Older Australia at a glance

This publication is a joint project of the Australian Institute of Health and Welfare and the Office for the Aged in the Commonwealth Department of Health and Family Services. It was prepared for the 1997 World Congress of Gerontology meeting in Adelaide, Australia, and aims to provide an overview of the health, well-being and social circumstances of older Australians and their health and welfare services.

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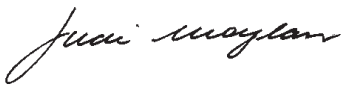
Foreword

The XVIth Congress of the International Association of Gerontology is an auspicious occasion for the Australian gerontological community. This is the first time that the meeting of world renowned expertise in the field of gerontology has assembled in the southern hemisphere and is deserved recognition of Australia's proud record of achievement in the standard of care within the aged care sector. The staging of the Congress in Adelaide provides an excellent opportunity to demonstrate to participants from all corners of the world the diverse range of services and research undertaken by governments and non-government organisations in Australia in relation to older people.

The Australian Government acknowledges the challenges posed by the speed and scale of ageing, especially in the developed countries of the world. It is committed to working with older people themselves and those who work with them to improve their health and well-being, encourage self-provision and independence and promote positive images of older people and ageing. The Government considers, however, that the age-related policy framework must be supported by a strong research and evidence base to which it is equally committed.

The Australian Government supports the Congress as a means of focusing on the issues presented by an ageing society. I am sure that this folder will provide a comprehensive overview to the international gerontological community of achievements in research, health service delivery, and technological and socioeconomic developments in relation to the continuing good health and well-being of older people in Australia.

I extend a warm welcome to Congress participants, in particular to those who have travelled from overseas to attend this significant event. I hope that all will be enriched by the diversity of views and experiences which will be offered.



JUDI MOYLAN

Minister for Family Services

Australia in context

1

Geography and climate

Australia is one of the world's most urbanised countries. About 70% of the population is concentrated in its 10 largest cities, which lie mainly along the eastern seaboard and in the south-eastern corner of the continent. Australia is the only nation that occupies a whole continent. It is an island of 7,682,300 square kilometres and is the sixth largest country in the world. Australia is one of the oldest land masses and is the flattest of the continents, with an average elevation of only 300 metres. Vast areas in the centre of the country are arid or semi-desert and unsuitable for settlement. Australia has a wide climate range, from tropical in the north to temperate in the south. After Antarctica, Australia has the lowest rainfall of any continent.

Social history

European settlement of Australia began in 1788 when a British penal settlement was established on the east coast at the site of present-day Sydney. Further settlements followed at Hobart, Tasmania, in 1803; the Brisbane River, Queensland, in 1824; the Swan River, Western Australia, in 1829; Port Phillip Bay, Victoria, in 1835; and Gulf St Vincent, South Australia, in 1836. Continued population growth and economic expansion throughout the latter half of the 19th century prompted the six colonies to call for self-government and in 1901, the colonies joined in a federation of states as the Commonwealth of Australia. Today, the States which comprise the Commonwealth of Australia are New South Wales, Victoria, Queensland, South Australia, Western Australia and Tasmania. There are also two mainland territories: the Northern Territory, and the Australian Capital Territory where the national capital, Canberra, is located.

Population characteristics

Australia is a multicultural society with a population of 18.3 million, enriched by more than five million settlers from almost 200 countries, who have migrated to Australia in the past 50 years. Forty per cent of Australians are migrants or first generation children of migrants, half of whom are from diverse linguistic and cultural backgrounds. In 1994, Australia's Aboriginal and Torres Strait Islander peoples numbered 303,300, representing 1.7% of the population. The Australian population growth rate has declined since 1989, mainly because of a sharp decline in net migration. Australian women have an average life expectancy at birth of 80 years, six years longer than the average for Australian men.

Government structures

Australia's political institutions and practices follow the Western democratic tradition, reflecting British and North American experience. The Australian federation has a three-tier system of government: federal, state and local. The Federal Parliament and the Federal Government deal with matters of national interest as prescribed in the Federal Constitution. The Cabinet is the major policy-making body of government and is headed by the Prime Minister. The six state and two territorial governments and their legislatures

administer education, transport, law enforcement, health services and agriculture. Local government comprises about 900 bodies at the city, town, municipal and shire levels, whose responsibilities include town planning, parks and recreation grounds, public libraries, community centres and sanitary services.

Economic overview

Australia has a mature industrialised economy with a large and growing services sector, a broad-based manufacturing sector, large-scale resource development, productive primary industries and a rapidly expanding base of high technology. In the past 10 years, manufacturing and services, particularly tourism, have played a major role in boosting Australia's exports and diversifying the export base. Although reliance on primary production has diminished, Australia remains a major producer and exporter of rural and non-rural commodities. Considerable investment has continued in export-oriented mining and energy projects.

Health care

The Australian health care system is a blend of public and private sector involvement: private medical practitioners provide primary and specialist care, and a public (state-controlled) and private hospital system provides comprehensive services. The national health funding system, Medicare, makes health care affordable and provides all Australian residents with access to medical services. The scheme is partly funded by a 1.5% levy on taxable income. State and local governments have responsibility for providing public health services. However, the Federal Government has become more involved in developing and coordinating national policies, legislation and standards. There are about 1,100 hospitals across Australia (excluding mental hospitals, nursing homes and veterans' hospitals), 65% of which are public. Australia has an average of 4.5 hospital beds per thousand of the population.

Social welfare

Australia's involvement in social security began with the introduction of federal old-age and invalid pensions in 1910 and maternity allowances in 1912. These kinds of social security payments gained Australia a reputation as a pioneer in public welfare. Today, the social security system in Australia provides income support to people and families who are without an adequate income because of age, disability, unemployment or sole parenthood. About five million Australians receive social security entitlements. The Federal Government funds a range of home and community support and transport services for frail older people and younger people with disabilities at home, as well as a benefit to people who care for chronically ill relatives at home. Expenditure on social security and welfare programs in 1995–96 was $49.5 billion.

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2 Older Australians: age, sex and living arrangements

The principal source of demographic data in Australia is the Census of Population and Housing conducted every five years by the Australian Bureau of Statistics (ABS). To derive the estimated resident population between census years, the census counts are used with adjustments made for births, deaths and net interstate and overseas migration.

As of 30 June 1996, the ABS estimated that there were 18.3 million persons in Australia, with 2.2 million of these aged 65 and over (12% of the total population). Almost a third of all older people were aged between 65 and 69 and almost a quarter were aged 80 and over. The majority of older people were women (57%), with this predominance particularly evident in the older age groups. In the 65–69 age group only 51% were women, increasing to 66% among those aged 80 and over.

Families are the 'largest source of emotional, practical and financial support in our society' and this support is provided primarily on a non-paid voluntary basis (McDonald 1995). The existence or non-existence of family members within a household is an important indicator of the availability of family support. It should be recognised, however, that a substantial amount of informal assistance is provided to frail and disabled older people by non co-resident family members (Gibson et al. 1997). The vast majority (91%) of Australians were living in families at the time of the 1991 Census, and 8% were living alone, a proportion which dramatically increases amongst older people. Six per cent of persons aged less than 65 were living alone compared to 27% of 65–79 year olds and 45% of those aged 80 and over.

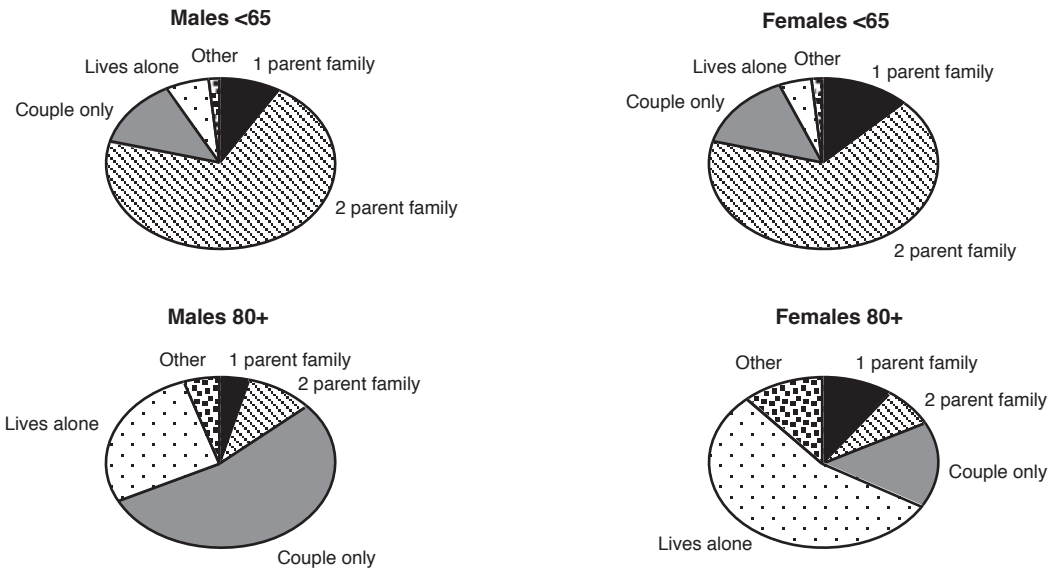
While the living arrangements of men and women were similar until age 65, women's greater longevity and their tendency to marry older men combine to create substantially higher proportions of women than men living alone after that age. Men aged 80 and over were three times more likely to be in a couple-only family than women (54% compared to 16%). Women aged 80 and

Persons aged 65 and over; sex by age, Australia 1996

	Age							
	65–69		70–79		80+		Total aged population	
Sex	**('000)**	**%**	**('000)**	**%**	**('000)**	**%**	**('000)**	**%**
Males	336.4	15.3	456.4	20.7	167.4	7.6	960.2	43.5
Females	355.0	16.1	572.5	26.0	317.8	14.4	1,245.3	56.5
Persons	**691.4**	**31.4**	**1,028.9**	**46.7**	**485.2**	**22.0**	**2,205.5**	**100.0**

Living arrangements by age and sex, Australia 1991 (%)

	Males					Females				
Age	**1–2 parent family**	**Couple only**	**Other**	**Lives alone**	**Total (N)**	**1–2 parent family**	**Couple only**	**Other**	**Lives alone**	**Total (N)**
<65	78.9	13.1	1.8	6.2	6,599,811	79.1	14.4	1.5	5.0	6,663,897
65+	16.5	62.4	3.5	17.6	686,655	16.6	38.0	5.8	39.6	882,464
80+	13.2	54.2	5.2	27.3	94,811	17.3	16.0	11.3	55.4	161,109



Living arrangement profiles by age and sex, Australia 1991

over were twice as likely as men to be living alone; 55% of all women aged 80 and over were living alone compared to only 27% of men.

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Data sources

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3 The changing demographic profile: 1976–2016

The Australian population is ageing, and this trend is expected to continue for at least the next 20 years. Annual rates of increase for the period 1976–2016 are significantly higher for the older population than for the entire population, with rates of increase highest amongst the very old. While the number of people aged 65 and over are of interest with regard to retirement and income security policies, changes within the age structure of the older population are of particular relevance with regard to planning for health services and long term care.

These rates of change are reflected in quite substantial growth in both the relative and absolute size of the older population. Twenty years ago, 9% of the population (or 1.3 million people) were aged 65 and over. By 1996 this had increased to 12% (2.2 million) and by 2016 this is projected to increase to 16% or 3.5 million persons. The internal age structure of the older population has also changed quite significantly. In 1976, one in six older people was aged 80 and over; by 1996 it was one in five and by 2016 it will be one in four. The number of people in Australia aged 80 and over thus increased from 218,000 in 1976, to 485,200 in 1996, and is predicted to grow to 852,100 by 2016. The proportion of women in the aged population also changes over this period, decreasing from 58% in 1976, to 56% in 1996, and is expected to decrease further to 54% in 2016.

Annual rate of increase; year by age and sex, Australia 1976–2016 (%)

	Males			Females			Persons		
Year	65+	80+	Total (all ages)	65+	80+	Total (all ages)	65+	80+	Total (all ages)
1976–1986	3.0	3.9	1.3	3.0	3.6	1.4	3.0	3.7	1.3
1986–1996	3.1	5.2	1.3	2.5	4.1	1.4	2.7	4.4	1.3
1996–2006	2.0	4.5	1.1	1.5	3.5	1.1	1.8	3.8	1.1
2006–2016	3.2	2.3	0.8	2.7	1.6	0.8	2.9	1.9	0.8

For persons aged 65 and over, the last 20 years saw substantially higher annual average rates of increase (3% and 2.7% per annum) than is expected in the decade 1996–2006 (1.8% per annum), although growth rates are then expected to increase substantially during the period 2006–16 (2.9% per annum) as the peak of the Australian baby boom generation reaches retirement age. Among the 80 years and over population the pattern is somewhat different, with the recent decade (1986–96) having the highest rate of increase (4.4% per annum) of the 40-year period under scrutiny here. For the next 10 years average rates of increase will drop to 3.8%, and the period 2006–16 is expected to have quite a low annual rate of increase at only 1.9%. The low growth rates in the 80 and over population for the period 2006–16 are the result of lower fertility rates in Australia during the depression years of the 1920s and 1930s. Amongst both age groups

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Resident and projected populations for persons aged 65 and over; year by age and sex, Australia 1976–2016

	Year									
	1976		1986		1996		2006		2016	
Age by sex	**('000)**	**%**	**('000)**	**%**	**('000)**	**%**	**('000)**	**%**	**('000)**	**%**
Males										
65+	525.5	3.7	709.2	4.4	960.2	5.3	1,171.4	5.8	1,599.5	7.2
80+	68.9	0.5	101.1	0.6	167.4	0.9	259.2	1.3	324.4	1.5
Total population (all ages)	7,032.0	50.1	8,000.2	49.9	9,104.6	49.8	10,112.5	49.7	10,948.4	49.6
Females										
65+	727.4	5.2	972.9	6.1	1,245.3	6.8	1,452.2	7.1	1,901.5	8.6
80+	149.1	1.1	213.3	1.3	317.8	1.7	448.2	2.2	527.7	2.4
Total population (all ages)	7,001.1	49.9	8,018.2	50.1	9,184.5	50.2	10,230.2	50.3	11,124.5	50.4

Data sources

Data presented here are drawn from Australian Bureau of Statistics, Estimated resident population by sex and age: States and Territories of Australia, for various years (June 1971–1981, June 1981–1987, June 1995 and Preliminary June 1996). Cat No. 3201.0. Canberra: AGPS; and unpublished data from the Australian Bureau of Statistics.

Indigenous peoples

4

The first inhabitants of Australia were Aboriginal and Torres Strait Islander peoples some 50,000 years ago. While the size of the Indigenous population prior to white settlement is unknown, an early 19th century estimate of 300,000 is now believed to have been a vast underestimate of the population at that time. Indigenous Australians show important differences in demographic, social and cultural characteristics from non-Indigenous Australians.

According to the 1991 Census there were an estimated 283,000 persons who identified themselves as being of Aboriginal or Torres Strait Islander descent (1.6% of the total population). The Northern Territory had a much higher proportion of Aboriginal and Torres Strait Islander peoples (26%) than was the case elsewhere.

While the 1991 Census is the most recent data collection for which information is available on Indigenous Australians, the Australian Bureau of Statistics derived experimental estimates for 1994. According to these estimates, there were 303,300 persons in Australia in 1994 who identified themselves as of Aboriginal or Torres Strait Islander descent.

Indigenous Australians have a younger population profile than non-Indigenous Australians. The vast majority of Indigenous peoples in 1994 were aged under 45 (88%), and only a small minority (almost 2%) were aged 70 and over. The corresponding proportions for the non-Indigenous population were 68% and 8%, respectively.

In the early 1990s Aboriginal and Torres Strait Islander life expectancy at birth was up to 20 years shorter than that for non-Indigenous Australians. The expectation of life for 65 year old Indigenous men and women was five to seven years less than that for 65 year old non-Indigenous Australians. The proportion of Indigenous Australian men who could expect to live to age 65 was 45% (81% for non-Indigenous men), and that for Indigenous Australian women was 54% (89% for non-Indigenous women).

Given that Indigenous Australians have a shorter life expectancy and a higher incidence of illness and disability than other Australians, it is not surprising to find that they make use of aged care services at earlier ages. Indigenous Australians comprise 3% of home and community care clients (HACC), 4% of care package clients, 6% of

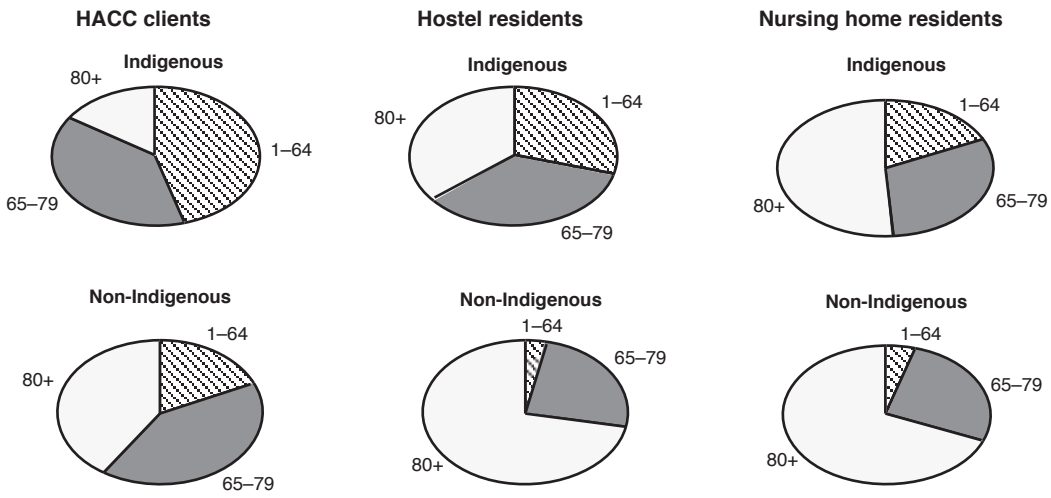
Estimated number of Aboriginal and Torres Strait Islander peoples, Australia 1991

	States and Territories								
	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Indigenous population ('000)	75.0	17.9	74.2	44.1	17.2	9.5	1.6	43.3	283.0
% of total population	1.3	0.4	2.5	2.7	1.2	2.0	0.6	26.1	1.6

Age and sex profiles of Indigenous and non-Indigenous Australians, 1994 (%)

	Indigenous Australians			Non-Indigenous Australians		
Age	Males	Females	Persons	Males	Females	Persons
<45	88.6	86.9	87.7	68.7	66.3	67.5
45–69	10.2	11.4	10.8	24.7	24.2	24.5
70+	1.3	1.7	1.5	6.6	9.5	8.1
All ages ('000)	**152.4**	**150.9**	**303.3**	**8,731.3**	**8,801.9**	**17,533.2**

Prepared by the Australian Institute of Health and Welfare



Aged care service use by age for Indigenous and non-Indigenous Australians

community options clients, 1% of hostel and nursing home residents and an estimated 1.6% of the Australian population. Indigenous Australians tend to prefer community-based to residential services, consistent with their expressed desire to remain on the land and with their families in old age.

The health status of Aboriginal and Torres Strait Islander peoples is much poorer than that of other Australians. Indigenous peoples were two to three times more likely to be hospitalised, with respiratory disease and injury among the most common causes. Indigenous peoples experienced substantially higher death rates than non-Indigenous people. Access to health services and health professionals is one of the barriers that affect Indigenous Australians. Indigenous peoples are also at a higher risk of poor health due to factors such as poor nutrition, obesity, substance abuse, exposure to violence, and inadequate housing and education.

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Data sources

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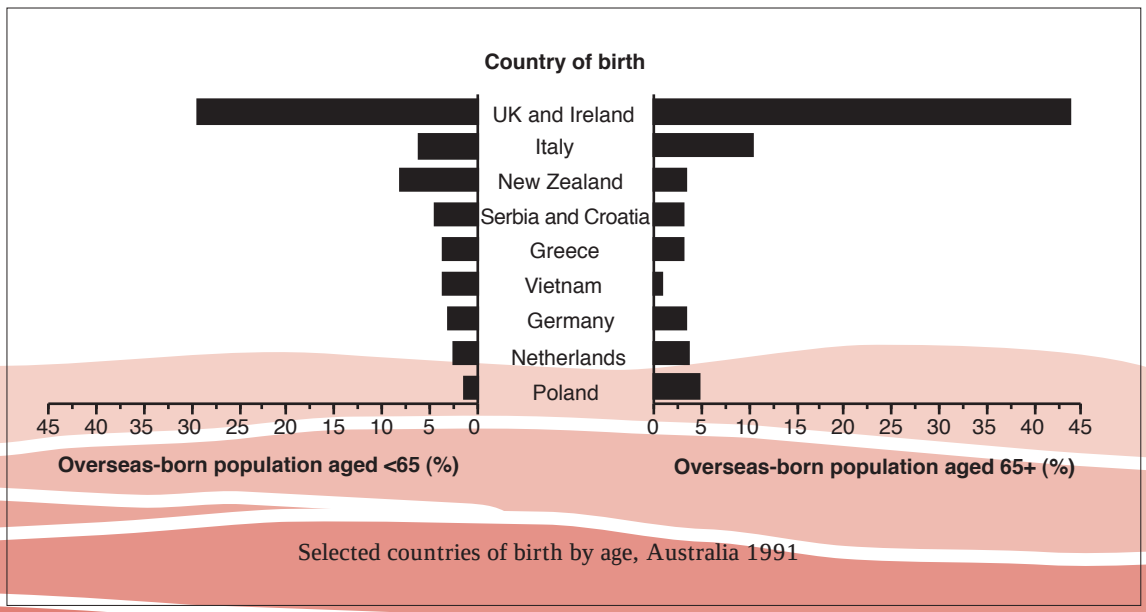
5 People from diverse linguistic and cultural backgrounds

Australian society is made up of people from many different cultural backgrounds, with much of the nature of this cultural diversity a result of the immigration policies of the post-war period. The population is becoming increasingly culturally diverse, with more older overseas-born Australians coming from a greater variety of countries (AIMA 1986). According to the 1991 Census 3.8 million people (23% of the total population) living in Australia were born overseas and originated from 224 different countries, while a further 3.3 million had one or both parents born overseas.

