Trends in the incidence of aged care program utilisation by older Aboriginal and Torres Strait Islander people, 2010–2019

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Abstract

Objective: To study the trends in incident aged care service use among Aboriginal and Torres Strait Islander Australians.

Methods: Annual incidence of aged care use among Aboriginal and Torres Strait Islander people (2010–2019) were evaluated using the Registry of Senior Australians Historical Cohort and Australian Bureau of Statistics population estimates. Trends were examined by incident rate ratios (IRRs) using Poisson or negative binomial regression adjusted for age, sex and remoteness.

Results: Among 15,106 individuals, incident aged care assessments increased from 10.6/1000 [95% confidence interval [CI]: 9.7–11.1) in 2010 to 14.6/1000 (95%CI: 14.0–15.2) in 2019 (IRR=1.04/year, 95%CI: 1.03–1.05). Incident aged care service use increased from 7.4/1000 (95%CI: 6.8–8.0) to 9.7/1000 (95%CI: 9.2–10.2; IRR=1.02/year, 95%CI: 1.01–1.03). Increases occurred in metropolitan and regional areas, with the greatest increase observed for home care packages (≥8% annually). In remote areas, the use of home care packages decreased by ≥5% annually.

Conclusions: Increased use of aged care programs is encouraging. However, declining use in remote areas highlight the need for improved access to aged care.

Implications for Public Health: Equitable access and use of aged care services will require the reforms underway to incorporate Aboriginal and Torres Strait Islander preferences for aged care.

Key words: aged care, Aboriginal and Torres Strait Islander, incident use, time trends

Introduction

Since its inception, the Australian aged care system has had 18 inquiries, including the most recent royal commission into Aged Care Quality and Safety.[1] The Australian age care system exists to support independent living in the community and where needed, living in supported accommodation.[2] Government-subsidised aged care services are available to Aboriginal and Torres Strait Islander people aged 50 years or 65 years and over for non-Indigenous people. Currently, home care packages provide for complex care needs (e.g. cleaning, meal preparation, podiatry to maintain movement), and residential aged care is available for people who need ongoing daily help. Short-term care is available through transition care support and residential respite care for those needing temporary health and wellbeing support and carer respite. Access to these services is based on eligibility assessment by a specific multidisciplinary team. The entry-level Commonwealth Home Support Programme (CHSP) provides support with, for example, shopping, social activities and home modifications, and for the most part does not require eligibility assessment. Since 2014, a national Aboriginal and Torres Strait Islander Flexible Aged Care Program, which includes support for transition, short-term restorative,

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multipurpose services and innovative care has been available. As at 30 June 2019, this program supported 29 aged care service providers nationally and 820 service places with 629 used by Aboriginal and/or Torres Strait Islander people.[3]

Aboriginal and Torres Strait Islander people aged 50 years and older comprise a small but growing proportion of the aged care population in Australia. The devastating and ongoing impacts of colonisation, including experiences of racism, intergenerational trauma and marginalisation, have led to health disparities among this population including higher prevalence and earlier onset of age-related chronic diseases and disability.[1] As a result and with unique cultural and supportive factors for ageing well, Aboriginal and Torres Strait Islander people may have additional aged care preferences and practices. These range from trauma aware and healing informed care, preference to use Aboriginal service providers, the ability to pass on cultural knowledge to younger generations, to participate in cultural business, options to remain living on Country and to die with dignity on Country.[4]

Over the last decade, the Aboriginal and Torres Strait Islander population aged 50 years and over has grown at more than twice the rate of non-Indigenous Australians of the same age group, increasing by almost 60% from around 97,000 in 2011 to 154,000 in 2021.[5,6] With similar growth projected to continue over the next decade, demand for aged care services that meet the health, social and cultural wellbeing needs of Aboriginal and Torres Strait Islander people is expected to grow substantially.[7] The geographical diversity of this population further exacerbates access challenges, with Aboriginal and Torres Strait Islander people more likely than non-Indigenous people to live in remote areas isolated from services (19% compared with 1%).[8]

