6.3 Older Australians and the use of aged care

Australians are living longer than ever before and, as each year passes, older people make up a larger proportion of the total population. This ageing of the population presents challenges for the welfare system, including the demand for aged care services. Policy changes, developed to ensure that service provision keeps up both with population growth and changing community expectations, also affect how we, as a community, care for our older residents.

Many older Australians want to remain in their own homes as they age—not just because of attachment to their homes but because of the areas and communities in which they live. And most are able to do so, at least until close to the end of their lives.

This article examines the changes in policy focus and service provision that have occurred over the last 30 years to help people remain at home for as long as possible. The major changes in aged care policy over the last few years mean that it is timely to review the past and set the scene for examination of aged care services in the future. Changes that will particularly affect program provision include the merging in 2013 of the Commonwealth low- and high-care package programs into Home Care Packages—incorporating Consumer Directed Care for the first time in aged care—and the establishment in 2015 of the Commonwealth Home Support Programme, which combines the large Commonwealth Home and Community Care Program with a number of smaller programs. These policy innovations will take effect as existing users exit and new users enter the system.

In this context, longitudinal analyses can answer important questions such as: have the changes in program provision kept pace with population change; have there been changes in patterns of service use over time; are people staying in their homes longer; and for those who do use services, what services are they using and in what combination?

Overall, at any one time the vast majority of older Australians are not using aged care services. In 2010–11, over two-thirds of people aged 65 and over (71%) did not use an aged care service over the year, other than perhaps assessment services. Of those who did, more than two-thirds only accessed community care. However, program use is more likely as a person gets closer to the end of life, with 67% of people aged 85 and over using an aged care service in 2010–11. Around 80% of people who live to at least age 65 will use community and/or residential care over their lifetime.

Background—the last 30 years

Ageing in the Australian community

The average age of the Australian population has been increasing since the 1970s, reversing the trend of the 1950s and 1960s caused by the post-war baby boom (ABS 2013). In 1985, 10% of the population were aged 65 and over compared with 15% in 2014 (ABS 2014a). Furthermore, within the older population, the number of ‘very old’—aged 85 and over—has been growing at a greater rate than the number aged 65 to 84, so that the proportion of older Australians who are very old has been increasing (ABS 2014a).
The prevalence of many health conditions is higher in older age groups (AIHW 2014a: Section 6.9). Consequently, the increasing numbers of old and very old people affects the provision of both health and aged care services. In particular, the high rate of dementia among very old people influences the need for, and provision of, home and residential aged care (AIHW 2014a: Table 6.3). The strong relationship between health and aged care is illustrated by the movement between hospital and residential aged care. For example, in 2008–09 nearly one-tenth (9%) of admissions into hospital for people aged 65 and over were for people coming from residential care, while about one-quarter (24%) of admissions into respite residential aged care and about two-fifths (39%) of admissions into permanent residential care were from hospital (AIHW 2013c).

Changing community attitudes also affect the provision of care services. For example, while permanent care in a residential care facility remains a key service for many, greater emphasis on provision of home-based support from the mid-1980s (AIHW 1993) led to the introduction of a range of community aged care programs, such as home care packages (see Box 6.3.1 for a list of the main national aged care programs since 1985). This trend towards home-based care was accompanied by the emergence of respite care as an important area of service provision, both to provide short-term emergency care and for planned respite to support carers (AIHW 2003).

Many older Australians want to remain in their own homes as they age. In 2007–08, over 90% of community-living older people wanted to stay in their home for the next 12 months, irrespective of whether they were owners, buyers or renters (AIHW 2013b). In addition, a majority of older home owners intend to stay in their current residence ‘for the foreseeable future’. However, for many, their attachment is not necessarily to the home but to the area and community in which they live (Olsberg & Winters 2005). Many older people do move, and not just to residential care: at the time of the 2011 Census, 18% of Australians aged 65 and over had moved in the preceding 5 years, although the likelihood of moving decreased with age until about age 85. Relocation is more likely among the very old compared with those aged 65 to 84, most likely due to increasing age-related disability (Judd et al. 2014: Tables 14 and 15).

Around one-half of the people who moved house after the age of 50 between 2006 and 2011 had ‘downsized’, based on number of bedrooms (Judd et al. 2014). Judd and others (2014) also found that lifestyle preference was the most common reason leading to moving, with other (often related) common motivations for downsizing including inability to maintain the house and/or garden, and children leaving home. Almost half of the people who reported downsizing remained within the same region (statistical division).

