3 Ageing and aged care

3.1 Introduction

The year 2007 marked the tenth anniversary of the passing of the *Aged Care Act 1997* and the announcement of the development of the National Strategy for an Ageing Australia. The *Aged Care Act 1997* provided the main vehicle for structural reforms in residential aged care, while the National Strategy for an Ageing Australia stimulated discussion of the wider context in which aged care programs and other services for older people operate. Discussion papers on healthy ageing, lifestyle and attitude, world class care, and self-provision and independence were released throughout 1999 and 2000, and the National Strategy itself was released in 2001 (Andrews 2001 & DoHA 2001). The following year saw the publication of the first Intergenerational report (Costello 2002), while the second such report was released in 2007 (Costello 2007). These initiatives have not only shaped developments in aged care over a decade but have also heralded changes in a wide range of policy areas that are affected by population ageing, and that in turn have shaped the experience of ageing of many older Australians.

Some of the major issues or themes which recur in these major policy documents include:

- labour force participation and productivity and the need to maintain an adequate labour supply, including for health and aged care
- retirement and the transition to retirement, including ensuring adequate provision for retirement, given longer life spans
- health and care costs, and how to influence the factors that will affect these, such as health and disability status, the supply of informal care, the type and quality of formal care services, and developing sustainable and equitable financing arrangements for such care
- social and community effects, and how to promote positive ageing in terms of health, economic and social participation, as well as access by older people to appropriate services and support including infrastructure, technology and information.

This chapter reports and discusses national data in relation to each of these themes, with the exception of reporting about the health and health costs of older people which is covered by various volumes of *Australia's health* (for example, AIHW 2004c, 2006a). Aged care workforce issues are discussed in Chapter 7.

Cross-sector implications

To understand the needs and circumstances of older Australians it is necessary to consider the interaction of several policy areas, and to take a life course perspective. For example, the adequacy of an older person's income is closely connected to housing tenure, which for many people relates to opportunities over a lifetime. Older people who do not own their homes can spend a disproportionate amount of their incomes on housing costs (see Section 3.5). Another example is the shift in employment policies to encourage mature

age people to remain in (or return to) paid employment; as people in this age group are an important source of informal care to ageing parents, and to spouses and other family members with disability, social policy provisions including those for respite care may need to take into account any changing employment trends. Long before baby boomers become concerned with their own aged care needs, many will be considering how to balance paid employment, mid-life and retirement lifestyle aspirations, and the care of ageing parents or other family members.

Available data limit the extent to which such cross-cutting analyses are possible. Increasingly, information systems will need to better support cross-policy perspectives, which require a wide range of data concerning the circumstances, needs and service experiences of older people. The Information Development Plan to improve statistics on older persons, currently under development by the Australian Bureau of Statistics (ABS) in consultation with relevant stakeholders, is one useful step in this direction, as are the ongoing activities to improve data consistency and quality under the National Community Services Agreement, and the activities at both national and state level to promote appropriate techniques of data linkage among administrative data sets and between survey data and administrative by-product data.

Current research initiatives, such as those funded through the Ageing Well, Ageing Productively research grants, are also fostering cross-sector views of ageing. Collaborative and multidisciplinary research is also being encouraged to inform the development of new, more integrated services for people with complex and changing care needs and their carers. For example, the recent funding provided by the Australian Government for Dementia Collaborative Research Centres and Dementia Research Grants is explicitly focused on promoting collaborative research that will improve the quality of life and care for people with dementia and their carers.

Service development

The goal of the Australian aged care service system has been the 'provision of a cohesive framework of high quality and cost-effective care services for frail older people and their carers' (DHFS 1996:117). Much of the early progress in implementing the *Aged Care Act 1997* was focused on funding and structural issues in the residential aged care sector. However, the last two decades have also seen the growing provision of community care options to support people in their own homes for as long as is reasonable. These have been accompanied by the development of respite care and other support services for carers.

In recent years there has been a strong and public emphasis on quality of care, prevention of elder abuse, consumer rights and access to information. The Office for Aged Care Quality and Compliance (which replaced the Aged Care Complaints Resolution Scheme in 2006) employs nationally centralised arrangements for the receipt and handling of complaints. Mandatory reporting of incidents of sexual or physical assault has been introduced (DoHA 2006b). Ongoing efforts aim to introduce common arrangements for accessing community care programs and to reduce the system's complexity for aged care consumers and providers (Section 3.7). The Securing the Future of Aged Care for Australians package announced in February 2007 includes six measures to expand and improve the provision of community care, as well as responding to the Hogan Review's recommendations about financing residential aged care (Section 3.7).

These developments illustrate the push towards integrating ageing and aged care issues into broader community concerns, and recognise their connection to policy developments in other areas. For example, the provision of high quality support and care to older people remaining at home poses challenges such as those highlighted by the National Strategy for an Ageing Australia on the role of infrastructure and community support (including housing, transport and communications infrastructure) in enabling older Australians to participate in and remain connected to society.

Aged care service provision continues to be challenged by and to respond to the diversity of consumers' needs and preferences. For example, the development of community care options responds to the preferences of older people to remain living in their own homes. However, this does not mean that all older people have been equally well served by the available options. Older people with high and complex needs had limited community care options targeted directly to them until Extended Aged Care at Home (EACH) packages were introduced: the creation of EACH Dementia packages in 2006 has now provided a community care option specifically targeted to high care clients with dementia and behavioural and psychological symptoms.

Other challenges relate to not only where the service should be delivered but what type of assistance should be offered, and how creatively and responsively services can be delivered to satisfy a spectrum of needs from social support and inclusion to physical care. For example, current home-based service delivery styles may meet the need for physical care and allow older people to remain at home but do little to counteract experiences of loneliness and social isolation of older people who live alone. For this group of people, psychosocial needs may eventually contribute to decisions to seek entry to residential care. Similarly, older people from diverse cultural and language backgrounds may feel poorly cared for if services are not delivered with appropriate levels of cultural sensitivity, even where the quality of the service and the intentions of the service provider are otherwise exemplary.

Questions about the balance of provision of community and residential aged care (or other forms of congregate living), the continuum of care offered in a home-based setting, and the role of and support for informal care providers remain central to understanding and further improving the quality and appropriateness of care.

Some important questions, however, continue to challenge researchers and policy makers alike. Among these questions are how the system of care and support programs is used by older people over time, and how the various program offerings fit together from the consumers' and providers' perspectives. For example, does the use of community care delay or prevent entry to residential aged care? Does the use of community care reduce the incidence of fall-related hospitalisations? Addressing questions of this nature currently requires the analysis of data linked across multiple aged care programs; the next few years should see considerable improvement in Australia's capacity to answer these types of questions. One such project is under way at the Australian Institute of Health and Welfare (AIHW) in collaboration with Professor Stephen Duckett (University of Queensland) and Dr Yvonne Wells (La Trobe University) as part of a project investigating the care pathways of older people across both community and residential care sectors funded by the National Health and Medical Research Council (NHMRC).

Chapter outline

This chapter discusses the characteristics of Australia's older population and the care and services they receive. The primary focus is on people aged 65 years or over, the age from which people can access the Age Pension. This age group potentially conceals considerable diversity in the circumstances and needs of older people. Wherever possible, the chapter disaggregates data by age group to reveal differences between 'younger' old and the very old (those aged 85 years or over). Other age groups, however, can also be relevant in discussions about ageing. For example, workers aged 45 years or over—mature-aged workers—are the focus of research and policy designed to retain older workers in the labour force. This age group is also an important source of family caregivers who support older parents and relatives. Where relevant, this chapter includes data on age groups younger than 65 years.

Section 3.2 examines the size and certain characteristics of the older population, including Indigenous status, cultural and linguistic diversity, accommodation and living arrangements, and disability. Section 3.3 discusses issues related to labour force participation by mature-aged and older people, while data on social participation by older people is presented in Section 3.4.

Older people are eligible for, and make use of, a range of benefits and services that are available to the general population, such as housing (see Chapter 5), hospital care, medical care and pharmaceuticals (AIHW 2006a). However, certain types of income support and care services are either targeted to, or primarily used by, older people. Sections 3.5 to 3.9 deal with support and care for older people, including the main forms of income support, informal care, and government-funded aged care services. Data on services and client profiles are presented to give a picture of the service system as it exists now, against the backdrop of developments in support for older people. Section 3.7 also covers recent developments in community and residential aged care.

It should be noted that the age group aged 65 years or over is not used by government as a planning or funding tool for the majority of the programs discussed, and that younger people can and do access these services. The use of services by younger people with disability is examined in Chapter 4.

Section 3.10 draws on the limited data available about outcomes to discuss trends in accessibility and use of the main national aged care programs, older people's satisfaction with their ability to leave home and participate in the community, and their reports of unmet need for formal and informal assistance.

Expenditure on aged care is covered in Section 3.11.

Throughout the chapter use is made of different terms that have subtly different meanings despite apparent similarities. What might appear to be inconsistent use of language in the chapter arises because the chapter draws on data from multiple sources, including administrative data collections and ABS surveys, each with its own lexicon. In addition to the Glossary in this volume, Box 3.1 lists some key terms and concepts used in this chapter.

Box 3.1: Key concepts and terminology used in Chapter 3

Activity limitation—As defined by the ABS Survey of Disability, Ageing and Carers, a person has a limitation if they have difficulty doing the activity, need assistance from another person or use an aid. The related terms 'core activity limitation'and 'profound or severe limitation' are used when referring to results from the ABS survey, consistent with the survey definitions (ABS 2004b).

Aged care home—This term is used as in the *Report on the operation of the Aged Care Act 1997* (DoHA 2006b) to refer to Australian Government-accredited facilities that provide supported aged care accommodation (low and high care).

Aged care accommodation—A term used in the ABS Survey of Disability, Ageing and Carers to refer to those components of 'cared accommodation' (see definition below) that are specifically for older people. Used here only for the purpose of reporting data from the ABS survey.

Cared accommodation—The ABS Survey of Disability, Ageing and Carers defines cared accommodation to include hospitals, homes for the aged such as nursing homes and aged-care hostels, cared components of retirement villages, and other 'homes', such as children's homes (ABS 2004b). Used here only for the purpose of reporting data from the ABS survey.

Community living—References to living 'in the community', or similar words, in this chapter mean that the place of usual residence is a private or non-private dwelling as distinct from residential aged care, hospital or other type of institutional accommodation. Community settings include private dwellings (a person's own home or a home owned by a relative or friend) and certain types of non-private dwellings, for example, retirement village accommodation.

Disability—When used in connection with data from the ABS Survey of Disability, Ageing and Carers 'disability' is defined as having one or more of 17 impairments, activity limitations, or participation restrictions which have lasted, or are likely to last, for at least 6 months and which restrict everyday activities (ABS 2004b). See also Chapter 4.

Profound or severe activity limitation—A person with profound or severe limitation needs help or supervision always (profound) or sometimes (severe) to perform activities that most people undertake at least daily, that is, the core activities of self-care, mobility and/or communication. People with profound or severe core activity limitation typically need daily assistance because of the frequency that core activities need to be performed for health, safety and quality of life.

Residential aged care—This is used here as an umbrella term to refer to low and high care services provided in Australian Government-accredited aged care homes, where high care and low care are as defined in the *Report on the operation of the Aged Care Act 1997* (DoHA 2006b). Includes accommodation-related services with personal care services (low and high care), plus nursing services and equipment (high care only).

3.2 Australia's older population

Age and sex

On 30 June 2006, an estimated 2.7 million Australian residents were aged 65 years or over, more than half of whom were aged 65–74 years (Table 3.1). Women accounted for around 55% of older people but are a higher share of the very old (68% of people aged 85 years or over).

Table 3.1: Persons aged 65 years or over, 30 June 2006

Age (years)	Males	Females	Persons	Males	Females	Persons
		Number			Per cent	
65–69	385,226	393,943	779,169	31.8	26.7	29.0
70–74	302,778	326,360	629,138	25.0	22.1	23.4
75–79	252,158	299,330	551,488	20.8	20.3	20.5
80–84	166,000	239,328	405,328	13.7	16.2	15.1
85 or over	104,337	217,654	321,991	8.6	14.7	12.0
Total 65 or over	**1,210,499**	**1,476,615**	**2,687,114**	**100.0**	**100.0**	**100.0**

Source: ABS 2007e.

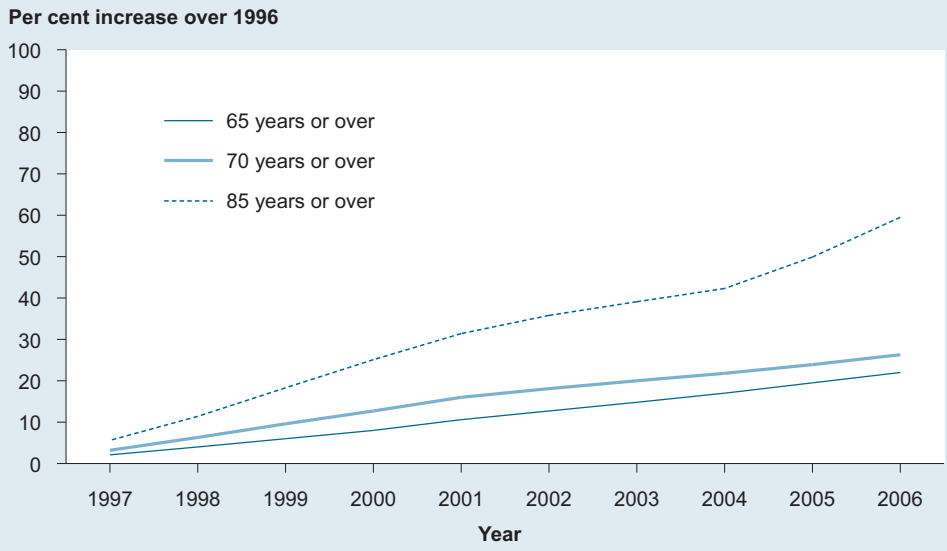
As a proportion of the total population, people aged 65 years or over increased from 12% in 1996 to 13% in 2006. More rapid growth in the older population as a share of total population will take place from 2011 onwards as surviving members of the baby-boomer generation reach 65 years of age. Growth in the older population has a direct effect on the provision of Australian Government-funded aged care places as planning targets are currently based on the size of the population aged 70 years and over.

In the last decade the rate of growth in the population aged 65 years or over has been fairly constant, while the considerably higher rate of growth of the very old population accelerated around 2004 (Figure 3.1). The number of people aged 85 years or over doubled in the 15 years to 2006. Growth in the very old population will be a major influence on government spending on aged care over the next 40 years; during this period the number of people aged 85 years or over is projected to more than quadruple to 1.6 million (Costello 2007).

Older Aboriginal and Torres Strait Islander people

The Aboriginal and Torres Strait Islander population of Australia has a much younger age structure than other Australians, but it too is ageing. People aged 65 years or over make up just 3% of the Indigenous population, and this proportion is expected to remain the same until at least 2009; however, the median age of Indigenous Australians is rising due to a falling proportion of Indigenous people aged less than 15 years (ABS 2004a).

ABS projections suggest that in 2006 between 41,000 and 45,000 Aboriginal and Torres Strait Islander people were aged 50–64 years (Table 3.2). People aged 50 years or over accounted for around 11% of the total Indigenous population in 2006. Like the general population, the age composition of Aboriginal and Torres Strait Islander communities varies considerably across regions: ABS projections for 2006 indicate that people aged 50 years or over represented anywhere between 9% and 15% of regional Indigenous communities (ABS 2004a:Table 33).



Source: Table A3.1.

Figure 3.1: Increase in number of people aged 65 years or over, 70 years or over and 85 years or over since 1996, 1997 to 2006

Much of the current Indigenous policy and research focus surrounds interventions that target children, young people and families, with the aim of improving health, education and employment outcomes in early and mid-life. Ageing policy and research on ageing specifically as it affects Indigenous people is still a relatively small field in this country and will perhaps remain so as long as the health and social inequalities between Indigenous and non-Indigenous Australians are apparent from the earliest ages. There are two main issues relating to ageing for many Indigenous people in contemporary Australia: the likelihood of reaching old age, and whether ageing policy and aged care systems designed primarily for the older non-Indigenous population are sensitive to the many different aspects of ageing among Indigenous Australians.

Table 3.2: Indigenous Australians aged 50 years or over, 2006 (low series projection)

Age (years)	Males	Females	Persons	Males	Females	Persons
	Number			Per cent		
50–54	8,976	9,728	18,704	34.6	33.0	33.7
55–59	6,644	7,258	13,902	25.6	24.6	25.1
60–64	4,220	4,576	8,796	16.2	15.5	15.9
65–69	2,790	3,355	6,145	10.7	11.4	11.1
70–74	1,724	2,144	3,868	6.6	7.3	7.0
75 or over	1,623	2,455	4,078	6.2	8.3	7.3
Total 50 or over	**25,977**	**29,516**	**55,493**	**100.0**	**100.0**	**100.0**

Note: The high series projection for 2006 estimates 60,073 Aboriginal and Torres Strait Islander persons aged 50 years or over.
Source: ABS 2004a.

Older people born overseas

Currently around one-quarter of Australia's population was born overseas. The median age of overseas-born residents is 14 years higher than their Australian-born counterparts (47 years versus 33 years respectively), reflecting the high numbers of post–World War II immigrants from Europe and, more generally, the ages at which people migrate to Australia (ABS 2007b). Major birthplace countries of origin with higher median ages were Italy (66 years), Greece (64 years), Germany (59 years) and the United Kingdom (54 years).

Numbering nearly one million, overseas-born older people accounted for 35% of all people aged 65 years or over on 30 June 2006 (ABS 2007b). While most of these people originate from non-English-speaking countries (61% of older people born overseas), a large minority came to Australia from mainly English-speaking countries, mostly the United Kingdom and Ireland, New Zealand, South Africa, the United States of America and Canada.

Older people from non-English-speaking countries account for around 21% of all older Australians (581,200 people). Of these, 51,500 were aged 85 years or over. Older people from these countries make up 23% of the 65–74 year old population, and 15% of those aged 85 years or over. A small number of non-English-speaking countries have contributed significant numbers of immigrants who are now aged 65 years and over. Italy is the major country of birth for older immigrants, contributing 113,900 people and 4% of the total older Australian population, followed by Greece with 57,200 older immigrants who account for 2% of the older Australian population. The other main birthplaces of older Australians from culturally and linguistically diverse backgrounds are Germany, the Netherlands, China and Poland (ABS 2007b).

However, older immigrants are present among all birthplace countries of origin, sometimes in very small numbers. The cultural and linguistic backgrounds of older people have implications for the provision of services in terms of the need for bilingual support, culturally sensitive service provision, and their access to care from family depending on the circumstances before and following settlement in Australia. The policy and service provision challenge is perhaps greatest for those many groups that are small in number.

Between 1 July 2005 and 28 February 2007, 7,732 people aged 65 years or over were granted Australian citizenship. People have cited varied reasons for applying for citizenship at older ages, among them identifying with younger members of family, especially grandchildren, as an Australian citizen, making official a personal feeling of belonging, and waiting until the laws of their country of origin changed to allow dual citizenship to enable them to satisfy a long-held desire to identify as an Australian while retaining the heritage of their country of origin (advice received from the Australian Government Department of Immigration and Citizenship).

Accommodation and living arrangements

ABS projections based on data from the 2001 Census estimate that around 94% of older people in 2006 lived in private dwellings as members of family, group and lone-person households (see Table A3.2). Just over 6% were usual residents in non-private dwellings, which include hotels, motels, guest houses, independent living units in retirement villages, and cared accommodation such as hospitals, aged care homes and supported accommodation offered by some retirement villages. A large majority of people in each age group 65–74 years, 75–84 years and 85 years or over lived in private dwellings.

Approximately 29% of older people live alone in private dwellings. The likelihood of living alone increases with age, with around 39% of people aged 85 years or over living in lone-person households. Even if lone-person households as a proportion of older person households remains the same over the next 15 years, significantly more older people will be living alone in private dwellings, with a projected increase from around 783,000 in 2006 to 1.3 million in 2021, 70% of whom will be women (Table A3.2).

The use of cared accommodation increases with age. Although only around 5% of older people live in cared accommodation, about 31% of those aged 85 years and over lived in cared accommodation in 2003 (1% of people 65–74 years, 7% of people 75–84 years, 31% of people aged 85 years or over) (AIHW analysis of ABS Survey of Disability Ageing and Carers; ABS 2004b). Cared accommodation mostly consists of, but is not limited to, Australian Government-accredited aged care homes. On 30 June 2006, 145,175 people aged 65 years or over were permanent residents in these homes, more than half of whom were aged 85 years or older (AIHW 2007b).

It has long been recognised that population ageing means that there will be many more people who need daily assistance. Another outcome is increased numbers of older people (especially older women) who live alone, some of whom will be at risk of reduced social participation and social isolation. While loneliness does not necessarily follow from spending time alone, widowhood and living alone are predictors of loneliness in older people and there is a strong relationship between amount of time spent alone and loneliness (Steed et al. 2007). For some people, loneliness and a sense of social isolation may also contribute to decisions to seek entry to an aged care home. Risks associated with loneliness and reduced social participation point to the importance of social contact with family and friends who live outside the household, and of formal services that offer such assistance with social support and transport.

Disability in the older population

Disability reflects a gap between a person's ability to perform their usual roles and the demands of the environment in which they live and function. It is a concept related to, but distinct from, activity limitation, since activity limitation describes capability, whereas disability is a social process (Verbrugge & Jette 1994). Iwarsson (2005) has shown that the gap between personal capability and environmental demands increases with age. Growing life expectancy has been accompanied by the hope that extra years of life are spent in good health and without disability.

Evidence in the international literature is somewhat equivocal, but recent Australian evidence suggests that most of the additional years of life gained during the 15-year period from 1988 to 2003 are years of life spent with disability. Over this period, men's life expectancy at age 65 years increased by 1.5 years— 67% of the gain (one additional year of life) is spent with disability and 27% of the gain is life with disability and profound or severe core activity limitation (abbreviated in this chapter to 'profound or severe limitation'). Older women increased their life expectancy at age 65 years by 1.2 years—over 90% of the gain is estimated to be time spent with disability, and around 58% is likely to be time spent with disability and profound or severe limitation (AIHW 2006b).

Over half of all people aged 65 years or over experience some type of disability that restricts everyday activities. Physical or multiple and diverse disability is the most common type of disability at older ages, affecting 45% of older people (AIHW 2005:Table 5.2). Having disability does not necessarily imply a need for assistance—for example, a person may

experience breathing difficulties that restrict the type and amount of physical activity they can undertake, but they do not need help or supervision with daily living activities. Among older people with physical or diverse disabilities, only 41% had a profound or severe limitation (AIHW 2005:Table 5.2).

People with profound or severe limitation who need help with the core activities of self-care, mobility and communication (see Box 3.1) could be considered the group most in need of assistance from formal care programs since a person with this degree of activity limitation usually needs help on at least a daily basis. Profound or severe limitation is strongly age-related, affecting around 12% of 65–74 year olds and increasing to 58% of people aged 85 years or over.

While a majority of older people with profound or severe limitation (73% in 2003) live in households, there are marked differences between their overall pattern of activity limitation and that of people living in aged care accommodation (Table 3.3). The predominant pattern of core activity limitation among older people in households is mobility limitation with or without self-care limitation. People in aged care accommodation are far more likely to have profound or severe limitation in all three core activity areas. With each additional area of profound or severe limitation, the chance of an older person residing in aged care accommodation increases considerably. Over 70% of people aged 65 years or over with profound or severe limitation in three core activity areas live in aged care accommodation, compared with 20% of older people so affected in two core activity areas, and 3% of older people with profound or severe limitation in just one core activity area.