The Aboriginal and Torres Strait Islander population were 2.8 times more likely to use home support (2021–2022) and as at 30 June 2022 home care (5.3 times) and residential aged care (2.3 times), than the non-Indigenous population, indicating the high need for aged care. However, despite this, inequity in access to aged care prevails; it is currently estimated that only 12% of eligible Aboriginal and Torres Strait Islander people receive aged care compared with 30% of eligible non-Indigenous people.[9] As a result, Aboriginal and Torres Strait Islander people comprised around 2% of aged care program users in 2022 and only 1% of people in residential aged care, compared with their 3.5% representation in the population eligible for aged care.[5,6,10]

The final report of the royal commission into Aged Care Quality and Safety[1] highlighted the current shortcomings of Australia's aged care sector, including its specific failings regarding older Aboriginal and Torres Strait Islander people. It proposed a new system built on evidence-based planning capable of providing culturally safe aged care to Aboriginal and Torres Strait Islander people wherever they live. However, to date, there has been limited research of aged care program use among older Aboriginal and Torres Strait Islander people and consequently the evidence base on which to inform policy and planning is lacking.[11-13] To explore Aboriginal and Torres Strait Islander people entering the aged care sector in Australia, we aimed to examine trends in the annual incidence of: i) aged care eligibility assessments approved and ii) aged care services used between 2010–2019. We also examined the incidence of the two outcomes by age, sex and remoteness. This will highlight challenges and opportunities for service access and policy improvement to address the aged care needs of Aboriginal and Torres Strait Islander people.

Methods

Study design and data sources

A population-based retrospective cross-sectional study was conducted using data from the Registry of Senior Australians (ROSA) National Historical Cohort, which includes de-identified linked aged care, health care and social welfare data.[14] From ROSA, this study utilised the Australian Institute of Health and Welfare National Aged Care Data Clearinghouse datasets; specifically, the Aged Care Assessment Program dataset and residential, community and transition aged care services records. The Aged Care Assessment Program dataset contains information on people seeking services obtained from the mandatory aged care eligibility assessments conducted by clinically trained aged care assessment teams prior to accessing government-subsidised aged care programs.[15] The residential aged care, community and transition care services records include information on episodes of permanent residential aged care (PRAC) and residential respite care, home care packages (under the Home Care Packages program and its predecessors Community Aged Care Packages, Extended Aged Care at Home and Extended Aged Care at Home Dementia) and transition care, including dates of service entry and exit.[16] Publicly available population estimates and projections from the Australian Bureau of Statistics (ABS) were also employed.[6]

Study cohort

The study cohort comprised 15,106 individuals who identified as being of Aboriginal and/or Torres Strait Islander origin who had: 1) an incident (first time) aged care eligibility assessment between 1 January 2010 and 31 December 2019 and were approved for any aged care service or 2) an incident admission to any aged care service for which an eligibility assessment is required (PRAC, home care package, respite and transition care).

Outcomes

The outcome of incident aged care assessments approved was defined as the first aged care assessment with approval between 2010 and 2019. The outcome of aged care service use included the first aged care service accessed between 2010 and 2019 for the overall (any aged care outcome) and included the first use of either PRAC, home care, respite and transition care. For each individual aged care service analyses, the first use of each service between 2010 and 2019 was included. The use of each individual aged care program was not mutually exclusive, and individuals may access multiple aged care types during the study period.

Covariates

Sociodemographic characteristics were identified from the aged care eligibility assessment and included sex, age (50–64 years, 65–74 years and ≥75 years) and remoteness (classified as major cities, inner / outer regional and remote / very remote). Remoteness was determined using individuals' postcodes at the time of aged care eligibility assessment and the ABS Accessibility/Remoteness Index of Australia Plus.[17]

Statistical analysis

Annual counts of incident aged care eligibility assessments approved and aged care service use (PRAC, home care, respite, transition care and any aged care service) were examined using descriptive statistics. Yearly incidence rates were calculated per 1,000 population using the ABS population estimates of Aboriginal and Torres Strait Islander people aged ≥50 years on June 30 each year[6] and 95% confidence intervals (CIs) were estimated assuming a Poisson distribution. Analyses were stratified by age, sex, and remoteness area subgroups. Overall and remoteness area-specific yearly rates were indirectly standardised to the age and sex distribution of the Aboriginal and Torres Strait Islander population in 2015. Poisson or negative binomial (in the case of overdispersion) regression were used to estimate incidence rate ratios (IRRs) for the average annual rate of change in aged care assessment approved or aged care service use over the study period. Models were estimated separately for each aged care service and adjusted for age, sex and remoteness area, where appropriate, with an offset variable to account for different follow-up time in study cohort. Complete case analysis was used in the multivariable analyses. Analyses were conducted using R v4.0 (R Core Team 2020, Vienna, Austria; www.R-project.org).

