Chapter 12: Aged care (AC)

The aged care chapter

The aged care system comprises all services specifically designed to meet the needs of Australia's frail older people for care and support. This chapter focuses on government funded residential and community based services for older people, particularly:

- residential services, which include high care services, low care services, services providing a mixture of high and low care, and residential respite services;
- community care services, which include Home and Community Care (HACC) program services, the Community Aged Care Package (CACP) program, the Extended Aged Care at Home (EACH) program and Veterans' Home Care (VHC);[1]
- respite services, which include HACC respite and centre-based day care and the National Respite for Carers Program (NRCP); and
- assessment services, which are provided by Aged Care Assessment Teams (ACATs).

This chapter focuses on residential care, community care and assessment services for older people. Services designed for the carers of older people are also within the scope of this chapter.

Government funded aged care services covered in this chapter relate to the three levels of government (Commonwealth, State and Territory, and some local) involved in service funding and delivery. The formal publicly funded services covered in this chapter represent a small proportion of total assistance provided to frail older people. Extended family and partners are the largest source of emotional, practical and financial support for older people. More than 90 per cent of older people living in the community in 1998 who required help with self care, mobility or communications received assistance from the informal care network of family, friends and neighbours (ABS 1999). Many people also receive assistance from both formal aged care services and informal sources.

[1] Unless otherwise stated, HACC expenditure excludes the Department of Veterans' Affairs expenditure on Veterans' Home Care.

A range of privately funded services also provide support for older Australians. These services do not receive government support and are not within the scope of reporting in the chapter.

Indigenous data in the aged care chapter

The aged care chapter in the *Report on Government Services 2003* (ROGS) contains the following data items on Indigenous people:

- Characteristics of older Indigenous people;
- Assessments per 1000 target population, 1999-2000 and 2000-01;
- Operational residential places and CACPs per 1000 people aged 70 years and over plus Indigenous people aged 50-69 years, June 2002;
- Residents per 1000 target population, June 2002;
- Community Aged Care Package recipients per 1000 target population, June 2002; and
- Home and Community Care service by recipient age and Indigenous status, 2001-02.

Services for older people are provided on the basis of the frailty or functional disability of the recipients rather than specific age criteria. Nevertheless, in the absence of more specific information, people aged 70 years and over are used as a proxy for the likelihood of a person in the general population requiring these services. Certain groups (notably Indigenous people) may require various services at a younger age. For Indigenous people, those aged 50 years and over are used as a proxy for the likelihood of requiring aged care services. The Commonwealth Government also uses these age proxies for planning the allocation of residential care and CACPs.

Supporting tables

Supporting tables for data within the aged care chapter of the compendium are contained in the attachment to the compendium. Supporting tables are identified in references throughout this chapter by the abbreviated chapter name (for example, AC.A5 is table 5 in the aged care attachment to the compendium).

As the data are directly sourced from the *Report on Government Services 2003*, the compendium also notes where the original table, figure or text in the Report can be

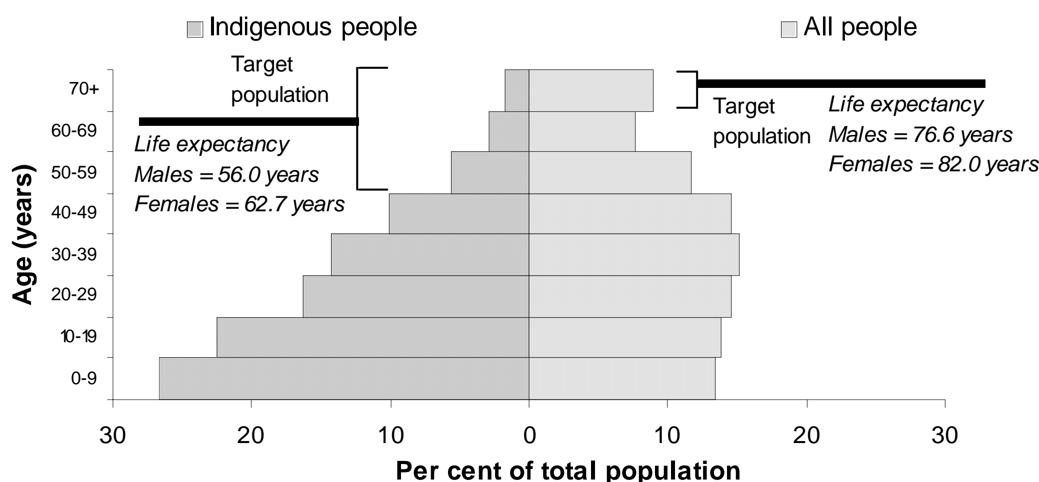
found. For example, where the compendium refers to 'ROGS 2003, p. 6.15' this is page 15 of chapter 6 of the Report and 'ROGS 2003, 6A.2' is attachment table 2 of attachment 6 of the Report.

