Older people make up a considerable proportion of Australia’s population—in 2017, over 1 in 7 people were aged 65 and over. This report provides an overview of this diverse and growing population group through a range of topics. These outline older people’s demographic characteristics, health status, and service use.

Findings from this report:
- In 2016, 1 in 8 older people were engaged in employment, education or training
- In 2016, 1 in 3 older people were born overseas; the majority of these were born in a non-English speaking country
- In 2017, over 1 in 7 Australians were aged 65 years and over
- In 2014–16, Australian men aged 65 could expect to live another 20 years and women another 22 years
In 2017, approximately 3.8 million people (15% of Australia’s total population) were aged 65 and over.

This report focuses on older Australians—generally those aged 65 and over, unless otherwise specified. For older Indigenous Australians, the age range 50 and over is used, reflecting the life expectancy gap between Indigenous and non-Indigenous Australians and the lower proportion of Indigenous people aged 65 and over.

Older Australians are a diverse group, with different ages and socioeconomic backgrounds and different life experiences and lifestyles. These factors all influence the ageing process.

This new release provides insights into this group of older Australians: who they are, how they are changing, how healthy they are and the services they are using. It comprises a rolling series of web-based snapshots that provide key statistics on a variety of topics. These snapshots are topic focused, and will be updated over time. Given the diversity of content, we have used a mix of data sources. Hence, the date range available for reporting varies for the information presented for each topic.
Demographics of older Australians

The Australian population is ageing, with older Australians a growing proportion of the total population. In 2017, 15% of Australians (3.8 million) were aged 65 and over; this proportion is projected to grow steadily over the coming decades.

Growth in the proportion of older Australians is partly due to increasing life expectancy: in 2014–16, a 65-year-old man could expect to live another 20 years and a 65-year-old woman another 22 years—7 years longer for both sexes than in the mid-1960s. Overall, Australians now enjoy one of the highest life expectancies in the world. These increases in life expectancy have generally not come at the expense of reduced functioning or worsened general health (see Health and functioning).

This section presents an overview of the changing demographic characteristics of older Australians.

Over 1 in 7
Australian are aged 65 and over (15%)

Around half
of older Australians aged 65 and over are women

3 in 10
older Australians aged 65 and over were born overseas

Distribution of older Australians at a glance

Instructions: Select a location and click on an SA3* to see its position in the graph below. Choose a population breakdown to change the measure.

Choose a location
Australia

Choose a population breakdown
People aged 65 and over

Proportion of people aged 65 and over across all SA3s of Australia, 2016

Notes:
Darker colours in the map indicate higher rates.
SA3* geography is based on 2006 boundaries.

*Statistical Area Level 3 (SA3) are geographical areas built by the Australian Bureau of Statistics for analysis of regional data. To find out more, see 1270.0.55.001 - Australian Statistical Geography Standard (ASGS): Volume 1 - Main Structure and Greater Capital City Statistical Areas, July 2016.
Demographics of older Australians

Australia’s changing age & gender profile

Population ageing

In 2017, there were 3.8 million Australians aged 65 and over (comprising 15% of the total population) —increasing from 319,000 (5%) in 1927 and 1.3 million (9%) in 1977 (Figure 1) [1, 2]. The number and proportion of older Australians is expected to continue to grow. By 2057, it is projected there will be 8.8 million older people in Australia (22% of the population); by 2097, 12.8 million people (25%) will be aged 65 and over [1].

Figure 1: Proportion of the Australian population aged 65 and over, at 30 June, over time

![Graph showing the proportion of the Australian population aged 65 and over, at 30 June, over time.](image)

Percent

Sources: ABS [1, 2].

As Australia’s population ages, the profile of the older population is also projected to change. In 2017, more than half of older people (57%, or 2.2 million) were aged 65-74, one-third were aged 75-84 (30%, or 1.2 million), and 13% were aged 85 and over (497,000). By 2047, it is projected there will be just under 3.4 million people aged 65-74, though this represents a smaller proportion of all older people (45%). People aged 75-84 will account for 35% (2.6 million) of the population and 1 in 5 older people will be aged 85 and over (20%, or 1.5 million) [2].

Sex

Women tend to live longer than men [4]. This is seen in the differences in life expectancy and is particularly apparent in older age groups. In 2017, approximately half of all people aged 65-74 (51%) and 75-84 (54%) were women. This rose to 63% for people aged 85 and over [2].

The proportion of women in the older age groups peaked in 1968, when women made up 58% of all people aged 65 and over. This proportion has been declining since. The peak for women aged 65-74 was in 1965 (56%) and for those aged 75-84 in 1974 (64%); for women aged 85 and over, it peaked in 1982 (73%) [1].

International comparisons

Like many developed countries, Australia has a high median age: a relatively large proportion of its population is aged 65 and over. In 2015, the median age in Australia was 37.2—slightly lower than that in the United States of America (37.6) and the United Kingdom (40.2) [3]. The proportion of people aged 65 and over in these countries was similar to Australia’s—15% in the United States of America and 18% in the United Kingdom [3], compared with 15% in Australia (Figure 2). In 2020, the proportion of people aged 65 and over are estimated to increase by around 1.2% for Australia, 2% for the USA and 0.9% for the United Kingdom [2, 3].
Figure 2: Proportion of people aged 65 and over in selected countries, 2015 and 2020

Sources: ABS [2]; UN [3].

References

Last updated 7/08/2018 v11.0
© Australian Institute of Health and Welfare 2020
Demographics of older Australians

Culturally & linguistically diverse people
Aboriginal and Torres Strait Islander people

Generally, ageing-related conditions affect Aboriginal and Torres Strait Islander people at a younger age than non-Indigenous Australians. This reflects the generally poorer health of Indigenous Australians compared with other Australians. Hence, planning for aged care services takes account of the Indigenous population aged 50 and over and 65 and over for non-Indigenous Australians.

In 2016, there were more than 650,000 Aboriginal and Torres Strait Islander people, accounting for 3% of the total Australian population [4]. Of these:

- 17% (108,000) were aged 50 and older
- 5% (31,000) were aged 65 and over
- less than 1% (0.3%) were aged 85 and over.

The proportions for those aged 65 and over, and 85 and over, are considerably smaller than equivalents for the non-Indigenous population (which were 16% and 2.1%, respectively), reflecting the higher mortality rate and lower life expectancy of Indigenous Australians (Figure 1). Just over half (53%) of Indigenous people aged 50 and over were women, similar to the non-Indigenous older population, demonstrating the longer life expectancy of women in both populations [1, 4].

Figure 1: Age structure of the older population, by Indigenous status and sex, 2016

In 2010-12, the estimated life expectancy at age 65 for Indigenous people was a further 13.9 years for males and 15.8 years for females [5]. An Indigenous girl born between 2010-12 had a life expectancy of 73.7 years, almost 10 years (9.5 years) less than for a non-Indigenous girl born in the same period [6]. The equivalent difference was greater for males: an Indigenous boy born between 2010-12 had a life expectancy that was 10.6 years less (69.1 years) than for a non-Indigenous boy (79.7 years) [5].

People born overseas

Older Australia is made up of people from different cultural and linguistic backgrounds. In 2016, over 3 in 10 (37%) people aged 65 and over were born overseas, up from 25% in 1981 [3].

One-fifth (20%) of people aged 65 and over in 2016 were born in a non-English speaking country, and a further 10% of older people were born in the United Kingdom and Ireland [4].

The most common non-English speaking countries of birth for older people were Italy (3% of all older people), Greece (2%) and Germany (1%). Italian was the most common non-English language spoken at home by people aged 65 and over in 2016 (110,000 people), then Greek (73,000) and Chinese (80,000) [3].

For more information on people from culturally and linguistically diverse backgrounds, see Diverse groups of older Australians.

Geographic distribution

Australia can be broadly divided into regions: Major cities, Inner regional, Outer regional, Remote and Very remote. In 2016, 66% of older people (2.4 million) lived in Major cities, 32% (1.2 million) in Inner regional and Outer regional areas and just over 1% (52,600) in Remote or Very Remote areas [4].
The most populous states have the largest share of older people, with one-third (33%) of all people aged 65 and over in 2016 living in New South Wales and 25% in Victoria. However, older people as a proportion of the total population varied across the jurisdictions: people aged 65 and over made up 19% of Tasmania's population, followed by South Australia (18%), New South Wales (16%) and Queensland (15%). Notably, just 7% of the Northern Territory's population was aged 65 and over, reflecting its larger Indigenous population [2].

You can explore the characteristics of older people in Australia in the interactive map.

References
Diverse groups of older Australians

Most older Australians are living longer and in better health than ever before. Some groups, however, continue to face disadvantage that affects both their mental and physical health and their opportunities for social and economic engagement within their communities. For example, the Aged Care Act 1997 defines some populations as ‘people with special needs’—people with particular care needs that should be taken into consideration. Currently, there is no systematic capacity to identify and report on the wellbeing of people from most of these population groups. This section provides a brief overview of some of these, including people:

- from Aboriginal and Torres Strait Islander communities
- from culturally and linguistically diverse backgrounds
- who are veterans of the Australian Defence Force or an allied defence force (or the spouse, widow or widower of a veteran)
- who live in rural or remote areas
- who are homeless or at risk of becoming homeless
- who identify as lesbian, gay, bisexual, transgender or intersex (LGBTI).

Almost 2 in 10 older Australians report speaking a language other than English

201,000 older Australians receive a Departments of Veterans’ Affairs pension

1 in 6 of all homeless people on Census night were aged 55 or over

Last updated 27/08/2018 v8.0
© Australian Institute of Health and Welfare 2020
Diverse groups of older Australians

Aboriginal and Torres Strait Islander people

Indigenous Australians continue to face disadvantage in areas of education, income, employment, and housing. The relationship between these social determinants and both mental and physical health is well established [6]. Indigenous Australians of all ages face substantial health issues. This population has a higher mortality rate and a lower life expectancy than other Australians, reflected in the younger age profile of Indigenous Australians— in 2016, just 5% (31,000) of the Indigenous population were aged 65 and over compared with 16% (3.4 million) of the non-Indigenous population [1].

Health and disability

According to the National Aboriginal and Torres Strait Islander Social Survey 2014-15, Indigenous people were half as likely as non-Indigenous people to assess their health as ‘excellent’ or ‘very good’. Long-term health conditions affect almost 9 in 10 (88%) Aboriginal or Torres Strait Islander people over the age of 55, with higher risks of certain conditions including diabetes, cardiovascular disease and respiratory disease [2].

Older Indigenous people tend to have higher rates of disability than non-Indigenous people. In the 2016 Census, just over 1 in 4 (27%) older Aboriginal and Torres Strait Islander people reported a need for assistance with core activities (self-care, mobility or communication tasks), compared with 19% of non-Indigenous people aged 65 and over [1].

Access to services

Reduced accessibility to health and welfare services may be one reason for the health gap between Indigenous and non-Indigenous Australians. In 2014–15, almost one quarter of Indigenous people (24%) reported problems accessing service providers; this proportion increased to 1 in 3 people (33%) for Indigenous people living in Remote or Very remote areas [2]. In this same period, the rate of potentially preventable hospitalisations for Indigenous Australians was around 3.4 times that for non-Indigenous Australians [4].

Aged care

In general, older Aboriginal and Torres Strait Islander people tend to be more highly represented in community-based care programs, such as Home Support and Home Care, compared with residential aged care services (Table 1). In 2016-17, around 20,000 Indigenous Australians aged 50 and over accessed Home Support services (3% of all clients)—a rate of 172.5 clients per 1,000 Aboriginal and Torres Strait Islander people aged 50 years and over. Home Care was accessed by around 2,500 older Indigenous Australians, representing almost 3% of all clients. Home Care had a usage rate of 21.2 per 1,000 people of the target population [7].

Aged care service usage rates per 1,000 of the target population(a), by service type and Indigenous status 2016-17

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Indigenous</th>
<th>Non-Indigenous</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Home Support</td>
<td>Home Care</td>
</tr>
<tr>
<td>Indigenous</td>
<td>172.5</td>
<td>21.2</td>
</tr>
<tr>
<td>Non-Indigenous</td>
<td>165.2</td>
<td>17.3</td>
</tr>
</tbody>
</table>

Note:

a. Target population refers to the number Aboriginal and Torres Strait Islander people aged 50 years and over for Indigenous clients, and the number of non-Indigenous people aged 65 years and over for non-Indigenous clients.

Source: SCRGSP [7].

Less than 1% of people in permanent residential aged care in 2016-17 identified as being of Aboriginal or Torres Strait Islander origin. The age profile of Indigenous Australians in permanent residential aged care was substantially younger than that of their non-Indigenous counterparts: 1 in 4 (26%) Indigenous Australians in care were aged under 65, compared with 3% of non-Indigenous Australians [3].

To address the inequality older Indigenous Australians may face in accessing aged care services, some places and programs within the aged care system are specifically allocated for people who identify as being Aboriginal and Torres Strait Islander. In particular, Indigenous Australians can access aged care services through the National Aboriginal and Torres Strait Islander Flexible Aged Care Programme. At 30 June 2017, the program had 820 operational places, predominantly located in rural and remote Australia [5]. For more information on aged care services, see Aged Care.
References

4. AIHW 2015. The health and welfare of Australia’s Aboriginal and Torres Strait Islander peoples: 2015. Cat. no. IHW 147. Canberra: AIHW.

Last updated 7/08/2018 v16.0
© Australian Institute of Health and Welfare 2020
Diverse groups of older Australians

Culturally & linguistically diverse people

Australia’s older population is multicultural and linguistically diverse. Many overseas-born Australians face substantial barriers in accessing and engaging with the essential supports and services that contribute to good outcomes.

Differing situations and needs

The older culturally and linguistically diverse (CALD) population of Australia is not homogenous, and the situation and needs of individuals varies greatly. However, in general, older people from CALD backgrounds:

- have poorer socioeconomic status, compared with the older Anglo-Australian population
- may face substantial language barriers in accessing services
- risk having differing cultural practices and norms, leading to lack of understanding of and barriers to service use [3].

Speaking English

In 2016, 37% of people aged 65 and over were born overseas, with 67% of these people born in Europe and 16% in Asia (for more information see Demographics). In 2016, among older Australians:

- most reported speaking English well or very well at home (8 in 10, or 82%)
- 12% spoke another language but reported speaking English well
- 5% reported speaking another language and English only poorly
- around 1% did not speak English at all [1].

Italian (3%) and Greek (2%) were the most commonly spoken languages other than English for people aged 65 and over.

Migration patterns

The proportion of migrants from Europe has been declining in recent years, falling from 52% in 2001 to 34% in 2016. This has been met with an increase in migration from Asian countries over the last few decades, with Asian languages represented more strongly in the younger population compared with the older population (Figure 1) [1].

Figure 1: Proportion of people born overseas, by region of birth and age, 2006–2016

![Changes in migration patterns affect the linguistic diversity of people aged 65 and over. This can provide new challenges for meeting these people's needs for health, aged care and other services.](image)

References
Diverse groups of older Australians

Veterans
People who served in the Australian Defence Force (ADF) or an allied defence force (as well as the spouse, widow or widower of a veteran) form an important minority of older Australians. This population can have a different experience of ageing, due to factors associated with ADF service.

The transition from military to civilian life is an important stage for veterans. While many can make this transition successfully, those who have chronic health issues, injury, pain or psychological concerns may find it more challenging [5].

