



Use of health and aged care services

- 28 The Australian health and welfare system
- 29 Care needs and sources of care
- 30 General practitioner services
- 31 Pharmaceuticals
- 32 Dental services
- 33 Hospital use
- 34 Reasons for admission to hospital
- 35 Aged care assessment
- 36 Home and Community Care (HACC) program
- 37 Community Aged Care Packages (CACPs)
- 38 Extended Aged Care at Home (EACH)
- 39 Respite Care
- 40 Residential aged care: resident profiles
- 41 Residential aged care: patterns of use

Australia's health care system

The Australian health system is complex, with many types of service providers and a variety of funding and regulatory mechanisms. Those who provide services include a range of medical practitioners, other health professionals, hospitals, clinics, and other government and non-government agencies. Funding is provided by the Australian Government, state and territory governments, health insurers, individual Australians and a range of other sources (see also AIHW 2006c).

Funding health care services

Almost 70% of total health expenditure in Australia is funded by government, with the Australian Government contributing two-thirds of this and state, territory and local governments the other third. The Australian Government's major contributions include the two national subsidy schemes: Medicare and the Pharmaceutical Benefits Scheme. These schemes subsidise payments for services provided by doctors and optometrists, and for a high proportion of prescription medications bought from pharmacies. The Australian Government and state and territory governments also jointly fund public hospital services. Between them, these arrangements aim to give all Australians—regardless of their personal circumstances—access to adequate health care at an affordable cost or no cost. These schemes are further integrated with social welfare arrangements, with larger rebates provided for individuals or families who receive certain income support payments (such as the Age Pension). There are also special health care arrangements for members of the defence forces, and for war veterans and their dependants.

Health care outside hospitals

Many people's first contact with the health system is through a general medical practitioner (GP) (see Topic 30: *General practitioner services*). People can choose their own GP and are reimbursed for all or part of the GP's fee by Medicare, depending on the GP's billing arrangements. For specialised care, patients can be referred to specialist medical practitioners, other health professionals, hospitals or community-based health care organisations. Community-based services—a range of which can also be accessed directly by patients—provide care and treatment in areas such as mental health, alcohol and other drugs, and family planning.

Australians also visit dentists (see Topic 32: *Dental services*) and other private sector health professionals

of their choice such as physiotherapists, chiropractors and natural therapists. Charges are usually met by the patients themselves or with the support of private health insurance.

Health care in hospitals

Patients can access public hospitals through emergency departments, where they may present on their own initiative, via the ambulance services, or after referral from a medical practitioner. Public hospital emergency and outpatient services are provided free of charge. Emergency ambulance services are not free of charge for most Australians, but subscription schemes are offered by the ambulance authorities or through private health insurance.

Patients admitted to a public hospital can choose to be treated as public or private patients. Public patients receive treatment from doctors and specialists nominated by the hospital, but are not charged for their care and treatment.

Patients treated in a private hospital—or as a private patient in a public hospital—can select their treating specialist, but charges then apply for all of the hospital's services (such as accommodation and surgical supplies). Medicare subsidises the fees charged by doctors, and private health insurance funds contribute towards medical fees and the hospital costs for insured patients. 'No-gap' or 'known-gap' arrangements are increasingly being agreed on between hospitals and insurers (see Topic 33: *Hospital use* and Topic 34: *Reasons for admission to hospital*).

Other services

The Australian Government and several state and territory governments have established 24-hour telephone-based health advice services which are staffed by health professionals who answer queries from callers about health problems, assisted by specialised reference software.

Complementing the services outlined above is the provision of public health services, which includes activities to ensure food quality; immunisation services and other communicable disease control; public health education campaigns; injury prevention activities; programs to reduce the use and harmful effects of tobacco, alcohol and illicit drugs; environmental monitoring and control; and screening programs for diseases such as breast cancer and cervical cancer.

Health insurance

Many Australians purchase health insurance provided by health benefits organisations (more commonly known as private health insurance funds). Hospital insurance schemes cover services in private hospitals as well as services provided in public hospitals for private patients and associated medical services. These are supplemented by other additional schemes that cover a wide range of allied health and other professional services including some alternative/complementary health services. As of late 2005, around 8.8 million Australians (43% of the population) were covered by private health insurance for hospital treatment.

Regulatory arrangements

The health system is regulated in various ways. State and territory governments are responsible for licensing or registering private hospitals (including free-standing day hospital facilities), medical practitioners and other health professionals; and each state and territory has legislation relevant to the operation of public hospitals. The Australian Government's regulatory roles include overseeing the safety and quality of pharmaceutical and therapeutic goods and appliances, managing international quarantine arrangements, ensuring an adequate and safe supply of blood products, and regulating the private health insurance industry. There is also an established role for governments in the regulation of food safety and product labelling. State and territory governments are also largely responsible for industry regulations, such as for the sale and supply of alcohol and tobacco products which have implications for associated health risks.

Australia's welfare system

Australia's welfare system consists of programs that are designed to enhance the wellbeing of individuals or communities, and to provide more equal opportunities for participation in the social and economic life of the Australian community. Its main components—income support and the provision of welfare services—are provided through government agencies, non-government organisations or private providers. However, family members and volunteers also provide substantial support and assistance to other Australians and form an intrinsic and invaluable part of the 'welfare' sector. This section outlines the support and services that constitute Australia's formal welfare system, with a focus on those that target, or are mainly used by, older people in the areas of income support, aged care, housing and disability services (see also AIHW 2007c).

Funding welfare services

The majority (almost 70%) of funding for welfare services is provided by governments. The states and territories contribute 35% and the Australian Government 32%. The remainder of government funding for welfare services is contributed by local governments. In addition, welfare services clients are charged fees for some services, and non-government organisations are sometimes called on to use their own resources to support some of the welfare services they provide.

Income support

The main source of income support for older Australians is the Age Pension, which is assets and income tested and available to people over the qualifying age (at 30 June 2006, the qualifying age for men was 65, and for women 63). Age pensioners may also be entitled to a range of additional payments and benefits such as the Pharmaceutical Allowance, Rent Assistance, Telephone Allowance, Remote Area Allowance, Utilities Allowance and a Pension Concession Card entitling the holder to medicines at a reduced cost as well as a range of state and local government concessions (see Topic 13: *Age Pension and superannuation*).

The Service Pension, paid to veterans, eligible partners, widows and widowers, is similar to the Age Pension but is generally available 5 years earlier. Other pensions are available from the Department of Veteran's Affairs (DVA) which are compensation payments (such as the Disability Pension and the War Widows' Pension), and are neither taxable nor subject to means testing.

Regardless of the source of their income, older Australians of Age Pension age, are entitled to the income-tested Senior Australians' Tax Offset, and may be exempted from the Medicare levy. The Pension Bonus Scheme provides an incentive for older Australians to defer claiming the Age Pension and instead to remain in the workforce.

Older people who are carers may be able to access two government payments, depending on their circumstances. The Carer Payment is an income support benefit payable to people who, because of their caring responsibilities, are unable to support themselves. For people of pension age it is an alternative to, and equivalent to, the Age Pension. The Carer Allowance is payable to carers who provide full-time daily care at home to people who need substantial amounts of care because of a disability or a severe medical condition or because they are frail older people (see Topic 9: *Care provided by older people*).

The Australian Government is the main source of income support for people with disability and for their carers, through the Disability Support Pension, Mobility Allowance, Sickness Allowance, Carer Allowance, Carer Payment, Wife Pension, Disability Pension, and other allowances.

Provision of aged care services

The Australian aged care system is characterised by a mix of types of provision and a high degree of cooperation between all levels of government, service providers and the community. The non-government sector has a long history in the provision of aged care and continues to provide the majority of residential service provision as well as community care services. Private sector involvement in aged care is mostly through high care residential services (see Topic 41: *Residential aged care: patterns of supply and use*).

The Australian Government has the major role in funding residential aged care services and aged care packages in the community. It establishes the policy directions in consultation with state and territory governments and the aged care industry and consumers, and provides the bulk of administrative support.

State and territory governments have a regulatory role in the residential aged care sector, in areas such as building compliance and fire safety regulations, and occupational health and safety requirements. State and territory governments administer the Home and Community Care (HACC) Program through an agreement with the Australian Government and directly operate some residential aged care services. Together the Australian Government and the state and territory governments provide funding for the HACC and the Aged Care Assessment Program.

Local governments provide some residential aged care services and community care services, as well as having a regulatory role.

Community and flexible aged care services

Community aged care services aim at enhancing the independence of frail older people or older people with disability, and delay or remove the need for entry to residential aged care services.

The bulk of home- and community-based services for older people are provided under the Home and Community Care (HACC) Program. The program includes home nursing services, delivered meals, home help and home maintenance services, transport and shopping assistance, allied health services, home- and centre-based respite care, and advice and assistance

of various kinds. It is jointly funded by the Australian Government and the state and territory governments (see Topic 36: *Home and Community Care Program*).

Veterans' Home Care (VHC) delivers in-home support services to eligible veterans, war widows and war widowers. The Program provides personal care assistance, domestic assistance, home and garden maintenance and respite care. Eligible people who need higher amounts of personal care or community nursing may be referred to the DVA Community Nursing program. Except for respite care, clients are required to pay a co-payment for VHC services.

Community Aged Care Packages (CACPs) provide support services to older people with complex needs living at home who would otherwise be eligible for admission to at least 'low-level' residential care. They provide a range of home-based services, excluding home nursing assistance (which may, however, be provided through HACC), with care being coordinated by the package provider. The CACP program is solely funded by the Australian Government. Clients may be asked to contribute towards the cost of their care (see Topic 37: *Community Aged Care Packages*).

The Extended Aged Care at Home (EACH) program aims at delivering care at home that is equivalent to high-level residential care. Clients may be asked to contribute to the cost of their care, as with the other community care programs. The program has been extended to include EACH Dementia packages which are designed to meet the needs of frail older people with dementia who experience behavioural and psychological symptoms associated with dementia. Many of the services available to EACH recipients are similar to those provided to CACP recipients (see Topic 38: *Extended Aged Care at Home*).

The Australian Government also provides other flexible aged care services, sometimes in partnership with other stakeholders, through:

- Multi-Purpose Services in rural and remote communities
- services under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program
- a short-term Transition Care Program for older people who have been in hospital, which aims at meeting their rehabilitation, recovery and care needs
- Aged Care Innovative Pool funding, which supports and evaluates pilot services or projects that will provide aged care services in new ways, including at the interface between aged care and other types of care.

Respite care

Respite care may be provided in the home, at a centre during the day, or in a residential service (see Topic 39: *Respite care*). It is used by older people living in the community including HACC, VHC and CACP recipients. Respite services can also be accessed through the National Respite for Carers Program, which provides information and support for carers as well as respite care.

Residential care services

Residential aged care services provide accommodation and support for older people who can no longer live at home. Two levels of care are available (low and high) and short-term respite care services are also available. All residential care services are required to meet a number of national standards. Residential aged care is mainly funded by the Australian Government, via daily subsidies. In addition, all residents pay fees, including an income-tested component, and government subsidies for individual permanent residents are reduced in line with the income-tested fees paid by residents (see Topic 40: *Residential aged care: resident profiles* and Topic 41: *Residential aged care: patterns of supply and use*).

Accessing aged care services

A network of Commonwealth Carelink Centres provide a single point of contact for obtaining comprehensive information on community aged care, residential care, disability and other support services available in any region within Australia. The centres are operated by a wide range of organisations, including not-for-profit and for-profit non-government organisations, and government agencies.

Aged Care Assessment Teams (ACATs) play a crucial role in the aged care system across Australia as they determine eligibility for CACP, EACH, EACH Dementia, the TCP and residential aged care. They also function as a source of advice and referral concerning HACC services but do not determine eligibility for these services, although many clients assessed by ACATs are recommended for HACC services (see Topic 35: *Aged care assessment*).

Provision of VHC services is based on assessed need. Assessments are undertaken by designated regional assessment agencies, which also arrange for the services to be provided. Veterans and war widow(er)s are eligible to be assessed for the full range of services provided under HACC, through arrangements with state and territory governments, and can access different services from both programs at the same time.

An ACAT assessment is not required for people accessing respite through the National Respite for Carers Program; there are, however, assessment procedures within the program with the focus being on primary carers and the relative need of clients. However, an ACAT assessment is required for people accessing residential respite in aged care homes.

To enter residential care, people must have an assessment and approval for such care by an ACAT. ACAT approval is also required for people moving between low and high permanent residential aged care facilities.

The Assistance with Care and Housing for the Aged initiative links generally low income, frail older people in insecure housing with appropriate community care and housing services.

Housing assistance

Key areas of assistance are the Commonwealth Rent Assistance program, which provides an income support payment for private renters linked to the eligible household's private rental costs; public rental housing; community housing managed by not-for-profit organisations; and various types of home ownership assistance aimed at lower income households including the First Home Owners Grant, low start loans, capital indexed loans and shared equity schemes (see Topic 4: *Housing*).

Disability

Older people with disability have access to the range of community care and aged care services discussed above (see Topic 17: *Disability levels* and Topic 29: *Care needs and sources of care*). Disability support services provided under the Commonwealth State/Territory Disability Agreement, which include accommodation support services, community support services, community access services, respite services and employment services, are generally aimed at younger people.

The relationship between disability, health and age is not necessarily straightforward, even though at first glance it may seem so because of the general tendency for the prevalence of certain health conditions and of disability to increase with age (see topics in Section 3). In the older age groups, illnesses affecting human functioning become more prevalent, including cardiovascular diseases, arthritis and dementia.

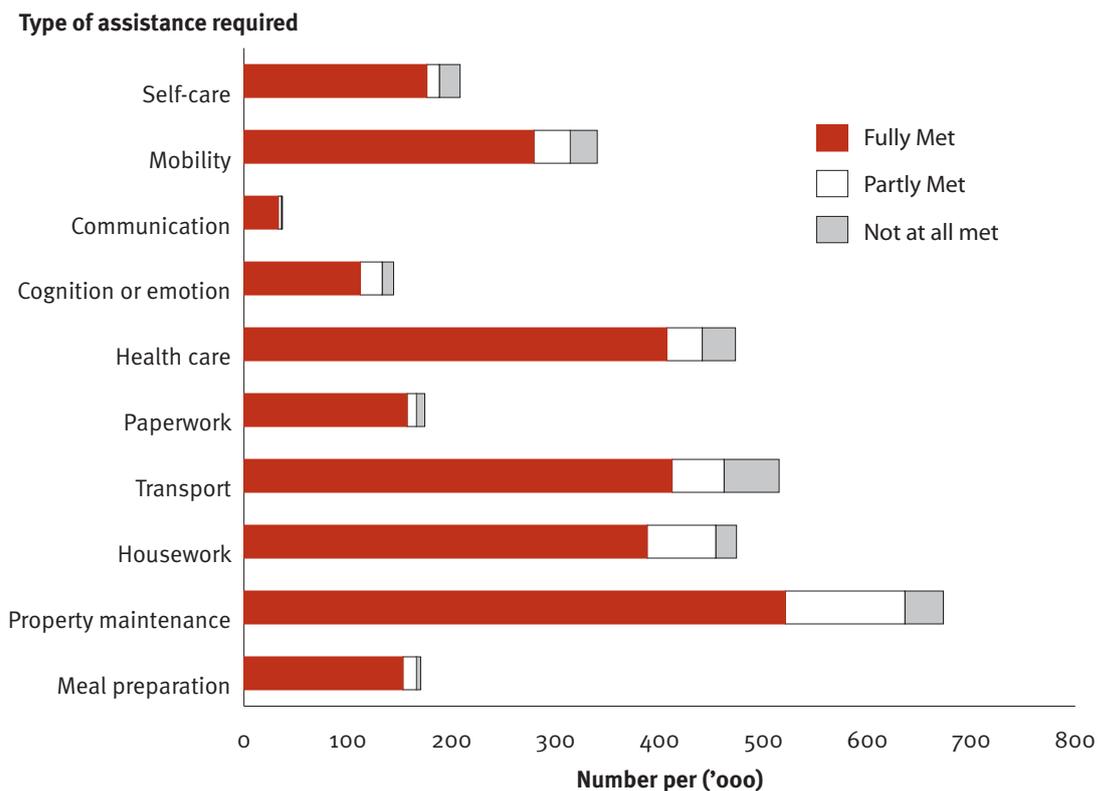
People with disability in older age groups need more frequent assistance than younger people and with more core activities. Older people also had more health conditions associated with disability (AIHW 2005b). Other factors which change the environment and circumstances of older people, such as loss of a spouse, technological change or surrendering a driver's licence, may also result in older people needing assistance with certain activities in order to support their capacity for community living.

Care needs and unmet need

The expression of need for services is shaped by the experiences, attitudes and beliefs of people, and therefore can be affected by what is known to be available or the perceived adequacy or accessibility of what is available. In addition, social and cultural norms can influence the likelihood of someone expressing a need for assistance, and interpersonal dynamics, such as the relationship between a carer and a care recipient, can affect the way need for assistance is experienced and expressed (Braithwaite 1996; AIHW: Jenkins 1999). Bearing these cautions in mind, reported need for assistance provides a valuable point-in-time account of need and unmet need.

The Survey of Disability, Ageing and Carers (SDAC) conducted by the ABS in 2003 (ABS 2004b) found that 43% (1,004,400 persons) of the 2.3 million people aged 65 years and over living in households expressed a need for some form of assistance to help them stay

Figure 29.1: People aged 65 and over living in households, whether need for assistance was met, by type of assistance required, 2003



Source: Table A29.1.

at home (Table A29.1). The most common area of need was property maintenance (29%) followed by transport (22%), housework (20%) and healthcare (20%) (Table A29.1 and Figure 29.1). Approximately 26% needed some assistance with personal activities, such as self-care, mobility, communication, cognition or emotion, and health care.

A higher proportion of women than men aged 65 years and over required assistance for all activities except communication, a result which is consistent with their older age profile; overall 50% of women needed assistance with at least one activity compared with 35% of men. Areas of greatest difference between men's and women's need for assistance were property maintenance (35% of women and 21% of men), housework (26% of women and 14% of men) and transport (26% of women and 17% of men).

Unmet need occurs when a person does not have sufficient assistance with activities where help is required. Almost two-thirds of older people who needed assistance with at least one activity (64% or 646,500) feel that their needs were fully met, over one-quarter (31% or 306,100) report that their needs were partly met, and 5% (51,800) report that none of their needs was met, even partially (Table A29.1).

