Australian Government
Australian Institute of Health and Welfare

# Pathways to permanent residential aged care

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## A Pathways in Aged Care (PIAC) analysis of people's aged care program use before first entry to permanent residential aged care in 2013–14

Australian Institute of Health and Welfare
Canberra
Cat. no. AGE 81

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ISSN 2205-4936 (PDF)
ISSN 1325-6025 (Print)
ISBN 978-1-76054-191-0 (PDF)
ISBN 978-1-76054-192-7 (Print)

**Suggested citation**

Australian Institute of Health and Welfare 2017. Pathways to permanent residential aged care in Australia: a Pathways in Aged Care (PIAC) analysis of people's aged care program use before first entry to permanent residential aged care in 2013–14. Cat. no. AGE 81. Canberra: AIHW.



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# Contents

# Acknowledgments

The authors of this report were Jenni Joenperä and Juliet Butler of the Disability and Ageing Unit at the Australian Institute of Health and Welfare (AIHW). Valuable assistance was also received from Kate Spyby, Charlie Blumer, Melissa Wilson and Nathan Wakefield.

The data were expertly linked and prepared for integration by Rosemary Karmel, Andrew Powierski and Phil Anderson of the AIHW Data Linkage Unit. The contributions of Mark Cooper-Stanbury, Felicity Murdoch and Louise York are also gratefully acknowledged.

This study was funded by the Department of Health.

# Abbreviations

| | |
|---|---|
| ABS | Australian Bureau of Statistics |
| ACAP | Aged Care Assessment Program |
| ACAT | Aged Care Assessment Team (conducting assessments under ACAP) |
| ACFI | Aged Care Funding Instrument |
| AIHW | Australian Institute of Health and Welfare |
| CALD | culturally and linguistically diverse [background] |
| CACP | Community Aged Care Packages |
| EACH | Extended Aged Care at Home |
| EACHD | Extended Aged Care at Home—Dementia |
| HACC | Home and Community Care |
| HCP | Home Care Packages [Program] |
| ICD-10 | International Statistical Classification of Diseases and Related Health Problems 10th revision |
| NACDC | National Aged Care Data Clearinghouse |
| PIAC | Pathways in Aged Care |
| PRAC | permanent residential aged care |
| RRAC | respite residential aged care |
| TCP | Transition Care Program |

# Symbols

| | |
|---|---|
| — | nil or rounded to zero |
| . . | not applicable |
| n.a. | not available |
| n.e.c. | not elsewhere classified |
| n.p. | not publishable because of small numbers, confidentiality or other concerns about the quality of the data |

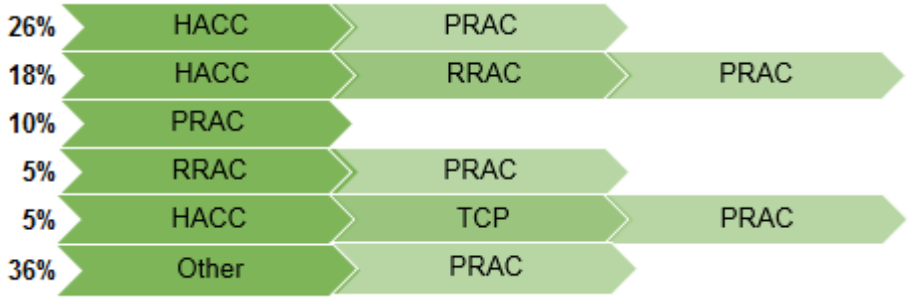
# Summary

In 2013–14, 61,300 people across Australia entered permanent residential aged care for the first time. This report presents analysis of their pathways through a range of aged care services, with a particular focus on the program last used before this transition. In all, the cohort had over 1,000 different pathways through the aged care system before entering permanent residential aged care (PRAC), using 1 or more of the following programs:

- Home and Community Care (HACC)
- Aged care packages
- Transition Care Program (TCP)
- respite residential aged care (RRAC).

**HACC was the most common point of entry to the aged care system**

The 5 most common pathways accounted for almost two-thirds of people:




Regardless of subsequent aged care program use, 76% of this cohort had first used HACC, and many of the pathways showed that people moved through aged care programs towards progressively higher levels of support.

**Respite was most likely to be the last-used aged care program prior to PRAC**

RRAC (39%) and HACC (36%) were the most common programs used last before entering PRAC. This was followed by TCP (8.2%) and aged care packages (7.0%). One in 10 (10%) people had not used other aged care programs before.

**Last-used aged care program varied according to people's demographic characteristics and health and functional status**

Compared with other common pathways, people who had used no other aged care programs before their first entry to permanent care were more likely to be male (51%, compared with 36%–37% of those who had used another aged care program before entering permanent aged care); to be aged under 65; to have limitations in all 4 core areas (*Self-care, Moving, Movement* and *Communication*); and less likely to have lived alone. Compared to other programs, people who had last used TCP were more likely to have lived alone, to have been diagnosed with heart or cerebrovascular disease or to have experienced frequent falls.

# 1 Introduction

The aged care system in Australia offers a range of different services to meet individuals' needs. The use of these services—and the transition between them—can be influenced by changes in care needs, service accessibility and personal preferences.

People generally prefer to remain living at home for as long as possible, and they may use aged care in different combinations to achieve this. Decisions about when and how to use aged care do not necessarily follow the recommendations made at the point of formal aged care assessment—one-quarter (25%) of people who were approved for aged care had not accessed any services within the following 2 years (AIHW 2011). The decision to take up a particular aged care program, or to change to a higher level of care, is triggered by a range of factors, including changes in care needs.

In particular, people's first entry to permanent residential aged care generally indicates an increased need for services, and for many people, this involves a key shift in their aged care service use. This point of transition, and the prior use (or lack of prior use) of aged care services, reflect people's demographic details, background, and health status. Examining these interactions can improve our understanding of how aged care services can best support people.

Age is a strong predictor for admission into permanent residential aged care—for example, in 1 longitudinal study of people aged 65 and over, the likelihood of entry to permanent residential aged care increased by 15% for every additional year of age (Kendig et al. 2010). As at 30 June 2016, 59% of people in permanent residential aged care in Australia were aged 85 and over, compared with 43% of people using the Home Care Packages Program (HCP) (AIHW 2017). The proportion of people aged 85 and over in each of these programs has increased over time: 10 years earlier, at 30 June 2006, just over half (53%) of people in permanent care, and 38% of those using Community Aged Care Packages (CACP), were aged 85 and over (AIHW 2007a; 2007b).

Gender is also closely associated with use of permanent residential aged care: reflecting the longer life expectancies of women compared with men, around two-thirds of people in permanent residential aged care at 30 June 2016 were women (AIHW 2017). Compared to men, women enter permanent residential aged care later in life, generally having received formal assistance through other aged care programs at younger ages (AIHW 2014a).

These gender differences may, in part, be influenced by the role of caring—people who have a carer available to provide informal care may not require formal services as early. People with a co-resident carer were less likely to enter permanent residential aged care than those with a non-resident carer, while those with a non-resident carer were less likely to have used respite residential aged care (because this program is intended to provide respite for the carer as well as for the older person themselves) (AIHW 2014a). The appropriate formal support at home can also delay people's entry to permanent residential aged care: people who used community-based aged care services took longer to enter permanent residential aged care, whereas people with no previous aged care use (or use of respite residential aged care only) were more likely to enter permanent residential aged care after an assessment (AIHW 2011).

There are also other demographic differences in how people use aged care. People from culturally and linguistically diverse (CALD) backgrounds and Aboriginal and Torres Strait Islander people may face additional barriers in accessing aged care services. For example, service use among people from CALD backgrounds may be influenced by cultural practices

and expectations around aged care; and by communication barriers, socio-economic disadvantage and lack of awareness of Australian services (FECCA 2015). Aboriginal and Torres Strait Islander people may face similar issues, as well as experiencing higher prevalence and earlier onset of many chronic health conditions that affect care needs. Compared with non-Indigenous people, Indigenous people generally use mainstream aged care services less, particularly permanent residential aged care (AIHW 2017), although this may partly be affected by under-reporting of Indigenous status among people who use services (AIHW 2012).

In general, health conditions that require ongoing nursing care and assistance may affect the level of care an individual needs. This is particularly the case with chronic or progressive conditions; for example, dementia results in higher care needs with disease progression, and is a strong predictor for entry to permanent residential aged care. One systematic review found that people with dementia had a 17-fold increased likelihood of entry to permanent care, compared to people without dementia (Luppa et al. 2010). Impaired mobility and general frailty are also associated with the need for permanent residential aged care. In particular, falls are a serious health risk that has an impact on care needs, affecting approximately 30% of older people (Gillespie et al. 2012). These—and other common conditions, such as cardiovascular disease, musculoskeletal problems and incontinence—influence the level of support required, and are common in people in permanent residential aged care (AIHW 2010; AIHW 2017; McLeod et al. 2011).

This report studies the use of other aged care programs prior to permanent residential aged care—with a particular focus on the last-used program, which can be indicative of the final transition between living in the community and living in permanent residential aged care. Here, 'other aged care programs' are Home and Community Care (HACC); community-based aged care packages (CACP), Extended Aged Care at Home (EACH), Extended Aged Care at Home—Dementia (EACHD) and the HCP; the Transition Care Program (TCP); and respite residential aged care (RRAC—in this report, commonly referred to as 'respite').

The level of support provided under these programs generally increase in this order, with HACC providing 'entry-level' support at home (including some nursing services) and the other programs providing progressively more services, or services of a time-limited but more intensive nature. Permanent residential aged care completes this picture as offering the highest level of support.

## 1.1 Pathways in Aged Care link map

The nature of the source data invariably affect any analyses that are conducted. Much of aged care reporting is drawn from administrative data, and focuses on system and program performance. The data used in this report come from the administrative data collections for a number of aged care programs that operate nation-wide (Box 1.1). These form discrete data sets, which have been linked using name-based probabilistic linkage and key-based linkage strategies, as appropriate, to create an analysis data set: the Pathways in Aged Care (PIAC) link map.

PIAC allows us to develop a broader view of aged care, highlighting the journeys people take through the system. In part, these journeys can be explained by the differences between aged care programs—with respite and TCP providing time-limited care for specific purposes, and HACC and aged care packages targeting on-going, and often increasing, need for care. However, the resulting linked data can be used to answer many complex questions about

questions about how people use aged care services, with data potentially spanning from people's initial assessment for eligibility for aged care to the end of their lives.

PIAC has recently been updated to include all program use reported from linkable data sets and deaths between 1 July 1997 and 30 June 2014. Once a person has been identified through PIAC, it is possible to obtain additional information on their service use captured in the different data collections (Box 1.1). See *Introduction to Pathways in Aged Care 2014* (AIHW 2016a) and *National Aged Care Data Clearinghouse data dictionary: version 1.0* (AIHW 2016b) for more information on common variables, the methods used to identify clients in the different data sets, associated data issues, and derivation of program use dates. An overview of the methodology used in this study is described in Appendix B.

**Box 1.1: Aged care programs included in PIAC**

**Aged Care Assessment Program**

An Aged Care Assessment Team (ACAT) carries out assessments under the Aged Care Assessment Program (ACAP) to determine people's care needs and make recommendations concerning their long-term living arrangements. In order to access residential aged care, HCP (and before July 2013, CACP, EACH and EACHD—see below) or TCP, people must have relevant ACAT approval. Approval can be given for more than 1 program at a time, approvals are no longer time-limited, and people may be re-assessed as their situation changes.

**HACC**

During the time during which the data for this report were collected, HACC also underwent changes. It provided a large range of services to support people at home and to prevent premature or inappropriate admission to residential care. An ACAT approval was not needed to access HACC services, and the program generally provided lower-level support: people with higher needs were more likely to require a HCP (or before July 2013, 1 of its predecessors).

Prior to mid-2012, HACC was funded jointly by state and territory governments and the Australian Government, with states and territories responsible for managing the program. From 1 July 2012, the Australian Government assumed responsibility for HACC services provided to older people (all people aged 65 and over, and Indigenous Australians aged 50–64), which became known as 'Commonwealth HACC' (states and territories continued to fund and administer HACC services for people under this age). These arrangements did not extend to Victoria and Western Australia, where HACC services for people of all ages continued to be delivered as a jointly-funded program (and this remained the case when Commonwealth HACC was incorporated into the newly-launched Commonwealth Home Support Programme from 1 July 2015).

Where this report refers to 'HACC', this includes both Commonwealth HACC and its Victorian and Western Australian equivalents. HACC was the largest program included in this report.

**Aged care packages**

Community-based aged care packages have undergone changes in recent years. The HCP now provides support at 4 levels of care for people living at home. In August 2013, it replaced 3 different community-based aged care packages programs: CACP, which corresponds to HCP level 2; EACH, which corresponds to HCP level 4; and EACHD, which also corresponds to HCP level 4.

(*continued*)

**Box 1.1 (continued): Aged care programs included in PIAC**

Many of the people who received community-based aged care packages before entry into permanent care during 2013–14 would have received services under 1 or more of the pre-July 2013 programs. (Note that the term 'aged care packages' used throughout this report refers to these 4 collectively). Where reference is made to the level of care at which packages are offered, 'low' level of care includes CACP and HCP levels 1–2, and 'high' includes EACH, EACHD and HCP levels 3–4.

**Transition Care Program**

TCP provides short-term care to older people leaving hospital, and it aims to improve recipients' independence and functioning to delay their entry into permanent care. Access requires an ACAT approval, which must assess the person as medically stable, able to benefit from the program, and eligible for residential care if they applied for it. The person must be concluding an in-patient hospital episode (and still be in hospital). Care can be provided in the community or in home-like residential facilities. For the purposes of this study, the setting in which care was provided is not distinguished. TCP was the smallest program included in this report.

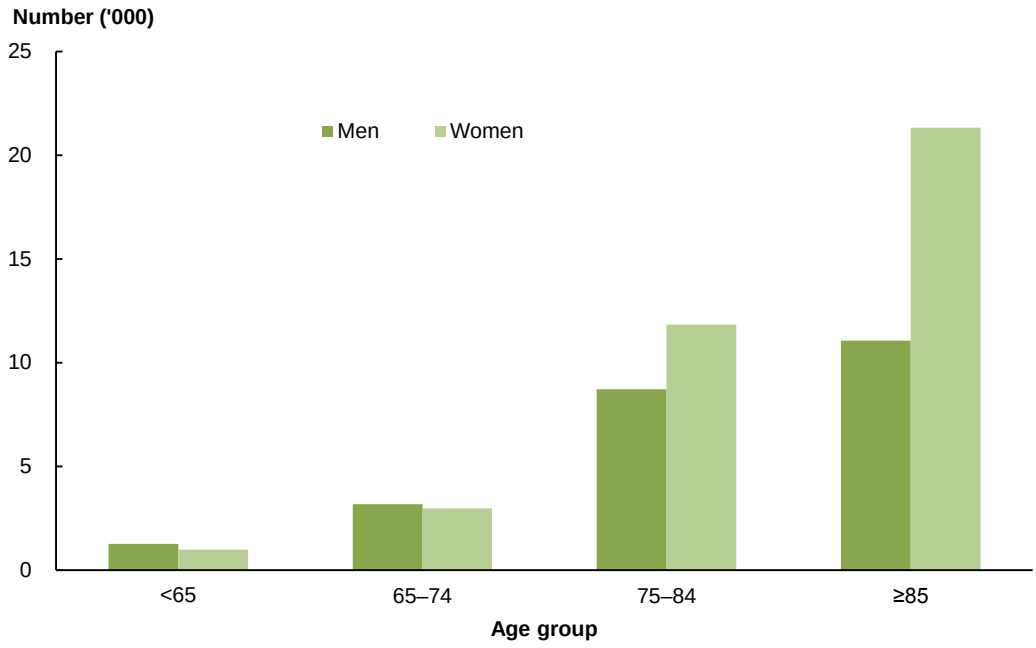
**Residential aged care**

Residential aged care provides permanent care in residential aged care facilities for people who have frailty or disability (such as medical conditions or loss of physical, cognitive or social functioning) and can no longer be supported to live at home, as well as time-limited respite care for people still living at home. After entry to permanent residential aged care, people's care needs and health conditions are assessed using the Aged Care Funding Instrument (ACFI).

This report uses the updated PIAC link map to examine which aged care programs people used before first entering permanent residential aged care, and what factors influence patterns of service use. It provides an overview of the characteristics of the cohort for this study (people who first entered permanent residential aged care in 2013–14), focusing on their demographic details, as well as on key aspects of their living arrangements and some of their care needs and health conditions. Program use prior to first entry into permanent residential aged care is captured through people's use of respite residential aged care; HCP (and of CACP, EACH and/or EACHD before it); HACC; and TCP. The most common combinations of different patterns of use are explored further, and a brief overview is provided of what happened after people first entered permanent care.

