Who Gets HACC

A Statistical Overview of the Home and Community Care Program in Victoria 2002–03

hacc
home and community care
A JOINT COMMONWEALTH AND STATE/TERRITORY PROGRAM
PROVIDING FUNDING AND ASSISTANCE FOR AUSTRALIANS IN NEED

Victoria
The Place To Be

Who Gets HACC

A Statistical Overview of the Home and Community Care Program in Victoria in 2002-03

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Who Gets HACC: A Statistical Overview of the Home & Community Care Program in Victoria 2002–03.

Foreword

I am pleased to present this report on the services provided by the Home and Community Care Program in Victoria, and the characteristics of the people receiving services.

With funding of over $350 million from the Australian and Victorian Governments in 2003–04, the HACC Program is the State's largest source of practical assistance for older people and for people with disabilities living in their own homes.

In any year over 200,000 Victorians of all ages receive one or more services from the Program. These services include home care (home help), personal care, nursing, social support, and delivered meals.

The report illustrates that the Program assists a wide range of people across all age groups. Sixty seven percent of people assisted are aged 70 or older, but there are also significant numbers of adults in their middle years who, because of various disabling conditions, require assistance with the tasks of daily living.

The culturally and linguistically diverse nature of HACC clients can be seen from the fact that 20 percent of clients were born in as many as 150 non-English speaking countries. Making sure that services are designed and delivered to accommodate this rich cultural diversity is a challenge that the Government has accepted as a priority.

The importance of the program in helping people remain independent is demonstrated by the fact that 42 percent of clients live alone, and many of these are people aged over 75 years.

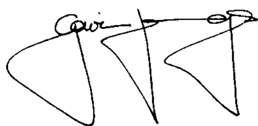
The Australian and Victorian governments jointly fund the HACC Program, with significant contributions also made by local government authorities. Fees from service users are collected and invested in services to increase the quantity and quality of services.

The Bracks Government is committed to supporting people to remain independent in the community and has consistently provided additional funding for HACC services. In 2003–04, on top of the Australian and Victorian government matching requirement, the Victorian government's additional expenditure has increased to $42.0 million.

Many Victorians seek assistance from the HACC Program. Because of people's preference for services to help them maintain their independence in their own homes, demand for community care is steadily rising. It is therefore important for government planners and service providers to have an accurate picture of client characteristics and the pattern of service usage.

The HACC Minimum Data Set (MDS) has been designed for this purpose. The MDS collects a range of key data items on each individual client, in a non-identifiable form to protect privacy. The managers of the HACC Program in Victoria have worked closely with their colleagues in the Australian Government and with service providers to collect and analyse all this information. The results of this ongoing work are presented in this report.

I trust that the report will prove to be accessible and useful for HACC clients, providers and system planners in making HACC services more responsive and successful in the years ahead.



GAVIN JENNINGS MLC
Minister for Aged Care

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Highlights

Numbers	• Over 200,000 Victorians received a service from the HACC Program in 2002-03. • More than half of all Victorians aged 75-plus who live alone receive a HACC service.
Age and sex	• 67 percent of clients were aged 70-plus. • 65 percent were female.
Ethnicity and Indigenous status	• 20 percent of clients came from 150 nations classified as non English speaking countries. • Italy accounted for 5 percent of all clients. • One percent of clients were Indigenous.
Place of residence	• 8 percent of clients live in rural areas outside of Melbourne and provincial towns, and their access to HACC services is better than average.
Living arrangements	• 42 percent of clients live alone.
Family carers	• Over 80,000 clients have a carer, typically a spouse or daughter. • 67 percent of carers live with the person cared for.
Services used	• Home care (home help) is the commonest service used, with over 70,000 clients. • Home Nursing (54,000 clients) and Allied Health services are the next most common. • HACC clients received an average of 34 hours a year, or about 1–2 hours a fortnight.
Service mix	• 55 percent of clients received only one kind of HACC service. • About 40,000 clients received two types of service. • About 7000 people received 5 or more types of service.
Source of referral	• 43 percent of clients (or their families) made direct contact with HACC services (i.e. self referral).
Exit from HACC	• Among people who ceased using HACC services during 2002-03, 12 percent moved into residential care, and about 9 percent died. (Thus HACC services were able to support them to the end of life.)
Case-managed services	• 3,700 people received case-managed Linkages services averaging $11,000 a year. • 53 percent were aged less than 70. • 65 percent lived with their family. • 36 percent of those aged 70-plus lived alone. • Clients with a carer received somewhat more hours of care than clients without family carers.

1 • Demographics

Overview

The Home and Community Care (HACC) Program provides services to frail aged people, people with disabilities, and caregivers, in order to help them maintain their independence, improve their quality of life, and prevent inappropriate or unnecessary admission to long-term residential care.

The program is cost-shared between the Commonwealth and State governments. In 2002-03 the budget for Victoria was $325.7 million. The Department of Human Services administers the program for the Victorian Government. Service provision is the responsibility of over 500 independent agencies – including some 76 local government authorities, over 100 community health centres, the Royal District Nursing Service, a range of non-metropolitan hospitals, and many non-government agencies. In 2002-03, fees from users of services contributed $44.9 million to service provision, in addition to the local government contributions.

The main types of service constituting the program are home care (home help), home nursing, delivered meals, planned activity groups, personal care, property maintenance, allied health services (including physiotherapy and podiatry), respite care, social support and assessment.

Nature of the HACC Minimum Data Set

This is a report on Victoria's HACC Minimum Data Set (MDS) for the 12-month period 1 July 2002 to 30 June 2003. The material is based on 204,450 linked client records from 493 agencies. Approximately 10 percent of possible client records are missing, due to the fact that not all agencies submitted data, and not all submitted complete data for the year. No attempt has been made in this report to adjust the figures to take account of non-responses or missing data. Quite different rates of client turnover in different service types also complicate the picture of missing data.

The importance of monitoring the actual levels of service provision and the coverage of particular target groups is now well recognised. A great advance has been made by the introduction of the HACC Minimum Data Set (MDS). This collects a standard set of data items on each person who receives HACC-funded services.

Nearly all the HACC-funded agencies in Victoria now collect the data on computerised systems, rather than on paper forms. The data items are transmitted to the Department each quarter, generally by email. Agencies are given immediate feedback to confirm the safe arrival of their files. After an automated validation process, the data items are added to the Victorian HACC

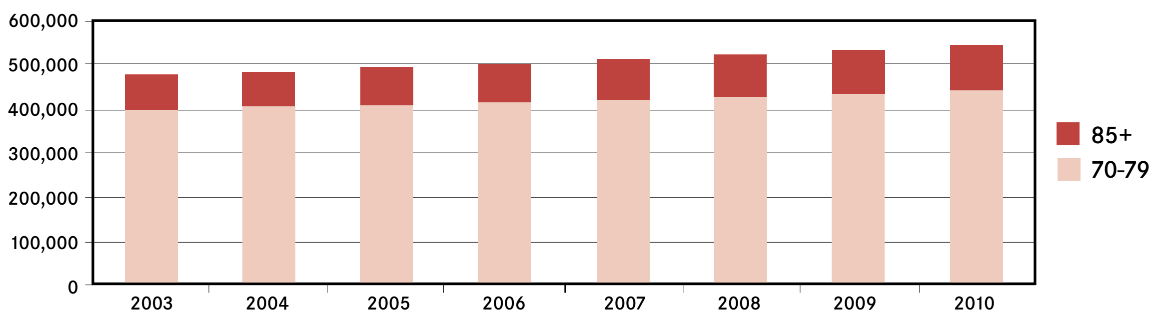
data repository. An automated process then sends each agency a summary of its own data, containing a mix of tables and graphs. Many agencies use this material for their own internal reports.

A consolidated copy of the Victorian MDS is then mapped to national HACC service types and forwarded to the HACC National Data Repository for storage and further analysis.

Individual clients are not identified in the coded data sent to the Department; instead, the agency sending the data creates a ‘statistical linkage key’ for each client record. The key preserves anonymity while enabling a statistically meaningful estimate to be made of the number of clients who have received services from two or more agencies during the same 3-month collection period (for example, home care from a council and home nursing from a hospital). The statistical linkage key also allows estimates of the proportion of clients who receive the same service across consecutive collection periods; in this way it is possible to estimate the typical ‘length of stay’ of people receiving home care, delivered meals and so on during the year.

In the present analysis, the individual client records have been sorted by using the statistical linkage key. Two or more records containing the same statistical linkage key are assumed to refer to the same person, and are therefore merged into a composite record. A certain rate of errors is likely to occur during this process, but this is considered acceptable, since the identity of any particular person is both unknown and irrelevant.

Figure 1: Victoria’s projected population aged 70+ 2003-2010



Source: ABS Estimated Resident Population, 30 June 2001

The information in this report is the result of work undertaken by HACC service providers across the State. Everyone involved in the implementation of the MDS is aware of the commitment needed to set up new client data gathering arrangements, convert and update hundreds of existing records, wrestle with computerised databases, and stay alert to errors and inconsistencies. We hope that these periodic reports on the accumulated data will demonstrate the real value of this effort.

Population trends and growth in demand

Victoria's aged and community care policy has long recognised that frail older people and younger people with a disability prefer to remain in their own homes rather than seek institutional forms of care. This creates a rising demand for all forms of home and community care.

The period 1990–2001 was characterised by slow but steady growth in the number of older Victorians. The rate of growth will accelerate in the next two decades. At the same time, older people's expectations of good quality home and community care services will rise. By 2002 there were 460,000 Victorians aged 70 years or more. Population projections suggest that this number will exceed 500,000 by 2010.

Age and sex profile

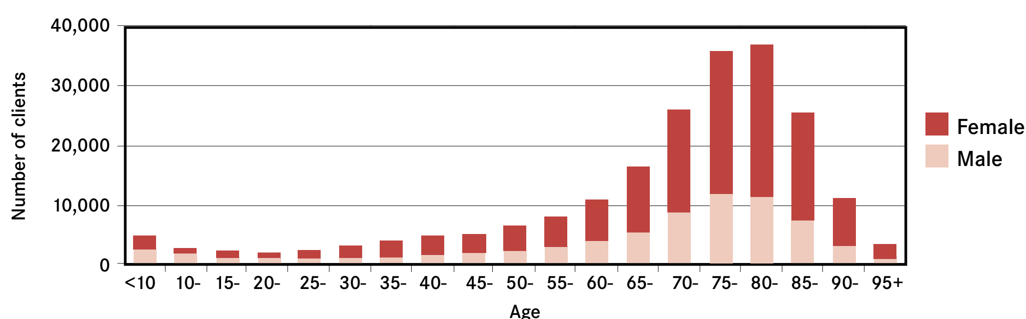
People using the HACC Program can be regarded as falling into two overlapping groups: frail aged people and people with disabilities living in the community. Table 1 shows that 67 percent of HACC clients were aged 70-plus in 2002-03.

