# 7 Ageing and aged care

## 7.1 Introduction

In recent years, the priority attached to ageing issues has increased substantially at both a national and international level. The proportion of the population in the older age groups is increasing, and this population ageing has been identified as an issue that will present opportunities and challenges for Australia, as it will for many countries. Its implications for all aspects of social and economic life are increasingly being recognised, including those for labour and capital markets, government pensions and assistance, services and informal support systems.

### Policy development

At the international level, in April 2002 delegates from 190 countries, including Australia, met in Madrid for the United Nations' Second World Assembly on Ageing. The Assembly recommended the International Plan of Action on Ageing to the General Assembly of the United Nations. This called for changes in attitudes, policies and practices at all levels in all sectors to ensure that people everywhere are able to age with security and dignity and to continue to participate in their societies as citizens with full rights. In the Asia–Pacific region, the Macao Plan of Action on Ageing provided a means of taking forward the International Plan in a manner tailored for the region (UN 2002a, 2002b). In addition, the World Health Organization adopted the term 'active ageing' to describe the process 'of optimising opportunities for health, participation and security in order to enhance quality of life as people age' (WHO 2002:12). Active ageing aims to extend healthy life expectancy and quality of life for all people as they age, including those who are frail, disabled and in need of care.

Within Australia, the Commonwealth Government's *National Strategy for an Ageing Australia* (Andrews & DoHA 2001) offered a framework for responding to the changes that population ageing would bring. The strategy concluded that the implications of population ageing affect more than aged care service planning and provision, and that a whole-of-government approach is required that takes into account a range of policy areas and addresses the issues ageing raises for individuals and for the larger community. As part of this whole-of-government approach, the Intergenerational Report, tabled with the 2002–03 Commonwealth Budget, explored the economic implications of population ageing in terms of the funding of future public expenditure and the broader impact on Australia's economic wellbeing and living standards (Costello 2002). This report indicated that Australia is economically better placed than many other OECD countries to deal with population ageing.

Concerns over the implications of population ageing have prompted responses to ensure the sustainability of economic, health and social support systems which are directly influenced by the changing age structure of the population. At the same time, recognition has been given to those positive aspects of ageing which contribute to national wellbeing. Financial independence in retirement, participation in community

life, including both paid and volunteer work, and healthy ageing are examples of those positive aspects of ageing being discussed and promoted in current debates. Indeed, a consistent theme in social and economic planning and policy in relation to ageing is the recognition of the opportunities that population ageing offers. In order to take advantage of these opportunities as a society, it is important to enhance quality of life as people age by optimising prospects for health, social participation and security. As the Declaration adopted by the Second World Assembly on Ageing stated:

> The potential of older persons is a powerful basis for future development. This enables society to rely increasingly on the skills, experience and wisdom of older persons, not only to take the lead in their own betterment but also to participate actively in that of society as a whole. (UN 2002a:Article 10, Annex I, Resolution 1)

## Service development

The goal of the Australian aged care service system has been the 'provision of a cohesive framework of high quality and cost-effective care services for frail older people and their carers' (DHFS 1996:117). Complementary to this objective is the broader goal of achieving positive and healthy ageing to improve the physical, emotional and mental wellbeing of older people. Thus, programs concerned with ageing are not just about responding to the dependency of older people but also about supporting people to lead independent lives and to continue to participate in all aspects of life including social, economic, cultural, spiritual and civic affairs as they age.

Reflecting the cross-sector implications of population ageing, the period since 2001 has seen a push towards the further integration and consolidation of ageing issues into broader community concerns. In addition, the need for a response not only from government but also from business, community organisations and individuals has also been recognised. With respect to service provision, increasing emphasis on community care and decreasing emphasis on residential care has continued. This trend began with the implementation of the Home and Community Care Program (HACC) in 1985, and its rapid expansion in subsequent years. The development of respite care services, and the introduction and rapid growth of Community Aged Care Packages in the 1990s further supported the growth of community-based care.

More recently, a number of initiatives have continued the expansion of community care. In 2001–02, the Commonwealth Government announced its intention to establish Extended Aged Care at Home (EACH) as an ongoing program. Operating as a pilot program since 1998, EACH provides high-level aged care to people in their own homes. In addition, Commonwealth Carelink Centres were established to provide a single contact point for comprehensive information about community, aged care and other support services. Also in 2001, Commonwealth funding was provided to identify best-practice models for Day Therapy Centres to better coordinate these allied health services with other health and aged care services (DoHA 2002b:128). Further reflecting the importance of best practice in service provision, the national Innovative Pool was established in the 2001–02 financial year to provide a means of testing alternative service models through the provision of flexible care places. Some of the first projects were developed, in collaboration with state governments, to test service delivery models to assist older Australians leaving hospital but not yet able to live

independently at home. Other projects under this program, such as those providing care for people with dementia, will pilot methods that assist people to age in place in residential aged care accommodation or to remain living in their own homes.

A number of other developments since the publication of *Australia's Welfare 2001* (AIHW 2001a) are summarised in Box 7.1. Most notably, in 2002, a pricing review of the residential aged care sector began, and the House of Representatives Standing Committee on Ageing was established to inquire into long-term strategies to address the ageing of the Australian population. In March 2003, a new Strategy for Community Care to reform the community care system was put forward for consultation. This reform strategy seeks to facilitate a more integrated community care system through such measures as instituting a common information system across all similar programs and establishing commonality in points of access, assessment processes, eligibility requirements, standards of service provision, user fees and accountability processes. Among the benefits that these proposed reforms anticipate are greater equity of access and simplified entry points for people requiring care and, for service providers and administrators, more streamlined administrative requirements.

## Chapter outline

The primary focus of this chapter is people aged 65 and over, and those programs, services and assistance directed towards both meeting their care needs and assisting their continued independence and participation in the community. The age group 65 and over is used as this is the age traditionally considered to be associated with retirement and the beginning of old age. It should be noted, however, that the population aged 65 and over is not used by government as either a planning or funding tool for the programs discussed, and that younger people can and do access these services. The use of services by younger people is examined in Chapter 8.

The range of services and assistance available to older people in Australia is extensive and by no means all such provisions are included in this chapter. For example, programs concerned with housing, hospital care, medical care and pharmaceuticals are discussed either in other chapters in this publication or in *Australia's Health* (Chapter 5; AIHW 2002b). Moreover, it must be remembered that older people are also eligible for, and make use of, various other benefits and services that are available to the general population.

Section 7.2 discusses current and future patterns of population ageing as it is experienced in Australia, and sets current trends in the context of population change over the last 20 years. It puts disability levels among older people into perspective, and describes those health factors and limitations which can predispose them to need services and assistance. Section 7.3 provides an overview of the support and services available to older people, and identifies recent national data development activities that will allow improved analysis of the sector. Sections 7.4 to 7.7 present data on aged care services and assistance, the clients of such services and the expenditure involved. Section 7.8 discusses outcomes for older people in relation to aged care services. A brief summary follows in Section 7.9.

## Box 7.1: Events in aged care, 2001 to 2003

***2001***

***Extended Aged Care at Home*** *(EACH) program was established following successful implementation of a pilot in 1998.*

***Veterans' Home Care****, a Department of Veterans' Affairs program to provide home-based services to veterans, commenced in January.*

***Commonwealth Carelink Centres*** *were established to provide single contact points for comprehensive information about community, aged care and other support services.*

*The national* ***Innovative Pool*** *of flexible care places was established. The Innovative Pool allows for the development of pilots for innovative service provision to test alternative models to meet specific needs. Most pilots are developed in collaboration with state and territory governments.*

*The* ***Safe at Home Initiative*** *was established to assist frail older people to remain in their homes through the provision of personal alert systems.*

*The report of the* **Two Year Review of Aged Care Reforms***, commissioned by the Commonwealth government in 1998, was released. Chaired by Professor Len Gray, the review's purpose was to evaluate the impact of the reforms (DHAC: Gray 2001).*

***2002***

*The next phase of the* ***National Strategy for an Ageing Australia****—a report entitled* An Older Australia, Challenges and Opportunities for All*—was released by the Minister for Ageing in February (Andrews & DoHA 2001).*

*The* ***House of Representatives Standing Committee on Ageing*** *was established to inquire into long-term strategies to address the ageing of the Australian population over the next 40 years.*

*The* ***Second World Assembly on Ageing*** *took place in Madrid, Spain. The Assembly adopted the Madrid International Plan of Action on Ageing.*

*The* **Intergenerational Report** *was tabled with the 2002–03 Commonwealth Budget. The report explored the economic implications of population ageing in terms of the funding of future public expenditure and the broader impact on Australia's economic wellbeing and living standards (Costello 2002).*

*The* ***Myer Foundation****, a philanthropic body, supported the development of a report entitled* 2020: A Vision for Aged Care in Australia *(Myer Foundation 2002). Based on research, discussion and policy dialogue of leading aged care experts from public, private and not-for-profit sectors, this vision provided an authoritative contribution to public debate on the future of aged care that is independent of government perspective.*

*The* ***National Advisory Committee on Ageing*** *was established to facilitate discussion about the consequences of the ageing population for the development of policies and programs.*

*(continued)*

**Box 7.1 (continued): Events in aged care, 2001 to 2003**

*Development of a* ***National Aged Care Workforce Strategy*** *began. The purpose of the strategy is to identify the workforce profile of the aged care sector and its needs until 2010. Current workforce needs led the Commonwealth Government to provide some funding in the May 2002 Budget for scholarships for aged care nursing students and for training for personal care workers (Andrews 2002).*

*A* ***Review of the Pricing Arrangements in Residential Aged Care*** *began. This review examines long-term financing options for the aged care sector, taking into account underlying cost pressures and the care outcomes required under accreditation.*

***2003***

*The* ***Resident Classification Scale Review*** *was completed and a report of recommendations released (Aged Care Evaluation and Management Advisors 2003). As a response to the report, trials to test a decrease in paperwork for staff of residential aged care services began in May 2003 (Andrews 2003d).*

*A new* ***Strategy for Community Care****, which is aimed at supporting care recipients to access the right service, was put forward for consultation (Andrews 2003b).*

*A recommendation of the* Two Year Review of Aged Care Reforms *(DHAC: Gray 2001) was to create a simpler system for entry to residential aged care. In response, the* ***Entry Pack for Residential Aged Care****, including a new form and information booklet, was launched in April (Andrews 2003c).*

## 7.2 Ageing in Australia

This section presents an overview of the structure of Australia's current population and sets this picture in the context of population changes that have occurred in the preceding 20 years and that are expected to occur in the next 20 years. The social backdrop within which these changes are occurring influences strategies adopted to meet the resulting challenges. While many older Australians experience disability-free lives, a proportion requires assistance and care. The health of the community and the disability levels people experience in older ages are important considerations in understanding current service and support needs and anticipating future needs.

### Population structure and change

Population ageing occurs when growth in the older population outpaces growth in the younger population. Changing patterns of fertility and mortality are the two main drivers of population ageing. Social and technological change has resulted in substantial increases in life expectancy, with life expectancy at birth increasing by more than 20 years and life expectancy at age 65 increasing by 7 years for women and 5 years for men over the past century (AIHW 2002c:101). At the same time, Australia's total fertility rate has been declining. Having reached a peak at the height of the 'baby boom' (3.5 births per woman in 1961), it now sits at its lowest level in Australia's history: 1.7 births per woman, well below the replacement fertility level of 2.1 (ABS 2002d:45). This, however, is still relatively high compared with most OECD countries. Over the

next 10 years, the oldest of the baby-boomer generation will reach 65, the age traditionally considered to be associated with retirement and the beginning of old age. It is this population shift that has been identified as an issue that will present opportunities and challenges for Australia, as it will for many countries. It has implications for all aspects of social and economic life, including government pensions and assistance, health and welfare services and informal support systems, and these factors will in turn have implications for the experience of ageing.

On 30 June 2002, people aged 65 years and over represented 12.7% of Australia's total population, or 2.5 million people (ABS 2003a). Of people aged 65 and over, 54% were aged 65–74 years, 35% were aged 75–84, and 11% were aged 85 and over. Thus, while over half of all older people were aged between 65 and 74, there was a significant minority (over 280,000) aged 85 and over. Fifty-six per cent of older people (65+) were women. As age increases, this predominance becomes progressively more evident: in the 65–69 age group, the proportions of men and women were almost equal; by age 85 and over, there were over twice as many women as men. In absolute numbers, in June 2002 there were 280,000 more women than men aged 65 and over in Australia (Table 7.1).

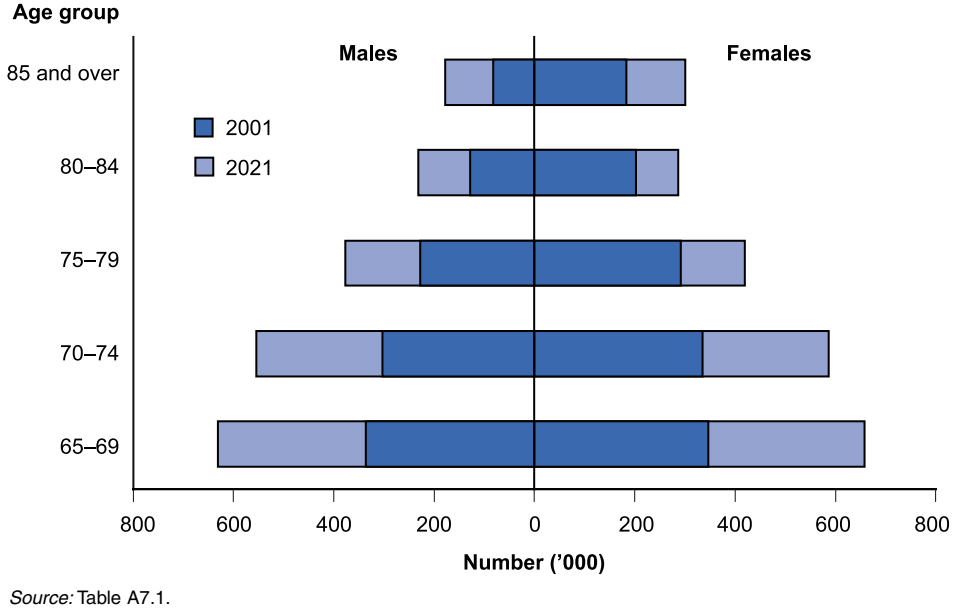
The Australian population is ageing numerically in that the number of older people is increasing, and structurally in that the proportion of people who are aged at least 65 is rising. In the 20 years up to 2021, the number of people aged 65 and over is expected to increase by 73%, from 2.4 million in 2001 to 4.2 million in 2021 (Figure 7.1). These older Australians are projected to then comprise 18% of the population (see Table A7.1). The number of people aged 85 and over, among whom we find those most likely to be in need of services and assistance, is also projected to expand rapidly over this period: from 265,200 in 2001 to 478,600 in 2021. This represents an increase of 80% in this age group. As a proportion of the population, the number of people aged 85 and over is projected to rise from 1.3% in 2001 to 2.1% in 2021.

While the above growth rates are high, it is not the first time Australia has experienced a rapid rate of increase of the older population. Over the decade 1981–91, the population aged 65 and over rose by 34%, higher than between 1991 and 2001 (23%) and higher than it will in the 10 years up to 2011 (26%). It is only in the decade 2011 to 2021, as increasing proportions of the Australian baby-boom generation reaches 65, that the rate of growth, at 39% over the decade, is projected to be higher than previously experienced; thereafter it will drop again. In the age group 85 and over, the last two decades saw overall growth rates of 50% (1981–91) and 69% (1991–2001). The projected rates for the next two decades are 50% and 23%. Thus, between 2011 and 2021, the structure of the aged population will shift towards a younger profile for the first time in three decades (AIHW 2002c:4–5). However, as baby boomers get progressively older, the population aged 65 years and over will again move towards an older structure.

**Table 7.1: Persons aged 65 years and over, 30 June 2002**

| Age | Males | Females | Persons | Males | Females | Persons |
|---|---|---|---|---|---|---|
| | | Number | | | Per cent | |
| 65–69 | 343,500 | 354,600 | 698,100 | 31.1 | 25.6 | 28.0 |
| 70–74 | 303,000 | 331,900 | 634,900 | 27.4 | 24.0 | 25.5 |
| 75–79 | 233,200 | 294,200 | 527,300 | 21.1 | 21.2 | 21.2 |
| 80–84 | 137,500 | 211,700 | 349,300 | 12.4 | 15.3 | 14.0 |
| 85+ | 87,800 | 192,600 | 280,400 | 7.9 | 13.9 | 11.3 |
| **Total** | **1,105,000** | **1,385,000** | **2,490,000** | **100.0** | **100.0** | **100.0** |

*Source:* ABS 2003a.




*Source:* Table A7.1.

**Figure 7.1: Population aged 65 years and over, 2001 and 2021**

A chief source of concern in the patterns of change that are occurring in the population structure is that, as the population ages, the growth in the number of people of working age will be less than the growth in the number of people outside these ages. In a report submitted to the House of Representatives Standing Committee on Ageing in January 2003, the Department of Treasury predicted that the growth in Australia's working population would slow to zero by 2042 (Treasury 2003a); that is, the pool of people of traditional working age (15 to 64) who are potentially able to support those traditionally considered to be of non-working age (under 15 and 65 and over) will cease to grow. In addition, the increase in the population aged 65 and over will outweigh the decrease in the population under 15 years of age. As a consequence, a number of government initiatives have been developed to reduce barriers and disincentives for continued participation in the workforce up to and beyond age 65. For example, the Commonwealth Government has abolished compulsory age retirement for its public

service; also, legislation is currently being developed to prohibit age discrimination across a broad spectrum of areas including employment (Attorney-General's Department 2002).

## Social context

While population ageing is expected to present a challenge for Australia in many areas including planning for health and community services, it has been widely recognised that the difficulty of these challenges—such as the increasing costs they are likely to bring—can be substantially lessened or overcome by undertaking appropriate action at an early stage. In March 2000, the Healthy Ageing Task Force (a joint federal, state and territory body)[1] released the *Commonwealth, State and Territory Strategy on Healthy Ageing* (HATF 2000). The initiatives outlined in this strategy seek to benefit individuals and the community as a whole. In addition, the following extract points to the economic benefits to be gained by bringing this strategy forward:

> Initiatives which aim to improve the health and wellbeing of older people, encourage them to remain productive, continue and extend their contribution to family and community life and plan for later life, will contribute to the cost associated with ageing being minimised and managed over the long term. (HATF 2000:6)

This strategy identified a number of areas where action should be taken to achieve positive ageing. Included among these actions were: improving community attitudes to ageing and older people; improving the health and wellbeing of older people; providing appropriate and affordable support so that older people can meet their needs and aspirations and remain in their own homes for as long as possible; and making use of research and good quality data to improve care and support and prevent illness.

