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Interfaces between the aged care and health systems in Australia—first results

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In 2016–17, nearly 900,000 people aged 50 and over used aged care services. People who use aged care also routinely use health care services, such as those provided by general practitioners (GPs), medical specialists and hospitals, and have medicines dispensed to them. These patterns of service use can be complex and influenced by many factors, such as the person's age, health status and location.

This report presents initial findings from a project that linked data across aged care and health services. These examine how people's use of primary care, patterns of prescription dispensing, and the rate and nature of their hospital use can vary with use of aged care.

In bringing these separate sources of information together, we develop the capacity to present a more comprehensive picture—one that better reflects the actual use of these systems. However, this report does not set out to cover all interactions between aged care and health services, or represent all people who use aged care. This report presents some first results to highlight the kinds of insights that can be gained from linking routinely collected administrative data. It concludes by providing an overview of possible future analyses using the linked data together with information about data gaps and limitations.

The report focuses on 4 groups of people aged 50 and over who had used only 1 type of aged care program during 2016–17, or no aged care at all. In general, we found that people who used aged care services were more likely to see a GP or specialist, and to use hospital services, than people who did not use aged care. However, the frequency of health care use varied by type of aged care program—generally, people in permanent residential aged care were less likely to see a GP or specialist or have a hospital separation than people who used community-based aged care. When people in permanent residential aged care were admitted to hospital, it was more likely to be related to an injury or fall than for people who used community-based aged care.

Some of the variation presented here may be due to the characteristics of people who use (or do not use) particular aged care programs—for example, people living in permanent residential aged care tend to be older, with more complex health needs, than other aged care users.

More detailed information is available in online supplementary tables.

Key findings

Compared with people using home support or home care, in 2016–17, people in permanent residential aged care were:



- less likely to have had at least 1 GP attendance (92%, compared with 96%–98%)—although they still averaged 1 GP attendance a fortnight



- more likely to have had at least 1 antipsychotic prescription dispensed (28%, compared with 4%–8%)



- less likely to have had an emergency department presentation (32%, compared with 37%–38%) or a hospital separation (37%, compared with 51%–58%)



- more likely to have had at least 1 hospital separation for a fall-related injury (10%, compared with 6%).

What is aged care?

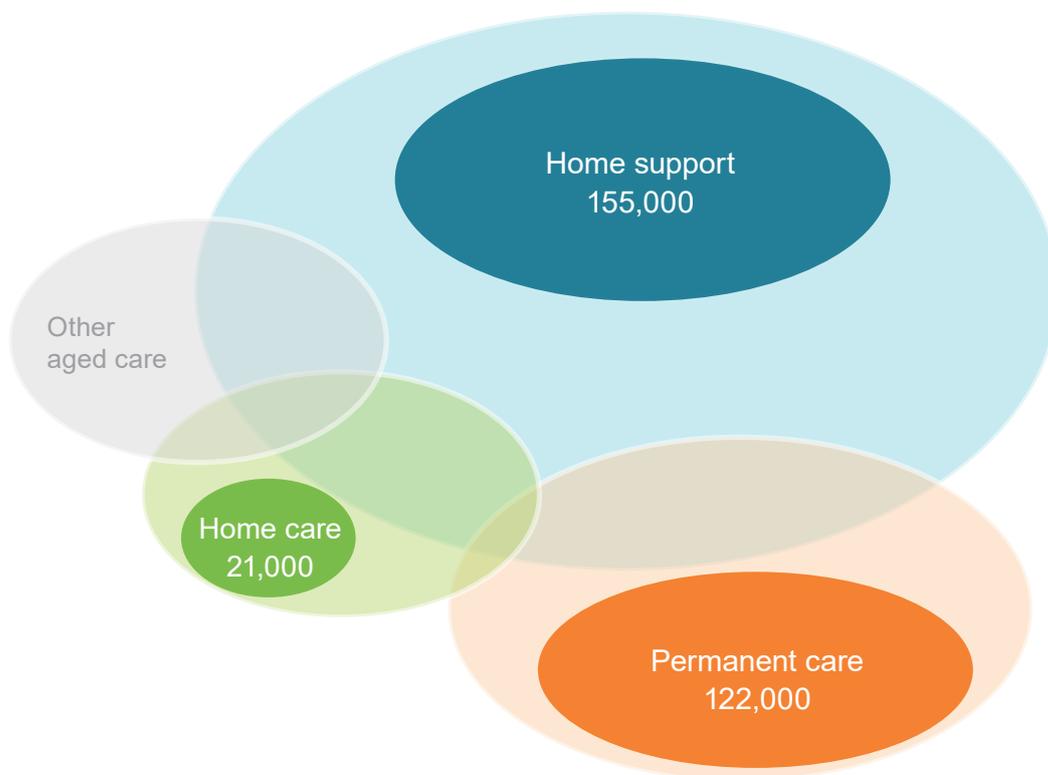
Aged care can be broadly thought of as a continuum of care from entry-level community-based care at home (Commonwealth Home Support Program, or 'home support') to higher levels of care at home (the Home Care Packages Program, or 'home care')—and when living at home is not an option, permanent residential aged care (or 'permanent care') in a facility. There are other programs, but these 3 are the biggest by number of users and are the ones referred to in this report.

People can use multiple aged care programs as their needs change or services become available. Of the nearly 900,000 people aged 50 and over who used aged care services and were enrolled in Medicare in 2016–17, 85% used only 1 program during the year. Home support services accounted for the largest share (534,000 people used only this program some time during the year, while around 30,000 people used only home care packages). Almost 178,000 people used only permanent care.

The focus here is further narrowed, presenting analysis for a cohort of people who were aged 50 and over at 1 July 2016, and were still alive on 30 June 2017. They were consistent users of 1 of these 3 biggest aged care programs across the year in 2016–17. That is, they did not die or use other aged care during the year (for example, changing between programs could indicate changes to care needs). In addition, the analyses include a comparison sample of people who had never used an aged care program.

In these selected aged care user groups, around 155,000 people used only home support, 21,000 used only home care and 122,000 used only permanent care (Figure 1). The sample of the older population not using any aged care was 69,000 people. These groups of people featured here can all be considered relatively 'stable'—however, this means that *not* all people using these programs (or all people using aged care) are included in these first results. An overview of planned further analyses is presented at the end of this report and more information about the methods used here is available in Note 1 in the supplementary tables.

Figure 1: Aged care program users, 2016–17^(a)



(a) This report focused on people who used only 1 aged care program in 2016–17 and who used that program consistently (home support for 2 or more quarters, home care for the full year, or permanent care for the full year) and were alive for the full year. This represented a subset of people who used 1 of these 3 programs (indicated by the darker shade) and did not take into account people who used other aged care during the year. In addition, a sample of people who had not used aged was randomly selected to match the age and sex distribution of people who had used any aged care in the year.

