

Discussion paper

Ageing and aged care

BACKGROUND

Demographic profile

By the end of 2006, 13% of Australians were aged 65 years or over. By 2036, this is expected to rise to 24% of the total Australian population. Older Australians aged 65 years and over are generally broken down into three age cohorts (65 – 74; 75 – 84; and 85 years and older).

The internal age structure of those aged 65 years or over is also expected to change, with those aged over 85 years projected to increase their share of the aged population from 12% in 2006 to 18% in 2036.¹

This changing demographic profile has implications for the cost and provision of services (especially health and allied services and aged care) and for the ratio of working age people to older Australians².

Social and economic profile

In 2006, the majority (57%) of older Australians were married; for those over 85 years of age, this was reversed with 65% being widowed. 6% of men and 4% of women have never married.

The AIHW reports that, while male mortality is higher than that for females, the gap is narrowing; currently at age 65, men are likely to live another 17.5 years and women a further 21.1 years.

94 per cent of older Australians live in private dwellings with a partner, family, group or alone; 29% of older people live alone. Those living alone are more likely to experience loneliness and to need outside help. By 2026, over 900,000 Australians aged 75 and over are projected to be living alone.

Housing tenure has a large impact on the quality of people's lives. While most older Australians (66%) rely on a government pension as their main or sole source of income, the proportion people spend on housing influences their capacity to afford both other essential and discretionary items.

The least well-off (and whose tenure is most insecure) are older people in the private rental market. There are nearly 30% of older Australians who pay more than 30% of their income from all sources in rent, with 6.5% of older Australians paying more than 50% of their income in rent. By contrast, housing costs for those who own their own homes are low (4% for those who own their home outright and 14% for those still paying off a mortgage). In addition, the home is a major asset for this latter group.

¹ Australian Institute of Health and Welfare (AIHW) (2007), *Older Australians at a Glance: 4th edition*, available at www.aihw.gov.au/publications/age/oag04/

² Costello, Peter (2007), *Intergenerational Report 2007 (IGR2)*, available at www.treasury.gov.au/documents/1239/PDF/IGR_2007_final_report.pdf

Access to transport plays a significant part in people's ability to retain their social and community connections. Loss of access to a driver or loss of one's licence can severely limit a person's participation. By the age of 85 years for men and 75 for women, only two-thirds reported being able to travel easily (walking, driving, using public transport). 22% of older people living in the community need help from another person with private transport; 20% of these people had their needs met only partially or not at all.

Contrary to popular perception, older people are contributors to, not takers from, the community. They support their families and communities through unpaid household, volunteer and community work, as well as providing free childcare and care to family members, spouses or friends with disability. Forty-three per cent of men and 53% of women aged 65 – 74 provide assistance to others. People aged 85 years and over are also still giving their free time and skills to others – albeit at lower levels, 21% of men and 14% of women are still actively involved.³

As for all age groups, where older Australians live impacts on their opportunities, choices and access to services.

Use of health and aged care services

Health and ageing expenditure have been identified in the Intergenerational Reports as two main pressures on government spending in the first half of the 21st century, with health spending rising from 3.8% of GDP in 2006-07 to a projected 7.6% of GDP in 2046-47 and aged care from 0.8 to 2.0% of GDP over the same period.⁴

Older Australians use GP services more often than younger people, averaging 8.6 visits per year, compared with an average 4.0 visits for other Australians. The level of use of prescription drugs also increases with age. In 2005-06, for people aged 25 years or under the level of prescriptions was 60 per 100 GP visits; for those aged 65 years or older, the rate was 100 per 100 visits. People in older age groups also make relatively high use of hospital services. In 2004-05, 2.5 million separations were recorded in private and public hospitals for older people. The national separation rate is 340 per 1,000 population; for people aged between 75 to 84, the rate is 1,120 per 1,000 persons.

About four out of every 10 people aged 70 years and over use aged care services and one in ten of those are in residential care.