Characteristics of older Indigenous people

The ABS estimated that about 41 700 Indigenous people were aged 50 years or more in Australia at 30 June 2002. The majority were located in NSW (29.7 per cent), Queensland (26.6 per cent), WA (13.9 per cent) and the NT (13.7 per cent) (table AC.A1).

Although the Indigenous population is also ageing, there are significant differences in the age profile and life expectancy of Indigenous Australians compared with the non-Indigenous population. The life expectancy of Indigenous males (56.0 years) and females (62.7 years) at June 2001 was nearly 20 years below that recorded for the total Australian population (figure AC.1). As a result, Indigenous people are likely to need aged care services earlier in life, compared with the general population.

Figure AC.1 **Age profiles, target populations and life expectancy differences between Indigenous and other Australians, June 2001**



Source: ABS (2001 and unpublished); ROGS 2003, p. 12.14.

Assessment services

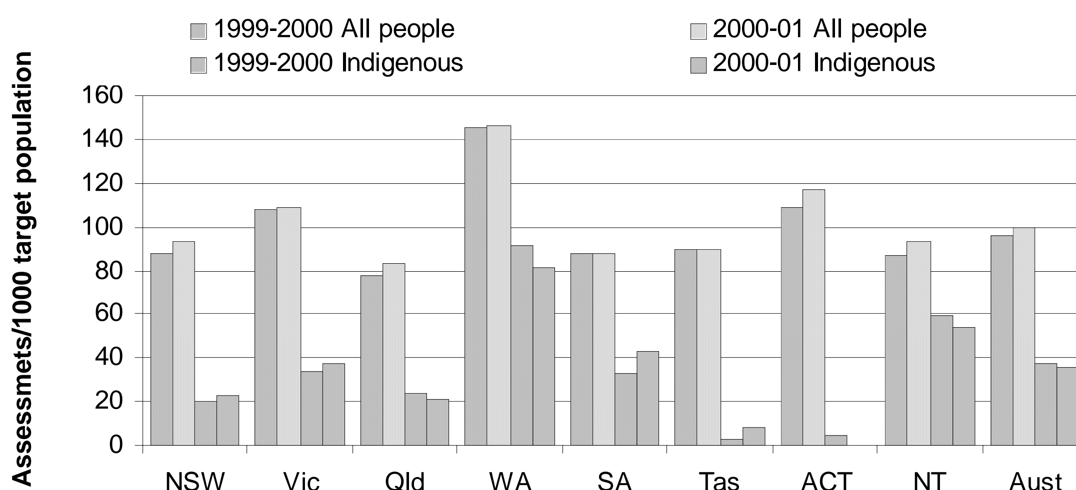
The Commonwealth established the Aged Care Assessment Program in 1984 based on the assessment processes used by State and Territory Area Health Services to determine eligibility for admission into residential care and the level of care

required (and thus the subsidy paid to such services). The core objective of ACATs is to assess the needs of frail older people and recommend appropriate services. Assessment and recommendation by ACATs is mandatory for admission to residential care or receipt of a CACP. People may also be referred by ACATs to other services, such as those funded by the HACC program. An ACAT referral is not mandatory for receipt of a HACC service.