The areas with the highest proportions of older people reporting that their need for assistance was fully met were paperwork and meal preparation (90%) and communication (89%). Transport and self-care were the areas with the highest proportions of older people feeling that their need for assistance was not met at all (10% each of people requiring assistance with transport and with self-care).

Providers of assistance

Informal care networks of friends and family provide most of the assistance received by older people in the community. Among those receiving assistance, 83% received help from informal providers, and 64% received help from formal providers (including government organisations as well as private for-profit and private not-for-profit agencies) (Table 29.1). Overall, 47% of older people received assistance from both informal and formal sources. Informal providers were the major source of support for communication and paperwork: 98% of those receiving assistance for these activities were being helped by informal providers. The lowest proportions receiving assistance from informal providers were in the area of health care (54% of recipients). For most activities, between 15% and 25% of those needing

and receiving assistance were getting help from both formal and informal sources. Among older people with disability who need assistance to manage their bladder or bowel control and live in households around 50% relied on informal self-care assistance, and another 26% used a mixture of informal and formal self-care assistance (AIHW analysis, ABS 2004a).

Among informal providers, there are clear gender and relationship differences (Table 29.1). Informal carers are predominantly female partners or daughters/daughters-in-law across most activities—the one exception being property maintenance. There are also clear gender differences in the types of assistance provided by informal carers. This is true for informal carers who are partners but is more pronounced between daughters and sons. In 2003, daughters/daughters-in-law were twice as likely as sons/sons-in-law to provide assistance for all activities except property maintenance. Interestingly, male partners were more commonly recorded as providing assistance with housework than female partners, although this possibly reflects dominant gender roles and the expectation that, for women, performing the bulk of household duties is part of their routine responsibilities.

Among formal providers, data from the 2003 SDAC indicate that government-owned agencies predominate across most activities. However, these figures may overstate the use of government providers because respondents may not be able to distinguish between government and non-government services. For example, most Home and Community Care services are provided by non-government agencies, even though the program is funded by governments. Areas where a greater proportion of people reported using non-government rather than government services were health care (the only area where more people received help from a formal rather than an informal provider) and property maintenance, both of which showed a clear majority of people who received this type of service getting assistance from a private for-profit source.

Data in Table 29.1 do not convey the total amount or frequency of help provided to older Australians living in the community. For instance, the greatest number of older people in the community need and receive assistance with property maintenance, yet the nature of property maintenance tasks means that this assistance is likely to be single episodes of short duration. In contrast, activities such as meal preparation or personal care typically occur on a daily basis for sustained periods of time.

Informal care

With the growing emphasis on home-based care, informal care by family, friends and neighbours is increasingly being recognised as an important source of support to people of all ages (see also Topic 9: *Care provided by older people*). Carers play a key role in assisting older people to remain in the community and the need for this support is expected to increase. In addition to providing direct assistance, a carer may also act as a 'bridge' to formal services. For example, results from the 2002 Community Aged Care Packages Census (AIHW 2004b) show that 58% of those with a carer were receiving CACP assistance with personal care compared with only 48% of those without a carer.

According to the 2003 SDAC, there were 472,500 primary carers in 2003, where a primary carer is defined as the person who provides the most ongoing informal assistance with core activities (self-care,

mobility, communication) to a person with one or more disabilities. Of these, around 239,400 were providing assistance to persons aged 65 years and over, and 113,200 were themselves aged 65 years and over (AIHW 2005b). A substantial proportion of primary carers of older people are also over the age of 65 (40% in 2003), and 87% are aged 45 years and over.

Women made up over two-thirds (69%) of primary carers of older people (AIHW analysis, ABS 2004a). Older men were most likely to be cared for by a female carer aged 65 years and over. The predominance of older female carers was more marked for men aged 75 years and over than among men aged 65–74 years. Women aged 65–74 years were most commonly cared for by an older male, and women aged 75 years and over were most likely to be cared for by a female carer aged 25–64 years, although older male carers were also important in this age group.

Table 29.1: Source of assistance received by people aged 65 and over living in households, 2003

Provider type	Per cent										
	Self-care	Mobility	Com- muni- cation	Cognition or emotion	Health care	Paperwork	Transport	Housework	Property main- tenance	Meal prep- aration	Any activity
Informal											
Female partner	30.2	19.1	33.4	25.7	18.6	23.4	13.4	15.3	11.2	24.5	18.5
Male partner	23.4	19.0	*9.1	13.7	11.9	11.5	16.4	19.5	15.3	16.8	18.2
Daughter/ daughter-in-law	24.8	35.1	47.1	37.4	14.7	39.0	36.8	23.5	14.7	32.7	29.0
Son/son-in-law	11.0	22.5	*22.5	16.5	5.3	20.8	24.5	11.7	26.4	13.2	26.0
Other female ^(a)	*5.5	11.9	*8.0	9.2	4.4	6.2	11.9	7.0	3.3	7.7	10.7
Other male ^(b)	*3.5	7.6	*7.4	*4.7	2.6	6.3	8.1	3.4	12.0	*3.5	12.8
<i>Total informal</i>	89.1	93.8	98.4	93.6	54.2	97.5	93.4	70.6	71.6	86.7	83.0
Formal											
Government	18.4	16.6	**4.4	12.0	26.3	*2.2	8.4	29.8	9.3	14.6	31.1
Private non-profit	6.6	7.1	**1.9	*1.7	6.4	**1.0	3.6	6.8	6.4	*5.3	10.6
Private for-profit	*4.8	4.3	**1.5	19.5	37.9	*2.9	4.8	15.3	36.4	*4.4	42.0
<i>Total formal</i>	28.8	26.6	*7.8	29.1	65.9	*6.1	16.0	51.0	49.7	24.3	63.7
Both informal & formal											
	17.9	20.3	6.2	22.7	20.1	3.6	9.4	21.5	21.3	11.1	46.7
Number	187,900	313,500	36,200	133,100	441,600	166,600	462,500	453,600	635,400	166,100	952,600

* Estimate has a relative standard error of 25% to 50% and should be used with caution.

** Estimate has a relative standard error greater than 50% and is considered too unreliable for general use.

(a) Includes mother, other female relative and female friend or neighbour.

(b) Includes father, other male relative and m

Source: AIHW analysis, (ABS 2004a).

General practitioners (GPs) play a significant role in the lives of many older people as primary health-care providers and as a point of referral to other health services. Most Australians (about 85%) will see their GP at least once in any year (AIHW: Britt et al. 2007). Information about the use of GPs by older people complements that from national health surveys, hospital services, aged care services and the mortality database, as indicators of population health and wellbeing.

Use of GPs by older people

By far the majority of visits to GPs by Australians of all ages are funded through the Commonwealth Medicare Benefits Schedule (MBS) (AIHW: Britt et al. 2007). During the financial year 2005–06 there were over 90 million unreferred attendances, or visits, paid by Medicare (A1 and A2 items), at an average rate of 4.6 visits per person (Table 30.1). Approximately 25% (23.6 million) of these attendances were older patients.

Older Australians use the services of GPs more often than younger people. For older Australians the average number of visits was 8.6 per person in 2005–06 compared with about 4.0 per person for people aged under 65 (Table 30.1). Although rates of use increased with age and were highest for people aged 85 years and over, visits in this oldest age group represented less than 4% of all visits to the GP. Table 30.1 also shows that for each age group, older women were more likely than older men to use the services of a GP.

Most frequent patient reasons for GP–patient encounters

Since 1998, Australia has had national data available on the types of services provided by GPs through a survey of general practice activity involving around 1,000 recognised practising GPs from across the country each year. Called the BEACH (Bettering the Evaluation and Care of Health) survey, it records where, how and what type of services are delivered by general practitioners each year (AIHW: Britt et al. 2005). BEACH provides data about ‘encounters’, which include face-to-face consultation of a patient with a GP, and indirect encounters, such as where the GP provides a clinical service (for example, a repeat prescription or a referral) without seeing the patient face-to-face.

Table 30.2 shows the most frequent reasons given by patients aged 65 years and over for their encounter with the GP. The reasons for encounter are those concerns and expectations that patients bring to the GP. Participating GPs were asked to record at least one and up to three reasons for encounter in words as close as possible to those used by the patient, before the diagnostic or management process had begun. These reflect patients’ views of their reasons for consulting the GP.

Table 30.1: Use of GPs by Australians, by age and sex, 2005–06

Age	Males	Females	Persons
Under 55	24,056,261	33,890,993	57,947,254
55–64	5,736,891	7,161,150	12,898,041
65–74	5,311,958	6,145,708	11,457,666
75–84	3,674,296	5,258,777	8,933,073
85 and over	842,433	2,378,888	3,221,321
Total 65 and over	9,828,687	13,783,373	23,612,060
Total	39,621,839	54,835,516	94,457,355
	Rate (per 1,000 population)		
Under 55	3,051	4,393	3,715
55–64	5,031	6,320	5,673
65–74	7,614	8,436	8,034
75–84	8,650	9,646	9,210
85 and over	7,589	10,480	9,531
Total 65 and over	7,969	9,185	8,636
Total	3,863	5,299	4,584

Note: Data relate to unreferred attendances paid by Medicare for Group A1 General Practitioner items and Group A2 Other non-referred items.
Sources: Medicare Australia 2007; ABS 2006d.

Overall, there were 158 individual reasons for every 100 encounters for older men and 163 for older women (Table 30.2). The 15 most commonly recorded reasons for the encounter in general practice account for about a half of all reasons given.

The most frequent reasons given by older patients were to obtain a prescription, a request for a check-up (both about 20 per 100 encounters), and to receive test results (about 8 per 100 encounters). Immunisation, cough, hypertension and back complaint also ranked highly for older men and older women. Rash was the main reason given for 2 out of every 100 encounters, slightly more often than skin symptom/complaint. Diabetes was the main reason given in 2.1 per 100 encounters for older men and 1.7 per 100 encounters for older women. Depression (not listed in Table 30.2) accounted for 0.9 per 100 encounters in older men and 1.4 per 100 encounters in older women.

Most frequently managed problems

In the BEACH survey, participating GPs can record up to four problems managed through each GP–patient encounter. A ‘problem managed’ is a formal statement of the provider’s understanding of a health problem presented by the patient, family or community, and can be described in terms of a disease, symptom or complaint, social problem or ill-defined condition managed at the encounter (AIHW: Britt et al. 2005).

The average number of problems managed at encounters increases steadily with patient age and is generally higher for female patients than for male patients. Overall, there were 167 problems managed per 100 encounters for older men and 173 for older women (Table 30.3). The 20 most frequently managed individual problems in general practice account for just over a half of all problems managed.

Table 30.2: Most frequent patient reasons for encounter by people aged 65 and over, by sex, 2005–06

Rank	Males			Females		
	Number	Rate per 100 encounters	Number	Rate per 100 encounters	Number	Rate per 100 encounters
1	Check-up—all	2,414	20.4	Prescription—all	3,125	20.8
2	Prescription—all	2,310	19.5	Check-up—all	2,964	19.7
3	Test results	997	8.4	Test results	1,189	7.9
4	Immunisation—all	837	7.1	Immunisation—all	1,081	7.2
5	Cough	528	4.5	Cough	596	4.0
6	Hypertension	379	3.2	Hypertension	542	3.6
7	Back complaint	313	2.6	Back complaint	539	3.6
8	Diabetes	247	2.1	Rash	298	2.0
9	Rash	235	2.0	Skin symptom/complaint	271	1.8
10	Skin symptom/complaint	235	2.0	Vertigo/dizziness	266	1.8
11	Administrative procedure NOS	221	1.9	Leg/thigh symptom/complaint	260	1.7
12	Blood test NOS	221	1.9	Knee symptom/complaint	257	1.7
13	Shortness of breath, dyspnoea	210	1.8	Diabetes	250	1.7
14	Knee symptom/complaint	183	1.5	Blood test NOS	237	1.6
15	Blood test blood/lymph	170	1.4	Administrative procedure NOS	230	1.5
	<i>Total (15 leading reasons)</i>	<i>9,501</i>		<i>Total (15 leading reasons)</i>	<i>12,104</i>	
	<i>Total reasons 65+</i>	<i>18,629</i>	<i>157.6</i>	<i>Total reasons 65+</i>	<i>24,431</i>	<i>162.6</i>
	<i>Total encounters 65+</i>	<i>11,822</i>	<i>100.0</i>	<i>Total encounters 65+</i>	<i>15,024</i>	<i>100.0</i>

Note: NOS = not otherwise specified. ‘Check-up—all’ includes, for example, cardiac check-up, general check-up, skin check-up.

Source: AIHW analysis of 2005–06 BEACH database.

The top five problems managed by GPs for both older men and women are hypertension, immunisation, diabetes, osteoarthritis and lipid disorders (Table 30.3). Diseases of the cardiovascular system, skin, and musculoskeletal (osteoarthritis, back complaint) and respiratory systems are also relatively common problems. Also common are oesophagus disease, sleep disturbance, depression, dementia (2.3 per 100 encounters for older women, 1.4 for older men) and urinary tract infection (3.2 per 100 encounters for older women, 1.3 for older men).

Many of the most common problems managed in older Australians are chronic in nature and are largely preventable—problems such as hypertension, heart disease, some forms of diabetes and osteoarthritis (see also Topic 31: *Use of pharmaceuticals*). Australia's

National Chronic Disease Strategy provides national direction for improving chronic disease prevention and care across Australia. One of its key directions is to encourage primary health care, particularly general practice, to engage in early intervention, through appropriate screening and identification of risk factors, and support for self-management (NHPAC 2006).

Annual health checks for older people

Voluntary annual health assessments arranged and performed by general practitioners are important for early intervention and monitoring of chronic health conditions in the older population. These Medicare-funded assessments are available to all people aged 75 years and over and to Aboriginal and Torres Strait Islander peoples aged 55 years and over, and can

Table 30.3: Most frequently managed problems by GPs for people aged 65 and over, by sex, 2005–06

Rank	Males			Females		
	Number	Rate per 100 encounters	Number	Rate per 100 encounters	Number	Rate per 100 encounters
1	Hypertension	2,185	18.5	Hypertension	3,068	20.4
2	Diabetes	973	8.2	Immunisation—all	1,138	7.6
3	Immunisation—all	867	7.3	Osteoarthritis	1,033	6.9
4	Lipid disorders	673	5.7	Diabetes	873	5.8
5	Osteoarthritis	575	4.9	Lipid disorders	806	5.4
6	Ischaemic heart disease	567	4.8	Prescription—all	579	3.9
7	Atrial fibrillation/flutter	404	3.4	Oesophagus disease	576	3.8
8	Oesophagus disease	403	3.4	Osteoporosis	573	3.8
9	Prescription—all	374	3.2	Sleep disturbance	485	3.2
10	General check-up	369	3.1	Urinary tract infection	475	3.2
11	Malignant neoplasm skin	322	2.7	Depression	474	3.2
12	Solar keratosis/sunburn	302	2.6	Atrial fibrillation/flutter	388	2.6
13	Chronic obstructive pulmonary disease	300	2.5	Back complaint	380	2.5
14	Acute bronchitis/bronchiolitis	297	2.5	General check-up	354	2.4
15	Sleep disturbance	272	2.3	Dementia (incl senile, Alzheimer's)	350	2.3
16	Heart failure	268	2.3	Ischaemic heart disease	340	2.3
17	Malignant neoplasm prostate	265	2.2	Acute bronchitis/bronchiolitis	330	2.2
18	Back complaint	252	2.1	Anxiety	325	2.2
19	Depression	231	2.0	Solar keratosis/sunburn	320	2.1
20	Cardiac check-up	231	2.0	Chronic ulcer skin (incl varicose ulcer)	294	2.0
	<i>Total (20 leading problems)</i>	<i>10,130</i>		<i>Total (20 leading problems)</i>	<i>13,160</i>	
	<i>Total problems 65+</i>	<i>19,742</i>	<i>167.0</i>	<i>Total problems 65+</i>	<i>25,963</i>	<i>172.8</i>
	<i>Total encounters 65+</i>	<i>11,822</i>	<i>100.0</i>	<i>Total encounters 65+</i>	<i>15,024</i>	<i>100.0</i>

Source: AIHW analysis of 2005–06 BEACH database.

involve referral to other health professionals, such as a physiotherapist, dietician or occupational therapist. Patients may agree to a home visit for an assessment of home safety and equipment needs. Assessment covers the medical, physical, psychological and social aspects of health and pays close attention to whether preventive health care and education should be offered. It provides an opportunity for older people to discuss with a GP any area of concern about their health.

Over 240,000 such services were recorded in 2005–06 (Table 30.4). Just over half the assessments were performed in doctors' consulting rooms; the rest were performed in other settings, which may include the patient's home.

Assessments were received by approximately 191 per 1,000 people aged 75 years and over. Assessments were accessed by relatively more people aged 75–84 years than people aged 85 years and over, and relatively more women than men. A lower rate of assessment of people aged 85 and over (150 assessed per 1,000 population) compared with that of people aged 75–84 years (204 assessed per 1,000 population) may in part reflect the greater propensity of the very old to live in residential settings where there is ongoing access to nursing care (comprehensive medical assessment for new and existing residents in aged care homes is funded under a Medicare item different from voluntary health assessments for older people).

Table 30.4: Voluntary annual health assessments for people aged 75 and over^(a), by sex, 2005–06

Sex/age	Location of assessment			Total services	Rate per 1,000 population ^(d)
	In GP consulting rooms ^(b)	Other ^(c)			
Males					
75–84	45,470	34,687		80,157	193
85+	6,678	7,552		14,230	140
Total	52,148	42,239		94,387	183
Females					
75–84	58,566	56,022		114,588	212
85+	14,014	19,107		33,121	155
Total	72,580	75,129		147,709	196
Persons					
75–84	104,036	90,709		194,745	204
85+	20,692	26,659		47,351	150
Total	124,728	117,368		242,096	191

(a) 242,098 assessments of people aged 75 and over under MBS item numbers 700 and 702 (table excludes 2 cases with unknown patient age). An additional 2,517 assessments were performed for Aboriginal and Torres Strait Islander peoples aged 55 and over, under different item numbers.

(b) MBS item no. 700.

(c) MBS item no. 702.

(d) Based on the estimated resident population aged 75 and over at 30 June 2005.

Source: AIHW analysis of Medicare statistics (data downloaded from <www.medicare.gov.au> on 5 April 2007); ABS 2006d.