At the 1991 Census there were more than 528,000 overseas-born persons aged 65 and over, comprising 29% of the total population aged 65 and older. Nearly half (44%) of overseas-born older people were originally from the UK and Ireland. Nonetheless, the numbers from diverse linguistic and cultural backgrounds are substantial at over 272,000, a figure projected to exceed 660,000 in 2001 (Rowland 1991). Among older people, the largest of these immigrant groups (after the UK and Ireland) were from Italy (10%), followed by Poland (5%) and the Netherlands (4%). These trends are different from those for younger age groups, where people from New Zealand were the largest single immigrant group after the UK and Ireland, and the proportion arriving from Asia was also significantly larger. Older people from diverse linguistic and cultural backgrounds (i.e. those from non-English-speaking backgrounds) warrant particular attention in policy terms since by 2001 they will comprise nearly one in four older people in Australia (Ethnic Aged Working Party 1987).

Improving equity of access to aged care services for people from diverse linguistic and cultural backgrounds has been a key policy objective over the past 10 years. Such people comprise 13% of home and community care clients (HACC), 19% of community options clients (COP), 22% of care package clients, 8% of hostel residents, 9% of nursing home residents, and an estimated 13% of the population of Australia. These data suggest that persons from diverse linguistic and cultural backgrounds were more likely to make use of home-based rather than residential services. Intensive forms of community support (community aged care packages and community options projects) appear to have been particularly successful in targeting services to these people.

Age and sex differences between clients from English-speaking and diverse linguistic and cultural backgrounds were relatively small across



Selected countries of birth by age, Australia 1991

Use of aged care services by persons from English speaking and diverse linguistic and cultural backgrounds, Australia (%)

	Diverse linguistic and cultural backgrounds					English speaking background				
Age	HACC	COP	Care packages	Hostels	Nursing homes	HACC	COP	Care packages	Hostels	Nursing homes
<65	17.4	14.8	7.5	3.8	5.0	19.3	30.7	7.3	3.2	5.0
65–69	49.2	46.6	40.2	31.5	33.6	39.5	33.0	32.0	24.0	26.8
80+	33.4	38.6	52.3	64.7	61.4	41.1	36.3	60.7	72.8	68.2
Total (N)	**4,839**	**1,149**	**828**	**3,584**	**7,283**	**34,380**	**4,944**	**2,898**	**41,715**	**70,968**

all service types. Clients from diverse linguistic and cultural backgrounds were generally younger than clients from an English-speaking background (except for community options clients). The proportion of males from diverse linguistic and cultural backgrounds was consistently larger (in the vicinity of 35%) across all service types than that for males from English-speaking backgrounds.

Persons born overseas generally have better health than the Australian-born population, not a surprising result given that the selection of immigrants to Australia is partially determined by their health status. The overseas-born population experienced significantly lower mortality rates leading to higher life expectancies, as well as lower death rates for most major causes of death compared to the Australian-born population. People born overseas reported less serious chronic illness than did those born in Australia, although those from continental Europe and Asia tended to report poorer health compared to those born in Australia. Overseas-born Australians had fewer hospital admissions than the Australian-born.

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Data sources

Data presented here are drawn from unpublished data from the Australian Bureau of Statistics and the Department of Health and Family Services for various years (1993–96) depending on the program.

International comparisons

6

Population ageing is a defining characteristic of all developed and many developing nations in the latter part of the 20th century, and one which will continue into the 21st. In 1950, between 8% and 9% of the population in North America, Europe, Australia and New Zealand were aged 65 and over. Today, that figure has increased substantially, but regional variations in rates of increase led to a situation where, by 1993, 18% of people in Sweden, and 16% in Norway and Denmark were aged 65 or older, compared to 13% in the USA and 12% in Australia and New Zealand.

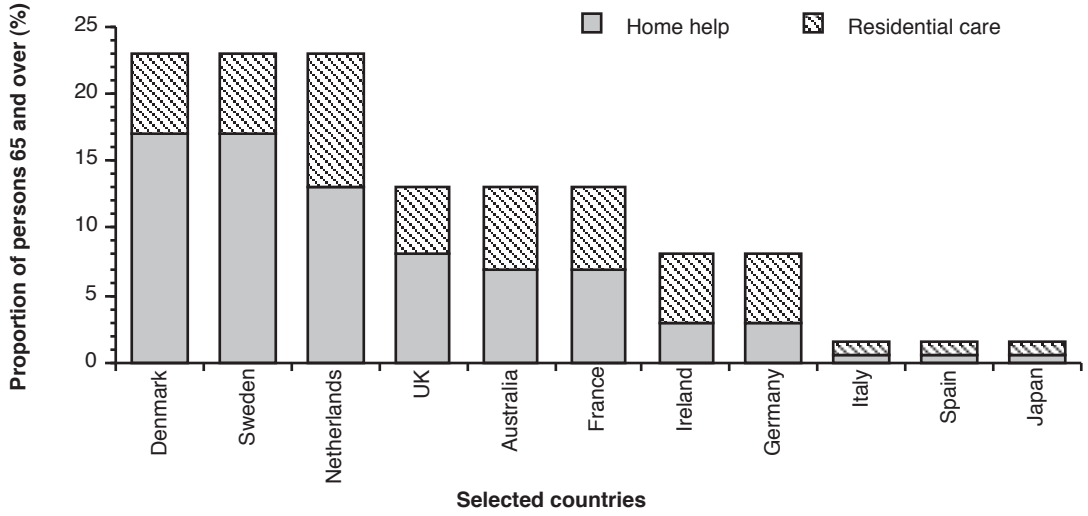
Australia is relatively young among developed nations. The 14-country comparison in the table below reveals three broad tiers in terms of population structure. The oldest tier includes most of the European countries, with between 14% and 18% of their populations aged 65 and over. The second tier is a more eclectic cultural mix, but comprises a recognisably 'younger' set of countries with around 11–13% of their populations in this age group. The third tier, comprising the so-called 'late initiation' countries (where the decline in fertility which precedes population ageing did not occur until much later), is represented by China, with only 6% of its population aged 65 and over. Similar trends are evident with regard to the size of the population aged 80 and over in each of these countries.

If countries are ranked according to the projected rates of growth of their older population for the next 10 years, however, a roughly inverse picture emerges. Japan and China lead the field with annual average rates of increase around 3%, followed by Australia, Canada and Germany (1.7–1.8%), with virtually all the remaining countries at less than 1%. The rate of growth in the population aged 80 and over is quite high for Australia at 3.9%, similar to that for both Japan and China. Canada, too, can expect a fairly rapid growth in this age group, with a 3% predicted rate of increase over the 10 years to 2005. Thus, while

International comparison of the age profiles and rates of increase for 14 countries (%)

	Proportion of the population (1992–93)		Annual rate of increase (1995–2005)	
Selected countries	**65+**	**80+**	**65+**	**80+**
Australia	11.7	2.4	1.8	3.9
Austria	15.2	3.9	0.6	0.6
Canada	11.8	2.5	1.7	3.1
China	5.6	0.7	2.8	4.1
Denmark	15.6	3.8	0.1	0.8
France	14.5	4.0	1.0	1.0
Germany	15.0	3.8	1.8	–0.1
Japan	13.1	2.7	3.0	3.6
Netherlands	13.0	3.0	1.1	1.9
New Zealand	11.5	2.4	0.9	2.1
Norway	16.2	3.9	–0.5	1.7
Sweden	17.7	4.5	–0.2	1.3
United Kingdom	15.8	3.8	0.1	0.7
USA	12.7	3.0	0.5	2.0

Source: Gibson (1997)



Proportion of persons aged 65 and over receiving home help services and in residential care

Australia is relatively young in an international context, it is experiencing a comparatively rapid rate of population ageing. These changes have been a key factor in the restructuring and adjustment of both the income support and aged care service sectors over the last decade.

Levels of home-based and residential care vary significantly in an international context, but not necessarily in relation to the likely level of demand for such services in the population. Thus, while the Netherlands is a high provider of both home-based and residential care, it has one of the younger populations among European countries. Denmark and Sweden have both high population profiles and high levels of home-based care provision, as well as moderate levels of residential care. Germany, on the other hand, with a relatively old population, is a comparatively low provider of home-based care and an average provider of residential care. Australia, one of the youngest countries among those selected here, falls into the moderate provider category for both home help and residential care services.

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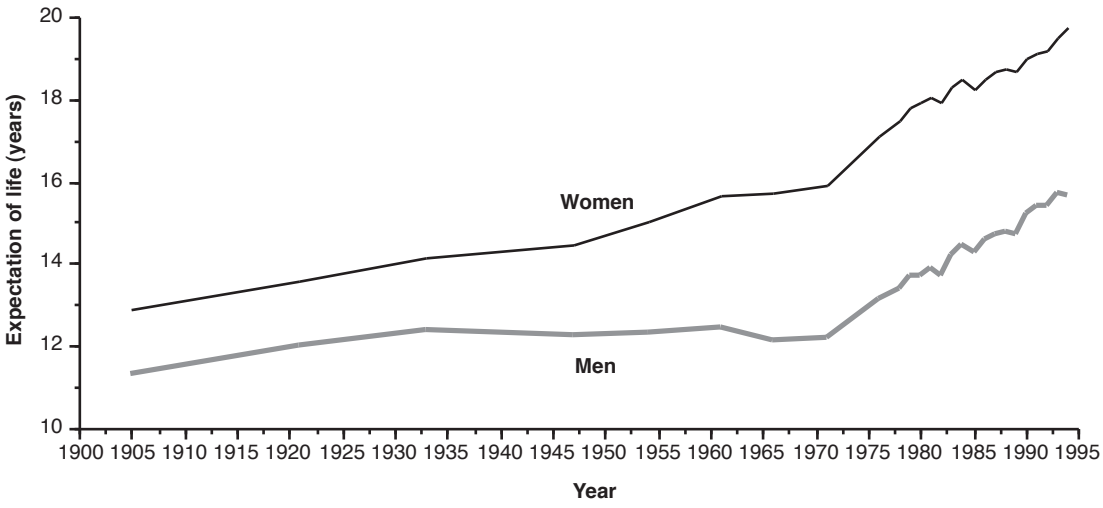
7 Life expectancies of older Australians

Life expectancy at birth in Australia has risen continuously during the 20th century, with the exception of the period during the 1960s, when death from cardiovascular disease increased, particularly for men. Life expectancy from age 65 years, by contrast, increased only marginally over the first six decades of the century—0.9 years for men and 2.8 years for women. Over the last three decades the increase has been at a substantially greater rate, 3.5 years for men and 4.0 years for women.

The gains in life expectancy have been concentrated among the middle-aged and older population. There have been dramatic declines in death due to some causes, particularly cardiovascular disease. Between 1968 and 1992 age-adjusted death rates from cardiovascular disease declined by 56% for men and 55% for women. For men and women aged 65–74 years, cardiovascular death rates declined at an even higher rate, by 59% and 64%, respectively, over the same period.



Trends in life expectancy at age 65, Australia 1905–94

The increases in life expectancy that occurred in the first half of the century were predominantly the result of rapid declines in infant and maternal mortality, particularly the lessening impacts of the infectious diseases associated with childhood and early adulthood. During the 1940s and 1950s, gains in life expectancy slowed and, for some age groups, reversed. This was due to the epidemics of cardiovascular disease, which peaked in the mid-1960s, and tobacco-caused lung cancer, which has now peaked for men but not women. Since the 1960s a new development has been in evidence.

International comparisons of the life expectancies at age 65 for Australia and selected other countries in 1993, in descending order of female life expectancy, are presented in the following table. Australian women aged 65 years have the sixth highest life expectancy in the world, following Japan, France, Hong Kong, Switzerland, and Canada. Men in Japan, France, Hong Kong, Switzerland and Greece have a higher life expectancy at age 65 than their counterparts in Australia, Canada, Spain and Israel.

Life expectancy at age 65 for Australia and selected countries, 1993

Country	Males	Females
Japan	16.7	21.3
France	16.2	21.0
Hong Kong	17.1	20.8
Switzerland	15.9	20.4
Canada	15.8	19.9
Australia	15.8	19.7
Spain (1992)	15.8	19.6
Sweden	15.6	19.3
Italy (1992)	15.5	19.3
USA (1992)	15.5	19.3
Norway	14.8	18.8
Netherlands	14.4	18.8
Greece	16.0	18.7
New Zealand	15.0	18.6
Germany	14.5	18.3
Singapore	15.3	18.0
United Kingdom	14.2	18.0
Israel	15.8	17.7
Chile (1992)	14.7	17.6
Ireland (1992)	13.6	17.3
Poland	12.5	16.2
Russian Federation	10.9	15.0

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Data sources

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Health differentials

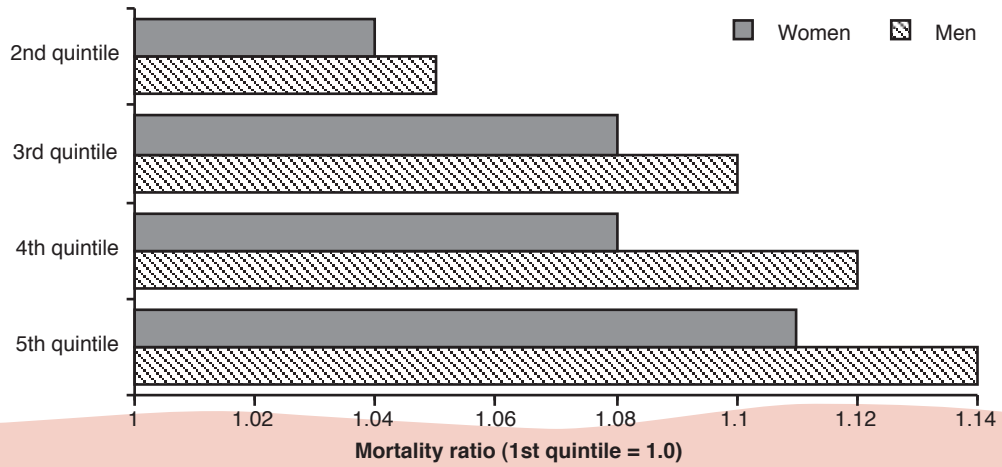
8

It is often assumed that old age is a time of universal ill-health and little attention tends to be paid to health differentials at older ages. It has been shown that inequalities in the health of younger Australians persist into older ages (Mathers 1994). According to a range of measures of socioeconomic disadvantage (such as low income, relatively low educational attainment levels and high unemployment), there is a consistent relationship between socioeconomic status and health among people aged 65 and over, although it is less marked than for younger people.

For older men and women in the late 1980s, there was a clear gradient of increasing mortality and worse perceived health status with increasing levels of socioeconomic disadvantage of area of residence. Older men living in areas classified into the quintile of greatest socioeconomic disadvantage had death rates 14% higher than men living in areas in the quintile of the least disadvantage. For older women the differential was slightly smaller (11%). Some of the strongest differentials between the quintile of most disadvantage (fifth) and the quintile of least disadvantage (first) for selected causes of death between 1985 and 1987 were: pneumonia/influenza (53% higher for men and 16% higher for women), diabetes (15% higher for men and 32% higher for women), lung cancer (28% higher for men), bronchitis, emphysema, and asthma (18% higher for men), coronary heart disease (10% higher for men and 15% higher for women), stroke (16% higher for men and 6% higher for women), and suicide (44% lower for women).

Older men and women in the fifth quintile were substantially more likely to be smokers (49% for men and 32% for women) and inactive (26% for men and 29% for women) than those in the first quintile. The prevalence of overweight and obesity increased with increasing disadvantage of area for older women but not for older men.

Older men and women with low family income or low education level reported that their health was worse, were generally more likely to be inactive, overweight and/or smokers, and reported higher levels of health service utilisation. In particular, older men and women who left school before the age of 15 were around 50% more likely to report that their health was fair or poor (rather than



Mortality differentials by quintile of area disadvantage, Australia 1985–87

Persons aged 65 years and over, proportion reporting fair or poor health, by equivalent family income level and education level, by sex, Australia 1989–90 (%)

	Equivalent family income			Education level		
Sex	High ($19,000 per year or more)	Medium	Low (less than $12,150 per year)	Post-school qualifications	Left school at age 15 or more, no further qualifications	Left school before age 15
Men	35	48	49	34	45	48
Women	36	46	45	33	39	49

excellent or good) than those with post-school qualifications.

For older Australian men and women, there were large differences in mortality between married and unmarried people. Death rates for unmarried older men and women were around 40% higher than those for married older men and women. The differentials were even larger for some specific causes: deaths from pneumonia and influenza were 150% higher for never married men and women, and around 100% higher for divorced and widowed men and women; the suicide rate was 140% higher for unmarried men and 125% higher for divorced and widowed women, but not higher for never married women; and diabetes death rates were 43% and 37% higher for previously married men and women, respectively (Mathers 1994).

Overseas-born older people have lower death rates than Australian-born people, with some exceptions: deaths from stomach cancer were higher for people born in Europe, Britain and Ireland; lung cancer death rates were 45% higher for men and 74% higher for women born in the United Kingdom and Ireland; diabetes mellitus death rates were higher for people born in Europe and Asia; and suicide rates were 47% higher for men and 210% higher for women born in continental Europe (Mathers 1994).

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Data sources

Data presented here are drawn from the Australian Institute of Health and Welfare national mortality database and unpublished data from the Australian Bureau of Statistics National Health Survey 1989–90.

Dementia and older Australians

The number of people with dementia is increasing in Australia as more people live to an age where the prevalence of dementia is highest. Dementia is characterised initially by the development of difficulties with everyday tasks of daily living, by personality changes and by a later progression to the loss of the capacity to act independently. Estimates vary depending on definition but, given this proviso, the number of people with dementia in Australia in 1996 has been estimated at 134,800 (6% of the population aged 65 years and over). While approximately half of those with dementia live in the community, higher levels of cognitive loss are generally associated with greater use of residential care.

Aged Care Assessment Teams provide services aimed at assessing and identifying the support needs of people with dementia and other conditions relating to ageing, as well as determining eligibility for Commonwealth-funded hostel and nursing home care. Psychogeriatric Community Teams provide services which relate to the psychiatry of old age for people with dementia or functional psychiatric and behavioural disorders.

Home and Community Care (HACC) services provide a range of general supports to frail older persons living in the community including those with dementia. The most recent survey of HACC clients found that 19% of clients (all ages) exhibited behaviours such as confusion or disorientation. Ten per cent of clients aged 70 years and over were assessed as having these behavioural problems. It is likely that most of this group or around 18,000 clients of the HACC program will have a dementia. HACC also supports a number of people with dementia through day care (including dementia-specific options) and respite care.

Community Options Projects provide case management and individually designed service packages for around 7,000 people throughout Australia. It has been reported that around 16% of these clients or 1,000 people need assistance because of dementia. Community aged care packages, another form of intensive case-managed home-based care, provide support to around 6,000 people. Around 26% of this client group have questionable mild dementia and 9% have moderate to severe dementia. Including around three-quarters of the people with questionable dementia and all with moderate to severe ratings of dementia suggests that 29% or around 1,700 people with dementia are supported by this program.

Using the baseline estimates presented above for the HACC, community options and care package programs, it is likely that around 20,000 people, or 30% of those with dementia living in the community, are receiving some level of ongoing formal support services.

Within the two major levels of residential care provided for older people in Australia (hostels and nursing homes), a variety of approaches to dementia care has been used. Residents with dementia are supported in both mainstream

Living arrangements of people with dementia, Australia 1996

	Commonwealth		State	Private	Total living in		
	Hostels	Nursing homes	Psycho-geriatric facilities	Supported residential services	Residential care	The community	All persons
Number	16,897	45,084	2,000	4,000	67,981	66,828	134,809
Per cent	12.5	33.4	1.5	3.0	50.4	49.6	100.0

Prepared by Richard Rosewarne

Distribution of hostel and nursing home beds, Australia 1996

	Dementia-specific beds				Mainstream beds		Total
	Wings	Co-located units	Stand-alone units	Total	Mainstream only	Mainstream with a dementia area	
Hostels							
Number	1,573	938	318	2,829	47,681	8,987	59,497
Per cent	2.6	1.6	0.5	4.8	80.1	15.1	100.0
Nursing homes							
Number	2,574	996	854	4,424	61,019	9,323	74,766
Per cent	3.4	1.3	1.1	5.9	81.6	12.5	100.0

(where residents with dementia and those without are integrated) and separated accommodation. Separation is achieved via dementia-specific wings attached to a 'mainstream' facility, dementia-specific 'units' co-located on the same site as a mainstream facility or in stand-alone dementia-specific facilities. For hostel care, 4.8% of all beds are in the dementia-specific category. For nursing home care, 5.9% of all beds are in the dementia-specific category. In 1996, there were 37.5 mainstream and 1.9 dementia-specific hostel places per 1,000 people over 70 years of age, and 46.5 mainstream and 2.9 dementia-specific nursing home beds per 1,000 people over 70 years of age. Special dementia programs are available in many mainstream and dementia-specific aged care facilities.

