13 Aged care services

The aged care system comprises all services specifically designed to meet the care and support needs of frail older Australians. This chapter focuses on government funded residential and community care for older people and services designed for the carers of older people. Some government expenditure on aged care is not reported, but continual improvements are being made to the coverage and quality of the data. The services covered include:

- residential services, which provide high care, low care and residential respite care (box 13.1)
- community care services, which include Home and Community Care (HACC) program services, Community Aged Care Packages (CACPs), the Extended Aged Care at Home (EACH) program, the EACH Dementia program, the Transition Care Program (TCP)[1] and Veterans' Home Care (VHC) [2]
- respite services, which include HACC respite and centre-based day care and the National Respite for Carers Program (NRCP)
- assessment services, which are largely provided by the Aged Care Assessment Program (ACAP).

A profile of aged care services appears in section 13.1. A framework of performance indicators is outlined in section 13.2 and key performance results are discussed in section 13.3. Future directions in performance reporting are discussed in section 13.4. Jurisdictions' comments are reported in section 13.5. Section 13.6 contains definitions for key terms and indicators. Section 13.7 lists the attachment tables for this chapter. Attachment tables are identified in references throughout this chapter by an 'A' suffix (for example, table 13A.3 is table 3 in the attachment). Attachment tables are provided on the CD-ROM enclosed with the Report or from the Review website: http://www.pc.gov.au/gsp/home. Section 13.8 lists references used in this chapter.

Additions and improvements made to the chapter this year include:

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[1] Some aspects of the TCP are related to residential care services.

[2] Unless otherwise stated, HACC expenditure excludes the Department of Veterans' Affairs expenditure on VHC.

- reporting for the first time age specific approval rates for aged care services
- restructure of the 'funding' section, including provision of a summary table
- inclusion of two additional categories of experimental expenditure data, for state and territory capital expenditure on residential aged care and additional state and territory expenditure on HACC services
- inclusion for the first time of expenditure data in relation to Multi-Purpose Services (MPS), TCP and Indigenous specific services
- improved presentation of the indicator 'use by different groups'
- reporting for the first time the indicator 'long term aged care in public hospitals'
- revision and improvement of the indicator 'waiting times for residential care'.

Older Australians also use other government services covered in this Report, including disability services (chapter 14), specialised mental health services (chapter 12), housing assistance (chapter 16) and services across the full spectrum of the health system (preface E and chapters 10–12). There are also interactions between these services that are likely to affect performance results in this Report — for example, the number of operational residential aged care places may affect demand for public hospital beds, and changes in service delivery in the public hospital sector may affect demand for residential and community aged care.

Box 13.1 **Interpreting residential aged care data**

This chapter describes the characteristics and performance of residential aged care in terms of residential services, residents (clients), places and locality.

- *Residential services data*. This chapter groups residential services for reporting purposes based on the eight level Resident Classification Scale (RCS) profile of residential services' clients.
  - Aged care homes with 80 per cent or more residents classified as RCS 1–4 are described as high care services.
  - Aged care homes with 80 per cent or more residents classified as RCS 5–8 are described as low care services.
  - A service that is neither high care nor low care as defined above is called a mixed service.

  These categories have been used for descriptive purposes and do not have any legal foundation under the *Aged Care Act 1997 (Cwlth)*. Similarly, the choice of 80 per cent as a cut-off is arbitrary but considered appropriate for descriptive purposes.
- *Residents data*. This chapter classifies clients as high care or low care based on their RCS assessment. High care residents have been assessed as RCS levels 1–4, and low care residents have been assessed as RCS levels 5–8.

(Continued on next page)

Box 13.1 **(Continued)**

- *Places data*. Part 2.2 of the Aged Care Act details the processes for planning and allocating subsidised services to meet residential aged care needs and community care needs. Planning is based on a national formula for people aged 70 years or over for high and low care. High care places are planned to meet the needs of residents with care needs equivalent to RCS levels 1–4. Low care places are planned to meet the needs of residents with care needs equivalent to RCS levels 5-8.

Although a needs match is expected when residents enter vacant places (that is, vacant low care places should usually be filled by low care residents), this can change over time with 'ageing in place', which allows a low care resident who becomes high care to remain within the same service until he or she is discharged.

- *Locality data.* Geographic data are based on the Australian Bureau of Statistics (ABS) Australian Standard Geographic Classification of Remoteness Areas (ABS 2003). Data are classified according to an index of remoteness that rates each ABS Census district based on the number and size of towns, and the distance to major towns and urban centres.

13.1 Profile of aged care services

Service overview

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

Government funded aged care services covered in this chapter relate to the three levels of government (Australian, State and Territory, and some local) involved in service funding and delivery. The formal, publicly funded services covered represent only a small proportion of total assistance provided to frail older people. Extended family and partners are the largest source of emotional, practical and financial support for older people: more than 90 per cent of older people living in the community in 2003 who required help with self-care, mobility or

communications received assistance from the informal care network of family, friends and neighbours (ABS 2004a). Many people receive assistance from both formal aged care services and informal sources. Older people also purchase support services in the private market, and these services are not covered in this chapter.

Roles and responsibilities

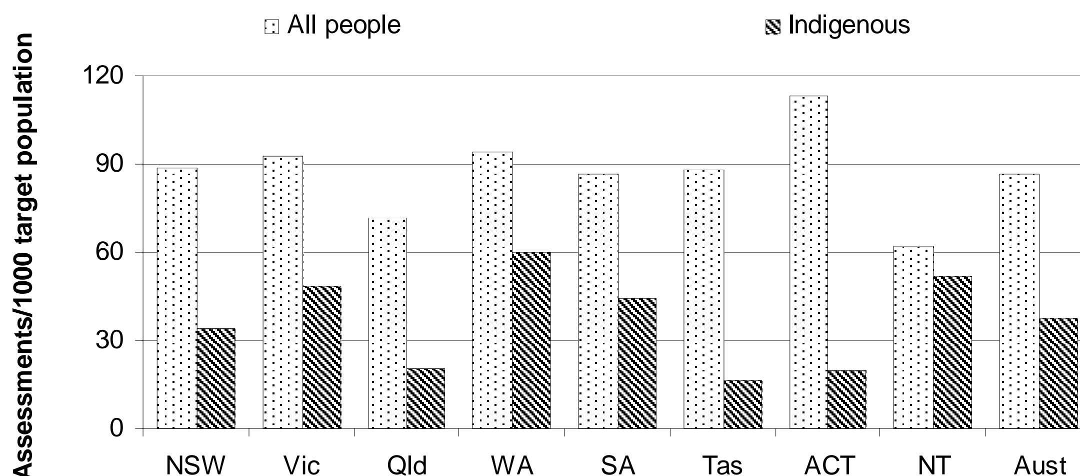
Assessment services

The Australian Government established the ACAP in 1984, based on the assessment processes used by State and Territory health services to determine (1) eligibility for admission into residential care and (2) the level of care required (and thus the subsidy paid to such services). The core objective of the ACAP is to assess the needs of frail older people and recommend appropriate services. Assessment and recommendation by Aged Care Assessment Teams (ACATs) are mandatory for admission to residential care or receipt of a CACP, EACH package, EACH Dementia package or TCP. People may also be referred by ACATs to other services, such as those funded by the HACC program. An ACAT referral is not mandatory for receipt of other services, such as HACC and VHC services.

State and Territory governments are responsible for the day-to-day operation and administration of the ACAP, and for provision of the necessary accommodation and support services. The scope and practice of the teams differ across and within jurisdictions, partly reflecting the service setting and location (for example, whether the team is attached to a residential service, a hospital, or a community service). This has an effect on program outputs.

The number of assessments per 1000 target population varied across jurisdictions in 2005-06. The national rate was 86.8 assessments per 1000 people aged 70 years or over and Indigenous people aged 50 years or over and 37.2 per 1000 Indigenous people aged 50 years or over (figure 13.1).

Figure 13.1 **Aged Care Assessment Team assessment rates, 2005-06[a, b, c, d, e]**



[a] Includes ACAT assessments for all services. [b] 'All people' includes all assessments of people aged 70 years or over and Indigenous people aged 50 years or over per 1000 people aged 70 years or over and Indigenous people aged 50 years or over. [c] 'Indigenous' includes all assessments of Indigenous people aged 50 years or over per 1000 Indigenous people aged 50 years or over. [d] The number of Indigenous assessments is based on self-identification of Indigenous status. [e] See table 13A.39 for further explanation of these data.

