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Pathways in aged care: do people follow recommendations?

Summary

Before people can access key aged care programs, they need to obtain approval for program eligibility from an Aged Care Assessment Team (ACAT). The assessment teams also make recommendations on the preferred setting for receiving care; that is, in the person's home or in a residential care facility with either a low or high level of care. The purpose of this bulletin is to look at care pathways of older Australians through the aged care system for 2 years following their first assessment for such services. Care pathways are analysed according to the long-term care setting recommended by the ACAT.

The bulletin uses data from the Pathways in Aged Care project, which links 2003–04 ACAT data to data sets showing use of five main aged care programs and deaths. Analysis concentrates on the cohort of 34,400 people who had an ACAT assessment in 2003–04, and who had not previously used aged care services.

The main findings are:

- Overall, and as expected, people with different long-term care setting recommendations tended to have different patterns of program use.
- Recommendations by ACATs were not always followed, and there was considerable variation in the type of programs accessed and the timing of this use within recommendation group.

(summary continued overleaf)

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- One-quarter of ACAT clients—including some recommended to live in residential care—did not use aged care services in the 2 years after assessment, with only a small proportion dying shortly after assessment.
- Rates of transition into permanent residential care varied with the use of community care and residential respite care.
- Among those recommended to live in residential care, people who used neither community nor respite care services after assessment, or only residential respite care, were initially more likely to enter permanent residential care than others. People who used community care but not residential respite care were least likely to enter permanent care within 2 years of assessment.

Results suggest that use of community care delays entry into permanent residential care. For example, for people recommended to live in low-level residential aged care:

- 43% of those who had used both residential respite and community care had accessed permanent residential aged care within 12 months
- A similar proportion (46%) of those who had used neither residential respite nor community care had accessed permanent residential aged care within only 3 months.

Results also suggest that timing of the use of community care is important in delaying entry.

Further analysis is currently being done to assess the relationships between use of care services over time and client demographic and health characteristics.

Introduction

Over the past 30 years, the focus of aged care has moved from predominantly residential aged care to include a wide range of community care services (AIHW 2001, 2007). The main role of community-based care services is to provide assistance to people so that they can continue to live in their own home (AIHW 2007: Chapter 3; Bruen 2005; DoHA 2009; DVA 2010). That is, the underlying premise of promoting the use of community care is to reduce people's lifetime use of residential care (Howe et al. 2006).

To understand how people use the mix of community and residential services that are available, a knowledge of transition patterns into community care, into residential care and between community care and residential care is vital. Importantly, the care needs of people can vary considerably when they first seek assistance from a government program, and so even at this early stage different people require different services—from limited assistance in a community care program to high-level care in a residential facility.

For a person to be able to access residential aged care and packaged community care programs, an Aged Care Assessment Team (ACAT) from the Aged Care Assessment Program (ACAP) must approve it. The assessment team also makes recommendations on the preferred setting for receiving care; that is, in the person's home or in a residential

care facility. Previous analysis has shown that people do not always use the programs for which they are approved (AIHW 2010), nor do they necessarily follow the care setting recommendation (AIHW 2011: tables 4.2 & A.23).

This bulletin looks at the relationship between recommended care setting and the use of aged care services by looking at people's care use pathways in the 2 years following their first assessment for aged care services. The analysis uses a cohort of 34,400 older people living in the community from across Australia who had an aged care assessment in 2003–04, and who had not previously used aged care services. By limiting the analysis to those who had not previously used aged care programs, we focus on people who were considering using aged care services, or people for whom medical or care professionals believed that additional care may be warranted. Differences in care pathways are looked at according to the long-term care setting recommended at the time of assessment. To allow a more concise view of the relationship between community care and residential care, the various community-based care programs included in the study are considered as a block.

Cohort data

Pathway data

Data for this analysis are from the Pathways in Aged Care (PIAC) project, which linked 2003–04 ACAP data for a cohort of 105,077 Australians to aged care program administrative data sets for 2002–03 to 2005–06 (AIHW 2009b; Karmel et al. 2010). The cohort was also linked to the National Deaths Index to find deaths before 1 July 2006. The PIAC data allow investigation of community and residential care pathways for all cohort members for 24 months following the completion of an ACAT assessment in 2003–04.

The service delivery programs included in PIAC are permanent and respite residential aged care and four key community aged care programs: Home and Community Care, Community Aged Care Packages, Extended Aged Care at Home packages (including Extended Aged Care at Home Dementia packages) and Veterans' Home Care (AIHW 2007: Chapter 3; see also AIHW 2009a: Chapter 3 for a brief description of the programs). A more detailed description of the PIAC cohort study is given in AIHW 2009b and AIHW 2011; the linkage strategy is described in Karmel et al. 2010. Before linkage and analysis were carried out, ethics approval and permission to use the required data were obtained from all relevant bodies.

The linked data provide a broad platform to analyse aged care pathways. Note, however, it is estimated that 15% to 20% of the study cohort may have had an earlier assessment that could not be identified, as client-level assessment data were not available before 1 July 2003. Reporting practices by ACATs may also be inconsistent (see AIHW 2011: Appendix B and ACAP NDR 2006).

Role of ACAT assessments

Before community care packages (that is, Community Aged Care Packages, Extended Aged Care at Home packages, and Extended Aged Care at Home Dementia packages) or residential aged care can be used, the relevant approval has to be obtained from an ACAP Aged Care Assessment Team. Although the target group for ACAP is older people, access to the program is neither age limited nor means tested. People can self-refer for an assessment, or be referred by medical or care professionals. A completed ACAT assessment results in recommendations for the client's long-term care setting and program support, and may include approval to use residential aged care or packaged care. Recommendations to use Home and Community Care or Veterans' Home Care can also be made; however, these programs each have their own assessment process, and an ACAT approval or referral is not required to access them.

ACATs can recommend that a person continue to live in the community, in low-level residential care or in high-level residential care, including a very small proportion recommended to live in other institutional care (AIHW 2010: Table 1.1). The recommended long-term care setting summarises the ability a person has to remain living at home. Only one long-term care setting can be recommended, but clients can be approved to use more than one type of care.

If the assessor and the client do not agree on the outcome of an assessment, given that eligibility criteria are met, approvals may reflect the client's view, whereas recommendations reflect the assessor's. Once approval is granted, accessing the services is subject to availability of places and client preferences. During the period covered by the PIAC data (2002–03 to 2005–06), approvals from ACAT assessments for all programs remained valid for 12 months. Reassessment within the 12-month period may have occurred for various reasons. In particular, people who wanted to make sure that they had continuous access to residential respite care would have needed to have a further assessment within the original 12-month approval period. More generally, changes in client attitude or health and social circumstances may have resulted in a new ACAT assessment within a 12-month period. Note that changes from 1 July 2009 meant that approvals for residential respite care, high-level residential care, Extended Aged Care at Home packages, and Extended Aged Care at Home Dementia packages no longer lapse unless specified as time limited by the ACAT (DoHA 2009).

Assessment data

As well as approvals for program use and care setting recommendations, ACAP data record the client's social circumstances, up to 10 types of care needs, and up to 10 health conditions affecting care needs at the time of assessment (AIHW 2002). For reported care needs, in this analysis two 5-point dependency scales were constructed that broadly correspond to activities of daily living (ADLs: self-care, movement, moving around, communication and health care) and instrumental activities of daily living (IADLs: transport, community participation, domestic assistance, meals and home maintenance) (ACAP NDR 2006).

Analysis in this bulletin uses the first 2003–04 ACAT assessment as the reference assessment, and investigations by client characteristics relate to those reported at that assessment. Care pathways are also measured from this point.