The overall prevalence of dementia in hostels was 28% and in nursing homes 60%. Estimates of the level of cognitive impairment are, however, a better indicator of subsequent care needs than a simple diagnosis of dementia. Estimates for the level of cognitive impairment in hostel residents were 46% none, 35% mild, 17% moderate and 3% severe and for nursing home residents, 10% none, 22% mild, 27% moderate and 41% severe.

While the dementia-specific accommodation areas of both hostels and nursing homes support a much higher proportion of residents with dementia, cognitive impairment and challenging behaviour compared with mainstream care areas, the overwhelming majority of people in these categories are supported in mainstream hostels and nursing homes. For hostels, 85% of all residents with dementia are supported in mainstream areas while 15% are supported in dementia-specific accommodation. For nursing homes, the comparable figures were 92% and 8%, respectively.

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Data sources

Data presented here are drawn from Australian Bureau of Statistics 1997, Australian Demographic Statistics. Cat. 3101.0. Canberra: AGPS; Henderson et al. 1994; Jorm et al. 1987; Rosewarne et al. (1997).

10 Self-rated health among older Australians

The majority of older Australians rate their health as either good, very good or excellent (64%), according to the 1995 National Health Survey conducted by the Australian Bureau of Statistics. Just over one-third (36%) reported their health as fair or poor. (Respondents were asked the question: 'In general, would you say your health is: excellent, very good, good, fair or poor?').

The pattern progressively shifts at older ages, with people in older age groups rating their health more poorly than those at younger ages. Only 9% of the 65–69 age group rated their health 'poor' compared with 17% of the 85–89 age group. Reports of 'fair' health showed a similar trend, with the proportions giving this response increasing at older ages. However, those surviving into their nineties were less likely to report 'poor' or 'fair' health than were those in their late eighties. This apparent improvement in the oldest group may be artifactual due to smaller numbers and high sampling variability in this age group. It may also indicate a selection effect as healthy people are more likely to live to an older age. (Given that these are cross-sectional data, however, it must be remembered that age differences are likely to combine both cohort effects and the processes of ageing).

Overall, men and women had similar profiles for self-rated health. While the 'poor' response was comparable for men and women in their mid to late sixties (9%), there was increasing divergence at older age groups. The proportions reporting poor health rose to 27% for men but only 12% for women in the 85–89 age group (there are problems associated with high sampling variability in this age group). Gender variations in self-rated health may reflect differences in the 'objective' health profiles of men and women. Male health problems tend to have sudden onset (such as heart attack) which may be reflected by a sharp increase in the proportion reporting poor health. By comparison, women tend to experience more chronic morbidity.

Self-ratings of health are an important predictor of mortality and this holds true even after controlling for objective health. Australian research (McCallum et al. 1994) found differences between men and women in the relationship between self-rated health and survival. While women's 'good' and 'fair' ratings were significant in predicting survival, for men only 'poor' ratings were significant in predicting lower survival rates. The evidence suggests that self-rated health is an

Age profile for self-rated health, Australia 1995 (%)

Age group	Excellent	Very good	Good	Fair	Poor	Total (N)
65–69	12	27	32	20	9	690,400
70–74	9	22	32	25	12	658,900
75–79	12	22	27	27	12	424,600
80–84	9	20	29	27	14	242,500
85–89	7	18	28	30	17	108,700
90+	12	11	36	28	13	30,600
Total	**10**	**23**	**31**	**24**	**12**	**2,155,700**

economical indicator of health status, principally defined by severe illness and disability.

Why does self-rated health predict mortality so well? What is it measuring? Although self-rated health is strongly associated with objective health status, self-ratings include more than physical aspects of health. It also may reflect psychological well-being, aspects of health behaviour, social support and self-efficacy; these findings are not, however, conclusive.

Qualitative methods have been used to link the older peoples' meaning of health to their self-rated health in an attempt to explore this gap. While the prevalence of disability and chronic illness rise sharply with age, older people appear to adapt to these limitations or perhaps adjust their expectations (Walker-Birckhead 1996). The same frame of reference is not used by all respondents: some use health problems as referents but others use physical functioning or health behaviours. This suggests that the meanings of health to older people are complex and multi-dimensional.

Research on the predictors and consequences of self-rated health is continuing, based on the longitudinal data from the Health Status of Older People Project. This is a community-based study of the health and lifestyles of 1,000 older people in Melbourne. Analyses to date suggest that self-rated health is an important health indicator and attention needs to be paid to it by both researchers and health care professionals.

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Data sources

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11 Dependency levels among older Australians

The most recent data available on the dependency levels of the Australian population come from the 1993 Survey of Disability, Ageing and Carers conducted by the Australian Bureau of Statistics (ABS). Dependency is measured in terms of impairment, disability and handicap; the basis of these definitions is the 1980 International Classification of Impairments, Disabilities and Handicaps (ICIDH). Since 1981 the ABS has conducted three surveys, with a fourth planned for 1998. For the older population, disability and handicap rates have remained relatively stable across the three surveys, particularly in the profound or severe handicap category (while these two categories are measured separately, they are usually combined for most analytic purposes).

In 1993 it was estimated that 3.2 million people in Australia had a disability (18% of the total population), with 36% of these aged 65 and over. Almost half (48%) of all older people had a handicap, with 17% reporting a profound or severe handicap, 10% a moderate handicap and 21% a mild or not determined handicap. Amongst very old people these proportions increase considerably, with 71% of persons aged 80 and over having a handicap and 41% a profound or severe handicap.

Handicap rates vary by age and sex, with the presence of a profound or severe handicap showing the greatest differences and the only distinct trend. The profound and severe handicap category is of most relevance in establishing need for assistance and hence demand for services among older people. It identifies three areas where assistance is always or sometimes needed—self-care, mobility and verbal communication. Profound and severe levels of handicap increased with age, with this trend particularly marked among the very old. Between the 75–79 age group and the 80–84 age group, the rates of profound and severe handicap doubled. Women were more likely than men to have a profound or severe handicap across all age groups. These differences became most evident between the ages of 70 and 84, with men having only two-thirds the prevalence rates of women. At age 85 and over, the rates for men and women converged.

Area of handicap provides an indication of the types of formal services which may be required in the absence of informal carers. Of the 352,800 older people with a profound or severe handicap, the vast majority reported needing assistance with mobility (88%), over half needed assistance with self-care and 20% with verbal communication. Women were more likely to report problems with mobility than were men, while men were more likely to report self-care problems than women.

Disability status and severity of handicap by age, Australia 1993

	Severity of handicap					Disability status			
Age	Profound	Severe	Moderate	Mild	Not determined	Handicap	No handicap	Total with disability	Total population
65+	262,600	90,100	198,200	387,300	43,000	981,300	163,600	1,144,800	2,046,700
80+	144,200	29,900	37,000	81,300	4,900	297,300	16,000	313,300	420,600
All ages	**419,900**	**301,100**	**455,500**	**941,800**	**382,000**	**2,500,200**	**676,400**	**3,176,700**	**17,627,100**

The number of older people with a profound or severe handicap is projected to more than double over the next 30 years, from 352,800 in 1993 to 709,600 in 2021, although this group will increase only marginally from 17% to 18% as a proportion of the total aged population over the period (AIHW 1995). These projected increases have important implications for service providers, planners and policy analysts.

Handicap prevalence rates by age and sex, Australia 1993 (%)

	Males					Females				
Severity of handicap	**65–69**	**70–74**	**75–79**	**80–84**	**85+**	**65–69**	**70–74**	**75–79**	**80–84**	**85+**
Profound/severe	6.2	9.0	12.0	25.5	50.8	8.4	14.4	18.8	35.4	59.1
Moderate	8.7	11.1	10.6	12.0	11.1	8.7	10.3	11.2	8.2	6.0
Mild	17.6	24.0	23.1	28.9	16.2	13.5	19.0	19.9	18.2	14.4
Not determined	2.7	2.8	3.9	2.6	1.0	2.5	1.3	1.5	0.7	0.6

Persons aged 65 and over with a profound or severe handicap; area of handicap by sex and age, Australia 1993 (%)

	Males		Females		Persons	
Area of handicap	**65+**	**80+**	**65+**	**80+**	**65+**	**80+**
Self-care	63.9	61.1	53.9	62.3	57.1	62.0
Mobility	82.4	87.1	91.1	91.6	88.3	90.4
Verbal communication	21.8	29.7	19.7	26.6	20.3	27.5
Total (N)	**111,300**	**48,900**	**241,500**	**125,200**	**352,800**	**174,100**

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Data sources

Data presented here are drawn from Australian Institute of Health and Welfare (1995) and unpublished data from the Australian Bureau of Statistics 1993 Survey of Disability, Ageing and Carers.

12

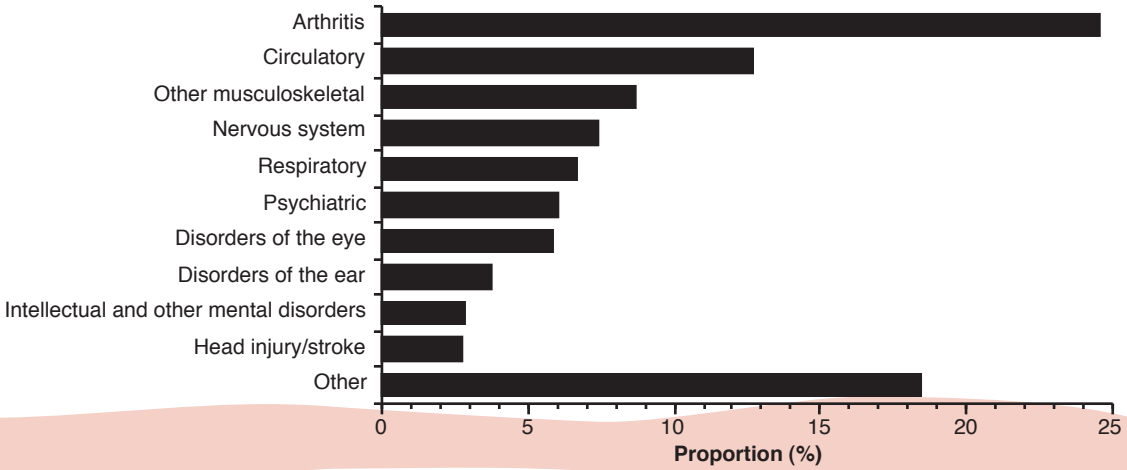
The nature of dependency among older Australians

Information on the nature of dependency among older people is fundamental in planning for adequate and appropriate aged care services. The Australian Bureau of Statistics 1993 Survey of Disability, Ageing and Carers collected comprehensive national data on the dependency levels of people of all ages in Australia. The majority of older people in Australia (56%) had at least one disabling condition which had lasted, or was expected to last, for at least six months. Despite this, not all persons with a condition were restricted by their illness or disability; 52% of those with a disability neither needed help nor had difficulties with the activities of self-care, mobility or verbal communication.

The data presented relate to those with a disability who were identified as needing assistance or experiencing difficulties with self-care, mobility or communication—those with a profound, severe or moderate handicap. This sub-group of older people are the ones most likely to be potential users of both home-based and residential aged care services (although it is important to recognise that only a relatively small proportion will actually use such services at any one point in time).

Of the 550,900 older people with a profound, severe or moderate handicap, the most prevalent disabling condition was arthritis (reported by 25% of the frail elderly). Circulatory diseases were the next most frequently reported main disabling condition (13%), followed by musculoskeletal conditions other than arthritis (9%), nervous system diseases (7%) and respiratory diseases (7%). These trends vary by age and sex, with the prevalence of arthritis and respiratory conditions decreasing with age, while eye problems and psychiatric conditions increased two and three-fold amongst the very old. Women aged 65 and over were more likely than men to report arthritis as their main disabling condition (29% compared to 17%), while respiratory conditions were more common among men than women (10% compared to 5%).

Many of the major disabling conditions experienced by older people in Australia are preventable, and it has been strongly argued that additional research is required into the effectiveness of preventive programs for older people (Gingold 1993). While the Australian Bureau of Statistics survey identifies the cause of



Main disabling condition of persons aged 65 and over with a profound, severe or moderate handicap, Australia 1993

Persons with a profound, severe or moderate handicap aged 65 and over; cause of main condition, Australia 1993

	Cause of main condition							
	Accident/ injury/ present at birth	Work conditions/ stress	Disease/ illness	Old age	Just came on	Don't know	War	Other
Number	51,200	38,200	118,700	80,100	85,800	87,200	19,800	69,900
Per cent	9.3	6.9	21.5	14.5	15.6	15.8	3.6	12.7

Persons with a profound, severe or moderate handicap living in the community aged 65 and over; likelihood of change in disabling condition by age, Australia 1993

	Whether condition is likely to change within the next 2 years							
	Yes					No	Don't know	Total
Age	Improve fully	Improve partially	Worsen	Unsure	Total			
65+	6,800	23,400	163,800	9,300	203,200	125,100	109,200	437,500
80+	1,800	4,200	48,200	3,700	57,800	44,500	29,400	131,700

the main disabling condition, the usefulness of these data is limited by the fact that almost one-third of all older people with a profound, severe or moderate handicap did not know the cause of their condition. One in five reported disease, illness or hereditary condition as the cause, of these stroke was the most common (16% of cases). The proportion stating 'old age' as the cause of their disability was also significant (15%), with this proportion increasing to 25% amongst those aged 80 and over.

Almost half of all older persons with a profound, severe or moderate handicap living in the community expected their condition to change within the next two years, while 29% expected no change and 25% were not sure whether their condition would change. Of those who expected their condition to change, the vast majority (81%) foresaw their condition getting worse, and only a small proportion expected their condition to improve fully or partially (15%). Amongst the very old a higher proportion (34%) expected no change in their condition within the next two years.

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Data sources

Data presented here are drawn from unpublished data from the Australian Bureau of Statistics 1993 Survey of Disability, Ageing and Carers.

Older Australians as volunteers

13

In its broadest definition, volunteer activity includes providing informal assistance to family members, to friends and neighbours, and more formally to others through an organisation or group. Volunteer activity is frequently defined more narrowly to include only those activities undertaken through a formal organisation or group, and it is this definition which is employed here. While volunteer activity has long been a feature of the lives of older Australians, organisations and groups are not the only means through which older Australians contribute voluntary labour. It is recognised that a great deal of help is provided on an informal basis within families, friendship groups and neighbourhoods.

The 1995 Australian Bureau of Statistics Survey of Voluntary Work found that 2,639,500 persons (19% of the total Australian population aged 15 years and over) performed some form of voluntary work during the 12 months to June 1995. Of these, 641,500 (24%) were aged 55 years or over and they contributed 141.1 million hours (33%) of voluntary work.

As a proportion of their age group, 20% of those aged 55–64 years and 17% of those aged 65 years and over were volunteers. These age groups contributed an average of 216 hours and 223 hours, respectively, per volunteer.

The number of organisations for which Australians aged 55 and over provided volunteer effort was similar to that for other age groups—two-thirds worked for only one organisation, just under a quarter worked for two organisations, 7% for three and 5% for four or more. Among volunteers aged 55 and over, the most common fields of voluntary work were welfare and community services (9%) and religious organisations (4%). Higher proportions of older men than older women were engaged in sport, recreation or hobbies and in emergency services, while older women were more likely than men to be engaged in all other fields of voluntary work.

The South Australian Office for the Ageing, the West Australian Office of Seniors Interests and the New South Wales Government's Consultative Committee on Ageing have reported that significant areas of volunteer involvement for older people in their respective States include pre-schools, school children (tutoring assistance), young offenders, the court system, National Parks and Wildlife Service, guides at cultural venues, information provision, fund raising, community transport and a variety of community services. Sporting organisations are also a popular outlet for voluntary work for older Australians. Roles in this area include coaching, injury assistance, committee work, canteen management, escorting disabled people, and general helping out.

Proportion of Australian population aged 15 and over engaged in voluntary work; field of voluntary work by age, 1995 (%)

Age	Sport/recreation/ hobby	Welfare/ community	Education/ training/youth development	Religious	Health	Emergency services
55–64	3.8	9.0	1.8	4.5	2.1	1.0
65+	3.3	8.9	0.9	4.1	2.0	0.5

According to the 1995 Survey of Voluntary Work, 49% of those aged 55–64 years and 48% of those aged 65 years and over gave as the main reason for becoming a volunteer 'to help others or the community'. Other important reasons for older people's involvement in voluntary work included 'to do something worthwhile' (29%), personal satisfaction (26%), personal or family involvement (21% and 17%, respectively) and 'social contact' (16% and 17%, respectively). To gain new skills or work experience scored very low (less than 4% in both cases). Eleven per cent of older people

reported becoming involved as a volunteer because they felt obliged to or it 'just happened'. The survey also found that 76% of volunteers aged 65 years and over first volunteered 10 or more years ago. This compared with 66% for those aged 35–64, and 32% for those aged 15–34 years.

The findings of a recent Australian study on retirement intentions (Rosenman et al. 1994) provide further information concerning attitudes to retirement and voluntary work. Almost two-thirds (61%) of women and 44% of men planned to do some voluntary work in retirement, while half of the total sample was already involved in voluntary work. For many who had retired, voluntary work was perceived as occupying their time as well as giving their life meaning. Both men and women in the sample identified the need to keep active in retirement, while maintaining social contact was also seen as important in order to avoid social isolation.

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Data sources

Data presented here are drawn from Australian Bureau of Statistics 1995.

14 Older people's organisations in Australia

There are a myriad of older people's organisations in Australia in virtually every local community—for example, senior citizens' clubs, Probus Clubs, pensioner clubs, retired unionists' groups—plus many other organisations whose membership is mostly older people. The membership of many ethnic organisations is largely older, reflecting the pattern of postwar migration to Australia, as is the membership of many self help, church and leisure interest groups. Most local older persons' groups are affiliated with a state-based organisation. In turn, many of these are part of a national group or network, reflecting Australia's federal system. A brief description of the major national groups follows.

The Council on the Ageing (COTA) had its origins in 1951 in the Old People's Welfare Councils. In 1970 the Australian Council on the Ageing was incorporated, becoming Council on the Ageing (Australia) in 1992. COTA now represents over 50,000 individuals and 1,500 organisations through State and Territory COTAs. Membership includes individuals over 50 years of age, consumer organisations, service providers, and professional and industry associations. Since 1991, at least two-thirds of the members of COTA boards have been older people.

COTA exists to protect and promote the well-being of all older people. It works as an advocate for older Australians by providing information, referral and advice, and publications, by conducting research, policy analysis, and seminars, by liaising with governments, by undertaking consultation and by representation. At a national level, COTA develops policy and promotes older people's views, in particular in the areas of health, housing, residential care, retirement income, community services, age discrimination and attitudes toward ageing.

COTA publishes newsletters, directories, reports and policy papers at the State and Territory level and at the national level publishes *Strategic Ageing*, *ReportAge*, and the *Australian Journal on Ageing* jointly with the Australian Association of Gerontology and the Australian Society for Geriatric Medicine.

Contact: Council on the Ageing (Australia), Level 2, 3 Bowen Crescent, Melbourne Vic 3004.
Ph (03) 9820 2655, Fax (03) 9820 9886.
Email cotaa@vicnet.net.au

In preparation for International Year of Older Persons in 1999, Australian Coalition '99 has been formed under the leadership of Council on the Ageing (Australia). It is a coalition of partnerships between older people in Australia and other countries, organisations of older people, community, business, government and other organisations which include interests of both younger and older people. Membership consists of partner organisations which operate at a national level. As at June 1997 there were 27 partner organisations. The partners have established a National Coordinating Committee to plan Australia's involvement in the International Year of Older Persons in 1999. Coordinating committees have also been convened at State level.

The vision statement of the Australian Coalition '99 includes: to achieve a full realisation of the United Nations principles on healthy ageing by and for all Australians; to work towards 1999 through the establishment of a coalition of partnerships and identify programs and policies which will promote positive ageing and an age-friendly society; to achieve positive, supportive and creative ways for Australians to approach older age by planning and implementing a wide range of local, regional, statewide and national activities; and to encourage collaboration and health promoting interactions across generations, which will use the developments to 1999 to promote successful and positive ageing into the 21st century.

Contact: Secretariat, c/- Council on the Ageing (Australia), Level 2, 3 Bowen Crescent, Melbourne, Vic 3004.
Ph (03) 9820 2655, Fax (03) 9820 9886. Email cotaa@vicnet.net.au

The National Seniors Association was formed in 1976 in Queensland, originally as Later Years. National Seniors' major objectives are to provide benefits to its members, to represent the concerns of its members to government and to make donations to assist the ageing. Its membership is open to people over 50 years of age. National Seniors offers members discounts on travel, insurance and other services, and runs a travel company and an investment advisory service. A third of its 107,000 members are of workforce age, a third receive a social security or veterans pension and a third live on independent income.

National Seniors has local branches in all States and offices in four States. It publishes a bimonthly magazine, *50 something*. The association aims to create an image of conservative positive responsibility in which seniors of Australia have equality with the rest of the community.

Contact: National Seniors Association Ltd, Level 1, Rowes Arcade, 235 Edward St, Brisbane Qld 4000. Ph (07) 3221 2977, Fax (07) 3229 0356.

The Association of Independent Retirees was established in Queensland in 1990. Its membership is open to retired or semi-retired people who depend wholly or partly on independent income—that is, whose level of independent income or assets disqualifies them from receiving a maximum rate age or veterans pension. Its objectives include lobbying governments on behalf of independent retired people, a reduction in the taxation they pay, gaining access to benefits at present available only to social security or veterans pensioners and providing advice.

The association has local branches in all States. It is a non-profit organisation staffed entirely by its volunteer members. It publishes a quarterly journal, *Independent Retiree*.

Contact: Association of Independent Retirees, Inc. PO Box 1259, Wodonga Vic 3689.
Ph (03) 5754 4891, Fax (03) 5754 4898.