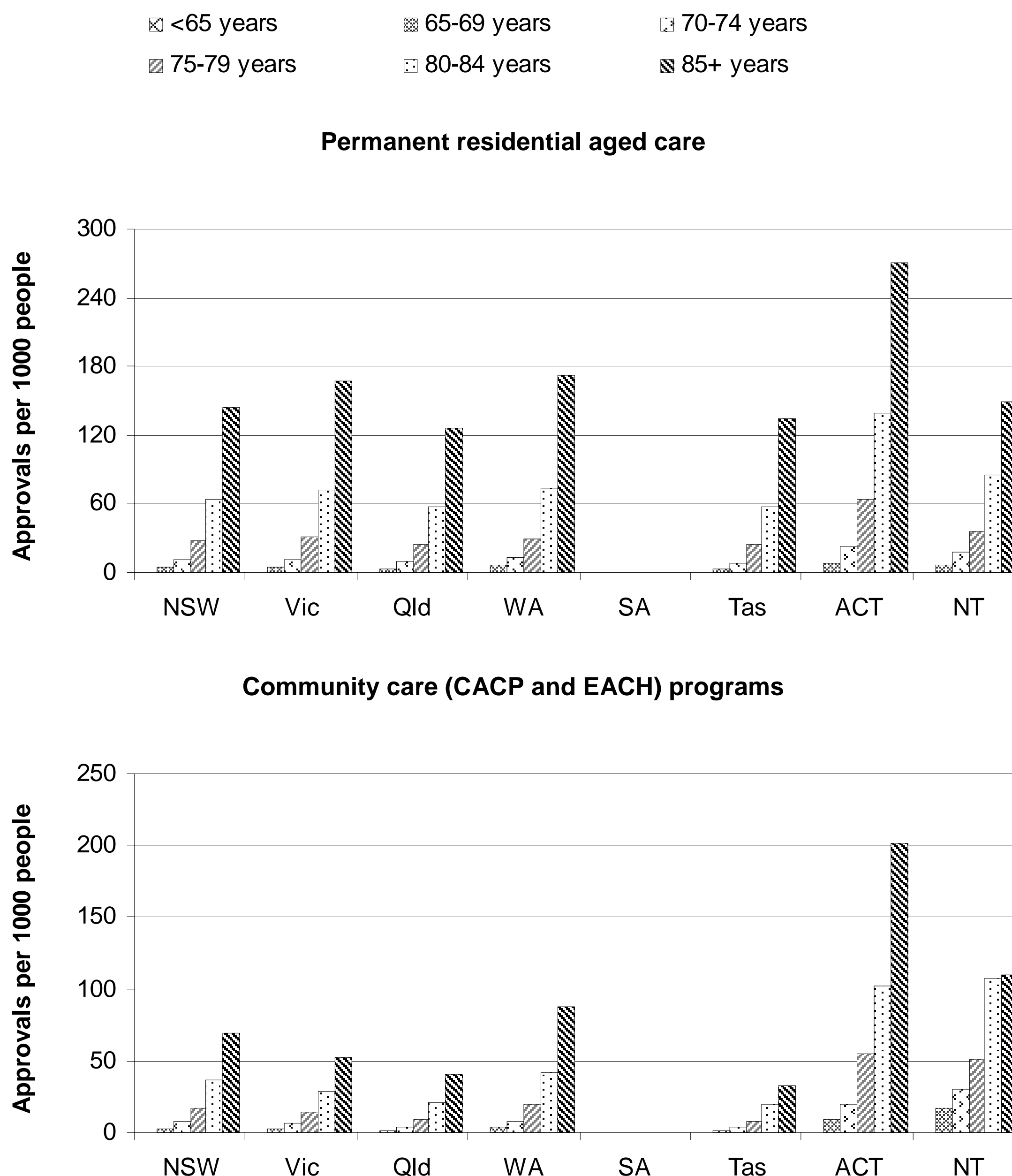
Source: Aged Care Assessment Program National Data Repository (unpublished); table 13A.39.

ACAT assessments which result in approvals of eligibility for various types of care can be shown by age-specific rates, for a series of age groups in the population. Data are provided for residential care and for community care (CACP, EACH and EACH Dementia).

These data reflect the numbers of approvals, which are a subset of assessments, as some assessments will not result in a recommendation or an approval for a particular level of care. The numbers of places accepted cannot be identified from these data (see boxes 13.9, 13.10 and 13.11 in relation to waiting time for residential and community care). As practices may vary across jurisdictions, data should be interpreted with care.

The approval rates for both residential and community care services vary across jurisdictions and increase with age (figure 13.2).

Figure 13.2 **Age-specific approval rates, per 1000 persons in the population, 2005-06**[a, b, c, d]



[a] Data for SA are not available. [b] Population numbers and the proportions of the population for older age groups in ACT and NT are smaller than other jurisdictions, and may show variation between years, so results should be interpreted with caution. [c] The age category population data for this table are derived from ABS estimated resident population figures as at 30 June 2006, which are preliminary and rebased on the 2006 Census of Population and Housing. [d] EACH packages include EACH Dementia packages.

Source: Aged Care Assessment Program National Data Repository (unpublished); table 13A.40; table AA.1.

The Council of Australian Governments (COAG) has agreed to improve aged care assessment services as part of its national health agenda (box 13.2).

Box 13.2 **Improved performance and streamlining of assessment processes**

In February 2006, COAG agreed to establish an initiative to simplify access to care services for the elderly, people with a disability and people leaving hospital.

The initiative consists of two components:

- more timely and consistent assessments for frail older people by ACATs
- simplified entry and assessment processes for the HACC Program.

The ACAT component provides for a range of activities to improve the timeliness, quality and consistency of ACAT recommendations, for implementation to improve the administration and performance of the ACAP. Initiatives already implemented include: a national ACAT Review, development of a National Training Strategy and a report on the variability of ACAT recommendations. In addition, states and territories are progressing a range of improvements to processes.

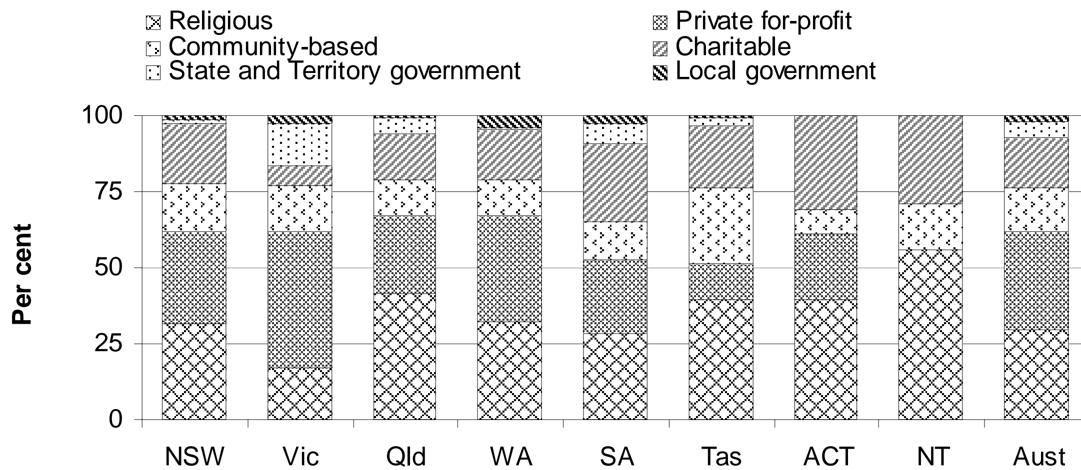
The HACC component has been progressed in 2006-07 to enable: increased national consistency in determining eligibility and assessment of client and carer; and simplified access points for clients and improved referral pathways. These are complex initiatives which affect other sectors such as primary care, residential aged care and disability services.

Source: DoHA (unpublished).

Residential care services

Religious and private for-profit organisations were the main providers of residential care at June 2007, accounting for 29.5 per cent and 32.5 per cent respectively of all Australian Government subsidised residential aged care places. Community-based organisations and not-for-profit charitable organisations accounted for a further 14.5 per cent and 16.0 per cent respectively. State, Territory and local governments provided the remaining 7.5 per cent (figure 13.3).

Figure 13.3 **Ownership of operational mainstream residential places, June 2007**[a, b]



a 'Community-based' residential services provide a service for an identifiable community based on locality or ethnicity, not for financial gain. **b** 'Charitable' residential services provide a service for the general community or an appreciable section of the public, not for financial gain.