Table 1: HACC clients by age group and sex

	Males	Females	Persons	Male %	Female %	Persons %
<10	2,586	1,917	4,503	*3.6*	*1.4*	*2.2*
10-14	1,495	900	2,395	*2.1*	*0.7*	*1.2*
15-19	1,051	816	1,867	*1.5*	*0.6*	*0.9*
20-24	880	832	1,712	*1.2*	*0.6*	*0.8*
25-29	916	993	1,909	*1.3*	*0.7*	*0.9*
30-34	1,113	1,694	2,807	*1.6*	*1.3*	*1.4*
35-39	1,298	2,219	3,517	*1.8*	*1.7*	*1.7*
40-44	1,671	2,722	4,393	*2.4*	*2.0*	*2.2*
45-49	1,885	2,824	4,709	*2.7*	*2.1*	*2.3*
50-54	2,423	3,574	5,997	*3.4*	*2.7*	*2.9*
55-59	3,067	4,562	7,629	*4.3*	*3.4*	*3.7*
60-64	3,926	6,571	10,497	*5.5*	*4.9*	*5.1*
65-69	5,596	10,316	15,912	*7.9*	*7.8*	*7.8*
70-74	8,865	16,667	25,532	*12.5*	*12.5*	*12.5*
75-79	11,740	23,546	35,286	*16.5*	*17.7*	*17.3*
80-84	11,204	25,174	36,378	*15.8*	*18.9*	*17.8*
85-89	7,338	17,650	24,988	*10.3*	*13.3*	*12.2*
90-94	3,170	7,737	10,907	*4.5*	*5.8*	*5.3*
95+	871	2,181	3,052	*1.2*	*1.6*	*1.5*
Total	**71,095**	**132,895**	**203,990**	***100.0***	***100.0***	***100.0***

About 65 percent of HACC clients are female. Female clients outnumbered male clients in all age categories, with the exception of people under 25. The preponderance of female clients is the result of three demographic factors: the fact that older people who live alone are more likely than couples to require home care services; the fact that female life expectancy is about 5 years greater than male life expectancy; and the fact that women tend to marry men a few years older than themselves, which increases the chances of being widowed.

Figure 2: Age range of HACC clients



Country of birth

HACC clients are drawn from a wide range of cultural groups. The HACC MDS has two indicators of ethnicity: country of birth, and language spoken at home[1].

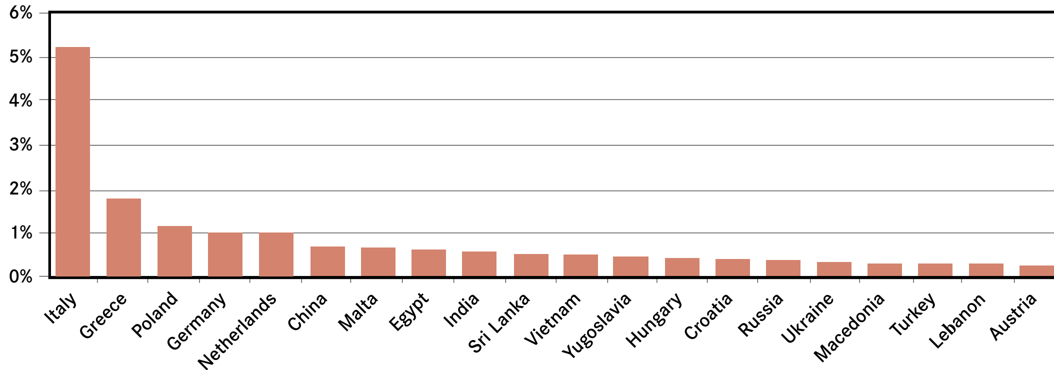
Australia was the recorded country of birth for 68 percent of clients. The other 27 percent of clients came from over 150 different countries. The relative numbers of people from the top twenty non-English speaking countries are shown in Figure 3. The highest was Italy with 5.2 percent of all clients.

Table 2: HACC clients by country of birth

	Number	*Percent*
Australia	138,564	*68*
Main English Speaking Countries	14,345	*7*
Non English Speaking Countries	40,339	*20*
Missing data	11,202	*5*
Total	**204,450**	***100***

[1] For convenience, all countries are classified by the ABS as either English-speaking or non-English speaking. There may be significant minorities of English speakers in a non-English speaking country, and vice versa, so the classification is merely indicative.

Figure 3: Clients from non-English speaking countries as % of HACC clients, ranked by top 20 countries



Language spoken at home

More than 80 languages were recorded. The top ten non-English languages spoken by HACC clients were (by rank) Italian, Greek, Chinese[2], Polish, Vietnamese, Arabic, Russian, German, Croatian and Maltese. Italian, the most common non-English language, accounted for 3.75 per-cent of all clients, or around 7,000 people.

Table 3: Language spoken at home

	Number	*Percent*
English	168,857	*83*
Other language	23,315	*11*
Missing	10,462	*5*
Non-verbal	1,816	*1*
Total	**204,450**	***100***

Comparing Tables 2 and 3, it can be seen that about 20 percent of clients were born in non English speaking countries, but only 11 percent spoke a language other than English at home. This is consistent with the assumption that some people born in countries classified as non English speaking live in families that normally speak English at home. Problems of data quality preclude closer examination.

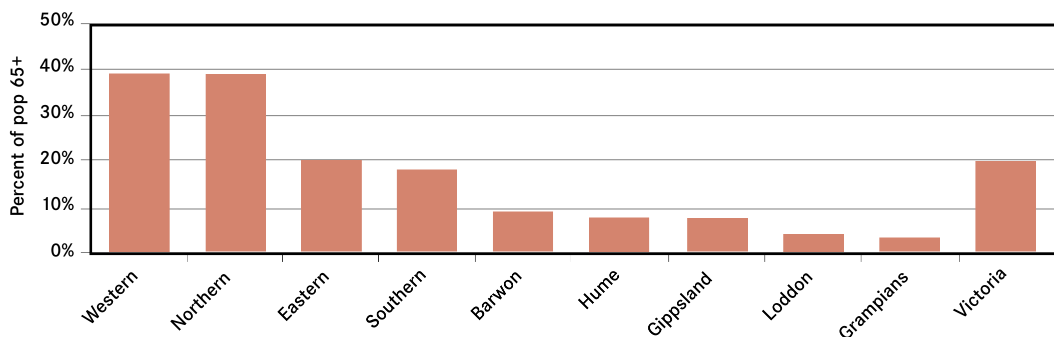
CALD communities: Access to HACC services

Census data can be used to show the extent to which people from culturally and linguistically diverse (CALD) communities have access to HACC services in Victoria. For the purposes of data analysis, the term 'CALD' can be defined in different ways: either as persons born in countries

[2] Chinese includes Cantonese, Mandarin, Teochew, Hokkien and Hakka.

defined by the ABS as non English speaking countries (about 20 percent of HACC clients), or as persons who speak a language other than English at home (about 11 percent of HACC clients). The latter definition is used below.

Figure 4: Prop. of people 65-plus speaking a language other than English at home, by DHS Region, Census 2001



CALD communities are not distributed equally across the State, but are concentrated in two metropolitan regions.[3] Figure 4 shows the proportion of people aged 65-plus who speak a language other than English at home, according to the Census 2001. While the state average is 20 percent, the proportion of older CALD people in Western and Northern metropolitan regions is 39 percent of the older population.

The uptake of HACC services by CALD populations varies according to the service type. Overall, as noted, people from non-English speaking countries made up about 20 percent of HACC clients.

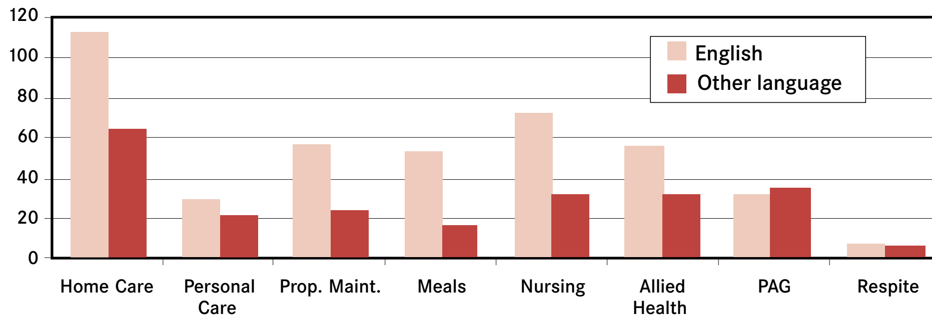
Figure 5 considers each of the HACC service types and compares the rate of uptake among the older CALD populations (defined as people speaking a language other than English at home) to the rate among the majority population of English speakers. It can be seen that, for every 1000 people in the English-speaking population aged 65-plus (Census data), about 112 had received HACC home care, 28 had received personal care, 56 property maintenance, and so on. By comparison, the proportions of older CALD people using these services was lower: 63 in 1000 had received home care, 21 personal care, 23 property maintenance, and so on. In Planned Activity Groups, there was a higher rate of use by older CALD people (34 per 1000) than English speakers (31 per 1000).

These figures need to be treated with caution, because they are affected by missing data on non English speaking HACC recipients and other problems of data quality. Nevertheless, they point to an underlying problem.

In order to improve ethnic access to mainstream HACC services, the Department has embarked on a Culturally Equitable Gateways Strategy, creating partnerships and ongoing working relations between major ethnic agencies and local councils. Over the next three years, this will result in

[3] Northern and Western regions were amalgamated in November 2003.

Figure 5: HACC service use per 1000 population aged 65-plus, by language spoken at home



improved access to the core HACC services of home care, personal care, property maintenance and in-home respite on the part of people from CALD communities. Progress towards these targets will be monitored via the HACC minimum data set.

Indigenous status

Almost 1 percent of clients were identified as Aboriginal or Torres Strait Islander. This is consistent with earlier surveys. According to the 2001 Census, 0.54 percent of Victorians were Indigenous. On these figures there does not appear to be an under-representation of Aboriginal people in the HACC Program, but the extent of need is not captured by these figures.

Table 4: HACC clients - Indigenous status

	Number	*Percent*
Aboriginal and/or Torres St Islander	1,696	*1*
Not Indigenous	183,719	*90*
Missing data	19,035	*9*
Total	**204,450**	***100***

Figure 6 shows the number of Aboriginal people receiving each HACC service type. The most common type of service was home nursing, followed by home care and planned activity groups.

Figure 6: Number of Aboriginal HACC clients by service type

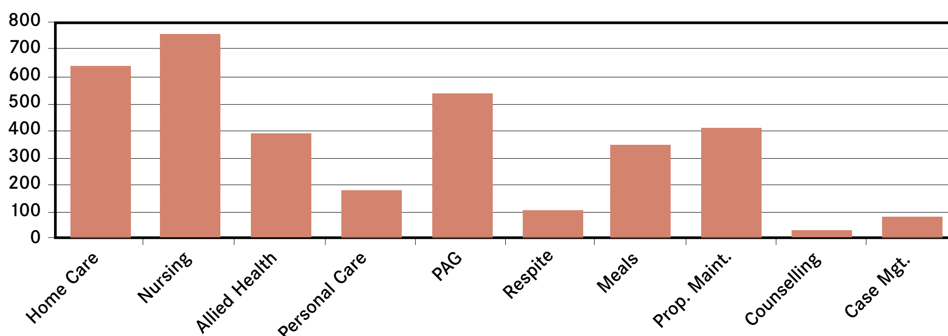


Figure 7 shows the proportion of Aboriginal HACC clients who received each service type, and compares this to the proportion of non-Aboriginal HACC clients using the same service types. Thus about 31 percent of Aboriginal clients received home care, compared to about 37 percent of non-Aboriginal clients. It can be seen that Aboriginal clients were *more* likely to receive home nursing and attend Planned Activity Groups. They were *less* likely to receive home care and personal care than were other clients. (Caution: No allowance has been made for missing data, so the figures can be regarded as indicative only. The graph should not be misinterpreted as showing the proportion of Aboriginal clients among all clients in any service type.)

