

6 Aged care

6.1 Introduction

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

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

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 concerned with healthy ageing, hospital care, medical care, pharmaceuticals and housing are not included. Moreover, although it is common to view aged care only in terms of programs aimed specifically at older people, it must be remembered that older people are also eligible for, and make use of, various benefits and services that are available to the general population.

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

6.2 The need for care

Age, sex and dependency

Traditionally, chronological age is the most commonly used predictor of the need for assistance among older people. The proportion of people aged 65 and over has, for example, always been a key component of the labour force dependency ratio, one of the calculations commonly undertaken by economists to test the economic viability of different societies at different times.¹ In analysing income security, the proportion of the

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

population aged 65 and over is a useful indicator of likely need for assistance. For analysts whose primary concern is aged care services, however, the population aged 75 and over, and indeed aged 85 and over, is a better guide, as rates of use of aged care services, particularly residential aged care, rise steeply at more advanced ages. The usefulness of age-based data is further increased if the data are classified by sex: women are not only more likely than males to survive to more advanced ages, they are also more likely to be poor, have a disability and be living in residential care (Gibson 1998:chs 4, 7).

As at 30 June 2000, the Australian Bureau of Statistics (ABS) estimated that there were 2.4 million people aged 65 years and over in Australia; this represents 12.3% of the total population. Of people aged 65 and over, 55% were aged 65–74 years, 34% were aged 75–84, and 11% were aged 85 and over. Thus, while over half of all older people are aged between 65 and 74, there is a significant minority (over a quarter of a million people) who are aged 85 and over. Fifty-six per cent of older people (65+) are women; this predominance becomes progressively more evident in the older age categories. In the 65–74 age group, the proportions of men and women are almost equal; by age 85 and over, however, there are over twice as many women as men. In absolute numbers, there are 283,300 more women than men aged 65 and over in Australia (Table 6.1). The numerical predominance of women is declining slowly as the life expectancy of older males increases relative to that of older females. In 1994, the sex ratio was 0.76, but by 2000 it was 0.79.

Table 6.1: Persons aged 65 years and over, by sex and age group, 30 June 2000

Sex	65–74 years		75–84 years		85 years and over		Total aged population	
	N	%	N	%	N	%	N	%
Males	624,000	26.4	336,100	14.2	78,400	3.3	1,038,500	44.0
Females	675,300	28.6	472,600	20.0	173,800	7.4	1,321,800	56.0
Persons	1,299,300	55.0	808,700	34.3	252,200	10.7	2,360,200	100.0

Source: ABS 2000a.

While age and sex combine to provide a useful indicator of the level of need for aged care services, direct measures of dependency are also useful. The surveys of disability, ageing and carers conducted by the ABS provide direct information about dependency levels in the older population, as reported by older people themselves. The most recent data are drawn from the 1998 Disability, Ageing and Carers Survey, the fourth since 1981.

The severe or profound core activity restriction categories are the most appropriate measures of need for assistance in relation to aged care services, since they describe people who are unable to perform a core activity or who always need assistance in doing so (profound core activity restriction), and people who sometimes need assistance (severe core activity restriction). Core activities are self-care (bathing, showering, dressing, eating, using the toilet and managing incontinence), mobility

(moving around at home and away from home, getting into or out of a bed or chair, and using public transport) and communication (understanding and being understood by others, including strangers, family and friends).

Among older people, the rates of severe or profound core activity restriction are quite low until age 75. For those aged 65–69 years, for example, in 1998 only 8% of men and 9% of women were so affected. The rates rise quite markedly with age, however, so that, by ages 75–79, 19% of men and 25% of women reported such a restriction, while at ages 80–84 the rates had risen to 24% and 36% respectively. By age 85 and over, more than half the population reported a severe or profound core activity restriction. At these advanced ages, the degree of difference between the sexes lessens somewhat, although the rates reported by women (69%) are still substantially higher than those reported by men (56%) (AIHW 1999a:169).

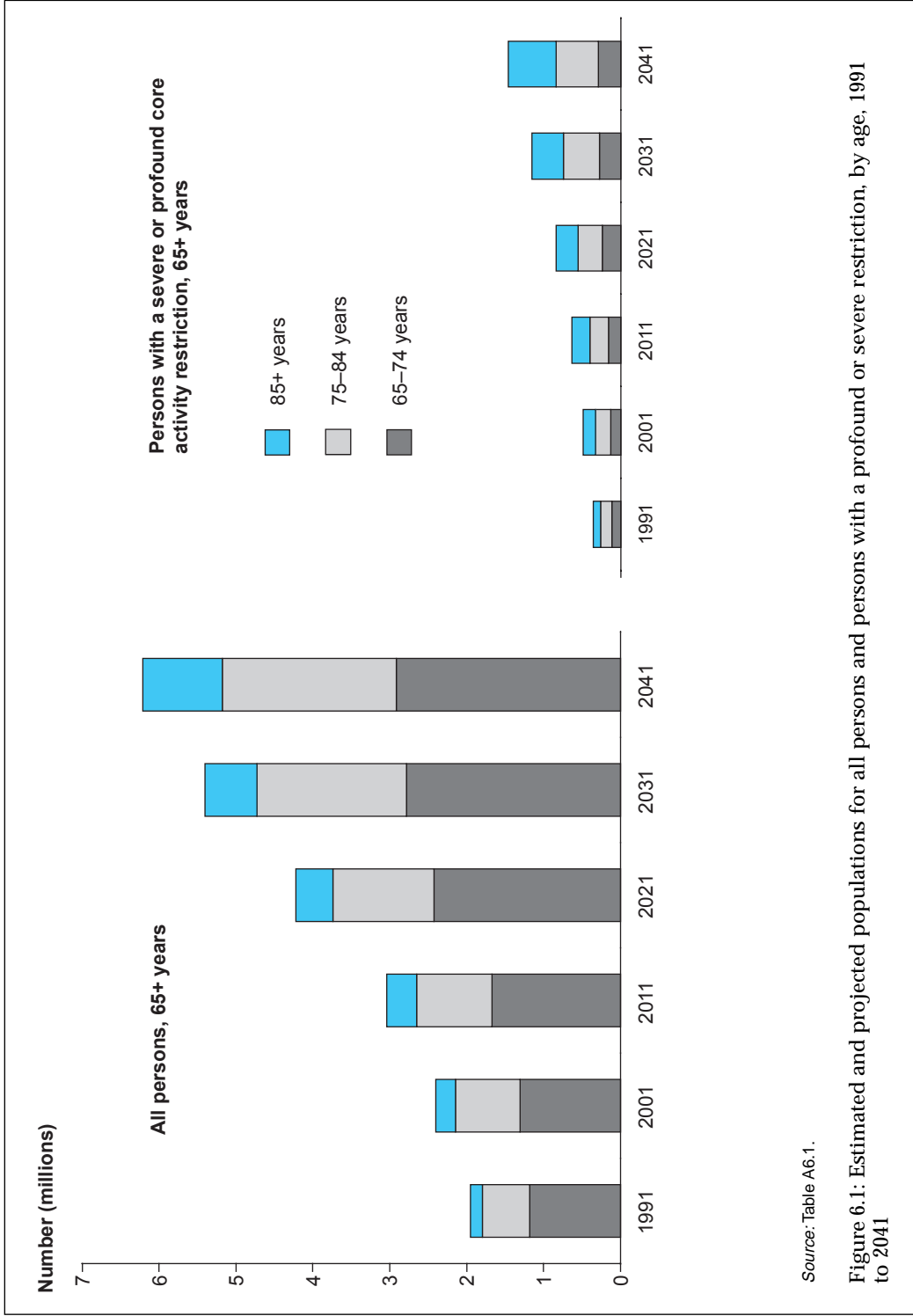
While rates of severe or profound restriction increase at older ages, the majority of people with such restrictions continue to live in the community, rather than in an institutional setting. Among people with a severe or profound restriction, 84% of 65–79 year olds and 55% of those aged 80 and over lived in the community, with the remainder living in some form of institutional care (AIHW 1999a:171).

The future

In 1991, the Australian population aged 65 and over numbered 2.0 million (11% of the total population), in 2001 it was 2.4 million (12%), and the ABS estimates that it will reach 3.0 million by 2011 (14%). Within the older population, the number of people aged 85 and over is projected to expand rapidly over this period: from 154,000 in 1991 to 260,000 in 2001, and to 389,000 in 2011 (Figure 6.1 and Table A6.1). Between 1991 and 2001, the population aged 85 and over grew by 69%, compared to 10% for the population aged 65–74. Between 2001 and 2011, the comparable figures are projected to be 49% and 28%. From 2011 to 2021, however, this pattern reverses, as the baby-boom generation begins to enter old age. Over this decade, the 85 and over population is projected to increase by only 23%, and the 65–75 year old population by 46%.

While these increases are large, it is important to recognise that the numbers of older people who are likely to require a substantial amount of assistance (i.e. those with a severe or profound core activity restriction in ABS terms) are considerably more modest. Using standard age- and sex-specific activity restriction rates derived from the 1998 ABS survey, among the 2.0 million people aged 65 and over living in Australia in 1991, there would have been around 385,000 older Australians with a severe or profound core activity restriction (some 20% of the older population). By 2001, this figure would be 526,000 (22% of the older population) and by 2011, 682,000 (22% of the older population). As is evident from Figure 6.1, the number of people aged 65 and over who are likely to be in need of some assistance (i.e. those with a severe or profound core activity restriction) is of a substantially lesser magnitude than the entire population aged 65 and over.

Another noteworthy feature in Figure 6.1 is the projected increase in the proportion of older people with a severe or profound core activity restriction who are aged 85 and over. In 1991 this proportion was 26%. In 2001 it was 32%. In 2011 it is projected to be 37%.



Source: Table A6.1.

Figure 6.1: Estimated and projected populations for all persons and persons with a profound or severe restriction, by age, 1991 to 2041

Calculations such as these are based on a constant age- and sex-specific activity restriction rate and allow the changing structure of the aged population together with increases in absolute numbers to determine changing patterns over time.² This is a straightforward and easily grasped basis from which to examine past trends and explore future projections. However, such a strategy assumes a constant rate of disability in the older population, an assumption which has been the subject of considerable debate in the international and national literature in recent years.

The background to the debate was an apparent trend towards increasing disability associated with population ageing, reported largely by researchers in the United States in the early 1980s, and based on data from the 1970s (Colvez & Blanchet 1981; Verbrugge 1984; Verbrugge et al. 1989). More recently, however, some international commentators have argued that there is evidence emerging of a decline in disability rates at older ages (Cambois et al. 1999; Waidmann & Liu 2000; Waidmann & Manton 1998). Findings did vary, however, according to country. No evidence of a decline in disability rates was reported for Australia, the United Kingdom and the Netherlands. Mixed findings (i.e. declines in some age or sex categories but not others) were reported for Canada and Sweden. Declines in disability were reported for the United States, Germany, France and Japan, among others.

Researchers from the United States have been the most vigorous exponents of the decline in disability hypothesis (Crimmins et al. 1997; Manton et al. 1993, 1997; Waidmann & Liu 2000). The reported decline, however, is concentrated in lower levels of disability, with no evidence of a decline among those with more severe personal care type disability (Schoeni et al. 2001).

The categorisation of Australia as showing no evidence of a decline in these reports may have been somewhat misleading, as available evidence to date has suggested at least the possibility of an increase in disability rates. The ABS has recently released a paper which undertakes a detailed exploration of the observed increase in the proportion of the Australian population with a severe restriction, and with a disability, over the period from 1988 to 1998 (ABS: Davis et al. 2001). Much of this observed increase occurred among younger population age groups, and some of the observed effect can be explained by changes in the population structure (particularly population ageing).³

Table 6.2 presents disability and severe restriction rates for older people, derived from the 1988, 1993 and 1998 surveys but standardised for age structure and adjusted (as far as is possible) for variations in the survey methodology. Of particular interest here is the observed increase with regard to severe restriction.⁴ The increase is evident for men

2 Calculations are undertaken using the rates of severe or profound core activity restriction for each 5-year age group for males and females, based on the 1998 ABS Survey of Disability, Ageing and Carers.

3 See Section 7.2 for a discussion of these trends in relation to younger people with a disability.

4 The severe restriction activity combines the severe and profound restriction (or severe and profound handicap in earlier surveys) categories. A number of adjustments are made to maximise comparability among the three surveys.

aged 75–79, and 85 and over. For the 65 and over population as a whole, once the data has been age standardised, the proportion with a severe restriction varies only marginally: from 18.4% in 1988, to 17.5% in 1993, to 19.6% in 1998. The question of interest for policy purposes is whether the increases which are observed represent a real increase in severe restriction, or whether they are a result of changes in the methodology. While the data presented in Table 6.2 have been adjusted where possible to standardise across the surveys, some methodological differences remain (see ABS: Davis et al. 2001 for a discussion of these differences). Of interest in the older population is the inclusion of more specific questions about stroke and dementia, which appear to have led to improved capture related to these diseases. Increasing numbers of very old people in the oldest age group may have contributed to an actual increase in prevalence in this group, and it is also thought that there may have been an actual increase of prevalence among men aged 75–79. The authors estimate that about half the reported increase is due to changes in prevalence in these two groups, and about half to changes in survey design (ABS: Davis et al. 2001:38).

The Australian evidence, then, suggests a relatively stable picture of severe restriction rates in the older population, with some possibility that increases may have occurred among males aged 75–79, and those aged 85 and over. Internationally, the evidence is somewhat mixed; the topic continues to be an area of active debate.

Table 6.2: Persons aged 65 and over with a severe restriction or disability, 1988, 1993 and 1998 (per cent)

	Males			Females			Persons		
	1988	1993	1998	1988	1993	1998	1988	1993	1998
Severe restriction									
65–69	7.5	5.9	7.2	7.9	7.7	8.2	7.7	6.8	7.7
70–74	10.2	8.5	9.8	12.3	13.7	12.7	11.3	11.3	11.4
75–79	10.8	11.7	17.8	20.5	18.2	22.6	16.4	15.4	20.5
80–84	25.7	22.8	22.3	31.9	33.9	34.3	29.5	29.7	29.8
85+	38.6	48.1	53.0	69.6	58.1	67.6	60.1	55.1	63.1
<i>Total 65+</i>	<i>13.1</i>	<i>12.6</i>	<i>14.9</i>	<i>22.6</i>	<i>21.3</i>	<i>23.3</i>	<i>18.4</i>	<i>17.5</i>	<i>19.6</i>
Disability									
65–69	47.3	44.0	45.4	35.9	35.2	35.9	41.3	39.5	40.5
70–74	50.8	58.3	55.2	45.9	48.6	45.1	48.1	53.1	49.8
75–79	53.0	59.6	65.1	54.1	53.7	55.9	53.6	56.2	59.8
80–84	67.8	73.2	66.9	66.9	61.5	67.2	67.2	65.9	67.0
85+	76.3	81.0	86.4	85.4	79.5	82.5	82.9	80.0	83.7
<i>Total 65+</i>	<i>53.7</i>	<i>57.0</i>	<i>57.3</i>	<i>52.7</i>	<i>51.6</i>	<i>52.5</i>	<i>53.1</i>	<i>54.0</i>	<i>54.6</i>

Note: Only criteria common to the three ABS disability surveys have been used to derive the data for comparative purposes. Age standardised to the 1998 benchmark population for the Survey of Disability, Ageing and Carers.

Source: ABS: Davis et al. 2001.

Dementia

One of the particular concerns associated with the ageing of the aged population is the increase in the number and proportion of the older population with dementia, and the associated need for both home-based and residential care. In 1998, Henderson and Jorm

produced estimates of the number of dementia cases in Australia, based on an earlier meta-analysis of prevalence rates undertaken by Jorm et al. (1987).⁵ On the basis of those prevalence rates, it is possible to estimate the number of people with dementia in Australia. The prevalence rates ranged from 1.4% at ages 65–69, to 5.6% at ages 75–79, and to 23.6% for those aged 85 and over. In 2000, there were an estimated 146,800 persons aged 65 and over with dementia, a number which is projected to increase to 191,100 in 2010 and to 242,600 in 2020.

Dementia among residents of aged care homes

Although there is no measure of dementia per se in the national residential aged care database, there are indicators of behaviours which are associated with a diagnosis of dementia. Those indicators are constituent elements of the Resident Classification Scale. In 2000, 33% of residents had extensive difficulty with understanding and undertaking living activities. This question alludes to remembering, planning and performing general living tasks. Other behaviours in which residents were rated as requiring extensive monitoring included being verbally disruptive or noisy (25%), problem wandering or intrusive behaviour (17%), and physically aggressive behaviour (12%).

The need for informal care

While government-funded aged care services are an important source of assistance to frail and disabled older people, it has been widely recognised that informal carers, predominantly family members, provide a large proportion of needed assistance.

According to the 1998 ABS Survey of Disability, Ageing and Carers, there were 125,300 primary carers providing help to persons aged 65 and over (Table 6.3). Two-thirds were women (67%), and the majority of carers of older people were themselves over 65 (58%). Older women were almost equally likely to be receiving care from older males (42%) or from women aged 25–64 (41%). This pattern differed by age. Women aged 65–74 were most likely to be cared for by an older male (58%), while women aged 75 and older were most likely to be cared for by a female carer aged 25–64 (51%), although older male carers also remained important in this age group (35%). Older men were most likely to be receiving help from older women (71%), followed by women aged 25–64 (22%). This pattern was consistent for both groups of older men, although the predominance of older female carers was more marked among men aged 75 and over (81%) than among men aged 65–74 (59%). This somewhat larger proportion of younger (aged 25–64) female carers for males aged 65–74 is presumably due to the tendency of males to marry younger women, with the 25–64 age category including spouse carers as well as daughters (and daughters in law) for males aged 65–74 (most same-age carers are spouses or partners) (see AIHW 1999a:174–5).

5 These prevalence rates were very similar to those derived from a meta-analysis undertaken by Hofman et al. in 1991, and higher than those derived by Ritchie et al. in 1992 (Henderson & Jorm 1998).

Table 6.3: Primary carer of persons aged 65 years or over, by age and sex of the carer and care recipient, 1998

	Male carer		Female carer		All carers	
	25-64	65+	25-64	65+	25-64	65+
Number						
Female care recipient						
65-74	*3,700	11,800	*3,800	**800	*7,600	12,600
75+	*4,600	17,400	25,100	**2,500	29,700	19,900
<i>Total females</i>	*8,300	29,200	28,900	*3,300	37,200	32,500
Male care recipient						
65-74	**1,200	**0	8,900	14,700	10,100	14,700
75+	*2,600	**0	*3,300	24,900	*5,900	24,900
<i>Total males</i>	*3,800	**0	12,200	39,600	16,000	39,600
Total	12,200	29,200	41,100	42,900	53,200	72,100
Per cent						
Female care recipient						
65-74	*18.5	58.4	*18.9	**4.2	*37.4	62.6
75+	*9.3	35.1	50.6	**5.0	59.9	40.1
<i>Total females</i>	*11.9	41.9	41.4	*4.8	53.4	46.6
Male care recipient						
65-74	**4.9	**0.0	36.0	59.1	40.9	59.1
75+	*8.4	**0.0	*10.7	80.9	*19.1	80.9
<i>Total males</i>	*6.9	**0.0	22.0	71.2	28.8	71.2
Total	9.7	23.3	32.8	34.2	42.5	57.5

Note: Estimates marked ** are subject to sampling variability too high for most practical purposes. Estimates marked * have an associated relative sampling error of between 25% and 50%. These estimates should be interpreted accordingly.