Source: Department of Health and Ageing (DoHA) (unpublished); table 13A.4.

The Australian Government is responsible for most of the regulation of Australian Government subsidised residential aged care services, including accreditation of the service and certification of the standard of the facilities. State, Territory and local governments may also have a regulatory role in areas such as determining staffing and industrial awards, and monitoring compliance with building and fire safety regulations (box 13.3).

Box 13.3 Examples of regulatory arrangements for residential services

The Australian Government controls the number of subsidised places. In May 2004, following a recommendation of the Review of Pricing Arrangements in Residential Aged Care, the Australian Government adopted a new ratio of 108 places for each 1000 people in the population aged 70 years or over. Of the 108 places, 88 are residential care places (40 high care and 48 low care) and 20 are community care places (CACP and EACH packages).

Under the arrangements:

- Services are expected to meet regional targets for places for concessional residents. These targets range from 16 per cent to 40 per cent of places, and are intended to ensure residents who cannot afford to pay an accommodation bond or charge have equal access to care. (The criteria for being deemed a concessional resident are based on home ownership and occupancy, receipt of income support and the level of assets held at entry.)
- Extra service places (where residents pay for a higher standard of accommodation, food and services) are restricted.
- To receive an Australian Government subsidy, an operator of an aged care service must be approved under the Aged Care Act as a provider of aged care.
- Principles (regulations) created under the Aged Care Act establish the obligations of approved providers relating to quality of care and accommodation.

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

In February 2007, the Australian Government announced a further increase in the provision ratio from 108 to 113 operational places per 1000 people aged 70 years or over, to be achieved by June 2011. The proportion of places offered has been adjusted from 20 to 25 places for community care, with 4 of these places for every 1000 people aged 70 years or over to be for high level care. In residential care, the provision ratio for high level care was increased from 40 to 44 places, while the ratio for low level residential care was adjusted from 48 to 44 places for every 1000 people aged 70 years or over.

Source: DoHA (unpublished).

Community care services

The main community care programs reported in this chapter — the HACC, CACP and VHC programs — fund services that aim to provide practical assistance to

enable frail older people (HACC and CACP), people with a disability (HACC) and veterans (VHC) to continue living in or return to the community. These services also provide assistance to carers. They are usually provided by State, Territory and local government organisations, charitable bodies, community organisations and commercial providers.

Flexibly funded services

Flexible care addresses the needs of care recipients in ways other than that provided through mainstream residential and community care. Flexible care provided under the Aged Care Act includes EACH packages, EACH dementia packages, Innovative Care Places, MPS and the TCP. In addition, flexible models of care are provided under the National Aboriginal and Torres Strait Islander Aged Care Strategy.

- The EACH program provides high level aged care to people in their own homes, complementing CACPs, which provide low level care. There were 3302 operational EACH places at 30 June 2007. EACH Dementia provides high level care in the home to people with complex care needs associated with dementia, as an alternative to high level residential care. There were 1267 operational EACH Dementia places at 30 June 2007 (table 13A.36).
- The Aged Care Innovative Pool is designed to test new approaches to providing aged care, either with time limited or ongoing flexible care allocations for innovative aged care services. It supports the development and testing of flexible models of service delivery in areas where mainstream aged care services may not appropriately meet the needs of a location or target group. For example, the TCP is built on the lessons learned from two pilot programs developed through the Innovative Pool which addressed the interface between aged care and hospital care — the Innovative Care Rehabilitation Services and the Intermittent Care Services (DoHA unpublished).
- The MPS program supports the integration and provision of health and aged care services for small rural and remote communities. At 30 June 2007, there were 101 operational services with a total of 2492 operational flexible aged care places. Some of the MPS serve more than one location (DoHA unpublished).

Transition care services

The TCP provides goal-oriented, time-limited and therapy-focused care to help eligible older people complete their recovery after a hospital stay. The TCP is intended to:

- enable a significant proportion of care recipients to return home, rather than enter residential care

- optimise the functional capacity of those older people who are discharged from transition care to residential care
- reduce inappropriate extended lengths of hospital stay for older people.

The TCP is jointly funded by the Australian Government and all states and territories. Its operation is overseen by the all-jurisdictional Transition Care Working Group chaired by the Australian Government.

Transition care can be provided in either a home-like residential setting or in the community, and targets older people who would otherwise be eligible for residential care. A person may only enter the TCP directly upon discharge from hospital. The average duration of care is 7 weeks, with a maximum duration of 12 weeks that may in some circumstances be extended by a further 6 weeks.

Across jurisdictions, the TCP operates with some differences, including differences in service systems, local operating procedures and implementation timetables, which are reflected in national data collections. An evaluation examining the impact of the TCP on consumers and the health and aged care systems is due to report in 2008.

At 30 June 2007, the Australian Government had allocated 2000 places to transition care, of which 1594 were operational, amongst 62 services across all jurisdictions. The average length of stay in 2006-07 was 48 days nationally (table 13A.69).

As part of the national health agenda, COAG have agreed to commence the Long stay older patient initiative (box 13.4).

Box 13.4 **Long stay older patient initiative**

From July 2006, a new four-year program commenced to assist older public patients who no longer require acute care or rehabilitation and are in hospital waiting for residential aged care by:

- providing more appropriate care for long-stay older patients in public hospitals, particularly in rural areas
- improving the capacity of rural hospitals to provide more age friendly services, including through making capital improvements such as establishing new multi-purpose services
- reducing avoidable or premature admission of older people to hospitals
- assisting older public patients requiring long-term care to take up appropriate care options.

Source: COAG (2006).

Indigenous-specific services

Aboriginal and Torres Strait Islander people access mainstream services under the Aged Care Act, including those managed by Aboriginal and Torres Strait Islander organisations, and services funded outside the Act, including those funded under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. Some services managed by non-Indigenous approved providers also have a significant number of Aboriginal and Torres Strait Islander clients.

All aged care services that are funded under the Act are required to provide culturally appropriate care. Whether they are located in a community or residential setting, services may be subject to specific conditions of allocation in relation to the proportion of care to be provided to particular groups of people, including Aboriginal and Torres Strait Islander people.

At 30 June 2007, there were 617 flexible places for Indigenous clients (outside the Aged Care Act) under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. This flexible care helps to ensure that Aboriginal and Torres Strait Islander people can access culturally appropriate care services as close as possible to their communities, mainly in rural and remote locations. As part of the 1994 National Strategy, services were established to provide aged care using a flexible model. Communities are encouraged to participate in every aspect of service provision, from the very early planning stages right through to the operation of the services. These services are now funded under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program.

In the 2006-07 Federal Budget, an additional 150 places were allocated for the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. The additional places will bring the total number of places under this program to 750 (DoHA unpublished).

Funding

Expenditure on aged care services covered by this Report was $8.4 billion in 2006-07 (table 13.1). Table 13.1 does not include the state and territory experimental estimates and capital expenditure reported at tables 13.3 and 13.4.

Table 13.1 **Expenditure on aged care services, 2006-07[a, b]**

Expenditure category	*$ million*
Assessment services	61.5
Residential care services	5 803.5
Community care services	2 546.3
Total	**8 411.3**

[a] Residential care services include DoHA, Department of Veterans Affairs (DVA) (including payroll tax supplement) and State and Territory expenditure. [b] Community care services include VHC, HACC and TCP (State and Territory expenditure), and other DoHA expenditure.

Source: tables 13A.44–48, 13A.68-69.

Assessment services

The Australian Government provided grants to State and Territory governments to operate 115 ACATs in 2005-06 (table 13A.56). There were 114 ACATs at 30 June 2007. In 2006-07, the Australian Government provided funding of $61.5 million nationally for aged care assessment (table 13A.48). Australian Government ACAT expenditure per person aged 70 years or over plus per Indigenous persons aged 50-69 years was $30.3 nationally during 2006-07 (table 13A.49). Some states and territories also contribute funding for ACATs, but this expenditure is not included in the Report.

Residential care services

The Australian Government provides most of the recurrent funding for residential aged care services. State and Territory governments also provide some funding for public sector beds. Residents provide most of the remaining service revenue, with some income derived from charitable sources and donations.

Australian Government expenditure

Australian Government expenditure on residential aged care was $5.7 billion in 2006-07, comprising DoHA expenditure of $4.8 billion (table 13A.44) and Department of Veterans' Affairs (DVA) expenditure of $870.4 million (table 13A.46). Combined DoHA and DVA expenditure per person aged 70 years or over (plus per Indigenous persons aged 50–69 years) was $2788 nationally during 2006-07 (table 13A.51).