Social and environmental supports can reduce disability and therefore play a critical role in improving quality of life and perceived quality of life. Supports act in two ways: by increasing individual capability or by reducing environmental demands (Verbrugge & Jette 1994). The role of environmental modifications and assistive technology is clear, especially given the numbers of older people in the community who experience mobility and self-care limitation. Well-designed home environments and access to aids and equipment help to reduce environmental demands, in turn reducing a person's reliance on others for assistance. This has obvious benefits for the person with disability, and their families and other providers of assistance.

Conversely, some of the impediments to functioning and participation for older people are poor or inappropriate housing conditions, low income, lack of transport services, low levels of community information and lack of community services (Comyn et al. 2006). Environmental difficulties, such as inaccessibility of rooms or objects, unsafe conditions such as clutter or a lack of needed handrails, and poor home maintenance that compromises safety or interferes with daily activities, mean constant exposure to the risk of reduced functioning (Gitlin et al. 2001). Functional limitation is strongly associated with depressive symptoms in older people, either in the presence or absence of disease, and with the risk of institutionalisation (Lichtenberg et al. 2000; Zeiss et al. 1996). It has also been found that perceived inability in meeting basic needs predicts depression in older adults and that access to assistive technology reduces the perception of disability (Sachs-Ericsson et al. 2006). Older people's use of assistive technology is discussed in Section 3.9.

Table 3.3: People aged 65 years or over, level and area of core activity limitation, by accommodation setting, 2003

Level/areas of core activity limitation	Age group (years) 65–74	75–84	85 or over	Total (number)	Total (per cent)
			Persons living in households		
Profound or severe limitation					
Self-care, mobility and communication	*5,300	*9,200	*8,200	22,700	1.0
Self-care and mobility	47,500	61,000	28,000	136,400	5.8
Mobility only	55,300	85,300	40,900	181,500	7.8
Self-care only	26,000	18,100	*4,000	48,100	2.1
Communication (with or without profound or severe self-care or mobility limitation)	*9,500	*6,800	**1,800	18,200	0.8
Total profound or severe	*143,600*	*180,400*	*82,900*	*406,900*	*17.4*
Moderate or mild core activity limitation	337,200	288,500	62,300	688,000	29.5
No core activity limitation[a]	824,300	362,900	51,200	1,238,400	53.1
Total	*1,305,000*	*831,800*	*196,400*	*2,333,300*	*100.0*
			Persons living in aged care accommodation		
Profound or severe limitation					
Self-care, mobility and communication	*8,400	30,200	46,600	85,200	61.5
Self-care and mobility	*3,000	11,600	18,700	33,200	24.3
Mobility only	n.r.	n.r.	n.r.	*2,400	*1.7
Self-care only	n.r.	n.r.	n.r.	*4,500	*3.2
Communication (with or without profound or severe self-care or mobility limitation)	n.r.	n.r.	n.r.	*5,200	*3.8
Total profound or severe	*12,900*	*46,100*	*71,500*	*130,500*	*94.2*
Moderate or mild core activity limitation	n.r.	n.r.	n.r.	*3,900	*2.8
No core activity limitation[a]	n.r.	n.r.	n.r.	*4,100	*3.0
Total	*13,600*	*49,400*	*75,500*	*138,500*	*100.0*
			Persons living in other types of accommodation		
Total[b]	**3,700*	**9,600*	*11,700*	*25,000*	*100.0*
			All persons		
Profound or severe	159,900	235,400	165,700	560,900	22.5
Moderate or mild	337,500	290,600	64,500	692,600	27.7
No core activity limitation[a]	825,100	364,800	53,400	1,243,300	49.8
Total	**1,322,500**	**890,700**	**283,600**	**2,496,800**	**100.0**

(a) 'No core activity limitation' includes people with disability who have no core activity limitation and people without disability.

(b) Most people in 'other types of accommodation' have profound or severe core activity limitation.

Notes

1. Households include private and special dwellings, which may include self-care units in retirement villages.
2. Aged care accommodation includes 'Home for the aged' and 'Accommodation for the retired or aged' as defined by ABS (excludes self-care accommodation for retired or aged people).
3. Other types of accommodation include hospitals, hotels and motels, hostels for the homeless and other short-term crisis accommodation, retired or aged accommodation (self-care), religious and educational institution, guest house, boarding house or other long-term accommodation.

Source: AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers confidentialised unit record file (CURF). Estimates based on the CURF may not exactly match those of ABS published reports as some potentially identifiable records are not included in the CURF.

3.3 Work and retirement

Population ageing puts the issues of future labour supply and labour productivity on the public policy agenda (Costello 2002, 2007). Recent government research on the medium-term effects of population ageing on the labour market predicts that Australia faces a potential shortfall of 195,000 workers over the 5 year period from 2004–05 to 2009–10 as a result of population ageing (DEWR 2005). While there is no statutory retirement age in Australia, labour force participation is low at ages 65 years and over by comparison with younger age groups, for both men and women. Only 13.8% of men and 4.5% of women aged 65 years or over in December 2006 were employed or looking for work (ABS 2007a). The participation rate for persons aged 65 or over has increased by 2.7 percentage points over the decade from October 1996 to reach 8.2% in October 2006, and remains considerably lower than the participation rate for persons aged 45–64 years.

With fewer young people than previously entering the workforce, the mature age groups are being promoted as a potential source of increased labour supply. Indeed, there has been a strong increase in workforce participation by people aged 45–64 years over the last decade. Participation by mature-aged people increased by 6.2 percentage points between October 1996 and October 2006, mainly due to rising labour force participation among mature-aged women, from 53% to 64%. The older proportion of the mature age cohort—those aged 55–64 years—recorded a larger rise in labour force participation over the decade than all persons aged 45–64. This is most evident for women aged 55–64 years, who recorded an increase in their participation rate of 17 percentage points over the period, to 48% in October 2006 (AIHW 2007).

Many factors have contributed to the increased labour force participation of mature-aged people. The increased availability of casual and part-time positions may have helped attract and retain women in the workforce. Changing employment practices may also have contributed. However, it is important to recognise the possibility of a cohort effect—the increase in mature-age participation may be influenced by people who are moving into the 45–54 and 55–64 year age groups with higher participation rates than those who are moving out of the cohort; this cohort effect is likely to be more pronounced among women. Together with a strengthened employment market, this has driven the proportion of all persons aged 45–64 years in employment from 61.5% in October 1996 to 69.5% in October 2006 (AIHW forthcoming).

Despite public policy encouragement for older people to remain in the workforce, age discrimination and negative employer attitudes still form a barrier to this in some industries and occupations. More than one-third (37%) of all discouraged job seekers in September 2006 said they could not find work because employers considered them too old (ABS 2007c).

The meaning and timing of retirement

The retirement of large numbers of the baby-boomer generation over the next 10 to 20 years has significant implications for the economy. For individuals, retirement represents a major life transition—issues such as the timing and process of retirement, retirement income and lifestyle plans are the focus of attention.

The idea of 'retirement' has different connotations for different people. Whereas for past generations (of mainly male full-time workers) retirement usually meant a sudden and complete withdrawal from paid employment, many workers now phase their retirement,

reducing hours of employment gradually or withdrawing from and re-entering the workforce intermittently over a period leading up to full retirement. Some workers, having fully retired, reverse the process and re-engage with the workforce. The notion of a 'transition to retirement' has become widely accepted (Borland 2005) along with the concept of partial retirement (Warren 2006).

In 2004–05, around three million people aged 45 years or over who had worked at some time in their lives were defined by the ABS as fully retired from the labour force. Around 33% of the men had retired when aged 60–64 years and 23% at ages 55–59 years. Historically, women have tended to retire earlier than men—around 33% of retired women in 2004–05 had retired at age 45 years or younger and a further 19% retired when aged 55–59 years (ABS 2006b).

A range of factors influence why, when and how people make the transition to full retirement, including sex, family and lifestyle considerations, health status and disability, access to Age Pension and superannuation benefits, job satisfaction and, in some cases, retrenchment. The 2004–05 ABS Multi-Purpose Household Survey found that, for retired people who had held a job in the previous 20 years, the main reason for stopping work altogether was reaching 'retirement age' or being eligible to receive superannuation or a pension (34%). Less common were reasons of sickness, injury or ill health (26%), or being retrenched, dismissed or no work being available (11%) (ABS 2006b).

Similar findings have come from an analysis of the Household, Income and Labour Dynamics in Australia Survey, from which Cobb-Clark and Stillman (2006) concluded that 'anticipating the age at which one will leave the labour market may be easier for workers in jobs with well-defined pension benefits and standard retirement ages'. It was found that individuals with long-term savings and spending goals are more likely than workers with short-term financial outlooks to nominate an age at which they expect to retire. Factors associated with higher levels of uncertainty about retirement age (and expectations of later retirement) include foreign-born status and being a single person. Living in a couple household, being in good health and anticipating a relatively high retirement income all seem to be associated with expectations of early retirement among middle-aged Australian workers (Cobb-Clark & Stillman 2006).

It is also acknowledged within policy circles that attitudinal and other reasons lie behind the decision of many workers to retire relatively early (Andrews & DoHA 2001; FaCS 2003). Cobb-Clark and Stillman (2006) reported that around 60% of working middle-aged Australians expect to retire later than they desire, which suggests that many workers perceive retirement to be more desirable than a prolonged working life.

The reasons why people re-enter the workforce following a period of retirement highlight some of the factors that workers take or fail to take into account in planning for retirement. Most commonly, financial need and boredom are the main reasons that retired people return to the workforce, affecting approximately 94,500 and 75,600 retired people aged 45 years or over in 2004–05 respectively (ABS 2006b). Currently, women account for over 70% of people who return to the labour force following retirement.

Greater awareness of the financial and lifestyle implications of retirement and access to flexible workplace arrangements may help people who would otherwise fully retire to consider combining paid employment with the perceived lifestyle advantages of retirement. Measures such as part-time work (for example job sharing or job redesign), the use of long service leave and leave without pay, and resignation without prejudice to return could conceivably help retain and attract older workers.

3.4 Social participation

Retirement from work offers the opportunity to devote more time and energy to family, community and personal interests. Previous volumes of *Australia's welfare* have highlighted the role of older people in volunteering, unpaid caring work and other activities that contribute to stronger families and communities (AIHW 2003, 2005). Equally, retirement and old age can pose challenges if associated with lowered social engagement. Two goals of the National Strategy for an Ageing Australia encapsulate the importance of attitudes, lifestyle and community support in enabling older people to participate in society:

- a positive social image of older Australians that appreciates their diversity and recognises the many roles and contributions they continue to make to the economy and the community
- public, private and community infrastructure to support older Australians and their participation in society.

The strategy acknowledges the many elements that contribute to an older person's quality of life and their participation in society, including housing, transport, the ability to use common forms of technology, access to health and aged care services, and access and capacity to participate in recreation, tourism and leisure activities. It also acknowledges the role of individuals, community, government and business resources in providing infrastructure to support the lifestyle needs of older Australians (Andrews & DoHA 2001).

Table 3.4 reports results from the 2006 ABS General Social Survey on selected aspects of social contact and community participation in older age groups compared with the corresponding results for the traditional pre- and early-retirement age group 55–64 years and the total adult population. A major limitation of the data is that the sample population only included people in private dwellings and excluded those living in some types of accommodation commonly used by older people, such as residential aged care and certain types of retirement village accommodation. Data about social and community participation is also collected through the ABS Survey of Disability Ageing and Carers, last conducted in 2003, but these particular data items are similarly limited to people living in households, including some non-private dwellings such as self-care units in retirement villages.

The results of the General Social Survey indicate that family is a prime source of social contact for older people. Older people are just as likely as people in younger age groups, and adults generally, to have face-to-face contact with family members or friends living outside their household but are somewhat less likely to visit or be visited by friends (Table 3.4). Apart from face-to-face contact, most (96%) older people rely on fixed telephones to maintain contact with family or friends outside the household; currently, people in the older age groups are less likely than younger people to maintain social contacts through mobile telephone or internet use (ABS 2007d:Table 31).

Participation in group activities is much lower among people aged 75 years or over, compared with the total adult population. This is particularly evident for people aged 85 years or over, only 43% of whom participate in social groups and 17% in community support groups, compared with 63% and 33% respectively for the total adult population (Table 3.4). The types of community support and social groups that attract higher proportions of older people include religious or spiritual groups (24%) and social clubs that provide restaurants or bars (18%–20%, by age group). Around the same proportion of older people as people in younger age groups participates in service clubs and welfare organisations (about 10%) (ABS 2007d:Table 29).

Attendance at cultural and leisure venues, and participation in community events, sport or recreational physical activity all decline with increasing age. Participation in sport or physical activity is lowest in the older age groups. While a smaller proportion of older people than younger age groups attends cultural and leisure venues or events, this is a more common form of activity among older people than sport and recreational physical activities. In 2006, only 25% of people aged 85 years or over participated in sport or physical activity but over half (59%) attended cultural or leisure venues or events. Libraries, cinemas and botanic gardens are the more popular venues, both among the very old and for people aged 65–84 years (ABS 2007d:Table 31). Performing arts, museums and galleries are also popular among the 'younger' old but attract relatively few people aged 85 years or over.

For people of all ages, being able to leave home is an important aspect of community participation and ability to access services. Section 3.10 examines data on the question of whether older people are able to go out as often as they would like and whether they encounter problems in accessing services.

Table 3.4: Participation in selected social and community activities and events, 2006 (per cent)

	Age group (years)				
	55–64	65–74	75–84	85 or over	All persons (18 or over)
Social contact					
Face-to-face contact in the last week with family or friends living outside the household	79	80	77	82	79
Visited or was visited by friends in last 3 months	92	88	86	81	93
Went out with or met a group of friends in last 3 months—outdoor activities	72	63	44	41	77
Went out with or met a group of friends in last 3 months—indoor activities	66	65	57	48	73
Participation in groups (last 12 months)					
Actively participated in social groups	64	66	57	43	63
Actively participated in community support groups	28	29	22	17	33
Actively participated in civic and political groups	23	15	12	*5	19
Participation in selected activities and events					
Participated in sport or recreational physical activity in last 12 months	59	53	41	25	62
Participated in a community event in last 6 months	62	57	46	29	64
Attended at least one cultural or leisure venue or event in last 12 months	87	79	67	59	89
Feels able to have a say within community on important issues at least some of the time[(a)]	56	54	51	40	54
Feels able to have a say among family and friends on important issues all or most of the time	84	82	81	78	84

(a) Includes 'feels able to have a say some, more or all of the time'.

Note: Includes only persons in private dwellings.

Source: ABS 2007d:tables 25 and 31.

3.5 Retirement income

Australia's retirement income system is built on three main 'pillars': pension payments (Age Pension and service pension payments), compulsory employer superannuation contributions (the Superannuation Guarantee) and voluntary savings, which include voluntary superannuation savings, home equity, and other cash and non-cash assets.

Among fully retired people in 2004–05, around 44% retired with a government pension or benefit as their main source of income (Table 3.5). Superannuation was the main source of income at the time of retirement for 12% of retired people. For their current main source of income, two-thirds of retirees relied on a government pension or benefit. This increase (up from 44% at the time of retirement) reflects the individuals who retired younger than pension qualifying age and subsequently reached that age and, for many people, the exhaustion of initial main sources of retirement income.

Retired women were more likely than their male counterparts to report a change in their main source of income over the course of their retirement. Among retired people in 2004–05, women were less likely than men (37% versus 54%) to have taken up a government pension immediately on retirement but were more likely than men to be currently receiving a government pension as their main source of income (Table 3.5). Female retirees more often than their male counterparts (30% versus 7%) reported 'other' as the main source of income at retirement; this includes living off a partner's income. However, in 2004–05, just over 2% of retired women were relying mainly on 'other' income. Interestingly, 'other' income at retirement is associated with the youngest average age at retirement of any of the source of income categories (40.1 years for females and 56.4 years for males) (ABS 2006c). Kelly and Harding (2004) have highlighted that low average superannuation savings is an acute problem for many women.

A partner's income, and perhaps a partner's own retirement plan, may be a major consideration in the timing of retirement for many currently retired people, particularly

Table 3.5: Retired people 45 years or over, main source of income at retirement and at time of survey, by sex, 2004–05 (per cent)

	Main source of income at retirement			Main source of income in 2004–05		
Source of income	**Males**	**Females**	**Persons**	**Males**	**Females**	**Persons**
Government pensions/ benefits	53.9	36.8	44.3	65.2	67.6	66.5
Superannuation/annuity	19.8	6.3	12.2	17.8	6.1	11.2
Dividends or interest	5.6	2.9	4.1	6.4	10.0	8.4
Profit or loss from business	2.2	2.5	2.4	0.9	1.4	1.2
Profit or loss from rental property	1.9	1.9	1.9	2.2	2.8	2.6
Other (includes partner's income)	6.8	29.8	19.7	1.8	2.4	2.1
No income[(a)]	6.6	17.7	12.8	3.1	6.8	5.2
Not known	2.0	1.7	1.8	0.2	0.5	0.4
Not stated	1.0	0.5	0.8	2.4	2.4	2.4
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total ('000)	**1,312.4**	**1,687.7**	**3,000.1**	**1,312.4**	**1,687.7**	**3,000.1**

(a) Includes living off savings, lump sumps and other assets.

Note: Table pertains to fully retired people. The 2004–05 Multi-Purpose Household Survey showed that, of the 7 million people aged 45 years or over who had, at some time, worked for 2 weeks or more, 3.7 million (53%) were in the labour force, 3 million (42%) had retired from the labour force, and the remaining 329,900 (4.6%) were neither in the labour force nor retired (consisting of people who intended to work in the future or whose retirement status was not determined).

Source: ABS 2006c.

women. Another area of difference between the sexes is in the proportion of retirees that retired to live off savings, lump sums and other assets, shown as 'No income' in Table 3.5 (7% of males compared with 18% of females). Overall, in 2004–05 almost 13% of retirees had drawn down on savings and assets at the time of their retirement, but only 5% were still doing so for their main source of income. A key question is whether historical trends will accurately describe the retirement intentions and experiences of people entering retirement now and in the future.

Pensions

The Age Pension and service pensions are the main source of government-funded income support for many older people who cannot support themselves fully in retirement. Since its introduction on 1 July 1909, the Age Pension has grown into a major income support program, with expenses totalling approximately $20.6 billion in 2005–06. In June 2006, approximately 75% of the Australian population over the qualifying age for the Age Pension received the Age Pension or a similar means-tested income support payment from the Australian Government Department of Veterans' Affairs (DVA) (FaCSIA 2006). Holders of a Pensioner Concession Card are eligible for a range of additional benefits: medicines listed under the Pharmaceutical Benefits Scheme are provided at a reduced cost and pension status reduces out-of-pocket medical expenses through general practitioner bulk-billing. Other concession schemes include telephone and utilities allowances, travel concessions and reduced motor vehicle registration fees.

Changes to pension policy over the past decade have influenced expenditure on the Age Pension and take-up rates (Box 3.2). Changes to superannuation preservation rules and the taxation treatment of superannuation will also have a major impact on the future take-up of the Age Pension. It has been estimated that by 2050 two-thirds of pensioners will receive a reduced government pension, compared with around one-third today, owing to rising superannuation coverage and, potentially, future higher workforce participation rates in older age groups (Costello 2007; FaCS 2003).

On 30 June 2006, 1.9 million people received the Age Pension, of whom 38% received a part-pension. Currently, around 58% of Age Pension recipients are women, among whom a higher percentage receives a full pension than a part-pension. In addition, about 338,600 people aged 60 years or over received a pension (Service Pension, Disability Pension or War Widow's Pension) from DVA (Table 3.6; see also Table A3.3 for a breakdown of Age Pension by part-and full pension recipients).

Recent trends show people reaching the qualifying age for the Age Pension with higher levels of income and assets, and more likely to receive a part-pension than a full pension than earlier cohorts of pensioners (FaCS 2006). Accordingly, the average assessed annual income of age pensioners from all sources has increased from $2,514 in March 2000 to $3,562 in March 2005. The average value of assessed assets increased from $40,607 to $55,890 over the same period (FaCS 2006). As at March 2005, among age pensioners who had been in receipt of the Age Pension for less than 1 year, 47% received a part-rate pension. Part-pensions are relatively more common among pensioners on a partnered rate of pension in the younger age groups 65–74 years (see also AIHW 2007).

In June 2006 the maximum single pension rate was $499.70 per fortnight and the maximum partnered rate was $417.20 for each member of a couple. Indexation of the Age Pension and service pensions to the consumer price index (CPI) and benchmarking to male average weekly earnings (see Box 3.2) ensures that the pension keeps pace with the growth in inflation and wages. Maximum pension payments increased in real terms over the period 1996–2006 (FaCSIA 2006:Table 2.23).

Box 3.2: Major changes affecting income support for older people, 1995–2007

1995 The eligibility age for women began its progressive increase from 60 years to reach 65 years on 1 July 2013.

Phasing-out of Wife Pension (Age) commenced.

1997 Benchmarking of the Age Pension to 25% of male average weekly earnings of employees, effective 20 September 1997 (to be applied in addition to twice-yearly indexation of pensions to the CPI).

Announcement that the superannuation preservation age would be progressively increased from 55 years to 60 years.

Phasing-out of Widow B Pension accelerated.

1998 Introduction of the Pension Bonus Scheme on 30 June. Under the scheme, a person who qualifies to receive the Age Pension can opt instead to accrue a pension bonus payment if he/she decides to defer claiming the pension while continuing to work.

1999 New superannuation preservation rules took effect from 1 July 1999 such that all superannuation contributions and fund investment earnings are preserved until the member's preservation age.

2000 Changes to all social security payments, including age and service pensions, to compensate recipients for increases in prices flowing from the introduction of Goods and Services Tax (GST) on 1 July 2000. Connected with these changes, the Pension Supplement was introduced.

2004 The Seniors Concession Allowance (a payment to assist with the cost of household bills) for Commonwealth Seniors Health Card holders was introduced.

Carer's Allowance extended to carers who do not live with the people for whom they provide substantial levels of care on a daily basis (a 2004–05 Budget measure).

One-off bonus payments for the recipients of the Carer Payment and Carer Allowance announced. These bonus payments have been made annually since 2004.

2005 Introduction of the Utilities Allowance for income support customers of qualifying age for the Age Pension or a DVA pension.

Aged care accommodation bonds exempt from social security and DVA's assets tests, effective 1 July.

2006–2007 The Government's Better Super reforms take effect on 1 July 2007. Changes include the removal of tax on superannuation benefits paid from a taxed source either as an income stream or as a lump sum to people aged 60 years and over, abolition of the superannuation reasonable benefit limits, and a halving of the pension assets test taper rate from $3 to $1.50 per fortnight per $1,000 of assets from 20 September 2007.

In rural and residential areas land that is both adjacent to the home and on the same title document as the home may be exempt from the assets test if the pensioner has a 20-year attachment to the land and home and is making effective use of productive land to generate an income.

Sources: Dapre 2006; FaCS 2006.

