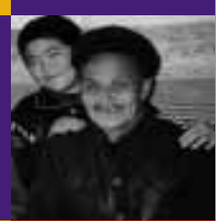
Older Australia at a Glance

SECOND EDITION

Australia 1999



Older Australia at a Glance

This is the second edition of Older Australia at a Glance, a joint undertaking of the Australian Institute of Health and Welfare and the Office for Older Australians in the Commonwealth Department of Health and Aged Care. The first edition of Older Australia at a Glance was prepared for the World Gerontology Congress, held in Adelaide in 1997. Demand for copies of the publication continued after the conference, however, and the available stocks were rapidly depleted.

This second edition has been prepared for the International Year of Older Persons (1999). The original material has been updated and further material added, to reflect the current health, well-being and social circumstances of older Australians and their health and welfare services.

Editors

Diane Gibson	Australian Institute of Health and Welfare
Christine Benham	Australian Institute of Health and Welfare
Lana Racic	Department of Health and Aged Care

Contributors

Christine Benham	Australian Institute of Health and Welfare
Ching Choi	Australian Institute of Health and Welfare
Geoff Davis	Australian Institute of Health and Welfare
Diane Gibson	Australian Institute of Health and Welfare
John Goss	Australian Institute of Health and Welfare
Jenny Hargreaves	Australian Institute of Health and Welfare
Bella Holmes	Australian Institute of Health and Welfare
Hal Kendig	Faculty of Health Sciences, University of Sydney
Sushma Mathur	Australian Institute of Health and Welfare
Colin Mathers	Australian Institute of Health and Welfare
Deborah Osborne	Lincoln Gerontology Centre, La Trobe University
Richard Rosewarne	Department of Pyschological Medicine, Monash University
Richard Webb	Australian Institute of Health and Welfare
David Wilson	Australian Institute of Health and Welfare

Staff of the Aged and Community Care Division of the Department of Health and Aged Care, the Department of Family and Community Services and the Department of Treasury.

A complete list of the Institute's publications is available from the Publications Unit, Australian Institute of Health and Welfare, GPO Box 570, Canberra ACT 2601, or via the Institute's web-site at http://www.aihw.gov.au.

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Foreword

I am pleased to introduce *Older Australia at a Glance* to you. This unique publication aims to meet a growing need for a single point of reference which brings together a variety of data and information about older Australians.

The ageing of Australia's population is inevitable and is due largely to historical patterns of growth. We will need to ensure we have policies which maximise the capacity of older people to participate and contribute, through better health, better retirement incomes and more flexible employment and caring arrangements. If older people and their families have the flexibility to make choices which allow them to maximise their participation and contribution to the community, then ageing can be about increasing our economic wellbeing, not an impending burden. Research has found that there is a significant contribution to be made to the Australian economy by mature aged workers and the purchasing power of a more affluent and healthy older population, compared to earlier generations.

The Government has taken several initiatives which demonstrate its credentials and understanding of the diverse needs of senior Australians:

- direct financial support for the International Year of Older Persons was doubled in the 1999–00 Budget to $11 million;
- $3.6 billion will be spent in 1999–00 on the relatively small proportion of the over 65 year population in need of residential aged care—some 135,000 people;
- an additional $82.2 million over the next four years to further boost respite care services for carers of people with dementia and other cognitive and behavioural disorders;
- the Budget also allocated around $41.2 million over four years for an exciting Carelink initiative. These funds will support single regional contact points across Australia for community care services; and
- Commonwealth funding of $805 million in 1999–00 for the Home and Community Care Program which provides community nursing, allied health services and personal care, community aged care packages, meals on wheels, home help, transport and community-based respite care.

The 1999 International Year of Older Persons is a time to recognise and celebrate the diversity, richness and contribution of older people to our community. The Government's key response will be to address the needs of senior Australians through the development of the National Strategy for an Ageing Australia. The National Strategy will take a whole of government approach to examine a range of issues affecting older people now and into the future. This will provide a foundation on which to develop new policies and enable individuals to make informed decisions as they age.

I recommend this publication to you as an informative and useful source of information.

BRONWYN BISHOP

Minister for Aged Care

Contents

Australia in context

1 Geography and climate

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

Social history

Australian Aboriginals are the indigenous people of Australia and have lived here for at least 50,000 years.

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

Population characteristics

Australia is a multicultural society with a population of 18.8 million, enriched by more than four million settlers from over 200 countries. Forty per cent of Australians are migrants or first generation children of migrants, half of whom are from culturally and linguistically diverse backgrounds. In 1996, Australia's Aboriginal and Torres Strait Islander peoples numbered 386,000, representing 2.1% of the population. The Australian population growth rate has declined since 1989, mainly because of a sharp decline in net migration. Australian women have an average life expectancy at birth of 80 years, six years longer than the average for Australian men.

Government structures

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

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

Economic overview

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

Health care

The Australian health care system is a blend of public and private sector involvement: private medical practitioners provide primary and specialist care, and a public (State-controlled) and private hospital system provides comprehensive services. The national health funding system, Medicare, makes health care affordable and provides all Australian residents with access to medical services. The scheme is partly funded by a 1.5% levy on taxable income. State and local governments have responsibility for providing public health services. However, the Federal Government has become more involved in developing and coordinating national policies, legislation and standards. There are about 1,100 hospitals across Australia (excluding psychiatric hospitals), 65% of which are public. Australia has an average of 4.5 hospital beds per thousand of the population. Government expenditure on health programs in 1997–98 was $31.9 billion; total government outlays in 1997–98 were $194.6 billion.

Social welfare

The Commonwealth Government's involvement in social security began with the introduction of federal old-age and invalid pensions in 1909 and maternity allowances in 1912. These kinds of social security payments gained Australia a reputation as a pioneer in public welfare. Today, the social security system in Australia provides income support to people and families who are without an adequate income because of age, disability, unemployment or sole parenthood. About five million Australians receive social security entitlements. The Federal, State and Territory Governments fund a range of home and community support and transport services for frail older people and younger people with disabilities at home, as well as a benefit to people who care for chronically ill relatives at home. Expenditure on social security and welfare programs in 1997–98 was $54.5 billion.

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Older Australians: age, sex and living arrangements

2

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

As of 30 June 1998, the ABS estimated that there were 18.8 million persons in Australia, with 2.3 million of these aged 65 and over (12% of the total population). Almost a third of all older people were aged between 65 and 69 and almost a quarter were aged 80 and over. The majority of older people were women (56%), with this predominance particularly evident in the older age groups. In the 65–69 age group only 51% were women, increasing to 65% among those aged 80 and over.

Families are the 'largest source of emotional, practical and financial support in our society' and this support is provided primarily on a non-paid voluntary basis (McDonald 1995). The existence or non-existence of family members within a household is an important indicator of the availability of family support. It should be recognised, however, that a substantial amount of informal assistance is provided to frail and disabled older people by non co-resident family members (Gibson et al. 1997).

The majority of Australians (98%) live in private dwellings. This is also the case for older Australians: 91% of people aged 65 and over live in private dwellings. The proportion of older people living in health establishments (as defined in the national population census) rose substantially among the very old, however, from 2% of those aged 65–79 to 21% of those aged 80 and over. This increase is much more marked for women than for men, with 24% of women aged 80 and over living in health establishments.

Of those living in private dwellings, 86% were living in families, while 10% lived alone. The proportion who lived alone dramatically increased at older ages. Nine per cent of persons aged 15–64 living in private dwellings were living alone, compared to 26% of 65–79 year olds and 46% of those aged 80 and over.

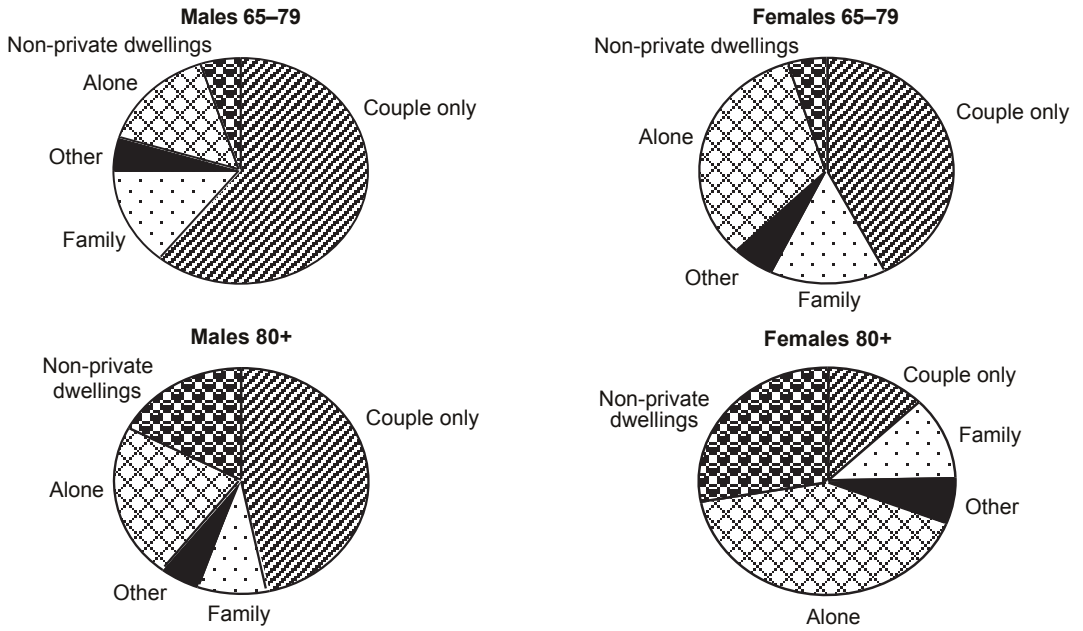
Persons aged 65 and over; by sex and age, Australia 1998

	65–69		70–79		80 and over		Total aged population	
Sex	**('000)**	**%**	**('000)**	**%**	**('000)**	**%**	**('000)**	**%**
Males	333.5	14.6	486.5	21.3	179.3	7.9	999.3	43.8
Females	348.3	15.3	597.5	26.2	338.2	14.8	1,284.0	56.2
Persons	**681.8**	**29.9**	**1,084.0**	**47.5**	**517.5**	**22.7**	**2,283.4**	**100.0**

Persons aged 65 and over: dwelling type, by age and sex, Australia 1996 (%)

	Males			Females			Persons		
Dwelling type	**65–79**	**80+**	**65+**	**65–79**	**80+**	**65+**	**65–79**	**80+**	**65+**
Private dwellings	95.0	82.8	92.8	95.0	71.9	89.0	95.0	75.6	90.6
Health establishments	1.9	13.0	3.8	2.6	24.3	8.3	2.2	20.5	6.4
Other non-private dwelling	3.1	4.2	3.3	2.4	3.7	2.8	2.7	3.9	3.0
Total (N)	**731,253**	**157,489**	**888,742**	**859,723**	**305,625**	**1,165,348**	**1,590,976**	**463,114**	**2,054,090**

Source: 1996 Census data based on place of enumeration. Excludes missing data.



Living arrangement profiles by age and sex, Australia 1996

While the living arrangements of men and women were similar until age 65, women's greater longevity and their tendency to marry older men combine to create substantially higher proportions of women than men living alone after that age. In the 65–79 age group, 64% of men living in a private dwelling were living with a spouse, whereas for women this proportion was 45%. By ages 80 and over, although the proportion of men living with a spouse in a private dwelling had also declined substantially, men were three times more likely to be in a couple only family than women (56% compared to 18%). Women aged 80 and over were twice as likely as men to be living alone; 57% of women aged 80 and over living in a private dwelling were living alone compared to 27% of men.

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Older people in private dwellings: living arrangements by age and sex, Australia 1996 (%)

	Males			Females			Persons		
Living arrangement	**65–79**	**80+**	**65+**	**65–79**	**80+**	**65+**	**65–79**	**80+**	**65+**
Couple only	63.9	56.0	62.7	44.8	17.9	39.1	53.6	32.1	49.5
Family	15.1	11.0	14.5	15.5	16.1	15.6	15.3	14.2	15.1
Alone	16.1	27.0	17.8	34.2	56.8	39.0	25.9	45.7	29.6
Other	4.9	6.0	5.1	5.5	9.2	6.3	5.2	8.0	5.7
Total (N)	**694,674**	**130,360**	**825,034**	**816,866**	**219,886**	**1,036,752**	**1,511,540**	**350,246**	**1,861,786**

Source: 1996 Census data based on place of enumeration. Excludes missing data.

The changing demographic profile: 1976–2016

3

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

For persons aged 65 and over, the last two decades saw substantially higher annual average rates of increase (3% and 2.7% per annum) than is expected in the next decade 1996–2006 (1.8% per annum), although growth rates are then expected to increase substantially during the period 2006–16 (2.9% per annum) as the peak of the Australian baby boom generation reaches retirement age. Among the 80 years and over population the pattern is somewhat different, with the recent decade (1986–96) having the highest rate of increase (4.4% per annum) of the 40-year period under scrutiny here. For the next decade average rates of increase will drop somewhat to 3.9%, while the period 2006–16 is expected to have quite a low annual rate of increase at only 1.9%. The low growth rates in the 80 and over population for the period 2006–16 are the result of lower fertility rates in Australia during the depression years of the 1920s and 1930s. Amongst both age groups (65 and over and 80 and over), men have higher rates of increase than women throughout the 40-year period.

These rates of change are reflected in quite substantial growth in both the relative and absolute size of the older population. Twenty years ago, 9% of the population (or 1.3 million people) were aged 65 and over. By 1996 this had increased to 12% (2.2 million) and by 2016 this is projected to increase to 16% or 3.5 million persons.

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

	Males			Females			Persons		
Year	65+	80+	Total (all ages)	65+	80+	Total (all ages)	65+	80+	Total (all ages)
1976–1986	3.0	3.9	1.3	3.0	3.6	1.4	3.0	3.7	1.3
1986–1996	3.1	5.1	1.3	2.5	4.1	1.4	2.7	4.4	1.3
1996–2006	2.0	4.5	1.1	1.6	3.5	1.1	1.8	3.9	1.1
2006–2016	3.2	2.3	0.8	2.7	1.6	0.8	2.9	1.9	0.8

The internal age structure of the older population has also changed quite significantly. In 1976, 17% of older people were aged 80 and over; by 1996 it was 22% and by 2006 it will peak at 27%, declining to 24% in 2016. The number of people in Australia aged 80 and over thus increased from 218,000 in 1976, to 484,400 in 1996, and is projected to grow to 707,400 in 2006 and 852,100 by 2016. The proportion of women in the aged population also changes over this period, decreasing from 58% in 1976, to 56% in 1996, and is expected to decrease further to 54% in 2016.

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

	Year									
	1976		1986		1996		2006		2016	
Age by sex	**('000)**	**%**	**('000)**	**%**	**('000)**	**%**	**('000)**	**%**	**('000)**	**%**
Males										
65+	525.5	3.7	709.2	4.4	959.3	5.2	1,171.4	5.8	1,599.5	7.2
80+	68.9	0.5	101.0	0.6	166.2	0.9	259.2	1.3	324.4	1.5
Male population (all ages)	*7,032.0*	*50.1*	*8,000.2*	*49.9*	*9,108.1*	*49.7*	*10,112.5*	*49.7*	*10,948.4*	*49.6*
Females										
65+	727.4	5.2	972.9	6.1	1,243.8	6.8	1,452.2	7.1	1,901.5	8.6
80+	149.0	1.1	213.3	1.3	318.2	1.7	448.2	2.2	527.7	2.4
Female population (all ages)	*7,001.0*	*49.9*	*8,018.2*	*50.1*	*9,202.7*	*50.3*	*10,230.2*	*50.3*	*11,124.5*	*50.4*
Persons										
65+	1,252.8	8.9	1,682.1	10.5	2,203.1	12.0	2,623.6	12.9	3,501.0	15.9
80+	217.9	1.6	314.3	2.0	484.4	2.6	707.4	3.5	852.1	3.9
Total population (all ages)	**14,033.1**	**100.0**	**16,018.4**	**100.0**	**18,310.7**	**100.0**	**20,342.7**	**100.0**	**22,072.9**	**100.0**

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Indigenous peoples

4

The first inhabitants of Australia were Aboriginal and Torres Strait Islander peoples some 50,000 years ago. While the size of the Indigenous population prior to white settlement is unknown, an early 19th century estimate of 300,000 is now believed to have been a vast underestimate of the population at that time (ABS 1994: 399). Indigenous Australians show important differences in demographic, social and cultural characteristics from non-Indigenous Australians.

According to the 1996 Census there were 386,000 persons who identified themselves as being of Aboriginal or Torres Strait Islander descent (2.1% of the total population). The Northern Territory had a much higher proportion of Aboriginal and Torres Strait Islander peoples (28.5%) than was the case elsewhere.

Indigenous Australians have a younger population profile than non-Indigenous Australians. The vast majority of Indigenous peoples in 1996 were aged under 45 (87%), and only a small minority (1.5%) were aged 70 and over. The corresponding proportions for the non-Indigenous population were 67% and 8%, respectively.

In the period 1991–96, life expectancy at birth for Indigenous males was 56.9 years and for Indigenous females was 61.7 years. By contrast, life expectancy at birth for all Australians was 75.2 years for males and 81.1 years for females. About 76% of deaths among Indigenous males and 67% of deaths among Indigenous females occured before age 65. Among non-Indigenous people, the comparable proportions are 27% for men and 16% for women (AIHW 1999).

Given that Indigenous Australians have a shorter life expectancy than other Australians, and a higher incidence of illness and disability, it is not surprising that they make use of aged care services at younger ages. A much higher proportion of Indigenous than non-Indigenous persons using such services were in the under 65 age group while a much lower proportion using aged care services were in the 80 and over age group. Within the HACC program, 48% of Indigenous clients were aged under 65 compared to only 19% of non-Indigenous clients. The same pattern emerges in residential care, with 44% of low care Indigenous residents being under 65 compared to 4% of non-Indigenous residents, and 26% of Indigenous high care residents being under 65 compared to 5% of non-Indigenous high care residents.

Because Indigenous Australians tend to make use of aged care services at younger ages than their non-Indigenous counterparts, age-specific usage rates between the two population groups differ markedly. When age-specific usage rates are examined, Indigenous Australians make either comparable or greater use of aged care services and facilities across almost every age category. So, for example, 5.4% of Indigenous people aged 70 and over used residential high care services, compared to 3.5% of non-Indigenous people.