Australian Government RCS subsidy

The Australian Government annual RCS subsidy for each occupied place varies according to clients' levels of dependency. The rates for each RCS level are at table 13A.5. At June 2007, the average annual RCS subsidy per residential place was $31 481 nationally (table 13.2). Variations across jurisdictions in average annual subsidies reflect differences in the dependency of residents. High care subsidy rates (RCS levels 1-4) and low care subsidy rates (RCS levels 5–8) are now uniform across all states and territories under the Australian Government's Funding Equalisation and Assistance Package. This is the first year that uniform national rates have been included.

Table 13.2 **Average annual Australian Government RCS subsidy per occupied place, and the dependency levels of high care and low care residents, June 2007**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Average annual Australian Government RCS subsidy per residential place[a, b]										
All RCS levels	$	31 772	31 123	30 703	30 733	33 255	32 064	31 928	31 546	31 481
Proportion of high care residents										
RCS 1	%	24.3	27.5	17.7	24.4	28.4	20.8	31.7	21.7	24.3
RCS 2	%	26.3	20.8	26.2	21.3	24.9	26.6	17.8	27.9	24.2
RCS 3	%	14.9	13.6	19.3	15.0	16.9	20.0	14.6	19.3	15.7
RCS 4	%	5.5	5.7	6.6	6.7	5.7	6.8	6.3	2.7	5.9
Proportion of low care residents										
RCS 5	%	11.2	14.5	11.4	14.9	10.8	10.4	13.0	7.0	12.3
RCS 6	%	9.1	10.1	9.3	10.4	7.7	7.9	9.7	8.3	9.3
RCS 7	%	8.2	7.6	8.9	7.2	5.4	7.4	6.7	10.2	7.8
RCS 8	%	0.5	0.2	0.6	0.2	0.2	0.1	0.1	2.9	0.4

a Includes only subsidies based on the RCS. Average Australian Government payments, including subsidies and supplements, were a total of $45 200 per high care resident (RCS 1–4), $16 200 per low care resident (RCS 5–8) and $36 000 for all permanent residents. **b** Differences in average annual subsidies reflect differences in the dependency of residents.

Source: DoHA (unpublished); table 13A.5.

State and Territory government expenditure

State and Territory government expenditure have been collected for three categories of residential care expenditure (adjusted subsidy reduction supplement, enterprise bargaining agreement supplement, and rural small nursing home supplement). Reported expenditure in these three categories was $148.1 million in 2006-07 (table 13A.68).

Capital expenditure

Although capital expenditure is not regarded as part of the total recurrent expenditure, it is presented here to illustrate this aspect of expenditure on aged care services. The Australian Government funds an ongoing program of targeted capital assistance to residential aged care services (table 13.3). In addition, experimental estimates of capital expenditure on residential services have been collected for some states and territories, for 2006-07. This category of expenditure is defined in section 13.6, but the data definition may require further development. Caution should be used in making comparisons across jurisdictions (table 13.3).

Table 13.3 **Selected capital expenditure 2006-07[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*
Australian Government targeted capital assistance to residential aged care services[b]									
$ million	17.2	4.0	7.2	6.7	3.2	6.9	–	1.8	47.0
Experimental estimates of State and Territory government capital expenditure on residential aged care[c]									
$ million	20.0	88.7	20.7	14.6	na	6.9	..	na	150.9

a These items of expenditure are not recurrent in nature and therefore not included in table 13.1. **b** Expenditure to assist aged care residential services that, as a result of their rural or remote location or because the homes target financially disadvantaged people, are unable to meet the cost of necessary capital works from the income they receive through resident accommodation payments (accommodation bonds and accommodation charges) and the capital component of Australian Government recurrent funding included in table 13.1. **c** Includes expenditure on building and other capital items, specifically for the provision of Australian Government funded residential aged care. **na** Not available. .. Not applicable – Nil or rounded to zero.

Source: DoHA (unpublished); State and Territory governments (unpublished).

Community care services

Following is a summary of expenditure on community care programs. More detailed data may be found in the attachment tables noted. Data on Australian Government expenditure per head of the target population by jurisdiction are contained in table 13A.49. Recipients of community care services may also contribute towards the cost of their care.

Expenditure on HACC, CACP, NRCP and DVA programs

Total government expenditure on HACC was $1.5 billion in 2006-07, consisting of $928.4 million from the Australian Government and $595.7 million from the State and Territory governments. The Australian Government contributed 60.9 per cent, while State and Territory governments funded the remainder (table 13A.45).

Experimental estimates of expenditure on HACC services (in addition to the State and Territory matching amounts expended under the HACC agreement and already reported) have been collected for some states and territories for 2006-07. This category of expenditure is defined in section 13.6. The data definition may require further development. Caution should be used in making comparisons across jurisdictions (table 13.4).

Table 13.4 **Experimental estimates of additional State and Territory government expenditure on HACC services 2006-07[a]**

	NSW[b]	*Vic*	*Qld*	*WA*	*SA*[c]	*Tas*	*ACT*	*NT*	*Total*
$ million	4.1	55.7	na	na	44.6	11.5	na	2.9	118.8

[a] Additional to state matching amount already reported but not including local Government. [b] NSW expenditure includes allocations to service providers to meet cost of award wage increases. [c] SA expenditure includes allocations to the Royal District Nursing Service to provide community nursing services, and to Domiciliary Care SA and Country Health Units for a range of HACC type services. **na** Not available.

Source: State and Territory governments (unpublished).

The Australian Government funds the CACP program, spending $404.9 million on the program in 2006-07 (table 13A.48). CACPs are also part funded by client contributions.

The NRCP provides community respite services and is funded by the Australian Government. Expenditure on this program was $166.9 million in 2006-07 (table 13.5). The NRCP assisted 129 803 people in 2006-07 (table 13A.36). A breakdown of Australian Government expenditure on the NRCP by State and Territory is provided in table 13.5.

Table 13.5 **Australian Government expenditures, National Respite for Carers Program, by state and territory, 2006-07 ($million)[a, b]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*National*	*Total*
Commonwealth Carer Respite Centres										
	14.8	11.5	9.8	4.6	4.6	2.1	0.9	2.9	–	51.2
Respite services										
	33.3	25.6	19.1	9.9	10.0	2.9	2.6	1.7	–	105.1
National projects[c]										
	–	–	–	–	–	–	–	–	10.6	10.6
Total	48.1	37.1	28.9	14.5	14.6	5.0	3.5	4.6	10.6	166.9

[a] Commonwealth Carer Respite Centres coordinate respite services, help carers access them, and arrange individual respite when needed. [b] Respite services reports funding for services directly providing respite care. [c] National project is for Carers Australia. – Nil or rounded to zero.

Source: DoHA (unpublished); table 13A.48.

The DVA also provided $94.9 million for the VHC program during 2006-07 (table 13A.47).

Flexibly funded services

The Australian Government funds the EACH and EACH Dementia programs, spending $103.9 million and $25.1 million respectively on these programs in 2006-07 (table 13A.48). EACH and EACH Dementia packages are also part funded by client contributions.

The Australian, State and Territory governments fund the TCP. In 2006-07 the Australian Government and the State and Territory governments spent $32.9 million and $35.1 million respectively (table 13A.69). The Australian Government also funds the MPS program and Indigenous specific services. In 2006-07, $69.2 million and $17.2 million were spent on each of these programs (table 13A.48).

Other community care services

Australian Government expenditure data by jurisdiction on a range of other community care programs targeting older people are contained in table 13A.48. These include Community Care Grants, Assistance with Care and Housing for the Aged, Day Therapy Centres, Continence Aids Assistance Scheme, Carers Information and Support, Commonwealth Carelink Centres and the National Continence Management Strategy. Australian Government expenditure on these programs was $70.6 million in 2006-07 (table 13A.48).