Medications are commonly used by older Australians to treat and manage illness and health conditions. Broadly defined, these include prescription pharmaceuticals, over-the-counter medications and vitamins and minerals. Prescription pharmaceuticals are provided through pharmacies and hospitals, with a wide range subsidised under the Pharmaceutical Benefits Scheme (PBS).

Prescribing patterns

Age

The level of use of pharmaceuticals generally increases with age. Data from the Bettering the Evaluation and Care of Health survey (BEACH) show that the number of prescriptions written at each encounter with a general practitioner rises with advancing age of the patient (AIHW: Britt et al. 2007). About 60 per 100 encounters with patients aged 25 years and under resulted in the provision of a prescription in 2005–06—for those aged 65 years and over the rate rose to over 100 per 100 encounters.

Types of medications prescribed

Data from the BEACH surveys of general practitioners reveal the types of medications prescribed to older Australians, and how prescriptions for these medications have changed over time. An important caveat for interpreting the results of the BEACH survey should be noted—a prescription, irrespective of the number of repeats ordered, is counted only once.

The results of the 2005–06 survey show that women and men aged 65 and over were prescribed medications at similar rates (131 and 123 per 100 encounters, respectively). Antihypertensive medication, for the treatment of high blood pressure, was the most frequently prescribed medication for both sexes (Table 31.1). With a prescription rate of almost 19 per 100 encounters, antihypertensives were prescribed at more than double the rate of the next most common medication (simple analgesics for women, immunisation for men).

Other common medications prescribed to both sexes were other cardiovascular system drugs (7.4 per 100 encounters for males, and 6.3 for females), beta-

Table 31.1: Top 15 groups of medications prescribed for people aged 65 and over, by sex, 2005–2006

Rank	Males	Rate per 100 encounters	Females	Rate per 100 encounters
1	Antihypertensive	18.5	Antihypertensive	18.8
2	Immunisation	8.4	Simple analgesics	8.7
3	Other cardiovascular system drugs ^(a)	7.4	Immunisation	8.4
4	Simple analgesics	6.9	Other cardiovascular system drugs ^(a)	6.3
5	Hypoglycaemic agents	5.7	Diuretics	5.1
6	Antilucerant	4.8	Non-steroidal anti-inflammatory drugs (NSAIDs)	4.6
7	Beta-blockers (for cardiovascular problems)	4.6	Beta-blockers (for cardiovascular problems)	3.9
8	Non-steroidal anti-inflammatory drugs (NSAIDs)	4.3	Hypoglycaemic agents	3.9
9	Other blood drug ^(b)	4.2	Sedative/hypnotic	3.6
10	Penicillin/cephalosporins	3.2	Penicillin/cephalosporins	3.6
11	Broad spectrum penicillin	2.8	Narcotic analgesics	3.5
12	Narcotic analgesics	2.8	Other antibiotics ^(c)	3.4
13	Other antibiotics ^(c)	2.7	Nutrition/metabolism/other	3.3
14	Bronchodilator/spasm relaxant	2.6	Antidepressants	3.1
15	Anti-angina	2.6	Anti-anxiety agents	2.9
	Total prescribed (all medication groups)	122.9	Total prescribed (all medication groups)	131.4

(a) Cardiovascular system drugs other than antihypertensive, anti-arrhythmic, anti-angina, cardiac glycoside, beta-blocker, adrenergic stimulant, peripheral vasodilator, antimigraine and hypolidaemic agents.

(b) Blood drugs other than haemopoietic.

(c) Antibiotics other than penicillin/cephalosporin, broad spectrum penicillin, tetracycline, antifungal, sulphonamide and anti-infective.

Source: AIHW analysis of 2005–06 BEACH data.

blockers and non-steroidal anti-inflammatory drugs. The greatest difference in prescription rates for older women and men, (for medications which were in the top 15 prescribed for both sexes) were for simple analgesics and hypoglycaemic agents (a difference of 1.8 encounters for both medication groups). Simple analgesics were prescribed at the higher rate for women, and hypoglycaemic agents were prescribed at the higher rate for men.

Differences in the types of medications prescribed to older women and men reflected the most frequent types of problems managed by GPs for each sex (see Topic 30: *General practitioner services*). Medications for mental wellbeing were among the top 15 prescribed medications for older women, but not for men. Sedative/hypnotic medication, anti-depressants and anti-anxiety medications were prescribed to older women at a rate of around 3–4 out of every 100 encounters. Other medications that were in the top 15 for one sex but not for the other included anti-ulcerant medication for older men and diuretic medication for older women.

Trends in medications prescribed

Prescriptions for the majority of medication groups have risen since the 2000–01 BEACH survey (which was reported in the previous edition of this publication). The total prescription rate rose by an average of 5.6 per 100 encounters for both older women and older men. Most notable is the rise in prescriptions for immunisation. A prescription or provision of an immunisation occurred in 8.4 per 100 encounters for both sexes—an increase of 4.5 encounters since 2000–01. The majority of immunisation prescriptions were for protection against influenza, which reflects government policy to promote flu vaccination to older people. The National Influenza Vaccine Program for Older Australians provides free influenza (and pneumococcal since 2005) vaccinations to Australians aged 65 years and over and to Indigenous Australians aged 50 years and over.

In contrast to the rise in immunisation provisions, prescriptions for non-steroidal anti-inflammatory drugs (NSAIDs) fell considerably since 2000–01. A decline from 7.3 to 4.6 per 100 encounters was noted for women and from 6.6 to 4.3 for men. This decline may, in part, reflect tightened Therapeutic Goods Administration measures on the prescribing of anti-arthritis drugs known as Cox-2 inhibitors (a type of NSAID) (Therapeutic Goods Administration 2005). The 2004–05 general practice activity report (AIHW: Britt et al. 2005) identified that the withdrawal of rofecoxib (a Cox-2 inhibitor) from the market had an impact on the prescription rate of NSAIDs.

Small declines in the prescriptions of other medication groups were gender-specific. Prescriptions for antidepressants and anti-anxiety agents fell slightly for women, and bronchodilator/spasm relaxant, diuretic and anti-angina medications declined for men.

Prescriptions for dementia

Prescription rates for medications for dementia are recorded by the PBS and the Repatriation Pharmaceutical Benefits Scheme (RPBS). Three dementia-specific drugs (anticholinesterases) are funded under the two schemes: Donepezil, Galantamine and Rivastigmine (AIHW 2007e). In 2004–05, there were 315,020 prescriptions under the PBS/RPBS for these drugs, with prescriptions for Donepezil making up the majority (66%).

Medication use

National Health Priority Area conditions

The 2004–05 ABS National Health Survey collected self-report data about medication use (both prescription pharmaceuticals and other medications) for National Health Priority Area conditions. National Health Priority Areas are cancer control, injury prevention and control, cardiovascular health, diabetes mellitus, mental health, asthma, and arthritis and musculoskeletal conditions. The most commonly used medications for priority conditions by people aged 65 years and over were medications for heart conditions (Table 31.2). Over 500 per 1,000 older people took medication for a heart condition in 2004–05; with the rate of use peaking at 600 per 1,000 persons aged 75–84 years.

Medications for arthritis—the second most common medication for priority conditions—were taken by just over 300 per 1,000 older people. Like medications for heart conditions, use of arthritis medication peaked at ages 75–84 years. The usage rate of medication for mental well-being, however, continued to increase with increasing age, with 280 per 1,000 people aged 85 years and over taking medication for mental wellbeing in 2004–05 (see Topic 23: *Mental health*).

Medications for diabetes and asthma were used at much lower rates than the medications used for the other health conditions. Just over 95 per 1,000 older people took medication for diabetes and 70 per 1,000 took medication for asthma.

Polypharmacy

Polypharmacy, the use of multiple medications at a time, is common among older people. The use of multiple medications increases with age. A South Australian survey (Goldney R & Fisher L 2005) found that 25% of people aged 65 years and over used four or five medicines concurrently. Although polypharmacy is often necessary for people with many health conditions (and may be the best treatment), it increases the risk of adverse events that can lead to hospitalisation. Data from the Australian Council for Safety and Quality in Health Care (2002) (now the Australian Commission on Safety and Quality in Health Care) show that for older people, approximately one in five unplanned admissions to hospital are medication-related.

Expenditure

The PBS, funded by the Australian Government, provides a subsidy for over 800 drug substances (AIHW 2006c). Subsidies are provided to the public at a general and concession rate. People who hold a

Pensioner Concession Card, Commonwealth Seniors' Health Card or Australian Government Health Care Card are eligible for concession benefit. Australians who are veterans, war widows or widowers and dependants may additionally be eligible for the RPBS. The White, Gold and Orange Cards issued by the Department of Veterans' Affairs determine the level of access to RPBS benefits.

Expenditure under the PBS for people of all ages totalled \$6.2 billion in 2005–06 (DoHA: Data and Modelling Section Pharmaceutical Policy and Analysis Branch 2006). Benefits paid under the RPBS in 2005–06 totalled \$465.7 million (DVA 2006a).

Per person expenditure on pharmaceutical benefits is higher for older age groups than for younger age groups (Table A31.1, Costello 2007). Per person expenditure on pharmaceutical benefits peaks for the 75–84 years age group where it is 4.5 times total per person expenditure. About one-fifth of expenditure on pharmaceutical benefits was for this age group (21%) and almost one-quarter (24%) was for people aged 65–74 years (Figure 31.1).

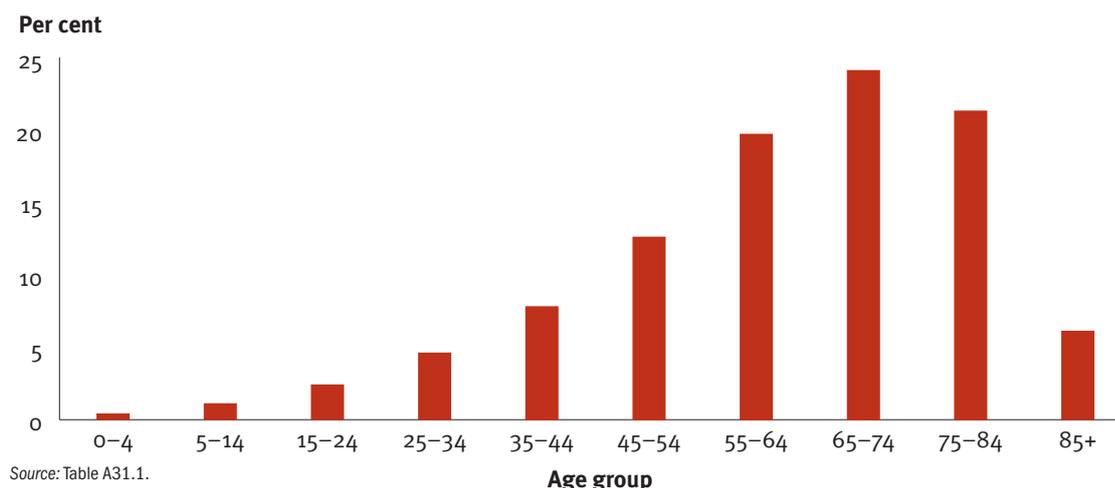
Table 31.2: Age-specific usage rates of medications for priority health conditions

Treatment area	65–74	75–84	85+	65+
	Rates per 1,000			
Ischaemic heart diseases	485.8	600.7	575.2	535.0
Arthritis	295.9	331.8	309.3	310.1
Mental wellbeing	231.7	246.3	280.3	240.9
Diabetes	98.5	93.7	81.3	95.4
Asthma	78.1	55.6	77.1	69.8

Note: The National Health Survey collects information only from people living in private dwellings. Because a significant proportion of people aged 85 and over live in aged care facilities, these rates need to be interpreted with this in mind.

Source: AIHW analysis of the 2004–05 ABS National Health Survey (ABS 2006q).

Figure 31.1: Government expenditure on pharmaceuticals by age group, as a proportion of total government expenditure on pharmaceuticals, 2005–06



Source: Table A31.1.

The Australian population has shown improved oral health over recent decades, with decreased tooth loss among adults (ABS 1979; AIHW: Carter & Davies 2002; see also Topic 27: *Oral health*). This is most pronounced among adults aged 75 years and over—the proportion of this age group who have lost all their teeth has declined from 36% to 27% between 1987–88 and 2004–06. Demographic changes are projected to increase the population of middle to older aged adults (see Topic 2: *The changing demographic profile*). Consistent with these population trends, there has been an increase in the proportion of middle-aged and older adults attending for private dental care (AIHW: Brennan & Spencer 2006). With declines in the prevalence of complete tooth loss and in the numbers of missing teeth, the dental needs of adults may increase because of the larger pool of teeth at risk (Joshi et al. 1996).

Changing demographics and technological advances are expected to lead to higher patient expectations and to a greater demand for oral health care (Douglass & Sheets 2000). With more people retaining their teeth and the age structure of the population changing, shifts in service provision have been observed among dental patients in private general practice and dental service patterns have changed towards more prevention and maintenance of natural teeth (Brennan & Spencer 2006).

Service provision in private general dental practice

In Australia the vast majority of dental practitioners are in the private sector (83%). The provision of oral health services is dominated by general dental practitioners (85%), with a small percentage of dental practitioners in specialist and restricted practice (12%), and the remainder in areas such as administration, teaching and research (AIHW: Teusner & Spencer 2003). Findings are presented in Table 32.1 for patients aged 55–64 years and 65 years and over from the 2003–04 Longitudinal Study of Dentists' Practice Activity.

Overall, older private dental patients received fewer fillings, and crowns. However, older patients had higher rates for dentures, and similar rates for total services per visit.

Trends in private dental service provision over time are presented in Figure 32.1. Patients aged 65 years and over tended to show increases in rates of dental service provision over time, with increases noted in the diagnostic service area for both oral examinations and radiographs, and also for provision of crowns. Increases in services such as these have contributed to an overall increase in total services per visit, which grew from 1.97 in 1993–94 to 2.08 in 1998–99 to 2.24 in 2003–04.

Table 32.1: Services per visit for dentate private dental patients, by age, 2003–04

	55–64	65 and over
	Mean [95% CI]	Mean [95% CI]
Oral examinations	0.39 [0.36, 0.43]	0.42 [0.37, 0.45]
X-rays	0.26 [0.21, 0.30]	0.23 [0.19, 0.28]
Fillings	0.74 [0.65, 0.83]	0.64 [0.56, 0.72]
Dental prophylaxis	0.25 [0.21, 0.28]	0.25 [0.22, 0.29]
Extractions	0.07 [0.04, 0.08]	0.09 [0.05, 0.13]
Endodontics/root canal treatment	0.11 [0.07, 0.15]	0.10 [0.06, 0.13]
Crowns	0.11 [0.08, 0.14]	0.07 [0.05, 0.09]
Dentures	0.15 [0.09, 0.21]	0.26 [0.16, 0.36]
Total services per visit	2.29 [2.17, 2.40]	2.24 [2.10, 2.38]

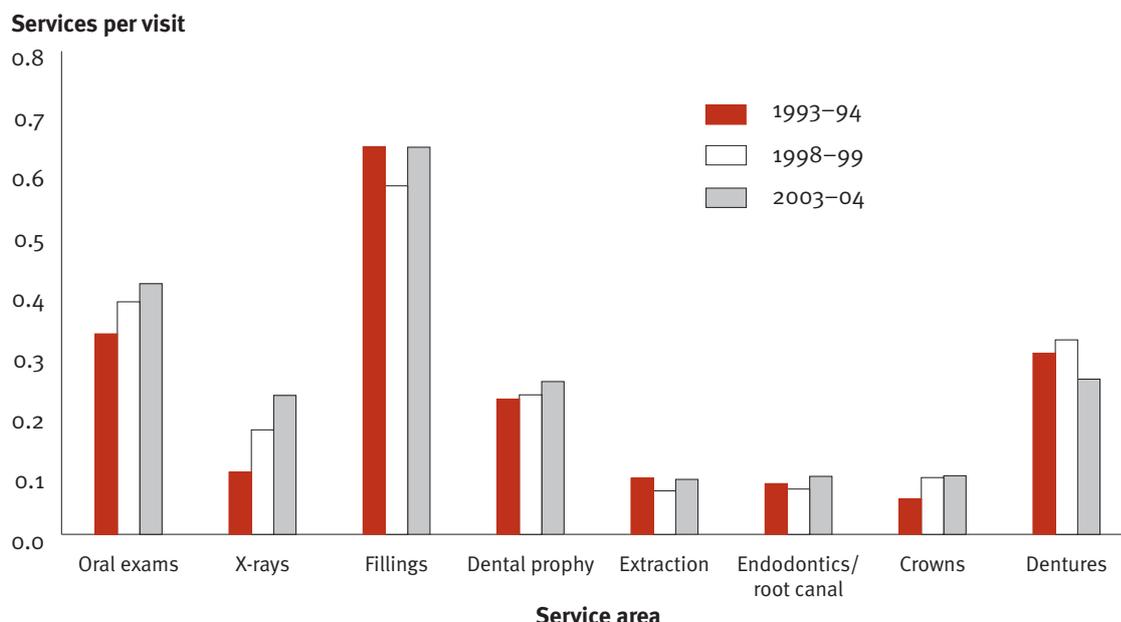
Notes

1 Total services per visit also includes periodontic, orthodontic and general/miscellaneous services.

2. 95% CI is the 95% confidence interval.

Source: Longitudinal Study of Dentists' Practice Activity 2003–04.

Figure 32.1: Trends in service provision in private general practice among patients aged 65 and over, 1993–94 to 2003–04



Source: AIHW: Brennan & Spencer 2006; see also Table A32.1.

Public dental patients

Health card holders such as aged pensioners and the unemployed constitute a low-income group and are the target population eligible for publicly-funded dental care. All Australian states and territories provide public dental services. These services are largely provided at minimal or no direct cost to the patient by publicly employed dentists in government clinics located in major regional centres, often associated with district hospitals or health centres. These clinics provide access to a restricted level of care and generally do not include all aspects of dental treatment (AHMAC Steering Committee for National Planning for Oral Health 2001).

Adults receiving public dental care have been shown to have high levels of emergency visits resulting in higher

rates of extraction than patients attending for private dental care (Brennan et al. 1997). This indicates a pattern of service provision that is unfavourable to the goal of maintaining a functional natural dentition for life. This is most likely to be a reflection of access problems such as waiting time for dental care among public dental patients. Findings from the 2001–02 Adult Dental Programs Survey are presented in Table 32.2 for patients attending for public dental care. A higher percentage of male public dental patients received emergency care.

The percentage of public patients receiving emergency care was higher than that reported for private general practice (29.2% of visits by people aged 65 and over were for emergency care).