Critical transition points

There are a number of crucial transition points throughout people's lives where interventions can make a difference to vulnerable individuals for whom these transitions may not be easy. For older people, these transition points include:

- retirement – this has been traditionally associated with males as a point at which some have difficulty, however, with women's changing workforce participation and family situations, this may change
- moving house – particularly to a new area where new relationships, networks and access to facilities (for example, shops, banks, GPs, clubs) need to be established or where tenure is insecure and moves are frequent
- separation from a spouse or partner through separation, divorce or death

³ Information in this section has been drawn from AIHW's *Older Australians at a Glance*

⁴ IGR2

- changed financial circumstances – for example on retirement, or on separation, divorce or death of a spouse or partner
- acquisition or worsening of an age-related disability or disease with consequent limitations on previous activities and lifestyles
- hospitalisation which may be associated with a traumatic event (such as a fall) or as a result of worsening health conditions
- entry to residential aged care, particularly where this was not a desired option.

Vulnerable older people

Within the older population there is a very small group (around 3 -5 per cent) that is particularly vulnerable and whose quality of life can be severely diminished.

The characteristics of this group include that they are:

- living alone
- male
- solely reliant on the aged pension
- renting in the private market (including boarding houses and other tenuous housing arrangements)
- paying greater than 30 per cent of their income on housing costs
- in poor physical and/or mental health,
- have limited mobility, through disability or frailty or lack of access to transport, and
- socially isolated, having few, if any, social contacts or informal support networks.⁵

DISCUSSION

The focus of Anglicare Australia's advocacy

At the national level, Anglicare Australia's role is to focus on the rights and needs of the most vulnerable. Those people who have limited resources – financial, social or personal – and who are at highest risk of being or remaining on the margins of society.

This is in keeping with the ethos that imbues Anglicare Australia member agencies' approach. Anglicare member agencies which provide community-based and residential aged care provide those services to people who need them, regardless of their social and financial position.

For example, in 2006-07, Benetas accommodated twice the number of concessional residents than required by the commonwealth, evidencing its commitment to providing quality residential care to all, including financially disadvantaged people.⁶ The Brotherhood of St Laurence is keenly concerned with improving the situations of those who are vulnerable, providing services that support and empower these individuals and advocating strongly on their behalf.

⁵ UK Social Exclusion Unit (2006), *A Sure Start to Later Life: Ending Inequalities for Older People*; see also Morris, A (2007), *Housing tenure does matter: social exclusion of older private renters in Sydney*, available at: www.apo.org.au/linkboard/results.chtml?filename_num=151731

⁶ Benetas Annual Report 2007

Community and aged care services

Community care

The three main community-based programs delivering services and supports to older people in their own homes are:

- Home and Community Care (HACC) is a joint commonwealth state/territory program that provides basic support services in the home⁷
- Community Aged Care Packages (CACP) is a commonwealth funded program that provides assistance to people who are eligible for low level residential care
- Extended Aged Care in the Home (EACH, including for people with dementia) is a commonwealth only program that provides assistance for people who have more complex needs and are eligible for high level residential care.

Access and eligibility to HACC is generally determined by individual service providers. The gateway to CACP and EACH is through Aged Care Assessment Teams (ACAT), which assess people's needs and determine their eligibility. ACATs may also make referrals for HACC services.

Residential care

The commonwealth is also responsible and provides funding for residential aged care. As with CACP and EACH, ACATs assess people's needs and determine their eligibility for entry to residential aged care funded by the commonwealth.

Commonwealth community and residential places are currently allocated annually on the following basis: a target of 113 places per 1000 people aged 70 or over (to be achieved by 2011), broken down as 44 high care and 44 low care residential places and 25 community-based places (CACP and EACH combined).

The states and territories are responsible for day-to-day management of the HACC program, including planning for the provision of HACC places.

Principles

Anglicare Australia advocates a number of principles to underpin effective provision of services – whether provided in the community or in a residential setting. These principles include:

- Recognising and upholding people's rights, including the right to be treated with dignity and respect, the right to access everyday community life and to enjoy, or where needed improve, their quality of life
- Individualised approach, a 'whole of person' approach, with flexibility to meet a person's changing (both reduced and increased) needs and circumstances
- Active living focus, maintaining, developing and improving a person's abilities and environmental supports so that the person can maintain (and expand) their current activities, achieve desired goals and fulfil valuable roles in their living, social, learning and community environments

⁷ HACC provides services for both older people and younger people with disability. Older people comprise around 75% of the HACC client base and people with disability the remaining 25%. While recognising the needs of younger people with disability, this paper is focused on aged care policy and program responses.

