Special population groups

42 OLDER ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES

Based on preliminary estimates from the 2006 Census, there were 517,200 Aboriginal and Torres Strait Islander peoples at 30 June 2006, accounting for 2.5% of the total Australian population. Around 90% of the Indigenous population were of Aboriginal descent only (463,900), around 6% were of Torres Strait Islander origin only (33,100) and around 4% were of both Aboriginal and Torres Strait Islander origin (20,200) (ABS 2007j).

The Indigenous population is not ageing in the same way as the non-Indigenous population. Although the number of older Indigenous people is increasing, the Indigenous population still has a relatively young age structure. Because of this, and because the absolute numbers of older Indigenous people are still relatively small, discussions about ageing may marginalise or exclude the experience and needs of older Indigenous Australians (Cotter et al. 2007).

Such exclusion may also occur because there have been, and remain, significant data issues around estimating the size and composition of the Indigenous population and understanding their health and disability status and patterns of service use. These issues include difficulty in reaching, identifying and counting the Indigenous population in the censuses, and accuracy of identification of Indigenous people in administrative data collections. The Australian Bureau of Statistics (ABS) and the AIHW have directed considerable efforts into resolving these data issues to produce better quality population estimates and administrative data. Nevertheless, it remains the case that considerable uncertainty surrounds a number of key data areas (for more information on data quality issues see AIHW & ABS 2005; ABS 2005c, 2007j).

Population profile

The age distribution of Indigenous Australians is different from that of non-Indigenous Australians; and the number of Indigenous people declines more sharply beyond the age of 45 than does the number of non-Indigenous people (Figure 42.1). These differences are associated with higher fertility rates and lower life expectancies among the Indigenous Australian population. During 1996 to 2001, life expectancy at birth was 59.4 years for Indigenous males and 64.8 years for Indigenous females compared with 76.6 and 82.0 years for Australian males and females respectively. Some researchers estimate that around one– third of this difference is due to excess mortality in the age group 40–64 (Kinfu & Taylor 2002).

The gap in life expectancy between Indigenous and non-Indigenous Australians is less at older ages. Life expectancy at age 65 for Indigenous males is estimated at 10.7 years and at 12.0 years for Indigenous females, around 6 years less for men and 8 years less for women than for male and female Australians respectively (AIHW 2005b). This has led some researchers to suggest the possibility of a 'healthy survivor' effect (Jackson-Pulver 2006).

It is clear that the life expectancy of non-Indigenous Australians is improving, but there are significant data issues which make it difficult to detect any significant improvement for the Indigenous population—moreover, there is no indication of improving survival at older ages as is the case for the non-Indigenous population (ABS 2005c; Cotter et al. 2007).

In 2006, only 11% of Indigenous Australians were aged 50 and over, 2.8% were aged 65 years and over, and less than 1% (0.8%) were aged 75 years and over. Older Indigenous people represent a smaller proportion of the Indigenous population than their non-Indigenous counterparts, among whom people aged 65 years and over represent 13% of the total population (ABS 2004c, 2006d, 2006p). Women make up 53% of Indigenous Australians aged 50 years and over, and 55% of those aged 65 years and over (ABS 2004c).

Despite their relatively small share of the Indigenous population, there were an estimated 36,800 Indigenous people aged 55 years and over in 2006, and 14,900 Indigenous people aged 65 years and over. Experimental projections (ABS 2004c: Table 34) suggest that by 2009 the older Indigenous population will increase to 40,905 people aged 55 years and over, with all of that increase occurring in the population aged 55–64 years.

Health and disability status

Data about the health and disability status of older Indigenous people has been collected through the ABS National Health Survey (NHS) and the National Aboriginal and Torres Strait Islander Social Survey (NATSISS). The 2002 NATSISS provided, for the first time, information on the prevalence of disability among Indigenous Australians. Not unexpectedly, the survey results reveal that Indigenous people have higher rates of disability across all age groups than non-Indigenous people (Figure 42.2). In 2002, almost three-quarters (72%) of people aged 65 years and over had a disability or long-term health condition. The overall prevalence of severe or profound core activity limitation was similar

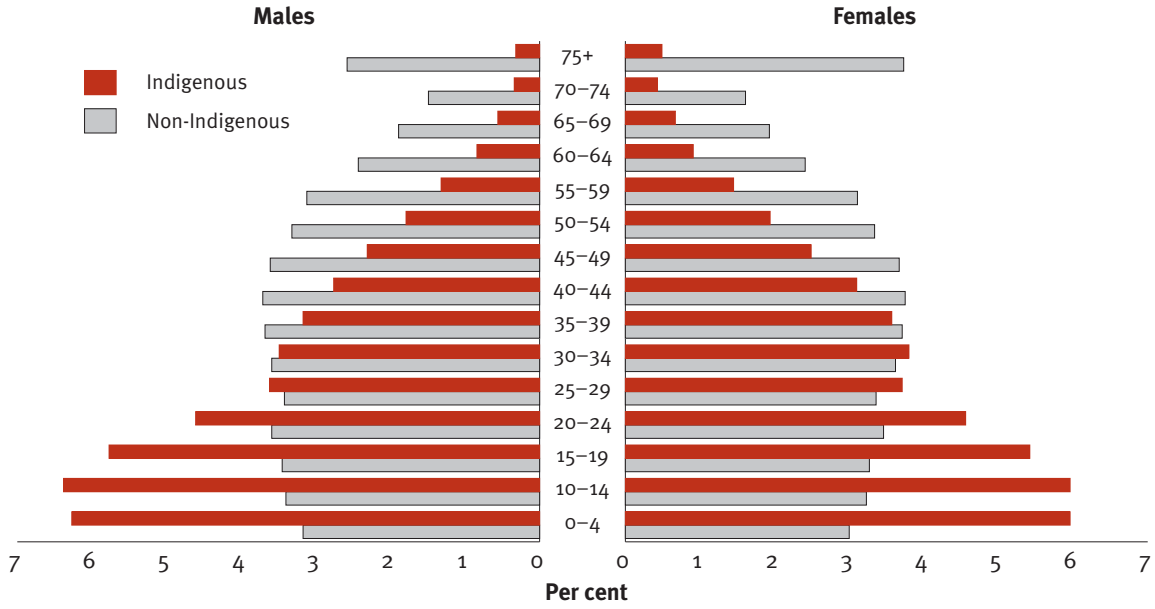
for males and females and generally increased with age. In 2002, 12% of Indigenous people aged 55–64 years and 25% aged 65 years and over had a severe or profound core activity limitation (11% and 20% in non-remote areas—1.9 and 1.6 times the rates respectively in non-Indigenous people) (AIHW & ABS 2005).