Cohort characteristics

To focus on the beginning of the care pathway, analysis was restricted to 34,400 PIAC cohort members who had not previously used aged care services (that is, established as having no service use for 12 months before their first 2003–04 ACAT assessment). This cohort was 59% female, and the average age was 79.6 years at the time of the client's first ACAT assessment in 2003–04 (Table 1). Three-quarters of the cohort had a carer, with the majority of these living with them. Carers were most commonly the client's child or spouse. Nearly 60% of the cohort lived with family, and 37% lived alone. Almost 70% lived in their own home and 14% lived in rental accommodation—predominantly public housing.

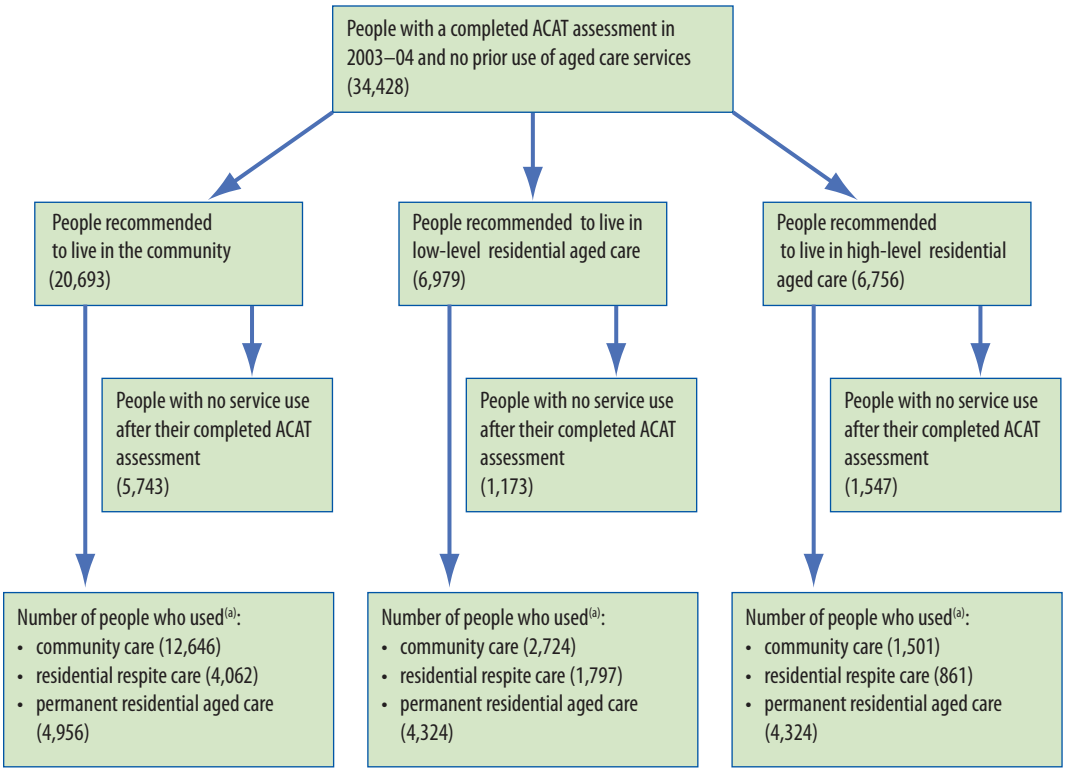
Overall, 29% of the cohort were in hospital at the time of their first assessment in 2003–04, and 36% had a second assessment before 30 July 2005 (Table 2). The average number of health conditions reported for a cohort member was 3.3, with 80% reporting more than one condition affecting care needs. Circulatory problems were highly prevalent (57%), as were musculoskeletal conditions (37%) and mental health conditions (37%, including 26% with dementia) (Table 3). At the first assessment, the cohort averaged 3.4 IADL limitations resulting from these health conditions, and 1.9 ADL limitations (Table 2).

Overview of care pathways

The purpose of this bulletin is to look at care pathways of older Australians for the 2 years following their first completed ACAT assessment in 2003–04. Care pathways are analysed according to the long-term care setting recommended by the ACAT. After the completed ACAT assessment, depending on the ACAT assessment approvals received, a person may have used any combination of:

- community care
- residential respite care
- permanent residential aged care.

Alternatively, a person may have not used any programs after the ACAT assessment. These pathways are illustrated in Figure 1.



(a) After a completed ACAT assessment a person may use community care, permanent residential aged care and/or residential respite care, depending on the ACAT assessment approvals received.

Figure 1: Pathways of people moving through the aged care system for 2 years following their completed ACAT assessment in 2003–04.

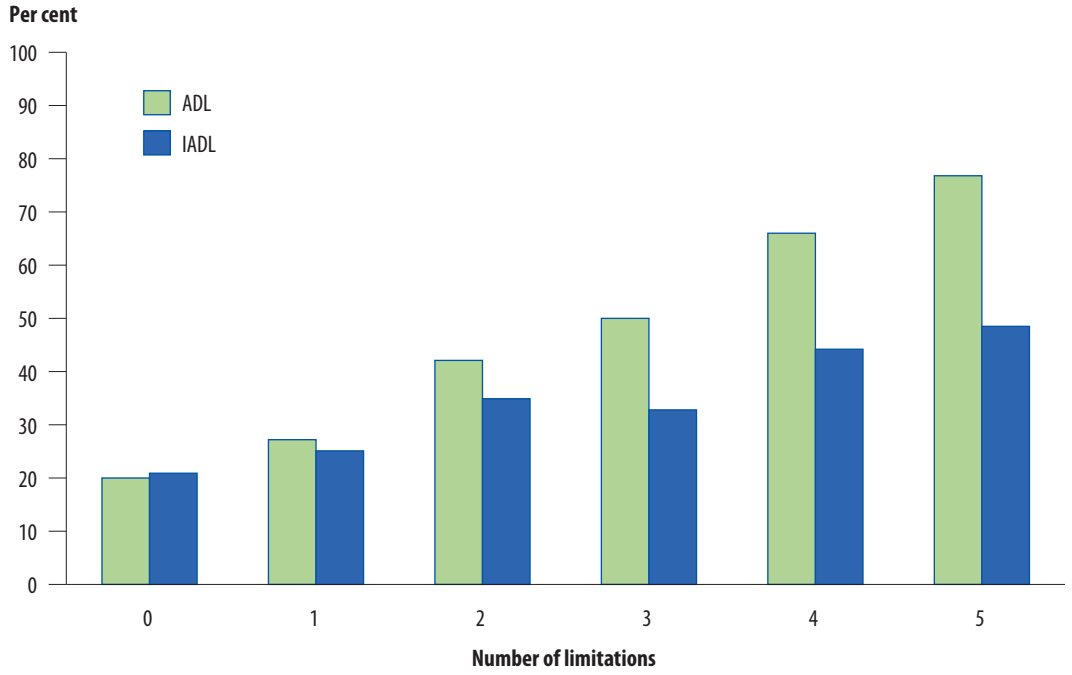
Results

Before looking at program use in detail, the characteristics of people with different recommended care settings are described. The use of community and residential care programs, and the time to key program use events are then looked at, focusing on differences between people with different recommendations for long-term care setting.

ACAT recommendations

Overall, 60% of the cohort were recommended to live in the community in the long term and 40% in residential aged care, with almost an even split between low-level and high-level residential care (Table 1). People who were more likely than others to be recommended to live in residential aged care were: those aged 85 years and over (47%); people living with non-relatives (57%) or without a co-resident carer (44%); and those who lived in retirement villages or supported accommodation (55%).