- Improving and maintaining quality of life in areas such as, continuing or re-engaging actively in community life, retaining relationships with families and friends, accessing leisure and recreational activities and maintaining their health and well-being
- Choice and decision making – providing access to honest and accurate information and involving the person (and/or their family, advocate or guardian) in decisions affecting their care and support, including end of life issues
- Coordinated, integrated quality service delivery, both within a service and between services, to provide accountable, effective, efficient services that respond to a person's changing needs and circumstances
- Collaborative partnerships with other services, government and non-government agencies and the private sector to meet the needs of older, frail people and to facilitate acceptance and inclusion of older Australians as valued, contributing members of the community.

What systemic changes could improve the service system?

Commonwealth places

Many people will be living longer and living healthier lives. The upcoming baby boomer generation (the older members of whom will be 65 years of age in 2011) have different expectations than former generations, particularly in terms of expectations of quality of life and access to, and quality of, services in their retirement years⁸. This raises a number of issues for future commonwealth aged care provision, such as:

- The sustainability of the current skewing of the allocation of commonwealth places in favour of residential places over community-based places. Given current, and future community expectations about life after retirement, shifting the ratio between residential and community-based places (CACP and EACH) over time towards a greater number of new community-based places may be a more responsive, and cost-effective, approach to aged care
- The need to find ways to enable individuals with few informal supports to remain in their homes (even where security of tenure is tenuous) for as long as they wish. There may need to be also new independent residential options that provide minimal or no care targeted to people with few financial and other resources or an expansion of low cost housing options, separate from support, to give these individuals a greater range of choices in older old age.

'Seamless' community-based services

For many people, the pathways into community-based and residential aged care services are complex and daunting. This is amplified by many people entering the system as a result of a crisis event. As noted above, access to HACC is generally by direct contact with a service provider, while access to CACP and EACH is only through an ACAT.

⁸ Information drawn from *IGRI & 2*; former Minister for Ageing, the Hon Julie Bishop, MP, address to Royal Institute of Architects 2005 Conference, available at: www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2005-jb-bissp220405a.htm?OpenDocument&yr=2005&mth=4

Confusion is experienced particularly around the interface, and gaps and exclusions that can occur, between HACC, CACP and EACH. People can therefore experience difficulty in navigating the system and coordinating the services they or their family member(s) need. Services are limited, with many people reporting that they receive fewer services or fewer hours than they need.⁹

It is quite common for service providers to be providing services through each of these streams and to be accounting separately to funding bodies for expenditure and service provision.

Given the stated appetite for 'stopping the blame game' between the commonwealth and states/ territories, now is an opportune time to work together to make the service system more streamlined, easier to navigate and more efficient. Options may include:

- At minimum, better synergies between the planning of CACP, EACH and HACC places for older people, and the investigation of options to move planning for these services to a common platform (such an approach could be trialled in a region where commonwealth and state planning boundaries coincide)
- Simplified and consistent gateways into services based on connections people are already likely to have (eg. GPs, community health, Centrelink, commonwealth Carelink centres)
- More creative approaches to providing information to potential clients – taking the information to them (eg. providing information in locations like social and sporting clubs, supermarkets, in addition to 'traditional' locations such as community service organisations), rather than relying on people coming to services and/or gatekeepers
- A common platform for assessing people's needs, with referrals to services to match levels and complexity of need, with a care coordinator involved where needed (eg. HACC and CACP provide a very similar, overlapping suite of supports and services)
- Better complementarity between programs – is it necessary for HACC and CACP to provide similar and overlapping suites of services and supports under different funding arrangements. A more efficient funding and service mix could result in better efficiencies and thus more services being provided
- Consistent fee structures, which will make it both easier for people to understand what they are paying for and how much they are expected to pay and also alleviate a problem reported in some areas of people choosing to remain in lower fee HACC services although they have complex needs due to co-contributions imposed for CACP on people whose income is above the aged pension
- Exploring the potential (through research or piloting) of giving eligible people funding to use at their discretion to purchase services from a range of community and/or private sector providers of their choosing. There would need to be strategies in place to protect the interests of people with limited financial or other literacy or cognitive or other disabilities