Indigenous people were more likely to report fair or poor health than non-Indigenous people at all ages, with the exception of those aged 18–24 years. The proportion of Indigenous people reporting fair or poor health increased with age, from 8% of people aged 18–24 years to 56% of people aged 65 years and over. Comparatively, around 7% of non-Indigenous people aged 18–24 years and 35% of non-Indigenous people aged 65 years and over reported fair or poor health (AIHW & ABS 2005:91–93). Indigenous people are at higher risk of poor health because of factors such as poor nutrition, substance abuse, exposure to violence, and inadequate housing and education. In 2004–05 most of those 55 years and over (97%) reported having at least one long-term health condition.

From age 25 years, diabetes is considerably more prevalent among Indigenous Australians than among non-Indigenous Australians. In both populations, prevalence is progressively higher in older age groups, but the prevalence among Indigenous Australians aged 35–44 years was almost as high as among non-Indigenous Australians aged 55 years or over (AIHW & ABS 2005). Similarly, the prevalence of hypertension increases with age for both Indigenous and non-Indigenous Australians. Among people aged 25 years and over, prevalence levels for Aboriginal or Torres Strait Islander people are similar to those experienced by non-Indigenous Australians who are 10 years older. The most marked difference is for those aged 45–64 years where Indigenous rates are 2–3 times higher than for non-Indigenous Australians (AIHW & ABS 2005). The proportion of Indigenous people with end-stage renal disease (ESRD) at ages 45–54 is about the same as the proportion for non-Indigenous people aged 65 and over (AIHW & ABS 2005).

In 2005–6 Indigenous people were almost three times as likely to be hospitalised as people in the general population (1,038.7 separations per 1,000 population compared with 352.4 per 1,000 in the four jurisdictions whose data on Indigenous status is considered adequate for analytical purposes, i.e.

Figure 42.1: Age and sex profile of Indigenous and non-Indigenous Australians, 2006



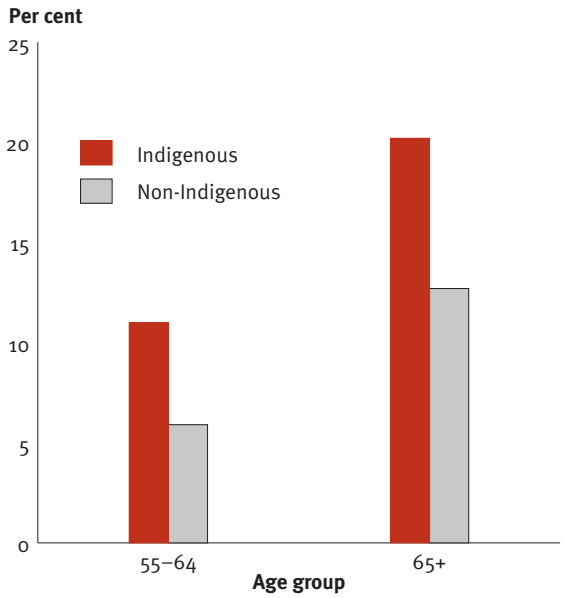
Source: Table A42.1.

Queensland, Western Australia, South Australia and Northern Territory) (AIHW 2007b:Table 8.7). About 80% of the difference in these rates was attributable to higher separation rates for Indigenous people with a principal diagnosis of *Care involving dialysis* or with a procedure involving *Haemodialysis. A* higher proportion of separations for Indigenous people were for those aged 64 years and under compared with separations for other Australians. In 2005–06, only 11% of separations for Indigenous people were for those aged 65 years and over, compared with 36% of separations for non-Indigenous people (AIHW 2007b:Table 8.9).

Indigenous people were less likely to have seen a dentist or doctor about their teeth, with nearly 50% of those 55 years and older having lost 10 or more adult teeth and reporting that they needed dentures but did not have them (AIHW & ABS 2005; ABS 2006p, 2007h).

Indigenous people experience substantially higher death rates across all age groups than non-Indigenous people. Between 1999 to 2003, the overall death rate[4] for Aboriginal and Torres Strait Islander Australians was almost three times the rate of non-Indigenous people—75% of Indigenous males and 65% of Indigenous females died before the age of 65, in contrast to the non-Indigenous population where only 26% of males and 16% of females who died were aged less than age 65. Death rates per 100,000 population for people aged 65 years and over were up to one-and-a-half times as high in Indigenous males and females than in the general Australian population (6,273 compared with 4,534 per 100,000 for males and 5,093 compared with 3,763 per 100,000 for females) (AIHW & ABS 2005).

Figure 42.2: Age-specific rates of profound or severe core activity limitation, persons aged 55 and over in non-remote areas, 2002



Note: These rates are based on comparable data from the ABS 2002 National Aboriginal and Torres Strait Islander Social Survey and the ABS 2002 General Social Survey. Comparisons cannot be made for remote areas because of methodological differences. These data are not strictly comparable with data presented in Topic 17: *Disability levels*, which are based on the ABS 2003 Disability, Ageing and Carers Survey.

Source: AIHW & ABS 2005.

Aged care services for Indigenous people

When planning service places and packages for older people, the Australian Government uses population estimates for the general population aged 70 and over. However, in the allocation of those places and packages across the country the Government also takes into account the number of Indigenous Australians who are aged 50 and over, (DHAC 2001).

Indigenous Australians have particular aged care needs. For example, the strict conditions within which residential aged care services operate are often unworkable for the care needs of Indigenous communities in regional areas. It has also been documented that it is the overwhelming preference of many Indigenous people to remain in their community rather than enter residential care. The Aboriginal and Torres Strait Islander Aged Care Strategy was developed in 1994 after consultation with Indigenous communities and organisations involved in aged care services. This Strategy seeks to tackle issues of access to services, including those related to the rural and remote location of many Indigenous communities. The Strategy established Aboriginal and Torres Strait Islander Flexible Services, which provide aged care services with a mix of residential and community care places that can change as community needs vary. Many of these services have been established in remote areas where no aged care services were previously available.

The flexible services developed as part of the Strategy are now funded under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. At 30 June 2006, there were around 30 services delivering 580 flexible places for Indigenous clients under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. These services are funded to deliver culturally

4 Based on mortality data from Queensland, South Australia, Western Australia and Northern Territory.

appropriate aged care, close to home and country, mainly in rural and remote areas.

In rural and remote locations that are too small to support the standard systems of aged care provision, Multi-Purpose Services also provide a more workable care and treatment model by bringing together a range of local health and aged care services, (often including residential aged care) under one management structure. At 30 June 2006, Multi-Purpose Services provided 1,951 additional residential places outside of mainstream residential and community care settings (AIHW 2007a, 2007f).

In general, the rates of use by Indigenous Australians of community-based care are higher than those of non-Indigenous Australians (Table 42.1). Indigenous Australians constitute 2.6% of Home and Community Care (HACC) clients, 4.0% of Community Aged Care Package (CACP) clients and only 0.6% of permanent residents in mainstream aged care homes.