What data was used?

This work was conducted using a series of bespoke project datasets, created with approval from the AIHW Ethics Committee and data custodians. The project datasets cover 5 years of data from 2012 to 2017 and bring together routinely collected administrative data from 6 sources:

- National Aged Care Data Clearinghouse—for aged care program data
- Medicare Benefits Schedule (MBS)—for patterns of GP and specialist use
- Pharmaceutical Benefits Scheme (PBS)—for patterns of prescriptions dispensed
- National Non-Admitted Patient Emergency Department Care—for emergency department (ED) presentations
- National Hospital Morbidity Database—for hospital separations
- National Death Index—for date of death.

Further information on aged care data and how aged care users were assigned to groups is available in Note 1 in the supplementary tables. Further information on how MBS, PBS and hospital data were analysed is available in Note 2 in the supplementary tables.

The datasets are all at the national level, apart from ED presentations and hospital separations, which include data for only Queensland and Victoria (however, data for both private and public hospital separations were included from these 2 jurisdictions). The patterns of ED presentations and hospital separations for same-day and overnight admissions are therefore presented only for people who lived in these 2 jurisdictions (or used hospitals in them).

Among people aged 50 and over, the group of people who do not use aged care services is dominated by people aged 50–64, while people using aged care services are generally aged 65 and over. To manage this, a random sample of non-users was selected with the same age/sex distribution as that of all aged care users in the year. For more information, see Note 1 in the supplementary tables.

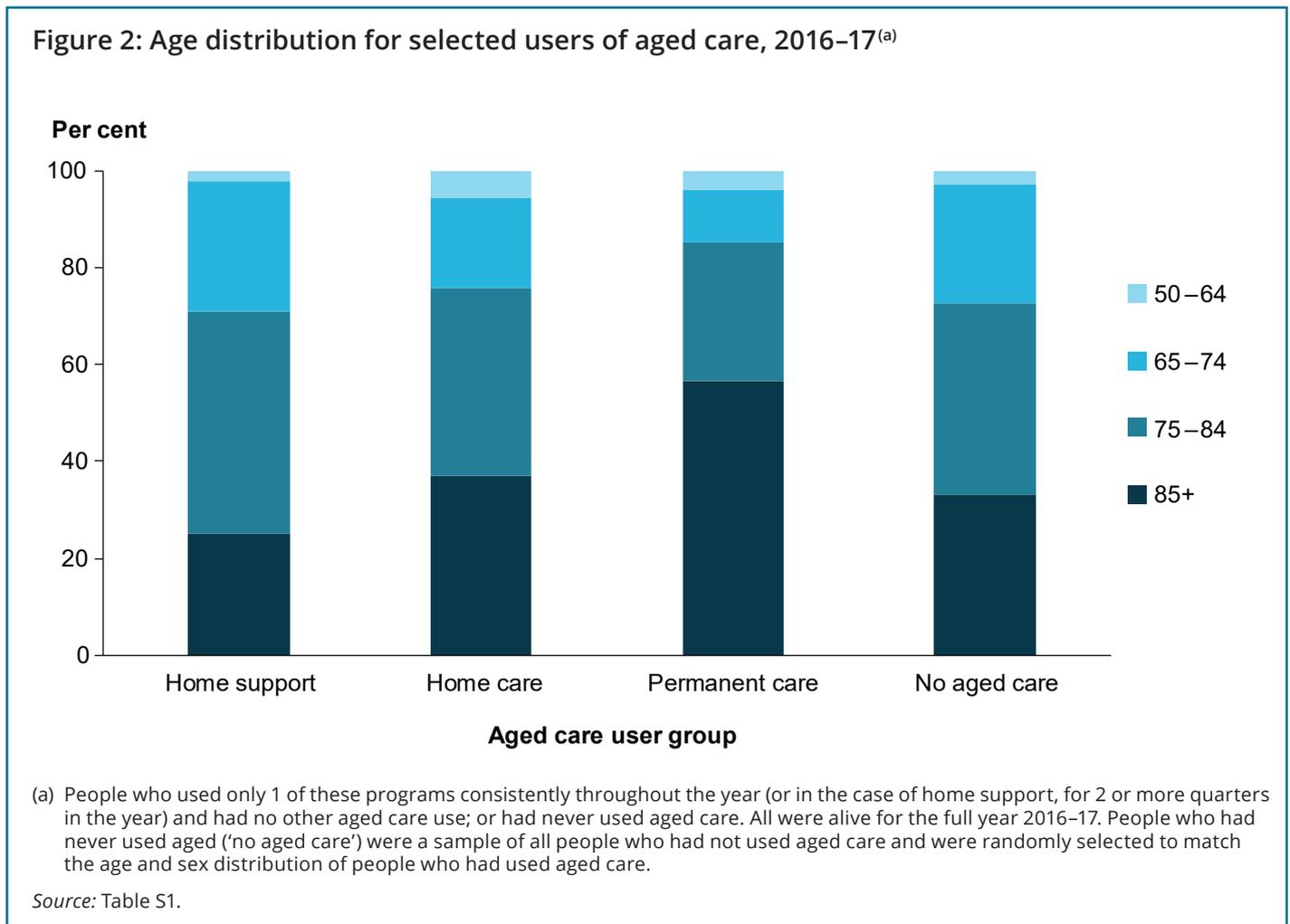
This allowed the comparison of health service use for distinct groups of people who were all in scope for the full year and had similar age and sex distribution. However, this does not take into account people's circumstances more broadly—some of the patterns observed here may be due to people's health needs, living arrangements and support networks, and the aged care program they used (or did not use) may reflect this.

Characteristics of the 4 groups

People do not have to be a given age to use aged care—in particular, people often take up community-based aged care earlier in life than residential aged care, and this is also reflected in the selected aged care user groups.

People living in permanent care are older than those in the community

People using community-based aged care (either entry-level home support, or the higher levels of assistance available through home care) were younger than those who were living in permanent care for the full year—of those using home support and home care, 25% and 37% were aged 85 and over, compared with 57% among people in permanent care (Figure 2).



The median age was 79 among those using home support and 82 among those using home care, rising to 86 among those using permanent care. Among the sample of older people living in the community and not using aged care in 2016–17, the median age was 80. One-third (33%) of this group were aged 85 and over.

Women tend to out-number men

Overall, about 7 in 10 people in each group were female. The proportion of females rose with age, reflecting that women, on average, live longer than men.

Around two-thirds of people in each group lived in *Major cities*, ranging from 60% of those using home support to 66% of those living in permanent care (Table S2). This aligns with the geographic distribution of people aged 65 and over in Australia.

What primary care services are people using?