The Australian Pensioners' and Superannuants' Federation (AP&SF) had its origins in 1933 with the establishment of the NSW Old Age and Invalid Pensioners Association. The national body was established in 1956, originally as the Australian Pensioners' Federation. AP&SF is a network of affiliated autonomous State, regional and national consumer organisations. It represents 44,000 individuals and membership includes pensioners, state superannuants, retired unionists and older women. AP&SF is run by an executive of older people elected by its affiliated groups.

AP&SF's basic goal is social justice and a fair deal for all—young or old—who may be affected by low income, ill-health or prejudice. It aims to promote older people's independence, opportunities and choices, by undertaking research from a consumer perspective, by providing information and resources, by lobbying governments, businesses and services, by using the media and by representation. AP&SF's particular policy interests at national level include retirement income, taxation, banking, residential and community care, health services, health promotion and housing. Some of AP&SF's affiliated groups offer information, advocacy and other services from staffed offices. Others operate on a volunteer basis. AP&SF publishes a bimonthly newspaper, *Action Network*, discussion papers and a range of resources for older people and those who work with older people.

Contact: Australian Pensioners' and Superannuants' Federation, Level 6, 8–24 Kippax St, Surry Hills NSW 2010.
Ph (02) 9281 4566, Fax (02) 9281 5951.

Other organisations with substantial older membership include the Older Women's Network (Australia), Ph (02) 9221 4618; Returned & Services League of Australia, Ph (06) 228 7199; Alzheimer's Australia, Ph (06) 285 3648; Over Fifties Focus, Ph (06) 9616 6600; Country Women's Association, Ph (02) 9358 2957; Carers Association of Australia, Ph (06) 288 4877; Arthritis Foundation of Australia, Ph (02) 9221 2456.

Older Australians as carers

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The vast majority of older Australians are neither frail nor in need of long-term care and assistance. Only 17% of older people were identified in the Australian Bureau of Statistics 1993 Disability, Ageing and Carers Survey as having a profound or severe handicap (that is, requiring at least some help in the areas of self-care, mobility or communication) and only 7% were identified as being in residential care.

The majority of people of all ages with a profound or severe handicap will receive most of the help they need from informal carers, rather than from formal services. In 1993, there were 541,200 principal carers providing assistance to people with a profound or severe handicap, of whom one in five (112,000) were themselves aged 65 and over. There were over 18,100 people aged 80 and over caring for someone who required assistance in the areas of self-care, mobility or communication.

Older carers are equally likely to be men or women; this is quite a different pattern from that for younger carers, where women predominate to a considerable extent. The vast majority of older carers were providing help to a spouse, with smaller proportions providing help to parents or to their children. Among older spouse carers, men predominate, while the reverse pattern is evident among those caring for a parent or a child. There were around 7,700 parents aged 65 and over living with and caring for a child with a severe or profound handicap—almost half of these had been caring for that child for over 30 years (Madden et al. 1996).

Older carers were no less likely to be caring for highly dependent people than younger carers, where 'highly dependent' was defined as people who required help with five or more activities of daily living (showering, eating, mobility, continence, etc). Older carers, particularly women, were more likely than other carers to be caring in vulnerable circumstances—that is, they were more likely to be caring without any assistance, without a fall-back carer if they needed to go out or they became ill, and for a person who required essentially constant supervision. Older carers were also less likely than younger carers to report an unmet need for help, and more likely to report 'no need', suggesting a willingness to cope under what appear to be not infrequently quite difficult caring circumstances (Gibson et al. 1997).

Older carers are themselves quite likely to have some form of disability or handicap. The majority of younger carers had neither a disability nor a handicap, while amongst those aged 65 and over 56% had a disability, and 45% a handicap. Of those with a handicap almost 50% had a mild handicap, a third had a moderate handicap and 13% a profound or severe handicap. At older ages these proportions increase considerably, with 60% of carers aged 80 and over having a handicap.

Principal carers aged 65 and over; age by sex by relationship to recipient, Australia 1993 (%)

	Males					Females				
Age	Spouse	Parent	Child	Other	Total (N)	Spouse	Parent	Child	Other	Total (N)
65–79	77.3	2.0	2.7	17.9	44,300	67.5	8.2	13.3	10.9	49,700
80+	89.1	0	7.6	3.3	11,400	89.0	0	5.9	5.1	6,600
Total 65 and over	**79.8**	**1.6**	**3.7**	**14.9**	**55,700**	**70.0**	**7.2**	**12.5**	**10.2**	**56,300**

Principal carers; age by disability status, Australia 1993 (%)

Age	Disability status				Total number of carers (N)
	Handicap	Disability, no handicap	Total with disability	No disability, no handicap	
15–44	17.5	5.5	24.7	77.0	208,400
45–64	31.0	6.9	43.2	62.1	220,800
65+	45.0	10.6	55.6	44.4	112,000
Total	**28.7**	**7.1**	**35.8**	**64.2**	**541,200**

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Data sources

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Healthy ageing

16

The World Health Organization (WHO) defines health broadly as a state of complete physical, mental and social well-being; and not solely as the absence of disease. In Australia, this WHO approach to health has long been advocated by consumer groups representing older people. Their efforts have been supported by a recognition that most older people retain high levels of independence, and indeed make substantial contributions to society in general. Many health difficulties, formerly thought to be inevitable in old age, are now known to be preventable, postponable, or ameliorable (Teshuva et al. 1994).

Social attitudes and policies are beginning to recognise the potential for more positive experiences of ageing. The healthy ageing movement has been stimulated by rising expectations for quality as well as length of life. Recent cohorts of older people have more personal and social resources than their predecessors. They are fitter and healthier and have more knowledge of the risks to good health, including smoking, excessive alcohol consumption, and sedentary lives. Their lifestyles are varied and offer ample opportunities for creative living.

Australian research has reported on older people's own views on healthy lifestyles. The Health Status of Older People Project, based on a survey of 1,000 older people in Melbourne, found that feeling healthy meant that respondents had a positive outlook on life and maintained physical and social activity (Kendig et al. 1996). The vast majority said they took actions to keep healthy, primarily through physical activity, healthy eating, and social activity. Substantial minorities, however, had low levels of physical activity even though they were physically capable. Overall, older people are more aware of the importance of healthy lifestyles than are younger people.

Qualitative studies show that older Australians have been strongly influenced by diverse life experiences, including war and economic depression. Many older people perceive themselves as survivors from the poor health prevalent when they were children, and from the thinning ranks of those who are growing older (Walker-Birckhead 1996). Older people demonstrate coping abilities, self-reliance and stoicism.

The vast majority of older people find their lives satisfying and they frequently feel happy. Conversely, the prevalence of depression is very low among older people except for the relatively few who live in residential care. Even those with chronic illness generally maintain satisfaction with life by adjusting their expectations and daily routines. Most people in middle and older age groups have mixed but largely positive feelings about the future. Many older people perceive negative stereotypes about ageing, leading them to call for a more assertive defence of their rights. They also believe that older people should receive more community recognition for their contributions to society (Shanahan 1994).

Older people's opportunities to live satisfying lives can be limited by economic and social circumstances which are amenable to public intervention. Those who live alone are especially likely to report financial strain as a major problem (Kendig et al. 1996; Shanahan 1994). Barriers to remaining socially and physically active include having to give up driving, poor public transport, and inaccessible shops and facilities. Older people can be vulnerable particularly to financial crimes, and fear of crime prevents some from leaving home at night.

Healthy ageing means that older people are able to be independent and active participants in Australian society. A number of studies have shown that older people deliver substantial (but largely unrecognised) benefits to their families and communities, through both informal support to friends and family members and voluntary work. Yet many older people accept the widespread negative stereotypes about older people, and these images are reinforced by the mass media.

Older people continue to contribute to the growth of the economy as well as form an expanding part of the nation's consumer market. Inevitably this will translate into more economic influence. A growing proportion of older people in the electorate increases their political influence in a system where voting is compulsory.

Older people were established as a priority group in the National Better Health Program in the late 1980s. This program, influenced by the WHO Ottawa Charter, funded community-based interventions for older people extending beyond the conventional health system. The 1994 National Health Goals and Targets focused mainly on generic issues—mortality, morbidity, and lifestyles—and paid little attention to older people. The Public Health Association (Australia) recently established a Health Promotion and Ageing policy statement, advocating greater emphasis on older people in preventative strategies addressing major causes of illness and disability.

There presently is renewed momentum for stimulating healthy ageing. State Governments, including Offices on Ageing and Health Promotion Foundations, have led interventions on positive ageing and healthy lifestyles. Under the Healthy Seniors Initiative, an election commitment of the Commonwealth Government, a range of projects will be funded which encourage good health and well-being for older Australians. The Healthy Ageing Task Force, established by Health and Community Services Ministers in October 1996 and comprising members from the Commonwealth and each State and Territory, is developing the strategic framework for healthy ageing in Australia. Australian Coalition '99, an alliance of advocacy groups and aged care providers, aims to place healthy and positive ageing as the centrepiece for public action during the International Year of Older Persons.

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Carers

17

With the growing emphasis on home-based care, informal care by family, friends and neighbours is increasingly being recognised as an important source of support to people of all ages. Carers play a key role in maintaining frail older people in the community and the need for this support appears set to increase in the future. According to the 1993 Survey of Disability, Ageing and Carers there were some 541,200 principal carers providing assistance to people with a profound or severe handicap, that is, people who required help in the areas of self-care, mobility or communication.

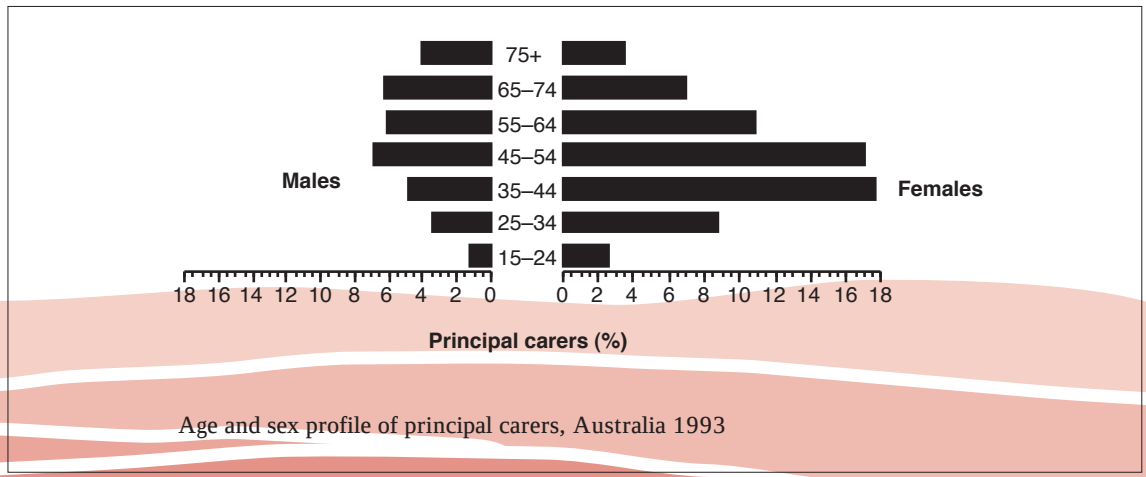
The vast majority of principal carers provide care to people living in the same household (72%). While those caring for someone in another household tended to be caring for somewhat less dependent people overall, the differences were not as marked as might have been expected. Non-co-resident carers were most commonly daughters, while among co-resident carers they were most commonly spouses (Gibson et al. 1997).

Variations exist in the age and sex profiles of principal carers, with over two-thirds of all principal carers being women. The modal age group was different for males and females, with the highest proportion of principal carers for women being the 35 to 54 age group (51% of all female carers falling into this age category), while for men the modal age group was the 45 to 74 age group (59% of male carers). While 31% of male carers were aged 65 and over, only 16% of women fell into this older age group.

Almost two-thirds (60%) of male carers provided care to their partner, while among female carers the proportion was significantly lower at 33%. Over half of all female carers provided care to children (23%) and parents (29%).

The majority of principal carers were caring for only one person (92%); however, non-co-resident principal carers were substantially more likely to care for more than one person than co-resident principal carers (19% compared to 5%). Young carers were more likely to be caring for more than one person than older carers, with all carers aged 80 and over caring for only one person. Carers aged 35 to 44 were most likely to be caring for two people.

The caring role can be physically, mentally and emotionally demanding. For co-resident carers, less than one-third reported feeling weary or lacking energy, a third reported feeling frequently worried, depressed or angry, and 15% reported stress-related illnesses as a result of the caring role. For non-co-resident carers, 20% reported feeling weary or lacking energy, 25% that they were frequently worried, depressed or angry, and 9% that they had suffered stress-related illnesses.



Age and sex profile of principal carers, Australia 1993

All principal carers; number of care recipients by type and age of principal carer, Australia 1993 (%)

	Co-resident principal carers					Non co-resident principal carers				
Number of recipients	**15–44**	**45–64**	**65–79**	**80+**	**Total**	**15–44**	**45–64**	**65–79**	**80+**	**Total**
One	94.2	94.8	98.1	100.0	95.5	76.6	82.6	95.4	100.0	81.2
Two or more	5.8	5.2	1.9	0.0	4.5	23.4	17.4	4.6	0.0	18.9
Total (N)	**142,400**	**147,800**	**81,400**	**17,400**	**388,900**	**65,900**	**73,000**	**12,600**	**700**	**152,300**

All principal carers; expressed need for assistance in caring role by relationship of carer to recipient, Australia 1993 (%)

Need for assistance	**Child**	**Parent**	**Spouse**	**Other**	**Total**
No need	30.7	29.9	68.0	37.3	47.2
Unmet need	21.9	22.1	9.0	12.1	15.1
Met need	47.4	48.1	23.0	50.6	37.7
Total (N)	**88,800**	**144,600**	**228,300**	**79,400**	**541,200**

Almost half of all principal carers neither received nor needed any help with the caring role from family, friends or formal organisations, 38% were receiving the help that they needed and 15% either needed help but were not receiving it, or needed more help than they were receiving. Principal carers of parents and children were twice as likely to report a 'met need' and an 'unmet need' for assistance compared to principal carers of partners, over two-thirds of whom reported 'no need' for assistance. These trends are supported by the age and sex profiles of principal carers, with older carers most likely to report 'no need' for assistance. This was particularly the case for women aged 80 and over, where two-thirds reported 'no need'. A different pattern emerged among male carers aged 80 and over where a higher proportion reported a 'met need' for assistance than reported 'no need' (46% compared to 40%).

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Data sources

Data presented here are drawn from unpublished data from the Australian Bureau of Statistics 1993 Survey of Disability, Ageing and Carers.

Formal vs informal care

The vast majority of older people living in the community who required help with self-care, mobility or communication (as the Australian Bureau of Statistics defines persons with a severe or profound handicap) received assistance from the informal care network (94%). Only a small proportion relied exclusively on formal assistance from a community organisation or a health professional, although around one-third received help from both informal carers and formal services.

Those living with family members were much more likely to be receiving help from the informal network only, than were those living alone. Persons living alone were more likely to be receiving help from formal services; almost two-thirds of older people living alone received formal assistance compared to around a quarter of those living in families. However, those who lived alone did receive informal assistance—85% of older people living alone received informal assistance. This provides a timely reminder of the importance of assistance from family and friends for those living alone. Males were more likely to be receiving only informal assistance, while females were more likely than males to be receiving both informal and formal assistance (AIHW 1995). This is in keeping with the greater proportion of older women than older men who live alone, particularly at advanced ages.

The types of activities with which assistance is received provide some insight into the kind of support provided by the informal and formal networks. Interestingly, severity of handicap was found to influence both the type of help received, and the source of that assistance.

In the 1993 Survey of Disability, Ageing and Carers conducted by the Australian Bureau of Statistics, there were an estimated 683,500 persons aged 65 and over with a disability and living in the community who reported a need for help in at least one activity. Of these, 36% had a profound or severe handicap, 22% had a moderate handicap and 34% had a mild handicap.

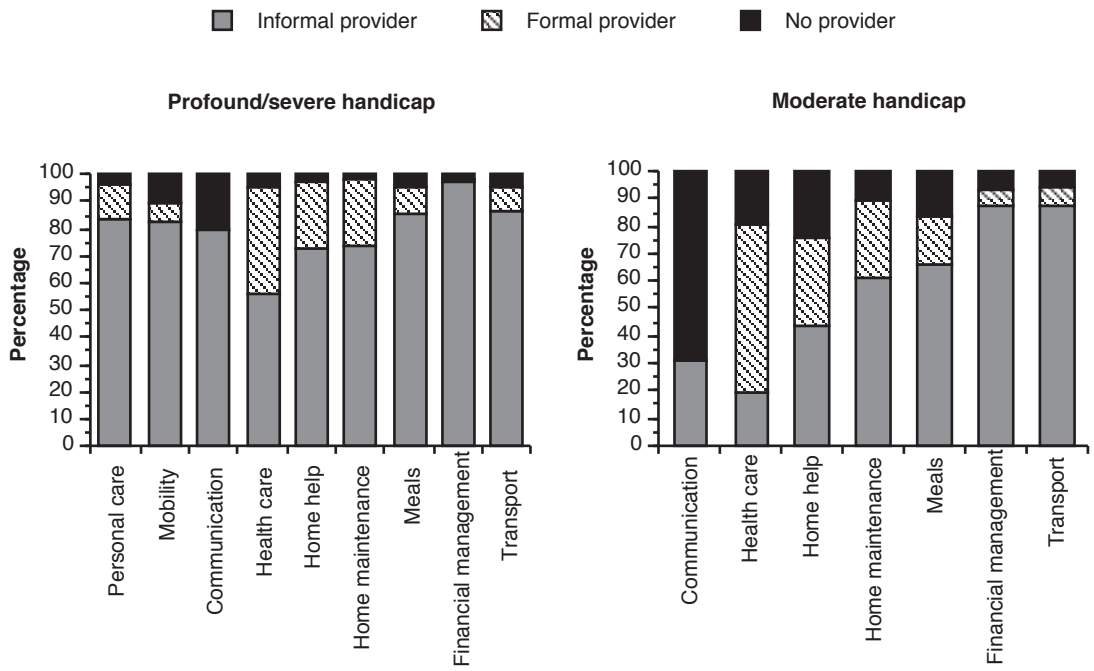
The vast bulk of assistance required by older people with a profound or severe handicap was provided by the informal care network of family, friends and neighbours. For activities such as personal care, mobility, communication, meals, financial management and transport, over 80% of respondents reported that an informal carer was their main source of help. Between 73 and 74% reported a similar pattern with regard to home help and home maintenance, and even for health care 56% of respondents reported the informal care network rather than formal services as their main provider. Formal providers of assistance were most commonly reported with regard to health care assistance (40%), followed by home help and home maintenance (25%) and personal care (13%). Verbal communication (20%) and mobility (11%) were the areas where respondents were most likely to report that they needed, but were not receiving, help.

For older people with a moderate handicap, the patterns were somewhat different, although informal care still predominated. Older persons

All persons aged 65 and over with a profound or severe handicap living in the community; type of assistance received by living arrangements, Australia 1993 (%)

Living arrangements	Informal only	Formal only	Both	None	Total (N)
Lives in family	71.7	0.3	26.5	1.5	150,400
Lives with non-relatives	50.5	0.0	49.5	0.0	1,400
Lives alone	34.3	10.4	51.1	4.2	75,600
Total	**59.2**	**3.6**	**34.8**	**2.4**	**227,400**

Prepared by the Australian Institute of Health and Welfare



All persons aged 65 and over with a profound, severe or moderate handicap living in the community; type of provider of assistance by activities they need assistance with, Australia 1993

with this level of dependency were more likely than those with a profound or severe handicap to receive help from formal services or to receive no help, and less likely to have an informal carer. (Note that, by definition, people with a moderate handicap do not require or use assistance with personal care or mobility.) Nonetheless, informal carers remained the predominant source of care for most older people with a moderate handicap across most areas in which they received assistance.

For those older people with a mild handicap, home help, home maintenance and meal preparation were the activities where a provider of assistance was most commonly reported. Again, most of this assistance was provided by informal carers.

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Data sources

Data presented here are drawn from unpublished data from the Australian Bureau of Statistics 1993 Survey of Disability, Ageing and Carers.

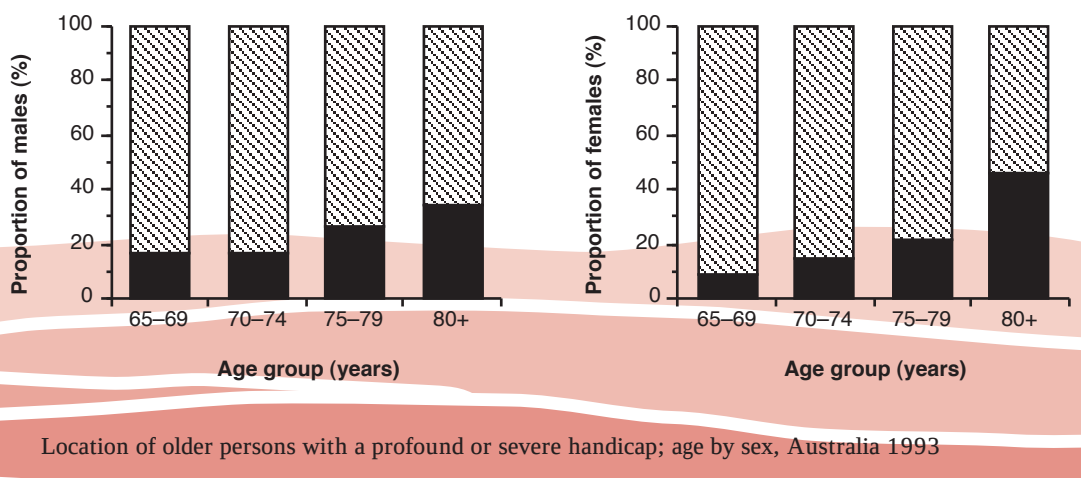
Changing patterns of care (1988–1993)

One of the more important policy developments in Australia over the last decade has been the shift in the balance of care away from the more intensive types of residential care and towards home-based care. Data from the Disability, Ageing and Carers Surveys provide a useful basis on which to examine this changing balance of care by looking at the current location of frail and disabled older people in Australia.