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

Table 6.4: Persons aged 65 and over receiving assistance, by source of assistance, 1993 and 1998 (per cent)

Source of assistance	1993				1998			
	Formal care	Informal care	Both	All receiving assistance (N)	Formal care	Informal care	Both	All receiving assistance (N)
Self-care	23	89	12	119,900	25	90	15	141,100
Mobility	7	95	2	190,400	20	95	15	258,600
Communication	0	100	0	22,000	0	100	0	25,200
Housework	37	72	9	349,200	46	73	19	386,700
Health care	65	46	11	275,700	67	49	16	354,100
Meal preparation	14	91	5	92,700	28	83	11	139,200

Note: Some of those surveyed reported that they did not receive assistance from formal or informal sources but did receive assistance from another source. These are included in the totals but individual values are not shown separately as they all have a relative standard error of more than 50%.

Source: AIHW analysis of the ABS Disability, Ageing and Carers Surveys, 1993 and 1998.

Table 6.4 shows how the pattern of assistance received by persons with a severe or profound core activity restriction has changed between the 1993 and 1998 ABS surveys. The proportion of older people receiving assistance from informal sources has remained relatively constant, with the possible exception of a modest decline in the proportion of

people receiving assistance with meals: from 88% to 83%. The data suggest, however, that the proportion of people receiving assistance from formal sources (i.e. government-funded programs or privately purchased services) has generally increased. This trend was most pronounced for mobility (from 7% to 20%), housework (from 32% to 46%) and meal preparation (from 15% to 28%). This trend is in keeping with contemporary trends towards maintaining older people in the community, and reducing the reliance of the aged care system on residential services.

6.3 Service provision

This section summarises recent policy developments, and presents data on patterns of income support and service use by older people. First, recent policy events are discussed, and a summary of key changes since 1999 presented. Second, some basic data are presented on pensions, superannuation and retirement income in old age. This is followed by a discussion of recent trends in assessment, home-based care, residential care, respite care, client profiles and aged care expenditure.

While a number of policy developments have occurred in the last 5 years, the restructuring of the residential aged care system in 1997 remains the most significant policy change in the recent history of aged care services in Australia. With the introduction of the *Aged Care Act 1997*, the two-tier system of residential care was replaced by a single system, and the contributions required of residents significantly expanded. The two-tier arrangement (nursing homes and hostels) had been in place since the implementation of personal care subsidies in aged person's homes almost 30 years earlier. The other dominant policy trend of recent years is a continuation of, rather than a departure from, developments in earlier years. The move towards an increased emphasis on community care and a decreased emphasis on residential provision has been evident in government policy since the implementation of the HACC (Home and Community Care) Program in 1985. This shift was further demonstrated by the expansion of HACC in subsequent years, the development of respite care services, and the introduction and rapid growth of community aged care packages in the 1990s.

In the context of these major policy trends, there have also been more specific developments since the publication of *Australia's Welfare 1999* (AIHW 1999a). Box 6.1 summarises recent key policy initiatives and events in aged care. Most notably, in 2001 the Department of Veterans Affairs commenced delivery of its Home Care Program, Commonwealth Carelink Centres began operations, the report of the two year review of aged care reforms was released (see Box 6.2), and the Aged Care Standards and Accreditation Agency completed an accreditation cycle for all aged care homes in Australia. This latter policy development is taken up in more detail in Section 6.4.

Veterans Home Care extends the range of services available to veterans and war widows/widowers through the Department of Veterans Affairs. Formerly, eligible members of the veteran community could receive community nursing, in-home and residential respite care, allied health services, home modifications, and transport for health care. Veterans Home Care adds to this list domestic assistance, personal care, garden and home maintenance, care coordination, delivered meals, and additional respite care. These services were previously available to veterans and war widows/widowers through HACC, financed by payments from the Department of Veterans Affairs to the Department of Health and Aged Care (DHAC). The development of Veterans Home Care reverses an earlier policy shift in 1987 when the Department of Veterans Affairs transferred its Veterans Home Help Program to HACC.

Box 6.1: Policy changes and events in aged care, 1999 to 2001

1999

The International Year of Older Persons was celebrated.

From July, the Domiciliary Nursing Care Benefit was merged with the Child Disability Allowance to become the Carer Allowance.

A background paper, discussion papers on Healthy Ageing and Independence and Self Provision, and an issues paper on Employment for Mature Age Workers were released by the Minister for Aged Care as part of the developmental process for the National Strategy for an Ageing Australia (Bishop 1999a, 1999b, 1999c, 199d).

The Aged Care Standards and Accreditation Agency, which came into being in 1998, began active accreditation work in September, following a delayed passage of the enabling Principles.

2000

A pilot test of the new HACC National Minimum Data Set (NMDS) was successfully completed, and the first national collection scheduled for implementation from January 2001.

Discussion papers on World Class Care and Attitude, Lifestyle and Community Support were released by the Minister for Aged Care as part of the developmental process for the National Strategy for an Ageing Australia (Bishop 2000a, 2000b).

The Residential Aged Care Funding Equalisation and Assistance Package was introduced to accelerate the transition to standard rates of Commonwealth subsidy across all States and Territories.

Income testing arrangements for clients of residential aged care services were simplified by moving from a daily to a quarterly assessment of fees.

An evaluation was undertaken of the Extended Aged Care at Home (EACH) Packages pilot program which provides services at home to people eligible for high-level care in an aged care home.

2001

Veterans' Home Care, a Department of Veterans' Affairs program to provide home-based care services to veterans, commenced in January.

Commonwealth Carelink Centres, announced in the 1999–00 Budget, became operational. The 54 centres across Australia provide a single contact point for information about community care services in the local area.

The Aged Care Standards and Accreditation Agency completed an accreditation process for all aged care homes by 1 January.

The report of the Two Year Review of Aged Care Reforms, commissioned by the Commonwealth Government in 1998, was released. The review was chaired by Professor Len Gray and its purpose was to evaluate the impact of the reforms (see Box 6.2).

(continued)

Box 6.1 (continued): Policy changes and events in aged care, 1999 to 2001

The new HACC NMDS collection was implemented, with the first quarter of national data being successfully collated and analysed.

The National Continence Management Strategy was implemented.

There was an expansion of resources for culturally appropriate care, including both 'ethnic clusters' and ethno-specific homes.

Box 6.2: Report of the Two Year Review of Aged Care Reforms

In May 2001 the report on the impact of the 1997 aged care reforms on residential aged care was released. The task set for the review was to assess and report on the extent to which the Aged Care Act 1997 was achieving its objectives. The ambit of the review included accessibility, affordability, quality, efficiency, industry viability, State and Territory programs, choice, appropriateness, and other considerations including dementia. Professor Len Gray, the chair of the review, noted in the report that there remained some significant ongoing challenges for the industry with regard to 'the scale of building and restructuring required to meet the new standards and the future needs of the industry', 'the availability of staff and staff costs' and 'continuing improvement in quality of care' (2001:xxx). Nevertheless, he put forward the following overall conclusion:

It is my conclusion, on completion of the Review, that the reforms have delivered substantial improvements to the aged care system. The fine-tuning undertaken to smooth the implementation of the reforms and address unanticipated anomalies has been largely successful. (Gray 2001:xxx)

The review makes seven recommendations concerning the need: for a review of indicators of supply and demand for residential and community care; for a critical analysis of current measures of need for care, type of care and care delivery; to consider the availability of appropriate acute, sub-acute and non-acute care options across a range of service delivery settings; to undertake a detailed analysis of respite services; to investigate the needs of and provision for people with dementia; to improve the availability of information available to intending residents and to simplify admissions procedures; to ask the Aged Care Standards and Accreditation Agency to review consistency issues between assessments and to continue to take particular care with regard to medication and nursing issues in homes with a small proportion of high care residents; to consider the introduction of objective measures of continuous improvement; and to further consider the processes and outcomes of accreditation with a view to future developments now that the first round of assessments is complete (Gray 2001:xxxi-xxxii).

Carelink Centres are an initiative of the Commonwealth Government, announced in the 1999—00 Budget, to provide a nation-wide network of information centres to facilitate access to a range of community services. The centres are intended to link health professionals, general practitioners, other service providers, carers and individuals in need of assistance with the agencies providing care and support in the region.

Information available through Commonwealth Carelink Centres include the types of services available and how to contact them, service availability, waiting list information, eligibility criteria and the costs associated with receiving the service.

Income support

Australia has 1,762,511 people receiving the Age Pension and a further 413,428 people aged 60 and over receiving pensions from the Department of Veterans Affairs (DVA). The Age Pension is income and assets tested, as is the Income Support Pension paid by DVA. Compensation pensions⁶ are neither taxable nor subject to means testing. In March 2001 the single rate for the DVA Income Support and Age pensions was \$402.00 per fortnight, while the couple rate was \$335.50 each per fortnight.

Table 6.5: Age and DVA pension recipients, by age and sex, 31 December 2000 (per cent)

Pension/sex	60–64	65–69	70–74	75–79	80–84	85–89	90+	Total
Age pensioners								
Males	0.0	13.1	12.8	6.1	3.3	2.0	0.8	38.1
Females	9.8	14.3	12.8	9.9	7.4	5.1	2.6	61.9
Persons	9.8	27.4	25.6	16.0	10.7	7.1	3.4	100.0
Total (N)	173,252	482,058	451,436	281,978	188,622	125,630	59,535	1,762,511
DVA pensioners								
Males	1.5	1.8	4.1	20.7	12.2	3.6	0.7	44.6
Females	2.1	4.3	13.3	19.5	10.7	4.1	1.4	55.4
Persons	3.6	6.1	17.4	40.2	22.9	7.7	2.1	100.0
Total (N)	15,060	25,079	72,018	166,300	94,547	31,739	8,686	413,428

Note: Eligibility for Age Pension is 61.5 years for women and 65 years for men.

Source: Unpublished data, Centrelink; DVA Ad Hoc Information System.

Women made up 62% of age pensioners and 55% of DVA pensioners (that is, those aged 60 and over). While over a third of age pensioners were aged between 60 and 69, a substantial minority (10.5%) were aged 85 and over. There were 59,535 age pensioners in Australia aged 90 and over. DVA pensioners were heavily concentrated in the 75–84 age groups: only 10% were aged between 60 and 69; 63% were aged between 75 and 84; 10% were aged 85 and over (Table 6.5). As at 31 December 2000, 84% of Australians over the age of 65 were receiving at least a partial Age or DVA pension (86% of women and 82% of men). The proportion receiving at least a part pension increased from 79% among those aged 65–74 to 89% among those aged 75 and over.

According to the 1997 ABS Survey of Retirement and Retirement Intentions, 71% of retired people aged 65 and over were dependent on a pension or benefit (predominantly the Age Pension) as their main source of income. Superannuation either a superannuation pension or a pension or annuity bought with superannuation lump-sum or rollover money was the main source of income for only 10% of this age

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

group. This pattern is likely to change in the future because the introduction of superannuation provisions into award entitlements in 1986 and the superannuation guarantee in 1992 has substantially increased superannuation coverage in all age groups. Growth in superannuation coverage was very rapid during the 1990s for older age groups (AIHW 1999a; OSW 1999). In the late 1990s, coverage of those in the workforce has grown slightly for both men and women, reaching around 87–88% by 2000. Rates of coverage are lower in the 60 and over age group than in the 55–59 age group, an effect which is likely to be partly a cohort effect, and partly to do with more part-time work (and hence lower superannuation coverage) in the 60 and over population (see Table 6.6). While superannuation coverage of the working population is now high at all ages and for both men and women, it must be remembered that increased coverage will take some time to translate into substantial retirement benefits, since entitlements are determined by the length of time during which superannuation has been accrued. Assuming a 40-year working life, the first cohort to be completely covered over their working life by the superannuation guarantee will not retire until 2032.

The Carer Payment (previously known as the Carer Pension) is an income-support benefit payable to people who, because of their caring responsibilities, are unable to engage in a substantial level of paid work. It is income and assets tested. In 2001, there were 23,268 people caring for a person aged 65 and over who were receiving the Carer Payment. The majority (68%) of these recipients were women. A large proportion of persons receiving the Carer Payment (and caring for a person aged 65 and over) were aged 45–64 (65% of men and 72% of women) (Table 6.7).

Table 6.6: Persons in workforce aged 55 and over, superannuation coverage by age and sex, 1997–00 (per cent)

Sex/age	1997	1998	1999	2000
Male				
55–59	91.9	90.8	92.6	91.4
60+	77.6	82.7	82.7	79.9
<i>Total 55+</i>	<i>86.3</i>	<i>87.6</i>	<i>88.6</i>	<i>87.0</i>
All in workforce, aged 55+ (N)	339,700	366,500	376,100	422,800
Female				
55–59	89.4	90.8	91.1	92.6
60+	76.0	78.1	77.8	80.1
<i>Total 55+</i>	<i>85.0</i>	<i>86.6</i>	<i>87.0</i>	<i>88.4</i>
All in workforce, aged 55+ (N)	181,400	211,600	206,600	263,400
Persons				
55–59	91.0	90.8	92.0	91.9
60+	77.1	81.2	81.3	80.0
<i>Total 55+</i>	<i>85.8</i>	<i>87.3</i>	<i>88.0</i>	<i>87.5</i>
All in workforce, aged 55+ (N)	521,100	578,100	582,600	686,200

Source: ABS survey of employee earnings, benefits and trade union membership, 1997–2000, unpublished data.

Table 6.7: Persons receiving Carer Payment, by age and sex of carer and care recipient, 30 March 2001 (row per cent)

Sex/age	Male carer					Total males	Female carer					Total females	Total carers (N)
	0-24	25-44	45-64	65-79	80+		0-24	25-44	45-64	65-79	80+		
Female care recipient													
65-69	0.6	18.3	27.7	5.4	0.0	52.0	1.8	33.9	11.5	0.4	0.3	48.0	1,568
70-79	0.7	13.2	20.3	1.5	0.3	35.9	2.0	23.1	38.7	0.3	0.0	64.1	5,577
80-89	0.4	3.9	24.1	0.9	0.2	29.5	0.9	7.3	60.9	1.3	0.1	70.5	7,352
90+	0.5	1.7	20.8	3.4	0.0	26.4	0.6	4.2	60.1	8.5	0.2	73.6	1,771
Total (%)	0.5	8.2	22.8	1.8	0.2	33.5	1.3	14.9	48.4	1.6	0.1	66.5	16,268
Total (N)	87	1,340	3,706	293	31	5,457	217	2,432	7,881	266	15	10,811	16,268
Male care recipient													
65-69	1.4	11.4	4.4	0.4	0.0	17.6	1.5	14.6	63.1	3.1	0.0	82.4	1,400
70-79	1.0	17.2	12.9	0.6	0.0	31.7	1.7	22.9	38.2	5.3	0.1	68.3	2,491
80-89	0.6	8.4	25.2	0.2	0.0	34.3	0.7	10.9	51.4	2.2	0.5	65.7	2,452
90+	0.9	4.6	26.3	1.2	0.0	33.0	0.6	5.8	55.6	4.6	0.5	67.0	657
Total (%)	0.9	11.8	16.8	0.5	0.0	29.9	1.2	15.5	49.4	3.7	0.3	70.1	7,000
Total (N)	64	825	1,174	33	0	2,096	84	1,082	3,461	258	19	4,904	7,000

Source: Centrelink, unpublished data.

Table 6.8: Persons receiving Carer Allowance, by age and sex of carer and care recipient, 30 March 2001 (row per cent)

Sex/age	Male carer					Total males	Female carer					Total females	Total carers (N)
	0-24	25-44	45-64	65-79	80+		0-24	25-44	45-64	65-79	80+		
Female care recipient													
65-69	0.2	5.8	12.4	61.0	1.1	80.6	0.7	12.5	4.7	1.1	0.4	19.4	4,262
70-79	0.2	5.0	8.8	42.9	10.3	67.3	0.6	11.8	18.9	1.2	0.2	32.7	13,698
80-89	0.2	1.9	14.4	8.7	17.9	43.1	0.4	5.0	46.8	4.1	0.6	56.9	13,725
90+	0.1	0.6	10.6	7.8	3.9	23.0	0.2	2.2	45.7	27.6	1.3	77.0	4,119
Total (%)	0.2	3.4	11.6	27.9	11.4	54.5	0.5	8.2	31.0	5.3	0.5	45.5	35,804
Total (N)	72	1,224	4,152	9,985	4,076	19,509	187	2,933	11,095	1,906	174	16,295	35,804
Male care recipient													
65-69	0.3	2.6	1.0	0.4	0.0	4.4	0.4	4.3	55.6	34.8	0.5	95.6	5,171
70-79	0.1	2.4	1.9	0.3	0.1	4.8	0.3	4.0	18.3	69.9	2.7	95.2	15,554
80-89	0.1	1.7	5.7	0.4	0.1	7.9	0.1	3.1	16.8	46.6	25.4	92.1	10,547
90+	0.1	1.7	9.8	2.6	0.1	14.3	0.1	2.3	32.4	21.9	29.0	85.7	1,607
Total (%)	0.1	2.2	3.4	0.5	0.1	6.2	0.2	3.7	24.4	54.5	11.0	93.8	32,879
Total (N)	45	716	1,108	156	21	2,046	74	1,203	8,021	17,931	3,604	30,833	32,879

Source: Centrelink, unpublished data.

The Carer Allowance (see Box 6.1) is paid to people caring for someone who requires a lot of additional care because of a disability or severe medical condition, in their own home.⁷

7 Medical eligibility for Carer Allowance (Adult) where the person being cared for is at least 16 years old is measured by the Adult Disability Assessment Tool (ADAT). This tool measures the functional ability of the person receiving care.

As at July 2001, the payment rate for the Carer Allowance was \$82.00 per fortnight. It is not means tested, nor is it treated as income for social security or taxation purposes. In March 2001, there were 68,683 people caring for a person aged 65 and over who were receiving the Carer Allowance, a substantial increase on the 32,700 people receiving the Domiciliary Nursing Care Benefit in relation to the care of a person aged 65 or over in 1999. Just over two-thirds (69%) of these recipients of the Carer Allowance were women. Carer Allowance recipients caring for older women were most likely to be men aged 65 and over (39%) or women aged 45–64 (31%). Recipients caring for older men were most likely to be women aged 65 and over (66%) or women aged 45–64 (24%) (Table 6.8).

Assessment

Aged care assessment teams play a crucial role in the Australian aged care system. They determine eligibility for community aged care packages and for admission to residential aged care. They also function as a source of advice and referral concerning HACC services but do not determine eligibility for these services. The desirability and practicality of establishing a national assessment strategy for HACC services has been a subject of ongoing policy discussions in recent years, including a government-sponsored consultancy on the topic (LGC 1998).