When age-specific usage rates are considered, Indigenous Australians in all age categories make relatively high use of aged care services compared with non-Indigenous Australians. At 30 June 2006, 27 per 1,000 Indigenous persons aged 60–69 years were using either a CACP, an Extended Care at Home (EACH) package or an EACH Dementia package compared with 2 per 1,000 non-Indigenous people in the same age group. Access to EACH and EACH Dementia packages is restricted by the currently limited availability of these packages in remote and very remote areas. Indigenous people also use residential aged care at higher rates for each age group with the exception of women aged 70 and over—for example, 13 people per 1,000 Indigenous Australians aged 60–69 were permanent residents compared with 4 per 1,000 non-Indigenous Australians. HACC usage rates in the Indigenous population are considered too unreliable to report, but also show higher use by Indigenous Australians than non-Indigenous Australians.

Since 2001, the use of aged care packages (CACPs and EACH packages) increased among Indigenous people of all ages—this is especially true of Indigenous women. For example, at 30 June 2001 usage rates of CACPs was 12 per 1,000 Indigenous Australians aged 60–69 years compared to 27 per 1,000 at 30 June 2006 (Table 42.1 and AIHW 2002b). Non-Indigenous women aged 70 years and over have also increased their use of care packages from 13 per 1,000 to 19 per 1,000 over the same period. Otherwise, the use of care packages and residential care by non-Indigenous Australians has risen only minimally between 2001 and 2006.

Table 42.1: Age- and sex-specific usage rates of Home and Community Care, Community Aged Care Packages and permanent residential aged care services (permanent residents)[(a)] by Indigenous status, (per 1,000 population)

	Indigenous			Non-Indigenous		
Age	Females	Males	Persons	Females	Males	Persons
Home and Community Care, 2004–05						
50–59	n.p.	n.p.	n.p.	23.6	15.1	19.4
60–69	n.p.	n.p.	n.p.	69.0	39.6	54.4
70 and over	n.p.	n.p.	n.p.	309.5	196.8	262.0
Aged care packages in the community (CACP, EACH and EACH Dementia), 30 June 2006						
50–59	8.0	6.1	7.1	0.2	0.2	0.2
60–69	33.3	10.0	27.0	1.8	1.2	1.5
70 and over	82.4	58.8	68.2	19.4	9.9	15.3
Permanent residential aged care, 30 June 2006						
50–59	3.3	3.7	3.5	1.0	1.1	1.0
60–69	12.4	13.8	13.1	4.0	4.3	4.1
70 and over	74.4	57.9	67.5	93.9	44.1	72.3

(a) Recipients with unknown Indigenous status have been pro rated.

Note: Use of places and packages provided by Multi-Purpose Services and the National Aboriginal and Torres Strait Islander flexible Aged Care program are not included in this table.

Sources: ABS 2006a; ABS 2004; AIHW analysis of DoHA Aged and Community Care Management Information System (ACCMIS) database and the HACC MDS.

43 PEOPLE FROM NON-ENGLISH-SPEAKING COUNTRIES

Older people born overseas in non-English-speaking countries, although generally healthier than the rest of the older population, can face barriers in accessing appropriate health and aged care services. An important principle of government is that its services are provided on an equitable basis to all Australians. Consequently, older people born in non-English-speaking countries are one of a number of groups given special consideration in the planning and allocation of government-funded aged care services.

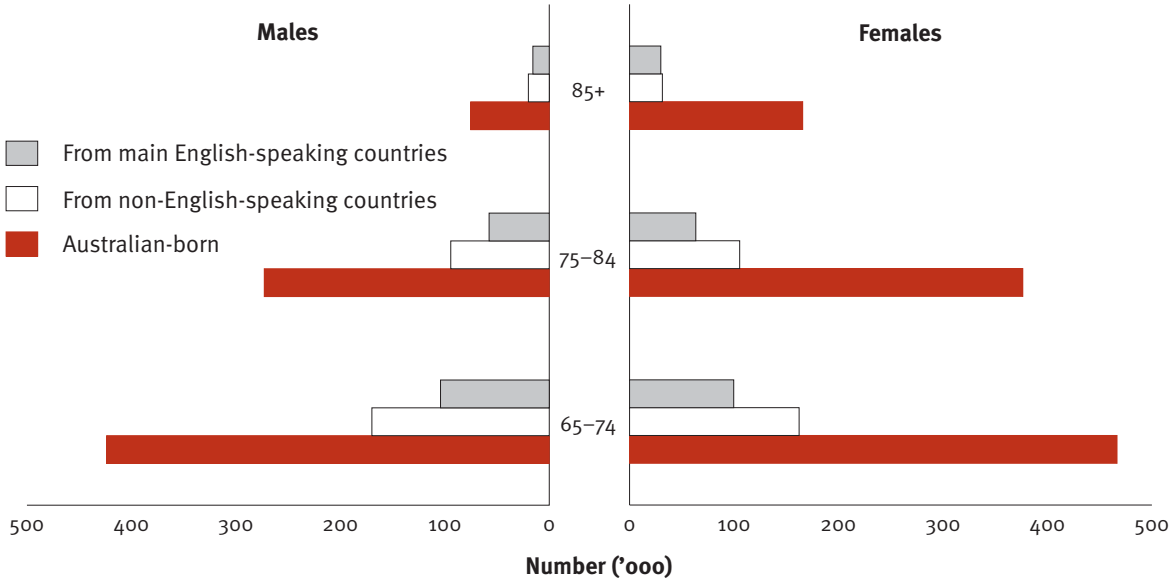
Demographic profile

One in five older Australians come from non-English-speaking countries, and this part of the older population is growing faster than other segments (AIHW 2004c; AIHW: Gibson et al. 2001). At 30 June 2006, these older people from non-English-speaking countries numbered over 583,200, compared with 370,500 from the main English-speaking countries and 1,780,400 who were born in Australia. In 2006, the most common countries of birth for non-English-speaking older people were Italy (113,900) and Greece (57,200) (ABS 2007g).

Although people from non-English-speaking countries made up only 15% of the very old population (85 and over) they represented a more significant part of the population aged 75–84 years (21%) and of those aged 65–74 years (23%) (Figure 43.1). In contrast, the proportion of people in each age group who were born overseas in the main English-speaking countries, were fairly similar (13–14% in each of the three age groups). Over the coming decades, immigrants from non-English-speaking European countries, who arrived in Australia during the peak of post-war immigration up to 1971, will become a more significant part of the very old (ABS 2002a, p.17), and Asian immigrants from countries such as Vietnam, Malaysia and the Philippines will become a more significant part of the younger old, with implications for provision of health and aged services.