In 1993 the majority of older people with a profound or severe handicap were living in the community (70%). The proportion in health establishments (including those in residential care) increased quite markedly with age; 17% of 65–79 year olds were in health establishments compared to 42% for people aged 80 and over. There was also a distinct sex effect, with older women more likely to be in health establishments than older men (46% compared to 34%), a finding consistent with the notion that men are able to remain in the community due to the greater availability of wives as carers for older men. Among the younger age groups, men were more likely than women to be in health establishments. This finding is consistent with the higher prevalence rates of profound and severe handicap among men than women in the pre-retirement years.

The proportion of frail and disabled older people living in the community has increased over the last decade. Between 1988 and 1993, the proportion of people aged 80 and over living in the community increased from 50% to 59%, while the comparable increase in the 65–79 age group was from 79% to 84%. These findings are also supported by analyses of administrative by-product data on residency in both hostels and nursing homes, which show an overall reduction in age-specific utilisation rates for nursing homes and hostels (AIHW 1997). These trends are consistent with government policy over the last decade, which has emphasised the need to reduce reliance on residential care in favour of an expanded community care sector. A finer analysis of the health establishment data revealed that this reduction has occurred in both acute care (hospitals) and chronic care facilities, with the trend being most marked in acute care facilities (AIHW 1995).

These increases in the proportion of the older population with a profound or severe handicap and living in the community have impacted differently according to sex and age group, with the shifts being most marked among women and the very old. The proportion of women aged 80 and over increased by 10 percentage points, while for men



Location of older persons with a profound or severe handicap; age by sex, Australia 1993

Location of persons aged 65 and over with a profound or severe handicap; sex by age, Australia 1993 (%)

	1988						1993					
	Males		Females		Persons		Males		Females		Persons	
Location	**65–79**	**80+**	**65–79**	**80+**	**65–79**	**80+**	**65–79**	**80+**	**65–79**	**80+**	**65–79**	**80+**
Private households	79.4	61.0	79.5	46.5	79.4	49.8	81.2	65.9	85.1	56.4	83.7	59.0
Health establishments	20.6	39.0	20.5	53.5	20.6	50.2	18.8	34.1	14.9	43.6	16.3	41.0
Total (N)	**64,500**	**34,600**	**114,400**	**117,300**	**178,900**	**151,900**	**64,700**	**48,500**	**120,800**	**129,200**	**185,500**	**177,700**

the increase was only 5 percentage points. Again, these findings are further supported by an analysis of administrative by-product data which examined changes in the age and sex structure of nursing home residents over this period (Gibson et al. 1993).

These changes in the balance of aged care services have important implications for home-based care services, residential care services, the informal support network and society at large. The increased proportion of highly dependent older people living in the community means greater demands on both informal and formal support. Access to respite care has become an increasingly important policy issue, and there has been greater provision and use of home-based respite care, day centre care and residential respite services. In addition, the implications for the roles, rights and expectations of older people need to be considered. Government moves to develop a system of quality appraisal for Home and Community Care services, and to promote community awareness and develop support systems pertaining to elder abuse, are both examples of the recognition of these issues in Australia.

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Australian age pension

The Australian age pension was introduced in 1909, and many of its core elements have not changed since that time. The aim of the age pension is to provide an adequate safety net payment to older people unable to support themselves financially in their retirement. Its primary objective is thus the alleviation of poverty. As at March 1997, the single rate of pension was $347.80 a fortnight and the married rate of pension was $290.10 a fortnight for each member of a couple.

The Australian age pension is and has always been a flat rate non-contributory payment funded from general revenue. It is not linked to previous labour force participation.

The pension is both income and assets tested; it is thus targeted at those in financial need. Under the income test, the pension is reduced by 50c for each dollar of income over a specified 'free area' of income. As at April 1997, some pension was payable until income reached $804.40 a fortnight for single people and $1,343.20 a fortnight for couples (combined). Under the assets test, the pension is reduced by $3 a fortnight for every $1,000 of assets over specified limits, which vary between single people and couples, and home-owners and non-home-owners. For home-owners, the value of the family home is excluded from the calculation of assets.

The age pension is currently payable to men at age 65 years and women at age 61 years. Traditionally, women became eligible for the age pension at 60, but the pensionable age for women is being slowly increased to 65 over the next 16 years. It will reach 65 years in July 2013. Of the 1.6 million people receiving the age pension in June 1996, 1 million were women; thus women outnumber men by almost 2 to 1 amongst age pension recipients.

The age pension is paid to Australian residents, that is, a person whose normal place of residence is Australia and who is an Australian citizen or has permanent resident status. Except for refugees, a person must have been an Australian resident for a total of 10 years before the age pension is payable. This rule can be modified under shared responsibility social security agreements with specific countries.

The rate of pension paid is indexed to the Consumer Price Index (CPI), and is adjusted every March and September according to movements in that index. In addition, the Commonwealth Government has introduced legislation to support its commitment to maintaining the single rate of pension at a minimum of 25% of Male Total Average Weekly Earnings. This, together with CPI indexation, ensures that the relative value of the pension is maintained and that people who are dependent upon the age pension are able to benefit from increases in community living standards.

Pensioners also receive additional support in the form of rent assistance (if renting privately), a pharmaceutical allowance and the pensioner concession card which entitles the holder to a range of concessions on services provided by Commonwealth, State and Local Government.

The Department of Social Security retirement income program (incorporating age pension and wife pension for some partners of age pensioners) is

Age profile of age pensioners, Australia 1996

Sex	60–64	65–69	70–74	75–79	80–84	85–89	90–94	95+	Total
Males	–	235,019	140,133	85,500	67,257	31,742	9,161	1,516	570,328
Females	193,988	229,398	195,064	162,602	136,026	78,002	29,474	7,952	1,032,506
Persons	**193,988**	**464,417**	**335,197**	**248,102**	**203,283**	**109,744**	**38,635**	**9,468**	**1,602,834**

Prepared by the Department of Social Security

one of the largest of the Australian Government's expenditure programs with some 1.7 million recipients and total estimated outlays of $13.6 billion in 1997–98. This represents some 32% of total social security portfolio outlays.

There is also a range of benefits available to war veterans and their dependants through the Department of Veterans' Affairs (DVA). One of these is the service pension which is similar in many ways to the age pension. It is subject to income and assets tests in the same way as age pension. Some 337,830 people receive this payment from DVA. The service pension is available five years earlier than the age pension, that is, at age 60 years for males and 56 years for females (the qualifying age for females is being progressively increased from 55 to 60 in a similar way to the increase in the age pension age for women described overleaf). Like the age pension, the rate of service pension is linked to increases in the CPI and increases in the value of Male Total Average Weekly Earnings.

The ageing of the Australian population will impose pressure on program outlays in the Social Security Portfolio in the future. A number of policy responses have been undertaken to moderate the effects of the increasing number and proportion of older people in the population. There has been a greater emphasis placed on encouraging self-provision for retirement. Strategies here include the provision of free financial information for retirees and pre-retirees, and other methods of innovative service delivery, such as Retirement Service Centres. The government has also encouraged greater superannuation coverage through the compulsory superannuation guarantee, and encouraged increased personal savings through a newly announced tax rebate for savings.

The phasing in of the increased age at which women become eligible for the age pension (to equalise it with that for men) is also expected to yield some savings, as is the introduction of a deferred pension bonus plan for people continuing in gainful employment beyond the age pension age. (This measure recognises that many people are choosing to put their considerable skills and experience to productive use in the workforce beyond age pension age.)

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Data sources

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Superannuation in Australia

21

In addition to the publicly provided age pension, Australia has a compulsory superannuation system which has the objective of facilitating the accumulation of private savings for retirement.

In the early 1980s, superannuation funds covered less than half of the workforce and existed mainly in the public sector and among large private sector employers. In recognition of the need to encourage individuals to provide for their retirement, from 1986 employer-provided superannuation benefits were introduced into industrial award arrangements.

In July 1992 the Superannuation Guarantee took effect, which, combined with the introduction of superannuation in awards, led to a marked increase in the membership of superannuation schemes. Prior to the inclusion of superannuation in industrial award agreements in 1986, only 47% of full-time employees were covered by superannuation. In 1988, 64% of men working full time were covered, increasing to 86% by 1995. For women in full-time employment the growth in coverage was even more dramatic, from 47% in 1988 (substantially below that for men) to 89% in 1995. Those in part-time employment (particularly women) also improved their position over this period.

The Superannuation Guarantee legislation requires employers to provide a minimum level of superannuation support for employees earning $450 or more per month or become liable to pay a Superannuation Guarantee Charge. The Superannuation Guarantee is being phased in over a ten-year period. In 1997–98, employers are required to make contributions equivalent to 6% of an employee's annual earnings, with this level rising to 9% by 2002–03. Employees who are under age 18 and are working less than 30 hours per week are excluded from these arrangements.

As a result of these superannuation arrangements, most Australian workers will receive a higher income in retirement than the age pension alone could provide. For example, it is estimated that a person on average weekly earnings over 40 years and in receipt of 9% employer contributions over that time would experience a 68% increase in their retirement incomes relative to the age pension.

Initiatives to encourage and require superannuation savings have contributed to the very rapid growth in the level of superannuation assets in the Australian economy. The total value of superannuation assets had risen from around $40 billion in 1983 to around $270 billion at the end of 1996. Most superannuation funds (with the

Superannuation coverage; sex by age and labour force status, Australia 1988 and 1995 (%)

	Coverage of male population		Coverage of female population	
	1988	1995	1988	1995
Labour force status				
Employed full time	63.5	85.5	46.8	88.8
Employed part time	20.4	47.8	19.0	66.1
Unemployed	3.2	4.3	2.2	4.5
Not in labour force	1.8	2.4	1.5	3.1
Age				
15–44	52.6	70.5	24.0	55.0
45–64	50.4	60.2	16.8	41.9
65–74	2.4	3.2	0.2	1.3

Prepared by the Commonwealth Treasury

exception of funds established for Commonwealth and State or Territory government employees) are privately managed. The Commonwealth Government does not mandate fund investment strategies, apart from requiring funds to meet prudential regulation requirements.

Superannuation is concessionally taxed at three levels: at the contribution stage, during accumulation and at the end-benefit stage. 'Reasonable Benefit Limits' limit the amount of concessionally taxed superannuation saving a person can accumulate over their lifetime to $434,720 where the benefits are taken in the form of a lump sum, or $869,440 where at least half the benefits are taken in the form of a life pension or lifetime annuity (these limits are indexed).

Superannuation benefits will in the future be required to be preserved in the superannuation system until retirement on or after age 55. Higher rates of tax apply to benefits taken before age 55. The government has indicated that it will increase the preservation age to age 60 by 2025.

Superannuation funds may generally only accept contributions made in respect of a gainfully employed member who is under age 70. However, there are exceptions for particular circumstances, including for individuals who temporarily leave the workforce to care for children, or who leave the workforce due to ill-health.

A number of initiatives have been introduced to improve the level of choice and competition in superannuation and to take account of the changing structure and composition of Australian families and the changing nature of work. These include allowing employees earning from $450 to $900 per month to receive salary and wages in lieu of compulsory Superannuation Guarantee contributions (to the extent that those contributions exceed award superannuation obligations, and if their employer agrees), and allowing a contributing spouse to receive a rebate for contributions on behalf of a non-income earning or part-time working spouse.

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Housing of older Australians

22

Housing is a major factor in the quality of life of all people, at all ages. Older Australians are characterised by very high rates of home ownership—over three-quarters of people aged 60 and over are home owners. Australia's rates of home ownership are among the highest of any of the advanced industrial countries (Kendig and Pynoos 1996). Housing therefore constitutes a significant personal, social and financial resource for many older people. Long-term residence in their own homes provides a sense of security and continuity, and a base for daily activities and social interaction in a familiar context.

Most persons aged 60 and over (94%) lived in private dwellings in 1993, although this decreased with age from 98% of those aged 60–69 to 84% of men and 74% of women aged 80 and over. At younger ages (60–69), the predominant living arrangement of both men and women was with a spouse in a private dwelling (80% and 64%, respectively), but this proportion reduced quite quickly with age, especially for women. By age 70–79 only 42% of women lived in a private dwelling with a spouse, and by 80 and over this had reduced to 14%. The proportions living with relatives other than a spouse or living alone increased with age, again more dramatically for women. This was also the case with regard to the proportions living in health establishments.

Home ownership is higher among older people—24% of those aged 15–59 owned their own homes, compared to 77% of those aged 60 and over. Even if those purchasing their own homes are included, rates of home ownership remain substantially higher among older people (82% compared to 54%). Living arrangement also enters into the picture, however, as home ownership rates were higher among older people in couple households (85%) than they were among people in lone person households (70%). There were correspondingly fewer older people who were renting; however, those who were renting were more likely to be public rather than private renters compared to the 15–59 age group. A larger proportion of older single people were renters than was the case for couple households.

While home ownership generally confers significant financial security on older Australians, it is also the case that property rates and maintenance costs may present difficulties to those

Living arrangements of older people; age by sex, Australia 1993 (%)

	60–69		70–79		80 and over		60 years and over
Living arrangements	**Men**	**Women**	**Men**	**Women**	**Men**	**Women**	**Persons**
Private dwellings	**97.6**	**98.4**	**96.1**	**94.9**	**83.9**	**74.3**	**94.0**
With spouse	79.6	63.5	74.1	41.8	54.5	13.8	59.4
With other family	4.0	9.9	3.8	12.6	8.6	17.1	8.7
With unrelated people	1.5	1.1	1.4	1.1	0	0.8	1.2
Alone	12.5	23.9	16.9	39.4	20.2	42.6	24.7
Non-private dwellings	**2.4**	**1.6**	**3.9**	**5.1**	**16.1**	**25.7**	**6.0**
Health establishments	1.1	1.0	3.3	4.4	15.7	25.0	5.2
Other	1.3	0.6	0.5	0.6	0	0	0.8
Total (N)	**686,100**	**714,300**	**410,700**	**531,200**	**142,900**	**277,700**	**2,763,000**

Housing tenure by age and household type, Australia 1994 (%)

	Lone person households		Couple households		All people	
Tenure type	**15–59**	**60 and over**	**15–59**	**60 and over**	**15–59**	**60 and over**
Owner	23.3	70.0	28.6	85.4	24.1	76.8
Purchaser	25.3	4.2	35.2	5.9	29.5	5.2
Renter	47.4	21.5	16.3	7.5	23.6	11.5
Public	7.0	11.3	2.9	3.4	3.7	5.6
Private	38.4	7.3	11.8	3.4	17.5	4.6
Other	4.1	4.3	19.9	1.1	22.7	6.5
Total (N)	**744,600**	**709,500**	**7,807,900**	**1,583,900**	**11,038,200**	**2,635,100**

living on the basic age pension. Nonetheless, in 1994, only 7% of older owners were classified as having affordability problems (that is, households who were in the lowest two income quintiles and spent more than 25% of their incomes on housing-related costs). In contrast, among older Australians, 67% of private renter households experienced housing affordability problems.

In old age the cumulative effects of housing choices and opportunities (including government housing policies) interact with contemporary health and welfare services. Housing, in combination with the accessibility and availability of services, strongly influences the extent to which individual needs for health and welfare assistance are met, and the ways in which they are met. The majority of older people who own their own home have an asset which can be used to obtain entry to a range of accommodation types, including retirement villages, self-contained accommodation within a supported environment, hostels and nursing homes. A key theme in current Australian debates concerning housing policies for older people is the need to achieve more flexible models of housing provision, which encompass a wide range of settings whilst fostering supportive environments and facilitating the delivery of appropriate care services.

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Retirement in Australia

Australia's population aged 65 years and over is projected to increase substantially into the next century. In 1993, 12% of the population was aged 65 years or over. This is projected to increase to 14% by 2021, rising to 22% by 2041. In the absence of any increase in retirement saving, the projected increase in the proportion of the population over age 65 could cause significant pressure on outlays and the maintenance of adequate social security payments.

These demographic shifts are occurring in conjunction with major changes in labour force participation for both men and women, including:

- a general decrease in the participation rate for men;
- a general increase in the participation rate for women;
- increasing importance of part-time and casual employment;
- women being older when they have their first child;
- longer periods spent in education by the young; and
- early retirement.

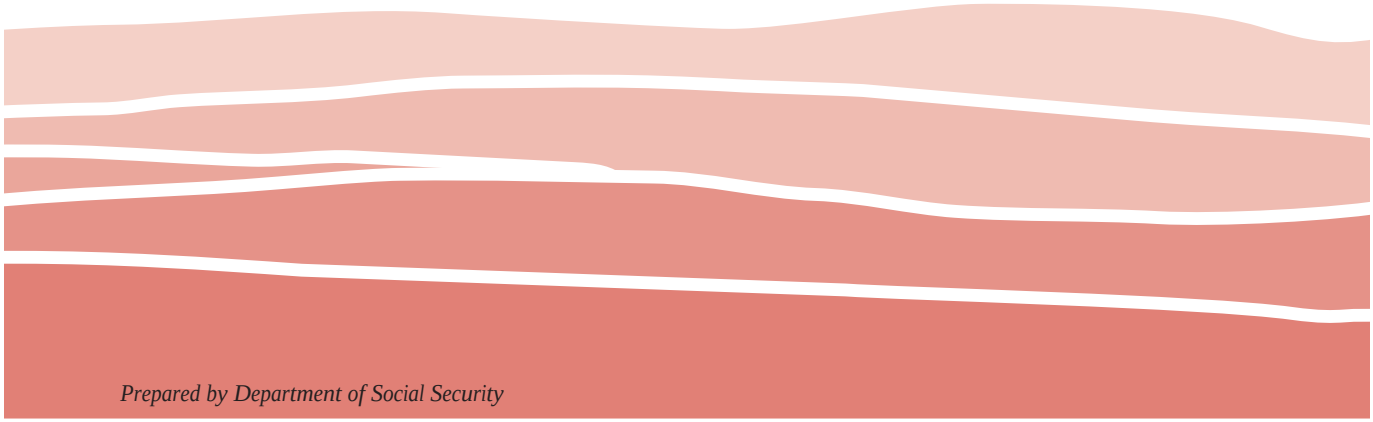
Labour force projections show a significant increase in full-time and part-time employment at older ages as the 'baby boomer' generation moves through. A move towards self-employment at older ages has also been noted. In recognition of women's increased labour force participation, the age at which they can qualify for the age pension is being progressively increased from 60 years to 65 years.

There is an increasing trend towards earlier retirement, that is, withdrawal from the labour force before age pension age (65 years for men and 61 years for women). According to data from the Australian Bureau of Statistics, in 1994, 74% of men and 87% of women had already retired from full-time work during the five-year period preceding their eligibility for age pension. This may be voluntary or, alternatively, given the major restructuring of the economy over recent years, many older workers may have been retrenched, with little possibility of re-entering the labour force.

There is no statutory retirement age in Australia. The retirement incomes system envisages a possible span of retirement starting between the ages of 55 to 70 years during which retirement savings can continue to accumulate or retirement income can be accessed.

Age at retirement of retirees from full-time work, Australia 1994

Age	Less than 45	45–49	50–54	55–59	60–64	65–69	70 and over	Total
Males	91,900	68,400	120,400	248,500	410,400	288,600	40,900	1,269,100
Females	1,061,100	162,900	206,100	208,500	179,400	46,600	12,400	1,877,000
Total persons	**1,153,000**	**231,300**	**326,500**	**457,000**	**589,800**	**335,200**	**53,300**	**3,146,100**



Prepared by Department of Social Security

Age regulations and qualifications governing superannuation and social security systems	
55	Age to which superannuation entitlements are compulsorily preserved. From age 55, preserved superannuation becomes available upon retirement. For people aged 55 to 60 years, Regulations under the Superannuation Industry (Supervision) Act 1993 define retirement as permanent withdrawal from the workforce. A phased increase in the superannuation preservation age to 60 is to begin in 2015 and will affect people born after 30 June 1960. By 2025, people born after June 1964 will be subject to a preservation age of 60 years. People aged 55 years and over can access a range of social security pensions and benefits depending on their circumstances, e.g. Disability Support Pension, Newstart Allowance, Carer Pension and Widow Allowance. From September 1997, superannuation assets of those aged 55 and over will be taken into account under the income and assets tests after 9 months on income support (pending legislation).
60	Under SIS Regulations, after age 60, retirement may be taken to have occurred upon cessation of a period of gainful employment even if the person intends to re-enter gainful employment . Current qualifying age for Mature Age Allowance.
61	Women's current qualifying age for age pension. The age pension age for women is being slowly increased to 65 over the next 17 years (reaching 65 years in July 2013).
65	Men's qualifying age for age pension.
70	From 1 July 1997 people will be allowed to continue to contribute to a regulated superannuation fund up to age 70, provided they are gainfully employed for at least 10 hours per week over the year.

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Hospital use by older Australians

In Australia in 1993–94 there were 702 public and 329 private acute and psychiatric hospitals. In 1995–96 Australia had a rate of 283 hospital separations per 1,000 persons, a rate higher than for the other OECD countries for which data were available. These higher rates are largely attributed to the inclusion of same-day admissions in the Australian data, which results in a comparatively short average length of stay (the lowest among OECD countries reporting length of stay).