Table 3.6: Age and DVA Pension recipients, June 2006/January 2007

	Age group (years)						
	60–64[a]	**65–69**	**70–74**	**75–79**	**80–84**	**85 or over**	**Total**
				Per cent of Age pensioners[b][c]			
Males	—	12.3	11.9	10.2	4.5	2.7	41.6
Females	5.1	14.6	13.0	10.8	7.4	7.6	58.4
Persons	**5.1**	**26.9**	**24.9**	**21.1**	**11.8**	**10.2**	**100.0**
Persons (number)	*97,056*	*514,713*	*475,408*	*402,391*	*226,046*	*195,280*	*1,910,894*
Per cent of age group population	*9.8*	*65.0*	*74.9*	*72.1*	*54.9*	*57.8*	*[d]66.3*
				Per cent of DVA pensioners[b]			
Males	5.4	2.5	2.1	3.0	16.2	12.5	41.6
Females	2.8	2.9	4.5	12.7	20.4	15.1	58.4
Persons	8.2	5.3	6.6	15.7	36.5	27.6	100.0
Persons (number)	*27,680*	*18,071*	*22,420*	*53,213*	*123,693*	*93,509*	*338,586*
Per cent of age group population	*2.8*	*2.3*	*3.5*	*9.5*	*30.0*	*27.7*	*[d]11.4*
Total as per cent of age group population	**12.6**	**67.3**	**78.5**	**81.6**	**84.9**	**85.4**	**[d]77.7**

(a) Eligibility for Age Pension in June 2006 was 63 years for women and 65 years for men.

(b) Age pensions administered by DVA are included in the 'DVA pensioner' figures.

(c) 1,183 manually assessed recipients and 3,716 suspended recipients paid by Centrelink are not included in calculations of 'Age pensioners'.

(d) Per cent of people aged 65 years or over.

Notes

1. Nine DVA cases with unknown age have been excluded.
2. Table includes full and part-pension recipients (see Table A3.3 for a breakdown of part- and full Age Pension recipients).
3. DVA pensioners include persons in receipt of a Service Pension, Disability Pension or War Widow's Pension.
4. Age pensioners as at 30 June 2006; DVA pensioners as at 5 January 2007; estimated resident population as at 30 June 2006.
5. Components may not add to total due to rounding.

Sources: Centrelink unpublished data; DVA unpublished data.

In June 2006, among people over the qualifying age for the Age Pension who were working (including those with earnings or business income), 29% received the Age Pension and another 20% were registered in the Pension Bonus Scheme. This scheme is part of the Age Pension Program and is intended to encourage older Australians, who are willing and able to do so, to continue working beyond Age Pension qualifying age rather than retiring from the workforce and claiming the Age Pension. It provides a one-off tax-free lump sum to eligible people, payable when a person registered in the scheme finally claims and receives the Age Pension. As of 30 June 2006, 104,165 people had registered in the scheme since it began on 1 July 1998. In 2005–06, a total of $91,973,124 was paid in bonuses to 8,030 people (FaCSIA 2006).

Income support for older carers

The Carer Payment and Carer Allowance are benefits payable to carers who meet the respective eligibility criteria. Older people who provide ongoing assistance to a frail older person or younger person with disability may receive one or both of these payments.

The Carer Payment is an income support payment, subject to the same income and assets tests and paid at the same rate as the Age Pension. Relatively few people aged 65 years or over receive the Carer Payment, which is targeted at people whose caring responsibilities limit their workforce participation (currently, a carer can work up to 25 hours per week without losing the Carer Payment). At the end of 2006, a total of 111,419 people were receiving Carer Payment. Carers aged 65 years or over accounted for 5% of Carer Payment recipients, but 35% of people being assisted by carers who received the Carer Payment were aged 65 or over (tables A3.4, A3.5). Most of the people receiving the Carer Payment, who were of working age and who were caring for an older person, were themselves aged between 45 and 64 years.

The Carer Allowance replaced the Domiciliary Nursing Care Benefit in 1999. It is a non-income-tested, non-means-tested income supplement for people who provide daily care and attention in the person's home to a person with disability or a serious medical condition. The allowance can be paid to carers whether or not they receive a government pension or benefit, and in 2004 was extended to carers who do not live with the care recipient. It is adjusted on 1 January each year and in 2007 was set at $98.50 per fortnight (Centrelink 2007). On 31 December 2006, 382,490 people were receiving the Carer Allowance (Table A3.4). One-quarter of the recipients were carers aged 65 years or over and 84% of these older recipients of the Carer Allowance were caring for an older person. Just over one-third of people receiving the Carer Allowance who were providing assistance to an older person were aged 45–64 years.

Living costs

The adequacy of retirement income needs to be considered in the context of the living costs of older person households, which differ from those of other life-cycle groups. On average, older people spend most of their income on consumer goods and services, and have lower expenses than younger people in the areas of income tax, mortgage repayments and insurance premiums (ABS 2006a). While 80% of older people living in households own their home and are mortgage-free, some groups of older people, most commonly full age pensioners, spend a significant proportion of income on costs associated with housing. Considering people aged 75 years or over, by which age any drawing-down on home equity for retirement income is likely to have started, the proportion incurring mortgage or rent expenses is 23% of people who rely primarily on pension income, compared with 8% of people with mainly private income (unpublished data from the ABS Household Income and Expenditure Survey 2003–04).

A breakdown of goods and services expenditure shows a greater share of income going towards current housing costs in older lone-person households (21%) than in older couple households (10%), most likely related to a higher proportion of renters among the former (21% versus 8%) (ABS 2006a:Table 18). In the 5 years to 2003–04, national average household expenditure on current housing costs rose by 47%, far in excess of the 18% increase in the CPI over the same period. Driven by higher mortgage interest and rent payments (ABS 2006a), this increase highlights the importance of Rent Assistance and utilities allowances or rebates for eligible pensioners, the vulnerability of people on fixed pensions or private incomes to rising housing costs, and the uncertainty at the time that retirement decisions are taken surrounding future life events and costs of living.

3.6 Support for older people—informal care

The term 'informal care' is used in this chapter to refer to assistance provided to a frail older person on an unpaid basis by relatives and friends (a broader definition includes assistance to people of all ages with disability). The assistance, or care, is informal as long as it is provided without state or organisational direction and without payment. Carers may provide assistance in a broad range of activities, both core activities (self-care, mobility and communication) and non-core activities (for example, transportation, shopping, meal preparation, household chores and paperwork). Informal care underpins Australia's social welfare system, not least of all in aged care (see Chapter 7 for an estimate of the imputed value of informal care). Population ageing has implications for the demand for and supply of informal care at the population level, as well as implications for individuals who take on caring roles and for those older people who become recipients of informal care.

An obvious implication is that the number of older people who need assistance has been increasing for some time and will continue to do so. Later in this chapter, the increasing use of community care packages is contrasted with a more stable trend in the use of residential care, reflecting the preference of many older people to receive assistance at home (see Section 3.9). Accordingly, increasing numbers of older spouses and mature-aged sons and daughters will be providing assistance with long-term care decisions and arrangements. For some this will mean balancing elder care with paid employment and other family responsibilities. As the baby-boomer generation moves into the mature age and older age groups, the provision of care for frail parents or a spouse with disability could influence the retirement plans of more mature-aged workers.

Australia's welfare 2005 presented data from the ABS Survey of Disability, Ageing and Carers on older carers and older people who need and receive assistance. To summarise, in 2003 around 454,000 people aged 65 years or over provided informal care to a person with disability. Of these carers, 113,200 were primary carers (24% of all primary carers) (see Glossary for definition of primary carer). Around 47% of people aged 65 years or over had a need for assistance in personal or other activities, with proportionately more in the very old age groups needing assistance. People aged 85 years or over (11% of the older population) accounted for 30% of older people who needed assistance (AIHW 2005:Table 3.5). This volume reports on the number of people by age group who received assistance from all informal providers (carers), based on data from the 2003 Survey of Disability, Ageing and Carers master unit record file (compiled for AIHW by the ABS).

In 2003, 690,000 older people with disabilities who were living in households received assistance from one or more carers (Table 3.7). Most of these people (95%) had a main carer, that is, one particular relative or friend who provided most of the assistance they received. About 345,000 care recipients were people with profound or severe limitation. In most cases the main carer was living with the person who received assistance. Overall, 66% of older people with a main informal care provider lived with that carer (72% in the case of those care recipients with profound or severe limitation). Table 3.7 highlights the different proportions of 'younger' old and very old people with non-resident or co-resident carers. The source of informal care for people aged 65–74 years with disability is most often a person or persons living in the same household (72%). The opposite is true for those aged 85 years and over, most of whom receive assistance from someone who lives in another household (79%), that is, more likely to be adult offspring than a spouse. This predominance of informal care from persons living separately from the care recipient is also true for the subset of people aged 85 years or over who have profound or severe limitation, although to a somewhat lesser extent (62%).

Higher rates of receipt of informal care are recorded for people with profound or severe limitation, compared with all older people with disability. This pattern can be seen across the older age groups, with between 810 and 890 older people per 1,000 with a profound or severe limitation receiving informal care, compared with age-specific rates for all older people with disability of between 500 and 740 per 1,000 (Table 3.7).

Table 3.7: Household population aged 15 years or over with disability with co-resident or non-resident carer, 2003 ('000)

Informal provider and co-residency status	People with disability and profound or severe limitation					All with disability				
	15–64	65–74	75–84	85 or over	Total 15 or over	15–64	65–74	75–84	85 or over	Total 15 or over
Has a main informal provider of assistance										
Co-resident	354.2	103.7	96.9	37.8	592.7	816.6	206.4	169.2	52.0	1,244.2
Not co-resident	76.3	19.5	49.5	28.7	173.8	301.4	95.4	140.0	62.5	599.4
Total	*426.2*	*122.6*	*141.9*	*65.4*	*756.0*	*1,028.7*	*274.7*	*276.6*	*103.2*	*1,683.4*
Has other informal providers of assistance (not main providers)										
Co-resident	—	—	—	—	—	—	—	—	—	—
Not co-resident	140.0	27.7	44.8	27.1	239.8	479.5	94.3	130.0	64.4	768.1
Total	*140.0*	*27.7*	*44.8*	*27.1*	*239.8*	*479.5*	*94.3*	*130.0*	*64.4*	*768.1*
All with informal providers of assistance										
Co-resident	354.2	103.7	96.9	37.8	592.7	816.6	206.4	169.2	52.0	1,244.2
Not co-resident	189.3	38.4	75.1	43.7	346.3	621.5	149.5	202.5	86.8	1,060.3
Total	**435.8**	**127.8**	**146.3**	**70.6**	**780.5**	**1,075.8**	**285.9**	**294.6**	**109.6**	**1,766.0**
Rate per 1,000 at risk[(a)]	880	890	810	850	860	480	500	580	740	510

(a) Denominators for the calculation of rates are the number of people living in households in 2003 who had profound or severe core activity limitation or disability (people at risk of needing ongoing assistance), as applicable, by age group. Rates rounded to nearest 10.

Notes

1. Totals may be less than the sum of the components as recipient may have more than one main carer but can have only one main carer for each area of activity.
2. Available data do not include children under 15 years with disability who have an informal provider of assistance because of disability. Totals therefore underestimate the number of people who received assistance from an informal provider due to disability or profound or severe core activity limitation.
3. 'Carers' refers to informal providers of assistance to people living in households.

Sources: ABS unpublished data from the 2003 Survey of Disability, Ageing and Carers master file (numbers of people with informal providers); AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers (rates per 1,000 persons at risk).

Assistance from a carer can be given instead of, or alongside, formal care. In fact, assistance from a carer is an important enabler of community care, without which formal care would not be sufficient for many highly impaired older people to remain at home in the community with maintained quality of life. This is demonstrated by:

- The Extended Aged Care at Home (EACH) program is intended as a community alternative for older people who would otherwise need residential high care. In 2005–06, 90% of EACH clients had a carer at the time of their assessment by an Aged Care Assessment Team (ACAT) (74% with a co-resident carer) (AIHW 2007a).

- The provision of care from family is a critical element of successful community living for people with dementia-related high care needs. In the Aged Care Innovative Pool Dementia Pilot some service providers required that a person have regular, ongoing assistance from family or friends as they considered informal care to be critical to the pilot's success (AIHW: Hales et al. 2006a). Based on carer availability at the time of the ACAT assessment, 97% of EACH Dementia clients at 30 June 2006 (297 clients) had a carer; 85% had a co-resident carer (AIHW 2007a).
- Among older people assessed by an ACAT in 2004–05, 76% had a carer. The presence of a co-resident carer was found to be protective against being recommended for residential care. In particular, ACAT clients with co-resident carers were least likely to be recommended for low-level residential care and more likely than other clients to be recommended for a community care package (ACAP NDR 2006). That ACAT clients with co-resident carers are more likely than others to be recommended for high-level residential care is attributed to the numbers of more highly dependent clients with carers because they have been able to be maintained at home for longer than if they had not had a co-resident carer (ACAP NDR 2006).

Primary carers of older people

An older person with profound or severe limitation who lives in the community is likely to have a primary carer. Caregiving by a primary carer, as defined by the ABS Survey of Disability, Ageing and Carers, is intense, in most cases is performed daily and typically extends over a number of years (ABS 2004b). In 2003, approximately 239,400 people were identified as being a primary carer with a main recipient of care aged 65 years or over (a primary carer can assist more than one person, in which case the ABS survey identifies one as the main recipient of care). Spouses and adult children, mostly daughters, made up equal proportions of all primary carers of older people (43%). It follows that primary carers of older people are concentrated in the older and mature age groups: 40% were themselves older people, 24% were aged 45–54 years and a further 23% were aged 55–64 years. These relationship patterns between carers and care recipients are reflected in residency arrangements; 66% of primary carers of older people in 2003 did not live in the same household as the person they were assisting. Among primary carers aged 45–64 years who were providing assistance to an older person (111,900), most (73,500) were caring for a parent and over three-quarters had a main recipient of care aged 75 years or over (AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers).

The types of assistance provided by primary carers cover help with core activities (Table 3.8) in addition to non-core activities (that is, other than self-care, communication and mobility). Over 80% of primary carers provide mobility assistance; primary carers are important facilitators of community participation for the people to whom they provide care by assisting with mobility when away from home (76%). More than half help with self-care, which may include bathing, showering, dressing and managing incontinence. This type of assistance is needed daily and contributes greatly to a care recipient's quality of life.

To summarise, more frail older people receive assistance from informal providers than from any one government-funded aged care program (see Table 3.7 and Figure 3.2). That assistance ranges from help with non-core activities through to the higher levels of assistance provided by primary carers as an alternative to institutional care, often with supplementation from community services. A person with very high care needs in up to three core activity areas may depend on support from both informal and formal providers of assistance to be able to live in the community.

Table 3.8: Primary carers with a main recipient aged 65 years or over, core daily activities for which assistance is provided, 2003

Selected tasks in core activity areas in which primary carer usually provides assistance	Per cent
Self-care	**55**
Bathing/showering	32
Dressing	42
Eating or feeding	21
Managing incontinence	14
Mobility	**84**
Getting into or out of a bed or chair	29
Moving about the house	28
Moving around away from home	76
Communication	**42**
Total primary carers (number)	**239,400**

Note: Figures may not add to totals as a primary carer can assist in more than one task grouped under self-care, mobility or communication.

Source: AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers confidentialised unit record file.

Caregiving is bound up with interpersonal relationships and role expectations (Hales 2007). In this sense, informal care for older people might be regarded by some as a 'constant', that, generally speaking, people will provide assistance to their frail older relatives and friends for similar reasons that the family is the central support for children. Along with personal rewards, caregiving can also involve significant costs—both real and opportunity costs—for carers and their families as well as for society as a whole. For the individual these costs might include lost earnings and the opportunity cost of premature retirement or reduced workforce participation as well as the personal costs of physical and emotional stress. At the societal level, the need for and demands of the caregiving role have a potential effect on labour supply, especially among mature-aged workers, lost taxation revenue and costs associated with providing support for carers.

The supply of informal carers, and changes in factors affecting this, is a matter of concern to policy makers. Informal care for frail older people enables many older people to avoid or delay admission to residential care and supports consumer preferences to remain living in the community. The number of older people with high care needs living in households is growing because of population ageing. Between 1998 and 2003 the older household population with profound or severe limitation who received some form of assistance increased from an estimated 320,300 to 395,300 people (AIHW 2003:Table 3.4; AIHW 2005:Table 4.8). Over the same period, the number of people who received assistance from both formal and informal sources of care or from informal sources only increased from 308,800 to 382,500. At the same time, mature-aged people are being encouraged to increase their labour force participation to counter the anticipated labour shortage resulting from population ageing.

In Australia, caregiving is associated with low female labour force participation (ABS 2004b; AIHW 2004d); internationally, studies have revealed that a strong sense of duty to provide care for elderly parents exists among baby-boomer women, to the extent that many give priority to caregiving over paid employment (see references in Hales 2007). A multi-

nation study of the empirical relationship between caregiving and paid employment has highlighted the role that formal service systems play in supporting employed carers. Spiess and Schneider (2003) reported that starting or increasing caregiving significantly reduces hours of paid employment, while stopping or decreasing caregiving does not significantly increase labour force participation. They further found that the nature of the association between employment and caregiving depends on the level of support available from community services. In countries with strong community care systems, changes to hours of employment to accommodate increased caregiving are more likely to be temporary than in countries with less formal supports, where permanent reductions in workforce participation are the more common scenario.

3.7 Support for older people—aged care services

The Australian, state and territory, and local governments fund care services for older people through a range of programs. Along with privately purchased services, government-funded assistance is sometimes referred to as 'formal care'. Services funded through government programs are delivered by various non-government organisations in the not-for-profit and for-profit sectors, as well as government agencies in some states and territories. Service delivery occurs in residential and community settings, according to the relevant legislation and program guidelines.

Government-funded aged care is a feature of the care arrangements for significant numbers of frail older people, either supplementing informal care or providing a substitute for those without access to practical assistance from family and friends or for whom family care is no longer able to meet their needs (Figure 3.2). The main national programs that deliver aged care in community and residential settings, and that are covered in this chapter are:

- the Home and Community Care program (HACC)
- community care package programs: Community Aged Care Packages (CACPs), Extended Aged Care at Home (EACH) and Extended Aged Care at Home Dementia (EACH Dementia)
- the Transition Care Program (TCP)
- programs for DVA clients, including Veterans' Home Care and Community Nursing
- residential aged care (permanent and respite care)
- the National Respite for Carers Program (NRCP).

Other programs not reported due to limited data availability are flexible care delivered through Multi-purpose Services in rural and remote communities and services funded under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program, Day Therapy Centres, the Continence Aids Assistance Scheme, and the Assistance with Care and Housing for the Aged Program. In addition, programs for older people that operate at a state, territory or local council level are not reflected in the national data reported here.

A person who receives government-funded community care may not know which particular program funds the services received, the service provider being the 'face' of formal care. However, they may be indirectly aware of different program sources of funding due to the different procedures that service providers follow when accepting referrals and assessing clients for eligibility and need, the types of assistance that an eligible person may receive and the settings in which assistance can be provided. Such aspects of service delivery are often program-specific.

Data about aged care programs reported in this chapter come from a number of sources, including minimum data sets (HACC and NRCP) and payment system data (residential aged care, CACP, EACH, EACH Dementia and TCP).

Collection of client–level data for the HACC Minimum Data Set (MDS) has occurred since January 2001, and implementation of the HACC MDS Version 2 began in January 2006. Data reported here are for 2004–05 and hence consist only of MDS Version 1 data; data for 2005–06 were not available at the time of preparing the chapter. The NRCP Minimum Data Set (MDS) is a relatively new client-level collection that collects information about carers, care recipients and service events. Significant efforts over the last couple of years have been made to improve the quality and comprehensiveness of information collected through the NRCP MDS, although only limited data was available in time for inclusion in this chapter.

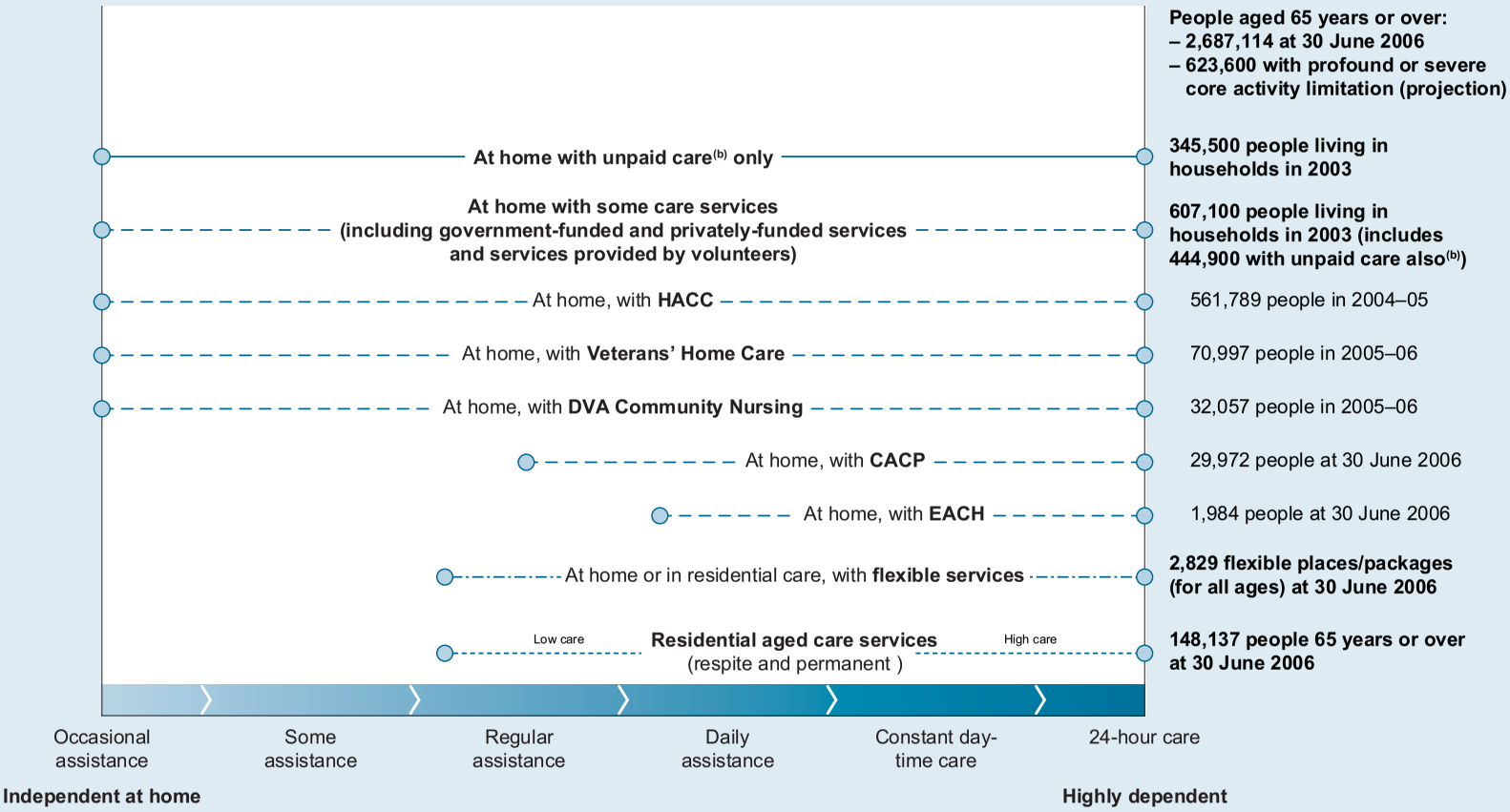
Payment system data are available from the Aged and Community Care Management Information System about clients and providers of residential aged care, CACP, EACH, EACH Dementia and (to a limited extent) TCP. This data repository contains information gathered through a number of instruments, including the Aged Care Client Record used for the assessment and approval of a care recipient by an ACAT, and the various provider claim forms used by the service provider for claiming the relevant subsidy payable for the service for a payment period.

One of the limitations of these data is that certain sociodemographic client characteristics are recorded at the time of application and hence may not reflect their true characteristics while receiving care from these programs. There is also no information on areas such as type of assistance received by care package recipients or care package clients' levels of dependency (AIHW 2007a, 2007b).