Health
In 2014–15, men aged 55 and over who had served in the ADF reported similar rates of chronic diseases to the non-serving population, including arthritis, back pain and problems, chronic obstructive pulmonary disease (COPD), diabetes, and diseases of the circulatory system. However, men aged 55–64 who had served had higher rates of mental and behavioural problems (1.8 times) and arthritis (1.6 times) than the non-serving population [1, 2].

Department of Veterans’ Affairs support
Veterans and their partners, widow(er)s or children receive various pensions and compensations from the Department of Veterans’ Affairs (DVA), which include help with health care and aged care services. At June 2017, more than 201,000 people aged 65 and over were receiving a DVA pension (which included service pensions, disability pensions and war widow pensions). People aged 65 and over made up 69% of all DVA pension recipients, with around 1 in 5 (19%) of all clients aged 90 and over [4] (Figure 1).

Aged care services
Prior military service may affect individuals throughout their lives, and both DVA-funded and mainstream aged care services are available to support older veterans.

The DVA provides two main community support programs for eligible veterans: the Veterans Home Care (VHC) program and community nursing services. The VHC program provides low-level support for DVA clients to continue living at home, through the provision of domestic assistance, personal care, home and garden maintenance and respite care services. In 2016–17, the VHC provided support for just under 50,000 veterans, and the most common services provided were domestic assistance (89%) and home and garden services (34%) [6].

Community nursing services provides high-level support for people with higher care needs or a disability, and these services include clinical care, personal care and palliative care services. In 2016–17, around 19,000 people received Community nursing services, and almost all clients had (95%) received clinical care services [6].

DVA clients can also access mainstream aged care services. The Commonwealth Home Support Programme (CHSP) is one of the main community- based programs, which provides entry-level support for older people to continue living independently in their homes. At 30 June 2017, the CHSP supported just under 24,000 DVA clients, representing around 3% of all CHSP clients.
Residential aged care is a higher level of support available for people who cannot remain living at home independently, and is available on a permanent or respite basis. At 30 June 2017, just over 26,000 DVA clients were in residential aged care, representing around 14% of all residential aged care clients [3, 6].

References
Diverse groups of older Australians

Regional & remote communities
Australia can be broadly divided into the regional classifications of *Major cities, Inner regional, Outer regional, Remote* and *Very remote* areas. Older Australians are less likely than the general population to live in *Major cities*.

In 2016, two-thirds (66%) of older Australians lived in *Major cities*, compared with 72% of people aged under 65 [1].

Health
People in regional and remote (including *Very remote*) communities tend to have poorer health outcomes, shown by higher death rates. The main contributors to these higher rates are coronary heart disease, other circulatory diseases, motor vehicle accidents and *chronic obstructive pulmonary disease* (for example, *emphysema*) [3].

It is likely these contributors are related to a combination of differences in access to services, lifestyle risk factors and the regional/remote environment. For example, when compared with *Major cities*:

- regional and remote areas have lower rates of general practitioner consultation and generally higher rates of hospital admission
- people from regional and remote areas tend to be more likely to smoke and drink in harmful quantities
- occupations in regional and remote area are more likely to be physically dangerous
- driving in regional and remote areas is more likely to involve risk factors such as long distances, greater speed, isolation, and animals on roads [2].

Aged care
The majority of people aged 65 and over in permanent residential aged care were in *Major cities* (70%), followed by *Inner Regional* or *Outer regional* (30%) and *Remote* or *Very remote* areas (0.6%). There are fewer residential aged care places available in *Remote* and *Very remote* areas, with 38% of facilities in *Remote* areas and 75% in *Very remote* areas having fewer than 20 places [3].

References

Last updated 7/08/2018 v10.0
© Australian Institute of Health and Welfare 2020 [CC BY-NC-ND]
Diverse groups of older Australians

People at risk of homelessness

Homelessness—and particularly the disadvantages associated with it—can contribute to premature ageing through earlier onset of health problems more commonly associated with later life. The Australian Bureau of Statistics defines homelessness as a situation where someone does not have suitable accommodation, and their current living arrangement:

- is in a dwelling that is inadequate (is unfit for human habitation and lacks basic facilities such as kitchen and bathroom facilities)
- has no tenure, or if their initial tenure, is short and not extendable
- does not allow them to have control of, and access to space for social relations (including personal or household living space, ability to maintain privacy and exclusive access to kitchen and bathroom facilities).

In the context of people who are homeless, the population of ‘older people’ is commonly defined as those aged 55 and over.

One in 6 (16%) of all homeless people on Census night in 2016 were aged 55 or over—around 18,600 people.

Out of this population, the majority (63%) were male, and around 8% identified as Aboriginal or Torres Strait Islander. The most common dwellings reported in older homeless people were living in boarding houses (27%), and staying temporarily in other households (24%). This contrasts with the younger age groups, where the most common condition reported was living in ‘severely’ crowded dwellings [1].

Homelessness is a growing problem for older Australians, and will likely continue to increase over time due to an ageing population and declining rates of home ownership among older people. Over the last decade, the number of older homeless people increased by 49%, with the largest changes measured in people aged 65-74 and 55-64 (Figure 1). Although older women do not account for the majority of homeless people, they represent a rapidly growing demographic in the homeless population—increasing by 31% from 2011. Factors such as domestic violence, relationship breakdown, financial difficulty and limited superannuation can put older women at risk of homelessness [1].

Figure 1: Number of older homeless people, by age and year, 2006–2016

![Graph showing the number of older homeless people by age and year from 2006 to 2016.](image)

Source: ABS [1]

People seeking Specialist Homelessness Services

People facing housing difficulties can access help through government-funded specialist homelessness agencies, which can be either not-for-profit or for profit agencies. People access specialist homelessness services due to homelessness, or being at risk of homelessness. In 2016-17, the most common reasons older people sought assistance were housing crisis (22%), domestic and family violence (19%) and financial difficulties (17%). Just over 23,600 older people used specialist homelessness services in 2016-17 (representing 8% of all clients). Most older clients (65%) were housed but at risk of homelessness at the time they presented to specialist homelessness services, compared with 56% of all clients. The majority of older clients were aged 55-64 (65%). While more than half (56%) were women, the rates of usage were similar for men and women [2].

The number of older Australians seeking assistance from specialist homelessness services grew by 8% on average per year between 2012-13 and 2016-17. The median number of days supported also increased from 18 days in 2012-13 to 27 days in 2016-17; this suggests that older people are presenting with more complex issues that take longer to resolve and that they have greater difficulty in securing housing [2].
References

Last updated 27/09/2018 v10.0
© Australian Institute of Health and Welfare 2020
Diverse groups of older Australians

Older Australians who identify as lesbian, gay, bisexual, transgender or intersex

Older Australians who identify as lesbian, gay, bisexual, transgender or intersex (LGBTI) have lived through a period of social and cultural transition. Many have likely suffered first hand stigma, discrimination, criminalisation, family rejection and social isolation. The rights of people who identify as LGBTI have substantially improved over the last 50 years; however, accessing appropriate services remains difficult for many older LGBTI Australians [4].

The history of discrimination experienced by older Australians who identify as LGBTI can be a source of anxiety in disclosing sexual orientation and gender identity. Approximately 34% of people who identify as LGBTI reported hiding their sexuality or gender identity when accessing services [3].

The LGBTI population is diverse, as individual needs vary substantially; however, many older LGBTI people will share similar experiences as a result of living through the recent social changes.

There are very little data regarding the older Australian LGBTI community. According to the Census in 2016, there were around 23,700 male same-sex couples and 23,000 female same-sex couples. Around 2% of all people aged under 25 in couples were in a same-sex couple, and this proportion decreased with age down to less than 1% in people aged 65 and over (Figure 1).

Overall, only 5% of people in same-sex couples were aged 65 or over, compared with 20% of people in opposite-sex couples [1].

The total number of same-sex couples who reported living together increased by 83% between 2006 and 2016, and the number of same-sex couples among people aged 65 and over is expected to increase over the coming decades [1]. This increase may reflect people’s greater willingness to disclose their sexual or gender identity due to reduced stigma associated with homosexuality, coupled with improved legal rights for same-sex couples and the ageing of the ‘baby boomer’ population.

The 2016 online Census had an opt-in service for people to more fully identify their sex or gender. This allowed the choice of ‘Other’, coupled with a response box to provide further detail. This was part of an initiative to make it possible for Australians to report their sex in a way not limited to ‘male’ or ‘female’ in the Census [2].

Around 1,300 people that had opted in using this form identified their sex or gender as ‘Other’, and the most common identities provided in the responses were Transgender (26%), ‘Another gender’ (18%) and ‘Non-Binary’ (17%). As this was a new item introduced on an opt-in basis, it is likely the Census did not capture all sex and gender diverse individuals. Just under 6% of people who responded ‘Other’ were aged 65 and over, and this proportion is likely an underrepresentation due to the decreasing preference for online forms with age. Improving the accessibility to this response option in future Census collections will ensure that this item captures more sex and gender diverse Australians, particularly for older people [2].
There is currently no way to identify LBGTI older Australians accessing aged care services. Recently, the specific concerns of the older LBGTI community have been highlighted at the national level in the form of The National Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Ageing and Aged Care Strategy. This strategy addresses the need for change in aged care services, to promote equitable access to high-quality aged care for all people who identify as LGBTI. This includes initiatives such as a full inclusion, empowerment, and consultation [4]. Over time, it may be more possible to measure access and quality of services for older Australians who identify as LGBTI and their families and carers.

References
Social & economic engagement

Older Australians are a vital part of the economy through their continued engagement in the workforce and, post-retirement, through their incomes and assets. They also contribute valuably to society by participating in family and community life: volunteering, community work and caring for family. This ongoing social and economic engagement has many benefits for both them (in promoting healthy ageing) and the wider community.

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 in 8</td>
<td>older Australians are employed</td>
</tr>
<tr>
<td>3 in 4</td>
<td>older Australians own their own home</td>
</tr>
<tr>
<td>1 in 5</td>
<td>older Australians volunteered their time within the last 12 months</td>
</tr>
<tr>
<td>3 in 4</td>
<td>older Australians had participated in one or more recreational activities away from home in the past 12 months</td>
</tr>
</tbody>
</table>

Last updated 7/08/2018 v6.0
© Australian Institute of Health and Welfare 2020
Social & economic engagement

Employment & economic participation
Work and retirement

Australians are increasingly working to older ages. In January 2018, Australians aged 65 and over had a workforce participation rate of 13% (17% for men and 10% for women), compared with 8% in 2006 (12% for men and 4% for women) (Figure 1).

Figure 1: Older Australians’ workforce participation rate by sex, over time

The rate is likely to continue to increase as the retirement intentions of Australians change. In 2004–05, just 8% of Australians aged 45 and over intended to work until age 70, compared with 20% in 2016–17 [6]. In 2016–17, the average intended retirement age was 65 (66 for men and 64 for women), with just under 1 in 4 (22%) men aged 45 and over intending to work beyond age 70 [5].

Underemployment and unemployment

Some older people are either working less than they would like to or are looking for work. Among people aged 55 and over in November 2017, 6.1% of employed people were underemployed; the unemployment rate was 3.5% of the workforce in that age group [3].

Workforce participation rates among older people have increased over time, and can vary a lot between countries. Australia and Canada have very similar rates (both 13% in 2015). Western European countries have lower rates (for example, 5% in Italy in 2015) while some other Pacific countries have much higher rates (for example, 53% in Papua New Guinea) (Figure 1). Globally, these differences may reflect both the longevity of the older population and the availability of social supports, such as government-funded pensions.
The government-funded age pension is still an important source of income for the majority of older Australians after retirement. In June 2017, 2.5 million people aged 65 and over received at least a partial age pension, representing 66% of older people [7, 9]. This rate has decreased over recent years, declining from 75% in 1997, when 1.7 million older people received any age pension [10, 11].

Superannuation

Access to superannuation to supplement the age pension has become increasingly important. In 1997, 12% of retired Australians aged 45 and over stated that superannuation was their main source of income, compared with 25% in 2016-17 [6, 5]. However, as compulsory superannuation only began in the 1980s, older people have not yet fully benefited from the scheme: the proportion of people aged 70 and over in 2007 who had never had superannuation coverage was 41% for males and 75% for females [6].

In 2016-17, around two thirds (65%) of people aged 45 or over who were retired reported that they had made contributions to a superannuation scheme (74% of men and 58% of women) [5].

Home ownership

Older Australians have traditionally had high rates of home ownership, which has provided a key financial asset on retirement. However, the overall proportion of Australians 15 years and over who owned their home without a mortgage decreased from 35% in 2003-04 to 30% in 2015-16 [1,2]. Similarly, home ownership rates among people aged 65 and over have decreased in recent years, with a higher proportion of older people renting or continuing to pay off a mortgage. In 2003-04, 79% older people owned their homes without a mortgage; this had declined to 76% in 2015-16 [1,2].

References

4. ABS 2018. Labour force, Australia, detailed--electronic delivery, Table 01: Labour force status by age, social marital status and sex. ABS cat no. 6291.0.55.001. Canberra: ABS
5. ABS 2017. Retirement and retirement intentions, Australia, July 2016 to June 2017. ABS cat. no. 6238.0. Canberra: ABS.

© Australian Institute of Health and Welfare 2020
Social & economic engagement

Civic & social participation

Unpaid care provision

For the purposes of the ABS Survey of Disability, Ageing and Carers (SDAC), a carer is a person who provides ongoing help to, or supervision of, people with disability or a long-term health condition, or people aged 65 and over [1]. Survey results showed that people aged 65 and over represented 23% of all carers in 2015.

Some 620,000 (18%) older Australians provided care—and over 1 in 3 older carers (234,000 people) were primary carers. More than half (52%) of older carers themselves had some degree of disability.

Unlike younger carers, the majority of whom were women, older carers were made up of a similar proportion of men and women (52% and 48%, respectively). However, this changes as age increased, with men becoming more likely to be carers than women. Men accounted for 56% of carers in the 75–84 year age group and 66% of carers aged 85 and over. Despite this, women made up the majority of older primary carers (57%).

The number of informal carers increased from 521,000 older people in 2009 to 620,000 people in 2015. The largest increase was in the number of carers aged 85 and over, which increased by around 42%. The number of male carers aged 85 and over increased the most (45%) between 2009 and 2015 [1].

Figure 1: Informal carers aged 65 and over by age and sex, 2009 and 2015

According to the Australian Bureau of Statistics, in 2017, around 1 in 5 (22%) children aged 0-12 received care from a grandparent. This proportion increased for children whose parents worked outside the home: grandparents provided child care for 28% of children who lived in two-parent families where both parents were working and single parent families where the parent was working [3].

Volunteering

Older Australians also participate in volunteering activities, providing time, service or skills through an organisation or group. According to the 2016 Census, around 668,000 Australians aged 65 and over (20%) volunteered their time within the 12 months prior to Census night, with the rate and time spent volunteering decreasing with age—24% for those aged 65–74, 19% for those aged 75–84 and 8% for those aged 85 and over [2].
Community and social engagement is an important part of wellbeing for Australians. According to the 2015 SDAC, almost all people aged 65 and over who were living in households had participated in social and community activities at home (98%) or away from home (94%) in the previous 3 months. Almost 9 in 10 (86%) older people reported visiting family or friends away from home [1].

The majority of older people living in households also participate in recreational activities in the community. In 2015, 49% of older people had participated in physical activities for exercise or recreation in the previous 12 months; 48% had attended a movie, concert, theatre or other performing arts event; 30% had visited a public library; and 24% had visited a museum or gallery. In total, over three-quarters of older Australians (77%) had participated in one or more recreational activities away from home in the past 12 months. [1].