Males form a larger proportion of the older population from non-English-speaking countries than is the case for the Australian-born older population. This is particularly the case for the 65–74 year age group, where males outnumber females (51% are males, compared with the older Australian population where 48% are males (Table A43.1)). Compared with the older Australian-born population and the older population born overseas in English-speaking countries, the male share of older age groups among the population from non-English-speaking countries is even more pronounced in the 74–85, 85–94 and 95 years and over age groups (31%, 35% and 39% respectively). This reflects past patterns of immigration and lower levels of marriage at earlier life stages among certain immigration groups, particularly those from Eastern Europe (Jackson 2001, p.28).

Figure 43.1: Older people, by age, sex and cultural and linguistic background, 30 June 2006



Source: Table A43.1.

Health status and life expectancy

People from non-English-speaking countries are a diverse group, and generalisations covering the whole group are often not appropriate. Because of variations within the group, the evidence is unclear as to whether these immigrants have better health than the Australian-born population. Better health tends to be reported among immigrants generally, which may result from Australian immigration being partially determined by their health status, but the evidence among different countries is mixed. Immigrants from non-English-speaking countries tend to have higher life expectancies than those from English-speaking countries, and higher than that in their country of origin. People from countries such as Vietnam and China have particularly high life expectancies (ABS 2002a; AIHW 2006c)

Use of aged care services

Improving the access of people from non-English-speaking countries to aged care has been a key policy objective over the past 10 years. Strategies have included providing residential aged care services for specific groups, promoting cultural sensitivity in mainstream services, and culturally appropriate assessment and referral. Another initiative is a flexible service model called clustering that brings together people of a particular ethnic background in a single facility.

Representing 21% of the older population, older people from non-English-speaking countries make up 18% of older Home and Community Care (HACC) clients, 18% of older Aged Care Assessment Program (ACAP) clients, 23% of older Community Aged Care Package (CACP) recipients, 27% of older recipients of Extended Aged Care at Home (EACH) and EACH Dementia packages combined, and around 15% of older permanent residents in aged care accommodation. Although the proportion of older people from non-English-speaking countries in residential aged care has doubled from around 7% in 2001 (AIHW 2002b), these data still suggest that these people are more likely to make use of home-based rather than residential services (AIHW 2002b). This may be partly explained by their younger age structure, cultural preferences and practices concerning family- and home-based care, their English language proficiency and the availability or residential care which is considered to be culturally appropriate. Overseas-born older people who do not speak English enter residential aged care at much higher dependency levels than English-speaking people born overseas and people born in Australia (Gibson 2007).

People from non-English-speaking countries used permanent residential aged care at lower rates than people from other backgrounds. At 30 June 2006, age-specific usage rates of permanent residential aged care by people from non-English-speaking countries was estimated to be 46 per 1,000 persons aged 75–84 years and 184 per 1,000 persons aged 85 years and over. The comparable figures for people born overseas in an English-speaking country were 49 and 238 respectively, and 57 and 248 respectively for people born in Australia (Table 43.1).

Table 43.1: Usage rates of selected aged care programs, by cultural and linguistic diversity[a] (per 1,000 people)

	Overseas-born								
	Non-English-speaking countries			Main English-speaking countries			Australian-born		
	65–74	75–84	85+	65–74	75–84	85+	65–74	75–84	85+
HACC (2004–05)	94.6	270.1	423.6	72.0	235.5	397.0	111.6	288.3	474.2
ACAP (2004–05)	10.2	55.1	164.1	7.2	44.7	153.3	11.3	56.2	170.4
CACP (at 30 June 2006)	3.1	17.9	42.0	2.1	12.0	34.4	3.5	12.7	34.7
EACH & EACH Dementia (at 30 June 2006)	0.4	1.5	3.7	0.3	0.8	1.8	0.4	0.9	1.9
Permanent residential aged care (at 30 June 2006)	7.1	46.4	183.8	6.8	49.0	237.9	10.5	56.7	248.2

(a) The cultural diversity classification is based on country of birth. Overseas-born people from the main English-speaking countries are those born in New Zealand, United Kingdom, Ireland, United States of America, Canada or South Africa. People from non-English-speaking countries are those born overseas in other countries.

Source: Table A43.1, Table A43.2; ABS 2006d, 2007g.

In contrast, rates of use CACPs are higher among people from non-English-speaking countries than among those from English-speaking countries, at 18 per 1,000 persons aged 75–84 years, and 42 per 1,000 persons aged 85 years and over, compared with around 13 and 35 per 1,000 respectively. A similar pattern is seen with use of community care packages providing high level care (EACH and EACH Dementia packages). Overall, there is a slightly lower level of use of HACC services among older people born overseas compared with older people born in Australia, although the use of HACC services by people from non-English-speaking countries is slightly higher than for people born overseas in the main English-speaking countries. Thus, CACPs, EACH and EACH Dementia packages, which are intensive packaged forms of community support, accessed through a single entry point (ACAT assessment) appear to have been particularly successful in providing services to people born in non-English-speaking countries.

OLDER PEOPLE IN REGIONAL AND REMOTE COMMUNITIES 44

In general, people who live in regional and remote areas of Australia have higher levels for several health risk factors and higher mortality rates than those living in major cities. This has raised questions about whether those in regional and remote areas have had inadequate access to health services, greater exposure to occupational or environmental hazards, more adverse social and economic conditions, or some combination of these factors (AIHW 2006c).

Studies have shown that people's geographical location is an important factor when considering their health and patterns of service use (AIHW 2005e) but few published analyses by geographical location look specifically at older Australians. As a result, the following sections on 'health status' and 'patterns of health service provision and use' make general points about people who live in regional and remote areas but include specific examples that are relevant to older people. The analysis of use of aged care services relates specifically to older people.

Box 44.1: Classifying the areas where we live

The ABS Australian Standard Geographical Classification (ASGC) Remoteness Areas classification (AIHW 2004e) allocates one of five remoteness categories to areas depending on their distance from a range of five types of population centre. Areas are classified as Major cities*, as* Inner regional *or* Outer regional *('regional' when taken together), or* Remote *and* Very remote *('remote' when taken together).*