## 1.2 People in the cohort for this report

There were 61,332 people who entered permanent residential aged care for the first time in 2013–14. Less than 4% of them were aged under 65 on their entry, with those aged 85 and over accounting for over half (53%) of the cohort. Overall, 61% were female, but the proportion varied between age groups: under half (44%) of those aged under 65 were women, rising to two-thirds (66%) of those aged 85 and over (Figure 1.1, Table A8).




*Source:* Table A8.

**Figure 1.1: People who first entered PRAC in 2013–14, by age and sex**

Just 455 people—or 0.7% of the cohort—identified as being of Aboriginal or Torres Strait Islander background. Reflecting the younger age at which Indigenous Australians often enter permanent residential aged care, 1 in 3 (33%) were aged under 65 at the time of their first entry, compared with 1 in 30 (3.5%) for other Australians. Selected other characteristics of interest for the full cohort are described below (Table 1.1). For more information on how stable demographic variables were derived for analyses, see Appendix B6.1 in *Patterns in use of aged care 2002–03 to 2010–11* (AIHW 2014a).

**Table 1.1: People who first entered PRAC in 2013–14, by selected characteristics**

| | | | |
|---|---|---|---|
| ***Region of birth*** | | ***Preferred language*** | |
| Australia | 70% | English | 91% |
| United Kingdom/Ireland | 11% | European languages | 7% |
| Southern and Eastern Europe | 10% | Other | 2% |
| Western and Northern Europe | 3% | High degree of English proficiency[(b)] | 82% |
| Other | 6% | | |
| ***Usual accommodation***[(a)] | | ***Recommended long-term accommodation***[(a)] | |
| Private residence (owned/mortgaged) | 69% | Residential aged care | 74% |
| Private residence (rented) | 13% | Private residence | 22% |
| Retirement village (self-care unit) | 13% | Retirement village | 2% |
| Other/unknown | 6% | Other/unknown | 2% |
| ***Carer status***[(a)] | | ***Current living arrangements***[(a)] | |
| Had a carer | 85% | Lived alone | 49% |
| *Co-resident carer* | *42%* | Lived with others | 49% |
| *Non-resident carer* | *44%* | Unknown/not applicable | 2% |
| No carer | 13% | | |
| Unknown/not applicable | 2% | | |

(a) At the time of their most recent ACAT assessment which provided approval for PRAC.

(b) Includes people born in Australia and those who are rated 1 for English-language proficiency.

Living arrangements differed further by age, with the proportion of people who had a carer available increasing for each age group (68% among those aged under 65, compared with 88% among those aged 85 and over). By contrast, the proportion of people who had a co-resident carer decreased for each age group (43% among those aged under 65, compared with 37% among those aged 85 and over) and the proportion with a non-resident carer increased (25%, compared with 51%).

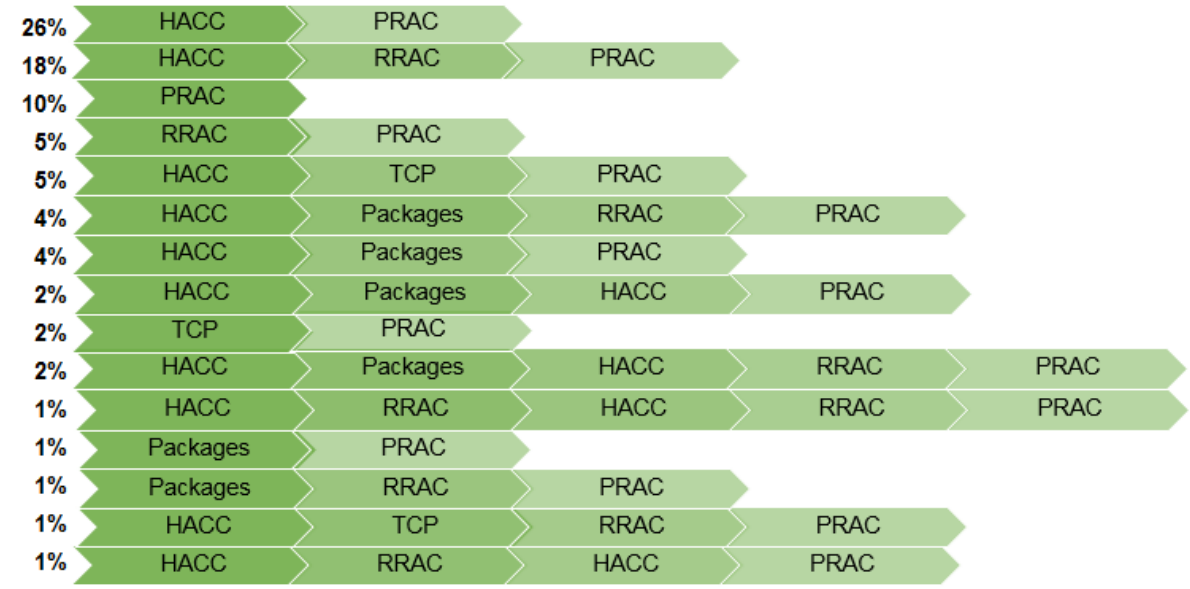
The nature of the relationship between the carer and care recipient also varied: among co--resident carers, ‘spouse or partner’ was most commonly the person to provide care (59%), but among carers who did not live with the care recipient, this was more likely to be child or the child’s partner (80% of non-resident carers).

# 2 Pathways before first entry

## 2.1 Broad patterns in the use of other aged care programs

Between the 61,300 people who first entered permanent residential aged care in 2013–14, there were 1,007 different pathways through the aged care programs covered by this report. (Note: episodes of care are ordered by their start date; changes within packaged care—such as moving from CACP to a HCP level 1–2 package—have been overlooked; and the interval between programs is not taken into account. Concurrent use of programs is not included in these pathways, nor are the pathways of people who did not enter permanent residential aged care; these may vary greatly from those shown here. More information on methodology is available in Appendix B.)

However, 83% of the cohort used the 15 most common pathways to permanent residential aged care, and the most common 3 pathways accounted for 54% (Figure 2.1, Table A1). Many of these showed a pattern of moving 'up' through aged care programs, for example, from entry-level services provided by HACC to progressively higher levels of support and permanent residential aged care—although some people also move back and forth between programs as their need for support changes.




*Source:* Table A1.

**Figure 2.1: Patterns of aged care service use before first entry to PRAC in 2013–14, 15 most common pathways**

While the 3 most common pathways were the same for men and women, men were slightly more likely to have taken 1 of these (57%, compared with 52% of women). This decreased as age increased for both sexes—75% of men aged under 65 took 1 of the 3 most common pathways, compared with 70% of women aged under 65, and this decreased to 55% of men aged 85 and over and 51% of women. Similarly, people who were born in Australia were slightly more likely to have taken 1 of the 3 most common pathways before entering permanent care (55%, compared with 51% of those born in the United Kingdom or Ireland

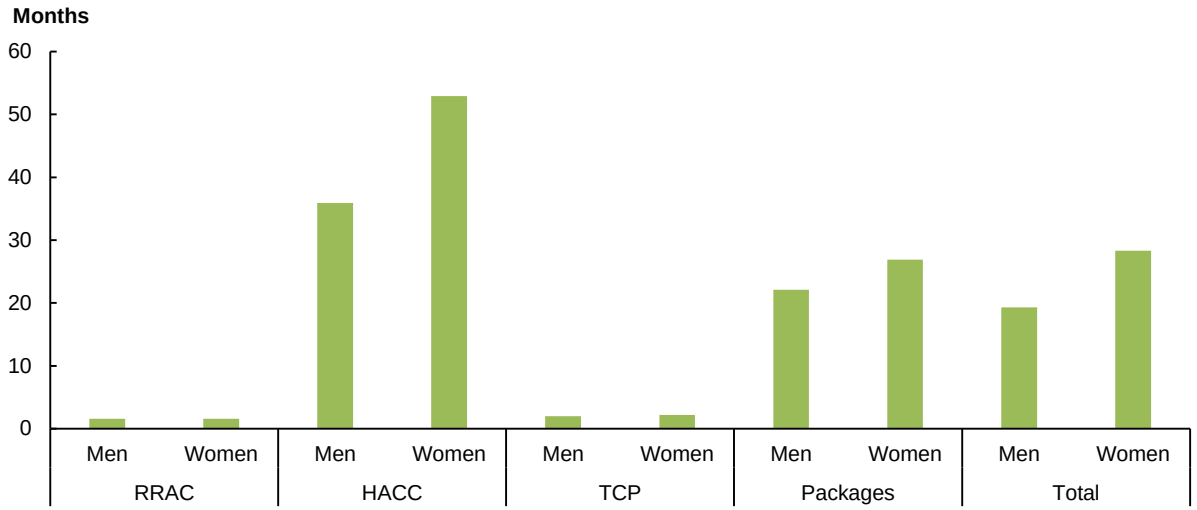
and 52% of those born elsewhere in Europe). These may reflect the relatively 'straighter' pathways certain groups of people take to permanent residential aged care, which reduces variation in the number of pathways taken—men, people aged under 65, and people born outside of Australia had a smaller number of pathways before their first entry to permanent residential aged care in 2013–14.

Around 48,900 (80%) of people who first entered permanent residential aged care in 2013–14 had used HACC at some time previously. Many had also used respite (27,600 people, or 45%); aged care packages (15,600 people, or 25%) and/or TCP (10,100 people, or 16%). For the cohort analysed in this report, the mean number of programs ever used was 4.2 (which may include any program used after first entry to permanent residential aged care); and there was a mean of 3.5 among those who were aged under 65 on their first entry to permanent residential aged care, rising to 4.3 among those aged 85 and over. On average, people only used each program once: where people had used a particular program before permanent residential aged care, the mean number of episodes of use was between 1.1 and 1.2 for all 4 programs.

In fact, while some people had complex patterns of use, and combinations of different programs were common, many people had a very simple pathway to permanent residential aged care: 26% had only ever used HACC before first entering permanent care, 10% had no prior use of any other program, 5.3% had used only respite care, 1.7% had used TCP only, and 1.1% had used aged care packages only. On the other hand (focusing on the point of entry to aged care and ignoring the variation in subsequent use), for three-quarters (76%) of the cohort, the first aged care program people ever used was HACC. Of people who eventually entered permanent residential aged care in 2013–14, respite was the first program for 6.9%; aged care packages for 3.9%; and TCP for 3.5%.

## Lengths of stay

On average, people in the cohort had used other aged care programs for more than 2 years before they first entered permanent residential aged care. Reflecting the fact that people were most likely to have begun using aged care through HACC, they had also used HACC the longest. In the years before they first entered permanent residential aged care, people's mean total length of stay with HACC was 47 months, or almost 4 years, while they had used packages for around half as long (25 months, or just over 2 years). TCP was used for an average of 2.1 months and respite for 1.6 months (Figure 2.2, Table A2). More information on how total lengths of stay for each program and the lengths of stay for individual episodes for the last-used program were defined is available in Appendix B.




*Source:* Table A2.

**Figure 2.2: Average length of stay (months) for other aged care programs before first entry to PRAC in 2013–14, by program**

Dates of use for HACC, in particular, must be interpreted cautiously, because the exact beginning or end of a person's HACC service use may differ considerably from the administrative data recorded, and information is collected quarterly which further affects data quality. Another way of looking at people's contact with HACC services over time is the timing of their first HACC assessment. However, this only provides another approximate measure, as people may not have taken up HACC services at the time of their first assessment for it (ACAT approval is not required to access HACC, although ACAT assessments may direct people to HACC) and people may not have used HACC services consistently in the time since they were assessed for them. Almost 1 in 4 (24%) people in the cohort had no record of having undertaken a HACC assessment. However, for 26% of the cohort, their first HACC assessment was in 2005 or earlier, while 9.6% had their first assessment in 2013 or later.

## 2.2 Most recent ACAT assessment

People may have multiple ACAT assessments over time to assess their need for care, and at any 1 of them people may be given approval for 1 or many types of aged care, and there is no obligation to take up the care approved. The following focuses on information from the person's latest ACAT assessment which approved them for entry into permanent residential aged care (referred to here as 'most recent ACAT assessment').

People's need for assistance and their health condition are captured at ACAT assessment, as well as through the ACFI after entry to permanent residential aged care (Box 2.1). These give an indication of people's wellbeing and functioning at different times during their use of aged care services. Further information on ACFI assessments for the cohort is provided in a subsequent section.

**Box 2.1: Assessing health conditions and care needs**

**Aged Care Assessment Program**

ACAT assessments under ACAP capture diseases or disorders that have an impact on the person's need for assistance with activities of daily living and social participation. Up to 10 conditions can be reported for each person. All 10 are considered here, as the impact they have on people can vary between assessment for, and entry to, permanent residential aged care—for example, someone may have dementia recorded as a secondary diagnosis at assessment, but on entry to permanent residential aged care, its impact on their wellbeing and functional ability may have increased considerably. Thus, the presence of a health condition on assessment—rather than its exact position on the list—may be more informative.

ACAT assessments also record whether activity limitations exist in 10 specific areas; whether current assistance is being received in these; and what the source of assistance is. The overall focus of the ACAT assessment is to appraise the person's current and future need for support and assistance, and the majority of ACAT assessments are carried out for people who still live in the community (although many of them are already receiving aged care services).

**Aged Care Funding Instrument**

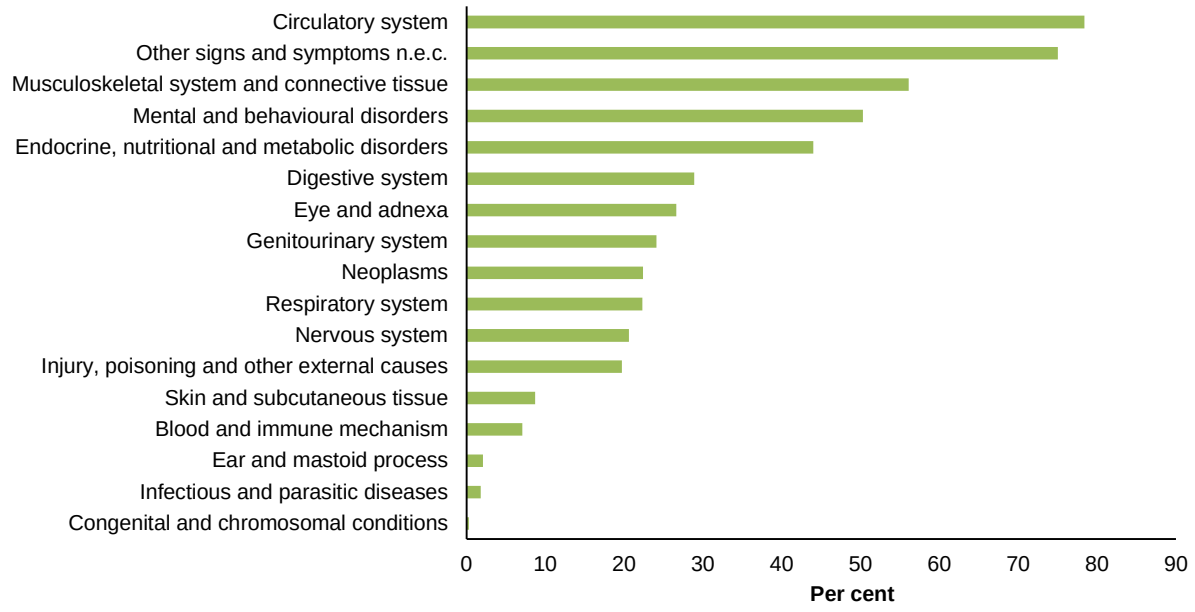
ACFI assessments capture diagnosed mental or behavioural conditions, as well as other medical conditions that have an impact on people's need for support and assistance in permanent residential aged care. Up to 3 conditions for each can be recorded. ACFI assessments provide 4 possible ratings on 12 areas of care needs. These are grouped under 3 broader domains (activities of daily living, behaviour, and complex health care) and given a rating of 'nil', 'low', 'medium' or 'high'. The overall focus of the ACFI assessment is to appraise the person's current need for support and assistance in permanent residential aged care, with a view to assessing the cost of their care.

**Health conditions**

ACAT and ACFI assessments rely largely on the same code list of health conditions, based on the ICD-10-AM classification (modified for the ACAP MDS V2.0), and it is comparable to the 4-digit code used in the ABS Survey of Disability, Ageing and Carers. For the full code lists, please refer to Appendix H in the ACAP MDS data dictionary (DoH 2014) and to Appendix 1 in the ACFI user guide (DoH 2017).