Older Australians account for a large number of hospital separations. They have a higher rate of admission to hospital than the general population, and tend to stay longer. In 1995–96 patients aged 65 and over accounted for 1.5 million hospital separations (30% of all separations) and 11 million patient days (48% of all patient days). While older men and older women accounted for roughly equal numbers of separations (763,600 and 772,600), women predominated in terms of patient days (4,864,300 for men and 6,306,400 for women). This reflects the larger proportion of women than men in the older population, particularly at more advanced ages where length of stay tends to be longer.

Given the relatively small proportion of older people in Australia (12%) and their substantially different age structure, hospital separations and patient days per 1,000 population provide a better indication of relative rates of hospital use than do absolute numbers of separations and patient days. Hospital use is greater among older persons than the general population; the number of separations per 1,000 persons aged 65 and over was 706, compared to an overall rate of 284 for the total population. For both males and females separation rates increased markedly with age, particularly for males. While separation rates were higher for females than for males in the general population (due in part to higher rate of admissions among women for reproductive health care), a different trend emerged amongst the older population.

Patients aged 65 and over; hospital separations and patient days by age and sex, Australia 1995–96

	Separations		Patient days	
Age by sex	**Number**	**Per 1,000 population**	**Number**	**Per 1,000 population**
Males				
65–69	215,300	640	1,029,800	3,060
70–74	221,400	811	1,193,300	4,371
75–79	163,400	934	1,094,800	6,255
80–84	102,000	978	867,100	8,310
85+	61,600	1,058	679,300	11,668
Total	763,600	806	4,864,300	5,136
Females				
65–69	180,600	508	929,500	2,617
70–74	190,500	588	1,166,800	3,603
75–79	160,100	664	1,307,100	5,420
80–84	130,600	752	1,383,000	7,958
85+	110,700	813	1,520,000	11,157
Total	772,600	628	6,306,400	5,126
Total 65+	**1,536,200**	**706**	**11,170,700**	**5,130**

Prepared by the Australian Institute of Health and Welfare

Older men had higher rates of hospital separations than older women, with these differences most prominent amongst the very old (85 and over age group). Separation rates increased at older ages for both men and women.

Similarly, older men accounted for a larger number of patient days per 1,000 population than did older women at any given age, and these rates again increased with age for both men and women. However, the older average age of women in comparison to men results in a situation where total patient day usage rates per 1,000 of the population were quite similar for older men and older women (5,136 and 5,126).

Older patients generally stay longer in hospitals, on average 7.3 days compared to 4.5 days for all age groups. Older women had longer average lengths of stay in hospital than older men, 8.2 days on average compared with 6.4 days. As was the case for both separations and patient day rates per 1,000 of the population, average length of stay increased with age for older patients, especially for women. The differences between men and women were most marked amongst the very old, with men aged 85 and over on average staying for 11 days in hospital compared to 14 days for women of the same age group.

Patients aged 65 and over; average length of stay (days) by age and sex, Australia 1995–96

Sex	65–69	70–74	75–79	80–84	85+	Total
Males	4.8	5.4	6.7	8.5	11.3	6.4
Females	5.1	6.1	8.2	10.6	13.7	8.2

References/further reading

Australian Institute of Health and Welfare 1996. Australia's health 1996: the fifth biennial report of the Australian Institute of Health and Welfare. Canberra: Australian Government Publishing Service (AGPS).

Australian Institute of Health and Welfare 1997. Australian hospital statistics 1995–96. Health Services Series No. 10. Canberra: AGPS.

Data sources

Data presented here are drawn from the Australian Institute of Health and Welfare National Hospital Morbidity Database (includes data from public acute and psychiatric hospitals, Department of Veterans' Affairs hospitals, and private acute and psychiatric hospitals).

25

Hospital statistics—diagnoses and procedures

There are many reasons why older people are admitted to hospitals; the data presented here examine the principal diagnosis and the main procedure performed on the patient whilst in hospital care. Principal diagnosis is defined here as 'the diagnosis established after study to be chiefly responsible for occasioning the patient's episode of care in hospital' (AIHW 1997). The primary diagnosis is coded from patient's medical records according to the International Classification of Diseases 9th revision Clinical Modification (ICD-9-CM).

The 20 most commonly reported principal diagnoses for people aged 65 and over and the general population highlight the reasons that older people are admitted to hospitals. The most common diagnosis for older Australians in 1995–96 was dialysis, reported for 8.2% of cases, followed by cataract (5.1%). Diagnoses associated with heart disease were also commonly reported (9.4%). Of the 20 diagnoses, all but general symptoms and gastritis and duodenitis were more commonly reported in the older age groups than overall. For example, cataract was the diagnosis for

Patients aged 65 and over; separations for the 20 most frequently occurring principal diagnoses, Australia 1995–96

Principal diagnosis	Number	Per cent
V56 Encounter for dialysis	126,551	8.2
366 Cataract	78,855	5.1
V58 Other and unspecified procedures and aftercare[(a)]	64,906	4.2
V57 Care involving use of rehabilitation procedures	50,203	3.3
428 Heart failure	35,155	2.3
411 Other acute and subacute forms of ischaemic heart disease	31,259	2.0
173 Other malignant neoplasm of skin	29,945	2.0
715 Osteoarthritis and allied disorders	24,775	1.6
530 Diseases of oesophagus	24,709	1.6
427 Cardiac dysrhythmias	20,748	1.4
562 Diverticula of intestine	20,587	1.3
410 Acute myocardial infarction	19,828	1.3
413 Angina pectoris	19,495	1.3
V67 Follow-up examination	18,845	1.2
786 Symptoms involving respiratory system, chest	18,561	1.2
600 Hyperplasia of prostate	17,795	1.2
414 Other chronic ischaemic heart disease	17,423	1.1
780 General symptoms	16,506	1.1
535 Gastritis and duodenitis	15,432	1.0
820 Fracture of neck of femur	15,373	1.0
– All other diagnoses	867,922	56.5
– Not stated	1,329	0.1
Total separations	**1,536,202**	**100.0**

(a) Includes chemotherapy.

Patients aged 65 or more; separations for the 20 most frequently occurring principal procedures, Australia 1995–96

Principal procedure	Number	Per cent
39 Other operations on vessels[a]	134,618	8.8
45 Incision, excision and anastomosis of intestine[b]	121,600	7.9
99 Other non-operative procedures[c]	103,165	6.7
13 Operations on lens	79,123	5.2
86 Operations on skin and subcutaneous tissue	43,993	2.9
57 Operations on urinary bladder	38,360	2.5
81 Repair and plastic operations on joint structures	33,022	2.2
87 Diagnostic radiology	26,588	1.7
37 Other operations on heart and pericardium	25,038	1.6
88 Other diagnostic radiology and related techniques	21,288	1.4
60 Operations on prostate and seminal vesicles	20,739	1.4
93 Physical, respiratory therapy, rehabilitation and related procedures	19,828	1.3
79 Reduction of fracture and dislocation	17,304	1.1
53 Repair of hernia	16,584	1.1
51 Operations on gall bladder and biliary tract	16,119	1.1
38 Incision, excision and occlusion of vessels	14,920	1.0
36 Operations on vessels of heart	13,544	0.9
92 Nuclear medicine	12,336	0.8
80 Incision and excision of joint structures	11,277	0.7
21 Operations on nose	9,251	0.6
– All other procedures	203,087	13.2
– No procedure or not stated	554,418	36.1
Total separations	**1,536,202**	**100.0**

(a) Includes haemodialysis. (b) Includes endoscopies. (c) Includes chemotherapy.

5.1% of older patients but only 1.8% of patients overall. Similarly, heart failure accounted for 2.3% of older patient separations compared with 0.8% of the total and osteoarthritis was reported for 1.6% and 0.9%, respectively. Other diagnoses such as diverticula of the intestine (1.3%), hyperplasia of the prostate (1.1%) and fractured neck of femur (1%) were also typically associated with older people in 1995–96.

During hospitalisation, the most frequently reported procedures for older Australians were other operations on vessels (including haemodialyisis) (8.7%), followed by incision, excision and anastomosis of the intestine (which incorporates endoscopies) (7.9%) and other non-operative procedures (including chemotherapy) (6.7%). Comparing the 20 most commonly reported procedures for older patients and those reported for all patients shows that most of the procedures were more frequently reported for older patients than overall. For example, operations on lens were reported for 5.2% of older patients but only 1.8% of all patients and operations on the urinary bladder were reported for 2.5% and 1.4%, respectively. Repair and plastic operations on joint structures (2.2%), operations on the prostate (1.4%) and operations on heart vessels (0.9%) were also more common for older patients.

References/further reading

Australian Institute of Health and Welfare (AIHW) 1997. Australian hospital statistics 1995–96. Health Services Series No. 10. Canberra: AGPS.

Data sources

Data presented here are drawn from the Australian Institute of Health and Welfare National Hospital Morbidity Database (includes data from public acute and psychiatric hospitals, Department of Veterans' Affairs hospitals, and private acute and psychiatric hospitals).

Assessment strategies

In 1986, the Report of the Nursing Homes and Hostels Review argued strongly that there was a need for the substantial restructuring of Australia's aged care services. The excessive emphasis on institutional care, the lack of coordination of services and the inefficiency of funding mechanisms were all central issues, as was the failure to develop adequate assessment procedures. Over ensuing years, this led to a number of policy initiatives including the creation of a national assessment program, with the objective of ensuring that older people in need of a substantial level of care and support gain access to the available residential care and community services appropriate to their needs.

In 1984, geriatric assessment teams had been trialed as a way of assessing people who wished to gain entry to Australian nursing homes. These were subsequently adopted as the preferred assessment strategy for nursing home entry, and expanded substantially over ensuing years under the new title of Aged Care Assessment Teams. By 1991–92, Aged Care Assessment Teams (often referred to as ACATs) were approving over half of the admissions to nursing homes and hostels.

Today, there is a network of 121 regionally based multidisciplinary Aged Care Assessment Teams which provide services across the entire continent. Some work out of large metropolitan teaching hospitals, others work in rural areas where the 'team' comprises only the community nurse and a part-time clerical assistant. Aged Care Assessment Teams are responsible for determining eligibility for admission to nursing homes (higher dependency residential care), hostels (lower dependency residential care) and for community aged care packages (an intensive form of home-based support akin to hostel level care). They may also recommend a range of Home and Community Care services, including the community options program, although they do not determine eligibility for these latter services. The clients seen by these teams thus include a number of people requiring general advice, referral or some form of assistance in managing their ongoing care in the community.

The most recently available national data from the Aged Care Assessment Teams are for the 1994–95 financial year. During this year, 156,156 assessments were undertaken, equivalent to 110 assessments per 1,000 persons aged 70 and over in the Australian population. Almost half of the clients assessed (45%) were recommended for long-term residential care, with 24% of these being for nursing home care and 22% for hostel care. Clients suffering from disabilities relating to mobility, continence or orientation were more likely to be recommended for nursing home care (Lincoln Gerontology Centre, undated).

The table overleaf provides an age by sex breakdown of people who were assessed by Aged Care Assessment Teams in the period from January to June 1994, and the recommendations made. People may be assessed as a result of a referral from a health or social welfare practitioner, or at their own request or that of family members.

For both men and women, the likelihood that some form of residential care would be recommended rose steadily across the three age groups. For women, the proportions range from 16 to 26% for nursing homes, and from 16 to 27% for hostels. For men, the comparable figures were 20 to 28% for nursing homes, and 16 to 21% for hostels. Overall, women were less likely than men to be assessed as requiring nursing home care, although the difference is quite small in the oldest age group. The proportion of hostel recommendations was quite similar among men and women aged 65 to 69, but for the older two groups it was higher for men than for women.

While only a very small proportion was recommended for intensive community-based care (community options or care packages), this is largely a reflection of the very small numbers of aged care packages available at that time, and the fact that Aged Care Assessment Teams do not determine eligibility for community options

Aged Care Assessment Team clients aged 65 and over; recommendations and assessments by age and sex, Australia, January–June 1994 (%)

	65–69	70–79	80+	Total
Males				
% Nursing homes	20.4	23.6	28.4	25.7
% Hostels	15.8	16.6	21.3	18.9
% Community aged care packages/community options	2.5	3.2	3.5	3.3
Assessments (N)	2,145	7,372	9,930	19,447
Females				
% Nursing homes	15.6	18.8	26.3	23.2
% Hostels	15.7	20.8	26.5	24.0
% Community aged care packages/community options	3.1	3.4	3.3	3.4
Assessments (N)	2,421	11,601	22,277	36,299
Persons				
% Nursing homes	17.8	20.7	26.9	24.1
% Hostels	15.7	19.2	24.9	22.2
% Community aged care packages/community options	2.8	3.3	3.4	3.3
Assessments (N)	**4,566**	**18,973**	**32,207**	**55,746**

services. Policy development work is currently under way by the Department of Health and Family Services to determine the feasibility and appropriateness of establishing a national system of independent assessment authorities to assess eligibility for home-based care provided under the Home and Community Care program.

References/further reading

Department of Community Services 1986. Nursing homes and hostels review. Canberra: Australian Government Publishing Service (AGPS).

Lincoln Gerontology Centre, Aged Care Group (undated). Aged care assessment program national minimum data set report, July 1994–June 1995. Melbourne: La Trobe University (mimeo).

Data sources

The databases used here are compiled by Aged Care Assessment Program Evaluation Units located in each State, with responsibility to collate and analyse data collected by Aged Care Assessment Teams in the relevant State or Territory.

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Home and Community Care (HACC) program

Prior to 1985, home-based care services in Australia were scanty and poorly coordinated. The problem had been raised in a succession of government reviews and inquiries, but gained particular prominence in a report of the House of Representatives Standing Committee on Expenditure in 1982. One consequence was the Home and Community Care (HACC) program, announced in the 1984 budget, and aimed at substantially improving the quantity and range of services available to frail and disabled older people living at home.

In the years that followed, both the quantity and variety of services increased substantially. Between 1985–86 and 1991–92, expenditure on this program doubled in real terms. In addition to the more commonly available areas of home nursing, home help and delivered meals, there was an expansion of centre-based and in-home respite services, transport services, gardening, and home handyman assistance. This rapid growth has not continued in recent years, although expansion of the program has, in broad terms, been sufficient to keep pace with the growth in the size of the dependent aged population for most service types (AIHW 1997).

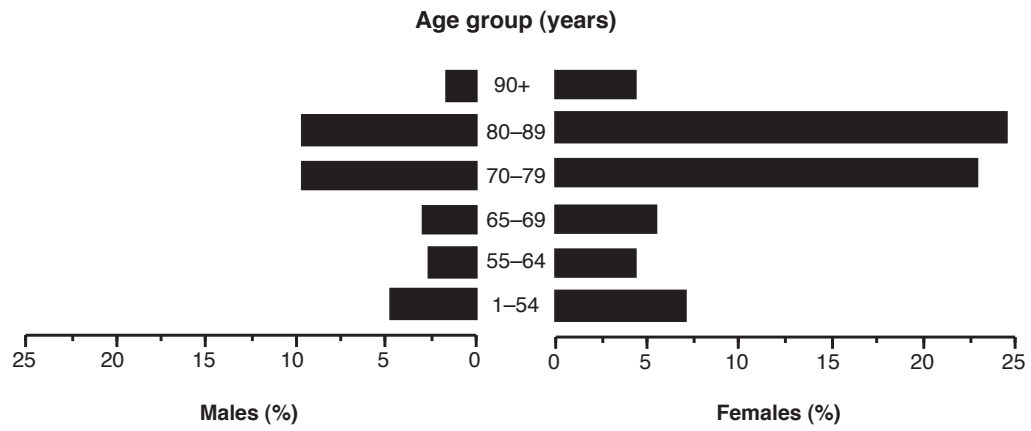
In 1995–96, there were 399 hours of home help provided per 1,000 persons aged 70 and over, 169 hours of home nursing, and 114 hours of personal care. In terms of absolute hours of service provided, nationally there were 588,300 hours of home help, 249,300 hours of home nursing and 167,200 hours of personal care. Further details of hours of service per 1,000 persons aged 70 and over, and the absolute number of hours provided are given for other service types in the table below.

Most HACC clients (69%) were women, with 29% being women aged 80 and over. Overall, 40% of clients were aged 80 and over, with 19% being aged under 65. The HACC program includes as part of its target group younger people with disabilities as well as older people and their carers. Perhaps one of the most pronounced differences in the age profiles of HACC and residential care clients is to do with the proportion aged 90 and over. While only 6% of HACC clients fell into this category, 19% of hostel and 22% of nursing home residents were aged 90 and over. For the more intensive forms of community care (community options and care packages), the comparable figures were 6% and 13% (Jenkins 1996). This pattern suggests that home-based care may less frequently be an option for clients in the 90 years and over age category.

Just over one-half of HACC clients lived alone, although this proportion increased with age.

HACC service provision levels by service type, Australia 1995–96

Service type	Average hours per 1,000 persons aged 70 and over	Hours of service provision per month
Home help	399	588,293
Personal care	114	167,246
Home nursing	169	249,251
Paramedical	22	32,760
Respite care	156	230,355
Centre day care	440	648,405
Home maintenance	40	58,882
Home meals (number)	680	1,002,345
Centre meals (number)	109	160,805



Age and sex profile of HACC clients, Australia 1993–94

Women were more likely to live alone than were men. Among female clients aged 80 and over, 66% lived alone. On average, 38% of HACC clients had a resident carer; this proportion was higher for men than for women, and higher among younger rather than older clients. So, while 59% of clients under 55 had a co-resident carer, only 38% of those over 80 did so. Moreover, among those aged 80 and over, the proportions with a co-resident carer were 50% for men, but only 32% for women (Jenkins 1996).

References/further reading

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Graham S, Ross R, Payne T, with Matheson G 1992. The evaluation of community options in New South Wales. SPRC Reports and Proceedings No. 103. Sydney: University of New South Wales.

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Jenkins A 1996. Client profiles for aged care services in Australia. Welfare Division Working Paper No. 11. Canberra: AIHW.

Data sources

Data presented here are drawn from unpublished data from the 1993–94 HACC Service Users Characteristics Survey and the 1995–96 HACC Service Provision Data Collection, supplied by the Department of Health and Family Services.

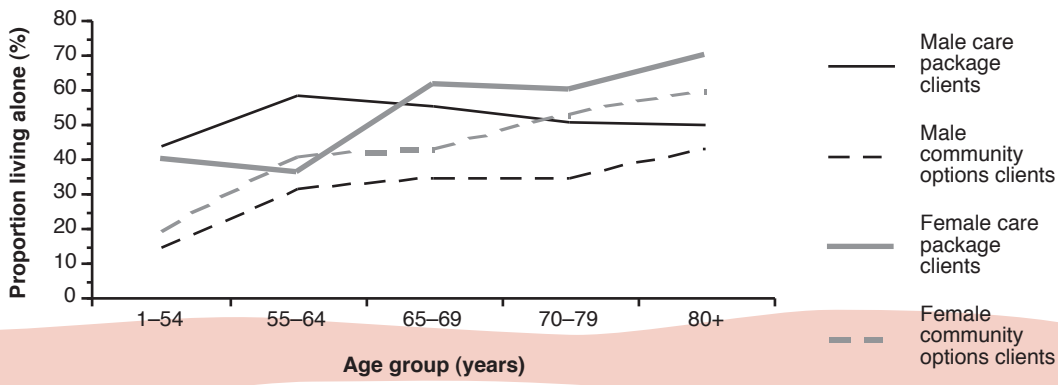
Care packages and community options

In Australia, two programs provide more intensive home-based care under brokerage-type arrangements—community options projects and community aged care packages.

Community options projects were the first government-led initiative to develop a more intensive form of home-based support. From a pilot phase in 1987, the projects were expanded and brought under the aegis of the Home and Community Care (HACC) program following a positive national evaluation in 1992. However, they retain their separate identity within the HACC program. Community options projects aim to reduce inappropriate admissions to institutional care among highly dependent people and those with complex care needs, but who could nonetheless remain at home with appropriate support. In 1994 over 6,000 people were receiving services from community options projects.

Given the success of the community options projects, a potentially more ambitious scheme was launched in pilot form in 1989 to provide an alternative home-based service for older persons who would otherwise require admission to a hostel at the 'Personal Care' level of admission. ('Personal Care' hostel residents are those who are assessed by Aged Care Assessment Teams as requiring assistance with specified personal care activities.) Originally termed 'hostel options', but renamed community aged care packages in 1992, this program has grown rapidly in recent years, from 527 packages in 1992–93 to 4,196 in 1995–96, and is expected to reach 6,077 in 1996–97. Community aged care packages and community options projects have demonstrated that both highly dependent people and people with complex care needs can be cared for in their homes, and therefore that effective home-based management of people requiring quite intensive levels of care is a feasible alternative to residential care.

Community options projects differ from care packages in that they are aimed at people of all ages; not surprisingly then, 23% of community options clients were aged under 60 years, but only 4% of care package clients. A substantial proportion of both client groups were over 80 years —59% of care package clients and 37% of community options clients. Women aged over 80 years accounted for 42% of care package clients and 26% of community options clients. Overall, around twice as many women as men were being



Proportion of community care clients living alone, Australia

Source: Mathur et al (1997)

Community care clients needing at least some assistance with an activity, Australia

	Care package clients		Community options clients	
Need for assistance with	**Number**	**Per cent**	**Number**	**Per cent**
Eating meals	699	18.4	1,898	31.1
Dressing	1,813	47.9	3,116	51.1
Caring for appearance	1,754	46.3	3,196	52.4
Mobility around house	673	17.7	1,681	27.6
Getting in and out of bed	449	11.8	1,754	28.8
Bathing/showering	2,255	59.5	3,690	60.5
Using telephone	1,257	33.2	2,590	42.6
Using transport	3,499	92.2	5,178	84.9
Shopping	3,630	95.8	5,457	89.6
Meal preparation	3,287	86.7	4,950	81.2
Housework	3,748	98.8	5,851	96.0
Minor home maintenance	3,743	99.0	5,951	97.7
Taking medication	2,206	58.3	3,724	61.2
Managing money/finances	2,763	73.0	3,944	64.8

supported in their homes by these programs, with the ratio of women to men being much higher at more advanced ages.