In the 15 years since their inception, aged care assessment teams have become an established part of the aged care system. In the process of determining eligibility, the teams generate data on the clients they assess: their age and sex, their dependency levels, and their assessed level of need for services. While these data provide some information about the flow of clients into the aged care system, the current 22-item national minimum data set has some limitations (particularly in relation to the measurement of dependency and the availability of informal care). The development of a revised national minimum data set for the Aged Care Assessment Program is all but complete, and a review of the data collection environment required to support the new national minimum data set has been undertaken. A firm date for implementation has yet to be identified, but it will not occur prior to the 2002–03 financial year (see Box 6.3 for further details).

Between January and June 2000, aged care assessment teams carried out 85,444 assessments of persons aged 65 and over (Table 6.9).⁸ This was 11,000 more assessments (an increase of 15%) than were carried out during the same period in 1997 (74,463 assessments). The percentage increase was markedly higher in the oldest age group (24% among those aged 85 and over) than in the younger age groups (2% for those aged 65–74, and 13% for those aged 75–84). This increase in the number of assessments being undertaken by aged care assessment teams is consistent with the trend in earlier years; between 1994 and 1997, there was a 14% increase in assessments.

8 It should be noted that while the data are reported here as national data, there are some interstate differences in the data collections; in particular, there have been historical differences in what is and is not defined as an ‘assessment’ in different jurisdictions. This was discussed in more detail in *Australia’s Welfare 1995* (AIHW 1995:183–5).

Box 6.3: Data development in aged care

In 1999, the AIHW began work on the Community Care Data Development Project under a Memorandum of Understanding with the Commonwealth Department of Health and Aged Care (DHAC). The project aims to improve the quality, relevance, consistency and comparability of national data on community care service provision. Ensuring consistency with national data standards (especially the National Community Services Data Dictionary) is a key focus of this project.

Aged Care Assessment Program

A major component of the project has been the development of Version 2.0 of the Aged Care Assessment Program Minimum Data Set (ACAP MDS V2.0). There have been many changes in the aged and community care sector since the introduction of the ACAP MDS V1.0 in 1994. The 127 aged care assessment teams across Australia play a pivotal role in this sector, applying a range of clinical and professional expertise to the comprehensive assessment of frail older persons and making recommendations on their future care needs. The Commonwealth and State/Territory Officials responsible for the program (ACAP Officials) wanted to ensure that the information reported in the MDS was relevant to the current and future needs of the program for policy development, planning and performance measurement. Version 2.0 of the MDS was endorsed by ACAP Officials in May 2001, with implementation to occur no sooner than 1 July 2002.

Major features of Version 2.0 of the ACAP MDS are the inclusion of information about informal carers, and more detailed information about the health condition of people assessed and their need for assistance in various areas of activity (e.g. self-care, mobility, communication, domestic assistance, transport). A set of national program-level performance indicators was also developed in conjunction with the development of Version 2.0. These indicators were also endorsed by ACAP Officials in May 2001 and will be reviewed 18 months after implementation of Version 2.0. The main product of this project is the ACAP Data Dictionary Version 1.0, containing definitions of all MDS Version 2.0 data elements and the national performance indicators.

Community aged care packages

Another major component of the Community Care Data Development Project has been the development of data definitions for the Community Aged Care Package (CACP) Program. This program has grown significantly in recent years and is designed to provide an individually tailored package of home and community-based care and assistance for people who would otherwise be eligible for low-level care in an aged care home. The Commonwealth Department of Health and Aged Care wanted to improve the amount, quality and relevance of information available about people receiving a community aged care package and the nature of the assistance they receive under it. As with the ACAP MDS V2.0 project, a set of national program-level performance indicators has been developed in conjunction with the development of data definitions. The main product of this project is the CACP Data Dictionary Version 1.0, containing definitions of data elements and the national program performance indicators. The Institute's work on CACP data development is scheduled for completion late in 2001.

(continued)

Box 6.3 (continued): Data development in aged care

Comparison of data collections

A report identifying any gaps or inconsistencies across data collections for the HACC, ACAP, CACP and the National Respite for Carers programs is another key product of the Community Care Data Development Project. This report uses the National Community Services Information Model as a framework. Each data element is assessed for consistency with national standards, and for internal consistency across these four programs.

During 2001–02, the AIHW's work on the Community Care Data Development Project will focus on developing minimum data sets for the Day Therapy Centre Program and the Continence Aids Assistance Scheme.

The rate of assessment (that is, the proportion of the age group assessed) has also increased slightly over the period: from 3.1% in 1994, to 3.3% in 1997, and to 3.6% in 2000. The rate was highest in the 85 and over age group (12.5%, compared with 4.8% of those aged 75–84 and 1.1% of those aged 65–74). These figures suggest quite a significant amount of contact between aged care assessment teams and those at more advanced ages, with around one in 8 of all people aged 85 and over being seen by a team in the given 6-month period. For the two younger age groups, the rate remained stable over the period, with a slight increase (from 11.3% in 1994 to 12.5% in 2000) for the 85 and over age group. Rates of assessment continue to be marginally higher among women than men in all age groups.

The proportion of people assessed who were deemed to require low and high residential care has changed little in recent years, remaining at around 22–23% over the period from 1994 to 2000 for high care places (formerly nursing homes) and at 21% over the same period for low-level places (formerly hostels). The proportion who received a recommendation for community aged care packages (or community options services) increased substantially, however, from 2% in 1994 to 10% in 2000. This latter result reflects the large increase in the number of community aged care packages available during the period. The vast majority of remaining clients had a recommended long-term living arrangement in the community, some with additional support from HACC services. For a small minority of clients, long-term arrangements were not specified or were classified as other .

Table 6.9: ACAT^(a) assessment rates and recommendations, by age and sex, January–June 1994, 1997 and 2000 (per cent)

Sex/recommendations	1994				1997				2000			
	65–74	75–84	85+	Total	65–74	75–84	85+	Total	65–74	75–84	85+	Total
Males												
Residential care:												
High care/Nursing home	20	24	29	24	20	23	28	24	21	23	28	24
Low care/Hostel	14	18	21	18	15	18	21	18	15	17	20	18
CACPs/COPs	2	2	2	2	4	4	5	4	9	9	11	10
Total assessments	5,992	10,851	6,073	22,916	6,604	12,430	7,352	26,386	6,471	14,076	9,193	29,740
All males	596,251	261,821	53,281	911,353	617,619	298,356	63,988	979,963	623,952	336,140	78,391	1,038,483
Per cent assessed	1.0	4.1	11.4	2.5	1.1	4.2	11.5	2.7	1.0	4.2	11.7	2.9
Females												
Residential care:												
High care/Nursing home	16	19	28	22	16	18	27	21	16	21	28	23
Low care/Hostel	16	23	25	23	16	23	25	23	16	22	25	22
CACPs/COPs	2	2	2	2	5	5	4	5	12	11	10	11
Total assessments	7,950	20,088	15,162	43,200	7,785	22,173	18,021	47,979	8,148	24,958	22,311	55,417
All females	671,773	394,968	127,506	1,194,247	680,038	434,694	149,112	1,263,844	675,349	472,565	173,837	1,321,751
Per cent assessed	1.2	5.1	11.9	3.6	1.1	5.1	12.1	3.8	1.2	5.3	12.8	4.2
Persons												
Residential care:												
High care/Nursing home	17	21	29	23	18	20	27	22	18	21	28	23
Low care/Hostel	15	21	25	21	15	21	24	21	15	20	24	21
CACPs/COPs	2	2	2	2	5	5	5	5	10	10	10	10
Total assessments	13,957	30,969	20,492	65,418	14,405	34,629	25,429	74,463	14,663	39,166	31,615	85,444
All persons	1,268,024	656,789	180,787	2,105,600	1,297,657	733,050	213,100	2,243,807	1,299,301	808,705	252,228	2,360,234
Per cent assessed	1.1	4.7	11.3	3.1	1.1	4.7	11.9	3.3	1.1	4.8	12.5	3.6

(a) Aged Care Assessment Team.

Notes

1. Total numbers of assessments reported for 1994 are higher than reported in *Australia's Welfare 1999*, as a result of revised figures supplied by ACAP Evaluation Units. In addition to the recommendations listed above, ACATs may also recommend a continuation of living in the community either alone or with a spouse, with others such as relatives, or in a boarding house.
2. The table shows the proportion of ACAT clients who are recommended for residential care or coordinated community care (CACPs or COPs). The remaining clients generally receive a recommendation to continue living in the community, some with the assistance of HACC-funded services.

Source: ACAP Evaluation Units; ABS 2000a.

Table 6.10: ACAT^(a) clients, by dependency, 1994–95 to 1999–00 (per cent)

Dependency	1994–95	1995–96	1996–97	1997–98	1998–99	1999–00
Mobility						
Walks independently	65.7	65.8	65.6	61.5	64.4	63.9
Does not walk independently	34.3	34.2	34.4	38.5	35.6	36.1
<i>Number</i>	127,419	158,011	160,501	160,897	173,011	179,341
Continence						
Fully continent	65.1	65.5	64.8	61.5	61.5	61.4
Not fully continent	34.9	34.5	35.2	38.5	38.5	38.6
<i>Number</i>	124,293	154,337	157,228	160,897	170,148	176,276
Orientation						
Aware, time & place	66.0	66.2	65.5	68.9	65.7	67.1
Not aware	34.0	33.8	34.5	31.1	34.3	32.9
<i>Number</i>	125,621	154,731	158,467	160,043	169,075	174,740
Total number	132,957	164,862	166,410	171,660	178,915	183,572

(a) Aged Care Assessment Team.

Source: AIHW 1999a; LGC 2000; ACAP Evaluation Units, 1999–00 unpublished data.

The Aged Care Assessment Program national minimum data set contains three items on client dependency: mobility, continence and orientation. For the period from 1994–95 to 1999–00, there was no clear change in the dependency profile of aged care assessment team clients as measured by these three items, although there was a modest decrease in the proportion who were fully continent (Table 6.10).⁹

Home and Community Care Program

The Home and Community Care (HACC) Program is jointly funded by the Commonwealth and State and Territory Governments. The bulk of home- and community-based services for older people are provided under the auspices of this program. It is important to recognise, however, that the target population is people of all ages with a moderate or severe level of disability (and their carers). The program includes home nursing services, delivered meals, home help and home maintenance services, transport and shopping assistance, paramedical services, home- and centre-based respite care, and advice and assistance of various kinds. HACC also provides brokered or coordinated care for some clients, through community options or linkages projects. (Community aged care packages, an alternative source of coordinated home-based care, are discussed later in this section.) While the implementation of the new HACC minimum data set will provide a rich basis for analysis of the HACC program, those data will not be available for analysis until late 2001. The discussion here is therefore somewhat limited, owing to the hiatus between the ending of the old HACC data collections and the as-yet unavailability of the new collection.

9 The inconsistency in the 1997–98 patterns for the mobility and orientation items may be related to the re-assessment of (former) hostel residents which occurred as a result of the restructuring of residential aged care services into one single system in late 1997.

Table 6.11: HACC^(a) service provision, in a sample month, by main service type, 1993–94, 1996 and 1999–00^(b)

Main service types	1993–94	1996	1999–00
	Total hours		
Home help (hours)	596,874	644,537	634,887
Personal care (hours)	152,462	188,810	251,759
Home nursing (hours) ^(c)	287,838	258,110	215,968
Paramedical (hours)	27,421	34,694	40,617
Home respite care (hours)	216,111	229,589	322,744
Centre day care (hours)	586,604	679,012	905,155
Home maintenance/modification (hours)	58,603	64,245	80,005
Home meals (meals)	1,040,599	1,120,744	1,147,807
Centre meals (meals)	141,117	172,112	152,292
Total hours^(d)	1,339,309	1,419,985	1,545,979
	Per 1,000 persons aged 70 and over		
Home help (hours)	428	429	378
Personal care (hours)	109	126	150
Home nursing (hours) ^(c)	206	172	129
Paramedical (hours)	20	23	24
Home respite care (hours)	155	153	192
Centre day care (hours)	421	452	539
Home maintenance/modification (hours)	42	43	48
Home meals (meals)	746	746	683
Centre meals (meals)	101	115	91
Total hours^(d)	960	946	920
	Per 1,000 persons aged 65 and over with a severe or profound restriction		
Home help (hours)	1,423	1,648	1,244
Personal care (hours)	364	483	493
Home nursing (hours) ^(c)	686	660	423
Paramedical (hours)	65	89	80
Home respite care (hours)	515	587	632
Centre day care (hours)	1,399	1,736	1,773
Home maintenance/modification (hours)	140	164	157
Home meals (meals)	2,481	2,866	2,249
Centre meals (meals)	337	440	298
Total hours^(d)	3,193	3,631	3,029

(a) Home and Community Care.

(b) Data on transport, other food services and other unspecified services are not included in this summary table. For more detailed information, see Table A6.2.

(c) Home nursing services are not provided by the Northern Territory.

(d) Excludes centre day care, home and centre meals, transport, other food services and other unspecified services.

Source: ABS 2000a; AIHW analysis of the ABS Disability, Ageing and Carers Survey 1998; AIHW 1997a, 1999a; DHAC unpublished data.

Table 6.11 provides data on the total hours of services provided under the program, and the hours in relation to the number of people aged 70 and over and the number of people aged 65 and over with a severe or profound restriction.¹⁰ In 1999–00, HACC delivered a total of 1,545,979 hours of service in the main program service areas.¹¹ The supply of services increased throughout the period: by 60% between 1993–94 and 1996, and by 8.9% between 1996 and 1999–00.

The remainder of the table explores the provision of HACC services in relation to the size of the potential client group in the aged population, allowing changes in the level of provision to be examined in the context of the increasing size of the aged population between 1993–94 and 1999–00. Neither of the two measures employed captures the entire potential client population, however, as HACC provides services to people with disabilities regardless of their age. It is estimated that 25% of HACC services are delivered to clients aged under 65; a clearer indication of these service patterns will be possible when data from the new HACC MDS are available for analysis.

The target group for the HACC program specifies people of all ages with a moderate or severe disability, and their carers. In a number of contexts, this has been defined as equivalent to those people who fall into the ABS category (Survey of Disability, Ageing and Carers) of having a moderate, severe or profound core activity restriction. In analyses undertaken by the AIHW, the moderate core activity restriction category is not included, as it refers by definition to people who do not require assistance with activities of daily living. In this and other AIHW publications, the HACC target population is therefore operationalised as equivalent to those people with a severe or profound core activity restriction in the terms employed by the ABS survey.

In 1999–00, HACC agencies provided 1,244 hours of home help (per month) per 1,000 people aged 65 and over with a severe or profound restriction. They also provided (again per month) 1,773 hours of centre-based respite care and 2,249 home-delivered meals per 1,000 people aged 65 and over with such restriction. The levels of provision were lower in the more intensive service types: for home-based respite care, 632 hours; for personal care, 493 hours; and for home nursing, 423 hours.

Five categories of HACC service showed a substantial increase in relation to the population aged 65 and over with a severe or profound restriction since 1993–94: personal care (a 35% increase), paramedical services (23%), respite care services (23%), centre day care (27%) and home maintenance (12%). There was a substantial reduction in home nursing (a 38% decrease), home help (13%), home-delivered meals (9%) and centre-based meals (12%). Much of this decrease has occurred in the period between 1996 and 2000, with service types such as home help, and home-delivered and centre-based meals, increasing between 1993–94 and 1996, and then decreasing thereafter. The pattern of expansion of HACC services in relation to the size of the aged population, which characterised the mid-1990s, appears to have slowed, or in the case of some service types reversed, in recent years. During this later period, however, the expansion of community aged care packages has been pronounced (see Table 6.12).

10 The base population data used for these and other service use calculations are included in Table P.4.

11 See Table A6.2 for more detailed data on all service types by State and Territory.

There are quite interesting State and Territory variations in these patterns of service delivery (see Table A6.2). The Northern Territory has a much higher level of provision for all HACC services in relation to both the number of people aged 70 and over and the number of people aged 65 and over with a severe or profound restriction. For example, for home help services, 6,863 hours were delivered per 1,000 people aged 65 and over with a severe or profound restriction, compared to the national average of 1,244 hours. This pattern is to be expected, given the high proportion of Indigenous Australians in the Northern Territory, their higher levels of morbidity and lower life expectancy, and their consequent need for both home-based and residential aged care services at (on average) younger ages than non-Indigenous Australians.

There are considerable variations among the other States and the Australian Capital Territory, and there is no clear evidence that these different patterns are converging over time. For home help in 1999–00, Victoria, Western Australia and Tasmania were relatively high providers, at 1,472, 1,567 and 1,713 hours respectively per 1,000 people aged 65 and over with a severe or profound restriction. The corresponding figure for South Australia was 925. For personal care services, New South Wales, Western Australia and the Australian Capital Territory were relatively high providers (respectively, 631, 584 and 659 hours), while Queensland was a relatively low provider (230 hours). For home-based respite care, the Australian Capital Territory and South Australia were comparatively high providers (respectively, 1,954 and 814 hours), while Victoria and Tasmania provided relatively low levels of this type of service (respectively, 403 and 564 hours).

It may be that these variations are partly artificial, deriving from State and Territory differences in how forms of care are defined for example, whether assistance is defined as personal care rather than home help, or as home nursing rather than respite care. Another possible contributing factor is that these differences represent a trade-off among service types. These explanations do not, however, fully account for the observed differences. If the hours of assistance provided in home help, home nursing, personal care, paramedical services, home-based respite care, home maintenance and other services are added together, there remains a clear difference in the level of supply across the States and Territories. The Northern Territory undoubtedly has the highest level of service provision (but note the earlier caveat about its population profile), at 13,487 hours per 1,000 persons aged 65 and over with a severe or profound restriction, even though hours of home nursing are not included as it is not a HACC-funded service in the Northern Territory. Next is the Australian Capital Territory (with 5,556 hours of service), followed by South Australia (3,933), Tasmania (3,793), Victoria (3,590), Western Australia (3,560), Queensland (3,128) and New South Wales (2,953).

The HACC program has undergone a substantial amount of review and development work in recent years. Developments include the implementation of both the HACC National Service Standards Instrument (from 1 July 1999) and the HACC NMDS (from 1 July 2000). Both the instrument and the data set were developed by the Institute (AIHW: Ryan et al. 1999; AIHW: Jenkins et al. 1998). A consumer appraisal instrument for use in the Service Standards review process was developed by the AIHW at the request of HACC Officials and accepted for implementation by HACC Officials (see Box 6.4). While no national data are yet available from the HACC National Service Standards Instrument, preliminary data have been received for the first quarter of the NMDS (January to March 2001). Other important issues in the HACC program revolve

around consideration of the findings of the report *Targeting in the Home and Community Care Program* (NARI & BECC 1998), the consultancy undertaken on standardised dependency items for use in the program, and of the role to be played by comprehensive assessment in community care.

Box 6.4: The HACC Service Standards Consumer Appraisal Data Development Project (1998–99)

Client appraisal of agency performance is an important component of the assessment of quality of service in HACC agencies. At the request of the HACC Officials Standards Working Group, the AIHW has developed a consumer survey instrument for use in the assessment of agencies against the HACC National Service Standards.