Figure 7: Proportion of Aboriginal clients receiving each service type, compared to non-Aboriginal clients

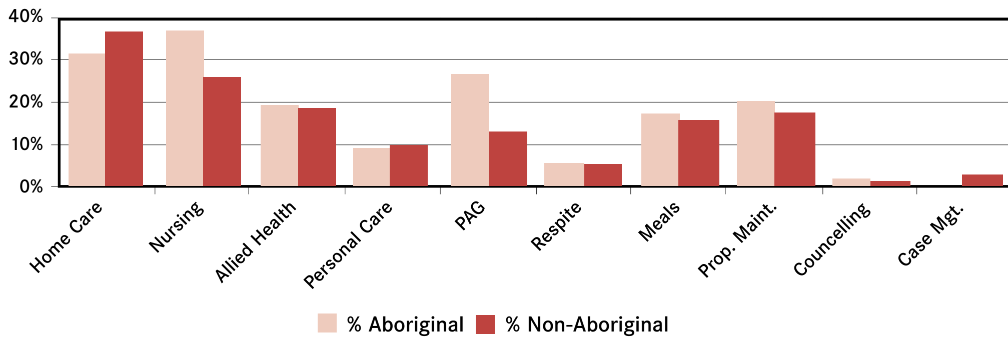
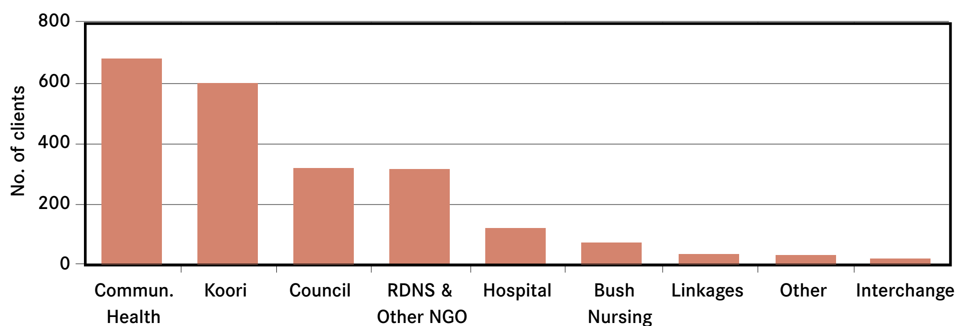


Figure 8 shows the range of HACC agencies used by Indigenous clients. It can be seen that the agencies reporting the largest number of Indigenous clients were community health centres and Koori agencies. Missing data will affect the accuracy of these figures.

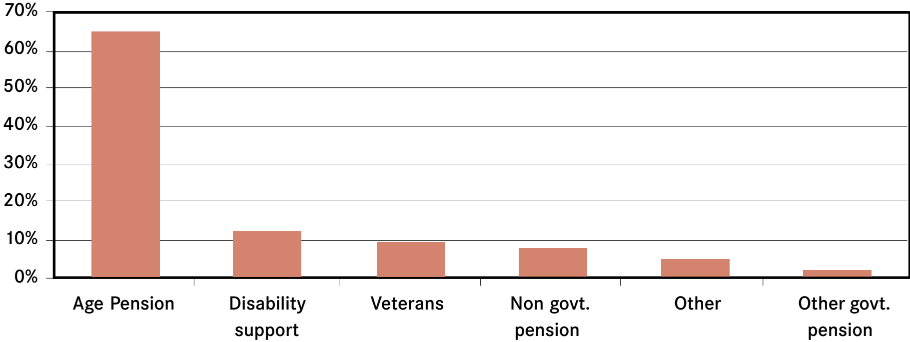
Figure 8: Number of Aboriginal clients in each agency type



Pension status

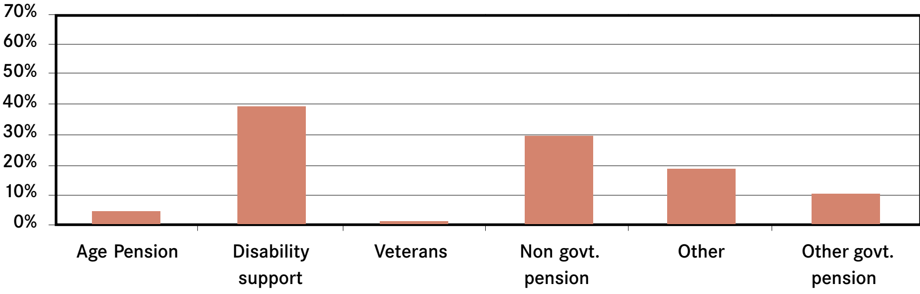
Most HACC clients receive a pension of some kind, the most common (64 percent of clients) being the Age Pension, with a further 10 percent receiving a Veterans Affairs pension. Data was not gathered on the proportion of full and part pensioners. See Figure 9.

Figure 9: Pension status, all clients, 2002-03



In Figure 10, a cross-tabulation by age shows that the younger group (clients aged 0–19) has a different pattern of pension status. As expected, the largest category for the younger group is the disability pension. However, there are clearly problems of data quality: none of this group should be recorded as receiving the age or veterans pension.

Figure 10: Pension status, clients 0-19 yrs



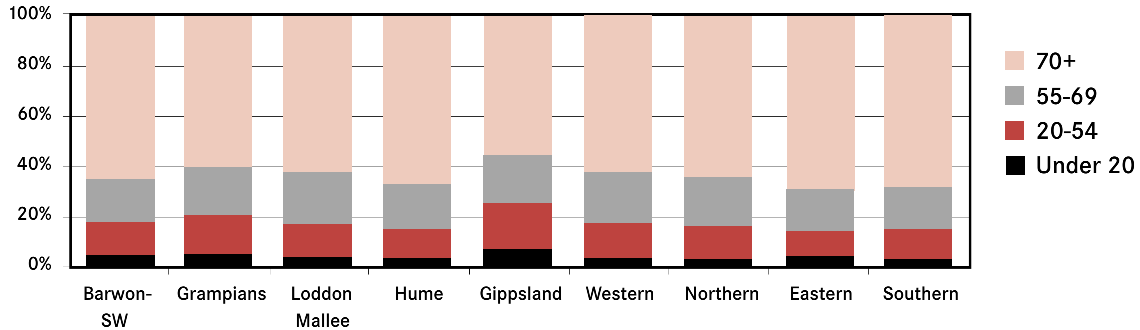
Regional distribution

Age profile

The Department of Human Services divides Victoria into nine regions, of which four were metropolitan at the time. Figure 11 shows that the age profile of HACC clients looks very similar across all regions. Gippsland had a slightly larger proportion of younger clients; 7 percent and 18 percent of their clients were aged under 20 and 20-54 respectively, compared to the State averages of 4 percent and 13 percent respectively. Conversely, Gippsland had a smaller proportion of clients aged 70-plus: only 55 percent. Eastern Metropolitan, Southern Metropolitan and Hume had the largest proportion of clients aged 70-plus, at 69 percent, 68 percent and 67 percent respectively.

Gippsland and Hume regions have a slightly higher proportion of Indigenous clients; both reported over 2 percent compared to the State average of 0.8 percent. It should be noted that there is a considerable amount of missing data.

Figure 11: Age profile by region



There was little difference between DHS regions regarding client living arrangements or referral sources.

ABS classification of localities

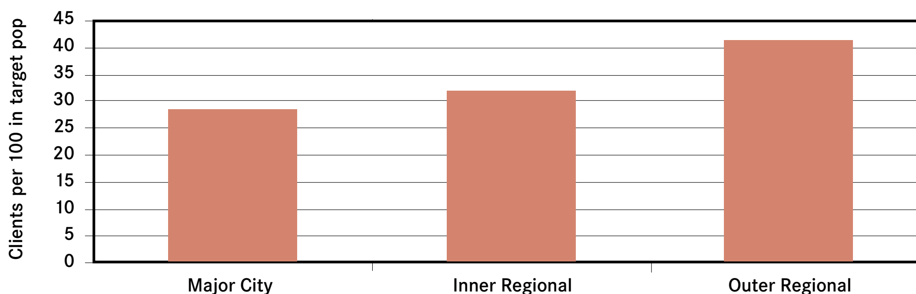
The ABS classifies all localities in Australia into five groups in terms of remoteness (Major City, Inner Regional, Outer Regional, Remote, Very Remote). This does not necessarily correspond to the nine DHS regions. Using the ABS categories, 53 percent of HACC clients reside in Melbourne and major cities, 38 percent in inner regional areas and 8 percent in outer regional areas. No clients were recorded as living in remote areas.

Table 5: HACC clients by geographical location

	Number	*Percent*
Major City	108,309	*53*
Inner Regional	77,753	*38*
Outer Regional	16,176	*8*
Missing Data	2,212	*1*
Total	**204,450**	***100***

Figure 12 below shows the number of clients per 100 people in the HACC target population in any given geographical area. A larger proportion of the HACC target population in the outer regions appears to be receiving HACC services. That is, the outer regional areas are more generously serviced by the HACC Program than the metropolitan area.

Figure 12: Clients per 100 people in HACC target population, by area of residence

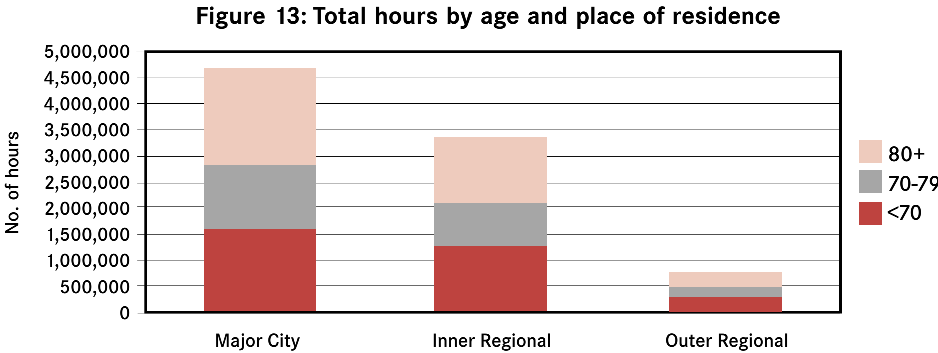


Extent of services by locality

The total hours of services consumed within each geographical location is proportional to the number of clients living in each respective region. That is, 53 percent of hours are consumed in the major cities, 38 percent in the inner regional areas and 8 percent in the outer regional areas.

The age range of clients receiving services does not differ significantly between locations. Refer to Figure 13 below. Similarly, the age distribution of clients does not differ greatly between activities.