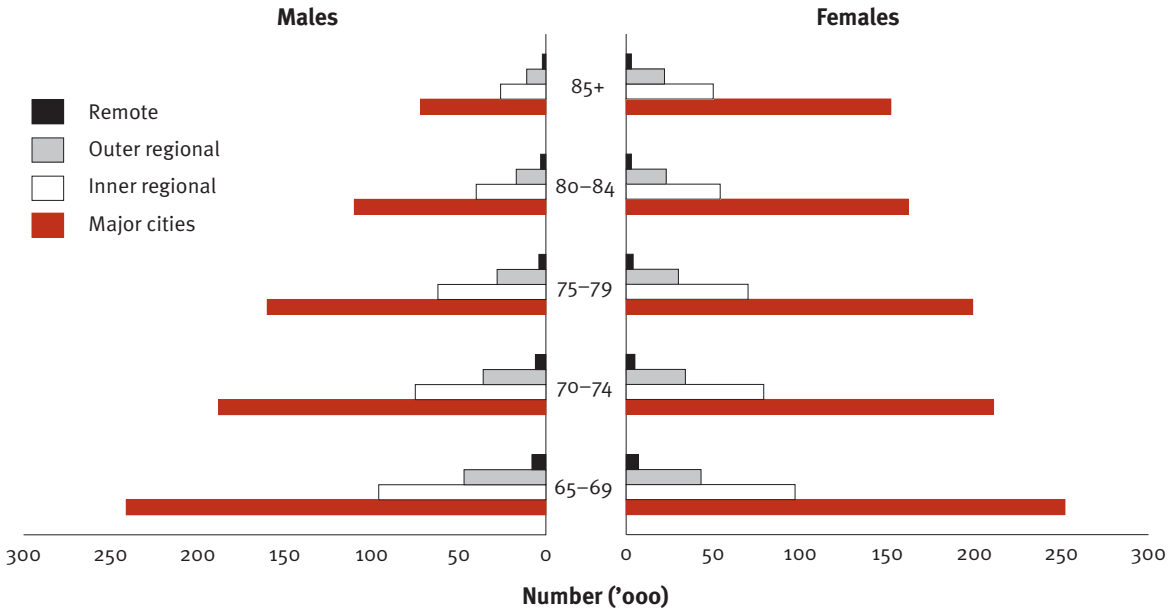
The bulk (66%) of the Australian population lives in Major cities*, 31% in regional areas and 3% in remote areas. Indigenous people live mainly in* Major Cities *(30%) and regional areas (43%), with the remaining 27% living in remote areas. Although Indigenous Australians constitute 2.4% of the total Australian population, they make up 12% of the population in* Remote areas *and 45% in* Very remote areas.

Where older people live

Regional and remote areas comprise large regional centres, coastal settlements, small inland towns, farms and so-called outback Australia. The shared experience of people in these areas is that they live some distance from the major population centres (Box 44.1).

Compared with the general population (see Box 44.1), older Australians are less likely to live in major cities or remote areas and more likely to live in regional areas. At 30 June 2006, there were 1,748,400 (64%) older people living in *Major cities*, 649,300 (24%) in *Inner*

Figure 44.1: Older people, by age, sex and geographical area, 30 June 2006



Source: Table A44.1.

regional areas, 291,500 (11%) in *Outer regional* areas, 32,700 (1.2%) in *Remote* and 12,300 (0.5%) in *Very remote* communities (Table A44.1 and Figure 44.1). Overall, 36% of the population aged 65 and over lived outside of major Australian cities, which is slightly higher than the proportion of those aged under 65 years who live outside of major cities (33%).

Some factors that influence the geographical distribution of older people relative to younger people include:

- the tendency among some older people to relocate to coastal and other non-urban areas in retirement (see Topic 2: *The changing demographic profile*)
- the migration of older people who require access to services not available in the more remote centres
- the movement of younger people to major cities for employment and other opportunities
- the age and geographic distributions of the Indigenous and non-Indigenous populations.

Health status and life expectancy

On a number of health status measures, people who live in regional or remote areas generally do poorer than people who live in major cities. For example, compared with people in major cities, those living in regional or remote areas are more likely to be smokers, to drink alcohol in hazardous quantities, to be overweight or obese, and to be physically inactive (AIHW 2005e). Also, life expectancies are highest in *Major cities* and lowest in *Very remote* areas, dropping from 78 years to 72 years for men and 84 years to 79 years for women (AIHW 2005e). In addition, death rates are generally higher in *Remote* and *Very remote* areas, an exception being death rates among those aged 85 years and over (Figure 44.2).

Higher death rates and poorer health outcomes in regional and remote areas are likely to be the result of factors such as higher levels of socioeconomic disadvantage (lower incomes and lower levels of education), poorer access to health services, higher levels of personal health risk factors such as smoking, and environmental factors (AIHW 2005e, 2006c). The relatively large proportion of Indigenous people in *Remote* and *Very remote* areas (12% and 45% respectively) compared with *Major cities*, coupled with their poor overall health is reflected in higher rates of death in remote areas.

The differences in regional life expectancy are likely to be strongly affected by much lower Indigenous life expectancy and also by the potential migration of the frail aged to less remote areas. Interestingly, life expectancies for non-Indigenous people are greater in remote areas than in *Major cities* (AIHW 2005e). It

Figure 44.2: Death rates per 100,000 people, by age, sex and geographic area, 2002– 2004

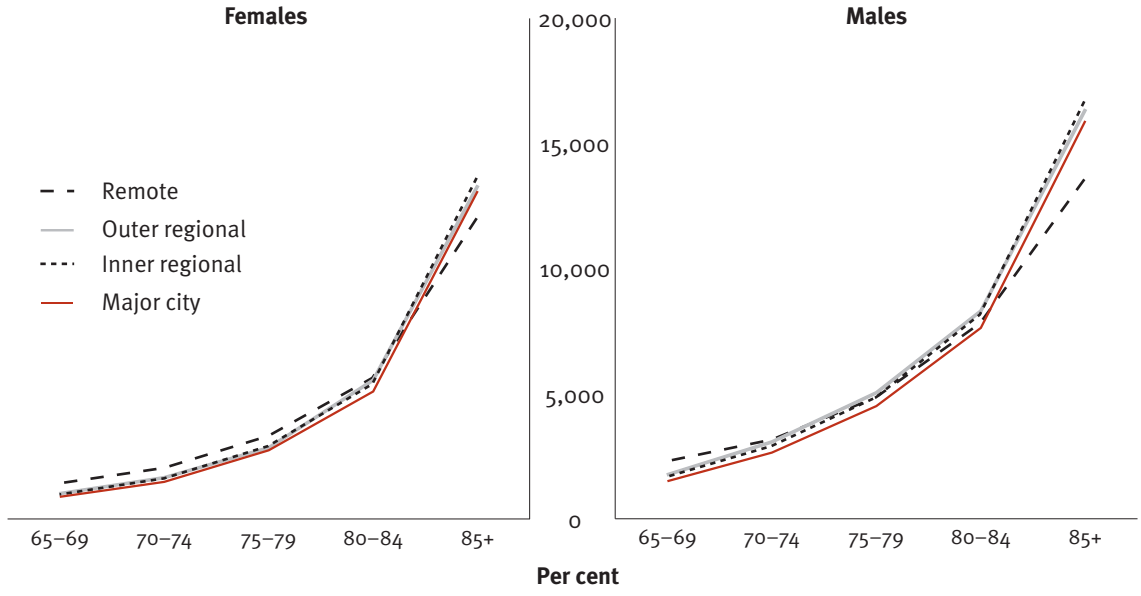


Table A44.2.

is believed that older people in remote areas tend to move to less remote areas so as to access services, particularly after the onset of ill-health. The resulting concentration of healthy older people in remote areas may help to explain their apparent lower rates of death at ages 85 or more (Figure 44.2) (AIHW 2006c).