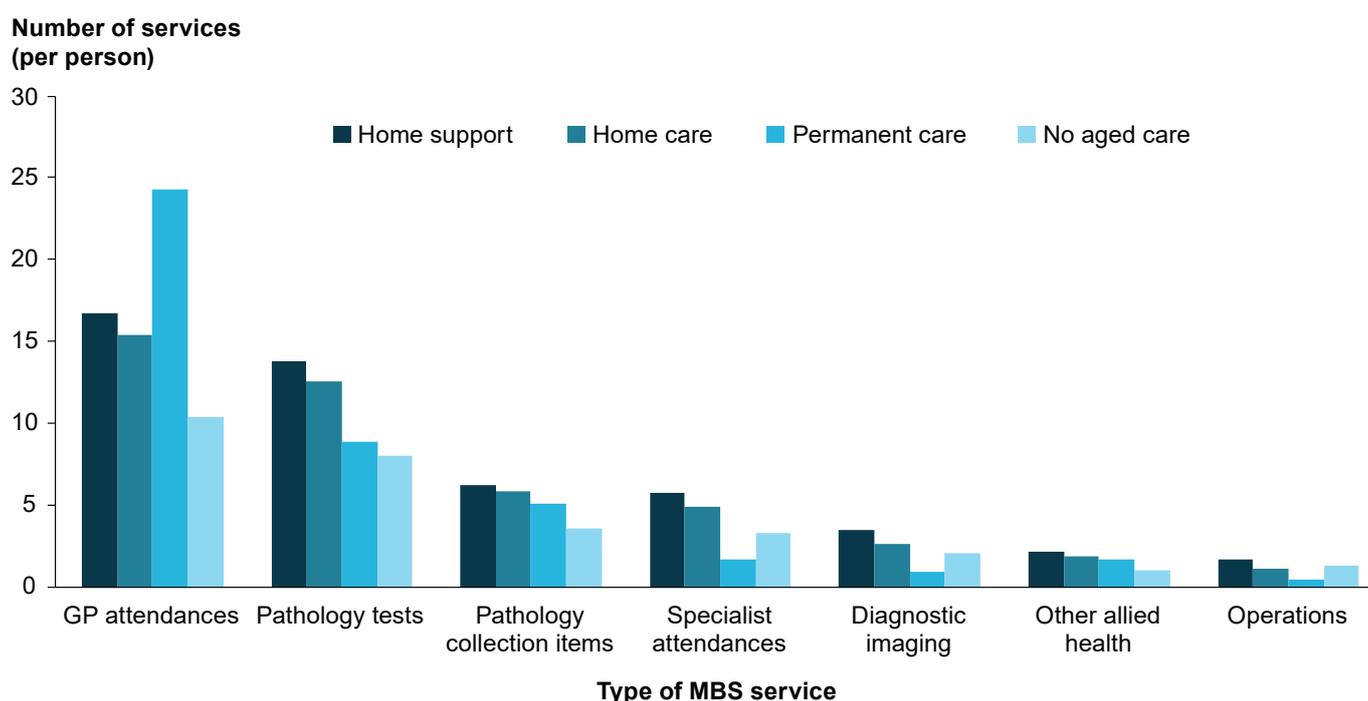
Primary care is often a person's first interaction with the health system and includes services provided in the community by GPs, specialists and allied health practitioners. This section examines MBS data to compare patterns of GP and specialist attendances among people in the 4 groups of interest.

Common types of services

Broadly, MBS claims were most commonly for GP attendances and pathology (Table S3).

Looking at services per person, people using aged care were generally more likely to use primary health care than people who did not use aged care. People living in permanent care had more GP attendances per person during the year than the other 3 groups, but fewer specialist attendances, diagnostic imaging services and operations (Figure 3).

Figure 3: Most common types of MBS services for selected users of aged care, 2016–17^(a)



(a) Number of services is calculated per person for all people in each group.

Source: Table S3.

What Medicare data are included?

MBS data relate to medical services that are subsidised by the scheme. People may receive medical services that are not captured here—either because no MBS claim was made, or because the service was delivered as part of another service or funding arrangement. For example, people using home care can receive some nursing and allied health care as part of their package, and residential aged care facilities can provide additional services such as podiatry, physiotherapy or occupational therapy in-house. Similarly, people may access additional allied health services privately (with some reimbursement through private insurance if relevant). Data on these services are not available.

In residential aged care, a GP may visit regularly and see a number of patients in 1 visit (most of the GP attendance claims for people living in permanent care related to MBS items that are specifically for use in residential aged care). Other medical care services are less likely to be delivered in this way; for example, medical specialists and dentists rarely visit facilities and it may be difficult for people to attend appointments outside the facility.

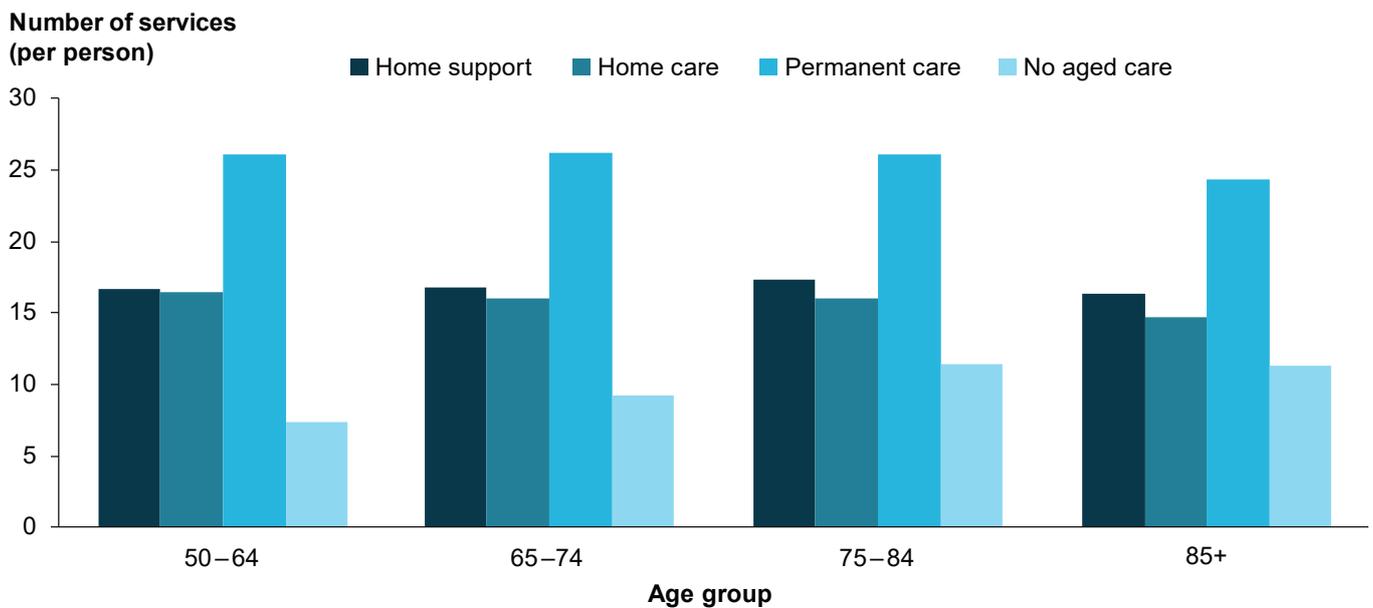
For more information, see Note 2 in the supplementary tables.