Table 32.2: Dentate public dental patients attending for emergency care, by age and sex, 2001–02

	55–64	65–74	75–84	85+	65+
	Per cent				
Males	47.2	48.8	52.3	46.7	49.5
Females	43.2	41.5	34.6	41.3	39.5
Persons	45.1	45.2	42.1	44.4	44.3

Source: Adult Dental Programs Survey 2001–02.

Hospitals are a major component of Australia's healthcare system. In 2004–05, hospitals accounted for over one-third (35% or \$29 billion) of recurrent health expenditure; expenditure on hospitals accounted for the largest proportion of real growth in recurrent health expenditure over the decade to 2004–05 (34%; AIHW 2006d). People in the older age groups make relatively high use of hospital services, and, hence, an ageing population presents a significant challenge for the management of supply of and demand for hospital services. This chapter examines some key aspects of hospital use by older people.

Access to hospital care is gained through referral by a medical practitioner performing primary or specialist care, through an emergency department, or via outpatient departments. When a person receives treatment as an admitted patient, the event is recorded as a 'separation', which indicates that a hospital stay was formally concluded. If a patient is treated in an emergency department and is not admitted to hospital, the event is recorded as a non-admitted patient emergency department occasion of service.

Number of visits

In 2004–05, 2.5 million separations were recorded by public and private hospitals throughout Australia for older admitted patients (65 and over), representing 35% of all separations (Table 33.1; AIHW 2006a).

Separation rates in the older age groups are considerably higher than the national average rate. Compared with a crude national rate of 340 separations per 1,000 population (AIHW 2006a), the age group 65 years and over recorded 926 separations per 1,000 persons (Table 33.1). Within the mature-age population, that is, 45 years and over, age-specific rates of separation increase with increasing age up to the 75–84 age group, for both males and females. The older male population recorded a higher rate of separation compared with older females (1,050 separations per 1,000 males versus 825 per 1,000 females).

Same-day separations constituted 53% of all older patient separations in 2004–05, which reflects a higher proportion of same-day separations than multi-day stays for older male patients. Older female patients

Table 33.1: Hospital separations for people aged 45 and over by same-day status, 2004–05

Age (years)/sex	Separations (per cent)			Total number	Number per 1,000 population
	Not same-day	Same-day	Total		
	Per cent			Number	
Males					
45–64	37.6	62.4	100.0	988,224	397
65–74	39.2	60.8	100.0	588,474	862
75–84	45.5	54.5	100.0	540,759	1,304
85+	64.4	35.6	100.0	130,063	1,277
Total 65+	44.5	55.5	100.0	1,259,296	1,050
Females					
45–64	35.5	64.5	100.0	964,971	387
65–74	38.2	61.8	100.0	505,188	705
75–84	51.5	48.5	100.0	510,573	946
85+	74.3	25.7	100.0	196,261	921
Total 65+	49.6	50.4	100.0	1,212,022	825
Persons					
45–64	36.5	63.5	100.0	1,953,195	392
65–74	38.7	61.3	100.0	1,093,662	782
75–84	48.4	51.6	100.0	1,051,332	1,102
85+	70.3	29.7	100.0	326,324	1,036
Total 65+	47.0	53.0	100.0	2,471,318	926

Notes

1. Table includes care types of acute care, rehabilitation, palliative care, geriatric evaluation and management, psychogeriatric care, maintenance care, other admitted patient care. Excludes care types of hospital boarder and posthumous organ procurement.
2. Rates (per 1,000 population) are based on the estimated resident population at 30 June 2005 (preliminary; ABS 2006d).

Source: AIHW analysis of the National Hospital Morbidity Database.

recorded equal proportions of same-day and multi-day separations. Same-day separations have increased as a proportion of total separations for both males and females since 2000–01 (AIHW 2002b). Much of the shift towards same-day separations for both sexes has been associated with increases in same-day cataract procedures and more same-day treatment of endocrine, nutritional and metabolic conditions.

For both males and females, same-day admission and discharge accounts for a reducing proportion of separations as age increases: from 61% of separations for males aged 65–74 years to just 36% for males aged 85 years and over, and from 62% of separations for females aged 65–74 years to 26% of separations for females aged 85 years and over (Table 29.1). This probably reflects different patterns of reason for admission to hospital of the ‘young old’ and the ‘old old’, which can be further explored by looking at principal diagnosis and care type by age group (see also Topic 34: *Reasons for admission to hospital*).

Detailed episode-level data on non-admitted patient emergency department occasions of service were reported for 76% of public hospitals in 2004–05. The data include 797,756 occasions of service for people aged 65 years and over, which make up approximately 18% of records in the non-admitted patient emergency department data set (AIHW 2006a).

Number of days and length of stay

Not only does the rate of separation from hospital increase with age, so too does the average number of days per stay (Table A33.1). In 2004–05, patients aged 65 years and over accounted for 11.4 million patient days, or 48% of all patient days (AIHW 2006a).

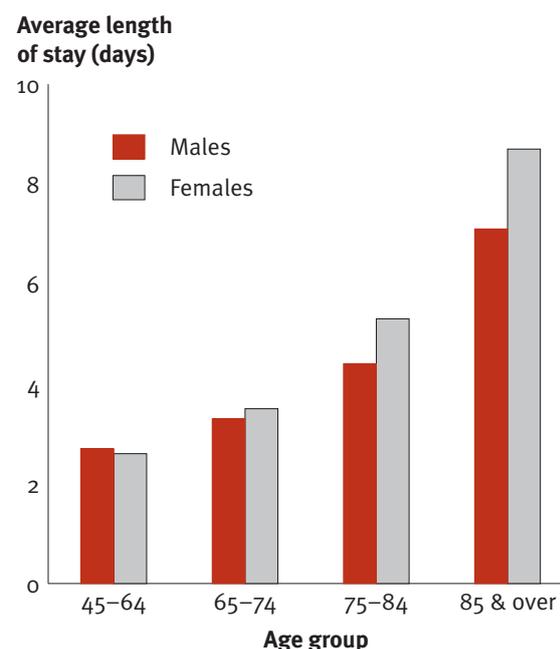
Older patients stayed in hospital for an average of 4.6 days, including same-day separations (down from 5.3 days in 2000–01). Average length of stay increases with increasing age, rising to 8.0 days for patients aged 85 years and over (Figure 33.1). Excluding same-day separations, length of stay for patients aged 85 and over averaged 11.3 days for women and 10.5 days for men.

The number of days that a patient stays in hospital is a function of patient clinical factors, for example the conditions being treated, type of treatment received, patient response to treatment and functional status; other factors relating to individual circumstances such as living arrangement and availability of support at home following discharge; and health system factors, including hospital discharge planning arrangements

and the availability and settings for receipt of care other than acute care, such as rehabilitation care and geriatric management and evaluation (Gray 2002; Liu et al. 2001). The way that a patient’s stay in hospital is sometimes recorded as multiple separations owing to changes in care type during the one continuous episode of care leads to a downwards bias in average length of stay when calculated using separations. This bias is more prevalent in the case of older patients because of their higher propensity to experience a change in care type (care types are discussed below; see also AIHW: Karmel et al. 2007).

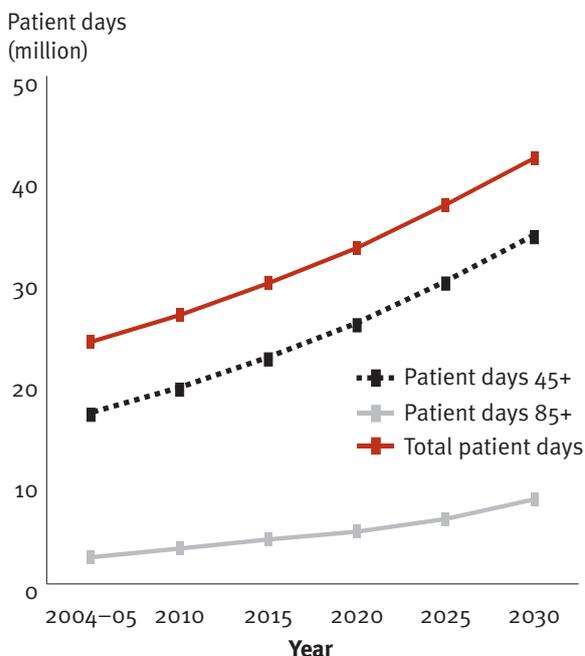
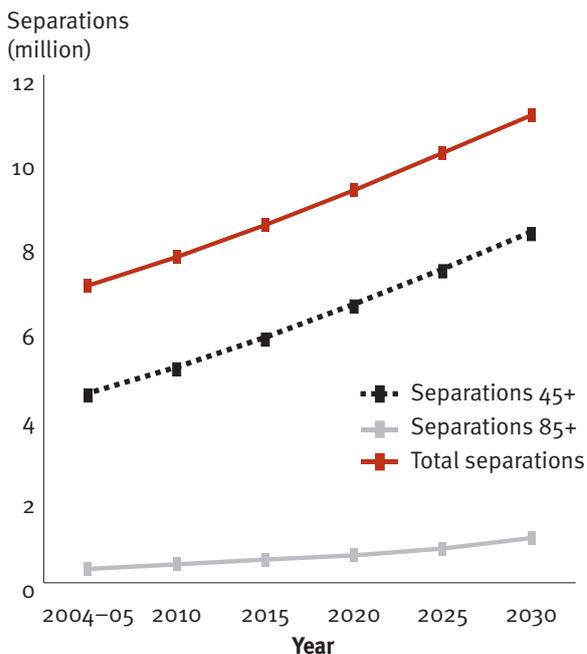
When the large baby boomer generation enters the age groups traditionally associated with higher separation rates and longer stays these two factors will contribute to increased demand for hospital services. If current rates of hospital separation and patient days by age and sex were to prevail for the next 25 years (that is, assuming that, with respect to age and sex, people continue to present to hospitals for the same conditions currently being treated in hospitals and that treatments result in similar length of stay outcomes as in 2004–05) there would be an increase from 7 million total separations in 2004–05 to around 11 million in 2030 and a corresponding increase from around 24 million to 42 million patient days (Figure 33.2).

Figure 33.1: Average length of stay in hospital per hospital separation, 2004–05



Source: Table A33.1.

Figure 33.2: Actual (2004–05) and projected (2010–2030) annual number of separations and patient days, by age



Source: AIHW analysis of National Hospital Morbidity Database; ABS 2003d.

Type of care received

Hospital separations can be classified according to the type of care received using the broad categories of acute care, rehabilitation, palliative care, geriatric evaluation and management (GEM), psychogeriatric care, maintenance care or other type of care. Higher proportions of separations for non-acute care are observed for the older, compared with younger, patients.

Acute care accounts for lower proportions of separations for patients aged 75–84 years (74%) and 85 years and over (66%), compared with separations for patients aged 65–74 years (82%) or under 65 years (99%) (AIHW 2006a). This is due mainly to higher proportions of separations in the older age groups that are classified as rehabilitation or maintenance care. According to AIHW: Health Data Standards Committee (2006), maintenance care is 'care in which the clinical intent or treatment goal is prevention of deterioration in the functional and current health status of a patient with a disability or severe level of functional impairment. Following assessment or treatment the patient does not require further complex assessment or stabilisation, and requires care over an indefinite period. This care includes that provided to a patient who would normally receive care in another setting, for example at home, or in a residential aged care service, by a relative or carer, that is unavailable in the short term. In 2004–05, over 26% of patient days for patients aged 85 years and over were classified as maintenance care or rehabilitation (Table A33.2).

When a person is admitted to hospital, information about the health conditions that cause or contribute to admission, or which influence, affect, or arise during treatment is recorded on the patient record. Of all the diagnoses recorded, the principal diagnosis is defined as 'the diagnosis established, after study, to be chiefly responsible for occasioning the admitted patient's episode of care in hospital' (AIHW 2006a). This section examines the principal diagnoses recorded on older patient separations, with a focus on types of (often preventable) injury that result in hospitalisation.

When a person experiences multiple chronic health conditions, it can be difficult to identify one condition that is responsible for hospitalisation. The interaction of multiple conditions, medication use and social factors can contribute significantly to the need for hospitalisation among older people and the complexity and cost of treatment. The likelihood of a person having multiple chronic conditions increases with age, but good primary care can reduce the risk of hospitalisation associated with many of these conditions. Another issue related to demand for hospital services by older people is their exposure to preventable causes of injury and their greater likelihood of experiencing an adverse event during an episode of care. One approach to managing increasing demand for hospital services by an ageing population is to monitor and reduce rates of preventable hospitalisation and adverse events.

Principal diagnosis

Table 34.1 shows the number and percentage of hospital separations of people aged 65 and over in 2004–05 by principal diagnosis, based on broad diagnosis categories in the International Classification of Diseases 10th revision Australian Modification (ICD-10-AM).

Four of these categories accounted for approximately 60% of older patient separations in 2004–05: *Factors influencing health status and contact with health services*, *Diseases of the circulatory system*, *Neoplasms* (benign and malignant tumours), and *Diseases of the digestive system*. The first three were also the top three when ranked by patient days (Table 34.1). *Injury, poisoning and other consequences of external causes* accounted for a higher number of patient days (956,977) than *Diseases of the digestive system* (713,489) and is thus ranked fourth in terms of older patient days by principal diagnosis category.

Factors influencing health status and contact with health services accounted for almost 30% of older

patient separations. Although 85% of separations in this category were for patients admitted and discharged on the same day, *Factors influencing health status and contact with health services* still accounted for more older patient days than any other category (Table 34.1). This category covers need for specific types of medical examination and investigation, care involving dialysis, care involving rehabilitation procedures, attention to artificial openings and prosthetic devices, and presentation of potential health hazards related to socioeconomic, psychosocial, personal and family circumstances:

- care involving dialysis accounted for the highest number of separations of older patients within this category (399,485), all for patients admitted and discharged on the same day
- the two diagnoses that accounted for the highest numbers of older patient days within this category in 2004–05 were *Care involving the use of rehabilitation procedures* (1,337,160 days) and *Problems related to medical facilities and other health care* (656,989 days). Most days recorded for older patients under the latter code were for separations coded as *Persons awaiting admission to residential aged care service* (452,930 days), for which average length of stay was 35 days.

Diseases of the circulatory system include any disease that affects the heart and blood vessels. *Angina pectoris* (severe pain over the heart that signals a possible impending heart attack) was associated with the highest number of separations of older people in 2004–05 (48,101 separations; average stay 3.7 days). Principal diagnosis of *heart failure* was associated with higher average length of stay (8.1 days) and patient days (289,386) than *angina pectoris*, despite fewer separations (35,920).

Congestive heart failure was the most frequently recorded specific heart failure principal diagnosis (73%), accounting for 251,299 older patient days. *Congestive heart failure* is one of a number of 'ambulatory sensitive care conditions'—chronic conditions for which access to timely and effective primary care can reduce the risk of hospitalisation, particularly in older populations (Culler et al. 1998; Zeng et al. 2006; Menec et al. 2006). Close monitoring of rates of potentially avoidable hospitalisations for elderly patients in Australian hospitals contributes to improved outcomes for older people with chronic conditions and more effective use of hospital services.

Other cardiovascular principal diagnoses associated with relatively high volumes of hospital patient days

include *Acute myocardial infarction*, commonly known as heart attack (28,790 separations; average 6.5 days) and *Cerebral infarction*, or stroke (11,468 separations; average 12.5 days).

A neoplasm, or tumour, is an abnormal, uncontrolled and progressive tissue growth. Tumours can occur throughout the body but in older people the tumours associated with the highest number of separations are those that occur in skin tissue. *Malignant melanoma of skin* and *Other malignancies of the skin* were principal diagnoses on 50,168 separations of older patients in 2004–05, together accounting for 97,196 patient days. *Malignant neoplasm of the colon* (11,585 separations) and *Malignant neoplasm of bronchus and lung*, or lung cancer (11,744 separations), contributed the highest volumes of patient days for older people: 102,181 and 99,793 days respectively.

Principal diagnoses for digestive system diseases and disorders were recorded for 222,154 older patient separations. The most common principal diagnosis in this category was *Diverticular disease of the intestine* (22,618 separations; 64,590 patient days). Diverticular disease is a condition of the large intestine (colon) in which small sacs or pouches (diverticula) form at weak points in the intestinal wall, thought to be caused by genetic factors or a diet low in fibre (over a third of older people have reported having diets low in fruit and vegetables; see Topic 15: *Ageing and health risk factors*, Table 15.2). Diverticular disease is a common diagnosis made by GPs for patients who present with abdominal pain.

Among principal diagnoses classified as *Injury, poisoning and other consequences of external causes*, fracture of the femur was the most frequently recorded on older patient separations (21,645). At an average of 11.8 days per separation, older patients admitted to hospital for femoral fractures accumulated 254,395 patient days in 2004–05. Fracture of the neck of femur (hip fracture) is the most frequently recorded femoral fracture associated with hospitalisation (49% of separations for femoral fracture). AIHW: Kreisfield & Newson (2006) have reported that most hip fractures are the result of falls (91%). The most common mechanism of falls that result in hospitalisation for older people with fractures is slipping, tripping and stumbling on a level surface (AIHW analysis of National Hospital Morbidity Database). Hip fractures impose a heavy burden on the community through death and increased morbidity, causing increased dependency, reduced quality of life, increased demands on families for the provision of care, high costs associated with

acute care, rehabilitation and long-term institutional care (AIHW: Kreisfield & Newson 2006; Swanson et al. 2000).

Other principal diagnoses in this category associated with high numbers of older patient days in 2004–05 include:

- fracture of lumbar vertebra (6,351 separations; 80,351 patient days)
- complications of internal orthopaedic prosthetic devices, implants and grafts, such as mechanical complication, infection or inflammatory reaction (8,065 separations; 91,727 patient days)
- complications with procedures, not elsewhere classified, for example, haemorrhage, shock, accidental puncture during a procedure, or disruption of an operation wound (10,346 separations; 79,095 patient days).

This overview of the predominant reasons for hospitalisation of older people serves to highlight the importance of initiatives that encourage healthy and active lifestyles (at all ages) and safe living environments. Successful targeting of the causes of chronic disease, improved primary care of chronic conditions, initiatives aimed at reducing injury, and close monitoring of clinical pathways of older surgical patients all contribute to reduced population disability and hospital use.