Figure 13: Total hours by age and place of residence

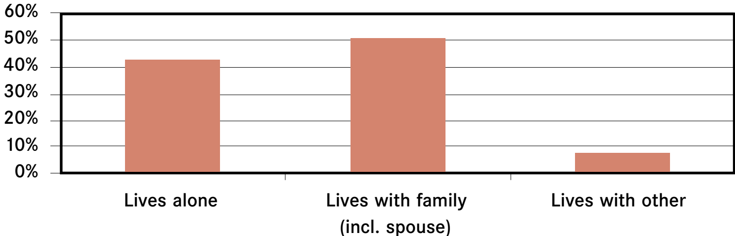


2 • Carers and client living arrangements

Living arrangements

The HACC Program is focussed on supporting people living 'in the community' rather than in residential care facilities. Fifty percent of clients live with spouse or other family, 42 percent live alone, and 8 percent live with other people. See Figure 14 (missing data excluded).

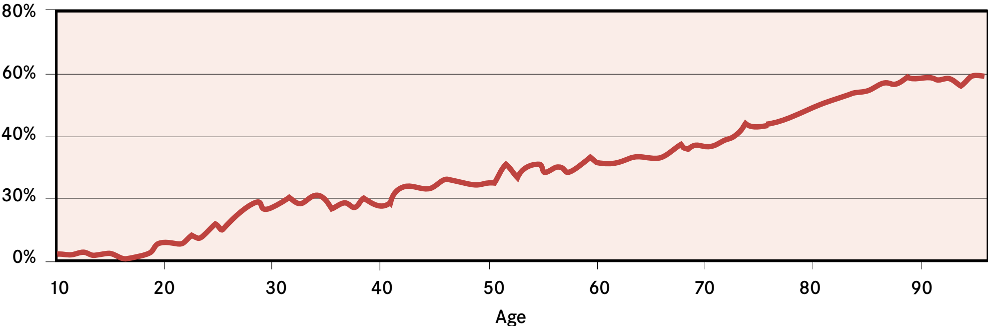
Figure 14: Living arrangements



According to the 2001 Census, 38.6 percent of people aged 75-plus live alone (approximately 89,000 people). There are approximately 110,000 HACC clients in Victoria aged 75-plus, of whom almost 48,000 live alone. It would therefore seem that the HACC Program is currently reaching about 54 percent of the 89,000 Victorians aged 75-plus who live alone. One of the principal aims of the program is to assist older people to retain their independence.

As shown in Figure 15, the proportion of HACC clients living alone rises steadily with age. At the age of 80 years, almost 50 percent of clients are living alone. The percentage falls after the age of 95. As would be expected, very few clients under the age of 20 are recorded as living alone.

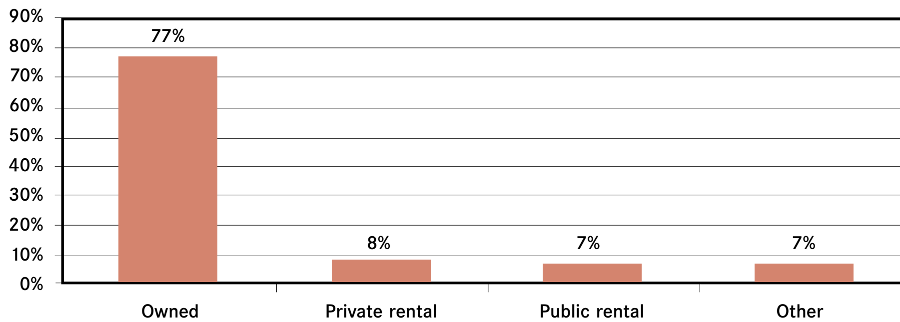
Figure 15: Percent of HACC clients living alone, by age



Accommodation

Nearly 77 percent of HACC clients live in owner-occupied dwellings (Figure 16). Another 15 percent live in rented housing, split evenly between public rental and private rental. With 17 percent of data missing, there is limited scope for more analysis.

Figure 16: Accommodation type *(excluding missing data)*



Care recipients and carers

For the purposes of the National HACC MDS, all HACC clients are classified as either care recipients or carers. This is because carers are recognized in the HACC Agreement as eligible for HACC services in their own right. The HACC MDS Guidelines ask service providers to treat Respite as the only service type in which the client is the carer. However, experience shows that there is considerable confusion with this data item, and the result is poor data quality.

Table 6 shows that 5 percent of HACC clients have been classified as carers. Note that a different data item displayed in Table 7 identifies almost 83,000 carers. In theory, the caregivers in Tables 6 and 7 are separate populations.

Table 6: Reason for HACC Client Status

	Number	*Percent*
Care Recipient	172,098	*84*
Carer	10,889	*5*
Missing	21,463	*11*
Total	**204,450**	***100.0***

Existence of a carer

HACC clients are also divided between those with a carer and those without. A carer is an unpaid person, typically a relative or friend. Table 7 shows that at least 40 percent of clients have a carer. It is possible that some clients classified as carers in Table 6 will also have a carer. There is a considerable amount of missing data.

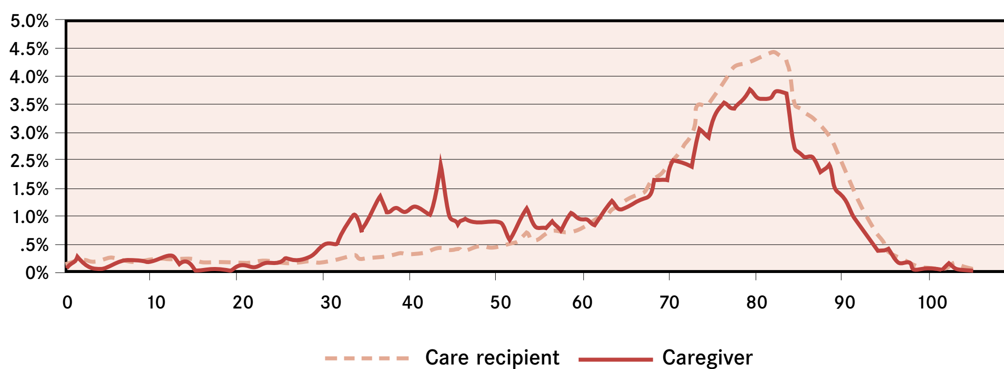
Table 7: Existence of a carer

	Number	*Percent*
Has a carer	82,533	*40*
Has no carer	86,579	*42*
Missing data	35,338	*17*
Total	**204,450**	***100***

Age profile of carers and care recipients

Figure 17 describes the 10,889 carers and 172,098 care recipients in Table 6. It can be seen that there is a bulge in the proportion of carers aged 30–50, compared to general HACC clients ('care recipients'). This is what would be expected: more people in the age group 30–50 are likely to be caregivers than care recipients.

Figure 17: Age proflie of caregivers and care recipients



Carer residency status

Most carers live with the person receiving HACC services. Table 8 describes only those clients who were reported as having a carer in Table 7. It suggests that, where a client has a carer, the carer is at least twice as likely to live with the client as not.

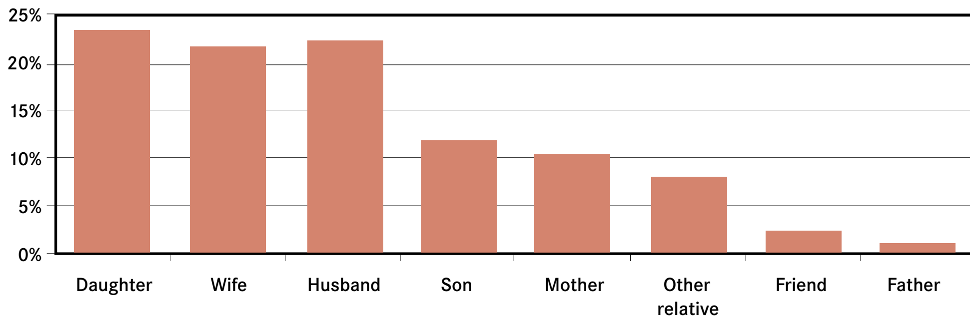
Table 8: Carer residency status

	Number	*Percent*
Co-resident carer	55,004	*67*
Non-resident carer	23,651	*29*
Missing data	**3,872**	*5*
Total	**82,533**	***100***

Relationship of carer to care recipient

Where a client has a carer, the carer is most likely to be a spouse/partner (42 percent) or a daughter (24 percent). A significant proportion of data is missing, suggesting that agencies are not routinely or accurately collecting this information on HACC clients. In Figure 18, only those clients reported as having a carer in Table 7 are included, and missing data has been excluded.

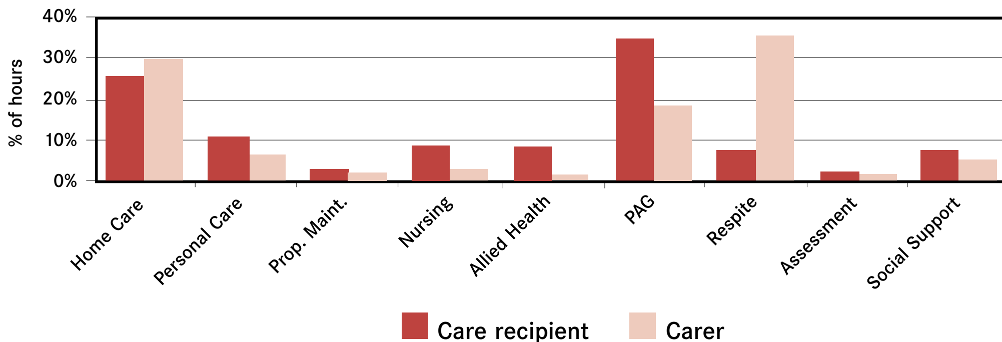
Figure 18: Carer's relationship to client *(missing data excluded)*



Services used by carers and care recipients

Figure 19 shows the range of services used by those HACC clients who were identified as carers and care recipients in Table 6. As noted above, the data item asked agencies to define as 'carers' only those HACC clients who were receiving Respite. Many agencies have queried the usefulness of this distinction, since it is arguable that both the carer and the care recipient are equal beneficiaries of Respite services.

Figure 19: Service usage by carers and care recipients



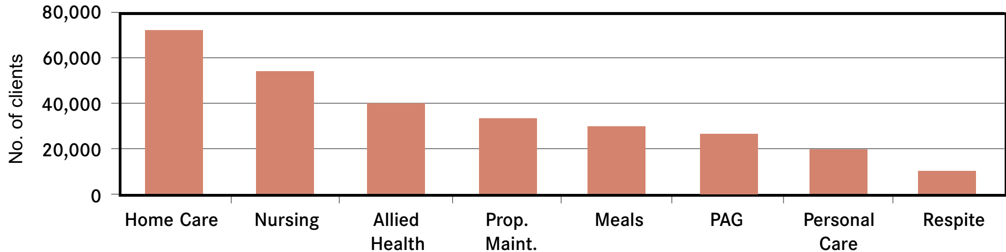
The contents of Figure 19 suggest that HACC agencies are not following the instructions in the MDS Guidelines with respect to this data item. Although, as expected, carers receive a larger proportion of respite hours than care recipients (35 percent of carers versus 7 percent of care recipients), carers also receive a large proportion of home care (29 percent). This strongly suggests that there is something arbitrary about whether the agency is reporting on the carer or the care recipient. There is therefore a good case for reviewing the definition of this data item.

