Veterans on Community Aged Care Packages: a comparative study

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AGED CARE SERIES
Number 9

Veterans on Community Aged Care Packages: a comparative study

Evon Bowler
and
Ann Peut

2006

Australian Institute of Health and Welfare
Canberra

AIHW cat. no. AGE 46

This publication is part of the Australian Institute of Health and Welfare's Aged Care Series. A complete list of the Institute's publications is available from the Business Promotion and Media Unit, Australian Institute of Health and Welfare, GPO Box 570, Canberra ACT 2601, or via the Institute's web site <www.aihw.gov.au>.

ISSN 1325-6025

ISBN 1 74024 579 2

Suggested citation

AIHW: Bowler E & Peut A 2006. Veterans on Community Aged Care Packages: a comparative study. Aged Care Series no. 9. AIHW cat. no. AGE 46. Canberra: AIHW.

Any enquiries about or comments on this publication should be directed to:

Evon Bowler
Australian Institute of Health and Welfare
GPO Box 570
Canberra ACT 2601

Phone: (02) 6244 1173

Published by Australian Institute of Health and Welfare

Printed by National Capital Printing

Contents

List of tables

List of figures

List of boxes

Acknowledgments

This analysis of the 2002 Community Aged Care Census data was carried out at the request of and with funding from the Australian Government Department of Veterans' Affairs (DVA). The report was authored by Evon Bowler and Ann Peut of the Ageing and Aged Care Unit. Thanks are extended to the DVA project management staff, Andrew Smart and Michael Kortt, for their support and assistance, to the project steering committee, Wayne Penniall, Eric McDonald, Karen O'Shannessy (DVA), David Martin (DoHA), Ruel Abello and Diane Gibson (AIHW), and to Terry Neeman for her assistance on statistical methodology.

Abbreviations

ABS	Australian Bureau of Statistics
ACAT	Aged Care Assessment Team
ADF	Australian Defence Forces
ASGC	Australian Standard Geographical Classification
BCAL	British, Commonwealth and Allied Veterans and Mariners
CAAS	Continence Aids Assistance Scheme
CACP	Community Aged Care Package
CSTDA	Commonwealth State/Territory Disability Agreement
DTC	Day Therapy Centres
DVA	Department of Veterans' Affairs
EACH	Extended Aged Care at Home
HACC	Home and Community Care
MBS	Medicare Benefits Schedule
NRCP	National Respite for Carers Program
POW	Prisoner of war
PRR	Prevalence relative risk
VEA	Veterans' Entitlement Act
VHC	Veterans' Home Care

Symbols

. .	when used in a table, means not applicable
–	when used in a table, means nil or rounded to zero
n.a.	not available
n.d.	no date

Summary

The aim of this study is to compile a profile of Community Aged Care Package (CACP) recipients who were holders of a Department of Veterans' Affairs gold or white Repatriation Health Card[1] and to examine differences between cardholders and other CACP care recipients.

Background

The Community Aged Care Package Program provides coordinated care to people with complex care needs who would otherwise be eligible for admission to at least low-level residential care, in order to enable them to remain in the community in their own homes. It is one of a number of government-funded aged care programs and should not be considered in isolation.

Veterans with a gold card are entitled to assistance from the Department of Veterans' Affairs (DVA) for the treatment of all health conditions. Veterans with a white card are entitled to assistance for specific conditions which are accepted as war or defence caused or are specifically designated conditions (for example cancer or tuberculosis). Most veterans with gold and white cards also have access to a wide range of medical, allied health and community care provided by DVA, in addition to assistance which is available to members of the general community.

Scope and methods

The study analyses the data from the Community Aged Care Packages Census which was conducted by the Australian Institute of Health and Welfare (AIHW) in 2002. The study was restricted to CACP care recipients who were aged 70 years or older for whom information was available about their age, sex and cardholder status.

Cochran-Mantel-Haenszel statistics (controlled for age and sex) were used to calculate the prevalence relative risk (also referred to as the relative risk) of specific characteristics of care recipients aged 75 years or older with an entitlement card compared with care recipients without a card. Veterans, spouses or widows/widowers of veterans who did not have a gold or white entitlement card were included in the non-cardholders group. Care is needed in interpreting results for white cardholders because of the small numbers, which make it difficult to precisely estimate relative risk for this group.

1 For eligibility conditions for a gold or white Repatriation Health Card see Appendix 3.

Main findings

There were 20,620 care recipients aged 70 years or older included in this study. Of these:

- 2,280 had a gold card
- 176 had a white card
- 18,164 care recipients had neither of these cards.

While there are some distinct differences between veterans with a gold or white card who are receiving assistance from the CACP Program and care recipients without a DVA health care entitlement card, there are many similarities.

Care recipient profile

The main differences observed in the demographic profile of care recipients who were cardholders were:

- Veteran cardholders had an older age structure than non-cardholders.
- There were a higher proportion of males among cardholders than non-cardholders.
- A higher proportion of veterans were born in Australia (93% of gold cardholders, 68% of white cardholders, and 62% of non-cardholders).
- Veterans were more likely than non-cardholders to live in a private home that they owned or were purchasing (72% compared with 65%) or a retirement village (12% compared with 9%).
- A higher proportion of veterans lived alone (67%) than non-cardholder care recipients (63%), and a lower proportion lived with family (31% compared with 35%). This was true for both males and females.
- The proportion of veterans in financial hardship (as defined under the *Aged Care Act 1997)* was lower for cardholders than for non-cardholders.