As expected, as a person's number of activity limitations increased so too did the likelihood of being recommended to live in residential aged care, with the association between the number of ADLs and recommendation for residential care being particularly pronounced (Figure 2). Assessment in hospital was also associated with a recommendation to live in residential care (70%) (Table 2). Mental health, cerebrovascular and genitourinary conditions and neoplasms were associated with relatively high proportions recommended to live in residential aged care—all above 45% (Table 3). People with an additional assessment were more likely to have been originally recommended to live in the community than those without a reassessment (69%compared with 55%). This is not surprising as people would have been reassessed if their care needs or attitudes changed to the extent that approvals for a different type of care were needed, or if they wanted to maintain access to residential respite care.



Source: Table 2.

Figure 2: Percentage of cohort recommended to live long term in residential care, by number of activity limitations affecting care needs

The split of recommendations between low-level and high-level care varied considerably with the social circumstances of the client (Table 1). Living alone at the time of the reference assessment, having a non-resident carer, and private rental or living in a retirement village were all associated with increased likelihood of being recommended to low-level—rather than high-level—residential care. On the other hand, having a co-resident carer (especially spouse) was associated with a recommendation for high-level care.

Health status was also important. The proportion recommended to live in high-level care—as opposed to low-level care—increased with the number of activity limitations

reported, from 6% (compared with 14% recommended for low-level care) for people with 0–3 limitations to 47% (compared with 15%) for people with 8–10 limitations (ADLs + IADLs, Table 2). Also, 47% of people assessed in hospital were recommended for high-level residential aged care, compared with 23% recommended for low-level care. Health conditions associated with relatively high proportions being recommended to live in high-level residential care included neoplasms, nervous system and genitourinary conditions, cerebrovascular disease and injuries. On the other hand, when reported, non-dementia mental health conditions and eye, ear, digestive and musculoskeletal conditions were associated with recommendation for low-level residential care (Table 3).

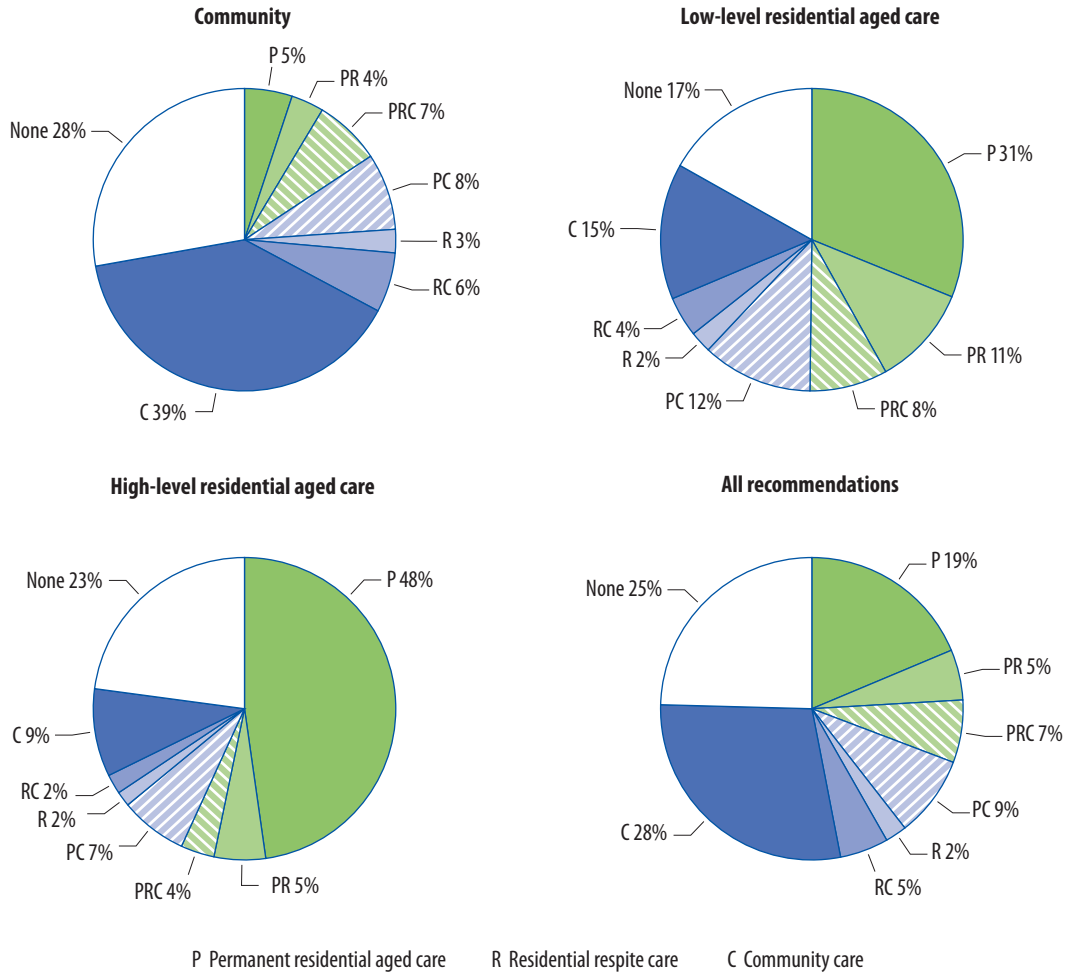
Program use

Program use over the 2-year period varied considerably among the cohort, from no use of any programs (25%) to use of all those in the study (7% used community care, residential respite care and permanent residential aged care). This diversity was seen across all recommendation groups; however, the proportions using the various program combinations varied.

Nearly 50% of the cohort used a community care program within 2 years of the end of their first assessment, 40% used permanent residential aged care and 20% used residential respite care (Table 4). Among those who accessed programs, more than one-quarter (21% out of 75%) used both community and residential aged care services. One-quarter of the cohort (26%) died within the study period (Table 4).

As would be expected, program use varied with recommended care setting (Figure 3; Table 4). People recommended to live long term in residential aged care were more likely than others to use permanent residential aged care: more than 60% of these people accessed permanent residential care at some stage compared with 24% of those recommended to live in the community. Similarly, 61% of people recommended to live in the community used community care programs, while 22% of those recommended to live in high-level residential aged care also accessed these programs. Residential respite care was most commonly used by people recommended to live in low-level residential aged care (26% compared with 20% of those recommended to live in the community).

Very different death rates were seen in the recommendation groups (Table 4). At 48% in 2 years, the death rate was more than twice as high for those recommended to live in high-level residential aged care as for others.



Source: Table 4.