3 • Services used

Range of HACC services used

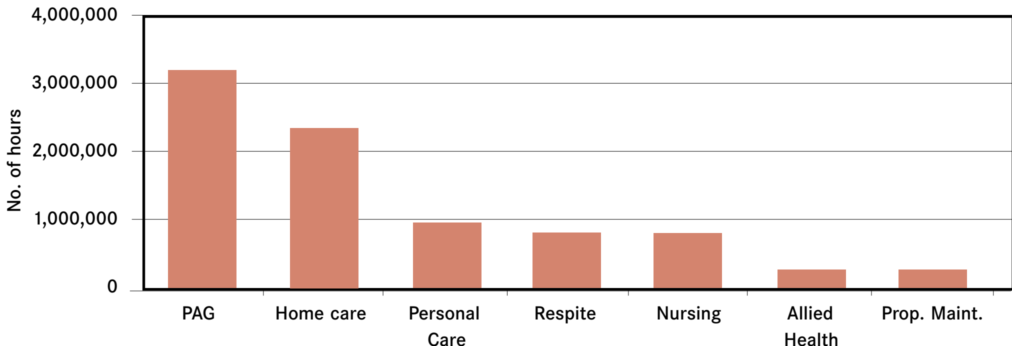
Home Care was the most frequently used service type during 2002–03, followed by nursing and allied health (Figure 20). Note that any given client could have received more than one type of HACC service during the period.

Figure 20: Number of clients receiving each service type, 2002-03



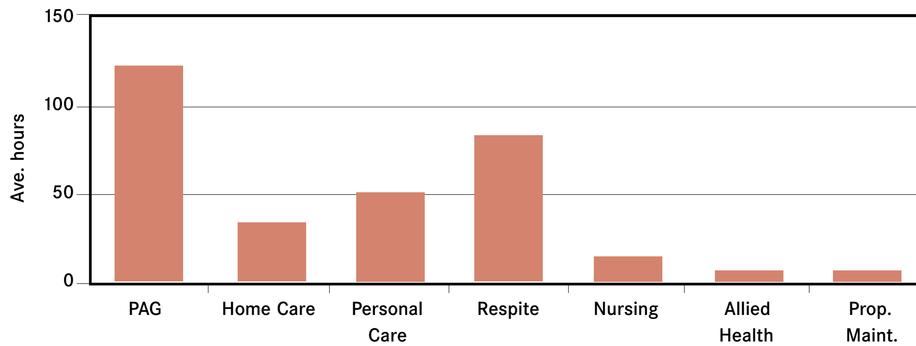
The aggregate number of hours for each of these service types is shown in Figure 21. Planned activity groups (PAGs) accounted for the largest number of hours, followed by home care. These two service types accounted for over 60 percent of all HACC hours. As well, over 3.1 million meals were delivered during the year.

Figure 21: Total hours per service type, 2002-03



As seen in Figure 22, people attending planned activity groups tended on average to receive the largest number of hours over the 12-month period (121 hours per client), followed by Respite clients (81.6 hours per client). Attendance at a PAG averaged about 4 hours a fortnight per client. Personal Care, Home Care and Nursing clients had smaller average hours (50.3, 33 and 14.3 hours per year, respectively). A rate of 50 hours a year is about an hour a week.

Figure 22: Average annual hours per client, by service type 2002-03

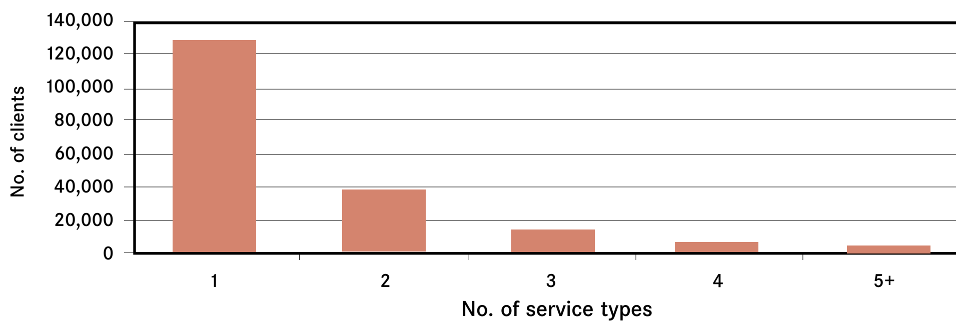


Across all major service types (except meals, case management, assessment and counselling), the average provision was 34 hours per client over the year. Not shown in the graph, 29,737 recipients of delivered meals received an average of 105 meals each during the year.

Single and multiple service users

Over half of HACC clients (55 percent) received only one type of HACC service (Figure 23). At the other end of the scale, a mere 3.4 percent of clients (6,957 people) received 5 or more service types during 2002–03. (Note that the rate of multiple-service use is strongly affected by the successful matching of client records via the statistical linkage key. Failed matches will result in an under-estimate of the extent of multiple service usage.)

Figure 23: Number of clients receiving one or more service types, 2002-03



Clients receiving a single type of service

Planned Activity Group, Nursing and Allied Health were the service types most likely to be received in isolation.

Table 9: Single-service users, 2002–03

Service type	No. clients with only this type	Total no. clients receiving this type	*Percent of clients with only this type*
Home Care	33,100	70,485	*47*
Nursing	30,994	53,704	*58*
Allied Health	22,164	40,349	*55*
PAG	15,158	26,262	*58*
Property Maintenance	11,825	33,098	*36*
Meals	10,547	29,295	*36*
Respite	4,409	9,631	*46*
Personal Care	1,903	19,142	*10*

Note: excludes Assessment, Voluntary Social Support and Aids & Equipment

Clients receiving multiple services

Almost 45 percent of clients received a combination of services. The most common combination was home care plus property maintenance. The 8,181 people who received this combination represented only 11.6 percent of all people who received home care. The next most common combinations were home care plus meals (4,702 people) and nursing plus allied health (3,452 people). See Table 10.

Table 10: Multiple Service Users, 2002–03

Mix of Service Types	No. of clients
Home care & prop. maintenance	8,181
Home care & meals	4,702
Nursing & allied health	3,452
Personal care & nursing	2,793
Home care & personal care	2,273
Home care & nursing	2,155
Home care & allied health	2,124
Home care, prop. maintenance & meals	1,525
Meals and nursing	1,332
Allied health & PAG	1,301
Meals & PAG	1,185
Property maintenance & allied health	1,057
Home care, prop. maintenance & allied health	1,038
Home care & PAG	1,013

Note: Includes only groupings with more than 1,000 clients. Also, excludes Assessment, Voluntary Social Support and Aids & Equipment.

Number of hours per client

The average hours of service received by a client tend to rise in proportion with the number of services received, for one, two and three services. But when more than three services are received, the average hours rise more steeply.

Table 11: Hours of service, 2002–03

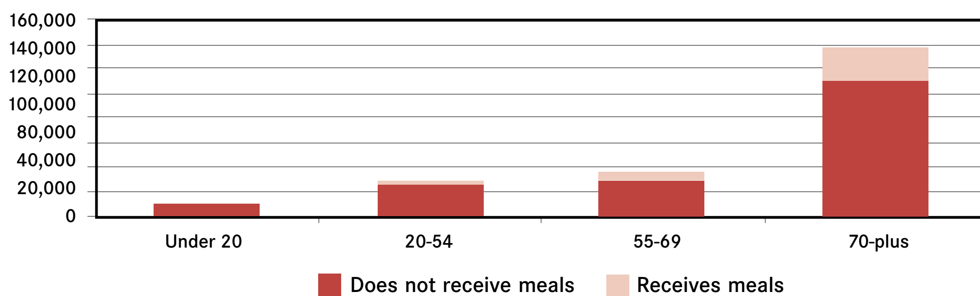
No. of services	Total number of hours	Total number of clients	Average number of hours per client
1	2,816,326	113,257	25
2	2,306,351	52,849	44
3	1,606,407	21,757	74
4	1,175,870	9,630	122
5	792,611	4,268	186
6	474,510	1,787	266
7	251,805	648	389
8	93,788	193	486
9	30,799	50	616
10+	10,697	11	972
Total	**9,559,164**	**204,450**	**46.76**

Note: Includes all services except for Aids & Equipment

Delivered Meals

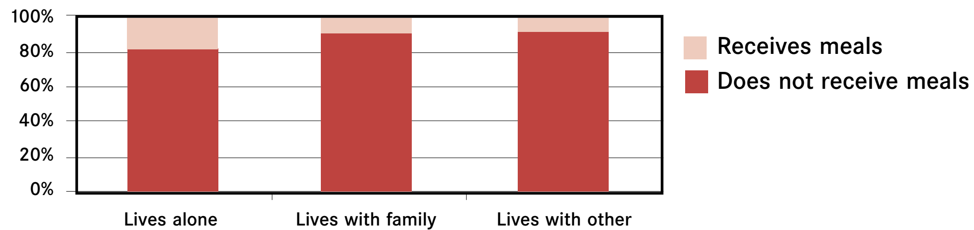
Overall, 14.5 percent of HACC clients received meals (Figure 24). This proportion increases with age: only 1.4 percent of clients aged under 20 received meals, whereas 18 percent of clients aged 70-plus received meals.

Figure 24: Number of meal recipients (and non-recipients) by age group, 2002-03



It appears from Figure 25 that a higher proportion (18.4 percent) of HACC clients who live alone receive meals than clients who live with their families (9.2 percent of whom receive meals).

Figure 25: Meals recipients compared to non-recipients by living arrangements, 2002-03



Source of referral to HACC

Table 12 below lists the sources of referral for all clients. Excluding missing data, 43 percent of clients were self-referrals (or referred by their families). Hospitals or nursing services were the second largest source of referral, accounting for 29 percent.

Table 12: Referral source

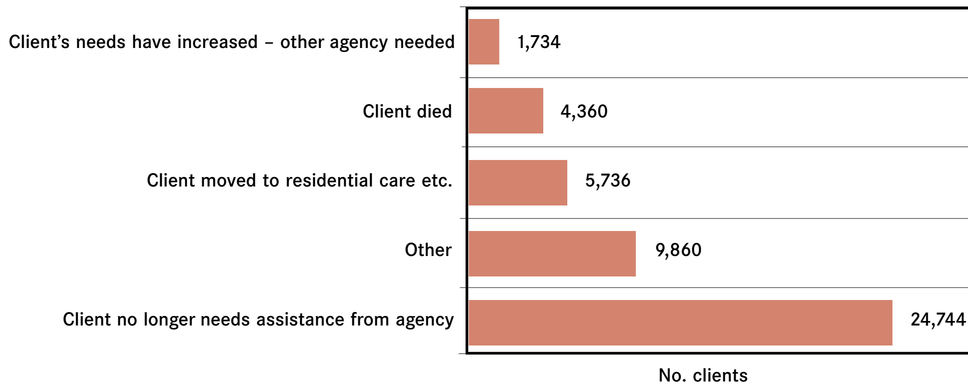
	Frequency	*Percent*	% Excl. missing data
Self	70,702	*35*	43
Hospital/Nursing service	47,876	*23*	29
GP/Medical practitioner	21,865	*11*	13
Aged care assessment team	10,180	*5*	6
Other	12,026	*6*	7
Carelink	181	*0.1*	0.1
Missing data	41,620	*20*	–
Total	**204,450**	***100***	**100**

The source of referral varies slightly between age groups. Clients aged 0-19 years were marginally more likely to be self-referrals, and less likely to receive GP and Hospital referrals than the other age categories. Note the large amount of missing data, which limits the certainty of this analysis.