Overview of community care programs

The HACC program aims to provide 'a comprehensive, coordinated and integrated range of basic maintenance and support services for frail aged people, people with disability and their carers' (DoHA 2006a). It aims to support people at home and to prevent premature or inappropriate admission to residential care. The types of assistance available through HACC include domestic assistance, personal care, personal and community transport, home maintenance, nursing and allied health care. HACC is jointly funded by the Australian Government (60%) and state and territory governments (40%). In some states local government also contributes to HACC funding.

In 2004–05, approximately 3,100 agencies submitted data for the HACC MDS (DoHA 2006a). Clients are referred to HACC agencies from a range of sources. The HACC MDS reports these sources as self-referral (26.9%), hospitals (16.4%), family, friends and significant others (16.0%), and medical practitioners (12.3%) (DoHA 2006a). Before establishing services for a new client, a service agency will usually complete an assessment with the client to determine their eligibility and agree on a level and mix of services appropriate to the client's needs. HACC clients with complex needs may be assigned a designated agency to be responsible for coordinating services from a number of agencies (this case management function is available in HACC Community Options Projects, also known as 'Linkages'). These higher levels of HACC service provide individually tailored packages of care, often through brokerage arrangements.



(a) Due to data availability, numbers refer to different time periods.

(b) Excluding payments from government pensions and benefits.

Note: Figure includes selected government-funded programs only. Some services can be used concurrently. Hospital services are not included.

Sources: Tables 3.1, 3.3, 3.13; AIHW analysis of ABS SDAC data; AIHW analysis of DOHA ACCMIS database.

Figure 3.2: Range of care arrangements for older people(a)

In terms of client numbers, HACC is the largest program providing assistance for frail older people, having assisted more than 560,000 people aged 65 years or over in 2004–05. Older people made up a slightly smaller proportion of HACC clients in 2004–05 (75.5%) than in 2001–02 (77.1%). However, use of HACC services within the older population increased over the period, from 181 per 1,000 to 211 per 1,000 persons aged 65 years and over (Table A3.7; see also AIHW 2003).

The CACP program delivers care packages. A package offers a mix of types of assistance, according to a client's need, together with case management and service coordination by the package provider. The CACP program was established in 1992 to provide care in community settings for people who are eligible for and might otherwise need low level residential care. Direct care received through a CACP service might include personal care, home help, social support, transport to appointments, meal preparation and gardening. Nursing and allied health care are not available through CACP. As at 30 June 2006, over 1,000 service outlets were delivering CACP services to 31,803 clients, most of whom were older people (Table 3.9 and Table A3.7).

Care package programs have grown in number and size since CACP was established, and now include EACH, EACH Dementia and TCP. These programs are directed at frail older people. EACH was piloted in 2002 as a community-based alternative to high level residential care and was made a national program in 2004. In addition to the types of assistance available through CACP, an EACH client is able to receive specialist nursing care. EACH now serves over 2,000 clients (Table 3.9 and Table A3.7). In 2006, two new programs, EACH Dementia and the TCP became operational (Table 3.9). EACH Dementia services are delivered as ongoing care packages targeted at older people with dementia-related high care needs who are able and wish to remain living in the community.

TCP delivers services in the form of short-term therapy and support to older people following a stay in hospital. TCP is expected to:

- enable a significant proportion of care recipients to return home, rather than enter residential care
- optimise the functional capacity of those older people who are discharged from Transition Care to residential care so that they require a lower level of care
- reduce inappropriate extended lengths of hospital stay by older people.

Given the joint responsibilities at the hospital–aged care interface, the program operates under a joint funding arrangement between the Australian Government, and state and territory governments. The current Transition Care Program operates alongside a range of state and territory government post-acute and sub-acute programs. As at 30 June 2006 there were 595 operational Transition Care places (see also Table A3.8).

DVA funds a number of programs that deliver community care to eligible veterans, war widows and widowers. Veterans' Home Care delivers in-home support services to over 70,000 clients each year, which can include up to 1.5 hours per week of personal care assistance. Eligible people who need higher amounts of personal care, or community nursing, may be referred to the DVA Community Nursing program (Gold or White Repatriation Health Card holders only). Other DVA programs that provide support to older people include the Rehabilitation Appliances Program for the supply of aids and equipment; HomeFront, a falls and accident prevention program; and a telephone service for assistance with property maintenance and emergency repairs. Clients of DVA programs may also receive assistance through HACC and other programs if they are eligible, on the basis of an assessment of care needs.

Table 3.9: Care package programs, number of operational packages, provision ratio, number of services and clients, 1996 to 2006 (as at 30 June)

Program/year	Operational places	Provision ratio[a]	Service outlets	Clients
CACP				
1996	4,431	2.9	255	4,081
1997	6,124	3.9	352	6,222
1998	10,046	6.3	480	9,583
1999	13,753	8.4	594	13,157
2000[b]	18,308	10.8	720	16,617
2001[b]	24,629	14.0	859	20,728
2002[b]	26,425	14.7	916	24,585
2003[b]	27,881	15.3	958	26,573
2004[b]	29,063	15.6	959	27,657
2005[b]	30,973	16.3	973	28,899
2006[b]	35,383	18.2	1,011	31,803
EACH				
2002	171	0.1	6	82
2003	255	0.1	9	282
2004	860	0.5	54	707
2005	1,673	0.9	105	1,203
2006	2,580	1.3	157	2,131
EACH Dementia				
2006	601	0.3	49	279
Transition Care[c]				
2006	595	0.3	25	296

(a) Number of operational packages per 1,000 persons aged 70 years or over.

(b) CACPs provided by Multi-Purpose Services and services receiving flexible care subsidy under the Aboriginal and Torres Strait Islander Aged Care Strategy are included in the calculation of places.

(c) May be provided in either a home-like residential setting or in the community.

Source: AIHW analysis of DoHA ACCMIS database (as at 16 October 2006).

Developments in community care

Care continuity is a linchpin of ageing in place and this has been recognised in program reforms that have enabled residential aged care to offer continuity of care within an older person's familiar living environment (through the amalgamation of low care facilities, formerly known as hostels, and high care facilities, or nursing homes, into a single service system for residential aged care). For frail older people at home and their carers, continuity of care encompasses the same provider, the same set of care assistants and familiar communication processes.

The community care sector is characterised by a large number of programs, many of them relatively small, which poses challenges to continuity of care for people in their own home. The Australian Government funds 19 community and flexible care programs which primarily target older people and/or their carers, including the jointly funded HACC and Transition Care programs. From a consumer's perspective the community care system can sometimes appear complex and hard to access. The existence of so many programs can have unintended consequences in terms of gaps in or duplication of services. Many

service providers deliver multiple programs and many clients receive services funded through different programs depending on their needs. This environment can thus also result in significant challenges for accountability and reporting requirements. Work towards increasing alignment of these various programs, streamlining service provision and developing new service offerings to meet the needs of special client groups is currently a significant driver of policy and program development in community care and flexible services, particularly through A New Strategy for Community Care—The Way Forward (Box 3.3).

The Securing the Future of Aged Care for Australians package announced in 2007 includes a number of measures to increase and improve the provision of community care (Box 3.3). The target ratio for the provision of community care will increase from 20 packages for every 1,000 people aged 70 years or over to 25 packages per 1,000 by 2011 (CACP, EACH and EACH Dementia packages). For the first time a separate target has been established for high level community care, so that, by 2011, 4 of every 25 packages will be EACH or EACH Dementia packages.

Securing the Future of Aged Care for Australians aims to raise the awareness of assistive technology and where it can be used effectively to improve the wellbeing of people in their homes. An industry body will be established to promote the use of assistive technology by community care service providers and to help providers aggregate their buying power for purchasing assistive technology solutions. An annual grants program will fund innovation in assistive technology.

Support for community care workforce development is another measure announced as part of Securing the Future of Aged Care for Australians (aged care workforce is discussed in Chapter 7).

Overview of permanent residential aged care

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. The Australian 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 accredited aged care homes (see Section 3.11). (Other types of accommodation specifically for the aged not funded by the Australian Government, for example, private nursing homes, retirement villages (which variously offer independent living and supported accommodation), and supported accommodation services funded by some state and territory governments are not covered here).

As at 30 June 2006, 145,175 people aged 65 years and over (53 in every 1,000) were permanent residents of Australian Government-funded aged care homes (AIHW 2007b; see also Table A3.7). Among older people with profound or severe limitation, 233 per 1,000 resided in these homes. Around 50,000 people enter permanent residential aged care each year.

Nationally, the main providers of residential aged care are in the not-for-profit sector, for example community organisations (61% of services), and the private for-profit sector (27%), with state and local government providers making up the balance (12%) (AIHW 2007b). Over the period 1998–2006, the average size of services has grown from 46.4 places to 60 places (AIHW 2007b). Care is provided on a high care or low care basis, according to care needs appraised using the Resident Classification Scale (RCS categories 1–4 equate to high care and 5–8 equate to low care).

Box 3.3: Developments in community aged care 2001–2007

2001 **Veterans Home Care** began.

Commonwealth Carelink Centres established.

2002 **Extended Aged Care at Home** established.

A review of community care was announced.

2003 **National pilots** in community care began: Aged Care Innovative Pool Dementia Pilot, Retirement Villages Care pilot; Innovative Pool Disability Aged Care Pilot.

2004 **Release of A New Strategy for Community Care—The Way Forward:** an action plan covering five areas to be addressed by Australian Government and state/territory community care officials and cross-jurisdictional working groups.

Evaluation of the Innovative Care Rehabilitation Services Pilot was completed (a forerunner to the Transition Care Program).

Transition Care Program announced in May 2004 Budget. Transition Care provides goal-oriented, time-limited (up to 12 weeks) and therapy-focused care to help eligible older people complete their recovery after a hospital stay.

2005 Evaluations of the Aged Care Innovative Pool Dementia Pilot and the Retirement Villages Care Pilot were completed (findings published in 2006).

Funding of $320.6 million over 5 years was allocated to the **Dementia Initiative** in the 2005 Budget, which included the announcement of an **EACH Dementia** program (further information can be found at <http://www.health.gov.au/internet/wcms/publishing.nsf/Content/ageing-dementia>).

Transition Care Program began operations.

2006 Announcement of $30 million of funding for the development of common administrative arrangements and data improvements in HACC.

Announcement of a **review of subsidies and services** in Australian Government-funded community aged care programs.

EACH Dementia program became operational.

A national evaluation of the Transition Care Program began.

The 2006 Budget included new funding for community care services:

- $19.4 million over 4 years for a supplement to providers of CACPs, EACH and EACH Dementia packages in rural and remote areas, in recognition of the higher costs in these areas for goods and services and the difficulties in attracting and training staff
- $24.2 million over 4 years to improve access to community care for people living in retirement villages. This initiative followed the Retirement Villages Care Pilot which trialled the delivery of community care to people living in retirement villages (AIHW: Hales et al. 2006b).

2007 **More and Better Community Care**, part of the **Securing the Future of Aged Care for Australians** package announced on 11 February 2007, provides for more community care packages ($298.6 million); support for workforce development ($32.1 million); improved quality assurance ($26.8 million); more community respite care ($26.5 million); support for assistive technology ($21.4 million); and additional support for Assistance for Care and Housing for the Aged ($5.7 million).

Sources: AIHW 2003, 2005; Australian Government Department of Health and Ageing.

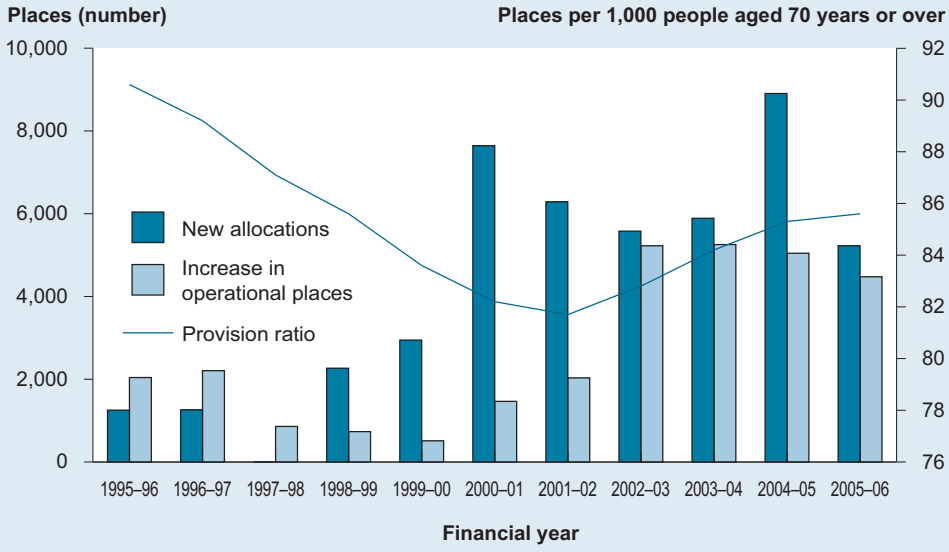
Residential aged care places are allocated to approved providers through annual Aged Care Approvals Rounds. Some time might elapse between places being allocated to a provider and those places becoming operational, that is, ready to be occupied by a resident, such as in situations where building or renovations must be completed. Hence, the distinction between allocated places—places that are 'in the pipeline' but not being used—and operational places. On 30 June 2006, there were 164,008 residential aged care places operated by 2,931 mainstream residential aged care services for the provision of permanent and respite care. The inclusion of places operated by Multi-Purpose Services and flexible services took total operational places at that date to 166,291. The number of new allocations in the 2005–06 Approvals Round returned to the levels of 2002–03 and 2003–04, after peaking in 2004–05 (Figure 3.3). That peak in allocations will be reflected in future operational places.

The ratio of residential care places to the target population used for planning purposes has shown a gradual increase since 2002. As at 30 June 2006 there were 85.6 residential aged care places per 1,000 people aged 70 years and over (Table A3.6 and Figure 3.3). The current target ratio is 88 places per 1,000 people aged 70 or over, to be achieved by 2007.

Developments in residential aged care

Developments in residential aged care address a wide range of issues including quality of care and service standards, financing and administration, and workforce (Box 3.4; the aged care workforce is discussed in Chapter 7).

Responses to incidents of serious abuse of residents have included the introduction of compulsory police checks for current and prospective employees and volunteers, increased unannounced visits to homes by the Aged Care Standards and Accreditation Agency,



Source: Table A3.6.

Figure 3.3: New residential aged care allocations and operational places, 1995–96 to 2005–06

Box 3.4: Major developments in residential aged care, 1996–2007

1996 Announcement of the **Aged Care Structural Reform Package** (1996 Budget).

1997–1998 Nursing homes and hostels were amalgamated into a **single system of residential care** on 1 October 1997, using the RCS funding model. Income and assets testing began on 1 March 1998. From 1 March 1998 residents entering residential high care could be asked to pay an accommodation charge. Low care residents could be asked to pay an accommodation bond.

1999 **The Aged Care Standards and Accreditation Agency** began active accreditation work.

2000 The **Residential Aged Care Funding Equalisation and Assistance Package** was introduced to assist the transition to standard rates of Commonwealth subsidy across the states and territories.

2001 Release of the report of the **Two Year Review of Aged Care Reform**, (commissioned in 1998).

2002 Announcement of a comprehensive review of pricing arrangements in residential aged care (Portfolio Budget Statements 2002–03: Department of Health and Ageing).

2003 The **Resident Classification Scale Review** completed (ACEMA 2003).

2004 The Aged Care Price Review Taskforce, chaired by Professor Warren Hogan, handed down its findings on the **Review of Pricing Arrangements in Residential Aged Care** (Hogan 2004).

Removal of the requirement for ACATs to assess residents moving between low and high care within the same aged care home (effective 1 July 2004).

2005 National trial of the **Aged Care Funding Instrument** (ACFI) to replace the RCS.

2006 New funding of $21.6 million over 4 years for **Encouraging Best Practice in Residential Aged Care** (see also Chapter 7 discussion of aged care workforce).

Legislation passed to strengthen **prudential regulatory arrangements** in residential aged care.

Establishment of the **Office for Aged Care Quality and Compliance**.

Mandatory reporting of incidents involving sexual or serious physical assault was introduced.

Launch of the **Aged Care Consumer website** (<http://www.agedcareaustralia.gov.au>).

2007 Announcement of a $1.5 billion package of reforms to residential aged care, **Securing the Future of Aged Care for Australians**.

On 29 March 2007 the provisions of the Aged Care Amendment (Residential Care) Bill 2007 were referred to the Senate Community Standing Committee on Affairs for inquiry and report by 17 May 2007.

reform of complaints-handling procedures with the establishment of the Office for Aged Care Quality and Compliance and an Aged Care Ombudsman, and the introduction of mandatory reporting of incidents of sexual or serious physical assault (DoHA 2006b).

An aged care home must be certified to be able to receive accommodation payments, Extra Service charges and concessional resident supplements. Progress has been made towards achieving privacy and space targets that come into force on 31 December 2008 (see Section 3.10).

Following the report *Review of Pricing Arrangements in Residential Aged Care*, known as the Hogan Review, work began on a replacement for the RCS with a new instrument as the basis for determining the Australian Government's daily care subsidy. The Hogan Review recommended the extension of funding supplements for care needs other than the provision of oxygen and enteral feeding, including short-term medical needs, dementia-related behavioural problems, palliative care and the care needs of people from disadvantaged backgrounds such as the homeless elderly and Indigenous Australians. A new funding instrument, the Aged Care Funding Instrument (ACFI) was developed to more reliably reflect a resident's care needs and the associated cost of support in a residential setting, and to take account of changes in the resident population's characteristics since the RCS was introduced in 1997. The ACFI was trialled nationally in 2005, in preparation for its phased implementation scheduled to begin in 2008.

Measures announced in early 2007 as part of the Securing the Future of Aged Care for Australians package are also planned to come into effect in 2008 (DoHA 2007a). This comprehensive reform package makes clearer the distinction between funding for accommodation and funding for the provision of care in Australian Government-accredited aged care homes:

- From 20 March 2008, the current pensioner and concessional resident supplements will be combined into a single accommodation supplement payable by the Government to aged care homes for pensioners and self-funded retirees with assets valued at less than a specified amount. Residents in receipt of the accommodation supplement will be known as 'supported residents'.
- Residents with assets worth less then $39,500 will not pay an accommodation charge. High care residents who can afford to make a greater contribution to the cost of their accommodation will be asked to do so. There is no change to accommodation bonds for residential low care.
- Resident contributions towards the cost of care will be made up of a basic daily fee and, for some residents, an income-tested fee. One maximum basic daily fee (85% of the basic age pension) will apply to all new residents, regardless of their social security status. A new income test treats all income (pension and private income) equally. Residents who are required to pay an income-tested fee will pay an amount equal to 41.67% of total assessable income above the maximum income for a full pensioner (no income-tested fee is payable on the first $659 per fortnight, subject to indexation). The maximum daily care fee payable will continue to be capped at $53.96 per day as at 20 March 2007.

From the provider's perspective, all new residents will generate the same level of revenue from a combination of the accommodation supplement and the accommodation charge. This removes any disincentive for a provider to accept a person based on whether they are a pensioner or self-funded retiree.

From the resident's perspective, self-funded retirees with lower levels of assets will be able to access Government assistance with their accommodation costs for the first time and greater assistance will be provided to pensioner residents with fewer assets.

The new arrangements will not apply to existing residents.

Respite care

Respite care supports community living for people who receive assistance from informal providers (family carers) by giving carers a break from providing assistance to see to their own affairs, to visit family and friends, or to take a holiday. Respite care can be provided in the person's home, in a day centre, in community-based overnight respite units (for example 'cottage' respite services) and in residential aged care homes. Service providers sometimes use respite care as an 'introductory' service for new clients, particularly those not used to receiving formal assistance (AIHW: Hales et al. 2006a).

Programs that deliver care services, such as care packages, HACC and Veterans' Home Care, typically offer respite care services in the community and may also help clients to access residential respite care. 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 DVA also funds residential respite care for eligible clients.

The National Respite for Carers Program (NRCP) is dedicated to the provision of respite care and other forms of support for carers. The NRCP funds direct and indirect respite care options, offering respite care in a range of accommodation settings (Box 3.5). These services can be arranged by Commonwealth Carer Respite Centres on behalf of clients. In 2004–05, about 56,000 carers received direct respite care through a Carer Respite Centre.

Residential respite care provides short-term accommodation and care in residential aged care homes on a planned or emergency basis. An 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 (see Table 3.11). 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. In 2005–06 there were 49,727 admissions to residential respite care (AIHW 2007b), equating to around 12 in every 1,000 people aged 65 years or over (55 for every 1,000 older people with profound or severe limitation; Table A3.7).

By providing support for people living at home and their carers, residential respite care can delay or obviate the need to enter permanent residential care. It can also be a 'stepping stone' towards permanent residential care: around 40% of residential respite care clients are admitted to permanent residential aged care within 3 months of using respite care (AIHW: Karmel 2006). Analysis of ACAT recommendations also supports the view that residential respite care is often a precursor to permanent placement since at low, medium and high levels of dependency the prior use of residential respite is associated with a higher likelihood of ACAT recommendation for permanent residential care (ACAP NDR 2006:176, 183). Less commonly, people may be connected, or re-connected, to community care services as a result of a period of residential respite.

Karmel's analysis (2006) has shown 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. This apparent interaction between use of residential respite and community care for delaying admission to permanent residential care indicates the importance of timely access to community care, and particularly of systems and processes to identify people who need formal assistance before carers reach

Box 3.5: Respite options funded, assisted or arranged by the National Respite for Carers Program

Through the NRCP, carers can receive direct respite care. Other forms of assistance can be funded by the NRCP that also have the effect of carer respite ('indirect' respite options). Direct respite consists of the types of respite care arranged where the primary purpose is meeting the needs of carers by the provision of a break from their caring role. A service or multiple services are arranged to ensure that the carer has a substitute to care for the person for whom they are the primary carer. Types of respite care arranged by Commonwealth Carer Respite Centres (with NRCP funding) are listed below.

Direct respite

- Australian Government-approved aged care homes residential respite services: respite care is available in homes that offer high and low level care and other residential services that operate under the Aged Care Act.
- State/territory-funded disability care homes residential respite.
- Community residential respite services: these services include overnight accommodation in crisis support facilities, hotel/motel accommodation, caravan parks, cottage homes and host family situations.
- Other residential respite services: residential organisations provide flexible and/or vacation respite care options. This provides for flexible residential options covering the variety of ways carers and care recipients are assisted during a period of respite, either together or separately.
- Community respite services (non-residential): respite care is delivered in a community setting other than residential or in-home respite, including the carer's neighbourhood, the care recipient's neighbourhood, recreational facility, day care centre.
- In-home respite services: covers the range of home-based services arranged to provide direct support to the carer in respect to a particular care recipient, in the home of the carer or care recipient.
- Individualised: this service enables the carer to access an appropriate level of support where this is unavailable from an existing service, for example, where existing respite care services do not exist or are otherwise not available in a region.

Indirect respite

Indirect respite offers the 'side benefit' of providing help to the carer by relieving them from the other tasks of daily living, which may or may not be directly related to their caring responsibility. Indirect respite includes services arranged by a Carer Respite Centre that are intended to indirectly assist the carer. The carer remains the primary focus although the services provided are for the person being cared for. It includes domestic assistance, social support, meals and nursing/personal care and showering assistance.

Source: Australian Government Department of Health and Ageing.

crisis point. In conjunction with the profile of ACAT recommendations, it suggests the existence of groups of 'at risk' ACAT clients for whom timely access to residential respite care may be a last chance for intervention by community care services before entry to permanent residential care. These groups include those who are recommended for residential respite and community care services but who, for one reason or another, do not access community care following ACAT assessment, and those who are approved for permanent care but recommended for community living with access to residential respite. For these people residential respite services might provide a vital link to community care services and providers.