The review of healthy ageing research in Australia (Kendig et al. 2001), undertaken for the Community Services Ministers' Advisory Council, suggested a number of broad priority areas for research. Improving and maintaining health was just one of seven areas identified. The remaining priority areas reflect the wider definition of healthy ageing as extending beyond health and community services issues in to broader aspects of wellbeing including social interactions, employment, housing and transport. In addition, as a move to increase the quality and quantity of statistical evidence available for policy development, in 2002 a project—Building Ageing Research Capacity—was established under a joint initiative of the Office for an Ageing Australia and the Australian Institute of Health and Welfare. The main purpose of the project is to maximise collaboration and coordination between Australian researchers on issues related to ageing. The key outputs of this project will be the development of an Australian Ageing Research Agenda and of the Ageing Research On-line (ARO) web site.

At the broad policy level, the *National Strategy for an Ageing Australia* (Andrews & DoHA 2001) focused on providing opportunities for, and removing barriers to, people's

1 Renamed the Positive Ageing Task Force in 2002 to reflect the broader focus of the group, this body continues to coordinate strategies concerned with positive ageing issues across jurisdictions.

participation in society and access to services across their lifespan, not just in old age. The report discusses strategies for supporting and encouraging healthy ageing, in its broadest definition, across the life course as well as better health in older age.

As discussed above, the importance of factors other than health in positive—or active—ageing have been recognised both in Australia and internationally. Older people participate in society in a variety of ways, from paid and unpaid work to involvement in spiritual and cultural affairs. It is estimated that in 2000–01 people aged 65 and over spent a total of 283 million hours during the year providing welfare services, including both voluntary work and care. This accounted for 16% of welfare service hours provided by the household sector (Table 4.23). Also, in the 1998 Survey of Disability, Ageing and Carers, 94% of people aged 65 and over living in households reported participating in community, cultural and leisure activities away from home in the 3 months preceding the interview. Activities included church activities (29%), voluntary work (19%) and other special interest group activities (18%; ABS 1999a:42). Programs which promote active ageing aim to encourage and support people so that they can participate in these endeavours. A brief overview of the social context within which such programs operate follows.

## Living arrangements

As only 5% of people aged over 65 live permanently in residential aged care (see Table A7.12), the overwhelming majority of older people live in households in the community. These people have a variety of living arrangements: at the time of the 2001 population census, 59% lived with a spouse or partner, 10% lived with other relatives (often their child), and 30% lived on their own. A small number of older people (2%) lived in group households or with an unrelated family (see Table A7.2).

People aged 75 and over are more likely to be living on their own than younger people, and, because of their greater longevity, older women are more likely to live alone than their male counterparts. Thus in 2001, 51% of women aged 75 and over lived alone and 31% lived with a spouse or partner; the corresponding figures for men aged 65 to 74 years were 16% and 78%.

## Income and work

Australians today are living longer, and so spending longer in retirement, than those in preceding generations. Income security during these years is important if older people are to be able to participate in society as much as they can.

The sources and amounts of the incomes of older Australians vary widely but continue to reflect past social policies concerning pensions and self-funded retirement. Income security is provided to older people through government pensions and allowances, and in 1999–00 these were the main source of income for three-quarters of income units with the reference person aged 65 or over (Table 7.2).[2] A proportion of people work past pension age, and in 1999–00 earned income was the main income source for 5% of older income units. Although 91% of employees in Australia had superannuation in 2000, the main effects of government measures designed to compel employers to contribute to superannuation accounts for their employees have yet to be seen in retirement income

**Table 7.2: Main source of income of income units with reference person aged 65 and over, 1999–00 (per cent income units)**

| Gross weekly income ($) | Government pensions and allowances | Superannuation | Earned income[a] | Other[b] | Total |
|---|---|---|---|---|---|
| <200 | 33.9 | *3.7 | *7.4 | 14.7 | [c]28.5 |
| 200–399 | 55.3 | 27.2 | *9.7 | 24.0 | 46.7 |
| 400–599 | 9.8 | 35.4 | 21.3 | 18.2 | 13.3 |
| 600–799 | *0.6 | 14.8 | *11.2 | 7.5 | 3.1 |
| >800 | *0.4 | 18.9 | 50.3 | 35.6 | 8.4 |
| **Total** | **100.0** | **100.0** | **100.0** | **100.0** | **100.0** |
| **Total (number)** | **1,197,800** | **134,700** | **78,700** | **179,400** | **1,604,500** |
| **Total (row per cent)** | **74.7** | **8.4** | **4.9** | **11.2** | **100.0** |

(a) Includes wage and salary and income from own business.

(b) Includes investments, property and other sources of income.

(c) Includes zero and negative incomes.

*Source:* AIHW 2002c:Table A8.1.

data (ABS 2002c). In 1999–00, superannuation was the main source of income for 8% of older income units. The remaining 11% had other sources of income, including income from property, shares and other sources of wealth.

Reflecting the pension income and assets tests, in 1999–00 only 11% of older income units relying on government payments had gross income greater than $400 per week; the corresponding proportions for those reliant on superannuation and earned income were 69% and 83%, respectively. Income units whose main source of income is paid work tend to have higher incomes than others. In 1999–00, this group had the largest proportion of older income units with incomes greater than $800 per week, at 50% of income units with the reference person aged 65 or over compared with 8% for all income groups.

### Income support

The Age Pension and pensions from the Department of Veterans' Affairs (DVA) are the two main sources of income support for older people (see Box 7.2 for a brief description). In December 2002, 66% of Australians (or 2,226,234) aged 60 and over (and 82% of people aged 65 and over) received either the Age Pension or a DVA payment (full and part pensions) (see Table A7.4). The proportion of people receiving payments from either of these sources increases with age, ranging in 2002 from 73% for 65–69 year olds to 89% of people aged 80–84. For both pension types, the majority of pensioners were women (61% of Age pensioners and 57% of DVA pensioners).

2 To examine the income of people, income units are often used rather than individuals, simply because income often tends to be shared among more than one person. Under the ABS definition, an income unit is a person or group of related persons within a household, whose command over income is assumed to be shared. Income sharing is assumed to take place within married (registered or de facto) couples, and between parents and dependent children.

## Box 7.2: Income support

### *Age Pension*

*The Age Pension is assets and income tested, and in December 2002 was available to men aged 65 and over and women aged 62 and over. The qualification age for women, which was 60 years until 1 July 1995, has been gradually increasing and will be raised to age 65 by 2014. The maximum single rate of pension is set at a minimum of 25% of male total average weekly earnings. Each member of a couple receives approximately 83% of the single rate of pension. The maximum single rate is adjusted every 6 months in line with the consumer price index. As at March 2003, a single person on the maximum rate Age Pension received $220.15 per week, and a couple $367.50 per week. In December 2002, 1,836,471 people were receiving either a full or part pension (see Table A7.4).*

### *DVA pension and benefits*

*The Service Pension is paid to veterans, eligible partners, widows and widowers. It is similar to the Age Pension, being paid at the same rate and subject to income and assets tests. In general, it is available 5 years earlier than the Age Pension; however, it may be granted at an earlier age in cases of invalidity. There are also other forms of income support available from DVA which are neither taxable nor subject to means testing. These include the war widow(er)'s pension and disability compensation. Depending on their income and assets, people on the war widow(er)'s pension may also be eligible for the income support supplement (ISS). Allowances payable in association with the Service Pension and ISS include a pharmaceutical allowance, rent assistance, telephone allowance and remote area allowance. In December 2002, there were 389,763 people receiving a DVA pension (see Table A7.4).*

### *Senior Australians' Tax Offset*

*Introduced in the 2001–02 Budget, this change to the taxation system means that older Australians are now entitled to income-tested tax offsets regardless of the source of their income; previously such offsets were available only to DVA and Age pensioners. Eligibility commences at age 65 for men and 62 for women. The effect of the offsets is that individuals who earn below $20,000 per year and couples who earn a combined amount of less than $32,612 per year do not pay income tax. As income rises, the amount of the tax offset is reduced by 12.5 cents per dollar earned above the tax-free income levels. This scaled reduction means that some tax offset is available to individuals with a taxable income up to $37,840 per year, and couples with a combined income up to $58,244. Had this offset not existed, it is estimated that the Australian Taxation Office would have collected an additional $1,310 million in tax from around 375,000 older Australians, including 200,000 pensioners, in the 2001–02 financial year (Treasury 2003b:45).*

### Workforce participation

The above picture of high levels of dependency on pension payments is expected to change in the coming years as the effects of increased superannuation coverage flow through. This increase is due both to the introduction of the national superannuation contributory system in the 1980s along with the Superannuation Guarantee in 1993, and

to the greater participation of women in the workforce. While the participation of men aged over 45 years in the labour force has remained reasonably stable over the last 15 years, participation rates for women have grown substantially. Between 1988 and 2002, the rate for women aged 55–59 increased from 33% to 51%, while that for women aged 60–64 increased from 16% to 27% (Table 7.3). This rise for women means that overall in all age groups over 45 there has been an increase in labour force participation since 1988. In December 2002, just over 6% of people aged 65 and over were in the labour force.

The decline in labour force participation with age, observed in Table 7.3, is not solely due to a desire to retire. People with a disability are less likely than others to participate in the labour force, with participation decreasing with increasing core activity restriction. Also, among those in the labour force, people with a disability are more likely to be unemployed than people without a disability. Consequently, as disability rates increase with age, in many cases retirement may be the result of an inability to work due to disability. Comparisons of age-specific rates of receipt of the Disability Support Pension with labour force participation rates for men suggest that as many as half of the men aged 60 to 64 who are not in the labour force are receiving this pension (Tables 7.3, 7.4; ABS 1999a:35; AIHW 2001a:450).

Given the projected rise in the ratio of older people and children to working-age people, policies aimed at changing patterns of participation in the labour force, as well as those aimed at changing patterns for saving for retirement, will have increasing prominence (Costello 2002:23–4). Currently there are initiatives to encourage older people to stay in the workforce until age 65 and beyond, where possible, and to delay their decision to retire. For example, the Pension Bonus Scheme provides a lump sum payment upon retirement for those who defer their choice to take up the Age Pension and continue to work. Also, in the 2001–02 Commonwealth Budget, the Senior Australians' Tax Offset was introduced to encourage independent income and to equalise the taxation treatment of pensioners and non-pensioners (see Box 7.2). This measure extended tax offsets already available to pensioners to non-pensioners on low incomes.

**Table 7.3: Labour force participation rates, December 1988, 1993, 1998, 2002 (per cent)**

| Sex/age | 1988 | 1993 | 1998 | 2002 |
|---|---|---|---|---|
| **Males** | | | | |
| 45–54 | 89.3 | 88.5 | 87.8 | 88.3 |
| 55–59 | 73.3 | 73.0 | 72.8 | 74.3 |
| 60–64 | 47.8 | 50.6 | 45.8 | 49.0 |
| 65+ | 9.7 | 9.2 | 9.7 | 10.4 |
| **Females** | | | | |
| 45–54 | 58.2 | 65.7 | 69.8 | 74.5 |
| 55–59 | 33.0 | 37.4 | 44.0 | 50.5 |
| 60–64 | 15.7 | 15.5 | 18.0 | 26.8 |
| 65+ | 2.7 | 2.8 | 2.9 | 3.3 |
| **Persons** | | | | |
| 45–54 | 74.1 | 77.3 | 78.8 | 81.4 |
| 55–59 | 53.3 | 55.4 | 58.7 | 62.6 |
| 60–64 | 31.5 | 33.1 | 31.9 | 38.0 |
| 65+ | 5.6 | 5.6 | 5.9 | 6.4 |

*Note:* Percentages are as a proportion of persons in the age/sex group.

*Sources:* ABS 1989, 1994, 1999b, 2003b.

## Volunteer work

Older people make a significant contribution through volunteer work. In the 12 months to June 2000, nearly 530,000 people aged 65 and over (or 25%) participated in some form of volunteer work through a formal organisation or group (AIHW 2002c:16–17). Older volunteers tend to contribute more hours to voluntary work than younger people and while, in 2000, people aged 65 and over made up 12% of the total number of volunteers, they provided 17% of the total hours contributed. Like younger people they have a variety of reasons for volunteering, the most common being to help others or the community, for personal satisfaction and to do something worthwhile. The type of voluntary work performed by older people varies depending on their age and sex. For example, in 1999–00, women aged 65 and over were more likely to volunteer for fund-raising and sales activities or the preparation and serving of food. Men were more likely to be involved in administrative and clerical or management and committee type work.

## Carers

Many older people provide care for family and friends who need assistance in their daily lives. Using data from the ABS Survey of Disability, Ageing and Carers, in 1998 an estimated 401,000 people aged 65 and over provided assistance to people with a disability (ABS 1999a:43). Nearly one-quarter of these care providers were the primary carer of the care recipient, that is they provided the most assistance, in terms of help or supervision, to the care recipient. People aged 65 and over accounted for 22% of primary carers of people with a disability. Chapter 3 contains a detailed examination of the role of carers in Australian society.

There are a number of aged care programs that support carers in the community, and these are discussed in Section 7.4. In addition, depending on their circumstances, carers may be able to access two government payments: the Carer Payment and the Carer Allowance. People receiving these payments may be caring for more than one person (see Tables A7.5 to A7.7).

The Carer Payment is an income-support benefit payable to people who, because of their caring responsibilities, are unable to engage in a substantial level of paid work and who are not eligible for other income support payments (see Box 8.7). It is set at the same rate as the Age Pension and is subject to the same income and assets tests. Because it is for people forgoing paid work due to caring responsibilities, relatively few older people receive it. In December 2002, a total of 71,210 people were receiving the Carer Payment; people aged 65 and over accounted for just over 4% (1,129) of the 26,333 people caring for people aged 65 and over, and 1% (633) of the 46,103 people caring for younger people (see Table A7.5). Older recipients of the Carer Payment were more likely to be men than younger recipients: among older recipients looking after people aged 65 and over, 40% were men, compared with 33% of all recipients looking after people aged 65 and over.

The Carer Allowance is payable to co-resident carers who provide full-time care on a daily basis for up to two people who need substantial amounts of care because of a disability or a severe medical condition or because they are frail older people (see Box 8.7). The allowance can be paid to carers whether or not they are in receipt of a government pension or benefit and is not income or assets tested. It is adjusted on

1 January each year, and in 2003 was set at $87.70 per fortnight (Centrelink 2003). In December 2002, 294,806 people were receiving the Carer Allowance. The majority (56%, or 51,638) of recipients looking after people aged 65 and over were themselves aged at least 65, while just under 5% (9,340) of recipients caring for younger people were aged 65 and over (see Table A7.6). As with the Carer Payment, older recipients were more likely to be men than younger recipients: 38% of older recipients looking after people aged 65 and over were men, with the corresponding figure for all recipients looking after older people being 32%. This difference was even more marked among recipients caring for people aged under 65: among all such carers, 15% were men compared with 44% of older recipients caring for younger people.

## Ageing and disability

Key factors affecting the ability of many people to take part in the spectrum of activities of life—from workforce participation to independent living—include illness or injury and the related level of disability which arises. While many older Australians are free from a disability for which they require assistance, a proportion have more intensive care and assistance needs.

The surveys of disability, ageing and carers conducted by the ABS provide information about the prevalence of disability in the older population. The most recent data are drawn from the 1998 Disability, Ageing and Carers Survey, the fourth since 1981. In this survey, disability is defined as the presence of one or more of 17 limitations, restrictions or impairments. These 17 categories include a variety of problems ranging from loss of speech to 'any … long term condition that restricts every-day activities' (ABS 1999a:4).

The prevalence of disability in the older population in 2001 has been estimated using the age-sex specific rates of disability derived from the 1998 ABS survey (Table 7.4). This method assumes a constant rate of disability in the older population over time, an assumption which has been the subject of considerable debate in the international and national literature in recent years. A summary of this debate can be found in *Australia's Welfare 2001* (AIHW 2001a:201–3). Internationally, the evidence is somewhat mixed on whether disability rates are declining or increasing. However, to date, the Australian evidence suggests a relatively stable picture of severe restriction rates in the older population.

In 2001, over half of all people aged 65 and over (54% or 1.3 million) were estimated to have some form of disability. Having a disability does not imply need for assistance. Core activity restriction—which relates to difficulty or need for assistance with self-care, mobility or communication—provides a more useful indicator of level of difficulty experienced or help needed in performing activities basic to living than does the overall disability measure. Core activity restriction is categorised into four levels: people who are unable to perform a core activity or who always need help to do so (profound core activity restriction); people who sometimes need help (severe core activity restriction); people who do not require help but have difficulty with a core activity task (moderate core activity restriction); and people who do not require help but who use aids and equipment to undertake core activity tasks (mild core activity restriction). The group of older people most likely to be in need of assistance from aged care programs providing higher levels of care are those with a severe or profound core activity restriction.

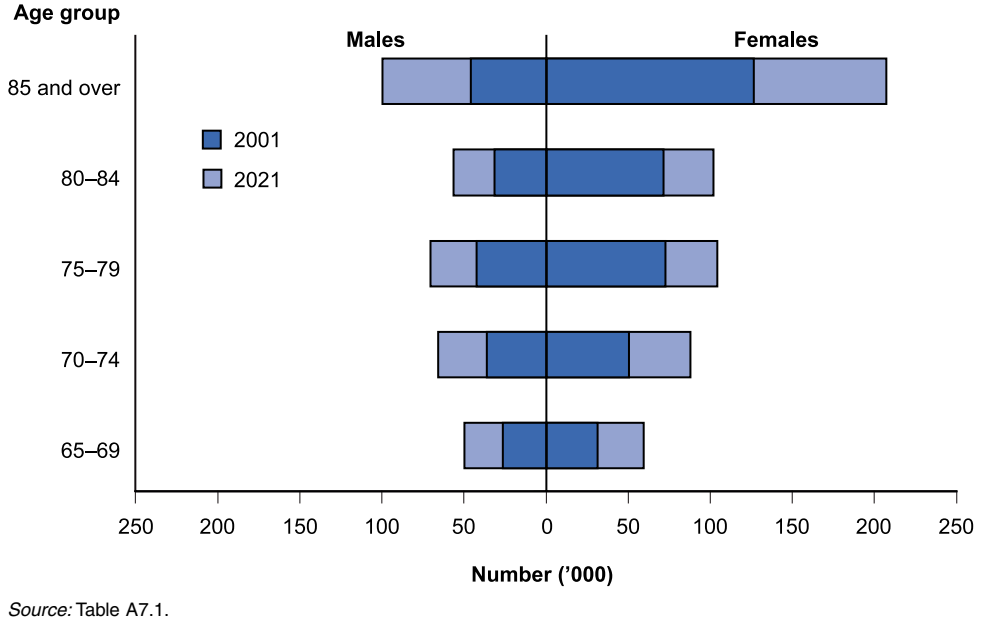
Among older people, the rates of severe or profound core activity restriction are quite low until age 75. In 2001, for those aged 65–74 years, an estimated 11% were so affected. The rates rise quite markedly with age, however, so that by age 85 and over, 65% of the population had a severe or profound core activity restriction.

The expected increase in the number of older people with a severe or profound core activity restriction between 2001 and 2021 has been calculated using ABS population projections (ABS 2000) and assuming constant rates of disability in the older population over the period (Figure 7.2). In 2001, there were an estimated 534,500 people aged 65 and over with such a restriction. This is expected to rise to 902,900 in 2021—an increase of 70% over the 20-year period. The number of people aged 85 and over with a severe or profound restriction is expected to increase by 78% (to 307,100).