Because Indigenous Australians make up a substantial proportion of *Remote* and *Very remote* populations, 'remote' issues can often be related to Indigenous issues. For example, overall rates of cervical cancer death tend to be higher in remote areas, but not in the non-Indigenous people who live there. In this case, the extra challenge is one of Indigenous health rather than 'remote' health as such (AIHW 2003b, 2006c).

Patterns of health service provision and use

Typically, the supply of health workers declines with remoteness. Generally, people in regional and remote areas have less access to medical practitioners, including general practitioners and medical specialists, and a range of other health services including dentists (AIHW 2005e, 2006c). Nurses are more evenly distributed across the regions than medical practitioners, ranging from 1,120 nurses per 100,000 in *Major cities* to 1,095 per 100,000 in *Very remote* areas.

Health workers in regional and especially remote areas tend to work longer hours than those in *Major cities*, which may partly compensate for the shortfall in the numbers of health workers in these areas, but this could impose additional strain and result in difficulties retaining staff in the longer term (AIHW 2005e, 2006c).

Different patterns of service provision in city, regional and remote areas can lead to inappropriate comparisons of resource use and access to services (AIHW 2003b). For example, people in regional and remote areas make greater use than people in major cities of hospital emergency departments as a source of primary care services and of hospital beds as a source of aged care services.

The rural and remote location of some communities can affect access to some health and aged care services. For example, there were differences in the rate at which people from *Major cities* and regional and remote areas were admitted to hospital for a range of surgical procedures in 2002–03. Notably, the rate of admission for coronary artery bypass graft surgery and coronary angioplasty was lower for residents of regional and especially remote areas than for those in *Major cities*. This contrasts with the higher death rates from coronary heart disease in these areas. Rates of surgical procedure are likely to be affected by issues such as need and access, both physical and financial (AIHW 2006c).

On the other hand, rates of breast cancer and cervical screening in 2001 appeared higher than in *Major cities* (AIHW 2005e). Also, there were more hospital beds per person in regional and remote areas in 2002–03 (respectively, 3 beds and 5 beds per 1,000 residents) than in *Major cities* (2.5 beds). Compared with hospitals in *Major cities*, hospitals in regional and remote areas were less likely to be accredited under a national accreditation scheme, and tended to be considerably smaller. Many hospitals outside *Major cities* had fewer than 30 beds, but about 30 had between 100 and 300 beds (AIHW 2005e, 2006c).

Use of aged care services

Table 44.1 shows the use of aged care services in each geographic area (see Box 44.1). Remote areas have relatively fewer people in residential care than other regions (23 residents per 1,000 people aged 65 years and over compared with 56 in *Major cities*) but relatively more people who receive Community Aged Care Packages (CACPs) (17 recipients per 1,000 population compared with 11 in *Major cities*) and Home and Community Care (HACC) services (254 clients per 1,000 population compared with 199 in *Major cities*). People living in *Outer regional* areas also tend to use residential aged care services relatively less often and HACC services relatively more often than people in *Major cities*.

The referral rate from the Aged Care Assessment Program (ACAP) is lower in remote areas (63 per 1,000) compared with clients in metropolitan areas (104 per 1,000) and clients in regional areas (95 per 1,000) (ACAP NDR 2006).

Residential aged care services in *Remote* and *Very remote* areas have markedly fewer places than their counterparts in other areas: 61% of services in *Remote* areas and 81% of services in *Very remote* areas had 20 or fewer places and most of the remainder in these regions had 40 or fewer places compared with an Australian average of 56 places per service. Similarly, CACP outlets operating in *Remote* and *Very remote* areas were smaller in size with 75% in *Remote* areas and 100% in *Very remote* areas having 20 packages or less (AIHW 2007a, 2007f). As noted above, however, both CACP and HACC services in remote areas have higher client useage rates than the rates in *Major cities*.

These data on provision and use of aged care services are limited to mainstream aged care services. In addition to these, the Australian Government also provides flexible aged care services through Multi-Purpose Services in rural and remote communities, and through services under the National Aboriginal and Torres Strait Islander Aged Care Strategy. As at June 2006, these services provided 2,273 residential care places and 556 Community Aged Care Packages.

Table 44.1: Use of aged care services, by age and geographic area, latest years

Age	Major cities	Inner regional	Outer regional	Remote[a]
		Per 1,000 population[b]		
Residential aged care residents in Australia (30 June 2006)				
65–74	9.9	9.0	8.1	7.2
75–84	56.5	55.8	46.8	26.9
85+	241.5	260.9	210.7	105.6
65+	*56.4*	*54.7*	*44.1*	*23.5*
Clients 65+ (number)	*98,677*	*35,544*	*12,859*	*1,057*
Community Aged Care Packages recipients (30 June 2006)				
65–74	3.0	3.2	3.1	10.3
75–84	14.0	13.4	11.0	22.5
85+	36.7	36.6	27.3	38.1
65+	*11.3*	*10.7*	*8.5*	*17.0*
Clients 65+ (number)	*19,808*	*6,918*	*2,483*	*763*
Extended Aged Care at Home[c] recipients (30 June 2006)				
65–74	0.4	0.4	0.3	..
75–84	1.0	1.0	1.1	..
85+	2.2	2.1	2.1	..
65+	*0.9*	*0.8*	*0.8*	..
Clients 65+ (number)	*1,488*	*530*	*227*	..
Home and Community Care clients (1 July 2004 to 30 June 2005)				
65–74	95.0	107.3	123.4	156.2
75–84	261.1	300.7	328.6	354.6
85+	452.6	518.1	553.3	520.1
65+	*199.0*	*220.8*	*239.3*	*253.9*
Clients 65+ (number)	*339,579*	*139,985*	*68,011*	*11,120*

(a) *Remote* and *Very remote* categories have been combined.

(b) Population denominators relate to the year reported.

(c) EACH and EACH Dementia recipients.

Note: The data are classified according to the remoteness area of the service except for HACC which uses the client location.

Source: AIHW analysis of DoHA Aged and Community Care management Information System (ACCMIS) data and AIHW analysis of HACC MDS.

OLDER VETERANS

45

Veterans and their widows/widowers make up a sizeable minority of the older Australian population. There are currently 266,100 Department of Veterans' Affairs (DVA) income support beneficiaries aged 65 and over representing 10% of all older Australians; among people aged 85 years and over, an even larger proportion (27%) are in receipt of DVA income support (Table A45.1; Table 1.1).