Almost everyone sees a GP

While people using home support or home care were more likely to have at least 1 GP attendance during the year than people in permanent care (96% and 98%, respectively, compared with 92%), when they saw a GP, they had fewer visits. People using home support had on average 17 GP attendances (and people using home care 16), while people living in permanent care averaged almost 1 attendance per fortnight (25).

There was little variation by age group in people using aged care, but the number of services in a year increased with age for the sample of people who did not use aged care (Figure 4).

Figure 4: GP attendances for selected users of aged care, by age group, 2016–17^(a)



(a) Number of services is calculated per person for all people in each group who had at least 1 GP attendance.

Source: Table S4.

Almost one-third (31%) of people living in permanent care had a claim for a medication management review—this compared with 4% for people living in the community and using aged care, and 1% for people living in the community and not using aged care (Table S5).

What is a medication management review?

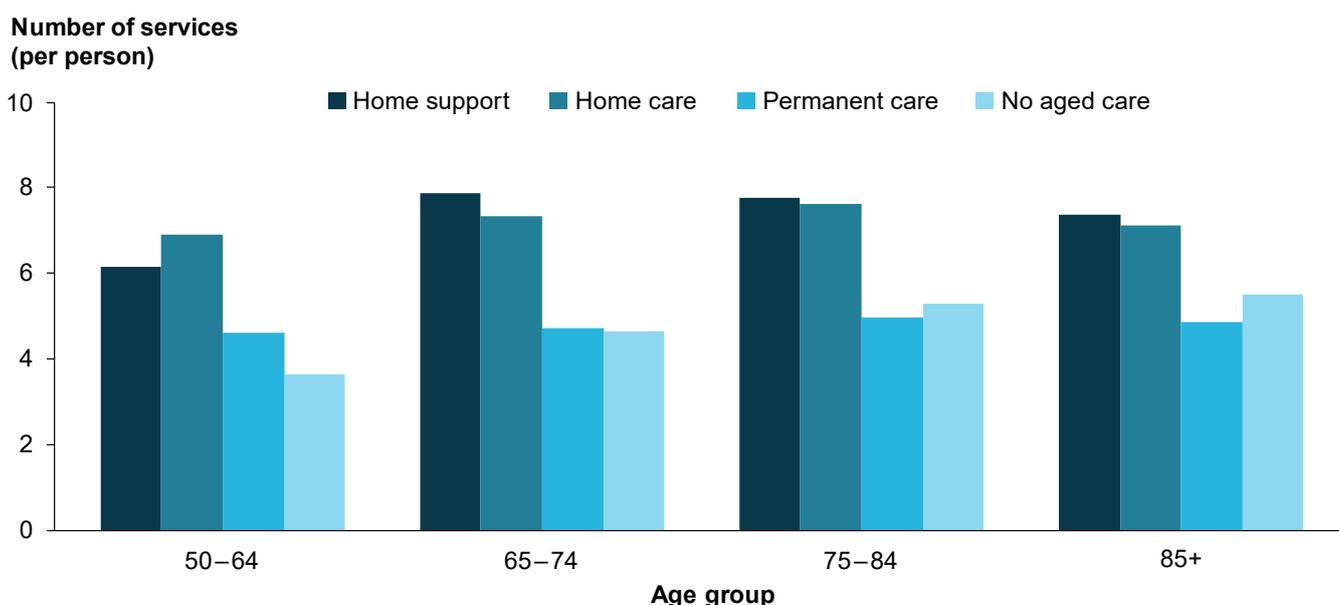
These seek to identify, prevent and resolve medicine-related problems for people living in a community setting or in residential aged care; the reviews are initiated by a GP and undertaken by pharmacists (for more information, see Note 2 in the supplementary tables).

People living in permanent care are less likely to use specialists than aged care users in the community

Around three-quarters (74%) of older people using home support, 65% of those using home care and 58% of those who did not use aged care had at least 1 specialist attendance. This proportion fell to one-third (32%) among those who lived in permanent care.

Among those who had any specialist attendances, people living in permanent care received a similar number of services in a year to those not using any aged care (5 services, compared with 8 for those using home support and 7 for those using home care). The pattern was similar across age groups (Figure 5).

Figure 5: Specialist attendances for selected users of aged care, by age group, 2016–17^(a)



(a) Number of services is calculated per person for all people in each group who had at least 1 specialist attendance.

Source: Table S6.

Ophthalmology was the specialty most commonly used by people using home support, home care and not using any aged care (accounting for 13%, 12% and 19% of their specialist attendances, respectively). People living in permanent care most commonly saw a consultant physician in geriatric medicine (15%), followed by an ophthalmologist (13%) (Table S7).

People in large residential aged care facilities are more likely to see a specialist

The proportion of people with at least 1 specialist attendance during the year was highest among people living in large residential aged care facilities operated by not-for-profit or privately-owned organisations (Table 1).

Table 1: Specialist attendances for people in permanent care, by facility type, 2016–17

| Service group (organisation type/size) | | Proportion of people with at least 1 specialist attendance (%) | Median number of specialist attendances |
|--|--------|--|---|
| Not-for-profit | Small | 31.2 | 4 |
| | Medium | 31.2 | 4 |
| | Large | 33.4 | 5 |
| Government | Small | 26.3 | 4 |
| | Other | 25.6 | 4 |
| Private | Small | 29.1 | 5 |
| | Medium | 30.7 | 5 |
| | Large | 34.5 | 6 |

Notes

1. 'Small' facilities had 50 or fewer operational places at 30 June 2017, 'medium' had 51–100 and 'large' had 101 and over.
2. Median calculated per person in service group for people with at least 1 specialist attendance.
3. Only includes people who lived in 1 facility for the full financial year.

Source: Table S8.

People living in larger privately owned residential aged care facilities were also more likely to have a higher number of GP attendances in the year than people in not-for-profit or government-run services. However, people in larger government-run services were most likely to have seen a GP at least once in the year (Table S8). Facilities were grouped by the organisation type and the size of the facility (based on the number of operational places), but particular facilities (or types of facilities) may cater to particular people with a range of care needs—potential resident characteristics were not taken into account in this report.