**Table 7.4: Disability status of persons aged 65 years and over, 2001**

| | 65–74 | 75–84 | 85+ | Ages 65+ |
|---|---|---|---|---|
| **With disability** | | **Per cent of age group** | | |
| Severe or profound core activity restriction | 10.8 | 25.5 | 65.0 | 21.9 |
| Moderate core activity restriction | 9.9 | 10.5 | 8.0 | 9.9 |
| Mild core activity restriction | 16.9 | 20.7 | 10.4 | 17.5 |
| Without specific activity restrictions | 6.5 | 4.1 | 1.0 | 5.1 |
| ***Total with disability*** | ***44.1*** | ***60.8*** | ***84.4*** | ***54.3*** |
| ***No disability*** | ***55.9*** | ***39.2*** | ***15.6*** | ***45.7*** |
| **Total** | **100.0** | **100.0** | **100.0** | **100.0** |

*Source:* AIHW 2002c:Table A17.1.




*Source:* Table A7.1.

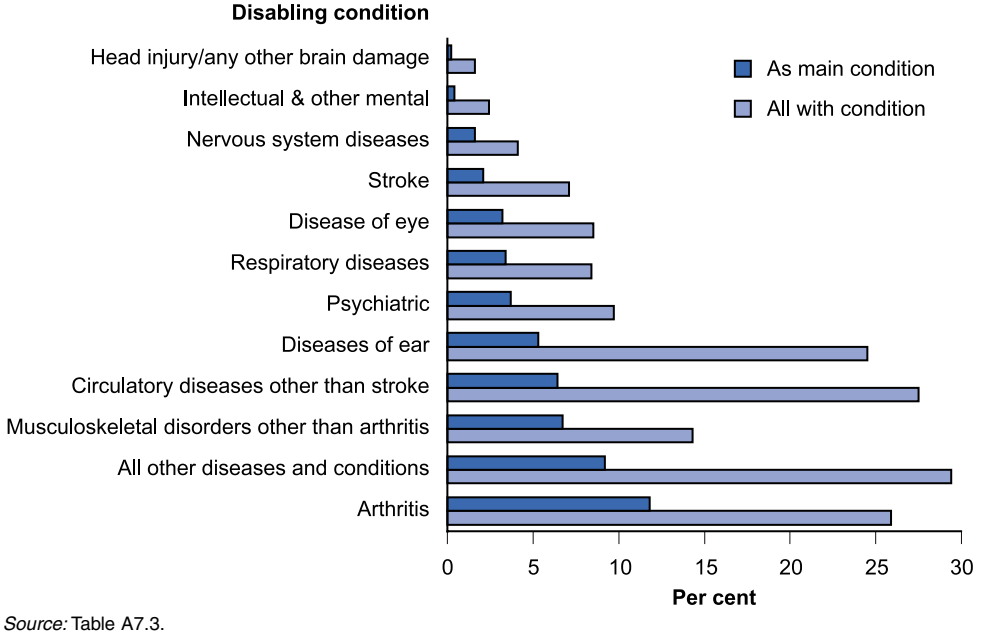
**Figure 7.2: Older people with a severe or profound core activity restriction, 2001 and 2021**

While rates of severe or profound core activity restriction increase at older ages, the majority of people with such a restriction continue to live in the community, rather than in an institutional setting. According to the 1998 ABS survey, among people with a severe or profound restriction, 84% of 65–79 year olds and 55% of those aged 80 and over lived in the community, with the remainder living in some form of institutional care (AIHW 1999a:171).

## Causes of disability

In order to improve the health and wellbeing of older people and to encourage appropriate individual behaviours and treatment practices, it is advantageous to have an understanding of the size and impact of health problems in the population, the causes of disability and loss of health, and to be able to identify the best ways to bring about change to prevent illness. It is possible to identify the conditions that most commonly give rise to disability among people aged 65 and over using the 1998 survey, in which a main condition was defined as 'a long-term condition identified by a person as the one causing the most problems' (ABS 1999a:69).

Figure 7.3 shows the prevalence of various disabling conditions as reported by those aged 65 and over. The extent to which conditions were identified as the main disabling condition is also presented. Among main conditions reported, arthritis was most common (12%), followed by other musculoskeletal disorders (7%). Circulatory conditions were also important, with stroke (2%) and other circulatory diseases (6%) being reported as the main disabling condition for a total of 9% of respondents.




*Source:* Table A7.3.

**Figure 7.3: Prevalence of main and all disabling conditions in people aged 65 and over, 1998**

Circulatory conditions and musculoskeletal disorders are also very prominent when all disabling conditions are considered: 7% and 28% of older people reported stroke and other circulatory diseases, respectively, as a disabling condition, while 26% and 14% reported arthritis and other musculoskeletal disorders. In addition, diseases of the ear were a common disabling condition (25%).

While these figures show the conditions that give rise to a disability, they do not take into account the severity of the disability or the extent to which it affects people's lives. Severity can be measured according to whether the condition results in premature mortality, which is captured by the Years of Life Lost (YLL) measure. Alternatively, it can be measured by estimating the number of healthy years of life lost, which is captured by Years of Life lost due to Disability (YLD). These measures take into account both the incidence of illness and the severity or level of impact on life and functioning due to that illness (AIHW 2000a:50). Previous analysis has identified dementia, adult-onset hearing loss and stroke as the leading causes of non-fatal disease burden. The leading causes of premature death among older Australians as measured by Years of Life Lost are cardiovascular diseases and cancers (AIHW: Mathers et al. 1999:218–24). Further work on the burden of disease is being conducted by the AIHW to update these 1993–94 estimates.

### Dementia

Because of its place as one of the leading causes of disease burden, a particular concern associated with the ageing of the population is the increase in the number and proportion of the older population with dementia, and the associated need for both home-based and residential care. In 1993–94, dementia accounted for the largest proportion of disease costs for any one condition. The prevalence of dementia can be difficult to estimate for a number of reasons; for example, in the mildest stages of dementia there may be little contact with the health or aged care services that would result in a diagnosis. Even when this contact does occur, the diagnosis of other conditions or diseases may be seen as more relevant to treatment than making a clinical assessment of dementia. Age-specific prevalence estimates were calculated by Jorm, Korten and Henderson (Henderson & Jorm 1998; Jorm et al. 1987) using meta-analysis of international studies. Their results suggest that the prevalence of dementia increases with age, rising from 1% among people aged 65–69 to 6% among 75–79 year olds and up to 24% for those aged at least 85. If these rates are used as a basis for calculating prevalence in the population (assuming constant prevalence rates over time), there were an estimated 153,800 persons with dementia aged 65 and over in Australia in 2001. This equates to 6.4% of the older population (AIHW 2002c:36).

The severity of the effects of dementia on the lives of people affected by this condition provide an indication of the extent to which they are likely to require assistance. Using the 1998 ABS survey, estimates can be derived of the prevalence of dementia or Alzheimer's disease. Because the survey uses self-reporting of health and disability status, these estimates are likely to be too low. However, the data can be used to examine the disability status of people with dementia.

**Table 7.5: Disability status of people with dementia, including Alzheimer's disease, 1998**

| Age | With a disability: Severe or profound core activity restriction | With a disability: Moderate or mild core activity restriction | With a disability: Disability without core activity restriction | With a disability: Total | No disability | Total |
|---|---|---|---|---|---|---|
| | | | Number | | | |
| 65–74 | 11,500 | *2,000 | **— | 13,600 | **500 | 14,000 |
| 75–84 | 33,800 | **300 | **100 | 34,100 | **400 | 34,500 |
| 85+ | 48,100 | **500 | **100 | 48,600 | **600 | 49,200 |
| **Total** | **93,400** | ***2,700** | ****200** | **96,300** | ***1,500** | **97,800** |
| | | | Per cent | | | |
| 65–74 | 82.3 | *14.1 | **0.2 | 96.6 | *3.4 | 100.0 |
| 75–84 | 97.9 | **0.8 | **0.2 | 98.9 | **1.1 | 100.0 |
| 85+ | 97.7 | **1.0 | **0.1 | 98.8 | **1.2 | 100.0 |
| **Total** | **95.6** | ***2.8** | ****0.2** | **98.5** | ***1.5** | **100.0** |

*Note:* Estimates are based on all reported long-term conditions.

*Source:* AIHW analysis of ABS 1998 Survey of Disability, Ageing and Carers.

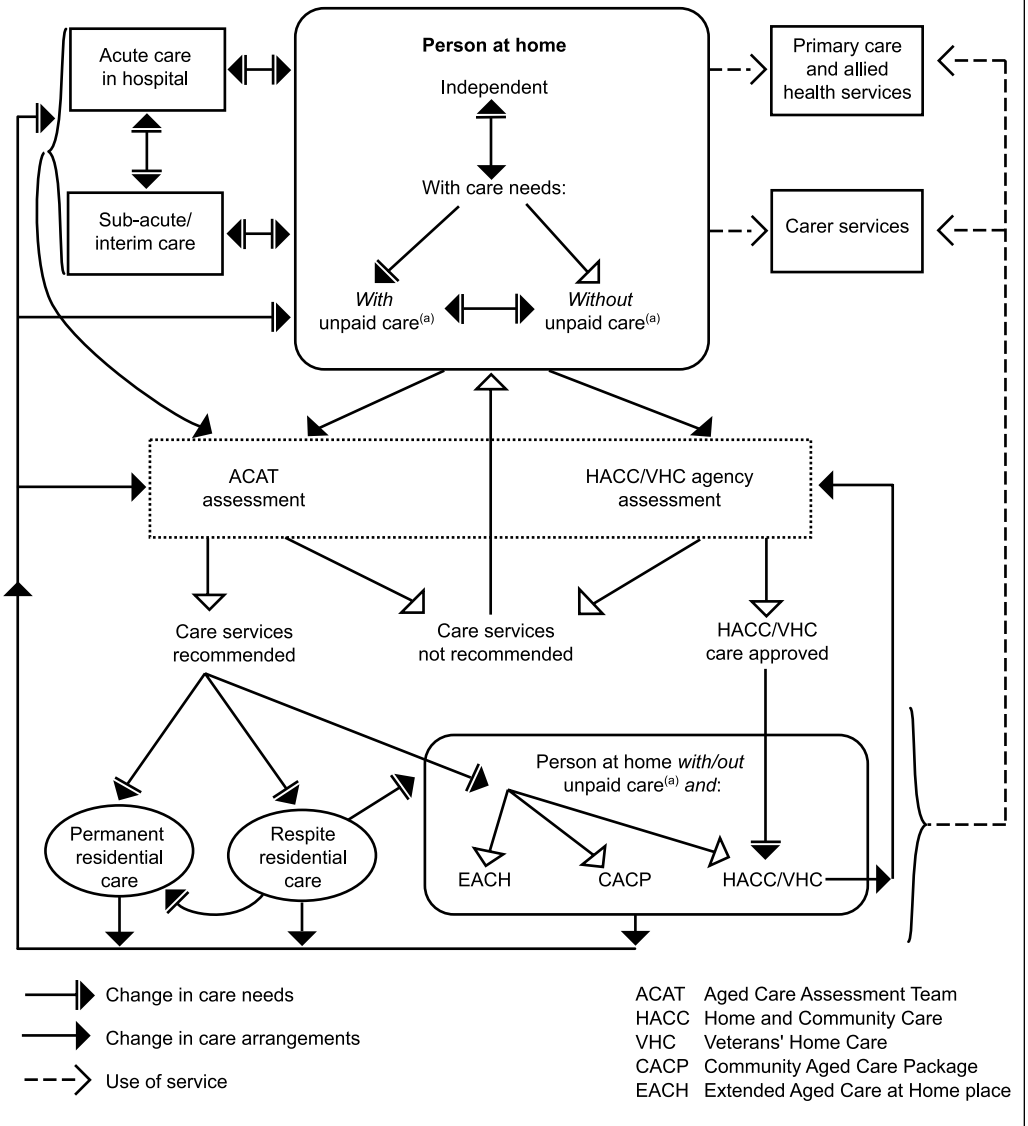
Nearly all people aged 65 and over reporting dementia, including Alzheimer's disease, had a disability (99%), with almost as many (approximately 96% of sufferers) having a severe or profound core activity restriction (Table 7.5). This proportion increases from 82% in the 65–74 age group, to 98% in the 75–84 and 85 and over age groups. The prevalence of dementia among clients of residential aged care services is discussed in Section 7.6. The care needs of clients with and without dementia are also compared.

While many older people live independently in the community, others require support. The care services available to older people are discussed in the following sections.

## 7.3 Support and care for older people

Support and care for older people are available from a variety of sources, and many people make their own arrangements. Care may be provided by friends and relatives, or by service providers either in the community or in a residential service. The range of services people can access is discussed in broad terms below. Sections 7.4 to 7.6 contain a more detailed description of these services and their clients.

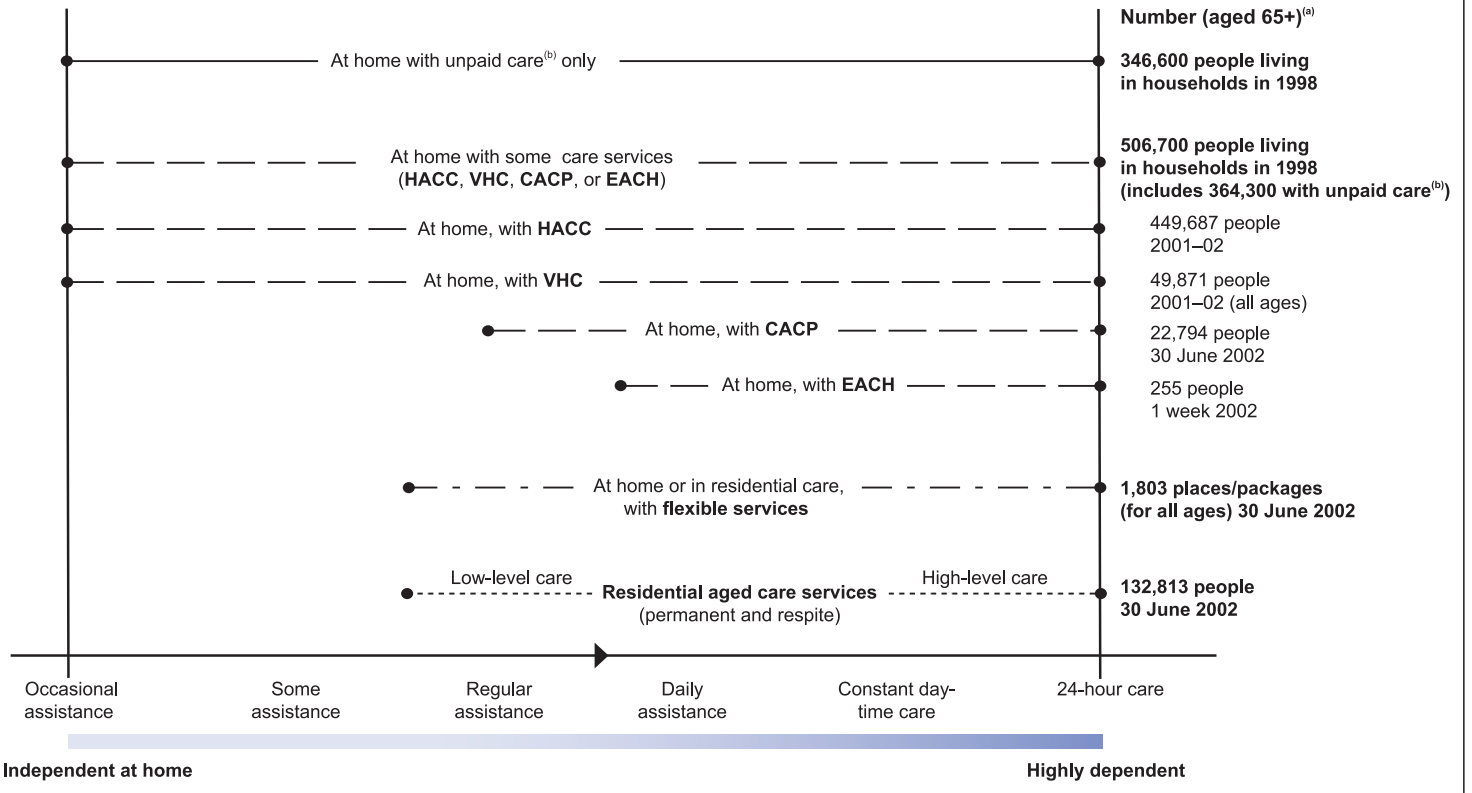
People may change their care arrangements and access a range of government-funded services as their care needs change (Figure 7.4). While living at home, they may use a number of care services, and such services can be accessed whether or not they are receiving care from friends and relatives. However, the types of services they can access often depend on a formal assessment of their care needs. Services for people with assistance needs that could be expected to be met by residential aged care require a recommendation from an Aged Care Assessment Team. Such services include permanent residential care, respite residential care, Community Aged Care Packages (equivalent to low-level residential care) and Extended Aged Care at Home places (equivalent to high-level residential care). Some community-based services are available more broadly—for example, Home and Community Care—and these services are




(a) Excluding payments from government pensions and benefits.

*Note:* Figure includes selected government-funded programs only.

**Figure 7.4: Changing care arrangements of older people**




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

(b) Excluding payments from government pensions and benefits.

*Note:* Selected government-funded programs only. Hospital services not included.

*Sources:* Table A7.12; ABS 1999a:40; AIHW 2003c.

**Figure 7.5: Care alternatives for older people**

provided after people are assessed by the agency as eligible. People also use a variety of hospital and primary care services (for example, general practitioners) and allied health services, such as podiatry, physiotherapy and occupational therapy. In addition to the services available to people with care needs, services are available to support their carers. Apart from government-funded services, people may make their own arrangements to meet their care needs, buying in services—like domestic assistance, home maintenance and nursing services—as they are required (not included in Figure 7.4).

While aged care programs target people with particular levels of care needs, not all people with those needs access services; that is, the shift from living independently at home without care to permanent residence in an aged care service is not an automatic progression. There are various care alternatives that can be accessed as care needs increase (Figure 7.5). Some people may never move into residential aged care but may stay living in the community under their own care arrangements. In other cases, people may remain in their home with a mixture of unpaid care and government-funded care services. Such care services may involve either a relatively low level of assistance, for example through day centres, or may be the intensive care included in the Extended Aged Care at Home program. Finally, residential care is available to people unable to remain living at home, either in the short term or permanently.

The importance of care by friends and relatives in the aged care system is brought out in Figure 7.5. In 1998, over 711,000 older people were living at home with unpaid carers providing support, either with or without the assistance of services. In comparison, on 30 June 1998 there were 127,900 people aged 65 and over in residential aged care and 8,800 in the same age group who were recipients of Community Aged Care Packages (AIHW 1999b:28, AIHW analysis of ACCMIS).

## Accessing services

As can be seen from the above, there is a wide range of services for older people and their carers available through a number of channels. However, before people can make use of these services, they need to be able to access them.