The different age profiles characteristic of Indigenous and non-Indigenous peoples result in a

Aboriginal and Torres Strait Islander peoples, Australia 1996

	States and Territories								
	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Indigenous population ('000)	109.9	22.6	104.8	56.2	22.1	15.3	3.1	51.9	386.0
% of total population	1.8	0.5	3.1	3.2	1.5	3.2	1.0	28.5	2.1

Age and sex profiles of Indigenous and non-Indigenous Australians, 1996 (%)

	Indigenous Australians			Non-Indigenous Australians		
Age	Males	Females	Persons	Males	Females	Persons
<45	87.7	86.4	87.0	67.7	65.4	66.5
45–69	11.1	11.8	11.4	25.4	24.8	25.1
70+	1.3	1.7	1.5	6.9	9.8	8.4
All ages ('000)	**190.5**	**195.6**	**386.0**	**8,917.6**	**9,007.1**	**17,924.7**

Prepared by the Australian Institute of Health and Welfare

Proportion of Indigenous and non-Indigenous people using aged care services, Australia 1998 (%)

	HACC[(a)]		Residential low care		Residential high care		Residential care total	
	Indigenous	Non-Indigenous	Indigenous	Non-Indigenous	Indigenous	Non-Indigenous	Indigenous	Non-Indigenous
1–49	0.3	0.2	0.0	0.0	0.0	0.0	0.0	0.0
50–59	5.1	0.7	0.1	0.0	0.2	0.1	0.3	0.1
60–69	20.8	2.6	0.2	0.2	0.7	0.3	0.9	0.5
70+	34.8	16.5	0.8	3.1	5.4	3.5	6.2	6.6
All ages	**1.6**	**1.6**	**0.0**	**0.3**	**0.1**	**0.3**	**0.1**	**0.6**

(a) Home and Community Care (HACC) data are for Western Australia only, as this is the only State which undertook a complete census of HACC clients (necessary for calculating usage rates).

very different picture when the overall pattern of use (i.e. for all ages together) is examined. Here the rates of use by Indigenous Australians are equivalent to those by non-Indigenous Australians for Home and Community Care, but lower than those for non-Indigenous Australians for both high and low level residential care. Based on the most recent data available, Indigenous Australians make up 2% of the population as a whole, yet comprise 3% of HACC clients, 4% of care package clients, 6% of community options clients, and less than 0.5% of residential care clients. Overall, these data show that patterns of service use mirror the preference for community-based care frequently expressed by Indigenous Australians.

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

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Data sources

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People from culturally and linguistically diverse backgrounds

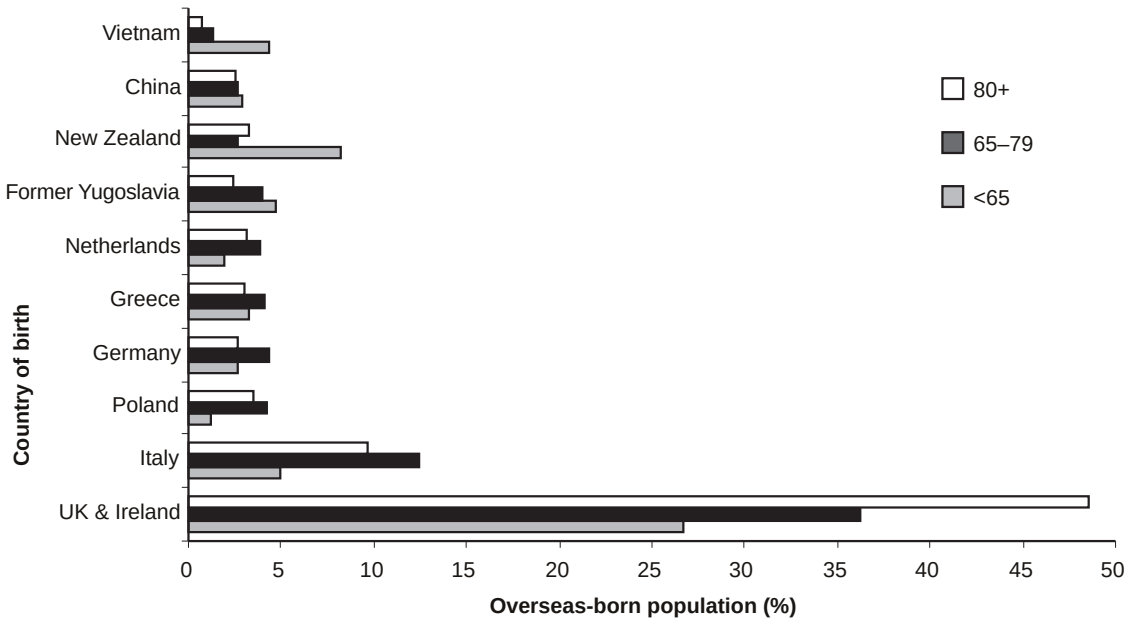
5

Australian society is made up of people from many different cultural backgrounds, with much of the nature of this cultural diversity a result of the immigration policies of the post-war period. The population is becoming increasingly culturally diverse, with more older overseas-born Australians coming from a greater variety of countries. According to the 1996 Census 4.3 million people (23% of the total population) living in Australia were born overseas and originated from more than 200 different countries, while a further 3.5 million had one or both parents born overseas.

At the 1996 Census there were more than 682,000 overseas-born persons aged 65 and over, comprising 31% of the total population aged 65 and older. While people originally from the UK and Ireland form the largest immigrant group among overseas-born older people (39%), the numbers from culturally and linguistically diverse backgrounds (i.e. those from non-English-speaking countries) are substantial at over 387,000, a figure projected to exceed 660,000 in 2001 (Rowland 1991). Within the overseas-born older population the proportion of persons from culturally and linguistically diverse backgrounds varies significantly with age. Among overseas-born persons aged 80 and over, 46% were from culturally and linguistically diverse backgrounds, with this proportion increasing to nearly 60% of overseas-born persons in the 65–79 age group.

In the 80 and over age group, the largest immigrant groups (after the UK and Ireland) were from Italy (10%) followed by Poland (3.5%) and New Zealand (3.5%). In the 65–79 age group, the largest immigrant groups (after the UK and Ireland) were from Italy (12%) followed by Germany, Poland, Greece, former Yugoslavia and the Netherlands, each comprising 4%. These trends are different from those for the under 65 age group, where people from New Zealand were the largest single immigrant group after the UK and Ireland, and the proportion arriving from Asia was also significantly larger.

Older people from culturally and linguistically diverse backgrounds warrant particular attention in policy terms since by 2001 they will comprise around one in four older people in Australia.



Selected countries of birth by age, Australia, 1996

Percentage of people from culturally and linguistically diverse backgrounds and from English-speaking backgrounds using residential care, Australia 1998 (%)

	Residential low care		Residential high care		Residential care total	
	Culturally & linguistically diverse	English-speaking background	Culturally & linguistically diverse	English-speaking background	Culturally & linguistically diverse	English-speaking background
55–64	0.0	0.1	0.1	0.2	0.1	0.3
65–69	0.1	0.3	0.3	0.5	0.5	0.9
70–74	0.4	0.7	0.9	1.2	1.3	1.9
75–79	0.9	1.8	1.8	2.6	2.7	4.4
80–84	2.8	5.0	5.3	6.1	8.2	11.1
85+	4.6	10.2	9.9	14.2	14.5	24.4

Note: The English-speaking background category used here comprises people whose country of birth was Australia, New Zealand, United Kingdom, Ireland, United States of America, Canada or South Africa. The culturally and linguistically diverse background category comprises people born in countries other than those already mentioned.

Improving equity of access to aged care services for people from culturally and linguistically diverse backgrounds has been a key policy objective over the past 10 years.

Based on 1998 data, people from culturally and linguistically diverse backgrounds make up 14% of the population as a whole, and comprise 14% of Home and Community Care clients (HACC), 20% of care package clients, 8% of residential low care clients, 11% of residential high care clients, and 10% of residential care clients overall. In terms of residential care, people from culturally diverse backgrounds had markedly lower rates of service use across all age groups than those from English-speaking backgrounds. These data suggest that persons from culturally and linguistically diverse backgrounds were more likely to make use of home-based rather than residential care services. Intensive forms of community support such as community aged care packages appear to have been particularly successful in targeting services to these people.

Persons born overseas generally have better health than the Australian-born population, not a surprising result given that the selection of immigrants to Australia is partially determined by their health status. The overseas-born population experienced significantly lower mortality rates leading to higher life expectancies, as well as lower death rates for most major causes of death compared to the Australian-born population. People born overseas reported less serious chronic illness than did those born in Australia, although those from continental Europe and Asia tended to report poorer health compared to those born in Australia. Overseas-born Australians had fewer hospital admissions than the Australian-born (AIHW 1998: 45–49).

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Data sources

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International comparisons

Population ageing is a defining characteristic of all developed and many developing nations in the latter part of the 20th century, and one which will continue into the 21st century. In 1950, between 8% and 9% of the population in North America, Europe, Australia and New Zealand were aged 65 and over. Today, that figure has increased substantially, but regional variations in rates of increase led to a situation where, by 1995, 17% of people in Sweden, 16% in Norway and 15% in Denmark were aged 65 or older, compared to 13% in the USA and 12% in Australia and New Zealand.

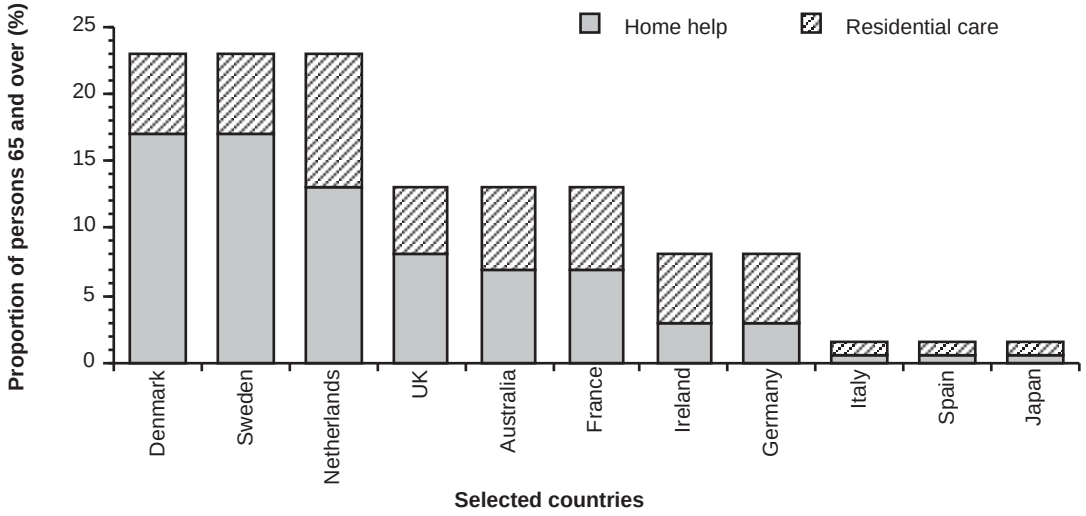
Australia is relatively young among developed nations. The 14-country comparison in the table below reveals three broad tiers in terms of population structure. The oldest tier includes most of the European countries, with between 15% and 18% of their populations aged 65 and over. The second tier is a more eclectic cultural mix, but comprises a recognisably 'younger' set of countries with around 11–13% of their populations in this age group. The third tier, comprising the so-called 'late initiation' countries (where the decline in fertility which precedes population ageing did not occur until much later), is represented by China, with only 6% of its population aged 65 and over. Similar trends are evident with regard to the size of the population aged 80 and over in each of these countries.

If the countries are ranked according to the projected rates of growth of their older population (65+) for the next 10 years, however, a roughly inverse picture emerges. Japan and China lead the field with annual average rates of increase close to 3%, followed by Australia, Canada and Germany (1.7–1.8%), and then New Zealand and France (1.2%) with all the remaining countries at less than 1%.

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

	Proportion of the population (1995)		Annual rate of increase (1995–2005)	
Selected countries	**65+**	**80+**	**65+**	**80+**
Australia	11.9	2.6	1.8	3.9
Austria	14.7	3.5	0.7	0.9
Canada	12.0	2.6	1.7	3.4
China	6.1	0.7	2.6	3.5
Denmark	15.1	3.7	–0.1	0.3
France	15.2	4.1	1.2	1.6
Germany	15.2	3.9	1.7	0.1
Japan	14.2	2.8	2.9	3.5
Netherlands	13.2	3.0	1.1	1.9
New Zealand	11.4	2.4	1.2	2.4
Norway	15.9	3.9	–0.6	1.4
Sweden	17.3	4.5	–0.2	1.2
UK	15.8	3.9	0.1	1.0
USA	12.6	3.0	0.6	2.2

Source: Gibson (1997)



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

The rate of growth in the population aged 80 and over is highest for Australia at 3.9%, followed by Japan and China (3.5%) and Canada (3.4%). Thus, while Australia is relatively young in an international context, it is experiencing a comparatively rapid rate of population ageing. These changes have been a key factor in the restructuring and adjustment of both the income support and aged care service sectors over the last decade.

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

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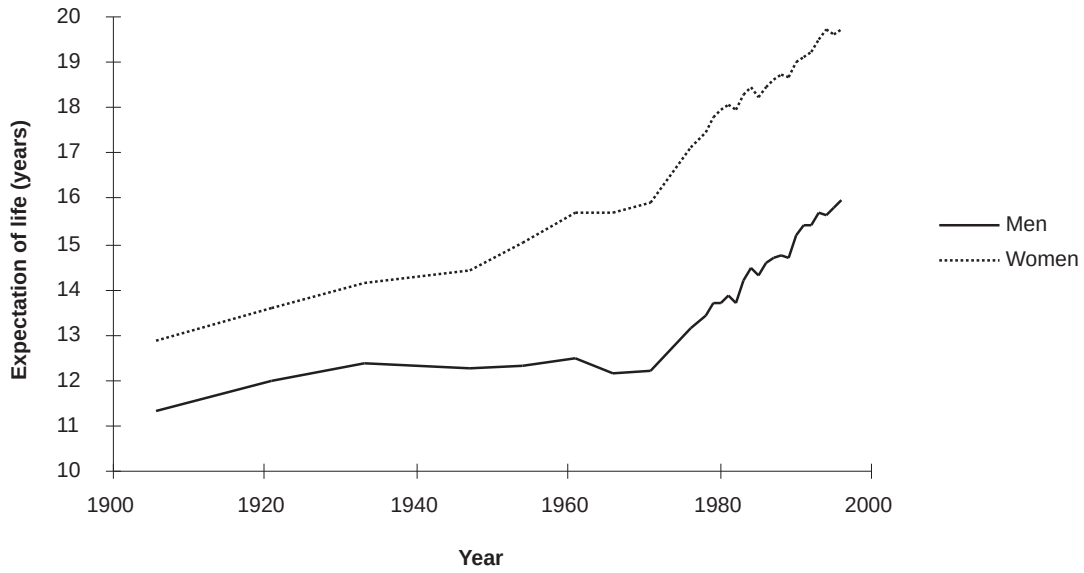
Life expectancies of older Australians

7

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

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



Trends in life expectancy at age 65, Australia

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

International comparisons of the life expectancies at age 65 for Australia and selected other countries in 1996, in descending order of female life expectancy, are presented in the following table. Australian women aged 65 years have the eighth highest life expectancy among OECD (Organisation for Economic Co-operation and Development) countries, following Japan, France, Switzerland, Canada, Spain, Sweden and Belgium. Men in Japan, Canada, Switzerland, Iceland, France, Sweden and Greece have a higher life expectancy at age 65 than their counterparts in Australia.

Life expectancy at age 65 for Australia and selected countries, 1996

Country	Males	Females
Japan	16.9	21.5
France	16.1	20.6
Switzerland	16.3	20.3
Canada	16.3	20.2
Spain	15.8	19.8
Sweden	16.1	19.7
Belgium	15.3	19.7
Australia	**15.8**	**19.6**
Italy	15.7	19.6
Norway	15.5	19.5
Iceland	16.2	19.1
New Zealand	15.5	19.0
USA	15.7	18.9
Mexico	15.5	18.8
Austria	15.3	18.8
Finland	14.6	18.7
Greece	16.1	18.6
Germany	14.9	18.6
Netherlands	14.4	18.6
Luxembourg (1993)	14.2	18.5
UK	14.7	18.4
Portugal	14.3	17.7
Denmark	14.2	17.7
Ireland (1993)	13.5	17.1
Korea (1995)	13.2	16.9
Poland	13.0	16.8
Czech Republic	12.9	16.5
Hungary	12.1	15.9

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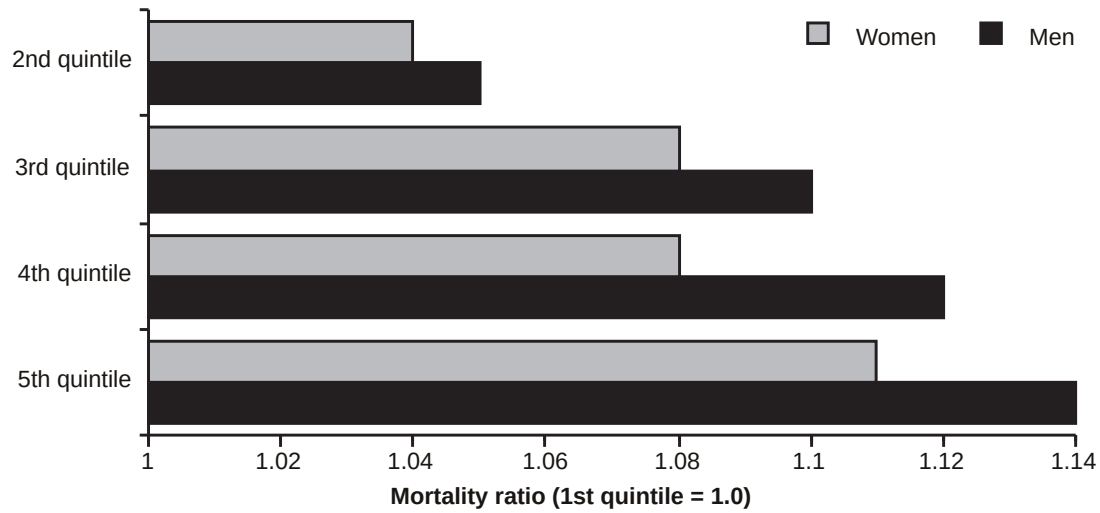
Health differentials

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

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

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

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



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

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

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

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

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

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

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Data sources

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Dementia and older Australians

The number of people with dementia is increasing in Australia as more people live to an age where the prevalence of dementia is highest. Dementia is characterised initially by the development of difficulties with everyday tasks of daily living, by personality changes and by a later progression to the loss of the capacity to act independently. Estimates vary depending on definition but, given this proviso, the number of people with dementia in Australia in 1996 has been estimated at 134,800 (6% of the population aged 65 years and over. This estimate does not include people with very mild dementia). While approximately half of those with dementia live in the community, higher levels of cognitive loss are generally associated with greater use of residential care.

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

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

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

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

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

Living arrangements of people with dementia, Australia 1996

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

Prepared by Richard Rosewarne

Distribution of hostel and nursing home beds, Australia 1996

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

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

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

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

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Data sources

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Self-rated health among older Australians

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

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

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

Self-ratings of health are an important predictor of mortality and this holds true even after controlling for objective health. Australian research has found differences between men and women in the relationship between self-rated health and survival. In a major Australian study, van Doorn et al. (1998) found that the relationship between self-rated health and mortality was stronger for men than women. This gender difference is

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

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

consistent with results from many other countries. Overall, the evidence suggests that self-rated health is a reliable and easily administered indicator of health status, principally defined by severe illness and disability.

Why does self-rated health predict mortality so well? What is it measuring? Although self-rated health is strongly associated with objective health status, self-ratings include more than physical aspects of health. It also may reflect psychological wellbeing, aspects of health behaviour, social support and self-efficacy.

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

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Data sources

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Dependency levels among older Australians

11

The most recent data available on the dependency levels of older Australians come from the 1998 Survey of Disability, Ageing and Carers conducted by the Australian Bureau of Statistics (ABS). In this survey, dependency is measured in terms of 'impairment', 'disability' and 'activity restriction'. In the previous three surveys in this series (conducted in 1981, 1988 and 1993) dependency was measured in terms of 'impairment', 'disability' and 'handicap'. These definitions are based on the 1980 International Classification of Impairments, Disabilities and Handicaps and draft material prepared for the 2001 revision (WHO 1997).