How many people are dispensed prescriptions?

People who used aged care were more likely (98%–99%) to have prescriptions dispensed to them than people who did not use aged care (93%) (Table S9).

On average, people using home support had 62 prescriptions dispensed in 2016–17, while the number was slightly higher for those using home care (69) and higher again for people using permanent care (76). The sample population of older people who had never used aged care had 38 prescriptions dispensed in the year.

Medicines for the cardiovascular system were the most common type dispensed for people in community-based aged care and those with no use of aged care. For people living in permanent care, the most commonly dispensed were medicines that act on the nervous system.

What prescription data are included?

The prescriptions that are dispensed by a pharmacist under the PBS are a subset of the prescriptions that are written by GPs, hospital-based doctors or other health care providers. Sometimes people can obtain medicines privately (meaning they do not attract a government subsidy and are therefore not captured in PBS data) or through other non-PBS channels such as inpatient medicines received in hospital or bought over the counter. The total volume of prescriptions dispensed under the PBS, therefore, does not include all of the medicines dispensed.

In addition, the administrative data collected through PBS dispensing does not account for how a medicine is used and whether it is ever used—some medicines are taken as prescribed, some are used inappropriately, and some are not used.

There is also little information on why a medicine was prescribed, such as what particular diagnoses people may have received or the conditions that warranted the prescribing, but looking at the class the medicine belongs to indicates its broad therapeutic intent. Medicines are classified by considering the body part they affect, as well as their therapeutic and chemical nature.

The Anatomical Therapeutic Chemical (ATC) Classification System is an international system using a hierarchical approach to classify medicines. At its least detailed level (ATC level 1), the classification summarises which body part the medicine acts on, while at its middle levels the focus is on the medicine's therapeutic intent and chemical composition. At its most detailed level (ATC level 5), the code indicates the distinct medicine that has been prescribed—here, data are presented at several ATC levels, using the PBS ATC mapping (which has been adapted somewhat from the international approach to take into account how medicines are used in Australia).

For more information, see Note 2 in the supplementary tables.

Most people have prescriptions for multiple medicines

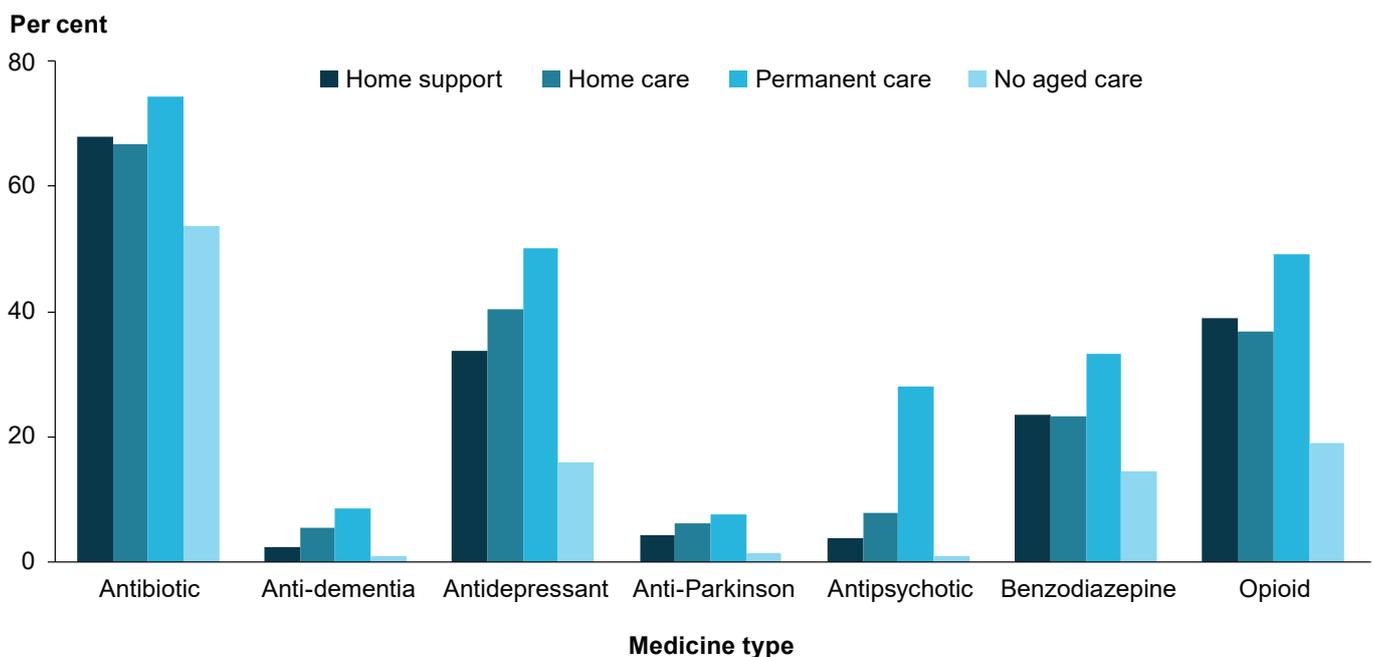
The number of distinct medicines dispensed (identified by ATC level 5) to the 3 groups of people using aged care during the year was similar—a median of 10 for each of the community-based groups, and 11 for people living in permanent care. The sample population of people who had never used aged care had a median of 6 distinct medicines dispensed (Table S10).

People living in permanent care are more likely to have at least 1 antipsychotic prescription

This section looks at specific medicine types of interest within the category of medicines that act on the nervous system, as well as antibiotics.

People living in permanent care were more likely than the other groups to have at least 1 prescription for all of the selected medicine types dispensed in 2016–17 (Figure 6). For example, 4% of those using home support, and 8% of those using home care, had a prescription dispensed for an antipsychotic medicine (these commonly include risperidone, olanzapine and quetiapine). This rose to 28% among those who were living in permanent care for the full year.

Figure 6: Selected medicine types dispensed for selected users of aged care, by medicine type 2016–17



Note: Proportion of people with at least 1 prescription dispensed for selected medicine type.

Source: Table S11.

People in government-run facilities are more likely to have at least 1 antipsychotic prescription

People in permanent care were dispensed antipsychotic medicines at different rates depending on what type of facility they were living in (Table 2). For example, the rate was higher for people living in government-run residential aged care facilities. However, this analysis did not adjust for the care needs of people living in particular types of facilities, and focused on people who lived in 1 facility for the full year. The patterns of dispensing for people with particular underlying health conditions, or people who are entering care or approaching death, may show marked differences.