### Commonwealth Carelink Centres

To help people find appropriate services, in 2001 the Commonwealth Government set up a network of Commonwealth Carelink Centres. These centres provide a single point at which comprehensive information about community, aged care and other support services can be obtained. They have been operating since April 2001 and the service targets both those in need of support and those providing support or advice to others. By June 2002, the network included a free call 1800 number, 65 shopfronts in 54 regions throughout Australia and over 90 access points such as free phones in rural and remote localities (DoHA 2002b:137). Commonwealth Carelink Centres are operated by a wide range of organisations, including not-for-profit and for-profit non-government organisations, and government agencies. During 2002–03, the centres responded to approximately 13,000 requests for information per month.

**Table 7.6: Aged Care Assessment Team assessments, by recommended long-term living arrangement, 1998–99 to 2001–02**

| Recommendation | 1998–99 | 1999–00 | 2000–01 | [a]2001–02 |
|---|---|---|---|---|
| Community recommendations | | **Number** | | |
| Coordinated community care[b] | 15,209 | 18,525 | 28,015 | 33,874 |
| Other[c] | 69,733 | 70,445 | 67,358 | 65,015 |
| *Total* | *84,942* | *88,970* | *95,373* | *98,889* |
| Residential recommendations | | | | |
| Low care | 36,072 | 37,635 | 39,474 | 39,885 |
| High care | 41,639 | 42,007 | 43,896 | 43,220 |
| *Total* | *77,711* | *79,642* | *83,370* | *83,105* |
| Other[d] | 4,775 | 4,642 | 4,692 | 4,776 |
| No recommendation required | | | | |
| Client died | 1,381 | 1,394 | 1,329 | 2,277 |
| Client transferred | 4,162 | 3,812 | 3,049 | 2,843 |
| Assessment cancelled | 2,393 | 1,858 | 2,685 | 2,616 |
| *Total* | *7,936* | *7,064* | *7,063* | *7,736* |
| Unknown | 3,551 | 3,266 | 3,432 | 3,359 |
| **Total** | **178,915** | **183,584** | **193,930** | **197,865** |
| | | | | |
| Community recommendations | | **Per cent[e]** | | |
| Coordinated community care | 8.9 | 10.5 | 15.0 | 17.8 |
| Other | 40.8 | 39.9 | 36.0 | 34.2 |
| *Total* | *49.7* | *50.4* | *51.0* | *52.0* |
| Residential recommendations | | | | |
| Low care | 21.1 | 21.3 | 21.1 | 21.0 |
| High care | 24.4 | 23.8 | 23.5 | 22.7 |
| *Total* | *45.5* | *45.1* | *44.6* | *43.7* |
| Other | 2.8 | 2.6 | 2.5 | 2.5 |
| Unknown | 2.1 | 1.9 | 1.8 | 1.8 |
| **Total** | **100.0** | **100.0** | **100.0** | **100.0** |
| **Total (number)** | **170,979** | **176,520** | **186,867** | **190,129** |
| **Assessments per 1,000 for people aged 65 and over[f]** | **66.9** | **68.0** | **70.3** | **71.3** |

(a) Includes data for Tasmania estimated from 2000–01 data in conjunction with the growth rate in assessments for the rest of Australia between 2000–01 and 2001–02.

(b) Includes care provided under Community Aged Care Packages and the Community Options Program.

(c) Includes assessments recommending a range of community services (such as home nursing, meals, respite and Carer Allowance), and also assessments in which no community services were recommended.

(d) Includes accommodation not in a private house or residential care; for example, boarding houses.

(e) Excludes deaths, cancellations and transfers.

(f) Assumes 93.4% assessments were for people aged 65 and over (based on data for January–June 2000).

*Sources:* AIHW 2001a:216; LGC 2000, 2001, 2002; LGC 2001–02 unpublished data.

## Assessment

Aged Care Assessment Teams (ACATs) play a crucial role in the Australian aged care system. They determine eligibility for Community Aged Care Packages, Extended Aged Care at Home places, and admission to residential aged care. They also function as a source of advice and referral concerning HACC services but do not determine eligibility

for these services. In the process of determining eligibility, the teams generate data on the clients they assess: their age and sex, their dependency levels, and their assessed level of need for services. Implementation of the new national minimum data set (MDS) for the Aged Care Assessment Program (ACAP MDS V2) commenced in April 2003, following the release of the data dictionary in late 2002 (AIHW 2002a).

Both need and availability of high-care services guide recommendations by ACAT teams. Using data from the first version of the ACAP MDS, Table 7.6 shows the outcomes of assessments by Aged Care Assessment Teams over the 4-year period 1998–99 to 2001–02. In 2001–02, there were just over 190,100 assessments, excluding incomplete assessments due to the death of the client, cancellation of the assessment or transfer to other assessment teams. An estimated 93% of these assessments were for people aged 65 and over, so that during the year there were 71 completed assessments for every 1,000 people aged 65 and over. Excluding cases with an unknown recommendation, just over half of assessments (53%) resulted in community recommendations for long-term living arrangements, 45% for residential care and 3% for other arrangements such as living in a boarding house. Among recommendations for community care, just over one-third were for coordinated care—that is, either with a Community Aged Care Package, or through the Community Options Program funded as part of the Home and Community Care Program. Slightly more recommendations for residential care were for high care (23%) than for low care (21%).

Over the 4 years examined there was a small but steady increase in the proportion of assessments resulting in community recommendations and a fall in the proportion resulting in residential recommendations. However, among community recommendations, the proportion recommended for care packages doubled (from 9% of assessments to 18%). This reflects the large growth in Community Aged Care Packages over the period, with the number of packages nearly doubling between 30 June 1999 and 30 June 2002 (see Table 7.15).

**Table 7.7: Dependency status of Aged Care Assessment Team clients, 1998–99 to 2001–02 (per cent)**

| | 1998–99 | 1999–00 | 2000–01 | 2001–02 |
|---|---|---|---|---|
| **Mobility** | | | | |
| Walks independently | 64.4 | 63.9 | 64.0 | 62.4 |
| Does not walk independently | 35.6 | 36.1 | 36.0 | 37.6 |
| *Number* | *173,011* | *179,353* | *187,201* | *190,167* |
| **Continence** | | | | |
| Fully continent | 61.5 | 61.4 | 61.3 | 60.9 |
| Not fully continent | 38.5 | 38.6 | 38.7 | 39.1 |
| *Number* | *170,148* | *176,309* | *183,743* | *186,145* |
| **Orientation** | | | | |
| Aware–time and place | 65.7 | 67.1 | 67.5 | 68.0 |
| Not aware | 34.3 | 32.9 | 32.5 | 32.0 |
| *Number* | *169,075* | *174,753* | *183,460* | *186,398* |
| **Total number (including unknown cases)** | **178,915** | **183,584** | **193,930** | **197,865** |

*Sources:* AIHW 2001a:217; LGC 2002; LGC 2001–02 unpublished data.

As part of the assessment, ACATs measure the level of dependency of clients in three key areas: mobility, continence and orientation. In 2001–02, about one-third of those assessed had difficulties in these areas (Table 7.7). For the period 1998–99 to 2001–02, there was no clear change in the dependency profile of ACAT clients as measured by these three items. Also, throughout that period 20% of clients had a primary diagnosis of dementia, that is dementia was the diagnosis that was the main reason for the person presenting for an ACAT assessment (LGC 2002:36, figure excludes Western Australia). Clients with restrictions in the areas of mobility, continence or orientation were more likely to be recommended for residential care. Over 40% of the clients who had any one of these restrictions in 2000–01 were recommended for high-level residential care (LGC 2002:63).

In the next four sections, the range of aged care services is discussed in some detail. Since the last edition of this publication, there have been a number of developments in the data available to describe these programs (Box 7.3).

## Box 7.3: Data development in aged care services

*The **Aged Care Assessment Program** (ACAP) Data Dictionary Version 1.0 was published in late 2002. It contains definitions of all data elements that Aged Care Assessment Teams are required to report as part of the ACAP Minimum Data Set Version 2.0 and a set of national program-level performance indicators (AIHW 2002a). The new ACAP MDS V2.0 was implemented in January 2003 and has been expanded to include information about carers, including use and recommendation of respite care, and information describing a client's health profile and need for assistance with activities of daily living.*

**Client Characteristics Meta-data in Residential Aged Care**, *released in 2003, aims to facilitate analysis of client characteristics data across programs by mapping data items (AIHW: Jeffery 2003). The report makes specific recommendations to improve the comparability of data across programs and consistency with national standards by the inclusion of guidelines for the reporting of client characteristics on the Resident Entry Record form, the addition of further codes in various collections, and the inclusion of the ACAP MDS V2.0 data into the Aged and Community Care Management Information System (ACCMIS).*

*The **Day Therapy Centre** Data Collection project involved the development of the* Day Therapy Centre Program Data Dictionary Version 1.0 *(AIHW 2003b), a data collection mechanism including field tests with providers (AIHW: Petrie & Van Doeland 2002), and development of a Guide for Use as a companion document to the Data Dictionary.*

*A 4-week census of Day Therapy Centres was carried out from 21 October 2002 (AIHW forthcoming-b). The questions in the census were based on definitions from the Data Dictionary. The project provides the first comprehensive data on service provision by these centres. Centre clients funded through residential aged care services were not included in the census.*

*A 1-week census of **Community Aged Care Packages** was carried out between 16 September and 14 October 2002, producing the first comprehensive data on the volume of service provided by these packages (AIHW forthcoming-a).*

*(continued)*

**Box 7.3 (continued): Data development in aged care services**

*A 1-week census of* ***Extended Aged Care at Home*** *places was carried out from 6 May 2002, resulting in the first comprehensive data on service provision through this program (AIHW forthcoming-c).*

*The* **Report on the Comparability of Dependency Information across Aged and Community Care Programs** *examines the comparability of dependency information for clients of Home and Community Care, the Aged Care Assessment Program and Community Aged Care Packages, to assess consistency with national and international standards and identify possible modifications to these items (AIHW: Van Doeland & Benham forthcoming).*

*A* ***Home and Community Care*** *(HACC) dependency measure has been developed in a study conducted by the Centre for Health Service Development at the University of Wollongong. A report has been released which contains a literature review, details of a field test carried out using the preferred instruments, and recommendations for implementation (Eagar et al. 2002). A two tiered assessment process is proposed, consisting of a simple functional screening, followed by a more detailed assessment for those requiring it.*

*The* ***Continence Aids Assistance Scheme*** *Data Dictionary Version 1.0 was completed and released in late 2001 (AIHW: Broadbent 2001).*

## 7.4 Care services in the community

While many older people live in their homes either by managing on their own, or with help from relatives and friends, others rely on a range of care services. In some cases, without these services people would not be able to remain living in the community, but would need to move into residential care. There are three main programs which provide care to people living in their own homes: Home and Community Care (HACC), Veterans' Home Care (VHC) and Community Aged Care Packages (CACP). A fourth program—the Extended Aged Care at Home (EACH) Program—is in the process of being extended following a successful pilot phase and currently provides services to only a small number of people. In addition, there are a number of other programs which support people and their carers; for example, Day Therapy Centres and the National Respite for Carers Program. These programs are discussed below. States and territories also provide a range of services independently of the Commonwealth Government; these services are not examined.

In addition to general service usage levels among people aged 65 or more, also of interest is the rate of service use among those who need care. In general, aged care services are targeted at frail or disabled older people. The 1998 ABS Survey of Disability, Ageing and Carers identified people who fall into the disability categories of having a mild, moderate, severe or profound core activity restriction. In analyses undertaken by the AIHW, the mild and moderate restriction categories are not included as they refer to people who do not require assistance with core activities of daily living according to the definition employed in the ABS survey. Accordingly, in this chapter,

where possible, we report usage relative to the number of people with a severe or profound core activity restriction, as defined by the ABS, to give an indication of take-up by people requiring assistance with core activities of daily living.

## Home and Community Care

The HACC program provides community care services to older people and to people of all ages with disabilities, and their carers. The aim is to enhance the independence of people in these groups and avoid premature or inappropriate admission to long-term residential care. The program is jointly funded by the Commonwealth and the state and territory governments.

The bulk of home- and community-based services for older people are provided under the auspices of this program. It is important to recognise, however, that the target population is people of all ages with a moderate, severe or profound level of disability (and their carers), and that an ACAT assessment is not a prerequisite to accessing the program. However, many clients assessed by Aged Care Assessment Teams are recommended for HACC services. The program includes home nursing services, delivered meals, home help and home maintenance services, transport and shopping assistance, allied health services, home- and centre-based respite care, and advice and assistance of various kinds. HACC also provides brokered or coordinated care for some clients, through community options or linkages projects.

Since the inception of the HACC program in 1985, both the quantity and variety of services have increased substantially, as has government expenditure (see Table 7.13). By mid-2002, there were approximately 3,500 service providers across the country who were part of this program (DoHA 2002a:7). The implementation of the new HACC minimum data set in January 2001 allows more detailed analysis of the HACC program than has previously been possible, and while not all agencies participate in the collection (74% provided data in 2001–02), it is possible to present data on the demographic profile of service users, and the services they receive (see Box 7.4 for data issues affecting the interpretation of results from the HACC MDS).

As stated above, the HACC program includes as part of its target group younger people with disabilities as well as older people and their carers. During the 12 months between 1 July 2001 and 30 June 2002, 583,156 clients were reported as receiving services through Home and Community Care (DoHA 2002d). Of these, 449,687 were aged 65 or more (Table 7.8). The target group for the HACC program specifies people of all ages with a moderate, severe or profound disability, and their carers. It is estimated that in 2001 in Australia there were 534,500 people aged 65 and over with a profound or severe core activity restriction, that is who always or sometimes needed help with a core activity task, and a further 241,000 with a moderate restriction, that is people who did not need help but had difficulty with a core activity task (see Tables 7.4 and A7.1). Information on services provided to people aged under 65 with a disability are discussed in Chapter 8.

### Patterns of service use

During 2001–02, among every 1,000 people aged 65 and over in the population at least 181 accessed HACC services (see Table A7.12). In general, people are increasingly more likely to access these services as they get older, with at least 87 per 1,000 people aged

## Box 7.4: Home and Community Care Minimum Data Set

*Version 1 of the HACC minimum data set was implemented in January 2001. Data are collected by HACC agencies on the use of HACC services by individuals, and forwarded to the HACC National Data Repository. Data items collected include client characteristics, carer information, and types and volume of service used. People may be assisted by more than one agency, and in the data set clients are counted using a statistical linkage key (not name).*

*Not all agencies providing HACC services submit data for the HACC minimum data set. Consequently, estimates from it of the numbers of people assisted, and of the volume of service, understate the total amount of service provided. For 2001–02 the estimated participation rate among HACC agencies was 74%. Rates varied across states and territories, ranging from an estimated 56% of agencies in the Northern Territory to 94% in Western Australia (DoHA 2002d:5). Participation rates have been increasing, and for the January quarter 2003 the estimated agency participation rate was 85%.*

*Indigenous status of clients is reported in the HACC MDS. However, AIHW comparisons of numbers of HACC clients who identified as Indigenous with estimates of Indigenous people in particular age groups as derived from the 2001 Population Census suggest that the reported number of Indigenous people using HACC services is too high (ABS 2002b). Consequently, because of concerns with the quality of information on Indigenous status, only very limited analysis of HACC service provision to this group is presented in this chapter.*

*During 2003, an evaluation of version 1 of the HACC MDS was undertaken by Alt Beatty Consulting and the Australian Institute for Primary Care of the Lincoln Gerontology Centre. The consultancy examined both the collection process used for the data set and the quality of the data. Results were not available at the time of publication.*

65 to 74 doing so in 2001–02, compared with at least 425 per 1,000 aged 85 and over (see Table 7.11). For every 1,000 people aged 65 and over with a severe or profound core activity restriction, there were at least 814 using HACC services.[3]

During 2001–02, assessment, case management and planning was the service reported for the largest number of older HACC clients (39%) (Table 7.8). Other services commonly reported were assistance with domestic chores (35%), meals (21%), nursing (20%) and transport services (17%). Centre-based day care, and personal care, were both reported for 10% of clients, while respite care was reported for 1% of clients. Based on reported service use, during 2001–02 on average HACC clients used 2.0 of the service groups listed in the table.

3 Note that this is a ratio of clients to potential users and not a usage rate, as disability status is not available in the HACC MDS and not all HACC clients will necessarily have a profound or severe core activity restriction as defined by the ABS.

**Table 7.8: Services received by Home and Community Care clients aged 65 and over, 2001–02**

| | Per cent of clients |
|---|---|
| Assessment, case management and case planning[(a)] | 38.7 |
| Domestic assistance | 35.1 |
| Meals (at home and at a centre)[(a)] | 21.3 |
| Nursing (home and centre-based)[(a)] | 19.9 |
| Transport services | 16.6 |
| Home maintenance | 14.4 |
| Counselling and social support[(a)] | 13.1 |
| Allied health (at home and at a centre)[(a)] | 11.5 |
| Personal care | 9.6 |
| Centre-based day care | 9.5 |
| Provision of aids/car modifications[(a)] | 4.8 |
| Home modification | 3.1 |
| Respite care[(b)] | 1.1 |
| Other food services | 0.5 |
| Linen services | 0.2 |
| **Total clients (number)** | **449,687** |

(a) Service type includes more than one service category.

(b) In the case of respite care, the carer is considered the HACC client. Anecdotal evidence indicates that the provision of respite care may be under-reported.

*Notes*

1. Not all HACC agencies submitted data to the HACC MDS. For 2001–02, an estimated 74% of agencies submitted data.
2. 0.5% of clients had missing/unknown age. These clients have been assumed to be aged 65 and over.

*Source:* DoHA and AIHW analysis of the HACC MDS.

## Veterans' Home Care

Similar in purpose and content to the HACC program, Veterans' Home Care is designed to help veterans, war widows and widowers with low-level care needs to enjoy a healthier lifestyle and remain living in their own homes longer. The program, which began in January 2001, has a preventive focus and, through the early intervention of home support services, aims to reduce the use of formal medical services and delay entry to aged care facilities. While available generally to eligible veterans and war widows(ers), the program targets those aged 70 years and over.

Provision of services is based on assessed need. Assessments are undertaken by regional assessment agencies, which also arrange for the services to be provided. Services include domestic assistance, personal care, safety-related home and garden maintenance (limited to 15 hours in a financial year) and respite care. Except for respite care, clients are required to pay a co-payment for Veterans' Home Care services.

Veterans and war widow(er)s continue to be eligible to be assessed for the full range of services provided under HACC through arrangements with state and territory governments. Veterans and war widow(er)s currently receiving HACC services are able to transfer to Veterans' Home Care. However, clients can access different services from both of the programs at the same time.

**Table 7.9: Services received by Veterans' Home Care clients, July–September 2002**

| | Clients | | Mean amount |
|---|---|---|---|
| | Number | Per cent | (hours:minutes) |
| Domestic assistance | 39,544 | 86.0 | 11:30 |
| Home and garden maintenance | 13,222 | 28.8 | 2:10 |
| Respite care[(a)] | 4,389 | 9.5 | 28:40 |
| Personal care | 2,039 | 4.4 | 15:30 |
| **Total** | **45,965** | . . | 14:00 |

(a) Includes in-home and emergency respite only, not residential respite. Residential respite may also be coordinated through Veterans' Home Care.