As noted by Olsberg and Winters (2005), home ownership is often people’s greatest financial asset and provides the conduit to all choices about where to live. The ability of people to remain in their home, or to choose where they live, is predicated on having sufficient resources. The fall in home ownership rates since 1991 (see Chapter 5 ‘Bricks and mortar’) and growing numbers of older people experiencing homelessness (see Chapter 7 ‘The diversity of Australia’s homeless population’) suggest that choice may be limited for an increasing proportion of older people.
Among older Australians there is strong demand for community-based services. The Australian Bureau of Statistics (ABS) Survey of Disability Ageing and Carers, last undertaken in 2012, indicates that many older people living in the community require assistance with personal activities, and that for a sizeable minority of these people some or all of these needs are not met. For example, in 2012 almost 30% of people aged 65 and over reported needing assistance with at least 5 personal activities and about one-quarter of these people had some unmet care needs (ABS 2014b: Tables 27 and 28).

Changes in aged care programs
Over the last 30 years, policy direction, and consequently program development, have been influenced by a small number of underlying principles. These include that many older Australians: prefer to live in the community rather than in residential care; prefer to ‘age in place’ rather than change residence when care needs change; and want aged care services to be flexible and easily accessed.

Increasing focus on community care
The underlying premise that people want to remain living in their communities has led to an increasing focus on the provision of community care services. This is reflected in the changing balance of the Australian Government’s provision of residential places and home care packages. Since the late 1990s, to allow for the ageing of the population, the provision of permanent residential aged care places and home care packages has been increasing relative to the number of people aged 70 and over. On 30 June 1998, altogether there were 93.5 places and packages per 1,000 people aged 70 and over; by 30 June 2014, despite a few minor fluctuations, this number had increased to 111.3 (SCRGSP 2003, 2015). Much of this increase was in community care, with home care packages accounting for 26% of provision in June 2014 compared with 7% in June 1998. This shift towards greater provision of community care is continuing, and by 2021–22, the Australian Government is aiming to have 125 residential and home care places for every 1,000 people aged 70 years and over, with over one-third of these places being in a home care setting (DSS 2013: Section 2.3). Over the last 30 years, the consistent move towards increasing community care has seen the provision ratio of residential care places fall from 99 per 1,000 in 1985 (AIHW 1993: Table 5.6) to 80 per 1,000 in 2015, while the provision ratio of home package places, introduced only in 1992, will have risen to 45 per 1,000 (from zero).

The growth of community care has also seen the number of older people using services delivered through the Home and Community Care Program (HACC) increase. About 171,000 people used HACC in an average month in 1990 (DHHCS 1992); by 2012–13 this had increased to over 370,000 a day (derived from DSS 2014c: Table A3, in conjunction with Table S6.3.1). This compares with much smaller growth in residential care: in 1992 there were around 125,000 residential aged care places (AIHW 1993: Table 5.7); this increased to just over 186,000 in 2012–13 (AIHW 2014c). Even allowing for more than one person using an aged care place in a year (as can be seen in Table S6.3.1), of all the national aged care programs HACC assists the largest number of people.

Ageing in place
The desire of many older Australians to age in place has significantly influenced program development. Ageing in place is a natural outcome of increasing the provision of community care. As seen in Box 6.3.1, in the first decade of this century, several programs were initiated and others were expanded to allow people to age in place in the community.
In 2013, the *Aged Care (Living Longer Living Better) Act 2013*, which amended the *Aged Care Act 1997*, formalised the aged care reforms that had been under consideration for a number of years, with the aims of giving consumers of aged care services more choice, easier access and better care. One of the priorities underpinning the Act was to provide more support and care in the home (see AIHW 2013a: 241–2 for summary, DSS 2014a for details).

The 2013 reforms included merging the Commonwealth high- and low-care home packages programs into the Home Care Packages Programme in August 2013 (see Box 6.3.1). This change also assists with ageing in place as the new program provides four levels of care, from basic care to high care, allowing clients to access additional services as their care needs change without needing to change care program. In addition, the new home care packages are delivered using Consumer Directed Care, giving package recipients greater control over their care.

For people living in residential aged care facilities, limiting the number of changes in residence is also seen as desirable. This idea of ‘ageing in place’ was an important objective of the *Aged Care Act 1997*, with the aim being to allow aged care residents to remain in a single facility as their dependency increased (AIHW 2001: 230–2). The removal of the distinction between low- and high-care places on 1 July 2014 further assists with ageing in place for people living in residential care.

**System simplification and program flexibility**

The proliferation of programs in the last 30 or so years resulted in an increasingly complex aged care system, prompting recent moves to simplify the system and increase the flexibility of care provision through program amalgamation. The complexity of the system was compounded by different programs having different access processes. For example, access to residential aged care, home care packages and the Transition Care Program requires an approval by an Aged Care Assessment Team (ACAT) under the Aged Care Assessment Program, while programs such as Home and Community Care and Veterans’ Home Care continue to have different assessment processes (see Box 6.3.1).