Table 2: Antipsychotic prescriptions dispensed for people in permanent care, by type of facility, 2016–17

| Service group (organisation type/size) | | Proportion of people with at least 1 antipsychotic prescription (%) | Median number of antipsychotic prescriptions |
|---|--------|--|---|
| Not-for-profit | Small | 26.2 | 7 |
| | Medium | 26.5 | 7 |
| | Large | 25.8 | 7 |
| Government | Small | 32.9 | 9 |
| | Other | 35.8 | 10 |
| Private | Small | 31.9 | 8 |
| | Medium | 30.2 | 7 |
| | Large | 27.7 | 7 |

Notes

1. 'Small' facilities had 50 or fewer operational places at 30 June 2017, 'medium' had 51–100 and 'large' had 101 and over.
2. Median calculated per person in service group for people with at least 1 antipsychotic prescription.
3. Only includes people who lived in 1 facility for the full financial year.

Source: Table S12.

Counting the number of prescriptions dispensed does not reflect the volume of medicine use, as the quantity of medicine in 1 prescription can vary. For example, the antipsychotic medicine risperidone is dispensed in a pack of 60 tablets, while olanzapine is dispensed in a pack of 28. These can be prescribed at the same rate (for example, one tablet a day), meaning that the risperidone supply would last 2 months while the olanzapine in this example would last a month. The median number of antipsychotic prescriptions dispensed in a year does not take this into account. A simple method to compare volume of medicine use and estimate consumption is calculating the defined daily dose.

What is the defined daily dose?

Defined daily dose (DDD) is a World Health Organization (WHO) measure for estimating the consumption of a medicine. The WHO determines the assumed average maintenance dose per day for its main indication in adults. This is different from the dose prescribed or recommended for the person, but using DDD may give an estimate of the average number of days a person was receiving the medicine during the year. The DDD is an international measure based on a whole-of-population approach and does not take into account local differences in prescribing practices or best-practice prescribing for different sub-populations. For more information on how the DDD was calculated, see Note 2 in the supplementary tables.

The DDD gives an estimate of the number of days for which each person living in a particular type of facility was receiving antipsychotic medicines during the year. For example, the median use of all antipsychotics was between 48 and 82 days in a year depending on the size of the facility, with the highest DDD among people living in government facilities (Table S11).

People can be prescribed a particular drug for longer or in higher doses than best practice would indicate is appropriate. For example, according to the Australian Medicines Handbook (AMH), the antipsychotic medicine oral risperidone can be used for behavioural disturbances for older people with dementia. The maximum recommended dose for this indication is 2 mg daily (with a maximum treatment of 12 weeks), whereas the WHO DDD for risperidone is based on schizophrenia as the main indication, and the average maintenance dose is assumed to be 5 mg daily.

For certain medicines, the WHO DDD may underestimate the average number of days for which the medicine was used, compared with using Australian prescribing guidelines to calculate the DDD. To put this another way, using the AMH guidelines for oral risperidone, people living in permanent care for the full

year in 2016–17 may have used this medicine for a median of 180 days in a year (whereas using the WHO DDD, this would be a median of 36 days in a year). A higher proportion of people with dementia had at least 1 prescription for oral risperidone (around 20%, depending on type of dementia, compared with 7% of people without dementia), but the median days of use in the year were the same regardless of dementia status (Table S13).

How many people visit hospital?

Generally, people who use aged care are more likely to use hospital services in a year than those who do not use aged care. This section presents information on ED presentations and hospital separations for people in the 4 groups of interest who were living (or using hospitals) in 2 jurisdictions only (Queensland and Victoria).

How is hospital use defined?

Emergency department presentations

Some public hospitals provide urgent medical care through dedicated 24-hour emergency departments. ED presentations are defined as the presentation of a patient at an ED. This occurs following the arrival of the person at the ED, and it is the earliest occasion of them being registered clerically, or triaged.

Hospital separations

Data were supplied for both public and private hospitals on episodes of admitted patient care (where a person has undergone a formal admission process to access hospital care). These data are collected based on separations from care (where people have completed an episode of care), and an individual person can have multiple episodes of care. Hospital separations are defined as an episode of care for an admitted patient, which can be a total hospital stay (from admission to discharge, transfer or death) or a portion of a hospital stay beginning or ending in a change in care type (for example, from acute care to rehabilitation) or transfer to a different hospital.

These can be **same-day separations**, meaning that the person’s episode of care began and ended on the same day, or **overnight separations**, meaning that the episode of care involved at least 1 night in hospital. The conclusion of an episode of care does not necessarily mark a departure from the hospital system—a hospital separation can signal a change in care type or transfer to a different hospital.

For more information, see Note 2 in the supplementary tables.

Many people had some hospital use

In 2016–17, people living in permanent care were less likely to have had an ED presentation or a hospital separation than people using community-based aged care—but people without aged care use had the lowest proportions of all groups for both types of hospital use (Table 3).

Table 3: Hospital use for selected users of aged care, 2016–17

| Type of hospital use | Home support | Home care | Permanent care | No aged care |
|--------------------------------|---------------------|-----------|----------------|--------------|
| | Percentage of group | | | |
| At least 1 ED presentation | 38.1 | 36.6 | 32.4 | 14.1 |
| At least 1 hospital separation | 58.3 | 50.8 | 36.9 | 31.6 |

Note: Data were available for only 2 jurisdictions. Hospital separations include both private and public hospital data in these 2 jurisdictions.