External causes of injury and illness

As indicated above, many admissions to hospital are the result of factors other than disease processes. An important category of principal diagnosis as a cause of hospitalisation is injury and effects owing to external—often preventable—causes. Injury prevention and control is one of seven National Health Priority Areas. The National Falls Prevention for Older People Initiative sits under this Health Priority Area.

Approximately 122,500 hospital separations for older patients in 2004–05 were associated with injury, poisoning or other consequence of an external cause. In the treatment of injuries it is not uncommon for patients to be transferred between hospitals or for a patient episode to be administratively split and recorded as multiple separations for different types of care. For example, a patient might remain in the same hospital but be reclassified from acute care to rehabilitation care and this would normally generate two separations for the patient; changes in care type

Table 34.1: Separations and patient days for patients aged 65 and over by principal diagnosis (ICD-10-AM chapter), all hospitals 2004–05

Principal diagnosis (ICD-10-AM chapter)	Not			Not			Patient days Number
	same-day	Same-day	Total	same-day	Same-day	Total	
	Number			Per cent			
Factors influencing health status and contact with health services	110,662	631,925	742,587	9.5	48.3	30.0	2,851,885
Diseases of the circulatory system	217,318	49,147	266,465	18.7	3.8	10.8	1,580,402
Neoplasms	121,751	120,800	242,551	10.5	9.2	9.8	1,147,160
Diseases of the digestive system	108,268	113,886	222,154	9.3	8.7	9.0	713,489
Symptoms, signs and abnormal clinical and laboratory findings	89,198	62,835	152,033	7.7	4.8	6.2	481,719
Diseases of the eye and adnexa	15,592	130,486	146,078	1.3	10.0	5.9	158,607
Diseases of the musculoskeletal system and connective tissue	88,900	37,519	126,419	7.7	2.9	5.1	701,508
Injury, poisoning and other consequences of external causes	100,785	21,764	122,549	8.7	1.7	5.0	956,977
Diseases of the respiratory system	102,507	11,259	113,766	8.8	0.9	4.6	829,546
Diseases of the genitourinary system	63,693	31,108	94,801	5.5	2.4	3.8	385,936
Endocrine, nutritional and metabolic diseases	30,271	25,470	55,741	2.6	1.9	2.3	286,536
Diseases of the nervous system	30,849	15,096	45,945	2.7	1.2	1.9	274,122
Mental and behavioural disorders	23,444	16,908	40,352	2.0	1.3	1.6	540,321
Blood, blood-forming organs and immunological disorders	17,519	20,599	38,118	1.5	1.6	1.5	110,609
Disease of the skin and subcutaneous tissue	20,098	14,382	34,480	1.7	1.1	1.4	205,933
Infectious and parasitic diseases	15,496	2,612	18,108	1.3	0.2	0.7	151,287
Diseases of the ear and mastoid process	4,393	2,755	7,148	0.4	0.2	0.3	19,192
Congenital malformations	642	587	1,229	0.1	–	–	4,358
All ICD chapters	1,161,386	1,309,138	2,470,524	11,399,587
Not reported/not applicable ^(a)	527	267	794	–	–	–	23,659
Total	1,161,913	1,309,405	2,471,318	100.0	100.0	100.0	11,423,246

(a) Includes 792 separations with a missing principal diagnosis and two with principal diagnosis of condition originating in the perinatal period.

Note: Separations for which the care type was reported as Hospital boarder or Posthumous organ procurement are excluded.

Source: AIHW analysis of the National Hospital Morbidity Database.

are recorded as statistical admissions and statistical discharges. Eleven per cent of these injury-related separations were patient transfers (in-transfers) or change in care type, leaving just over 109,000 'hospitalisations' of people aged 65 years and over with a principal diagnosis of injury and one or more external causes recorded (Table A34.1). The following discussion refers to these hospitalisations, not total injury-related separations.

At age 65 years and over, the rate of hospitalisation for injury increases markedly with increasing age. In 2004–05 there were around 78 injury-related hospitalisations per 1,000 men aged 85 and over and 100 per 1,000 women aged 85 years and over, compared with around 25 per 1,000 men and 25 per 1,000 women aged 65–74 years (Table A34.1). Falls were the most frequently recorded external cause, followed by complications of medical and surgical care (Table A34.2). Home was the most common place of occurrence of falls that resulted in hospitalisation (approximately 49% of cases), followed by aged care facilities (22%).

National hospital data on falls and complications of medical and surgical care do not distinguish injuries and complications that occur after admission to hospital, that is, where a patient is admitted to hospital for another reason and experiences an adverse event in hospital. It has been found that older patients are more susceptible to adverse events during a stay in hospital, compared with younger patients³. For example, the occurrence of adverse events associated with elective surgery increases with age: an estimated 22% of patients aged 65 years and over who undergo elective procedures experience one or more complications (Moje et al. 2006) and patients who experience a post-admission adverse event have an estimated mean age of 62.9 years (Ehsani et al. 2006). Ehsani and colleagues estimated the cost of post-admission adverse events in public hospitals in Victoria alone in 2003–04 to have been \$460.3 million (adverse events that take place during a hospital stay can be identified in the Victorian Admitted Patient Episode Data Set).

³ The relevant data element 'Diagnosis onset type' (primary or post-admit condition) is defined in the National Health Data Dictionary (AIHW: Health Data Standards Committee 2006) but is not currently implemented in the Admitted Patient National Minimum Data Set.

The Aged Care Assessment Program (ACAP) is jointly funded by the Australian Government and state and territory governments to support a network of multidisciplinary Aged Care Assessment Teams (ACATs) which operate as a single point of entry to packaged and residential aged care services and as a point of referral to other aged care services. ACATs assess people referred because they need assistance. A referral for ACAT assessment may be a self-referral or it may come via family or friends, health care practitioners or community services known to the person. ACAT assessment of a person's care needs takes into account physical, medical, psychological and social factors and facilitates access to appropriate care services.

ACAT approval is a prerequisite for admission to Australian Government accredited aged care homes (for either permanent or respite care), or to receive a Community Aged Care Package (CACP), an Extended Aged Care at Home (EACH) or Extended Aged Care at Home Dementia (EACH-D) package or a place in the Transition Care Program (TCP). ACATs also function as a source of advice and referral concerning other community services such as those provided by the Home and Community Care Program and the National Respite for Carers Program, but they do not determine eligibility for these services.

Aged Care Assessment Teams

ACATs may be hospital- or community-based. The main professional groups represented in teams are doctors, nurses, social workers, physiotherapists and occupational therapists. The number and composition of staff on teams can vary depending on the location of the team (i.e. whether they are in urban, rural or remote regions), and the role, operation and organisation of teams vary between jurisdictions, partly reflecting the different health system environments within which they operate.

Client profiles

Although the target population for services accessed through ACAT assessment is people aged 70 years and over and Indigenous people aged 50 and over, access to services is based on assessment of care needs, not merely chronological age. Although not part of the ACAT target group, young people with disability may be assessed by ACATs if their care needs cannot be met by other sources.

Almost half of all ACAP clients in 2004–05 (49%) were aged 80–89 years and a further 16% were aged 90 years and over (ACAP NDR 2006:Table 30). Only 3% of ACAP clients were aged less than 60. The average age of clients has increased since 1995–96, with an increase in the proportion aged 85 years and over (from 30% in 1995–96 to 39% in 2004–05). The majority of ACAP clients are female (63%).

Almost three-quarters of clients assessed in 2004–05 (72%) had a severe or profound core activity limitation, that is, they needed assistance or supervision with self-care, movement activities, moving around places at or away from home, or communication (ACAP NDR 2006: Table 35a).

The most common diagnosed health conditions among ACAP clients were diseases of the heart (50,311 clients), arthritis (48,284), hypertension (45,294) and dementia (41,707) (ACAP NDR 2006:Table AB19a). Arthritis was the most commonly recorded main condition, that is, the health condition that has most impact on the person's need for assistance with activities of daily living and social participation. Arthritis was the main health condition for 29,158 clients, followed by dementia (13,889), diseases of the heart (12,980) and eye and vision disorders (12,459) (ACAP NDR 2006:Table AB19b).

Assessments and recommendations

Recommendations and approvals in relation to care needs and care arrangements are made following comprehensive assessment and remain valid for 12 months unless otherwise specified. If a person's care needs change to the extent that a different level or type of care is required within a 12-month period, he or she may need to be reassessed. Once approval is granted and should the client wish to proceed, the client is then directed to the appropriate service providers. Receipt of services is then subject to the availability of places and other such considerations as client and family care preferences.

Generally, the waiting time to receive an ACAT assessment is short. In 2004–05, the median waiting time for ACAP clients was 8 days from referral to the first face-to-face contact (ACAP NDR 2006). Ninety per cent of clients received a first face-to-face contact within 47 days. The length of time clients wait for their first clinical intervention and first face-to-face contact varies according to the priority category accorded to them, their location at assessment and certain client characteristics. Hospital-based assessments were

undertaken much more quickly than those in residential care or in the community. This is partly because of the efficiencies that result when several clients are located in the same facility. Clients were less likely to wait a long time for assessment if they had a core activity limitation, had a non-resident carer, or had used residential respite care.

In 2004–05, over half of the clients living in the community at assessment (54%) were recommended to remain in the community; around one-quarter were recommended for low-level residential care and 19% were recommended to high-level care. Of those clients living in low-level residential care at assessment, 79% were recommended for high-level care (Table 35.1).

In 2004–05, there were 13,964 younger ACAP clients living in the community at assessment, and 59.1% of this group were recommended to remain in the community. The remainder were slightly more likely to be recommended for high-level residential care (20%) than low-level care (19%).

Clients with a primary diagnosis of dementia, clients with a severe or profound core activity limitation and clients assessed in hospital were all less likely to be recommended to remain in the community and more likely not only to receive a recommendation for residential care but a recommendation for high-level care (ACAP NDR 2006).

Assistance with activities

More than half of clients living in the community at assessment were already receiving assistance, formal or informal, with housework (65%), transport (57%), and meals (56%) before ACAT assessment (ACAP NDR 2006: Tables AB15 and 38B). Thirty-seven per cent had been receiving help with personal care. Across most assistance types, relatively more clients had been receiving assistance from informal providers (family and friends) than from formal providers. Particularly in the areas of mobility, transport, social and community participation and communication, informal providers of assistance provide help to the majority of ACAT clients with needs in those areas.

Around one third of clients living in the community at assessment had not been accessing government-funded community care programs. Of those with a known history of using community care programs, most (52%) had been receiving assistance from HACC, followed by CACP (14%).

For those clients with a recommendation to live in the community (88,012), domestic assistance was recommended for 58% and meals assistance for 38%; assistance with health and personal care were recommended for 35% and 31% respectively. More than one-third of these clients were recommended to receive help with transport (40%) and social participation (37%) (ACAP NDR 2006: Tables AC20 and 38B).

Table 35.1: ACAT assessment outcomes, recommended long-term care setting by usual accommodation setting, 2004–05

	Recommended long-term care setting				Total	Total (number)
	Community	Low-level residential care	High-level residential care	Other/missing		
	per cent					
Usual accommodation setting						
Community	54.3	25.4	18.8	1.5	100.0	152,696
Residential aged care service— low care	0.9	19.0	78.6	1.5	100.0	11,654
Residential aged care service—high care	5.3	11.2	78.9	4.7	100.0	1,751
Other/missing	45.5	20.8	24.2	9.5	100.0	10,776
Total	49.8	24.6	23.7	2.0	100.0	176,877

Notes

1. Table includes MDS version1 and MDS version2 data for complete assessments only as appropriate (clients of all ages).
 2. Figures in the table reflect percentages (and numbers) of recommendations for completed assessments. A person can have more than one assessment per year.
- Source: ACAP NDR 2006: Tables 38a, 38b.

The Home and Community Care (HACC) Program is the main provider of home-based care services in Australia. It provides a range of services to both frail older people and younger people with disability as well as their carers. The program was created in 1984 (via the *Home and Community Care Act 1985*) following a report of the House of Representatives Standing Committee on Expenditure (HRSCE 1982), and brought together into one system a range of separately funded programs. HACC is funded jointly by the Australian Government and state and territory governments.

In 2004–05 (the most recent data available in time for publication) approximately 3,250 agencies delivered HACC services, 3,100 of which reported service provision data for the HACC Minimum Data Set (MDS)

collection (DoHA 2006a). Nearly 60% of HACC clients in 2004–05 were referred to the program by formal services such as general practitioners, hospitals, or other government or non-government organisations. The remainder were either self-referred or referred by family or friends (DoHA 2006a).

Client profile

In 2004–05, HACC provided assistance to over 744,000 people, 75% of whom were aged 65 years and over. Two-thirds of older clients were women, with the single biggest group being women aged between 75 and 84 years (32% of all older clients) (Table A36.1). People using HACC services have a younger profile than people in residential aged care or people receiving care

Table 36.1: Home and Community Care clients aged 65 and over, by assistance type and age, 2004–05

Assistance type	65–74		75–84		85+		65 and over ^(a)	
	Clients	Rate per 1,000 ^(b)	Clients	Rate per 1,000 ^(b)	Clients	Rate per 1,000 ^(b)	Clients	Rate per 1,000 ^(b)
Assessment, case management or case planning ^(c)	62,400	44.6	121,700	127.6	69,400	220.2	254,300	97.6
Domestic assistance	38,200	27.3	83,000	86.9	48,500	154.1	169,900	65.2
Meals (at home or at a centre) ^(c)	21,100	15.1	56,200	58.9	42,800	136.0	120,600	46.3
Nursing (home or centre based) ^(c)	29,500	21.1	52,300	54.8	34,500	109.4	116,600	44.8
Transport	22,400	16.0	48,100	50.4	25,800	81.7	97,000	37.2
Allied health (at home or at centre) ^(c)	29,100	20.8	43,200	45.3	21,900	69.5	94,600	36.3
Home maintenance	22,900	16.3	45,900	48.1	22,000	69.8	90,900	34.9
Centre based day care	15,500	11.1	28,700	30.1	16,600	52.8	61,000	23.4
Social support	13,000	9.3	27,700	29.0	18,100	57.5	59,100	21.8
Personal care	9,400	6.7	21,500	22.5	18,500	58.7	49,400	19.0
Counselling	11,500	8.2	18,300	19.2	9,900	31.5	40,000	14.8
Provision of aids/car modifications ^(c)	7,400	5.3	12,700	13.3	7,400	23.6	27,600	10.6
Home modification	4,500	3.2	8,900	9.4	4,500	14.3	18,000	6.9
Respite care	2,200	1.5	2,100	2.2	700	2.2	5,200	2.0
Other food services	500	0.4	1,000	1.0	800	2.6	2,300	0.9
Linen services	200	0.1	400	0.5	300	1.0	900	0.4
Total clients	143,400	102.5	265,700	278.5	149,600	474.9	561,800	207.5
Total clients (%)	25.5	..	47.3	..	26.6	..	100.0	..

(a) Includes clients with missing age.

(b) Usage per 1,000 people in the age group.

(c) Assistance type includes more than one category. Clients are counted only once per assistance type. For example, a client receiving allied health service both at home and at a centre is counted only once for allied health services.

Notes

1. For 2004–05, 3,100 agencies submitted data to the HACC MDS.
2. Age is calculated at the end of the period. Clients with missing age are assumed to be over 65 and are included in 65+ totals.
3. Total number of clients is less than the sum of all clients as people may receive more than one type of assistance.

Source: AIHW analysis of the HACC (MDS). Methodological differences result in slightly different numbers from those published in the HACC MDS 2004–05 annual bulletin.

packages in the community. Looking at clients aged 65 and over, only 27% of those receiving HACC services were aged 85 years and over, compared with 40% of people using Community Aged Care Packages, 33% of people using Extended Aged Care at Home packages and 57% of all older people in permanent residential aged care (see also Topic 37: *Community Aged Care Packages*, Topic 38: *Extended Aged Care and at Home and Extended Aged Care at Home Dementia Packages* and Topic 40: *Residential aged care: resident profiles*).

Service provision

HACC clients may receive assistance over a prolonged period, or for just a short period of time. Of the 561,800 older people receiving assistance at some stage in 2004–05, around 355,000 received assistance in any one quarter of the year. Clients aged 85 years and over were more likely to have received assistance more continuously throughout the year (40%) than clients aged 65–74 years (31%) (AIHW analysis of HACC MDS).

Table 36.2: Quarterly median volume^(a) and total volume of Home and Community Care services used, by assistance type and age, 2004–05

Assistance type	65–74	75–84	85+	All 65+	65–74	75–84	85+	All 65+
	Quarterly median ^(a)				Annual total service volume ('000)			
Centre-based day care (hours)	33	40	45	40	1,951.6	3,996.4	2,449.1	8,413.5
Respite care (hours)	26	23	17	24	167.8	136.4	36.3	350.7
Personal care (hours)	12	12	13	12	454.6	834.3	776.6	2,066.2
Domestic assistance (hours)	9	9	9	9	1,150.3	2,426.1	1,447.7	5,028.0
Other food services (hours)	8	7	9	8	18.2	24.1	23.8	66.2
Social support (hours)	7	8	9	8	315.9	673.5	485.8	1,482.9
Nursing (home or centre based) (hours) ^(b)	4	4	5	4	429.8	834.6	608.1	1,880.2
Home maintenance (hours)	3	3	3	3	167.5	331.7	158.1	660.3
Assessment, case management or case planning (hours) ^(b)	2	2	2	2	319.6	600.9	378.0	1,304.9
Allied health (at home or centre-based) (hours) ^(b)	1	1	1	1	149.8	221.6	112.0	484.9
Counselling (hours)	1	1	1	1	66.1	80.3	36.7	186.2
Total hours	7	8	9	8	5,191.4	10,159.9	6,512.2	21,924.0
Meals (at home or centre) ^(b)	18	26	37	29	1,511.8	4,732.5	4,270.6	10,548.3
Linen services (deliveries)	7	7	6	7	3.8	8.1	6.2	18.2
Transport (one-way trips)	8	8	11	9	720.6	1,637.2	985.8	3,359.1
Home modification (\$)	70	68	66	68	1,381.3	2,394.6	1,020.9	4,801.7
Provision of aids/car modifications (number) ^(c)	2	2	2	2	44.4	73.0	40.6	158.2
Average number of types of assistance^(c)	1.7	1.8	1.9	1.8

(a) HACC service is reported quarterly. In 2004–05, 33% of clients received assistance in only one quarter, 17% in two quarters, 14% in three quarters and 36% in four quarters. As median service provision is strongly influenced by the number of quarters in which a client receives assistance, this table shows the median amount of service received in any one quarter. The annual service received by a HACC client is broken down by quarters; a client who received assistance in all four quarters will contribute four times to the calculation of the quarterly median amount of service.