One measure to simplify the system, and increase flexibility for clients, has been to bring the low- and high-care home care package programs together under the umbrella of the Home Care Packages Programme, as mentioned above. However, the change affecting the largest number of people is the creation of the Commonwealth Home Support Programme (CHSP). In July 2012, the Australian Government assumed full responsibility for HACC services for older Australians, except in Victoria and Western Australia (see Box 6.3.1). This change in responsibility facilitated streamlining HACC and other smaller programs. In July 2015, the Commonwealth HACC Program, National Respite for Carers Program, Day Therapy Centres Program and Assistance with Care and Housing for the Aged Program, were combined under the CHSP (DSS 2014f).

The changes in policy focus and service provision over the last 3 decades raise the question of how these changes have affected the way that people use the various programs to help meet their care needs. In this article, Australia-wide data are used to investigate changing patterns of use of aged care programs that have come about as population needs have changed, and as policy changes have reshaped the aged care system.
Box 6.3.1: Main aged care programs

- **Residential Aged Care** (Commonwealth-funded from 1963). RAC provides both permanent and respite care in residential care facilities. An Aged Care Assessment Team (ACAT) approval is required to access funded places. Until 1 July 2014, an ACAT approval was also required for residents moving between facilities in order to change from low care to high care. From 1 July 2014, the distinction between low care and high care was removed in permanent RAC as part of the 2012 aged care reforms (DSS 2014e).

- **Home and Community Care** (from 1985, became part of the Commonwealth Home Support Programme formed in 2015). HACC brought together a number of separate programs operating from the mid-1950s under Commonwealth–state agreements. Previously funded jointly by the Commonwealth (Australian) and state and territory governments, on 1 July 2012 the Australian Government assumed full policy, funding, and day-to-day responsibility for HACC services for people aged 65 and over, and for Aboriginal and Torres Strait Islander people aged 50 and over in all states and territories except Victoria and Western Australia (termed ‘Commonwealth HACC’). HACC provides a large range of services, including allied health and home nursing services, to support people at home and to prevent premature or inappropriate admission to residential care. An ACAT approval is not required for access. HACC became the main part of the Commonwealth Home Support Programme from July 2015.

- **Aged Care Assessment Program** (from 1985). Under ACAP, multi-disciplinary ACATs determine people’s care needs and make recommendations on preferred long-term living arrangements for clients. Relevant approvals are required from an ACAT in order to access RAC, the various home care packages and the Transition Care Program (TCP).

- **Community Aged Care Packages** program (from 1992, replaced by Home Care Packages Programme in 2013). CACPs provided support services for older people with complex needs living at home who were otherwise eligible for admission to ‘low-level’ residential care. They provided a range of home-based services, but not home nursing assistance and allied health services, with care being coordinated by the package provider. Access required an ACAT approval.

- **Veterans’ Home Care** (from 2001). VHC provides a limited range of services (also available through HACC) to help veterans, war widows and widowers with low-level care needs to remain living in their own homes longer. Eligible veterans who need higher amounts of personal care than provided under VHC may be referred to the Community Nursing program (Gold or White Repatriation Health Card holders only). An ACAT approval is not required for access.

- **Extended Aged Care at Home** program (from 2002, replaced by Home Care Packages Programme in 2013). EACH provided care at home equivalent to ‘high-level’ residential care. Access required an ACAT approval.

continued
Box 6.3.1 (continued): Main aged care programs

- **Transition Care Program** (from 2005). TCP provides short-term care to older people who are leaving hospital who are assessed as otherwise being eligible for at least low-level RAC. It aims to improve recipients’ independence and functioning and delay entry into RAC. Access requires an ACAT approval. TCP care can be provided at home or in ‘live-in’ facilities, including RAC and hospital.

- **Extended Aged Care at Home Dementia** program (from 2006, replaced by Home Care Packages Programme in 2013). EACHD provided a community care option specifically aimed at high-care clients with dementia and behavioural and psychological symptoms. Access required an ACAT approval.

- **Home Care Packages Programme** (from 2013). The Home Care Packages Programme began on 1 August 2013, replacing the former packaged care programs (CACP, EACH, and EACHD). Four levels of packages are available, from Level 1, which supports people with basic care needs, to Level 4 which supports people with high-care needs. Home care packages are required to be delivered using Consumer Directed Care (CDC). CDC was phased in from 2013, with all home care packages using a CDC model of care from July 2015. As with the earlier package programs, an ACAT approval is required.