*Source:* DVA unpublished data, correct as at 23 June 2003.

### Patterns of service use

During 2001–02, 49,871 people of all ages received services through Veterans' Home Care, with some services being accessed more than others. Domestic assistance and safety-related maintenance were the services most commonly provided (to 81% and 36% of clients, respectively, during the year), while in-home and emergency respite care was provided to 14% of clients, and personal care to 6%. Many people received more than one service, with clients averaging 1.4 services each over the year.

The different services involve varying amounts of assistance (Table 7.9). During the July quarter 2002, in-home and emergency respite care averaged the highest number of hours of care (28 hours 40 minutes per client using respite care over the 3-month period). Personal care—provided to relatively few clients—averaged 15 hours 30 minutes per client, while domestic assistance involved an average of 11 hours 30 minutes. Home and garden maintenance averaged the least time—2 hours 10 minutes. Overall, an average of 14 hours of services and/or assistance was provided to clients during the quarter.

## Community Aged Care Packages

Community Aged Care Packages provide support services for older people with complex needs living at home who would otherwise be eligible for admission to 'low-level' residential care. They provide a range of home-based services, excluding home nursing assistance (which may, however, be provided through HACC), with care being coordinated by the package provider. To receive a package, older people must be assessed by an Aged Care Assessment Team as needing the type of assistance provided by a package; that is, their needs are such that they can only be met by a coordinated package of care services.

Unlike the HACC program which is jointly funded by the Commonwealth and state and territory governments, the Community Aged Care Packages (CACP) program is solely Commonwealth funded. From a small beginning of 235 packages in 1992, the program has expanded rapidly. The bulk of this growth occurred after 1997, with the number of packages increasing more than four-fold over 5 years, from 6,124 packages in 1997 to 26,425 operational packages in 2002 (including flexible care and Multi-purpose Service packages, discussed separately later). This growth rate is much higher than that of the population aged 70 and over, and of residential care places (see Table 7.15; AIHW 2003a:2). Consequently, an increasing proportion of older people in need of

assistance are receiving care through Community Aged Care Packages. On 30 June 2002 there were 24,585 people in receipt of a Community Aged Care Package; 22,794 of these recipients were aged 65 and over (see Table A7.10). These figures do not include supplementary clients or recipients of flexible care and Multi-purpose Service packages.[4]

## Patterns of service use

On 30 June 2002, 9 per 1,000 people aged 65 and over were receiving care under a Community Aged Care Package (not including supplementary clients or recipients of flexible care and Multi-purpose Service packages). This equates to 41 CACP recipients for every 1,000 people aged 65 and over with a severe or profound core activity restriction (see Table A7.12). As with HACC services, use of a Community Aged Care Package increases with age, from 3 per 1,000 people aged 65–74 to 31 per 1,000 people aged 85 and over (see Table 7.11).

A range of services can be included in a Community Aged Care Package, including domestic assistance, personal care, social support, rehabilitation support, respite care, meals and food preparation, home maintenance, transport and linen services. In 2002, data on the type and quantity of services people received were collected for the first time, via the CACP census (AIHW forthcoming-a).

**Table 7.10: Length of support provided to Community Aged Care Package recipients aged 65 and over,[(a)] separations during 2001–02**

| | Number | Per cent |
|---|---|---|
| <4 weeks | 678 | 5.7 |
| 4–<8 weeks | 880 | 7.4 |
| 8–<13 weeks | 1,073 | 9.1 |
| 13–<26 weeks | 2,054 | 17.4 |
| 26–<39 weeks | 1,410 | 11.9 |
| 39–<52 weeks | 1,076 | 9.1 |
| 1–<2 years | 2,409 | 20.4 |
| 2–<3 years | 1,009 | 8.5 |
| 3–<4 years | 625 | 5.3 |
| 4+ years | 599 | 5.1 |
| **Total** | **11,813** | **100.0** |

(a) 'Length of support' includes continuous time as a CACP recipient from a particular provider. Disjoint periods on a CACP by the same person are not combined, but are counted separately.

*Note:* Figures do not include clients of Multi-purpose and flexible services.

*Source:* AIHW analysis of DoHA ACCMIS database.

4 Package recipients are permitted to take leave from their packaged care for a number of reasons; for example, for a holiday, residential respite care, or for a stay in hospital. In these situations, the subsidy paid for these packages may be used to fund care for other recipients who are eligible for placement in a package. These recipients are called 'supplementary care recipients'.

In 2001–02, there were just over 11,800 separations from packages by people aged 65 and over (Table 7.10). Of these, nearly half of the recipients had been receiving the package for more than 9 months, with 29% having been in receipt of one for between 1 and 3 years. Five per cent of clients had been assisted through the same service provider for more than 4 years. Given the very rapid growth in the program in recent years, as the rate of program growth slows and hence the proportion of clients in 'new' packages decreases, it is likely that the proportion of clients using packages for long periods will be higher in the years to come.

The most common reasons for the cessation of a package are clients moving into residential aged care or the death of the client: in 2001–02, almost half (46%) of all separations—including those for younger people—were to residential aged care, while 20% were the result of the death of the care recipient (AIHW 2003a:44). In addition, 6% of separations were the result of a recipient leaving one care package to take up another.

## Extended Aged Care at Home

The Extended Aged Care at Home (EACH) program aims to deliver care at home that is equivalent to high-level residential care. This program began as a pilot in 2000, offering care to 300 clients in ten areas across Australia. In 2001–02, the Commonwealth Government announced its intention to establish EACH as an ongoing program, and provided funding for the continued development of its management and quality assurance framework (DoHA 2002b:127). An allocation of an additional 160 EACH places was announced for 2002–03. As with CACPs, access to an EACH place is through assessment by an Aged Care Assessment Team.

Information on the characteristics of recipients of EACH places, and the services they receive, was collected in the 2002 EACH 1-week census. Many of the services available to EACH recipients are similar to those provided to CACP recipients. In addition, nursing and allied health care services can be provided to EACH care recipients as part of the package. At the time of the 2002 EACH census, almost 290 people were EACH care recipients; 11% of these clients were aged under 65 (AIHW forthcoming-c).

## Day Therapy Centres

Prior to 1987, the Commonwealth funded a number of nursing home proprietors in the not-for-profit sector to provide therapy services in a day care setting. Under this arrangement, nursing home and hostel residents and people living in the community could receive a number of specialist services. In 1987, a revision of funding methodologies resulted in the establishment of Day Therapy Centres to provide therapy services specifically to hostel residents and people in the community; equivalent services for nursing home residents were to be included under funding for nursing homes.

The purpose of Day Therapy Centres is to assist people to maintain or recover a level of independence which will allow them to remain either in the community or in low-level (formerly hostel) residential care (DoHA 2002c). There are currently around 150 Commonwealth-funded centres operating nationally. The centres vary in size and in the range of therapy services that they provide. They are used more commonly in some states and territories than others, with provision depending on the need and availability

of equivalent services through other programs. For example, almost half of Day Therapy Centre clients live in South Australia (AIHW forthcoming-b). Usually, a Day Therapy Centre will develop an agreed care plan for the client which may include the provision of therapy from other service providers where necessary—an ACAT assessment referral is not required for access to the centres.

Data on the people using Day Therapy Centres, their care needs, and the services they use are available from a census of centres carried out over 4 weeks from 21 October 2002 (see Box 7.3). Centre clients funded through residential aged care services were not included in the census. During the census period, almost 17,000 people living in the community (including just over 15,200 aged 65 or more) were reported using Day Therapy Centres. Services provided included nursing services, podiatry, physiotherapy, diversional therapy and occupational therapy (AIHW forthcoming-b).

## Respite care and National Respite for Carers Program

With the trend towards increasing home-based care and reduced rates of residential care, respite care has emerged as an important area of service provision. This has been evident in a number of government policy initiatives, in particular in the development of the National Respite for Carers Program, and in respite care being a key component of the Staying at Home measures announced in the 1998–99 Budget and extended in the 2002–03 Budget.

Respite care may be provided in the home, at a centre during the day, or in a residential service. In 2001–02, 10% (42,900) of older HACC clients used centre-based day care and 1% (4,900) used in-home respite care services (see Table 7.8).[5] In addition, 14% (6,800) of Veterans' Home Care clients received in-home or emergency respite care during 2001–02. Preliminary analysis of the 2002 CACP census suggests that a small proportion of recipients access respite assistance (AIHW forthcoming-a).

In addition to the above respite services, nearly half of admissions into residential aged care are for respite care: among the 86,120 admissions for older people into residential care in 2001–02, just over 40,700 (47%) were for respite care (see Table A7.8). While the ratio of respite to permanent admissions remained fairly constant between 1998 and 2002, and the number of respite admissions increased by 6% over that period, there was a fall in the total number of days used in residential respite care. This fall was the result of a decrease in the average length of stay for all respite care admissions, from 3.5 weeks in 1998–99 to 3.2 weeks in 2000–01 and 2001–02. As a consequence, the total number of respite bed-days provided dropped by 2% over the period (Tables 1.8, 3.9 and 3.10 in: AIHW 2000b, 2001b, 2002d, 2003c).

The National Respite for Carers Program began with its announcement in the 1996–97 Commonwealth Budget. It funds Commonwealth Carer Respite Centres, state- and territory-based Commonwealth Carer Resource Centres, and a number of projects to assist carers of people with dementia, including the National Dementia Behaviour

5 In the case of respite care, the carer is considered the HACC client. Anecdotal evidence suggests that the provision of respite care may be under-reported.

Advisory Service and the Carer Education and Workforce Training Project for dementia. In line with the growing recognition of the importance of carers in supporting older people living in the community, the funding for this program has increased from $19 million in 1996–97 to $92.6 million in 2002–03. This growth includes an additional $80 million over 4 years provided in the 2002–03 Budget.

The Commonwealth Carer Resource Centres in each state and territory provide carers with information and advice about their caring role, including the services and assistance available to them. The Respite Centres work closely with the Resource Centre in their state or territory to ensure comprehensive support for carers and access to carer information and training materials. The Respite Centres are run by a wide variety of community organisations, and assist carers by acting as a single contact point for information needed by carers, and by organising, purchasing or managing respite care assistance packages for carers.

Overall, in 2001–02, the program funded the 8 state- and territory-based Commonwealth Carer Resource Centres, 62 regional Commonwealth Carer Respite Centres, 423 regional respite services for carers and 3 national projects to assist carers of people with dementia. The Respite Centres assisted approximately 38,250 carers in the same period, and the Resource Centres helped 29,500 carers. These numbers were up from the previous year, with the corresponding numbers being 29,000 and 27,450 carers, respectively (DoHA 2002b:127–8, 141–2).

### Other programs

The above discussion centres on the main services available to older people living in the community. In addition, there are many smaller programs—both Commonwealth and state and territory—targeting older people. Examples include the Safe at Home Initiative, Assistance with Care and Housing for the Aged (ACHA), and the Homefront program for veterans.

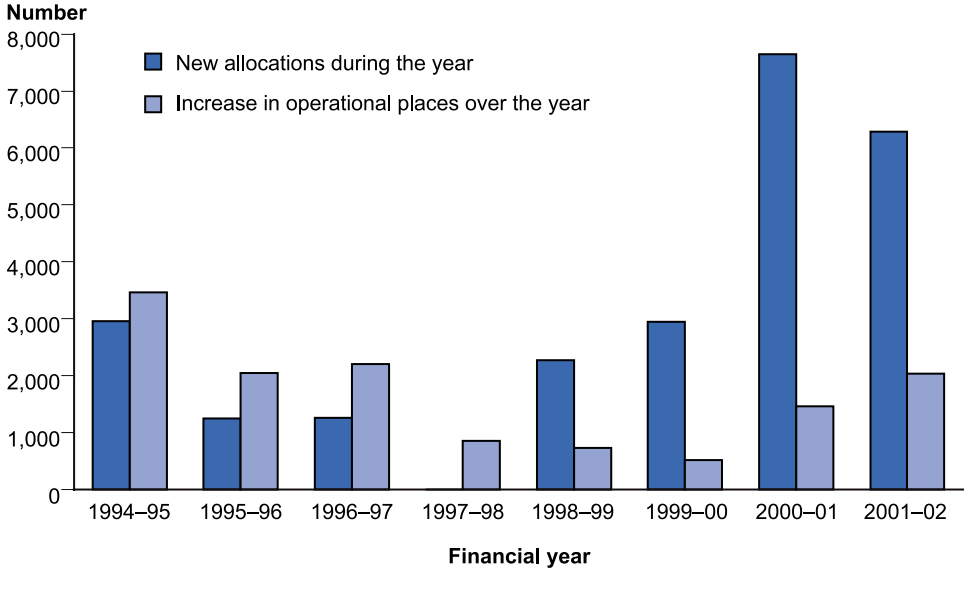
## 7.5 Residential care

Residential aged care services provide accommodation and support for older people who can no longer live at home. To enter residential care, people must have the appropriate recommendation from an Aged Care Assessment Team. Two levels of care are available: low-level care (Resident Classification Scale (RCS) categories 5 to 8, see later), and high-level care (RCS categories 1 to 4). Short-term respite care services are also available. Depending on their financial circumstances, residents contribute to the cost of their care (see Section 7.7). All residential care services are required to meet a number of national standards (see Section 7.8).

Since the aged care reforms following the *Aged Care Act 1997*, the number of operational residential aged care places has been increasing by an average of 1% a year, rising from 139,917 at 30 June 1998 to 146,268 operational places at 30 June 2002, (including flexible and Multi-purpose Service places; AIHW 2003c:2). As at 30 June 2002, there were 2,961 residential aged care services in Australia providing these places. By 30 June 2003, there were 150,496 operational residential care places (provisional estimate).

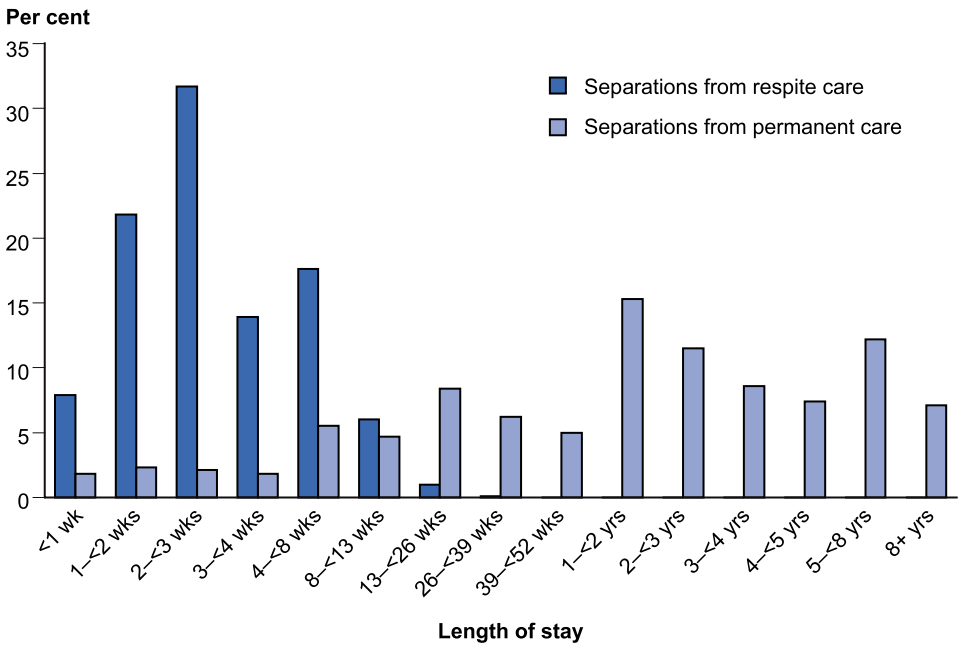
Given the time lags between residential places being approved and allocated and then becoming operational, consideration of operational places alone does not give the complete picture of changes in place provision. The development of residential aged care places (and similarly new Community Aged Care Packages) can only occur where places have been formally allocated to a provider. This usually occurs as part of a governmental Approvals Round (AIHW 2001a:224). In recent years, a modest number of places have been made available outside the Approvals Round process for allocation to flexible care, emergency care and Multi-purpose Services (see below).

The time period between allocation and a residential aged care place becoming available to clients varies. While the majority of Community Aged Care Packages become available for use reasonably quickly, residential aged care places may take longer to come on line, especially where capital works are involved. The time lag between allocation of residential places and their becoming operational is apparent in Figure 7.6 which shows that, while allocations began to increase during 1998–99, the number of new operational places in a year did not start to increase until 2 years later. As can be seen, in the last few years there have been substantially more approvals than new operational places coming on line. In addition, a further 6,105 places will be allocated in the 2003 Aged Care Approvals Round. Since the majority of allocated places do generally become operational, this suggests that we should see greater growth in the coming years in the number of operational places than has been the case in the recent past. This predicted pattern is a direct result of the high level of new allocations which occurred in the last three Approvals Rounds compared with the preceding period.




*Source:* Table A7.14.

**Figure 7.6: New residential aged care allocations and operational places, 1994–95 to 2001–02**




*Source:* Table A7.9.

**Figure 7.7: Length of stay of older clients (65+) who left residential aged care during 2001–02**

## Mix of respite and permanent care

People may use residential care either as their permanent place of residence, or for the short-term accommodation and care associated with respite care. Residential respite care is important both for people who need a higher level of care just for the short term and as a component of the carer support system, whether for emergency care, to provide a 'break' while carers attend to other affairs or take a holiday, or for instances where carers themselves encounter health, personal or family problems. On 30 June 2002, respite residents made up just under 2% (2,290) of 132,813 aged care service residents aged 65 and over (AIHW 2003c:29–30). These figures, however, under-represent the importance of respite care because, as stated earlier, respite care accounted for nearly half (47%) of the 86,120 admissions for older people during 2001–02 (see Table A7.8). The disparity is explained by the short-term nature of respite care: three-quarters of older people who left residential respite care during 2001–02 stayed fewer than 4 weeks, compared with just 8% of permanent residents (Figure 7.7). On the other hand, almost one-fifth (19%) of clients ceasing permanent residence had been a resident for more than 5 years.

As the name 'respite' suggests, most of the people who are admitted for respite care return to the community. During 2001–02, at the end of 68% of episodes of respite care, the resident returned to the community (AIHW 2003c:56–7). In only 1% of episodes, the person died while in residential respite care, with the remainder either going to another

residential aged care service or to hospital (14% and 5%, respectively). The story for permanent residents is quite different, with 83% of separations resulting from the death of the resident, and just 4% involving a return to the community. The remainder of people who left a permanent residential aged care service were evenly split between going to hospital and moving to another aged care service (following 6% and 5% of separations, respectively).