(b) Assistance type includes more than one category. Clients are counted only once per assistance type in any one quarter. For example, a client receiving allied health service both at home and at a centre in the same quarter is counted only once for allied health services for that quarter.

(c) Average of the 15 assistance categories listed in the table.

Notes

- For 2004–05, 3,100 agencies submitted data to the HACC MDS.
- Age is calculated at the end of the period. Clients with missing age are assumed to be over 65 and are included in 65+ totals.
- 'Median' amount of assistance is the value of an item where half the clients are below this value and half are above it. Median measures in this table refer only to those clients who received that particular type of assistance in the 12-month period.
- Table includes a small proportion of clients with very heavy reported use. These are unlikely to affect the median value.

Source: AIHW analysis of the HACC MDS. Methodological differences result in slightly different numbers from those published in the HACC MDS 2004–05 annual bulletin.

Table 36.1 shows that the usage rate for all assistance types increases substantially with age. Overall, out of every 1,000 people aged 85 years and over, 475 were using HACC services at some time during the year. The corresponding usage rates for people aged 65–74 years and 75–84 years were 103 and 279 per 1,000 people, respectively.

Around 45% (254,300 out of 561,800) of all older clients required assessment, management or planning of their requirements during 2004–05. After this, assistance with domestic chores (30%) was the service used by the largest number of older HACC clients, followed by assistance with meals (22%), nursing services (21%) and transport (17%) (Table A36.2).

The volume of service received by a HACC client in the year is influenced by the length of time he or she receives assistance. Version 1 of the HACC MDS (applicable to data for 2004–05) does not record service start and end dates, which means the period of the year over which assistance has been provided to a client and the corresponding rate of service provision cannot be measured. The intensity of service provision to clients is estimated here using the median amount of service provided to a client in any quarter (Table 36.2).

Although domestic assistance is the most commonly used service (received by 30% of older clients) it does not involve the highest number of hours of assistance, compared with other service types. The median quarterly amount of domestic assistance received by older HACC clients was 9 hours. Provision of meals at either home or in a centre was the next most commonly used type of assistance (22%), with a quarterly median of 29 meals (Tables 36.2 and A36.2).

The service type with the highest amount of assistance provided was centre-based day care which was received by 11% of older clients, with a quarterly median of 40 hours per client.

Personal care and respite care were also service types with relatively high amounts of assistance. Clients received a median of 12 hours of personal care in a quarter. Respite care was recorded for only 1% of older HACC clients, with a median of 24 hours in a quarter. However, respite care is recorded as a service for carers (carers are HACC clients in their own right) and this results in recorded use of respite care being higher in younger age groups: over two-thirds of HACC clients receiving respite care were under 65.

For most service types, the amount of assistance provided did not vary greatly according to the age of the client. However, the hours of service provided per quarter increased with age for centre-based day care and social support, and nursing care to a lesser extent. So too did the number of meals provided, and the use of transport services by clients aged 85 and over.

Overall, the HACC program provided 21.9 million hours of assistance to older people in 2004–05, over a third of this as centre-based day care, a service provided to groups, (8.4 million hours), and nearly a quarter, as domestic assistance (5.0 million hours). In addition, it provided 10.5 million meals, 3.4 million one-way trips and \$4.8 million in assistance with home modifications which help prevent injury in the home (Table 36.2).

Community Aged Care Packages (CACPs) are funded by the Australian Government and began in 1992 as an alternative to low-level residential aged care. It provides home-based care to frail or disabled older people living in the community following an ACAT assessment and recommendation. A CACP provides a package of assistance managed by a care coordinator, who manages the complex care needs of the recipients and arranges provision of the following types of assistance: personal care, domestic assistance, social support, assistance with meal preparation and other food services, respite care, rehabilitation support, home maintenance, delivered meals, linen services and transport.

A CACP recipient is not excluded from receiving additional community care if required. For example, CACPs do not provide nursing services or allied health care but these services are offered by the Home and Community Care (HACC) Program. An exploratory study (AIHW: Karmel & Braun 2004) found that at least 35% CACP recipients were using at least one HACC service in the second half of 2002, and that 11% of CACP recipients were using HACC nursing services.

Growth in CACPs

The CACP program has grown rapidly since its inception, from 235 packages in 1992 to 35,383 at 30 June 2006 (Figure 37.1). This 2006 figure equates to 18.2

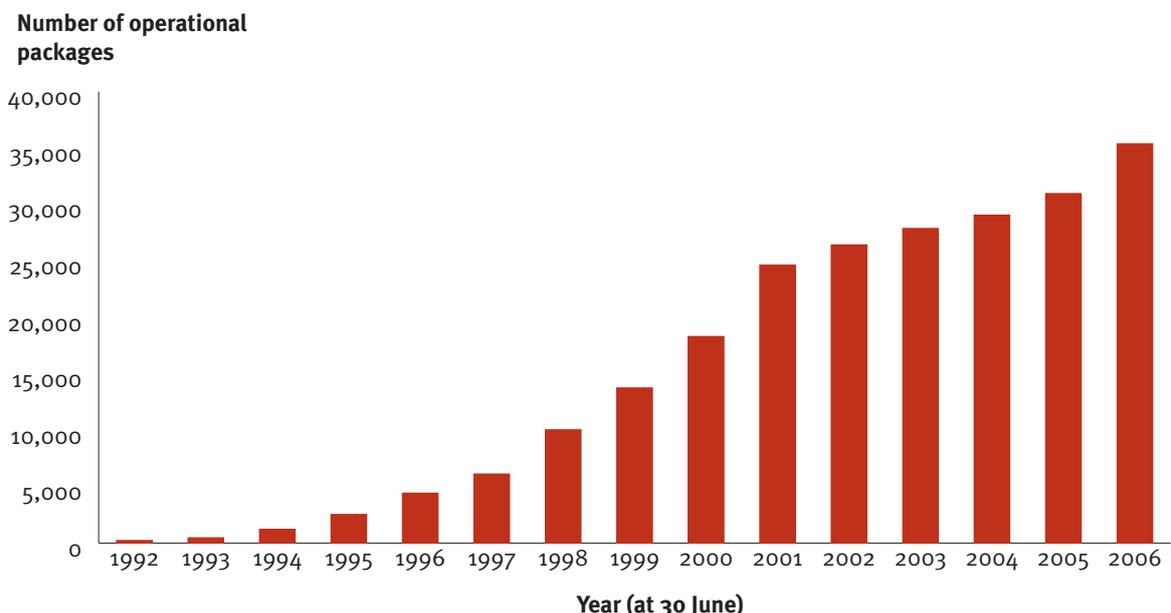
packages per 1,000 persons aged 70 and over. There were 1,011 service outlets providing these packages throughout Australia as at 30 June 2006.

In 2005–06, the Australian Government target for community aged care provision was 20 operational places and packages per 1,000 persons aged 70 and over. The majority of these packages are currently CACPs, but Extended Aged Care at Home (EACH) packages are emerging as a significant community care option for people with high care needs (see Topic 38: *Extended Aged Care at Home and Extended Aged Care at Home Dementia Packages*). The combined operational provision ratio for CACPs, EACH and EACH Dementia packages at 30 June 2006 was 19.9 per 1,000 persons aged 70 and over (AIHW 2007a).

Profile of CACP recipients

At 30 June 2006, a large proportion of CACP recipients were aged 85 and over (38%), with 3% aged 95 and over. Around 6% of package recipients were younger than 65, and less than 1% of recipients were under the age of 50 (derived from Table 37.1). Female recipients predominated in all age groups, varying from 59% of all recipients under age 50, to 74% of all recipients aged 85 years and over. Over 59% of all package recipients were women aged 75 years and over (derived from Table 37.1).

Figure 37.1: Number of Community Aged Care Packages, 1992–2006.



Source: Table A37.1.

At 30 June 2006, of those with known responses, over half of CACP recipients lived alone and a further 41% lived with family. A small proportion (5%) lived with others. Almost two-thirds (62%) owned their own home, and 12% lived in public rental housing. Only 6% lived in a private rental property and 1% lived in boarding or lodging houses.

Length of time on CACP

Of those care recipients who left the program in 2005–06, 48% entered a residential aged care service, and

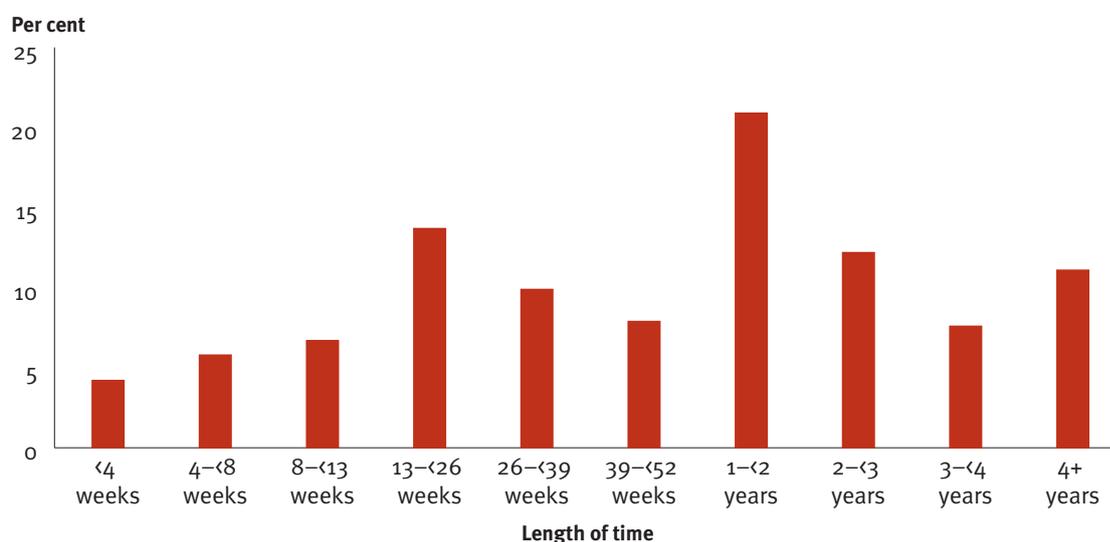
18% died. The proportion of men who ceased receiving the service and entered a residential aged care service was lower (44% of male care recipients) than that for women (51%). Conversely, there were a higher proportion of deaths among men (24%) than among women (16%). Just over half of the care recipients leaving the program had been clients for more than 1 year (52%); 19% had used a package for 3 years or more (Figure 37.2).

Table 37.1: Community Aged Care Package recipients, by age and sex, at 30 June 2006

Age	Females		Males		Persons	
	Number	Per cent	Number	Per cent	Number	Per cent
0–49	110	0.5	76	0.8	186	0.6
50–54	110	0.5	118	1.3	228	0.7
55–59	297	1.3	215	2.4	512	1.6
60–64	570	2.5	335	3.7	905	2.8
65–69	1,104	4.9	700	7.7	1,804	5.7
70–74	1,855	8.2	933	10.2	2,788	8.8
75–79	3,705	16.3	1,593	17.4	5,298	16.7
80–84	5,918	26.1	2,076	22.7	7,994	25.1
85–89	5,391	23.8	1,866	20.4	7,257	22.8
90–94	2,900	12.8	971	10.6	3,871	12.2
95+	702	3.1	258	2.8	960	3.0
Total	22,662	100.0	9,141	100.0	31,803	100.0

Source: AIHW analysis of DoHA Aged and Community Management Information System (ACCMIS) database.

Figure 37.2: Length of time with a CACP, separations, 2005–2006.



Source: Table A37.2.

EXTENDED AGED CARE AT HOME AND EXTENDED AGED CARE AT HOME DEMENTIA PACKAGES

Extended Aged Care at Home (EACH) packages are funded by the Australian Government to deliver care at home to people who are otherwise eligible for high-level residential care. EACH started as a pilot in 2000 and was established as a program in 2002. At 30 June 2006 there were 2,580 available EACH packages and 2,131 EACH recipients. EACH packages provide a similar range of care services as CACPs (see Topic 37: *Community Aged Care Packages*), with the addition of nursing and allied health care services.

EACH Dementia is a new program with packages specifically aimed at frail older people with dementia related high-care needs. A care recipient on an EACH Dementia package can access the same types of assistance that are available to an EACH package care recipient. However, delivery of that assistance may be provided using a more flexible approach and strategies that are appropriate for people with dementia. In addition, EACH Dementia packages also provide access to dementia-specific specialist services and support (DoHA 2005a).

The first allocation of 667 EACH Dementia packages occurred in December 2005, and a total of 2,000 packages will be allocated over 4 years. At 30 June 2006 there were 601 operational EACH Dementia packages and 297 EACH Dementia recipients.

Access to both types of package requires approval from an Aged Care Assessment Team (ACAT). The combined provision of EACH and EACH Dementia packages per 1,000 persons aged 70 and over was 1.6. The combined operational provision ratio for CACPs, EACH and EACH Dementia packages at 30 June 2006 was 19.9 per 1,000 persons aged 70 and over (AIHW 2007a).

Profile of EACH package recipients

As at 30 June 2006, 70% of EACH recipients were aged 75 and over and 31% were aged 85 and over (Table 38.1). Around 7% of recipients were aged less than 65. Women predominate, especially at older ages where they make up 71% of all recipients aged 85 years and over. Of the EACH recipient population, 61% were women.

Similar proportions (163 clients; 58%) of EACH Dementia package recipients were women. Forty-four per cent of EACH Dementia recipients were younger than age 80. This proportion is higher than in CACP (37%) and slightly lower than EACH (49%). Nearly 7% of EACH Dementia package recipients were aged less than 65 although none were under age 50.

Table 38.1: EACH recipients by age and sex, 30 June 2006

Age group	Females		Males		Persons	
	Number	Per cent	Number	Per cent	Number	Per cent
0-49	6	0.5	5	0.6	11	0.5
50-54	9	0.7	4	0.5	13	0.6
55-59	19	1.5	12	1.4	31	1.5
60-64	46	3.6	46	5.5	92	4.3
65-69	104	8.1	97	11.5	201	9.4
70-74	144	11.2	142	16.9	286	13.4
75-79	206	16.0	198	23.5	404	19.0
80-84	284	22.0	155	18.4	439	20.6
85-89	240	18.6	107	12.7	347	16.3
90-94	158	12.3	57	6.8	215	10.1
95+	73	5.7	19	2.3	92	4.3
Total	1,289	100.0	842	100.0	2,131	100.0

Note: This table excludes EACH Dementia recipients.

Source: AIHW analysis of DoHA Aged and Community Care Management Information System (ACCMIS) database.

EACH packages are available in all states and territories, with the majority of recipients living in major cities (1,378). There were no recipients in remote areas but 535 recipients lived in inner regional areas and 218 recipients lived in outer regional areas.

A high percentage of care recipients live with others (76%) reflecting the importance of informal care (mostly provided by family) in supporting high-care recipients in their homes. The majority lived with family. Living arrangement was not recorded for 16% of recipients but some were reported to have a co-resident carer. An even higher proportion of EACH Dementia package recipients lived with others—83% lived with family and 4% lived with others.

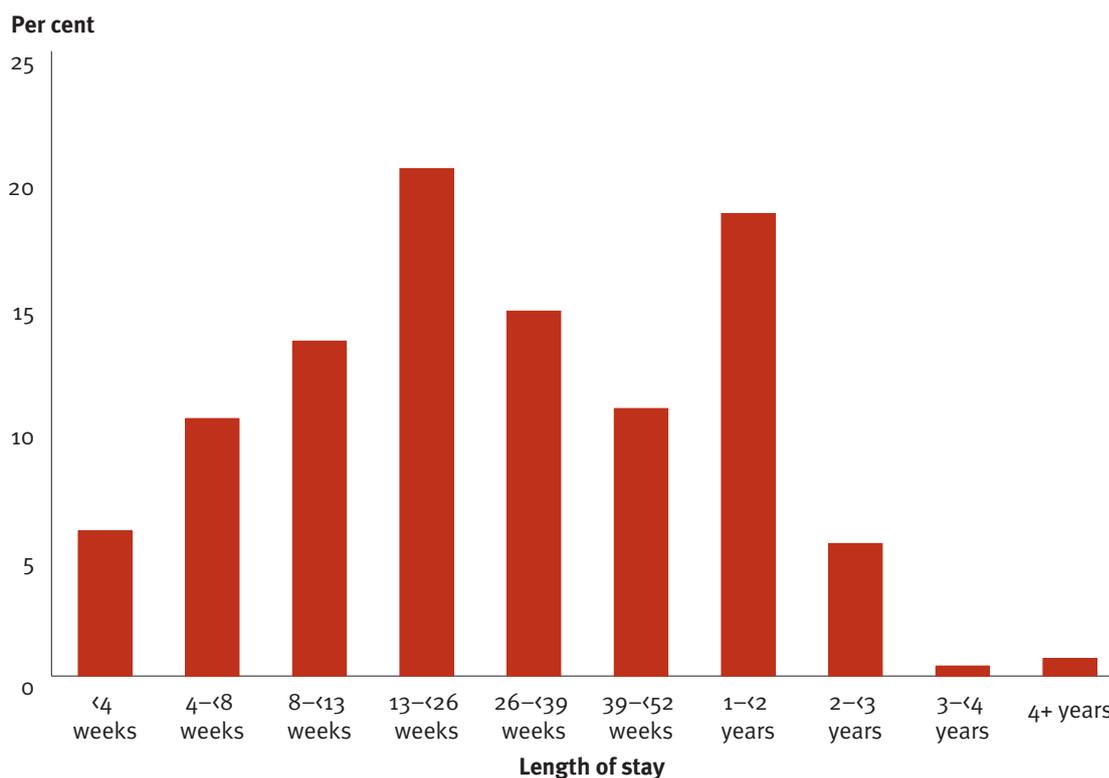
Most EACH package recipients (90%) were receiving assistance from a carer at the time of their ACAT assessment; 74% had a co-resident carer. Almost all EACH Dementia package recipients (97%) were receiving assistance from a carer at the time of ACAT assessment, reflecting the critical need for assistance from both formal service providers and from family

and/or friends. Most care recipients (85%) had a co-resident carer, but 12% had a carer who did not live with the care recipient.