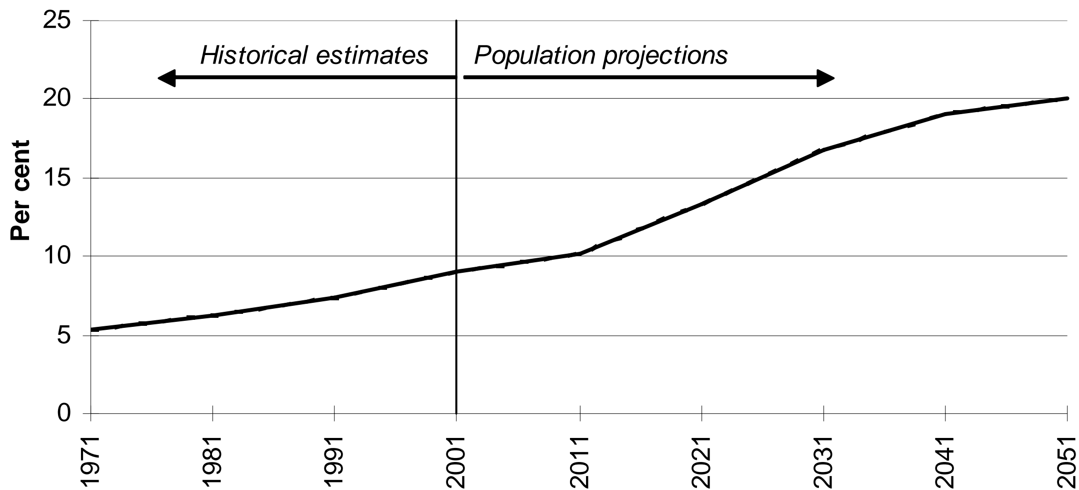
Size and scope of sector

Size and growth of the older population

The Australian population is ageing, as indicated by an increase in the proportion of people aged 70 years or over in the total population. This trend is expected to continue, and the proportion of older people is expected to increase dramatically in the 21st century (figure 13.4). The proportion of older people is 9.3 per cent nationally but varies across jurisdictions (figure 13.5). A breakdown by locality is provided in attachment table 13A.3. Higher life expectancy for females resulted in all jurisdictions (except the NT) having a higher proportion of older females than older males.

Demographic profiles affect the demand for aged care services because females use aged care services (particularly residential services) more than males. Females are more likely to use residential services partly because they tend to live longer (that is, there are more women than men in the older population) and they are less likely to have a partner to provide care.

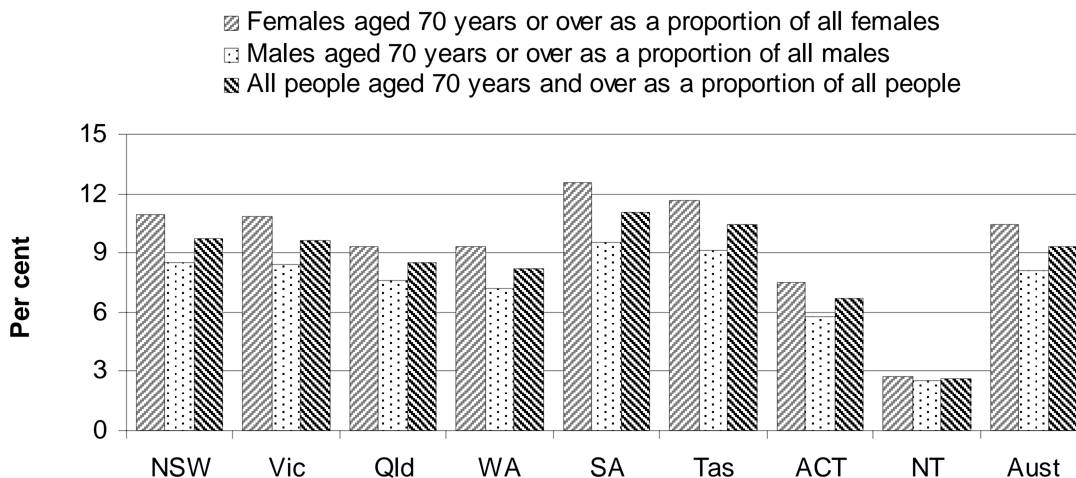
Figure 13.4 **Persons aged 70 years or over as a proportion of the total population**[a]



[a] Historical estimates and population projections are based on the ABS 2001 Census of Population and Housing that is held at five year intervals. Population projections are derived from the 'B' series projections.

Source: ABS (2006a) *Australian Historical Population Statistics, 2006*, Cat. No. 3105.0.65.001; ABS (2006b) *Population Projections Australia 2004–2101* Cat. no. 3222.0.

Figure 13.5 **Estimated proportion of population aged 70 years or over, by gender, June 2007**

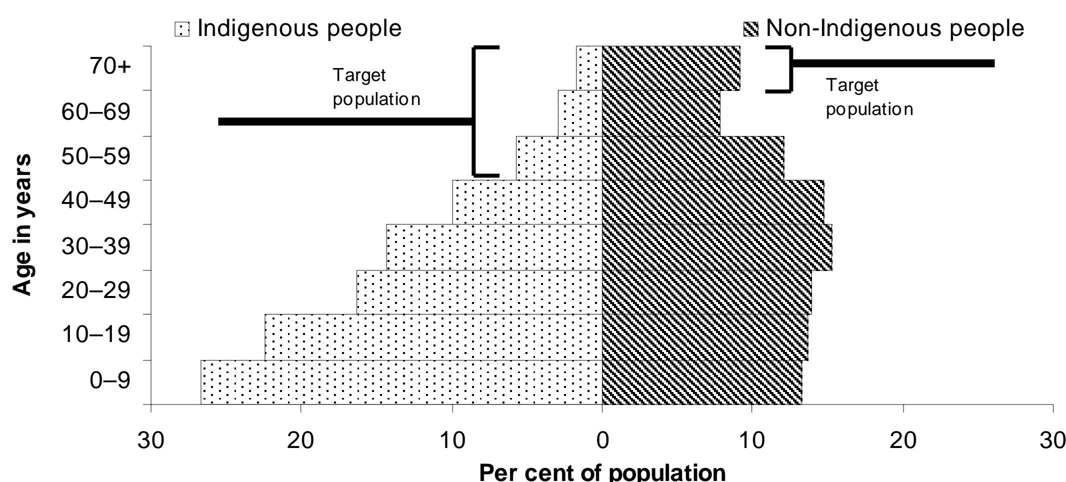


Source: Population projections prepared by the ABS in 2007, using preliminary rebased estimated resident populations based on the 2006 Census according to assumptions agreed to by the Treasury and Department of Health and Ageing (unpublished); table 13A.1.

Characteristics of older Indigenous people

The ABS (based on assumptions provided by DoHA) estimates that about 55 600 Indigenous people were aged 50 years or over in Australia at 30 June 2007 (table 13A.2). Although the Indigenous population is also ageing, there are marked differences in the age profile of Indigenous Australians compared with non-Indigenous Australians (figure 13.6). Estimates for both males and females show life expectancy at birth in the Indigenous population is around 17 years less than in the total Australian population (ABS 2004b). These figures indicate that Indigenous people are likely to need aged care services earlier in life, compared with the general population.

Figure 13.6 **Age profile and target population differences between Indigenous and other Australians, June 2001**



Source: ABS (2004b).

Residential care services

The size and location of residential services — which may influence the costs of service delivery — vary across jurisdictions. Nationally, there were 167 070 mainstream operational places in residential care services (72 647 in predominantly high care services, 14 420 in predominantly low care services and 80 003 in services with a mix of high care and low care residents) at June 2007 (tables 13A.6–9). These figures exclude flexible care places in a residential setting.

As the trend towards 'ageing in place' (box 13.5) increases, there has been a steady increase in the number of services categorised as providing a mix of high care and low care places. In June 2003, 36.5 per cent of all places were located in services

offering both high care and low care places. This proportion decreased to 33.4 per cent of places in June 2004, but increased to 47.9 per cent in June 2007 (table 13A.10).

Box 13.5 **Ageing in place in residential care**

In its Objects, the *Aged Care Act 1997* (Cwlth) aims to:

> *... encourage diverse, flexible and responsive aged care services that:*
>
> *(i) are appropriate to meet the needs of the recipients of those services and the carers of those recipients; and*
>
> *(ii) facilitate the independence of, and choice available to, those recipients and carers.*

Further, the Aged Care Act explicitly aims to encourage and facilitate 'ageing in place'. The Act does not define 'ageing in place', but one useful definition is 'the provision of a responsive and flexible care service in line with the person's changing needs in a familiar environment'. In effect, 'ageing in place' refers to a resident remaining in the same residential aged care service as his or her care needs increase from low level to high level. This is changing the profile of people in services.

The Aged Care Act does not establish any 'program' or require any residential aged care service to offer ageing in place. Rather, it creates the opportunity for providers to choose to provide the full continuum of care, by removing the legislative and administrative barriers that prevented this outcome in the past.