The four principal objectives of the HACC Service Standards Consumer Appraisal Data Development Project were:

- *to refine the survey tool;*
- *to test the usefulness of survey methods in providing information about the quality of the service provided by an agency;*
- *to test the capacity of this tool to stand alone as an accurate indicator of agency service quality, as described by the HACC National Service Standards, and to analyse the extent to which consumer appraisals provide a useful means of validating and informing HACC agency appraisals; and*
- *to examine the viability of survey methods according to such criteria as cost, timeliness, practicality, acceptability to clients, and usefulness to service providers.*

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

The second stage of the project involved an extensive field trial, with data collected from over 2,000 HACC clients from a sample of 41 participating HACC agencies, in addition to interviews and questionnaires completed by agency staff and HACC agency assessors. As a result of the fieldwork, a refined tool was developed which is expected to yield valid and reliable measures of client appraisals of HACC services, based on the HACC National Service Standards, for incorporation into the assessment process (see AIHW: Jenkins 2000 and AIHW: Jenkins & Gibson 2000 for further details).

Residential aged care and community aged care packages

As at 30 June 2001, there were 2,973 occupied aged care homes in Australia providing a total of 142,444 places. In addition, 24,430 community aged care packages were provided. Community aged care packages are designed to provide care services to those living at home who would otherwise be eligible for low-level residential care. This section presents data on operational aged care places and packages. Allocated places and packages are not included here, but are discussed in a later section.

Because aged care places and community aged care packages (CACPs) are intrinsically linked, they are usually combined to present an indication of the provision of aged care against the planning ratio. The planning ratio target is 100 places and packages per 1,000 persons aged 70 years and over. The provision ratio declined in the late 1980s and early 1990s but stabilised in the mid-1990s at around 93 places and packages per 1,000 persons aged 70 years and over (AIHW 1995:381—2; AIHW 1997a:384—5). Recently the ratio has begun to rise, reaching 96.5 in 2001. Table 6.12 shows the number and ratio of operational aged care places and community aged care packages in Australia from 1996 to 2001.

Supply

Community aged care packages, first implemented in 1992, provide support services for people living at home who would otherwise be eligible for admission to what was previously Personal Care level in a hostel (approximately equivalent to RCS levels 5 to 7 in the present system). They provide a range of home-based services, excluding home nursing assistance, with care being coordinated by the care package provider. Unlike the HACC program which is jointly funded by Commonwealth and State and Territory Governments, the community aged care packages program is Commonwealth funded. From a small beginning of some 470 community aged care packages in 1992, the program had grown to reach 18,149 care packages by 2000, and 24,430 by 2001 (provisional data).¹² The bulk of this growth occurred in the past 4 years, with the number virtually quadrupling: from 6,124 packages in 1997 to 24,422 in 2001. This growth rate is higher than that of the population aged 70 and over, with the consequence that care packages are providing care to an increasing proportion of older people in need of formal assistance. In 1997 there were 3.9 packages per 1,000 people aged 70 and over (or 13.1 packages per 1,000 people aged 65 and over with a severe or profound core activity restriction); by 2001, this figure had increased to 14.1 packages per 1,000 people aged 70 and over (provisional data) (or 46.4 packages per 1,000 people aged 65 and over with a severe or profound core activity restriction) (Table 6.12). Patterns for State and Territory provision are presented in Table A6.3.

While community age care package provision has expanded rapidly, the growth in residential aged care places has been slower. Residential aged care places have increased over the past 4 years: from 136,851 operational places in 1996, to 139,917 in 1998, and to 142,310 in 2001 (provisional).¹³ The ratio of places to people in need of assistance has declined over the period. In terms of the Commonwealth government

12 These numbers refer to operational packages.

13 The data in this sub-section on supply refer to operational places.

provision ratio, there has been a shift from 90.6 places per 1,000 people aged 70 and over in 1996, to 87.4 places in 1998, and to 82.4 places in 2001. In terms of the more closely targeted measure also presented in Table 6.12, this represents a decline from 300.7 places per 1,000 people aged 65 and over with a severe or profound core activity restriction in 1996, to 270.5 places per 1,000 people aged 65 and over with a severe or profound core activity restriction in 2001.

Table 6.12: Operational aged care places and packages, 30 June 1996 to 30 June 2000

Year	Aged care type	No. of places/packages	Ratio of places/packages per 1,000 persons	
			Aged 70+	Aged 65+ with a severe or profound restriction
1996	Community aged care packages	4,431	2.9	9.7
	Hostels	62,471	41.4	137.2
	Nursing homes	74,380	49.2	163.4
	Residential aged care ^(a)	136,851	90.6	300.7
	Total	141,282	93.5	310.4
1997	Community aged care packages	6,124	3.9	13.1
	Hostels	64,825	41.7	138.2
	Nursing homes	74,233	47.7	158.2
	Residential aged care ^(a)	139,058	89.4	296.4
	Total	145,182	93.3	309.5
1998	Community aged care packages	10,046	6.3	20.7
	Residential aged care	139,917	87.4	288.8
	Total	149,963	93.7	309.5
1999	Community aged care packages	13,753	8.4	27.7
	Residential aged care	140,651	85.6	283.3
	Total	154,404	94.1	311.1
2000	Community aged care packages	18,149	10.8	35.4
	Residential aged care	141,162	83.8	275.5
	Total	159,311	94.5	311.0
2001	Community aged care packages ^(b)	24,430	14.1	46.4
	Residential aged care ^(b)	142,310	82.4	270.5
	Total^(b)	166,740	96.5	316.9

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

(b) Rates are calculated using population projections for 30 June 2001, 2001 data supplied by DHAC are provisional figures.

Source: ABS 2000a; AIHW 1999a:192; AIHW 2000a, 2000b, 2001a, 2001b; AIHW analysis of ABS Survey of Disability, Ageing and Carers, 1998; DHAC, unpublished data.

The availability of residential places has thus declined in recent years, to be below the official planning ratio for residential care of 90 places per 1,000 people aged 70 and over, set in the mid-1980s. Since 1985, the provision ratio for high care places (formerly nursing home beds) has moved from 67 places per 1,000 people aged 70 and over to 44

places in 2000, while that for low-level places (formerly hostel places) has moved from 32 places per 1,000 people aged 70 and over to 40 places (SCRCSSP 2001). The target planning ratio has been set for some years at 40 high care places and 50 low care places per 1,000 people aged 70 and over.

The national residential provision ratio of 83.8 places per 1,000 people aged 70 and over in 2000 conceals some noticeable differences in supply at the State and Territory level, with Victoria well below the national average at 79.7 places. New South Wales, Western Australia, South Australia, Tasmania and the Australian Capital Territory all lie quite close to the national average, while Queensland and the Northern Territory are higher at 88.3 and 89.2 respectively. The Northern Territory level of provision must be understood in the context of the comparatively high proportion of Indigenous Australians in the Northern Territory, the poorer health status of these people, their shorter life expectancy, and their use of aged care services at younger ages.

New allocations

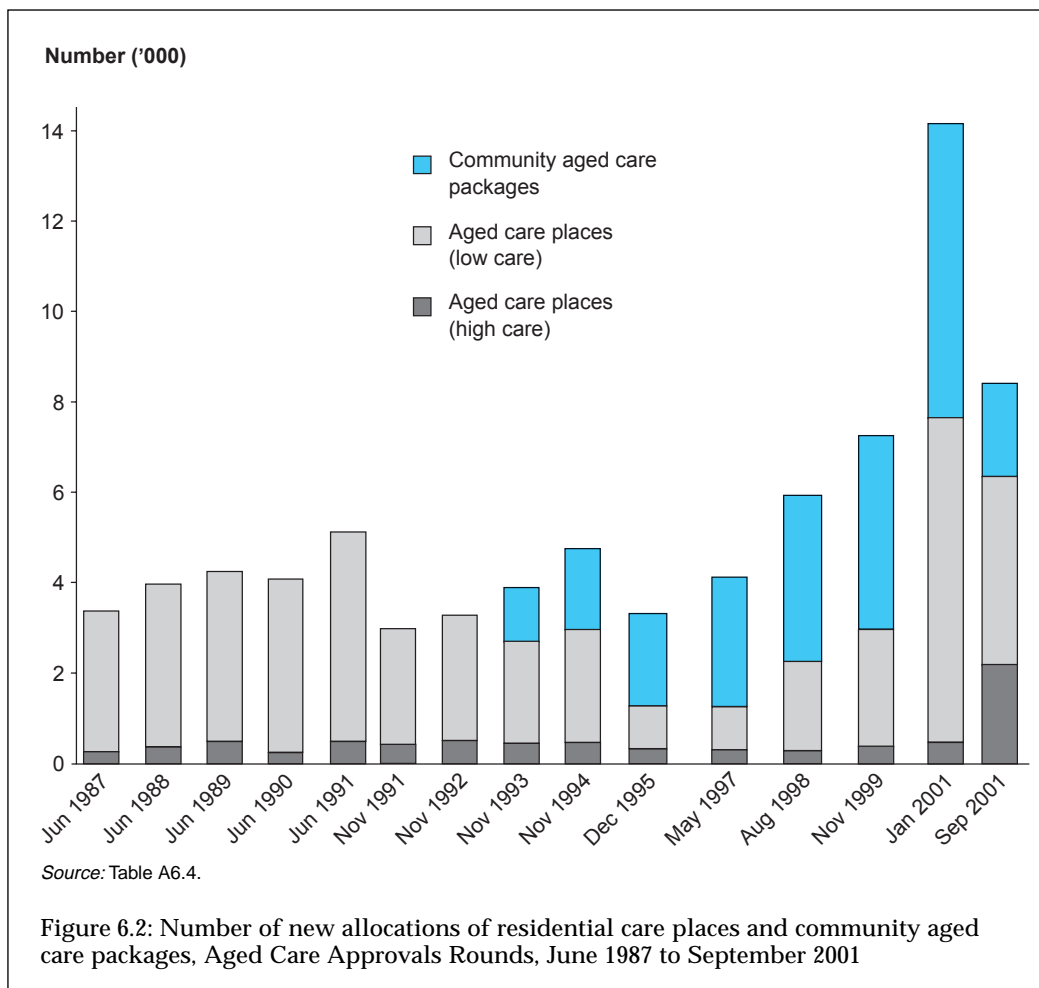
The development of new community aged care packages and residential aged care places can only occur where packages and places have been formally allocated to a provider as part of an Approvals Round. Prior to the Approvals Round process, the Commonwealth Government determines the number of places and packages to be offered and their general geographic distribution. Each Approvals Round takes place over a period of several months. The minister makes an initial announcement of the numbers of places and packages to be made available at the beginning of the Approvals Round, submissions for those places and packages are then received and reviewed, and an announcement of the final number of allocated places and packages is made at the conclusion of the Approvals Round.¹⁴ Figure 6.2 shows data on new allocations for community aged care packages and residential aged care places over the period from 1987 to 2001.

The number of new allocations for care packages rose steadily from their inception in 1993, reaching 6,532 in the 2000 Approvals Round (announced in January 2001). The number of packages (2,029) released as part of the 2001 Approvals Round is lower than in recent years.

The number of new allocations for residential care places was between three and four thousand in the late 1980s, rising to over 8,000 in 1991 (with two approvals rounds in that year). From 1992, the number of residential places allocated in the approvals rounds began to fall, with 1,253 places allocated in 1995, and none in 1996. By 1998, the

14 Allocated places and packages refer to the end point of the approvals process, when places and packages have been allocated to a specific provider who undertakes to begin supply of that service within the subsequent 2 years. The time period between allocation and the service becoming available to clients varies. On the one hand, the majority of care packages become available for use reasonably quickly, but on the other, where residential aged care places require capital works, the period to commencement of service is substantially longer. In recent years, a modest number of places have been made available outside the Approvals Round process for allocation to flexible care, emergency care and multi-purpose services.

number of new places allocated had begun to rise again, and this trend has accelerated in the last 2 years. There were 7,642 residential places allocated to providers in the 2000 Approvals Round, and a further 6,362 were made available to providers in the 2001 Approvals Round.¹⁵



Multi-purpose services and flexible services provided under the Aboriginal and Torres Strait Islander Aged Care Strategy

In addition to the services already described, the Commonwealth Government provides aged care services through multi-purpose services in rural and remote communities, and through flexible services under the Aboriginal and Torres Strait Islander Aged Care

15 A further 975 residential places are available in 2001, outside the Approvals Round, for flexible care, emergency care and multi-purpose services.

Strategy. Multi-purpose services were trialed in 1990 and expanded in 1994. In 2000, there were 44 multi-purpose services providing 905 residential places and 68 packages. Flexible services provided under the Aged Care Strategy for Indigenous Australians began operating in 1996, with a total of 27 places and packages, expanding to 246 places and packages by 1997. In 2000, there were 21 flexible services providing 275 places and 92 packages.¹⁶

Respite care

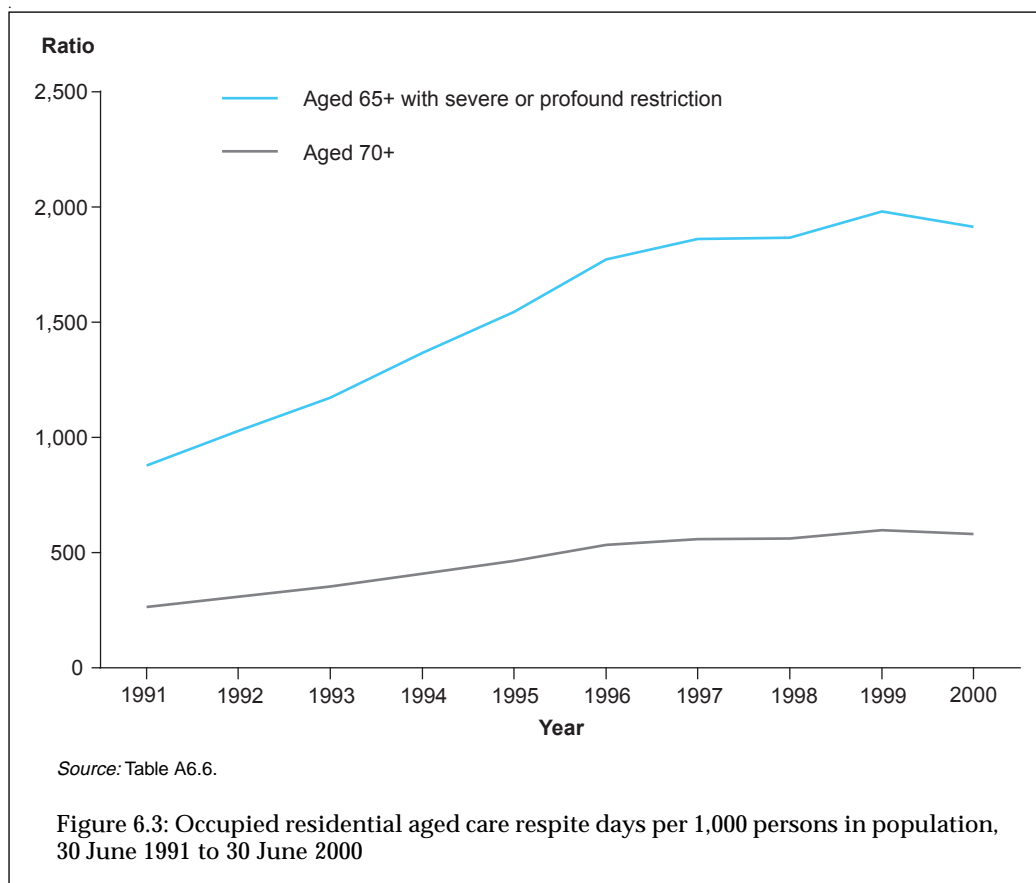
With the increasing trend towards home-based care and away from residential service provision, respite care has emerged as an important area of service provision. This has been evident in a number of government policy initiatives, with the announcement of the national Respite for Carers Program in the 1996—97 Budget, and respite care being a key component of the Staying at Home measures announced in the 1998—99 Budget. The data presented in Table 6.11 demonstrate that there was substantial growth in the provision of in-home respite care under the HACC program in relation to the population aged 65 and over with a profound or severe restriction (23% since 1993—94). Indeed, in-home respite and centre-based day care are the only areas of HACC where growth in program hours has outpaced growth in that population aged 65 and over with a profound or severe restriction in recent years. Respite care is also provided under the community aged care packages program, although no data are available as to the actual services received by care package recipients. The ratio of care package provision has also increased dramatically from its beginnings in 1993, and continued to expand rapidly in recent years (Table 6.12).

Residential respite care is also recognised as an important component of the carer support system, whether for emergency care, to provide a break while carers attend to other affairs or take a holiday, or for instances where carers themselves encounter health, personal or family problems. The number of days of residential respite supplied has steadily increased over the last decade, as has the proportion of residential care days used for respite care. Total respite days increased from 337,020 in the year ending 1991 to 978,408 in the year ending 30 June 2000; this is an average annual percentage increase of 12.8%. The increase was most pronounced during the period from 1991 to 1996 (19% per annum), weakening to an average of 5.0% per annum between 1996 and 2000. Between 1999 and 2000, the number of residential respite bed-days provided fell marginally (the only time this decade): from 980,545 to 978,408 (0.2% decrease in total days). This fall was more pronounced in Victoria (a 5.6% decrease) and in the Australian Capital Territory (8.9%), with more stable patterns in South Australia and Tasmania, and increases in New South Wales, the Northern Territory, Western Australia and Queensland. As a percentage of total bed-days, respite care increased from 0.8% in 1991 to 1.7% in 1996, and then to 2.0% in 1999, remaining at that figure in 2000 (Table A6.5).

16 More detailed information on these programs is provided in AIHW: Gibson et al. (2000).

The policy target for residential respite is generally regarded as the equivalent of 2 places per 1,000 persons aged 70 and over. Converting place days to places at the rate of 365 days per annum gives a figure of 0.72 places per 1,000 people aged 70 and over in 1991, rising to 1.64 places in 1999, then falling to 1.59 places in 2000.

These data on available respite can also be considered in relation to the population aged 70 and over and the population aged 65 and over with a severe or profound restriction. In 1990–91, 877 days of residential respite were provided per 1,000 people aged 65 and over with a severe or profound restriction. By 1998–99, this figure had more than doubled: to 1,979 days per 1,000 people aged 65 and over with a severe or profound restriction. The ratio of residential respite provision dropped slightly in 1999–00: to 1,913 days of residential respite per 1,000 people aged 65 and over with a severe or profound restriction.



Patterns of use in residential care

Data on the number of residential care places and the ratios of provision are static measures of the availability of residential care. The way these services are used that is, the movement of people through the residential care system is also important. Time-series data on admissions, separations, turnover, occupancy rates and length of stay have usually been included in this section. The merging of hostels and nursing homes into one system of care (and the consequent creation of a single residential care database) has, however, rendered certain of these measures largely non-comparable before and after the reforms. Movements from low care to high care were formerly recorded as a separation and admission as a resident moved from hostel to nursing home. Under the new system, low and high care will frequently be provided in the one aged care home, and thus a separation and admission is no longer recorded. Similarly, under the old system, length of stay in a hostel followed by length of stay in a nursing home were two separate measures; now they are often one continuous measure. Thus, the number of admissions and separations is lower in the new single system than the total for the dual system, and the length of stay is longer for those moving between low and high care. In this volume of *Australia's Welfare*, therefore, data are reported on these measures since the restructuring of the system in October 1997. Reliable data are not available for the period July to December 1997, so half-yearly data only are reported for that financial year.