For the older population, disability and handicap rates remained relatively stable across the first three surveys conducted between 1981 and 1993, particularly in the profound or severe handicap category (while these two categories are measured separately, they are frequently combined for analytic purposes). In the 1998 survey, the rates of disability and activity restriction increased. While this may reflect an underlying increase in disability levels within the community, it is likely that the increase is at least partially explained by improved measurement techniques developed by the ABS for use in the 1998 survey.

For the purposes of understanding dependency among older people, the 'specific activity restriction' category is a useful indicator of very mild levels of dependency, while the combination of the 'profound and severe core activity restriction' categories is the best indicator of more serious levels of dependency. Almost half (49%) of all older people had a specific activity restriction, with 21% reporting a profound or severe core activity restriction, 18% a moderate core activity restriction and 18% a mild core activity restriction. Amongst very old people these proportions increase considerably, with 71% of persons aged 80 and over reporting a specific activity restriction and 46% a profound or severe core activity restriction. Women had higher rates of profound or severe core activity restriction than did men, particularly at older ages. At age 65 and over, 25% of women and 16% of men had a profound or severe core activity restriction. At age 80 and over, 51% of women and 37% of men had a profound or severe core activity restriction.

Disability status by age and sex, Australia 1998

	People with a disability							
Sex and age	Profound core activity restriction	Severe core activity restriction	Moderate core activity restriction	Mild core activity restriction	Total with specific restrictions[(a)]	Without specific restrictions	Total with disability	Total population
Males								
65+	99,800	62,400	111,200	193,600	467,100	70,400	537,500	993,200
80+	47,500	17,600	15,800	38,700	119,700	7,700	127,400	178,200
All ages	218,800	286,600	338,600	534,300	1,566,700	254,400	1,821,100	9,282,300
Females								
65+	219,700	99,200	115,400	205,900	640,200	47,500	687,700	1,278,000
80+	136,100	35,600	23,100	52,100	246,800	4,800	251,600	335,800
All ages	318,900	311,600	321,700	497,500	1,589,200	200,000	1,789,200	9,378,200
Persons								
65+	319,500	161,400	226,600	399,500	1,107,300	117,900	1,225,200	2,271,300
80+	183,600	53,100	38,900	90,800	366,500	12,500	379,000	514,100
All ages	537,700	598,200	660,300	1,031,800	3,155,900	454,400	3,610,300	18,660,600

(a) 'All ages' category includes 907,700 males and 752,700 females with schooling or employment restrictions.

Prevalence rates for core activity restrictions among older persons, by age and sex, Australia 1998 (%)

	Males					Females				
Severity	**65–69**	**70–74**	**75–79**	**80–84**	**85+**	**65–69**	**70–74**	**75–79**	**80–84**	**85+**
Profound/severe	7.8	11.8	19.0	24.2	56.0	9.2	15.1	24.9	35.5	68.8
Moderate	10.8	10.3	15.3	*7.8	*10.4	8.9	10.4	10.2	6.9	6.9
Mild	16.0	21.6	20.3	24.8	16.9	14.8	16.5	18.3	22.6	7.5

** Figure has a relative standard error greater than 25%.*

Based on 1998 rates and ABS population projections, the number of older people with a profound or severe core activity restriction can be expected to rise considerably over the next two decades—from an estimated 481,000 in 1998 to 844,500 in 2021 (AIHW 1999). While this group will remain a stable 21% of the total aged population over the period, these projected increases in absolute numbers have important implications for service providers, planners and policy analysts.

The category of profound and severe core activity restriction (profound or severe handicap in earlier surveys) is of most relevance in establishing need for assistance and hence demand for services among older people. It comprises three areas where assistance is either always (profound) or sometimes (severe) needed—self-care, mobility and communication. Area of activity restriction provides an indication of the types of services which may be required, whether from formal services or informal carers, or both. Of the 481,000 older people with a profound or severe core activity restriction, almost all reported needing assistance with mobility (99%), most (82%) needed assistance with self-care and around half (47%) needed assistance with communication. While need for assistance with mobility remained remarkably high across all age groups, need for assistance with self-care and communication increased at older ages. This trend is particularly marked in regard to communication difficulties, with need for assistance in this area almost doubling among those over 80 compared to those aged 65 to 79.

Older persons with a profound or severe core activity restriction, area of restriction by age, Australia 1998 (%)

Age	Self-care	Mobility	Communication	Total (N)
65–79	77.6	98.0	34.3	244,300
80+	86.6	99.2	59.2	236,800
Total	**82.0**	**98.6**	**46.6**	**481,200**

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Data sources

Data presented here are drawn from Australian Institute of Health and Welfare (1999); the Australian Bureau of Statistics (1999); and unpublished data from the ABS 1998 Survey of Disability, Ageing and Carers.

The nature of dependency among older Australians

12

Information on the nature of dependency among older people is fundamental in planning for adequate and appropriate aged care services. The Australian Bureau of Statistics 1998 Survey of Disability, Ageing and Carers collected comprehensive national data on the dependency levels of people of all ages in Australia. The majority of older people in Australia (54%) had at least one disabling condition which had lasted, or was expected to last, for at least six months. Despite this, not all persons with a condition were restricted by their illness or disability; 51% of those with a disability neither needed help nor had difficulties with the activities of self-care, mobility or communication.

Older people are not a population categorised by homogenously high levels of dependency. As such, in assessing dependency and need for assistance, it is important to recognise the differences between younger and older categories of older people. Among the 'young old' relatively small proportions required assistance with either personal care activities or activities associated with living in the community more generally. With advancing age, however, need for assistance rises substantially across the range of activities presented in the table below. For instance, while only one in twenty people aged 65 to 69 required assistance with self-care activities (such as bathing, dressing, grooming etc.), this rises to one in ten among those aged 70 to 79, and to one in three among those aged 80 and over.

Overall, the proportion of people requiring assistance with personal care activities rises from 14% among the 65 to 69 year olds, to 54% among those aged 80 and over. The proportion requiring assistance with at least one of the activities listed in the table rises from 28% among those aged 65 to 69 to 77% among those aged 80 and over. Activities with which older people were most likely to report a need for assistance included property maintenance, health care, transport and mobility, though there are clear age-related differences in support needs. For instance, need for assistance with property maintenance and housework are less prominent at older ages, no doubt reflecting changes in the living arrangements of people at older ages. Conversely, need for assistance with basic activities such as mobility and health care become more prominent among those aged 80 and over.

Older persons, need for assistance with particular activities, Australia 1998 (%)

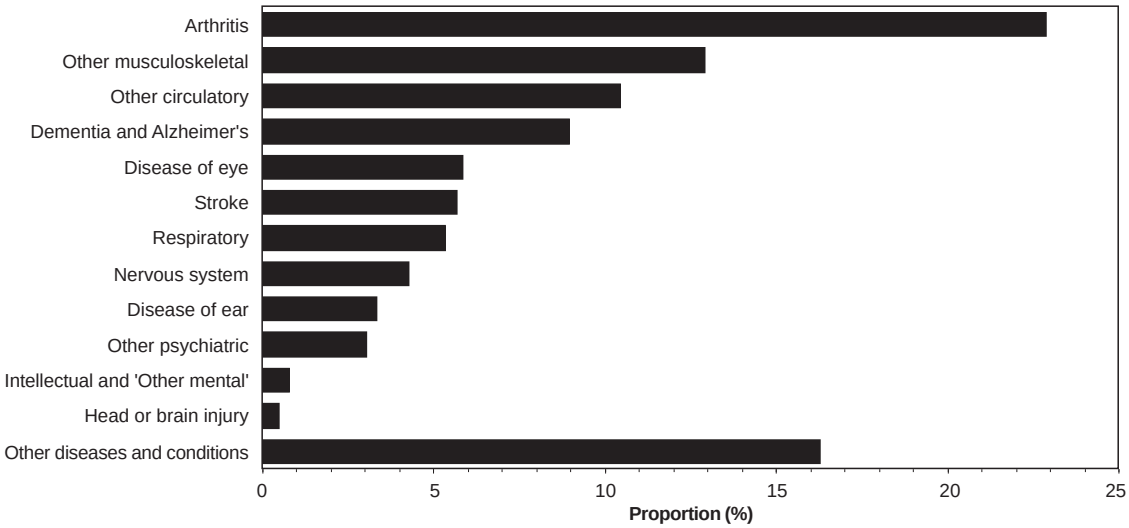
Activity	65–69	70–79	80+	Total
Self-care	5.2	9.9	31.4	13.3
Mobility	6.7	13.8	42.1	18.1
Communication	1.1	3.5	17.3	5.9
Health care	10.4	20.3	46.8	23.4
Transport	8.8	18.7	37.5	20.0
Paperwork	3.2	7.7	30.7	11.6
Housework	10.0	17.7	28.4	17.8
Property maintenance	19.4	28.3	36.8	27.6
Meal preparation	2.3	5.8	12.5	6.3
Total needing assistance with personal activities [(a)]	13.7	25.1	53.8	28.2
Total needing assistance with at least one activity	27.9	42.9	77.0	46.2
No assistance needed	72.1	57.1	23.0	53.8
All persons (N)	**681,900**	**1,075,300**	**514,100**	**2,271,200**

(a) Only persons with a disability were asked about need for assistance with personal activities (self-care, mobility, communication and health care).

While age itself is an important indicator of need for assistance, the sub-group of older people who are most likely to be potential users of formal home-based and residential aged care services are those identified as needing assistance or experiencing difficulties with self-care, mobility or communication—those with a profound, severe or moderate core activity restriction (although it is important to recognise that again only a relatively small proportion will actually use such services at any one point in time).

The kinds of conditions which result in disability and activity restrictions are also indicative of the kinds of formal services which may be required by older people. Of the 707,600 older people with a profound, severe or moderate core activity restriction, the most prevalent disabling condition was arthritis (23%), followed by other musculoskeletal conditions (13%), circulatory conditions other than stroke (10%), dementia and Alzheimer's Disease (9%), diseases of the eye (6%), stroke (6%) and respiratory conditions (5%).

These trends vary by age and sex, with the prevalence of respiratory and musculoskeletal conditions tending to decrease with age, while eye and ear problems tended to increase. The most striking age-related trend in terms of main disabling condition, however, is that for the category 'dementia and Alzheimer's Disease', the incidence of which increases from under 2% among persons aged 65 to 69 to 19% among those aged 85 and over. While this trend is consistent across the sexes, the magnitude of the increase is substantially greater among women than men (from 2% to 21% for women compared to from 2% to 13% for men). Overall, older women were also more likely than men to report arthritis as their main disabling condition (27% compared to 16%), while respiratory conditions were more common among men than women (8% compared to 4%).



Main disabling condition of persons aged 65 and over with a profound, severe or moderate core activity restriction, Australia 1998

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Data sources

Data presented here are drawn from Australian Bureau of Statistics (1999); and unpublished data from the ABS 1998 Survey of Disability, Ageing and Carers.

Older Australians as volunteers

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

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

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

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

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

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

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

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

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

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

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Data sources

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

Older people's organisations in Australia

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

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

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

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

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

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

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

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

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

The association has local branches in all States. It is a non-profit organisation staffed entirely by its

volunteer members. It publishes a quarterly journal, *Independent Retiree*.

Contact: Association of Independent Retirees Inc.
PO Box 158, Buderim QLD 4556
Ph. (07) 5445 3310

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

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

Contact: Australian Pensioners' and Superannuants' Federation,
Level 3, 25 Cooper St,
Surrey Hills NSW 2010
Ph. (02) 9211 7711
Fax (02) 9211 7230
Email: secretary@apsf.org.au
Web site: http://www.apsf.org.au

In preparation for the International Year of Older Persons in 1999, Australian Coalition '99 has been formed under the leadership of Council on the Ageing (Australia). It is a coalition of partnerships between older people in Australia and other countries, organisations of older people, community, business, government and other organisations which include interests of both younger and older people. Membership consists of partner organisations which operate at a national level. As at October 1998 there were 62 national partner organisations and the total partner tally was 626. The partners have established a National Coordinating Committee to plan Australia's involvement in the International Year of Older Persons in 1999. Coordinating committees have also been convened at State level.

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

Contact: Australian Coalition '99
c/- Level 2, 3 Bowen Crescent,
Melbourne VIC 3004
Ph. (03) 9820 4463
Fax (03) 9510 7355
Email: ac99nat@vicnet.net.au
Web site: http://avoca.vicnet.net.au/~ac99

Other organisations with substantial older membership include the:

Older Women's Network (Australia), ph. (02) 9221 4618;

Returned & Services League of Australia, ph. (02) 6248 7199;

Alzheimer's Association Australia, ph. 1800 639 331;

ARPA Over Fifties Association Ltd., ARPA ph. 1800 033 262;

Country Women's Association, ph. (02) 9358 2923;

Carers Association of Australia Inc., ph. (02) 6288 4877;

Arthritis Foundation of Australia, ph. (02) 9552 6085.

Healthy ageing

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

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

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

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

The HSOP and other Australian studies show that the vast majority of older people find their lives satisfying and they frequently feel happy. Indeed, on this evidence the prevalence of depression is very low among older people, except for the relatively small proportion who live in residential care. While most people in middle and older age groups have mixed feelings about the future, four out of five report positive aspects about growing old.

Older people's opportunities to live satisfying lives can be limited by economic and social circumstances which are amenable to public intervention. Those who live alone are especially

Positive aspects about growing old, 1994 (%)

	Men	Women	Total
More freedom/time	36	46	41
Can do what you want to do	25	36	30
Gaining experience/wisdom/knowledge	27	20	24
Being more in control/calm	11	16	13
Other	26	28	26
No positive things	21	16	21
Don't know	1	2	1
Total (N)	**689**	**726**	**1,415**

likely to report financial strain as a major problem (Kendig et al. 1996; Shanahan 1994). Barriers to continuing social and physical activity include having to give up driving, poor public transport, and inaccessible shops and facilities. Older people can be vulnerable particularly to financial crimes, and fear of crime prevents some from leaving home at night.

Healthy ageing means that older people are able to be independent and active participants in Australian society. Research has shown that older people deliver substantial (but largely unrecognised) benefits to their families and communities (Kendig & Browning 1997). Between a third and a half of older people are engaged in voluntary work at any time. They commonly provide both goods and services to family members, including assistance with child-minding. Much of the caregiving to older people is in fact done by other older people. While many older people accept the widespread negative stereotypes about older people, reinforced by the mass media, others have called for a more assertive defence of their rights; they believe that older people should receive more community recognition (Shanahan 1994).

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

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

There presently is renewed momentum for stimulating healthy ageing. State Governments, including Offices on Ageing and Health Promotion Foundations, have led interventions on positive ageing and healthy lifestyles. For example, a Victorian all-party State Committee recently produced a report from the Inquiry into Planning for Positive Ageing (1997). The national Healthy Seniors Initiative, an electoral initiative of the Commonwealth Government, is developing a wide-ranging strategy for bringing about a more 'age-friendly' society. Australian Coalition '99, an alliance of advocacy groups and aged care providers, emphasised the role of healthy and positive ageing as a centrepiece for public action during the International Year of Older Persons in 1999.

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Shanahan P 1994. An optimistic future: attitudes to ageing and well being into the next century. Canberra: Office for the Aged, Department of Human Services and Health.

Walker-Birckhead W 1996. Meaning and old age: time, survival and the end of life. Lincoln Papers in Gerontology No. 35. Melbourne: La Trobe University, Lincoln Gerontology Centre.

Data sources

Data presented here are drawn from Shanahan (1994).

The National Strategy for an Ageing Australia has identified healthy ageing as one of its four major themes requiring consideration of 'the impacts of, and potential policy responses to, ageing'. The National Strategy is the Commonwealth Government's key response to the International Year of Older Persons. The National Strategy has identified falls prevention, regular exercise and better use of medications as important areas for consideration, as well as general exploration of the potential for promoting health in old age (Bishop 1999).

Carers

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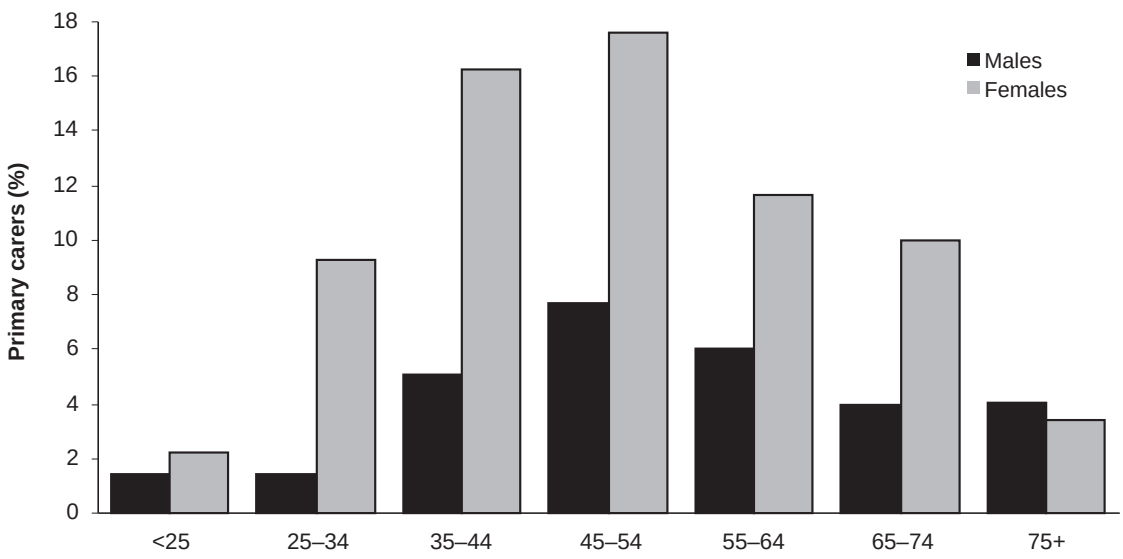
With the growing emphasis on home-based care, informal care by family, friends and neighbours is increasingly being recognised as an important source of support to people of all ages. Carers play a key role in maintaining frail older people in the community and the need for this support appears set to increase in the future. According to the 1998 Survey of Disability, Ageing and Carers there were some 450,000 primary carers providing assistance to people with a profound or severe core activity restriction, that is, people who required help in the areas of self-care, mobility or communication.

The great majority (79%) of primary carers aged 15 and over provide care to people living in the same household. Of these co-resident carers, most were caring for a partner (54%) or a child (26%), with a further 15% caring for a parent. The pattern is quite different for non-resident primary carers, however. Most non-resident primary carers were providing care to a parent (63%) or to a person who was neither their partner, parent or child (32%). Non-resident primary carers were most commonly daughters, while co-resident primary carers were most commonly spouses.

Variations exist in the age and sex profiles of primary carers. Women comprise over two-thirds (70%) of all primary carers and outnumber men across all age groups except the very oldest (75+). While most primary carers of both sexes were aged between 35 and 64 (63% of men and 65% of women), the age distribution of female primary carers tended to be somewhat younger than their male counterparts. Nearly half (48%) of female primary carers were aged between 35 and 54, compared to 43% for male primary carers. Conversely, only 19% of female primary carers were aged 65 and over compared to 27% of male primary carers. Overall, 22% of all primary carers were aged 65 and over.

Almost two-thirds (65%) of male carers provided care to their partner, while among female carers the proportion was significantly lower at 34%. Over half of all female carers provided care to children (27%) and parents (27%). Among older carers (those 65 and over), 96% of male carers were caring for a partner compared to only 63% of female carers.