## Health and functional status

At the time of their most recent ACAT assessment, the average number of health conditions for people in the cohort was 7.7. Only 0.3% had 1 or fewer, while 3 in 10 (31%) had 10 health conditions recorded. By broad groups of conditions, the most common was *Diseases of the circulatory system*, with 78% of people having at least 1 condition in this group recorded. Around half had *Disorders of the musculoskeletal system and connective tissue* (56%) or *Mental and behavioural disorders* (50%) (Figure 2.3, Table A3).




*Note:* Based on the ICD-10 chapter-level classification for diseases.

*Source:* Table A3.

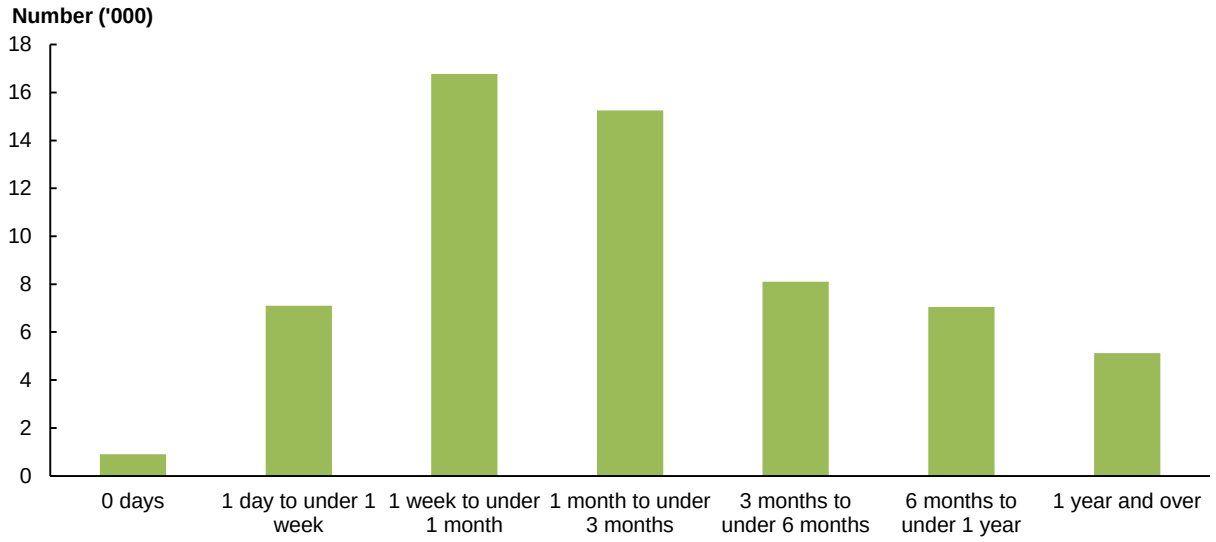
**Figure 2.3: Proportion of people who first entered PRAC in 2013–14 who had any condition in each broad group of conditions at their most recent ACAT assessment**

Looking at specific conditions, the 10 most common conditions that had an impact on people's need for assistance were heart disease (46%), arthritis (38%), dementia (31%), abnormal gait or mobility (28%), falls (28%), mental health conditions (26%), incontinence (23%), cerebrovascular disease (22%), diabetes (21%) and chronic lower respiratory diseases (17%) (Table A3). Further information on the health condition codes used is available in Appendix B.

At the time of assessment, 9 in 10 (91%) people had an activity limitation in at least 1 of the 4 core areas of *Self-care, Moving, Movement* and *Communication*—and 13% had activity limitations in all 4. Among people aged under 65, the proportion who had at least 1 core limitation was slightly higher than among people in each of the older age groups (93%, compared with 91% of those aged 85 and over). Similarly, the proportion with limitations in all 4 core areas was higher among the youngest age group (23%, compared with 13% of those aged 85 and over).

## Interval between assessment and entry

People's health and functional status, and their personal circumstances and preferences—and those of their family or carers—all influence how and when people use aged care services. Despite being approved for permanent residential aged care, people may delay their take-up of care for a number of reasons. For example, they may have approval for more than 1 program and have chosen to use 1 of the others to meet their needs; they may be able to access other formal support; and/or they may be supported by informal carers such as family members. Their preferred permanent residential aged care service may also not have a place available immediately, and people may take some time to organise their personal affairs before entering permanent residential aged care. After the completion of their most recent ACAT assessment, almost two-thirds (65%) of people had entered permanent residential aged care within 3 months (Figure 2.4, Table A4).




*Source:* Table A4.

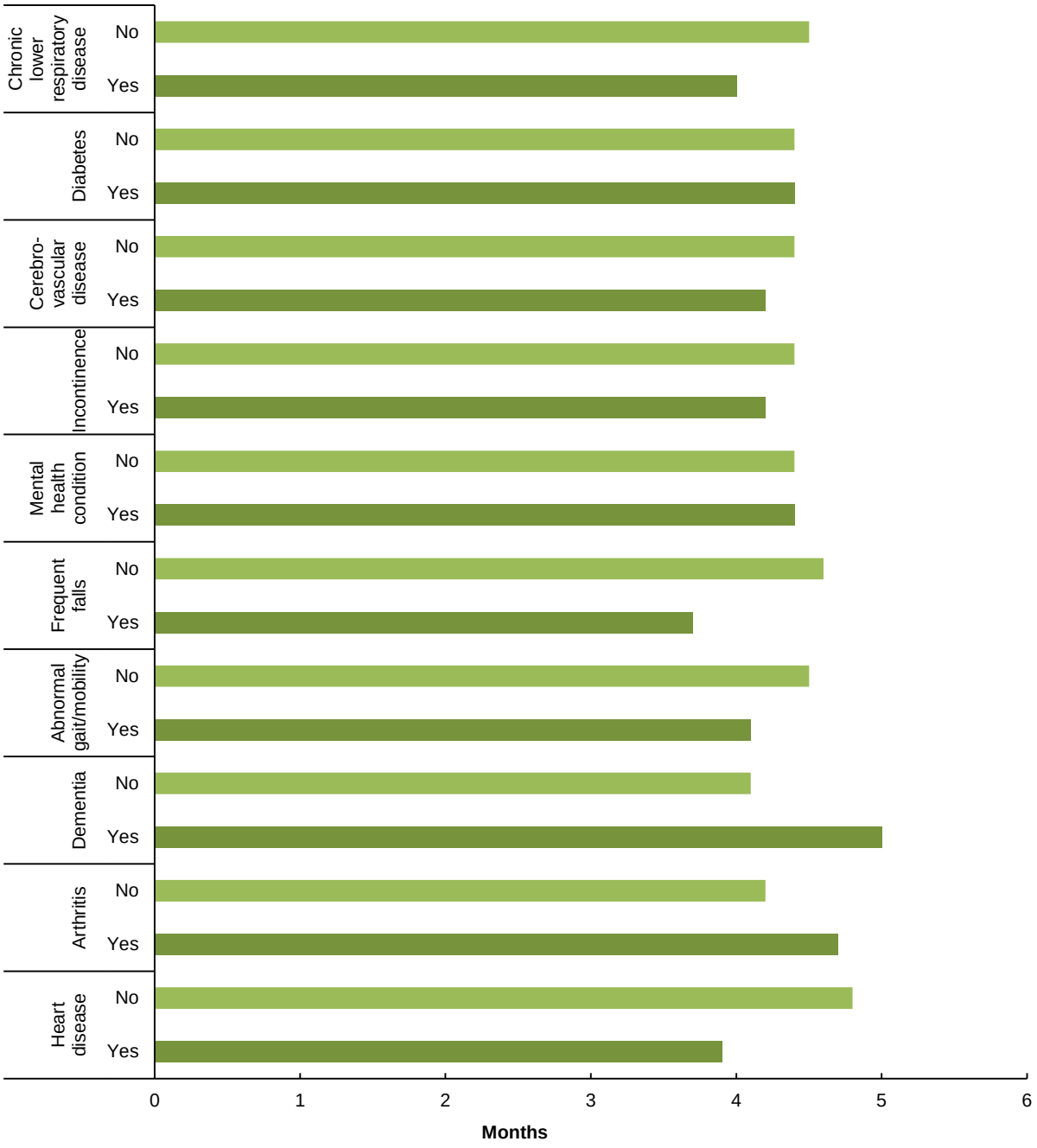
**Figure 2.4: Distribution of time between the most recent ACAT assessment and first entry to PRAC in 2013–14**

The average time ('entry period') between the assessment and the person's subsequent first entry was 4.4 months, rising slightly with age. People who entered permanent residential aged care aged under 65 had the shortest entry periods between assessment and entry. Overall, there was little variation in entry periods between the sexes, with only men aged under 65 having a somewhat shorter entry period (an average of 3.2 months, compared with 4.3 months for women in that age group) (Table A5).

Entry periods also showed slight variation by other factors, particularly those related to people's living arrangements—both those current at the time of assessment, and recommendations made regarding the most suitable long-term setting. For example, people aged under 65 and living alone at the time of assessment had shorter entry periods (an average of 2.6 months, compared with 5.4 months for people aged 85 and over and living with family). Similarly, people in all age groups who had a co-resident carer had longer entry periods than people who had a non-resident carer. People whose assessment recommended residential aged care as most appropriate for them in the long-term were more likely to have a considerably shorter entry period (an average of 2.7 months, compared with 9.5 for those recommended to live in a private residence) (Table A5).

The same pattern was evident when age and activity limitations, and age and selected health conditions, were considered: entry periods generally increased as age increased (Table A6). However, there was also a difference between people who had a limitation in any of the 4 core areas (an average of 4.4 months) and people who had a limitation in all of the 4 core areas (3.8 months).

Of the common conditions, in each age group, people with dementia and people with arthritis had longer entry periods than people who did not have these conditions. People with heart disease; abnormal gait or mobility; or those who experienced frequent falls had shorter average entry periods than people without these conditions recorded at their ACAT assessment—but for other common conditions, the differences were small (Figure 2.5, Table A6).



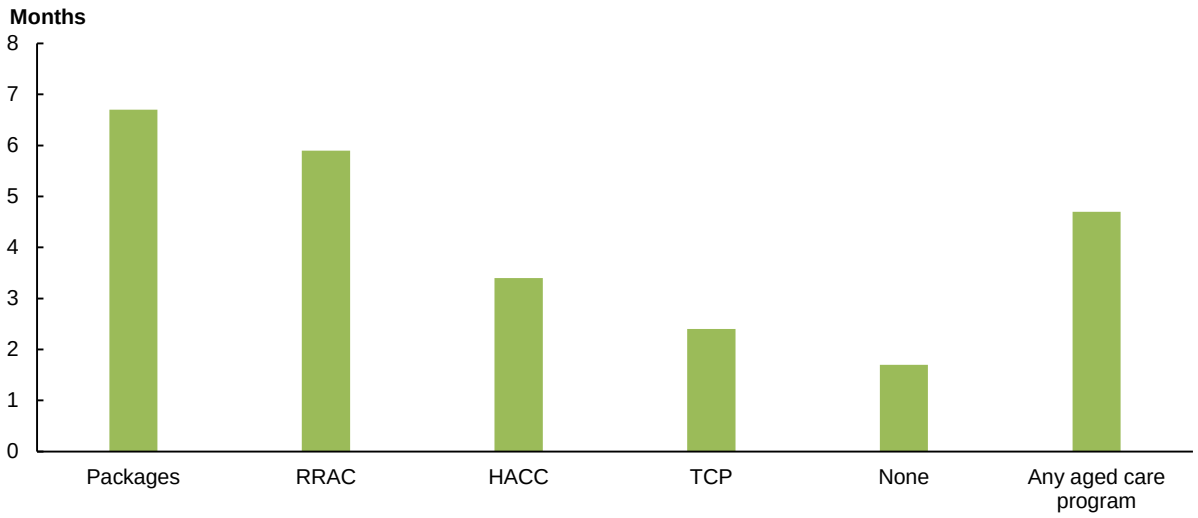

Note: 'No' indicates the condition was not recorded for the person; 'Yes' indicates it was.

***Source:*** **Table A6.**

**Figure 2.5: Average time (months) between most recent ACAT assessment and first entry to PRAC in 2013–14, by common health conditions**

Entry periods also varied depending on which aged program people had last used before entering permanent care. People who entered without having used any other programs had the shortest average entry periods (1.7 months, compared with 2.4 for those whose last-used program was TCP; 3.4 for HACC; and 5.9 months for respite). People who last used aged

care packages had the longest entry period between assessment and entry to permanent residential aged care (6.7 months) (Figure 2.6, Table A7).




*Source:* Table A7.

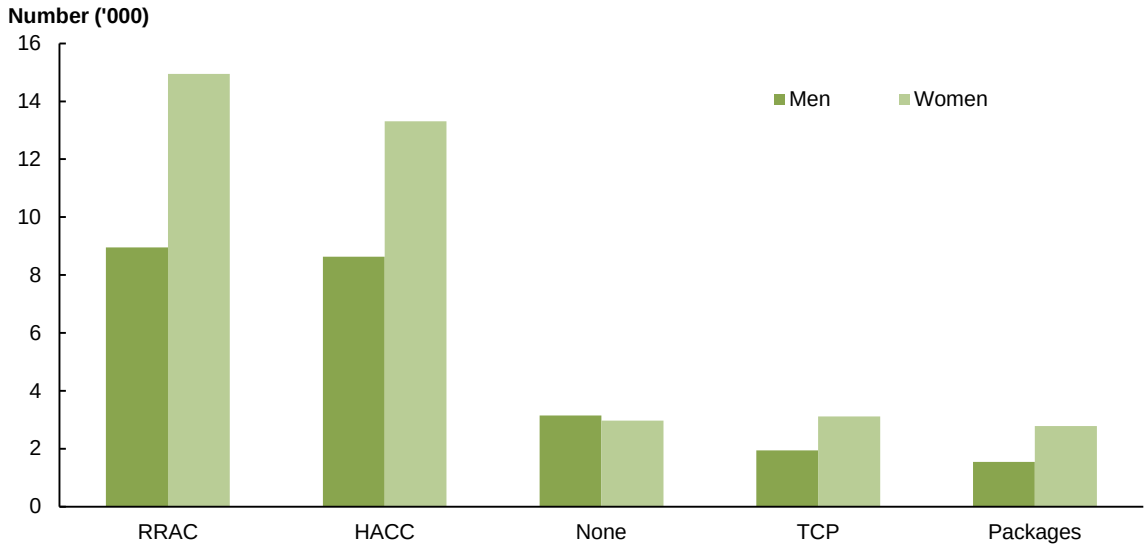
**Figure 2.6: Average time (months) between most recent ACAT assessment and first entry to PRAC in 2013–14, by last-used program**

# 2.3 Last use of other aged care programs

People's use of other aged care programs—namely HACC, aged care packages, TCP and respite—prior to their first entry into permanent residential aged care in 2013–14 varied greatly. In addition, some people entered permanent residential aged care without any prior use of the aged care programs included in this study. These patterns, and people's pathways from assessment to first entry, also varied depending on the degree of activity limitation and the nature of the health conditions people had at their most recent ACAT assessment beforehand.

Many people used more than 1 other aged care program at the same time before their first entry to permanent care. (For allowable concurrent use, see *Introduction to Pathways in Aged Care 2014* (AIHW 2016a) and Appendix B of this report). Some of these programs may potentially be used for considerably longer than others, particularly when contrasted with TCP and RRAC, where each episode of care is generally time-limited. This section takes into account only people's most recently-begun last-used program before first entering permanent residential aged care.

Respite was the most common last-used program before first entry to permanent residential aged care in 2013–14 (39% of the cohort), followed by HACC (36%). One in 10 (10%) people had not used any of the other aged care programs included in PIAC prior to their first entry. TCP accounted for 8.2%, and aged care packages for 7.0% of the cohort (Figure 2.7, Table A8).




*Source:* Table A8.