In 1999–00, 45,476 people were admitted to aged care homes for permanent care, compared to 45,258 in 1998–99. For respite care, the figures were 42,531 in 1999–00, and 40,806 in 1998–99. Thus, almost half the admissions were for respite care, although in terms of bed-days respite residents occupy only 2%. Turnover for permanent residents did not change between 1998–99 and 1999–00, remaining constant at 0.32 permanent admissions per bed (Table 6.13).

Table 6.13: Residential aged care admissions, by care type, January–June 1998, 1998–99 and 1999–00

Care type	Jan–Jun 1998	1998–99	1999–00
Permanent	21,165	45,258	45,476
Respite	18,487	40,806	42,531
Total	39,652	86,064	88,007

Source: AIHW 1999b, 2000b, 2001b.

Figure 6.4 presents quarterly data on occupancy rates for nursing homes, hostels and the two systems combined for the period from July 1993 to December 2000. The combined system occupancy rate has been stable over the period, mostly ranging between 95% and 96%. Occupancy rates appear to drop slightly at the time of the reforms (1997), but there was a discontinuity in the data series at this time (owing to a change in the method of calculation) which makes the apparent shift unreliable. Since late 1997, occupancy has been trending up slightly: from 94.3% in the fourth quarter of 1997, to 96% in the fourth quarter of 2000.

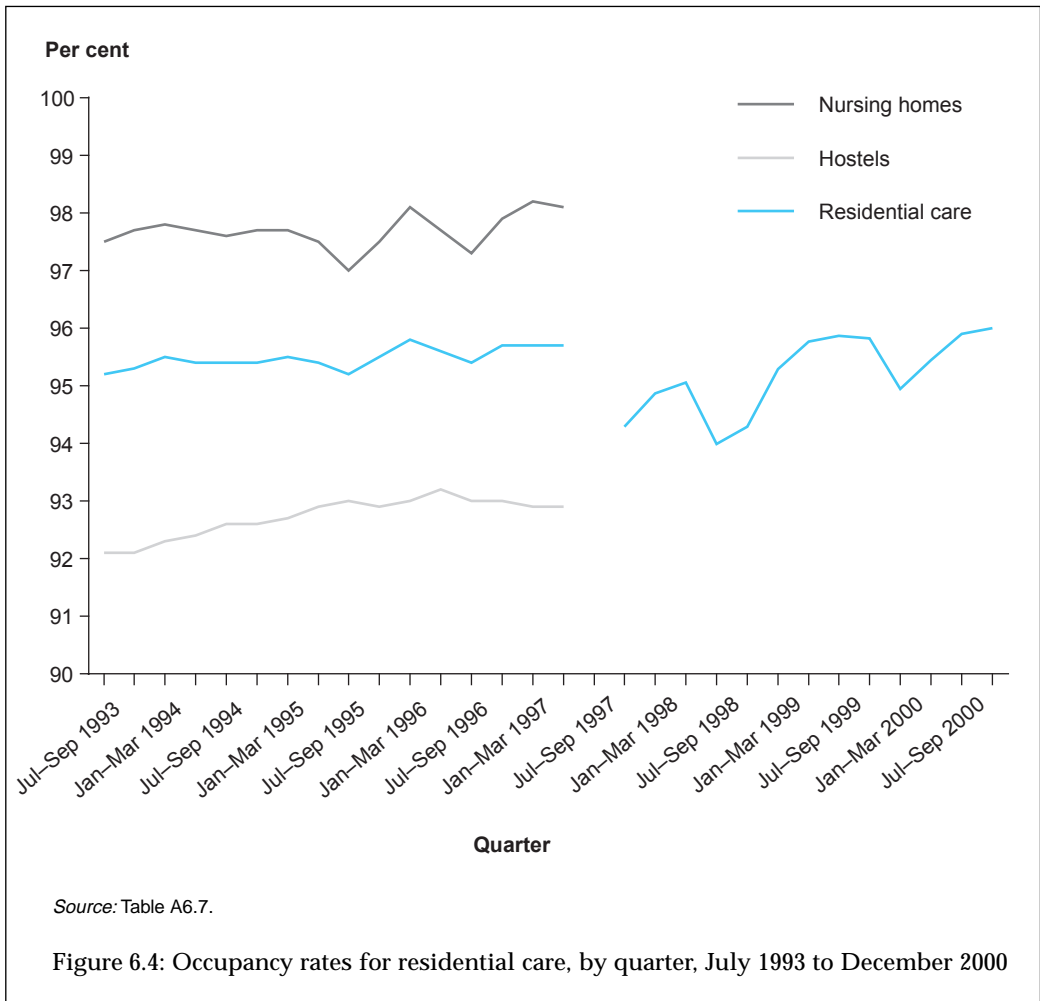


Table 6.14 presents data on length of stay for permanent residents of aged care homes as at 30 June 1998, 1999 and 2000. The data refer to people who were residents of an aged care home at that point in time. There is no strong trend evident in these data, although there is some evidence of a modest increase in the proportion of residents in the longer stay categories. Thus, at 30 June 1998, 38% of residents had stayed 3 years or more, while by 2000 the comparable figure was 42%. This change may well be associated with the impact of the ageing in place policy, implemented as part of the 1997 reforms, which allowed formerly low care residents who are reclassified to the higher care category to remain in the same aged care home (with service provider agreement).

Table 6.14: Current permanent residents, length of stay to date, 30 June 1998 to 30 June 2000 (per cent)

Length of stay	1998	1999	2000
<4 weeks	2.4	3.0	2.5
4-<13 weeks	4.6	5.8	4.8
13-<26 weeks	6.4	7.8	6.1
26-<52 weeks	13.4	13.8	11.9
1-<2 years	21.0	20.5	18.2
2-<3 years	14.7	14.6	14.5
3-<5 years	17.4	17.7	20.1
5 years or more	20.2	16.8	21.9
Total (%)	100	100	100
Total (N)	131,170	132,420	133,387

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

Source: AIHW 1999b:47, 2000b:47, 2001b:46.

Ageing in place

One of the more significant ramifications of the merging of the two systems of residential care, and the creation of the single eight-category Resident Classification Scale, was that residents of what were formerly hostels acquired the capacity, subject to the agreement of the service management, to age in place. Ageing in place is one of the specified objectives of the *Aged Care Act 1997*, and simply means that low care residents who become more dependent and require additional care can move to a high care classification within the same aged care home, without physically moving from a low care to a high care home. This has the advantage for residents that they (or their relatives) do not have to negotiate a move to a new service, and there is no need to adjust to new surroundings, new staff and new co-residents. This section explores the extent to which this policy has been taken up by residents and low care service providers by focusing analytic attention on those aged care homes which were historically hostels prior to the reforms, and hence exclusively low care providers.¹⁷

A number of effects can be expected as a result of the implementation of this policy. The most direct effect would be an increase in the level of dependency amongst residents of former hostels. Another expected effect would be a change in patterns of separation.

Between 30 June 1998 and 30 June 2000, the proportion of high care residents in former hostels increased from 11% to 19% (Table 6.15). The 11% represents the proportion of clients who were reclassified within the 9 months following the implementation of the ageing-in-place policy, and the shift from 11% to 19% the continuing impact of the

17 Increases in dependency can result from either the 'ageing in place' of existing residents or the admission of an increased proportion of high-dependency residents. By focusing on former hostels, which generally continue to be providers of low care services, this analysis essentially excludes increases in dependency associated with the admission of a greater proportion of high care residents, and focuses on those residents living in services which admit low care residents.

policy over the next 2-year period. By 30 June 2000, almost one in five residents living in what were hostels under the old system were receiving a high care level of subsidy. Most of these residents were at RCS levels 3 and 4, with less than 1% at RCS level 1 and only 3% at RCS level 2.¹⁸ Another trend evident in Table 6.15 is that, even among low care residents in former hostels, dependency as indicated by RCS category increased, with the proportion of RCS level 8 residents falling from 10% to 5%, and the proportion of RCS level 7 residents falling from 45% to 37%. By contrast, the proportion in RCS level 6 remained relatively steady, while that in RCS level 5 (the highest level of dependency in the low care category) increased.

While Table 6.15 shows that a change in RCS levels did occur among residents of former hostels, it does not indicate to what extent this shift was concentrated among particular establishments or occurred more generally across a large proportion of services. To establish how widespread the policy shift has been in this sense, service-level data are required (Table 6.16). Less than a year after the implementation of the reforms, at 30 June 1998, only 28% of former hostels had no high care residents. By 30 June 2000, this proportion had dropped even further, to 14%. These data suggest a very broadly based uptake of the ageing-in-place policy across former hostel establishments. Although the policy is widespread, for most of these establishments only a minority of clients fall into the high care category. At 30 June 2000, 41% of former hostels had no more than 10% of high care clients, 21% had between 11% and 20%, and 17% had between 21% and 30%. The time series presented in the table does suggest, however, that the proportion of former hostels with a larger percentage of high care residents is increasing over time.

Table 6.15: Permanent residents in former hostels, by dependency level, 30 June 1998 to 30 June 2000

Year	High care					Low care					Total
	RCS 1	RCS 2	RCS 3	RCS 4	RCS 1–4	RCS 5	RCS 6	RCS 7	RCS 8	RCS 5–8	
Number											
1998	50	618	2,750	2,536	5,926	7,686	11,539	24,651	5,362	49,145	55,071
1999	268	1,332	4,707	2,983	9,239	9,465	12,040	21,296	3,772	46,441	55,680
2000	406	1,728	5,189	3,427	10,750	9,655	12,209	20,441	2,856	45,161	55,911
Per cent (row)											
1998	0.1	1.1	5.0	4.6	10.8	13.9	20.9	44.7	9.7	89.2	100
1999	0.5	2.4	8.4	5.3	16.6	16.9	21.6	38.1	6.8	83.4	100
2000	0.7	3.1	9.3	6.1	19.2	17.3	21.8	36.6	5.1	80.8	100

Note: RCS is the Resident Classification Scale.

Source: AIHW analysis of DHAC ACCMIS database.

18 The Resident Classification Scale (RCS) is an eight-point scale used to classify residents in aged care homes. High care (formerly nursing home) residents have an RCS rating of 1 to 4, while low care (formerly hostel) residents have a rating of 5 to 8. The RCS level determines the level of payment which the home receives for each resident. In July 2001, the full Commonwealth daily subsidy for an RCS 5 resident was \$36.63 and for an RCS 1 resident it was \$109.97 (New South Wales data are used here; there are some interstate variations in subsidy levels for high care places).

Table 6.16: Former hostels, by per cent of high care residents, 1998, 1999 and 2000

Year	Per cent of high care residents (RCS 1–4)									
	0–10	11–20	21–30	31–40	41–50	51–60	61–70	71–80	81–90	91–100
	Number									
1998	971	273	131	56	29	16	13	6	4	2
1999	684	357	189	129	56	26	20	9	4	6
2000	597	314	242	150	72	40	20	12	10	7
	Per cent (row)									
1998	64.7	18.2	8.7	3.7	1.9	1.1	0.9	0.4	0.3	0.1
1999	46.2	24.1	12.8	8.7	3.8	1.8	1.4	0.6	0.3	0.4
2000	40.8	21.4	16.5	10.2	4.9	2.7	1.4	0.8	0.7	0.5

Notes

1. RCS is the Resident Classification Scale.
2. There were 419,249 and 210 services in 1998, 1999 and 2000 respectively with no high care residents.

Source: AIHW analysis of DHAC ACCMIS database.

Table 6.17: Discharges from former hostels for permanent residents, by separation mode, 1994–95 to 1999–00 (per cent)

Separation mode	1994–95	1995–96	1996–97	1997–98	1998–99	1999–00
Death	30.1	29.4	32.3	43.4	53.0	53.5
Return to community	9.0	8.6	7.8	8.5	7.4	6.5
To hospital	17.6	17.8	16.9	16.1	17.6	18.3
To other residential care	42.2	42.8	40.8	27.6	17.3	17.0
Unknown	1.2	1.4	2.1	4.4	4.7	4.6
Total separations (N)	16,306	17,117	17,895	14,208	12,276	12,496

Source: AIHW analysis of DHAC ACCSIS and ACCMIS databases.

Table 6.17 demonstrates the changing patterns of separation for residents of former hostels as a result of the implementation of the ageing-in-place policy. Between 1994–95 and 1999–00, the proportion of residents who left the (former) hostel in order to move to another residential care service decreased from 42% to 17%. (It is reasonable to assume that the majority of these moves would have been to a nursing home for higher level care.) Over the same period, the proportion of residents who remained in the home until their death increased from 30% to 54%, consistent with a strong trend towards ageing-in-place for these residents.

A cohort perspective

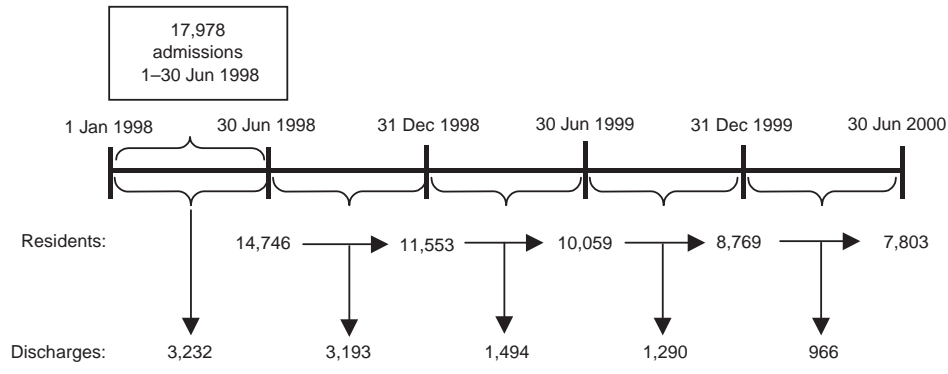
Apart from the conventional measures of the flow of residents through the residential aged care system, the movement of residents within the system is also of interest. This aspect of understanding the way in which residential aged care services are used by clients has received little attention to date, but has become more important under the present one-tier system of residential care. Figure 6.5 presents the results of an analysis which explores the extent of client movement within the residential care system. It focuses on the cohort of residents who entered aged care homes for permanent care between 1 January and 30 June 1998, and records the various transitions which occurred in the course of their stay.

In total, 17,978 people were admitted to aged care homes for permanent care over the first 6 months of 1998 (transfers are not included). This is the study population for the present discussion. By 30 June 1998 (i.e. the end of the 6-month entry period), 3,232 people (18%) had already been discharged. The majority of these had died (2,587), but 393 had returned to live in the community and 150 had been discharged to an acute care hospital. In the second 6-month period, from 30 June to 31 December, a further 3,193 people (18%) left aged care homes. Again, the vast majority of these had died (2,542), but a certain number returned to live in the community (285) and others separated to hospital (247). By the end of the period, 30 June 2000, 10,175 of the original cohort (57%) had left the system. While most had died (45% of the original admissions), a small proportion (5%) had returned to live in the community and another 4% had been discharged and admitted to an acute care hospital.

Over the period of study, there were 1,162 transitions from low to high care (as determined by the RCS category of residents), based on care status of the residents at the end of each 6-month period. There were also 265 transitions from high to low care. Looking at each 6-month period in turn, this shows a modest but significant proportion of care transitions. Of the 11,553 people still resident at 31 December 1998, 2% had moved from low to high care since admission, and 0.1% from high to low care. Between 31 December 1998 and 30 June 1999, 4% of those remaining at the end of the period had moved from low to high care, and 2% from high to low. In the next 6-month period to 31 December 1999, 2% had moved from low to high care and 0.2% from high to low. And in the final 6-month period, 5% of remaining residents were reclassified from low to high care, and 1% from high to low. Only 54% of those who were classified as low care residents at 30 June 1998 remained in the system classified as low care residents at the end of the period. The corresponding figure for high care residents was 42%.

Of those cohort members who left the system during the period under study, a number were re-admitted at a later stage.¹⁹ Of the original cohort members, 19% were subsequently discharged and re-admitted once, 3% twice, and 0.6% three or more times.

19 The analysis presented here focuses on the cohort admitted from 1 January to 30 June 1998. Those who were discharged and re-admitted at a later date remain outside the scope of the analysis.



Remaining residents

	30 Jun 1998	31 Dec 1998	30 Jun 1999	31 Dec 1999	30 Jun 2000
High	8,448	6,334	5,597	4,818	4,445
Low	5,984	5,012	4,342	3,872	3,306
No RCS category ^(a)	314	207	120	79	52
Total number	14,746	11,553	10,059	8,769	7,803

Movements

	1 Jan 1998 to 30 Jun 1998	1 Jul 1998 to 31 Dec 1998	1 Jan 1999 to 30 Jun 1999	1 Jul 1999 to 31 Dec 1999	1 Jan 2000 to 30 Jun 2000	Cumulative total
Category changes						
Low to high	n.a.	185	452	142	383	1,162
High to low	n.a.	12	167	17	69	265
Insufficient information	n.a.	207	204	109	85	605
No change during 6-month period						
High	n.a.	6,149	5,131	4,673	4,059	—
Low	n.a.	5,000	4,105	3,828	3,217	—
<i>Total</i>	<i>n.a.</i>	<i>11,149</i>	<i>9,236</i>	<i>8,501</i>	<i>7,276</i>	—
No change since 30 Jun 1998						
High	—	6,149	4,987	4,147	3,546	—
Low	—	5,000	4,096	3,625	3,045	—
<i>Total</i>	—	<i>11,149</i>	<i>9,083</i>	<i>7,799</i>	<i>6,591</i>	—
Discharges						
To the community	393	285	82	48	27	835
To hospital	150	247	165	119	100	781
Died	2,587	2,542	1,193	1,065	798	8,185
Other	102	119	54	58	41	374
<i>Total discharges</i>	<i>3,232</i>	<i>3,193</i>	<i>1,494</i>	<i>1,290</i>	<i>966</i>	<i>10,175</i>

Note: Does not allow for readmissions and the initial cohort excludes residents without a residential classification.

(a) RCS = Residential Classification Scale.

Source: AIHW analysis of Department of Health and Aged Care ACCMIS database.

Figure 6.5: The movement of the cohort of aged care home clients, by high (RCS 1–4) or low (RCS 5–8) dependency,^(a) who were admitted between 1 January and 30 June 1998

Probability of using an aged care home

Cross-sectional data indicate only the proportion using an aged care home at a particular point in time, and hence tend to give the impression that aged care homes are relevant only to a small proportion of older people. Table 6.18 presents data on the probability of entering an aged care home during the remaining lifetime, given that they have never entered an aged care home before, at various ages for both men and women. These data are important because they give an indication of the likelihood that any individual in the community will come to use an aged care home before they die. At any point in time, only 5.5% of people over the age of 65 are living in an aged care home. However, at age 65, the likelihood that a man in the community will enter an aged care home for permanent care before he dies is 0.28, or in other words 28% of men aged 65 living in the community could expect to enter an aged care home before they die. The corresponding figure for women is much higher, at 46%. These probabilities increase with age, meaning that those who survive to more advanced old age have a higher chance of entering an aged care home prior to death. At age 80, the probabilities are 0.36 for men and 0.52 for women, while at age 90 they increase again: to 0.42 for men and 0.54 for women.

The probabilities are higher again if respite care is included as well as permanent care. If the probabilities were calculated for all men and women at a given age, the probability of use before death is higher. These issues have been discussed in more detail, and alternative probabilities calculated, in a recent publication of the Institute (AIHW: Mason et al. 2001).