A majority of care package clients lived alone (61%), as did a substantial proportion of community options clients (43%). This proportion increased at older ages for all female clients and to some extent for male community options clients, with a reverse trend evident for male care package clients. Twenty-five per cent of care package clients had a co-resident carer, and a further 40% had a non-co-resident carer. For community options clients the proportions were 48% and 22%, respectively. These findings both confirm the importance of informal care to maintaining highly dependent frail older people in the community, and the capacity of intensive care packages to fulfil that role in the absence of such support for a certain proportion of clients.

In general, community options clients were somewhat more likely to be highly dependent than care package clients. Both groups were somewhat less likely to be as dependent as 'Personal Care' hostel residents. Nonetheless, there was a significant proportion of the community-based clientele that was highly dependent. Among care package clients, 18% required assistance with eating, 48% with dressing, 18% with mobility inside the house and 60% with showering or bathing. For community options clients, 31% required assistance with eating, 51% with dressing, 28% with mobility inside the house, and 61% with showering or bathing.

References/further reading

Mathur S, Evans A, Gibson D 1997. Community aged care packages: how do they compare? Aged and Community Care Service Development and Evaluation Reports No. 32. Canberra: Australian Government Publishing Service (AGPS) (in press).

Data sources

Data presented here are drawn from Mathur et al. 1997.

Hostels

29

The Australian system of residential care has traditionally comprised two levels of care—nursing homes (for higher dependency residents) and hostels (for lower dependency residents). Under the recently announced National Aged Care Strategy, hostels and nursing homes are to be combined into one uniform system from 1 October 1997. The data presented here describe hostels, their use and their residents, as at 1995–96.

While hostels cater to a lower dependency clientele, the range of resident dependency has increased since their inception. Initially developed as a form of supported accommodation, there has been an increasing trend towards the provision of more extensive personal care services. In 1992, this was recognised when the 'Personal Care' benefit, paid by the Federal Government on behalf of residents who require assistance, was split into three levels of payment associated with high, medium and low dependency levels. Indeed, dependency among hostel residents has increased to a point where it was estimated by the Federal Department of Health and Family Services that as many as 20% of 'Personal Care' residents in hostels had dependency levels similar to nursing home residents in the three lower dependency classifications. (Nursing home residents are classified into one of five funding categories based on their dependency levels according to the Resident Classification Instrument or RCI). The proportion of 'Personal Care' (residents assessed by an Aged Care Assessment Team as requiring assistance with personal care activities) to 'Hostel Care' residents (those not requiring assistance with personal care activities) has increased considerably in recent years, from 54% in 1992, to 73% in 1996.

At 30 June 1996, there were 62,645 hostel places in Australia. This is equivalent to 41.4 places per 1,000 persons aged 70 and over. Over the last decade the ratio of hostel places to older people has been progressively expanded. In 1985, the level of provision stood at 32.5 places per 1,000 persons aged 70 and over (in absolute terms, 34,885 places). During this same period, the supply of nursing home beds was decreased and that of home-based services progressively increased, as part of a deliberate plan (the Aged Care Reform Strategy) to reduce the reliance of the Australian aged care system on the more intensive nursing home level of care.

Perhaps not surprisingly given the large increase in the number of hostel places, the number of admissions to hostels has increased in recent years, from 27,438 in 1991–92 to 37,402 in 1995–96. There has, however, been little change in the overall pattern of use by permanent residents, with average length of stay and turnover (i.e. admissions per place per year) remaining relatively constant throughout the period (turnover for permanent residents was 0.27 in 1991–92, and 0.26 in 1995–96). While not as dramatic as for nursing homes, there has been an increase in the use of hostels for respite care, with the proportion of respite admissions growing from 51% of all admissions in 1991–92, to 58% in

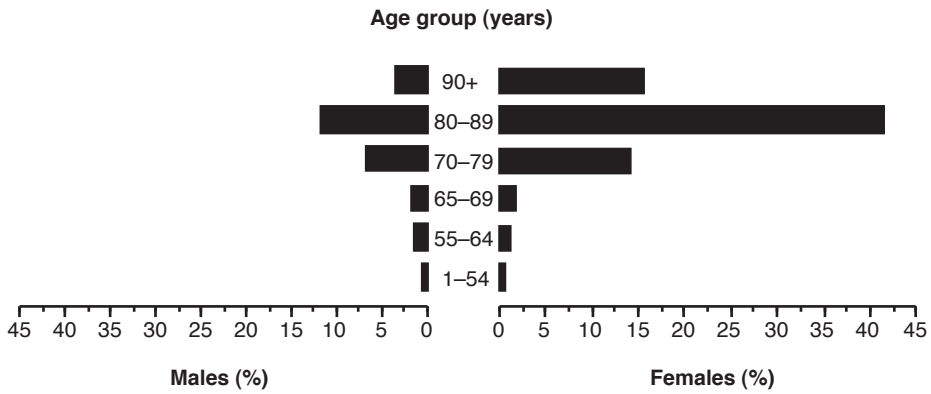
Hostel admissions and turnover, Australia 1991–92 to 1995–96

	Permanent		Respite		Total	
Year	Admissions	Turnover	Admissions	Turnover	Admissions	Turnover
1991–92	13,435	0.27	14,003	0.29	27,438	0.56
1995–96	15,692	0.26	21,710	0.36	37,402	0.63

Prepared by the Australian Institute of Health and Welfare

Length of stay for recent hostel admission cohorts, Australia 1991–92 and 1995–96 (%)

	Permanent		Respite		Permanent and respite	
Length of stay	**1991–92**	**1995–96**	**1991–92**	**1995–96**	**1991–92**	**1995–96**
0–29 days	3.8	3.0	79.9	81.3	37.5	40.4
1–2 months	3.1	3.5	15.2	13.4	8.4	8.2
2–3 months	2.7	3.0	4.3	4.5	3.4	3.7
3–6 months	7.4	7.7	0.5	0.6	4.3	4.4
6 months +	83.0	82.7	0.1	0.2	46.3	43.3
Total (N)	**14,937**	**19,535**	**11,895**	**17,867**	**26,832**	**37,402**



Age and sex profile of hostel residents, Australia 1996

1995–96. Turnover for respite residents increased over the period, from 0.29 in 1991–92 to 0.36 in 1995–96.

The median expected length of stay (calculated using a life-table technique) for residents admitted to hostels in 1995–96 was 746 days (over twice that for nursing homes). Length of stay for permanent residents appears to be growing longer in recent years, while that for respite residents was relatively constant.

The majority of hostel residents (75%) were women, although this was most evident at older ages. Over half of the residents in hostels were women aged 80 and over. As is the case for nursing homes, there were very few younger people with disabilities accommodated in hostels (less than 2% aged under 65), in keeping with government policy to avoid admission of younger people with disabilities to aged care facilities. The majority of residents were aged 80 and over, with 53% aged 80 to 89, and 19% aged 90 and over.

References/further reading

Australian Institute of Health and Welfare (1993 and 1995). Australia's welfare: services and assistance. Canberra: Australian Government Publishing Service (AGPS).

Data sources

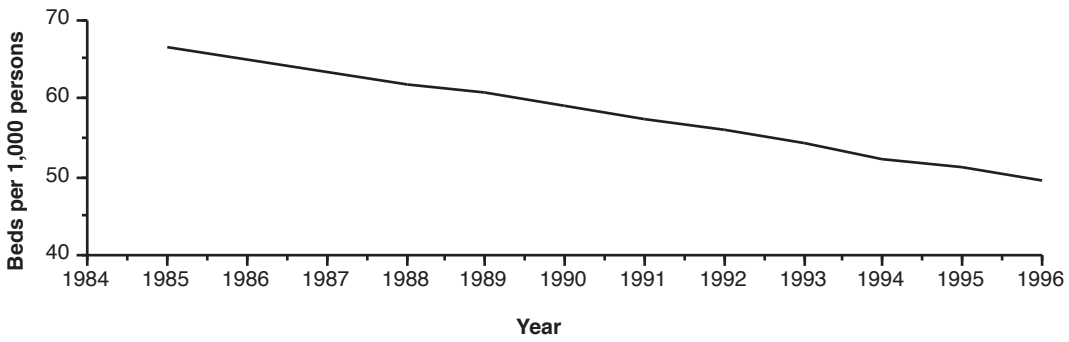
Data presented here are drawn from unpublished residential care data supplied by the Department of Health and Family Services.

Nursing homes

30

The Australian system of residential care has traditionally comprised two levels of care—nursing homes (for higher dependency residents) and hostels (for lower dependency residents). Under the recently announced National Aged Care Strategy, these two streams of care are to be combined into one uniform system from 1 October 1997, providing care for residents with a range of dependencies within the one aged care facility.

At 30 June 1996, there were 75,008 nursing home beds in Australia. This is equivalent to 49.5 beds per 1,000 persons aged 70 and over. Over the last decade the ratio of nursing home beds to older people has been progressively reduced. In 1985, the level of provision stood at 66.5 beds per 1,000 person aged 70 and over (in absolute terms, 71,503 beds). During this same period, the supply of hostel places and home-based services has increased, as part of a deliberate plan (the Aged Care Reform Strategy) to reduce the reliance of the Australian aged care system on the more intensive nursing home level of care.



Nursing home provision levels for the 70 and over population, Australia 1985–96

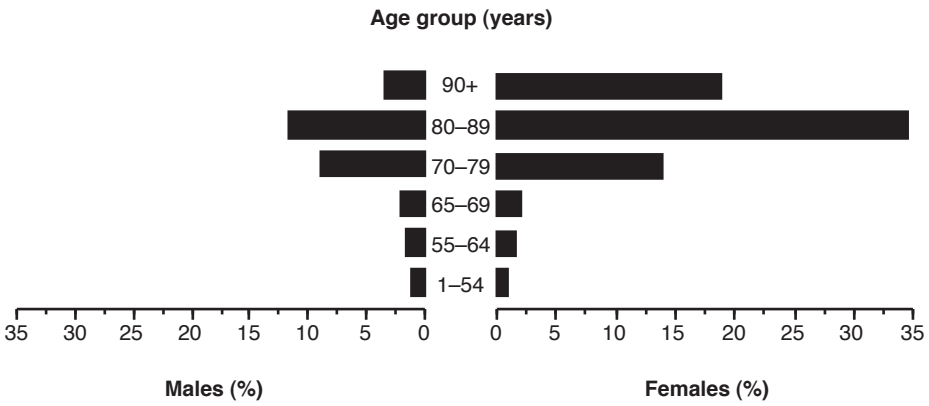
This reduction in the level of provision by 17 nursing home beds per 1,000 persons aged 70 and over, in combination with the introduction of a national aged care assessment program to control eligibility for admission to nursing homes, led to an increase in the dependency levels of nursing home residents. Nursing home residents are classified according to the Residential Classification Instrument (RCI), with high dependency residents receiving an RCI of 1 and lower dependency residents an RCI of 5. Federal funding is tied to the RCI level, with nursing homes receiving higher levels of payment for more dependent residents. In 1987, 30% of nursing home residents fell into the 'high dependency' categories (RCI 1 and 2); in 1996 this proportion had increased to 47%. This targeting of nursing home beds on a more dependent segment of the ageing population was an expected (and desired) outcome of a series of policy reforms, which included not only reduced supply and more systematic assessment for eligibility, but also increased financial incentives for nursing home proprietors to admit more dependent residents.

An important shift in patterns of use for nursing homes occurred over this period. There was a dramatic increase in the number and proportion of admissions for respite, rather than permanent care. The proportion of respite admissions increased from 8% of all admissions in 1991–92, to 27% in 1995–96 (however, respite residents still account for less than 1% of total bed days in nursing homes). Respite admissions have a maximum length of stay of 62 days in any one financial year.

One predicted correlate of this increasing dependency among nursing home residents was a shorter length of stay, and thus an increase in turnover rates (i.e. admissions per bed per year).

This shift has not transpired, however. In 1991–92, the turnover rate was 0.54, and in 1995–96 it was 0.55. When permanent residents only are considered, the length of stay has actually increased slightly among nursing home residents, with turnover dropping from 0.50 in 1991–92 to 0.40 in 1995–96. In 1995–96, over one-third of people admitted to a nursing home remained for less than two months, with a further 13% staying for between two and six months. The remaining half stayed for six months or more. Using a life-table technique, the median length of stay for this cohort (i.e. those admitted in 1995–96) was calculated to be 356 days.

The majority of nursing home residents (72%) were women, although this predominance of women was most evident at older ages. Over half the residents in nursing homes were women aged 80 and over. There were very few younger people with disabilities accommodated in nursing homes, in keeping with government policy to avoid such admissions. Only 2% of residents were aged under 55, with a further 3% being aged between 55 and 64. The majority of residents were aged 80 and over, with 46% aged 80 to 89, and 22% aged 90 and over.



Age and sex profile of nursing home residents, Australia 1996

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Data sources

Data presented here are drawn from unpublished residential care data supplied by the Department of Health and Family Services.

31 Dependency levels among service users

Clients of Australian aged care services may receive assistance at home through the Home and Community Care (HACC) program, or through the more intensive brokered services provided by community options or community care package services. Alternatively, they may be admitted to residential care, which has historically been provided in either a nursing home (more intensive) or hostel (less intensive) context. Within both nursing homes and hostels, there are varying levels of government subsidy associated with the dependency level of the resident, with more dependent residents attracting higher rates of payment.

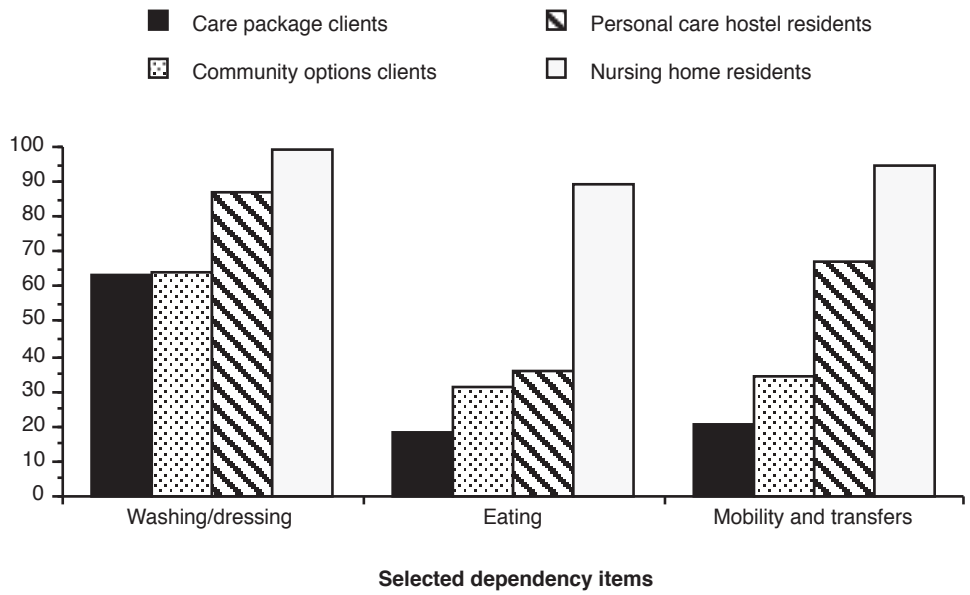
While the available data collections do not consistently measure dependency across each of these service types, there are some items which appear in four of the relevant data collections. Using these items, it is possible to explore the relative dependency of clients of each service type.

Nursing home residents were markedly more dependent than all other client groups. Virtually 100% of nursing home residents required at least some help with washing and dressing, 90% required at least some help with eating, and 95% required at least some help with mobility and transfers. Within the nursing home population, the classifications which attract the higher subsidy (according to the Resident Classification Instrument, these are RCI levels 1–2) were indeed characterised by more dependent clients than those which attract the lower levels of subsidy (according to the Resident Classification Instrument, RCI levels 3–5). Hostel residents were also quite dependent, although less so than nursing home residents; 87% of hostel residents required at least some help with washing and dressing, 36% required at least some help with eating, and 67% required at least some help with mobility and transfers. (Only hostel residents receiving a 'Personal Care' subsidy were included in this analysis, as no dependency data are collected for the less dependent 'Hostel Care' category of residents.) Again, the classifications receiving the highest subsidy (Personal Care–High) were markedly more dependent than those receiving the lowest subsidy (Personal Care–Low).

Clients using community and residential services; need for at least some assistance with selected dependency items, Australia

	Community care clients		Personal care hostel residents				Nursing home residents		
Dependency items	Care packages	Comm-unity options	Low	Inter-mediate	High	Total	RCI 3–5	RCI 1–2	Total
Washing and dressing									
Per cent	63.7	64.2	80.0	91.1	99.9	86.9	99.2	100.0	99.6
Number	3,778	6,096	21,680	11,847	7,721	41,248	36,447	33,369	69,816
Eating									
Per cent	18.4	31.1	23.5	30.2	78.7	35.8	80.2	99.6	89.5
Number	3,793	6,098	21,680	11,847	7,721	41,248	36,447	33,369	69,816
Mobility and transfers									
Per cent	20.7	34.1	62.2	57.9	94.2	67.0	89.8	99.9	94.6
Number	3,791	6,098	21,680	11,847	7,721	41,248	36,447	33,369	69,816

Prepared by the Australian Institute of Health and Welfare



Clients of community care and residential services needing at least some assistance, Australia

Care package and community options clients were on average less dependent than hostel and nursing home residents, being close to or slightly below the dependency levels for hostel residents in the 'Personal Care–Low' category. For care package clients, 64% required at least some help with washing and dressing, 18% with eating and 21% with mobility and transfers. For community options clients, 64% required at least some help with washing and dressing, 31% with eating and 34% with mobility and transfers.

References/further reading

Rickwood D 1994. Dependency in the aged: measurement and client profiles for aged care. Welfare Division Working Paper No. 5. Canberra: Australian Institute of Health and Welfare.

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Data sources

Data presented here are drawn from unpublished residential and community care data (for 1994 and 1996 depending on the program) supplied by the Department of Health and Family Services.

Fitting the pieces together—the Australian system

Australia has a three-tiered system of aged care—nursing homes, hostels and a range of services which support people living in the community. It is underpinned by quality assurance mechanisms, access strategies and a national focus which ensure that appropriate services are available to all frail older people.

Protective mechanisms are built into the system to ensure equitable access to services. Nursing homes have fixed charges regardless of income and hostels are required to provide places for a prescribed ratio of people who are financially disadvantaged. Hostels and community care services target special needs groups, for example Aboriginal and Torres Strait Islander peoples and people with dementia, through the provision of facilities and services specifically designed for the needs of these people.

The residential aged care sector supports a mixed economy of care. Private (for profit) organisations provide 47% of nursing home beds and 2% of hostel places, not-for-profit organisations provide 37% of nursing home beds and 92% of hostel places, and State Governments provide 16% of nursing home beds and 6% of hostel places. Residential care places are set at a planning ratio of 100 places per 1,000 people aged 70 and over. This is further broken down into 40 nursing home, 50 hostel and 10 community aged care places. Access to residential care and to community aged care packages is determined by Aged Care Assessment Teams which assess medical, physical, psychological and social needs.

Nursing homes provide accommodation and other support services, such as domestic services (laundry, cleaning), help with performing daily tasks (moving around, dressing, personal hygiene, eating) and medical care (continuous nursing care and therapy services). Nursing homes target frail older people with physical, medical or psychological care needs which cannot be met in the community and who need ongoing access to nursing care. There are over 1,480 nursing homes in Australia, providing some 75,000 beds.

Hostels provide accommodation and associated support services, such as domestic services (laundry, cleaning), assistance with daily tasks (moving around, dressing, personal hygiene, eating) and occasional nursing care. Hostels target frail older people with physical, medical, psychological or social care needs which cannot be met in the community, but who do not require ongoing access to nursing care. There are over 1,500 hostels in Australia, providing some 62,600 places.

Community aged care packages support people who prefer to remain at home but who require care equivalent to that provided in hostels. A total of 235 organisations provide 4,200 packages.

The Home and Community Care program provides community-based support services, such as home nursing, personal care, respite, domestic help, meals and transport, to people who can be appropriately cared for in the community and can remain at home. There are over 2,200 organisations providing community care services to some 220,000 clients.

Day therapy centres provide a range of services, such as physiotherapy and occupational therapy, to hostel residents and people living in the community. There are 161 centres providing services to about 11,000 people each year.

Flexible care services are intended for people whose needs are not easily met in mainstream facilities and services. These include multi-purpose services which operate in small rural communities lacking the population to support stand-alone services, and which provide a range of aged care services, including health care. Home nursing care packages provide high quality care nursing and personal care services to high dependency people living in their own homes.

Carers are also a focus of services in the Australian aged care system. As well as assistance (including respite care) provided under the Home and Community Care (HACC) program, and residential respite services, the Commonwealth Government announced a National Carer Respite Plan in 1996. The plan has three main elements: respite care, financial assistance for carers, and carer needs-assessment, information and advice. A national network of Carer Respite Centres is being established, costing $36.7 million over the next four years. In addition, the Commonwealth Government provides a Domiciliary Nursing Care Benefit, paid to carers of people living at home who qualify for nursing home care.