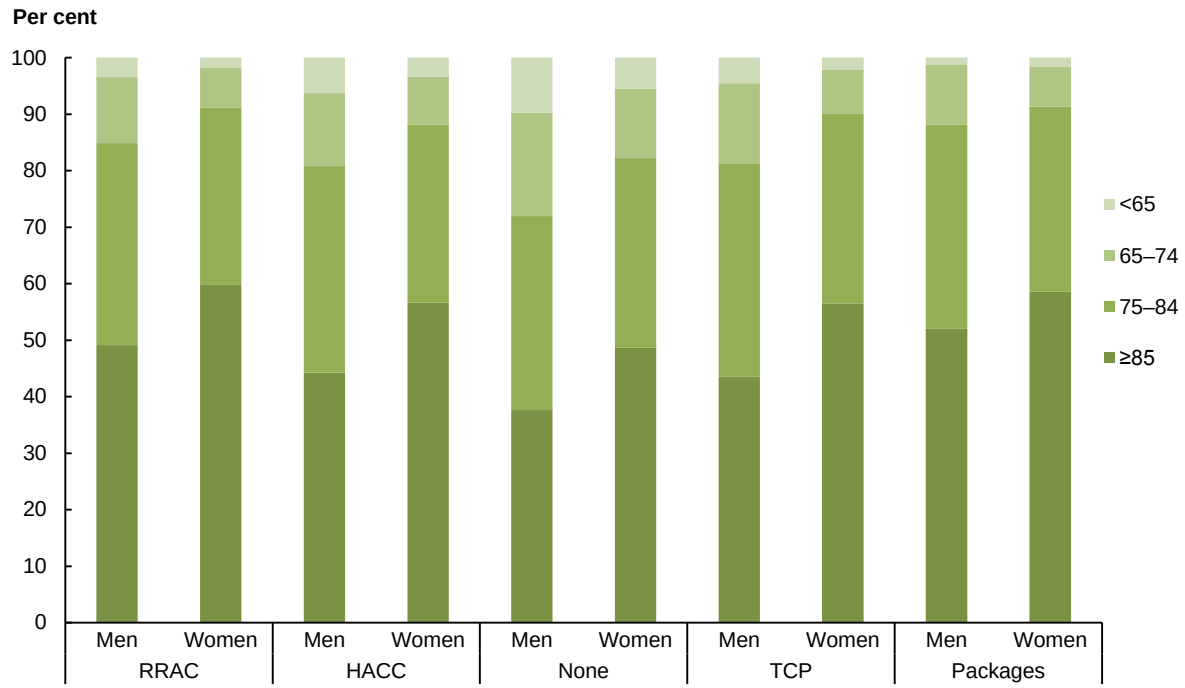
**Figure 2.7: Last-used program before first entry to PRAC in 2013–14, by sex**

## Characteristics in relation to last program used

### Age and sex

People who had not used aged care before entering permanent residential aged care were slightly more likely to be younger, compared with those who had used other programs. Just 2.4% of people who had last used respite were aged under 65, rising to 4.5% among those who last used HACC, and to 7.7% among those who had not used any aged care. In particular, men with no prior use of aged care were more likely to be aged under 65 on their first entry to permanent residential aged care (9.7%, compared with 5.5% of women who had no prior use) (Figure 2.8, Table A8).

In addition to being younger, people who entered permanent residential aged care directly were somewhat more likely to be male. Of those who had had no prior use of aged care before their first entry to permanent care, more than half (51%) were men, compared with under two-fifths of those who last used any of the other programs (39% among those who last used HACC; 38% among TCP and respite; and 36% among aged care packages). Grouped by the last program used, the proportion of men in each decreased as age increased (except among those who last used aged care packages, where the pattern was mixed) (Table A8).




Source: Table A8.

**Figure 2.8: People who first entered PRAC in 2013–14, by age, by sex and by last-used program**

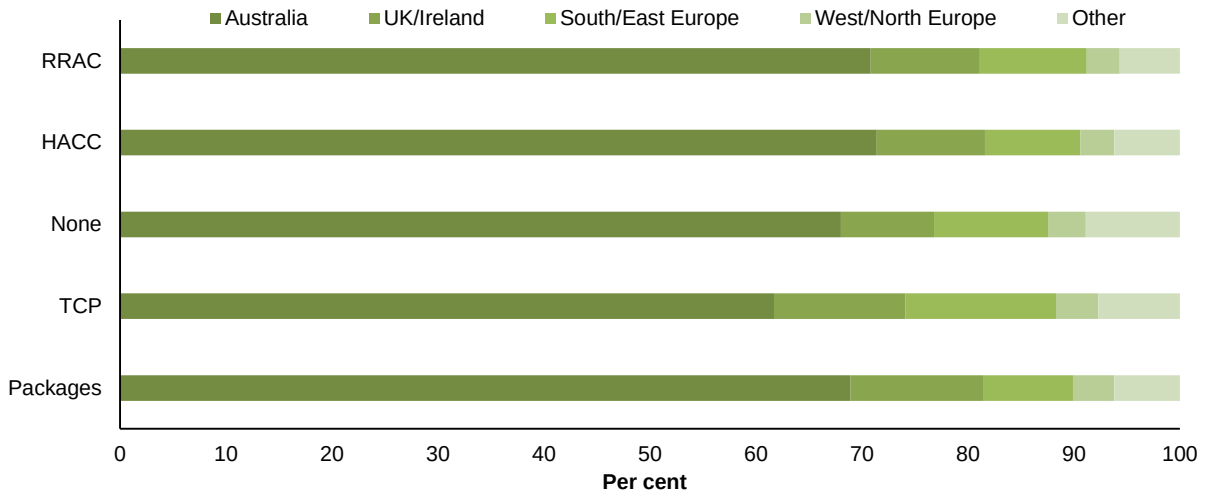
## Indigenous status

Overall, Aboriginal and Torres Strait Islander people accounted for 0.7% of the cohort. The pattern was similar regardless of which program people had last used—Indigenous Australians made up 0.9% of those who entered permanent care without prior use of other aged care programs and 0.4% of those who last used TCP before entering permanent care (Table A9).

Indigenous Australians were slightly more likely to have entered permanent residential aged care without using any of the other programs first (12% took this pathway, compared with 10% for other Australians). They were as likely as other Australians to have last used respite care (39% for both groups) and packages (7.0% for both); slightly more likely to have used HACC (38%, compared with 36%); and less likely to have used TCP (4.4%, compared with 8.3%). However, this is not likely to present a full picture of aged care service use for Aboriginal and Torres Strait Islander people, because people may choose not to disclose their Indigenous status when they use a service, and because Indigenous Australians may use services provided under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program in addition to mainstream services included in PIAC.

## Country of birth and preferred language

People's cultural background influences how they use aged care. Around 7 in 10 people in the cohort were born in Australia, but the proportions varied depending on which program people had last used. People who were born in Australia made up a slightly lower proportion of those who last used TCP (62%), compared with the other programs (68% of those who entered permanent care with no other prior use were born in Australia, 69% of those who last used packages, and 71% of those who last used HACC or respite). For each program 'last used', a higher proportion of women than men were born in Australia (Figure 2.9, Table A9).




*Source:* Table A8.

**Figure 2.9: People who first entered PRAC in 2013–14, by last-used program, by region of birth**

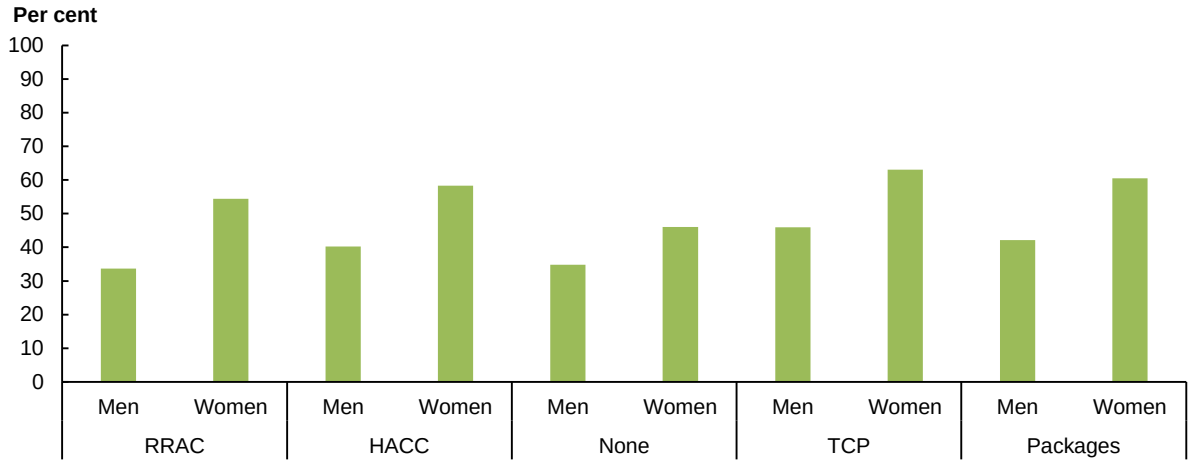
Similar patterns were observed for preferred language—of those who last used TCP, or who entered permanent care with no other prior use of aged care services, a lower proportion spoke English at home (88% for both), compared with 92% of those who last used HACC, packages or respite.

## Living arrangements

The absence of informal support—having no carer available, or having a non-resident carer—and living alone are likely to increase people's need for formal support services. For the cohort in this report, people's living arrangements varied depending on which program they had last used before permanent care. People who last used respite residential aged care before entering permanent care were the largest of the groups, and less likely to live alone than other people, and similarly likely to have dementia as those who last used packages. Otherwise there were no considerable differences between this group and people who had entered permanent care through 1 of the other 4 pathways.

Overall, people who last used TCP were more likely to be living alone (57%, compared with 40% of those who entered permanent care with no prior use of aged care and 47% of those who last used respite)—and almost 1 in 6 (17%) of people who entered permanent care without using other programs beforehand had no carer available, slightly higher than the proportion for any of the other groups (Table A9).

Regardless of the last program used, women were more likely to be living alone (56%, compared with 38% of men)—but this varied from 46% of women who had had no prior use of aged care to 63% of those who had last used TCP. Men who had last used respite care or no program were less likely to live alone than men who had last used TCP (34% and 35%, respectively, compared with 46%) (Figure 2.10, Table A10). People's living arrangements and existing relationships are known to affect how they use aged care programs, particularly when it comes to transitions to permanent residential aged care (AIHW 2014a). However, only a partial picture of this is possible through these analyses, as the cohort only includes people who entered permanent residential aged care, and not those who chose not to.

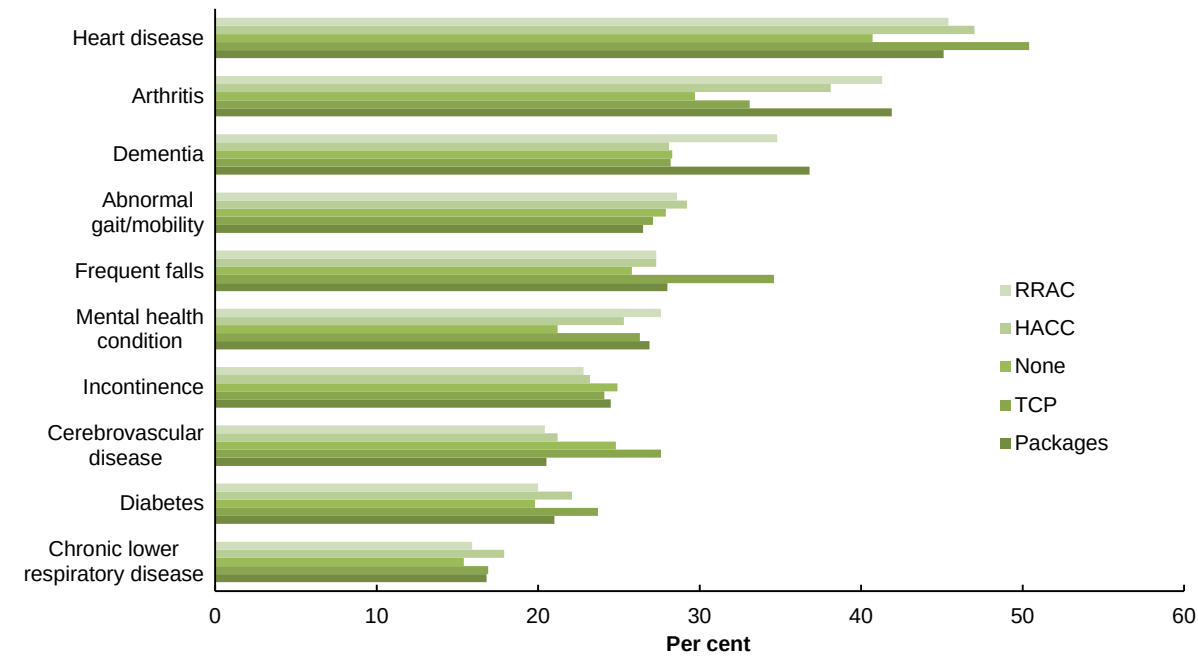



*Source:* Table A10.

**Figure 2.10: People who first entered PRAC in 2013–14, proportion living alone beforehand, by sex, by last-used program**

## Health and functional status

People's overall health has an impact on when and how they use aged care services, and looking at particular factors associated with health and functional status highlighted different patterns. While many common health conditions were spread relatively evenly across the cohort regardless of which program had been last used, the distribution of some health conditions varied (Figure 2.11, Table A11).




*Source:* Table A11.

**Figure 2.11: People who first entered PRAC in 2013–14, by health conditions and last-used program**

People who entered permanent residential aged care without any prior use of aged care differed somewhat from those who had used any of the 4 programs included in the study—particularly on key demographics such as age and sex. They also had a higher likelihood of having many of the common health conditions. At their most recent ACAT assessment, people who had not used aged care before were also more likely to have been assessed as having a limitation in all 4 core areas (19%, compared with 11% among those who had last used respite and 13% among those who had last used HACC). On the other hand, they were also slightly more likely to have no limitation in any 4 core areas (Table A11).

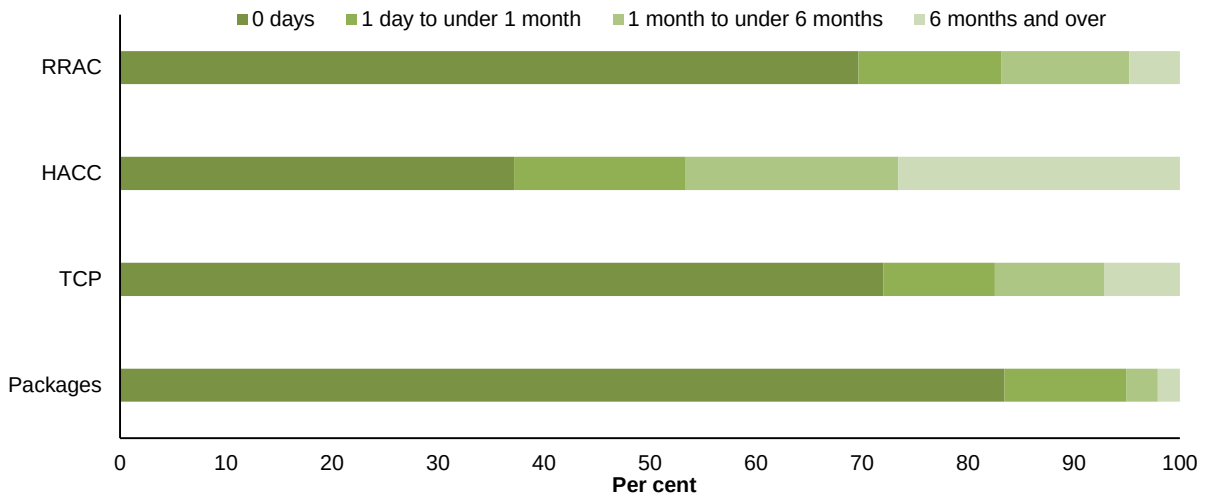
People who last used TCP showed a slightly different profile with regard to their health status. They were more likely to have heart disease or cerebrovascular disease and to have experienced frequent falls, compared with people who had last used any of the other 4 options. They were also less likely to have had a dementia diagnosis recorded at their most recent ACAT assessment. This may reflect the fact that this is a subsection of the overall group of people who used TCP: it is likely that people who last used TCP before entering permanent residential aged care have higher needs and worse health status than people who used the TCP overall (and did not require entry to permanent residential aged care soon after). They may have also experienced another hospitalisation or major change in their health or functional status since the beginning of their episode of care with the program. More generally, people who enter permanent residential aged care shortly after a hospitalisation were also shown to have higher need for care (AIHW 2013; AIHW 2014b).

## Interval between last-used program and first entry

People may leave a previous program on the same day as they enter another, or there can be a gap (sometimes considerable) between the two. These timelines can vary for a number of reasons. People may have had a hospital stay or significant change in their health status (such as an injury or acute illness), making it necessary to access an increased level of support quickly. As with entry periods after assessment, other personal circumstances and the availability of services may also influence the time taken for transition to permanent residential aged care. In addition, the end date of program use may not accurately reflect the end date of a person's use of that program: people may no longer have received services on the day they 'left' a program but instead may have stopped receiving services earlier, and this date simply captures the administrative end of the program's use. With the exception of respite, the transition between 1 aged care program and permanent residential aged care may be difficult to record accurately, as there can be limited communication between aged care services.