State and Territory governments are responsible for the day-to-day operation and administration of ACATs and provide the necessary accommodation and support services. The role of the teams differs across jurisdictions and within a jurisdiction, partly reflecting the service location (for example, whether the team is attached to a residential service, a hospital or a community service).

The number of assessments per 1000 target population varied across jurisdictions in 2000-01. Western Australia had the highest assessments of people aged 70 years and over per 1000 people aged 70 years and over (146.1) and the highest rate for Indigenous assessments per 1000 Indigenous people aged 50 years and over (81.8).[2] The lowest rate of assessment for all people during 2000-01 was in Queensland (83.4) while the ACT had no Indigenous assessments during the same period (figure AC.2).

Figure AC.2 **Assessments per 1000 target population[a, b]**



a 'All people' includes all assessments of people aged 70 and over per 1000 people aged 70 and over. **b** 'Indigenous' includes all Indigenous assessments per 1000 Indigenous people aged 50 and over.

Source: Lincoln Gerontology Centre (2001, 2002); ROGS 2003, p. 12.5; table AC.A2.

2 Remote areas of WA often do not have other agencies and services in a position to perform 'comprehensive assessments' for many groups, and therefore a higher rate of referral to ACATs than in metropolitan areas may occur.

Indigenous specific and flexibly funded services

Flexible models of care are provided under the Aboriginal and Torres Strait Islander Aged Care Strategy. Services delivered under the Strategy are outside the Aged Care Act (Department of Health and Ageing [DHA] 2002). About 70 per cent of Indigenous Australians receiving residential aged care services have their needs met through the mainstream services covered by this chapter (DHA unpublished). A number of aged care residential services are targeted to Indigenous people and these services are funded under the Aged Care Act. The DHA also actively targets CACPs to Indigenous communities and contracts Aboriginal Hostels Limited to provide ongoing assistance to ensure that services in rural and remote areas remain viable (DHA 2002).

Operational residential places and CACPs

The aged care reforms introduced in October 1997 resulted in a government funding system that does not differentiate between high care and low care services and incorporates high and low care services into a single funding system. One aim of this funding system is to promote 'ageing in place' — that is, enabling residents to remain in one aged care facility irrespective of their dependency level. Access to 'ageing in place' is subject to the decision of service providers to offer this option.

Box AC.1 sets out the Commonwealth targets for the provision of residential places and CACPs.

Box AC.1 **Examples of regulatory arrangements for residential services**

The Commonwealth Government controls the number of subsidised bed places, with a target of 40 high care places, 50 low care places and 10 community aged care packages for each 1000 people in the population aged 70 years and over. In addition:

- services are expected to meet regional targets for places for concessional residents, ranging from 16 per cent to 40 per cent of places, to ensure residents who cannot afford to pay an accommodation bond or charge have equal access to care (with criteria for being deemed a concessional resident being based on home ownership and occupancy, receipt of income support and the level of assets held at entry); and
- extra service places (where residents pay for a higher standard of accommodation, food and services) are restricted.

Various Commonwealth, State and Territory laws govern regulatory arrangements for residential care. State and Territory legislation may prescribe matters such as staffing, the dispensing of medication and/or certain medical procedures, occupational health and safety, workers' compensation requirements, building standards, and fire prevention and firefighting measures. Staff wages and conditions are generally set by jurisdictional based awards. Local government by-laws may also apply (for example, waste disposal rules).

Source: Productivity Commission (1999); ROGS 2003, p. 12.7.

Figure AC.3 shows the combined number of high care residential places, low care residential places and CACPs.

The number of operational places can also be shown using a target population that incorporates Indigenous 50–69 year olds (figure AC.4). Using this 'adjusted' target population has a noticeable effect on smaller jurisdictions with a large proportion of Indigenous people.