Figure 3: Combinations of aged care programs used within 2 years of first assessment, by long-term care setting recommendation (percentage within recommendation)

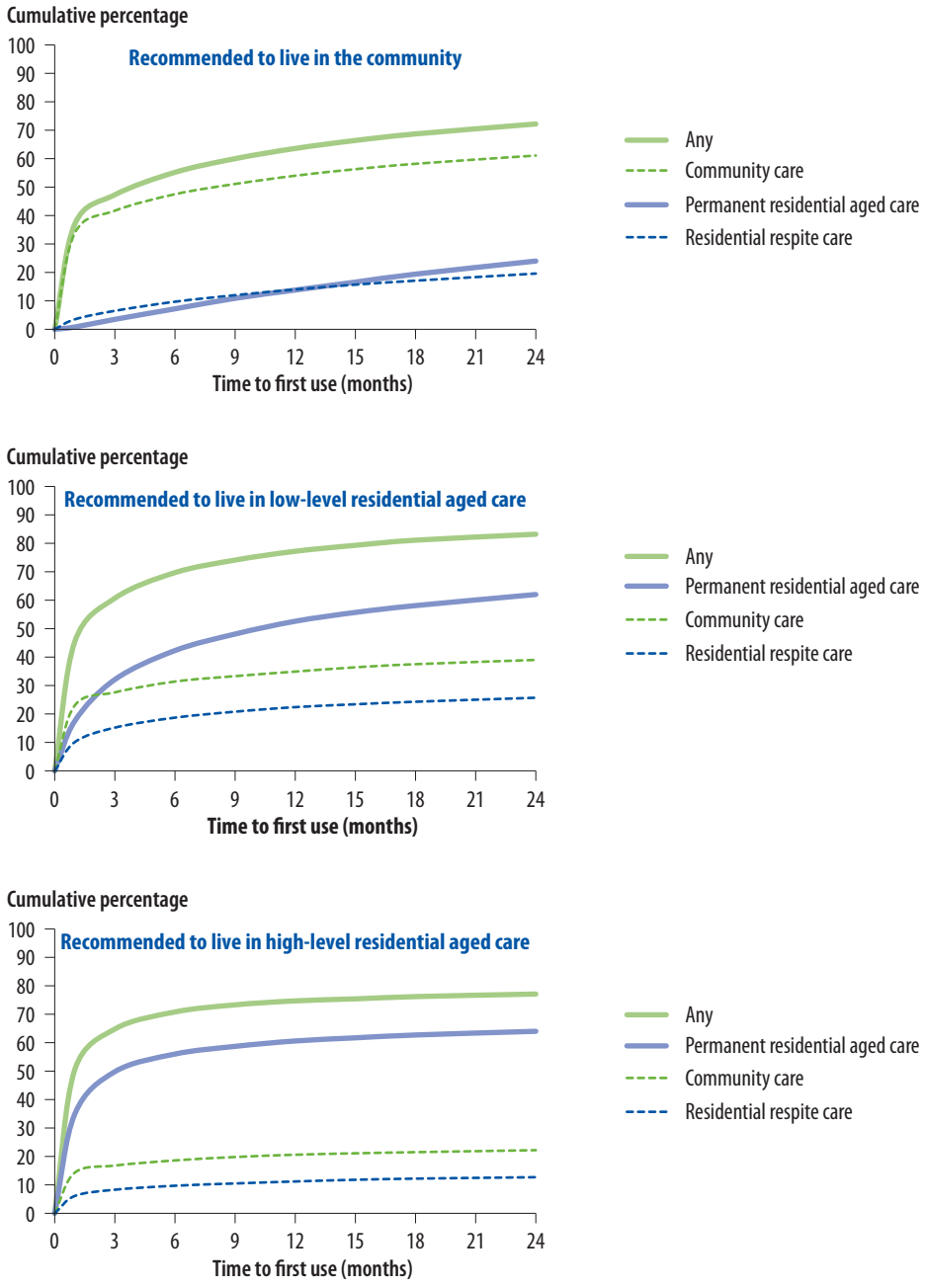
Time to program use

By recommendation

Overall, within 1 month of their first assessment 41% of the cohort had used at least one care program, and 3% had died (Table 5). The time to take up of care, and the type of care used, varied with the care setting recommended (Figure 4). Of people recommended to live in the community, 37% had accessed a care program within 1 month compared with more than 45% of those recommended to live in residential aged care. Within 6 months of assessment, 55% of people with a community recommendation and 70% with a residential aged care recommendation had used at least one care program.

As expected, among people who accessed services within 1 month, those recommended to live in the community generally accessed community care (34% out of 37%). While people recommended to live in residential aged care were less likely to use community care shortly after assessment, a sizeable proportion also accessed these services within a month of their assessment (for example, 23% of people recommended to live in low-level residential aged care accessed community care within one month) (Table 5). People recommended to live in low-level residential aged care were more likely to use community care (23%) than respite (10%) or permanent residential aged care (18%) in the first month after assessment. At 10%, early use of residential respite care was highest among those recommended to live in low-level residential aged care.

Almost 18% of those recommended to live in low-level residential aged care and 35% of those recommended for high-level residential aged care used permanent residential care within 1 month. After 6 months, these percentages had risen to 42% and 56%, respectively. There was also a steady flow of people recommended to live in the community into permanent residential care. Overall, 7% of this group had moved into such accommodation within 6 months, and 24% within 2 years.



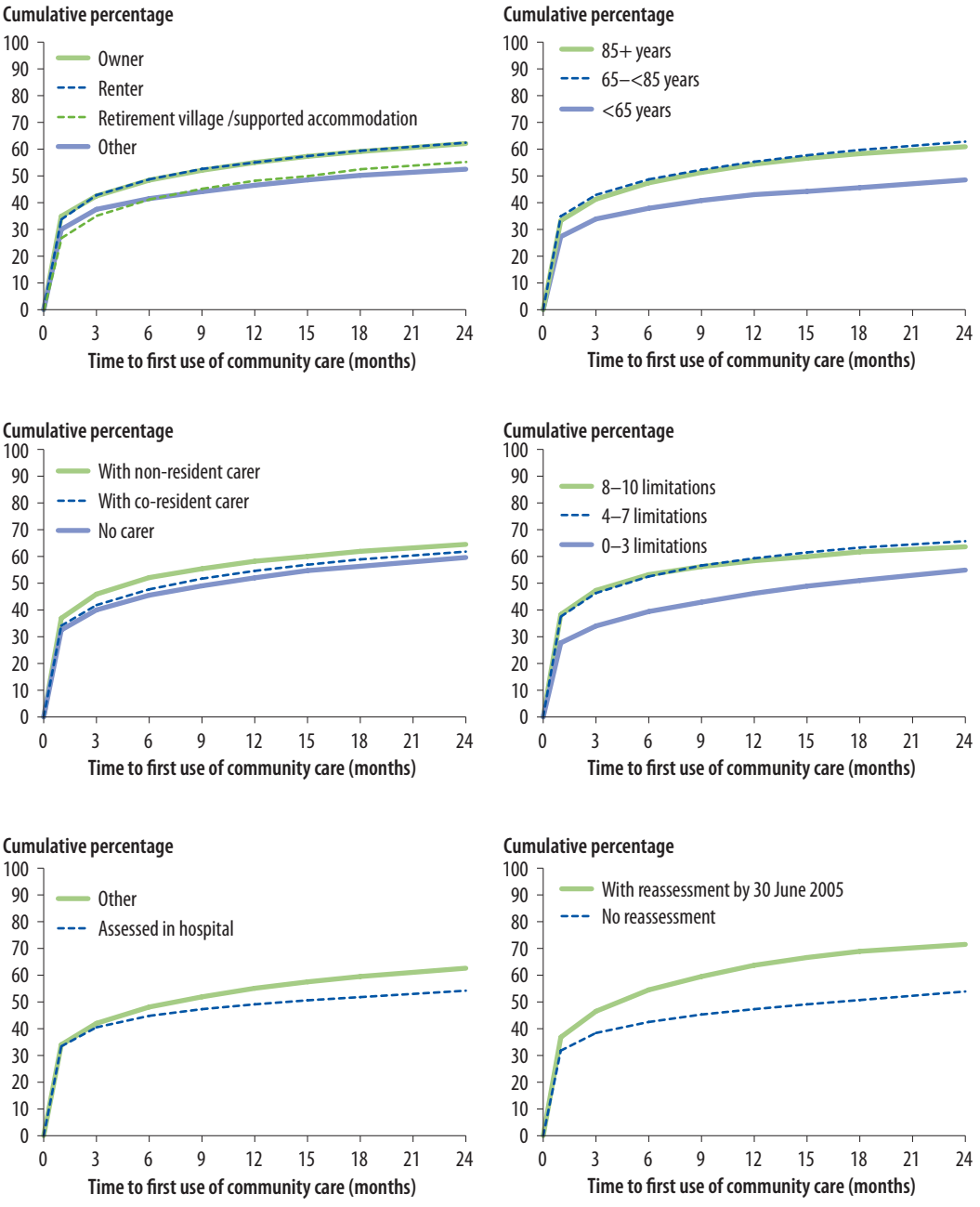
Source: Table 5.