Most primary carers reported their health as good (40%), very good (27%), or excellent (13%),



Age and sex profile of primary carers, Australia 1998

though almost one-quarter reported their health as either fair (17%) or poor (6%). Overall, female carers reported better health than their male counterparts with only 21% of women reporting their health as fair or poor compared to 29% of men. Perhaps not surprisingly, younger carers reported better health than older carers, with 47% of carers aged 15 to 44 reporting their health as either very good or excellent compared to 37% of those aged 45 to 64 and 27% of those aged 65 and over.

While most primary carers reported relatively good health, a notable one in three were themselves classified as having a mild (13%), moderate (12%), or severe or profound (9%) core activity restriction. Among primary carers aged 65 and over, the proportion with some degree of core activity restriction rises to one in two.

In terms of time spent caring, 38% of primary carers had spent less than five years in the caring role, 29% had spent between five and nine years, 23% had spent between 10 and 20 years, and 10% had spent in excess of 20 years in the caring role.

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Formal and informal care

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One of the more important policy developments in Australia over the last decade has been the shift in the balance of care away from residential care and towards home-based care. While older Australians continue to rely on family and friends for the vast bulk of the assistance they need, the increased availability of formal community-based and domiciliary services has resulted in greater opportunities for frail older people to remain living in the community. Data now available from the 1998 Survey of Disability, Ageing and Carers conducted by the Australian Bureau of Statistics provides information on the need for and receipt of assistance across a range of personal care and everyday activities among older Australians (65 and over) living in the community.

In 1998, there were an estimated 887,900 persons aged 65 and over and living in the community who reported a need for help with at least one activity (about 42% of the estimated 2.1 million older Australians living in households). Of these, two-thirds (67%) reported that their needs were fully met and over one-quarter (29%) reported that their needs were partly met; only 4% reported that they received no assistance whatsoever.

The most common areas in which older people reported that they needed assistance were property maintenance (71% of all those reporting a need for assistance with any activity), transport (51%), housework (46%) and health care (42%). Taking each area in turn, the majority of older people reported that their need for assistance was fully met (at least 80%, except in the case of property maintenance where the proportion was 78%). For meal preparation and paperwork, over 90% reported that their need for assistance was fully met. The areas with the highest proportions of older people reporting that their need for assistance was not met at all were transport (12%), communication (11%) and self-care (9%).

The vast bulk of assistance received by older people in the community is provided by the informal care network. Among those receiving some assistance, 83% received help from informal providers such as family, friends and neighbours, 59% received help from formal providers (including government organised as well as private for-profit and private not-for-profit agencies), and 43% received assistance from both informal and formal sources. The highest proportions receiving help from informal providers (at least 90%) were those receiving assistance with personal care activities such as self-care, mobility and communication, and with paperwork and transport. The lowest proportions receiving informal assistance were in the areas of health care

Older persons in households, extent to which need for assistance is met, and provider type, Australia 1998 (%)

	Extent to which met				Provider type			
	Fully	Partly	Not at all	*Total (N)*	Informal	Formal	Both	*Total (N)*
Self-care	86.0	*5.0	9.0	155,000	90.3	25.0	15.3	141,100
Mobility	81.4	12.7	5.9	275,000	95.3	19.8	15.0	258,600
Communication	86.2	n.p.	*11.0	28,300	100.0	n.p.	–	25,200
Health care	85.1	9.0	5.8	376,000	48.7	67.4	16.1	354,100
Transport	80.6	7.6	11.8	453,900	93.1	16.2	9.3	400,500
Paperwork	91.1	*4.7	*4.2	144,300	96.7	8.0	4.7	138,200
Housework	83.2	12.6	4.3	403,900	72.7	45.9	18.6	386,700
Property maintenance	77.5	17.2	5.3	626,100	71.2	48.1	19.3	592,900
Meal preparation	92.2	*5.7	*2.1	142,200	83.1	28.2	11.3	139,200
Any activity	67.0	29.1	3.9	887,900	83.3	59.4	42.7	853,300

n.p. Not available for publication but included in totals where applicable.

** Subject to a relative standard error greater than 25%.*

(49%), property maintenance (71%) and housework (73%). For most activities, between 10% and 20% of those needing and receiving assistance were getting help from both formal and informal sources.

Among informal providers, there are clear gender and relationship differences. Female partners and daughters dominate across most activities, with the one exception being property maintenance. While there are clear gender differences with regard to partners, the magnitude of the difference is more pronounced for daughters and sons. Daughters are from two to six times more likely than sons to provide assistance for all activities except property maintenance. Interestingly, male partners are more commonly recorded as providing assistance with housework than female partners, though this probably reflects dominant gender roles and the expectation that for women, performing the bulk of household duties is part of their routine responsibilities.

Among formal providers, government agencies and (to a lesser degree) private non-profit agencies predominate for most activities, with this pattern being most evident for self-care, mobility, transport and meal preparation. Notable exceptions are health care (the only area where more people receive help from a formal rather than an informal provider) and property maintenance, both of which show a clear majority receiving assistance from a private for-profit source. Private for-profit agencies also feature relatively prominently for paperwork and housework

It should be noted that these figures do not indicate the total amount or frequency of help provided to older Australians living in the community. For instance, the greatest number of older people in the community need and receive assistance with property maintenance, and this help is most likely to come from male relatives and private for-profit providers. Yet, the nature of property maintenance tasks means that this assistance is likely to be intermittent and discrete compared to activities such as meal preparation or personal care where female relatives and government and non-profit providers dominate. Moreover, while older people may receive 'help' in particular areas, this does not mean that they themselves are not also contributing to the completion of the relevant tasks.

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Australian Institute of Health and Welfare (AIHW) 1997. Australia's welfare 1997: services and assistance. Canberra: AIHW.

Data sources

Data presented here are drawn from Australian Bureau of Statistics (1999).

Older persons in households receiving assistance, activities by provider type, Australia 1998 (%)

	Self care	Mobility	Com-munic-ation	Health care	Trans-port	Paper-work	House-work	Property mainten-ance	Meal prepara-tion	Any activity
Informal providers[(a)]										
Female partner	36.3	20.7	37.7	38.1	10.9	27.3	21.2	15.8	29.0	20.1
Male partner	26.6	19.3	*12.3	17.2	17.0	14.5	30.6	21.7	22.0	21.3
Daughter	30.9	34.3	44.8	29.0	35.6	36.8	32.0	18.4	33.1	31.4
Son	*5.9	15.9	*7.1	9.7	16.7	13.3	13.5	27.6	9.2	24.0
Total (N)	*127,400*	*246,400*	*25,200*	*172,600*	*372,800*	*133,700*	*281,000*	*422,400*	*115,700*	*710,900*
Formal providers										
Government organised	65.7	64.0	n.p.	44.4	59.3	*40.0	60.9	14.9	51.0	46.9
Private non-profit	21.2	22.1	–	6.0	28.5	*19.1	7.7	8.6	31.4	14.7
Private for-profit	*17.8	18.4	–	55.4	18.3	*41.8	33.7	82.3	*19.4	69.1
Total (N)	*35,300*	*51,100*	*n.p.*	*238,600*	*64,900*	*11,000*	*177,500*	*284,900*	*39,200*	*506,700*
Total (N)	**141,100**	**258,600**	**25,200**	**354,100**	**400,500**	**138,200**	**386,700**	**592,900**	**139,200**	**853,300**

(a) Not all informal providers listed.

n.p. Not available for publication but included in totals where applicable.

** Subject to a relative standard error greater than 25%.*

Location of older people with a disability

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A person's care and support needs tend to impact on their living arrangements, and the distribution of older people across community and institutional settings varies in line with a range of factors including age, sex, severity of disability, and the availability of both formal and informal support networks. While the 1998 Survey of Disability, Ageing and Carers conducted by the Australian Bureau of Statistics (ABS) provides a basis for examining the living arrangements of older people generally, this discussion concentrates on the subset of older people most in need of assistance with basic activities of daily living—those with a severe or profound core activity restriction.

The vast majority of older Australians live in the community. Based on the ABS 1998 survey, only an estimated 7% of persons aged 65 and over lived in a form of cared accommodation such as a nursing home, aged care hostel or hospital. Not surprisingly, older Australians living in cared accommodation settings had markedly higher levels of disability than those living in the general community. Of the estimated 166,800 older Australians living in cared accommodation settings, 93% were classified as having a severe or profound core activity restriction compared to 15% of the 2,056,100 older Australians living in private dwellings. People in retirement villages (which comprise a range of private and non-private dwellings, including some cared accommodation) fell somewhere in between, with 49% of the estimated 84,000 residents classified as having a severe or profound core activity restriction. Despite the high levels of disability characteristic of people living in cared accommodation settings, two-thirds of older people with a severe or profound core activity restriction lived in a private dwelling in the community, while just under one-third lived in cared accommodation.

Living arrangements among older Australians also varied by age and sex. This is true of the older population generally, as well as the subset of older Australians with a serious disability. As illustrated by the two graphs over the page, the proportion of older persons with a severe or profound activity restriction living in a non-private dwelling (or establishment) increased steadily with age, and rose dramatically after age 80. While 13% of 65 to 69 year olds lived in an establishment, this rises to 22% among 75 to 79 year olds and then more than doubles to 50% among those aged 80 and over. Women were consistently more likely to live in an establishment than men, and this difference increased with age; 43% of men over 80 lived in an establishment, but 53% of women. (While 'establishments' are not synonymous with 'cared accommodation', cared accommodation accounts

People aged 65 and over, living arrangements by severity of core activity restriction, Australia 1998

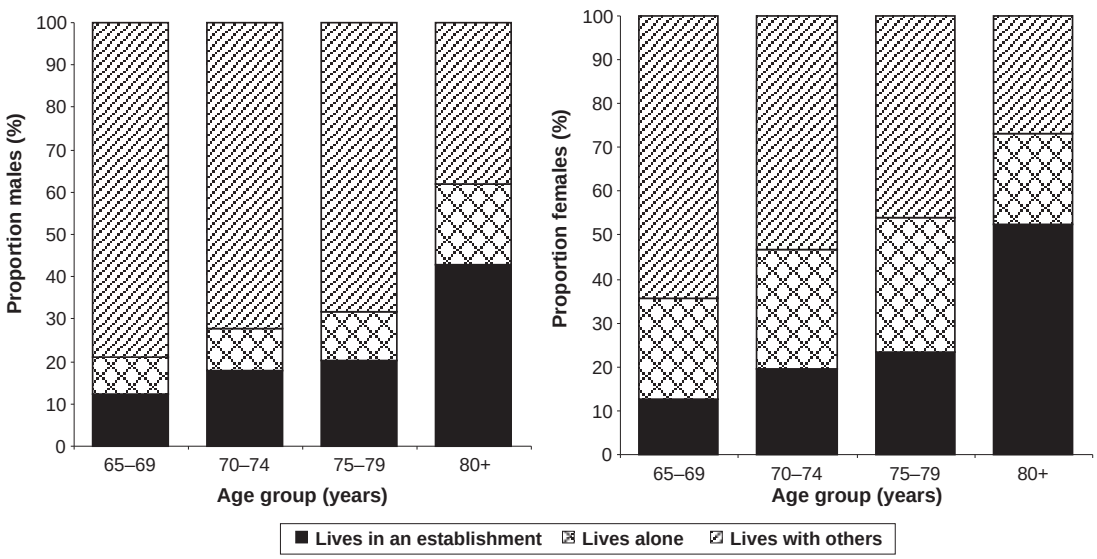
	All with a core activity restriction					
Living arrangements	**Profound**	**Severe**	**Moderate**	**Mild**	**Total**	**Total aged population**
Lives in a private dwelling						
Alone	52,400	45,500	86,800	124,600	309,400	626,300
With at least one other person	124,900	94,000	131,800	261,600	612,300	1,429,800
Total private	*177,300*	*139,500*	*218,600*	*386,300*	*921,700*	*2,056,100*
Lives in a non-private dwelling						
Cared accommodation	136,900	17,800	2,400	3,500	160,700	166,800
Other non-private dwelling	5,300	4,200	5,400	9,900	24,800	48,300
Total non-private	*142,300*	*22,100*	*7,900*	*13,300*	*185,500*	*215,100*
Total	**319,600**	**161,600**	**226,400**	**399,600**	**1,107,200**	**2,271,200**

for the bulk (78%) of older people living in establishments—the remainder being made up of other non-private dwellings such as boarding houses, hotels etc.).

The incidence of living alone also increased with age, and women were substantially more likely to live alone than men, reflecting both their longer life expectancies and the tendency for women to marry older men. The higher incidence of women living alone is particularly marked between the ages of 65 and 79 (33% of women compared to 17% of men), whereas among those aged 80 and over there is some convergence between the patterns for women and men (38% and 30% respectively).

This same trend emerged among those with serious disability: at age 65 to 69 one in four women with a severe or profound activity restriction lived alone compared to one in twelve men with a comparable level of disability; at age 70 to 74 the figure was one in four women to one in ten men; and, by ages 75 to 79, one in three women compared to one in nine men. After age 80, women and men with a severe or profound activity restriction have a roughly comparable chance of living alone, at around one in five.

In absolute terms, while women comprised 56% of the population aged 65 and over, they accounted for 66% of those with a severe or profound core activity restriction, and 78% of those with a severe or profound core activity restriction who were living alone. Not only were women more likely to have high levels of disability than men, but they were also more likely to be living alone, even at comparably high levels of disability.



Persons aged 65 and over with a severe or profound core activity restriction, sex and age by living arrangments, Australia 1998

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Data sources

Data presented here are drawn from the Australian Bureau of Statistics (1999); and unpublished data from the Australian Bureau of Statistics 1998 Survey of Disability, Ageing and Carers.

Australian Age Pension

19

The Australian Age Pension was introduced in 1909, and many of its core elements have not changed since that time. The aim of the Age Pension is to provide an adequate safety net payment to older people unable to support themselves financially in their retirement. Its primary objective is thus the alleviation of poverty. As at March 1998, the single rate of pension was $354.60 a fortnight and the married rate of pension was $295.80 a fortnight for each member of a couple.

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

The pension is both income and assets tested; it is thus targeted at those in financial need. Under the income test, the pension is reduced by 50c for each dollar of income over a specified 'free area' of income. As at July 1998, some pension was payable until income reached $820 a fortnight for single people and $1,370 a fortnight for couples (combined). Under the assets test, the pension is reduced by $3 a fortnight for every $1,000 of assets over specified limits, which vary between single people and couples, and home-owners and non-home-owners. For home-owners, the value of the family home is excluded from the calculation of assets, but a lower specified limit applies before the assets test cuts in.

The Age Pension is currently payable to men at age 65 years and women at age 61 years. Traditionally, women became eligible for the Age Pension at 60, but the pensionable age for women is being slowly increased to reach 65 years in July 2013. Of the 1.7 million people receiving the Age Pension in June 1998, 1.1 million were women; thus women outnumber men by almost two to one amongst Age Pension recipients.

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

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

Pensioners also receive additional support in the form of rent assistance (if renting privately), a pharmaceutical allowance, a Seniors Card (health services) and the pensioner concession card which entitles the holder to a range of concessions on services provided by Commonwealth, State and Local Government. From 1 January 1999, self-funded retirees become eligible for concessions available to Commonwealth Seniors Card holders such as purchasing eligible pharmaceuticals for $3.20.

Age and sex profile of Age Pension recipients, Australia 1998

Sex	60–64	65–69	70–74	75–79	80–84	85–89	90–94	95+	Total
Males	0	234,621	181,982	88,969	62,129	33,975	10,176	1,735	613,587
Females	187,256	245,263	206,492	169,787	134,286	84,545	32,900	8,502	1,069,031
Total	**187,256**	**479,884**	**388,474**	**258,756**	**196,415**	**118,520**	**43,076**	**10,237**	**1,682,618**

The Department of Family and Community Services retirement income program (incorporating Age Pension and Wife Pension for some partners of age pensioners) is one of the largest of the Australian Government's expenditure programs with some 1.7 million recipients, and total estimated outlays of $13.6 billion in 1997–98. This represents some 32% of total social security portfolio outlays.

There is also a range of benefits available to war veterans and their dependants through the Department of Veterans' Affairs (DVA). One of these is the Service Pension which is similar in many ways to the Age Pension. It is subject to income and assets tests in the same way as the Age Pension. Some 321,195 people receive this payment from DVA. The Service Pension is available five years earlier than the Age Pension, that is, at age 60 years for males and 56 years for females (the qualifying age for females is being progressively increased from 55 to 60 in a similar way to the increase in the Age Pension age for women described overleaf). Like the Age Pension, the rate of Service Pension is linked to increases in the CPI and increases in the value of Male Total Average Weekly Earnings.

The ageing of the Australian population will impose pressure on program outlays in the Family and Community Services Portfolio in the future. A number of policy responses have been undertaken to moderate the effects of the increasing number and proportion of older people in the population. There has been a greater emphasis placed on encouraging self-provision for retirement. Strategies here include encouraging greater superannuation coverage through the compulsory superannuation guarantee, the implementation of fully portable 'retirement savings accounts', the provision of free financial information for retirees and pre-retirees, and introducing other methods of innovative service delivery, such as Retirement Service Centres.

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

The extent to which an ageing population will put pressure on retirement income support programs will depend on the asset level of retiring populations. With the increasing proportion of people with superannuation coverage, it is expected that future generations of older Australians will be less reliant on the full pension and are more likely to be partly or fully self-funded retirees.

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Data sources

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Superannuation in Australia

20

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

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

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

The Superannuation Guarantee legislation requires employers to provide a minimum level of superannuation support for employees earning $450 or more per month or become liable to pay a Superannuation Guarantee Charge. The Superannuation Guarantee is being phased in over a 10-year period. In 1998–99, employers are required to make contributions equivalent to 7% of an employee's annual earnings, with this level rising to 9% in 2002–03 and subsequent years. Employees who are under age 18 and are working less than 30 hours per week are excluded from these arrangements.

As a result of these superannuation arrangements, it is expected that, in the future, most Australian workers will receive a higher income in retirement than the Age Pension alone could provide. For example, it is estimated that a person on average weekly earnings over 40 years and in receipt of 9% employer contributions over that time would experience a 100% increase in their retirement incomes relative to the Age Pension.

Initiatives to encourage and require superannuation savings have contributed to the very rapid growth in the level of superannuation assets in the Australian economy. The total value of superannuation assets has risen from around

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

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

$34 billion in 1983 to around $365 billion at the end of the September quarter of 1998. The Commonwealth Government does not mandate fund investment strategies, apart from requiring funds to meet prudential regulation requirements.

Superannuation is concessionally taxed at three levels: at the contribution stage, during accumulation and at the end-benefit stage. 'Reasonable Benefit Limits' limit the amount of concessionally taxed superannuation saving a person can accumulate over their lifetime to $471,088 where the benefits are taken in the form of a lump sum, or $942,175 where at least half the benefits are taken in the form of a pension or annuity that satisfies the relevant standards (for 1998–99, these limits are indexed).

At present, some superannuation benefits are required to be preserved in the superannuation system until retirement on or after age 55. From 1 July 1999, these rules will be tightened so that all future superannuation contributions and fund earnings will be preserved. Higher rates of tax apply to lump sum benefits taken before age 55. The government has also introduced a phased increase in the preservation age to age 60 by 2025.