- **Commonwealth Home Support Programme** (from 2015). The CHSP commenced in July 2015. The program brought together a number of existing programs providing home support, including the Commonwealth HACC program, the National Respite for Carers Program, the Day Therapy Centres Program and the Assistance with Care and Housing for the Aged Program. The purpose of combining these programs under the CHSP was to create a single program that was better coordinated and easier for older people and their carers to access.

Information on current aged care programs can be found at the My Aged Care website [www.myagedcare.gov.au](http://www.myagedcare.gov.au) (DSS 2014d).

Sources: AIHW 2011; DSS 2014b; DSS 2014f.
How do we know about changes in service use?

Computerised person-level administrative data have been maintained for RAC and home care packages since the 1990s, and administrative data have been collected for the VHC program and TCP as they became operational. In addition, the client-level HACC Minimum Data Set (MDS) was implemented in 2001. For the ACAP, from 1994 there was a nationally agreed minimum data set with jurisdictional data sets maintained by each state and territory. However, it wasn't until the implementation of the client-level ACAP MDS (version 2) that unit-record data became available nationally. Consequently, with the implementation of client-level MDSs for HACC in 2001–02 and ACAP in 2003–04, data became available for the main national aged care programs. Even so, the data collections for the different programs were, and are, held on different databases without a common person identifier, so that analyses are still generally program-specific (see, for example, ACAP NDR 2007; AIHW 2010, 2014c; DoHA 2009).

Given that there are national data sets that separately contain data on individuals’ use of various care programs, integrating the data from these sources can provide a valuable resource for examining people’s use of different programs and the relationships between programs. As described in Box 1.1.3, statistical data linkage is a powerful tool for achieving such integration, and so these techniques have been used to develop a linked database—termed the Pathways in Aged Care (PIAC) linked database—that can be used to examine aged care pathways and to investigate issues related to cross-program use (see Box 6.3.2 for an overview of the database). Data linkage has also been used to investigate the flow of people between aged care and hospital (AIHW 2013c).

The analyses reported below use data from the PIAC linked database, which covers all individuals who used aged care services in the 9 years to 30 June 2011. In a number of places, however, analysis is limited to selected cohorts to allow investigation into particular issues.

The PIAC database enables analyses of service use over a year or a number of years, and on a particular day taken as an example day for each year. In the current analysis, 30 September was chosen as the example day as it is not affected by holiday periods and so shows more typical service use. Detailed results of a range of analyses using PIAC data, along with a description of the processes used to link the contributing data sets, are contained in two AIHW reports, Patterns in use of aged care 2002–03 to 2010–11 and Use of aged care services before death 2010–11 (AIHW 2014b, 2015).

How many people use aged care?

The number of people using services provided by aged care programs grew steadily between 2002–03 and 2010–11. People can use a range of services provided by a number of programs over various periods, including short periods, such as with respite care or transition care. Consequently, many more people access care over a year than on a particular day: just over 874,000 people aged 65 and over used aged care services in 2010–11 compared with 555,000 on 30 September 2010.

The number of people using aged care services over a year increased from some 642,000 in 2002–03 to just over 874,000 in 2010–11, an increase of 36%. The number of people being assisted on the example day increased from an estimated 393,000 on 30 September 2002 to 555,000 on 30 September 2010, an increase of 41% (Table S6.3.1). These increases compare with an increase of 25% in the population aged 65 and over between 30 June 2002 and 30 June 2011.
Box 6.3.2: The PIAC linked database

In order to explore changes in program use by older people, data on the use of seven key aged care programs and ACAT assessments were linked by the AIHW to obtain a person-based database containing data on aged care program use. This database is termed the Pathways in Aged Care (PIAC) linked database.

**Scope:** The database covers the period 1 July 2002 to 30 June 2011 and contains person-level data on:
- use of seven service programs operational between 2002 and 2011—in order of the annual number of clients: HACC, RAC (including both permanent and respite care), VHC, CACP, EACH, EACHD and TCP (see Box 6.3.1)
- assessments conducted by ACATs under ACAP
- all deaths.

All people who used services provided by the above programs or who died in the reference period are included in the database (3.5 million people), irrespective of age.

**Data sources:** The data come from three main sources:
- program-specific annual national minimum data sets (for ACAP and HACC)
- program administrative data (for RAC, CACP, EACH, EACHD, TCP and VHC)
- the National Death Index (held at the AIHW) which contains deaths registration data from state and territory registries of births, deaths and marriages and the National Coronial Information System.

The creation of the PIAC linked database means that the AIHW can now analyse the use of services from a combination of programs, rather than just looking separately at the use of specific services. It also allows us to identify people who are just beginning their care pathway. In addition, including the data on deaths allows the identification of completed care pathways and whether people used programs before they died.