Results

Of the 15,106 Aboriginal and Torres Strait Islander people included in the study cohort, 14,708 had an incident aged care eligibility assessment between 2010 and 2019. Of these, 95% (N=13,976) were approved for at least one aged care program following their eligibility assessment and 5% (N=732) were not approved. Table 1 shows the characteristics of those with an aged care eligibility assessment and approved. Incident aged care eligibility assessments approved increased from 10.4/1000 (95%CI: 9.7–11.1) in 2010 to 14.6/1000 (95% CI: 14.0–15.2) in 2019 (IRR=1.04/year, 95%CI: 1.03–1.05) (**Figure 1**).

Of the 15,106 Aboriginal and Torres Strait Islander people included in the study cohort, 9,974 accessed an aged care service for first time during the study period (Table 1). Two-thirds (n=6478, 66%) used only one aged care service, while 33% (n=3,296) accessed two or more during the study period. Home care packages were the most frequent incident service accessed (n=5,073, 52%), followed by respite care (n=1,953, 20.0%). The number and sociodemographic characteristics of incident users of each aged care service each year are shown in Supplementary Table 1). Home care package use increased from 3.8/1000 (95%CI: 3.4–-4.2) in 2010 to 6.3/1000 (95%CI: 5.9–6.7) in 2019 (IRR=1.04/year, 95%CI: 1.03–1.06) as did PRAC use with annual rates increasing from 2.2/1000 (95%CI: 1.9–2.5) in 2010 to 3.5/1000 (95%CI: 3.2–3.8) in 2019 (IRR=1.04/year, 95%CI: 1.03–1.05). Increased use of respite and transition care was also observed (Figure 1). Annual age- and sex- standardised utilisation rates for each aged care service are provided in Supplementary Table 2.

Aged care eligibility assessment approval and service use rates by remoteness area are shown in Supplementary Figure 1. In both major cities and regional areas, use of all aged care programs increased between 2010 and 2019 (**Figure 2**). Specifically, in major cities, aged care eligibility assessments approved increased from 9.2/1000 (95% CI: 8.2–10.4) in 2010 to 13.6/1000 (95%CI: 12.7–14.7) in 2019 (IRR=1.06/year, 95%CI: 1.04–1.08) and use of any aged care service increased from 6.7/1000 (95%CI: 5.8–7.7) to 10.2/1000 (95%CI: 9.3–11.1) between 2010 and 2019 (IRR=1.04/year, 95%CI: 1.03–1.06).

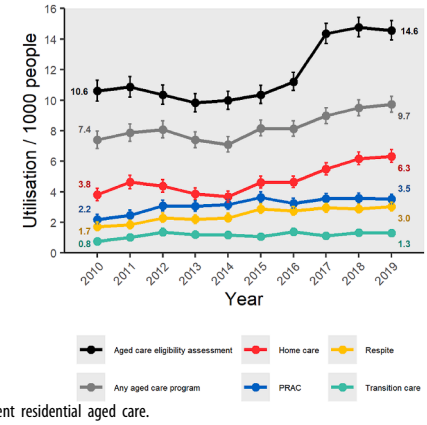
Table 1: Characteristics of Aboriginal and Torres Strait Islander people receiving an incident aged care eligibility assessment or incident aged care service between 2010 and 2019.