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

A number of initiatives have been announced to improve the level of choice and competition in superannuation and to take account of the changing structure and composition of Australian families and the changing nature of work. These include giving employees greater choice as to the superannuation fund or retirement saving account to receive Superannuation Guarantee and award contributions; allowing a contributing spouse to receive a rebate for contributions on behalf of a non-income earning or part-time working spouse; permitting banks and other financial institutions to offer retirement savings accounts; and allowing employees earning from $450 to $900 per month to receive salary and wages in lieu of compulsory Superannuation Guarantee contributions where those contributions exceed award superannuation obligations.

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Housing of older Australians

21

Housing is a major factor in the quality of life of all people, at all ages. Older Australians are characterised by very high rates of home ownership—three-quarters of people aged 65 and over are home owners. Australia's rates of home ownership are among the highest of any of the advanced industrial countries (Kendig & Pynoos 1996). Housing therefore constitutes a significant personal, social and financial resource for many older people. Long-term residence in their own homes provides a sense of security and continuity, and a base for daily activities and social interaction in a familiar context.

Australia's high rates of home ownership in combination with a preference for suburban living have resulted in increasing numbers of older people living in family homes in residential suburbs (Kendig & Gardner 1997). At the 1996 Census, 69% of older people resided in a separate house, although this proportion was lower at older ages. At earlier ages (65–79), 77% of men and 71% of women resided in a separate house, predominantly in a couple only family. Among those aged 80 and over, the proportion living in a separate house had dropped to 61% for men, and 47% for women.

Like their younger counterparts, a substantial (albeit reduced) proportion (35%) of these older men were living in a separate house as part of a couple only family. The proportion of men living alone in a separate house was somewhat higher for the older age group; while 9% of men aged 65–79 lived alone in a separate house, the comparable figure for those aged 80 and over was 15%.

A similar pattern was found among older women, although here the proportion living as part of a couple only family in a separate house declined substantially at older ages (from 35% among those aged 65–79 to 9% among those aged 80 and over). Older women were more likely than older men to live alone and in a separate house, with 19% of women aged 65–79 and 22% of women aged 80 and over living alone in a separate house (compared to 9% and 15% respectively for men).

Living arrangement and housing type by age and sex, Australia 1996 (%)

	Males			Females			Persons		
Living arrangement/housing type	**65–79**	**80+**	**65+**	**65–79**	**80+**	**65+**	**65–79**	**80+**	**65+**
Couple only									
Separate house	51.2	34.7	48.3	35.2	9.4	28.5	42.6	18.0	37.0
Other private	9.5	11.7	9.9	7.3	3.5	6.3	8.3	6.3	7.9
Family									
Separate house	12.9	8.2	12.1	12.8	9.9	12.0	12.8	9.3	12.0
Other private	1.4	1.0	1.3	1.9	1.7	1.9	1.7	1.4	1.6
Alone									
Separate house	9.4	14.5	10.3	19.3	21.9	20.0	14.8	19.4	15.8
Other private	5.9	7.9	6.2	13.2	19.0	14.7	9.8	15.2	11.0
Other									
Separate house	3.4	3.8	3.4	3.8	5.3	4.2	3.6	4.8	3.9
Other private	1.3	1.2	1.3	1.4	1.3	1.4	1.4	1.3	1.3
Non-private dwelling	5.0	17.2	7.2	5.0	28.1	11.0	5.0	24.4	9.4
Total									
Separate house	76.9	61.1	74.1	71.1	46.5	64.7	73.8	51.5	68.8
Other private	18.1	21.7	18.7	23.9	25.4	24.3	21.2	24.2	21.9
Non-private dwelling	5.0	17.2	7.2	5.0	28.1	11.0	5.0	24.4	9.4
Total (N)	**731,253**	**157,489**	**888,742**	**859,723**	**305,625**	**1,165,348**	**1,590,976**	**463,114**	**2,054,090**

Source: 1996 Census data based on place of enumeration. Excludes missing data.

People aged 65 and over living in private dwellings: housing tenure by living arrangement, Australia 1996 (%)

	Couple only	Family	Lone person	Other	Persons		
Housing tenure	**65+**	**65+**	**65+**	**65+**	**65–79**	**80+**	**65+**
Fully owned	82.7	73.2	66.8	54.4	75.7	71.4	74.9
Being purchased	4.3	11.8	2.5	6.7	5.4	3.5	5.0
Rented: public	3.3	4.7	9.4	3.3	5.3	5.3	5.3
Rented: private	4.3	7.1	9.3	9.0	6.3	7.0	6.4
Rented: total	7.7	11.9	19.1	12.5	11.8	12.6	12.0
Other	2.4	1.2	5.0	2.5	2.5	5.1	3.0
Not stated	2.9	1.9	6.6	23.9	4.6	7.4	5.1
Total (N)	**922,502**	**281,128**	**551,293**	**106,853**	**1,511,557**	**350,219**	**1,861,776**

Source: 1996 Census data based on place of enumeration. Excludes missing data.

Home ownership is high among older people—according to the 1996 Census, among people living in private dwellings, 75% of those aged 65 and over fully owned their own homes. If those who are purchasing their homes are included the home ownership rate is 80% of older persons, significantly higher than the 70% home ownership rate for all households (i.e. those at all ages).

Home ownership rates are affected by living arrangements, with higher rates of home ownership among older people in couple only households (83%) than for older people living alone (67%). Twelve per cent of older people were renting either public or private rental dwellings in 1996. Again living arrangements are related to patterns of tenure, with older single people more likely to be renting (19%) than older couple only households (8%).

While home ownership generally confers significant financial security on older Australians, some authors state that property rates and maintenance costs may present difficulties to those living on the basic age pension. Nonetheless, in 1996, housing-related costs consumed on average only 4% of income for older owners, whereas private renters spent on average 29% of their income on housing costs.

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

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Data sources

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Retirement in Australia

22

Australia's population aged 65 years and over is projected to increase substantially into the next century. In 1997, 12% of the population was aged 65 years or over. This is projected to increase to 17.5% by 2021, rising to 23% by 2051. In the absence of any increase in retirement saving, the projected increase in the proportion of the population over age 65 could cause significant pressure on outlays and the maintenance of adequate social security payments.

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

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

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

There is an increasing trend towards earlier retirement, that is, withdrawal from the labour force before Age Pension age (currently 65 years for men and 61 years for women). According to data from the Australian Bureau of Statistics, in 1997, 77% of men and 87% of women had already retired from full-time work before they reached Age Pension age. This may be voluntary or, alternatively, given the major restructuring of the economy over recent years, many older workers may have been retrenched, with little possibility of re-entering the labour force. Further analyses of the underlying causes of the trend towards early retirement are being undertaken by the Department of Family and Community Services.

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

Age at retirement of retirees from full-time work, Australia 1997

Sex	less than 45	45–49	50–54	55–59	60–64	65–69	70 and over	Total
Males	91,100	85,600	139,900	288,800	401,900	253,300	36,300	1,296,900
Females	1,044,700	173,400	240,700	220,900	182,800	49,700	6,200	1,918,400
Total	**1,135,800**	**259,000**	**380,600**	**509,700**	**584,700**	**303,000**	**42,500**	**3,215,400**

Age regulations and qualifications governing superannuation and social security systems

55 years	Age to which superannuation entitlements are compulsorily preserved. From age 55, preserved superannuation becomes available upon retirement. For people aged 55 to 60 years, Regulations under the *Superannuation Industry (Supervision) Act 1993 (SIS)* define retirement as permanent withdrawal from the workforce. A phased increase in the superannuation preservation age to 60 is to begin in 2015 and will affect people born after 30 June 1960. By 2025, people born after June 1964 will be subject to a preservation age of 60 years. Currently, people aged 55 years and over can access a range of social security pensions and benefits depending on their circumstances, e.g. Disability Support Pension, Newstart Allowance, Carer Pension and Widow Allowance, although superannuation assets of those aged 55 and over are taken into account under the income and assets tests after 9 months on income support.
60 years	Under SIS Regulations, after age 60, retirement may be taken to have occurred upon cessation of a period of gainful employment even if the person intends to re-enter gainful employment . Current qualifying age for Mature Age Allowance.
61 years	Women's current qualifying age for Age Pension. The Age Pension age for women is being slowly increased to 65 over the next 15 years (reaching 65 years in July 2013).
65 years	Men's qualifying age for Age Pension.
70 years	People are allowed to continue to contribute to a regulated superannuation fund up to age 70, provided they are gainfully employed for at least 10 hours per week over the year.

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Data sources

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Hospital use by older Australians

23

In Australia in 1996–97 there were 704 public and 319 private acute and psychiatric hospitals. In 1996–97 Australia had a rate of 289 hospital separations per 1,000 persons, a rate higher than for the other Organisation for Economic Co-operation and Development (OECD) countries for which data were available. These higher rates are largely attributed to the inclusion of same-day admissions in the Australian data, which results in a comparatively short average length of stay (the lowest among OECD countries reporting length of stay).

Older Australians account for a large number of hospital separations. They have a higher rate of admission to hospital than the general population, and tend to stay longer. In 1996–97 patients aged 65 and over accounted for 1.6 million hospital separations (30% of all separations) and 10 million patient days (46% of all patient days). While older men and older women accounted for relatively similar numbers of separations (799,700 and 815,300), women predominated in terms of patient days (4,573,500 for men and 5,673,100 for women). This reflects the larger proportion of women than men in the older population, particularly at more advanced ages where length of stay tends to be longer.

Given the relatively small proportion of older people in Australia (12%), hospital separations and patient days per 1,000 population provide a better indication of relative rates of hospital use than do absolute numbers of separations and patient days. Hospital use is greater among older persons than the general population; the number of separations per 1,000 persons aged 65 and over was 727, compared to an overall rate of 289 for the total population. For both males and females separation rates increased markedly with age, particularly for males. While separation rates were higher for females than for males in the general population (due in part to a higher rate of admissions among women for reproductive health

Patients aged 65 and over; hospital separations and patient days by age and sex, Australia 1996–97

	Separations		Patient days	
Age by sex	**Number**	**Per 1,000 population**	**Number**	**Per 1,000 population**
Males				
65–69	219,100	651	963,800	2,864
70–74	232,200	835	1,136,900	4,086
75–79	175,400	951	1,033,700	5,605
80–84	109,000	1,019	818,500	7,647
85+	64,000	1,022	620,700	9,921
Total	*799,700*	*826*	*4,573,500*	*4,721*
Females				
65–69	186,900	529	835,600	2,367
70–74	199,500	609	1,055,400	3,224
75–79	173,600	696	1,195,900	4,795
80–84	138,400	780	1,222,400	6,892
85+	116,900	803	1,363,900	9,367
Total	*815,300*	*651*	*5,673,100*	*4,529*
Total 65+	**1,615,000**	**727**	**10,246,600**	**4,613**

care), there was a different pattern in the older population. Older men had higher hospital separation rates than older women, with these differences most prominent amongst the very old (85 and over age group). Separation rates increased at older ages for both men and women.

Similarly, older men accounted for a larger number of patient days per 1,000 population than did older women for all age groups, and these rates again increased with age for both men and women. However, the older average age of women in comparison to men results in a situation where total patient day usage rates per 1,000 of the population were reasonably similar for older men and older women (4,721 and 4,529).

Older patients generally stay longer in hospitals, on average 6.3 days compared to 4.2 days for all age groups. Older women had longer average lengths of stay in hospital than older men, 7.0 days on average compared with 5.7 days. As was the case for both separations and patient day rates per 1,000 of the population, average length of stay increased with age for older patients, especially for women. The differences between men and women were most marked amongst the very old, with men aged 85 and over on average staying for 10 days in hospital compared to 12 days for women of the same age group.

Patients aged 65 and over; average length of stay (days) by age and sex, Australia 1996–97

Sex	65–69	70–74	75–79	80–84	85+	Total
Males	4.4	4.9	5.9	7.5	9.7	5.7
Females	4.5	5.3	6.9	8.8	11.7	7.0

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Data sources

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

Hospital statistics—diagnoses and procedures

There are many reasons why older people are admitted to hospitals. The data presented here are the principal diagnosis and the main procedure performed on the patient whilst in hospital care. Principal diagnosis is defined as 'the diagnosis established after study to be chiefly responsible for occasioning the patient's episode of care in hospital' (AIHW 1998). The principal diagnosis is coded from the patient's medical records according to the International Classification of Diseases 9th revision Clinical Modification (ICD-9-CM).

The 20 most commonly reported principal diagnoses for people aged 65 and over and the general population highlight the reasons that older people are admitted to hospitals. The most common diagnosis for older Australians in 1996–97 was dialysis, reported for 9.1% of separations, followed by cataract (5.3%). Diagnoses associated with heart disease were also commonly reported (8.2%). Of the 20 diagnoses, all but general symptoms were more commonly reported in the older age groups than in the population overall. For example, cataract was the

Patients aged 65 and over; separations for the 20 most frequently occurring principal diagnoses, Australia 1996–97

Principal diagnosis	Number	Per cent
V56 Encounter for dialysis	147,651	9.1
366 Cataract	85,030	5.3
V58 Other and unspecified procedures and aftercare[(a)]	71,055	4.4
V57 Care involving use of rehabilitation procedures	58,169	3.6
428 Heart failure	35,293	2.2
411 Other acute and subacute forms of ischaemic heart disease	33,875	2.1
173 Other malignant neoplasm of skin	31,929	2.0
530 Diseases of oesophagus	26,417	1.6
715 Osteoarthritis and allied disorders	25,810	1.6
V67 Follow-up examination	23,142	1.4
427 Cardiac dysrhythmias	22,809	1.4
413 Angina pectoris	21,401	1.3
562 Diverticula of intestine	20,375	1.3
496 Chronic airways obstruction not elsewhere classified	19,934	1.2
786 Symptoms involving respiratory system, chest	19,818	1.2
410 Acute myocardial infarction	19,539	1.2
486 Pneumonia, organism unspecified	18,756	1.2
780 General symptoms	17,086	1.1
535 Gastritis and duodenitis	16,159	1.0
820 Fracture of neck of femur	16,085	1.0
– All other diagnoses	883,936	54.7
– Not stated	705	0.0
Total separations	**1,614,974**	**100.0**

(a) Includes chemotherapy.

Patients aged 65 or more; separations for the 20 most frequently occurring principal procedures, Australia 1996–97

Principal procedure	Number	Per cent
399 Other operations on vessels[(a)]	147,844	9.2
992 Injection or infusion of other therapeutic or prophylactic substance[(b)]	78,875	4.9
134 Extracapsular extraction of lens by fragmentation & aspiration technique	64,785	4.0
451 Diagnostic procedures on small intestine	52,565	3.3
452 Diagnostic procedures on large intestine	44,639	2.8
990 Transfusion of blood & blood components	28,357	1.8
815 Joint replacement of lower extremity	25,987	1.6
930 Diagnostic physical therapy	24,529	1.5
863 Other local excision or destruction of lesion or tissue of skin & sub. tissue	23,737	1.5
573 Diagnostic procedures on bladder	20,745	1.3
932 Other physical therapy musculoskeletal manipulation	20,035	1.2
454 Local excision or destruction of lesion or tissue of large intestine	19,727	1.2
870 Soft tissue X-ray of face, head and neck	19,713	1.2
372 Diagnostic procedures on heart & pericardium	18,528	1.1
602 Transurethral prostatectomy	15,616	1.0
947 Social work assessment and management	13,562	0.8
938 Other rehabilitation therapy	13,418	0.8
929 Nutritional assessment and management	11,923	0.7
931 Physical therapy exercises	11,227	0.7
135 Other extracapsular extraction of lens	11,118	0.7
– All other procedures	466,362	28.9
– No procedure or not stated	481,682	29.8
Total separations	**1,614,974**	**100.0**

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

diagnosis for 5.3% of older patients but only 1.9% of patients overall. Similarly, heart failure accounted for 2.2% of older patient separations compared with 0.8% of the total and osteoarthritis was reported for 1.6% and 0.9%, respectively. Other diagnoses such as diverticula of the intestine (1.3%), and fractured neck of femur (1%) were also typically associated with older people in 1996–97.

During hospitalisation, the most frequently reported procedures for older Australians were other operations on vessels (including haemodialyisis) (9.2%), followed by injection or infusion of other therapeutic or prophylactic substance (including chemotherapy) (4.9%) and extracapsular extraction of lens by fragmentation and aspiration technique (4.0%). Comparing the 20 most commonly reported procedures for older patients and those reported for all patients shows that all of the procedures were more frequently reported for older patients. For example, diagnostic procedures on the small intestine were reported for 3.3% of older patients but only 3.0% of all patients and diagnostic procedures on the bladder were reported for 1.3% and 0.8%, respectively. Transfusion of blood and blood components (1.8%), joint replacement of the lower extremity (1.6%) and transurethral prostatectomy (1.0%) were also more common for older patients.

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Australian Institute of Health and Welfare (AIHW) 1998. Australian hospital statistics 1996–97. Health Services Series No. 11. Canberra: AIHW.

Data sources

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

Assessment strategies

25

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

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

Today, there is a network of 125 regionally based multidisciplinary Aged Care Assessment Teams which provide services across the entire continent. Some work out of large metropolitan teaching hospitals, others work in rural areas where the 'team' comprises only the community nurse and a part-time clerical assistant. Aged Care Assessment Teams are responsible for determining eligibility for admission to residential aged care facilities and for community aged care packages (an intensive form of home-based support akin to hostel-level care). They may also recommend a range of Home and Community Care services, including the Community Options Program, although they do not determine eligibility for these latter services. The clients seen by these teams thus include a number of people requiring general advice, referral or some form of assistance in managing their ongoing care in the community.

The most recently available national data from the Aged Care Assessment Teams are for the 1996–97 financial year. During this year, 166,410 assessments were undertaken, equivalent to 108 assessments per 1,000 persons aged 70 and over in the Australian population. Of the total, 154,360 assessments were undertaken in the older population (those aged 65 and over). Among older people who were assessed, 43% were recommended for long-term residential care, with 23% being for nursing home level care and 21% for hostel level care. Clients suffering from disabilities relating to mobility, continence or orientation were more likely to be recommended for nursing home care, with almost half of the clients who had any one of these disabilities being recommended for nursing home care.

The table over the page provides an age by sex breakdown of older people who were assessed by Aged Care Assessment Teams in the period July 1996 to June 1997, and the recommendations made. People may be assessed as a result of a referral from a health or social welfare practitioner, or at their own request or that of family members.

For both men and women, the likelihood that some form of residential care would be recommended rose steadily across the three age groups. For women, the proportions range from 17 to 26% for nursing home-level care, and from 15 to 23% for hostel-level care. For men, the comparable figures were 20 to 25% for nursing home-level care, and 18 to 21% for hostel-level care. Women were less likely than men to be assessed as requiring nursing home level care in the 65 to 69 and the 70 to 79 age groups, however in the oldest age group the proportions were similar. The proportion of hostel-level care recommendations was higher among men aged 65 to 69, but higher for women than for men in the older two age groups.