The average time between separating from the last-used aged care program and first entering permanent residential aged care differed by program: the interval was largest where HACC was the last program used (with an average of 9.5 months before entry to permanent residential aged care) and shortest where the last program was an aged care package (18 days). People who last used HACC may have been least likely to have entered permanent residential aged care immediately after their period of care ended because of the nature of the program, with those with lower levels of need generally using HACC. On the other hand, in terms of the level of need, aged care packages may be closer to permanent residential aged care, particularly when 'high' level of care is provided. (For more detail on aged care packages, see the following section on length of stay at the last-used program.) The average time between ending an episode of care with TCP and entering permanent residential aged care was around 1.9 months, compared with 1.2 months between respite and permanent care.

Regardless of which program was last used, many people entered permanent residential aged care on the same day they left a previous program: 58% of people who had used another aged care program prior to permanent residential aged care had no interval between separation and first entry. Reflecting the average interval, a higher proportion of people who last used an aged care package entered permanent residential aged care immediately (83%, compared to 37% of those who last used HACC) (Figure 2.12, Table A12).




*Source:* Table A12.

**Figure 2.12: Distribution of time between last-used program and first entry to PRAC in 2013–14, by aged care program**

There were differences in the characteristics of people who had no interval between their last-used program and their first entry to permanent residential aged care, compared with those who had an interval of between 1 day and less than 1 month, or 1 month and over. The proportion of males increased as the length of the interval increased for each—except for those whose last-used program was TCP, where the pattern was mixed. People who last used TCP and then entered permanent residential aged care without any interval were less likely to be born in Australia (60%, compared with 64% where the interval was 1 day to less than 1 month, and 69% where the interval was 1 month and over) (Table A13).

People who last used respite and entered permanent residential aged care with no interval showed similar characteristics to those who had longer intervals—with the exception that the longer the interval, the less likely they were to be living alone (49%, compared with 45% of those who entered care between 1 day and less than 1 month after leaving an aged care package, and 38% of those who had an interval of 1 month and over). The likelihood of having a carer available also increased slightly depending on the length of the interval: 87% of those who had no interval between respite and permanent residential aged care had a carer, compared with 89% of those who entered permanent residential aged care between 1 day and less than 1 month after using respite, and 92% of those who entered after an interval of 1 month and over. The opposite pattern was evident among people whose last-used program before their first entry to permanent residential aged care was 1 of the other 3 forms of aged care (HACC, aged care packages, or TCP): as the proportion with a carer decreased, the interval increased (Table A13).

For each of the last-used programs, activity limitations in all 4 core areas were somewhat more common among those who had an interval of any duration, compared with those who

had no interval. On the other hand, for each of the last-used programs, people who had longer intervals before their entry to permanent residential aged care were less likely to have no core limitations, but common health conditions were not clearly associated with shorter or longer intervals (Table A14). For example, for all 4 groups, the proportion of people with dementia was higher among those who had no interval and those who had an interval of 1 month and over, compared with those who entered permanent residential aged care between 1 day and less than 1 month of leaving the last-used program.

## Length of stay at last-used program

Looking at only the last episode of 'other' aged care program use before first entry to permanent residential aged care showed that people who last used an aged care package had a longer duration of program use at the last episode than people who last used any of the other aged care programs. Their average length of stay was 14.6 months, compared with 8.0 months where HACC was the last-used program (although this may not fully reflect the time the service was used or provided, due to the nature of HACC data collection).

The time-limited nature of respite and TCP meant that both of these had shorter durations of use (1.1 and 1.5 months, respectively). For TCP, this is lower than could be expected based on the average duration—in 2013–14, the average completed episode of care received through TCP was 2 months (DoH 2015). It is possible that this cohort entered permanent residential aged care because the program was not able to provide the necessarily level of support or reablement of function. The effectiveness of TCP has also previously been associated with the length of the hospital stay that preceded it, with those who had had shorter stays more likely to benefit from the program (AIHW 2014b).

The distribution of lengths of stay showed that—as could be expected based on the program guidelines—98% of people who last used respite, and 92% of those who last used TCP, concluded their use of a program within 3 months of starting it. Conversely, almost one-third (31%) of those who last used HACC, and almost three-fifths (58%) of those who last used packages, had used the program for more than 6 months (Table A15).

### Aged care packages as a point of transition to permanent residential aged care

Due to the time-limited provision of respite care and of TCP, and the data collection methodology of HACC, lengths of stay were examined in more detail only for aged care packages (where the last-used program was any of CACP, EACH, EACHD or HCP). People who last used an aged care package before entering permanent aged care were the most likely to have entered permanent residential aged care immediately after their period of care ended—and the average length of stay in their previous use period was also the longest among each of the groups in the cohort.

The 4 aged care packages programs can be broadly characterised as either 'low' (CACP and HCP levels 1–2) or 'high' level of care (EACH, EACHD and HCP levels 3–4), based on the amount of support they provide to people. The average length of stay was 4 months higher among those who last used 1 of the lower-level packages, compared with those using packages at a 'high' level of care. A similar pattern was evident across a range of characteristics—although, overall, there was more variation in the average lengths of stay among those who had used packages at a 'low' level of care (Table 2.1). As people often progress from 'low' to 'high' level of care, it is possible that the cumulative average length of stay for those whose use of packages concluded at 'high' level would have been longer if preceding use of any packages was also taken into account.

**Table 2.1: Average length of stay (months) for people who last used an aged care package before first entry to PRAC in 2013–14, by selected demographic characteristics, by age group, by level of care**

| Characteristic | Low[(a)] | High[(b)] | Total |
|---|---|---|---|
| | | Months | |
| **Age** | | | |
| <65 | 11.1 | 11.3 | 11.3 |
| 65–74 | 16.1 | 11.1 | 13.8 |
| 75–84 | 13.2 | 12.2 | 12.8 |
| ≥85 | 17.9 | 12.1 | 15.9 |
| **Sex** | | | |
| Male | 13.8 | 11.8 | 13.1 |
| Female | 17.4 | 12.1 | 15.5 |
| **Country of birth region** | | | |
| Australia | 15.7 | 12.0 | 14.4 |
| United Kingdom/Ireland | 15.0 | 11.4 | 13.5 |
| South/East Europe | 17.5 | 12.4 | 15.7 |
| West/North Europe | 19.6 | 11.7 | 16.0 |
| Other | 19.8 | 12.7 | 17.2 |
| **Preferred language** | | | |
| English | 15.6 | 12.0 | 14.3 |
| European | 20.9 | 11.7 | 17.2 |
| Other | 28.2 | 13.0 | 24.2 |
| **Living arrangements** | | | |
| Living alone | 17.4 | 13.0 | 16.1 |
| Living with others | 14.2 | 11.2 | 12.8 |
| **Carer status** | | | |
| Carer available | 15.6 | 11.9 | 14.2 |
| *Co-resident carer* | *14.4* | *11.0* | *12.7* |
| *Non-resident carer* | *16.2* | *13.0* | *15.2* |
| No carer | 19.4 | 12.3 | 17.4 |
| **Total** | **16.1** | **12.0** | **14.6** |

(a) People who last used CACP or HCP levels 1–2.

(b) People who last used EACH, EACHD or HCP levels 3–4.

*Source:* AIHW analyses.

Those who last used an aged care package were slightly more likely to have dementia than people in the other 4 groups (those who last used respite, HACC, TCP or no care), and in each age group among package-users, people's dementia status was also associated with shorter duration of use. Overall, the average length of stay was almost 3 months shorter for people with dementia than for people without dementia, regardless of whether their packages were 'low' or 'high' level of care. People who had many of the other common conditions had slightly longer lengths of stay than people who had not had these conditions recorded (Table 2.2).

**Table 2.2: Average length of stay (months) for people who last used an aged care package before first entry to PRAC in 2013–14, by selected health/functional status factors, by level of care**

| Factor | | Low[a] | High[b] | Total |
|---|---|---|---|---|
| | | | Months | |
| **Health condition**[c] | | | | |
| Heart disease | Yes | 15.7 | 12.5 | 14.6 |
| | No | 16.5 | 11.7 | 14.7 |
| Arthritis | Yes | 17.3 | 12.7 | 15.6 |
| | No | 15.3 | 11.5 | 13.9 |
| Dementia | Yes | 14.1 | 10.7 | 12.6 |
| | No | 17.1 | 13.0 | 15.8 |
| Abnormal gait/mobility | Yes | 17.1 | 13.2 | 15.6 |
| | No | 15.8 | 11.6 | 14.3 |
| Frequent falls | Yes | 16.7 | 12.5 | 15.3 |
| | No | 15.9 | 11.8 | 14.4 |
| Mental health condition | Yes | 16.1 | 12.5 | 14.8 |
| | No | 16.2 | 11.8 | 14.6 |
| Incontinence | Yes | 16.5 | 13.3 | 15.2 |
| | No | 16.0 | 11.5 | 14.4 |
| Cerebrovascular disease | Yes | 17.6 | 12.8 | 15.9 |
| | No | 15.8 | 11.8 | 14.3 |
| Diabetes | Yes | 16.7 | 12.1 | 15.0 |
| | No | 16.0 | 12.0 | 14.5 |
| Chronic lower respiratory disease | Yes | 16.3 | 10.0 | 14.0 |
| | No | 16.1 | 12.4 | 14.7 |
| **Activity limitation**[d] | | | | |
| Any 4 core areas | | 16.4 | 11.9 | 14.7 |
| *All 4 core areas* | | *17.8* | *11.9* | *15.2* |
| No limitation in 4 core areas | | 13.8 | 14.6 | 13.9 |
| **Total** | | **16.1** | **12.0** | **14.6** |

(a) People who last used CACP or HCP levels 1–2.

(b) People who last used EACH, EACHD or HCP levels 3–4.

(c) For further information on health conditions, see Appendix B.

(d) Core areas of activity limitations assessed at ACAT assessment are *Self-care, Moving, Movement* and *Communication*.

*Source:* AIHW analyses.

However, this was a subsection of the cohort and thus limited to those who last used aged care packages and later entered permanent residential aged care, rather than including all people who used packages. The differences in average lengths of stay may reflect this. They may also reflect differences in levels of need, which affect how long a person may use a program for, and when they decide to transition to permanent residential aged care. In addition, the scope of a given aged care program may affect the characteristics of those who used it—for example, dementia could be expected to be more common among people who

used EACHD, compared with CACP or EACH, as dementia was a specific qualifier for that program. However, dementia is not a prerequisite for any level of HCP, and, in the future, the health status of people who last used HCP could be different from the results seen here.

The exact eligibility requirements have also changed and this may affect findings in the future. Under CACP/EACH/EACHD, to be eligible for a package, a person had to also be assessed as eligible to receive residential care. Under HCP, this requirement no longer applies—the person must be assessed as having needs that can be met by a coordinated package of care services at either low (levels 1–2) or high (levels 3–4) levels. At the time the cohort in this study was using aged care, this may have contributed to some overlap between aged care packages and permanent residential aged care due to similarities in the underlying population: essentially, both may have experienced ill health or frailty to such a degree that they qualified for entry to permanent residential aged care (whether they entered care or not). For this cohort, this similarity was likely further amplified by the fact that they did enter permanent residential aged care.

# 3 Further analysis options

This report explored patterns in prior aged care service use for a cohort of people who first entered permanent residential aged care in 2013–14. This exploration, with a focus on a key point of change in program use, provided an opportunity to explore commonalities and differences among this cohort, based on their use of other programs before permanent residential aged care.

However, this presented only a part of the full set of possible pathways that people take through aged care because analysis was restricted to those people who then went on to use permanent residential aged care. The characteristics of the full cohort of people who used any given pathway may differ. For example, the profile of the cohort examined in this report would differ from those that used an aged care program, but did not yet require the higher level of support provided through permanent care.

Even after entry to permanent residential aged care, people's use of services vary, and PIAC can be used to follow people retrospectively to capture changes over time in how they use aged care (Box 3.1). While PIAC is limited to people who interacted with the aged care system before 2014, analyses using PIAC are not strictly limited to this time period: once a cohort of people have been identified in PIAC, it is possible to examine the subsequent aged care service use for those people beyond the specified end-date of PIAC.

**Box 3.1: What happened to people after they first entered permanent aged care?**

Most people who first entered permanent residential aged care in 2013–14 underwent at least 1 ACFI assessment after entry to determine their care needs and the level of care and corresponding funding required. Just 1.2% of the cohort were without an ACFI assessment record, and many had had 1 or more re-assessments before September 2015.

At their first ACFI assessment, the most common combination of care need ratings was 'high' in all 3 domains (activities of daily living, behaviour, and complex health care—there are 81 possible rating combinations in all). Around 1 in 8 (13%) of the cohort received this combination of ratings, increasing to over 1 in 4 (28%) on their last ACFI assessment before September 2015.

Most conditions that were common at ACAT assessment were captured less frequently on ACFI assessments, and either decreased or remained stable between first and last ACFI assessments. However, in line with the instrument's focus on mental and behavioural conditions (3 of the 6 possible health conditions recorded at an ACFI assessment are focused on these, while ACAT assessments do not place a similar qualifier on how health conditions are reported), the proportion of people with dementia or any mental health condition was higher than that captured earlier at their most recent ACAT assessment. Some 44% of the cohort had dementia at their first ACFI assessment, rising to 49% at the last, and 47% had any mental health condition, rising to 54%. In addition to these, only the proportions with arthritis or incontinence increased between the first and last ACFI assessments (from 32% to 35%, and from 22% to 26%, respectively).

Almost 27,300 people who first entered permanent residential aged care during 2013–14 had died by September 2015, representing 44% of the cohort. On their first ACFI assessment, 1 in 5 (20%) people who later died had been rated 'high' in all 3 domains, compared with 7.9% for those who did not die during the study period. One in 15 people (6.2%) had been identified as requiring palliative care at the first ACFI assessment, and 96% of them had died by September 2015.

As a person-based link map, PIAC allows for both broad and specific analyses. For example, it is possible to examine how different aged care programs may be used concurrently. Further exploring this additional complexity to highlight the different profiles of people who use aged care services is warranted. For example, people's simultaneous use of multiple aged care programs may be indicative of higher need for care, as well as of needing to piece together multiple services to obtain the required level of support.

The trajectory of increasing care needs could also be examined in more detail, as people generally move 'up' in need level in the aged care system. Many factors can be involved in this, such as the sudden loss of a carer or changes to other personal circumstances. Additional linkage work to include people's use of other health services (such as data on hospitalisations, use of Medicare services, or access to pharmaceuticals) would enable analyses that better take into account significant or sudden changes in people's need for aged care. People may experience an injury or a fall, or develop a health condition, that make it increasingly difficult to manage at home, and these may trigger a transition to a different, higher level of aged care.

Looking backwards provides a useful lens to assess how the aged care system has been performing, and how people are using it, and the comprehensive data recorded through PIAC can guide future improvements to how aged care services are provided. Although this report focused only on people who first entered permanent residential aged care in 2013–14, a cohort can be defined in ways other than their program use. For example, a specific characteristic of interest can be used to determine the cohort of study, such as identifying people from non-English speaking backgrounds or those who lived alone at the time of assessment, to examine which pathways they take through aged care and to ensure aged care services meet people's needs now and in the future.

# Appendix A: Data tables

**Table A1: Simplified paths of aged care programs used before first entry to PRAC, by people whose first entry took place in 2013–14**[(a)]

| Paths[(b)] | Number | Per cent |
|---|---|---|
| HP | 16,235 | 26.5 |
| HRP | 11,004 | 17.9 |
| P | 6,091 | 9.9 |
| RP | 3,222 | 5.3 |
| HTP | 2,839 | 4.6 |
| HCRP | 2,618 | 4.3 |
| HCP | 2,464 | 4.0 |
| HCHP | 1,232 | 2.0 |
| TP | 1,050 | 1.7 |
| HCHRP | 992 | 1.6 |
| HRHRP | 802 | 1.3 |
| CP | 693 | 1.1 |
| CRP | 682 | 1.1 |
| HTRP | 661 | 1.1 |
| HRHP | 634 | 1.0 |
| HTHP | 536 | 0.9 |
| HRCRP | 434 | 0.7 |
| HTHRP | 342 | 0.6 |
| HCTP | 295 | 0.5 |
| RHRP | 274 | 0.5 |
| Other | 8,232 | 13.4 |
| **Total** | **61,332** | **100.0** |

(a) Excluding aged care programs used after first entry to permanent residential aged care.

(b) H = HACC
C = any aged care packages program delivered in the community (CACP/EACH/EACHD/HCP)
T = TCP
R = RRAC
P = PRAC.