	Incident aged care eligibility assessment and approval N=13,976 N (%)	Incident aged care service use[a] N=9,774 N (%)
Sex		
Male	5,900 (42.2)	4,038 (41.3)
Female	8,073 (57.8)	5,724 (58.6)
Missing	3 (0.02)	12 (0.1)
Age (median, IQR)		
Age category	68 (60–76)	69 (62–78)
50–64 years	5,568 (39.8)	3,273 (33.5)
65–74 years	4,314 (30.9)	3,155 (32.3)
≥ 75 years	4,094 (29.3)	3,346 (34.2)
Remoteness area		
Major cities	4,343 (31.1)	3,170 (32.4)
Inner/outer regional	6,684 (47.8)	4663 (47.7)
Remote/very remote	2,855 (20.4)	1,875 (19.2)
Missing	94 (0.7)	66 (0.7)
Received aged care assessment only[b]	5,124 (36.7)	Not applicable
Aged care programs utilised		
Any aged care program	8,852 (63.3)	9,774 (100)
Permanent residential aged care		
Any	3,575 (25.6)	3,767 (38.5)
First service	1,428 (10.2)	1,586 (16.2)
Home care package		
Any	5,039 (36.1)	5,709 (58.4)
First service	4,463 (31.9)	5,073 (51.9)
Respite care		
Any	2,777 (19.9)	2,987 (30.6)
First service	1,829 (13.1)	1,953 (20.0)
Transition care		
Any	1,269 (9.1)	1,393 (14.3)
First service	1,132 (8.1)	1,242 (12.7)
Time from aged care eligibility assessment to first service (median days, IQR)	76 (14–340)[c]	43 (10–228)[d]
Proportion aged care service use within 6 months	5,494 (39.3)	6970 (71.3)
Proportion aged care service use within 12 months	6,786 (48.6)	8,215 (84.0)
Deceased by 31 Dec 2019	5,187 (37.1)	3,925 (40.2)

IQR = interquartile range.
[a]Approvals for service could have occurred prior to 2010 (n=922).
[b]May have received lower-level home support (Commonwealth Home Support Programme, CHSP).
[c]Time calculated from first ACAT to incident service.
[d]Time calculated from closest ACAT prior to incident service.

Home care packages had the greatest increase in use in major cities (IRR=1.09/year, 95%CI: 1.06–1.11) and regional areas (IRR=1.09/year, 95%CI: 1.06–1.11). For those living in remote and very remote areas, aged care services use decreased over the study period (Figure 2, Supplementary Figure 1). Aged care eligibility assessment approval rates reduced from 15.8/1000 (95%CI: 14.0–17.7) in 2010 to 13.7/1000 (95%CI: 12.3–15.1) in 2019 (IRR=0.98/year, 95%CI: 0.96–0.99), while any aged care service use fell from 9.9/1000 (95%CI: 8.5–11.5) to 6.9/1000 (95%CI: 6.0–8.0) over the same period (IRR=0.95/year, 95%CI: 0.94–0.97). The greatest decline was observed for home care

Figure 1: Age- and sex-standardised annual aged care program use (incident admissions per 1,000 older Aboriginal and Torres Strait Islander people), 2010 to 2019.



PRAC = permanent residential aged care.

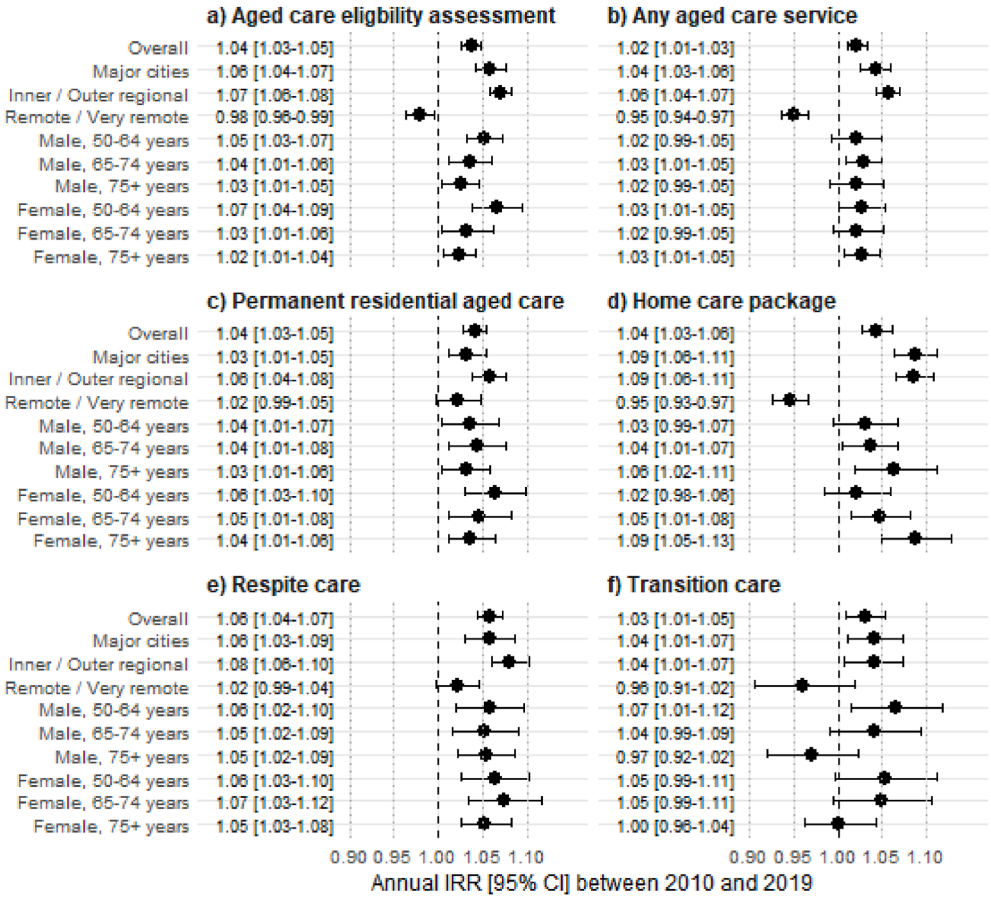
packages in remote and very remote areas, with use decreasing from 5.5/1000 (95%CI: 4.5–6.7) to 3.5/1000 (95%CI: 2.9–4.3) between 2010 and 2019 (IRR=0.95/year, 95%CI: 0.3–0.97).