Figure 4: Time to first use of care programs after reference assessment

Effect of client characteristics

Program use varied with the characteristics of clients. However, take-up rates within client subgroups followed the general trends seen within the recommendation group as a whole (figures 5 & 6). Some differences were seen for people assessed in hospital or for those with a reassessment, indicating the influence of changes in circumstance.

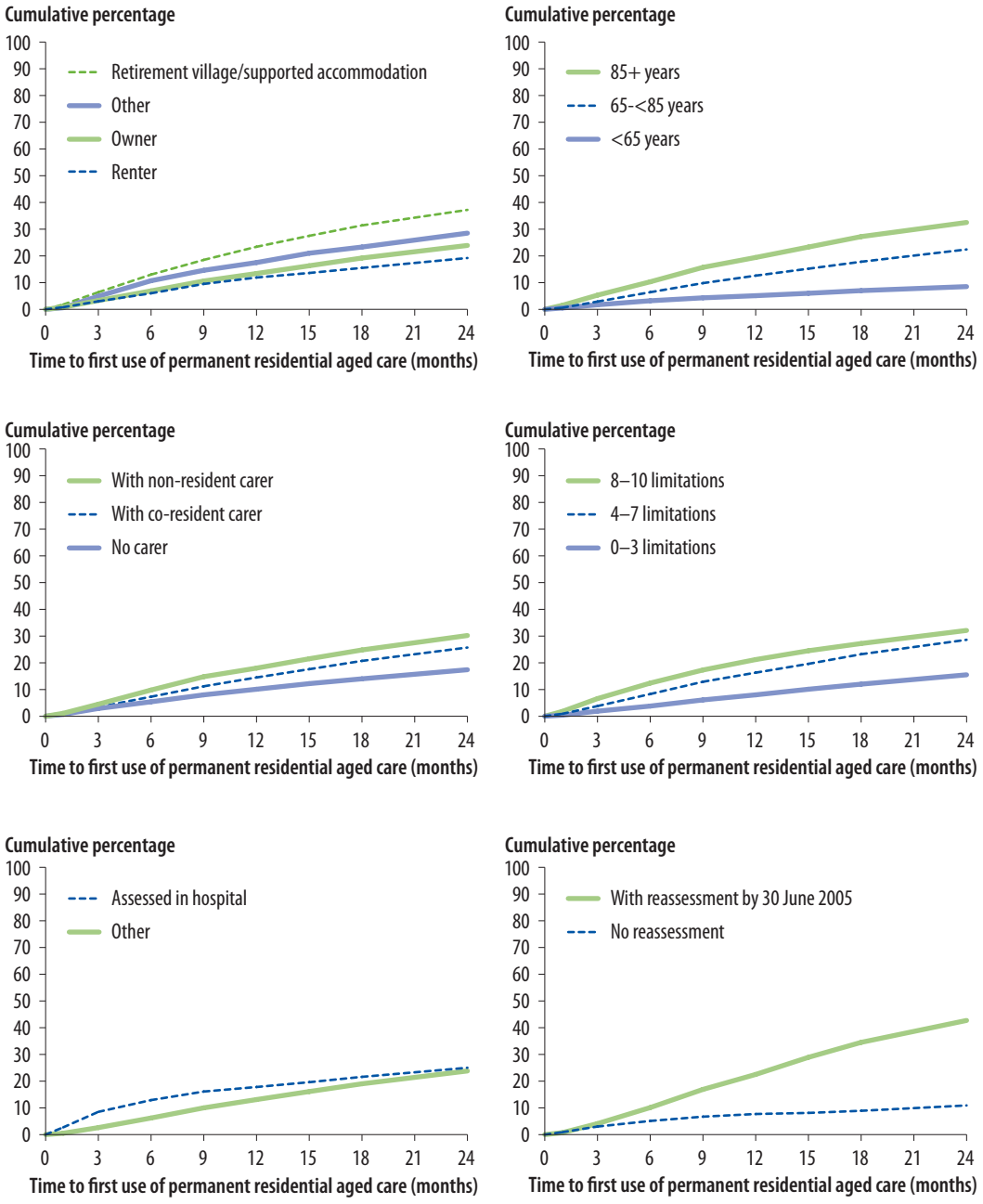
While the number of activity limitations was associated with a recommendation to live in permanent residential aged care (Figure 2), analysis shows that this is an incomplete measure of need (or desire) for program support. In particular, almost 40% of people with



Source: Table 6.

Figure 5: Time to first use of community care, by client characteristic for people recommended to live in the community

8–10 identified limitations affecting care needs were recommended to remain living in the community, and two-thirds of these did not enter permanent residential aged care within the study period (tables 2 & 7). On the other hand, 60% of people recommended to live in high-level residential aged care had 8–10 limitations; of these 56% entered permanent residential care within 3 months of the assessment and 70% within 2 years. That is, while people in different recommendation groups sometimes had similar numbers of limitations contributing to care needs either the degree of limitation was not the same or other factors, such as carer availability, were playing a role. Also, it suggests that it is more likely the gap between care needs and support (including aids) that matters, rather than the number of needs.



Source: Table 7.

Figure 6: Time to first entry into permanent residential care, by client characteristic for people recommended to live in the community

Movement into permanent residential care

Several characteristics were associated with relatively high transition rates into permanent residential aged care, most notably high-care needs, having a non-resident carer and assessment in hospital (Table 7; Figure 6 for people recommended to live in the community). In addition, patterns of entry into permanent residential aged care were affected by the occurrence of a reassessment.

Rates of transition into permanent residential aged care also varied with the use of community care and residential respite care for all recommendation groups. In particular, people who used residential respite care but not community care were overall more likely than others to have entered permanent residential aged care within 24 months (Figure 7). Also, people who used both respite and community care were more likely to have entered permanent residential aged care than those who had used only community care services. This effect was particularly noticeable among those recommended to live in the community.