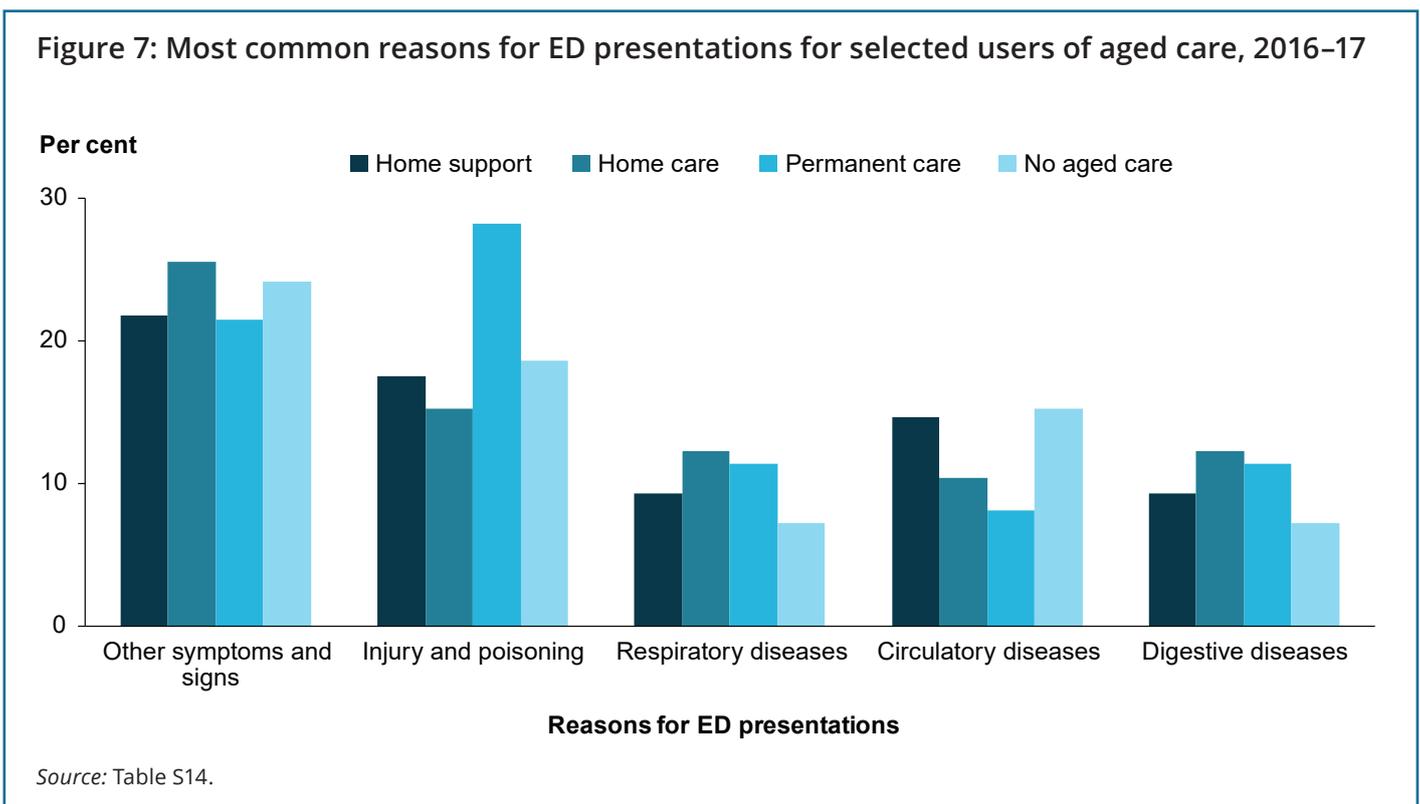
Source: Tables S14 and S17.

People who had any ED presentations in 2016–17 most commonly had only 1 visit (52–54% among people using community-based aged care, 58% among people living in permanent care, and 70% among people without aged care use). This was also reflected in the rate of ED presentations (Table S15).

Pain, injuries and problems with heart and breathing the main reasons for going to ED

The principal diagnosis is recorded at the end of the ED presentation—this is the condition or other cause that clinical assessment determined to be mainly responsible for the ED presentation. These can be grouped with other similar diagnoses; the most common reasons for presenting at an ED varied between the groups.

Where people living in permanent care visited an ED, their presentations were most commonly due to injuries (accounting for 28% of all presentations for this group) (Figure 7).



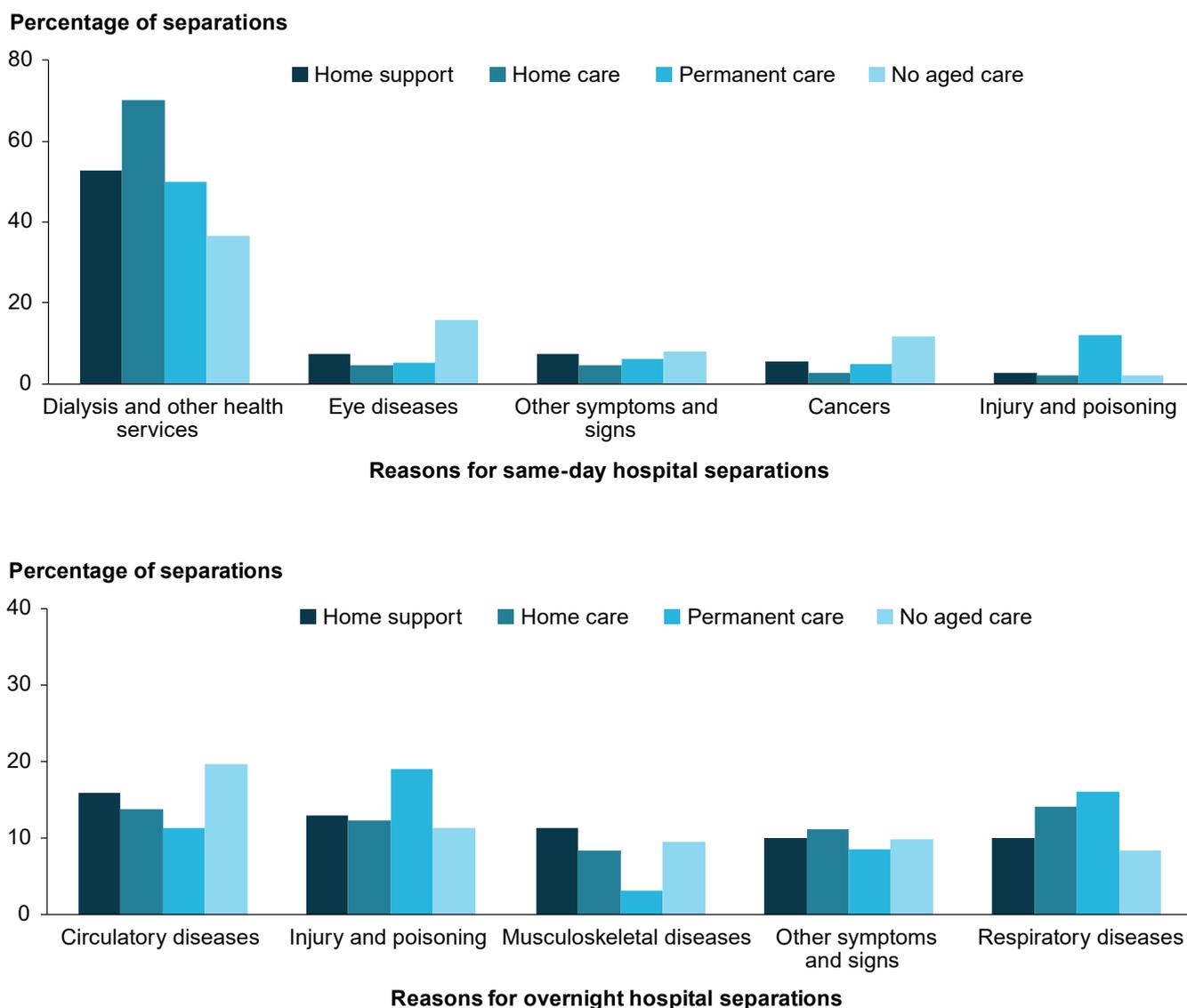
Reflecting these higher-level reasons, the most common specific principal diagnosis also differed between the groups. These were:

- pain in the throat and chest for people using home care and not using any aged care
- angina for those using home support
- superficial injury to the head for those living in permanent care (Table S16).