References

2. ABS 2016. Census, generated using ABS TableBuilder. Canberra: ABS.
Healthy ageing

The health of the increasing number of older Australians is an important social and economic challenge facing Australia. It is also an opportunity, as extending a lifetime of good health enables older Australians to continue to contribute socially, culturally and economically to the wider community (see Social and economic engagement).

A range of factors influence older people's ability to remain healthy as they age; these include a number of behavioural and biomedical risk factors and ongoing social and mental wellbeing. This section explores some of these factors.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>9 in 10</td>
<td>9 in 10</td>
</tr>
<tr>
<td>older people believe they have someone outside the household in whom they can confide</td>
<td>older people reported that they had support available in a time of crisis from someone outside their household</td>
</tr>
<tr>
<td>Over 9 in 10</td>
<td>1 in 8</td>
</tr>
<tr>
<td>older people reported being sufficiently active during the preceding week</td>
<td>older people were engaged in employment, education or training</td>
</tr>
<tr>
<td>2 in 5</td>
<td>7 in 10</td>
</tr>
<tr>
<td>older people are overweight or obese</td>
<td>older people are overweight or obese</td>
</tr>
</tbody>
</table>
Healthy ageing

Behavioural risk factors

Many serious health issues, including some chronic diseases (such as cardiovascular disease, chronic kidney disease, certain types of cancer, type 2 diabetes, influenza and high blood pressure) can relate to lifestyle factors—particularly lack of physical exercise, poor nutrition, obesity, smoking, excessive alcohol consumption, non-vaccination and psychological distress.

Overall, there is a mixed story on the healthy lifestyles of older Australians. In addition, when compared with people aged 18-64, older people do well on some measures, but poorly on others.

### Behavioural risk factors, by age group, 2014-15

<table>
<thead>
<tr>
<th></th>
<th>Aged 65 and over</th>
<th>Aged 18-64</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sufficiently active</td>
<td>35%</td>
<td>48%</td>
</tr>
<tr>
<td>Current daily smoker</td>
<td>7%</td>
<td>16%</td>
</tr>
<tr>
<td>Vaccinated against influenza</td>
<td>75%</td>
<td>23%</td>
</tr>
<tr>
<td>More than 2 standard drinks of alcohol a day</td>
<td>16%</td>
<td>18%</td>
</tr>
<tr>
<td>At least 2 fruit + 5 vegetables a day</td>
<td>8%</td>
<td>5%</td>
</tr>
<tr>
<td>Overweight or obese</td>
<td>72%</td>
<td>61%</td>
</tr>
<tr>
<td>Experienced stress</td>
<td>52%</td>
<td>63%</td>
</tr>
</tbody>
</table>

Source: ABS [1,2].

These factors are now explored in more detail for older Australians.

Physical activity

National guidelines state that older Australians should aim for 30 minutes of moderate exercise (for example, brisk walking, sports, gardening or swimming) on most, if not all, days of the week [6]. Being active can help to maintain a healthy Body Mass Index. Regular physical activity has important benefits for both physical and mental health, including:

- reducing the risk of many health problems, such as cardiovascular disease, diabetes, anxiety, depression, and musculoskeletal problems
- enhancing social and community connectedness by providing opportunities for social engagement [7].

In 2014-15, 35% of people aged 65 and over surveyed as part of the Australian Bureau of Statistics (ABS) National Health Survey (NHS) reported being sufficiently active (doing more than 150 minutes of exercise over 5 or more sessions) during the preceding week; 37% reported being insufficiently active (less than 150 minutes of exercise); and 28% reported doing no exercise at all (Figure 1).

![Pie chart showing levels of exercise: Inactive, Sufficiently active, Insufficiently active](source: ABS [2])

Nutrition
A diet with a wide range of fruit and vegetables protects against conditions such as heart disease, type 2 diabetes and certain eye diseases such as cataracts and macular degeneration [4]. A high intake of fruit and vegetables promotes a healthy lifestyle; the National Health and Medical Research Council (NHMRC) recommends that adults have 2 servings of fruit and 5 servings of vegetables every day [10].

Based on data from the 2014-15 NHS, across all age groups, most Australians (95%) reported not eating enough fruit and vegetables to meet these recommended guidelines. Older Australians, however, tend to consume more fruit and vegetables than younger cohorts, with 8% of people aged 65 and over (8% aged 65-84, and 6% of people aged over 85) meeting the guidelines compared with 5% of people aged 18-64 [2].

**Obesity**

Obesity is a key health issue for older Australians and can increase the risk of developing heart disease, type 2 diabetes and certain cancers, among other things. Based on data from the 2014-15 NHS, 72% of people aged 65 and over (around 2.4 million) were overweight or obese, compared with an average of 63% for all Australians aged 18 and over and 61% for Australians aged 18-64.

The proportion of people who are overweight or obese increases with age (Figure 2) among both sexes, peaking at ages 55-64 for men and at ages 65-74 for women. Among people aged 65 and over, the proportion who were overweight or obese declined from 80% of men and 69% of women aged 65-74, to 58% of men and 56% of women aged 85 and over [2].

**Smoking**

Rates of smoking have dramatically decreased in Australia since the late 1980s. This may be due to an improved awareness of the negative health effects of tobacco, and a range of control measures aimed at reducing smoking rates.

Smoking is the leading risk factor for a number of diseases and conditions, including coronary heart disease and lung disease. As well, smoking is estimated to be responsible for 22% of all cancer deaths per year.

Older Australians tend to have lower rates of smoking than younger cohorts—only 9% of people aged 65-74, and 5% of people aged 75 and over, were daily smokers in 2016, compared with 13% for all people aged 18 and over. However, the proportion of older people who smoked daily did not change between 2001 and 2016, while the rates decreased in all younger age groups during the same time period [5].

Around one-third of older people (35% of those aged 65-74, and 32% of those aged 75 and over) reported being previous smokers. Among those who were current smokers, smoking a pack a day was common: 44% of people aged 65-74 and 41% of those aged 75 and over smoked on average 20 or more cigarettes a day [5].

The most common reasons older people reported for quitting were financial cost (46% of people aged 65-74, and 53% of those aged 75 and over) and health: 57% of people aged 65-74, and 43% of people aged 75 and over, reported that they were motivated by reasons such as “I think it was affecting my health or fitness” and “My doctor advised me to give it up” [5].

**Alcohol consumption**

Alcohol plays a prominent role in society; most Australians drink at light to moderate levels. However, drinking excessive amounts of alcohol is a health risk, and can contribute to long-term health issues such as liver disease, some cancers, and brain damage [8].

The NHMRC recommends no more than 2 standard drinks daily to reduce one’s lifetime risk, and no more than 4 drinks in one event to reduce single-occasion risk [9]. In 2016, older Australians were less likely to have single-occasion risk than younger people. Around 13% of people aged 65-74 (and just 5% of those aged 75 and over) had drunk more than 4 standard drinks on any one occasion in the last month, compared with 21% of people aged 55-64, and 40% of people aged in their 20s. Older people were also more likely to not have consumed any alcohol in the last 12 months: 24% of people aged 65-74, and 34% of those aged 75 and over were abstainers, compared with around 20% in younger age groups [5].
In terms of lifetime risk—that is, drinking on average more than 2 standard drinks per day—some 16% of people aged 65–74, and 9% of those aged 75 and over drank alcohol above the recommended guidelines. Men were more likely than women to drink more than 2 standard drinks per day (Figure 3) [5].

Vaccinations
One of the most effective health interventions against preventable health issues is vaccination. Influenza and pneumonia can seriously affect the health of older Australians, and vaccinations are free for people aged 65 and over to ensure a high coverage. The influenza vaccine is available annually; the pneumonia vaccine is administered less often, with only one re-vaccination required every 5 years after the first dose. In 2009, around three-quarters (75%) of people aged 65 and over were vaccinated against seasonal influenza, and more than half (54%) against pneumococcal disease (pneumonia) [3]. Combined, half (51%) of older people were vaccinated against influenza and pneumonia—and conversely, more than 1 in 5 (22%) were not vaccinated for either disease.

Stress
Chronic stress can potentially lead to anxiety and depression, as well as to physical health issues such as high blood pressure. In 2014, stress affected more than half (52%) of people aged 65 and over in the last 12 months, with serious illness and the death of a loved one some of the most common types of stressors older people experienced [1]. Stress management strategies, such as relaxation, physical activity, time management and social connections, can help lower stress levels and reduce the negative impact experienced as a result of chronic stress.

Another factor that has a significant impact on the health outcomes of older Australians is their exposure to abuse. Comprehensive data on elder abuse in Australia— including its prevalence, the type of abuse, the perpetrator and in what context the abuse may be more likely to occur— are not currently collected or reported. The importance of bridging this data gap is widely recognised, with the Elder Abuse: A National Legal Response report by the Australian Law Reform Commission in 2017 calling for a national prevalence study, including the development of standardised measures for consistent data collection [11, 12].

References
9. National Health and Medical Research Council (NHMRC) 2009. Australian guidelines to reduce health risks from drinking alcohol. Canberra: NHMRC.
Healthy ageing

Mental & social wellbeing

Healthy ageing involves more than just promoting good physical health. Social and mental wellbeing are also important determinants for a high-quality life into older age.

Staying mentally active

Staying mentally active throughout life can help maintain cognitive functioning, mental wellbeing, and promote independence into older age. Continued learning is highly encouraged for older Australians:

- In 2016, more than 21,000 people aged 65 and over were enrolled in a full-time or part-time educational course [3].
- Around 13% (468,050 people) of people aged 65 years and over were engaged in employment, education or training in 2016 [3].
- In 2012, around 43% of men and 61% of women aged 65 and over reported reading books 3 or more times a week [6]. Cognitive activities such as reading, writing and doing puzzles help participants to keep mentally active.

Social engagement

Older Australians tend to have regular social engagement. In 2014, 63% of people aged 65 and over had contact with people outside their household at least once a week, including 19% who had daily contact [1].

According to the 2015 Survey of Disability, Ageing and Carers, almost all (94%) older Australians reported that they had someone outside the household who could support them in a time of crisis. The most commonly reported relationship to the person living outside the household who would provide support was a family member (84%), followed by a friend (54%) or neighbour (37%) [4].

Social engagement through community groups, sports, societies and volunteering can also help to strengthen and expand these social networks. For more information on volunteering, see Civic and social participation.

References

Healthy ageing

Biomedical risk factors

Biomedical risk factors are bodily states that contribute to the development of chronic disease. These states can be caused by a range of factors including: genetic, socioeconomic, psychological and behavioural, or a combination of these. Biomedical factors contribute to the risk of developing serious health conditions such as cardiovascular disease, type 2 diabetes and chronic kidney disease. Biomedical risk factors may also be influenced by behavioural risk factors—for example, physical inactivity and poor diet can adversely affect blood pressure and blood cholesterol. For more information on these in older Australians, see Behavioural risk factors.

Behavioural and biomedical risk factors tend to increase each other’s effects when they occur together in an individual [7]. Overall, older Australians experience a higher prevalence of biomedical risk factors than younger Australians, and these generally increase with age. This snapshot focuses on 3 biomedical risk factors that have direct and specific risks for health. These risk factors may be able to be modified by undertaking sufficient physical activity and eating a healthy diet.

High blood pressure

Blood pressure is the force that is exerted by the blood on the walls of the arteries (Box 1). When high blood pressure is controlled by medication, the risk of disease is reduced, although not to the levels seen in unaffected people [10].

Box 1: What is high blood pressure?

High blood pressure—also known as hypertension—is a major risk factor for cardiovascular diseases including stroke, coronary heart disease, heart failure, peripheral vascular disease and chronic kidney disease [8]. Blood pressure is measured by the level of systolic pressure (pressure in the arteries when the heart beats, pumping blood into the arteries) and diastolic pressure (pressure in the arteries when the heart is relaxed between beats), expressed as millimetres of mercury (mmHg). Blood pressure varies between individuals; as such, there are a number of different factors a medical practitioner will consider when diagnosing high blood pressure. The World Health Organization (WHO) defines blood pressure of 140/90 mmHg or more as high [10].

The methodology of determining the proportion of people with high blood pressure can differ between surveys. For example, while the Australian Bureau of Statistics (ABS) 2014–15 National Health Survey (NHS) uses data based on measured blood pressure, people who might otherwise have high blood pressure but are managing their condition with blood pressure medications are not included.

The proportion of adults with high blood pressure increases with age. Based on data from the ABS 2014–15 NHS, 1 in 2 people (47%) aged 75 and over had measured high blood pressure (42% for men and 51% for women) compared with 42% among people aged 65–74 (Figure 1).

Figure 1: Prevalence of high blood pressure in older people, by sex and age group, 2014-15

![Figure 1: Prevalence of high blood pressure in older people, by sex and age group, 2014-15](image)

Source: ABS [1]

In Indigenous people blood pressure also increases with age, however, the prevalence of high blood pressure for Indigenous people is higher than for non-Indigenous people in younger age groups—based on the ABS 2011-13 Australian Aboriginal and Torres Strait Islander Health Survey, the greatest disparity between prevalence was for the 35–44 age group (1.6 times as high for Indigenous people). For Indigenous people aged 55 and over the proportion with high blood pressure (36%) was similar to that of non-Indigenous people (38%) [6].

Abnormal blood lipids (dyslipidaemia)

Blood lipids are fats in the blood and include cholesterol (a fatty substance that is an essential part of cell walls and is produced in the liver) and triglycerides (fat in the blood that assists in transporting and supplying metabolic energy throughout the body) [3]. Dyslipidaemia—abnormal levels of blood lipids—is a risk factor for chronic diseases such as coronary heart disease and for some types of stroke. Abnormal levels of blood lipids have previously been linked to atherosclerotic damage to arteries and heart disease [3].
The ABS 2011-12 Australian Health Survey (AHS) classifies a person as having dyslipidaemia if they had one or more of the following:

- total cholesterol = 5.5 mmol/L
- low density lipoprotein (LDL) cholesterol = 3.5 mmol/L
- high density lipoprotein (HDL) cholesterol < 1.0 mmol/L for men, and < 1.3 mmol/L for women
- triglycerides = 2.0 mmol/L
- taking lipid-modifying medication [3].

In 2011-12, for both men and women, the prevalence of dyslipidaemia generally increases with age, peaking in the 65-74 age group (78% for men and 84% for women). Although the proportion was lower among those aged 75 and over (74% and 81%, respectively). The prevalence of specific types of dyslipidaemia varies:

<table>
<thead>
<tr>
<th>Fraction</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/3</td>
<td>People aged 65 and over (32%) in 2011-12 had a total cholesterol level that was considered high.</td>
</tr>
<tr>
<td>Over 1/5</td>
<td>People aged 65 and over (22%) had low levels of HDL (good) cholesterol in their blood.</td>
</tr>
<tr>
<td>3/10</td>
<td>People aged 65 and over (30%) had high levels of LDL (bad) cholesterol.</td>
</tr>
<tr>
<td>1/7</td>
<td>People aged 65 and over had high levels of triglycerides (some people have more than one type of dyslipidaemia) [2].</td>
</tr>
</tbody>
</table>

**Impaired glucose regulation**

Impaired glucose regulation is a characteristic of pre-diabetes, a condition in which blood glucose levels are higher than normal, although not high enough to be diagnosed with type 2 diabetes. There are two measures of impaired glucose regulation—impaired glucose tolerance (IGT) and impaired fasting glucose (IFG) (Box 2). Both IGT and IFG are pre-diabetic states associated with insulin resistance—where cells fail to respond normally to insulin—which leads to high levels of blood sugar. Both of IGT and IFG are risk factors for type 2 diabetes, and are associated with a greater risk of heart disease. [7].