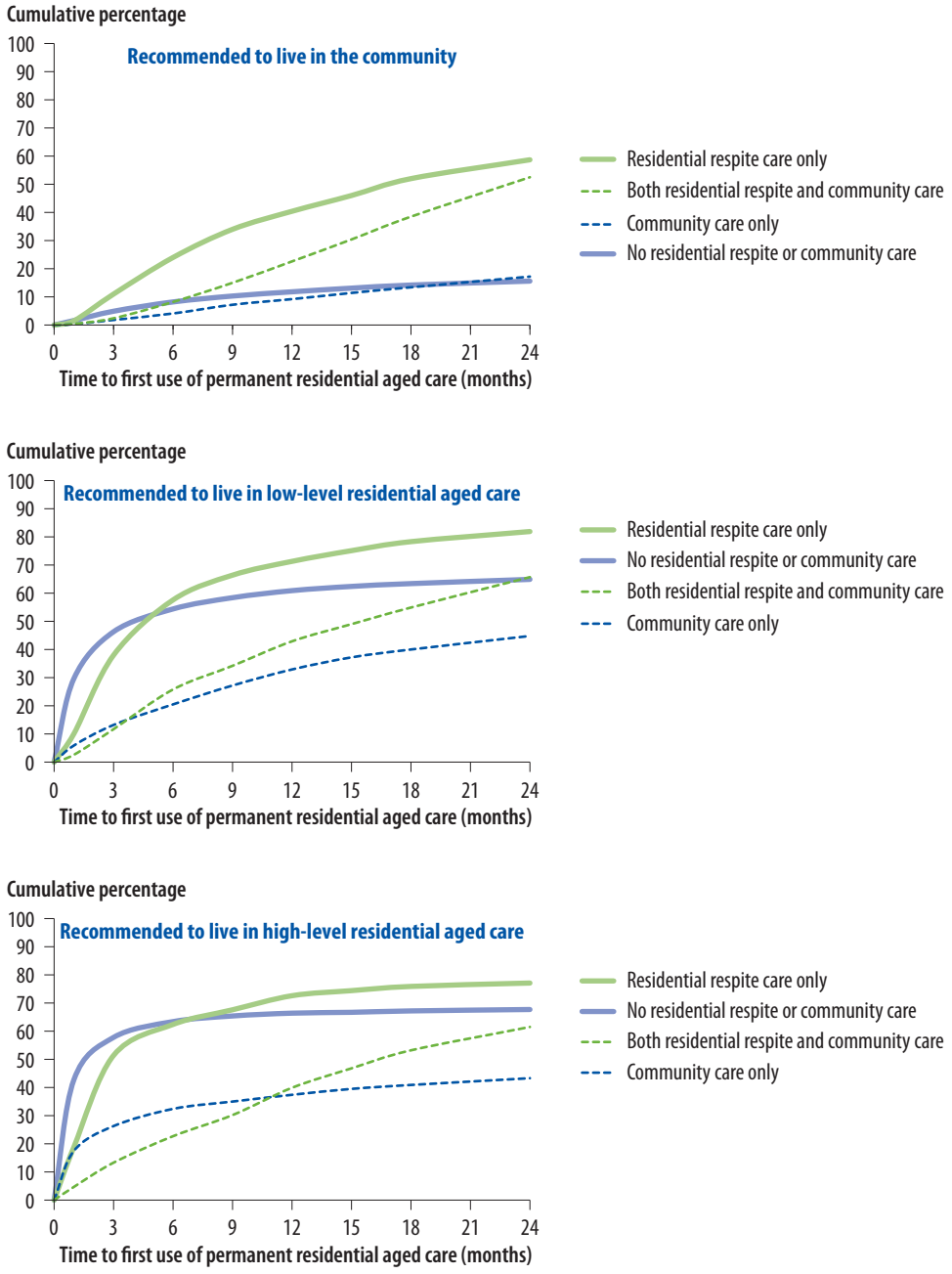
Among those recommended to live in residential aged care, people who used neither community nor residential respite care services, or only residential respite care, were initially more likely to enter permanent care than others (Figure 7). However, after 3 months the entry rate among these people slowed considerably.

Figure 7 shows that, irrespective of recommendation group, residential respite care was often a precursor to movement into permanent residential care, an effect that has been noted in other analyses (ACAP NDR 2005; AIHW 2009b; Howe et al. 2006; Wells 2009). This may be because: there may be stress on carer support arrangements; people may enter residential respite care while waiting for more suitable permanent care; people may like to try out a particular care arrangement before making the final commitment; and familiarity with residential aged care arising from previous use of respite care may mean that such people are more inclined than others to make the transition.

The stated aim of many community care services is to provide support that will delay entry into permanent residential aged care. The above results suggest that use of community care does indeed delay entry into permanent residential aged care. For example, a sizeable proportion of people recommended to live in low-level residential aged care remained living in the community and accessing residential respite care and/or community care. The entry by these people into permanent care was fairly steady over time, and, after 12 months, 43% of those who had used both respite and community care had accessed permanent residential aged care compared with 46% within 3 months among those who had not accessed these services. Among people who only used community care services, this level of entry into permanent care was reached after 21–24 months.

Previous studies have shown that for particular groups the timing of community service use in turn affects the timing of transition into residential aged care (Brodaty & Gresham 1992; Cheek et al. 2006; Gaugler et al. 2005; Howe et al. 2006; Kosloski & Montgomery 1995). The current analysis suggests that the period just around assessment is critical,

with high transition rates into residential aged care soon after the assessment among those recommended to live in such care. The much lower rates seen among those who first access community care—both in the first 3 months and after 2 years—suggest that timely use of these services plays a key role in delaying entry into residential aged care.



Source: Table 8.

Figure 7: Time to permanent residential care, by use of residential respite care and community care

Divergence from recommendation

The above analysis shows that recommendations by ACATs were not always followed. In particular, many people recommended to live long-term in residential aged care did not move into this type of accommodation. For example, in the 6 months following the reference ACAT assessment, only 42% of people recommended to live in low-level residential aged care made this transition (Table 5). However, many of these people had accessed other care services, with 31% having accessed at least one community care program. Only a small proportion (8%) had died. The proportion moving into residential aged care also varied depending on other care services accessed (Figure 7). These findings suggest that the difference between recommendation and outcome could have several causes, including: change in client circumstances, the client disliking the recommendation; and lack of suitable care services. In addition, the recommendation may, to some extent, be the result of assessors' preferences, and arise under pressure from a crisis, such as hospitalisation. Recommendations affected by such factors may not be the most suitable option in the long term (Kane et al. 2006; Magro & Ferry 2005; Taylor & Donnelly 2006).

There was also a steady flow of people recommended to live in the community moving into residential aged care (Figure 4). Higher movement rates seen for people with additional assessments suggest that this divergence from the recommendation most likely resulted from changed health or social circumstances (such as loss of the carer or a decline in the capacity of the carer to deal with accumulated stressors) or a desire to move into a more supported living environment.

Finally, the results suggest that some people make do, rather than access care services. While some people recommended to live in the community may have been assessed as not needing program assistance (see AIHW 2011: tables A.26, A.28 & A.29), this would not have been the case for those recommended to live long term in residential aged care. Within both residential aged care recommendation groups, there was a set of people who neither entered permanent residential aged care nor used residential respite care or community care services, and most of these people had not died shortly after their assessment (tables 4 & 5). The reasons people made this choice, and whether it was a choice, require separate investigation.

Tables

Table 1: Demographic profile of the cohort, by long-term care setting recommended at reference ACAT assessment

	Recommended long-term care setting (row per cent)					
	Community	Low-level residential aged care	High-level residential aged care	Total	Number	Column per cent
Age						
<65 years	64.4	12.0	23.5	100.0	2,608	7.6
65–<85	63.0	18.9	18.1	100.0	21,479	62.4
85+	53.0	25.2	21.8	100.0	10,337	30.0
Mean/total	**78.8**	**81.7**	**79.8**	**79.6**	**34,424**	**100.0**
Sex						
Male	59.9	18.5	21.6	100.0	14,115	41.0
Female	60.3	21.5	18.2	100.0	20,300	59.0
Total					**34,415**	**100.0**
Living arrangement						
Alone	56.0	29.1	14.9	100.0	11,617	37.1
With family	66.1	14.1	19.8	100.0	18,513	59.1
With others	43.0	27.5	29.5	100.0	1,176	3.8
Total					**31,306**	**100.0**
Carer availability						
Co-resident	65.0	13.7	21.2	100.0	15,234	49.9
Non-resident carer	56.8	29.0	14.2	100.0	8,010	26.2
None	55.5	25.5	18.9	100.0	7,304	23.9
Total					**30,548**	**100.0**
Carer relationship						
Friend/neighbour	53.2	26.8	20.0	100.0	771	3.7
Offspring	57.9	24.7	17.4	100.0	9,545	45.7
Offspring-in-law	62.5	25.5	12.0	100.0	518	2.5
Other relative	51.6	27.6	20.8	100.0	1,433	6.9
Parent	70.7	10.9	18.4	100.0	174	0.8
Private employee	48.8	17.4	33.9	100.0	121	0.6
Spouse	69.2	10.0	20.8	100.0	8,347	39.9
Total					**20,909**	**100.0**
Usual accommodation						
Home owner	65.5	17.2	17.4	100.0	22,660	69.8
Renter—private	56.5	25.5	18.0	100.0	2,105	6.5
Renter—public	62.7	20.6	16.7	100.0	2,413	7.4
Retirement village/supported accommodation	45.1	33.7	21.2	100.0	3,098	9.5
Other	31.7	30.2	38.1	100.0	2,209	6.8
Total					**32,485**	**100.0**
All	**60.1**	**20.3**	**19.6**	**100.0**	**34,428**	**..**

Note: Within each characteristic, cases with missing values have not been included.