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 Community Respite initiative (DoHA 2006b). Additional funding for overnight respite in community settings, particularly in areas where respite options are currently limited, and Multi-purpose Services in rural areas was announced in the 2006 Budget. The role of ACATs in assisting older people to access respite care is covered under 'Aged Care Assessment Program', below.

3.8 Accessing services

The processes by which an older person gains access to government-funded services vary according to the person's need, how and by whom the need is identified, and the type of care or service for which they are referred. Typically, a referral is made to a service agency (which may be an assessment agency) either by the person, a relative or friend, or a health practitioner, and referral is followed by an assessment of need and eligibility. Referral may be through direct contact with a service provider or through an information service. Commonwealth Carelink Centres operate in all states and territories as a point of contact for information on and referral to community care, residential aged care, and other support services in the region.

The Internet is now a well-established mechanism for providing information about aged care services. The Aged Care Australia website <http://www.agedcareaustralia.gov.au> launched in November 2006 provides a comprehensive online source of information from all levels of government and non-government agencies, including service-related information. People may also contact state or local government agencies with portfolio responsibility for ageing or community services, or community and seniors organisations in their local area (see also, for example, <http://www.seniors.gov.au> for a range of topics of interest to over-50s).

Assessment for formal care provided under the *Aged Care Act 1997* is performed by Aged Care Assessment Teams (ACATs) throughout Australia, according to Aged Care Assessment Program (ACAP) guidelines. ACATs are able to approve people for CACP, EACH and EACH Dementia, Transition Care and residential aged care (permanent and respite care). ACAT approval is not required for Multi-purpose Services and flexible services allocated under the Aboriginal and Torres Strait Islander Aged Care Strategy and pilot programs. However, some states request ACATs to assess people for entry. Other programs, such as the HACC Program, NRCP, and DVA programs have their own assessment frameworks. ACATs often act as a referral mechanism for these programs.

Aged Care Assessment Program

An existing single point of entry system for government-funded aged care, the ACAP is the formal gateway to a range of services (some of which involve joint funding arrangements with state and territory governments):

- care packages for ongoing assistance under the CACP, EACH and EACH Dementia programs
- short-term therapeutic care through the TCP
- Multi-purpose Services and flexible services under the Aboriginal and Torres Strait Islander Aged Care Strategy
- residential aged care, both permanent and respite care.

The ACAP funds ACATs in each state and territory to 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.

ACATs perform comprehensive assessment covering five dimensions of care need: physical, psychological, medical, cultural and social (DoHA 2002). The target population for services accessed through ACAT assessment is all people aged 70 years or over and Indigenous people 50 years or over. However, the *Aged Care Act 1997* makes no reference to age. In practice, ACATs may also accept referrals for people aged under 70 years. Young people with disability are not part of the ACAT target group but may be assessed by ACATs if their care needs cannot be met by other sources that are more appropriate to their needs (see 'Younger people in residential aged care' in Chapter 4). An ACAT approval remains valid for 12 months. If a person's care needs change to the extent that a different level or type of care is required, they may be reassessed within that period. Once approval is granted, and should the client wish to proceed, they are directed to the appropriate service providers. Receipt of services is then subject to the availability of places and other considerations.

A person who completes an ACAT assessment receives one recommendation for long-term care (accommodation setting and support programs) but the ACAT assessor may *approve* the client for types of care other than the one recommended as most suitable. Including all assessments in 2004–05 there was 71% agreement between approved and recommended long-term care settings (ACAP NDR:Table 50). For example, of the recommendations to community settings, 38% had approval for residential care. This may indicate 'just in case' approvals for clients or problems in accessing certain types of community care in some areas, and also reflects the validity of an ACAT approval for a period of 12 months. Clients and family members may not always agree with ACAT recommendations and this can give rise to differences between recommendations and approvals, in which case additional carer support and counselling beyond ACAT assessment may be called on to provide information on and support decisions about long-term care. The ACAP National Data Repository (2006) lists possible indications of differences between approvals and recommendations.

The data on ACAP clients in 2004–05 reported below reflect a subset of all older people seen by ACATs that year. Specifically, they pertain to clients with known age, Indigenous status and usual accommodation setting as defined for version 2 of the ACAP Minimum Data Set (MDS). They exclude Queensland and some parts of New South Wales that did not report data in version 2 format (version 2 excludes 30,025 clients of all ages; for more details see ACAP NDR 2006).

In 2004–05, assessments were completed for 123,443 clients with known age and Indigenous status, of whom around 95% were older people (Table 3.10).[1] At assessment, 91% of clients were living in the community, including 79% in private residences, and 9% in institutional settings including residential aged care and hospitals. Permanent residential aged care was recommended for just under half of older ACAP clients (47%), mostly for high care, with 48% recommended to live in a private residence.

Table 3.10: ACAP clients by accommodation at assessment and recommended, 2004–05[a][b] (per cent)

	Usual accommodation at assessment			Recommended long-term care setting at assessment		
	Age <65 or Indigenous <50	Age 65+ or Indigenous 50+	Total	Age <65 or Indigenous <50	Age 65+ or Indigenous 50+	Total
Community setting						
Private residence	80.6	78.8	78.9	53.7	48.2	48.5
Independent living in a retirement village	1.3	7.4	7.2	0.8	3.0	2.9
Supported community accommodation	4.9	1.4	1.5	4.2	0.8	0.9
Other	7.1	3.4	3.5	1.7	0.7	0.7
Total	*93.9*	*90.9*	*91.1*	*60.3*	*52.7*	*53.1*
Institutional setting						
Residential aged care service—low care	2.8	7.5	7.3	13.3	20.9	20.5
Residential aged care service—high care	1.7	1.1	1.1	25.0	26.0	26.0
Hospital	0.7	0.2	0.2	0.4	0.4	0.4
Other institutional care	0.9	0.3	0.3	0.9	0.1	0.1
Total	*6.1*	*9.1*	*8.9*	*39.7*	*47.3*	*46.9*
Total (per cent)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Not stated or inadequately described (number)	229	3,382	3,611	—	—	—
Total (number of clients)	**5,666**	**117,777**	**123,443**	**5,666**	**117,777**	**123,443**

(a) Queensland and some parts of New South Wales did not report in ACAP MDS Version 2. Version 2 excludes 30,025 clients of all ages (ACAP NDR 2006).

(b) Table includes only results from the last assessment for clients assessed more than once in the financial year.

Notes

1. Table excludes 4,809 cases with missing, unknown or inadequately described information on age and/or Indigenous status in MDS v2.
2. Percentages based on numbers of clients cases with known age, Indigenous status and accommodation setting.
3. Components may not add to total due to rounding.
4. Effective 1 July 2004, people in residential low care who need to move to high level care within the same aged care home no longer need ACAT approval. This is reflected in an increase in the share of ACAT assessments that were for older people living in the community (from 87% in 2003–04 to 91% in 2004–05) and a relatively smaller percentage of ACAT clients in residential low care when assessed in 2004–05 (7%) compared with 2003–04 (11%).

Sources: ACAP NDR; AIHW analysis of ACAP MDS v2.

1 Data for the ACAP in 2004–05 are reported, as 2005–06 data were not available for this publication.

Of clients with an ACAT recommendation for care services in the community, 62% had been receiving formal assistance from a government program before assessment (Table 3.11). Almost 40% had been receiving HACC services and 9% had been receiving a CACP service. ACAP clients who had been using HACC before assessment were less likely to be recommended for permanent residential care than clients who were not using formal services (ACAP NDR 2006:176). More than half (56%) of the clients recommended for community living had been receiving care services funded by two or more programs, excluding respite care programs (Table 3.11). The use of multiple programs suggests that

Table 3.11: ACAP clients with a recommendation to live in the community: program support at assessment and as recommended, 2004–05[a][b] (per cent)

	Program support at time of assessment received by clients with recommendation to live in the community			Program support recommended at assessment for clients with a recommendation to live in the community		
	Age <65 or Indigenous <50	Age 65+ or Indigenous 50+	Total	Age <65 or Indigenous <50	Age 65+ or Indigenous 50+	Total
EACH	1.2	0.8	0.9	5.1	3.4	3.5
CACP	4.9	9.4	9.2	19.7	38.8	37.8
HACC	38.5	39.6	39.6	42.6	42.3	42.3
Veterans' Home Care	0.8	8.3	7.9	0.4	8.1	7.7
Day Therapy Centre	2.8	2.6	2.7	4.7	4.7	4.7
Any two or more of above programs[c]	*45.6*	*56.7*	*56.1*	*61.7*	*79.0*	*78.1*
NRCP	7.7	5.0	5.1	19.6	19.9	19.9
Residential respite	11.3	10.7	10.8	49.1	66.8	65.9
Other	13.4	7.9	8.2	13.6	7.6	7.9
None	43.6	37.7	38.0	26.7	14.5	15.1
Total (number)	**3,072**	**57,353**	**60,425**	**3,131**	**59,011**	**62,142**

(a) Queensland and some parts of New South Wales did not report in ACAP MDS Version 2. Version 2 excludes 30,025 clients of all ages (ACAP NDR 2006).

(b) Table includes only results from the last assessment for clients assessed more than once in the financial year.

(c) Clients using or recommended for multiple programs are counted against each applicable program.

Notes

1. EACH includes EACH Dementia.
2. Clients who receive or are recommended to receive support from multiple programs are counted separately under each applicable program.
3. Table excludes 7,645 cases with missing, unknown or inadequately described information at assessment: 2,101 cases of unknown Indigenous status or age; 5,049 cases of unknown program support at assessment; 495 cases of unknown Indigenous status/age and unknown program support.
4. Table excludes 5,928 cases missing, unknown or inadequately described information recorded against the recommendation: 2,271 cases of unknown Indigenous status or age; 3,332 cases of unknown recommended program support; 325 cases of unknown age/Indigenous status and unknown recommended program support.
5. Cases with missing, unknown or inadequately described Indigenous status or age include 194 cases of multiple program use at assessment and 1,188 cases of recommended multiple program support.

Sources: ACAP NDR; AIHW analysis of ACAP MDS v2.0.

clients or providers were seeking to find a mix of assistance types not readily available from one program and/or to increase total available hours of support through multiple program sources of funding. For example, the HACC and EACH programs provide community nursing, whereas CACP does not. A CACP client who needs nursing care may be eligible to receive HACC services—it has been reported that around 40% of CACP clients also use HACC services (AIHW: Karmel & Braun 2004). Patterns of prior service use and recommendations for ACAP clients demonstrate that aged care consumers do not necessarily move from one program to another in a linear fashion, but may use services funded by various different programs at different times according to need and eligibility.

ACATs recommended slightly more clients to receive HACC services than had been using HACC before referral to ACAT and recommended far more clients for care packages than had previously used that type of service (see CACP and EACH; Table 3.11). A higher proportion of clients were recommended for support from multiple programs (78%) than had been accessing multiple programs before assessment (56%). These results underscore the role of ACATs in assisting people as their care needs change, by helping them to access different or higher levels of formal care and carer support.

For many older people, ACAT assessment is a pathway to receipt of respite care. Approximately 11% of older ACAP clients recommended to live in the community had already been using residential respite care (through an earlier ACAT assessment) and 5% had been receiving assistance through the NRCP (Table 3.11). Following assessment, ACATs recommended 67% for residential respite and 20% for NRCP services. ACAT approval is required for access to residential respite services. The NRCP does not require ACAT approval; however, ACATs play an important role in referring clients to this and other sources of respite care.

Over two-thirds of community-based clients were already receiving domestic assistance, meals and transport assistance, and around half were receiving assistance with health care, home maintenance and self-care. Across all areas of assistance, higher proportions of clients were receiving support from informal providers than from formal providers only (Table 3.12). Particularly in the areas of mobility, transport, social and community participation, and communication, informal providers are the main source of assistance to ACAT clients with needs in those areas.

As might be expected, in most areas of activity ACAT recommended substantially more clients to receive formal assistance than were receiving formal assistance when assessed (Table 3.12). Most clients recommended to live in the community were recommended for formal domestic assistance (70%). Recommendations show recognition for an increased role for formal services in the provision of transport assistance and social and community participation for many clients. Of clients living in the community at assessment, 13% had been receiving formal transport assistance before assessment; of those recommended to continue to live in the community, 48% were recommended for this type of formal assistance. Similarly, 15% of community-based clients had been receiving formal assistance to engage in social and community activities; formal assistance in this area was recommended for 44% of clients recommended to continue to live in the community.

Table 3.12: ACAP clients aged 65 years or over and Indigenous clients aged 50 years and over living in the community at assessment, assistance with activities, 2004–05 (per cent)[(a)]

	Source of assistance for clients living in the community						Formal assistance recommended for clients with a recommendation to live in the community
Type of assistance	Formal only	Informal only	Both	Not stated	Total	All	
Domestic assistance	38.8	44.1	15.4	1.8	100.0	80.3	69.7
Transport	13.3	70.6	14.4	1.7	100.0	69.9	47.5
Meals	27.1	61.3	9.8	1.8	100.0	68.3	44.8
Activities involved in social and community participation	15.3	66.9	14.6	3.1	100.0	55.7	44.2
Health care	33.7	51.1	13.3	1.9	100.0	55.4	40.9
Self-care	37.9	45.7	14.1	2.3	100.0	44.6	36.2
Home maintenance	23.0	67.7	7.3	2.0	100.0	52.3	34.3
Moving around places at or away from home	12.5	74.5	10.6	2.4	100.0	38.4	20.6
Movement activities	20.3	65.0	11.5	3.2	100.0	16.3	7.5
Communication	10.4	77.2	10.2	2.2	100.0	11.8	4.3
Other	33.9	56.8	4.2	5.1	100.0	4.6	7.6
None	. .	. .	. .	. .	. .	7.1	11.5
Total (number)	**66,827**	**78,827**	**30,972**	**. .**	**. .**	**104,020**	**59,502**

(a) Queensland and some part of New South Wales have not yet adopted the MDS v2 format for reporting data on usual accommodation setting: 30,025 clients (all ages) assessed in these regions are therefore not included in this table.

Notes

1. 'Source of assistance for clients living in the community' figures exclude clients living permanently in residential aged care, hospitals or other institutional settings. 'Clients with a recommendation to live in the community' figures exclude clients recommended to live permanently in residential aged care or other institutional settings.
2. Table excludes cases with missing or incomplete data on assistance: 2,010 recommendations, as recorded in MDS v2.0.
3. Components may not add to total due to rounding.

Sources: ACAP NDR; AIHW analysis of ACAP MDS v2.

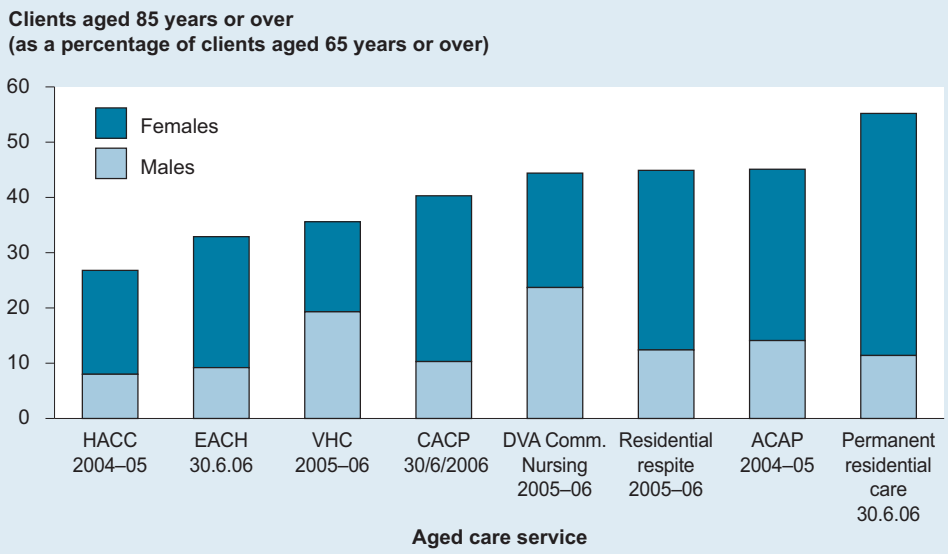
3.9 Client profiles and patterns of service use

In this section selected characteristics of clients of aged care programs are presented and compared. Due to the limitations of existing data collections, not all characteristics can be reported for all programs. The section then presents data on patterns of service use by older population subgroups.

Age and sex

Across the programs, with the exception of DVA programs, aged care clients are predominantly women. In 2006, the proportion of female clients ranged from 61% of EACH recipients to 73% of older people in permanent residential care. Reflecting women's greater longevity, the predominance of female clients in aged care services increases with age. The profile of permanent residential care clients particularly reflects this pattern, with women accounting for 52% of residents aged 65–74 years, rising to 82% of residents aged 90 years and over (Table 3.13). Women outnumber men in permanent residential care by almost three to one; the sexes are more balanced in residential respite care, with around 1.7 women to every male client in 2005–06 (see Table A3.7).

People aged 85 years or over make up a higher proportion of people in residential care, compared with community care (Figure 3.4 and Table 3.13). Over half (55%) of older permanent residents and 44% of older people who used residential respite care in 2005–06 were aged 85 years or over. Over 70% of newly admitted permanent residents in 2005–06 were aged 80 years or over. There has been a steady rise in average age at admission since 1998–99, when 64% of people admitted for permanent care were aged 80 years or over (AIHW 2007b).



Source: Table 3.13.

Figure 3.4: Use of selected aged care programs by clients aged 85 years or over, 2004–05/2005–06

Table 3.13: Clients (65 years or over) of aged care programs by age and sex, 2004–05/2005–06 (per cent)

	ACAP	HACC	Veterans' Home Care	DVA Community Nursing	Residential respite care	CACP	EACH	Permanent residential care
	2004–05		2005–06		2005–06	As at 30 June 2006		
	Clients	Clients	Clients	Clients	Clients	Clients	Clients	Residents
Males								
65–69	2.0	3.8	0.6	0.7	2.2	2.3	4.9	1.7
70–74	3.5	5.4	1.0	1.0	3.9	3.1	7.2	2.6
75–79	6.8	8.0	3.3	2.9	7.3	5.3	10.0	4.8
80–84	9.4	7.8	24.1	23.0	10.3	6.9	7.8	6.7
85–89	8.3	5.3	15.8	18.0	8.2	6.2	5.4	6.4
90 or over	5.8	2.7	4.0	6.3	4.9	4.1	3.8	5.0
Total males	*35.8*	*32.9*	*48.8*	*51.9*	*36.8*	*28.0*	*39.1*	*27.2*
Females								
65–69	2.3	6.7	0.6	0.4	2.0	3.7	5.2	1.6
70–74	4.4	9.9	2.3	1.5	4.0	6.2	7.3	3.1
75–79	9.8	14.9	10.4	7.2	9.5	12.4	10.4	8.0
80–84	16.7	16.9	21.2	17.9	16.9	19.7	14.3	16.3
85–89	16.9	12.0	12.7	14.1	17.7	18.0	12.1	20.7
90 or over	14.1	6.8	4.0	7.0	13.1	12.0	11.6	23.1
Total females	*64.2*	*67.1*	*51.2*	*48.1*	*63.2*	*72.0*	*60.9*	*72.8*
Persons								
65–69	4.3	10.4	1.3	1.1	4.3	6.0	10.1	3.2
70–74	7.9	15.3	3.2	2.5	7.9	9.3	14.4	5.7
75–79	16.6	22.9	13.7	10.1	16.8	17.7	20.4	12.8
80–84	26.1	24.7	45.3	40.9	27.2	26.7	22.1	23.0
85–89	25.3	17.3	28.5	32.1	25.9	24.2	17.5	27.1
90 or over	19.9	9.5	8.0	13.3	17.9	16.1	15.5	28.1
Total persons 65+	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total persons 65+ (number)	**121,533**	**561,789**	**70,997**	**32,057**	**33,801**	**29,972**	**1,984**	**145,175**
Clients aged <65 (number)	**6,354**	**182,408**	**1,544**	**681**	**1,755**	**1,831**	**147**	**6,562**
Clients aged <65 (% clients all ages)	**5.0**	**24.5**	**2.1**	**2.1**	**4.9**	**5.8**	**6.9**	**4.3**

Notes

1. EACH includes EACH Dementia.
2. For figures as at 30 June, age is as at that date. For ACAP clients, age is at the time of the last assessment in the financial year. For residential respite, age is as at the end of the last admission. For Veterans' Home Care age is as at last service date. For DVA Community Nursing age is as at 30 June 2006. For residential respite care clients, age is as at first admission in the financial year.
3. For ACAP, 365 clients with missing age and/or sex have been excluded. There were no cases with missing age and/or sex for CACP, EACH and EACH Dementia, residential aged care, Veteran's Home Care and DVA Community Nursing.
4. HACC cases with missing age were assumed to be aged 65 or over. Cases aged over 65 years with missing sex and cases with missing age (2,546) have been pro-rated accordingly.
5. Not all HACC service providers submitted data to the HACC MDS. In 2004–05, 82% of providers submitted data.
6. Figures for CACP recipients and residential care do not include clients of Multi-purpose and flexible services.

Sources: AIHW analysis of DoHA ACCMIS database; AIHW analysis of HACC MDS v1; ACAP NDR; DVA unpublished data: Community Nursing data current as at 19 April 2007 (subject to change) and Veterans' Home Care data current as at 30 March 2007 (subject to change).

Of the community care programs reported here, CACP recorded the oldest age profile, with two out of five older clients in 2005–06 aged 85 years or over; this may partly reflect the program's maturity. The majority of people who commenced with a CACP in 2005–06 (82%) were aged 75 years or over; a similar proportion of people commencing on an EACH package (85%) were aged 70 years or over (AIHW 2007a).

The use of HACC, community care packages (CACP and EACH) and residential aged care, both respite and permanent, increases markedly with increasing age (Table 3.14). Community care in the form of HACC services is used by relatively more people in each of the age groups 65–74 years, 75–84 years and 85 years or over, compared with other programs: in 2004–05, 103, 280 and 478 per 1,000 persons by age group respectively used HACC services. As at 30 June 2006, the rates of permanent residence in Australian Government-accredited aged care homes for age groups 65–74 years, 75–84 years and 85 years and over were 9, 54 and 237 per 1,000 persons respectively. Older people (65 years or over) accounted for half of carers who used direct respite care services funded by the NRCP in 2004–05 (see Table A3.10). The NRCP also provides assistance to younger carers, including those providing care to frail older people.

Table 3.14: Usage rates of selected aged care programs by country of birth (per 1,000 people)

Age (years)	ACAP 2004–05	HACC 2004–05	Residential respite 2005–06	CACP 30 June 2006	Permanent residential care 30 June 2006
	Clients	Clients	Clients	Clients	Residents
Australian-born					
65–74	11.5	113.1	3.0	3.5	10.5
75–84	56.2	291.2	15.5	12.7	56.7
85 over	181.0	503.7	49.2	34.7	248.2
Overseas-born: main English-speaking countries					
65–74	7.2	72.0	2.3	2.1	6.8
75–84	44.7	235.5	14.0	12.0	49.0
85 over	153.3	397.0	47.6	34.4	237.9
Overseas-born: non-English-speaking countries					
65–74	10.2	94.6	2.2	3.1	7.1
75–84	55.1	270.1	12.1	17.9	46.4
85 over	164.1	423.6	36.2	42.0	183.8
All					
65–74	10.6	103.1	2.7	3.2	9.1
75–84	54.5	280.0	14.6	13.7	53.6
85 or over	174.8	477.7	47.0	35.8	237.0

Notes

1. See notes to Table A3.7 concerning derivation of statistics and caveats, including allowance for missing values.
2. ACAP MDS v2 excludes data for all ACATs in Queensland and four ACATs in New South Wales still reporting in MDS v1 in 2004–05.
3. For ACAP, before 1 July 2004, people moving from residential low care to high care within the same facility required ACAT approval. Removal of this requirement from 1 July 2004 has contributed to lower usage rates in 2004–05 compared with 2003–04 and previous years.