**Box 2: How is impaired glucose regulation measured?**

To test glucose tolerance, people fast for 8-12 hours and are given a glucose drink and their blood sugar levels are measured before and 2 hours after drinking.

People are diagnosed with IGT if they have blood glucose levels between 7.8 and 11.0 mmol/L 2 hours after the test (levels above this are classified as diabetes).

People are diagnosed with IFG if their blood glucose levels are between 6.1 mmol/L and 6.9 mmol/L after fasting (levels above this are classified as diabetes) [5].

The ABS 2011-12 AHS measured data on IFG, however, IGT was not measured and is not available for reporting in this snapshot.

For more information on diabetes in older Australians, see Diabetes.

**Impaired fasting glucose**

Based on data from the ABS 2011-12 AHS, IFG is more prevalent among older Australians, with 7% of people aged 65-74, and 8% of people aged 75 and over having the condition. Overall, 7% of older Australians had IFG. A further 13% had fasting blood glucose levels that classified them as having diabetes (IFG of 7.0mmol/L or above) [2].

**References**
Health & functioning

As the number of older people in Australia continues to grow, optimising their health and wellbeing is an increasingly important economic and medical challenge. To best respond to the increased demands of this larger aged population, the health system needs to understand the most common health conditions that older Australians might experience.

This section outlines these health conditions, together with information on the overall health status and life expectancy of older Australians, and how these have changed over time.

7 in 10
Australians aged 65 years and over considered they had good, very good or excellent health

1 in 5
Australians aged 65 and over experienced disability in the form of a severe or profound core activity limitation

13%
of all deaths of Australians aged 65 and over were caused by coronary heart disease
Health & functioning

Health & disability status

Health

According to the 2014–15 National Health Survey (NHS), nearly three-quarters (73%) of older Australians (aged 65 and over) reported they had good, very good or excellent health. Two in five (39%) older people self-assessed their health as being very good or excellent [1].

In the NHS, women were more likely than men to report their health as being excellent or very good in all older age groups. The exception was people aged 85 and over: men were slightly more likely than women to report that they had excellent or very good health (Figure 1). For men and women, the likelihood of rating their health as fair or poor increased with age; 25% of people aged 65–74, and 30% of people aged 75–84, assessed their health as being fair or poor, compared with 34% of people aged 85 and over [1]. The oldest age group also had higher levels of disability (see Disability).

Disability

The 2015 ABS Survey of Disability, Ageing and Carers reported that 50% of men and 52% of women aged 65 and over had some form of disability [2] (Figure 2). This proportion was higher for those aged 85 and over, with 4 in 5 experiencing disability (78% of men and 80% of women). In 2015, 15% of men and 22% of women aged 65 and over experienced disability as a severe or profound core activity limitation (that is, sometimes or always needing help with self-care, mobility or communication). Again, this was higher for those aged 85 and over—38% for men and 56% for women.
Over time, the proportion of severe and profound core activity limitations in older Australians has generally reduced, especially for those aged 85 and over, with similar reductions for both men and women between 1998 and 2015 (19 and 13 percentage points, respectively) (Figure 3).

References

Health & functioning

Life expectancy

Life expectancy for older Australians is increasing, with people expecting to live longer and with more years free of disability [1].

In 2014-2016, Australian men aged 65 could expect to live for another 19.6 years, and women another 22.3 years [3] (Figure 1). This is an increase of more than 8 years for men and 10 years for women since the turn of the century.

Figure 1: Life expectancy at age 65 and 85 years by sex, 1881–1890, 1960–62 and 2014–16

Source: AIHW [2,3]

Disability

Improvements in life expectancy are often considered alongside disability: increases in life expectancy hopefully accompany an increase in the number of healthy years people live.

AIHW analysis of the 2015 Survey of Disability, Ageing and Carers (SDAC) indicates that, at age 65:

- men could expect to live an additional 9 years disability free (47% of their total average remaining life expectancy)
- women could expect to live an additional 10 years disability free (45% of their total average remaining life expectancy)
- compared with 2003, men could expect to live an additional 1.6 years of disability-free life
- compared with 2003, women could expect to live an additional 1.2 years of disability-free life (Figure 2).

There have also been changes in the expected years of life with a severe or profound core activity limitation, for both men and women. Men aged 65 in 2015 could expect to live an additional 3.4 years with a severe or profound core activity limitation, and women an additional 5.6 years, compared with 3.3 years for men and 6.2 years for women in 2003 (Figure 2).

The expected years of life with disability, but no severe or profound core activity limitation, has increased slightly for men and women between the 2003 and 2015 analysis (Figure 2).
Figure 2: Expected years of life at age 65, by level of disability and sex, 2003 and 2015

Source: AIHW [1]

References
Health & functioning

Causes of death

In Australia between 2014 and 2016, there were over 380,000 deaths of people aged 65 and over (82% of all deaths). Only 1 in 5 (19%) of these deaths were of people aged 65-74 (32% aged 75-84, 41% aged 85-94 and 8% for people aged 95 and over). The leading cause of death for all older Australians was coronary heart disease—51,600 deaths between 2014 and 2016, followed by dementia and Alzheimer disease (37,400 deaths), cerebrovascular disease (29,800), chronic obstructive pulmonary disease (19,500) and lung cancer (19,200) [1].

Coronary heart disease was also the leading cause of death in each age group, except for those aged 65-74, whose leading cause of death was lung cancer (Figure 1). Dementia and Alzheimer disease featured as the second leading cause of death among people aged 75 and older.

Figure 1: Five leading causes of death for older Australians, by age group, 2014–16

<table>
<thead>
<tr>
<th>65-74</th>
<th>75-84</th>
<th>85-94</th>
<th>95+</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st</td>
<td>Lung cancer</td>
<td>Coronary heart disease</td>
<td>Coronary heart disease</td>
</tr>
<tr>
<td>2nd</td>
<td>Coronary heart disease</td>
<td>Dementia and Alzheimer disease</td>
<td>Dementia and Alzheimer disease</td>
</tr>
<tr>
<td>3rd</td>
<td>Chronic obstructive pulmonary disease</td>
<td>Cerebrovascular disease</td>
<td>Cerebrovascular disease</td>
</tr>
<tr>
<td>4th</td>
<td>Cerebrovascular disease</td>
<td>Lung cancer</td>
<td>Chronic obstructive pulmonary disease</td>
</tr>
<tr>
<td>5th</td>
<td>Colorectal cancer</td>
<td>Chronic obstructive pulmonary disease</td>
<td>Heart failure and complications</td>
</tr>
</tbody>
</table>

Source: AIHW [1]

Coronary heart disease

Coronary heart disease (CHD) is the leading cause of death of older Australians; it accounted for 13% of all deaths in people aged 65 and over between 2014-2016 [1]. The sex distribution for older Australians who died from CHD changes dramatically between age groups.

Nearly three-quarters (75%) of older Australians who died of CHD aged 65-74 were men. This reduced to 62% for those aged 75-84, 45% for those aged 85-94 and 29% for those aged 95 years and over [1].

Figure 2: Coronary heart disease deaths, by age and sex, 2014–16

Source: AIHW [1]

Dementia

Dementia is not a single specific disease. It describes a syndrome linked with over 100 different diseases that exhibit impaired brain function [2]. The most common types of dementia are:

- Alzheimer disease (up to 50-75% of cases, although only half of these are thought to be ‘pure’ Alzheimer disease—mixed types of dementia are also common)
- vascular dementia (20-30% of cases), with frontotemporal dementia and dementia with Lewy bodies accounting for around 5% of cases [2].
The type and severity of dementia vary. Dementia is usually of gradual onset, progressive and irreversible. Studies consistently show that people with dementia have an increased risk of death, due to complications and causes directly or indirectly related to dementia [2]. Between 2014-2016, 10% of deaths of people aged 65 and over were due to dementia, with the number of deaths increasing with age, although there was a decline in deaths due to dementia for people aged 95 years and over [1].

AIHW analysis of a range of national and international sources estimates there were 354,000 people with dementia in Australia in 2016, almost all of whom were aged 65 and over (328,000 or 93%). This number is predicted to rise markedly in future—projected to more than double by the year 2046 to around 833,000. As a leading cause of death and burden of disease, the demand that dementia places on health and aged care services is expected to increase considerably over time [2].

Dementia deaths—sex distribution
The sex distribution of the proportion of deaths attributed to dementia in older Australians changed across age groups. In those aged 75 and over, women have a higher number of deaths from dementia and Alzheimer’s disease than men.

- For people aged 65-74, there was a similar sex distribution for dementia related deaths- 53% of deaths were men and 47% were women
- For people aged 75-84, the proportions were 44% for men and 56% for women
- For those aged 85-94 and those aged 95 and over—in line with the gender differences on life expectancy—fewer deaths were attributed to dementia for men than for women (33% and 67% respectively for those aged 85-94 and 19% and 81% for those aged 95 and over) [1].

Cerebrovascular disease
Cerebrovascular disease is any disorder related to the blood vessels that supply the brain and covering membranes. Stroke is the most common cause of death from cerebrovascular disease. In 2014-2016, 7.8% of all deaths of people aged 65 and over were due to cerebrovascular disease [1].

As expected, the sex distribution for deaths attributed to cerebrovascular disease changes as people age. For those aged 65-74, more deaths were attributed to cerebrovascular disease for men than women (59% for men), and there were similar proportions of deaths attributed to cerebrovascular disease for men and women aged 75-84 (48% for men and 52% for women). For those aged 85-94 and those aged 95 years and over, more deaths were attributed to cerebrovascular disease for women than men. For those aged 85-94, 66% of cerebrovascular attributed deaths were women and for those aged 95 years and over 79% of cerebrovascular attributed deaths were for women [1].

Cancer
Cancer is a diverse group of diseases in which some of the body's cells can become defective, multiply out of control, and damage tissues around them.

- In 2014, people aged 65 and over were estimated to account for half (58%) of new cancer cases diagnosed (74,393 new cases) [3] 
- In 2015, people aged 65 and over accounted for three-quarters (76%) of cancer related deaths (35,153) [3].

Between 2014-16, lung cancer was the most common cause of death from cancer for people aged 65 and over, followed by colorectal, unknown cancers, prostate, pancreatic and breast cancer [1].

The most common type of cancer causing death varies with sex.

Cancer in older men
In 2014–16, the most common types of cancer causing death in older men were lung cancer (around 11,700 deaths), prostate cancer (9,900 deaths) and colorectal cancer (nearly 4,500 deaths) [1]. Deaths from the 6 most common cancers causing death in older men accounted for 19% (35,300) of all deaths of men aged 65 and over (Figure 5).

Cancer in older women

In 2014–16, the most common types of cancer causing death in older women were lung cancer (around 7,500 deaths), breast cancer (5,500 deaths) and unknown or ill-defined cancer (4,800 deaths) [1]. Deaths from the 6 most common cancers causing deaths in older women accounted for 14% (27,100) of all deaths of women aged 65 and over (Figure 5).

Figure 5: Six most common types of cancer causing death for people aged 65 and over, by sex, 2014–16

Generally, the number of new cases of all types of cancer per 100,000 Australians aged 65 and over have increased over time, peaking in 2008–2009; since then, there has been some decline (Figure 6).

Figure 6: Incident rates of all types of cancer in people aged 65 years and over, 1982–2014

References


Last updated 7/08/2018 v9.0
© Australian Institute of Health and Welfare 2020
Health & functioning

Burden of disease

Burden of disease (BoD) is a standard method for analysis of the causes of health loss. BoD measures the impact of fatal burden (the impact from dying prematurely measured by years of life lost) and non-fatal burden (the burden from living with ill-health measured by years lived with disability) of diseases and injuries to provide an estimate of a population’s health and the attribution of risk factors to the total disease burden.

BoD analysis provides a quantifiable measure of total burden—the disability-adjusted life year (DALY) that allows for diseases and risk factors to be ranked in terms of their contribution to the overall disease burden. One DALY represents 1 lost year of ‘healthy life’ due to premature death, or living with ill health or disability or a combination of these factors. A DALY is a combination of the years of life lost (YLL or fatal burden) due to premature death and years of life lived with ill health or disability (YLD or non-fatal burden) [1].

The results discussed in this section use data from the 2011 Australian Burden of Disease Study. To learn more about the methodology applied to burden of disease analysis, please refer to Australian Burden of Disease Study 2011: methods and supplementary material.

Total burden in the older Australian population

Overall, older Australians (Australians aged 65 and over) lost more than 1.8 million DALY due to premature death or living with a disease in 2011, equating to around 600 DALY per 1,000 people. The burden was largely due to premature death (over 1.1 million YLL) which accounted for 63% of the total burden, as opposed to years lived with disability which contributed to 37% of the burden (around 700,000 YLD) [1].

Total burden by age

The burden was highest for 65–69 year olds (around 360,000 DALY), and remained relatively constant at this level before decreasing with age from 85–89 year olds (down to approximately 4,200 DALY for those aged 100 and over). In contrast, the rate of burden (that is the DALY rate per 1,000 people) increased progressively with age from 376 per 1,000 people aged 65–69 years to 1,388 per 1,000 people aged 100 and over (Figure 1).

Figure 1: Fatal and non-fatal composition of the total burden, by age, 2011

Source: AIHW [1].

Total burden by sex

The burden was spread relatively evenly between the sexes with men accounting for just over half (51%) of the burden (women accounted for 49%). Men experienced more burden than women between the ages of 65 and 84 years (around 780,000 DALY compared with 630,000 DALY), whereas women experienced more burden than men from the age of 85 and over (270,000 DALY compared with 170,000 DALY). Among men, the burden was highest for 65–69 year olds (209,000 DALY), with the number of YLL and YLD decreasing with age. For women, the burden was highest among 80–84 year olds (175,000 DALY) (Figure 2).

Figure 2: Number of DALY, by age and sex, 2011
Leading causes of burden of disease: disease group
Cardiovascular disease and cancer were the leading causes of burden for older Australians (contributing 24% of total DALY, each) followed by neurological conditions (11%), musculoskeletal conditions, and respiratory conditions (9%, each).
Among these top disease groups, the rate of burden per 1,000 people increased with age—except for cancer, where the rate was highest for 80–84 year olds.
The leading causes of burden were the same for men and women with only the order differing between them.
- For men, the leading cause was cancer and other neoplasms (28%), followed by cardiovascular disease (25%), respiratory diseases (9%), neurological conditions (8%) and musculoskeletal diseases (7%).
- Cardiovascular disease was the leading cause in women (23%), followed by cancer and other neoplasms (20%), neurological conditions (13%), musculoskeletal conditions (11%) and respiratory diseases (9%) (Figure 3).

Figure 3: Proportion of total burden for older Australians aged 65 and over, by sex and disease group, 2011

Fatal and non-fatal component of total burden
Overall, fatal burden contributed to a larger component of total burden than non-fatal burden (63% and 37%, respectively). Cancer had the largest fatal component of all disease groups (93%), followed by infections (84%) and cardiovascular diseases (79%) (Figure 4). Respiratory diseases had the most even split between the fatal and non-fatal component, while the burden due to hearing and vision disorders was all non-fatal.

Figure 4: Fatal and non-fatal component of total burden for older Australians aged 65 and over, by disease group, 2011
As established earlier, the total burden experienced in Australia in 2011 was distributed relatively evenly between men (51%) and women (49%). There were differences, however, in the distribution of burden by disease group between men and women (Figure 5):

- The difference was greatest for reproductive and maternal conditions which were unsurprisingly higher for women by 78 percentage points.
- Neurological conditions were 20 percentage points higher for women than men (60% and 40%, respectively).
- Men had a higher proportion of the burden due to cancer and other neoplasms than women (59% and 41%).
- The burden of gastrointestinal diseases was distributed evenly between men and women.