The concept of 'ageing in place' is linked to the outcomes of increasing choice and flexibility in residential aged care service provision. These are difficult outcomes to measure. Data on 'ageing in place' is reported for the indicator 'intensity of care'.

Source: DoHA (unpublished).

The client profile of services that had predominantly low care residents in 2000 has changed over time, with low care residents staying in their current service as their dependency levels rise, and with aged care services expanding and diversifying. Low care services are generally smaller (as measured by number of places) than high care services. At June 2007, 66.6 per cent of low care services had 60 or fewer places (table 13A.8), compared with 43.6 per cent of high care services (table 13A.7).

The combined number of operational high care and low care residential places per 1000 people aged 70 years or over at June 2007 was 85.5 (41.6 high care and 44.0 low care) on a national basis (table 13.6). Nationally, the proportion of low care places relative to high care places rose between 2003 and 2007 (table 13A.11).

Table 13.6 **Operational high care and low care residential places, 30 June 2007[a, b, c]**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Number of places per 1000 people aged 70 years or over										
High care places	no.	43.9	39.7	39.4	38.0	46.0	44.5	29.0	60.0	41.6
Low care places	no.	40.5	46.5	45.8	45.1	46.3	41.3	42.0	44.0	44.0
Total places	**no.**	84.5	86.2	85.2	83.1	92.3	85.7	71.0	104.0	85.5
Proportion of places										
High care places	%	52.0	46.1	46.2	45.7	49.8	51.9	40.8	57.7	48.6
Low care places	%	48.0	53.9	53.8	54.3	50.2	48.1	59.2	42.3	51.4

[a] Excludes places that have been 'approved' but are not yet operational. Includes multi-purpose and flexible services attributed as high care and low care places. [b] For this Report, Australian Government planning targets are based on providing 88 residential places per 1000 people aged 70 years or over. In recognition of poorer health among Indigenous communities, planning in some cases also takes account of the Indigenous population aged 50–69 years. This means that the provision ratio based on the population aged 70 years or over will appear high in areas with a high Indigenous population (such as the NT). [c] See table 13A.11 for further information regarding the calculation of provision ratios, which vary from corresponding data published in the DoHA Annual Report 2006-07.

Source: DoHA (unpublished); table 13A.11.

Age specific usage rates for these services, by jurisdiction and remoteness, at 30 June 2007 are included at tables 13A.59 and 13A.61, and 13A.62 and 13A.64 respectively. Indigenous usage by remoteness category is identified at table 13A.65.

Community care services

Services provided under the HACC program include domestic assistance and home maintenance, personal care, food services, respite care, transport, allied health care and community nursing (box 13.6).

Box 13.6 HACC Services

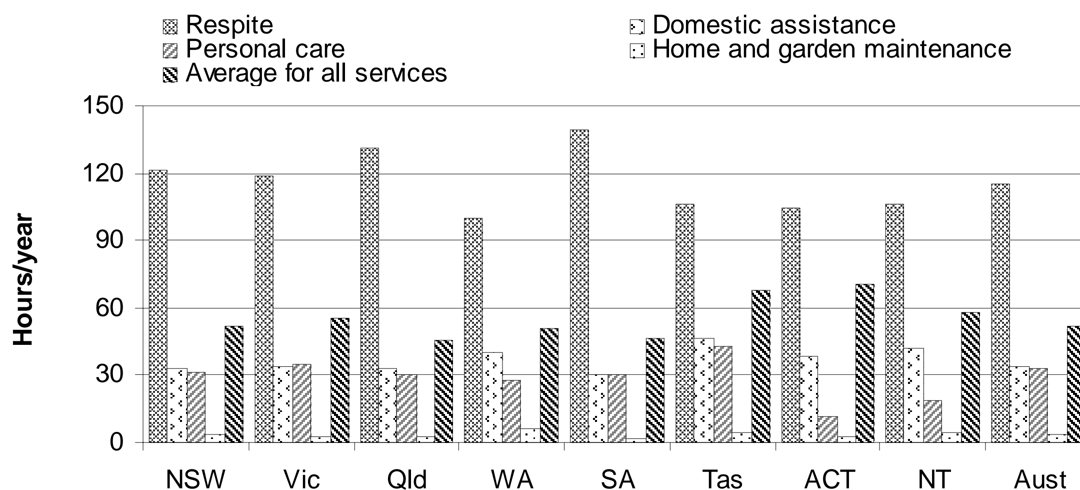
HACC services are basic maintenance and support services, including allied health care, assessment, case management and planning, centre-based day care, counselling, support, information and advocacy, domestic assistance, home maintenance, nursing, personal and respite care, social support, meals, home modification, linen service, goods and equipment, and transport.

Not all HACC services are directed towards the ageing population described in this chapter. The target population is defined as people living in the community who are at risk, without these services, of premature or inappropriate long term residential care. The target population comprises both frail aged people and younger people with a disability, and their carers.

Over 68 per cent of the program's recipients are aged 70 years or over, but the program is also an important source of community care for younger people with a disability and their carers, with nearly 12 per cent of recipients under 50 years (table 13A.34). (Chapter 14 covers services for people with a disability, which manifests before the age of 65 years, that are provided under the Commonwealth State/Territory Disability Agreement.)

The services of the VHC program target veterans and war widows/widowers with low care needs. There were 80 058 people approved for VHC services in 2006-07 (table 13A.47). The program offers veterans and war widows/widowers who hold a Gold or White Repatriation Health Card home support services, including domestic assistance, personal care, home and garden maintenance, and respite care. Other services, such as community transport, social support and delivered meals, are also available under the DVA's arrangements with State and Territory governments. Eligibility for VHC services is not automatic, but based on assessed need. The average number of hours approved per year for veterans who were eligible to receive home care services was 51.9 nationally in 2006-07 (figure 13.7).

Figure 13.7 **Average number of hours approved for Veterans' Home Care, 2006-07**



Source: DVA (unpublished); table 13A.47.

Provision of CACPs is an alternative home-based service for older people assessed by ACATs as eligible for care equivalent to low level residential care (RCS levels 5–8). A CACP typically provides 5 to 6 hours of direct assistance per week. The EACH program is similar to the CACP program but targets people who would be eligible for high level residential aged care. An EACH package typically provides 15 to 20 hours of direct assistance each week. The main distinctions between the HACC, CACP and EACH programs are summarised in table 13.7.

Table 13.7 **Distinctions between the HACC, CACP and EACH programs**

	HACC	*CACPs*	*EACH*
Range of services[a]	Wider range of services available	Narrower range of services available	Narrower range of services available
Relationship to residential care	Aims to prevent premature or inappropriate admission	Substitutes for a low care residential place	Substitutes for a high care residential place
Eligibility	ACAT assessment not mandatory	ACAT assessment mandatory	ACAT assessment mandatory
Funding	Cost shared by the Australian, State and Territory governments and client contributions	Funded by the Australian Government and client contributions	Funded by the Australian Government and client contributions
Target client groups[b]	Available to people with profound, severe and moderate disability and their carers. Not age specific.	Targets older people with care needs similar to low level residential care	Targets older people with care needs similar to high level residential care
Size of program	$1.5 billion funding in 2006-07	$404.9 million funding in 2006-07	For EACH and EACH Dementia:
	At least 800 505 clients in 2006-07[c]	37 747 operational places at 30 June 2007[d]	$129.0 million funding in 2006-07 4569 operational places at 30 June 2007.

[a] HACC services such as community nursing, which are not available under CACPs, can be supplied to someone receiving a CACP. [b] Most HACC recipients at the lower end of the scale would not be assessed as eligible for residential care — for example, an individual may receive only an hour of home care per fortnight. At the higher end, some people have levels of need that would exceed the level available under CACPs and EACH. [c] Based on 83 per cent of HACC funded agencies that submitted Minimum Data Set data for 2006-07. Consequently, the total number of clients will be higher than those reported here. [d] Excludes flexible care delivered in a community setting.