Reason for cessation

During 2002-03, a total of 46,434 clients stopped receiving HACC services (Fig. 26). Overall, more than 50 percent of these clients reported no longer needing assistance from the agency as the main reason for the cessation. Clients aged 70 plus were less likely to report this as the reason; as a corollary, the proportion of 70-plus clients moving to residential or supported accommodation was higher than any other age group. For almost 10 percent of clients in that age bracket, the reason for cessation of services was that the client died.

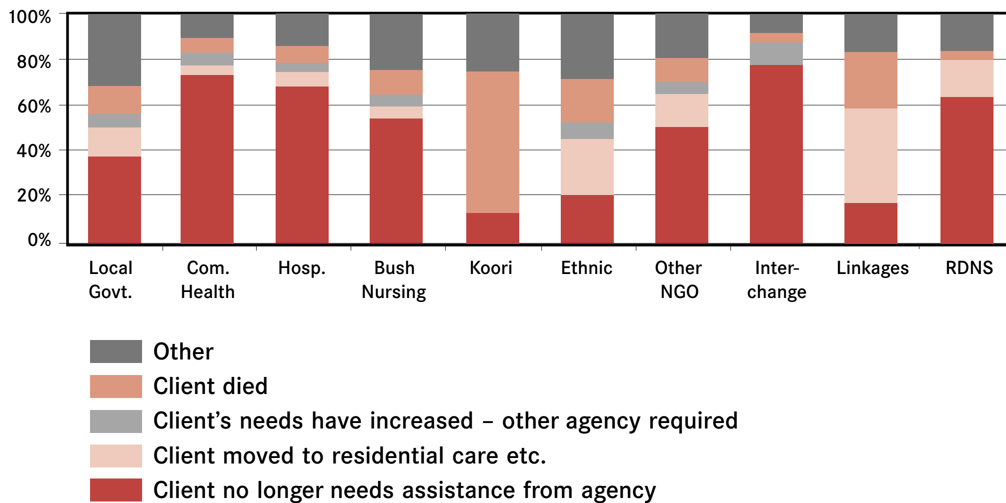
Figure 26: Reason for cessation of HACC service



Neither living arrangements (living alone or with family) nor the existence of a carer had any significant impact on the reason for cessation of services.

Reasons for cessation of services differ according to the type of agency (see Figure 27). For community health centres, hospitals and the RDNS, the most common reason was that the client no longer required assistance from that agency. For Linkages agencies, the most common reason was that the client moved into residential care. For Koori agencies, the death of the client appeared to be the most common reason (though absolute numbers were small).

Figure 27: Reason for cessation, by agency type



4 • Linkages agencies

Characteristics of Linkages clients

This chapter looks separately at clients of 24 agencies funded to deliver Linkages packages. It examines the services these 3752 people received during the year from all HACC agencies. Linkages (called Community Options in other states) is a case-management service with brokerage funds to purchase additional services for people whose needs exceed what can be met by the usual level of HACC services. Each package was worth $11,042.40 in 2002-03, but agencies are able to vary the quantity between individuals within this average value.

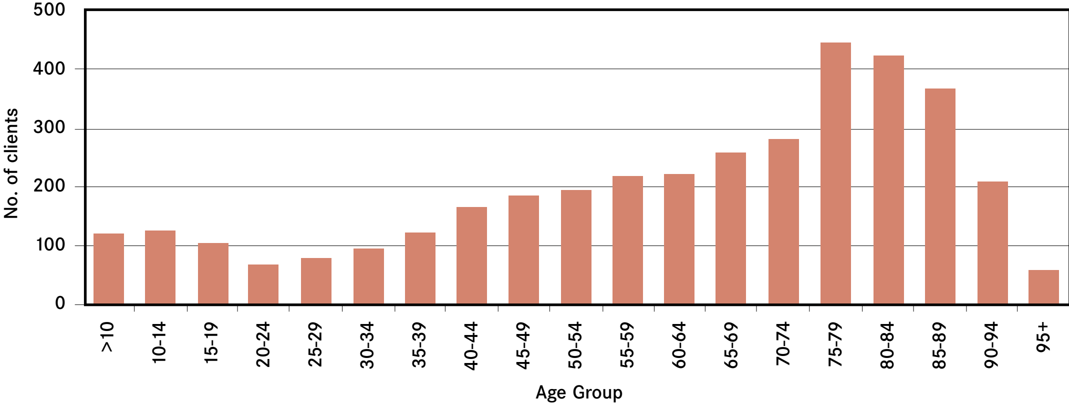
Age range

Linkages clients were found across the whole age spectrum, with a peak in the 75-89 year group (Table 13 and Fig. 28). Although nearly half the clients were aged 70-plus, there was a cluster of children and substantial numbers in every age group above 40 years.

Table 13: Age profile

Age	No. of clients	*Percent*
0-19	362	*10*
20-49	712	*19*
50-69	892	*24*
70+	1,786	*48*
Total	**3,752**	***100***

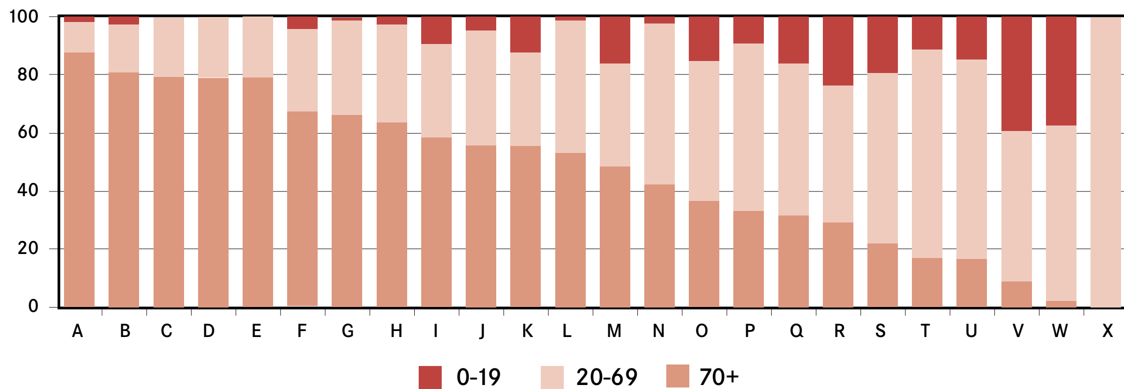
Figure 28: Age profile – Linkage clients, 2002-03



Age profiles of different agencies

Not all agencies and regions have the same age profile. In half the agencies (12 out of 24) a majority of the clients were aged under 70. See Figure 29, which shows the age profiles of the clients of each of the 24 agencies, labelled A to X. Client ages have been grouped as: 0-19, 20-69 and 70-plus years.[4]

Figure 29: Age profile of each Linkages agency (%)



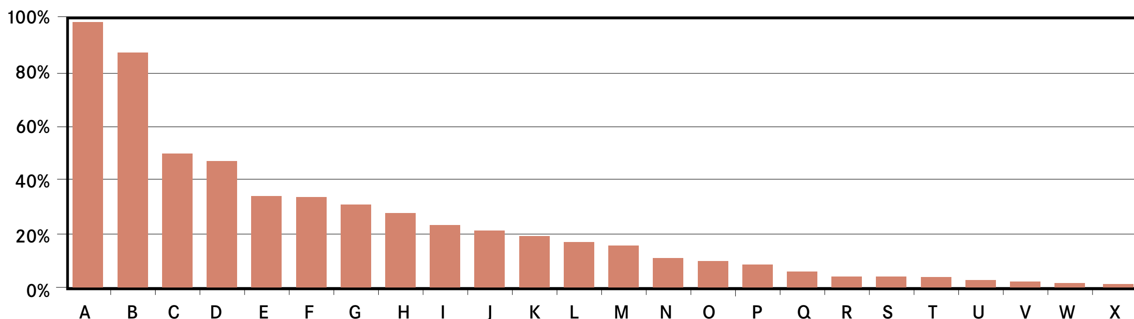
Gender, Ethnicity and Indigenous status

Almost 60 percent of Linkages clients were female. One percent were Indigenous. Overall, 15 percent spoke a language other than English (LOTE) at home.

Average hours per LOTE client were slightly lower than for clients who spoke English at home (366 hours versus 382). LOTE clients also received less volunteer social support: an average of only 4 hours compared to 43 hours for English-speaking clients. Similarly, LOTE clients received fewer meals per annum, 17 meals compared to 40.

As shown in Fig. 30, almost half of all agencies providing a Linkages service had 20 percent or more clients from non-English speaking countries. Four agencies had a majority of such clients.

Figure 30: Percentage of Linkages clients born in a non-English speaking country, by agency



[4] Agency A in Figure 29 does not necessarily correspond to Agency A in Figure 30

Living arrangements

Excluding missing data, 65 percent of Linkages clients live with family, 29 percent live alone, and 7 percent live with others. This is a different pattern from HACC clients generally, of whom 50 percent live with spouse or other family, 42 percent alone, and 8 percent with others. The lower proportion of Linkages clients who live alone is explicable on the assumption that a person's ability to continue living at home at these high levels of frailty and dependency is often due to the fact that they are living with family. Nevertheless, it is noteworthy that as many as 29 percent of Linkages clients live alone. Living alone was more common in the older group: 36 percent of Linkages clients aged 70-plus lived alone, but only 23 percent of under 70s lived alone.

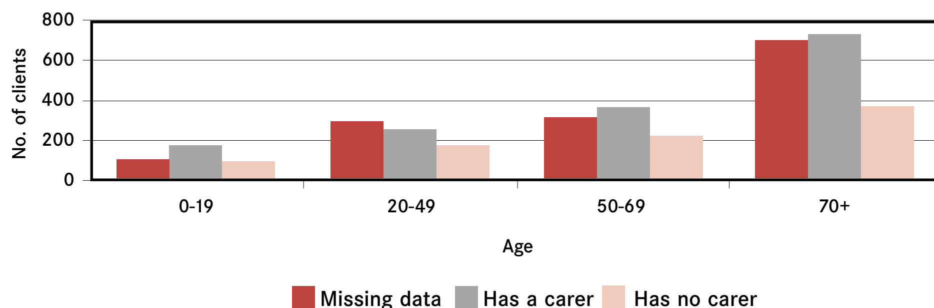
Carer availability

Excluding missing data, 64% of Linkages clients had a carer. This trend is consistent across all age groups. See Table 14 and Fig. 31.

Table 14: Carer availability

	0-19	20-49	50-69	70+	Total	*Percent*	*% (excl. missing data)*
Has no carer	87	171	213	370	841	*22*	*36*
Total	**362**	**712**	**892**	**1,786**	**3,752**	*100*	*100*

Figure 31: Existence of a carer by age of Linkages client



Some 342 people (almost one in six, excluding missing data) were recorded as living alone and having no carer. These Linkages clients are presumably among the most vulnerable to loss of independence if their health deteriorates.

In 2002-03, clients *with* a carer received on average more hours of service than those without a carer: 438 hours versus 396 hours. The existence of a carer could therefore imply that the client is more dependent and therefore requires a higher level of support service in order to continue living at home.