Figure AC.3 **Operational residential places and CACPs per 1000 people aged 70 years and over, June 2002[a, b, c, d]**

[a] Excludes places that have been 'approved' but are not yet operational. [b] 'Ageing in place' may result in some low care places being filled by high care residents. [c] Government planning targets are based on providing 100 places per 1000 people aged 70 years and over. However, in recognition of poorer health among Indigenous communities, planning in some cases also takes account of the Indigenous population aged 50–69 years. This means that the provision ratio based on the population aged 70 years and over will appear high in areas with a high Indigenous population (such as the NT). [d] CACPs are not residential services but are included in the Commonwealth planning targets of 100 places per 1000 people in the target population. See box AC.1 for interpretation of residential care data.

Source: DHA (unpublished); ROGS 2003, p. 12.10; table AC.A3.

Figure AC.4 **Operational residential places and CACPs per 1000 people aged 70 years and over plus Indigenous people aged 50–69 years, June 2002[a, b, c]**

[a] Places do not include those that have been 'approved' but are not yet operational. [b] 'Ageing in place' may result in some low care places being filled by high care residents. [c] CACPs are not residential services but are included in the Commonwealth planning targets of 100 places per 1000 people in the target population. See box AC.1 for interpretation of residential care data.

Source: DHA (unpublished); ROGS 2003, p. 12.11; table AC.A4.

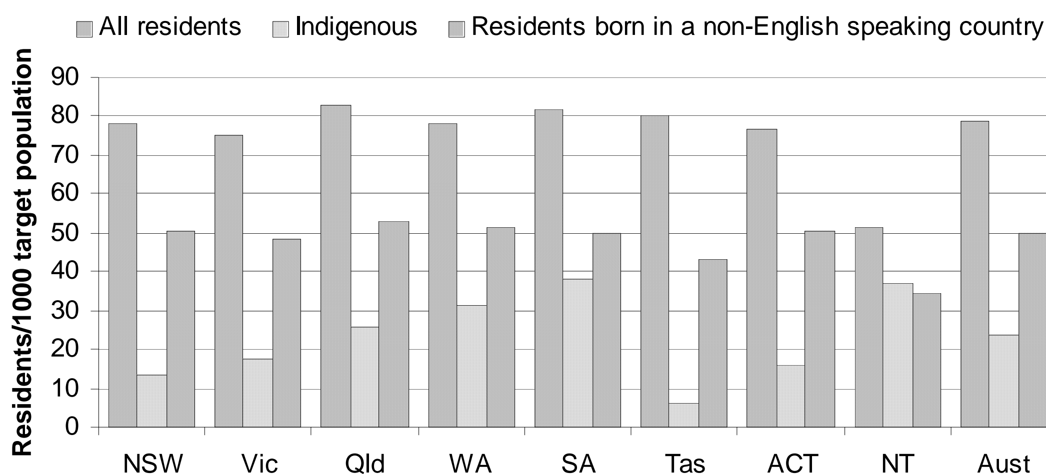
Residential services per 1000 target population

Special needs groups identified by the Aged Care Act are people from Indigenous communities, people from non-English speaking countries, people who live in rural or remote areas, people who are financially or socially disadvantaged, and veterans. A key national objective of the aged care system is to provide equitable access to residential services for all people who require these services. Indigenous people tend to require aged care services at a younger age than the general population. Participation is therefore based on Indigenous people aged 50 years and over.

One way of measuring accessibility is to compare the proportion of residents from a special needs group with their representation in the target population (which is all people aged 70 years and over, plus Indigenous people aged 50–69 years). However, factors such as cultural differences — which may influence the extent to which various special need groups use residential care services — need to be considered in the interpretation of such results.

In all jurisdictions, on average, Indigenous people and people from mainly non-English speaking countries have lower rates of use of aged care residential services, compared with the rest of the population, at June 2002 (figure AC.5).