Table 6.18: Probability of someone in the community entering an aged care home, by care type and sex, 1999–00

Care type/sex	Age (years)							
	0	65	70	75	80	85	90	95
Permanent care								
Males	0.24	0.28	0.30	0.33	0.36	0.40	0.42	0.33
Females	0.42	0.46	0.47	0.50	0.52	0.54	0.54	0.48
Permanent and respite care combined								
Males	0.33	0.39	0.41	0.45	0.49	0.55	0.61	0.50
Females	0.59	0.64	0.67	0.70	0.74	0.79	0.87	1.00

Notes

1. The databases used in this analysis were the DHAC SPARC system 2000; ABS 1999:93–4; ABS 2000b:16–33.
2. The data in this table are estimated using life table models based on 1999–00 use patterns in aged care homes. These life tables are not included in this report.
3. The term 'someone in the community' is used to refer to a person who is not in an aged care home and has not used one before.

Source: AIHW: Mason et al. 2001.

Client profiles

Age and sex

Table 6.19 presents the most recent available data on the age and sex profiles of clients of community aged care packages and residential services. In contemporary Australia, aged care homes generally cater to a very old clientele. In 2000, almost one-quarter were aged over 90, fully half the residents were aged 85 or older, and almost three-quarters were aged 80 and over. Women predominate, making up 72% of the total resident population. Two in every five residents were women aged 85 or older. Community aged care package clients are somewhat younger, although the majority (59%) are still aged 80 or older. As was the case for residential aged care, women make up the majority of package clients (71%). Data on the clientele of HACC services are not yet available from the new HACC MDS, while data from the most recently completed HACC client survey (1998) were reported in *Australia's Welfare 1999* (AIHW 1999a:197).

Table 6.19: Aged care clients, by age, sex and dependency, 30 June 2000 (per cent)

Sex/age	Community aged care package clients	Residential aged care clients		
		High (1–4)	Low (5–8)	Total
Females				
Under 65	3.9	2.5	1.6	2.1
65–69	3.6	1.8	1.4	1.7
70–74	7.2	4.2	3.7	4.0
75–79	12.8	9.4	9.0	9.2
80–84	17.9	14.6	16.4	15.3
85–89	16.4	19.8	22.8	20.9
90+	8.9	19.6	18.6	19.2
<i>Total females</i>	<i>70.6</i>	<i>71.8</i>	<i>73.4</i>	<i>72.4</i>
Males				
Under 65	3.1	2.6	2.1	2.4
65–69	2.1	1.7	1.5	1.6
70–74	3.5	3.3	2.9	3.2
75–79	5.2	5.4	4.3	4.9
80–84	6.3	5.8	5.3	5.6
85–89	5.9	5.7	6.2	5.9
90+	3.3	3.7	4.4	4.0
<i>Total males</i>	<i>29.4</i>	<i>28.2</i>	<i>26.6</i>	<i>27.6</i>
Persons				
Under 65	7.0	5.1	3.7	4.5
65–69	5.7	3.5	3.0	3.3
70–74	10.7	7.6	6.6	7.2
75–79	18.0	14.8	13.3	14.2
80–84	24.2	20.4	21.7	20.9
85–89	22.3	25.4	28.9	26.8
90+	12.2	23.3	51.9	23.1
<i>Total persons</i>	<i>100.0</i>	<i>100.0</i>	<i>100.0</i>	<i>100.0</i>
Total (N)	16,617	80,483	49,833	130,316

Note: This table excludes 3,071 residents whose dependency levels were not reported.

Source: AIHW 2001a, 2001b.

Use by Aboriginal and Torres Strait Islander people

Table 6.20 shows the rates of use for Indigenous and non-Indigenous Australians using residential aged care services and community aged care packages.²⁰ The age categories employed are somewhat different to those used in the remainder of the chapter, owing to the relatively small size and the younger age structure of the Indigenous resident population. Usage rates for community aged care packages were markedly higher for Indigenous Australians than for non-Indigenous Australians. Among people aged 50–74, the rate of use was 8 per 1,000 for Indigenous Australians and 1 per 1,000 for non-Indigenous Australians. For those aged 75 and over, the rates were 39 per 1,000 and 12 per 1,000 respectively.

Rates of residential care use were also higher for Indigenous Australians than for non-Indigenous Australians. For those aged 50–74, the rate of use was 10 per 1,000 persons for Indigenous Australians, and 4 per 1,000 for non-Indigenous Australians. At ages 75 and over, the numbers were 133 per 1,000 and 106 per 1,000 respectively. This finding of higher use rates within these age categories is striking, given that the average age of Indigenous people in each age category is lower than the average age of non-Indigenous people in the comparable category.

Table 6.20: Age- and sex-specific usage rates for aged care services, by Indigenous status, 30 June 2000

Indigenous status/sex	Community aged care packages per 1,000 population		Permanent residential aged care places per 1,000 population	
	50–74	75+	50–74	75+
Indigenous				
Female	10	42	8	151
Male	6	34	11	105
<i>Total Indigenous</i>	<i>8</i>	<i>39</i>	<i>10</i>	<i>133</i>
Not Indigenous				
Female	1	14	4	133
Male	1	8	4	65
<i>Total not Indigenous</i>	<i>1</i>	<i>12</i>	<i>4</i>	<i>106</i>

Notes

- Residents with unknown status have been pro rated.
- This table does not include places and packages provided by multi-purpose services operating in regional and remote areas of Australia or places and packages funded under the Aboriginal and Torres Strait Islander Flexible Care Program for which no age data are available.

Source: ABS 1998, 2000a; AIHW analysis of DHAC ACCMIS database.

²⁰ Data on the use of HACC services by Aboriginal and Torres Strait Islander people are not yet available from the new HACC MDS, and data from the most recently completed HACC client survey were reported in *Australia's Welfare 1999*. Rates of use are calculated as the number of clients in each age and sex group per 1,000 people in that age and sex group.

Use by people from culturally and linguistically diverse backgrounds

Table 6.21 shows rates of use of community aged care packages and residential care services by overseas-born people from culturally and linguistically diverse backgrounds, overseas-born people from English-speaking backgrounds, and the Australian born.²¹ The table shows the different rates of use according to English Proficiency (EP) Group. The EP Group classification was developed by the Bureau of Immigration, Multicultural and Population Research in 1999 (DIMA 1999), and divides the overseas-born population into four groups based on the English proficiency levels of recently arrived migrants according to country of birth. EP Group 1 comprises people born in English-speaking countries; EP Group 2 comprises those countries from which at least 80% of recent immigrants speak only English or another language and good English (e.g. Malta, Austria and Germany); EP Group 3 comprises those countries from which at least 50% but less than 80% of recent immigrants speak only English or another language and good English (e.g. Greece, Italy and Poland); and EP Group 4 comprises those countries from which less than 50% of recent immigrants speak only English or another language and good English (e.g. Turkey, Viet Nam and China).²² The classification was developed to counter the tendency to use concepts such as Non-English-Speaking Background (NESB) which fail to recognise the diversity evident within that category. The EP Group classification has been shown to be a useful tool in exploring the social and economic circumstances of older people from a culturally and linguistically diverse background, and their use of government benefits and services (AIHW: Benham & Gibson 2000).

As is evident from the table, the rates of use for community aged care packages were largely comparable across all groups, ranging from 5 to 7 packages per 1,000 people aged 65 and over. When age-specific categories are examined, however, some differences do emerge. For the older age categories, and especially among people aged 85 and over, EP Groups 2, 3 and 4 have higher rates of use of community aged care packages than either EP Group 1 (those from English-speaking countries) or the Australian born. These differences are concealed in the general 65 and over usage rate because older overseas-born people from a culturally and linguistically diverse background tend to have a younger population profile than either EP Group 1 or the Australian born. As the population profiles of EP Groups 2, 3 and 4 are expected to age more rapidly over the next decade than the Australian born, these data suggest a likely increasing demand for community aged care packages among older overseas-born people from a culturally and linguistically diverse background.

For residential aged care, the usage rates for persons 65 and over show a marked difference among the five groups. Rates are highest among the Australian born, at 60 people per 1,000 persons aged 65 and over, with a somewhat lower rate of use by those in EP Group 1 (49 people per 1,000). Rates for EP Groups 2, 3 and 4 are substantially

21 Data on the use of HACC services by overseas-born people from culturally and linguistically diverse backgrounds are not yet available from the new HACC MDS, and data from the most recently completed HACC client survey were reported in AIHW (1999a).

22 For more details of the classification, see AIHW: Benham & Gibson (2000).

lower, at 38 per 1,000, 27 per 1,000 and 20 per 1,000 respectively. Older Australian-born people are thus three times more likely to use aged care homes than members of EP Group 4, and twice as likely as members of EP Group 3. When the age structure of the population is taken into account by examining age-specific usage rates, the differences do become somewhat less pronounced, but they remain substantial. Among those aged 85 and over, for example, there were 279 Australian-born people in aged care homes for every 1,000 in the population. The comparable numbers are 235 for EP Group 1, 224 for EP Group 2, 153 for EP Group 3 and only 106 for EP Group 4.

Table 6.21: Age- and sex-specific usage rates for aged care services, by English Proficiency Group, 30 June 2000

Sex/EP Group	CACP ^(a) recipients per 1,000 population				Residential aged care clients per 1,000 population			
	65–74	75–84	85+	65+	65–74	75–84	85+	65+
Females								
EP1	2	8	20	7	8	56	276	67
EP2	3	13	28	9	9	63	263	50
EP3	3	11	21	7	7	45	185	35
EP4	2	11	18	7	6	35	129	28
Australian born	2	9	20	7	12	74	319	77
<i>Total females</i>	2	9	21	7	11	68	299	69
Males								
EP1	1	4	14	3	7	32	151	28
EP2	2	6	22	4	8	40	147	25
EP3	1	5	15	3	6	28	108	19
EP4	1	6	17	4	4	20	62	12
Australian born	1	5	16	4	12	46	180	36
<i>Total males</i>	1	5	16	4	10	41	164	32
Persons								
EP1	1	6	18	5	7	46	235	49
EP2	2	10	26	7	9	53	224	38
EP3	2	8	18	5	6	37	153	27
EP4	2	9	18	5	5	29	106	20
Australian born	2	7	19	6	12	63	279	60
Total persons	2	7	19	6	10	57	257	53

(a) Community Aged Care Packages.

Notes

1. There were 3,205 residential aged care residents and 2,380 CACP recipients for whom country of birth data were missing.
2. The English Proficiency Groups classification was developed by the Bureau of Immigration, Multicultural and Population Research. This classification uses the English proficiency levels of recently arrived migrants in order to divide the overseas-born population into four groups. Overseas-born people are assigned to a group according to their country of birth.

Source: ABS 2000a; AIHW 2001a, 2001b.

Dependency levels

Data on dependency are collected for residents of aged care homes, but no recent data are available on the dependency levels of community aged care package clients, and dependency data are not collected in the HACC program.²³ This means that the only service-based dependency data are those describing the residential aged care program.

Recent years have seen considerable conjecture and debate about the rising dependency levels of residents in aged care homes. There was some evidence of rising dependency within the former two-level residential care system. Previous data published by the AIHW have shown that dependency levels were increasing in both nursing homes and hostels (AIHW 1997b, 1998a, 1998b, 1998c, 1999b). In addition, the relative increase in the number of hostel places has meant that, with time, an increasing proportion of the residential care population was accommodated in hostels rather than in nursing homes (AIHW 1999a:204–5). Under the current single-tier system, the proportion of residents at higher dependency levels has also been increasing. In 1998, 57.8% of residents were classified as RCS 1 to 4, and by 2000 it was 61.8%. At the other end of the spectrum, the percentage of residents classified as RCS 8 has declined from 4.5% in 1998 to 2.3% in 2000 (Table 6.22). The change in systems has made comparison over time difficult, as the various dependency classifications in use prior to and after the reforms are not strictly comparable.

Table 6.22: Permanent residents, by level of dependency at 30 June 1998, 1999 and 2000

Year	RCS 1	RCS 2	RCS 3	RCS 4	RCS 5	RCS 6	RCS 7	RCS 8	Total
Number									
1998	8,868	32,279	26,250	7,398	9,910	12,576	26,287	5,835	129,403
1999	15,971	33,279	22,995	5,875	11,072	13,036	22,383	3,944	128,555
2000	18,786	33,835	21,781	6,081	11,538	13,399	21,869	3,027	130,316
Per cent (row)									
1998	6.9	24.9	20.3	5.7	7.7	9.7	20.3	4.5	100.0
1999	12.4	25.9	17.9	4.6	8.6	10.1	17.4	3.1	100.0
2000	14.4	26.0	16.7	4.7	8.9	10.3	16.8	2.3	100.0

Notes

1. RCS is the Resident Classification Scale.
2. In 1998, 1999 and 2000, there were 1,767, 3,865 and 3,071 residents respectively whose dependency levels were not recorded in the databases at the time.

Source: AIHW 1999b, 2000b 2001b.

There are, however, some personal care items which were in use in the previous hostel and nursing home classifications, and are also in use in the present residential classification scale. Data on these items are presented in Table 6.23 for 1994, 1997 and 2000. These data show a substantial increase in the proportion of residents requiring at

²³ A consultancy on possible dependency measures for inclusion in the HACC MDS has recently been completed. Such measures, if agreed, will not be scheduled for inclusion in the HACC MDS prior to July 2003.

least some assistance with toileting, eating and drinking, washing and dressing, continence, and the management of verbally disruptive behaviour or physical aggression. The greater part of this increase appears to have occurred in the period from 1997 to 2000. By 2000, 93% of residents required at least some assistance with washing and dressing, 81% with continence, 76% with eating and drinking, 68% with toileting, and 55% with regard to verbally disruptive or physically aggressive behaviour. Some caution must be exercised in interpreting these data, however, as although the data items are consistent across the time series, the items form part of the RCI and PCAI scales for 1994 and 1997, and the RCS in 2000.²⁴

Table 6.23: Dependency of permanent residents of aged care homes, by selected RCS^(a) items, 30 June 1994, 1997 and 2000

Assessment items	Per cent requiring at least some assistance		
	1994	1997	2000
Toileting	59	60	68
Eating and drinking	60	64	76
Washing and dressing	81	83	93
Continence	55	58	81
Verbal disruption/physical aggression	28	30	55

(a) RCS is the Resident Classification Scale.

Source: AIHW analysis of DHAC ACCMIS database.

As was demonstrated earlier in this chapter, some 20% of former hostel places are now occupied by high care residents. While some component of this change involves the simple reclassification of people who were previously inappropriately classified as low care residents, the dependency items reported here suggest that there may well have been a real shift in the dependency levels of the client population. This pattern, while in some ways quite dramatic, is broadly consistent with government policy, which aims to provide assistance to a greater proportion of frail and disabled older people at home, rather than in residential care, via services provided through community aged care packages and the HACC program. Residential aged care is thus being concentrated on a progressively more dependent component of the aged population.

Pension status

Table 6.24 shows the pension status of aged care home residents admitted during the period 1993–94 to 1999–00. The most obvious trend is the reduction in the proportion of missing data. Taking this into account, it appears that the pension status profile of persons entering aged care homes remained largely unchanged over the period. For those residents admitted during 1999–00, 87% received either a full or part pension, 10% no pension, and data were not available for the remaining 3%. Data presented in

24 The Resident Classification Instrument (RCI) and Personal Care Assessment Instrument (PCAI) were the scales on which Commonwealth subsidy levels were based in nursing homes and hostels respectively, prior to the implementation of the 1997 aged care reforms.

Table 6.24: Admissions to residential aged care, by sex and pension status, 1993–94 to 1999–00 (per cent)

Sex/pension status	1993–94	1994–95	1995–96	1996–97	1998^(a)	1998–99	1999–00
Males							
Receives pension	79	80	85	87	84	85	86
Does not receive pension	4	3	4	4	8	10	10
Missing data ^(b)	17	17	12	10	8	6	4
<i>Total males (N)</i>	<i>17,118</i>	<i>18,191</i>	<i>17,447</i>	<i>17,562</i>	<i>13,190</i>	<i>16,016</i>	<i>15,482</i>
Females							
Receives pension	80	82	86	87	80	87	87
Does not receive pension	3	2	3	3	8	9	10
Missing data ^(b)	16	16	11	10	11	3	3
<i>Total females (N)</i>	<i>31,950</i>	<i>33,755</i>	<i>33,645</i>	<i>33,632</i>	<i>7,748</i>	<i>28,164</i>	<i>28,935</i>
Persons							
Receives pension	80	81	85	87	83	86	87
Does not receive pension	4	3	3	3	8	9	10
Missing data ^(b)	17	16	11	10	9	4	3
Total persons (N)	49,068	51,946	51,092	51,194	20,938	44,180	44,417

(a) Six-month period (January to June 1998) only.

(b) Missing data are unknown plus not reported.

Source: AIHW 1999a, 2001b.

the *Two Year Review of Aged Care Reforms* report indicate that, of those admitted during 1999–00, just under three-quarters of those receiving a pension were receiving a full pension (Gray 2001:64).

Expenditure

Government expenditure on aged care services

Table 6.25 presents data on aged care recurrent expenditure in both current and constant (1998–99) prices for the years from 1995–96 to 1999–00. Total expenditure on aged care homes, HACC, assessment, community aged care packages, multi-purpose services, Carer Allowance and the Accreditation program increased from \$3,379.8 million in 1995–96 to \$4,839.9 million in 1999–00 (current prices). This represents an increase of 43% in real terms over the past 4 years. The proportions allocated to each area have remained relatively stable, although there has been an increase in the proportion allocated to community aged care packages (from 1% to 3%, or in actual dollar terms from \$33.1 million to \$148.9 million). Aged care homes were the largest area of expenditure, dropping slightly from 80% in 1995–96 to 77% in 1999–00. HACC remained relatively constant, moving from 16% in 1995–96 to 15% in 1999–00.

Table 6.25: Recurrent aged care expenditure in current and constant (1998–99) dollars, by program, 1995–96 to 1999–00

Program	1995–96	1996–97	1997–98	1998–99	1999–00
Current prices (\$m)					
Aged care homes	2,695.0	2,997.0	3,381.0	3,584.0	3,741.3
Home and community care ^(a)	554.0	615.6	630.2	673.4	722.4
Assessment	38.2	38.4	39.8	38.6	40.1
Community aged care packages	33.1	51.6	84.1	121.8	148.9
Multi-purpose flexible services	12.8	17.7	25.3	29.4	38.7
DNCB ^(b) /Carer Allowance ^(c)	46.7	51.9	52.9	71.6	140.8
Accreditation	—	—	5.1	5.9	7.8
Total	3,379.8	3,772.2	4,218.3	4,524.7	4,839.9
Constant prices (\$m)					
Aged care homes	2,848.8	3,112.1	3,460.6	3,584.0	3,660.7
Home and community care ^(a)	585.7	639.3	645.0	673.4	706.8
Assessment	40.4	39.9	40.7	38.6	39.2
Community aged care packages	35.0	53.6	86.1	121.8	145.7
Multi-purpose flexible services	13.5	18.4	25.8	29.4	37.9
DNCB ^(b) /Carer Allowance ^(c)	49.4	53.9	54.1	71.6	137.8
Accreditation	—	—	5.2	5.9	7.6
Total	3,572.8	3,917.2	4,317.6	4,524.7	4,735.7

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

(b) Domiciliary Nursing Care Benefit.