Client turnover in Linkages

As shown in Table 15, some 68 percent of Linkages clients (or 2,548 people) received services throughout the year (i.e. in every quarter). Of the 700 clients who ceased to be Linkages clients during the year, at least 7.4% (277 clients) had received services for only one quarter. For these people, it is possible that accepting a Linkages package was a last-ditch attempt to remain at home, but the attempt failed. A small percentage of people received services only in intermittent quarters.

Table 15: Number of clients appearing in each quarterly period, 2002-03

	No. of clients	*Percent*
1st only	204	*5.4*
2nd only	44	*1.2*
3rd only	29	*0.8*
4th only	98	*2.6*
1st & 2nd	155	*4.1*
2nd & 4th	24	*0.6*
2nd & 3rd	46	*1.2*
3rd & 4th	109	*2.9*
1st & 4th	15	*0.4*
1st & 3rd	13	*0.3*
1, 2 & 3	209	*5.6*
1, 3 & 4	35	*0.9*
1, 2 & 4	40	*1.1*
2, 3 & 4	183	*4.9*
All 4	2,548	*67.9*
Total	**3,752**	***100***

Hours of service

Excluding Volunteer Social Support, Linkages clients received on average 411 hours of service during 2002-03. This equates to 34 hours per month, although not all clients accessed services for all 12 months. The following table shows the number of clients who received on average less than 15 hours, 15-39 hours and 40-plus hours of service per month. Some 777 Linkages clients received on average 15 meals per month.

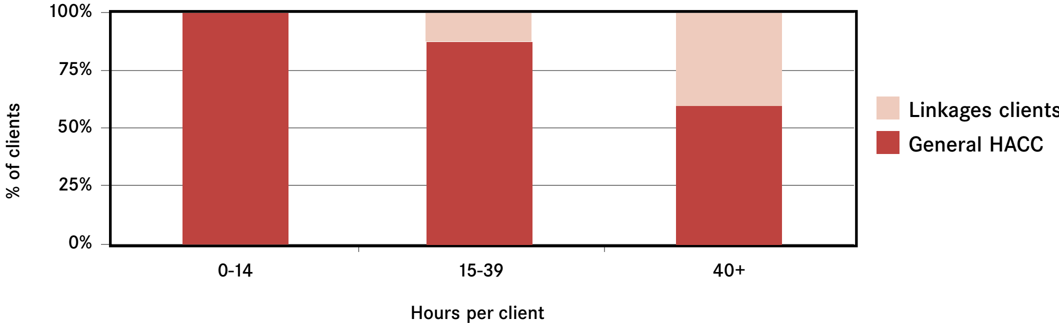
Table 16: Hours of service

Hours per month	No. of clients	*Percent*
< 15	1,294	*35*
15-39	1,364	*36*
40+	1,094	*29*
Total	**3,752**	***100***

The Linkages sub-program is intended to target those people who need above-average quantities of service. However, it appears that most such people are still found in the main-stream system and do not receive a Linkages package.

While Linkages clients comprised only 1.8 percent of all HACC clients, they made up 12 percent of medium-level users and almost 40 percent of high-level users of HACC services. Put the other way around, some 60 percent of high-level users are receiving services from mainstream providers, not Linkages agencies. See Fig. 32.

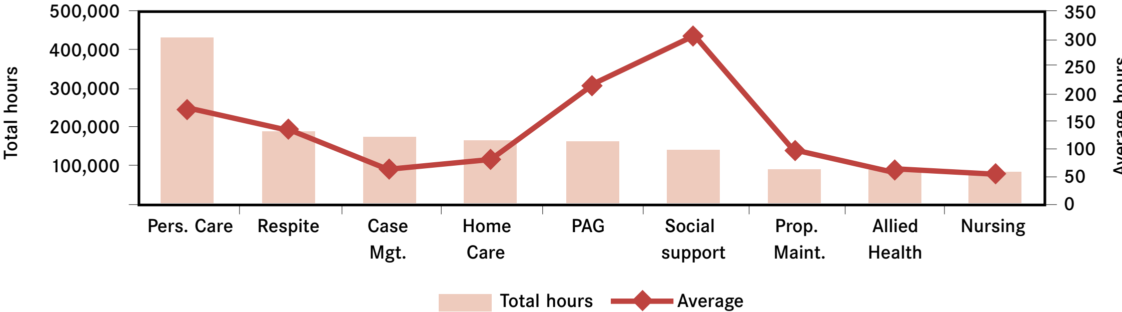
Figure 32: Linkages & General HACC clients: % of clients in low, medium and high user groups



Type and quantity of services used

Figure 33 shows the total annual hours (left hand scale) and average hours per client per annum (right hand scale), for each of the major service types used by Linkages clients. Personal care was the most important service type, accounting for 28 percent of all Linkages hours, followed by respite (12%). Volunteer social support was the most intensive service type, with each client receiving on average 307 hours of service for the year.

Figure 33: Total hours and average hours per service, 2002-03



Some 52 percent of Linkages clients were aged under 70 years. This group received almost 60 percent of all Linkages hours of service, and on average received more hours each (424 hours) than Linkages clients aged 70-plus (374 hours per annum).

Costs

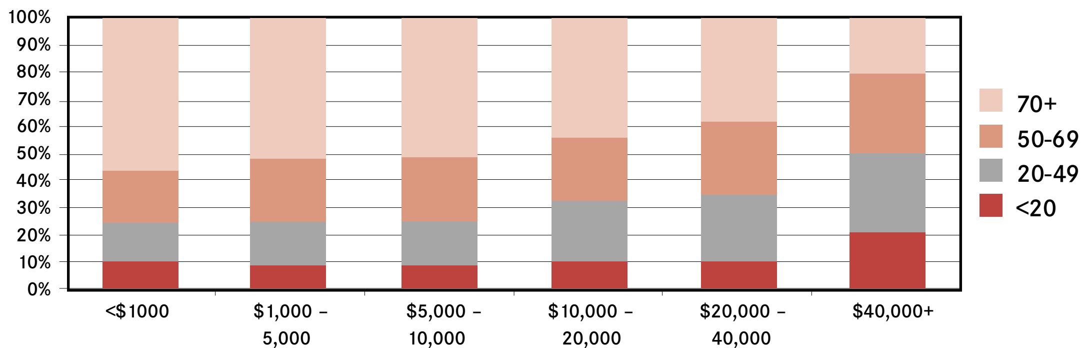
Table 17 below shows the number of clients falling within various cost ranges. A total of 638 clients received services worth more than $20,000 during the year.

Table 17: Number of clients per cost range.

	No. of clients	*Percent*
$1-999	377	*10*
$1000-4,999	1,044	*28*
$5,000-11,041	1,025	*27*
$11,042-19,999	667	*18*
$20,000+	638	*17*
Total	**3,752**	***100***

Figure 34 shows the cost range by age group. Clients aged 70-plus account for almost 60 percent of clients in the under-$1,000 category, but only 20 percent of clients in the $40,000-plus category. In other words, the highest-cost packages tend to go to the younger age groups. This may reflect the perception of service providers that older people requiring very high levels of support have the alternative of aged residential care, but this is not a possible option for people in the younger age groups.

Figure 34: Cost range by age group of Linkages client

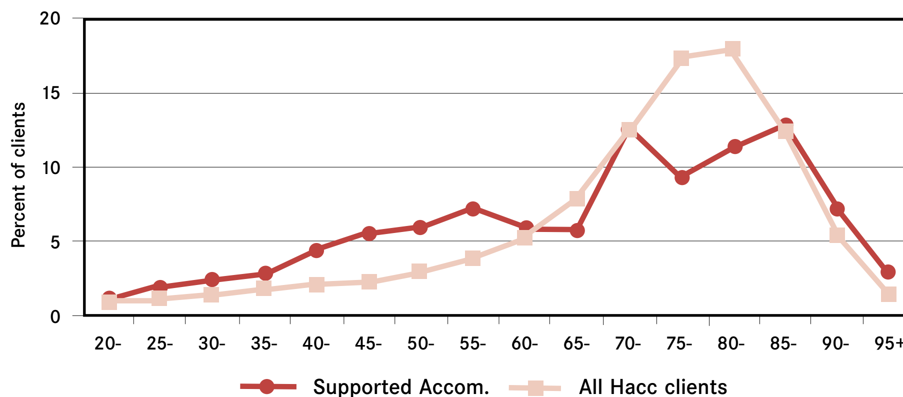


5 • HACC clients in supported accommodation

Of all HACC clients, 2.4 percent were reported as living in a supported residential service (SRS) or a rooming house or boarding house. An SRS is essentially a private-sector hostel registered with the Department of Human Services as a provider of personal care. An SRS is unsubsidised. A rooming house or boarding house is not registered as a provider of personal care; in a rooming house the residents generally provide their own meals.

The age profile of HACC clients in these forms of accommodation is somewhat different from other HACC clients (Figure 35). Instead of a peak at ages 75–85, a larger proportion of residents range across 25–60 years (the sharp peak at 70 is probably poor data and should be ignored). This is consistent with the profile of SRS residents comprising substantial numbers of people in the 40–69 age group with chronic conditions such as mental illness and alcohol-induced brain damage.

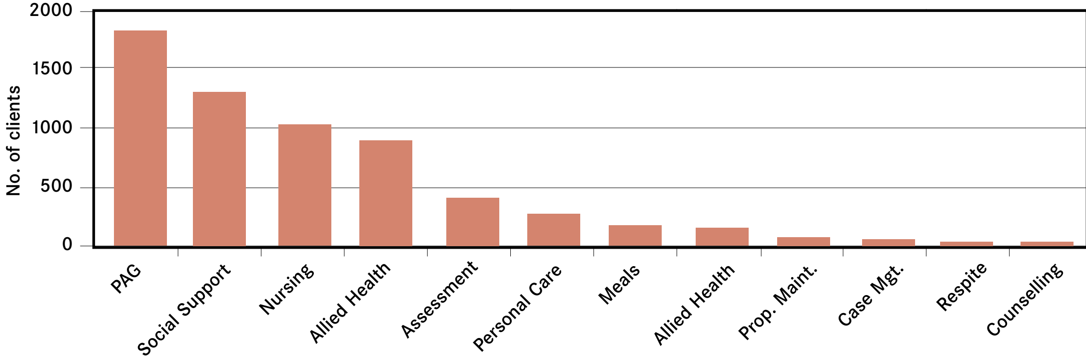
Figure 35: Age profile of HACC clients in supported accommodation and rooming houses



In effect, these facilities cater for two populations–the frail aged, and non-aged people with chronic disabilities in need of supported accommodation.

Figure 36 shows that the range of HACC services used by people living in SRSs and rooming houses is also quite different from HACC clients in general. Planned Activity Groups and Social Support are the dominant types, with over 80 percent of hours attributed to PAGs. Substantial numbers of residents also receive Nursing and Allied Health services. HACC home care, personal care and meals are not generally available to a person living in a registered SRS, because the equivalent services are provided by the management. Thus, where these services are reported, it can be assumed that the client is living in a rooming house.