Figure AC.5 **Residents per 1000 target population, June 2002[a, b, c]**



a All residents data are per 1000 people aged 70 years and over plus Indigenous people aged 50–69 years. **b** Indigenous residents data are per 1000 Indigenous people aged 50 years and over. **c** Residents from a non-English speaking country data are per 1000 people from non-English speaking countries aged 70 years and over.

Source: DHA (unpublished); ROGS 2003, p. 12.23; tables AC.A5 and AC.A6.

Community care services

The main community care programs reported in this chapter — the HACC, CACP and VHC programs — fund services that aim to provide practical assistance to enable frail older people (HACC and CACP), people with a disability (HACC) and veterans (VHC) to continue living in the community. These services also provide assistance to carers of older people. The services are usually provided by State, Territory and local government organisations, charitable bodies, community organisations and commercial providers.

A range of services are provided by HACC, such as domestic assistance and home maintenance, personal care, food services, respite care, transport, allied health care and community nursing. The target population is defined as people living in the community who are at risk, in the absence of basic maintenance and support services, of premature or inappropriate long term residential care. The target population comprises both frail aged people and younger people with a disability, and their carers. Approximately 70 per cent of the program's recipients are aged 70 years and over, but the program is also an important source of community care for younger people with a disability and their carers (DHA unpublished). (Chapter 13 of the Report on Government Services covers younger people with a disability.)

The services of the Veterans Home Care (VHC) program target veterans and war widows/widowers with low care needs. There were 56 073 VHC recipients in 2001-02. The program offers veterans and war widows/widowers home support services, including domestic assistance, personal care, home and garden maintenance, and respite care. Other services, such as community transport, social support and delivered meals, are also available under the DVA's arrangements with State and Territory governments. Eligibility for VHC services is not automatic, but based on assessed need.

Community Aged Care Packages provide an alternative home-based service for older people who ACATs assess as eligible for care equivalent to low level residential care. The main distinctions between the HACC and CACP programs are summarised in table AC.1. Community care is likely to continue to play an increasing role in aged care services, given the longer term policy objective of improving the capacity of aged care services to support people at home, which reflects a strong consumer preference.

Table AC.1 **Distinctions between the HACC and CACP programs**

	HACC	*CACPs*
Range of services[a]	Wider range of services available	Narrower range of services available
Relationship to residential care	Prevents premature or inappropriate admission	Substitutes for a bed
Eligibility	ACAT assessment not mandatory	ACAT assessment mandatory
Funding	Cost shared by Commonwealth, State and Territory governments and client contributions	Funded by the Commonwealth and client contributions
Target client groups[b]	Available to people with a greater range of care needs	Targets people with care needs similar to low level residential care
Size of program	$1 billion funding in 2001-02	$246 million funding in 2001-02
	About 583 000 clients for the year 2001-02	About 26 400 places for the year 2001-02

[a] HACC services such as community nursing, which are not available under CACPs, can be supplied to someone receiving a CACP. [b] Most HACC recipients at the lower end of the scale would not be assessed as eligible for residential care; for example, an individual may receive only an hour of home care a fortnight. At the higher end, some people have levels of need that would exceed the level available under CACPs.

Source: DHA (unpublished); ROGS 2003, p. 12.18; tables AC.A7.