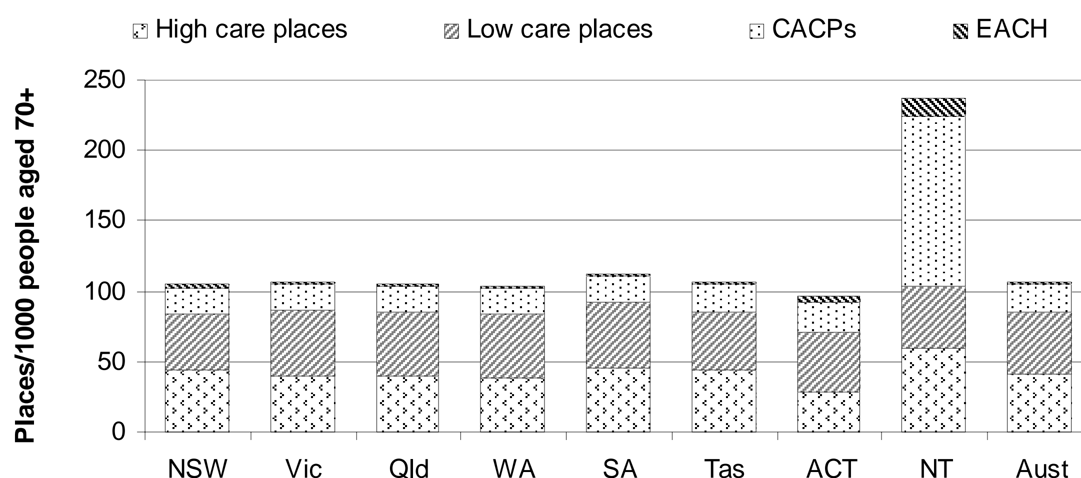
Source: DoHA (unpublished); tables 13A.33, 13A.36, 13A.45, 13A.48.

Changing government policies over the past decade — shifting the balance of care away from the more intensive types of residential care towards home-based care — have meant that the HACC, VHC, CACP and EACH programs have become increasingly important components of the aged care system. During 2006-07, the HACC program delivered approximately 18 599 hours per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years (table 13A.21). The total number of CACPs per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years increased between June 2003 and June 2007, from 15.2 to 18.6 (table 13A.12).

Combined residential and community care services rates

The combined number of high care residential places, low care residential places, CACPs and EACH packages, at 30 June 2007, was 106.3 per 1000 people aged 70 years or older (figure 13.8). EACH Dementia and Transition Care places add an additional 0.6 and 0.8 packages respectively per 1000 people aged 70 years or older. The Australian Government's targets for the provision of residential and community care places were outlined previously (box 13.3).

Figure 13.8 **Operational residential places, CACPs and EACH packages, 30 June 2007**[a, b, c, d, e, f]



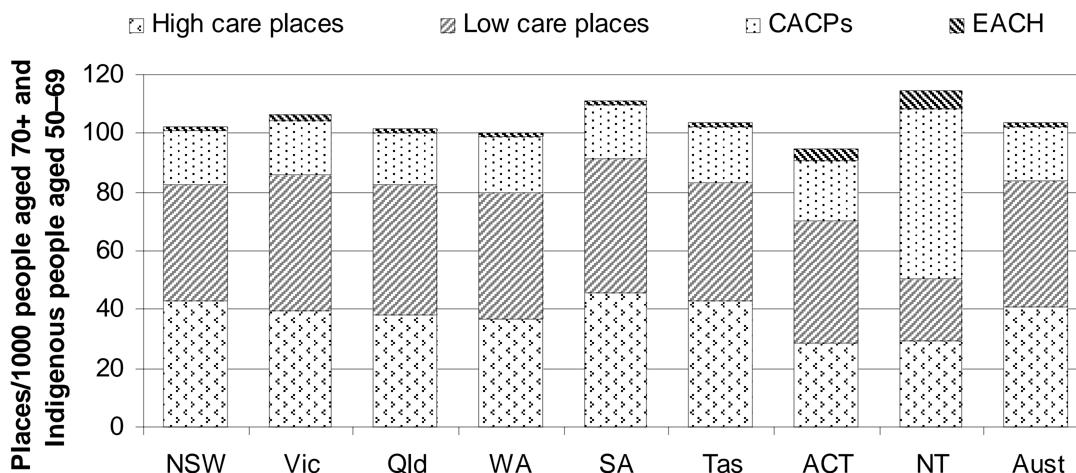
[a] Excludes places that have been approved but are not yet operational. [b] 'Ageing in place' may result in some low care places being filled by high care residents. [c] For this Report, Australian Government planning targets are based on providing 108 places per 1000 people aged 70 years or over. However, in recognition of poorer health among Indigenous communities, planning in some cases also takes account of the Indigenous population aged 50–69 years. This means that the provision ratio based on the population aged 70 years or over will appear high in areas with a high Indigenous population (such as the NT). [d] CACPs and EACH packages are not residential services but are included in the Australian Government planning targets (see boxes 13.1 and 13.3 for an interpretation of residential care data and Australian Government planning targets). [e] EACH Dementia places and TCP are not shown (table 13A.11). [f] See table 13A.11 for further information regarding the calculation of provision ratios, which vary from corresponding data published in the DoHA Annual Report 2006-07.

Source: DoHA (unpublished); table 13A.11.

The number of operational places can also be shown using the target population that incorporates Indigenous people aged 50–69 years (figure 13.9). Use of this 'adjusted' target population has a noticeable effect on the NT, which has a large proportion of Indigenous people.

Age-specific usage rates for these services, by jurisdiction and remoteness and for Indigenous usage, at 30 June 2007 are reported in tables 13A.59 to 13A.65.

Figure 13.9 **Operational residential places, CACPs and EACH packages adjusted for Indigenous people age 50–69, 30 June 2007[a, b, c, d, e]**



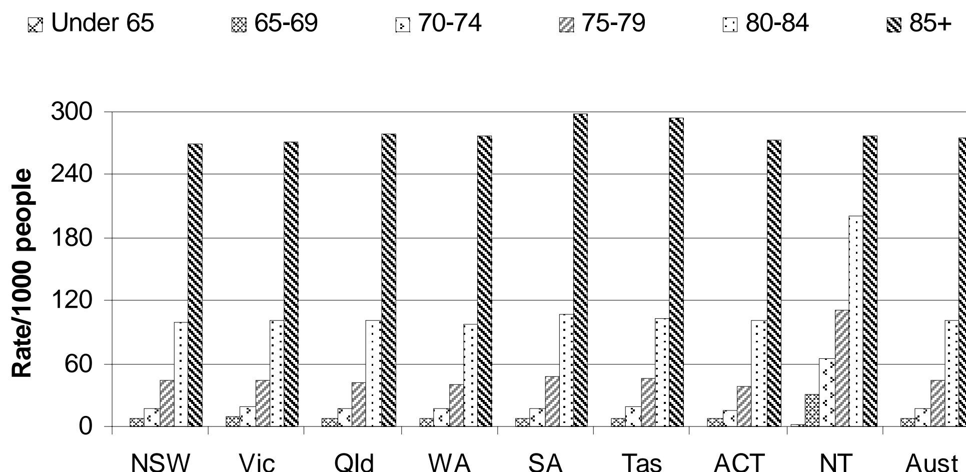
[a] Places do not include those that have been approved but are not yet operational. [b] ‘Ageing in place’ may result in some low care places being filled by high care residents. [c] CACPs and EACH packages are not residential services but are included in the Australian Government planning targets (boxes 13.1 and 13.3 contain an interpretation of residential care data and Australian Government planning targets). [d] CACPs provide a more flexible model of care more suitable to remote Indigenous communities, so areas with a high Indigenous population (such as the NT) may have a higher proportion of CACPs. [e] EACH Dementia places and TCP places are not shown (table 13A.12).

Source: DoHA (unpublished); table 13A.12.

Presentation of age-specific usage rates raises particular data issues. In particular, if the numbers of people within a particular range for a given service are small, this may lead to apparently large fluctuations in growth rates. This can be seen from some of the usage rates identified for the EACH program, which, whilst growing rapidly, are doing so from a relatively small base.

Age-specific rates in this Report are for 2006-07. The national age specific usage rates per 1000 persons for high and low residential care, CACP and EACH in combination at 30 June 2007 is 0.5 for people under 65 rising to 275.6 for people over 85. These rates vary across jurisdictions (figure 13.10).