Table 2: Care needs affecting need for assistance, by long-term care setting recommended at reference ACAT assessment

	Recommended long-term care setting (row per cent)					
	Community	Low-level residential aged care	High-level residential aged care	Total	Number	Column per cent
ADL limitations (number)						
0 (independent)	80.0	15.7	4.3	100.0	7,700	23.8
1	72.8	23.9	3.3	100.0	7,188	22.2
2	57.9	32.1	10.0	100.0	6,109	18.9
3	50.0	25.4	24.6	100.0	4,708	14.6
4	34.0	12.6	53.4	100.0	4,179	12.9
5 (dependent)	23.2	5.0	71.8	100.0	2,423	7.5
Mean	**1.4**	**1.8**	**3.6**	**1.9**	**32,307**	**100.0**
IADL limitations (number)						
0 (independent)	79.1	8.3	12.6	100.0	2,879	9.1
1	74.8	15.4	9.7	100.0	2,094	6.6
2	65.0	18.3	16.6	100.0	3,706	11.7
3	67.2	23.0	9.8	100.0	4,819	15.2
4	55.7	25	19.2	100.0	7,663	24.1
5 (dependent)	51.5	21.5	27.0	100.0	10,580	33.3
Mean	**3.1**	**3.7**	**3.8**	**3.4**	**31,741**	**100.0**
ADL + IADL limitations (number)						
0–3	80.0	14.3	5.7	100.0	8,583	27.0
4–7	60.5	27.2	12.3	100.0	15,419	48.6
8–10	39.0	14.5	46.5	100.0	7,739	24.4
Mean	**4.6**	**5.4**	**7.4**	**5.3**	**31,741**	**100.0**
Place of assessment						
Hospital	30.1	22.5	47.4	100.0	9,722	29.2
Other	73.5	18.8	7.7	100.0	23,607	70.8
					33,329	**100.0**
Reassessment by 30 June 2005						
No	55.2	19.5	25.3	100.0	22,123	64.3
Yes	69.0	21.6	9.4	100.0	12,305	35.7
All	**60.1**	**20.3**	**19.6**	**100.0**	**34,428**	**100.0**

Note: Within each characteristic, cases with missing values have not been included.

Table 3: Health conditions affecting care needs, by long-term care setting recommended at reference ACAT assessment

	Recommended long-term care setting (row per cent)					
Health condition	**Community**	**Low-level residential aged care**	**High-level residential aged care**	**Total**	**Number**	**Percentage of cohort**
Infections	58.4	19.5	22.1	100.0	190	0.6
Neoplasms	52.8	19.0	28.2	100.0	4,051	12.2
Blood & blood forming organ disorders	52.2	23.8	23.9	100.0	1,128	3.4
Endocrine	59.8	20.5	19.6	100.0	6,528	19.6
Mental—all	*51.7*	*25.0*	*23.3*	*100.0*	*12,457*	*37.4*
Dementia	49.5	24.2	26.3	100.0	8,491	25.5
Other	53.8	27.2	19.0	100.0	5,245	15.8
Nervous system	58.6	16.5	24.8	100.0	3,064	9.2
Eye and adnexa	59.5	25.0	15.6	100.0	4,713	14.2
Ear and mastoid process	58.6	28.3	13.0	100.0	2,715	8.2
Circulatory—all	*58.3*	*21.5*	*20.2*	*100.0*	*19,068*	*57.3*
Heart disease	57.7	22.1	20.2	100.0	9,343	28.1
Cerebrovascular	50.1	18.7	31.2	100.0	5,613	16.9
Other	59.4	22.7	17.9	100.0	11,137	33.5
Respiratory system	57.8	22.1	20.2	100.0	4,570	13.7
Digestive system	57.6	23.6	18.7	100.0	3,678	11.1
Skin and subcutaneous tissue	57.1	20.7	22.2	100.0	886	2.7
Musculoskeletal system and connective tissue	64.4	21.6	14.0	100.0	12,417	37.3
Genitourinary system	52.6	21.3	26.1	100.0	3,465	10.4
Congenital	68.2	13.6	18.2	100.0	88	0.3
Injury and poisoning	56.9	18.4	24.6	100.0	3,722	11.2
Symptoms and signs, not elsewhere classified	54.2	21.8	24.0	100.0	7,303	21.9
Other, not elsewhere specified	54.5	24.3	21.2	100.0	890	2.7
Mean number of health conditions	**3.1**	**3.6**	**3.6**	**3.3**	**33,285**	**..**

Note: Table excludes 1,143 cases with missing health condition data. Percentages of cohort do not sum to 100 as people can have more than one health condition.

Table 4: Use of care programs within 2 years of first assessment, by recommended long-term setting (per cent)

	Recommended long-term care setting			
Programs used	**Community**	**Low-level residential aged care**	**High-level residential aged care**	**All**
Permanent residential aged care only	5.1	31.1	47.8	18.7
Permanent and respite residential aged care	3.5	10.7	5.5	5.4
Permanent and respite residential aged care, and community care	7.1	8.3	3.6	6.7
Permanent residential aged care and community care	8.2	11.8	7.2	8.7
Residential respite aged care only	2.5	2.3	1.6	2.3
Residential respite aged care and community care	6.4	4.3	2.1	5.2
Community care only	39.4	14.5	9.4	28.5
None	27.8	16.8	22.9	24.6
Total	**100.0**	**100.0**	**100.0**	**100.0**
Ever used permanent residential aged care	24.0	62.0	64.0	39.5
Ever used residential respite aged care	19.6	25.7	12.7	19.5
Ever used community care	61.1	39.0	22.2	49.0
Died within 2 years	20.4	23.8	47.7	26.5
Total number	**20,693**	**6,979**	**6,756**	**34,428**

Note: Community care includes Home and Community Care, Veterans' Home Care, Community Aged Care Packages, and Extended Aged Care at Home and Extended Aged Care at Home Dementia packages.