## Patterns of service use

Currently, residential aged care is the second most commonly used aged care program after HACC. On 30 June 2002, 52 out of every 1,000 people aged 65 and over (or 5%) were permanent aged care residents, with just 1 additional person per 1,000 being in residential respite care (see Table A7.12; AIHW analysis of ACCMIS database). Use of residential care increases substantially with age, from 10 permanent residents per 1,000 people aged 65–74 to 247 per 1,000 people aged 85 and over (see Table 7.11). Comparing use with the number of people with a disability, on 30 June 2002 for every 1,000 people aged 65 and over with a severe or profound core activity restriction, there were 236 people in permanent residential aged care and 4 people in residential respite care.

Overall, during the 12 months to 30 June 2002, per 1,000 people aged 65 and over, 68 used permanent residential aged care and there were 16 respite admissions into residential services. Again, comparing use with the number of people with a disability, for every 1,000 people aged 65 and over with a severe or profound core activity restriction, 308 people used permanent residential aged care over the year and there were 74 admissions into residential respite care. As with permanent residential care, residential respite care is accessed more by older than younger people: there were five respite admissions over the year per 1,000 people aged 65–74, 21 per 1,000 aged 75–84 and 59 per 1,000 aged 85 and over (see Table 7.11).

## Flexible aged care services

In addition to the services already described, the Commonwealth Government provides flexible aged care services through Multi-purpose Services in rural and remote communities, and through services under the National Aboriginal and Torres Strait Islander Aged Care Strategy (the Strategy). Multi-purpose Services were trialled in 1990 and expanded in 1994. As at June 2003, there were 83 Multi-purpose Services providing 1,810 flexible aged care places, consisting of 1,643 residential places and 167 Community Aged Care Packages. Flexible services provided under the Strategy began operating in 1996. In June 2003, there were 28 operational flexible services providing 420 flexible aged care places, comprising 155 high care places, 151 low care places and 114 Community Aged Care Packages.[6]

Data on clients of the Multi-purpose Services and the National Aboriginal and Torres Strait Islander Aged Care Strategy are not currently included on the national database for residential aged care and Community Aged Care Packages (the Aged and Community

6 Numbers of places and packages for 2003 are provisional estimates only.

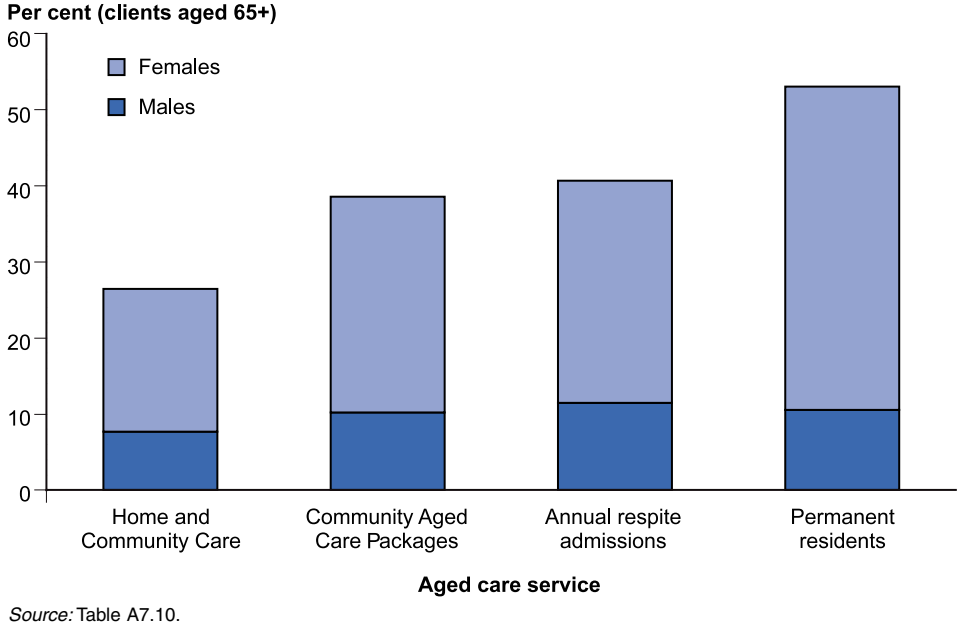
Care Management Information System, known as ACCMIS). Consequently, there is no information on the precise number and characteristics of people using these services.

## 7.6 Client profiles

The programs covered in this section are Home and Community Care, Community Aged Care Packages and residential aged care. Data limitations do not permit other programs to be included in this discussion of client profiles.

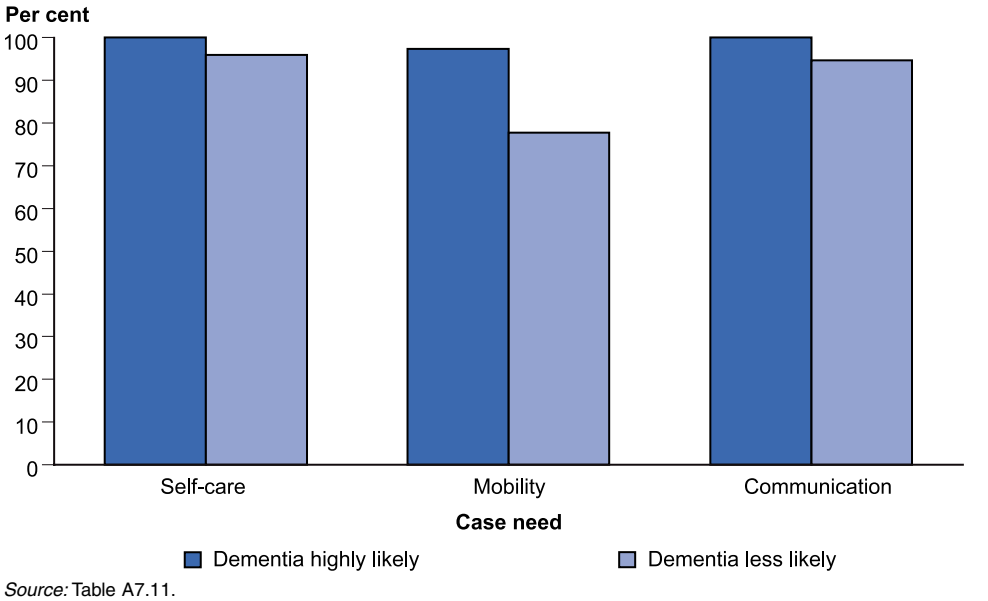
### Age and sex

People in residential aged care tend to be older than those accessing formal care in the community (see Table A7.10). In addition, those in permanent care have an older profile than people using respite care. HACC clients have the youngest profile among the services examined. As stated above, the HACC program includes as part of its target group younger people with disabilities as well as older people and their carers. Consequently, in 2002, 23% of HACC clients were people aged under 65. For Community Aged Care Packages, 7% of recipients were under 65. Residential aged care services had the smallest proportion of clients aged under 65, with fewer permanent than respite residents being under this age (4%, compared with 6%). Conversely, residential care has the oldest profile of the three programs. These patterns across programs continue for clients aged 65 and over: 53% and 41% of permanent and respite aged care residents, respectively, were aged 85 or more , compared with 39% of people using Community Aged Care Packages and 26% of HACC clients (Figure 7.8).




*Source:* Table A7.10.

**Figure 7.8: Use of aged care services by clients aged 85 and over, as a percentage of older clients (65+), 2002**




*Source:* Table A7.11.

**Figure 7.9: Care needs and dementia diagnosis for older permanent aged care residents (65+), 30 June 2002**

Clients of aged care services are predominantly women. In 2002, for all services except residential respite, at least 70% of clients aged 65 and over were women; among those using residential respite care, 63% were women. Permanent aged care residents had the highest ratio of female to male clients (2.8 to 1; see Table A7.12). The ratio was lowest among residential respite admissions (1.7 to 1).

## Dependency

Currently data on dependency characteristics of clients of aged care services are only available for people in permanent residential aged care. However, information on the dependency of CACP recipients was collected in the 2002 census and this will allow for analysis of dependency levels among clients of Community Aged Care Packages (see Box 7.3).

In June 2002, over 96% of permanent residents had needs in the areas of eating, bathing, dressing, toileting and managing incontinence (i.e. with self-care), and with communication (i.e. with understanding others or being understood). The majority also had problems related to mobility (84%; see Table A7.11). Furthermore, most had care needs related to their behaviour (95%) or other needs such as particular medical and social needs (99.6%). From this it can be seen that an overwhelming majority of aged care residents have multiple care requirements.

As noted earlier, one-fifth of the people assessed by Aged Care Assessment Teams have a primary diagnosis of dementia. While data on diagnosed dementia are not specifically collected for people in residential aged care, information on people's ability to understand and undertake living activities—a core indicator of dementia—is reported

as part of the Resident Classification Scale. In June 2002, among the 128,852 permanent residents aged 65 and over for whom RCS data are available, only 13% had no difficulty understanding and undertaking living activities; 27% had some difficulty, 29% had major difficulty and 31% had extensive difficulty. These figures suggest that at least 31% of permanent residents are highly likely to have had dementia, and this figure may be as high as 60%. Although most people in residential care have significant care needs, those identified as having extensive difficulty with understanding and undertaking living activities (i.e. those who are highly likely to have dementia) had higher care needs than other residents (Figure 7.9). The largest difference was seen in the area of mobility, with 97% of permanent residents highly likely to have dementia requiring assistance with mobility, compared with 78% of other residents.

## Use by country of birth

The use of particular aged care services varies across population groups. A relatively high number of CACP recipients were born in non-English-speaking countries: 21%, compared with 16% of HACC clients and around 11% of aged care residents. On the other hand, residential aged care had the highest proportion of older clients born overseas in English-speaking countries (15% of residential respite admissions and 14% of permanent residents of aged care services, compared with 11% of HACC clients and 12% of CACP recipients; see Table A7.12).

The age and sex profiles of different population groups vary. In particular, a greater proportion of older overseas-born people are male, compared with their Australian-born counterparts. Also, among those aged 65 and over, people born in non-English-speaking countries have a younger age profile than those born elsewhere. Some of these differences are apparent in the observed usage patterns of the groups. For example, for all programs examined, the median age of older clients born in non-English-speaking countries was lower than that for those born elsewhere, and the ratio of female to male clients was lower among clients born overseas than among those born in Australia. The lowest ratio was observed among residential respite admissions for people born in non-English-speaking countries (1.4 to 1).

The pattern of increased use with age was evident for both Australian-born and overseas-born people for all services (Table 7.11). However, Australian-born people—especially the very old (85+)—were more likely to access HACC services than other people: 452 per 1,000 Australian-born people, compared with 336 per 1,000 born overseas in an English-speaking country and 369 per 1,000 born in a non-English-speaking country. People born in non-English-speaking countries were more likely than others to be CACP recipients. In contrast to their higher CACP use, however, they used both respite and permanent care less than other groups at all ages.

**Table 7.11: Age-specific usage rates and cultural diversity of clients of selected aged care services, 2002 (per 1,000)**

| Age | HACC clients 2001–02 | CACP recipients 30 June 2002 | Residential respite admissions 2001–02 | Permanent aged care residents 30 June 2002 |
|---|---|---|---|---|
| **Australian-born** | | | | |
| 65–74 | 94.0 | 3.0 | 5.0 | 11.5 |
| 75–84 | 257.9 | 10.8 | 21.7 | 58.2 |
| 85+ | 452.0 | 30.4 | 60.5 | 258.2 |
| **Overseas-born: main English-speaking countries** | | | | |
| 65–74 | 66.6 | 2.0 | 4.8 | 7.8 |
| 75–84 | 203.5 | 10.5 | 22.3 | 53.6 |
| 85+ | 335.6 | 30.3 | 67.6 | 262.3 |
| **Overseas-born: non-English-speaking countries** | | | | |
| 65–74 | 76.8 | 2.9 | 3.1 | 6.8 |
| 75–84 | 226.4 | 15.9 | 15.4 | 41.7 |
| 85+ | 368.7 | 37.7 | 42.1 | 169.7 |
| **All** | | | | |
| 65–74 | 86.7 | 2.8 | 4.5 | 10.0 |
| 75–84 | 245.3 | 11.7 | 20.7 | 54.7 |
| 85+ | 424.7 | 31.4 | 59.0 | 247.0 |

*Note:* See notes to Table A7.12.

*Sources:* ABS 2003a, 2003c; AIHW analysis of HACC MDS and DoHA ACCMIS database; AIHW analysis of ABS 1998 Survey of Disability, Ageing and Carers.

## Use by Indigenous status

Aboriginal and Torres Strait Islander peoples have a shorter life expectancy than their non-Indigenous counterparts. As a result of their poorer health status, Indigenous people tend to need and use aged care services at a younger age than other people, and consequently the examination here of their use of these services includes people aged 50 and over.

A relatively high percentage of CACP recipients are Indigenous: 3% of CACP recipients aged 50 and over identified as Indigenous, compared with 0.8% of people aged 50 and over at 30 June 2001 (see Table A7.13; ABS 2003a). Under 1% of permanent aged care residents identified themselves as Indigenous. It is estimated that Indigenous Australians made up just over 3% of HACC clients aged 50 and over. However, there are indications that this is an overestimate (see Box 7.4).

**Table 7.12: Age-specific usage rates and Indigenous status of clients of selected aged care services, 2002 (per 1,000)**

| Age | CACP recipients 30 June 2002 | Residential respite admissions 2001–02 | Permanent aged care residents 30 June 2002 |
|---|---|---|---|
| **Indigenous** | | | |
| 50–64 | 11.3 | 2.7 | 4.9 |
| 65–79 | 48.3 | 17.2 | 26.3 |
| 80+ | 67.2 | 57.2 | 116.6 |
| **Non-Indigenous** | | | |
| 50–64 | 0.4 | 0.6 | 1.5 |
| 65–79 | 4.3 | 7.4 | 17.1 |
| 80+ | 25.3 | 45.5 | 166.4 |
| **All** | | | |
| 50–64 | 0.5 | 0.6 | 1.6 |
| 65–79 | 4.5 | 7.4 | 17.2 |
| 80+ | 25.4 | 45.5 | 166.2 |

*Notes*

1. At the time of preparation, estimated resident population for Indigenous people was not available for 2002. Therefore, program use has been compared to 30 June 2001 estimated resident population numbers. This will result in a slight over-estimation of usage rates.
2. See notes to Table A7.13.

*Sources:* ABS 2003c; AIHW analysis of DoHA ACCMIS database.

Differences in the age profile of Indigenous and non-Indigenous people are reflected in client profiles for all aged care services. For example, Indigenous recipients of Community Aged Care Packages have a younger median age than non-Indigenous recipients (70 versus 82 years). However, although the sex ratio among older Indigenous and non-Indigenous Australians is very similar (47% and 48% of people aged 50 and over were male for the two groups, respectively), Indigenous clients of services have a lower female to male ratio than non-Indigenous clients (see Table A7.13; ABS 2003a).

At all ages, Indigenous people had much higher usage rates of Community Aged Care Packages than all other groups examined: 48 and 67 per 1,000 among people aged 65–79 and 80 and over, respectively. The next highest rates were observed among those born in non-English-speaking countries: 16 and 38 per 1,000 for people aged 75–84 and 85 and over, respectively (Tables 7.11 and 7.12). While Indigenous people aged 80 and over had lower usage rates than non-Indigenous people of permanent residential aged care, at ages 50–79 their rates were higher. Indigenous people used respite services more frequently during 2001–02 than non-Indigenous people at all ages.

## 7.7 Expenditure

Overall, the largest source of funds for the aged care system is the Commonwealth Government, which has primary responsibility for funding residential aged care. It also provides funding for a number of other programs, including Community Aged Care Packages, Multi-purpose and flexible services, Aged Care Assessment Teams, and the Home and Community Care and Veterans' Home Care programs. The HACC program is cost-shared with state and territory governments, with contributions from local

government. State and territory governments also provide some funding for other areas of aged care, including residential aged care and assessment services. Governments are not, however, the only source of funding in the aged care system. Users of programs meet part of the costs, and non-government community services organisations contribute funds to some services (see Chapter 4). In addition, volunteers contribute to the sector.

## Government expenditure

Total recurrent government expenditure on aged care services increased from $4,552.9 million in 1998–99 to $5,769.5 million in 2001–02 (Table 7.13). The largest area of expenditure in 2001–02 was $4,228.6 million for residential aged care, representing 73% of expenditure, compared with 79% in 1998–99. Over $1,000 million in capital and recurrent funds were provided for the HACC program in 2001–02; of this, an estimated $786.3 million was used to deliver services to people aged 65 and over. Home and Community Care accounted for around 14% of expenditure across the 4-year period. On the other hand, expenditure on Community Aged Care Packages increased steadily and, at $246.3 million, accounted for 4.3% of government expenditure on aged care services by 2001–02, compared with 2.7% in 1998–99. Expenditure on the Carer Allowance, where the care recipient was aged 65 and over, also rose significantly over the period, both in absolute terms and as a proportion of total expenditure: in 2001–02, $190.5 million was spent on the allowance, accounting for 3.3% of expenditure. Funding for National Respite for Carers grew quickly between 1998–99 and 2000–01, and was $68.5 million in 2001–02.

Both the Veterans' Home Care program and Commonwealth Carelink Centres were set up in 2000–01. Expenditure on the program reached almost $52 million in 2001–02, and $11.5 million was spent on the centres in that year. The Extended Aged Care at Home program has developed from a pilot program to being operational across Australia and the proportionally large expenditure increase from $2.8 million in 1998–99 to $8.9 million in 2001–02 reflects this expansion.

Comparisons of program expenditure as expressed in constant prices show whether there has been growth in expenditure after allowing for inflation. In real terms, total government expenditure on aged care services increased by 19% over the 4 years examined. The policy emphasis on developing and supporting programs that enable older Australians to remain in the community, where possible, is reflected in the expenditure data. Overall, expenditure on residential aged care rose 11% in real terms between 1998–99 and 2001–02. Expenditure on HACC services (provided to people aged 65+) is estimated to have risen by 16% between 1998–99 and 2001–02. However, Veterans' Home Care and HACC provide similar services, and if the expenditures on these programs are amalgamated, the rise in real terms for these home-based services was 24% over this period. The emphasis on developing community support programs is also demonstrated in CACP expenditure, which rose by 90% between 1998–99 and 2001–02. In addition, Carer Allowance expenditure increased by 150%, and funding for the National Respite for Carers Program rose by 82%. Over the 4-year period, expenditure on the accreditation of residential aged care providers doubled.