The success of the Australian aged care system depends on, and is characterised by, a high degree of cooperation between all levels of government, the service providers and the community. The roles of each level of government are complementary and delineated to avoid duplication of effort and resources, and the relationship with, and role of, the non-government sector is clearly established.

The Commonwealth Government has the major role in the provision of residential aged care services. It establishes the policy directions, in consultation with State Governments and the aged care industry and consumers, and provides the bulk of the administrative support and funding. The Commonwealth Government is responsible for defining outcomes and monitoring performance in residential aged care services.

State Governments have a regulatory role in the nursing home and hostel sectors, such as ensuring compliance with building and fire safety regulations, occupational health and safety requirements and industrial awards. State Governments administer the Home and Community Care program through agreement with the Commonwealth and directly operate some nursing homes, hostels and community care services.

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

The non-government sector is the major provider of services and comprises private (for profit) operators, and not-for-profit (religious, charitable and community) organisations. In broad terms private operators operate nursing homes; the religious and charitable organisations operate hostels, some nursing homes and some community care services; and community organisations operate community care services and some hostels.

The links between each level of government and the non-government sector are through formal agreements, such as the Home and Community Care Agreements, joint setting of strategic directions and joint planning processes, and consultative mechanisms. Service providers are subject to legally enforceable conditions of grant.

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33 Financing the Australian aged care system

The Commonwealth Government has the primary responsibility for funding residential aged care (nursing homes and hostels) and provides most of the funding for the Home and Community Care program which is cost-shared with State/Territory Governments. The Commonwealth also provides funding for other small programs, such as community aged care packages, multi-purpose services and Aged Care Assessment Teams.

State and Territory Governments provide the remainder of Home and Community Care program funding (with contributions from local government), provide funding for some residential aged care services and provide some operational funding (actual or in-kind) for assessment services.

In addition, the charitable sector provides a substantial non-monetary contribution through the active participation of a large volunteer labour force, which augments the services provided by paid staff.

For nursing homes, about 75% of funding comes from the Commonwealth, with the remainder coming from resident charges. Nursing homes are funded on a per occupied place day basis, on a five-point scale according to the dependency level of each resident measured by the Resident Classification Instrument (RCI). Nursing home residents pay a standard fee set at 87.5% of the sum of the full single rate age pension plus supplementary rent assistance (currently $26.40 per day).

Total Commonwealth outlays on nursing homes in 1995–96 were $2,001 million.

Hostels receive less than half of their funding by way of Commonwealth subsidy. Like nursing homes they are funded on a per occupied place day basis, but use a different four point scale to assess dependency (the Personal Care Assessment Instrument or PCAI). Hostel residents pay variable fees which comprise a base fee of 85% of the sum of the single rate age pension plus rent assistance, plus up to 50% of the first $49 of income above the pension, plus all additional income above this amount providing that the resident retains a prescribed minimum amount (currently $58.78). Residents who are financially disadvantaged, for example, people whose only source of income is the age pension, pay no more than the base fee. Hostels may also charge an accommodation bond or entry payment.

Total Commonwealth outlays on hostels in 1995–96 were $417 million.

Community aged care packages are funded on a flat amount per client per day, based on the mid-scale of the 'Personal Care' hostel subsidy (Personal Care–Medium). Clients are charged depending on income, with people on the full pension paying no more than 17.5% of their income.

Total Commonwealth outlays on care packages in 1995–96 were $33 million.

Commonwealth funding for the Home and Community Care (HACC) program is about 60%, with State/Territory Governments contributing the remaining 40%. As yet the program has not implemented a national standard fee system for its clients, but some income is generated by individual provider organisations via client contributions, either through donations or small fixed charges for services. To provide an additional source of funding and to address national inequities in HACC user charges, the Commonwealth Government announced in 1996 that a national fees policy would be implemented in consultation with State and Territory Governments.

HACC has a broader target group than the nursing home and hostel sectors, and includes younger people with disabilities and carers in its focus. A survey of HACC clients conducted in 1993

Summary of major Commonwealth outlays for aged care services (current prices), Australia 1995–96 and 1996–97 ($m)

	Home and community care	Community aged care packages	Hostels	Nursing homes	Other*	Total
1995–96	423.2	33.1	417.3	2,001.7	136.9	3,012.2
1996–97	451.2	56.7	475.2	2,102.9	146.9	3,232.9

* Includes Commonwealth Respite for Carers Program, Day Therapy Centres, Domiciliary Nursing Care Benefit, Aged Care Assessment Program.

indicated that over 80% of clients were aged 65 or over, and that the median age was 77 years. In 1995–96, Commonwealth outlays for HACC were $423 million, with State and Territory outlays totalling $274 million.

In 1996 the Commonwealth Government announced major reforms to the residential aged care system which will be introduced in the latter half of 1997. The reforms include the unification of the nursing home and hostel sectors and their funding systems, and an equitable fee system for residents.

References/further reading

Department of Health and Family Services 1996. Annual report 1995–96. Canberra: Australian Government Publishing Service (AGPS).

Recent policy initiatives

The residential aged care structural reform package

In its 1996 Budget, the Commonwealth Government announced major restructuring of the residential aged care system. It recognises and builds on the strengths in the existing system and is designed to address pressures, putting the system on a sustainable footing for the future. It will bring the focus back to individuals by giving service providers the funding and flexibility to meet the changing needs of consumers in a way that encourages quality and excellence. Strong protections of access and care for people who are financially disadvantaged are built into the system. The reforms will be implemented in the latter half of 1997. New legislation, the Aged Care Bill 1997, has been tabled in Parliament, to provide for the reforms.

Unifying the system The Commonwealth Government pays a subsidy to service providers, based on the assessed dependency levels of individual residents. A new resident classification scale will assess the dependency of residents irrespective of their location in a nursing home or hostel. This will ensure that residents are funded according to their care needs no matter what kind of facility they are in and will allow facilities to meet residents' care needs as they change over time. The classification scale improves on assessment of the particular care needs of people with dementia and increases funding by over 30% for hostel residents with dementia.

Income testing The introduction of income-tested fees will ensure that nursing home and hostel residents make a fair and reasonable contribution to their daily living costs. The income test arrangements will be equitable, with a graduated scale so that fees will be set according to the capacity of each resident to pay. The standard fee for all residents will be set at 85% of the full rate age pension (currently $21.10 per day) for pensioners and part pensioners. Non-pensioners will pay a set rate of (currently) $26.40 per day. In addition, residents with an income in excess of the pension free area (currently $49 per week) will pay an income-tested fee of 25 cents in the dollar up to a maximum of three times the pensioner daily rate or the cost of care, whichever is the lower. Commonwealth funding will be on a per occupied place day basis using the new resident classification scale. The total cost of care of a resident will be met by a combination of Commonwealth subsidy plus standard fee plus income-tested fee if applicable, with the government subsidy reducing by the amount of any income-tested fee.

Accommodation bonds Accommodation bond arrangements were introduced for hostels 10 years ago and have worked well in enabling the hostel sector to maintain and improve the quality of hostel accommodation. This arrangement is being improved and extended to nursing homes. Residential aged care service providers who meet prescribed building and care standards will be able to charge accommodation bonds. The quantum and timing of the bond will be agreed between the service provider and resident at the time of entry.

Service providers will be able to draw down $2,600 per year from the bond for a maximum of five years and retain interest earned on the principal. The money raised will be used to meet the cost of acquiring funds to improve and upgrade facilities with the aim of creating an environment close to the standard of living that many people are accustomed to. The legislation requires that the retention amount must be used for the purpose of providing aged care services. Specifically the pool of funds created by the payment of bonds is intended for use in maintaining, upgrading or replacing building stock. The pool has a target amount of $130 million per year, to be reached in four years. Prudential arrangements will ensure the security of residents' funds in the event of a provider becoming insolvent.

Resident protections The legislation provides strong protections for residents to ensure that their access to appropriate care is based on need, not on ability to pay. Facilities will be required to set aside a proportion of places for concessional (financially disadvantaged) residents. Concessional residents will not be required to pay an accommodation bond and the Commonwealth Government will pay a higher subsidy on their behalf.

Accommodation bond arrangements will require that a resident be left with a minimum equivalent to 2.5 times the age pension (currently $22,500) in assets after paying. For incoming residents who leave a spouse, close family member or long-term carer in the family home, the home will be exempt from consideration as an asset. Residents will have a range of options in paying the bond. They may pay a lump sum up front, make periodic payments, or a combination of both. They will have a seven day 'cooling off' period after entry and six months in which to make the first payment.

The Commonwealth Government will also provide up to $10 million per year for capital upgrading and new facilities in circumstances where there is limited capacity to raise accommodation bonds, including in rural and remote areas of Australia. This will particularly benefit Aboriginal and Torres Strait Islander communities.

Quality assurance The quality of residential aged care in Australia will be improved by the introduction of a quality assurance system based on accreditation, from January 1998. A three-year transition period will be allowed for all facilities to become accredited. Accreditation will be a requirement for funding and to become accredited facilities will be assessed against an agreed set of standards covering four categories: health and personal care; resident lifestyle; safe practice and physical environment; and management systems, staffing and organisational development.

The accreditation arrangements will be overseen by an Aged Care Standards Agency, a partnership between the Commonwealth Government, the aged care industry and consumers. Previously, quality of care in nursing homes and hostels was monitored by Commonwealth-funded standards monitoring teams, against national outcome standards.

Community care

User charges In the Home and Community Care program, the Commonwealth Government is maintaining real growth and announced an increase of over 6% for 1996–97. In a context where user charges varied considerably from region to region and among service types as well as different service providers, the Commonwealth Government announced in 1996 that a national fees policy would be implemented in consultation with State and Territory Governments. The policy will ensure fair and consistent treatment of HACC clients across Australia and protect people on low incomes and those who need a number of services. The increased user charges will contribute to future growth in the program, which will be maintained at 6% per year.

Quality assurance The Commonwealth Government in conjunction with State and Territory Governments is currently testing a system of quality appraisal for use in HACC agencies. The method appraises performance against the nationally agreed HACC Service Standards, and incorporates both agency reporting and consumer feedback.

Expenditure on aged care

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Expenditure is a key indicator of changes occurring in any service delivery system over time. Changes in the allocation of resources among nursing homes, hostels and community care are an important measure of changing patterns of service provision. In current prices, expenditure on aged care and related services in 1996–97 is expected to be $3,232.9 million.

Total recurrent expenditure on aged care services in constant price terms increased from $2,181.8 million in 1991–92 to $2,725.9 million in 1995–96. (The 1989–90 Government Final Consumption Expenditure (GFCE) deflator has been used to calculate constant prices for the time series data.) Expenditure on assessment, Home and Community Care (HACC) and hostels increased by over 300% and nursing homes by 93% between 1986–87 and 1995–96. The rates of increase have moderated in recent years, however, in keeping with government policy of restraining expenditure of aged care. Between 1991–92 and 1995–96, recurrent expenditure on assessment increased by 11%, on HACC by 22%, on hostels by 68%, on nursing homes by 18%, and on all sectors by 25%.

The proportion of aged care expenditure allocated to HACC and aged care assessment have remained relatively constant over the period (21% for HACC and 1% for assessment), while the proportion of expenditure allocated to hostels increased from 10% in 1991–92 to 13% in 1995–96. Expenditure on community aged care packages increased from a zero base, but is still less than 2% of total expenditure in 1995–96. Total aged care expenditure on nursing homes declined from 67% to 63%, consistent with the decline in the size of this sector relative to the hostel and home-based care sectors. Nursing home expenditure remains, however, the single most expensive component of the aged care service system. These changes are broadly consistent with government policy to control increases in nursing home expenditure, and to direct additional resources to the hostel and community care sectors.

Expenditure on a per capita basis provides an indication of levels of service provision in relation to the size of the aged population. In Australia, both the number of older people, and the proportion who are aged 80 and over, have been growing quite rapidly in recent years. Indeed, the last decade has seen the fastest rates of growth this century in the population aged 80 and over (among whom aged care service use is concentrated); this rate of growth will not be equalled until 2021.

Aged care expenditure per person aged 65 and over with a profound or severe handicap in 1995–96 was $8,160—an increase of 7% from 1994–95. The rates of increase were significantly lower between 1991–92 and 1993–94, in the

Aged care recurrent funding in constant prices (GFCE deflator) by program, Australia 1991–92 to 1995–96 ($m)

Year	Assessment	HACC	Care packages	Hostels	Nursing homes	Total
1991–92	26.5	476.0	0.0	213.9	1,465.4	2,181.8
1992–93	27.4	479.2	2.9	244.1	1,493.5	2,247.0
1993–94	29.2	543.9	6.5	273.8	1,495.8	2,349.2
1994–95	29.3	548.2	15.6	319.2	1,586.5	2,498.8
1995–96	29.3	581.6	28.6	360.0	1,726.5	2,725.9

Prepared by the Australian Institute of Health and Welfare

Recurrent expenditure (in constant prices) per person aged 65 and over with a profound or severe handicap, Australia 1991–92 to 1995–96 ($)

Year	Assessment	HACC	Care packages	Hostels	Nursing homes	Total
1991–92	86	1,540	0	692	4,740	7,057
1992–93	88	1,539	9	784	4,795	7,214
1993–94	92	1,711	20	862	4,707	7,392
1994–95	89	1,666	48	970	4,822	7,595
1995–96	88	1,741	86	1,078	5,168	8,160

vicinity of 2–3% per annum. The higher growth rate in 1995–96 was largely influenced by a 7.2% increase in nursing home expenditure. The growth in expenditure on hostels has remained relatively constant over the period from 1991–92 to 1995–96, with substantial growth in expenditure on community aged care packages. Per person expenditure on assessment appears to be reducing, while for HACC the trends were much more variable.

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36 Health expenditure on older people

As would be expected, health expenditure per person for older persons is greater than for younger persons. In 1993–94, health expenditure per person aged 65 and over was four times greater than for those aged under 65. Although older Australians constitute only 12% of the total population, they used $11 billion (35%) of the $31 billion total expenditure on health services in 1993–94.

The increase in per person expenditure with age was greatest for nursing homes and pharmaceuticals, with older Australians consuming 31% of total expenditure on pharmaceuticals. Expenditure on pharmaceuticals was 2.5 times higher for over 65 year olds than for those aged under 65. Similarly, per person expenditure for acute hospitals was 2.3 times higher for older people than for those aged under

Total recurrent health expenditure; age by sex, Australia 1993–94 ($m)

Age	Males	Females	Persons	Percentage of total expenditure (%)
0–14	2,017	1,855	3,872	12.4
15–24	1,219	1,759	2,978	9.5
25–34	1,259	2,424	3,683	11.8
35–44	1,343	1,979	3,323	10.6
45–54	1,403	1,744	3,147	10.0
55–64	1,743	1,723	3,465	11.1
65–74	2,377	2,377	4,754	15.2
75 and over	2,155	3,950	6,105	19.5
65 and over	4,532	6,327	10,859	34.7
All ages	**13,516**	**17,812**	**31,328**	**100.0**

Recurrent health expenditure per person; age by area of expenditure, Australia 1993–94 ($)

Age	Acute hospital services	Medical services	Pharma-ceuticals	Nursing homes	Other health expenditure	Total
0–14	281	180	123	11	199	1,008
15–24	309	209	133	12	198	1,090
25–34	493	280	151	25	153	1,303
35–44	409	295	168	24	152	1,232
45–54	516	353	221	21	157	1,467
55–64	884	453	404	83	249	2,329
Total 0–64	564	321	223	46	209	1,301
65–74	1,595	606	570	265	333	3,746
75 and over	2,464	627	564	2,056	294	6,504
65 and over	1,323	615	567	1,027	317	4,919
All ages	**627**	**316**	**227**	**148**	**199**	**1,756**

Prepared by the Australian Institute of Health and Welfare

65, while expenditure on medical services was 1.9 times higher and for other health services 1.5 times higher than for younger people.

Overall, health expenditure per person aged 65 and over was 3.8 times higher than the health expenditure for those under 65. In absolute numbers, per person health expenditure for the 65 and over population was $4,919, compared to $1,301 for those under 65 and $1,756 for all ages.

A significant proportion of the costs of nursing home care are not true health costs, but are the costs of food and accommodation. However, all nursing home costs are classified as 'health' costs. Thus, the domination of health costs for the very old by nursing home care is to some extent a statistical illusion.

In the period 1982–83 to 1994–95, Australian real health expenditure per person grew by 2.8% per year. Only one-fifth of this increase or 0.6% per year was a result of the costs associated with an ageing population.

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Data sources

Data presented here are drawn from unpublished data from the Australian Institute of Health and Welfare Disease Costs and Impact Studies database.

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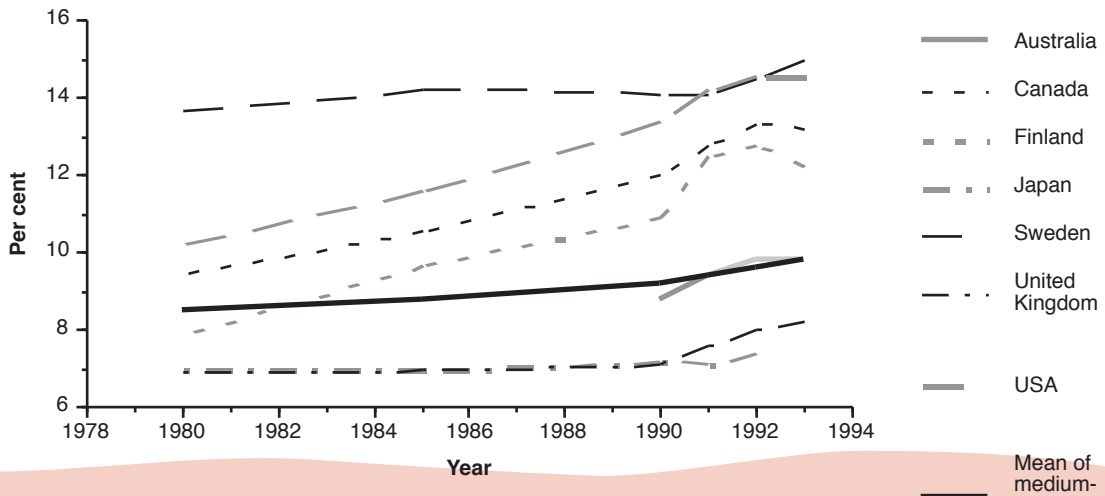
Expenditure trends and international comparisons

Health and welfare services expenditures of different nations are best compared as a percentage of Gross Domestic Product (GDP). Health and welfare services expenditure are combined here because services, especially for older people, can be classified as health services or welfare services. Generally, nursing homes are classified as health expenditure and other services for older people as welfare services, but this varies. For example, in Sweden and the United Kingdom, almost all health and welfare services for older people are classified as welfare services expenditure.

The figure below shows health and welfare services expenditure as a percentage of GDP for Australia and selected member countries of the Organisation for Economic Cooperation and Development (OECD). In 1992 and 1993, Australia was ranked equal seventh with Norway, at 9.8% in percentage of GDP terms. Sweden recorded the highest level of health and welfare services expenditure during the period, except for the years 1991 and 1992 when the United States spent more as a proportion of GDP.

Between 1980 and 1992 there was an increase from 8.6% to 10.2% in the average percentage of GDP spent on health and welfare services in the OECD countries. In the 1980s, most OECD countries showed a moderate growth in health and welfare services expenditure as a percentage of GDP of 0.7 percentage points. The 1990s showed a faster growth in health and welfare services expenditure: 0.6 percentage points in three years. Australia's expenditure as a proportion of GDP has been marginally under the OECD average. Australia's health and welfare services expenditure has been growing at an average rate of 4.4% per year.

The age composition of a country's population is a determinant of total health expenditure, because a comparatively high proportion of the health budget is spent on older people. In Australia it is estimated that 35% of health expenditure in 1993–94 was for those aged 65 years and over, who represent 12% of the population. The increasing proportion of older people in Australia has directly led to increases in health expenditure of around



Health and welfare expenditure for Australia and selected OECD countries as a percentage of GDP, 1980–93

Comparison of age profiles and health and welfare expenditure as a proportion of GDP, Australia and selected OECD countries, 1992 (%)

Country	Proportion of the population 65+	Health and welfare services expenditure as a proportion of GDP
Sweden	17.7	14.5
Norway	16.2	9.8
United Kingdom	15.8	8.0
Denmark	15.6	11.7
Austria	15.2	9.1
Germany	15.0	9.1
France	14.5	9.6
Japan	13.1	7.4
Netherlands	13.0	10.5
USA	12.7	14.6
Canada	11.8	13.3
Australia	11.7	9.8
New Zealand	11.5	8.0

0.5% per year, well below the growth of GDP per person (about 1.7% per year in the last decade). While the trend to an older population will continue, the ageing population will not, in itself, require an increase in health expenditure as a proportion of GDP. However, the increasing per person use of health services by older people may do so. Factors contributing to growth in the use of health services by all people, but especially older people, include greater expectations of being healthy and the introduction of new technologies.

Many countries (particularly in Europe) with large proportions of older people have lower levels of expenditure than younger countries. Countries like the United States of America, Canada and Australia, with relatively young populations, have reasonably high proportions of GDP spent on health and welfare services. It appears that the United Kingdom is under funded with only 8% of GDP being spent on health and welfare services and 16% of the population 65 and over. In a survey on attitudes to health care by Elias Mossialos (1997), 82% of people in the United Kingdom thought that the United Kingdom needed more health care funding. This was the highest response for all countries surveyed.

References/further reading

Australian Institute of Health and Welfare 1992. Australia's health 1992: the third biennial report of the Australian Institute of Health and Welfare. Canberra: AGPS.

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Data sources

Data presented here are drawn from unpublished data from the Australian Institute of Health and Welfare Health Expenditure database and unpublished OECD health and welfare expenditure data.