When examined by age and sex groups, the main differences in aged care program use between 2010 and 2019 were observed for the younger cohort aged 50–64 years (Figure 2, Supplementary Figure 2). Individuals in this age group had increased aged care eligibility assessment approvals (males: IRR=1.05/year, 95%CI: 1.03–1.07; females: IRR=1.07/year, 95%CI: 1.04–1.09) transition care (males: IRR = 1.07/year, 95%CI: 1.01–1.11), and PRAC (females: IRR=1.06/year, 95%CI: 1.03–1.10) (Figure 2). Among older females, increased use of respite care by those aged 65–74 years was observed (IRR=1.07/year, 95%CI: 1.03–1.12), while increased home care packages use by those aged ≥75 years was observed in both females (IRR=1.09/year, 95%CI: 1.05–1.13) and males (IRR=1.06/year, 95%CI: 1.03–1.10). The greatest changes in use in males aged ≥65 years between 2010 and 2019 was observed in respite care (IRR=1.05, 95%CI: 1.0–1.1 (Figure 2).

Discussion

This large population-based study of over 15,000 older Aboriginal and Torres Strait Islander people has shown that aged care eligibility assessment approvals and use of aged care services have increased over the past decade. This likely reflects the ageing of the Aboriginal and Torres Strait Islander population and greater need for aged care supports. It may also be due, in part, to changes to aged care policy and delivery, most notably the introduction of the Home Care Packages Programme in July 2013 and the shift towards greater provision of home care from this time.[18] Increased uptake of home care packages was particularly evident from 2014, coinciding with the home care packages reforms. The increased use of respite and transition care observed among the younger cohort is particularly encouraging given the preventative and restorative nature of these

Figure 2: Adjusted incidence rate ratios (IRRs) of annual changes in aged care program use between 2010 and 2019.



programs.[19,20] Use of these programs before care needs become complex is a welcome observation that may help older Aboriginal and Torres Strait Islander people remain in the community for as long as possible. However, the increased entry into PRAC observed among younger females is less positive. Aboriginal and Torres Strait Islander people are included in the target population for government-funded aged care services from the age of 50 years (*vs.* 65 years for non-Indigenous Australians) on account of their lower life expectancy and "premature ageing".[21] However, the appropriateness of this policy is questionable as it potentially excludes people in the 50–65 year age bracket from receiving more age-appropriate community-based chronic disease care services.[22]