**Table 7.13: Recurrent government expenditure on aged care services, 1998–99 to 2001–02**

| Program[(a)] | 1998–99 | 1999–00 | 2000–01 | 2001–02 |
|---|---|---|---|---|
| | | Current prices ($m) | | |
| Residential aged care | 3,584.3 | 3,741.4 | 3,955.6 | 4,228.6 |
| Community Aged Care Packages | 121.8 | 148.9 | 194.6 | 246.3 |
| Home and Community Care | 636.0 | 676.1 | 725.1 | 786.3 |
| Veterans' Home Care | . . | . . | 13.9 | 51.9 |
| Extended Aged Care at Home | 2.8 | 6.8 | 8.4 | 8.9 |
| Day Therapy Centres | 27.3 | 27.8 | 28.5 | 29.3 |
| Multi-purpose and flexible services | 25.4 | 30.7 | 49.8 | 74.0 |
| National Respite for Carers | 35.3 | 45.8 | 68.6 | 68.5 |
| Carer Allowance[(b)] | 71.6 | 140.8 | 179.6 | 190.5 |
| Assessment | 38.6 | 40.1 | 41.7 | 43.6 |
| Commonwealth Carelink Centres | . . | — | 12.1 | 11.5 |
| Accreditation | 5.9 | 7.8 | 10.4 | 12.5 |
| Other | 3.8 | 5.3 | 15.4 | 17.5 |
| **Total** | **4,552.9** | **4,871.4** | **5,303.8** | **5,769.5** |
| | | Constant 2000–01 prices ($m) | | |
| Residential aged care | 3,729.8 | 3,865.9 | 3,955.6 | 4,130.3 |
| Community Aged Care Packages | 126.7 | 153.9 | 194.6 | 240.6 |
| Home and Community Care | 661.8 | 698.6 | 725.1 | 768.0 |
| Veterans' Home Care | . . | . . | 13.9 | 50.7 |
| Extended Aged Care at Home | 2.9 | 7.0 | 8.4 | 8.7 |
| Day Therapy Centres | 28.4 | 28.7 | 28.5 | 28.6 |
| Multi-purpose and flexible services | 26.4 | 31.8 | 49.8 | 72.3 |
| National Respite for Carers | 36.7 | 47.3 | 68.6 | 66.9 |
| Carer Allowance[(b)] | 74.5 | 145.5 | 179.6 | 186.1 |
| Assessment | 40.1 | 41.4 | 41.7 | 42.6 |
| Commonwealth Carelink Centres | . . | — | 12.1 | 11.2 |
| Accreditation | 6.2 | 8.0 | 10.4 | 12.2 |
| Other | 4.0 | 5.5 | 15.4 | 17.1 |
| **Total** | **4,737.7** | **5,033.5** | **5,303.8** | **5,635.3** |

(a) To improve the coverage of aged care programs, the programs included in the table have changed slightly from those in the corresponding table in the previous edition of this publication (AIHW 2001a:Table 6.25). In particular, expenditure on Day Therapy Centres, Extended Aged Care at Home packages and 'Other' programs have been included for the first time. Consequently, the numbers in the two publications are not strictly comparable.

(b) Includes Domiciliary Nursing Care Benefit. The Carer Allowance replaced the Domiciliary Nursing Care Benefit in July 1999.

*Notes*

1. Expenditure on residential aged care includes DoHA, DVA and state and territory funding. The state and territory funding for 2001–02 has been estimated based on DoHA administrative data and AIHW calculations.
2. Home and Community Care expenditure includes Commonwealth and state and territory funding for the aged (estimated for 65+), and funding for HACC National Initiatives ($0.4m in 2001–02).
3. Veterans' Home Care expenditure includes funding for all ages.
4. National Respite for Carers expenditure includes funding for the Carer Support Strategy ($1.3m in 2001–02).
5. Carer Allowance expenditure on older people is based on the proportion of care recipients aged 65 and over of carers receiving the allowance (29.5% in March 2002).
6. 'Other' comprises Assistance with Care and Housing for the Aged (ACHA, all years), Dementia Education and Support program (from 1999–00), Safe at Home (from 2000–01) and Continence Management program (all years, includes Continence Aids Assistance Scheme from 2000–01).
7. Constant dollar values were calculated using the GFCE deflator, referenced to 2000–01.

*Sources:* AIHW 2001a:Table 6.25; AIHW health expenditure database; DHAC 1999, 2000, DHAC unpublished data; FaCS 2000.

**Table 7.14: Recurrent government expenditure on aged care services, expressed as dollars per person aged 65 and over with a severe or profound core activity restriction, 1998–99 to 2001–02**

| Program[a] | 1998–99 | 1999–00 | 2000–01 | 2001–02 |
|---|---|---|---|---|
| | | Constant 2000–01 prices ($) | | |
| Residential aged care | 7,465.5 | 7,595.2 | 7,400.9 | 7,477.0 |
| Community Aged Care Packages | 253.6 | 302.4 | 364.1 | 435.5 |
| Home and Community Care | 1,324.7 | 1,372.5 | 1,356.6 | 1,390.4 |
| Veterans' Home Care | . . | . . | 26.0 | 91.8 |
| Extended Aged Care at Home | 5.9 | 13.7 | 15.8 | 15.8 |
| Day Therapy Centres | 56.9 | 56.4 | 53.3 | 51.8 |
| Multi-purpose and flexible services | 52.9 | 62.4 | 93.2 | 130.9 |
| National Respite for Carers | 73.6 | 92.9 | 128.4 | 121.2 |
| Carer Allowance[a] | 149.1 | 285.8 | 336.0 | 336.8 |
| Assessment | 80.4 | 81.3 | 78.1 | 77.2 |
| Commonwealth Carelink Centres | . . | — | 22.7 | 20.4 |
| Accreditation | 12.4 | 15.8 | 19.4 | 22.1 |
| Other | 8.0 | 10.8 | 28.9 | 30.9 |
| **Total** | **9,482.8** | **9,889.3** | **9,923.4** | **10,201.6** |
| | | Annual growth rate (per cent) | | |
| Residential aged care | . . | 1.7 | –2.6 | 1.0 |
| Community Aged Care Packages | . . | 19.2 | 20.4 | 19.6 |
| Home and Community Care | . . | 3.6 | –1.2 | 2.5 |
| Veterans' Home Care | . . | . . | . . | [b]252.9 |
| Extended Aged Care at Home | . . | 132.7 | 15.1 | 0.3 |
| Day Therapy Centres | . . | –0.7 | –5.5 | –2.8 |
| Multi-purpose and flexible services | . . | 17.9 | 49.4 | 40.4 |
| National Respite for Carers | . . | 26.4 | 38.1 | –5.6 |
| Carer Allowance[a] | . . | 91.7 | 17.6 | 0.2 |
| Assessment | . . | 1.2 | –4.0 | –1.2 |
| Commonwealth Carelink Centres | . . | . . | [c]. . | –10.1 |
| Accreditation | . . | 27.3 | 23.4 | 13.8 |
| Other | . . | 35.2 | 166.5 | 6.2 |
| **Total** | **. .** | **4.3** | **0.3** | **2.8** |

(a) See Table 7.13.

(b) Large increase is from start-up in 2000–01.

(c) Not appropriate to present due to very small start-up expenditure in the preceding year.

*Notes*

1. See notes to Table 7.13 for information on expenditure derivation.
2. Population estimates by disability status are obtained using age/sex disability rates from the ABS 1998 Survey of Disability, Ageing and Carers in conjunction with the estimated resident population. The estimates assume constant disability rates over time within age/sex groups.
3. Constant dollar values were calculated using the GFCE deflator, referenced to 2000–01.

*Sources:* Table 7.13; ABS 2003a; AIHW analysis of ABS 1998 Survey of Disability, Ageing and Carers.

The segment of the older population most likely to be in need of assistance from aged care programs in general is people aged 65 and over with a severe or profound core activity restriction. Table 7.14 shows whether real (constant price) program expenditure has been keeping pace with the increasing number of people in this group. In 1998–99, total aged care expenditure in real terms broadly equated to $9,483 per person aged 65 and over with a severe or profound restriction. By 2001–02, this figure had risen by 8%

to $10,202. Growth in expenditure calculated in these terms varied from year to year, growing by 4% between 1998–99 and 1999–00, by less than 1% the following year and by 3% in 2001–02.

The above pattern was not consistent across programs. Relative to the number of people aged 65 and over with a severe or profound core activity restriction, expenditure on residential aged care rose slightly between 1998–99 and 2001–02, from $7,466 per person to $7,477. On the other hand, CACP expenditure showed consistent large annual growth, rising by 72% from $254 to $436 per person. Relative expenditure on National Respite for Carers and the Carer Allowance also rose considerably, from the equivalent of $74 and $149 per person to $121 and $337, respectively; however, most of this growth happened before 2001–02. If the expenditures on HACC and the Veterans' Home Care program are merged, by 2001–02 the combined expenditure of these programs broadly equated to $1,482 per person aged 65 and over with a severe or profound core activity restriction—12% higher than in 1998–99.

### User contributions

Users of many aged care services pay a contribution towards the provision of the service. For example, clients of the HACC program may pay a service fee, depending on the care that they receive. However, if such a contribution causes financial difficulty for the user, the provider is obliged to reduce or waive charges. Similarly, CACP recipients may be required to make a contribution. Although no national data are available on user charges for community care services, there are some data for residential care.

For full-pensioner permanent residents and all respite residents, the daily care fee is set at 85% of the Age Pension. For part-pensioner and non-pensioner residents who are on higher incomes, income-tested fees are charged at the rate of 25 cents for every additional dollar of income up to a maximum level of 3 times the pensioner rate or the cost of care, whichever is the lower. In 1999–00, the basic daily care fee yielded $1,060.7 million in user charges, and the income-tested component an additional $21.4 million. In 2000–01, the comparable figures were $1,102.6 million and $54.5 million. Basic daily care fees raised $1,172.1 million in 2001–02, while the income-tested payments contributed $70.1 million. These amounts together represented 23% of the $5,470.7 million available to residential aged care services from the Commonwealth, state and territory governments and residents, compared with 22% in 1999–00.

## 7.8 Outcomes

As with other welfare services, the measurement of outcomes for aged care services is an important tool for examining the delivery and quality of the services provided. However, outcome measurement lends itself more readily to the acute care context, where desired outcomes can be more clearly specified, than to aged care services. Aged care with its varied client mix, combining a range of chronic and acute conditions and receiving varied services from the formal sector and supported by a myriad of informal sector activities, does not readily lend itself to specific outcome measures (Gibson 1998:ch. 8). In care contexts where successful management may be followed by death or

a deterioration in health status, such measures are problematic. These caveats aside, it is still possible to report on measures relevant to program achievements. This section presents data on the accessibility and quality of aged care services.

## Accessibility

### Supply of residential aged care places and packages

One of the tools used to plan the provision of residential aged care places and packages is the planning ratio; this ratio is based on achieving a desired number of places and packages for the number of people likely to need these services. Because Community Aged Care Packages provide care equivalent to low care in residential aged care, and the recently introduced Extended Aged Care at Home places provide care equivalent to high care in residential aged care, residential aged care places, Extended Aged Care at Home places and Community Aged Care Packages are intrinsically linked; they are therefore combined to present a comparison of the provision of aged care services against the planning ratio. The planning ratio target in 2002 was 100 operational places and packages per 1,000 persons aged 70 years and over, including places in flexible care; it has been set at this level since the early 1980s (AIHW 1993:208, 222; DoHA 2002b:124). In the mid-1990s, provision sat at around 93 places and packages per 1,000 (AIHW 2002d:2). However, this ratio rose slowly after 1999 as new aged care places and packages were made available, increasing from 94.0 at 30 June 1999 to 96.5 in 2002 (Table 7.15). An additional 5,653 places and packages became operational during 2002–03 (provisional estimate).

While in recent years the provision of residential aged care places has declined relative to the number of people aged 70 and over, CACP provision has increased rapidly, leading to a rise in the combined provision ratio of places and packages. At 30 June 1999, there were 8.4 packages and 85.6 residential aged care places per 1,000 people aged 70 or more; in 2002, the corresponding figures were 14.7 and 81.6 (not including the small number of EACH places operational in 2002: 0.2 per 1,000 people aged 70+). In terms of the more closely targeted measure of supply per 1,000 people aged 65 and over with a severe or profound core activity restriction, provision changed from an estimated 27.8 packages and 283.4 places in 1999, to 47.8 packages, 0.5 EACH places and 264.8 residential aged care places in 2002. Consequently, on this measure over the 4 years, there was little total change: from 311.2 to 313.1 places and packages per 1,000 people aged 65 and over with a severe or profound restriction.

### Use of residential aged care places and packages

The use of places and packages by older people reflects the relative growth in the provision of Community Aged Care Packages. Between 1999 and 2002, the use of packages grew for both men and women in all age groups (Table 7.16). In particular, use by the very old (85+) grew by 170%, from 18.4 people per 1,000 in 1999 to 31.4 in 2002. Conversely, the use of residential aged care places fell: over the 4-year period, among people aged 85 and over use of residential aged care went from 274.6 people per 1,000 in 1999 to 250.7 in 2002.

**Table 7.15: Operational residential aged care places and Community Aged Care Packages, 30 June 1999 to 30 June 2002**

| | | | Places/packages per 1,000 persons | |
|---|---|---|---|---|
| | | Number of places/ packages | Aged 70+ | Aged 65+ with a severe or profound core activity restriction |
| 1999 | Community Aged Care Packages | 13,896.5 | 8.4 | 27.8 |
| | Residential aged care places | 141,697.5 | 85.6 | 283.4 |
| | **Total** | **155,594.0** | **94.0** | **311.2** |
| 2000 | Community Aged Care Packages | 18,308.5 | 10.8 | 35.5 |
| | Residential aged care places | 142,341.5 | 83.6 | 275.7 |
| | **Total** | **160,650.0** | **94.4** | **311.1** |
| 2001 | Community Aged Care Packages | 24,629.5 | 14.0 | 46.1 |
| | Residential aged care places | 144,012.5 | 82.2 | 269.4 |
| | **Total** | **168,642.0** | **96.2** | **315.5** |
| 2002 | Community Aged Care Packages | 26,425.0 | 14.7 | 47.8 |
| | Extended Aged Care at Home places[(a)] | 290.0 | 0.2 | 0.5 |
| | Residential aged care places | 146,268.0 | 81.6 | 264.8 |
| | **Total** | **172,983.0** | **96.5** | **313.1** |
| 2003[(b)] | Community Aged Care Packages | 27,850.0 | n.y.a | n.y.a |
| | Extended Aged Care at Home places | 290.0 | n.y.a | n.y.a |
| | Residential aged care places | 150,496.0 | n.y.a | n.y.a |
| | **Total** | **178,636.0** | **n.y.a** | **n.y.a** |

(a) In June 2002, EACH places were still formally provided under pilot projects.

(b) 2003 data supplied by DoHA are provisional figures.

*Note:* Population estimates by disability status are obtained using age/sex disability rates from the ABS 1998 Survey of Disability, Ageing and Carers in conjunction with the estimated resident population. The estimates assume constant disability rates over time within age/sex groups.

*Sources:* ABS 2003a; AIHW 2003c:2, AIHW analysis of ABS 1998 Survey of Disability, Ageing and Carers; DoHA unpublished data.

**Table 7.16: Age-specific usage rates of residential aged care and Community Aged Care Packages, 30 June 1999 to 2002 (per 1,000)**

| | Males | | | | Females | | | | Persons | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 65–74 | 75–84 | 85+ | 65+ | 65–74 | 75–84 | 85+ | 65+ | 65–74 | 75–84 | 85+ | 65+ |
| **CACP** | | | | | | | | | | | | |
| 1999 | 1.2 | 4.8 | 16.2 | *3.4* | 2.2 | 8.7 | 19.3 | *6.7* | 1.7 | 7.1 | 18.4 | 5.2 |
| 2000 | 1.5 | 5.7 | 19.8 | *4.2* | 2.6 | 10.7 | 24.1 | *8.3* | 2.1 | 8.6 | 22.7 | 6.5 |
| 2001 | 1.8 | 6.8 | 24.6 | *5.2* | 3.1 | 12.8 | 29.8 | *10.2* | 2.5 | 10.3 | 28.2 | 8.0 |
| 2002 | 2.1 | 7.5 | 26.6 | *5.8* | 3.6 | 14.7 | 33.7 | *11.8* | 2.8 | 11.7 | 31.4 | 9.2 |
| **Residential aged care[(a)]** | | | | | | | | | | | | |
| 1999 | 10.8 | 44.3 | 177.3 | *33.2* | 11.8 | 73.7 | 317.2 | *72.5* | 11.3 | 61.6 | 274.6 | 55.2 |
| 2000 | 10.4 | 42.7 | 173.1 | *32.9* | 11.4 | 70.1 | 308.9 | *71.6* | 10.9 | 58.8 | 267.3 | 54.6 |
| 2001 | 10.1 | 41.0 | 166.1 | *32.1* | 11.0 | 68.0 | 298.9 | *70.6* | 10.6 | 56.7 | 257.9 | 53.6 |
| 2002 | 9.8 | 40.2 | 159.8 | *31.9* | 10.6 | 67.2 | 292.1 | *70.4* | 10.2 | 55.8 | 250.7 | 53.3 |
| **Total** | | | | | | | | | | | | |
| 1999 | 11.9 | 49.1 | 193.5 | *36.6* | 14.0 | 82.4 | 336.5 | *79.2* | 13.0 | 68.7 | 293.0 | 60.5 |
| 2000 | 11.9 | 48.4 | 192.9 | *37.1* | 14.1 | 80.8 | 333.0 | *80.0* | 13.0 | 67.4 | 290.0 | 61.1 |
| 2001 | 11.8 | 47.8 | 190.6 | *37.3* | 14.1 | 80.9 | 328.7 | *80.8* | 13.0 | 67.0 | 286.1 | 61.6 |
| 2002 | 11.9 | 47.7 | 186.4 | *37.8* | 14.2 | 81.9 | 325.8 | *82.2* | 13.1 | 67.5 | 282.1 | 62.5 |

(a) Includes permanent and respite residents.

*Note:* Table does not include clients of Multi-purpose and flexible services.

*Sources:* ABS 2003a; AIHW analysis of DoHA ACCMIS database.

**Table 7.17: Level of dependency of permanent aged care residents aged 65 and over, at 30 October 1998, 30 June 2000 and 30 June 2002**

| | High care | | | | | Low care | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | RCS1 | RCS2 | RCS3 | RCS4 | *RCS1–4* | RCS5 | RCS6 | RCS7 | RCS8 | *RCS5–8* | Total |
| | | | | | | Number | | | | | |
| 1998 | 9,236 | 31,627 | 23,969 | 6,113 | *70,945* | 9,492 | 12,014 | 25,087 | 4,893 | *51,486* | 122,431 |
| 2000 | 17,616 | 32,205 | 20,817 | 5,819 | *76,457* | 11,068 | 12,933 | 21,154 | 2,977 | *48,132* | 124,589 |
| 2002 | 24,028 | 32,438 | 19,002 | 5,971 | *81,439* | 13,627 | 14,036 | 17,969 | 1,781 | *47,413* | 128,852 |
| | | | | | | Per cent | | | | | |
| 1998 | 7.5 | 25.8 | 19.6 | 5.0 | *57.9* | 7.8 | 9.8 | 20.5 | 4.0 | *42.1* | 100.0 |
| 2000 | 14.1 | 25.8 | 16.7 | 4.7 | *61.4* | 8.9 | 10.4 | 17.0 | 2.4 | *38.6* | 100.0 |
| 2002 | 18.6 | 25.2 | 14.7 | 4.6 | *63.2* | 10.6 | 10.9 | 13.9 | 1.4 | *36.8* | 100.0 |

*Notes*

1. Assessments were unavailable for 3,079 residents in 1998, 2,825 residents in 2000 and 1,671 residents in 2002.
2. Table does not include clients of Multi-purpose and flexible services.