⁹ See the Senate Community Affairs References Committee report *Quality and Equity in Aged Care* (2005)

- Dismantling artificial barriers between programs, commencing with CACP and EACH, facilitating easy transition between levels of care for older Australians
 - It is time to move towards creating a single unified system of community-based services for older people (without disadvantaging younger people with disabilities)¹⁰

Role of services in reducing social isolation

As noted above, people are living longer and, generally, in better health than past generations. As also noted, 29% of older people currently live alone and by 2026, over 900,000 older Australians are estimated to be living alone. Among the older population, this group has been identified as being most likely to be experiencing loneliness and social isolation.

Supporting the ongoing engagement of older people with family, friends, interest groups and their broader communities has benefits to both older people and to the community. The HACC, CACP and EACH programs all have a responsibility to facilitate the maintenance or development of relationships and networks of their clients. There are currently insufficient policy attention and financial resources directed to services and programs to enable people to remain connected or reconnect to their families, friends and communities.¹¹

- Increasing social connectedness needs to be built into the objectives and principles for programs such as HACC, CACP and EACH, with appropriate resourcing being allocated to socialisation activities by governments and service providers
- Changes are needed for activity programs to be more responsive to the diverse social and leisure interests and wishes of older Australians
- Programs need to be designed to harness the skills, experience and interests of older Australians to provide them a way of ‘giving back’, not just be recipients of a service
- Isolated individuals should be identified, encouraged and supported to take part in a range of social and other activities. Key points of engagement are at assessment for and entry into HACC, CACP or EACH, for example. However, support to facilitate continuing engagement by such individuals is needed (support could be either transitional or ongoing, based on individual needs and characteristics). Options such as ‘friendly visitors’ and buddies/mentors could be explored to augment, and potentially replace, more formal, service-based support from providers.

An Australian social inclusion agenda that includes older Australians

The Rudd government’s social inclusion agenda clearly focuses on working families and the future workforce – today’s children. It appears older Australians have been overlooked.

Research has identified the multi-dimensional nature of disadvantage amongst older people. As might be expected, it has found that older people require decent health

¹⁰ See note 6 above re eligibility for HACC services

¹¹ Hillier, M (2007), *Rebuilding connections: Creating opportunities for socially isolated older Australians*

services, retirement income, housing, transport and affordable access to residential and community care services. But it has also identified the significance of social factors including good relationships with family and friends, feeling useful, feeling safe and being treated with respect and dignity¹². It has highlighted the social and economic dimensions of disadvantage in older age.

Building a society in which all older people have the opportunity to age well requires the integration of economic and social policy and will not be achieved by a singular focus on the adequacy of pensions, benefits and services. It needs to recognise the significant economic and social contribution of older Australians to society and their engagement in and beyond the economic sphere. It needs to encourage greater connectivity between formal and informal supports.

What would a social inclusion agenda look like for Australia? Issues to consider include equity in policies to encourage retirement savings, so that low income earners can benefit; access to affordable housing for older Australians who are not homeowners; adequacy of the aged pension to keep pace with the cost of living; improved choice and control of older people in accessing services; and a stronger emphasis on the value of older people's contributions in the workforce and community.

Strategy

Anglicare Australia will:

- lobby the Rudd government for a person-centred, sustainable community and aged care system that delivers choice, independence and quality outcomes for older Australians
- together with the Brotherhood of St Laurence, host a think tank to develop a social inclusion agenda for older Australians
- encourage the Rudd government to include older Australians in the social inclusion agenda

¹² Scarf, T., Phillipson, C., Smith, A., (2005) Multiple Exclusion and Quality of Life amongst Excluded People in Disadvantaged Neighbourhoods, Social Exclusion Unit, Office of the Deputy Prime Minister, London.