The difference was greatest for reproductive and maternal conditions which were unsurprisingly higher for women by 78 percentage points.

Neurological conditions were 20 percentage points higher for women than men (60% and 40%, respectively).

Men had a higher proportion of the burden due to cancer and other neoplasms than women (59% and 41%).

The burden of gastrointestinal diseases was distributed evenly between men and women.

### Table 1: Comparison of age-standardised DALY rates, rate differences and rate ratios between men and women aged 65 and over, by disease groups, 2011

<table>
<thead>
<tr>
<th>Disease group</th>
<th>ASR: men(a)</th>
<th>ASR: women(a)</th>
<th>Rate difference</th>
<th>Rate ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood &amp; metabolic disorders</td>
<td>6.9</td>
<td>5.9</td>
<td>1.0</td>
<td>1.2</td>
</tr>
<tr>
<td>Cancer &amp; other neoplasms</td>
<td>187.5</td>
<td>108.8</td>
<td>78.7</td>
<td>1.7</td>
</tr>
</tbody>
</table>
Leading causes of burden of disease: individual diseases

At the individual disease level, coronary heart disease was the leading cause of burden for older Australians, followed by dementia and chronic obstructive pulmonary disease (COPD). The top 10 individual diseases for older Australians accounted for over half (51%) of the total burden (Table 2).

While coronary heart disease remained the leading cause of burden for men and women, there were some differences between the sexes:

- In men, coronary heart disease was the leading cause of disease burden accounting for 14% of the total burden, followed by COPD (6.5%) and lung cancer (5.8%).
- In women, coronary heart disease accounted for 11% of the burden, followed by dementia (10%) and stroke (6.3%).
- The age-standardised rate of burden due to coronary heart disease was 99 per 1,000 men compared with 52 per 1,000 women. As such, men had 1.9 times the burden of coronary heart disease as women.

Age patterns

The leading causes of burden for men and women differed by age (Figure 7 and 8). A notable pattern was evident for both sexes, whereby the rate of burden from neurological conditions increased with age. For example, dementia was not one of the top 10 leading diseases for men or women aged 65-69 years, however from the age of 70 onwards it remained as one of the leading causes of burden for both men and women with its rank within the top 10 leading diseases differing by age group. Furthermore, the rate of total burden due to dementia increased with age for both sexes—from 16 to 219 per 1,000 men aged 70-74 and 100 years and older, respectively, and from 18 to 319 per 1,000 women of the same age range (Figure 6).
Table 2a: Top 10 diseases causing burden in persons aged 65 years and over, DALY number and proportion of DALY total, 2011

<table>
<thead>
<tr>
<th>Rank</th>
<th>Condition</th>
<th>DALY</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Coronary heart disease</td>
<td>233,731</td>
<td>12.7</td>
</tr>
<tr>
<td>2</td>
<td>Dementia</td>
<td>142,091</td>
<td>7.7</td>
</tr>
<tr>
<td>3</td>
<td>COPD</td>
<td>113,732</td>
<td>6.2</td>
</tr>
<tr>
<td>4</td>
<td>Stroke</td>
<td>103,296</td>
<td>5.6</td>
</tr>
<tr>
<td>5</td>
<td>Lung cancer</td>
<td>87,928</td>
<td>4.8</td>
</tr>
<tr>
<td>6</td>
<td>Diabetes</td>
<td>60,779</td>
<td>3.3</td>
</tr>
<tr>
<td>7</td>
<td>Other musculoskeletal</td>
<td>60,708</td>
<td>3.3</td>
</tr>
<tr>
<td>8</td>
<td>Bowel cancer</td>
<td>53,222</td>
<td>2.9</td>
</tr>
<tr>
<td>9</td>
<td>Hearing loss</td>
<td>43,184</td>
<td>2.3</td>
</tr>
<tr>
<td>10</td>
<td>Osteoarthritis</td>
<td>41,241</td>
<td>2.2</td>
</tr>
</tbody>
</table>

Top 10 diseases: 939,911 (51.0)

All other diseases: 903,391 (49.0)

Total: 1,843,302 (100.0)

Table 2b: Top 10 diseases causing burden in men aged 65 years and over, DALY number and proportion of DALY total, 2011

<table>
<thead>
<tr>
<th>Rank</th>
<th>Condition</th>
<th>DALY</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Coronary heart disease</td>
<td>135,617</td>
<td>14.3</td>
</tr>
<tr>
<td>2</td>
<td>COPD</td>
<td>61,533</td>
<td>6.5</td>
</tr>
<tr>
<td>3</td>
<td>Lung cancer</td>
<td>55,058</td>
<td>5.8</td>
</tr>
<tr>
<td>4</td>
<td>Dementia</td>
<td>50,808</td>
<td>5.4</td>
</tr>
<tr>
<td>5</td>
<td>Stroke</td>
<td>46,836</td>
<td>5.0</td>
</tr>
<tr>
<td>6</td>
<td>Prostate cancer</td>
<td>40,029</td>
<td>4.2</td>
</tr>
<tr>
<td>7</td>
<td>Diabetes</td>
<td>34,228</td>
<td>3.6</td>
</tr>
<tr>
<td>8</td>
<td>Bowel cancer</td>
<td>30,748</td>
<td>3.3</td>
</tr>
<tr>
<td>9</td>
<td>Other musculoskeletal</td>
<td>26,934</td>
<td>2.8</td>
</tr>
<tr>
<td>10</td>
<td>Hearing loss</td>
<td>21,404</td>
<td>2.3</td>
</tr>
</tbody>
</table>

Top 10 diseases: 503,195 (53.2)

All other diseases: 441,928 (46.8)

Total: 945,123 (100.0)

Table 2c: Top 10 diseases causing burden in women aged 65 years and over, DALY number and proportion of DALY total, 2011

<table>
<thead>
<tr>
<th>Rank</th>
<th>Condition</th>
<th>DALY</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Coronary heart disease</td>
<td>98,114</td>
<td>10.9</td>
</tr>
<tr>
<td>2</td>
<td>Dementia</td>
<td>91,283</td>
<td>10.2</td>
</tr>
<tr>
<td>3</td>
<td>Stroke</td>
<td>56,460</td>
<td>6.3</td>
</tr>
<tr>
<td>4</td>
<td>COPD</td>
<td>52,198</td>
<td>5.8</td>
</tr>
</tbody>
</table>

Top 10 diseases: 243,875 (10.9)

All other diseases: 138,372 (39.0)

Total: 382,247 (100.0)
<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Other musculoskeletal</td>
<td>33,775</td>
<td>3.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Lung cancer</td>
<td>32,870</td>
<td>3.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Osteoarthritis</td>
<td>27,711</td>
<td>3.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Diabetes</td>
<td>26,551</td>
<td>3.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Breast cancer</td>
<td>25,427</td>
<td>2.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Bowel cancer</td>
<td>22,473</td>
<td>2.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Top 10 diseases</strong></td>
<td>466,862</td>
<td>52.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>All other diseases</strong></td>
<td>431,316</td>
<td>48.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td>898,178</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: AIHW [2].

Figure 7: Leading causes of total burden (DALY ’00, proportion of age group) for men, by age group, 2011

<table>
<thead>
<tr>
<th>Age Group</th>
<th>1st</th>
<th>2nd</th>
<th>3rd</th>
<th>4th</th>
<th>5th</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-69</td>
<td>Cardiovascular Coronary heart disease (262.2, 12.5%)</td>
<td>Cancer Lung cancer (165.7, 7.9%)</td>
<td>Respiratory COPD (129.9, 6.2%)</td>
<td>Cancer Bowel cancer (84.7, 4.1%)</td>
<td>Endocrine Diabetes (84.6, 4.0%)</td>
</tr>
<tr>
<td>70-74</td>
<td>Cardiovascular Coronary heart disease (261.3, 12.9%)</td>
<td>Respiratory COPD (144.0, 7.1%)</td>
<td>Cancer Lung cancer (142.4, 7.1%)</td>
<td>Cancer Prostate cancer (81.5, 4.0%)</td>
<td>Endocrine Diabetes (77.9, 3.9%)</td>
</tr>
<tr>
<td>75-79</td>
<td>Cardiovascular Coronary heart disease (257.1, 13.5%)</td>
<td>Respiratory COPD (132.8, 7.0%)</td>
<td>Cancer Lung cancer (116.8, 6.1%)</td>
<td>Cardiovascular Stroke (100.5, 5.3%)</td>
<td>Mental Dementia (92.4, 4.8%)</td>
</tr>
<tr>
<td>80-84</td>
<td>Cardiovascular Coronary heart disease (271.1, 15.3%)</td>
<td>Mental Dementia (132.0, 7.5%)</td>
<td>Respiratory COPD (116.7, 6.6%)</td>
<td>Cardiovascular Stroke (109.8, 6.2%)</td>
<td>Cancer Prostate cancer (89.3, 5.0%)</td>
</tr>
<tr>
<td>85-89</td>
<td>Cardiovascular Coronary heart disease (205.2, 17.9%)</td>
<td>Mental Dementia (116.9, 10.2%)</td>
<td>Cardiovascular Stroke (84.5, 7.4%)</td>
<td>Respiratory COPD (68.6, 6.0%)</td>
<td>Cancer Prostate cancer (54.0, 4.7%)</td>
</tr>
<tr>
<td>90-94</td>
<td>Cardiovascular Coronary heart disease (80.5, 19.0%)</td>
<td>Mental Dementia (57.9, 13.7%)</td>
<td>Cardiovascular Stroke (32.8, 7.7%)</td>
<td>Respiratory COPD (19.9, 4.7%)</td>
<td>Cancer Prostate cancer (17.0, 4.0%)</td>
</tr>
<tr>
<td>95-99</td>
<td>Cardiovascular Coronary heart disease (17.3, 20.0%)</td>
<td>Mental Dementia (13.2, 15.3%)</td>
<td>Cardiovascular Stroke (6.5, 7.5%)</td>
<td>Cancer Prostate cancer (3.5, 4.1%)</td>
<td>Respiratory COPD (3.2, 3.7%)</td>
</tr>
<tr>
<td>100+</td>
<td>Cardiovascular Coronary heart disease (1.5, 22.0%)</td>
<td>Mental Dementia (1.2, 17.5%)</td>
<td>Cardiovascular Stroke (0.7, 10.1%)</td>
<td>Infection Lower respiratory infections (0.2, 3.4%)</td>
<td>Kidney Chronic kidney disease (0.2, 3.2%)</td>
</tr>
</tbody>
</table>

Source: AIHW [2]

Figure 8: Leading causes of total burden (DALY ’00, proportion of age group) for women, by age group, 2011

<table>
<thead>
<tr>
<th>Age Group</th>
<th>1st</th>
<th>2nd</th>
<th>3rd</th>
<th>4th</th>
<th>5th</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-69</td>
<td>Cancer Lung cancer (98.9, 6.6%)</td>
<td>Musculoskeletal Other musculoskeletal (94.3, 6.3%)</td>
<td>Cardiovascular Coronary heart disease (85.3, 5.7%)</td>
<td>Respiratory COPD (80.3, 5.4%)</td>
<td>Cancer Breast cancer (77.3, 5.2%)</td>
</tr>
<tr>
<td>70-74</td>
<td>Cardiovascular Coronary heart disease (118.1, 7.8%)</td>
<td>Respiratory COPD (101.1, 6.7%)</td>
<td>Cancer Lung cancer (83.9, 5.6%)</td>
<td>Musculoskeletal Other musculoskeletal (78.2, 5.2%)</td>
<td>Mental Dementia (66.3, 4.4%)</td>
</tr>
<tr>
<td>Age Group</td>
<td>Disease Category</td>
<td>Condition</td>
<td>Rate</td>
<td>Rate Ratio</td>
<td></td>
</tr>
<tr>
<td>-----------</td>
<td>-----------------</td>
<td>-----------</td>
<td>-------</td>
<td>------------</td>
<td></td>
</tr>
<tr>
<td>75–79</td>
<td>Cardiovascular</td>
<td>Coronary heart disease</td>
<td>149.7</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Respiratory</td>
<td>COPD</td>
<td>111.8</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mental</td>
<td>Dementia</td>
<td>105.3</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cardiovascular</td>
<td>Stroke</td>
<td>85.9</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cancer</td>
<td>Lung cancer</td>
<td>64.6</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>80–84</td>
<td>Mental</td>
<td>Dementia</td>
<td>203.7</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cardiovascular</td>
<td>Coronary heart disease</td>
<td>202.6</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cardiovascular</td>
<td>Stroke</td>
<td>130.0</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Respiratory</td>
<td>COPD</td>
<td>114.4</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Endocrine</td>
<td>Diabetes</td>
<td>51.7</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>85–89</td>
<td>Mental</td>
<td>Dementia</td>
<td>245.6</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cardiovascular</td>
<td>Coronary heart disease</td>
<td>231.6</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cardiovascular</td>
<td>Stroke</td>
<td>144.7</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Respiratory</td>
<td>COPD</td>
<td>77.9</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Endocrine</td>
<td>Diabetes</td>
<td>44.9</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>90–94</td>
<td>Mental</td>
<td>Dementia</td>
<td>231.6</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cardiovascular</td>
<td>Coronary heart disease</td>
<td>140.7</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cardiovascular</td>
<td>Stroke</td>
<td>81.8</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Respiratory</td>
<td>COPD</td>
<td>29.4</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Injury</td>
<td>Falls</td>
<td>20.2</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>95–99</td>
<td>Mental</td>
<td>Dementia</td>
<td>57.1</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cardiovascular</td>
<td>Coronary heart disease</td>
<td>46.6</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cardiovascular</td>
<td>Stroke</td>
<td>24.0</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Injury</td>
<td>Falls</td>
<td>7.1</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Infection</td>
<td>Lower respiratory infection</td>
<td>6.8</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>100+</td>
<td>Mental</td>
<td>Dementia</td>
<td>8.0</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cardiovascular</td>
<td>Coronary heart disease</td>
<td>46.6</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cardiovascular</td>
<td>Stroke</td>
<td>2.9</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Infection</td>
<td>Lower respiratory infection</td>
<td>1.7</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mental</td>
<td>Epilepsy</td>
<td>1.3</td>
<td>1.0</td>
<td></td>
</tr>
</tbody>
</table>

Source: AIHW [2].

Burden of disease by location

Variation in disease burden can be affected by where a population lives. Burden was highest in Very remote areas and areas with low socio-economic status (SES).

1.5 times
The rate of burden in Very remote areas was 1.5 times the rate in Major cities

1.3 times
The rate of burden was 1.3 times as high for lowest SES areas as highest SES areas

Remoteness

Burden was greater in Very remote areas than Major cities, with the age-standardised rate (ASR) of burden increasing from 571 DALY per 1,000 people in Major cities to 871 per 1,000 people in Very remote areas (Table 3). This difference was largely driven by the rate of non-fatal burden in Very remote areas, which was almost twice as high as the rate in Major cities (396 and 216 YLD per 1,000, respectively). Non-fatal burden therefore contributed to a greater proportion of the total burden in Very remote areas (45%) than Major cities (37%).