*Source:* AIHW analysis of DoHA ACCMIS database.

The increasing provision of Community Aged Care Packages is part of the general policy of enabling people with lower care needs to remain in their homes with the assistance of community care programs. At the same time as this growth in CACPs, there has been a rise in the profile of care needs of permanent residents (Table 7.17). In October 1998, 58% of older residents had high care needs; by June 2002, this had risen to 63%. In addition, the greatest increase seen in the eight RCS care need categories (RCS1–RCS8) was in the highest care group (RCS1); this group accounted for 8% of older permanent residents in 1998 but 19% in 2002. A shift towards higher care needs was also seen among low care residents: in 1998, one-quarter (25%) of residents aged 65 and over were in the lowest two care groups (RSC7 and RCS8), compared with 15% in 2002.

The high occupancy rate being experienced in residential care services indicates high demand for residential places: in 2002, this rate was 96% (AIHW 2003c:26). Difficulties in assessing unmet demand for residential aged care places led Professor Gray to recommend in the two year review of aged care reforms that:

> … the Department [DoHA] review and enhance indicators of supply and demand for residential and community care to ensure the adequacy and reliability of these measures, particularly with respect to the balance, within overall provision of high care and low care, given the effects of ageing in place. (DHAC: Gray 2001:35).

While the overall provision of residential aged care places and packages has been keeping pace with the growth in the population aged 70 and over, the ageing of the older population, combined with the increasing use of aged care services with increasing age, is likely to be placing greater pressure on the accessibility of aged care. In 1999, 238,900 (or 10.2% of people aged 65+) were aged 85 and over; by 2002, this had risen by 17% to 280,400 (or 11.3% of older people). Over the same period, the number of people aged 65–74 increased by just under 2%, or from 1,307,800 to 1,333,000 people (ABS 2003a). While the combined use of residential aged care places and packages rose slightly for people age 65–74, among the very old (85+) use fell steadily between 1999 and 2002, from 293.0 people per 1,000 in 1999 to 282.1 in 2002 (Table 7.16). Data on age-specific usage rates of HACC services and unmet demand for all programs would be

required to determine whether this trend was due to decreasing accessibility or falling demand. Such data are not currently available.

## Standards and quality of care

National standards and quality appraisal data are currently only available for residential aged care services. However, the collection of national data on service standards quality within the HACC program is expected to begin in 2003.

While there are no national service quality data on the HACC program available for this publication, a plan is being implemented that will see all HACC-funded agencies undergoing an external appraisal, based on the HACC National Service Standards Instrument, by the end of the 2003–04 financial year. Results from the instrument, which includes the Consumer Survey Instrument, will be used to assess services provided against the HACC Standards (see AIHW 1999a:188 and AIHW 2001a:221 for discussion of instrument development).

National data on standards and quality of residential aged care are available from the Aged Care Standards and Accreditation Agency. Replacing the Outcome Standards Monitoring Program, this agency was established in 1997 to oversee and improve service quality within residential aged care, via accreditation of services and promotion of high-quality care (for more details, see AIHW 2001a:249–51). By 1 January 2001, all residential aged care services had received an accreditation decision from the agency, and performance against the accreditation standards to December 2000 (round one accreditations) were presented in the previous issue of this publication.

Since then, some changes have occurred in the appraisal and accreditation process. Residential aged care services were previously rated on a four-level rating scale on each of four accreditation standards, based on the 44 expected outcomes of the standards: management systems, staffing and organisational development; health and personal care; residents' lifestyle; and physical environment and safe systems (AIHW 2001a:442–3). The practice of rating each of the four has been discontinued and instead, for round two accreditations, the Accreditation Agency simply records compliance (or non-compliance) with each of the 44 expected outcomes. Results will be available after the second round of accreditations is completed at the end of 2003.

**Table 7.18: Accreditation status of residential aged care services, 31 December 2002**

| | Number | Per cent |
|---|---|---|
| Accredited for 3 years | 2,811 | 95.4 |
| Accredited for between 1 and 3 years | 90 | 3.1 |
| Accredited for 1 year | 43 | 1.5 |
| Granted exceptional circumstances[(a)] following decision not to accredit | 1 | 0.3 |
| Not accredited and not granted exceptional circumstances | 0 | 0 |
| **Total** | **2,945** | **100.0** |

(a) Section 42-5 of the *Aged Care Act 1997* allows the Secretary of the Department of Health and Ageing to determine that a residential aged care service meets its accreditation requirement, if exceptional circumstances apply.

*Source:* Aged Care Standards and Accreditation Agency unpublished data.

At this stage, only data on the accreditation status of residential aged care services are available (Table 7.18). As at 31 December 2002, 95% of the 2,945 operating residential, aged care services were accredited for 3 years, and 3% were accredited for between 1 and 3 years. All but one of the remaining 44 services were accredited for 1 year. Just one service was not accredited but was granted accreditation under exceptional circumstances.

# 7.9 Summary

## Population ageing

Over the next 10 years, the oldest of the baby-boomer generation will reach 65, the age traditionally considered to be associated with retirement and the beginning of old age. The resulting population shift has implications for all aspects of social and economic life, including government pensions and assistance, health and welfare services and informal support systems.

In the 20 years up to 2021, the number of people aged 65 and over is expected to increase by 73%, from 2.4 million in 2001 to 4.2 million in 2021. The number of people aged 85 and over, among whom we find those most likely to be in need of services and assistance, is also projected to expand rapidly over the same period: from 265,200 to 478,600—an increase of 80%. While the projected growth rates for the next two decades are high, it is not the first time Australia has experienced a rapid rate of increase of the older population. In the age group 85 and over, the 1981–91 and 1991–2001 decades saw overall growth rates of 50% and 69%, respectively, compared with projected growth rates of 50% and 23% for 2001–11 and 2011–21.

## Social context

Older people participate in society in a variety of ways, from paid and unpaid work to involvement in spiritual and cultural affairs. Programs which promote active ageing aim to encourage and support people so that they can participate in these endeavours.

As only 5% of people aged over 65 live permanently in residential aged care, the overwhelming majority of older people live in households in the community, mostly with a spouse or partner (59% in 2001) or on their own (30%). At the end of 2002, 83% of people aged 65 and over were in receipt of the Age Pension or a DVA payment, and 6% were in the labour force. This picture of high levels of dependency on pension payments is expected to change in the coming years as the effects of increased superannuation coverage flow through. In addition, over the last 15 years, labour force participation rates for women have risen substantially; for example, between 1988 and 2002, the participation rate for women aged 60–64 increased from 16% to 27%.

In the 12 months to June 2000, nearly 530,000 people aged 65 and over (or 25%) participated in some form of volunteer work through a formal organisation or group, with older people contributing 17% of the total volunteer hours worked. Furthermore, many older people care for family and friends: in 1998, an estimated 401,000 people aged 65 and over provided assistance to people with a disability. In December 2002, a considerable number of older people were providing full-time care on a daily basis to people and so

were receiving the Carer Allowance: 51,600 allowance recipients aged 65 and over were providing care to people of a similar age, and 9,300 were caring for younger people.

## Aged care services

Increasing emphasis on community care and decreasing emphasis on residential care has continued. For all aged care services, the proportion of people using a service increases with age.

The bulk of home- and community-based services for older people are provided under the auspices of the Home and Community Care Program. In 2001–02, at least 450,000 people aged 65 and over received HACC services—or 181 people per 1,000. The Community Aged Care Packages program has continued to grow, from 18,309 packages on 30 June 2000 to 27,850 on 30 June 2003.

With the trend towards increasing home-based care and reduced rates of residential service provision, respite care has emerged as an important area of service provision. During 2001–02, 10% of older HACC clients (42,900) used centre-based day care and 1% (4,900) used in-home respite care services; also, 14% (6,800) of Veterans' Home Care clients received in-home or emergency respite care. Furthermore, 47% (40,700) of admissions into residential aged care for older people during 2001–02 were for respite care.

Currently, residential aged care is the second most commonly used aged care service after HACC. At 30 June 2002, 52 out of every 1,000 people aged 65 and over (or 5%) were permanent aged care residents, with just 1 additional person per 1,000 being in residential respite care. On 30 June 2003, there were 150,496 operational residential aged care places, including flexible and Multi-purpose Service places.

The profile of care needs of permanent residents has continued to shift towards higher care needs. By June 2002, 63% of older residents had high care needs. Nearly all residents have multiple care needs. However, clients with dementia tend to have greater care needs than other people.

At all ages, Indigenous people have much higher CACP usage rates than all other groups examined, and access respite services more frequently than non-Indigenous people. While Indigenous people aged 80 and over had lower usage rates than non-Indigenous people of permanent residential aged care, at ages 50–79 their usage rates were higher.

Australian-born people—especially the very old—were more likely to access HACC services than other people. People born in non-English-speaking countries were more likely to be CACP recipients than Australian-born people or people born in other English-speaking countries. In contrast, their usage rates of both respite and permanent care were lower than those for other groups at all ages.

## Expenditure

Total expenditure on aged care services was $5,769.5 million in 2001–02, an increase of 19% in real terms over the previous 4 years. The proportions allocated to each area of expenditure have changed, with relatively more going to community care and less to residential aged care in 2001–02 than in 1998–99. Overall, the increase in expenditure on aged care services kept pace with the growth in the number of older people likely to need some assistance.

## Future outlook

The implications of population ageing for all aspects of social and economic life are increasingly being recognised. In the future, programs concerned with ageing will not just be about responding to the dependency of older people but will be more and more concerned with supporting people to lead independent lives and to continue to participate in all aspects of life as they age. Recent initiatives to this end include measures to enable and encourage older people to stay in the workforce until age 65 and beyond and to delay their decision to retire (for example, the Pension Bonus Scheme), and legislation currently being developed to prohibit age discrimination across a broad spectrum of areas including employment.

With respect to aged care service provision, there have recently been a number of developments aimed at improving service delivery and ensuring that services can meet the needs of their clients. These include the development of a National Aged Care Workforce Strategy, the Review of the Pricing Arrangements in Residential Aged Care and the release of a consultation paper concerning a Strategy for Community Care.

## References


ABS (Australian Bureau of Statistics) 1989. Labour force Australia: December 1988. Cat. no. 6203.0. Canberra: ABS.

ABS 1994. Labour force Australia: December 1993. Cat. no. 6203.0. Canberra: ABS.

ABS 1999a. Disability, ageing and carers: summary of findings Australia, 1998. Cat. no. 4430.0. Canberra: ABS.

ABS 1999b. Labour force Australia: December 1998. Cat. no. 6203.0. Canberra: ABS.

ABS 2000. Population projections, Australia: 1999 to 2101. Cat. no. 3222.0. Canberra: ABS.

ABS 2002a. 2001 Census basic community profile and snapshot: Australia. Viewed 5 August 2003, <www.abs.gov.au/ausstats/abs@census.nsf/Lookup2001Census/3B612BEC56D2B42BCA256C690026121F>.

ABS 2002b. Australian demographic statistics. Cat. no. 3101.0. Canberra: ABS.

ABS 2002c. Australian social trends 2002. Cat. no. 4102.0. Canberra: ABS.

ABS 2002d. Births, Australia. Cat. no. 3301.0. Canberra: ABS.

ABS 2003a. Australian demographic statistics. Cat. no. 3101.0. Canberra: ABS.

ABS 2003b. Labour force Australia: December 2002. Cat. no. 6203.0. Canberra: ABS.

ABS 2003c. Migration Australia. Cat. no. 3412.0. Canberra: ABS.

Aged Care Evaluation and Management Advisors 2003. Resident classification scale review. Aged and Community Care Service Development and Evaluation Report no. 43. Canberra: DoHA.

AIHW (Australian Institute of Health and Welfare) 1993. Australia's welfare 1993: services and assistance. Canberra: AGPS.

AIHW 1997. Australia's welfare 1997: services and assistance. Canberra: AIHW.

AIHW 1999a. Australia's welfare 1999: services and assistance. Cat. no. AUS 16. Canberra: AIHW.

AIHW 1999b. Residential aged care facilities in Australia 1998: a statistical overview. Cat. no. AGE 14. Canberra: AIHW.

AIHW 2000a. Australia's health 2000. Cat. no. AUS 19. Canberra: AIHW.

AIHW 2000b. Residential aged care facilities in Australia 1998–99: a statistical overview. Cat. no. AGE 16. Canberra: AIHW.

AIHW 2001a. Australia's welfare 2001. Cat. no. AUS 24. Canberra: AIHW.

AIHW 2001b. Residential aged care in Australia 1999-00: a statistical overview. Cat. no. AGE 19. Canberra: AIHW.

AIHW 2002a. Aged Care Assessment Program data dictionary version 1.0. Cat. no AGE 26. Canberra: AIHW.

AIHW 2002b. Australia's health 2002. Cat. no. AUS 25. Canberra: AIHW.

AIHW 2002c. Older Australia at a glance (3rd edn). Cat. no. AGE 25. Canberra: AIHW.

AIHW 2002d. Residential aged care in Australia 2000–01: a statistical overview. Cat. no. AGE 22. Canberra: AIHW.

AIHW 2003a. Community Aged Care Packages in Australia 2001–02: a statistical overview. Cat. no. AGE 30. Canberra: AIHW.

AIHW 2003b. Day Therapy Centre Program data dictionary version 1.0. Cat. no. AGE 27. Canberra: AIHW.

AIHW 2003c. Residential aged care in Australia 2001–02: a statistical overview. Cat. no. AGE 29. Canberra: AIHW.

AIHW forthcoming-a. Community Aged Care Packages (CACP) census 2002. Canberra: AIHW.

AIHW forthcoming-b. Day Therapy Centres (DTC) census 2002. Canberra: AIHW.

AIHW forthcoming-c. Extended Aged Care at Home (EACH) census 2002. Canberra: AIHW.

AIHW: Broadbent A 2001. Continence Aids Assistance Scheme data dictionary version 1.0. Cat. no. DIS 28. Canberra: AIHW.

AIHW: Jeffery K 2003. Client characteristics meta-data in residential aged care. Cat. no. AGE 28. Canberra: AIHW.

AIHW: Mathers C, Vos T & Stevenson C 1999. The burden of disease and injury in Australia. Cat. no. PHE 17. Canberra: AIHW.

AIHW: Petrie M & Van Doeland M 2002. Report on the Day Therapy Centre (DTC) Program data development field test. Welfare Division Working Paper no. 39. Canberra: AIHW.

AIHW: Van Doeland M & Benham C forthcoming. Report on the comparability of dependency information across aged and community care programs. Canberra: AIHW.

Andrews, the Hon. K (Federal Minister for Ageing) 2002. Media release: Minister announces national aged care workforce strategy. 15 August 2002.

Andrews, the Hon. K 2003a. Media release: 8624 new aged care places for older Australians. 3 April 2003.

Andrews, the Hon. K 2003b. Media release: A new strategy for community care. 28 March 2003.

Andrews, the Hon. K 2003c. Media release: A simpler system for entering aged care homes. 14 April 2003.

Andrews, the Hon. K 2003d. Media release: Minister announces changes to cut paperwork in aged care homes. 2 March 2003.

Andrews K & DoHA (Department of Health and Ageing) 2001. National strategy for an ageing Australia: an older Australia, challenges and opportunities for all (reprint with amendments Feb. 2002). Canberra: DoHA.

Attorney-General's Department 2002. Information paper: proposals for Commonwealth age discrimination legislation. Canberra: Commonwealth of Australia.

Centrelink 2003. Individuals. Viewed 28 July 2003, <www.centrelink.gov.au/internet/internet.nsf/individuals/index.htm>.

Costello P 2002. Intergenerational report 2002–03. Canberra: Commonwealth of Australia.

DHAC (Department of Health and Aged Care) 1999. Annual report 1998–99. Canberra: DHAC.

DHAC 2000. Annual report 1999–00. Canberra: DHAC.

DHAC: Gray L 2001. Two year review of aged care reforms. Canberra: DHAC.

DHFS (Department of Health and Family Services) 1996. Annual report 1995–96. Canberra: DHFS.

DoHA (Department of Health and Ageing) 2002a. Aged care in Australia. Canberra: DoHA.

DoHA 2002b. Annual report 2001–02. Canberra: DoHA.

DoHA 2002c. Day therapy centres. Information about community and residential care services in Australia. Viewed 16 December 2002, <www.health.gov.au/acc/commcare/dayther.htm>.

DoHA 2002d. HACC national minimum data set 2001–02 annual bulletin. DoHA. Home and Community Care. Viewed 9 July 2003, <www.health.gov.au/acc/hacc/download/mdsann0102.htm>.

Eagar K, Owen A, Green J, Cromwell D, Poulos R, Gordon R, et al. 2002. A national measure of functional dependency for Home and Community Care services in

Australia. Aged and Community Care Service Development and Evaluation Report no. 41. Canberra: DoHA.

FaCS (Department of Family and Community Services) 2000. Annual report 1999–00. Canberra: FaCS.

Gibson D 1998. Aged care: old policies, new problems. Cambridge: Cambridge University Press.

HATF (Healthy Ageing Task Force) 2000. Commonwealth, state and territory strategy on healthy ageing. Canberra: DHAC.

Henderson A & Jorm A 1998. Dementia in Australia. Aged and Community Care Service Development and Evaluation Report no. 35. Canberra: AGPS.

Jorm AF, Korten AE & Henderson AS 1987. The prevalence of dementia: a quantitative integration of the literature. Acta Psychiatrica Scandinavica 76:465–9.

Kendig H, Andrews G, Browning C, Quine S & Parsons A 2001. A review of healthy ageing research in Australia. Report prepared for the Community Services Ministers' Advisory Council 2000. Canberra: Commonwealth of Australia.

LGC (Lincoln Gerontology Centre) 2000. Aged Care Assessment Program national minimum data set report July 1998 – June 1999. Melbourne: LGC.

LGC 2001. Aged Care Assessment Program national minimum data set report July 1999–June 2000. Melbourne: LGC.

LGC 2002. Aged Care Assessment Program national minimum data set report July 2000–June 2001. Melbourne: LGC.

Myer Foundation 2002. 2020: a vision for aged care in Australia. Melbourne: Myer Foundation.

Treasury (Department of the Treasury) 2003a. Submission to the House of Representatives Standing Committee on Ageing: inquiry into long term strategies to address the ageing of the Australian population over the next 40 years. Canberra: Commonwealth of Australia.

Treasury 2003b. Tax expenditures statement 2002. Viewed 6 August 2003, <www.treasury.gov.au/contentitem.asp?ContentID=505&pageId=>.

UN (United Nations) 2002a. Report of the Second World Assembly on Ageing, Madrid, 8–12 April 2002. A/CONF.197/9. New York: UN.

UN 2002b. Shanghai implementation strategy: regional implementation strategy for the Madrid international plan of action on ageing 2002 and the Macao plan of action on ageing for Asia and the Pacific 1999. Division for Social Policy and Development. Second World Assembly on Ageing 2002. Viewed 3 May 2003, <www.un.org/esa/socdev/ageing/waa/shanghai.htm>.

WHO (World Health Organization) 2002. Active ageing: a policy framework. WHO/NMH/NPH/02.8. Geneva: WHO.