By remoteness area, our findings provide evidence of a decrease in the use of aged care services in the past decade by Aboriginal and Torres Strait Islander people living in remote and very remote areas for the most services accessed. This decline may be explained, in part, by the expansion of services funded under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP) from 2013.[18] In 2010, 29 services and 820 service places were supported by NATSIFACP. By 2019, this had increased to 35 services (27 of these located in remote and very remote areas) and 1,072 services places.[3] Although regardless of the number of service places, between 1 January 2019 and 30 June 2019 only 629 Aboriginal and Torres Strait Islander people used the program.[23] Limited data and inconsistent reporting on NATSIFACP are published and data are not available to researchers to explore the use of the program. Nevertheless, the royal commission into Aged Care Quality and Safety reported that the availability of already scarce aged care services in remote and very remote areas has worsened since 2014 and that changes introduced through aged care reforms may have impeded access to services for Aboriginal and Torres Strait Islander people living remotely.[1] For example, the My Aged Care website and contact centre introduced in 2015 as a single point of entry into the aged care system requires reliable access to phone and internet services, as well as the language skills and digital literacy to navigate the portal and understand the provided information.[4] Furthermore, as a result of the 2017 Increasing Choice in Home Care Reform, which allocated home care packages to consumers rather than providers, the delivery of services in small remote communities is no longer safeguarded through targeted allocation in response to community needs.[24]

Aged care eligibility assessments are a mandatory first step in accessing government-funded aged care programs and thus provide an indication of the demand for aged care services.[21] While direct comparisons were not made, differences were observed between rates of aged care eligibility assessment and aged care program use across all population subgroups throughout the study period. For example, in 2019, the rate of any aged care program use was less than half the rate of aged care eligibility assessment for those living in remote areas and for those under the age of 65 years. These estimates likely underestimate the degree of eligibility for aged care among Aboriginal and Torres Strait Islander people as many may not even seek eligibility assessments. Failure to properly engage with older Aboriginal and Torres Strait Islander people has resulted in a lack of awareness of aged care services and how to access them.[25] Despite their poorer health status, stemming from generations of social and economic exclusion, Aboriginal and Torres Strait Islander people are assessed for aged care service eligibility at around half the rate of non-Indigenous people.[21]

The overall trends in aged care program use observed in this study were similar to those seen in a previous study[26] where publicly available aged care admissions data[27] were used to examine trends in annual aged care service admissions in the general aged care population aged ≥65 years between 2008–2009 and 2015–2016. A notable difference between this and the previous study, however, was the much higher use of PRAC in the general population, which was approximately 10 times higher than observed in this study for Aboriginal and Torres Strait Islander people, despite the higher burden of chronic disease and prevalence of dementia among this population.[28,29] Unlike other aged care programs, increased PRAC use was not observed in this study, either among the overall cohort or by most population subgroups considered, including those aged 75 years and older, and Aboriginal and Torres Strait Islander people remain greatly underrepresented in residential aged care.[21] The trauma and discrimination experienced by many older Aboriginal and Torres Strait Islander people has led to a deep mistrust of institutions and the lack of culturally safe care is a widely reported barrier to the uptake of residential aged care among this population.[1] The previous study[26] did not report on aged care program use by remoteness area and therefore we have no insight on equity in the use of aged care programs by Aboriginal and Torres Strait Islander people living remotely.

The main strength of this study is the use of linked national aged care datasets that capture individuals who identified as Aboriginal and/or Torres Strait Islander in multiple data sources, providing the most comprehensive and contemporary overview of aged care service use among this population. Within ROSA, we are only provided data from the data custodians on individuals who are identified as being Aboriginal or Torres Strait Islander in any of the datasets held within ROSA. We recognise that identification of Aboriginal and Torres Strait Islander people maybe incomplete in aged and health care datasets but linkage of multiple datasets within ROSA likely improved identification. From the entire linked ROSA dataset of 3,484,925 individuals, 3.3% (n=115,424) have missing Aboriginal and Torres Strait Islander status. A limitation was the lack of inclusion of aged care services accessed through the NATSIFACP or the evaluation of short-term episodic services provided through the CHSP. As at 30 June 2109, 5,156 people were using residential, home care and/or multipurpose support packages, 22,148 were using CHSP and 629 were using NATSIFCP.[30] Approximately 70% of Aboriginal and Torres Strait Islander people who receive any form of aged care receive low-level in-home support through the CHSP.[4] It is therefore likely that a reasonable proportion of those people who did not access PRAC, a home care package, respite or transition care did receive CHSP services to some degree. However, it remains that over 95% of the cohort were approved for higher level care and that nearly half of those people did not utilise it. A further limitation is that the available data do not indicate the quality or cultural safety of the aged care received and provide no insight into equity of aged care use relative to the non-Indigenous population.

