS) 1995b. Community care statistics 1994–95. Canberra: DHS.
- Doyle L & Gough I 1991. A theory of human need. London: Macmillan.
- Duckett S 1995. Keynote address to the Aged Care Australia 8th national conference, Canberra, 9 November. Canberra: Office of the Secretary, Department of Human Services and Health (Mimeo).
- Gibson D 1997. Aged care: old policies, new problems. Cambridge: Cambridge University Press (forthcoming).
- Gibson D & Allen J 1993. Parasitism and phallogocentrism in social provisions for the aged. *Policy Sciences* 26:79–98.
- Gibson D, Butkus E, Jenkins A, Mathur S & Liu Z 1996. The respite care needs of Australians: respite review supporting paper 1. Canberra: AIHW (Aged Care Series No. 3).
- Jenkins A 1996. Client profiles for aged care services in Australia. Canberra: AIHW (Welfare Division Working Paper No. 11).
- Liu Z 1996. Length of stay in Australian nursing homes. Canberra: AIHW (Aged Care Series No. 1).
- Mathers C 1996. Trends in health expectancies in Australia 1981–1993. *Journal of the Australian Population Association* 13(1):1–16.

Mathur S 1996. Aged care services in Australia's States and Territories. Canberra: AIHW (Aged Care Series No. 2).

Mathur S, Evans A & Gibson D 1997. Community aged care packages—how do they compare? Aged and Community Care Service Development and Evaluation Reports (DHFS). Canberra: AGPS.

Rickwood D 1994. Dependency in the aged: measurement and client profiles for aged care. Canberra: AIHW (Welfare Division Working Paper No. 5).

Rosewarne R, Opie J, Bruce A, Doyle C, Ward S & Sach J 1997. Care needs of people with dementia and challenging behaviour living in residential facilities. Aged and Community Care Service Development and Evaluation Reports Nos 24–31. Canberra: AGPS.

Teshuva K, Stanislavsky Y & Kendig H 1994. Towards healthy ageing: literature review. Melbourne: Collins Dove.

Wen X, Madden R, Black K 1995. Population indicators of needs for disability services: an exploration. Canberra: AIHW (Welfare Division Working Paper No. 9).

Widdowson J 1996. Explaining disability trends. Paper presented at Australian Population Association conference, Adelaide, 3–6 December.

Woenne-Green S 1995. They might have to drag me like a bullock: the Tjilpi Pampa Tjutaka project. Alice Springs: Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council Aboriginal Corporation.