While only a small proportion was recommended for intensive community-based care (community options or care packages), this is largely a

Aged Care Assessment Team clients aged 65 and over; recommendations and assessments by age and sex, Australia July 1996–June 1997 (%)

	65–69	70–79	80+	Total
Males				
% Nursing homes	19.6	21.2	25.3	23.3
% Hostels	18.4	18.4	21.1	19.9
% Community aged care packages/community options	6.3	6.3	7.0	6.7
Assessments (N)[a]	*4,769*	*19,547*	*28,776*	*53,092*
Females				
% Nursing homes	16.6	18.4	25.8	23.1
% Hostels	14.9	19.9	23.2	21.8
% Community aged care packages/community options	8.6	8.1	7.0	7.4
Assessments (N)[a]	*5,192*	*28,985*	*62,553*	*96,730*
Persons				
% Nursing homes	17.5	18.9	24.9	22.5
% Hostels	16.1	18.7	21.9	20.5
% Community aged care packages/community options	7.3	7.1	6.8	6.9
Assessments (N)[b]	**10,248**	**50,035**	**94,077**	**154,360**

(a) Data for Tasmania not available by sex.
(b) Includes total figures for Tasmania.

reflection of the relatively small numbers of aged care packages available, and the fact that Aged Care Assessment Teams do not determine eligibility for community options services. Despite these factors, the proportion of recommendations for intensive community-based care have doubled since 1994. During this period the proportion of recommendations for residential care have decreased, particularly at the older age groups.

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

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Data sources

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

Home and Community Care (HACC) program

26

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

In the years that followed, both the quantity and variety of services increased substantially. Between 1985–86 and 1991–92, expenditure on this program doubled in real terms. In addition to the more commonly available areas of home nursing, home help and delivered meals, there was an expansion of centre-based and in-home respite services, transport services, gardening, and home handyman assistance. This rapid growth has not continued in recent years, although expansion of the program has, in broad terms, been sufficient to keep pace with the growth in the size of the dependent aged population for most service types (AIHW 1999).

In 1996–97, in a sample month, there were 434 hours of home help provided per 1,000 persons aged 70 and over, 167 hours of home nursing, and 131 hours of personal care. Further details of service provision per month per 1,000 persons aged 70 and over, and the absolute levels of service provision, are given in the accompanying tables.

The HACC program includes as part of its target group younger people with disabilities as well as older people and their carers. Recent data on HACC service users indicates that most HACC clients (68%) were women, with 30% being women aged 80 and over. Overall, 41% of clients were aged 80 and over, with 30% being aged under 65. Perhaps one of the most pronounced differences in the age profiles of HACC and residential care clients is to do with the proportion aged 90 and over. Based on 1998 data across the different sectors, only 7% of HACC clients were aged 90 and over compared to 16% of residential low care and 18% of residential high care clients. For community aged care packages (which provide a more intensive form of community care) the comparable figure was 11%.

Almost one-half (48%) of HACC clients lived alone. The proportion living alone increased with age; older women were more likely to live alone than older men. Among those aged 65 to 79, 54% of female HACC clients lived alone compared to 37% of their male counterparts, while among those aged 80 and over these proportions rose to 64% for women and 43% for men. Overall, 32% of HACC clients had a resident carer, though this proportion was higher for men than for women (42%

Service provision levels by service type for a sample month, Australia 1996–97[(a)]

Service type	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Home help (hours)	135,643	306,281	84,539	75,150	29,263	22,255	5,347	6,323	664,801
Personal care (hours)	95,185	41,601	11,490	25,871	16,124	6,231	2,635	1,882	201,019
Home nursing (hours)	58,471	83,015	52,744	29,740	17,834	8,607	5,378	(c)	255,789
Paramedical (hours)	6,774	13,077	5,638	3,094	5,774	566	201	408	35,532
Home respite (hours)	121,778	41,530	37,072	16,354	34,525	6,423	6,325	3,899	267,906
Centre day care (hours)	172,891	194,555	190,862	58,887	54,205	15,586	4,805	829	692,620
Home meals (meals)	343,870	321,984	196,780	106,344	112,620	31,381	8,609	10,986	1,132,574
Centre meals (meals)	43,740	52,667	26,593	37,553	14,519	3,342	426	2,278	181,118
Home maintenance/ modification (hours)	19,760	17,475	9,330	8,382	7,571	2,540	1,464	239	66,761
Transport (people)	36,246	(b)	44,851	5,812	7,464	3,929	723	1,134	100,159

(a) Data for Western Australia has been estimated on the basis of 1993–94 levels of provision.
(b) Excludes Vic: Transport data not collected in Vic.
(c) Excludes NT: Home nursing not HACC funded in NT.

Average service provision per 1,000 persons aged 70 and over, by service type, for a sample month, Australia 1996–97[(a)]

Service type	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Home help (hours)	249	772	326	596	201	527	353	1,847	434
Personal care (hours)	175	105	44	205	111	148	174	550	131
Home nursing (hours)	107	209	203	236	122	204	355	(c)	167
Paramedical (hours)	12	33	22	25	40	13	13	119	23
Home respite (hours)	224	105	143	130	237	152	418	1,139	175
Centre day care (hours)	318	491	736	467	371	369	317	242	452
Home meals (meals)	632	812	759	843	772	743	569	3,210	739
Centre meals (meals)	80	133	103	298	100	79	28	666	118
Home maintenance/ modification (hours)	36	44	36	66	52	60	97	70	44
Transport (people)	67	(b)	173	46	51	93	48	331	88

(a) Data for Western Australia has been estimated on the basis of 1993–94 levels of provision.

(b) Excludes Vic: Transport data not collected in Vic.

(c) Excludes NT: Home nursing not HACC funded in NT.

compared to 27%), and higher among younger rather than older clients. So, while half (49%) of the female clients under 55 had a resident carer, only a quarter (24%) of those aged 80 and over had a resident carer. For men, the proportion with a resident carer decreased from 58% among those under 55 to 37% among those aged 80 and over.

In 1998 and 1999 there have been a number of major developments in the HACC program. The Commonwealth Government announced the implementation of a national fees policy for HACC services; a quality appraisal process for HACC services, based on performance against the HACC national service standards, was implemented from July 1999; a National Minimum Data Set for HACC services has been developed for implementation from July 2000; work has been undertaken on classifying the care needs of HACC clients; and the feasibility and appropriateness of establishing a national system of independent assessment of eligibility for HACC services is under review. Reports on these projects are detailed in the following bibliography.

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Care packages and community options

27

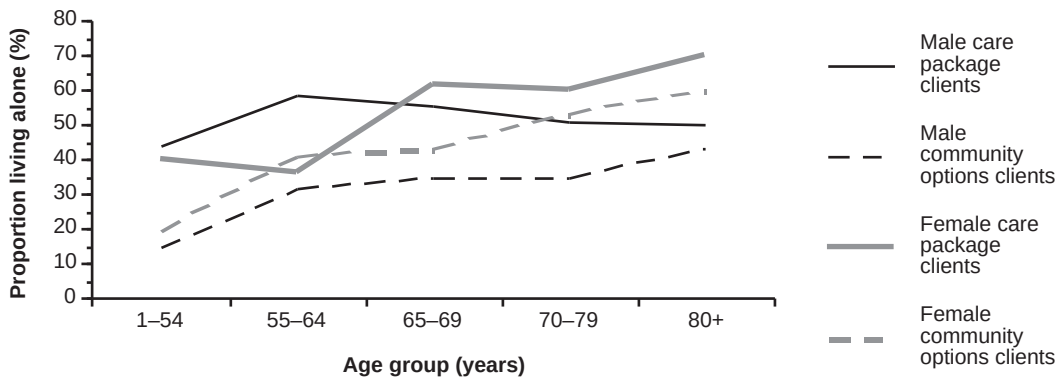
In Australia, two programs provide more intensive home-based care under brokerage-type arrangements—Community Options Projects and community aged care packages.

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

Given the success of the COPs, a potentially more ambitious scheme was launched in pilot form in 1989 to provide an alternative home-based service for older persons who would otherwise have required admission to a hostel at the 'Personal Care' level of admission. ('Personal Care' hostel residents were those who, prior to the 1997 reforms and the introduction of the new Resident Classification Scale (RCS), were assessed by Aged Care Assessment Teams as requiring admission to a hostel and assistance with specified personal care activities.) Originally termed 'hostel options', but renamed community aged care packages in 1992, this program has grown rapidly in recent years, from 527 packages in 1992–93 to 4,196 in 1995–96, and 10,046 at 30 June 1998. Community aged care packages and COPs have demonstrated that both highly dependent people and people with complex care needs can be cared for in their homes, and that effective home-based management of people requiring quite intensive levels of care is a feasible alternative to residential care.

In 1993, the capacity of the aged care system to deliver even more intensive home-based services was further tested with the implementation of a pilot 'nursing home care packages' project in South Australia. The pilot program was expanded to a maximum of 10 projects in the 1995–96 Budget, with seven additional projects having been approved as of April 1998. Now called Extended Aged Care at Home packages, the pilot program provides an opportunity to test alternatives to residential care for persons who would otherwise have required a level of care which could only be met in a high-care (previously nursing home) residential aged care facility. An evaluation of the pilot projects will test the extent to which the packages are economically viable, meet the needs of recipients and deliver a good standard of care.

COPs differ from care packages in that they are



Proportion of community care clients living alone, Australia

Source: Mathur et al. (1997)

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

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

aimed at people of all ages; not surprisingly then, 23% of community options clients were aged under 60 years, but only 4% of care package clients. A substantial proportion of both client groups were over 80 years—59% of care package clients and 37% of community options clients. Women aged over 80 years accounted for 42% of care package clients and 26% of community options clients. Overall, around twice as many women as men were being supported in their homes by these programs, with the ratio of women to men being much higher at more advanced ages.

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

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

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Data sources

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

Hostels

28

Prior to October 1997, the Australian system of residential care consisted of two discrete systems of care—hostels (for lower dependency residents) and nursing homes (for higher dependency residents). As part of the reforms implemented under the National Aged Care Strategy, however, hostels and nursing homes have now been combined into one residential aged care system. The most recent data available on the Australian residential aged care system predate this policy shift, however; thus in this and the following sheet data are presented on hostels and nursing homes as discrete systems—their use and their residents for the year 1996–97.

While hostels cater to a lower dependency clientele, the range of resident dependency was progressively increased since their inception. Initially developed as a form of supported accommodation, there has been an increasing trend towards the provision of more extensive personal care services. In 1992, this was recognised when the 'Personal Care' benefit, paid by the Federal Government on behalf of residents who require assistance, was split into three levels of payment associated with high, medium and low dependency levels. Indeed, dependency among hostel residents had increased to a point where it was estimated by the former Federal Department of Health and Family Services that as many as 20% of 'Personal Care' residents in hostels had dependency levels similar to nursing home residents in the three lower dependency classifications. (Nursing home residents prior to October 1997 were classified into one of five funding categories based on their dependency levels according to the Resident Classification Instrument or RCI.) The proportion of 'Personal Care' (residents assessed by an Aged Care Assessment Team as requiring assistance with personal care activities) to 'Hostel Care' residents (those not requiring assistance with personal care activities) has increased considerably in recent years, from 54% in 1992, to 80% in 1997.

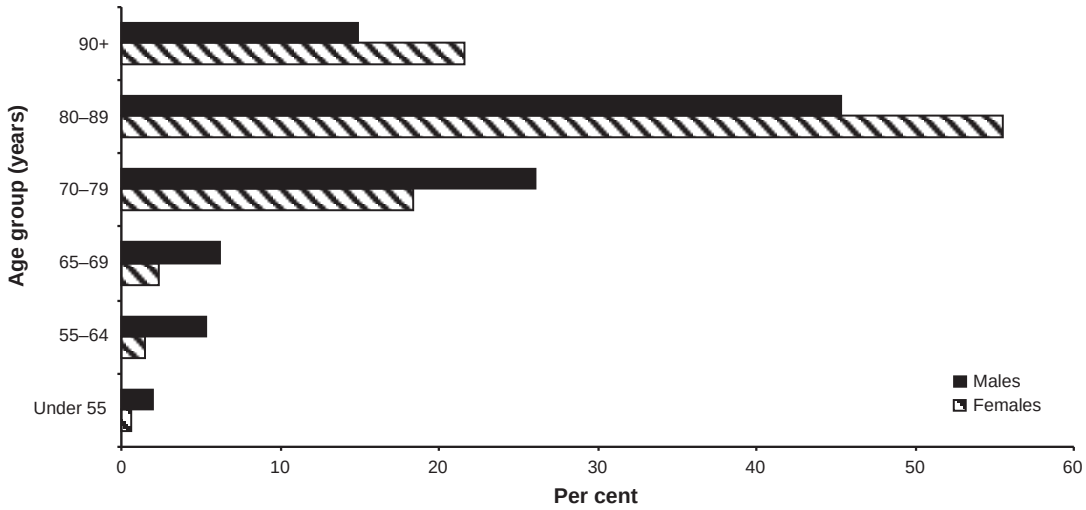
At 30 June 1997, there were 64,825 hostel places in Australia. This is equivalent to 41.6 places per 1,000 persons aged 70 and over. Over the last decade the ratio of hostel places to older people has been progressively expanded. In 1985, the

Hostel admissions and turnover, Australia 1991–92 and 1996–97

	Permanent		Respite		Total	
Year	Admissions	Turnover	Admissions	Turnover	Admissions	Turnover
1991–92	13,435	0.27	14,003	0.29	27,438	0.56
1996–97	19,900	0.31	23,507	0.37	43,407	0.68

Length of stay for recent hostel admission cohorts, Australia 1991–92 and 1996–97 (%)

	Permanent		Respite		Permanent and respite	
Length of stay	1991–92	1996–97	1991–92	1996–97	1991–92	1996–97
0–29 days	3.8	5.3	79.9	74.6	37.5	42.8
1–2 months	3.1	4.4	15.2	17.0	8.4	11.2
2–3 months	2.7	3.3	4.3	7.2	3.4	5.4
3–6 months	7.4	6.6	0.5	1.0	4.3	3.6
6 months +	83.0	80.3	0.1	0.2	46.3	36.9
Total (N)	**14,937**	**19,900**	**11,895**	**23,507**	**26,832**	**43,407**



Age and sex profile of hostel residents, Australia 1997

level of provision stood at 32.5 places per 1,000 persons aged 70 and over (in absolute terms, 34,885 places). During this same period, the supply of nursing home beds was decreased and that of home-based services progressively increased, as part of a deliberate plan (the Aged Care Reform Strategy) to reduce the reliance of the Australian aged care system on the more intensive nursing home level of care.

Perhaps not surprisingly given the large increase in the number of hostel places, the number of admissions to hostels has increased in recent years, from 27,438 in 1991–92 to 43,407 in 1996–97. There has, however, been little by way of change in the overall pattern of use by permanent residents, with a slight increase in the proportion of very short stay residents (in 1991–92, 7% of residents stayed for less than two months compared to 10% in 1996–97) and a corresponding small increase in turnover (i.e. admissions per place per year), from 0.27 in 1991–92 to 0.31 in 1996–97. There has also been a slight increase in the use of hostels for respite care, with the proportion of respite admissions growing from 51% of all admissions in 1991–92, to 54% in 1996–97. Turnover for respite residents increased over the period, from 0.29 in 1991–92 to 0.37 in 1996–97. The median expected length of stay (calculated using a life-table technique) for permanent residents admitted to hostels in 1996–97 was 758 days (over twice that for nursing homes).

While only a small proportion of the older population of Australia are resident in hostels at any one point in time (around 6% of those aged 75 and over), the likelihood that an older person will at some time enter a hostel for permanent care is much higher than that. At age 65, the probability of requiring hostel care at some point in the future is 0.20 (0.12 for men and 0.26 for women). For those who survive to age 80, the likelihood increases substantially to 0.35 (0.22 for men and 0.45 for women). Thus, at age 80, women have almost one chance in two of requiring a permanent admission to hostel care at some time before they die (AIHW 1997).

The majority of hostel residents (75%) were women, although this was most evident at older ages. Over half of the residents in hostels were women aged 80 and over. As is the case for nursing homes, there were very few younger people with disabilities accommodated in hostels (less than 4% were aged under 65), in keeping with government policy to avoid admission of younger people with disabilities to aged care facilities. The majority of residents were aged 80 and over, with 53% aged 80 to 89, and 20% aged 90 and over.

References/further reading

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Data sources

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

Nursing homes

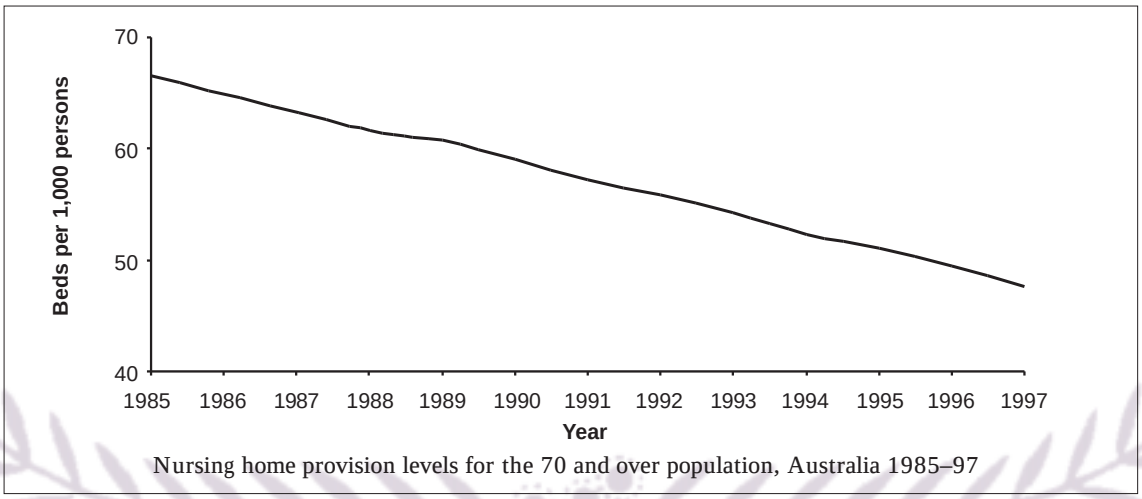
29

Prior to October 1997, the Australian system of residential care consisted of two discrete systems of care—hostels (for lower dependency residents) and nursing homes (for higher dependency residents). As part of the reforms implemented under the National Aged Care Strategy, however, hostels and nursing homes have now been combined into one residential aged care system. The most recent data available on the Australian residential aged care system predate this policy shift; thus in this and the preceding sheet-data are presented on hostels and nursing homes as discrete systems—their use and their residents for the year 1996–97.

At 30 June 1997, there were 74,233 nursing home beds in Australia, a slight reduction on the corresponding 1996 figure of 75,008. In Australia at 30 June 1997 there were 47.6 beds per 1,000 persons aged 70 and over. Over the last decade the ratio of nursing home beds to older people has been progressively reduced. In 1985, the level of provision stood at 66.5 beds per 1,000 persons aged 70 and over (in absolute terms, 71,503 beds). During this same period, the supply of hostel places and home-based services has increased, as part of a deliberate plan (the Aged Care Reform Strategy) to reduce the reliance of the Australian aged care system on the more intensive nursing home level of care.