Conclusions

Given their underrepresentation in the aged care system, increased eligibility assessment and incident use of aged care programs by

older Aboriginal and Torres Strait Islander people is encouraging. However, these increases were only observed in major cities and regional areas, and over a decade had declined in remote areas. Continued growth towards equitable access and use of aged care eligibility assessments and services will require the aged care reforms currently underway to incorporate Aboriginal and Torres Strait Islander preferences for aged care and to not further exclude those who most need aged care, by for example, only being available through a single digital entry point. Adequate investment in existing Aboriginal community-based and -centric services with more connected aged care, health and social systems and a culturally aware aged care workforce would contribute to this. Given the current health of the Aboriginal and Torres Strait Islander population, growth in the older population and the dire state of the aged care system, these initiatives cannot happen soon enough. To act on and measure the impact of the aged care reforms, relevant data must be accessible, timely and reported publicly and consistently. Results presented in this study can serve as a baseline to determine whether the reforms are producing improvements in access and use of aged care services in the short and longer term.

Conflicts of interest

The authors declare the following financial interests/personal relationships which may be considered as potential competing interests: Odette Pearson reports financial support was provided by the National Health and Medical Research Council. If there are other authors, they declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Ethics approvals

Ethics approvals were obtained from the University of South Australia (Ref: 200489), the Australian Institute of Health and Welfare (Ref: EO2018/1/418) and the Aboriginal Health Council (Ref: 04-20-895) Ethics Research Committees.

Author contributions

OP, GEC, MCI, TA and GBH designed and conceptualised the study. GEC, MCI and SW acquired the data. GBH and TA analysed the data. All authors interpreted the data. GBH drafted the manuscript. All authors critically revised the manuscript. OP, a Kuku Yalanji/Torres Strait Islander person, maintained Aboriginal research principles.

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Data availability statement

Data are not available due to data privacy and ethical reasons.

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References

1. Commonwealth of Australia. *Royal commission into aged care quality and safety. Final report: care, dignity and respect*. Canberra: Commonwealth of Australia; 2021.
2. Department of Health and Aged Care. *About aged care. : Australian government; 2025*. 2025 [updated 9 April 2025. Available from: https://www.health.gov.au/topics/aged-care/about-aged-care. [Accessed 17 April 2025].
3. Australian Government. *Report on the operation of the aged care act 1997*. Canberra: Australia; 2022. p. 23–88.
4. National Advisory Group for Aboriginal and Torres Strait Islander Aged Care. Our Care. Our Way. *Aboriginal and Torres Strait Islander aged care*. Background paper; 2020.
5. Australian Bureau of Statistics. *3101.0 national, state and territory population, 1981-2022*. 2021.
6. Australian Bureau of Statistics. *3238.0 estimates and projections, Aboriginal and Torres Strait Islander Australians, 2006 to 2031*. 2021.
7. Temple JB, Wilson T, Taylor A, Kelaher M, Eades S. Ageing of the Aboriginal and Torres Strait Islander population: numerical, structural, timing and spatial aspects. *Aust N Z J Publ Health* 2020;**44**(4):271–8. https://doi.org/10.1111/1753-6405.13001.
8. Australian Bureau of Statistics. *Estimates of Aboriginal and Torres Strait Islander Australians*. 2016.
9. Department of Health. *Governance (pillar 5 of the royal commission response) – more equitable access to aged care for first nations people and special needs groups*. 2021.
10. Australian Institute of Health and Welfare. *GEN data: aged care data snapshot—2022*. 2022 [Available from: https://www.gen-agedcaredata.gov.au/Resources/Access-data/2022/October/Aged-care-data-snapshot%E2%80%942022.
11. Pearson O, Air T, Humphrey G, Bradley C, Tunny N, Brown A, et al. Aged care service use by Aboriginal and Torres Strait Islander people after aged care eligibility assessments, 2017-2019: a population-based retrospective cohort study. *Med J Australia* 2024 Jul 1;**221**(1):31–8.
12. Caughey GE, Lang CE, Bray SC, Moldovan M, Jorissen RN, Wesselingh S, Inacio MC. *International and national quality and safety indicators for aged care: Report for the Royal Commission into aged care quality and safety*. South Australian Health and Medical Research Institute; Research Paper; 8, 2020 Aug. p. 1–176.
13. Clapham K, Duncan C. *Indigenous Australians and ageing: responding to diversity in policy and practice*. New York: Springer; 2017. p. 103–25.
14. Inacio MC, Caughey GE, Wesselingh S. Registry of senior Australians (ROSA): integrating cross-sectoral information to evaluate quality and safety of care provided to older people. *BMJ Open* 2022;**12**(11):e066390. https://doi.org/10.1136/bmjopen-2022-066390.
15. Australian Institute of Health and Welfare. *Aged care assessment program data dictionary version 1.0. Canberra*. 2002.