*Source:* AIHW analyses.

**Table A2: Cumulative average length of stay (months) at other aged care programs before first entry to PRAC in 2013–14, by sex, by program**

| Program | Men | Women | Total |
|---|---|---|---|
| | | Months | |
| RRAC | 1.6 | 1.6 | 1.6 |
| HACC | 35.9 | 52.9 | 46.5 |
| TCP | 2.0 | 2.2 | 2.1 |
| Packages[(a)] | 22.1 | 26.9 | 25.3 |
| **Total** | **19.3** | **28.3** | **24.9** |

(a) Any aged care packages program delivered in the community (CACP/EACH/EACHD/HCP).

**Table A3: Health conditions recorded at the most recent ACAT assessment before first entry to PRAC in 2013–14**[(a)(b)]

| Condition | Proportion (%) |
|---|---|
| Diseases of the circulatory system | 78.4 |
| *Heart disease* | *45.9* |
| *Cerebrovascular disease* | *21.7* |
| Disorders of the musculoskeletal system and connective tissue | 56.1 |
| *Arthritis and related disorders (excluding rheumatoid arthritis)* | *38.3* |
| *Back problems and dorsopathies* | *8.4* |
| Mental and behavioural disorders | 50.3 |
| *Dementia* | *31.4* |
| *Mental health conditions* | *26.0* |
| Endocrine, nutritional and metabolic disorders | 44.0 |
| *Diabetes (types 1, 2 and unspecified)* | *21.1* |
| Digestive system diseases | 28.9 |
| *Diseases of the intestine* | *15.7* |
| Disease of the eye and adnexa | 26.6 |
| *Poor vision* | *9.7* |
| Diseases of the genitourinary system | 24.1 |
| *Incontinence (includes stress, urinary and faecal)* | *23.4* |
| Diseases of the respiratory system | 22.3 |
| *Chronic lower respiratory diseases* | *16.7* |
| Neoplasms | 22.4 |
| Diseases of the nervous system (excluding dementia) | 20.6 |
| *Parkinson disease* | *5.2* |
| Injury, poisoning and consequences of other external causes | 19.7 |
| *Fracture of femur or neck of femur (hip)* | *5.7* |
| Diseases of the skin and subcutaneous tissue | 8.7 |
| Diseases of blood and blood forming organs and immune mechanism | 7.1 |
| Diseases of the ear and mastoid process | 2.1 |
| Infectious and parasitic diseases | 1.8 |
| Congenital malformations, deformations and chromosomal abnormalities | 0.3 |
| Other signs and symptoms | 75.0 |
| *Abnormal gait and mobility (not elsewhere classified)* | *28.4* |
| *Falls (frequent with unknown aetiology)* | *27.8* |

(a) The conclusion of the most recent ACAT assessment which provided approval for permanent residential aged care.

(b) For more information on health conditions, see Appendix B.

*Source:* AIHW analyses.

**Table A4: Distribution of time between the most recent ACAT assessment and first entry to PRAC in 2013–14, by sex, by age**[(a)]

| Sex/Age group | 0 days | 1 day–<1 week | 1 week–<1 month | 1 month–<3 months | 3 months–<6 months | 6 months–<1 year | 1 year and over | After entry | None[(b)] | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Per cent | | | | | |
| **Men** | | | | | | | | | | |
| <65 | 1.7 | 14.0 | 31.9 | 25.4 | 11.4 | 7.8 | 5.0 | 0.4 | 2.5 | 100.0 |
| 65–74 | 1.7 | 10.7 | 29.2 | 25.2 | 12.8 | 9.9 | 8.5 | 0.4 | 1.8 | 100.0 |
| 75–84 | 1.4 | 12.7 | 28.1 | 23.9 | 12.3 | 10.8 | 9.1 | 0.4 | 1.3 | 100.0 |
| ≥85 | 1.5 | 12.8 | 28.1 | 24.3 | 12.7 | 10.9 | 8.1 | 0.6 | 1.1 | 100.0 |
| *Total* | *1.5* | *12.5* | *28.4* | *24.3* | *12.5* | *10.6* | *8.3* | *0.5* | *1.3* | *100.0* |
| **Women** | | | | | | | | | | |
| <65 | 1.9 | 11.5 | 28.3 | 24.2 | 13.6 | 7.8 | 8.9 | 0.4 | 3.4 | 100.0 |
| 65–74 | 1.3 | 11.1 | 28.4 | 23.7 | 14.4 | 10.5 | 8.3 | 0.6 | 1.7 | 100.0 |
| 75–84 | 1.4 | 11.1 | 26.4 | 25.1 | 14.0 | 12.1 | 8.4 | 0.5 | 1.0 | 100.0 |
| ≥85 | 1.5 | 10.8 | 26.5 | 25.6 | 13.4 | 12.5 | 8.4 | 0.5 | 1.0 | 100.0 |
| *Total* | *1.5* | *10.9* | *26.7* | *25.2* | *13.7* | *12.1* | *8.4* | *0.5* | *1.1* | *100.0* |
| **People** | | | | | | | | | | |
| <65 | 1.8 | 12.9 | 30.3 | 24.9 | 12.4 | 7.8 | 6.7 | 0.4 | 2.9 | 100.0 |
| 65–74 | 1.5 | 10.9 | 28.8 | 24.5 | 13.6 | 10.2 | 8.4 | 0.5 | 1.7 | 100.0 |
| 75–84 | 1.4 | 11.8 | 27.1 | 24.6 | 13.3 | 11.6 | 8.7 | 0.5 | 1.1 | 100.0 |
| ≥85 | 1.5 | 11.5 | 27.0 | 25.1 | 13.2 | 12.0 | 8.3 | 0.5 | 1.0 | 100.0 |
| **Total** | **1.5** | **11.6** | **27.4** | **24.9** | **13.2** | **11.5** | **8.4** | **0.5** | **1.2** | **100.0** |

(a) The conclusion of the most recent ACAT assessment which provided approval for permanent residential aged care.

(b) No ACAT assessment record was identified.

*Source:* AIHW analyses.

**Table A5: Average time (months) between the most recent ACAT assessment and first entry to PRAC in 2013–14, by age group, by selected demographic characteristics**[(a)]

| Characteristic | <65 | 65–74 | 75–84 | ≥85 | Total |
|---|---|---|---|---|---|
| | | | Months | | |
| **Sex** | | | | | |
| Men | 3.2 | 4.2 | 4.4 | 4.2 | 4.2 |
| Women | 4.3 | 4.4 | 4.5 | 4.5 | 4.5 |
| **Indigenous status** | | | | | |
| Indigenous | n.p. | n.p. | n.p. | n.p. | 6.5 |
| Non-Indigenous | n.p. | n.p. | n.p. | n.p. | 4.4 |
| **Country of birth region** | | | | | |
| Australia | 3.8 | 4.3 | 4.3 | 4.2 | 4.3 |
| UK/Ireland | 4.4 | 4.5 | 4.7 | 4.2 | 4.4 |
| South/East Europe | 3.0 | 3.9 | 4.8 | 4.8 | 4.7 |
| West/North Europe | 1.6 | 3.8 | 4.2 | 5.0 | 4.5 |
| Other | 3.2 | 4.3 | 4.8 | 5.3 | 4.9 |
| **Preferred language** | | | | | |
| English | 3.6 | 4.3 | 4.4 | 4.3 | 4.3 |
| European | 3.9 | 4.0 | 4.7 | 5.2 | 4.9 |
| Other | 4.7 | 4.6 | 5.5 | 6.4 | 5.7 |
| **Recommended long-term setting** | | | | | |
| Residential aged care | 2.8 | 2.9 | 2.7 | 2.7 | 2.7 |
| Private residence | 9.9 | 9.7 | 9.8 | 9.3 | 9.5 |
| Other | 5.9 | 5.4 | 7.0 | 7.0 | 6.9 |
| **Living arrangements** | | | | | |
| Living alone | 2.6 | 2.9 | 3.2 | 3.6 | 3.4 |
| Living with others | 4.3 | 5.3 | 5.5 | 5.4 | 5.4 |
| **Carer status** | | | | | |
| Carer available | 4.1 | 4.7 | 4.7 | 4.5 | 4.6 |
| *Co-resident carer* | *4.9* | *5.7* | *5.7* | *5.7* | *5.7* |
| *Non-resident carer* | *2.8* | *3.1* | *3.3* | *3.6* | *3.5* |
| No carer | 2.5 | 2.6 | 3.2 | 3.4 | 3.1 |
| **Total** | **3.7** | **4.3** | **4.5** | **4.4** | **4.4** |

(a) The conclusion of the most recent ACAT assessment which provided approval for permanent residential aged care.

*Source:* AIHW analyses.

**Table A6: Average time (months) between the most recent ACAT assessment and first entry to PRAC in 2013–14, by age group, by selected health/functional status factors**[(a)]

| Selected factor | <65 | 65–74 | 75–84 | ≥85 | Total |
|---|---|---|---|---|---|
| | | | Months | | |
| **Health condition**[(b)] | | | | | |
| Heart disease | 3.2 | 3.5 | 4.0 | 4.0 | 3.9 |
| No heart disease | 3.8 | 4.7 | 4.8 | 4.9 | 4.8 |
| Arthritis | 4.3 | 4.3 | 4.6 | 4.7 | 4.7 |
| No arthritis | 3.6 | 4.3 | 4.4 | 4.1 | 4.2 |
| Dementia | 4.8 | 5.3 | 5.0 | 5.1 | 5.0 |
| No dementia | 3.3 | 3.8 | 4.1 | 4.1 | 4.1 |
| Abnormal gait/mobility | 3.5 | 3.9 | 4.2 | 4.1 | 4.1 |
| No abnormal gait/mobility | 3.8 | 4.4 | 4.5 | 4.5 | 4.5 |
| Frequent falls | 3.2 | 3.7 | 3.9 | 3.7 | 3.7 |
| No frequent falls | 3.8 | 4.5 | 4.7 | 4.7 | 4.6 |
| Mental health conditions | 3.7 | 4.3 | 4.5 | 4.5 | 4.4 |
| No mental health condition | 3.7 | 4.3 | 4.4 | 4.3 | 4.4 |
| Incontinence | 3.2 | 4.0 | 4.2 | 4.3 | 4.2 |
| No incontinence | 3.9 | 4.4 | 4.5 | 4.4 | 4.4 |
| Cerebrovascular disease | 3.1 | 4.0 | 4.4 | 4.2 | 4.2 |
| No cerebrovascular disease | 3.8 | 4.4 | 4.5 | 4.4 | 4.4 |
| Diabetes | 3.1 | 4.0 | 4.5 | 4.5 | 4.4 |
| No diabetes | 3.9 | 4.4 | 4.4 | 4.4 | 4.4 |
| Chronic lower respiratory diseases | 3.4 | 3.5 | 3.9 | 4.2 | 4.0 |
| No chronic lower resp. disease | 3.7 | 4.5 | 4.6 | 4.4 | 4.5 |
| **Activity limitation**[(c)] | | | | | |
| Any 4 core areas | 3.7 | 4.4 | 4.5 | 4.4 | 4.4 |
| *All 4 core areas* | *3.1* | *3.9* | *4.0* | *3.7* | *3.8* |
| No limitation in 4 core areas | 2.8 | 3.1 | 4.2 | 4.3 | 4.1 |
| **Total** | **3.7** | **4.3** | **4.5** | **4.4** | **4.4** |

(a) The conclusion of the most recent ACAT assessment which provided approval for permanent residential aged care.

(b) For more information on health condition, see Appendix B.

(c) Core areas of activity limitations assessed at ACAT assessment are *Self-care, Moving, Movement* and *Communication*.

*Source:* AIHW analyses.

**Table A7: Average time (months) between the most recent ACAT assessment and first entry to PRAC in 2013–14, by age group, by last-used program**[(a)]

| Program | <65 | 65–74 | 75–84 | ≥85 | Total |
|---|---|---|---|---|---|
| | | | Months | | |
| RRAC | 6.3 | 6.3 | 6.1 | 5.7 | 5.9 |
| HACC | 2.9 | 3.6 | 3.5 | 3.3 | 3.4 |
| None | 1.7 | 1.5 | 1.4 | 1.9 | 1.7 |
| TCP | 2.3 | 2.6 | 2.4 | 2.4 | 2.4 |
| Packages[(b)] | 9.3 | 7.0 | 6.7 | 6.6 | 6.7 |
| **Total** | **3.7** | **4.3** | **4.5** | **4.4** | **4.4** |

(a) The conclusion of the most recent ACAT assessment which provided approval for permanent residential aged care.

(b) Any aged care packages program delivered in the community (CACP/EACH/EACHD/HCP).

*Source:* AIHW analyses.

**Table A8: People who first entered PRAC in 2013–14, by last-used program, by sex, by age group**

| | RRAC | | HACC | | None | | TCP | | Packages[(a)] | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Sex/Age group** | **Number** | **%** | **Number** | **%** | **Number** | **%** | **Number** | **%** | **Number** | **%** | **Number** | **%** |
| **Men** | | | | | | | | | | | | |
| <65 | 309 | 3.4 | 539 | 6.2 | 306 | 9.7 | 88 | 4.5 | 20 | 1.3 | 1,262 | 5.2 |
| 65–74 | 1,042 | 11.6 | 1,118 | 13.0 | 575 | 18.3 | 276 | 14.2 | 162 | 10.5 | 3,173 | 13.1 |
| 75–84 | 3,203 | 35.8 | 3,152 | 36.5 | 1,080 | 34.3 | 730 | 37.6 | 558 | 36.2 | 8,723 | 36.0 |
| ≥85 | 4,404 | 49.2 | 3,819 | 44.3 | 1,185 | 37.7 | 846 | 43.6 | 803 | 52.0 | 11,057 | 45.7 |
| *Total* | *8,958* | *100.0* | *8,628* | *100.0* | *3,146* | *100.0* | *1,940* | *100.0* | *1,543* | *100.0* | *24,215* | *100.0* |
| **Women** | | | | | | | | | | | | |
| <65 | 264 | 1.8 | 453 | 3.4 | 163 | 5.5 | 67 | 2.2 | 44 | 1.6 | 991 | 2.7 |
| 65–74 | 1,051 | 7.0 | 1,116 | 8.4 | 366 | 12.3 | 240 | 7.7 | 197 | 7.1 | 2,970 | 8.0 |
| 75–84 | 4,677 | 31.3 | 4,195 | 31.5 | 999 | 33.6 | 1,047 | 33.6 | 909 | 32.7 | 11,827 | 31.9 |
| ≥85 | 8,949 | 59.9 | 7,542 | 56.7 | 1,449 | 48.7 | 1,759 | 56.5 | 1,630 | 58.6 | 21,329 | 57.5 |
| *Total* | *14,941* | *100.0* | *13,306* | *100.0* | *2,977* | *100.0* | *3,113* | *100.0* | *2,780* | *100.0* | *37,117* | *100.0* |
| **Total** | | | | | | | | | | | | |
| <65 | 573 | 2.4 | 992 | 4.5 | 469 | 7.7 | 155 | 3.1 | 64 | 1.5 | 2,253 | 3.7 |
| 65–74 | 2,093 | 8.8 | 2,234 | 10.2 | 941 | 15.4 | 516 | 10.2 | 359 | 8.3 | 6,143 | 10.0 |
| 75–84 | 7,880 | 33.0 | 7,347 | 33.5 | 2,079 | 34.0 | 1,777 | 35.2 | 1,467 | 33.9 | 20,550 | 33.5 |
| ≥85 | 13,353 | 55.9 | 11,361 | 51.8 | 2,634 | 43.0 | 2,605 | 51.6 | 2,433 | 56.3 | 32,386 | 52.8 |
| **Total** | **23,899** | **100.0** | **21,934** | **100.0** | **6,123** | **100.0** | **5,053** | **100.0** | **4,323** | **100.0** | **61,332** | **100.0** |

(a) Any aged care packages program delivered in the community (CACP/EACH/EACHD/HCP).

*Source:* AIHW analyses.