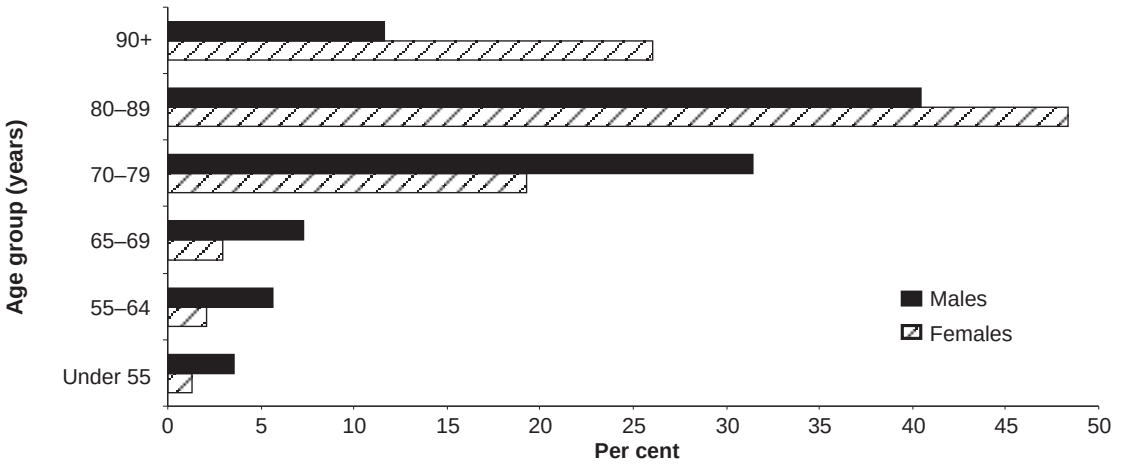
This reduction in the level of provision by 19 nursing home beds per 1,000 persons aged 70 and over, in combination with the introduction of a national aged care assessment program to control eligibility for admission to nursing homes, has led to an increase in the dependency levels of nursing home residents. Prior to the implementation of the new single Resident Classification Scale (RCS) for all residents in aged care facilities in October 1997, nursing home residents were classified according to the Residential Classification Instrument (RCI), with high dependency residents receiving an RCI of 1 and lower dependency residents an RCI of 5. Federal funding was tied to the RCI level, with nursing homes receiving higher levels of payment for more dependent residents. In 1987, 30% of permanent nursing home residents fell into the 'high dependency' categories (RCI 1 and 2); in 1997 this proportion had increased to 56%. This targeting of nursing home beds on a more dependent segment of the ageing population was an expected (and desired) outcome of a series of policy reforms, which included not only reduced supply and more systematic assessment for eligibility, but also increased financial incentives for nursing home proprietors to admit more dependent residents.

An important shift in patterns of use for nursing homes occurred over this period. There was a dramatic increase in the number and proportion of admissions for respite, rather than permanent, care. The proportion of respite admissions increased from 8% of all admissions in 1991–92, to 28% in 1996–97 (however, respite residents still account for only 1% of total bed days in nursing



Nursing home provision levels for the 70 and over population, Australia 1985–97

Prepared by the Australian Institute of Health and Welfare



Age and sex profile of nursing home residents, Australia 1997

homes). Respite admissions have a maximum length of stay of 63 days in the same nursing home in any one financial year.

One expected result of this increasing dependency among nursing home residents was a shorter length of stay, and thus an increase in turnover rates (i.e. admissions per bed per year). This shift has not transpired, however. Although the overall turnover rate in 1996–97 is higher than it was in 1991–92 (0.60 compared to 0.54), the difference is explained by the dramatic increase in the number of respite admissions. When permanent residents only are considered, the length of stay actually increased slightly among nursing home residents, with turnover dropping from 0.50 in 1991–92 to 0.43 in 1996–97.

In 1996–97, 43% of people admitted to a nursing home remained for less than two months, with a further 12% staying for between two and six months. The remaining 45% stayed for six months or more. Using a life-table technique, the median length of stay for this cohort of permanent residents (i.e. those admitted in 1996–97) was calculated to be 395 days.

While only a small proportion of the older population of Australia are resident in nursing homes at any one point in time (around 7% of those aged 75 and over), the likelihood that an older person will at some time enter a nursing home for permanent care is much higher than that. At age 65, the probability of requiring nursing home care at some point in the future is 0.33 (0.25 for men and 0.39 for women). For those who survive to age 80, the likelihood increases substantially to 0.51 (0.39 for men and 0.59 for women). Thus, at age 80, women have more than one chance in two of requiring a permanent admission to nursing home care at some time before they die (AIHW 1997).

The majority of nursing home residents (71%) were women, although this predominance of women was most evident at older ages. Over half the residents in nursing homes were women aged 80 and over. There were very few younger people with disabilities accommodated in nursing homes, in keeping with government policy to avoid such admissions. Only 2% of residents were aged under 55, with a further 3% being aged between 55 and 64. The majority of residents were aged 80 and over, with 46% aged 80 to 89, and 22% aged 90 and over.

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Data sources

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

Dependency levels among service users

30

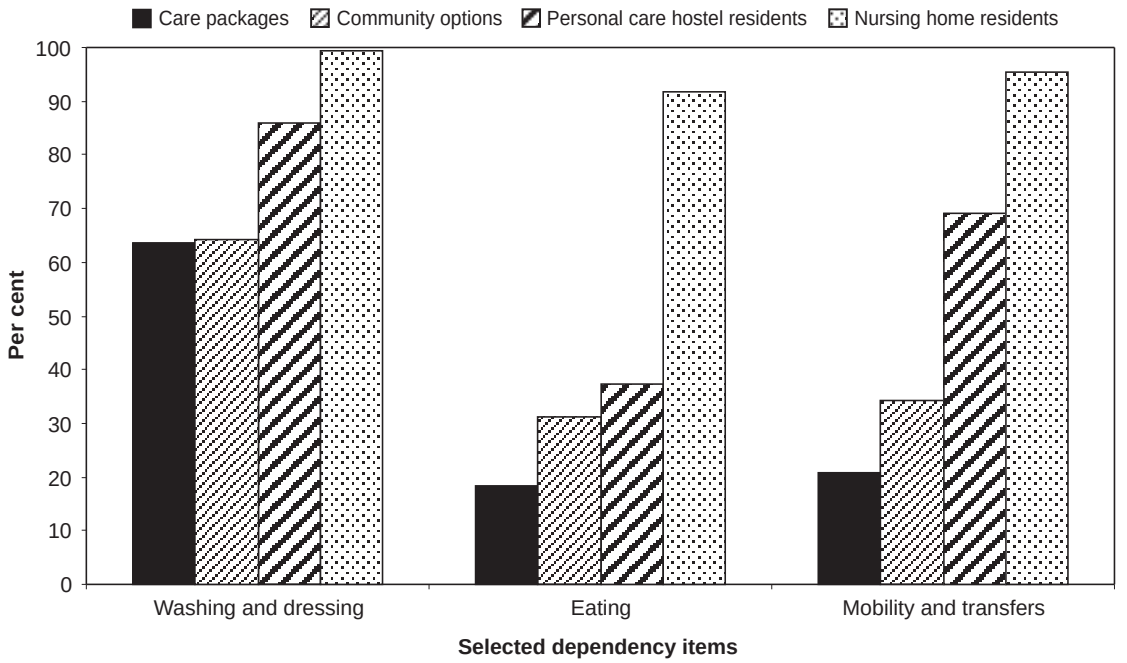
Clients of Australian aged care services may receive assistance at home through the Home and Community Care (HACC) program, or through the more intensive brokered services provided by community options or community care package services. Alternatively, they may be admitted to residential care, which prior to October 1997 was provided in either a nursing home (more intensive) or hostel (less intensive) context (see sheets 29 and 30). Within both nursing homes and hostels, there were varying levels of government subsidy associated with the dependency level of the resident, with more dependent residents attracting higher rates of payment.

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

Nursing home residents were markedly more dependent than all other client groups. Virtually 100% of nursing home residents required at least some help with washing and dressing, 92% required at least some help with eating, and 96% required at least some help with mobility and transfers. Within the nursing home population, the classifications which attract the higher subsidy (according to the Resident Classification Instrument, these are RCI levels 1–2) were indeed characterised by more dependent clients than those which attract the lower levels of subsidy (according to the Resident Classification Instrument, RCI levels 3–5). Hostel residents were also quite dependent, although less so than nursing home residents; 86% of hostel residents required at least some help with washing and dressing, 37% required at least some help with eating, and 69% required at least some help with mobility and transfers. (Only hostel residents receiving a 'Personal Care' subsidy were included in this analysis, as no dependency data was collected for the less dependent 'Hostel Care' category of residents.) Again, the classifications receiving the highest subsidy (Personal Care—High) were markedly more dependent than those receiving the lowest subsidy (Personal Care—Low).

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

	Community care clients		Personal care hostel residents (1997)				Nursing home residents (1997)		
Dependency items	Care packages (1996)	Community options (1994)	Low	Inter-mediate	High	Total	RCI 3–5	RCI 1–2	Total
Washing and dressing									
Per cent	63.7	64.2	77.6	90.7	99.9	85.9	98.7	100.0	99.4
Number	2,408	3,912	18,608	12,029	9,602	40,239	30,951	40,488	71,439
Eating									
Per cent	18.4	31.1	23.7	30.8	79.6	37.2	81.3	99.6	91.6
Number	699	1,898	5,674	4,080	7,652	17,406	25,501	40,323	65,824
Mobility and transfers									
Per cent	20.7	34.1	63.5	60.3	94.9	69.0	89.8	99.9	95.5
Number	785	2,079	15,235	7,993	9,124	32,352	28,177	40,442	68,619
Total clients	**3,793**	**6,098**	**23,986**	**13,266**	**9,614**	**46,866**	**31,364**	**40,489**	**71,853**



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

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

References/further reading

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

Data sources

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

Fitting the pieces together—the Australian system

Australia has a two-tiered system of aged care—residential aged care facilities, which offer nursing home level (high level) care or hostel level (low level) care, and a range of services which support people living in the community. It is underpinned by quality assurance mechanisms, access strategies and a national focus which ensure that appropriate services are available to all frail older people.

Protective mechanisms are built into the system to ensure equitable access to services. Residents of aged care facilities contribute to their accommodation and other living costs in line with their capacity to pay. The basic daily care fee is set as a proportion of the maximum rate income tested Age Pension so that it is affordable to all residents. From 1 March 1998 new residents who are part-pensioners or non-pensioners pay an additional income tested fee. Services certified as meeting set standards of care and accommodation can charge accommodation payments. Services must provide a set proportion of their places to residents who cannot afford to make an accommodation payment. The government pays an additional subsidy for these residents. Residential aged care facilities and community care services both provide facilities and services specifically designed for special needs groups. A special capital funding program of $10 million a year is targeted to services for residents with special needs, including Aboriginals and Torres Strait Islanders and people in rural and remote communities. Care for people with dementia is available in most residential aged care facilities as well as in specifically designed facilities.

The residential aged care sector supports a mixed economy of care. Private (for-profit) organisations provide 48% of nursing home-level care places and 3% of hostel-level care places, not-for-profit organisations provide 38% of nursing home-level care places and 91% of hostel-level care places, and State Governments provide 14% of nursing home-level care places and 6% of hostel-level care-places. Residential care places are set at a target planning ratio of 90 places per 1,000 people aged 70 and over. This is further broken down into 40 high care (nursing home-level care) and 50 low care (hostel-level care) places per 1,000 people aged 70 and over. In addition, a target planning ratio for community aged care packages is set at 10 community aged care packages per 1,000 people aged 70 and over. By 2002–03, 10% of community aged care packages will receive a higher level of funding for people with complex care needs. Access to residential care and to community aged care packages is determined by Aged Care Assessment Teams which assess medical, physical, psychological and social needs.

Nursing home-level care provides accommodation and other support services, such as domestic services (laundry, cleaning), help with performing daily tasks (moving around, dressing, personal hygiene, eating) and medical care (continuous nursing care and therapy services). Nursing home-level care targets frail older people with physical, medical or psychological care needs which cannot be met in the community and who need ongoing access to nursing care. There are approximately 75,000 nursing home-level places in Australia.

Hostel-level care provides accommodation and associated support services, such as domestic services (laundry, cleaning), assistance with daily tasks (moving around, dressing, personal hygiene, eating) and some nursing care. Hostel-level care targets less frail older people with physical, medical, psychological or social care needs which cannot be met in the community, but who do not require 24-hour access to nursing care. There are approximately 65,000 hostel-level places in Australia.

Community aged care packages support people who prefer to remain at home but who require care equivalent to that provided in hostels. A total of 540 organisations provide over 10,000 packages. A benchmark of 10 community aged care packages per 1,000 people aged 70 and over was announced in April 1998 as part of the Staying at Home initiative.

The Home and Community Care Program provides community-based support services, such as home nursing, personal care, respite, domestic help, meals and transport, to people who can be appropriately cared for in the community and can remain at home. There are 4,000 organisations providing community care services to some 240,000 clients.

Day therapy centres provide a range of services, such as physiotherapy and occupational therapy, to hostel residents and people living in the community.

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

Carers of the frail aged, that is family members and friends who assist someone to stay at home, are also a focus in the Australian aged care system. The Government's policy is to support primary carers through information services, respite services and financial assistance. A national network of Carer Resource Centres has been established to provide information and advice to carers, which complements a national network of carer respite centres which assist carers to access the wide range of respite services provided through different programs and by different levels of government. In addition, the Commonwealth Government provides financial support through the Carers Payment (a pension paid to full-time carers) and the Carers Allowance which combined the Child Disability Allowance and the Domiciliary Nursing Care Benefit (DNCB) into a single carers allowance from July 1999. The Carers Allowance is paid to carers of people living at home who qualify for nursing home-level care—this focus will remain but the eligibility criteria will be broadened under the new allowance.

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

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

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

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

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

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

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Financing the Australian aged care system

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

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

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

Residential aged care services

In its 1996 Budget, the Commonwealth Government announced major restructuring of the residential aged care system. It brings the focus back to individuals by giving service providers the funding and flexibility to meet the changing needs of consumers. Strong protections of access and care for people who are financially disadvantaged are built into the system. The reforms were implemented in the latter half of 1997. New legislation, the *Aged Care Act 1997*, provides for the reforms.

Commonwealth outlays for the new residential aged care sector have increased in real terms.

The Commonwealth Government will also provide up to $60 million over four years for capital upgrading and new facilities in rural and remote areas of Australia. This will particularly benefit Aboriginal and Torres Strait Islander communities.

Unifying the system

The cost of care of a resident is met by a combination of Commonwealth subsidy plus standard fee plus income tested fee if applicable. The Commonwealth Government pays a subsidy to service providers on a per occupied place day basis, based on the assessed dependency levels of individual residents. A new resident classification scale assesses the dependency of residents irrespective of their location in a nursing home or hostel. This ensures that residents are funded according to their care needs no matter what kind of facility they are in and allows facilities to meet residents' care needs as they change over time. The new classification scale takes an improved account of the particular care needs of people with dementia.

Income testing

The introduction of income tested fees is a key element in the re-structuring of funding arrangements in the aged care system. The income test arrangements are based on a graduated scale so that fees are set according to the capacity of each resident to pay. The standard fee for all residents is set at 85% of the full rate Age Pension (currently $21.52 per day) for pensioners and part-pensioners. Non-pensioners pay a set rate of (currently) $26.91 per day. In addition, new residents entering care from 1 March 1998 with an income in excess of the pension-free area (currently $50 per week) pay an income-tested fee of 25 cents in the dollar up to a maximum of three times the pensioner daily rate or the cost of care, whichever is the lower.

Accommodation payments

Accommodation bond arrangements were introduced for hostels 10 years ago and have worked well in enabling the hostel sector to maintain and improve the quality of hostel accommodation. Residential aged care service providers (of both nursing home- and hostel-level care) who meet prescribed building and care standards will be able to charge accommodation payments. Under legislation currently before Parliament, accommodation payments must be

used to improve accommodation and services in the facility.

- *Accommodation charges*

  Residents entering nursing home care can be asked to pay an accommodation charge of up to $12 a day if they can afford to do so. Residents can only be asked to pay the maximum of $12 a day if their assets are over $44,900.

- *Accommodation bonds*

  Residents entering hostel care can be asked to pay an accommodation bond. The quantum and timing of the bond is agreed between the service provider and resident at the time of entry. Service providers are able to draw down $2,600 per year from the bond for a maximum of five years and then retain interest earned on the principal for the duration of the resident's stay.

Resident protections

The legislation provides strong protections for residents to ensure that their access to appropriate care is based on need, not on ability to pay. Facilities are required to set aside a proportion of places for concessional (financially disadvantaged) residents. Concessional residents are not required to pay an accommodation payment and the Commonwealth Government will pay a higher subsidy on their behalf. Accommodation payment arrangements require that a resident be left with a minimum equivalent to 2.5 times the age pension (currently $23,000) in assets after paying. For incoming residents who leave a spouse, close family member or long-term carer in the family home, the home is exempt from consideration as an asset.

Quality assurance

The quality of residential aged care in Australia will be improved by the introduction of a quality assurance system based on accreditation from January 1998. A three-year transition period will be allowed for all facilities to become accredited. Accreditation will be a requirement for funding.

Community care

Home and Community Care

In the Home and Community Care program, the Commonwealth Government is maintaining real growth and announced a real increase of 5% in Commonwealth funding for 1997–98. To provide an additional source of funding and to address inter- and intra-State inequities in HACC user charges, the Commonwealth Government announced in 1996 that a national fees policy would be implemented in consultation with State and Territory Governments. The policy will ensure fair and consistent treatment of HACC clients across Australia and protect people on low incomes and those who need a number of services. Future growth in the program will be maintained at 6%, taking into account the expected increased level of user charges.

Community aged care packages

Community aged care packages are funded on a flat amount per client per day (currently $27.92), which is approximately $10,000 per year for each care package. Clients are charged depending on income, with people on the full pension paying no more than 17.5% of their income. There are requirements for providers to allocate packages to financially disadvantaged clients, and these currently make up approximately 10% of clients.

Domiciliary Nursing Care Benefit

Expenditure in respect of carers has grown significantly in the last few years under programs that have a specific carers' focus. Financial support through the Domiciliary Nursing Care Benefit has grown by around 5% in the last four years and increased by 28% in 1998–99 from $72 million to $96 milllion due to an increase in the rate of the allowance.

Respite for carers

Funding for respite services under the National Respite for Carers programs increased in 1996–97 and again in 1998–99 through expansion of these programs.

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Expenditure on aged care

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Expenditure is a key indicator of changes occurring in any service delivery system over time. Changes in the allocation of resources among residential aged care and community care are an important measure of changing patterns of service provision. In current prices, government funding on aged care and related services in 1997–98 is expected to be $3,849.8 million. Residential aged care facilities (previously nursing homes and hostels) attract by far the largest component of aged care funding, at $2,847.3 million (74%).

Aged care recurrent government funding in current prices by program, Australia 1991–92 to 1997–98 ($m)

Year	Assessment	HACC[b]	Care packages	Domiciliary nursing care benefit	Hostels	Nursing homes	Total[a]
1991–92	29.0	521.1	1.9	33.5	234.3	1,605.5	2,391.8
1992–93	31.9	573.8	3.3	40.3	274.8	1,680.9	2,605.0
1993–94	34.5	620.9	7.4	49.9	312.0	1,704.0	2,728.7
1994–95	35.1	671.3	17.7	54.0	363.1	1,804.7	2,946.0
1995–96	35.7	716.2	33.1	59.0	417.4	2,001.7	3,263.2
1996–97	35.8	764.6	51.6	65.0	478.1	2,170.9	3,566.2
1997–98	36.1	810.6	84.1	71.7	2,847.3 [c]		3,849.8

(a) Administration costs have not been included.

(b) Includes expenditure on the National Respite for Carers Program.

(c) Expenditure on nursing homes and hostels. As of 1 October 1997 nursing homes and hostels were combined into one residential aged care system.

Expenditure on aged care has increased substantially since 1991–92. Total recurrent expenditure on aged care services in constant price terms increased from $2,577.4 million in 1991–92 to $3,792.9 million in 1997–98, an increase of 47%. (The Government Final Consumption Expenditure (GFCE) deflator has been used to calculate 1996–97 constant prices for the time series data.) Between 1991–92 and 1997–98, recurrent expenditure on assessment increased by 14% in real terms, on HACC by 42%, and on residential care by 44%.