Same-day separations commonly related to dialysis

The rate of same-day separations was higher than the rate of overnight separations for all 4 groups (Table S18). This is partly influenced by the reasons people have for admitted patient care: same-day separations from hospital often involve reasons such as dialysis, which do not require overnight care, but may require repeated visits. Overnight separations from hospital commonly related to more serious acute or chronic issues across all 4 groups (Figure 8).

Figure 8: Most common reasons for hospital separations for selected users of aged care, 2016–17

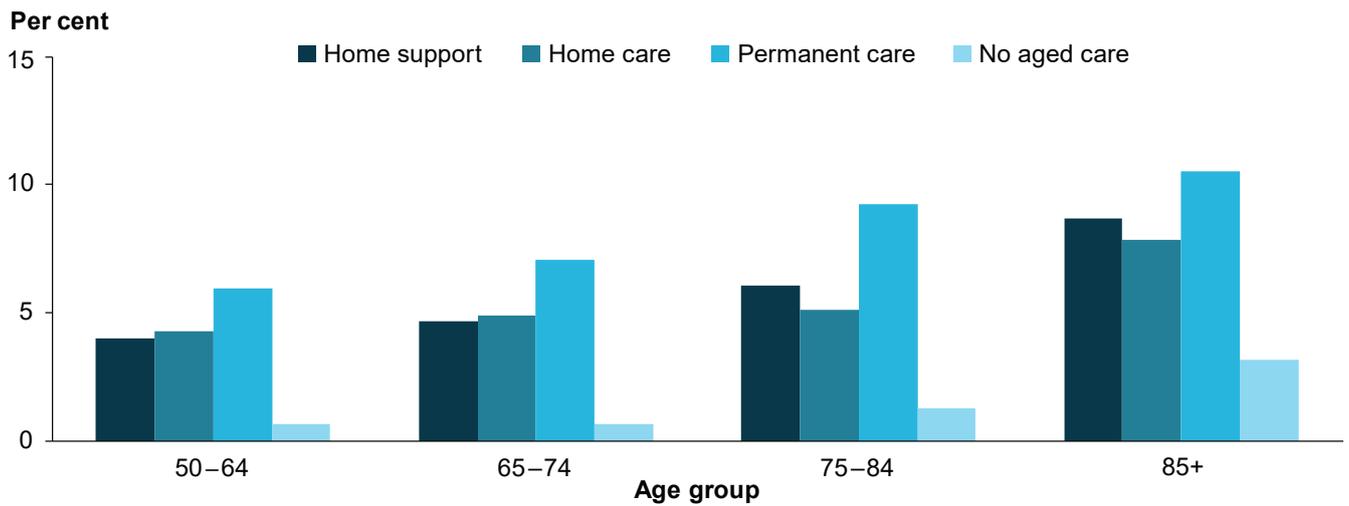


Source: Table S17.

Principal diagnosis is defined as the diagnosis established after study to be chiefly responsible for occasioning an episode of admitted patient care. The most common principal diagnosis for same-day separation from hospital for all 4 groups was renal dialysis. The most common principal diagnosis for overnight separations was other chronic obstructive disease (chronic lower respiratory diseases not including bronchitis and emphysema) for people using either type of community-based aged care; heart failure for people not using any aged care; and a fractured femur (leg) for people living in permanent care (Table S19).

Overall, fall-related injuries were relatively more common among people living in permanent care—almost 1 in 10 (10%) had at least 1 hospital separation for a fall-related injury during 2016–17, compared with 6% of people using home support or home care and less than 2% among those not using any aged care. This proportion rose with increasing age in all groups (Figure 9).

Figure 9: Hospital separations for fall-related injuries for selected users of aged care, 2016-17



Note: Proportion of people with at least 1 hospital separation for a fall-related injury.

Source: Table S20.

Where to next?

The nature of administrative data can make it difficult to interpret the differences presented in this report. Some of the variation may be related to people's underlying health conditions, their general health and care needs, or their life situation more broadly. People living in permanent care are generally older, and often need higher levels of care than people living in the community (who may need permanent care in the future, but their current situation allows them to live at home).

Some health needs may also be met within aged care services instead of through health services, and are not captured in this data source. Using the linked data described in these first results, future AIHW reports on the interactions between people's use of aged care and health services are planned. These will examine:

- MBS, PBS and hospital use for different groups of people using residential aged care—expanding the analysis to include people at points of transition (for example, people using respite care, or people with shorter periods of use in permanent care or who died soon after moving into care)
- the characteristics of people using aged care and health services and the varying patterns of use (such as identifying particular groups of interest to investigate the patterns and pathways of health and aged care use)
- the patterns of prescriptions dispensed for selected medicines around the time of people's first admission into permanent care, as well as their rate of GP attendance
- the combined load of different prescriptions dispensed to people, and the combinations over time (for example, anticholinergic drugs can be prescribed for different reasons, but overall, they have a similar effect on the body), and prescriptions for particular medicines or classes of medicines (such as for opioids and benzodiazepines or cardiovascular or respiratory systems)
- the full variation across residential aged care facilities and how the people living in them use health services—for example, the variation between facilities based on their geographic location, peer grouping or provider organisation type
- health and aged care service use at the end of life, for example through identifying people who were dispensed prescriptions for palliative care medicines, to examine their health and aged care use patterns before death
- movements between aged care services and hospital and the reasons for these movements
- deaths, in particular the location of death
- the broader demographic context in which aged care and health services are used.

While routine linkage of a broad range of administrative data would allow for more comprehensive and timely reporting on these issues, some questions will remain difficult to answer due to gaps and limitations in the underlying data sources. For example, little information is currently available about people's support needs and how well these are being met, and the quality of care more broadly. Similarly, improved data is needed about the aged care workforce, including how well it meets the current and future needs of aged care users.



More information

This report is accompanied by supplementary data tables available for download on the AIHW website (www.aihw.gov.au). The AIHW GEN website (gen-agedcaredata.gov.au) also contains information relating to this report.

About the data

Notes are included in the supplementary data tables (see <https://www.aihw.gov.au/reports/aged-care/interfaces-between-the-aged-care-and-health-system/data>). These outline the data sources and methods in more detail.

Acknowledgments

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Glossary

For definitions of terms used in this report, see <https://www.aihw.gov.au/reports-data/health-welfare-services/aged-care/glossary>.

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