### Table 3a: Burden by remoteness area, numbers, rates and rate ratios, Australians aged 65 and over, 2011

<table>
<thead>
<tr>
<th>Remoteness area</th>
<th>DALY ('000)</th>
<th>ASR</th>
<th>Rate ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major cities</td>
<td>1,201</td>
<td>571.2</td>
<td>1.0</td>
</tr>
<tr>
<td>Inner regional</td>
<td>419</td>
<td>613.8</td>
<td>1.1</td>
</tr>
<tr>
<td>Outer regional</td>
<td>188</td>
<td>627.6</td>
<td>1.1</td>
</tr>
<tr>
<td>Remote</td>
<td>22</td>
<td>706.3</td>
<td>1.2</td>
</tr>
<tr>
<td>Very remote</td>
<td>11</td>
<td>871.2</td>
<td>1.5</td>
</tr>
<tr>
<td>Australia</td>
<td>1,841</td>
<td>588.5</td>
<td></td>
</tr>
</tbody>
</table>

### Table 3b: Fatal burden by remoteness area, numbers, rates and rate ratios, Australians aged 65 and over, 2011
<table>
<thead>
<tr>
<th>Remoteness area</th>
<th>YLL ('000)</th>
<th>ASR</th>
<th>Rate ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major cities</td>
<td>751</td>
<td>355.4</td>
<td>1.0</td>
</tr>
<tr>
<td>Inner regional</td>
<td>268</td>
<td>392.1</td>
<td>1.1</td>
</tr>
<tr>
<td>Outer regional</td>
<td>123</td>
<td>410.4</td>
<td>1.2</td>
</tr>
<tr>
<td>Remote</td>
<td>14</td>
<td>431.8</td>
<td>1.2</td>
</tr>
<tr>
<td>Very remote</td>
<td>6</td>
<td>475.3</td>
<td>1.3</td>
</tr>
<tr>
<td>Australia</td>
<td>1,162</td>
<td>370.2</td>
<td></td>
</tr>
</tbody>
</table>

**Table 3c: Non-fatal burden by remoteness area, numbers, rates and rate ratios, Australians aged 65 and over, 2011**

<table>
<thead>
<tr>
<th>Remoteness area</th>
<th>YLD ('000)</th>
<th>ASR</th>
<th>Rate ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major cities</td>
<td>450</td>
<td>215.8</td>
<td>1.0</td>
</tr>
<tr>
<td>Inner regional</td>
<td>151</td>
<td>221.7</td>
<td>1.0</td>
</tr>
<tr>
<td>Outer regional</td>
<td>65</td>
<td>217.2</td>
<td>1.0</td>
</tr>
<tr>
<td>Remote</td>
<td>9</td>
<td>274.6</td>
<td>1.3</td>
</tr>
<tr>
<td>Very remote</td>
<td>5</td>
<td>395.9</td>
<td>1.8</td>
</tr>
<tr>
<td>Australia</td>
<td>680</td>
<td>218.3</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** Rates are age-standardised to the 2001 Australian Standard Population and are expressed per 1,000 people. The base for calculating rate ratios is Major cities.

**Source:** AIHW [2].

The rate of burden progressively increased with remoteness and age, with a similar pattern by age across Major cities, Inner regional, Outer regional and Remote areas (Figure 9). The pattern in Very remote areas was different, with a slight plateau in the rate between 75-79 and 80-84 year olds (957 and 1,045 DALY per 1,000 people), before increasing sharply to 1,552 DALY per 1,000 people aged 85 and over. The rate ratio was highest for 75-79 year olds where the rate of burden in Very remote areas was 1.6 times that in Major cities. The difference between the burden in Very remote and Major cities was lowest for those aged 80-84 years (rate ratio of 1.4).

**Figure 9: Total burden by remoteness area and age group, rate and rate ratio between very remote areas and major cities, 2011**

**Source:** AIHW [2].

**Socio-economic status**

There was some difference in the burden experienced by people living in the lowest SES areas compared with those in the highest SES areas, with higher rates in the lowest areas (512 and 656 per 1,000 people, respectively). This difference was largely due to the higher rate of fatal burden in low SES areas, which was 1.3 times the rate in high SES areas. Accordingly, the proportion of total burden attributable to fatal burden was higher in low SES areas (65%) than high SES areas (60%) (Table 4).

**Table 4a: Total burden by socio-economic status area, numbers, rates and rate ratios, Australians aged 65 and over, 2011**

<table>
<thead>
<tr>
<th>Socio-economic status area</th>
<th>DALY ('000)</th>
<th>ASR</th>
<th>Rate ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 (lowest)</td>
<td>437</td>
<td>655.7</td>
<td>1.3</td>
</tr>
</tbody>
</table>
Table 4b: Fatal burden by socio-economic status area, numbers, rates and rate ratios, Australians aged 65 and over, 2011

<table>
<thead>
<tr>
<th>Socio-economic status area</th>
<th>YLL ('000)</th>
<th>ASR</th>
<th>Rate ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 (lowest)</td>
<td>284</td>
<td>425.1</td>
<td>1.4</td>
</tr>
<tr>
<td>Q2</td>
<td>272</td>
<td>399.9</td>
<td>1.3</td>
</tr>
<tr>
<td>Q3</td>
<td>236</td>
<td>367.0</td>
<td>1.2</td>
</tr>
<tr>
<td>Q4</td>
<td>191</td>
<td>337.3</td>
<td>1.1</td>
</tr>
<tr>
<td>Q5 (highest)</td>
<td>179</td>
<td>307.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Australia</td>
<td>1,162</td>
<td>370.4</td>
<td></td>
</tr>
</tbody>
</table>

Table 4c: Non-fatal burden by socio-economic status area, numbers, rates and rate ratios, Australians aged 65 and over, 2011

<table>
<thead>
<tr>
<th>Socio-economic status area</th>
<th>YLD ('000)</th>
<th>ASR</th>
<th>Rate ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 (lowest)</td>
<td>153</td>
<td>230.6</td>
<td>1.1</td>
</tr>
<tr>
<td>Q2</td>
<td>151</td>
<td>224.8</td>
<td>1.1</td>
</tr>
<tr>
<td>Q3</td>
<td>136</td>
<td>212.6</td>
<td>1.0</td>
</tr>
<tr>
<td>Q4</td>
<td>123</td>
<td>220.4</td>
<td>1.1</td>
</tr>
<tr>
<td>Q5 (highest)</td>
<td>118</td>
<td>204.5</td>
<td>1.0</td>
</tr>
<tr>
<td>Australia</td>
<td>682</td>
<td>219.0</td>
<td></td>
</tr>
</tbody>
</table>

Note: Rates are age-standardised to the 2001 Australian Standard Population and are expressed per 1,000 people. The base for calculating rate ratios is Q5 (highest).

Source: AIHW [2].

The rate of burden rose with increasing disadvantage and age. The rate ratio between the lowest and highest SES areas distinctly fell with increasing age. Rates in the lowest SES areas were 1.4 times as high as the rate in the highest SES areas for 65-69 year olds, falling to just 1.1 times the rate for those aged 85 and over (Figure 10).

Figure 10: Total burden by socio-economic area and age group, rate and rate ratio between lowest and highest socio-economic areas, 2011

Source: AIHW [2].
The number of DALY for people aged 65 and over increased from 1.7 million to 1.8 million between 2003 and 2011. However, the overall rate of DALY was lower in 2011 than in 2003, falling from 667 to 597 per 1,000 people aged 65 and over. The age-specific DALY rates show the rate of burden was lower in 2011 than in 2003 for those aged 65 through to 89 years of age and higher for those aged 95 and over (Figure 11). The number of DALY was higher in 2011 than in 2003 from the age of 80 years, indicating that the increase is largely due to increases in the ageing population (more people living longer).

After adjusting for differences in the population structure, the overall rate of burden between 2003 and 2011 decreased by 10%—from 663 to 589 per 1,000 people aged 65 and over.

Figure 11: Number and rates of total burden, by age, 2003 and 2011

Source: AIHW [1].

References
Health & functioning

Diabetes

Diabetes is a chronic condition characterised by high levels of glucose in the blood. It is caused either by the body's inability to produce insulin (a hormone produced by the pancreas to control blood glucose (sugar) levels), or by the body not being able to use insulin effectively [8]. There are 3 main types of diabetes:

- **Type 1 diabetes** is a non-preventable autoimmune disease that develops when the immune system destroys the insulin-producing cells of the pancreas. Although type 1 diabetes can occur at any age, it mainly develops during childhood and adolescence. Insulin replacement is an essential treatment for type 1 diabetes. Type 1 diabetes requires careful balance of diet, exercise and management of insulin throughout the day using insulin injection or insulin pump.

- **Type 2 diabetes** is largely associated with modifiable lifestyle risk factors, but also has genetic and family related risk factors. This condition occurs when the body becomes resistant to the insulin being produced by the pancreas and/or the amount produced is inadequate to meet the body's needs. When first diagnosed with type 2 diabetes, blood glucose levels can often be maintained at normal levels through lifestyle modification and/or oral glucose lowering medication, although insulin may eventually be required as the condition progresses.

- **Gestational diabetes** is a condition marked by high blood sugar levels appearing for the first time during pregnancy that usually disappears once the baby is born. Gestational diabetes can be treated with a combination of lifestyle modifications and medication [8].

Prevalence

Based on the Australian Bureau of Statistics (ABS) 2014–15 National Health Survey (NHS), around 1 in 6 people aged over 65 reported having diabetes—just over 574,000 people [2]. The rate of diabetes tends to increase with age, with the highest prevalence (19.4%) reported in people aged 85 and over. Men reported slightly higher rates of diabetes than women, accounting for 55% of cases in people aged 65 and over. Consistent with the wider population, the most common type of diabetes reported by people aged 65 and over was type 2 diabetes—accounting for more than 9 in 10 cases (90%) (Figure 1) [2].

The rate of self-reported diabetes for people aged 65 and over has doubled over the last 2 decades—from 8.5% in 1995 to 17.4% in 2014–15 (Figure 2). This increase is likely due to a number of factors including: an increased prevalence of risk factors, improved public awareness, better detection techniques, improved survival through management techniques, and an ageing population [8].
Causes and complications

The cause of type 1 diabetes is unknown, although it is believed to result from genetic predisposition and environmental factors. Type 2 diabetes also has a strong genetic component, and is more likely to affect people with a family history of the condition. Certain lifestyle risk factors also increase the risk of developing this condition, such as a high body mass index (BMI) and high blood pressure, and this risk increases with age [9]. Further information on the prevalence of some of the main lifestyle risk factors in the older population is given in Healthy ageing.

Diabetes can result in a number of acute and chronic health conditions, including heart attack and stroke, kidney damage, vision loss, nerve damage (neuropathy) and delayed wound healing, which can lead also to lower limb amputation. Early and intensive management of blood sugar levels can delay the onset or slow the progression of these complications [10].

Type 2 diabetes pharmacological management in older people

Management of type 2 diabetes in older people using medication is more complex. For older people, the benefits of intensive glucose control need to be weighed against the associated risks, such as the impact of medications on the kidneys and the risk of interaction with other medicines used for managing multiple conditions (polypharmacy) [7].

In 2012, the pharmacological management of type 2 diabetes in a concessional population of people aged 65 and over was examined, and the following key findings were made [7]:

- 8 in 10 (85%) were supplied with glucose lowering medicines
- 2 in 10 (20%) were supplied with insulin
- 4 in 10 (40%) were supplied with medicines as a monotherapy (a single medication)
- 3 in 10 (33%) were supplied with dual therapy
- 1 in 10 (11%) were supplied with triple therapy.

Hospitalisations

Diabetes was recorded as a diagnosis for over 1 million hospitalisations in 2015–16—representing 10% of all hospitalisations that year. There were 59,900 hospitalisations related to type 1 diabetes, and 980,000 hospitalisations related to type 2 diabetes [8].

Hospitalisation rates for type 2 diabetes increased with age, with the majority (87%) of hospitalisations recorded in people aged 55 and over. The hospitalisation rate is highest in people aged 75–84, at 22,500 per 100,000 population (Figure 3).
Deaths

In 2016 diabetes was the seventh leading cause of death in Australia. A total of 16,500 deaths were related to diabetes, accounting for 10.4% of all deaths that year. Diabetes mellitus was the underlying cause for 4,770 of these deaths (29% of all diabetes deaths) and an associated cause of death for a further 8,330 deaths [3].

Diabetes mellitus death rates increase with age (Figure 4). In 2014-16, the death rate for people aged 85–94 was almost 3 times as high as those aged 75–84 [8].

Aboriginal and Torres Strait Islander people

Diabetes is an important health issue for older Aboriginal and Torres Strait Islander people, based on data from the ABS 2011–13 Australian Aboriginal and Torres Strait Islander Health Survey. Just under 2 in 5 (38%) Indigenous people aged 55 and over were diagnosed with diabetes (based on HbA1c testing), compared with 12% of non-Indigenous Australians [6].

There were more than 52,000 hospitalisations related to diabetes for Indigenous people in 2013-14, and 90% of these hospitalisations had either a principal or additional diagnosis of type 2 diabetes. The type 2 diabetes hospitalisation rate was 4 times the rate of non-Indigenous Australians, and the rate of hospitalisation increased with age (Figure 5). The highest rate was observed for people aged 65-74 (around 40,000 per 100,000) [5].
According to the ABS, diabetes was the second leading cause of death in Aboriginal and Torres Strait Islander people in 2016. The standardised death rate was 5.0 times the rate in non-Indigenous people (81.2 and 16.4 deaths per 100,000 people, respectively) [3].

References
5. AIHW 2015a. Cardiovascular disease, diabetes and chronic kidney disease—Australian facts: Aboriginal and Torres Strait Islander people. Cardiovascular, diabetes and chronic kidney disease series no. 5. Cat. no. CDK 5. Canberra: AIHW.
6. AIHW 2015b. The health and welfare of Australia’s Aboriginal and Torres Strait Islander peoples: 2015. Cat. no. IHW 147. Canberra: AIHW.

Last updated 27/08/2018 v13.0
© Australian Institute of Health and Welfare 2020
Health & functioning

Oral health & disease

The two main forms of oral disease are dental caries (tooth decay) and periodontal disease (a group of inflammatory diseases of the gum, connective tissue and dental bone) [1]. Oral disease also incorporates a number of other conditions, such as mouth ulcers, oral cancers, tooth impactions and misaligned teeth, and traumatic injuries to the teeth and mouth. However, oral health is a broader concept than simply the absence of disease—it covers the ability to eat, speak and socialise without discomfort or active disease in the teeth, mouth or gums [1].

Oral health

Since the 1970s, significant effort has gone into understanding the relationship between oral health and general health and wellbeing, which has expanded on the biomedical and clinical perspective to build a broader understanding of oral health-related quality of life [4, 8, 6]. Oral health can be affected by biomedical risks accumulated over a lifetime, as well as clinical conditions or age-related functional impairment, but oral health-related quality of life also considers its psychosocial aspects and impacts [5, 7].

Data sources and measures of oral health

In Australia, there are two main sources of information on the oral health of people aged 65 and over that capture some aspects of oral health-related quality of life. The National Survey of Adult Oral Health (NSAOH) collects comprehensive information from Australians aged 15 years and over, across all states and territories, through a combination of interviews and dental examinations. The first NSAOH was conducted in 1987-88 and the second (and most recent) was conducted in 2004-06. Results from this survey were presented in Older Australia at a glance (fourth edition) [3].

The second main source of information is the National Dental Telephone Interview Survey (NDTIS), which is conducted every 2 to 3 years and collects oral health and dental care information from a random sample of Australians aged 5 years and over. The first survey was run in 1994 and the most recent in 2013. The NDTIS uses a number of self-reported measures—such as those detailed in Table 1. These are rated in five categories (‘very often’, ‘often’, ‘sometimes’, ‘hardly ever’, and ‘never’) [1].