Sources: ABS 2007b; AIHW analysis of DoHA ACCMIS database; AIHW analysis of HACC MDS; ACAP NDR.

Service use by people born overseas

People born overseas are increasing as a share of the older population and certain groups of overseas-born people are ageing more rapidly than the population as a whole. Programs that provide community care have relatively more clients born in non-English-speaking countries compared with residential services: CACP and EACH recorded higher use by this group compared with the HACC program. Between 18% and 27% of older clients of community care programs were born in non-English-speaking countries, compared with around 15% of older people in permanent residential care and 35% of all people aged 65 years or over (Table A3.7). The pattern of increasing use of aged care services with increasing age is evident for both Australian-born and overseas-born people (Table 3.14).

Overseas-born people, from both English-speaking countries and non-English-speaking countries, record relatively low usage of HACC services compared with people born in Australia. However, people born in non-English-speaking countries make relatively high use of CACP services at ages 75 years or over.

Service use by Aboriginal and Torres Strait Islander people

The reporting of service use by Aboriginal and Torres Strait Islander people relies on accurate identification of Indigenous clients of aged care services. Some qualification needs to be placed on the data reported here due to poorly collected data relating to Indigenous status for ACAP and HACC clients. Possibly compounding the problem, the age composition of the Indigenous population is necessarily based on projections from population census data that are now 6 years old (see Chapter 2 for further details).

Like other groups in the population, available data suggest that Indigenous Australians access some services in preference to others. A relatively high proportion of CACP recipients are Indigenous: 4% at 30 June 2006 compared with less than 1% of permanent aged care residents and around 2% of HACC clients (Table A3.9). Indigenous clients of aged care services are at least 10 years younger on average than their non-Indigenous counterparts (Table A3.9).

Among people aged 50 years or over, Indigenous people have much higher usage rates than other people of residential care (both permanent and respite) and CACPs. For example, Indigenous Australians aged 65–74 years used permanent residential aged care at a rate of 21.4 per 1,000, compared with 9.1 per 1,000 for all other Australians and 6.8 per 1,000 for people born in the main English-speaking countries (Table 3.14 and Table 3.15). In the oldest age group for which population data are available for Indigenous Australians (75 years or over), data in Table 3.15 suggest that they use all residential care services, CACPs and EACH packages at higher rates than other people. However, the comparison between usage rates is affected significantly by the different age structures of the two populations and particularly by the relatively low percentage of Aboriginal and Torres Strait Islander people aged 75 years or over.

Those data which are available for ACAP indicate under-representation of Aboriginal and Torres Strait Islander people in referrals for assessments in all states and territories, given their representation in the ACAP target population (ACAP NDR 2006). Despite this, use of the range of services that require ACAT approval is comparatively high for Aboriginal and Torres Strait Islander people, across all older age groups (Table 3.15). Age-specific usage rates for HACC in 2004–05 were found to be too unreliable to report.

Table 3.15: Usage rates and Indigenous status of clients of selected aged care programs

Age (years)	Residential respite 2005–06	CACP 30 June 2006	EACH 30 June 2006	Permanent residential care 30 June 2006
	Clients per 1,000 population			
Indigenous persons				
50–64	1.9	9.2	0.3	4.9
65–74	7.9	42.4	0.6	21.4
75 or over	34.8	84.7	1.7	105.2
Non-Indigenous persons				
50–64	0.4	0.4	—	1.5
65–74	2.7	2.9	0.4	9.1
75 or over	23.0	19.2	1.3	101.1
All persons				
50–64	0.4	0.5	—	1.5
65–74	2.7	3.2	0.4	9.1
75 or over	23.1	19.4	1.3	101.1

Notes

1. EACH includes EACH Dementia.
2. See notes to Table A3.9 concerning derivation of statistics and caveats, including allowance for missing values.
3. HACC usage rates in the Indigenous population are considered too unreliable to report. Table A3.9 shows Indigenous people as a proportion of older HACC clients and other key statistics relating to Indigenous HACC clients.

Source: AIHW analysis of DoHA ACCMIS database as at 16 October 2006.

Client living arrangements

Data are available on the living arrangements of HACC and DVA Community Nursing clients (see Table A3.11 and Table A3.12). The ACAP NDR (2006) reports on the living arrangements of ACAP clients.

In 2004–05, over one–third (36%) of HACC clients of all ages were living alone. A larger proportion of older, compared with younger, clients lived alone (42%), particularly clients aged 85 years or over (49%). In each age group 65–74, 75–84 and 85 years or over, women living alone made up at least one-quarter of all older HACC clients. In the older age groups 75–84 years and 85 years or over, women living alone outnumbered women in other living arrangements, whereas the opposite is true for male clients, more of whom live with family than live alone. With population ageing, the already high proportion of community aged care clients who live alone will increase and this has potential implications for the delivery of social support services which contribute to meeting a client's need for social interaction.

An estimated 53% of older DVA Community Nursing clients live alone, reflecting in part the older age profile of Community Nursing clients (84% aged 80 years or over; Table A3.12) but also highlighting that many older community care clients need nursing care, on either a continuous or episodic basis.

Dependency levels

The Resident Classification Scale (RCS) produces 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 functional domains. Results of appraisals indicate a trend of rising dependency among permanent residents that has been evident for some time (Gray 2001; see also the AIHW report *Residential aged care in Australia*, published annually). This trend continued in 2005–06, with 68% of permanent residents on 30 June in high care (RCS 1–4), up from 65% in 2004 and 61% in 2000, and is most evident in the increasing number of residents at the top level of the high care range, RCS 1 (Table 3.16).

Dependency levels on admission to permanent residential care for new residents in the age groups 50–64 years and 65–74 years are quite similar—51% of admissions for people in both age groups are classified as RCS 1–2. Somewhat lower proportions of admissions for people in the older age groups, 75–84 years and 85 years or over, have the same classification (45% and 43% respectively). By comparison, admissions among these older age groups show higher proportions classified at RCS 5–8 compared with younger age groups (Figure 3.5). This pattern may be partly associated with the psychosocial needs, as distinct from the physical support needs, of a proportion of people in the much older age groups (assessment of a person's psychosocial needs is often a main reason for an ACAT recommendation for residential low care; see Lincoln Gerontology Centre (2002)). In addition, if a younger person is admitted to an aged care home (especially under the age of 65 years), it is likely they will have high levels of dependency.

Table 3.16: Level of dependency of permanent aged care residents aged 65 years or over, at 30 June 2000, 2002, 2004 and 2006

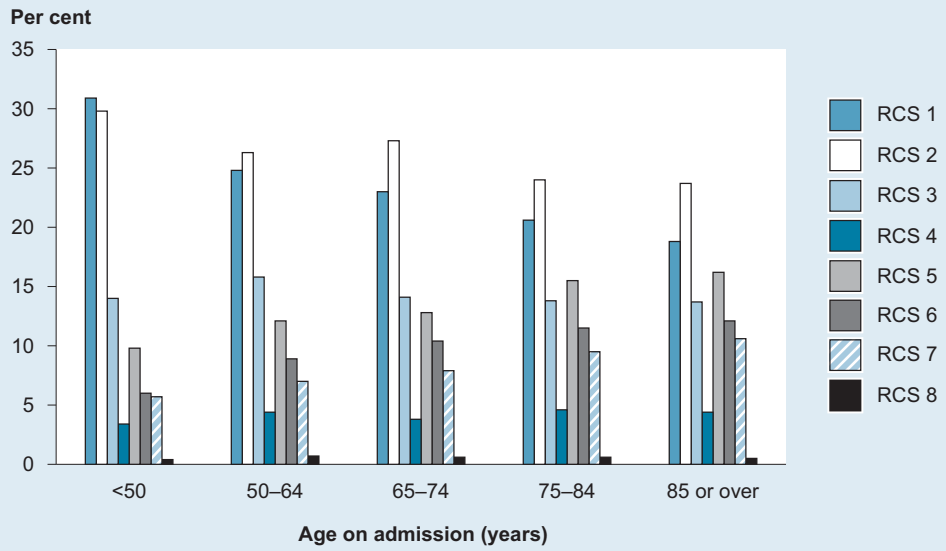
	High care					Low care					
	RCS 1	RCS 2	RCS 3	RCS 4	RCS 1–4	RCS 5	RCS 6	RCS 7	RCS 8	RCS 5–8	Total
						Number					
2000	17,618	32,205	20,818	5,820	*76,461*	11,071	12,933	21,153	2,978	*48,135*	124,596
2002	24,010	32,455	19,016	5,964	*81,445*	13,643	14,057	17,989	1,781	*47,470*	128,915
2004	29,692	33,680	19,973	6,577	*89,922*	16,630	14,653	15,450	1,052	*47,785*	137,707
2006	33,321	34,706	22,211	8,319	*98,558*	17,630	14,299	12,878	645	*45,452*	144,009
						Per cent					
2000	14.1	25.8	16.7	4.7	*61.4*	8.9	10.4	17.0	2.4	*38.6*	100.0
2002	18.6	25.2	14.7	4.6	*63.2*	10.6	10.9	13.9	1.4	*36.8*	100.0
2004	21.6	24.5	14.5	4.8	*65.3*	12.1	10.6	11.2	0.8	*34.7*	100.0
2006	23.1	24.1	15.4	5.8	*68.4*	12.2	9.9	8.9	0.4	*31.6*	100.0

Notes

1. Assessments unavailable for 2,825 residents in 2000, 1,671 residents in 2002, 1,088 residents in 2004 and 1,233 residents in 2006.
2. Table does not include clients of Multi-purpose and flexible services.

Source: AIHW analysis of DoHA ACCMIS database.

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.



Source: Table A3.13.

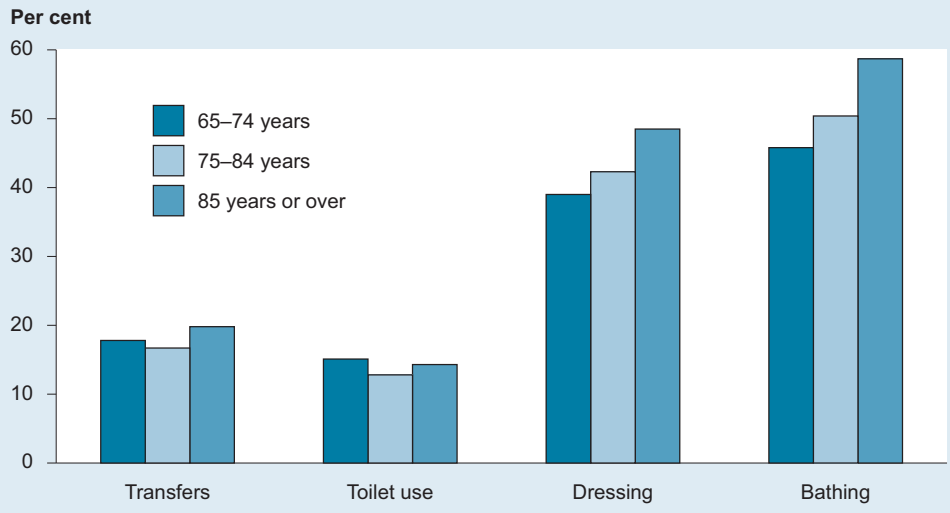
Figure 3.5: Percentage of people admitted to permanent residential aged care by RCS level and age on last admission, 1 July 2005 to 30 June 2006

The recording of client dependency for community care programs varies from none to use of generic activities of daily living (ADL) tools and special-purpose administrative instruments such as the RCS and ACFI. Version 2 of the HACC National Minimum Data Set has been implemented with national definitions for HACC client dependency, although adoption of the standard dependency data items currently varies across the states and territories. National program data for CACP and EACH do not currently include a measure of client dependency, other than as at the most recent ACAT assessment.

DVA collects dependency data for its Community Nursing clients. Data pertaining to selected daily activities for which providers have used comparable measurement scales reveal that high proportions of older DVA Community Nursing clients need assistance with bathing/showering and dressing, and relatively smaller numbers need assistance with transfers (for example from bed to a chair) and toilet use (Figure 3.6). The proportions of clients needing assistance in transfers and toilet use are similar across the age groups 65–74 years, 75–84 years and 85 years or over; for bathing and dressing the proportion of clients in need of assistance increases with increasing age, representing around half of clients aged 85 years or more.

Types of assistance received

Most aged care programs offer care services that can be provided over an extended period of time, or for as long as required. Some types of assistance are received more frequently than others. Domestic assistance and personal care, for example, might be provided on an ongoing basis, whereas other services such as home maintenance tend to be required less frequently. In order to report data about less frequently received services, the types of assistance received by clients of the various programs are examined here using the measure of the proportions of clients who receive them within a given financial year.



Source: Table A3.14.

Figure 3.6: DVA Community Nursing clients aged 65 years or over, percentage who need assistance, by area of core daily activity and age group, 2006

Because there are no overarching data definitions or service delivery schedules to cover all community care programs, HACC types of assistance were used as a template for reporting patterns of service use in multiple programs. Table 3.17 indicates those types of assistance recorded as having been delivered to clients under each program. An entry of 'X' denotes a type of assistance that is not offered by the program. For example, HACC delivers a comprehensive range of types of assistance, whereas DVA provides services to eligible DVA clients through a number of different programs. (Two main DVA programs, Veterans' Home Care and Community Nursing are reported here, whereas a number of smaller DVA programs are not reported at this level of detail). An entry of a tick mark '✓' indicates that that type of assistance is available but detailed national data on service use are not available. The type of assistance delivered to CACP and EACH clients is not routinely collected by government, hence the '✓' entries in those columns. Censuses of CACP and EACH clients and service agencies conducted in 2002 produced snapshot data on service provision that have been reported previously (AIHW 2004a, 2004b, 2005). CACP and EACH are included in Table 3.17 to allow comparison of the services provided by these and other programs.

The direct care services received by the largest proportions of older HACC clients were domestic assistance, food services and nursing care (each of these service types was recorded for at least 20% of older clients; Table 3.17). Less than 10% of HACC clients in 2004–05 received personal care. Patterns of service use may not give a true indication of need within a client population—for example, it has been estimated that one in six people within the frail aged HACC target population in Victoria in 2002 had a need for higher levels of personal assistance than the average older HACC client (Vic DHS 2003).

Table 3.17: Community and flexible care programs: services provided to clients aged 65 years or over, 2004–05/2005–06 (per cent)

		DVA programs[a]		Care packages	
Service type	HACC 2004–05	Veterans' Home Care[a] 2005–06	Community Nursing[a] 2005–06	CACP 30 June 2006	EACH 30 June 2006
	Per cent of clients in program				
Non-specialist care services					
Domestic assistance	30.2	92.3	X	✓	✓
Food services[d]	21.7	X	X	✓	✓
Transport services	17.3	X	X	✓	✓
Home or garden maintenance	16.2	19.9	X	✓	✓
Delivered meals	15.3	X	X	✓	✓
Activity programs (home or centre-based)	10.9	X	X	X	X
Social support	10.5	X	✓	✓	✓
Personal care	8.8	4.0	[c]11.0	✓	✓
Centre-based meals[d]	7.3	X	X	✓	✓
Counselling	7.1	X	✓	✓	✓
Goods and equipment	4.9	X	X	✓	✓
Home modifications	3.2	X	X	✓	✓
Respite care	0.9	[b]10.3	X	✓	✓
Other food services	0.4	X	X	✓	✓
Linen services	0.2	X	X	✓	✓
Accommodation and related services	X	X	X	X	X
Specialist services					
Nursing (home and centre-based)	20.8	X	89.0	X	✓
Allied health/therapy (at home or at a centre)	16.8	X	X	X	✓
Total clients (number)	**561,789**	**70,997**	**32,057**	**29,972**	**1,984**

(a) DVA programs other than Veterans' Home Care and Community Nursing are used for assessment and to deliver services including minor home modifications, goods and equipment, transport, residential respite, counselling and allied health care to eligible DVA clients. Veterans' Home Care data are independent from Community Nursing data. Clients who received Veterans' Home Care services may have received Community Nursing services at the same time. Data on simultaneous receipt of Veterans' Home Care and Community Nursing services are not provided in the table.

(b) Figure relates to provision of in-home respite care only. Veterans' Home Care can approve in-home, emergency and residential respite services; however, payments for residential respite services are managed through a separate appropriation. Respite care figures under Veterans' Home Care exclude DVA clients who used residential respite but not other types of respite care funded by Veterans' Home Care. In addition to in-home respite, 0.1% of older Veterans' Home Care clients received emergency respite.

(c) The figure for personal assistance delivered by DVA Community Nursing indicates personal assistance provided without any general and/or technical nursing care.

(d) Includes more than one related type of assistance.

Notes

1. Data for HACC, CACP and EACH are for clients aged 65 years or over; Veterans' Home Care and DVA Community Nursing include clients aged under 65 (1,544 Veterans' Home Care clients and 681 Community Nursing clients).
2. EACH includes EACH Dementia.
3. Figures relate to the percentage of clients in each program who received each type of assistance at any time in the specified reporting period.
4. A person may receive more than one service type therefore percentages may not sum to 100.

✓ Service type provided but data not available to report.

X Service type not provided.

Sources: AIHW analysis of HACC MDS v1 (see also Table A3.13, A3.14); AIHW analysis of DoHA ACCMIS database; DVA unpublished Veterans' Home Care MDS current as at 30 March 2007 but subject to change; DVA unpublished Community Nursing data current as at 19 April 2007 but subject to change.

Just over 23,000 older HACC clients received case management for the coordination of HACC services provided by multiple agencies—case planning, coordination and review, as distinct from 'case management', involved a higher number of HACC clients that received multiple types of assistance but not necessarily from multiple service agencies. Older clients receiving case management comprised two-thirds of all HACC clients who received a care package-type service under HACC (DoHA 2006a:Table A3.19). Although this number represents less than 5% of all older clients in 2004–05, there are some indications that the supply of case-managed HACC services (known as Linkages and Community Options) and care packages available through other programs is not meeting demand for higher levels of service within the HACC target population (AIHW: Hales et al. 2006a; Vic DHS 2003). Package-type services delivered by HACC agencies through internal and external brokerage have been found to be a suitable form of medium-to long-term community care for many clients with high and special care needs. For people with dementia-related high care needs, for instance, service providers consider that a case-management HACC service is often preferable to a CACP and as appropriate as an EACH package (AIHW: Hales et al. 2006a). *A* New Strategy for Community Care—The Way Forward is currently grappling with the complexities of levels of community care and program interfaces.

Proportionately more older than younger HACC clients received domestic assistance (30% versus 19%), meal services (22% versus 10%) and home maintenance (16% versus 9%). The seemingly low level of respite care use by older clients (0.9%) is an artefact of reporting in version 1 of the HACC minimum dataset whereby respite care is recorded against the carer (using version 2, which began roll-out in 2005–06, respite care services can be reported according to both carer and care recipient characteristics). For domestic assistance and meals, the proportions of older clients using services increase with increasing age (15% of clients aged 65–74 years rising to 29% of clients 85 years or over used HACC meal services; 27% of clients aged 65–74 years rising to 32% of clients aged 85 years or over used domestic assistance services; see Table A3.15).

Veterans' Home Care can deliver up to 1.5 hours per week of personal care assistance in addition to services such as domestic assistance, home and garden maintenance, and respite care. In 2005–06, 92% of Veterans' Home Care clients received domestic assistance and 20% received formal help with home maintenance and gardening (Table 3.17). Respite care, received by 10% of Veterans' Home Care clients in 2005–06, can include in-home and emergency respite care and referral services for residential respite care. In addition to respite provided by DVA, veterans, like other older Australians, may access respite through other programs such as the HACC program and the NRCP.

Eligible DVA clients who need community nursing or a higher amount of personal assistance may be referred for DVA Community Nursing services. In 2005–06, 11% of DVA Community Nursing clients received personal assistance without specialist nursing care; the majority (89%) received specialist nursing care (Table 3.17). Data on the total volume of types of assistance to older HACC and Veterans' Home Care clients are included in the Appendix tables (Tables A3.15 and A3.16).

Direct respite care services arranged by Commonwealth Carer Respite Centres in 2004–05 were primarily in-home respite (46% occasions of respite care) and residential respite in Australian Government-accredited aged care homes (21%; see Table A3.18).

Provision and use of assistive technology

Assistive technology can help compensate for functional loss and prevent further loss by reducing the demands of living environments on frail older people. The provision of aids

and equipment and minor home modifications is offered by a number of programs. In addition, items may be purchased privately or acquired through the health system.

In 2004–05, 5% of older HACC clients received goods and equipment through the program and 3% had home modifications (Table 3.17). The DVA Rehabilitation Appliances Program meets clinically assessed needs for aids and appliances prescribed by professionals in nominated health disciplines. Mobility and functional support items and continence products account for approximately 72% of expenditure on aids and appliances under the program. In 2005–06, the DVA HomeFront (falls and accident prevention) program assisted 9,966 DVA clients, and 5,159 used the home maintenance and repairs telephone referral service.

Current applications of assistive technology in the homes of older Australians tend to be conventional in nature, that is, low technology home modifications, aids and equipment. Approximately 24% of older people with disability who were living in private dwellings in 2003 had made modifications to their dwelling because of disability. Installation of handrails was the most common type of modification (18%), followed by toilet, bath or laundry modifications (13%). Relatively fewer people reported structural changes to dwellings (2%) or installation of ramps (5%) (AIHW analysis of ABS 2003 SDAC CURF). In terms of aids, older people mostly make use of low technology self-care and mobility aids (see Table A3.19).

Interestingly, only 9% of older people with disability and 15% of those with profound or severe limitation use a cordless or mobile telephone. Simply rushing to answer the telephone can put an older, less mobile person at risk of injury and increased disability (hospital data show that slipping, tripping or stumbling on a level surface at home is the most common type of fall that results in serious injury among older people). Relatively low cost environmental improvements such as a cordless telephone help to reduce that risk.

Duration of support—care packages and residential care

People remain on a care package until they can no longer benefit from the type of assistance offered, or until they need another type of care or die. The main reasons that clients ceased receiving CACP services in 2005–06 were to enter residential aged care (48%) or death (18%) (AIHW 2007a). Smaller proportions of separations were due to hospitalisation or transfer to another CACP service provider. Similar patterns were observed for the EACH program, although with a higher mortality rate: 44% left EACH to enter residential aged care, 35% were due to death, 9% were due to hospital admission and 5% were withdrawals from the service (AIHW 2007a).

Three-quarters of CACP clients who ceased receiving CACP services during 2005–06 had been supported by the program for up to 3 years, including 50% who had received services for 1 year or less (Table 3.18).

The EACH program shows shorter duration of support on average, compared with CACP: 94% of EACH clients who separated from a package in 2005–06 had been supported for up to 2 years and around half for up to 6 months. Relatively fewer separations from the EACH program (1%) in 2005–06 than for either CACP (19%) or permanent residential aged care (34%) were clients who had been supported on the program for 3 or more years. However, it is important to note that, as a relatively new and growing program, EACH would not have the same proportion of long stay clients as longer established programs (recent rapid growth in EACH provision is discussed in Section 3.10).