Need for assistance

There were no significant differences in the proportion of veterans with a severe or profound self-care limitation (64%), mobility limitation (69%) or dementia (19%) compared with non-cardholders.

Twelve per cent of gold cardholders and 17% of white cardholders had a severe or profound communication limitation compared with 15% of non-cardholders. After controlling for age and sex, this was a statistically significant 30% lower risk for gold cardholders compared with non-cardholders (relative risk 0.70 [0.62–0.80[2]]).

Carers

Around one-half to two-thirds of care recipients (54% of gold cardholders, 63% of white cardholders, and 58% of non-cardholders) had a carer. After controlling for age and sex, this was a statistically significant 9% lower likelihood of having a carer for gold cardholders compared with non-cardholders (relative risk 0.91 [0.87–0.95]).

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2 Figures in brackets show the 95% confidence interval.

Around half of the carers lived with the care recipient (47% of carers of gold cardholders, 52% of carers of white cardholders, and 49% of carers of non-cardholders). After controlling for age and sex, this was a statistically significant 9% lower likelihood of the carer of a gold cardholder living with the care recipient (relative risk 0.91 [0.85–0.97]). However, the likelihood of a carer of a white cardholder living with the care recipient was similar to that for non-cardholders (1.01 [0.85–1.21]).

The relationship of carers to care recipients differed between sexes but not between entitlement groups. Males were more likely to be cared for by their spouse (48% for cardholders, 50% for non-cardholders), while females were more likely to be cared for by their child or child's spouse (65% for cardholders, 64% for non-cardholders).

Service use

- It is estimated that between 11.5 and 12.5 per 1,000 people aged 70 or older in the population[3] receive assistance from a CACP. After standardising for age and sex, gold cardholders were between 17% and 35% less likely to receive assistance from a Community Aged Care Package than non-cardholders, and white cardholders were between 14% and 32% less likely (see table below).

Entitlement group	Crude utilisation rate (per 1,000 70+)[2]	Age- and sex-standardised utilisation ratios (compared with no card)	
		Minimum	Estimated maximum
Gold card	9.4–12.7	0.65 (0.62–0.68)	0.83 (0.80–0.86)
White card	8.1–10.9	0.68 (0.58–0.78)	0.86 (0.76–0.98)
Gold or white	9.3–12.5	0.65 (0.62–0.68)	0.84 (0.81–0.86)
No card	11.9–12.5	Not applicable	

Note: Figure in brackets show 95% confidence limits.

- The most common assistance types received by veteran CACP recipients during the census week were domestic assistance (89% of care recipients), CACP case management/care coordination (74%), social support (63%), and personal care (56%).
- After controlling for age and sex, gold cardholders receiving CACP assistance were 35% more likely to be receiving delivered meals, 9% more likely to be receiving assistance with the preparation, cooking and storage of meals in the care recipient's own home (other food services), and 12% more likely to be receiving assistance with home maintenance than non-veteran CACP recipients.
- White cardholders receiving CACP assistance were 11% more likely to have received assistance from their case managers or care coordinators during the census week and 6% more likely to have received domestic assistance. These differences were statistically significant.
- While gold cardholders were also 20% less likely than non-cardholders to receive respite care and rehabilitation services, and white cardholders were 26% more likely to receive

3 The lower value is a minimum based on care recipients with known data for age, sex, and card entitlement group. The higher value is an estimate based on all CACP care recipients included in the 2002 CACP census, pro-rating missing data.

delivered meals, 6% more likely to receive other food services and 16% less likely to receive home maintenance services, these differences were not statistically significant.

- The average total hours of CACP service received was 6 hours 24 minutes for gold cardholders, 6 hours 15 minutes for white cardholders, and 6 hours 16 minutes for non-cardholders.
- Veteran CACP recipients were more likely to have received assistance from other government programs (55% for gold cardholders, 45% for white cardholders, 31% for non-cardholders). The difference mainly was related to veterans' access to assistance from DVA.
- The most commonly received types of assistance from other government services were generally not available through the CACP Program (nursing care, allied health care, and goods and equipment[4]; delivered meals were also commonly received by care recipients). These types of assistance were received by 10–15% of cardholders.

Conclusion

Cardholders had a significantly lower utilisation rate of community aged care packages. The dependency level of those on CACPs were similar to that of non-cardholder CACP recipients with the exception of a lower rate of severe or profound communication limitation. While the type and amount of assistance received from the CACPs were generally similar, DVA cardholders receiving a CACP were more likely to receive assistance from other government programs than non-cardholders, particularly as a result of their access to assistance from DVA.

Utilisation rates may depend on many things such as eligibility, accessibility, acceptability and appropriateness. Veteran cardholders may prefer to receive their assistance from DVA programs, or may prefer to receive assistance from other community care programs such as HACC and VHC because of cost considerations. Other possible reasons for the lower utilisation rate in veterans are a lack of understanding about general community programs among veterans, a bias in the selection of care recipients, or possibly higher dependency levels of DVA cardholders resulting in a need for higher care levels than can be provided through CACPs.

The CACP Program is only one element of the aged care system. Utilisation rates of veterans in other community care programs (HACC and VHC) and in low- and high- level residential care, will give a more complete picture of veterans' use of aged care services and how these interact. Projects which are looking at the use of other aged care services by cardholders should help us understand some of the differences we are seeing in the clients of the CACP Program. Information obtained through these projects should provide a useful insight for policy and planning of aged care services for veterans.

4 While some goods and equipment are provided through the CACP Program, this is not a designated CACP assistance type and no data is collected on the extent of provision.