A detailed description of the processes used to link the contributing data sets can be found in *Patterns in use of aged care 2002–03 to 2010–11* (AIHW 2014b). (See also Box 1.1.3 ‘Data linkage—expanding the information base’).

The programs with the largest numbers of clients were HACC and permanent RAC. Over the period, annually, over two-thirds of clients used HACC and about one-quarter used permanent RAC; and these two programs accounted for around 85% of clients on a particular day.

People can be clients of more than one program at a time. For example, a person can be the recipient of a care package and go into short-term residential respite care while on that package; or an individual may be receiving allied health services through HACC but personal care through VHC. The proportion of people using multiple programs in a year is much larger than the corresponding proportion on a particular day. Across all years, between 12% and 13% of aged care clients used more than one program during the year. In contrast, fewer than 1 in 25 clients were using two or more programs on the example day.
These differences in annual use and use on the example day are clearly seen in population rates of use: 29% of people aged 65 and over were using an aged care service at some time in 2010–11 compared with 18% on 30 September 2010.

Around 70% of aged care clients are women (AIHW 2014b: Tables A2.5, A2.7, A2.8). However, the age profile has changed: the share of clients who were very old (aged 85 and over), increased from 35% on 30 September 2002 to 41% on 30 September 2010. As expected from their greater longevity compared with men, female clients were more likely than male clients to be very old: 42% compared with 38% on 30 September 2010.

Is program use changing?

Much of the growth in client numbers was due to the increasing numbers of older people, especially very old people, rather than to higher usage rates. Overall, there was a small increase in the rate of use of community care between 2002–03 and 2010–11, and a marginal decline in the use of permanent residential care.

As seen above, since the turn of the 21st century the absolute number of people accessing aged care services has increased by more than one-third (Table S6.3.1). After standardising for changes in the age and sex structure of the older population, the proportion of people using aged care services in a year increased by 3 percentage points, from 26% in 2002–03 to around 29% in 2010–11, with most of the increase happening before 2007–08 (AIHW 2014b: Table A2.11, age–sex standardised to 30 June 2002 population). This growth resulted from increased use of community care programs. There was a small but steady decline in the proportion of people accessing only permanent RAC from 2005–06, from 5.8% to 5.2%, age-sex standardised.

These small population level changes mask more significant changes within particular age and sex groups. The most noticeable changes have been among people aged 85 and over. As would be expected, people in this age group are relatively high users of aged care, although, as Figure 6.3.1 shows, men and women have different usage rates. However, for both sexes the usage rate of community care services only, in a year, increased by about 8 percentage points between 2002–03 and 2010–11, and the use of permanent residential care only fell slightly, by 1–2 percentage points. There were also small increases in the proportion of people using combinations of community and residential care (both respite and permanent care) in a year (AIHW 2014b: Tables 2.14 and 2.15).

There have also been some changes in service use before death (AIHW 2014b: Section 2.4). Overall, use of aged care services in the 12 months before death has risen: in 2003–04, 70% of older people who died had used community and/or residential aged care in the preceding 12 months compared with 75% in 2010–11. This change resulted from small increases in both the proportions using only permanent residential care, and using combinations of community and residential care. This last result suggests that people are tending to stay longer in their homes before going in to residential care.
Program use before death is quite different for men and women (AIHW 2014b: Figure 2.10). The reasons for these differences have yet to be examined, although living arrangements and the role of spouse and non-resident carers are likely to be key. However, while there are differences between the sexes, there are also similarities. Among both very old men and women (85 and over), use of any permanent residential care in the year before death was fairly steady over the years under study, at around 52% for men and 68% for women. Despite this stability, both groups had small increases in the proportion using community care only or using a combination of community and residential care, again suggesting that either people are tending to move to residential care later in their care pathway, or that they are accessing community care earlier.

**Does assessment lead to program use?**

People commonly use HACC or VHC services before accessing the programs which require an ACAT assessment. However, a proportion of people use HACC or VHC following an ACAT assessment. Take-up of particular care programs depends on the person’s health, social circumstances and care needs.

Access to RAC, home care packages and TCP requires an approval by an ACAT. While HACC and VHC have their own assessment processes to gauge client needs (as outlined in Box 6.3.1), ACATs can also recommend these programs to clients. In addition, individuals can act on advice given to them during an assessment that results in some individuals approaching HACC or VHC shortly after. Conversely, a HACC or VHC service provider may suggest that a client have an ACAT assessment if circumstances indicate that the person requires further assistance.
The take-up of care over a period following an initial ACAT assessment can be examined using the PIAC database by identifying people who had an ACAT assessment ending during a particular period—that is, an ‘assessment’ cohort—and then identifying their service use over the period of interest. In the discussion below, take-up of care is considered for the assessment cohort consisting of 41,000 people who were assessed by an ACAT in 2009–10 and who had not used aged care in the preceding 3 years, other than transition care. The period considered for take-up (or otherwise) of services is the 12 months after a person’s first assessment in 2009–10. These outcomes have been reported in detail in the publication *Patterns of use of aged care services 2002–03 to 2010–11* (AIHW 2014b). Key findings include:

• 31% of the assessment cohort entered permanent RAC within the 12-month period
• 38% used HACC or VHC services, including some who were subsequently admitted into permanent RAC
• 17% of the cohort did not obtain an ACAT approval for program use, but around one-half of this ‘no approval’ group had some program use in the year after assessment
• overall, 18% of the assessment cohort used only HACC or VHC, but none of the programs which required an ACAT assessment.

As is to be expected, a person’s health affects program use. Among the 2009–10 assessment cohort, people with many activity limitations, people with a diagnosis of dementia, or people whose first assessment in 2009–10 was in hospital, were:

• more likely than people without one of these characteristics to move into permanent RAC following an assessment, at between 42% and 49%
• less likely to access only HACC or VHC or not to use any services, at 21% to 36% compared with 45% for the cohort.

The social circumstances of people are also associated with varying take-up of aged care programs:

• relatively high use of permanent RAC, at over 35%, was seen among very old people (aged 85 or older), people with non-resident carers and people living in retirement villages
• use of a program that required an ACAT approval was more common among cohort members with a non-resident carer, at 60% compared with 53% for people with a resident carer or without a carer.

Due to a variety of factors, an approval to use services from a program does not necessarily mean that those programs will be accessed (SCRGSP 2014). Among the people in the 2009–10 assessment cohort:

• 27% did not use services from any program in the 12 months after assessment; about one-third of these non-users had been approved to access services from a program that required an ACAT assessment
• overall, less than one-half of the assessment cohort used their highest care approved, using a hierarchy of permanent RAC, followed by home care packages, respite RAC, transition care, and services not requiring an ACAT approval (HACC and VHC). More particularly:
  – just 49% of people approved for permanent RAC entered this type of care within a year of the assessment resulting in the approval
  – use of an approval for TCP was the exception: 9 out of 10 approvals for transition care were taken up.
When do people start using aged care services?

The closer a person is to the end of their life, the more likely he or she is to have accessed aged care. Also, the type of program being used tends to change with proximity to death. However, not all program users are in care at the time of death, with a relatively large proportion of program clients stopping program use in the 3 months before death. This is most likely due to hospitalisation or use of specialist palliative care before death.

While people commonly use aged care services in the last few years of life, some people access care programs for many years (see Figure 6.3.2). Around 50% of those who died in 2010–11 at age 65 or over used a service more than 4 years before their death, and 20% had used care services 8 years or more before they died (but not necessarily continuously). Furthermore:

- All older age groups showed an increased take-up of care in the last few months of life. However, looking at Figure 6.3.2, among those who died between the age of 65 and 84, the number of people who started using aged care began to increase about a year or so before death.
- Having first use of aged care in the last 6 months of life was highest in the 65 to 74 years age group; just 30% of this younger age group accessed services more than 2 years before death, and by the time of death, this proportion had nearly doubled to 57%.
- Among people who died at age 85 or over, there was generally steady growth in take-up of aged care until the last 3 months before death when there was an additional rise.

Notes
1. Figure includes use of RAC, home care packages, TCP, HACC and VHC.
2. Quarters are relative to death and are all 91.3 days long (365.25 ÷ 4). Quarter 1 is that which ends with the death of the person. People who accessed care programs only more than 8 years before their death could not be identified and so are included in the 20% classified as never having accessed care.

Source: AIHW 2015: Table A2.

Figure 6.3.2: Proximity to death of earliest program use in the 8 years before death, by age at death, people who died in 2010–11 aged 65 and over
These differences between the younger and older age groups most likely reflect the differing care needs of people who have a sudden health event in their younger years that results in disability, such as stroke, compared with those whose capacity to live independently gradually declines due to exacerbation of chronic conditions, such as osteoarthritis, or who experience later onset of disabling conditions. Also, care needs related to dementia are likely to contribute to increasing service use at advanced ages in line with the increasing prevalence of dementia (AIHW 2012).

**What combinations of community and residential care do people use?**

Most people aged 65 and over do not use aged care services in the course of a year. Among those who do, over two-thirds only access community care. Nearly all people who entered permanent RAC had used another program shortly before admission. Just over half of those who used aged care before they died had entered permanent RAC.