Table 5: Time to first use of care programs after reference assessment by recommended long-term setting (cumulative percentage)

	Recommended long-term care setting			
	Community	Low-level residential aged care	High-level residential aged care	All
Time to first use of any program				
Within 1 month	37.0	45.4	50.5	41.4
Within 3 months	47.3	60.7	64.8	53.5
Within 6 months	55.2	69.7	70.8	61.2
Within 24 months	72.2	83.2	77.1	75.4
Time to first use of community care				
Within 1 month	33.8	23.0	14.3	27.8
Within 3 months	41.7	27.6	16.8	33.9
Within 6 months	47.5	31.4	18.6	38.5
Within 24 months	61.1	39.0	22.2	49.0
Time to first use of respite residential aged care				
Within 1 month	3.5	10.1	6.1	5.3
Within 3 months	6.5	15.2	8.3	8.6
Within 6 months	9.7	18.7	9.7	11.5
Within 24 months	19.6	25.7	12.7	19.5
Time to first use of permanent residential aged care				
Within 1 month	0.8	17.5	34.9	10.9
Within 3 months	3.5	32.1	49.8	18.4
Within 6 months	7.2	42.3	56.0	23.9
Within 24 months	24.0	62.0	64.0	39.5
Time to death				
Within 1 month	1.3	1.5	11.0	3.3
Within 3 months	3.7	4.5	21.5	7.4
Within 6 months	6.5	7.9	28.6	11.1
Within 24 months	20.4	23.8	47.7	26.5
Total number	**20,693**	**6,979**	**6,756**	**34,428**

Table 6: Time to first use of community care after reference ACAT assessment, by client characteristic at assessment within recommended long-term care setting (cumulative percentage)

	Community			Low-level residential aged care			High-level residential aged care		
	Within 3 months	Within 6 months	Within 24 months	Within 3 months	Within 6 months	Within 24 months	Within 3 months	Within 6 months	Within 24 months
Sex									
Male	41.6	47.2	60.7	26.3	30.1	37.7	17.4	19.3	23.1
Female	41.8	47.7	61.4	28.3	32.1	39.8	16.2	18.0	21.5
Age									
<65 years	33.9	37.9	48.5	21.0	23.2	30.6	16.0	18.2	26.2
65–<85	42.9	48.7	62.8	28.4	32.3	40.1	18.3	20.4	23.9
85+	41.3	47.4	60.9	27.1	30.8	38.4	14.3	15.5	18.2
Carer status									
Co-resident	41.8	47.7	61.8	29.5	33.8	43.1	21.1	23.1	26.8
Non-resident	45.9	52.1	64.5	30.1	33.7	40.5	14.7	16.5	19.2
No carer	40.0	45.5	59.6	23.9	27.1	34.2	10.9	12.4	16.8
Usual accommodation									
Owner	42.5	48.4	62.1	30.4	34.5	42.7	19.0	21.0	24.6
Renter	42.8	48.7	62.4	29.6	33.6	41.6	17.5	19.2	23.3
Retirement village/supported accommodation	35.1	41.2	55.2	21.4	25.0	31.4	8.5	9.7	12.0
Other	37.5	41.5	52.5	20.7	23.8	29.8	15.2	17.4	21.6
Place of assessment									
Hospital	40.5	44.8	54.2	20.9	23.5	28.2	12.0	13.7	16.8
Other	42.0	48.1	62.6	32.2	36.9	46.3	30.0	32.4	37.6
ADL + IADL limitations (number)									
0–3	34.0	39.4	54.9	24.2	28.3	38.3	19.3	22.2	30.6
4–7	46.3	52.5	65.7	29.1	33.1	40.3	17.7	20.0	23.6
8–10	47.3	53.2	63.6	27.4	30.8	37.5	16.3	17.8	20.6
Additional assessment									
No	38.4	42.5	53.9	24.2	27.0	32.4	13.5	14.4	16.5
Yes	46.5	54.5	71.5	33.1	38.5	49.9	32.4	39.0	49.8
Total	**41.7**	**47.5**	**61.1**	**27.6**	**31.4**	**39.0**	**16.8**	**18.6**	**22.2**

Table 7: Time to first entry into permanent residential aged care after reference ACAT assessment, by client characteristic at assessment within recommended long-term care setting (cumulative percentage)

	Community			Low-level residential aged care			High-level residential aged care		
	Within 3 months	Within 6 months	Within 24 months	Within 3 months	Within 6 months	Within 24 months	Within 3 months	Within 6 months	Within 24 months
Sex									
Male	3.3	7.1	23.5	31.9	41.8	59.9	47.5	53.7	61.1
Female	3.5	7.2	24.2	32.2	42.5	63.2	51.6	57.9	66.4
Age									
<65 years	1.7	3.2	8.5	30.6	40.4	52.9	39.6	45.6	53.7
65–<85	2.9	6.4	22.4	31.6	41.8	61	48.6	54.6	63.1
85+	5.3	10.3	32.5	33.1	43.2	64.5	54.5	61.2	68.4
Carer status									
Co-resident	3.4	7.3	25.7	26.5	36.3	59.8	47.3	54.3	63.6
Non-resident	4.5	9.8	30.2	32.8	44.6	65.5	59.1	63.7	71.3
No carer	2.9	5.4	17.4	36.9	45.2	60.6	48.0	54.2	59.0
Usual accommodation									
Owner	3.3	6.9	23.9	28.9	38.9	59.7	51.2	57.5	65.3
Renter	3.0	6.0	19.2	33.5	43.9	61	52.2	58.6	65.3
Retirement village/supported accommodation	6.4	13.0	37.2	39.7	52.0	72.6	59.3	65.3	75.4
Other	4.9	10.7	28.5	36.7	48.0	65.7	43.3	51.0	60.6
Place of assessment									
Hospital	8.5	12.9	25.0	46.0	53.5	64.8	56.8	61.7	66.4
Other	2.6	6.2	23.8	24.2	36.0	60.6	33.9	43.9	60.6
ADL + IADL limitations (number)									
0–3	1.9	3.8	15.5	26.4	36.6	54.6	29.2	34.3	41.5
4–7	3.8	8.3	28.6	32.8	43.6	63.8	50.8	57.0	67.0
8–10	6.6	12.4	32.1	35.8	46.2	66.2	55.8	62.6	70.0
Additional assessment									
No	3.0	5.1	10.9	36.2	45.9	57.4	54.8	60.7	64.8
Yes	4.1	10.1	42.7	25.5	36.4	69.4	25.3	33.2	60.3
Total	**3.5**	**7.2**	**24.0**	**32.1**	**42.3**	**62.0**	**49.8**	**56.0**	**64.0**

Table 8: Time to first entry into permanent residential aged care after reference ACAT assessment, by program use within recommended long-term care setting (cumulative percentage)

Recommended long-term care setting	Neither residential respite care nor community care	Residential respite care only	Community care only	Residential respite care and community care	Total
Community					
Within 1 month	1.6	1.5	0.3	0.4	0.8
Within 3 months	4.9	11.0	1.8	2.4	3.5
Within 6 months	8.2	24.0	4.1	8.2	7.2
Within 24 months	15.6	58.7	17.2	52.5	24.0
Total (number)	**6,801**	**1,251**	**9,835**	**2,806**	**20,693**
Low-level residential aged care					
Within 1 month	29.7	10.1	5.9	2.6	17.5
Within 3 months	46.3	38.0	13.2	11.7	32.1
Within 6 months	54.4	57.6	20.5	25.8	42.3
Within 24 months	64.9	81.9	44.8	65.7	62.0
Total (number)	**3,345**	**913**	**1,840**	**881**	**6,979**
High-level residential aged care					
Within 1 month	42.8	18.9	17.5	4.7	34.9
Within 3 months	57.8	51.4	26.3	13.3	49.8
Within 6 months	63.4	62.4	32.4	22.7	56.0
Within 24 months	67.7	77.1	43.3	61.5	64.0
Total (number)	**4,793**	**481**	**1,121**	**361**	**6,756**

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Abbreviations

ACAP Aged Care Assessment Program

ACAT Aged Care Assessment Team

ADL Activity of Daily Living

IADL Instrumental Activity of Daily Living

PIAC Pathways in Aged Care

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