Including veterans, their dependants, war widows and widowers, and DVA health card holders it is estimated that around 394,516 Australians received some form of assistance from DVA at 30 June 2007 of whom about 78% were aged 65 years and over (DVA 2007a). This may be in the form of an income support and/or disability pension, and may include access to assistance with medical or pharmaceutical services through provision of a repatriation health care card (Gold, White or Orange Card) or a Commonwealth Seniors Health Card. Around 6% of older Australians received a Department of Veteran's Affairs (DVA) disability or war widow(er)s pension, 10% received some form of DVA income support, and 9% held a Gold or White DVA health care treatment card (derived from DVA 2007e, 2007f).

Veterans are also eligible for mainstream aged care services available to all Australians. It is estimated that DVA clients make up at least 17% of permanent residents of aged care services and 9% of Home and Community Care (HACC) clients (AIHW 2007f; DoHA 2006a). Data from the 2002 census of Community Aged Care Package recipients indicate that, at that time, 14% of CACP recipients were DVA clients (AIHW 2004b).

Health and health care

A 2006 survey of veterans and war widows found that the most common medical condition reported was vision problems, alleviated by glasses or contact lenses (90%), (DVA unpublished data). However, among those with vision impairment there has been an increase in degenerative eye conditions such as macular degeneration since the previous 2004 survey (see also Topic 26: *Vision problems).* Other prevalent medical conditions in 2006 included complete or partial deafness (55%), foot/leg problems that affect mobility (54%), arthritis (51%), high blood pressure (47%), and dementia and memory loss (41%). Since the previous survey in 2004 there has been a noticeable increase in self-reported mental health conditions, including insomnia, anxiety, depression and Post-Traumatic Stress Disorder (see also Topic 23: *Mental health*).

Specific health care benefits and services are available to eligible veterans and dependants with one of three treatment entitlement cards. These entitle holders to health services (Gold and White Cards) and pharmaceuticals (Orange Card). Holders of a Gold Card are entitled to the full range of health care and pharmaceutical services at no cost to them, and White Card holders are entitled to free health services for service-related disabilities or illnesses. General practitioner and specialist medical services, dental care, hospital care and psychological services are available. White Card holders may also have an Orange Card.

Holders of a Gold or White Card constituted the 'treatment population', which in June 2007 consisted of 293,623 people, 78% of whom were aged 65 and over (DVA 2007f). Holders of an Orange Card (14,963 people), (either alone or with a White Card) were all aged 70 and over (DVA 2007b).

In 2005–06, 31% of the treatment population received care from private hospitals, 96% accessed other medical services, 73% received allied health services, 96% received medicines and dressings through the Repatriation Pharmaceutical Benefits Scheme and 11% received community nursing services (DVA 2006a).

Veterans in residential aged care still retain entitlements to assistance with health and pharmaceutical care. A study of health service use by Gold Card holders aged 70 and over found that, compared with Gold Card holders living in the community, those living in residential aged care had, on average, more general practitioner and local medical officer consultations, a lower rate of specialist use with fewer specialist consultations, filled more prescriptions under the Repatriation Pharmaceutical Benefits Scheme and had lower rates of hospital use although the average stay was slightly longer (AIHW: Anderson & Lloyd 2007 in press).

Veterans' mental health problems are as varied as the conflicts in which ex-servicemen and women have served. Society's understanding and acceptance of mental health problems has improved dramatically since the men and women who served in World War I returned home to the care of dedicated repatriation hospitals. Views about where to provide mental health treatment have changed considerably since then—current thinking is that veterans benefit from being treated in the community, close to family and friends, with as little disruption as possible to their daily routines.

As at June 2007, it is estimated that some 143,000 people within the DVA treatment population have some experience of mental health concerns. This population includes those people who have an accepted mental health disability and those who have received some type of mental health treatment through their use of mental health services or pharmacological interventions. Within this population, approximately 55,000 have an accepted mental health disability—38,000 were receiving treatment as at June 2007 while approximately 17,000 did not receive treatment during 2006–07. A further 88,000 have no accepted mental health disability but had received some form of mental health treatment or pharmacological intervention—80,241 were aged 65 and over. The most common conditions among veterans with an accepted mental health disability are generalised anxiety disorder, depression, alcohol dependence and post-traumatic stress disorder.

The Veterans and Veterans' Families Counselling Service provides counselling and group programs to Australian veterans/peacekeepers and their families under the *Veterans' Entitlements Act 1986*. The service provides centre-based counselling, case management, outreach programs, a telephone crisis service (Veterans Line), group sessions and other specialist programs. Nearly 24,500 clients received counselling services in 2005–06 (DVA 2006a:113–21.)

DVA pensions

At 7 July 2007, 394,516 people were receiving some form of DVA-funded income support or a compensation pension. DVA clients can receive either or both types of pension—52% of all DVA disability pensioners (92% for those aged 65 and over) and 76% of people on a war widow(er)s' pension also received some amount of income support (DVA 2007e).

The Service Pension is the main income support pension and is similar in many ways to the Age Pension (see Topic 13: *Age Pension and superannuation*). In July 2007, there were 113,698 veteran service pensioners and 96,864 partner/widow(er) service pensioners and 79% were aged 65 and over. The Service Pension is paid on the basis of age or invalidity at the same single and couple rates as the Age Pension—from September 2007, a maximum of $537.70 a fortnight for a single person and $449.10 a fortnight for each member of a couple (DVA 2007d). It is also subject to income and assets tests. However, an important difference is that, when paid on the basis of age, the Service Pension is available to veterans 5 years earlier than the Age Pension. As with the Age Pension, the qualifying age for females is being progressively increased to bring it into line with the qualifying age for males. At the time of writing, female veterans were eligible for a service pension at 59.5 years of age. The qualifying age for females is being progressively increased from 55 to 60 in a similar way to the increase in the Age Pension eligibility age for women; from January 2014 the qualifying age for both male and female veterans will be age 60 (DVA 2007c).

The War Widow's/Widower's and Orphan's Pensions, Income Support Supplement, Disability Pension and various other allowances are payments to service personnel or their dependents. No DVA compensation payment is taxable or subject to means testing (DVA 2006b). The Disability Pension, which is a payment for injuries or disease caused or aggravated by war or defence service, was being paid to 139,727 people (57,995 people aged 65 and over) in July 2007 and the War Widow's/Widower's Pension was being paid to 110,592 (106,317 aged 65 and over).