(c) Carer Allowance estimated according to the proportion of recipients aged 65 or more years.

Source: AIHW health expenditure database; DHAC 1998, 1999, 2000; DHAC, unpublished data; DHFS 1996, 1997; FaCS 2000.

Table 6.26 presents data on aged care recurrent expenditure, in both current and constant (1998–99) prices for the years from 1995–96 to 1999–00, in relation to the number of people aged 65 and over with a severe or profound restriction. The increase in expenditure on aged care services overall has kept pace with the growth in the number of older people needing some assistance; indeed, the amount of expenditure per person aged 65 and over with a severe or profound restriction increased during the last 4 years in real terms. In 1995–96, total aged care expenditure (in constant 1998–99 prices) was \$7,857.7 per person aged 65 and over with a severe or profound restriction. In 1999–00, the figure had increased to \$9,243.5. Annual growth was around 6 to 7% per person per annum for the first part of the period, falling to 1.8% in the period between 1997–98 and 1998–99 and then to 1.4% in the period from 1998–99 to 1999–00. The largest areas of growth in terms of expenditure per person aged 65 years and over with a severe or profound restriction were community aged care packages, multi-purpose and flexible type services and the Carer Allowance. For assessment, expenditure per person aged 65 years and over with a severe or profound restriction declined over the period.

Table 6.26: Recurrent aged care expenditure per person with a profound or severe core activity restriction, in constant (1998–99) dollars, 1995–96 to 1999–00

Program	1995–96	1996–97	1997–98	1998–99	1999–00
Constant prices (\$m)					
Aged care homes	6,265.5	6,639.3	7,178.6	7,220.0	7,145.2
Home and community care ^(a)	1,288.1	1,363.8	1,338.0	1,356.6	1,379.6
Assessment	88.8	85.1	84.5	77.8	76.6
Community aged care packages	77.0	114.3	178.6	245.4	284.4
Multi-purpose flexible services	29.8	39.3	53.6	59.2	73.9
DNCB ^(b) /Carer Allowance ^(c)	108.6	115.0	112.3	144.2	268.9
Accreditation	—	—	10.7	11.9	14.8
Total	7,857.7	8,356.7	8,956.3	9,115.1	9,243.5
Annual growth rates (per cent)					
Aged care homes	—	6.0	7.5	0.6	-1.0
Home and community care ^(a)	—	5.9	-1.9	1.4	1.7
Assessment	—	-4.2	-0.7	-8.0	-1.5
Community aged care packages	—	48.5	36.0	37.4	15.9
Multi-purpose flexible services	—	31.9	26.8	10.5	24.9
DNCB ^(b) /Carer Allowance ^(c)	—	5.9	-2.4	28.4	86.4
Accreditation	—	—	—	10.9	24.7
Total	—	6.4	6.7	1.8	1.4

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

(b) Domiciliary Nursing Care Benefit.

(c) Carer Allowance estimated according to the proportion of recipients aged 65 or more years.

Source: AIHW health expenditure database; DHAC 1998, 1999, 2000; DHAC, unpublished data; DHFS 1996, 1997; DHAC FaCS 2000.

User charges

Although no national data are available on user charges for community care services, there are some data for residential care. For residents who meet the income and assets test, the maximum daily care fee is set at 85% of the Age Pension. For residents on higher incomes, income-tested fees are charged, at the rate of 25 cents for every additional dollar of income, up to a maximum level of three times the pensioner rate or the cost of care, whichever is the lower.

In 1997–98, the basic daily care fee yielded \$1,067.5 million in user charges, and the income-tested component an additional \$1.7 million. By 1999–00, the comparable figures were \$1,138.0 million and \$37.5 million. Focusing on payments for care services (i.e. excluding accommodation payments and Commonwealth capital subsidies), user charges accounted for 26.1% of the \$4,098 million available to aged care homes in 1997–98, and 24.8% of the \$4,740 million available in 1999–00. Taking all payments by the Commonwealth Government and residents into account, residents contributed 27.6% in 1997–98, and 29.0% in 1999–00.

Expenditure on older Australians

Table 6.27 provides a broader view of expenditure on older Australians, taking into account expenditure on income support (including both Department of Veterans Affairs and Age pensions), residential care, home-based care, and medical, hospital and pharmaceutical services. Total expenditure on people aged 65 and over in 1998–99 was

\$29,000 million. The largest area of expenditure was income support (\$16,611 million), followed at some distance by hospital expenditure (\$5,228 million) and residential care (\$3,423 million). Over the period from 1989–90 to 1998–99, the fastest growing areas of expenditure were pharmaceutical services and home-based care (both 8.6% per annum), followed by medical services. The slowest growth was in the area of income security (2.7% per annum).

Table 6.27: Expenditure on people aged 65 and over, by service type, 1998–99

Service type	\$million	Average annual growth 1989–90 to 1998–99
Age Pension ^(a)	16,611	2.7
Public hospitals	5,228	4.9
Medical services	1,874	7.5
Pharmaceutical services	959	8.6
Residential aged care	3,423	5.6
Home-based care ^(b)	905	8.6

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

(b) Includes community aged care packages, Commonwealth-funded respite services, the Aged Care Assessment Program, HACC and Cover Allowance.

Source: Updated from AIHW: Choi 1998.

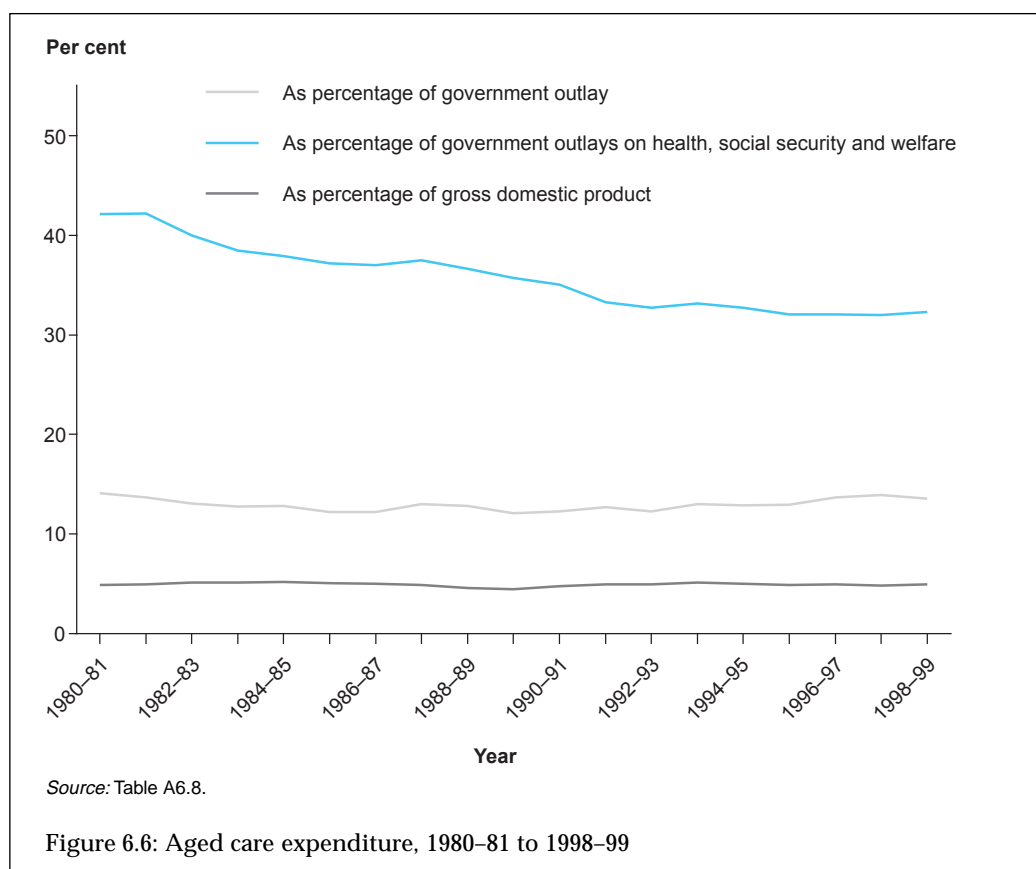


Figure 6.6: Aged care expenditure, 1980–81 to 1998–99

As a proportion of GDP, government expenditure on older Australians remained relatively unchanged over the 18 years from 1980—81 to 1998—99 (at around 4.9%). As a proportion of total government outlays, expenditure has remained relatively stable, moving from 14.1% in 1980—81 to 13.5% in 1998—99. As a proportion of government outlays on health, welfare and social security, expenditure on older Australians declined from 42.2% in 1980—81 to 32.1% in 1995—96, and since then has largely stabilised (see Figure 6.6).

6.4 Outcomes

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

Accessibility

The measure of accessibility used in this chapter has previously related admissions to the population with a severe or profound core activity restriction (AIHW 1999a). Given that this would allow only a 2-year time series, however, in this edition the number of residents at a point in time has been substituted as a numerator, thus allowing a longer time series to be presented. This measure should be a reasonable indicator of accessibility, given that there is no evidence of a significant change in turnover.

Section 6.3 presents data on changes in the number of permanent and respite admissions to aged care homes in the last 2 years and on changes in turnover. The restructuring of residential care into a single residential care system in late 1997 precludes comparison with data prior to 1998—99, as admissions and separations prior to that point included movements between hostels and nursing homes, movements which are not recorded. There was a very small trend towards reduced turnover for permanent care prior to the structural reforms (AIHW 1999a), while in the 2 years of data since the reforms turnover has been stable.

In 1994, there were 56 people aged 65 and over living in aged care homes for every 1,000 people aged 65 and over in Australia (Table 6.28). In 1997, that figure was still 56, but by 2000 it had dropped to 54. The change was most evident in the 85 and over age group, dropping from 307 persons per 1,000 people aged 85 and over in 1994 to 256 in 2000. There was virtually no change in the usage rate for those aged 65—74, with a shift from 12 per 1,000 to 11 per 1,000. The change in rate of use was also somewhat more pronounced among women than men. These figures inevitably show that access to aged care homes in Australia has reduced in this period. However, it is important to recognise that this shift is consistent with government policy, which has for a number of

years focused on expanding the range of community-based services, and increasing the proportion of frail and disabled older people who are able to remain in their own homes. In this context, declining accessibility to aged care homes is not necessarily negative, if it indicates an expression of the preference among older people to remain in the community with appropriate levels of assistance. Such data are best interpreted in conjunction with survey information on unmet demand for residential care, or data on waiting times for those people actively seeking admission to an aged care home.²⁵ Unfortunately, such data are not available.

Table 6.28: Age- and sex-specific usage rates for residents of aged care homes, 30 June 1994, 1997 and 2000

	Per 1,000 persons											
	Female				Male				Persons			
	65-74	75-84	85+	65+	65-74	75-84	85+	65+	65-74	75-84	85+	65+
1994	12.5	85.1	351.1	72.7	11.0	50.0	200.9	33.3	11.8	71.1	306.9	55.6
1997	12.2	80.1	331.1	73.2	10.8	46.3	183.9	32.9	11.5	66.4	286.9	55.6
2000	11.6	70.8	299.0	70.5	10.6	41.6	161.6	32.0	11.1	58.7	256.3	53.6

Source: ABS 2000a; AIHW 2001b; DSHS 1995.

Geographic distribution of services

Figure 6.7 provides a summary illustration of the supply of HACC services, community aged care packages and residential aged care per 1,000 people aged 70 and over by geographic region. The vertical axis represents the supply of residential places plus care packages, while the horizontal axis represents HACC service hours per month. The dotted lines indicate the national average for both service types.

If residential aged care places are considered separately (Table A6.10), it is clear that some regions have a level of supply well below the national average (84.5). The remote regions of New South Wales, and the rural regions of Western Australia and of South Australia, were all more than 10 places per 1,000 people aged 70 and over below the national average. The other metropolitan and the rural regions of New South Wales, Melbourne, remote Victoria and remote Tasmania were all five or more places below the national average. However, most of these regions have supplies of home-based care services (through the Community Aged Care Packages and HACC programs) which are above the national average. Overall, a recent AIHW analysis of this issue concluded that there was a reasonable level of equity in the overall supply of aged care services across States and Territories and regions (AIHW: Gibson et al. 2000).

25 There are presently no data available on length of time from the date of decision to enter an aged care home to date of admission. DHAC and the Productivity Commission publish data on elapsed time between an aged care assessment team recommendation for admission to an aged care home, and actual admission to a home. However, such data include people who elect not to enter the home at that time, or who delay entry for personal reasons unrelated to the availability of care. This substantially reduces the usefulness of such a measure as an indication of the unmet demand for residential care.

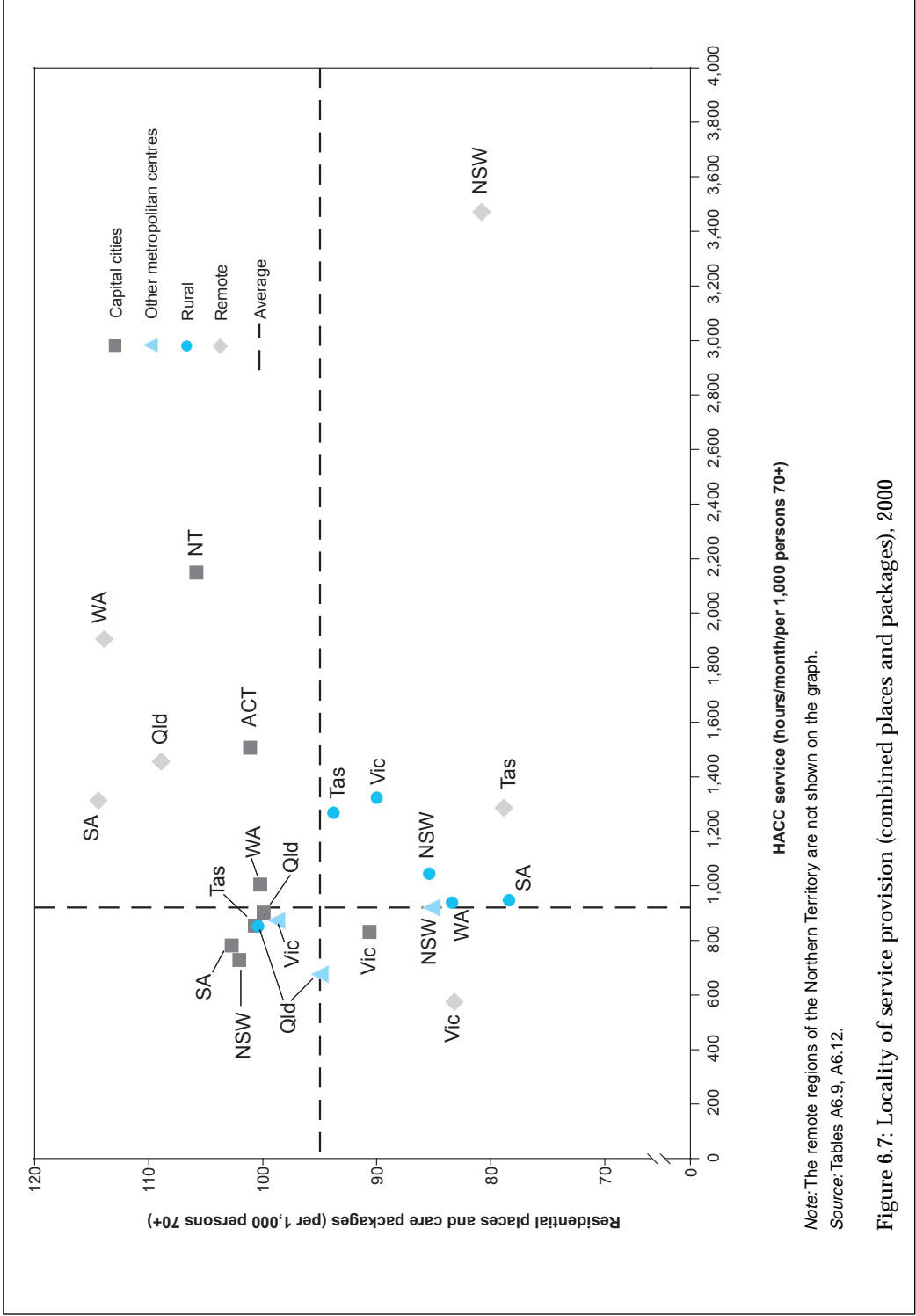


Figure 6.7: Locality of service provision (combined places and packages), 2000

Figure 6.7 shows that this continues to be the case, with most regions in most States and Territories clustered around the national average. Those regions which were somewhat more widely dispersed were either high on both dimensions (i.e. in the right upper quadrant), as was the case with remote Queensland, or below average on one dimension with a compensating higher supply on the other, such as Sydney or remote Tasmania. The lower left quadrant represents those regions which have a lower than average supply on both dimensions. Only remote Victoria and Melbourne fell into this quadrant, with Melbourne being relatively close to the national average on both dimensions.

Some areas fell below the average level of supply on one dimension, without a compensating above-average level of supply on the other dimension. The other metropolitan areas of New South Wales, and the rural areas of South Australia and Western Australia, had a below-average supply of places and packages, with a roughly average level of HACC services. Rural Queensland had a lower than average supply of HACC services, combined with an average supply of places and packages. More detailed tables on levels of services available in each region of each State and Territory are included in the Appendix (Tables A6.9, A6.10, A6.11).

Standards and quality of care

Recent years have seen significant developments with regard to quality appraisal in both residential care and HACC services. The accreditation process for residential aged care homes is now well established, and national data are now available. For the HACC program, although implementation is well under way in most States and Territories, no national data are available. The data presented in this section thus focus on residential care.

The *Aged Care Act 1997* sets out a process of accreditation which residential aged care homes must undergo successfully in order to continue to receive Commonwealth government funding as approved providers of residential aged care services. The Aged Care Standards and Accreditation Agency (the Agency) is the body authorised to conduct accreditation against the Accreditation Standards (the four standards are discussed below, and the 44 associated outcomes are included in Table A6.13).

The Agency has four legislated roles: to manage the residential aged care accreditation process; to promote high-quality care and assist the industry to improve service quality by identifying best practice and providing information, education and training; to assess and strategically manage services working towards accreditation; and to liaise with the Commonwealth regarding services not meeting the relevant standards.

The Agency was established as an independent, but wholly owned, Commonwealth entity. The Board of the Agency first met in November 1997. The Accreditation Grant Principles were gazetted in September 1999 and the Agency commenced accreditation audits shortly after. By 1 January 2001, all residential aged care homes in Australia had received an accreditation decision from the Agency (the results are presented in Table 6.29).

Table 6.29: Performance against aged care accreditation standards to 31 December 2000

Standard	Assessor ratings									
	Commendable		Satisfactory		Unacceptable		Critical		Total	
	N	%	N	%	N	%	N	%	N	
1 Management systems, staffing and organisational development	277	9.4	2,576	87.7	54	1.8	29	1.0	2,936	
2 Health and personal care	274	9.3	2,519	85.8	124	4.2	19	0.6	2,936	
3 Residents' lifestyle	293	10.0	2,593	88.3	41	1.4	9	0.3	2,936	
4 Physical environment and safe systems	240	8.2	2,568	87.5	78	2.7	50	1.7	2,936	

Note: These data do not include commencing services. A site audit is not undertaken for commencing services. Table A6.13 lists the expected outcomes for each standard.