16. Inacio MC, Lang C, Bray SCE, Visvanathan R, Whitehead C, Griffith EC, et al. Health status and healthcare trends of individuals accessing Australian aged care programmes over a decade: the Registry of Senior Australians historical cohort. *Intern Med J* 2021;**51**(5):712–24. https://doi.org/10.1111/imj.14871.
17. Department of Health. *Measuring remoteness: accessibility/ remoteness index of Australia (ARIA), Revised Ed. Occasional Paper New Series No. 14*. Canberra: Department of Health; 2001.
18. Department of Health. Living Longer. *Living Better. Aged care reform package, April 2012*. Canberra: Commonwealth of Australia; 2012.
19. Harrison SL, Lang C, Whitehead C, Crotty M, Corlis M, Wesselingh S, et al. Residential respite care use is associated with fewer overall days in residential aged care. *J Am Med Dir Assoc* 2020;**21**(5):653–659.e2. https://doi.org/10.1016/j.jamda.2019.08.023.
20. Cations M, Lang C, Crotty M, Wesselingh S, Whitehead C, Inacio MC. Factors associated with success in transition care services among older people in Australia. *BMC Geriatr* 2020;**20**(1). https://doi.org/10.1186/s12877-020-01914-z.
21. Productivity Commission. *Report on Government Services 2023, Part F*. 2023 [Chapter 14] Aged Care Services.
22. Cotter PR, Condon JR, Barnes T, Anderson IPS, Smith LR, Cunningham T. Do Indigenous Australians age prematurely? The implications of life expectancy and health conditions of older Indigenous people for health and aged care policy. *Aust Health Rev* 2012;**36**(1):68. https://doi.org/10.1071/ah11996.
23. *Department of Health and Aged Care. Aged care service list: 30 June 2019*. 2019. https://www.gen-agedcaredata.gov.au/Resources/Access-data/2019/September/Aged-care-service-list-30-June-2019. [Accessed 30 November 2023].
24. Gibb H. Addressing neglected contexts of ageing: the situation in remote northern Australia. *Ager Rev Estud Sobre Despoblación Desarro Rural/AGER* 2019;**27**:75–101. https://doi.org/10.4422/ager.2019.11.
25. Thomas K, Dettwiller P, Gonzalez-Chica D. Who cares about Aboriginal Aged Care? Evidence of home care support needs and use in rural South Australia. *Aust J Rural Health* 2023. https://doi.org/10.1111/ajr.12992.
26. Khadka J, Lang C, Ratcliffe J, Corlis M, Wesselingh S, Whitehead C, et al. Trends in the utilisation of aged care services in Australia, 2008–2016. *BMC Geriatr* 2019;**19**(1). https://doi.org/10.1186/s12877-019-1209-9.
27. Australian Institute of Health and Welfare. GEN data: admissions into aged care 2008-09 to 2015-16 [Available from: https://www.gen-agedcaredata.gov.au/Resources/Access-data/GEN-data-Admissions-into-aged-care.
28. Australian Institute of Health and Welfare. *Dementia in Australia. Canberra*. 2023.
29. Australian Institute of Health and Welfare. *Australian Burden of Disease Study: impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2018. Canberra*. 2022.
30. Australian Institute of Health and Welfare. GEN data: aboriginal and Torres Strait Islander people using aged care services, 2018-19 [Available from: https://www.gen-agedcaredata.gov.au/resources/AboriginalandTorresStraitIslanderpeopleusingagedcareservices accessed 15 April 2025.

Appendix A Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.anzjph.2025.100294.