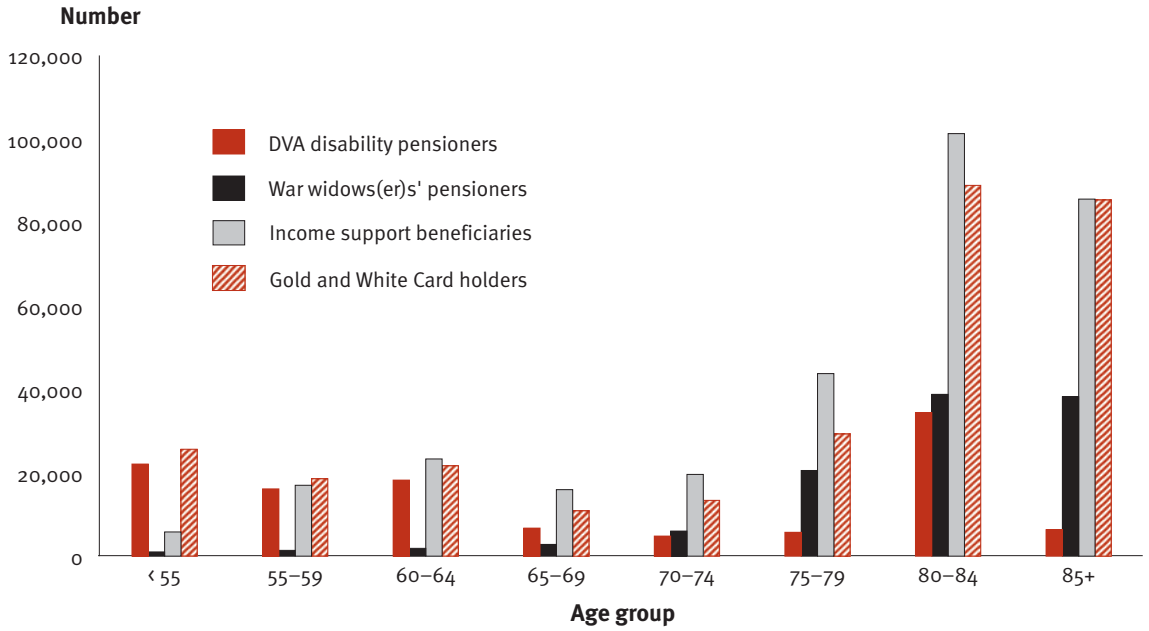
The majority of veterans on a Disability or Service Pension (69%) and War Widow's/Widower's Pension (96%) were aged 65 years and over. Of the 121,800 older veterans on a Disability Pension, 69% served in World War II, 15% served in the Korean War, the Malayan Emergency or the Far Eastern Strategic Reserve, and 7% served in Vietnam. Most older disability and war widow(er) pensioners (73% and 62% respectively) were aged 80–89 (DVA 2007e).

Veterans' Home Care and DVA community nursing

The Veterans' Home Care (VHC) program began in January 2001 providing low-level care to assist veterans, war widows and war widowers to remain in their own homes for as long as possible. It provides domestic assistance, personal care, home and garden maintenance, and respite care to eligible members of the veteran community. Other services such as delivered meals and community transport are provided through special arrangements with state and territory governments. Veterans and war widows or widowers are required to provide a co-payment for VHC services, except for respite care. In 2005–06, 77% of those approved for VHC were approved for one of the four types of assistance, and 22% for two (DVA 2006a:111–12).

During 2005–06, 72,541 people received services through VHC, 98% (70,997) of whom were aged 65 and over. Nearly half (44%) of the VHC clients were

Figure 45.1: DVA disability pension recipients, income support beneficiaries, and treatment card holders, by age and sex, June 2007



Source: Table A45.1.

aged 80–84 with an additional 28% aged 85–90 (Table 45.1). For those aged 65 years or over, domestic assistance (92% of clients) and safety-related home and garden maintenance (20%) were the services received by most clients at some time during the year (Table 43.2). Similar proportions of clients in each age group used domestic assistance. However, the use of personal care and respite care for those aged 65 years and over increased with age, whereas the reverse was true for home and garden maintenance.

Veterans and war widows/widowers with higher personal care needs or specific clinical needs can access personal care and nursing services through the DVA community nursing program. The community nursing program aims to assist veterans and war widows/widowers to continue living in their own homes, avoiding early admission to hospital and residential care. DVA's community nursing services provided personal care services to 11% of its 32,100 older clients. As with VHC, 98% of community nursing clients are aged 65 years and over (AIHW 2007c). Veterans and war widows/widowers may also be referred to other DVA services such as the Rehabilitation Aids and Appliances program or minor home modifications through DVA's HomeFront program.

Other services

Other DVA services are available to veterans and their families. These include a free financial information service and housing assistance through the Defence Service Homes Scheme, as well as home loans and insurance. Less direct, but still important, services include commemoration activities. One activity in particular is the Their Service—Our Heritage Program, which provides an avenue for educating the community about and acknowledging the service and sacrifice of Australia's veterans. Details of benefits and services provided to DVA clients are available on DVA's website (<www.dva.gov.au>).

Table 45.1: Clients receiving assistance from Veterans' Home Care and DVA community nursing, by age and sex, 2005–06

	< 65	65–69	70–74	75–79	80–84	85–89	90+	Total 65+	Total
Veterans' Home Care									
Males	1.7	0.6	1.0	3.2	23.6	15.4	3.9	47.7	49.4
Females	0.5	0.6	2.2	10.2	20.7	12.4	3.9	50.0	50.6
Persons	**2.1**	**1.2**	**3.2**	**13.4**	**44.3**	**27.9**	**7.8**	**97.8**	**100.0**
Persons (number)	**1,544**	**890**	**2,307**	**9,743**	**32,155**	**20,219**	**5,681**	**70,995**	**72,541**
DVA Community Nursing									
Males	1.7	0.6	1.0	2.9	22.6	17.6	6.1	50.8	52.5
Females	0.5	0.4	1.5	7.0	17.5	13.8	6.9	47.1	47.5
Persons	**2.1**	**1.1**	**2.5**	**9.9**	**40.1**	**31.4**	**13.0**	**98.0**	**100.0**
Persons (number)	**681**	**344**	**813**	**3,240**	**13,122**	**10,278**	**4,260**	**32,057**	**32,738**

Source: AIHW 2007c; DVA unpublished data (current as at 30 March 2007 but subject to change).

Table 45.2: Services received by Veterans' Home Care clients, by age, 2005–06

	< 65	65–74	75–84	85+	Total 65+	Total
	Per cent within client age group					
Domestic assistance	86.8	89.7	92.5	92.4	92.3	92.2
Home and garden maintenance	26.8	25.4	21.2	17.1	19.9	20.0
Respite care (excluding residential respite)	10.0	7.0	9.0	13.1	10.4	10.4
Personal care	1.0	2.3	3.2	5.5	4.0	3.9
Total (number)	**1,544**	**3,197**	**41,899**	**25,901**	**70,997**	**72,541**

Note: Total number of recipients will be less than the sum for all service types, as one recipient may receive more than

Source: AIHW 2007c; DVA unpublished data (current as at 30 March 2007 but subject to change).