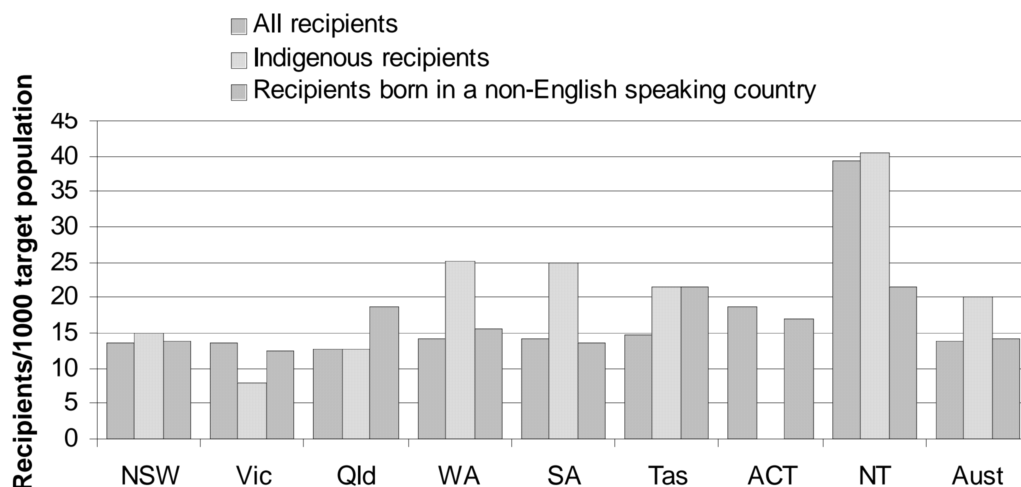
Changing government policies over the past decade — shifting the balance of care away from the more intensive types of residential care towards home-based care — have meant that the HACC, EACH and CACP programs have become increasingly important components of the aged care system. During 2001-02, the HACC program delivered approximately 9023 hours per 1000 people aged 70 years and over plus Indigenous people aged 50–69 years (ROGS 2003, table 12A.20). The total number of CACP places per person aged 70 years and over plus Indigenous people aged 50–69 years increased by 5.0 per cent between June 2001 and June 2002, from 14.0 to 14.7 (table AC.A4).

Community Aged Care Packages

The number of CACP recipients per 1000 people aged 70 years and over plus Indigenous people aged 50–69 years has grown in recent years but at June 2002 was small relative to the total number of recipients of residential care (13.8 compared with 78.5 recipients respectively per 1000 people aged 70 years and over plus Indigenous people aged 50–69 years) (table AC.A5). The jurisdictions with smaller populations had the highest proportion of CACP recipients per 1000 people aged 70 years and over plus Indigenous people aged 50–69 years at June 2002. The NT had the highest proportion of CACP recipients per 1000 Indigenous people aged 50 years and over (40.4) (table AC.A6). Tasmania and the NT had the highest proportion of CACP recipients from non-English speaking countries

per 1000 people aged 70 years and over (figure AC.6). The Commonwealth's allocation of CACPs in every jurisdiction at June 2002 exceeded its target of ten CACPs per 1000 target population.

Figure AC.6 **CACP recipients per 1000 target population, June 2002**[a, b, c, d]



[a] All recipients data are per 1000 people aged 70 years and over plus Indigenous people aged 50–69 years. [b] Indigenous recipients per 1000 Indigenous people aged 50 and over. [c] Recipients from non-English speaking countries per 1000 people from non-English speaking countries aged 70 years and over. [d] The ACT has a very small Indigenous population aged over 50 years and a small number of packages will result in a very high provision ratio. Consequently, the ACT Indigenous CACP figures are not considered to be reliable and have not been reported.

Source: DHA (unpublished); ROGS 2003, p. 12.25; tables AC.A5 and AC.A6.