**Program use in a year by the population aged 65 and over**

People access different services as their care needs change so that, over time, they may access a range of programs in any year. As seen in Figure 6.3.3, during 2010–11 the majority of people (71%) did not use a service. Among the 29% of the population aged 65 and over who did use a service, most accessed only HACC or VHC services (20% out of 29%), emphasising the importance of these community-based programs. Permanent RAC was the second most commonly used program, with 7% of the population—or almost one-quarter of program users—being in permanent residential care for at least part of the year. About 10% of program users accessed a combination of permanent RAC, respite RAC, home care packages and HACC or VHC.

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**Figure 6.3.3: Community and residential care use rates, 2010–11 (per cent of population aged 65 and over)**

Notes:
1. PRAC = permanent residential aged care; RRC = respite residential aged care.
2. Figure does not include TCP and ACAP.
3. Service use includes people aged 65 and over on 1 July 2010.

Source: AIHW 2014b: Table A2.9.

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Program use in the last years of life

Due to their changing care needs, there is quite a shift between the profile of programs that people first access and programs they access last before they die. In 2010–11, nearly 145,000 people died in Australia, and of these, 116,500 were aged 65 or more. Among the latter group, 93,100 people (or 80%) had used at least one of RAC, a home care package, TCP, HACC or VHC in the 8 years before death (AIHW 2015).

The role of community care

Most people access community care first; this was so for 84% of program users who died in 2010–11, with only 10% having permanent RAC as their first care reported in the 8 years before death (AIHW 2015: Table A7). The remainder used residential respite care or transition care first. In addition, community care was the last program used by 43% of people who had used aged care, with permanent RAC being the last program used by just over one-half (54%).

As expected from the high proportion of people who use community care first, most people who go into permanent residential care have used another program beforehand (AIHW 2014b: Table A2.10): 90% of those who entered permanent RAC for the first time in 2010–11 had used other aged care services in the 12 months before admission. Among the new permanent RAC residents who had already accessed some care, 9 in 10 had used community care in the preceding 12 months; 1 in 2 had used residential respite care.

Many people used only community care. Of all program users who died in 2010–11, 40% accessed community care only, compared with 10% who used only permanent residential care (AIHW 2015: Table A9). Furthermore, 23% of program clients used both community care and permanent residential care, while almost 18% used community care and both respite and permanent residential care.

Changes in program use

Figure 6.3.4 illustrates that people are more likely to use aged care programs in their last year of life than earlier, as expected. The mix of programs used also changes. Among older people who died in 2010–11, 41% had used an aged care service in the fifth year before death compared with 75% in their last year of life. In the fifth year before death, 31% of people accessed community care and 12% used permanent RAC, but over the last 12 months of life, this balance had changed to 42% accessing community care and 43% using permanent residential care.

Program use at the time of death

In 2010–11, just over three-quarters (77%) of people who had used services from an aged care program before they died were receiving care at the time of their death. This equates to 62% of all the people who died aged 65 and over during 2010–11, and just under half of people of all ages who died in that year. These figures are overestimates as a proportion of those who died while still a program client would have been in hospital at the time of their death (see AIHW 2013c).

Not surprisingly, older clients were more likely than younger clients to have been reported as using a care program at the time of death (AIHW 2015: Table A6). However, in all older age groups, a relatively large proportion of clients stopped using care programs in the last quarter before death. It is likely that hospitalisation and use of specialist palliative care before death explains this: almost half the deaths of older people in 2010–11 occurred in hospital (AIHW 2013c: Table 1.2 and AIHW 2014b: Table A2.16).
Program use by people with dementia

The patterns of program use are slightly different for older people with dementia. Based on a 2003–04 cohort used in the initial PIAC study, 3 in 5 cohort members with dementia used permanent residential care within 2 years of their first ACAT assessment, compared with a cohort average of 40%. Just over 40% of these people used community aged care services before entering residential care. People with dementia were also more likely than average to use residential respite care (28% versus 20%) (Karmel et al. 2012). Conversely, fewer people with dementia had no service use (16%) or used only community services (17%) compared with the whole cohort (24% and 29% respectively). More information on care for older people with dementia is given in Box 6.3.3.

Looking ahead

The increasing emphasis on home-based care in government policy has shaped program planning and delivery for 3 decades now. The outcomes reported in this chapter indicate that growth in government service provision has kept pace with population growth. Further, consistent with current directions in planning and service development, the analyses also show that patterns in the use of aged care services have changed gradually but steadily, with use of community care overall increasing relative to the use of permanent residential aged care. Along with other factors, these trends have resulted in people being more likely to use a combination of community and residential care over a period. As the capacity of community care programs increases over the coming years, we would expect to see more people using a combination of services to meet their care needs as they age.
Box 6.3.3: Extra support for older Australians with dementia

The prevalence of dementia in Australia is expected to increase from around 343,000 people in 2015 to about 900,000 in 2050 (AIHW 2012). This growth will clearly have implications for the formal aged care system—and for informal carers—in terms of expanding capacity to meet the needs of older people with dementia.