Length of stay

The amount of data on length of stay within the EACH program is limited and current patterns may change as the program matures. However, of those recipients who left the program between 1 July 2005 and 30 June 2006, 30% had received an EACH package for less than 3 months and 75% had used a package for less than 1 year (Figure 38.1). Overall, 44% left an EACH package to enter residential care; 35% died and 9% went into hospital (Table 38.2). Among those who received a package for less than one 1 month, almost equal proportions died (39%) as entered residential aged care (38%).

Figure: 38.1: Length of time on EACH package, separations 2005–06



Source: Table A38.1.

Table 38.2: EACH separations, length of stay by separation mode, 2005–06

Length of stay	Death	To hospital	To residential aged care	Resident withdrew	Other	Total
Number						
<4 weeks	24	2	23	7	5	61
4 to <8 weeks	41	14	41	6	5	107
8 to <13 weeks	49	12	65	7	7	140
13 to <26 weeks	69	19	99	7	18	212
26 to <39 weeks	50	7	80	5	10	152
39 to <52 weeks	32	12	46	6	16	112
1 to <2 years	72	18	78	7	18	193
2 to <3 years	20	5	24	2	4	55
3 to <4 years	2	0	2	0	0	4
4+ years	2	0	3	1	1	7
Total	361	89	461	48	84	1,043
Per cent (row)						
<4 weeks	39.3	3.3	37.7	11.5	8.2	100.0
4 to <8 weeks	38.3	13.1	38.3	5.6	4.7	100.0
8 to <13 weeks	35.0	8.6	46.4	5.0	5.0	100.0
13 to <26 weeks	32.5	9.0	46.7	3.3	8.5	100.0
26 to <39 weeks	32.9	4.6	52.6	3.3	6.6	100.0
39 to <52 weeks	28.6	10.7	41.1	5.4	14.3	100.0
1 to <2 years	37.3	9.3	40.4	3.6	9.3	100.0
2 to <3 years	36.4	9.1	43.6	3.6	7.3	100.0
3 to <4 years	50.0	0.0	50.0	0.0	0.0	100.0
4+ years	28.6	0.0	42.9	14.3	14.3	100.0
Total	34.6	8.5	44.2	4.6	8.1	100.0

Note: EACH Dementia packages are not included.

Source: AIHW 2007a.

Respite care serves a mixture of functions in the aged care service sector. Carers may require a break from providing assistance to see to their own affairs, to visit family and friends, to take a holiday or in instances where they encounter health, personal or family problems. Some carers may require relief on a regular basis from the intensity of their caring role. Frail older people without a carer (including those receiving formal care services) may also require a level of care for short periods of time outside of their usual accommodation setting, to provide them with a break from the demands of caring for themselves or to provide them with opportunities for social interaction. Both groups (people with and without a carer) may need short-term respite care at particular times such as during recovery from an acute care episode in hospital or after a traumatic event such as a fall.

Respite care can be provided in the person's home, in a day centre, in community-based overnight respite units (e.g. 'cottage' respite services) and in residential aged care homes. Programs that deliver care services, such as care packages, HACC and Veterans' Home Care, typically offer respite care services. HACC, for instance, provides assistance to carers in the form of a substitute carer in the home, centre-based respite, host family and peer support respite care. Veterans' Home Care offers in-home respite care and the Department of Veterans' Affairs also funds residential respite care for eligible clients. Two programs which specifically focus on the provision of respite care are the National Respite for Carers Program and respite places available through the Residential Aged Care program.

Residential respite care

Residential respite care is recognised as an important component of the carer support system and provides short-term accommodation and care in residential aged care homes on a planned or emergency basis. Apart from emergencies, Aged Care Assessment Team (ACAT) approval is required to access residential respite care and an approval remains valid for 12 months. Assessing clients for need and eligibility for residential respite care is core work for ACATs and they play a key role in raising awareness of respite care, both in-home and residential-style, for ACAT clients recommended to live in the community. A person with a valid ACAT approval for residential respite care may use up to 63 days of respite care in a financial year, which can be taken in 'blocks', for example, 1 or 2 weeks at a time. An extra 21 days may be available if deemed necessary by an ACAT.

There were 49,727 admissions to residential respite care during 2005–06. Of these admissions, 30,692 (62%) were for women. Over 5% of all persons admitted for respite care were under aged 65. Overall, the age group 75–84 years accounted for the largest number of admissions (41%) during the year (Table 39.1). This was also true for men, among whom 44% of admissions were in the 75–84 year age group. But the largest number of admissions for women was for the 85–94 year age group (43%).

The number of residential respite occupied bed-days per year has generally increased over the last 6 years while remaining close to 2% of total occupied bed-days in residential care. Total respite days increased

Table 39.1: Respite admissions to residential aged care, by sex and age at admission, 2005–06

Age	Females	Males	Persons
Number			
Under 65	1,320	1,389	2,709
65–74	2,892	3,218	6,110
75–84	12,139	8,385	20,524
85–94	13,069	5,614	18,683
95+	1,272	429	1,701
Total	30,692	19,035	49,727
Per cent			
Under 65	4.3	7.3	5.4
65–74	9.4	16.9	12.3
75–84	39.6	44.1	41.3
85–94	42.6	29.5	37.6
95+	4.1	2.3	3.4
Total	100.0	100.0	100.0

Source: AIHW analysis of DoHA Aged and Community Care Management Information System (ACCMIS) database.

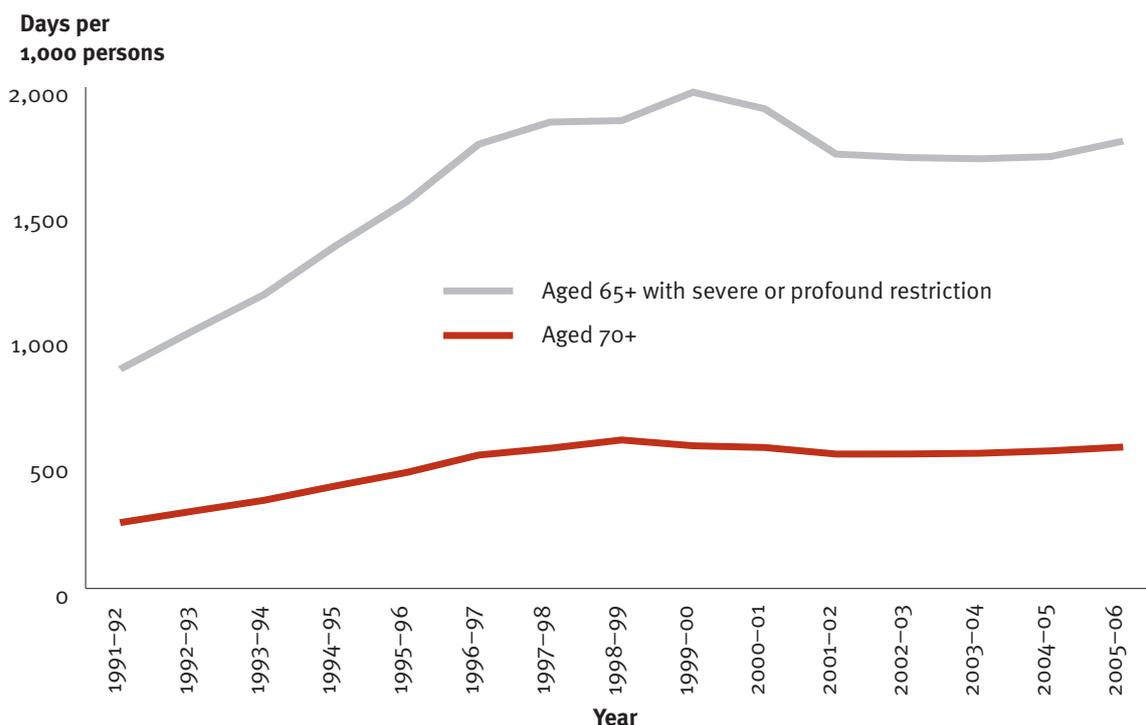
from 968,791 in the year ending 30 June 2000 to 1,095,220 in the year ending 30 June 2006. There is no obvious year-by-year trend.

Average completed length of stay for respite care was 3.1 weeks in 2005–06. It had declined from 3.5 weeks in 1998–99 to 3.1 weeks in 2002–03, after which it has remained stable (AIHW 2007f). A residential respite bed is used on average between 15 and 17 times in a year for respite residents.

Use of respite care can also be considered in relation to the population aged 70 and over, and the population aged 65 and over with a severe or profound limitation as shown in Figure 39.1. In terms of these measures of provision, respite use has doubled in both cases between 1991–92 and 2005–06. The ratio of occupied bed-days per 1,000 persons with a severe or profound limitation peaked in 1999–00 at 1,979 but then declined year by year to 1,713 days in 2003–04 (approximately the 1996–97 level). This ratio has increased over the last 2 years and in 2005–06 it was 1,783. In contrast, the ratio of occupied bed-days per 1,000 persons aged 70 and over has remained within a narrower band between 1996–1997 and 2005–06 of around 550 days.

By providing support for people living at home and their carers, residential respite can delay or obviate the need to enter permanent residential care. It can also be a 'stepping stone' towards permanent residential care. About one-fifth (19%) of admissions to permanent care are transfers of residents from respite care to permanent care (transfers are defined as admissions following separation within the residential aged care system within 2 days). Further, around 40% of residential respite care clients are admitted to permanent residential aged care within 3 months of using respite (AIHW: Karmel 2006). Analysis of ACAT recommendations also supports the view that residential respite is often a precursor to permanent placement: at each level of client dependency a higher likelihood of ACAT recommendation for permanent residential care is associated with the previous use of residential respite (ACAP NDR 2006:176, 183). Less commonly, people may be connected, or reconnected, to community care services as a result of a period of residential respite.

Figure 39.1: Occupied residential aged care respite bed-days per 1,000 persons in stated population, for financial years 1991–92 to 2005–06



Source: Table A39.1.

Community-based respite care

Respite care in the community is provided through the Home and Community Care (HACC) program, the Community Aged Care Package (CACP) program, Extended Aged Care at Home (EACH) packages and the Veterans' Home Care program (see Topic 36: *Home and Community Care Program*, Topic 37: *Community Aged Care Packages*, Topic 38: *Extended Aged Care at Home and Extended Aged Care at Home Dementia Packages* and Topic 45: *Older Veterans*). The Australian Government also funds respite care services, through the National Respite for Carers Program (NRCP).

The NRCP funds direct and indirect respite care options, offering respite care in a range of accommodation settings, including day centres, host homes, overnight cottages and in-home respite services. These services can be arranged by Commonwealth Respite and Carelink Centres (Centres) on behalf of clients. In 2004–05, approximately 56,000 carers received direct respite care through the Centres where the primary purpose of the respite care was to meet the needs of carers by the provision of a break from their caring role.

Under the NRCP, Centres are able to purchase short-term and emergency respite for carers. This includes indirect respite options which offer the 'side benefit' of providing help to carers by relieving them from the other tasks of daily living, which may or may not be directly related to their caring responsibility. The carers remain the main focus although the services provided are for the people being cared for, including domestic assistance, social support, meals, and nursing/ personal care and showering assistance.

Over the last decade there has been substantial growth in the provision of in-home respite care under the HACC Program. In 2004–05, 82% of HACC agencies participated in annual reporting for the HACC Minimum Data Set. The coverage is higher than the figures indicate, because non-participation by smaller agencies contributed to the bulk of the information gap. Nevertheless, the figures stated below are underestimates of the actual statistics. In 2004–05 HACC provided respite services to 16,452 people with an average number of 92.6 hours of assistance during the period. This compares with 14,889 clients who received HACC respite services in 2001–2002 with an average of 86.3 hours of assistance.

HACC also provided centre-based day care (which is often called centre-based respite care) to 80,802 clients with an average of 137.9 hours of assistance in 2004–05, compared with 60,050 clients with an average of 121.9 hours in 2001–02. Note that respite care, centre-based day care and home meals provided by far the highest average number of hours per client of all the types of HACC assistance (DoHA 2002, 2006a).

Data about the provision and use of respite care by care package recipients is not available through an ongoing data collection. In a 2002 Census of Community Aged Care Package recipients, 1,144 of 25,410 recipients received respite care as part of their package with an average of 3.3 hours of assistance during the census week (AIHW 2004b).

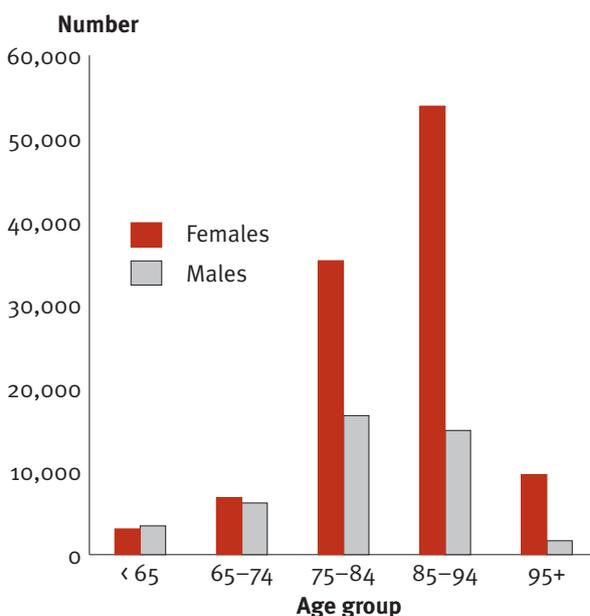
Karmel reported that people who use community care services in conjunction with residential respite tend to enter permanent residential aged care later than those who use only residential respite care (AIHW: Karmel 2006). This apparent interaction between use of residential respite and community care for delaying admission to permanent residential care has important implications. It indicates the importance of timely access to community care, particularly systems and processes to identify people who need formal assistance before carers reach crisis point.

Several initiatives are seeking to develop models of respite care for groups of carers with special needs, including the Employed Carer Innovation Pilots and the Overnight Respite in Community Houses initiative introduced under the National Respite for Carers Program.

Permanent residential aged care provides accommodation and care services to people who are no longer able to support themselves or be supported by others in their own homes. Government makes a substantial financial contribution to residential aged care in the form of subsidised daily care fees and payments for concessional residents and residents with special needs in Australian Government-accredited aged care homes with recurrent funding of \$5.3 billion in 2005–06. This includes funding appropriated through the Department of Health and Ageing as well as funding for veterans in residential care through the Department of Veterans' Affairs (DoHA 2006b).

The number of occupants in residential aged care places at 30 June each year has steadily increased from 132,655 in 1997, to 138,929 in 2002 and 154,872 in 2006. Although there is growing provision of care packages which may prevent or delay entry into residential aged care (see Topic 37: *Community Aged Care Packages* and Topic 38: *Extended Aged Care at Home and Extended Aged Care at Home Dementia packages*), the pattern over the last 10 years has still seen regular annual increases in the number of residential aged care places and residents.

Figure 40.1: Residents in aged care by age and sex, 30 June 2006



Source: AIHW analysis of DoHA Aged and Community Care Management Information System (ACCMIS) database.

Age and sex

At 30 June 2006, there were 151,737 permanent residents and 3,135 respite residents in residential aged care (Table A40.1; AIHW 2007f). Around 72% of permanent residents were women. By far the majority of permanent residents were aged 75 years and over (87%); 53% were aged 85 years and over, and 7% were 95 years and over. The proportion of permanent residents who were aged 80 years and over increased from 64% in 1998–99 to 71% in 2005–06. In younger age groups, men have proportionally higher representation than women. For example, only 20% of women were under age 80 compared with 39% of men. This gender pattern reverses in older age groups with 58% of females being 85 years and over compared with 37% of men. At 30 June 2006 there were 6,562 residents of aged care services who were under 65, which equates to 4% of all permanent residents. Of these, less than half (47%) were women (Figure 40.1).

Marital status

A majority of permanent residents at 30 June 2006 were widowed at the time they entered an aged care service (57%). Widowhood was predominant among female residents—68% of women were widows but only 29% of men were widowers (AIHW 2007f). In contrast, relatively more men than women in permanent residential aged care were married or in a de facto relationship (41% of men compared with 18% of women), single (16% of men compared with 8% of women) or divorced (9% of men, 4% of women).

Birthplace and Indigenous status

Almost three-quarters of aged care residents were born in Australia (73%), with most of the remainder born in the United Kingdom and Ireland (11%) and 'other' areas of Europe (11%) (AIHW 2007f). Given the increasing diversity in the origins of older people, these proportions could be expected to change over the coming decade, (see Topic 1: *Age, sex and cultural diversity* and Topic 2: *The changing demographic profile*).

There were also 872 Indigenous Australians in mainstream permanent residential aged care. This may be an underestimate, however, as 5% of residents (6,972 people) did not report their Indigenous status. At 30 June 2006, an additional 2,283 places were provided by services receiving flexible funding under the Aboriginal and Torres Strait Islander Aged Care Strategy,

and from Multi-Purpose Services which serve people in rural and remote communities (AIHW 2007f).

Need for assistance

The Resident Classification Scale (RCS) provides a measure of dependency of people in residential aged care based on an appraisal of care needs carried out by the service provider. Providers use the instrument to determine the level of care needed by a client across a number of functional domains. The level of Australian Government care subsidy to services is based on the level of care need indicated by each resident's score on this scale. Phasing-in of the Aged Care Funding Instrument (ACFI) to replace the RCS is planned to begin in 2008. This instrument will produce a different, though comparable, measure of client dependency (DoHA 2005d).

Over two-thirds of residents (69%) are classified as high-care (RCS categories 1–4). A larger proportion of younger residents have high levels of dependency compared with older residents (except for those aged 95 and over). Seventy-five per cent of those under 65 were classified as high-care along with 74% of those

aged 95 years and over. There were few differences between male and female residents in relation to dependency levels.

Residents' need for different types of assistance over the past 8 years is shown in Table 40.2. The area where need for assistance has increased most in this period is bowel management (an increase of 21 percentage points). There have been steady increases in the proportions of residents needing assistance in most of the remaining categories. More than 90% of residents required assistance with personal hygiene (95% in 2006) and communication (96% in 2006) over the whole period.

Incontinence is considered a significant predictor for institutionalisation of older people (see AIHW 2006b). In 2006, 88% of permanent residents needed some assistance with bowel management, 70% needed assistance with toileting, and 69% needed assistance with bladder management (Table 40.2). Estimates of the prevalence and severity of incontinence among permanent aged care residents suggested that, in 2003, 75,300 residents experienced profound problems with urinary and/or faecal incontinence and a further 48,000 had severe problems (AIHW 2006b: Table 6.10).