**Table A9: People who first entered PRAC in 2013–14, by last-used program, by selected demographic characteristics**

| | RRAC | | HACC | | None | | TCP | | Packages[(a)] | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Characteristic** | **Number** | **%** | **Number** | **%** | **Number** | **%** | **Number** | **%** | **Number** | **%** | **Number** | **%** |
| **Indigenous status** | | | | | | | | | | | | |
| Indigenous | 175 | 0.7 | 172 | 0.8 | 56 | 0.9 | 20 | 0.4 | 32 | 0.7 | 455 | 0.7 |
| Non-Indigenous | 23,724 | 99.3 | 21,762 | 99.2 | 6,067 | 99.1 | 5,033 | 99.6 | 4,291 | 99.3 | 60,877 | 99.3 |
| **Country of birth region** | | | | | | | | | | | | |
| Australia | 16,918 | 70.8 | 15,664 | 71.4 | 4,165 | 68.0 | 3,118 | 61.7 | 2,978 | 68.9 | 42,843 | 69.9 |
| United Kingdom/Ireland | 2,471 | 10.3 | 2,239 | 10.2 | 539 | 8.8 | 625 | 12.4 | 540 | 12.5 | 6,414 | 10.5 |
| South/East Europe | 2,410 | 10.1 | 1,981 | 9.0 | 662 | 10.8 | 715 | 14.2 | 367 | 8.5 | 6,135 | 10.0 |
| West/North Europe | 728 | 3.0 | 706 | 3.2 | 211 | 3.5 | 200 | 4.0 | 167 | 3.9 | 2,012 | 3.3 |
| Other | 1,362 | 5.7 | 1,344 | 6.1 | 529 | 8.6 | 394 | 7.8 | 271 | 6.3 | 3,900 | 6.4 |
| **Preferred language** | | | | | | | | | | | | |
| English | 21,913 | 91.7 | 20,192 | 92.1 | 5,387 | 88.0 | 4,442 | 87.9 | 3,995 | 92.4 | 55,929 | 91.2 |
| European | 1,594 | 6.7 | 1,351 | 6.2 | 463 | 7.6 | 491 | 9.7 | 239 | 5.5 | 4,138 | 6.8 |
| Other | 390 | 1.6 | 391 | 1.8 | 265 | 4.3 | 118 | 2.3 | 88 | 2.0 | 1,252 | 2.0 |
| **Carer status** | | | | | | | | | | | | |
| Carer available | 21,063 | 88.1 | 18,298 | 83.4 | 4,895 | 79.9 | 4,331 | 85.7 | 3,740 | 86.5 | 52,327 | 85.3 |
| *Co-resident* | *10,889* | *45.6* | *8,540* | *38.9* | *2,806* | *45.8* | *1,850* | *36.6* | *1,569* | *36.3* | *25,654* | *41.8* |
| *Non-resident* | *10,172* | *42.6* | *9,757* | *44.5* | *2,088* | *34.1* | *2,481* | *49.1* | *2,171* | *50.2* | *26,669* | *43.5* |
| No carer | 2,407 | 10.1 | 3,160 | 14.4 | 1,013 | 16.5 | 657 | 13.0 | 528 | 12.2 | 7,765 | 12.7 |
| Unknown | 429 | 1.8 | 476 | 2.2 | 215 | 3.6 | 65 | 1.3 | 55 | 1.2 | 1240 | 2.0 |
| **Total** | **23,899** | **100.0** | **21,934** | **100.0** | **6,123** | **100.0** | **5,053** | **100.0** | **4,323** | **100.0** | **61,332** | **100.0** |

(a) Any aged care packages program delivered in the community (CACP/EACH/EACHD/HCP).

*Source:* AIHW analyses.

**Table A10: People who first entered PRAC in 2013–14, by last-used program, by sex, by living arrangements**

| Sex/Living arrangements | RRAC | | HACC | | None | | TCP | | Packages[(a)] | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Number | % | Number | % | Number | % | Number | % | Number | % | Number | % |
| **Men** | | | | | | | | | | | | |
| Alone | 3,014 | 33.6 | 3,464 | 40.1 | 1,095 | 34.8 | 891 | 45.9 | 650 | 42.1 | 9,114 | 37.6 |
| With others | 5,787 | 64.6 | 4,966 | 57.6 | 1,934 | 61.5 | 1,017 | 52.4 | 869 | 56.3 | 14,573 | 60.2 |
| Unknown | 157 | 2.0 | 198 | 2.0 | 117 | 4.0 | 32 | 2.0 | 24 | 2.0 | 528 | 2.0 |
| *Total* | *8,958* | *100.0* | *8,628* | *100.0* | *3,146* | *100.0* | *1,940* | *100.0* | *1,543* | *100.0* | *24,215* | *100.0* |
| **Women** | | | | | | | | | | | | |
| Alone | 8,131 | 54.4 | 7,761 | 58.3 | 1,369 | 46 | 1,964 | 63.1 | 1,683 | 60.5 | 20,908 | 56.3 |
| With others | 6,542 | 43.8 | 5,269 | 39.6 | 1,512 | 50.8 | 1,114 | 35.8 | 1,066 | 38.3 | 15,503 | 41.8 |
| Unknown | 268 | 2.0 | 276 | 2.0 | 96 | 3.0 | 35 | 1.0 | 31 | 1.0 | 706 | 2.0 |
| *Total* | *14,941* | *100.0* | *13,306* | *100.0* | *2,977* | *100.0* | *3,113* | *100.0* | *2,780* | *100.0* | *37,117* | *100.0* |
| **Total** | | | | | | | | | | | | |
| Alone | 11,145 | 46.6 | 11,225 | 51.2 | 2,464 | 40.2 | 2,855 | 56.5 | 2,333 | 54.0 | 30,022 | 48.9 |
| With others | 12,329 | 51.6 | 10,235 | 46.7 | 3,446 | 56.3 | 2,131 | 42.2 | 1,935 | 44.8 | 30,076 | 49.0 |
| Unknown | 425 | 2.0 | 474 | 2.0 | 213 | 4.0 | 67 | 1.0 | 55 | 1.0 | 1,234 | 2.0 |
| **Total** | **23,899** | **100.0** | **21,934** | **100.0** | **6,123** | **100.0** | **5,053** | **100.0** | **4,323** | **100.0** | **61,332** | **100.0** |

(a) Any aged care packages program delivered in the community (CACP/EACH/EACHD/HCP).

*Source:* AIHW analyses.

**Table A11: Selected health/functional status factors for people who first entered PRAC in 2013–14, by last-used program**[a]

| | RRAC | | HACC | | None | | TCP | | Packages[b] | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Health/functional status** | **Number** | **%** | **Number** | **%** | **Number** | **%** | **Number** | **%** | **Number** | **%** | **Number** | **%** |
| **Health condition**[d] | | | | | | | | | | | | |
| Heart disease | 10,860 | 45.4 | 10,317 | 47.0 | 2,494 | 40.7 | 2,547 | 50.4 | 1,951 | 45.1 | 28,169 | 45.9 |
| Arthritis | 9,861 | 41.3 | 8,357 | 38.1 | 1,816 | 29.7 | 1,673 | 33.1 | 1,811 | 41.9 | 23,518 | 38.4 |
| Dementia | 8,321 | 34.8 | 6,156 | 28.1 | 1,734 | 28.3 | 1,425 | 28.2 | 1,592 | 36.8 | 19,228 | 31.4 |
| Abnormal gait or mobility | 6,823 | 28.6 | 6,396 | 29.2 | 1,707 | 27.9 | 1,367 | 27.1 | 1,144 | 26.5 | 17,437 | 28.4 |
| Frequent falls | 6,521 | 27.3 | 5,991 | 27.3 | 1,582 | 25.8 | 1,748 | 34.6 | 1,212 | 28.0 | 17,054 | 27.8 |
| Mental health conditions | 6,600 | 27.6 | 5,543 | 25.3 | 1,296 | 21.2 | 1,329 | 26.3 | 1,162 | 26.9 | 15,930 | 26.0 |
| Incontinence | 5,437 | 22.8 | 5,082 | 23.2 | 1,526 | 24.9 | 1,215 | 24.1 | 1,058 | 24.5 | 14,318 | 23.4 |
| Cerebrovascular disease | 4,875 | 20.4 | 4,659 | 21.2 | 1,516 | 24.8 | 1,392 | 27.6 | 886 | 20.5 | 13,328 | 21.7 |
| Diabetes | 4,773 | 20.0 | 4,853 | 22.1 | 1,210 | 19.8 | 1,197 | 23.7 | 909 | 21.0 | 12,942 | 21.1 |
| Chronic lower respiratory diseases | 3,791 | 15.9 | 3,930 | 17.9 | 945 | 15.4 | 855 | 16.9 | 725 | 16.8 | 10,246 | 16.7 |
| **Activity limitation**[c] | | | | | | | | | | | | |
| Any 4 core areas | 21,642 | 90.6 | 19,685 | 89.8 | 5,484 | 89.6 | 4,644 | 91.9 | 4,053 | 93.8 | 55,508 | 90.5 |
| *All 4 core areas* | *2,570* | *10.8* | *2,864* | *13.1* | *1,148* | *18.8* | *661* | *13.1* | *509* | *11.8* | *7,752* | *12.6* |
| No limitation | 2,257 | 9.4 | 2,249 | 10.3 | 639 | 10.4 | 409 | 8.1 | 270 | 6.3 | 5,824 | 9.5 |
| **Total** | **23,899** | **100.0** | **21,934** | **100.0** | **6,123** | **100.0** | **5,053** | **100.0** | **4,323** | **100.0** | **61,332** | **100.0** |

(a) Health/functional status factors as identified at the most recent ACAT assessment which provided approval for permanent residential aged care.

(b) Any aged care packages program delivered in the community (CACP/EACH/EACHD/HCP).

(c) Core areas of activity limitations assessed at ACAT assessment are *Self-care, Moving, Movement* and *Communication*.

(d) For more information on health conditions, see Appendix B.

*Source:* AIHW analyses.

**Table A12: Distribution of time between last-used program and first entry to PRAC in 2013–14, by sex, by aged care program**

| Sex/Program | 0 days | 1 day–<1 week | 1 week–<1 month | 1 month–<3 months | 3 months–<6 months | 6 months–<1 year | 1 year and over | Total |
|---|---|---|---|---|---|---|---|---|
| | | | | Per cent | | | | |
| **Men** | | | | | | | | |
| RRAC | 68.8 | 6.7 | 7.0 | 8.6 | 4.2 | 2.7 | 2.1 | **100.0** |
| HACC | 36.6 | 5.0 | 11.1 | 13.4 | 8.1 | 7.6 | 18.1 | **100.0** |
| TCP | 70.5 | 2.7 | 8.9 | 8.1 | 3.4 | 2.6 | 3.8 | **100.0** |
| Packages[(a)] | 82.0 | 7.7 | 4.3 | 2.7 | 1.0 | 0.8 | 1.5 | **100.0** |
| **Women** | | | | | | | | |
| RRAC | 70.2 | 6.7 | 6.6 | 7.8 | 3.8 | 2.7 | 2.1 | **100.0** |
| HACC | 37.5 | 5.7 | 10.5 | 12.0 | 7.2 | 7.8 | 19.3 | **100.0** |
| TCP | 73.0 | 3.0 | 6.7 | 6.8 | 2.8 | 2.5 | 5.1 | **100.0** |
| Packages[(a)] | 84.2 | 6.8 | 4.4 | 1.9 | 0.7 | 0.6 | 1.4 | **100.0** |
| **Total** | | | | | | | | |
| RRAC | 69.7 | 6.7 | 6.8 | 8.1 | 3.9 | 2.7 | 2.1 | **100.0** |
| HACC | 37.2 | 5.4 | 10.7 | 12.6 | 7.5 | 7.7 | 18.9 | **100.0** |
| TCP | 72.0 | 2.9 | 7.6 | 7.3 | 3.0 | 2.6 | 4.6 | **100.0** |
| Packages[(a)] | 83.4 | 7.1 | 4.3 | 2.2 | 0.8 | 0.7 | 1.4 | **100.0** |

(a) Any aged care packages program delivered in the community (CACP/EACH/EACHD/HCP).

*Source:* AIHW analyses.

**Table A13: People who first entered PRAC in 2013–14, interval between last-used program and first entry, by selected demographic characteristics, by last-used program**

| Characteristic | RRAC | | | HACC | | | TCP | | | Packages[a] | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 0 days | 1 day–<1 month | ≥1 month | 0 days | 1 day–<1 month | ≥1 month | 0 days | 1 day–<1 month | ≥1 month | 0 days | 1 day–<1 month | ≥1 month |
| | Per cent | | | | | | | | | | | |
| **Age** | | | | | | | | | | | | |
| 0–64 | 2.4 | 2.6 | 2.1 | 4.1 | 3.9 | 5.0 | 3.3 | 3.0 | 2.2 | 1.4 | 2.0 | 2.3 |
| 65–74 | 8.7 | 8.8 | 8.9 | 10.6 | 9.8 | 10.0 | 10.0 | 11.1 | 10.4 | 8.3 | 7.7 | 9.1 |
| 75–84 | 33.3 | 34.3 | 30.6 | 34.8 | 33.5 | 32.4 | 34.8 | 38.0 | 34.8 | 33.8 | 35.5 | 32.3 |
| 85+ | 55.6 | 54.3 | 58.4 | 50.4 | 52.9 | 52.5 | 51.8 | 47.9 | 52.6 | 56.5 | 54.8 | 56.4 |
| **Sex** | | | | | | | | | | | | |
| Men | 37.0 | 38.1 | 39.0 | 38.8 | 39.3 | 39.8 | 37.6 | 42.5 | 39.2 | 35.1 | 37.3 | 41.8 |
| Women | 63.0 | 61.9 | 61.0 | 61.2 | 60.7 | 60.2 | 62.4 | 57.5 | 60.8 | 64.9 | 62.7 | 58.2 |
| **Indigenous status** | | | | | | | | | | | | |
| Indigenous | 0.7 | 1.0 | 0.8 | 0.8 | 0.7 | 0.8 | 0.4 | 0.2 | 0.7 | 0.8 | 0.4 | 0.9 |
| Non-Indigenous | 99.3 | 99.0 | 99.2 | 99.2 | 99.3 | 99.2 | 99.6 | 99.8 | 99.3 | 99.2 | 99.6 | 99.1 |
| **Country of birth region** | | | | | | | | | | | | |
| Australia | 70.9 | 71.9 | 69.6 | 70.6 | 73.1 | 71.5 | 59.7 | 63.9 | 68.5 | 68.2 | 73.6 | 69.1 |
| UK/Ireland | 10.1 | 10.3 | 11.5 | 10.9 | 10.1 | 9.7 | 13.1 | 12.0 | 9.4 | 12.6 | 13.7 | 8.2 |
| South/East Europe | 10.3 | 9.6 | 9.5 | 8.6 | 8.1 | 9.7 | 15.2 | 11.8 | 11.2 | 8.6 | 5.6 | 13.2 |
| West/North Europe | 3.0 | 2.8 | 3.5 | 3.6 | 3.3 | 2.9 | 3.7 | 4.9 | 4.6 | 4.1 | 2.2 | 4.1 |
| Other | 5.7 | 5.5 | 5.9 | 6.3 | 5.4 | 6.2 | 8.2 | 7.3 | 6.2 | 6.5 | 4.8 | 5.5 |

*(continued)*

**Table A13 (continued): People who first entered PRAC in 2013–14, interval between last-used program and first entry, by selected demographic characteristics, by last-used program**

| Characteristic | RRAC | | | HACC | | | TCPn | | | Packages[(a)] | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 0 days | 1 day–<1 month | ≥1 month | 0 days | 1 day–<1 month | ≥1 month | 0 days | 1 day–<1 month | ≥1 month | 0 days | 1 day–<1 month | ≥1 month |
| | | | | | | Per cent | | | | | | |
| **Preferred language** | | | | | | | | | | | | |
| English | 91.5 | 91.6 | 92.5 | 92.4 | 93.2 | 91.4 | 86.8 | 90.0 | 91.2 | 92.2 | 95.6 | 88.6 |
| European | 6.9 | 6.7 | 5.7 | 5.9 | 5.4 | 6.6 | 10.6 | 7.3 | 7.5 | 5.5 | 4.0 | 9.1 |
| Other | 1.6 | 1.7 | 1.7 | 1.7 | 1.4 | 2.0 | 2.5 | 2.6 | 1.4 | 2.2 | 0.4 | 2.3 |
| **Living arrangements** | | | | | | | | | | | | |
| Living alone | 49.1 | 45.0 | 37.8 | 49.5 | 53.7 | 51.6 | 56.8 | 55.1 | 56.0 | 54.6 | 55.6 | 40.5 |
| Living with others | 49.1 | 53.2 | 60.5 | 48.6 | 44.6 | 45.9 | 42.1 | 42.5 | 42.3 | 44.5 | 42.7 | 53.6 |
| Unknown | 1.8 | 1.8 | 1.6 | 1.9 | 1.7 | 2.5 | 1.0 | 2.4 | 1.7 | 0.9 | 1.6 | 5.9 |
| **Carer status** | | | | | | | | | | | | |
| Carer available | 87.1 | 89.1 | 91.6 | 85.4 | 83.2 | 81.9 | 86.0 | 85.5 | 84.7 | 86.3 | 89.9 | 82.3 |
| *Co-resident* | *42.3* | *48.3* | *56.9* | *40.8* | *36.7* | *38.2* | *36.4* | *37.2* | *37.0* | *35.8* | *35.9* | *44.5* |
| *Non-resident* | *44.8* | *40.9* | *34.7* | *44.6* | *46.5* | *43.7* | *49.6* | *48.3* | *47.7* | *50.5* | *54.0* | *37.7* |
| No carer | 11.1 | 9.0 | 6.6 | 12.7 | 15.1 | 15.5 | 13.0 | 12.0 | 13.6 | 12.8 | 8.5 | 11.8 |
| Unknown | 1.7 | 1.8 | 1.7 | 1.9 | 1.7 | 2.6 | 1.0 | 2.4 | 1.7 | 0.9 | 1.6 | 5.9 |
| **Total** | **100.0** | **100.0** | **100.0** | **100.0** | **100.0** | **100.0** | **100.0** | **100.0** | **100.0** | **100.0** | **100.0** | **100.0** |

(a) Any aged care packages program delivered in the community (CACP/EACH/EACHD/HCP).