Toothache

In 2013, around 1 in 7 (16%) dentate people aged 15 years and over reported experiencing toothache—ranging from just under 1 in 10 (9%) people aged 65 and over (similar to 2010 findings in which 10% aged 65 and over reported experiencing toothache) to just over 2 in 10 for those aged 25-44 years [1, 2]. Older people who were not-insured were more likely to report experiencing toothache than those who were (10% compared to 8%) as were those older people eligible for public dental care compared with those who were not (9% and 8%, respectively). Household income also impacted the likelihood of older people reporting toothache, with those in the lowest annual household income bracket (<$30,000) being almost twice as likely to report experience toothache as those in the highest household annual income bracket ($140,000+) 11% compared with 6% (Table 1).

Dental appearance

In 2013, just over one-quarter (27%) of people aged 15 years and over reported that they felt uncomfortable with their dental appearance—ranging from 2 in 10 people aged 65 and over (22%, down from 24% in 2010) to 31% for those aged 45-64 [1, 2]. There was little difference for this measure across annual household income, insurance status or eligibility for public dental care—however, woman aged 65 and over were more likely to report feeling uncomfortable with their dental appearance than men (26% compared with 17%) and older people in Remote/Very remote areas were more likely to report feeling uncomfortable with their dental appearance than those in Major cities (37% compared with 21%) (Table 1).

Avoiding certain foods

In 2013, 20% of people aged 15 years and over reported avoiding eating some foods due to issues with their teeth—ranging from 15% of people aged 15-24 to 24% of those aged 65 and over (up from 19% in 2010) [1, 2]. For people aged 65 and over women were more likely to report avoiding certain foods due to issues with their teeth than men (26% compared with 20%) and those living in Major cities were much more likely to report avoiding certain foods than those in Remote/Very remote areas (24% compared with 9% (Table 1).

Table 1: Proportion (per cent) of people aged 65 and over, selected measures of oral health experienced in the last 12 months, by selected characteristics, 2013

<table>
<thead>
<tr>
<th></th>
<th>Experienced toothache(a)</th>
<th>Uncomfortable with appearance(b)</th>
<th>Avoided some foods(c)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Remoteness area</td>
</tr>
<tr>
<td>----------------------</td>
<td>-------</td>
<td>--------</td>
<td>-----------------</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>8.3</td>
<td>16.5</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>9.5</td>
<td>25.9</td>
<td></td>
</tr>
<tr>
<td><strong>Remoteness area</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major cities</td>
<td>9.4</td>
<td>21.0</td>
<td></td>
</tr>
<tr>
<td>Inner regional</td>
<td>4.7</td>
<td>22.9</td>
<td></td>
</tr>
<tr>
<td>Outer regional</td>
<td>13.3</td>
<td>21.8</td>
<td></td>
</tr>
<tr>
<td>Remote/Very remote</td>
<td>26.1</td>
<td>37.2</td>
<td></td>
</tr>
<tr>
<td><strong>Insurance status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insured</td>
<td>7.7</td>
<td>22.2</td>
<td></td>
</tr>
<tr>
<td>Uninsured</td>
<td>9.7</td>
<td>21.2</td>
<td></td>
</tr>
<tr>
<td><strong>Public dental care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eligible</td>
<td>9.3</td>
<td>22.4</td>
<td></td>
</tr>
<tr>
<td>Ineligible</td>
<td>8.0</td>
<td>20.0</td>
<td></td>
</tr>
<tr>
<td><strong>Annual household income</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;$30,000</td>
<td>10.5</td>
<td>23.1</td>
<td></td>
</tr>
<tr>
<td>$30,000–&lt;60,000</td>
<td>6.0</td>
<td>22.1</td>
<td></td>
</tr>
<tr>
<td>$60,000–&lt;90,000</td>
<td>9.3</td>
<td>24.7</td>
<td></td>
</tr>
<tr>
<td>$90,000–&lt;140,000</td>
<td>2.1</td>
<td>21.2</td>
<td></td>
</tr>
<tr>
<td>$140,000+</td>
<td>5.9</td>
<td>24.7</td>
<td></td>
</tr>
</tbody>
</table>

a. Toothache: people who responded with ‘very often’ or ‘often’ in the NDTIS when asked how often they experienced a toothache.
b. Uncomfortable with dental appearance: people who responded with ‘very often’ or ‘often’ in the NDTIS when asked how often they felt uncomfortable about the appearance of their teeth, mouth or dentures.
c. Avoiding foods due to oral problems: people who responded with ‘very often’ or ‘often’ in the NDTIS when asked how often they had to avoid eating some foods because of issues with their teeth, mouth or dentures.

Sources: AIHW [1].

The NDTIS also collects information on people’s perceptions about their need for dental treatment. In 2013, the most common perceived need for treatment was a dental check-up, with half (50%) of people aged 65 and over reporting this, followed by a scale and clean (44%), a denture (17%), and gum treatment (6%) [2].

For information on older people’s use of dental services, see Dental services.

**Oral conditions and diseases**

Although data on oral health-related quality of life is limited with respect to older Australians, research has identified oral conditions and diseases that have the greatest impact on older people’s day-to-day lives [5, 8]. This section explores the occurrence of some of these conditions as indicators of the oral health of older Australians.

**Missing teeth**

There are two main types of tooth loss—edentulism (having no natural teeth) and accumulated tooth loss (teeth are lost gradually over time) [8]. Edentulism can involve full or partial loss, full edentulism usually involves a decision to remove all remaining natural teeth (including some healthy teeth). Research has shown that removal decisions are often related to disease or social norms, and while edentulism can resolve persistent dental issues and discomfort, it is also associated with poorer quality of life, particularly in relation to nutritional and social health [5, 8].

In 2013, 1 in 5 (19%) people aged 65 and over had no natural teeth [1]. However, the rate of edentulism has been decreasing over time: for example, the proportion of people aged 75 and over who had lost all their teeth declined from 36% in 1987-88 to 28% in 2010 [2, 3].

In younger people, accumulated tooth loss is a strong predictor for poorer oral health-related quality of life. Research has also indicated that tooth loss over time is an ongoing issue for older people, and there is an association between missing teeth and age [5, 8], as well as missing teeth and oral health-related quality of life [4].
The average number of missing teeth for people aged 65 and over in 2013 was 10.8 (the number of missing teeth was derived from a self-reported number of natural teeth and includes all missing teeth, regardless of reason) [1]. On average, women had a slightly higher number of missing teeth than men (11, compared with 10.6), and the average number of missing teeth was also affected by a number of socio-demographic factors, particularly remoteness and income (Figure 1).

**Figure 1: Average number of missing teeth for people aged 65 and over, by selected factors, 2013**

Source: AIHW [1].

Older people living in Remote/Very remote areas had a higher average number of missing teeth (12.7) than those in Major cities (10.4). In addition, the average was higher for those without insurance than those with (12.8 and 8.9, respectively), those eligible for public dental care than those who were ineligible (11.8 and 8.6, respectively), and those living in households with an annual income below $30,000 than those with an annual household income of $140,000+ (12.3 missing teeth compared with 4.9) [1].

**Dental caries**

Dental caries (tooth decay) is the most commonly occurring dental condition. Dental plaque—a bacterial layer that forms on the tooth—causes the demineralisation of the structure, which results in decay [1]. In 2010, for dentate people aged 65 and over, tooth decay was the most commonly reported reason (44%) for a tooth extraction [2].

Dental caries experience in adults—represented by the term DMFT— is measured by the number of teeth (T) that are decayed (D), missing due to decay (M) and/or filled due to decay (F). For people aged 65 and over, missing teeth due to decay contributed the most towards their DMFT score (Table 2) [1].

**Table 2: Number of permanent teeth with caries, people aged 65 and over, 2004-2006**

<table>
<thead>
<tr>
<th>Decayed (D)</th>
<th>Missing (M)</th>
<th>Filled (F)</th>
<th>DMFT</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.4</td>
<td>12.9</td>
<td>10.4</td>
<td>23.7</td>
</tr>
</tbody>
</table>

Notes
1. Dentate people aged 65 years and over.
2. Total DMFT may not equal the sum of parts due to rounding.

Source: AIHW [2].

**Periodontitis**

Periodontitis (also known as gum disease or periodontal disease) is the inflammation of dental tissue and bone caused by bacteria. It can affect the connective tissue—particularly the gum and ligaments—and bone that support the tooth, and can develop ‘pockets’ or gaps between the tooth and surrounding gum. In severe cases, there can be extensive loss of tissue and bone, which can cause teeth to become loose or fall out [1].

Older people are at higher risk of periodontitis, and are more likely to experience advanced forms of the disease. This may be due to the accumulation of risk factors and longer-term exposure to periodontal bacteria—smoking, diabetes, obesity, osteoporosis, and heart disease all increase the risk of periodontitis, and the length of time a person is exposed to periodontal bacteria may increase the severity of the disease [5, 8]. According to the last National Survey of Adult Oral Health 2004-2006, 53.4% of people aged 65 and over had periodontal disease, compared with 2.7% of people aged 15-24. In 2010, for dentate people aged 65 and over [2].

**Potentially preventable hospital separations**

In Australia, oral conditions and diseases have considerable social and economic impact. In 2013-14, dental conditions were responsible for more than 8,000 hospital separations for people aged 65 and over, where the hospitalisation was considered potentially preventable. Although the number of potentially preventable hospital separations for older people due to dental conditions increased by 38% between 2007-08 and 2013-14, the separations rate only increased from 2.1 to 2.4 per 1,000 people aged 65 and over (Figure 2) [1].

**Figure 2: Rate of potentially preventable hospital separations due to dental conditions for people aged 65 and over, 2007-08 to 2013-14**
References

Last updated 7/08/2018 v10.0
© Australian Institute of Health and Welfare 2020
Health & aged care service use

Australia’s health and aged care systems are complex. There are many types of service providers and a variety of funding mechanisms. The Australian Government provides the majority of funding for health and aged care services in Australia; state and territory governments, insurers and individual Australians provide additional resources (see Australia’s health and Australia’s welfare).

Services in the health and aged care sector include those provided by medical practitioners, specialists, other health professionals, hospitals and clinics; respite and support services, transition services and community-based and residential aged care. Some of these services—and older Australians’ use of them—are described in this section.

| 3 in 10 | Medicare claims for unreferred general practitioner attendances were for people aged 65 and over |
| 1 in 10 | Medicare-subsidised services related to mental health were for people aged 65 and over |
| 1 in 5  | Emergency department presentations were for people aged 65 and over |

Last updated 7/08/2018 v6.0
© Australian Institute of Health and Welfare 2020
Health & aged care service use

Health care—GPs & specialists

General practitioners

The Australian Government’s funding contributions to health care include the universal public health insurance scheme, Medicare. Medicare provides access for all Australian residents to medical and hospital services, including to general practitioners (GPs), medical specialists and public hospitals.

In 2016–17, there were just under 38 million Medicare claims for unreferred GP attendances for people aged 65 and over—29% of the total 130 million claims for unreferred GP attendances [2]. There were more than twice as many claims per person for those aged 65 and over than for those aged under 65 (10.0 compared with 4.4 claims) [2].

Overall usage rates for people aged 65 and over grew only slightly between 2005–06 and 2016–17, but have increased more sharply in recent years among people aged 85 and over (Figure 1). By total number, this oldest age group accounted for 6.9 million Medicare claims for unreferred GP attendances in 2016–17 (5% of all unreferred GP attendances).

Medical specialists

There were 13.9 million specialist attendances claimed through Medicare in 2016–17 for people aged 65 and over (representing 45% of all specialist attendance claims) [2]. On average, people aged 65 and over made 4 times as many claims for specialist services as people aged under 65 (3.7 compared with 0.8 claims) [2].

Age-specific usage rates rose in the 10 years to 2016–17, particularly among people aged 75-84, and 85 and over (Figure 2).
Figure 2: Age-specific usage rates for specialist attendances, 2009–10 to 2016–17

Source: ABS [1], DHS [2]

References
Health & aged care service use

Health care—hospitals

Use of emergency departments

In 2016–17, there were 1.6 million emergency department (ED) presentations among people aged 65 and over—around one-fifth of the total 7.8 million presentations. In that year, people aged 85 and over accounted for almost 1 in 4 (23%) of all presentations for people aged 65 and over.

The 3 most common diagnoses that were recorded for ED presentations varied by age group (Figure 1). For presentations among people aged between 65–84, ‘Pain in throat and chest’ were the most common diagnoses recorded; for presentations among those aged 85 and over, ‘Other symptoms and signs involving the nervous and musculoskeletal systems’ was the most common diagnosis.

Figure 1: Five most common diagnoses for people aged 65 and over presenting at emergency departments, by age group, 2016–17

<table>
<thead>
<tr>
<th>1st</th>
<th>75-84</th>
<th>85+</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st</td>
<td>Pain in throat and chest</td>
<td>Other symptoms and signs involving the nervous and musculoskeletal systems</td>
</tr>
<tr>
<td>2nd</td>
<td>Abdominal and pelvic pain</td>
<td>Abdominal and pelvic pain</td>
</tr>
<tr>
<td>3rd</td>
<td>Inner layer skin infection</td>
<td>Fainting</td>
</tr>
<tr>
<td>4th</td>
<td>Other chronic obstructive pulmonary disease</td>
<td>Pneumonia</td>
</tr>
<tr>
<td>5th</td>
<td>Back or spine pain</td>
<td>Other disorders of urinary system</td>
</tr>
</tbody>
</table>


Hospitalisations

In 2016–17, people aged 65 and over accounted for 2.8 million same-day hospitalisations (42% of the total 6.6 million) and 1.8 million overnight hospitalisations (41% of the total 4.4 million).

The main reason that older people experienced a same-day hospitalisation in 2016–17 was for ‘Care involving dialysis’. For overnight hospitalisations, the most common principal diagnoses among people aged 65 and over was ‘Other chronic obstructive pulmonary disease’.

In 2016–17, acute care (medical, surgical and other acute care) was the most common broad type of care older people received in hospital (90%), followed by rehabilitation (7%).

Most older people are discharged to their place of usual residence on leaving hospital. However, sometimes older people enter residential aged care after a period of hospitalisation. Excluding those whose usual place of residence was residential aged care, less than 2% of hospital separations (76,200 in 2016–17) for older people were to residential aged care.
Health & aged care service use

Mental health

Good mental health is a key factor associated with healthy ageing, and this is determined by a combination of psychological, biological and/or social and cultural factors [4]. While the prevalence of mental health disorders tends to decrease with age [1], there are certain sub-groups of the older population that are at higher risk. These groups include people in hospital, supported accommodation, people with dementia, and older carers [3]. Good access to effective clinical and non-clinical services can help support older people with their mental health.

Mental health services

Older Australians access services to support their mental health needs through a number of pathways, including: hospital and community-based services, emergency departments, GPs, medical specialists and/or allied health professionals. Due to the diversity of mental health support services available; there is no single, overarching data collection which can be used to report on the mental health care being received by older Australians.

In 2016–17, people aged 65 and over received 950,000 Medicare-subsidised mental health related services. These services represented 9% of the total 11 million mental health-related services subsidised by Medicare in that year [2]. GPs, psychologists and psychiatrists provided a similar proportion of the mental health-related services received by people aged 65 and over (Figure 1).