Table 40.1: Dependency levels of permanent residents, by age, 30 June 2006

Age	High dependency (RCS1–RCS4)	Low dependency (RCS5–RCS8)	Total (RCS1–RCS8)
	Number		
Under 65	4,911	1,594	6,505
65–69	3,343	1,321	4,664
70–74	5,922	2,360	8,282
75–79	13,083	5,347	18,430
80–84	22,561	10,579	33,140
85–89	25,624	13,367	38,991
90–94	19,690	9,586	29,276
95+	8,334	2,892	11,226
Total	103,468	47,046	150,514
	Per cent		
Under 65	75.5	24.5	100.0
65–69	71.7	28.3	100.0
70–74	71.5	28.5	100.0
75–79	71.0	29.0	100.0
80–84	68.1	31.9	100.0
85–89	65.7	34.3	100.0
90–94	67.3	32.7	100.0
95+	74.2	25.8	100.0
Total	68.7	31.3	100.0

Note: This table excludes 1,223 residents whose dependency levels were not reported at 30 June 2006.

Source: AIHW analysis of DoHA Aged and Community Care Management Information System (ACCMIS) database.

Table 40.2: Permanent aged care residents: need for at least some assistance for selected dependency items, 30 June 1999 to 30 June 2006 (per cent)

Type of assistance	1999	2000	2001	2002	2003	2004	2005	2006
Communication	90.8	91.6	93.0	93.7	94.4	95.1	95.6	96.1
Personal hygiene	92.2	92.8	93.2	93.4	93.7	94.2	94.4	94.6
Understanding and undertaking living activities	83.2	85.1	86.3	87.0	87.6	88.5	89.3	89.7
Mobility	82.8	82.9	83.5	83.7	84.2	84.6	84.7	85.5
Meals and drinks	75.9	75.5	76.5	76.5	77.3	78.5	79.1	79.1
Bowel management	67.5	73.1	77.2	80.3	82.7	85.1	87.3	88.2
Bladder management	64.5	65.9	67.2	67.0	67.8	68.4	68.9	69.4
Toileting (assistance)	68.0	67.6	68.1	67.5	67.8	68.7	69.4	70.1
Problem wandering or intrusive behaviour	29.4	29.5	29.2	29.2	29.9	30.6	31.3	31.7
Verbally disruptive or noisy	46.1	50.7	50.3	50.3	50.5	51.3	52.4	53.5
Physically aggressive	30.2	26.6	26.1	25.9	25.6	25.7	26.0	26.1
Emotional dependence	61.2	68.2	66.4	63.6	63.2	64.3	64.8	65.5
Danger to self or others	53.7	56.9	58.0	58.0	59.4	61.4	63.4	64.8

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

A number of these functional areas are indicative of resident needs resulting from behavioural and psychological symptoms of dementia or other types of cognitive impairment. Such symptoms can include aggression, agitation, wandering, and anxiety. In 2006, over half (54%) of residents required some intervention because of being 'verbally disruptive or noisy', and around two-thirds displayed 'emotional dependence' (66%) and/or were considered a 'danger to themselves or others' (65%). Smaller proportions needed assistance for 'problem wandering or intrusive behaviours' (32%) or for 'physical aggression' (26%). Caring for people with these needs increases the complexity and cost of care, although there is evidence that the environment in the residential aged care facility also has an effect on resident behaviour (Low et al. 2004).

RESIDENTIAL AGED CARE: PATTERNS OF SUPPLY AND USE

41

Population ageing poses challenges for the provision of aged care to growing numbers of older people, particularly when the fastest rates of population growth are among the very old age groups (see Topic 1, *Age, sex and cultural diversity*). A key mechanism used by the Australian Government in planning residential aged care service provision is the planning target for levels of provision relative to population. In 2006, this target was 88 residential aged care places per 1,000 persons aged 70 and over. Of these 88 places, 40 were targeted to high-care places and 48 to low-care places. This planning target has applied since 2004—before that the planning target for residential aged care was 90 places per 1,000 persons aged 70 years and over (50 targeted to low-care and 40 targeted to high-care).

Only a small proportion of the older population of Australia is in residential aged care at any point in time, and use among those aged 65 years and over has declined from 5.9% in 1997 to 5.7% in 2006. This decline needs to be understood in the context of the growing provision and use of aged care packages in the community (see Topic 37: *Community Aged Care Packages* and Topic 38: *Extended Aged Care at Home and Extended Aged Care at Home Dementia Packages*).

Supply of residential aged care places

At 30 June 2006, there were 166,291 operational residential aged care places, including 2,273 places provided by Multi-Purpose Services and places funded under the Aboriginal and Torres Strait Islander Aged Care Strategy (AIHW 2007f). The number of residential aged care places has grown by 19% since 1998.

Although the absolute number of places has been increasing steadily, the ratio of operational places to the population aged 70 and over (the provision ratio) decreased between 1995 when the provision ratio was 92.2 and 2002 when it reached 81.7 (Table 41.1). Since then the ratio has increased quite substantially—in 2006, it was 85.6, compared to the planning ratio of 88. Provisional figures indicate that the provision ratio for residential care will rise to 86.8 at 30 June 2007. Taken together, the overall provision ratio (residential and community places) had increased from 96.4 in 2002 to 109.3 places for every 1,000 people aged 70 and over (DoHA unpublished data); above the combined target of 108 places.

Aged Care Approval Rounds cater for the ongoing provision of new residential places and aged care packages in the community (CACPs and EACH packages) that are needed to achieve the planning

targets. Service providers who receive an allocation of new places and/or packages are required to make them operational within 2 years or the places are either reallocated or renegotiated. In the year to 30 June 2006, the main allocation from the planning round announced on 15 December 2005 was 11,112 places and packages of which 28% were low-care places, 19% were high-care places, 39% were CACPs and 14% were EACH packages (AIHW 2007f). Allocations from the rounds in 2004–05 and onwards are still not fully reflected in the number of operational places.

Table 41.1: Operational residential aged care places, 30 June 1996 to 30 June 2006

Year	Number of places	Places per 1,000 persons aged 70 and over
1996 ^(a)	136,851	90.6
1997 ^(a)	139,058	89.2
1998	139,917	87.1
1999	141,698	85.6
2000	142,342	83.6
2001	144,013	82.2
2002	146,268	81.7
2003	151,181	82.8
2004	156,580	84.2
2005	161,765	85.3
2006	166,291	85.6

(a) Combines nursing homes and hostels places. From 1 October 1997 nursing homes and hostels were combined into a single residential aged care system.

Notes

1. Places available in Multi-Purpose Services and places supplied with flexible funding under the Aboriginal and Torres Strait Islander Aged Care Strategy have been included since 1999.
2. Ratios are recalculated using updated population data.

Source: AIHW 2007f.

Residential aged care service providers

As at 30 June 2006, there were 2,931 mainstream residential aged care services in Australia providing a total of 164,008 places (AIHW 2007f). Also at 30 June 2006, Multi-Purpose Services provided 1,951 residential care places, and services receiving flexible funding under the Aboriginal and Torres Strait Islander Aged Care Strategy provided 332 residential care places. The number of mainstream services has declined since 30 June 1998 when a total of 3,015 services provided residential aged care. At the same time, the corresponding number of operational places has risen, resulting in an increase in the average number of places per facility from 46 at 30 June 1998 to 60 at 30 June 2006.

At a national level, the main providers of residential aged care services were religious organisations (29%), private providers (26%), community-based providers (17%) and charitable organisations (15%). There are state and territory variations in this service provider profile (AIHW 2007f).

Use by age and sex

Rates of use of residential aged care increase with age—in 2006 rates of residency for people aged 85 years and over were 153 per 1,000 men and 284 per 1,000 women. This compares with rates of 41 per 1,000 men and 66 per 1,000 women aged 75–84 years in the same year. Use of residential aged care is higher for women than men (Figure 41.1). These are similar patterns of use of residential aged care in the 65–74 year age group for both men and women. However, at older ages, use by women is substantially higher than that by men.

At all ages there has been a decrease in usage rates between 2000 and 2006 which is particularly marked among the older groups. To some extent this reflects the growing availability and use of community care

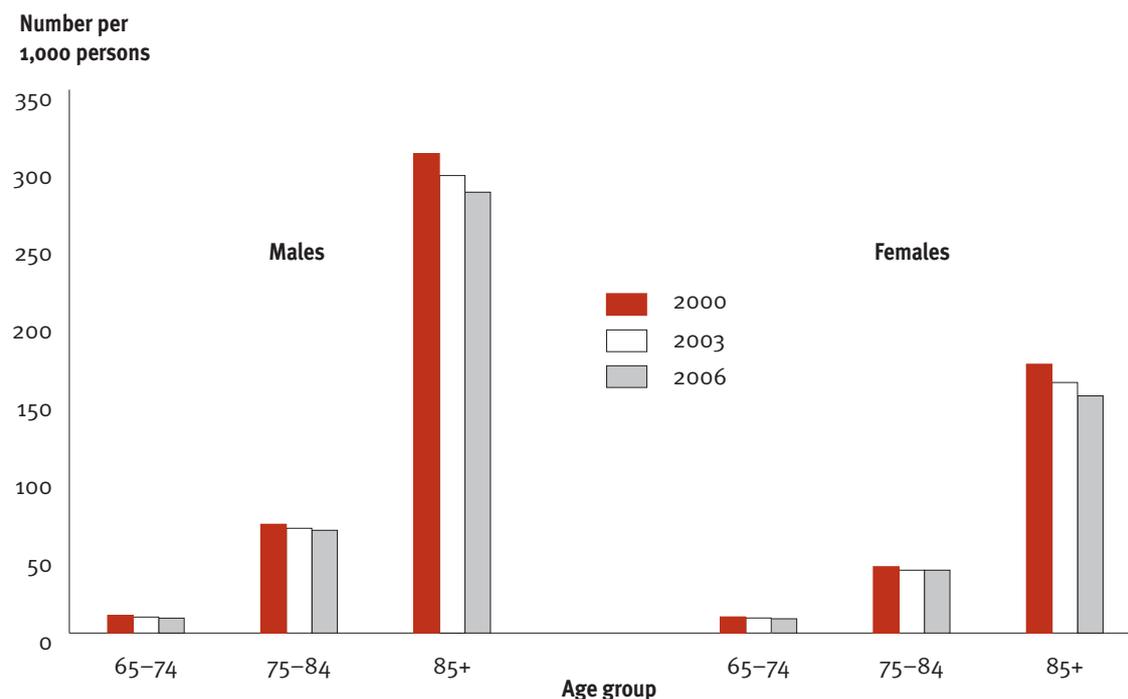
options by people who are assessed as eligible for residential aged care (see Topic 37: *Community Aged Care Packages* and Topic 38: *Extended Aged Care at Home and Extended Aged Care at Home Dementia Packages*).

Patterns of use by dependency

There has been a consistent and long-term trend of rising dependency levels among permanent residents, as measured by scores on the Resident Classification Scale (RCS) (Gray 2001; see also AIHW report *Residential aged care in Australia*, published annually).

Table 41.2 shows changes in the distribution of residents across the eight RCS categories between 1998 and 2006. The most dramatic change in use can be seen in the highest care category (RCS 1). The proportion of residents classified as RCS 1 has more than tripled, from 7% in 1998 to 23% in 2006. At the other end of the scale, the proportion of residents assessed as needing least care (in categories RCS 7 and RCS 8) has declined from 20% to 9% and from 5% to less than half a percent, respectively.

Figure 41.1: Age- and sex-specific usage rates of residential aged care, 30 June 2000, 2003 and 2006.



Source: Table A41.1.

Length of stay

The number of residents staying in residential aged care for 5 years or more increased from 17% at 30 June 1999 to 23% in 2002, and at 30 June 2006 was a little lower at 21%. The proportion of shorter stays has decreased over the same period (Table 41.3). As at 30 June 2006, 39% of permanent residents had already stayed 3 years or more and over one-fifth had stayed 5 years or more. In part, these patterns reflect structural changes in residential aged care since 1997. Under the unified system of residential aged care, low and high care may often be provided in the same aged care home, resulting in increased lengths of stay for those moving between low and high care.

The data in Table 41.3 measure the length of stay of an existing resident up to a particular point in time (in this case, 30 June each year). It does not take into account how much more time an existing resident will spend in care before leaving; it also excludes residents who separated before the 30 June in the year reported. Figure 41.2 shows differences in average completed

length of stay for male and female permanent residents who left care during a financial year since 2001–02.

In general, female residents have longer average completed length of stay than their male counterparts. For separations during 2005–06, female and male residents had average lengths of stay of 167 weeks and 109 weeks respectively. The aggregate completed length of stay for the period of separations was 146 weeks. These differences between males and females have been consistent over the time period examined.

Death was the major reason for separation from permanent residential aged care in 2005–06 (87%); 4% returned to the community, 4% moved to another residential aged care service and 5% were discharged to hospitals (AIHW 2007f). Among those who died, 17% had stayed for less than 3 months, 19% for between 3 months and 1 year, 45% for 1 to 5 years and 20% for 5 years and more. People leaving residential aged care after a shorter period of stay were more likely to return to the community and less likely to die in residential aged care than those with longer periods of stay.

Table 41.2: Permanent residents, by level of dependency, at 30 June 1998 to 30 June 2006

Year	RCS 1	RCS 2	RCS 3	RCS 4	RCS 5	RCS 6	RCS 7	RCS 8	Total
1998	6.9	24.9	20.3	5.7	7.7	9.7	20.3	4.5	100.0
1999	12.4	25.9	17.9	4.6	8.6	10.1	17.4	3.1	100.0
2000	14.4	26.0	16.7	4.7	8.9	10.3	16.8	2.3	100.0
2001	17.3	25.5	15.6	4.7	9.9	10.6	14.9	1.7	100.0
2002	18.9	25.3	14.8	4.6	10.5	10.8	13.8	1.4	100.0
2003	20.5	24.6	14.6	4.7	11.1	10.8	12.7	1.0	100.0
2004	21.9	24.5	14.5	4.8	12.0	10.6	11.1	0.8	100.0
2005	22.5	24.5	14.9	5.6	11.7	10.1	10.1	0.6	100.0
2006	23.4	24.2	15.4	5.7	12.1	9.8	8.8	0.4	100.0

Source: AIHW analysis of DoHA Aged and Community Care Management Information System (ACCMIS) database.

Table 41.3: Current permanent residents, length of stay to date, 30 June 1998 to 2006 (per cent)

	1999	2000	2001	2002	2003	2004	2005	2006
< 4 weeks	3.0	2.5	2.7	2.6	2.6	2.6	2.5	2.5
4–13 weeks	5.8	4.8	4.8	5.1	5.1	5.3	5.1	5.0
13–26 weeks	7.8	6.1	6.4	6.4	6.7	6.8	6.4	6.6
26–52 weeks	13.8	11.9	12.1	6.0	12.9	13.1	12.6	12.4
1–2 years	20.5	18.2	18.0	18.8	18.5	19.6	20.2	19.3
2–3 years	14.6	14.5	13.6	13.4	13.7	13.4	14.5	15.0
3–5 years	17.7	20.1	19.6	18.2	17.2	17.0	17.3	18.0
5 years or more	16.8	21.9	22.7	23.4	23.2	22.2	21.4	21.2
Total (number)	132,420	133,387	134,004	136,507	140,297	144,994	149,091	151,737

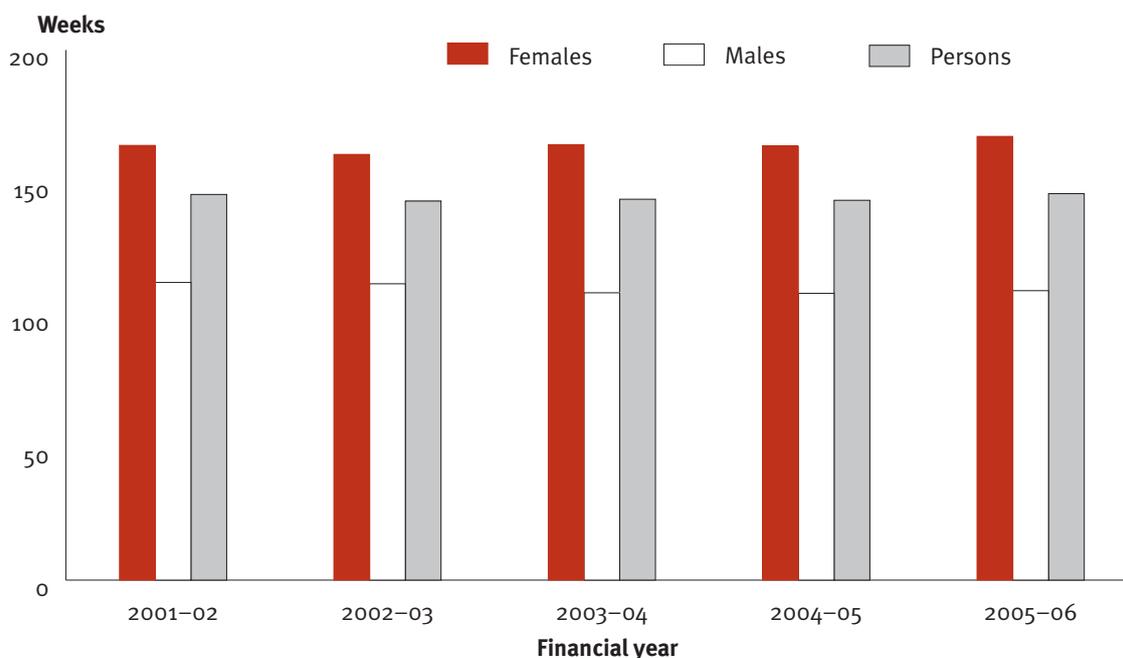
Source: AIHW analysis of DoHA Aged and Community Care Management Information System (ACCMIS) database.

Occupancy and place turnover

The national occupancy rate in 2006 was 95%, which varied by state and territory and by region. Over the last 8 years the occupancy rate at the national level has remained in a narrow band between 95% and 96% (AIHW 2007f).

The amount of turnover in the system is a function of the number of admissions, length of stay and the overall growth, or reduction, in the size of the system. Turnover of permanent and respite places has been relatively stable over the last 8 years. Approximately one-third of permanent places are associated with new admissions in a year, whereas nominal respite places are used by about 15 to 17 people per year (AIHW 2007f).

Figure 41.2: Average completed length of stay, separations of permanent residents, 2001–02 to 2005–06.



Source: AIHW analysis of DoHA Aged and Community Care Management Information System (ACCMIS) database.