*Source:* AIHW analyses.

**Table A14: People who first entered PRAC in 2013–14, interval between last-used program and first entry, by selected health/functional status factors, by last-used program**

| | RRAC | | | HACC | | | TCP | | | Packages[a] | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Health status** | **0 days** | **1 day–<1 month** | **≥1 month** | **0 days** | **1 day–<1 month** | **≥1 month** | **0 days** | **1 day–<1 month** | **≥1 month** | **0 days** | **1 day–<1 month** | **≥1 month** |
| | | | | | | **Per cent** | | | | | | |
| **Health condition**[b] | | | | | | | | | | | | |
| Heart disease | 44.8 | 46.4 | 47.1 | 45.7 | 48.5 | 47.6 | 48.9 | 52.6 | 55.4 | 44.8 | 46.4 | 47.7 |
| Arthritis | 41.0 | 41.3 | 42.1 | 39.3 | 38.6 | 37.0 | 32.3 | 32.5 | 36.8 | 42.7 | 37.5 | 39.1 |
| Dementia | 34.7 | 33.8 | 36.3 | 29.9 | 28.0 | 26.7 | 31.0 | 21.6 | 20.7 | 37.6 | 31.9 | 35.9 |
| Abnormal gait | 28.5 | 28.3 | 28.7 | 29.2 | 27.8 | 29.6 | 25.0 | 28.0 | 35.1 | 26.6 | 24.8 | 27.3 |
| Falls | 27.3 | 27.4 | 27.0 | 26.0 | 27.6 | 28.2 | 34.4 | 32.7 | 36.4 | 27.8 | 28.2 | 30.9 |
| Mental health | 27.5 | 28.2 | 27.4 | 25.7 | 24.2 | 25.3 | 26.1 | 26.5 | 27.2 | 27.5 | 23.8 | 24.1 |
| Incontinence | 22.4 | 23.1 | 24.0 | 22.4 | 20.7 | 24.6 | 24.2 | 23.5 | 23.9 | 24.1 | 23.0 | 33.2 |
| Cerebrovascular | 20.1 | 20.5 | 21.6 | 19.4 | 19.3 | 23.4 | 27.6 | 27.8 | 27.2 | 20.1 | 23.6 | 19.5 |
| Diabetes | 19.8 | 20.7 | 20.2 | 21.6 | 22.6 | 22.3 | 23.3 | 25.8 | 23.9 | 21.1 | 20.2 | 21.8 |
| Chronic lower respiratory | 15.8 | 15.8 | 16.0 | 17.9 | 18.6 | 17.7 | 15.6 | 22.2 | 19.3 | 16.7 | 18.3 | 14.5 |
| **Activity limitation**[c] | | | | | | | | | | | | |
| Any 4 core areas | 90.6 | 89.6 | 91.3 | 90.0 | 89.1 | 89.8 | 91.1 | 93.0 | 94.4 | 94.0 | 93.1 | 91.8 |
| *All 4 core areas* | *10.3* | *10.5* | *12.7* | *11.7* | *11.9* | *14.5* | *12.5* | *15.0* | *14.3* | *11.4* | *10.5* | *20.0* |
| No core limitation | 9.4 | 10.4 | 8.7 | 10.0 | 10.9 | 10.2 | 8.9 | 7.0 | 5.6 | 6.0 | 6.9 | 8.2 |
| **Total** | **100.0** | **100.0** | **100.0** | **100.0** | **100.0** | **100.0** | **100.0** | **100.0** | **100.0** | **100.0** | **100.0** | **100.0** |

(a) Any aged care packages program delivered in the community (CACP/EACH/EACHD/HCP).

(b) For further information on health conditions, see Appendix B.

(c) Core areas of activity limitations assessed at ACAT assessment are *Self-care, Moving, Movement* and *Communication*.

*Source:* AIHW analyses.

**Table A15: Distribution of time spent at last-used program before first entry to PRAC in 2013–14, by sex, by aged care program**

| Sex/Program | 0 days | 1 day–<1 week | 1 week–<1 month | 1 month–<3 months | 3 months–<6 months | 6 months–<1 year | 1 year and over | Total |
|---|---|---|---|---|---|---|---|---|
| | | | | Per cent | | | | |
| **Men** | | | | | | | | |
| Respite | 0.1 | 5.3 | 52.8 | 39.4 | 2.2 | 0.1 | 0.0 | **100.0** |
| HACC | 5.4 | 4.0 | 13.5 | 26.9 | 21.3 | 14.8 | 14.1 | **100.0** |
| Transition | 0.2 | 5.9 | 34.7 | 50.8 | 8.5 | 0.0 | 0.0 | **100.0** |
| Packages[(a)] | 0.1 | 0.7 | 6.2 | 19.4 | 18.5 | 21.3 | 33.7 | **100.0** |
| **Women** | | | | | | | | |
| Respite | 0.1 | 4.5 | 51.0 | 42.0 | 2.4 | 0.1 | 0.0 | **100.0** |
| HACC | 7.4 | 3.6 | 12.2 | 25.0 | 20.3 | 14.9 | 16.7 | **100.0** |
| Transition | 0.2 | 5.0 | 33.1 | 54.1 | 7.6 | 0.0 | 0.0 | **100.0** |
| Packages[(a)] | 0.2 | 0.6 | 5.8 | 16.5 | 17.4 | 20.1 | 39.5 | **100.0** |
| **Total** | | | | | | | | |
| Respite | 0.1 | 4.8 | 51.7 | 41.0 | 2.3 | 0.1 | 0.0 | **100.0** |
| HACC | 6.6 | 3.8 | 12.7 | 25.7 | 20.7 | 14.6 | 16.0 | **100.0** |
| Transition | 0.2 | 5.3 | 33.7 | 52.8 | 7.9 | 0.0 | — | **100.0** |
| Packages[(a)] | 0.2 | 0.6 | 5.9 | 17.6 | 17.8 | 20.4 | 37.5 | **100.0** |

(a) Any aged care packages program delivered in the community (CACP/EACH/EACHD/HCP).

*Source:* AIHW analyses.

# Appendix B: Methodology

## PIAC link map

The Data Linkage Unit at the AIHW was responsible for the PIAC link map—both the earlier version known as PIAC 2011 and the current update used in this report referred to as PIAC 2014. To protect the privacy of individuals, the linkage was approved by the AIHW Ethics Committee and carried out using the AIHW data-linkage protocol for linking data sets held within the AIHW.

State, territory and Australian Government agencies gave permission to include aged care data, obtained through the National Aged Care Data Clearinghouse held at the AIHW, which includes the annual national minimum data sets for assessments and HACC, and administrative data for the other service-delivery programs. State and territory registries of births, deaths and marriages and the National Coronial Information System gave permission to include data on deaths, obtained through the National Death Index held at the AIHW, which contains deaths registration data from state and territory registries of births, deaths and marriages, and from the National Coronial Information System.

For more information on PIAC 2011 and the underlying methods used for linking aged care data, please see *Patterns in use of aged care 2002–03 to 2010–11* (AIHW 2014a). The PIAC 2014 link map used in this study covers the period 1 July 1997 to 30 June 2014 and contains person-level data on ACAT assessments conducted under the ACAP and 7 aged care service-delivery programs: HACC, RRAC and permanent residential aged care, packaged care provided in the community (CACP, EACH, EACHD and HCP), and TCP—as well as all deaths. In all, the PIAC 2014 link map contains data for 5.03 million people.

## Dates of service use

This study focused on only a small sub-set of the PIAC linkage data. The cohort was identified on the basis of their dates of service use for permanent residential aged care on the PIAC link map—people whose first recorded entry into permanent residential aged care took place between 1 July 2013 and 30 June 2014. Prior use of other aged care programs was then identified on the basis of the date of first entry, taking into account only the last program used before this occurred (using PIAC 'events'). As some people had used 2 or more programs concurrently, 'last program' was further narrowed to the episode of care that had most recently commenced. CACP, EACH, EACHD and HCP were considered as 1 program, resulting in 4 possible pathways before first entry to permanent residential aged care, in addition to those entering permanent residential aged care with no prior use of aged care. The timelines between last program used and first entry to permanent residential aged care were calculated on the basis of the end date for the last program used, and the timelines of duration at last program used before first entry to permanent residential aged care were calculated on the basis of the start and end dates for the last program used.

For the cohort's ACAT assessments, only the most recent completed assessment which provided approval for permanent residential aged care was taken into account. The timelines between assessment and first entry to permanent residential aged care were calculated on the basis of the date on which the ACAT assessment concluded.

Further information on service-use dates and how these are edited can be found in Appendix B6.2 of *Patterns in use of aged care 2002–03 to 2010–11* (AIHW 2014a)**.** Analyses of the broader patterns of use of aged care drew on PIAC 'pathways', which identify the use of all

service delivery programs as a 'string' for each person, with each program represented by a particular character in chronological order based only on start dates. The pathways were further simplified to ignore changes within packages, and where people had used CACP, EACH, EACHD or HCP in a row, these were collapsed into a single character. On the other hand, the analyses conducted specifically on last program used drew on PIAC 'events' information, where each service use event forms a record, identified by the person. The last program was selected based on the most recent end date of service use, and as a result, these do not fully match information generated through the 'pathways'.

## Cohort characteristics

### Demographic variables

People's ages were calculated as age on the day they first entered permanent residential aged care. Other demographic variables for the cohort were obtained from the PIAC link map. Further information on this is available in Appendix B6.1 in *Patterns in use of aged care 2002–03 to 2010–11* (AIHW 2014a).

The English proficiency (EP) group classification indicates a migrant's level of English proficiency and it is derived from country of birth. The EP index is defined as the percentage of recent immigrants (those entering in the 5 years before the Census) who speak English only or another language and spoke English 'Very well' or 'Well'. The 2001 English proficiency groups were defined as Australian-born, EP1 (all countries rating 98.5% or higher on the EP index with at least 10,000 residents in Australia); EP2 (countries rating 84.5% or higher on the EP index, other than those in EP1); EP3 (countries rating 57.5% to less than 84.5% on the EP index; and EP4 (countries rating less than 57.5% on the EP index). In this report, 'high degree of English language proficiency' refers collectively to people who were either born in Australia, or had an English language proficiency rating of 1.

### Health and functional status

Health conditions, activity limitations and selected other demographic details (such as living arrangements and carer availability) were obtained from ACAT assessments; health condition codes and other supporting information for ACAT assessments are further outlined in the ACAP data dictionary (DoH 2014). The ACAT assessment determines whether the person needs the help or supervision of another individual in different activities. The tasks of *Self-care*, *Moving*, *Movement* and *Communication* are considered core activities.

Needing assistance with these tasks is not an eligibility criterion for aged care or other services. Rather, the need for assistance with these tasks is a way of identifying clients with higher level needs. This also allows them to be compared with members of the general population: the Australian Bureau of Statistics (ABS) Survey of Disability, Ageing and Carers (SDAC) defines a person with a severe or profound core activity limitation as someone who sometimes, or always, needs assistance with 1 or more of the tasks of *Self-care*, *Mobility* (*Moving* and *Movement* combined) or *Communication*. The construct 'any core activity limitation' used in this report can thus be aligned with the ABS construct of 'disability with severe or profound core activity limitation' (for more information, see the ACAP data dictionary and SDAC glossary).

The ACAT records up to 10 diagnosed disease(s) or disorder(s) that have an impact on the person's need for assistance with activities of daily living and social participation (the disease or disorder listed first being taken as the health condition with the greatest impact). The code list is included in Appendix D of the ACAP data dictionary; the list is presented by body system, as mirrored in this report.

Most of these health condition codes can be mapped against equivalent ICD-10-AM codes, and the 10 conditions that were examined in closer detail in this report have the following correspondences:

| Condition | ACAP health condition code | Equivalent ICD-10-AM code |
|---|---|---|
| Heart disease—includes rheumatic fever or rheumatic heart disease, angina, myocardial infarction, congestive heart failure and acute or chronic ischaemic heart disease | 0900 | — |
| | 0901 | I00–02 |
| | 0902 | I05–09 |
| | 0903 | I20 |
| | 0904 | I21–22 |
| | 0905 | I24–25 |
| | 0906 | I50.0 |
| | 0907 | I23, I26–52 |
| Arthritis—includes gout, arthritis and osteoarthritis (excludes rheumatoid arthritis) | 1302 | M00–04, M07–19 |
| Dementia—includes dementia in Alzheimer disease, vascular dementia and dementia in other diseases | 0500 | — |
| | 0501 | F00.0, G30 |
| | 0502 | F00.1, G30 |
| | 0503 | F00.2, G30 |
| | 0504 | F00.9, G30 |
| | 0510 | — |
| | 0511 | F01.0 |
| | 0512 | F01.1 |
| | 0513 | F01.2 |
| | 0514 | F01.3 |
| | 0515 | F01.8 |
| | 0516 | F01.9 |
| | 0520 | — |
| | 0521 | F02.0 |
| | 0522 | F02.1 |
| | 0523 | F02.2 |
| | 0524 | F02.3 |
| | 0525 | F02.4 |
| | 0526 | F02.8 |
| | 0530 | — |
| | 0531 | F10.7 |
| | 0532 | F03 |
| Abnormal of gait or mobility—includes ataxic and spastic gait or difficulty in walking not elsewhere classified | 1714 | R26 |
| Falls—frequent with unknown aetiology | 1715 | R29.81 |
| | 0550 | — |
| | 0551 | F20 |

| Condition | ACAP health condition code | Equivalent ICD-10-AM code |
|---|---|---|
| Mental health conditions—includes depression and mood-affective disorders, psychoses and schizophrenia, and anxiety disorders | 0552 | F30–39 |
| | 0553 | F04, F06, F21–29 |
| | 0560 | — |
| | 0561 | F40–41 |
| | 0562 | F43 |
| | 0563 | F42 |
| | 0564 | F44–48 |
| Incontinence—includes stress, faecal and unspecified urinary incontinence | 1403 | N39.3–39.4 |
| | 1707 | R32 |
| | 1708 | R15 |
| Cerebrovascular disease—includes subarachnoid, intracerebral and other intracranial haemorrhage, cerebral infarction, cerebrovascular accidents (stroke) and transient ischaemic attacks (mini-strokes) | 0605 | G45–46 |
| | 0910 | — |
| | 0911 | I60 |
| | 0912 | I61 |
| | 0913 | I62 |
| | 0914 | I63 |
| | 0915 | I64 |
| | 0916 | I65–67, I69 |
| Diabetes—includes types 1, 2 and unspecified | 0402 | E1 |
| | 0403 | E11 |
| | 0404 | E13–14 |
| Chronic lower respiratory diseases—includes emphysema, asthma and chronic obstructive pulmonary disease | 1005 | J40–70 |

Domain ratings were obtained from ACFI assessments. Further information on these is available in the *Aged Care Funding Instrument (ACFI) user guide* (DoH 2017).

# Data quality statements

There are currently 2 data quality statements (DQS) available:

- a general DQS for the National Aged Care Data Clearinghouse
- a separate DQS for the Aged Care Funding Instrument.

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# List of tables

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# Related publications

Further information and comprehensive Australian aged care data are available through the GEN website <gen-agedcaredata.gov.au>.

Some 61,300 people first entered permanent residential aged care (PRAC) in 2013–14. While they used over 1,000 different combinations of other aged care in the preceding years, the most common pathway (used by 1 in 4 people) was through Home and Community Care (HACC). Many pathways showed a similar pattern of moving 'up' to progressively higher levels of support.

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