Table 3.18: Length of support or stay for CACP, EACH and residential aged care by people aged 65 years or over, separations during 2005–06 (per cent)

	CACP	EACH	Residential respite care	Permanent residential care
<1 week	0.5	1.7	8.0	1.9
1–<2 weeks	1.0	1.3	22.1	2.3
2–<3 weeks	1.3	1.7	32.7	2.1
3–<4 weeks	1.3	2.1	12.7	1.7
4–<8 weeks	5.8	10.7	16.9	5.6
8–<13 weeks	6.8	13.9	6.4	4.7
13–<26 weeks	13.7	20.0	1.0	8.3
26–<39 weeks	9.9	14.6	0.1	5.9
39–<52 weeks	7.9	10.4	—	5.2
1–<2 years	21.0	17.7	—	16.1
2–<3 years	12.1	4.9	—	12.3
3–<4 years	7.5	0.4	—	9.0
4–<5 years	5.4	0.4	—	6.4
5–<8 years	4.8	0.3	—	10.6
8 or more years	0.9	—	—	7.8
Total	**100.0**	**100.0**	**100.0**	**100.0**
Total (separations)	**13,487**	**1,001**	**46,729**	**49,319**

Notes

1. Age is at separation.
2. EACH includes EACH Dementia.
3. Table does not include clients of Multi-purpose and flexible services.
4. Residential age care figures exclude transfers between service providers for care of the same type (that is, respite or permanent care).
5. Components may not add to total due to rounding.

Source: AIHW analysis of DoHA ACCMIS database current 16 October 2006.

The median period of residency for the 49,319 people aged 65 years or over who left permanent residential care in 2005–06 was between 1 and 2 years; however, one-quarter (25%) of separations were for people who had been in care for 4 years or more (Table 3.18).

It is common for people to move from one program to another so that the duration of formal care can be greater than that indicated by the length of support on any one program. In addition, a significant minority of aged care consumers receive assistance concurrently through multiple programs. Transitions between HACC and residential respite care involve the largest number of people, followed by movements from HACC services to permanent residential care; similarly, it has been found that nearly half of all people starting on a CACP in a quarter had been HACC clients in the previous quarter, and 37% of people entering permanent residential aged care had been receiving assistance through a CACP and/or HACC service (AIHW: Karmel 2005).

3.10 Outcomes

Outcome measurement and reporting in aged care is currently limited by a paucity of data on patterns of service use and the effect of services on the people who use them. As a result, reporting on outcomes in past volumes of *Australia's welfare* has necessarily concentrated on service-related outcomes, for example, accessibility (provision and use of allocated and operational places and packages by specific populations) and summary results of quality assurance processes such as aged care home certification and accreditation.

Australia's welfare has also reported on the needs of older people and their receipt of assistance as one, albeit high-level and indirect, measure of consumer outcomes. While the ABS Survey of Disability, Ageing and Carers is a useful existing source of data for this purpose, analysis and reporting of the data pertaining to older people and aged care is perhaps less well supported by current research than is the case in other areas of social services. For example, outcome measurement in education is well developed by comparison and, in the disability services sector, demand studies have been undertaken over a number of years.

Signs of change are appearing due at least in part to a strong focus in the Dementia Initiative on outcomes and quality of life for people with dementia and their carers. A main objective of aged care assistance is improvement or maintenance of an individual's physical and psychosocial functioning to enhance their quality of life. Quality of life measurement in this field is not a straightforward matter: observable and measurable outcomes do not always match the older consumer's perceived quality of life; obtaining reliable data from cognitively impaired people, for example, can be a significant challenge; and consumers live in, or rely on, the service environment. While acknowledging that difficulties exist, experience in Australia and overseas has demonstrated that the challenges in obtaining useful feedback from aged care clients and their families are not insurmountable (see for example AIHW: Hales et al. 2006a, 2006b; AIHW: Jenkins 2000; Straker et al. 2007;). Levels of consumer satisfaction provide a credible perspective on quality of care and quality of life that is different from and complementary to clinical and system indicators (Harris-Kojetin & Stone 2007).

Service-related outcomes

Accessibility

Accessibility is considered, firstly in terms of the provision of residential and community care places at a national level and, secondly, through older people's use of these services and experiences in accessing service providers. The provision of aged care is an outcome of government planning and allocation processes, which affects consumers' access to services. At best an indirect measure of accessibility for individuals, trends over time in the number of aged care places relative to the size of the population at risk of needing care provide a useful population-based summary outcome measure.

The experiences of older people in attempting to access and use the full range of services they need reflects not only on service-specific issues but also on the level of support for older people to live in the community. This section examines aspects of accessibility to services generally, as reported by older people in households. Of particular interest is whether disability is a barrier to accessing services, since aged care is concerned with identifying older people whose activity limitations are the cause of disability and helping them overcome, or manage, disability.

Supply of community packages and residential aged care places

For the purpose of reporting on provision outcomes, aged care places and packages include CACP, EACH, EACH Dementia, Transition Care and residential aged care, both permanent and respite care, places. Allocated and operational places/packages in these programs can be measured against targets (described below). It is not possible to provide this sort of analysis for HACC—the other main aged care program—because discrete 'places' and 'packages' have no meaning in the context of the provision of HACC services.

One of the tools used to plan the provision of services under the *Aged Care Act 1997 (*Australian Government-funded residential, community care packages and flexible care places) is the planning ratio. This ratio is based on achieving a desired number of places in relation to the size of population likely to need formal aged care. Residential aged care places, EACH, EACH Dementia, CACP and Transition Care places are intrinsically linked through the planning ratio because community care packages are intended to provide care to people who are eligible for and who might otherwise use residential aged care. These service models are all included in the planning ratio.

A key recommendation of the 2004 *Review of pricing arrangements in residential aged care* (Hogan 2004) was for the Australian Government to confirm its 2001 commitment to provide 108 places for every 1,000 people aged 70 years or over, that is, a planning ratio of 108.0. When the review was undertaken in 2003, provision stood at 98.2 places per 1,000 target population. In 2004–05 the Australian Government increased the target from 100 to 108 places per 1,000 people aged 70 years or over and, as at 30 June 2006, provision had reached 105.8 places per 1,000 people aged 70 years or over, including 85.6 residential aged care place, 18.2 CACPs and 1.6 EACH and EACH Dementia packages (Table 3.19). In February 2007 the Australian Government committed to raising the target ratio to 113 places per 1,000 people aged 70 years or over by 2011.

Growth in CACP provision has slowed in recent years. While the number of EACH places remains low compared with CACP, EACH provision (places per 1,000 people aged 70 years or over) has more than doubled since 2004 and has almost tripled if provision is considered relative to the older population with profound or severe limitation. Provision of residential aged care places to the target population has been stable since 2005, at around 85 places per 1,000 people aged 70 years or over.

In terms of the more closely targeted supply measure of places and/or packages per 1,000 people aged 65 years or over with a severe or profound limitation, between 2003 and 2006 provision increased from 49.3 to 62.8 community care packages, including 5.2 EACH packages that are directed to people with high care needs. The supply of residential aged care places relative to this population increased from 265.4 to 270.7. On this measure, total provision has increased over this period from 314.8 to 333.4 places and packages for every 1,000 people aged 65 years or over with a severe or profound limitation. This represents an increase of 5.9%, which is higher than the 1.5% increase recorded for the period 2001–04 reported in the previous volume of *Australia's welfare* (AIHW 2005).

The 5.9% increase in provision for the older population with severe or profound limitation compares with an increase of 7.7% in places per 1,000 people aged 70 years or over. The difference in growth for these two measures is a consequence of the ageing of the population. Disability rates increase with age (see Section 3.2), so that as increasing proportions reach very old age so too are larger proportions of the older population affected by severe or profound limitations.

Table 3.19: Operational residential aged care places, Community Aged Care Packages, Extended Aged Care at Home places and Transition Care places at 30 June, 2003 to 2007

			Places/packages per 1,000 persons	
		Number of places/ packages	Aged 70 years or over	Aged 65 years or over with profound or severe limitation
2003	Community Aged Care Packages	27,881	15.3	48.9
	Extended Aged Care at Home places	255	0.1	0.4
	Residential aged care places	151,181	82.8	265.4
	Total	**179,317**	**98.2**	**314.8**
2004	Community Aged Care Packages	29,063	15.6	49.6
	Extended Aged Care at Home places	858	0.5	1.5
	Residential aged care places	156,580	84.2	267.1
	Total	**186,501**	**100.3**	**318.2**
2005	Community Aged Care Packages	30,973	16.3	51.7
	Extended Aged Care at Home places	1,673	0.9	2.8
	Residential aged care places	161,765	85.3	269.9
	Total	**194,411**	**102.5**	**324.4**
2006	Community Aged Care Packages	35,383	18.2	57.6
	Extended Aged Care at Home places	2,580	1.3	4.2
	Extended Aged Care at Home Dementia places	601	0.3	1.0
	Residential aged care places	166,291	85.6	270.7
	Transition Care places	595	0.3	1.0
	Total	**205,450**	**105.8**	**333.4**
2007[a]	Community Aged Care Packages	37,747	n.a.	n.a.
	Extended Aged Care at Home places	3,302	n.a.	n.a.
	Extended Aged Care at Home Dementia places	1,267	n.a.	n.a.
	Residential aged care places	169,594	n.a.	n.a.
	Transition Care places[b]	1,594	n.a.	n.a.
	Total	**213,504**	n.a.	n.a.

(a) Figures for 2007 supplied by DoHA are provisional as at July.

(b) May be provided in either a home-like residential setting or in the community.

Notes

1. Population estimates by disability status are obtained using age–sex disability rates from the ABS 2003 Survey of Disability, Ageing and Carers in conjunction with the estimated resident population. The estimates assume constant disability rates over time within age–sex categories.
2. Places for residential aged care and Community Aged Care Packages include those provides by Multi-purpose Services and places funded under the Aboriginal and Torres Strait Islander Aged Care Strategy.

Sources: ABS 2006d; AIHW 2007b:4; AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers; DoHA unpublished data.

Accessing and using aged care services

In the ABS General Social Survey respondents of all ages report on their experiences in accessing service providers—this covered providers in the government, private and non-profit service sectors and was not limited to aged care providers (ABS 2007d:Table 36). An estimated 75% of the adult population reported no problems with access. People aged 85 years or over were somewhat more likely (32%) to report problems than all adults (25%), or people aged 65–74 years (20%) or 75–84 years (23%). For all adults, inadequate services in the area of residence was the most common problem (10%) but relatively fewer people in the older age groups (4%–8%) reported this type of problem. More commonly, older people reported transport and distance as the main difficulty in accessing service providers, particularly people aged 85 years or over, 16% of whom were affected in this way. The very old were also more likely (13%) to report disability as restricting access to services than any other age group (under 2% of all persons reported disability as an access barrier). (Caution should be used with this estimate for the very old as the small sample size affects its reliability.)

In the 5 years to 2006, use of established aged care programs—care packages (CACP and EACH) and residential aged care—by the older population increased by around 7% (Table 3.20). Use of care packages increased in each age group, for both men and women, and by 48% when averaged over the total older population. Over a shorter period of time (2001–02 to 2004–05) usage rates of HACC also increased for each age group (see Table 3.14; AIHW 2003, 2005), although this partly reflects increased reporting by agencies of data for the MDS in the earlier years. Age-specific HACC usage rates between 2003–04 and 2004–05 have declined for the 85 or over age group (from 481.1 per 1,000 people to 477.7) while showing a small increase per 1,000 people aged 65–74 years (from 102.2 to 103.1).

Higher rates of use of care packages in each age group 65–74 years, 75–84 years and 85 years or over occurred in parallel with decreased rates of use of residential aged care in those age groups. Particularly in the oldest age group, 85 years or over, where greater use is made of residential aged care, strong growth in the use of care packages has coincided with a period of declining rates of use of residential aged care.

Although age-specific rates of use of residential aged care decreased over the 5 years to 2006 for both men and women, usage averaged over the entire older population suggests modest overall growth of 1% (Table 3.20). These seemingly contradictory results arise from the changing age structure of the older population. By 2006, a higher proportion of people fell into the older age group, 85 years or over, than in 2001. This age group records much higher use of residential care, which effects an overall increase in usage for the 65 years or over population even though age-specific rates of use of residential aged care places fell over the period. This phenomenon illustrates the importance of looking more deeply into usage patterns when the underlying age structure is changing. A simple total population usage rate may not provide a reliable picture of whether provision of services is keeping pace with population growth and changing age composition.

The above results indicate access to different types of aged care services (packages and residential places) but do not provide a measure of the adequacy of assistance, relative to need, provided by those services.

However, they highlight one of the issues associated with planning aged care provision: what is the appropriate population to use in planning both the amount and distribution of aged care places and packages? Current planning processes are based on changes in the size of the population aged 70 years or over. However, as this chapter illustrates,

age is a weaker predictor of residential aged care use than disability (and particularly severe or profound limitation). Over two-thirds (70%) of the older population with severe or profound limitations in all three core activity areas are in aged care accommodation, and they account for 61% of the aged care accommodation population (Section 3.2). Against that, only 24% of the population aged 85 years or over use residential aged care (Table 3.20) although they account for 53% of permanent residents (Table 3.13).

Table 3.20: Age-specific usage rates of community/flexible care packages and residential aged care, 30 June 2001, 2004, 2006 (per 1,000 population)

	Males				Females				Persons			
	65–74	75–84	85 or over	65 or over	65–74	75–84	85 or over	65 or over	65–74	75–84	85 or over	65 or over
CACP and EACH												
2001	1.8	6.8	24.6	*5.2*	3.1	12.8	29.9	*10.3*	2.5	10.3	28.2	*8.0*
2004	2.3	8.1	28.3	*6.4*	4.1	16.2	37.2	*13.2*	3.2	12.7	34.3	*10.1*
2006	2.7	9.6	29.7	*7.5*	4.4	18.7	41.9	*15.3*	3.6	14.7	37.9	*11.8*
5-year growth (per cent)	50.0	41.2	20.7	*44.2*	41.9	46.1	40.1	*48.5*	44.0	42.7	34.4	*47.5*
Residential aged care												
2001	10.0	41.0	165.8	*32.1*	11.0	68.0	299.0	*70.6*	10.5	56.7	257.9	*53.6*
2004	9.4	41.0	162.2	*32.6*	10.1	67.6	297.7	*71.7*	9.8	56.2	254.8	*54.2*
2006	9.2	40.5	152.8	*32.9*	9.6	66.2	284.0	*71.7*	9.4	54.9	240.9	*54.2*
5-year growth (per cent)	–8.0	–1.2	–7.8	*2.5*	–12.7	–2.6	–5.0	*1.6*	–10.5	–3.2	–6.6	*1.1*
Total												
2001	11.8	47.8	190.4	*37.3*	14.1	80.8	328.9	*80.9*	13.0	67.0	286.1	*61.6*
2004	11.7	49.1	190.5	*39.0*	14.2	83.8	334.9	*84.9*	13.0	68.9	289.1	*64.3*
2006	11.9	50.1	182.5	*40.4*	14.0	84.9	325.9	*87.0*	13.0	69.6	278.8	*66.0*
5-year growth (per cent)	0.8	4.8	–4.1	*8.3*	–0.7	5.1	–0.9	*7.5*	0.0	3.9	–2.6	*7.1*

Notes

1. EACH includes EACH Dementia.
2. Table excludes Transition Care clients.

Sources: ABS 2006d; AIHW analysis of DoHA ACCMIS database.

Standards and quality of care

The last 2 years have seen a continued focus on improving quality of care in government-funded aged care homes. The Aged Care Standards and Accreditation Agency assesses homes against standards in four areas: management systems, staffing and organisational development; health and personal care; resident lifestyle; and physical environment and safe systems. At 30 June 2006, 93% of homes were accredited for at least 3 years and over 96% of homes were compliant with all 44 Accreditation Standards Outcomes (DoHA 2006b).

All residential aged care services were required to meet the requirements of the 1999 Certification Instrument for building standards by 31 December 2005. The fire and safety requirements were met by 88% of services at 30 June 2006; the 12% of services that were non-compliant are being closely monitored.

In addition, space and privacy targets for aged care homes will apply from 31 December 2008:

- for services that existed before July 1999, there should be no more than four residents accommodated in any room, no more than six residents sharing each toilet and no more than seven residents sharing each shower
- for new buildings constructed since July 1999, there is to be an average for the whole residential aged care service of no more than 1.5 residents per room, no room may accommodate more than two residents, and there is a mandatory standard of no more than three residents per toilet, including those off common areas, and no more than four residents sharing shower or bath.

As at 30 June 2006, 95% of services met the above targets (DoHA 2006b).

New measures have been introduced to address sexual abuse and serious physical assault in aged care homes. From 2007 background checks by police will be conducted on all aged care workers. The Aged Care Complaints Resolution Scheme has been replaced by the new Office for Aged Care Quality and Compliance in a move to strengthen the system for receiving and handling consumer complaints, among other quality issues. The Aged Care Standards and Accreditation Agency received additional funding in the 2004–05 Budget to increase the number of inspections of aged care homes and ensure that all homes are visited annually. In 2005–06 the Agency and the Department of Health and Ageing conducted 5,495 visits (the Agency undertook an average of 1.7 visits per home). From 2006–07 all homes will receive at least one unannounced visit each year.

In community care, the 2004–05 Budget provided funding for Quality Reporting in Community Care, which began on 1 July 2005. This program applies to CACP, EACH and the NRCP, and aims to ensure that clients receive the levels of care they need, and to improve measurement and reporting of the programs' operation (DoHA 2006b).

HACC services are subject to appraisal using the HACC National Service Standards Instrument, which includes a Consumer Survey Instrument. In the first evaluation cycle from July 2001 to June 2004, 2,709 out of 3,335 HACC agencies were appraised. A new cycle began in 2006.

Participation outcomes

A main objective of aged care—both informal and formal care—is to enable an older person to participate in domestic and community life. Participation is a multi-faceted concept, being highly individual and related to many factors including age, health conditions, functional limitations, social support and cultural and personal preference. Participation in activities varies from one person to the next, and extent of participation may be a poor indicator of social opportunity as it encompasses personal choice as well as access to the supports that enable participation, for example, transport, companionship and physical support. Levels of satisfaction with participation, as reported by older people, give more useful insight into whether older people believe they have adequate opportunity to participate in community life.

In 2003, around 80% of older people living in private dwellings reported they were able to go out as often as they liked. However, levels of satisfaction show strong association with disability status (Table 3.21). Fewer than half (47%) of older people with profound or severe limitation, living in private dwellings, were able to go out as often as they liked, regardless of their living arrangements. This compares with 86% of older people without profound or severe limitation.

Among the very old an interesting interaction between disability status and living arrangement is apparent. As might be expected, people 85 years or over with profound or severe limitation were somewhat more likely to go out as often as they liked if they lived with other people (53%) than if they lived alone (47%). For those without profound or severe limitation, the opposite is true: 88% who lived alone could go out as often as they liked, compared with only 70% who did not live alone.

Table 3.21: Older people living in private dwellings, whether can go out as often as would like, by level of core activity limitation, age and living arrangement, 2003 (per cent)

	Without profound or severe limitation				With profound or severe limitation			
Living arrangement	**65–74**	**75–84**	**85 or over**	**Total**	**65–74**	**75–84**	**85 or over**	**Total**
Lives alone								
Can go out as often as would like	86.5	85.4	87.6	86.2	*33.7	53.7	46.5	47.0
Cannot go out as often as would like	13.5	14.6	*12.4	13.8	66.3	46.3	53.5	53.0
Total (per cent)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**249,200**	**202,800**	**61,100**	**513,100**	**22,700**	**47,000**	**32,200**	**101,900**
Lives with others								
Can go out as often as would like	88.3	83.9	69.6	86.4	45.1	45.7	52.6	46.4
Cannot go out as often as would like	11.7	16.1	30.4	13.6	54.9	54.3	47.4	53.6
Total (per cent)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**883,000**	**397,400**	**41,100**	**1,321,600**	**114,200**	**109,400**	**36,100**	**259,700**
All living arrangements								
Can go out as often as would like	87.9	84.4	80.4	86.4	43.2	48.1	49.8	46.6
Cannot go out as often as would like	12.1	15.6	19.6	13.6	56.8	51.9	50.2	53.4
Total (per cent)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**1,132,200**	**600,300**	**102,200**	**1,834,700**	**136,900**	**156,400**	**68,300**	**361,600**

Note: Table excludes 22,600 people who did not leave home at all.

Source: AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers confidentialised unit record file (see ABS 2004b for comparable data on all people with disability).

The reason given most often for not being able to go out was 'own disability or health/physical condition'. Of older people with a profound or severe limitation, 71% reported this as the main barrier to leaving home, compared with 26% of people without profound or severe limitation. Other reasons given by people without profound or severe limitation included another person's disability or condition (17%), could not be bothered or nowhere to go (14%), and cost/affordability (13%) (AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers Confidentialised Unit Record File).

Lack of companionship and 'other reasons' as main barriers to going out were reported more often by people living alone who experience profound or severe limitation compared with other groups; few in this group reported another person's disability or condition as a main barrier to going out. In the absence of profound or severe limitation, people not living alone who said they could not go out as often as they wished most often attributed this

to their own disability or health condition (moderate or mild core activity limitation, or long-term health condition but no core activity limitation) or another person's disability. The last-mentioned reason points to possible effects arising from the responsibilities and relationships associated with a caregiver role.

The data highlight two important points. First, many older people with high levels of activity limitation want to be able to leave home and participate in community, yet feel disabled by their functional capacity. Verbrugge and Jette (1994) define 'social disadvantage' as the 'placement of impediments in the path of limited/disabled people so they cannot do the things they want and are able to do' and caution that 'feedback loops' are a common feature of the disablement process for frail people and people with long-term disability. Second, activity limitation is not the only cause of social disablement—psychosocial factors and service issues (for example access to transport or respite care) are implicated, again suggesting the importance of addressing social participation needs in order to maintain and perhaps enhance individual functioning.

Unmet need for assistance

Information collected by the ABS Survey of Disability, Ageing and Carers on unmet need for formal and informal assistance in the older population covers 10 broad areas of activity: self-care, mobility, oral communication, cognitive or emotional tasks, health care, household chores, meals preparation, property maintenance, private transport and paperwork. Mobility and transport have previously been reported as particular areas of unmet need among older people (AIHW 2005). Table 3.22 gives a breakdown of reported unmet need by broad area of activity and whether more assistance is desired from formal or informal providers.

Older people who report unmet need for assistance divide into two broad groups according to type of unmet need. Nearly all of those who report unmet need for assistance in core activities are people with profound or severe limitation. On the other hand, those who report unmet need in other activities, such as transport, household chores or home maintenance, are a mix of people with core activity limitation and others who have a disability without core activity limitation. The distinction of need for assistance in core activities (self-care, mobility, communication) versus other activities reflects people at different stages of the disablement process: some with advanced care needs and others whose care needs are just beginning to show or whose reduced ability to move about in the community and perform domestic tasks is a short-term or transient need (for a more theoretical discussion of disablement see Verbrugge & Jette 1994).

Most notable in the reports of unmet need in 2003 were 102,000 community-dwelling older people with unmet need for formal assistance with property maintenance (Table 3.22). The most common main reason for not using more formal assistance for property maintenance was cost (40,000 people), followed by pride (19,000), not knowing about services (16,000) or considering the need as not important enough to ask for help (16,000). A related area of unmet need for formal assistance is household chores, reported by 61,000 people.

Transport is a critical area of assistance for supporting independence, community engagement and access to services. Around 46,000 older people reported unmet need for formal transport services, for example for shopping, social outings and getting to medical appointments. While access to a motor vehicle to drive is high for the population overall—86% of Australian adults have access to one or more registered motor vehicles—only 68% of people aged 75–84 years, and 32% of people aged 85 years or over in 2006 had access to

a private vehicle to drive (see Chapter 8). Vehicle ownership is just one consideration for the older person: health status, particularly visual acuity, licensing, road design and traffic volume are all relevant to the older person's ability to meet their own transport needs. Stopping driving becomes necessary for some older people for their and others' safety. It does, however, have major emotional and practical consequences, including being linked with social isolation and depression in older persons (NSWCOA 2000).