Source: Aged Care Standards and Accreditation Agency.

The accreditation process involves the following steps:

- Self-assessment against 44 outcomes of the Accreditation Standards
- Application for accreditation
- Desk audit by a team of registered Quality Assessors
- Site visit by the team of registered Quality Assessors
- A site audit report to the Agency by the team of registered Quality Assessors
- An accreditation decision by the Agency
- Publication of the site audit report

In its report to the Agency, the team of Quality Assessors appraises each of the 44 outcomes against one of four ratings. These are commendable, satisfactory, unacceptable and critical. A rating is also given to each of the four standards. The residential aged care service has an opportunity to rectify deficiencies before an accreditation decision is made.

The Agency is required under the Accreditation Grant Principles to make its accreditation decision based on the following information: the desk audit report, the site audit report, information (if any) received from the Secretary about matters that must be considered under Division 38 of the *Aged Care Act 1997*, for the certification of the service, other information (if any) received from the Secretary, information (if any) received from the applicant in response to the report of the site audit, and whether it is satisfied that the residential care service will undertake continuous improvement, measured against the Accreditation Standards. On the basis of this information, the Agency awards a period of accreditation or can make a decision not to accredit.

The results of the accreditation process are reported in Table 6.29. Around one in 10 aged care homes received a rating of commendable on each of the four aged care standards. A rating of commendable means that the service has demonstrated a high level of achievement, innovation and creativity in its quality system, that its policies and procedures are well documented and regularly reviewed, that it achieves consistent results, and that there is evidence of continuous improvement. The vast majority of homes (86–88%) received a rating of satisfactory on each of the four standards. A

satisfactory rating indicates that the service generally achieves the requirements of the standards but with some minor discrepancies which can be rectified within an agreed time.

A minority of homes were rated either unacceptable or critical against the standards. An unacceptable rating means that major deficiencies have been identified which will require considerable time to remedy. A critical rating means that a major health or safety risk or major concern about residents wellbeing has been identified and immediate corrective action is required.

Standard 1 is entitled Management Systems, Staffing and Organisational Development. The principle associated with this standard is: Within the philosophy and level of care offered in the residential care service, management systems are responsive to the needs of residents, their representatives, staff and stakeholders, and the changing environment in which the service operates. Two per cent of homes were rated unacceptable against this standard, and 1% critical.

Standard 2, Health and Personal Care, asserts that Residents physical and mental health will be promoted and achieved at the optimum level in partnership between each resident (or his or her representative) and the health care team. This was the standard with the highest proportion of unacceptable ratings, at 4%, with a further 1% rated as critical.

The principle associated with Standard 3, Resident Lifestyle, is Residents retain their personal, civic, legal, and consumer rights, and are assisted to achieve active control of their own lives within the residential care service and in the community. Only 1% of homes were rated as unacceptable against this standard, and well under 1% as critical.

Standard 4 is entitled Physical Environment and Safe Systems. Its principle is Residents live in a safe and comfortable environment that ensures the quality of life and welfare of residents, staff and visitors. Three per cent of homes were rated unacceptable against this standard, and 2% as critical.

Of the 2,936 aged care homes which had undergone a full assessment process as at 1 January 2001, only one had its approval as an aged care provider withdrawn. Twenty homes were allowed to continue to operate under an exceptional circumstances determination, which means that the home was given a further 6 months to meet its accreditation requirement, while continuing to receive a government subsidy. As at 3 May 2001, 11 homes had sanctions in place. The most commonly imposed sanction was the requirement that an advisor or administrator be appointed to the home, followed by a loss of Commonwealth government funding for new residents for a certain period. Another sanction imposed was that no further allocation of places was to be allowed for a period of either 6 or 12 months. Only one aged care home had places revoked.

6.5 Summary

Increases in demand

In June 2000, there were 2.4 million people aged 65 and over in Australia, representing some 12.3% of the total population. The figure was 2 million in 1991, and it is projected to reach 3 million by the year 2011 and 5.4 million by 2031. Quite a small proportion of these people, however, are in need of or will be in need of aged care services. Of people aged 65 and over in 2000, for example, 55% were aged 65—74 and only 9.4% in this age group required assistance with basic activities of daily living (self-care, mobility and communication).

The number of people aged 65 and over who require at least some assistance with the basic activities of daily living is increasing, however, from just over a third of a million in 1991 to a projected half a million by 2001, and just over two-thirds of a million by 2011. The proportion of this group who are aged 85 and over is also increasing: from 26% in 1991 to 32% in 2001, and a projected 37% in 2011.

Trends such as these raise the question as to whether the increasing longevity which has characterised the last quarter century has brought with it an increased level of disability. Are older people living longer, but in a condition of greater disability? Or is disability among the older population falling due to improved medical and technological interventions, and improved lifestyle choices concerning health-related behaviour? The evidence on this question remains mixed, with some international commentators arguing strongly that disability is falling at older ages, and others reporting some evidence of increases within particular age and sex groups. A recent ABS analysis suggests that there may have been a modest increase in severe disability levels among men aged 75—79 and 85 and older, although the methodological issues are far from straightforward.

The continuing role of informal care

With the continued emphasis on maintaining older people at home, the important role played by informal carers seems set to continue into the future. In 1998, there were 125,345 primary carers providing help to persons aged 65 and over. Two-thirds were women, and the most carers of older people were themselves over 65.

The changing system of residential care

The new system of residential care introduced in 1997 is now well established. The bringing together of nursing homes and hostels into a single residential aged care system, the introduction of a new single instrument for the classification of residents according to their care needs, the extended use of accommodation bonds and charges, and the introduction of means-tested fees all combine to produce a system that is very different from that which operated prior to 1997. The new quality appraisal system for the accreditation of residential aged care facilities has now completed a full annual cycle of aged care home inspections, with only one home having its approval as a provider withdrawn, and another 20 operating under an exceptional circumstances determination, which means that the homes were given a further 6 months to meet accreditation requirements, while continuing to receive a government subsidy.

The number of residential care places continues to increase: up from 137,653 in 1996 to 139,917 in 1998, and to 141,162 in 2000. The ratio of residential care places to people aged 70 and over has decreased: from 91 places per 1,000 people aged 70 and over in 1996 to 82 places in 2001. This trend has been counterbalanced by the increasing availability of community aged care packages the combined residential care and care package ratio has been relatively stable for much of the period, at 93—94 places and packages per 1,000 people aged 70 and over, rising most recently to 96.5 places in 2001.

Increasing dependency levels in residential care

Available data support the view that dependency levels in aged care homes increased during the 1990s. Prior to the amalgamation of the residential aged care system in 1997, dependency levels had been increasing in both nursing homes and hostels. Between 1998 and 2000, the proportion of residents classified as high care (RCS 1 to 4) increased. Individual data items drawn from the dependency classification scales in use over the past 7 years show a substantial increase in frailty levels; in 2000, 93% of residents required at least some assistance with washing and dressing, 76% with eating and drinking, and 55% with regard to verbally disruptive or physically aggressive behaviour.

Home-based care

Home-based care services continue to expand, although the expansion of services provided under the HACC program evident in the mid-1990s has slowed in more recent years. Community aged care packages, a coordinated and intensive form of home-based care, have expanded quite dramatically in the last 3 years, virtually tripling from 6,124 places in 1997 to 18,149 places in 2000. In relation to the size of the aged population, this represents a large increase in supply: from 4 places per 1,000 people aged 70 and over in 1997 to 11 places in 2000. Despite this expansion, HACC remains by far the major supplier of home-based care services for older Australians.

Trends in expenditure on older Australians

Total expenditure on aged care homes, HACC, assessment, community aged care packages, multi-purpose services, Carer Allowance, and accreditation was \$4,839.9 million in 1999—00, an increase of 43% in real terms over the past 4 years. The proportions allocated to each area of expenditure (i.e. assessment, community care, residential care) remained relatively stable. The increase in expenditure on aged care services overall has kept pace with the growth in the number of older people needing some assistance; indeed, expenditure per person aged 65 and over with a severe or profound restriction increased during the last 4 years in real terms.

A more broadly based picture of expenditure on older Australians taking into account income support, residential care, home-based care, and medical, hospital and pharmaceutical services shows a total outlay on people aged 65 and over in 1998—99 of \$29,203 million. In the two decades since 1980—81, total government expenditure on older people has remained stable as a percentage of GDP, declined marginally as a percentage of total government outlays, and declined more markedly as a percentage of government outlays on health, welfare and social security.

References

- ABS (Australian Bureau of Statistics) 1998. Experimental projections of the Aboriginal and Torres Strait Islander population, 1996—2006. Cat. no. 3231.0. Canberra: ABS.
- ABS (Australian Bureau of Statistics) 1999. Disability, ageing and carers: summary of findings. Cat. no. 4433.0. Canberra: ABS.
- ABS (Australian Bureau of Statistics) 2000a. Australian demographic statistics, June quarter, 2000. Cat. no. 3101.0. Canberra: ABS.
- ABS (Australian Bureau of Statistics) 2000b. Population by age and sex: Australian States and Territories, June quarter 2000. Cat. no. 3201.0. Canberra: ABS.
- ABS (Australian Bureau of Statistics) 2000c. Population projections Australia 1999—2101. Cat. no. 3222.0. Canberra: ABS.
- ABS: Davis E, Beer J, Gligora C & Thorn A 2001. Accounting for change in disability and severe restriction, 1981—1998: working papers in social and labour statistics. Working Paper no. 2001/1. Canberra: ABS.
- AIHW (Australian Institute of Health and Welfare) 1995. Australia's welfare 1995: services and assistance. Canberra: AGPS.
- AIHW (Australian Institute of Health and Welfare) 1997a. Australia's welfare 1997: services and assistance. Canberra: AGPS.
- AIHW (Australian Institute of Health and Welfare) 1997b. Nursing homes in Australia 1995—96: a statistical overview. Cat. no. AGE 6. AIHW & DHFS Aged Care Statistics Series no. 1. Canberra: AIHW.
- AIHW (Australian Institute of Health and Welfare) 1998a. Hostels in Australia 1995—96: a statistical overview. Cat. no. AGE 7. AIHW & DHFS Aged Care Statistics Series no. 2. Canberra: AIHW.
- AIHW (Australian Institute of Health and Welfare) 1998b. Nursing homes in Australia 1996—97: a statistical overview. Cat. no. AGE 9. AIHW & DHFS Aged Care Statistics Series no. 3. Canberra: AIHW.
- AIHW (Australian Institute of Health and Welfare) 1998c. Hostels in Australia 1996—97: a statistical overview. Cat. no. AGE 10. AIHW & DHFS Aged Care Statistics Series no. 4. Canberra: AIHW.
- AIHW (Australian Institute of Health and Welfare) 1999a. Australia's welfare 1999: services and assistance. Cat. no. AUS 16. Canberra: AGPS.
- AIHW (Australian Institute of Health and Welfare) 1999b. Residential aged care facilities in Australia 1998: a statistical overview. Cat. no. AGE 14. AIHW & DHAC Aged Care Statistics Series no. 5. Canberra: AIHW.
- AIHW (Australian Institute of Health and Welfare) 2000a. Community care packages in Australia 1998—99: a statistical overview. Canberra: AIHW.
- AIHW (Australian Institute of Health and Welfare) 2000b. Residential aged care facilities in Australia 1998—99: a statistical overview. Canberra: AIHW.
- AIHW (Australian Institute of Health and Welfare) 2001a. Community aged care packages in Australia 1999—00: a statistical overview. Canberra: AIHW.

- AIHW (Australian Institute of Health and Welfare) 2001b. Residential aged care in Australia 1999—2000: a statistical overview. Canberra: AIHW.
- AIHW: Benham C & Gibson D, with Holmes B & Rowland D 2000. Independence in ageing: the social and financial circumstances of older overseas-born Australians. Canberra: DIMA & AIHW.
- AIHW: Choi C 1998. Government health and welfare expenditure on older Australians. AIHW Working Paper no. 20. Canberra: AIHW.
- AIHW: Cooper D & Jenkins A 1998. Obtaining consumer feedback from clients of home based care services: a review of the literature. Welfare Division Working Paper no. 21. Canberra: AIHW.
- AIHW: Gibson D, Braun P & Liu Z 2000. Spatial equity in the distribution of aged care services. Welfare Division Working Paper no. 25. Canberra: AIHW.
- AIHW: Jenkins A 2000. Obtaining consumer views of service standards in home and community care: main report of findings. Welfare Division Working Paper no. 34. Canberra: AIHW.
- AIHW: Jenkins A, Butkus E & Gibson D 1998. Developing quality measures for home and community care. Aged Care Series no. 4. Canberra: AIHW.
- AIHW: Jenkins A & Gibson D 2000. Obtaining consumer views of service standards in home and community care. Supplementary report: examining the validity of consumer feedback collected for the HACC National Service Standards Instrument. Welfare Division Working Paper no. 35. Canberra: AIHW.
- AIHW: Mason F, Liu Z & Braun P 2001. The probability of using an aged care home over a lifetime (1990—00). Welfare Division Working Paper no. 36. Canberra: AIHW.
- AIHW: Ryan T, Holmes B & Gibson D 1999. A national minimum data set for home and community care. Canberra: AIHW.
- Australia 1997. Aged care principles. Quality of care principles 1997. Schedule 2 Section 18.8 Accreditation standards.
- Bishop B (Minister for Aged Care) 1999a. The national strategy for an ageing Australia. Background paper. Canberra: Commonwealth of Australia.
- Bishop B (Minister for Aged Care) 1999b. The national strategy for an ageing Australia. Employment for mature age workers issues paper. Canberra: Commonwealth of Australia.
- Bishop B (Minister for Aged Care) 1999c. The national strategy for an ageing Australia. Healthy ageing discussion paper. Canberra: Commonwealth of Australia.
- Bishop B (Minister for Aged Care) 1999d. The national strategy for an ageing Australia. Independence and self-provision discussion paper. Canberra: Commonwealth of Australia.
- Bishop B (Minister for Aged Care) 2000a. The national strategy for an ageing Australia. Attitude, lifestyle & community support paper. Canberra: Commonwealth of Australia.

- Bishop B (Minister for Aged Care) 2000b. The national strategy for an ageing Australia. World class care discussion paper. Canberra: Commonwealth of Australia.
- Bishop B (Minister for Aged Care) 2001a. Record level of high care aged care places released. Media release 3/4/2001. Available at www.health.gov.au/acc/press/presindx.htm (accessed May 2001).
- Bishop B (Minister for Aged Care) 2001b. National call for applications for new aged care places. Media release 20/7/2001. Available at www.health.gov.au/acc/press/presindx.htm (accessed August 2001).
- Cambois E, Jacobzone S & Robine JM 1999. Is the health of older persons in OECD countries improving fast enough to compensate for population ageing? Meeting on Implications of Disability for Ageing Populations: Monitoring Social Policy Challenges. Paris: OECD. DEELSA/ELSA/WP1/DIS(99)6. (Working Party on Social Disability Project).
- Colvez A & Blanchet M 1981. Disability trends in the United States population: 1966—1976: analysis of reported causes. *American Journal of Public Health* 71:464—71.
- Crimmins EM, Saito Y & Reynolds SL 1997. Further evidence on recent trends in the prevalence and incidence of disability among older Americans from two sources: the LSOA and the NHIS. *Journal of Gerontology: Social Sciences* 52B:S59—71.
- DHAC (Department of Health and Aged Care) 1998. Annual report 1997—98. Canberra: DHAC.
- DHAC (Department of Health and Aged Care) 1999. Annual report 1998—99. Canberra: DHAC.
- DHAC (Department of Health and Aged Care) 2000. Annual report 1999—00. Canberra: DHAC.
- DHFS (Department of Health and Family Services) 1996. Annual report 1995—96. Canberra: DHFS.
- DHFS (Department of Health and Family Services) 1997. Annual report 1996—97. Canberra: DHFS.
- DHSH (Department of Human Services and Health) 1995. Aged persons hostels. A statistical overview 1993—94. Canberra: DHSH.
- DIMA (Department of Immigration and Multicultural Affairs) 1999. 1996 classification of countries into English proficiency groups. Canberra: DIMA.
- DPIE & DHSH (Department of Primary Industry and Energy & Department of Human Services and Health) 1994. Rural, remote and metropolitan areas of classification, 1991 census edition. Canberra: AGPS.
- FaCS (Department of Family and Community Services) 2000. Annual report 1999—00. Canberra: FaCS.
- Gibson DM 1998. Aged care: old policies, new problems. Cambridge: Cambridge University Press.
- Gray L 2001. Two year review of aged care reforms. Canberra: Commonwealth of Australia.

- Henderson AS & Jorm AF 1998. *Dementia in Australia*. Canberra: AGPS.
- Jorm AF, Korten AE & Henderson AS 1987. The prevalence of dementia: a quantitative integration of the literature. *Acta Psychiatrica Scandinavica* 76:465—9.
- LGC (Lincoln Gerontology Centre) 1998. National framework for comprehensive assessment of the HACC program. *Aged and Community Care Service Development and Evaluation Reports no. 34*. Canberra: DHFS.
- LGC (Lincoln Gerontology Centre) 2000. Aged care assessment program. National minimum data set report. July 1998—June 1999. Melbourne: La Trobe University.
- Manton KG, Corder L & Stallard E 1993. Estimates of change in chronic disability and institutional incidence and prevalence rates in the U.S. elderly population from the 1982, 1984, and 1989 National Long Term Care Survey. *Journal of Gerontology: Social Sciences* 48:S153—66.
- Manton KG, Corder L & Stallard E 1997. Chronic disability trends in elderly United States populations: 1982—1994. *Proceedings of the National Academy of Sciences* 94:2593—8.
- NARI (National Ageing Research Institute) & BECC (Bundoora Extended Care Centre) 1998. Targeting in the Home and Community Care Program. *Aged and Community Care Service Development and Evaluation Reports no. 37*. Canberra: DHAC.
- OSW (Office of the Status of Women) 1999. *Women in Australia 1999*. Canberra: OSW.
- Schoeni RF, Freedman VA & Wallace RB 2001. Persistent, consistent, widespread, and robust? Another look at recent trends in old-age disability. *Journal of Gerontology: Social Sciences* 56B(4):S206—18.
- SCRCSSP (Steering Committee for the Review of Commonwealth/State Service Provision) 2001. Report on government services 2001. Volume 2: emergency management, community services, housing. Canberra: SCRCSSP.
- Verbrugge L 1984. Trends in health and mortality of middle-aged and older persons. *Milbank Memorial Fund Quarterly* 62:475—519.
- Verbrugge L, Lepowski J & Imanaka Y 1989. Comorbidity and its impact on disability. *Milbank Memorial Fund Quarterly* 67:450—84.
- Waidmann TA & Liu K 2000. Disability trends among elderly persons and implications for the future. *Journal of Gerontology: Social Sciences* 55B:S298—307.
- Waidmann TA & Manton KG 1998. International evidence on disability trends among the elderly. Duke University: Urban Institute.