Figure 36: Clients in SRSs and Rooming Houses: HACC services used

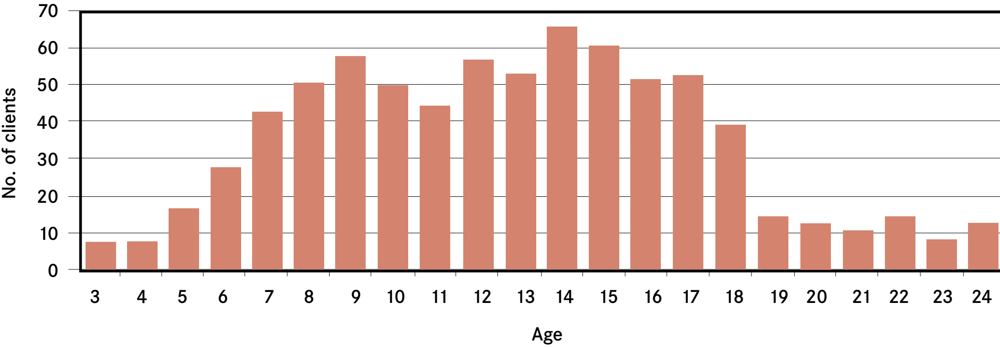


6 • Interchange agencies

Interchange agencies are funded by the HACC Program to provide a service to families of children and young people with disabilities. In 2002-03 there were 787 Interchange clients across Victoria.

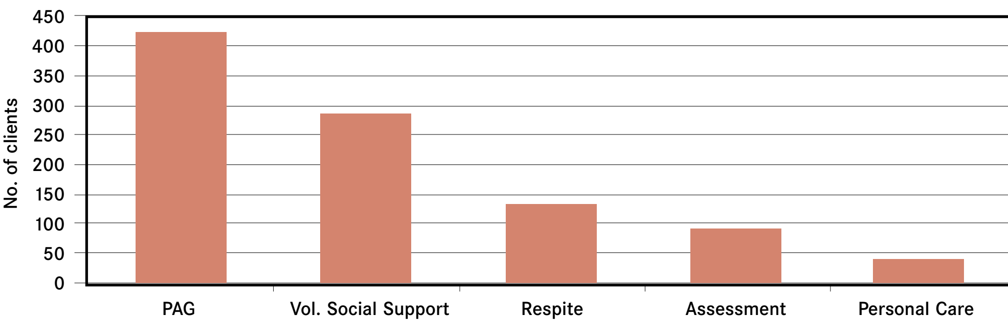
Nearly all Interchange users were under the age of 25. Almost 75 percent were aged 7–17 years. See Figure 37.

Figure 37: Interchange clients – Age range



Types of service used

Figure 38: HACC services used by Interchange clients



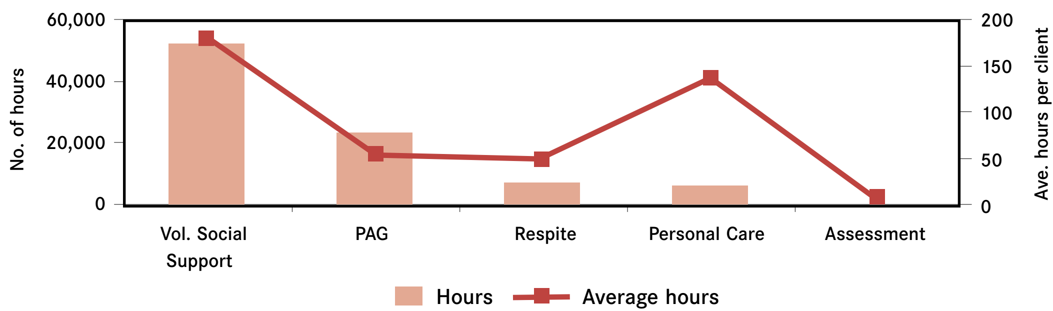
The most common service types used by clients of Interchange agencies were planned activity group, volunteer social support, and respite. See Figure 38.

Aggregate hours of service received

The aggregate hours of service received by Interchange clients follows a similar pattern to the types of service received. PAG and Social Support accounted for the bulk of hours to clients.

Figure 39 also shows that, on average, hours per Interchange client were highest for Social Support (183 hours per annum, or roughly 7 hours a fortnight), followed by personal care (138 hours per annum). Although more clients attended Planned Activity Groups, their average use was about half an hour a fortnight.

Figure 39: Total hours per activity and average hours per Interchange client, 2002-03



Appendix

Data collection form

The data items in the HACC MDS can be viewed in the sample data-collection form. Very few agencies now use the paper form; most agencies store their client records in a computerized system which makes an extract containing the quarterly HACC MDS.

hacc

home and community care

HACC MINIMUM DATA SET

Agencies receiving HACC funds in Victoria are required to supply a set of data items for each client who receives HACC services during the 3-month collection period. Agencies may choose to use this paper form as an alternative to 'electronic' data collection. Please consult the Guidelines. Enquiries 9616 7255. Send the completed forms to HACC Data Team, Aged Care Branch, Department of Human Services, 10/555 Collins Street, Melbourne. Data is due by the 15th of the month following each quarterly collection period.

AGENCY IDENTIFIER

Q1. Agency Name:

Q2. Agency Identification Number:
Use the MDS Agency ID assigned by DHS

Q3. Data Collection Identifier:
eg: 2001/3 for July to September 2001

STATISTICAL LINKAGE KEY

Q4. Statistical Linkage Key:
Refer to instructions.

HACC CLIENT STATUS

Q5. Reason for HACC Client Status

Please choose 1 or 2:

1 The details in this record describe a HACC **Care Recipient**.

2 The details in this record describe a **Carer** who is receiving HACC **Respite**.

See Guidelines 3.1

AREA OF RESIDENCE

Q6. State:

1 New South Wales
2 Victoria
3 Queensland
4 South Australia
5 Western Australia
6 Tasmania
7 Northern Territory
8 Australian Capital Territory
9 Other Territories

See Guidelines 3.6

Q7. Suburb/Town/Locality:

See Guidelines 3.7

Q8. Postcode:

See Guidelines 3.8

BACKGROUND

Q9. Country of Birth:
Write down country name.

Q10. Main Language Spoken at Home:
Write down language name.

Q11. Indigenous Status

[ ]

Is the client of Aboriginal or Torres Strait Islander origin?

1 YES, Aboriginal
2 YES, Torres Strait Islander
3 YES, both Aboriginal and Torres Strait Islander
4 NO

See Guidelines 3.11

CLIENT CIRCUMSTANCES

Q12. Living Arrangements

[ ]

1 Lives alone
2 Lives with family
3 Lives with others

See Guidelines 3.13

Q13. Government Pension/ Benefit Status

[ ]

1 Age Pension
3 Disability Support Pension
4 Carer payment (pension)
5 Unemployment-related allowance
6 Other Gov't pension/benefit
7 No Gov't pension/benefit
11 DVA gold cardholder
12 DVA white cardholder

See Guidelines 3.14

Q14. Accommodation Setting

[ ]

1 Private residence – owned/purchased
2 Private residence – private rental
3 Private residence – public rental
4 Private residence – mobile home
5 Independent unit within retirement village
6 Boarding house/private hotel
7 Short-term crisis or transitional accommodation
8 Domestic-scale supported living facility (e.g. group home)
9 Supported Residential Service
10 Residential aged care facility (nursing home or hostel)
11 Psychiatric community care facility
12 Public place/temporary shelter
13 Private residence rented from Aboriginal Community
14 Temporary shelter within Aboriginal Community
19 Other

See Guidelines 3.15

CLIENT CIRCUMSTANCES

Q15. Carer – Existence of

[ ]

1 Has a Carer
2 Has no Carer
3 Not Applicable – the client is a Carer (i.e. Q5 = code 2)

See Guidelines 3.16 & 3.1

Q16. Carer Residency Status

[ ]

Does the Carer live with the Care Recipient?

1 Yes – Co-resident Carer
2 No – Non-resident Carer
3 Not Applicable – the Client has no Carer

See Guidelines 3.17

Q17. Relationship of Carer to Care Recipient

What is the relationship of the Carer to the Care Recipient?
E.g. if the Carer is the DAUGHTER of the Care Recipient, code 5

1 Wife/female partner
2 Husband/male partner
3 Mother
4 Father
5 Daughter
6 Son
7 Daughter-in-law
8 Son-in-law
9 Other relative – female
10 Other relative – male
11 Friend/neighbour – female
12 Friend/neighbour – male
99 Not stated/inadequately described

See Guidelines 3.18

Q18. Source of Referral

*Describe the **most recent** occasion.*

1 Self
2 Family, significant other, friend
3 GP/medical practitioner
4 Specialist aged or disability assessment team (eg ACAT)
5 Comprehensive HACC assessment authority
6 Community nursing service
7 Hospital (public)
8 Psychiatric/mental health service
9 Extended care/rehabilitation service
10 Palliative care service/hospice
11 Government residential aged care facility
12 Aboriginal health service
13 Carelink centre
14 Other community-based government medical/health service (e.g. community health centre)
15 Other government medical/health service
16 Other government community-based agency (e.g. local govt. home care service)
17 Hospital (private)
18 Non-government residential aged care facility
19 Other non-government medical/health service
20 Other non-government community-based service (e.g. welfare agency, Linkages agency)
21 Law enforcement agency
22 Other

See Guidelines 3.19

Q19. Date of Last Assessment

Record date of client's most recent assessment.

Day Month Year

See Guidelines 3.20

SERVICE TOTALS

Q20. Total Amount of Assistance

	At Home	At Centre / Total Hours
Home Care		
Volunteer social support		
Nursing care		
Allied health care		
Personal care		
Planned activity group – Core		
Planned activity group – High		
Respite – Home & Community		
Respite – Overnight		
Assessment		
Case management		
Property maintenance		
Counselling, information, advocacy		
Delivered meals *(total number delivered)*		

See Guidelines 4.1-4.6

Q21. Provision of Goods and Equipment

Up to 10 codes may be listed. Refer to codes in Guidelines.

See Guidelines 4.7

Q22. Other Service Types: *Not Applicable without further instructions from DHS.*

Assistance Types	*Quantity*

EXIT FROM MOST RECENT SERVICE EPISODE

Complete only if the client has ***stopped receiving services*** *during this HACC MDS reporting period.*

Q23. Main Reason for Cessation of Services

1 Client no longer needs assistance from agency
2 Client moved to residential, institutional or supported accommodation setting
3 Client's needs have increased – other service provider required
4 Services terminated due to budget/staffing constraints
5 Services terminated due to Occupational Health and Safety (OHS) reasons
6 Client moved out of area
7 Client died
8 Client terminated service
9 Other
11 Transferred to VETS Home Care

See Guidelines 3.21

Q24. Accommodation Setting after Cessation of Services

Not Applicable if the client is a Carer (Q5, code 2).

1 Private residence – owned/purchased
2 Private residence – private rental
3 Private residence – public rental
4 Private residence – mobile home
5 Independent living unit within retirement village
6 Boarding house/private hotel
7 Short-term crisis or transitional accommodation
8 Domestic-scale supported living facility
9 Supported Residential Service
10 Residential aged care facility (nursing home or hostel)
11 Psychiatric/mental health community care facility
12 Public place/temporary shelter
13 Private residence rented from Aboriginal Community
14 Temporary shelter within an Aboriginal Community
15 Hospital
16 Extended care/rehabilitation facility
17 Palliative care service/hospice
18 Not applicable – client died
19 Other
20 Not known

See Guidelines 3.22

End of Survey