One practical implication of a lack of private transport or suitable public/community transport is a reduced ability to shop, which can reduce role satisfaction and sense of competency, ultimately leading to functional loss. For example, in losing the ability to shop, a person may cease to prepare meals. Over time they lose food preparation skills, become reliant on others for meals assistance, experiencing reduced activity and life satisfaction as a result. Particularly in rural areas, the impact of losing access to a car is stark: distances to needed destinations are great and getting to them is unlikely to be possible by other means (NSWCOA 2000). The decision to make a sea or tree change in early retirement is often predicated on private car use, which remains relatively high (75%) up to around age 75 years. When that is no longer possible, life for the older person who lives a distance from services can become very difficult. As more people retire to regional areas and age into the older age groups at those locations, pressure on regional transport systems is likely to increase.

People with unmet need for community services may need to relocate because of anxiety about home upkeep, physical risks associated with poorly maintained dwellings and grounds, and/or limited capacity to get about in the community. Data from the Survey of Disability, Ageing and Carers suggest that these needs may arise relatively early in the development of functional limitation at older ages (that is, in connection with mild or moderate, as distinct from profound or severe, limitation) but if they remain unmet or are not addressed in some way they can have long-lasting and serious effects. Intervention and support for older people with less severe limitations can enhance independence, reduce individuals' perception of disability, and thus remove some of the 'push factors' that cause a loss of confidence in being able to live in the community.

Table 3.22: Household population aged 65 years or over with disability[(a)], need for more formal or informal assistance by broad area of activity, 2003 (per cent)

Broad area of activity	Need more formal assistance	Need more informal assistance	Total people with need for assistance in activity (number)
Property maintenance	17.7	9.6	576,600
Health care	7.2	2.9	473,200
Private transport	10.3	6.1	445,500
Household chores	13.9	6.1	437,300
Mobility (core activity)	10.2	7.2	339,800
Self-care (core activity)	5.5	4.6	207,900
Paperwork	4.8	1.7	167,300
Meal preparation	7.7	2.3	166,400
Cognitive or emotional tasks	14.9	8.7	143,800
Oral communication (core activity)	8.5	3.7	37,000

(a) Total people with need for health care includes older people without disability who have a long-term health condition.

Source: AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers confidentialised unit record file.

3.11 Aged care expenditure

The Australian Government is the largest source of funding for the aged care system primarily because of its responsibility for residential aged care. It also provides funding for a range of other aged care programs including CACP, EACH, ACAP, Multi-purpose Services and flexible care, the HACC program, Veterans' Home Care, the NRCP and the Transition Care Program. The HACC program, Transition Care Program and ACAPs are cost-shared with state and territory governments. State and territory governments also provide some funding for other areas of aged care, including residential and assessment services. Governments are not the only source of funding in the aged care system. Users of programs meet part of the costs, and non-government community service organisations contribute funds to some services (see Chapter 7). In addition, the sector receives services from volunteers.

Government expenditure on aged care

Aged care expenditure is spread across both health and welfare services. When classifying expenditure to either health or welfare, expenditure on high care clients in residential aged care services is generally included in health while expenditure on low level residential care and community–based programs is allocated to welfare. This discussion of aged care expenditure includes expenditure on low level residential care and community-based programs as well as on high level residential care. For this reason, the figures presented here differ from those in Chapter 7 for expenditure on older people. The data presented here do not capture all sources of aged care expenditure. In particular, expenditure by local government and non-government organisations is not included. Government concessions (such as concessional land and water rates) and welfare-related social expenditures (for example, the Age Pension) that can be accessed by older people are discussed in Chapter 7.

Total Australian Government, state and territory recurrent government expenditure on aged care services increased from $7,715 million in 2003–04 to $8,580 million in 2005–06 (see Table A3.20). The largest area of expenditure was in residential aged care ($5,608 million), representing 65% of total expenditure in 2005–06 compared with 69% in 2003–04. The overwhelming majority of these funds—99%—was spent on residential care subsidies. Recurrent expenditure on residential care subsidies increased by 32% between 2001–02 and 2005–06.

Expenditure on older people in the HACC program was the second largest area of expenditure. Overall $1.4 billion in capital and recurrent funding was provided for HACC in 2005–06. Of this an estimated $1,069 million was used to deliver services to people aged 65 years or over. In 2005–06, HACC accounted for 12% of recurrent expenditure on aged care, a similar proportion to that observed for the previous 2 years and slightly down from the 13% observed for the few years before that. This decline reflects the relatively greater increases in expenditure on other programs rather than a decrease in expenditure on HACC (HACC funding has been growing in real terms for a number of years).

In 2005–06 expenditure on CACP packages amounted to $357 million. EACH packages continue to grow and in 2005–06 EACH Dementia packages became available, with resulting expenditure in 2005–06 for both programs amounting to $67 million. CACP, EACH and EACH Dementia packages accounted for 5% of government expenditure on aged care services.

This volume reports on expenditure on a number of programs supporting carers, including Carer Allowance and Carer Payment. The proportion of these payments attributed to aged care has been based on the proportion of care recipients aged 65 years or over who are cared for by a Carer Allowance recipient. The inclusion of other carer support programs results in significantly higher expenditure being reported than in previous volumes ($912 million in 2005–06, over 10% of aged care expenditure).

Program expenditure from year to year as expressed in constant prices shows whether there has been growth in expenditure after allowing for inflation. In real terms, total government expenditure on aged care services increased by 22% over the 5 years examined, from $7,024 million in 2001–02 to $8,580 million in 2005–06 (expressed in 2005–06 dollars, Table 3.23).

Expenditure in real terms on HACC services provided to people aged 65 years or over increased by 17% over this period. If the expenditures on HACC and Veterans' Home Care, which provide similar home–based services, are combined, then the rise was 20%. Expenditure in real terms on other community support programs (CACP, EACH, EACH Dementia and NRCP) grew strongly. Combined expenditure on these programs grew by 50% over this period, although from a relatively small base. Overall expenditure on the largest program, residential aged care, rose 19% in the period 2001–02 to 2003–04. However, expenditure in real terms on residential aged care has declined between 2003–04 and 2005–06, reflecting the reduction in real expenditure on residential aged care subsidies.

The segment of the population most likely to be in need of assistance from aged care programs in general is people aged 65 years or over with profound or severe limitation. In 2001–02, total aged care expenditure in real terms broadly equated to $12,671 for every person aged 65 or over with profound or severe limitation (in 2005–06 prices). By 2005–06, this figure rose by 9% to reach $13,760. Most of this growth took place between 2002–03 and 2003–04. Since 2003–04 real expenditure per person aged 65 or over with profound or severe limitation has declined, reflecting the reduction in real per capita expenditure on residential aged care subsidies. Growth in expenditure calculated in these terms varied from year to year and across programs. For example, areas of major increase such as EACH (460% growth over this period) are growing from a very small base. Real expenditure on NRCP in relation to this population increased by 40% between 2001–02 and 2003–04 but declined by 4% between 2003–04 and 2004–05.

User contributions to the cost of aged care

Users of many aged care services pay a contribution towards the provision of the service, subject to government-set limits on fees chargeable by providers of residential and community care. Clients of the HACC program, Veterans' Home Care, CACP and EACH may all be required to make a copayment for certain services. If such a contribution causes financial difficulty for the user, providers are usually required to reduce or waive charges.

Care fees payable by people in residential aged care depend on both the person's resident status and pensioner status. For all respite residents and pensioner permanent residents (both full and part-pension recipients), the maximum basic daily care fee is set at 85% of the Age Pension ($30.77 at 1 March 2007). Non-pensioner permanent residents can be charged a higher basic daily care fee—up to $38.35 as at 20 March 2007 (DoHA 2007b).

Table 3.23: Recurrent government expenditure on aged care programs, 2001–02 to 2005–06[a]

Program	2001–02	2002–03	2003–04	2004–05	2005–06	2005–06
	Constant 2005–06 prices					Current prices
Residential aged care—subsidies	4,897.3	5,047.4	5,823.9	5640.4	5,565.8	5,565.8
Residential aged care—resident and provider support	11.0	17.4	22.3	41.7	42.2	42.2
Community Aged Care Packages	285.2	322.4	336.5	343.2	356.6	356.6
Home and Community Care	910.8	955.2	1,002.3	1,031.3	1,069.3	1,069.3
Veterans' Home Care and DVA in-home respite	71.7	104.7	99.6	105.1	112.4	112.4
Other veterans' aged care programs	45.3	39.1	45.5	33.5	25.0	25.0
Extended Aged Care at Home	10.3	11.8	16.9	34.9	65.3	65.3
Extended Aged Care at Home Dementia	. .	. .	. .	. .	1.2	1.2
Transition Care	. .	. .	. .	. .	3.3	3.3
Day Therapy Centres	33.9	34.7	34.5	34.0	33.3	33.3
Multi-purpose and flexible services	46.7	57.6	66.3	70.4	85.4	85.4
National Respite for Carers	79.4	105.2	110.9	106.2	140.8	140.8
Support for Carers[b]	522.7	586.9	749.7	824.6	912.3	912.3
Assessment	47.5	48.0	52.9	55.5	55.6	55.6
Commonwealth Carelink Centres	13.3	13.5	15.2	14.6	16.4	16.4
Accreditation	14.5	13.3	7.1	18.0	9.6	9.6
Flexible care pilot projects	. .	5.2	19.2	26.3	21.7	21.7
Other	34.1	31.0	29.1	47.3	64.5	64.5
Total	**7,023.7**	**7,393.4**	**8,431.9**	**8,427.0**	**8,580.4**	**8,580.4**
Amount per person aged 65 or over with profound or severe limitation (dollars)	**12,671**	**12,980**	**14,418**	**13,948**	**13,760**	**13,760**
GFCE deflator	86.3	89.3	91.5	95.5	100.0	. .

(a) Expenditure excludes departmental program administration and running costs. State and territory funding for high-level residential aged care subsidies and HACC only have been included.

(b) Includes Carer Allowance, Carer Payments, Assistance for Carers and the price of departmental outputs for the proportion of care recipients aged 65 years or over among those cared for by people receiving Carer Allowance.

Notes

1. See notes to Appendix Table A3.20 for information on expenditure derivation and comparability with previous volumes. Constant dollar values were calculated using the GFCE deflator referenced to 2005–06.
2. Components may not add to total due to rounding.

Sources: Tables A3.20, A3.21.

In addition to basic daily care fees, permanent residents who receive a part-pension or do not receive a pension at all, and who are on higher incomes may be required to pay additional income-tested care fees (reviewed quarterly). Currently, income-tested fees are capped at 25 cents for every additional dollar of income over the relevant pension income test free area, and cannot exceed 3 times the daily standard pensioner rate or the cost of care, whichever is the lower (DoHA 2001:Section 7.3.4.1). As at 20 March 2007, the maximum daily income-tested fee payable by part-pension recipients and non-pensioners was $53.96. In 2004–05, basic daily care fees yielded $1,555.7 million in user contributions, and income-tested fees amounted to $157.7 million. Basic daily care fees raised $1,665.9 million in 2005–06, while the income-tested fees totalled $183.6 million (information supplied by the Australian Government Department of Health and Ageing). These user contributions were in addition to the $5,565.8 million spent in 2005–06 on residential aged care subsidies by the Australian, state and territory governments (Table A3.20). Basic daily care fees and income-tested fees paid by residents accounted for 25% of the total $7,430.1 million spent on care in residential aged care services in 2005–06, compared with 22% in 2003–04 (AIHW 2005).

In addition to the basic and income-tested care fees, people entering permanent residential aged care may contract, on entry, to make accommodation payments to contribute to the cost of their accommodation. These payments are assets-tested, and can only be charged to people who have assets exceeding a prescribed minimum level and who entered into an accommodation payment agreement on entry into their current permanent care. Payments may be in the form of either an accommodation bond or an accommodation charge. An accommodation bond is an amount payable by people who enter residential care at low level care, and by those who receive care on an extra service basis (with either high or low level care needs). An accommodation charge is an additional daily amount which is payable by people who enter permanent residential care at a high level of care; it is payable for up to 5 years.

The amount of the accommodation bond or charge is agreed by the resident and the aged care provider, and may vary widely between residents, both within a residential aged care service and between services. The Australian Government does not dictate the amount of bonds for residents at different assets levels, but provides a number of legislative protections, including the requirement that residents be left with a minimum level of assets after payment of the accommodation bond; as at 1 January 2007 this minimum was set at $32,000. Other than meeting the minimum assets requirement, there is no upper limit for an accommodation bond. Unlike accommodation bonds, maximum daily accommodation charges are set by the Australian Government, with annual indexation. However, the daily rate for existing residents does not change when these indexations occur. For 2006–07, the maximum daily accommodation charge for new residents was $17.13 (DoHA 2007b). In addition, residents may choose to pay for extra services not funded through care fees.

In 2005–06 an estimated $278.0 million in income to residential aged care providers was raised through accommodation charges paid by residents ($278.3 million in 2004–05). The value of accommodation bonds held by providers at the end of the 2005–06 financial year was estimated at $5,333.6 million ($4,270.3 million at the end of financial year 2004–05) (estimates supplied by the Australian Government Department of Health and Ageing).

3.12 Summary

This chapter focuses on older Australians—their living arrangements, participation in the workforce and social activities, care needs and the provision of care—and the interaction of social and economic policy in this context. Over the last 10 years population ageing has attracted considerable policy and research attention that focused on the economic and fiscal implications of a population with a larger number and proportion of older people. The development of the National Strategy for an Ageing Australia ensured that the policy and research agenda also included concerns with quality of life for older people and harmony between generations.

Ageing in Australia

On 30 June 2006, an estimated 2.7 million Australians were aged 65 years or over, accounting for 13% of the Australian population compared with 12% in 1996. It is the population aged 85 years or over, however, which has grown most rapidly, reaching 322,000 people in 2006, and projected to grow to about 576,000 by 2021. It is growth in the very old population, along with their health status and disability rates, that will be a major influence on government spending on health and aged care in the future.

People aged 65 years or over make up just 3% of the Indigenous population while Indigenous people aged 50 years or over account for 11% (55,000 people). Overseas-born older people account for 35% of all people aged 65 years or over, with those born in non-English-speaking countries making up 21% of the older population. Italy and Greece are the major countries of birth for older immigrants, but all birthplace countries of origin are represented. This considerable diversity among the older population poses policy and service provision challenges for the delivery of culturally appropriate and sensitive services including in locations and for population subgroups with relatively small numbers.

Living arrangements and social participation

The large majority of older people (94%) live in private dwellings, but the use of cared accommodation (including aged care homes) increases with age. Only around 5% of older people live in cared accommodation but this is the situation for 31% of those aged 85 years or over. Of significance to policy considerations is the proportion of older people living alone (29%). This proportion also rises with age, reflecting loss of spouses and partners—around 39% of those aged 85 years or over live alone.

Quite apart from functional limitation, the loss of personal relationships that commonly occurs in old age can have negative consequences for social participation. At very old ages people are also participating to a lesser extent than younger people in group activities, are less likely to have private transport, and find it harder to engage in community activities because of this. A recent Australian study which looked at the prevalence and correlates of loneliness in older people reported findings consistent with research from other countries: that being widowed, living alone and poor self-rated health are predictors of loneliness in older people (Steed et al. 2007). Moreover, the study established a strong relationship between amount of time spent alone and loneliness.

Psychosocial needs continue to be a factor prompting some older people to seek admission to aged care homes, especially at lower levels of care. The need for social interaction and participation experienced by some older people living alone also points to the importance of community-based services and informal care that provide social support, transport and companionship. There is therefore a continuing issue of building system capacity for

addressing the spectrum of care needs of people, including social support needs as well as physical support needs, while still targeting services on the basis of need.

Over half of all people aged 65 years or over experience some type of disability and more than one in five (23%) have a profound or severe limitation. Profound or severe limitation is also strongly age-related, affecting 12% of 65–74 year olds and increasing to 58% of those aged 85 years or over. About 70% of those with profound or severe limitation live in aged care accommodation. The most common core activity limitation experienced by older people living in households is mobility limitation with or without a self-care limitation. Disability prevention through such means as the management of chronic health conditions, injury prevention, age-friendly housing, the use of assistive technology, occupational therapy and activity programs for older people will reduce demand on aged care services by enabling people to live as independently and actively for as long as possible. Strategies that reduce mobility limitation in older people and forestall the development of self-care limitation as a direct result of mobility limitation are critical to supporting frail older people in the community.

Work and retirement

Labour force participation of mature-age-people is a major focus of policy initiatives that aim to ensure future economic growth. Participation in the workforce by the age group 45–64 years increased by 6.2 percentage points over the decade 1996–2006, largely due to rising participation by mature-age-women. However, there remains considerable room for growth if older workers are willing to prolong their working lives. Female labour force participation rates drop sharply between the age groups 45–54 years (76.7%, as at December 2006) and 55–59 years (59.3%), and male labour force participation shows a similar level of decline between the age groups 55–59 years (76.1%) and 60–64 years (55.8%). At the end of 2006, only 13.8% of men and 4.5% of women aged 65 years or over were employed or looking for work.

These days, retirement from work is less often the sudden and complete withdrawal from full-time employment experienced by earlier generations of retirees; flexible workplace arrangements that enable mature-age-workers to achieve their mid-life lifestyle aspirations and, for an increasing number, to balance work and family commitments, will be critical in encouraging people to delay full retirement. Notwithstanding the importance of labour supply to the national economy, due recognition should be given to the other ways that retired people contribute both economically and socially, for example, by providing child care assistance to younger working family members, through volunteer work, and by assisting young and older family members with illness or disability.

Support and care for older people

Three-quarters of the population who had reached the qualifying age for the Age Pension received the Age Pension or similar income support payment from the DVA in 2006. Of the 1.9 million people receiving the Age Pension, 38% received a part-pension. By 2050 it is expected that two-thirds of pensioners will receive a reduced government pension owing to rising superannuation coverage and, potentially, future higher workforce participation rates.

More frail older people receive assistance from informal providers than from any single government-funded aged care program. Spouses and adult children, mostly daughters, made up equal proportions of all primary carers of older people (43%). Income support for carers (Carer Payment) was received by 39,500 carers of older people, and 5% of Carer

Payment recipients were over the age of 65 years. A larger group of older people were eligible for Carer Allowance (96,200) and 145,900 people who cared for an older person received Carer Allowance.

Formal service provision to high care clients in the community is often predicated on parallel provision of informal care. Among the household population aged 65–74 years, 75–84 years and 85 years or over with profound or severe limitation, 890, 810 and 850 per 1,000 persons respectively have informal providers of assistance (carers). In the two younger groups, it is more often the case that a carer lives with the person who needs care, reflecting a large element of spousal care in these age groups. Very old people with profound or severe limitation who receive informal care are more likely than not to have a non-resident carer. When considering the wider population of older people with disability (not limiting disability to core activity limitation), it can be seen that relatively larger numbers of people in the two age groups 75–84 years and 85 years or over have non-resident carers. High care in the community relies heavily on support for carers, and with increasing numbers of very old people needing high care, carer support will increasingly need to cater for the needs of both older and younger, possibly employed, family carers.

Aged care services

The use of aged care places by older people, including care packages (CACP and EACH) and residential aged care places, increased by approximately 7% in the 5 years to 2006, driven by substantially increased use of care packages (48% growth in usage overall). More people in each age group 65–74 years, 75–84 years and 85 years or over make use of residential aged care places (accounting for 9, 55 and 241 residents per 1,000 persons respectively in 2006) than care packages (4, 15, and 38 recipients per 1,000 persons respectively). Nevertheless, the use of care packages increased between 2001 and 2006 across the three age groups, while corresponding rates of use of residential aged care fell. Even in the oldest age group, 85 years or over, the use of care packages rose by 34% over the period, while use of residential care fell by 7%. There are thus two established and related trends: increasing numbers of older people who need daily living assistance and increased use of community care packages.

HACC remains the largest program for the provision of aged care, in terms of number of clients, and plays a central role in preventive care by delivering a comprehensive range of support services that include nursing and allied health care. In 2004–05 over 560,000 older people received HACC-funded assistance. Use of HACC within the older population increased from 181 clients per 1,000 people in 2001–02 to 211 clients per 1,000 in 2004–05. The arrangements by which people access HACC services are therefore critical to ensuring timely service provision for people with aged care needs.

Multiple program use is common among people referred for ACAT assessment. Over 50% of older ACAT clients with a recommendation to live in the community had been receiving care services funded by more than one program before assessment and 78% were recommended for more than one program as a result of ACAT assessment. If a person has access to a service provider with funding from multiple programs, the fact that assistance is delivered through multiple programs can be virtually invisible to the consumer. In other situations, such as where a person has multiple service providers in order to access different types of assistance, there may be a lack of overall service coordination, placing greater demands on consumers and family carers. Receipt of assistance via multiple programs, as recommended by an ACAT, would depend on where a person is located in relation to allocations made through submission-based funding.

There is an unanswered question about whether ACAT clients with high or complex needs who are recommended for support from multiple programs go on to receive multiple program support, whether the arrangements are satisfactory, and whether outcomes compare favourably with those of clients using coordinated packages of care. Measures announced as part of the Securing the Future of Aged Care for Australians package will benefit people with high care needs living in the community, and their carers. Increased provision of community care packages (CACP, EACH and EACH Dementia) will mean that more people have access to assistance in the form of individually tailored packages and case management. Perhaps even more significantly, for the first time a separate provision ratio has been created for high level community care.

An established trend of rising age at admission in aged care programs is associated with increasing longevity and changing health profiles of the older population that has been occurring for some years. Disability is the main driver of the need for care, and disability is strongly age-related. In 2005–06, over 70% of new admissions to permanent residential aged care were people aged 80 years or over, up from 64% in 1998–99. Around 40% of CACP clients are aged 85 years or over, and 82% of people starting on a package in 2005–06 were aged 75 years or over. As the ageing of the baby-boomer generation brings increasing numbers of more healthy younger old, it is essential that analyses of older people' needs and outcomes distinguish the well old from their age counterparts with higher levels of activity limitation.

This chapter explores the limited data that are available to touch on the issue of whether older people feel supported in terms of daily living assistance and opportunity for community participation. This is an important question, since perceived unmet need is predictive of higher levels of disability and increased use of institutional care. More importantly, it goes to the issue of quality of life and whether older people are regarded and regard themselves as valued members of society. Projections of future costs of aged care and associated policy analysis frequently assume that current and historical patterns of aged care provision will continue in the future. This could be taken to imply that such provision adequately meets the needs of older people. There are only limited data available to explore the question of aged care outcomes, and most of these are at a system level. Measures of consumer satisfaction with aged care services are few and far between, and aggregate reporting of individual outcomes is poor by comparison with some other areas of social service.

Understanding the needs of older people

The key to improved support for older people lies in a more complete understanding of their service needs and experiences. Concerted research efforts are being undertaken in this area, for example, through the Ageing Well, Ageing Productively Grants and the Dementia Initiative. Research findings that are directly relevant to the health and care of older people promise benefits to service systems and consumers. Other efforts related to service delivery frameworks, including work under A New Strategy for Community Care—The Way Forward, are aiming to deliver improved information on aged care clients and the services they receive. Consistency of data and reporting across programs and systems is needed, as is a greater capacity to integrate program data with population data such as the Census and the Survey of Disability, Ageing and Carers. In addition, there is scope for improved reporting of client outcomes in the form of direct feedback from consumers across the range of programs about whether services meet their needs and how they might be improved.

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