The proportion of aged care expenditure allocated to aged care assessment remained relatively constant over the period (1%), while that for HACC dropped marginally from 22% to 21%. Expenditure on community aged care packages increased dramatically, though was still less than 3% of total expenditure in 1997–98. Similarly, while expenditure on Domiciliary Nursing Care Benefits increased by more than 50% over the period, it also remains at less than 2% of total expenditure on aged care programs. Expenditure on residential care decreased from 77% to 74%, consistent with government policy to control increases in residential care expenditure, and to direct additional resources to the community care sector. Residential care expenditure, however, continues to dominate overall expenditure on aged care programs.

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

In constant prices, aged care expenditure per person aged 65 and over with a profound or severe handicap in 1997–98 was $8,074 —an increase of 4.6% from 1996–97.

Aged care recurrent government funding in constant prices[a] by program, Australia, 1991–92 to 1997–98 ($m)

Program	1991–92	1992–93	1993–94	1994–95	1995–96	1996–97	1997–98
Assessment	31.3	33.6	36.1	36.5	36.4	35.8	35.6
HACC[b]	561.5	604.6	650.2	698.5	730.1	764.6	798.6
Care packages	2.0	3.5	7.7	18.4	33.7	51.6	82.9
Domiciliary nursing care benefit	36.1	42.5	52.3	56.2	60.1	65.0	70.6
Hostels	252.5	289.6	326.7	377.8	425.5	478.1	–
Nursing homes	1,730.1	1,771.2	1,784.3	1,877.9	2,040.5	2,170.9	2,805.2[c]
Total[d]	**2,577.4**	**2,745.0**	**2,857.3**	**3,065.6**	**3,326.4**	**3,566.2**	**3,792.9**

(a) Deflated to 1996–97 prices using the 1996-97 Government Final Consumption Expenditure (GFCE) deflator.
(b) Includes expenditure on the National Respite for Carers Program.
(c) Expenditure on Nursing homes and Hostels. As of 1 October 1997 Nursing homes and Hostels were combined into one residential aged care system.
(d) Administration costs not included.

Recurrent aged care expenditure by government per person aged 65 with a profound or severe core activity restriction, in constant prices[a], by program, 1991–92 to 1997–98 ($)

Program	1991–92	1992–93	1993–94	1994–95	1995–96	1996–97	1997–98
Assessment	74	79	82	81	80	77	76
HACC[b]	1,328	1,413	1,481	1,551	1,601	1,654	1,700
Care packages	5	8	18	41	74	112	176
Domiciliary nursing care benefit	85	99	119	125	132	141	150
Hostels	597	677	744	839	933	1,035	–
Nursing homes	4,092	4,141	4,063	4,169	4,473	4,697	5,971[c]
Total[d]	**6,096**	**6,417**	**6,507**	**6,805**	**7,293**	**7,717**	**8,074**

(a) Deflated to 1996–97 prices using the 1996–97 Government Final Consumption Expenditure (GFCE) deflator.
(b) Includes expenditure on the National Respite for Carers Program.
(c) Expenditure on Nursing homes and Hostels. As of 1 October 1997 Nursing homes and Hostels were combined into one residential aged care system.
(d) Administration costs not included.

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Health expenditure on older people in Australia

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

The increase in per person expenditure at older ages was greatest for nursing homes and acute hospital services, with older Australians consuming 35% of total expenditure on acute hospital services. Expenditure on acute hospital services was 4.1 times higher for over 65 year olds than for those aged under 65. Similarly, per person expenditure for pharmaceuticals was 3.3 times higher for older people than for those aged under 65, while expenditure on medical services was 2.4 times higher and for other health services 2.1 times higher than for younger people.

Overall, health expenditure per person aged 65 and over was 4.1 times higher than the health expenditure for those under 65. In absolute numbers, per person health expenditure for the 65 and over population was $5,278, compared to $1,289 for those under 65 and $1,760 for all ages.

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

In the period 1982–83 to 1994–95, Australian real health expenditure per person grew by 2.9% per year. Only one-fifth of this increase or 0.6% per year was, however, a result of the costs associated with an ageing population. The major contributing factors to the growth in health expenditure over this period were increasing use of medical services, including new technologies, and increasing pharmaceuticals costs.

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

Age	Males	Females	Persons	Percentage of total expenditure (%)
0–14	1,991	1,841	3,832	12.2
15–24	1,199	1,748	2,947	9.4
25–34	1,224	2,393	3,616	11.5
35–44	1,314	1,961	3,275	10.4
45–54	1,386	1,768	3,153	10.0
55–64	1,712	1,736	3,448	11.0
65–74	2,386	2,401	4,788	15.2
75 and over	2,184	4,153	6,337	20.2
65 and over	4,570	6,554	11,125	35.4
All ages	**13,395**	**18,002**	**31,397**	**100.0**

Note: Total expenditure includes expenditure for persons where sex and/or age are not stated.

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

Age	Acute hospital services	Medical services	Pharma-ceuticals	Nursing homes	Other health expenditure	Total
0–14	397	180	123	2	295	997
15–24	458	209	133	2	276	1,078
25–34	612	280	151	3	234	1,279
35–44	512	296	168	5	234	1,214
45–54	638	353	221	11	246	1,470
55–64	1,032	453	404	57	372	2,318
Total 0–64	*559*	*272*	*177*	*9*	*271*	*1,289*
65–74	1,823	605	570	280	495	3,773
75 and over	2,958	701	631	2,560	705	7,556
65 and over	2,275	643	594	1,187	579	5,278
All ages	**762**	**316**	**227**	**148**	**307**	**1,760**

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Data sources

Data presented here are drawn from unpublished data from the 1998 versions of Australian Institute of Health and Welfare Disease Costs and Impact Studies and Health Expenditure databases. These data have been revised since the last set of fact sheets issued in 1997.

Government expenditure on older people in Australia

In Australia, assistance is provided to older people in a variety of cash and non-cash forms, by the Commonwealth, State and Territory Governments, local governments, the not-for-profit and for-profit sectors, volunteers, family members and friends. While a full accounting of the costs of the diverse array of services and assistance provided by these various groups must await further developments in our national data systems, it is possible to report on expenditure by Commonwealth, State and Territory Governments across key areas of provision. Such data provide a broad overview of the services and assistance provided to older people, and help to place in context some of the information provided on more specific topics in each of the fact sheets in this collection.

The Age Pension, funded by the Commonwealth Government, is paid to men aged 65 and over and women aged 61 and over, subject to a means test applied to both income and assets. Similar pensions are paid to the dependent wives of aged pensioners (the widow's and wife's pensions) and to returned service men and women (the Veteran's Pension). In total, pension payments to older people (including the Age Pension, the Veteran's Pension, the widow's pension and the wife's pension) totalled $15,700 million in 1995–96; this represented a real growth rate over the period from 1990–91 to 1995–96 of 3.5% per annum.

Public hospitals are administered by State and Territory Governments, but funded jointly by the Commonwealth and State and Territory Governments. (Private hospitals, which handle about 31% of hospital patients, are not funded by either Government; patients are either insured by a private health insurance fund or make independent out-of-pocket payments.) In 1995–96, public hospitals received around $3,900 million of public funding for services to older people. (This proportion is calculated on the basis that those aged 65 and over consumed 35.5% of hospital expenditure.)

Medical services include expenditure on consultations with general practitioners and specialists, pathology tests, screening and diagnostic imaging services. Public funding is provided through Medicare, which pays 85% of the scheduled fee set by Medicare. The remaining 15%, and any amount charged by individual practitioners above the scheduled fee, is the responsibility of the patient. In 1995–96, it is calculated that $1,600 million in public funds were expended on medical services for older people. (This proportion is estimated on the basis that approximately 24.0% of medical services were used by people aged 65 and over in that year.)

Pharmaceutical services are provided via subsidies to both concessional beneficiaries (who pay a set amount for each item, currently $3.20) and general beneficiaries (who pay a maximum of $20 for any item). The Pharmaceutical Benefits Scheme also provides a safety net that sets separate upper boundaries for both concessional and general beneficiaries, beyond which all costs for drugs for the rest of the year are met by the Scheme. The items that do or do not attract benefits under the Scheme, the basic price and the benefit level are reviewed regularly. In 1995–96, it is estimated that $780 million were expended under the Pharmaceutical Benefits Scheme on behalf of persons aged 65 and over. (This proportion is estimated on the basis that approximately 31% of pharmaceutical services were used by people aged 65 and over in that year.)

Residential care services are funded by the Commonwealth Government, but the services are provided by for-profit and not-for-profit organisations, and, in a small number of cases, by local and State Governments. In 1995–96, the Commonwealth paid some $2,600 million for residential care services to older people. (This figure represents 95% of nursing home costs and 100% of hostel costs for 1995–96.)

Expenditure on persons aged 65 and over under main program areas (1995–96)

Age Pension[a]	$15,700 million
Public hospitals	$3,900 million
Medical services	$1,600 million
Pharmaceutical services	$780 million
Residential care	$2,600 million
Home-based care[b]	$650 million

(a) Includes the Age Pension, the Veteran's Pension, the widow's pension and the wife's pension.

(b) Includes community aged care packages, Commonwealth-funded respite services, the Aged Care Assessment Program and Home and Community Care Program.

Home-based care services are those which provide care and assistance to older people living at home. These include services provided under the jointly funded (Commonwealth and State) Home and Community Care Program (HACC), Commonwealth-funded community aged care packages and other Commonwealth-funded respite services. For the purposes of this overview, expenditure under the Aged Care Assessment Program has also been included in this category. In total, this amounted to $650 million expended on home-based care services for older people in 1995–96. (This represents 100% of expenditure on community aged care packages, Commonwealth-funded respite services and the Aged Care Assessment Program, and 75% of expenditure on HACC in 1995–96.)

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Expenditure trends and international comparisons

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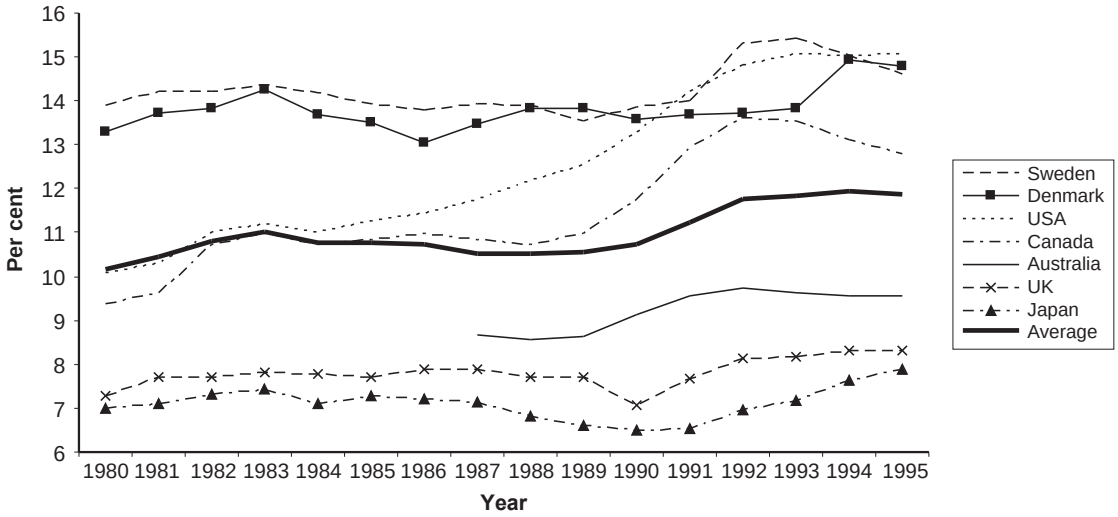
Health and government welfare services expenditures of different nations are best compared as a percentage of Gross Domestic Product (GDP). Health and government welfare services expenditure are combined here because services, especially for older people, can be classified as health services or welfare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

Between 1980 and 1995 there was an increase from 10.2% to 11.9% in the average percentage of GDP spent on health and government welfare services in selected OECD (Organisation for Economic Co-operation and Development) countries shown in the graph below. In the 1980s, most OECD countries showed a moderate growth in health and government welfare services expenditure as a percentage of GDP of 0.4 percentage points. The 1990s showed a faster growth in health and government welfare services expenditure: 1.2 percentage points in five years. Sweden recorded the highest level of health and government welfare services expenditure during the period. Denmark spent the highest as a proportion of GDP in 1989. The USA was the highest in 1991, 1994 and 1995. The USA was high because of very high levels of health expenditure. The USA has low levels of government welfare services expenditure compared to other OECD countries.

Australia's expenditure on health and welfare services as a proportion of GDP has been under the OECD average. Australia's health and government welfare services expenditure has been growing at an average rate of 1.3% per year.

The table shows health and government welfare services expenditure in 1995 as a percentage of GDP for Australia and thirteen selected member countries of the OECD. In 1995 Australia was ranked tenth, at 9.6% in percentage of GDP terms. The USA ranked highest at 15.1%, closely followed by Denmark (14.8%), Sweden (14.6%) and Norway (14%). The lowest ranked countries were New Zealand (7.6%) and Japan (7.9%).

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



Health and government welfare services expenditure for Australia and selected OECD countries as a percentage of GDP, 1980–95

Prepared by the Australian Institute of Health and Welfare

Comparison of age profiles and health and government welfare services expenditure as a proportion of GDP, Australia and selected OECD countries, 1995 (%)

Country	Proportion of the population 65+	Health and government welfare services expenditure as a proportion of GDP[(b)]
Sweden	17.3	14.6
Norway	15.9	14.0
UK	15.8	8.3
Denmark	15.1	14.8
Austria	14.7	9.2
Germany	15.2	12.4
France	15.2	11.5
Japan	14.2	7.9
Finland	14.1	11.4
Netherlands	13.2	10.5
USA	12.6	15.1
Canada	12.0	12.8
Australia[(a)]	11.9	9.6
New Zealand	11.4	7.6

(a) Australian data is for the financial year 1995–96.

(b) Only government-funded welfare services information is available from the OECD social expenditure data base, so that is all that can be provided here. In Australia government welfare services expenditure as a proportion of GDP was 1.2% in 1995–96 and total welfare services expenditure as a proportion of GDP was 1.8%.

population. The increasing proportion of older people in Australia has directly led to increases in real health expenditure of around 0.6% per year, well below the growth of GDP per person (about 1.7% per year in the last decade). While the trend to an older population will continue, the ageing population will not, in itself, require an increase in health expenditure as a proportion of GDP. However, the increasing per person provision of health services to older people may do so. Factors contributing to growth in the use of health services by all people, but especially older people, include greater expectations of being healthy and the introduction of new technologies.

Many countries (particularly in Europe) with large proportions of older people have higher levels of expenditure than younger countries. Countries like the USA, Canada and Australia have reasonably high proportions of GDP spent on health and government welfare services even though they have relatively young populations. The UK however, with 16% of the population aged 65 years and over, spent only 8% of GDP on health and government welfare services. In a recent survey on attitudes to health care by Elias Mossialos (1997), the UK recorded the highest level of support for increased health care funding among the 15 countries included in the survey.

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1999 International Year of Older Persons

The United Nations General Assembly has designated 1999 as the International Year of Older Persons (Resolution 47/5 of 16 October 1992). Australia has adopted the theme 'Australia—towards a society for all ages' for the Year.

The Commonwealth Minister for Aged Care, the Hon Bronwyn Bishop MP, has been appointed Minister responsible for the 1999 International Year of Older Persons on behalf of the Australian Government.

The International Year of Older Persons provides an important opportunity to recognise and celebrate the diversity, value and contribution of older people. In recognition of the unique opportunities the International Year affords the Australian community, the Federal Government has committed $5.9 million to ensure that 1999 results in tangible and lasting benefits for the welfare and wellbeing of older people.

The Federal Government's objectives for 1999 are to:

- encourage greater reciprocity of responsibility between the community and older people;
- recognise the significant contribution of older people to communities and families;
- build partnerships involving government, business and the community to better meet the needs of older people;
- improve, among the young, understanding of older people and their contribution to Australia; and
- promote greater responsibility by families and individuals in planning for and responding to the needs of people as they age.

Planning for the Year has occurred at a number of levels.

The Government established the Conference for Older Australians, an advisory committee on ageing, to advise Government on Australia's involvement in the International Year. Senator Kay Patterson was appointed as Chairman of the Conference.

The Conference adopted a four-pronged approach to the Year that involves:

- a national consultation process;
- a whole of Government approach, with each Federal Government department asked to look at what it can contribute;
- a focus on creating partnerships between business, professional and community organisations to achieve real and lasting benefits for older Australians; as well as
- identifying and celebrating the achievements of older people.

In preparation for the International Year, the Conference undertook community consultations around Australia to help identify practical actions that can be taken during the Year as well as some of the long-term policy issues which need to be addressed.

The consultations have been very successful in highlighting issues of interest to older people and focusing on ways governments, professional organisations, business and the community can fully recognise the contribution of older people and provide opportunities to help them remain active participants at all levels in our community. The consultations have identified some key themes and issues that will guide Commonwealth activity during the Year and provide a framework for broader community involvement. Consultations also included some specific groups in the community such as Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds and people who are growing older with disabilities.

Key themes and issues raised during the consultations include:

- attitudes/ media/ image;
- respect/ value/ volunteers;
- information/ technology/ communications;
- isolation/ security/ safety;
- wellbeing/ health/ preventative health;

- transport/ housing/ access;
- employment/ education/ skills;
- retirement planning/ retirement income; and
- access to services and goods.

The Commonwealth and States and Territories are working together through the Healthy Ageing Task Force to ensure a coordinated approach to healthy ageing and the 1999 International Year of Older Persons. The Task Force is developing an Australian vision on ageing for announcement in 1999 and has produced a draft National Healthy Ageing Strategy as one of the International Year Initiatives.

The Task Force and the Conference have worked with Australian Coalition '99, a network of community organisations and private sector companies, to link the efforts of government and non-government organisations to create a successful International Year of Older Persons.

As a key response to the International Year, the Commonwealth Minister for Aged Care has announced the development of a National Strategy for an Ageing Australia. The Strategy will provide a vehicle to examine the broad policy issues created by population ageing, as well as a framework for activities already underway to improve the wellbeing of all Australians as they age.

In the lead-up to, and throughout the Year, the Federal Government will announce a number of important initiatives to enhance the health and wellbeing of older Australians, including:

- funding of $563,000 to Australian Coalition '99 to organise and promote events for the International Year and to raise awareness about the positive aspects of ageing;
- release of the Interim Report of the Conference for Older Australians;
- development of an Australian International Year of Older Persons web site with links to related national and international sites;
- release of a Community Kit which will include practical ideas raised during the community consultations that can be implemented at the local level;
- issue of commemorative postage stamps and a special $1 coin;
- a national recognition program to acknowledge the contribution that older people make to communities and to families; and
- development of a comprehensive national information strategy involving an ongoing program of information products.

Further information can be obtained from:

Office for Older Australians
Department of Health and Aged Care
GPO Box 9848
CANBERRA ACT 2601
Ph. (02) 6289 5246
Fax (02) 6282 4412
Web site: http://iyop.health.gov.au

Australian Coalition '99
c/- Level 2, 3 Bowen Cr
MELBOURNE VIC 3004
Ph. (03) 9820 4463
Fax (03) 9510 7355
Email: ac99nat@vicnet.net.au
Web site: http://avoca.vicnet.net.au/~ac99

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