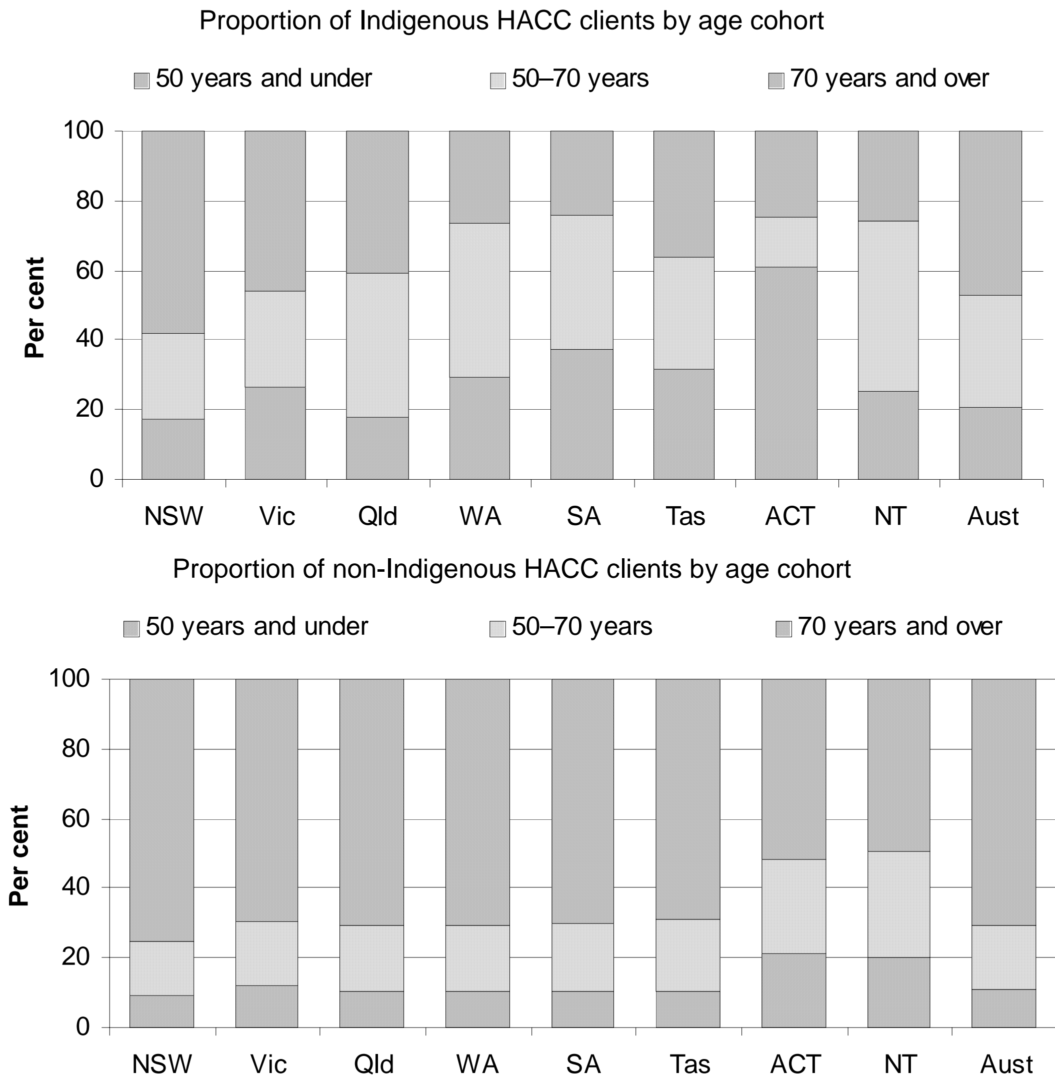
Home and Community Care program

The services of the HACC program are provided in the client's home or community to frail older people with a severe, profound or moderate disability and to their carers. Around 69.8 per cent of HACC recipients are estimated to be aged 70 years and over (table AC.A7).

The HACC Minimum Data Set (MDS) will facilitate separate reporting of the three client groups (frail older people, young people with a disability and their carers), which previously has not been possible. Data from the MDS are reported for the first time this year and need to be interpreted with extreme caution. The items reported are broadly similar to estimated HACC data in previous editions of the Report, but they are not directly comparable. It should also be noted that the proportion of HACC funded agencies that submitted MDS data for 2001-02 differed across jurisdictions, and ranged from 94 per cent to 56 per cent. Consequently, actual service levels will be higher than those reported. Future data from the HACC MDS are expected to have wider coverage.

Use of HACC services reported for all people compared with Indigenous people across all age groupings shows a substantial difference in the age profile for the two groups. This reflects the substantial difference in morbidity and mortality trends between Indigenous people and the general population (figure AC.7).

Figure AC.7 **HACC service by recipient age and Indigenous status, 2001-02**



Source: DHA (unpublished); ROGS 2003, p. 12.27; table AC.A8.