There is little national data on dementia prevalence among particular sub-populations, although there is some evidence that, for example, dementia affects Aboriginal and Torres Strait Islander Australians at younger ages, and at a greater rate than other Australians (AIHW 2012).

Among permanent aged care residents in Australian Government subsidised care, 1 in 2 have a recorded diagnosis of dementia affecting their care needs. People with dementia are more likely than those without diagnosed dementia to have high-care needs in relation to the care domains ‘Activities of daily living’ and ‘Behaviour’, but not in relation to ‘Complex health care’ (AIHW 2013d).

Based on AIHW analysis for 2011, for every 3 people with dementia in cared accommodation, there were another 7 living in the community. Drawing on the ABS’s 2009 Survey of Disability, Ageing and Carers, people with dementia living in the community most commonly needed assistance with mobility (80%), followed by self-care (62%) (AIHW 2012). These figures indicate that those with less severe forms of the condition can be supported in the community, often with substantial support from informal carers. However, more severe dementia is associated with admission to cared accommodation: 76% of those with dementia living in the community had mild dementia, compared with 6% in cared accommodation (AIHW 2012).

As indicated in Box 6.3.1, the Australian Government subsidises community care packages for people with dementia at a higher level than for people without dementia. Up to July 2013 this funding was by way of a separate package of care, EACHD, compared with EACH. From August 2013, with the introduction of the Home Care Packages Programme that replaced the CACP, EACH and EACHD programs, a dementia supplement is available at each of the four levels of care packages.

The government programs delivering care to older people are continuing to change. In particular, the recent integration of low- (CACP) and high- (EACH, EACHD) care packages into the four level Home Care Packages Programme, the introduction of Consumer Directed Care into home care packages and the removal of the categorisation of residential care into low and high care are now flowing through to the provision, access and use of care services. In addition, in July 2015 the Australian Government launched the Commonwealth Home Support Programme. Under this reform, Commonwealth HACC and a number of other smaller programs were combined to create a single program that aims to provide better-coordinated services that are easier for older people and their carers to access (DSS 2014f).
What is missing from the picture?

This article is an account of aged care service use at a changeover point between the programs developed over the last 30 years and those which are operating from 2015 as a result of the reform process begun in 2012. Further system-wide analyses will be required to gauge the impact of the continuing changes in aged care programs. The PIAC-based analyses from 2002 to 2011 have demonstrated the value of this linked database for understanding past patterns of program use. Continuation of the current PIAC linked database and similar analyses will enable a better understanding of trends in the coming years stemming from the interaction of changes in the older population and in service provision. Ideally, to allow person-based analyses to look at changes over time, linkage between the various aged care programs would be carried out every 2–3 years.

While analyses of the movement between hospital and residential aged care have been carried out (AIHW: Karmel et al. 2008; AIHW 2013c), there has been no broad-based statistical examination of the relationship between hospital care and community aged care. In particular, there are currently no data that allow investigation into the role of periods in hospital in the aged care pathway. A broad-based analysis of this issue would require a linked database containing person-level hospital, community aged care and residential aged care service use data.

There is also limited information on the experiences of services and quality of life of people in residential and community-based aged care, with the last survey of community care clients conducted in 2008, and no similar survey for residential aged care.

Where do I go for more information?

Chapter 6 ‘Australians aged 85 years and over’ describes the characteristics of people in this age group. The pivotal role of carers in helping older people to remain living in the community is discussed in Chapter 2 ‘Informal carers’. The impact of the ageing of the Australian population on the welfare system is examined in Chapter 6 ‘Ageing and the welfare system’. Issues affecting the aged care workforce are considered in Chapter 2 ‘The changing face of the welfare workforce’.


- Patterns in use of aged care: 2002–03 to 2010–11 and Use of aged care services before death
- earlier work on care pathways—Pathways in Aged Care: program use after assessment, Pathways in aged care: do people follow recommendations?, and Dementia and the take-up of residential respite care
- the latest analysis of movement between hospital and residential aged care—Movement between hospital and residential aged care 2008–09
- statistics on the use of residential aged care and home care packages, published annually on the web, the most recent publication being Residential aged care and aged care packages in the community 2012–13.

Information on accessing current aged care programs, and the latest news in service provision, can be found at [www.myagedcare.gov.au](http://www.myagedcare.gov.au).
References


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AIHW 2013b. The desire to age in place among older Australians. AIHW bulletin no. 114. Cat. no. AUS 169. Canberra: AIHW.


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