In 2015–16, there were 46,500 hospital separations for Australians aged 65 and over that had overnight admitted mental health-related care (representing 19% of all mental health related separations). For two-thirds (67%) of these separations, the patient had not received any specialised care within a psychiatric unit or ward, compared with 36% for mental health-related separations for all ages [2]. For community mental health services during the same period, older people accounted for 779,000 service contacts (8% of the total) [2].

References

Health & aged care service use

Aged care

The Australian aged care system delivers services through a range of provider and care types within community-based and residential settings. This section is limited to discussion of the mainstream residential and community-based aged care programs. For more information on aged care in Australia, see GEN aged care data.

Community-based aged care

Commonwealth Home Support Programme

The Commonwealth Home Support Programme (CHSP) provides a basic level of aged care services to support continued independence for people aged 65 and over living at home and their carers. It incorporated the Commonwealth Home and Community Care (HACC) program on its launch in 2015, although HACC will continue in Western Australia until 2018. In 2016–17, more than 720,000 people aged 65 and over received home support services (CHSP and HACC in WA) [1].

Home Care Packages Programme

The Home Care Packages Programme (Home Care) assists frail older people to remain at home for longer. In 2017, the Australian Government introduced the Increasing Choice in Home Care reforms. These reforms aimed to change Home Care to a more consumer-driven system, whereby places are allocated to individuals based on demand, and providers are better able to expand to meet this changing local demand. Between 30 June 2016 and 30 June 2017, the number of operational approved providers had increased by 41.5% [1].

At 30 June 2017, there were around 71,400 Home Care recipients, and the majority (68%) were receiving care at Levels 1-2 (basic–moderate care needs). Home Care recipients were likely to be aged 65 and over (97%), with the average age at admission into Home Care at 80.2 [2]. The number of Home Care recipients has increased by 84% over the last 10 years, reflecting an increasing preference by older Australians to age in place, and increased capacity of the system to deliver community-based care.

Figure 1: Home Care recipients, by age and year, 2007–2017


Box 1: Home Care Packages Programme

The Home Care Packages Programme (Home Care) replaced the three community packaged aged care programs in place before August 2013. It offers four levels of care (with levels 1 and 3 being available only to new clients from 1 August 2013). The translations to Home Care were:

- CACPs translated to Home Care level 2
- Extended Aged Care at Home (EACH) packages translated to Home Care level 4
- Extended Aged Care at Home Dementia (EACHD) Packages also translated to Home Care level 4.

Further information on Home Care is available on the AIHW GEN aged care data website.
Residential aged care

Residential aged care provides:

- permanent accommodation and care for people who can no longer live at home due to increased care needs (permanent residential aged care)
- short-term accommodation and care for people who (or whose carers) need a break from their normal living arrangements (respite residential aged care).

In 2016–17, almost all (97%) people in either type of residential aged care were aged 65 and over: some 232,000 of these people used permanent residential aged care and some 57,500 used respite residential aged care [2].

The capacity of the residential aged care sector has been gradually expanding: the overall number of operational places available in residential aged care rose from 167,000 at 30 June 2007 to 201,000 in 2017 (an increase of 17%). Over the same period, the number of people in permanent residential aged care at 30 June rose from 153,000 to 179,000 (an increase of 17%) [2].

The Aged Care Funding Instrument (ACFI) is used to assess people in permanent residential aged care for care needs that affect the cost of care delivery. The ACFI measures care needs across three different areas of care — ‘activities of daily living’, ‘cognition and behaviour’, and ‘complex health care’. The proportion with people with a ‘high’ care needs assessment has increased over time for every care domain, except for a reduction in the complex health care domain in 2017 (Figure 2).

Figure 2: Care need ratings of people in residential aged care, by care domain, 2009–2017

![Care need ratings graph](source)


References


Last updated 7/08/2018 v10.0
© Australian Institute of Health and Welfare 2020
Health & aged care service use

Aged care assessments

Before people are able to access most government-funded aged care services, they undergo an assessment. Aged Care Assessment Teams (ACAT) conduct assessments in line with the government’s Aged Care Assessment Program (ACAP) guidelines and relevant legislation, and approve people for entry into the aged care programs that operate under the Aged Care Act 1997—these are residential aged care (permanent or respite), Home Care and Transition Care. The Commonwealth Home Support Program is accessed through a Regional Assessment Service.

At 30 June 2016, 80 ACATs operated across Australia. The teams are based in hospitals or in the local community, and they are generally made up of—or consult with—a range of health professionals. There are no age limits to assessments, as ACATs carry out comprehensive assessments of people’s circumstances and care needs, and identify the most appropriate ongoing supports.

For more information, see Accessing aged care services. Information on assessments undertaken in permanent residential aged care is available through Care needs in residential aged care.

People assessed

In 2014–15, over 167,000 people had at least one completed ACAT assessment, almost all of whom were aged 65 years and over (96%) [1].

Characteristics of people with a completed ACAT assessment 2014–15 (at most recent assessment)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Half (50%) were aged between 65 and 84 and almost half (46%) were aged 85 and over</td>
<td></td>
</tr>
<tr>
<td>3 in 5 (60%) were women</td>
<td></td>
</tr>
<tr>
<td>1.4% were Indigenous</td>
<td></td>
</tr>
<tr>
<td>1 in 3 (33%) were born overseas, with non-English speaking countries of birth accounting for over three-fifths (63%) of this</td>
<td></td>
</tr>
<tr>
<td>More than 2 in 5 (44%) had a co-resident carer, most commonly their spouse or partner</td>
<td></td>
</tr>
<tr>
<td>Around 1 in 10 (11%) had a DVA entitlement (such as a health card)</td>
<td></td>
</tr>
</tbody>
</table>

People’s living arrangements at the time of assessment varied. More than 8 in 10 (86%) people were usually living in a private residence at the time of their assessment. For 11%, their usual residence was a retirement village—includes persons living in self-care or independent-living units within a retirement village. Overall, 2 in 5 (45%) people lived alone, and the likelihood increased with age—39% of people aged 65-74, 40% of 75-84, and 51% of those aged 85 and over lived alone. Women were also more likely to live alone (53%, compared with 34% of men) [1]. The 6 most common main health conditions recorded on assessment were dementia (15%), musculoskeletal disorders (8%), injuries (8%), cancer (8%), cerebrovascular disease (6%, primarily stroke), and nervous system disorders (6%). Among these broader groupings, some specific conditions were common—arthritis was the most frequent musculoskeletal disorder, fractures the most common injury, lung cancer the most frequently specified type of cancer, and Parkinson’s disease accounted for the majority of nervous system disorders [1].

Assessments

There were around 182,000 completed ACAT assessments in 2014–15—some people may receive more than one assessment in a year. Around 44% of ACAT assessments were completed within 1 week of a referral being received. On average, for ACAT assessments completed during that year, it took almost 18 days from the day the referral for assessment was received to its completion [1].
Activity limitations

ACAT assessments are a comprehensive assessment of a person’s physical, medical, psychological and social needs, and they identify whether people have activity limitations in 10 specific activities (self-care, movement, moving around, communication, health care tasks, transport, social or community participation, domestic duties, meal preparation and home maintenance). Almost all completed ACAT assessments identified limitations that required the help or support of another person in more than one of these activities—there were only 1,955 (1.1%) assessments where the person was assessed as having no limitation in any activity. Most commonly, assessments identified activity limitations in domestic duties (95% of all completed ACAT assessments), transport for getting to and from places (90%) and social or community participation (88%) [1].

Recommendations for the future

ACAT assessments make recommendations regarding future needs and support services. This includes recommendations for assistance for specific activity limitations, and for specific government aged care programs or supports, as well as recommending the most appropriate long-term care setting for the person assessed.

The majority of completed assessments recommended private residence or residential aged care as the most appropriate settings (Figure 1). The majority (86%) of completed ACAT assessments were undertaken for people who usually lived in a private residence, and for more than half of these (56%) a private residence was recommended as the most appropriate long-term care setting, while for most of the remainder residential aged care was recommended (29%). (Figure 1).

Figure 1: ACAT assessment outcomes, recommended long-term care setting by usual accommodation setting, 2014-15

Notes

1. ‘Usual accommodation setting’ refers to where the person usually lived at the time of assessment, while ‘long-term care setting’ indicates the living environment ACAT assessment considered to be the most appropriate for the person’s long-term care needs.

2. The figure shows completed ACAT assessments by combinations of usual accommodation setting and recommended long-term care setting.

Source: NACDC [1].

Approvals for residential aged care

In addition to recommendations for formal support from specific government-funded aged care programs, ACAT assessments provide the required approval for accessing these services, such as permanent or respite residential aged care. It is possible that an individual can have a recommendation and approval for different services—for example an individual may have an approval for permanent residential aged care (as it is likely they will require this in the future) but they are currently still being recommended to live at home.

More than 98% of completed assessments resulted in approval for at least one aged care program—there were just 2,452 (1.4%) completed assessments with no approval for any program—and approvals for more than one program were common. Overall, more than two-thirds of completed ACAT assessments in 2014-15 concluded with approval for either respite or permanent residential aged care (75% and 67% respectively). Combined, approval was given for both permanent and respite residential aged care in 59% of completed assessments [1].

References

1. National Aged Care Data Clearinghouse (NACDC) 2016. AIHW analysis of unpublished ACAP data.
Health & aged care service use

Dental services

Dental services are provided to improve oral health and reduce disease. As more people are retaining more of their teeth into old age, this is also likely to increase older people’s need for dental services [9]. For example, in 2013, 42% of people aged 65 and over who had some natural teeth also wore dentures [5].

For more information on the oral health of older Australians, see Oral health and disease.

Use of dental services

Dental services are commonly delivered by dental practitioners (such as dentists and dental surgeons), and range from routine and preventive care to treatment of dental problems and emergencies.

In 2013, around 6 in 10 adults aged 15 and over reported visiting a dentist in the last 12 months. This ranged from 55% of those aged 25–44 years to 7 in 10 (70%) of those aged 65 and over (up from 60% of older people in 1994) [3, 5].

Table 1: Average number of dental services received, people aged 65 and over, by type of service, 1994, 1999, 2002, 2008, 2010 and 2013 (a)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Extraction</td>
<td>0.17</td>
<td>0.36</td>
<td>0.27</td>
<td>0.28</td>
<td>0.36</td>
<td>0.32</td>
</tr>
<tr>
<td>Filling</td>
<td>0.93</td>
<td>0.85</td>
<td>1.00</td>
<td>0.88</td>
<td>0.80</td>
<td>0.80</td>
</tr>
<tr>
<td>Scale and clean</td>
<td>0.95</td>
<td>1.12</td>
<td>0.99</td>
<td>1.00</td>
<td>1.09</td>
<td>1.18</td>
</tr>
<tr>
<td>Number of visits</td>
<td>2.34</td>
<td>2.37</td>
<td>2.32</td>
<td>2.39</td>
<td>2.55</td>
<td>2.58</td>
</tr>
</tbody>
</table>

(a) Dentate people whose last dental visit was in the last 12 months.

Sources: National Dental Telephone Interview Surveys [1, 2, 3, 4, 5, 7].

In 2013, the dental visiting pattern could be described as ‘favourable’ (visiting a dentist once or more per year and having a usual dental provider) for almost half (48%) of people aged 65 and over who had any natural teeth (dentate people). For their most recent visit, 53% of older dentate people reported check-up as the reason [5]. When people’s reason for last visiting a dentist was a dental problem instead, their average number of visits was higher.

The ABS 2012 Survey of Disability, Ageing and Carers (SDAC) also collected people’s self-reported use of dental services and experiences of services received for those aged 65 and over (the survey was carried out more recently in 2015, but this iteration restricted these questions to only those people aged 65 and over who were identified as having a disability—in the 2012 survey, these questions applied to all older people, but other differences in methodology may account for the differences reported here compared with the proportions reported for the National Dental Telephone Interview Survey). The 2012 SDAC found that around half of men (51%) and women (52%) aged 65 and over reported having visited a dental professional (dentist, dental hygienist or dental specialist) in the last 12 months, and the proportions decreased with age for both genders (Figure 1). Overall, 51% of older people had seen a dental professional in the previous year [8].

Figure 1: Proportion of people who had seen a dental professional in the last 12 months, by sex and age group, 2012

Source: AIHW analysis of ABS 2012 Survey of Disability, Ageing and Carers data. Findings based on use of ABS TableBuilder data [8].

Dental service settings
In Australia, the majority of dentists (85% in 2013) work in the private sector as general dental practitioners—specialist dentists made up only 10% of registered dentists [5]. Dental services are also delivered in hospitals, and around 5% of registered dentists were employed in hospitals in 2013 [5].

According to the SDAC, among people who had used dental services in the last 12 months in 2012, 1 in 10 (12%) people aged 65 and over had received public dental care [8].

The proportion of older people whose last visit had been to a public dental clinic also varied by sex and age group (Figure 2)—overall, women were slightly more likely to report receiving public dental care in the last 12 months (12%) than men (11%), with this pattern more evident in some age groups than others [8].

Figure 2: Proportion of older people who had received public dental care in the last 12 months, by sex and age group, 2012

![Graph showing the proportion of older people receiving public dental care by sex and age group.]

(a) People who had seen any dental professional in the last 12 months and last received care through a public dental clinic.

Source: AIHW analysis of the ABS 2015 Survey of Disability, Ageing and Carers data. Findings based on use of ABS TableBuilder data [8].

Cost of dental services

The cost of dental services is frequently reported as a barrier to accessing services—in 2013, 29% of people aged 65 and over whose annual household income was below $30,000 reported avoiding or delaying dentist visits, compared with just 14% of people whose household income was $60,000–$90,000. Similarly, 32% of people aged 65 and over who had no insurance cover for dental services reported avoiding seeing a dentist—among people with insurance, the proportion was half of this (15%). Overall, more than half (51%) of older people with teeth, and one-quarter (25%) of older people without any teeth, had insurance cover for dental services in 2013 [5].

Publicly-funded dental care is targeted towards low-income groups, with aged pensioners and unemployed people eligible for services at minimal or no cost to the patient. However, public dental clinics may not routinely offer a full range of services, such as preventative dental care. Wait times for services, and their availability, can also be problematic and lead to poorer outcomes for people [5, 10].

References


Last updated 7/08/2018 v8.0
© Australian Institute of Health and Welfare 2020
Notes

Amendments

27 Sep 2018 · Change to the wording of the 'People at risk of homelessness' chapter and references.

26 Jul 2019 · The edition of this report released on 10 September 2018, stated on the Culturally and linguistically diverse people page under Demographics of older Australians ‘Older Australia is made up of people from different cultural and linguistic backgrounds. In 2016, just over 3 in 10 (33%) people aged 65 and over were born overseas, up from 25% in 1981’.

The method of producing the proportion ‘33% of people aged 65 and over were born overseas’ was inconsistent with the method used for producing this statistic on the Culturally and linguistically diverse people page under the Diverse groups of older Australians, which states ‘In 2016, 37% of people aged 65 and over were born overseas’. This is due to the inclusion of the not stated population in the denominator for the first statistic. Excluding the not stated population aligns the first statistic with the method used throughout the report and what is reported by the ABS.

Last updated 28/07/2020 v2.0
© Australian Institute of Health and Welfare 2020
In 2016, 3.7 million people were older Australians aged 65 and over. 67% of these people did not use aged care services, 76% owned their own home, 72% reported good or better health, 93% didn't smoke and 41% were still sufficiently active.

Download Infographic: Older Australia at a glance 2016. Format: PDF 345Kb PDF 345Kb Get text alternative of Infographic: Older Australia at a glance 2016. Format: TXT 1Kb TXT 1Kb