Figure 13.10 **Permanent aged care residents, CACP and EACH recipients at 30 June 2007: age specific usage rates per 1000 persons[a, b, c, d]**

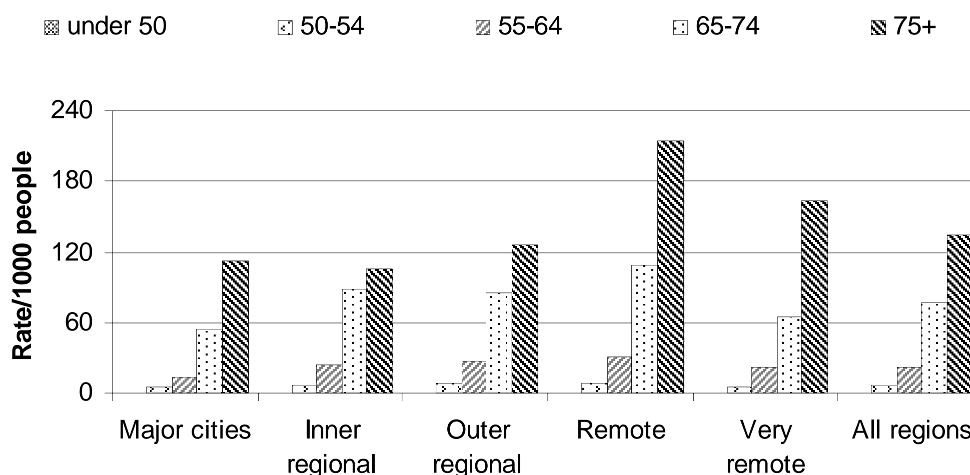


[a] Population projections by SLA for 2002-2022 based on 2001 census prepared by ABS according to assumptions agreed to by the Department of Health and Ageing. [b] Residents without a recorded RCS were omitted. [c] These figures exclude places funded by Multi-purpose services and those provided by flexible funding under the Aboriginal and Torres Strait Islander Aged Care Strategy. [d] EACH packages include EACH Dementia packages.

Source: DoHA (unpublished); table 13A.61.

The national age specific usage rates per 1000 Indigenous persons for high and low residential care, CACP and EACH in combination at 30 June 2007 is 0.3 for people under 50 rising to 133.7 for people over 75. The data show that Indigenous people tend to access these services at a younger age than the population as a whole. These rates vary by remoteness category (figure 13.11).

Figure 13.11 **Indigenous permanent residents classified as high or low care and Indigenous CACP, and EACH at 30 June 2007: age specific usage rates per 1000 persons by remoteness**[a, b, c, d, e]



[a] Geographical data are based on the ABS Australian Standard Geographic Classification of Remoteness Areas 2001. Data are classified according to an index of remoteness which rates each ABS Census District based on the number and size of towns, the distance to major towns and urban centres. [b] Indigenous population estimates are based on ratios from ABS Census 2001 data applied to population projections by SLA 2002-2022. This is a different measure from those used for these age specific usage data in previous Reports. [c] Residents without a recorded RCS were omitted. [d] These figures exclude places and packages funded by Multi-purpose services and those provided by flexible funding under the Aboriginal and Torres Strait Islander Aged Care Strategy. [e] EACH packages include EACH Dementia packages.

Source: DoHA (unpublished); table 13A.65.

13.2 Framework of performance indicators

The framework of performance indicators aims to provide information on equity, efficiency and effectiveness, and to distinguish the outputs and outcomes of government aged care services. This approach is consistent with the general performance indicator framework and service process diagram outlined in chapter 1 (see figures 1.2 and 1.3) that have been agreed by the Steering Committee. The performance indicators relate to government objectives in the aged care sector (box 13.7). At this stage, no outcome indicators are reported for aged care services.

Box 13.7 **Objectives for aged care services**

The aged care system aims to promote the wellbeing and independence of frail older people and their carers through the funding and delivery of care services that are:

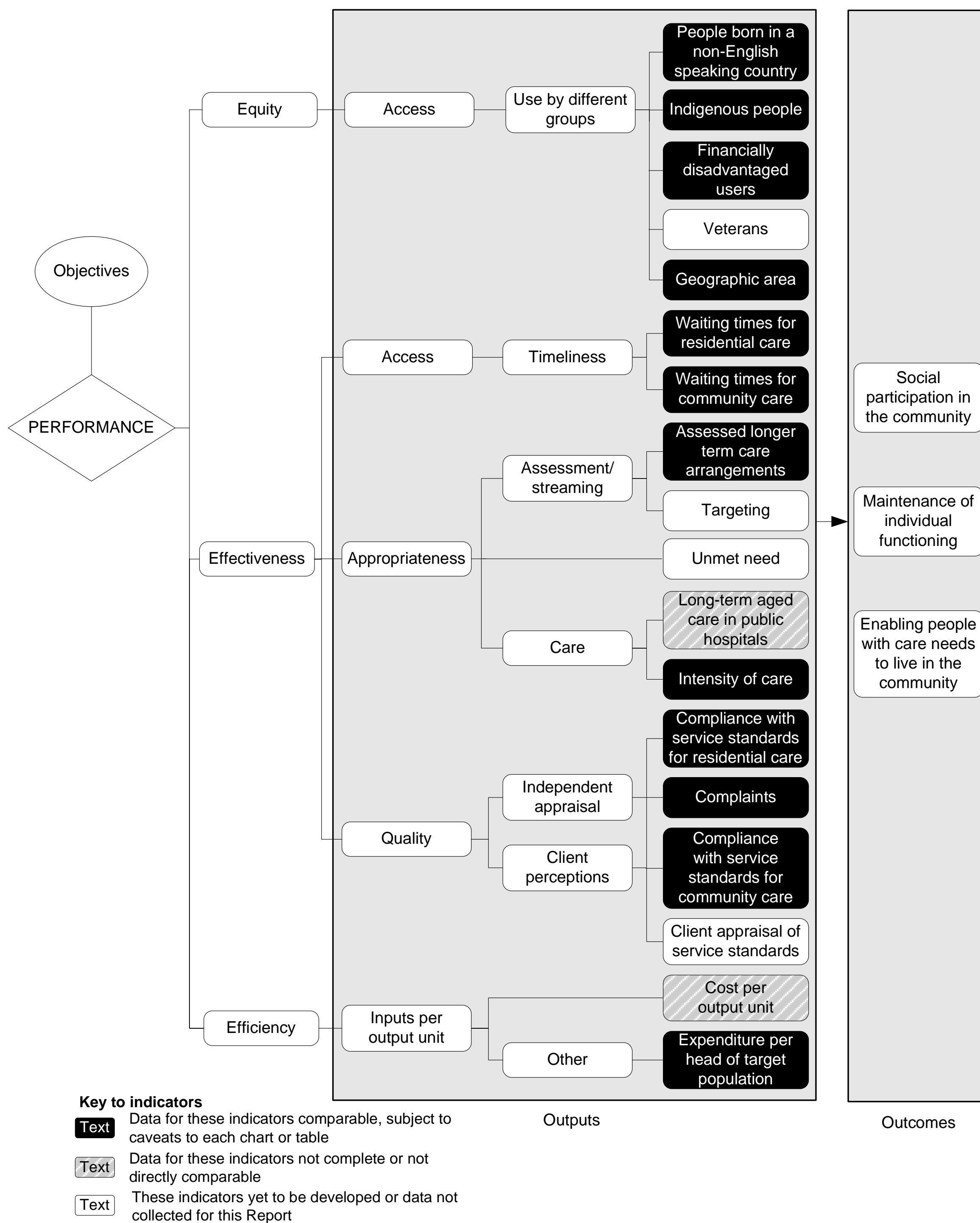
- accessible
- appropriate to needs
- high quality
- efficient.

The performance indicator framework shows which data are comparable in the 2008 Report (figure 13.12). For data that are not considered strictly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

13.3 Key performance indicator results

Different delivery contexts, locations and types of client may affect the effectiveness and efficiency of aged care services. Appendix A contains detailed statistics and short profiles on each State and Territory, which may assist in interpreting the performance indicators presented in this chapter.

Figure 13.12 **Performance indicators for aged care services**



Key to indicators

Text — Data for these indicators comparable, subject to caveats to each chart or table

Text — Data for these indicators not complete or not directly comparable

Text — These indicators yet to be developed or data not collected for this Report

Outputs

Outputs are the actual services delivered (while outcomes are the impact of these services on the status of an individual or group) (see chapter 1, section 1.5).

Equity — Access

Use by different groups

'Use by different groups' is an indicator of the equity of aged care services (box 13.8).

Box 13.8 **Use by different groups**

A key national objective of the aged care system is to provide equitable access to aged care services for all people who require these services. 'Use by different groups' is a proxy indicator of equitable access. Various groups are identified by the Aged Care Act and its principles (regulations) as having special needs, including people from Indigenous communities, people born in non-English speaking countries, people who live in rural or remote areas, people who are financially or socially disadvantaged, and veterans (including widows and widowers of veterans). The indicator is reported for each special needs group except veterans, using the following definitions:

- the number of people born in non-English speaking countries using residential services, CACPs, EACH and HACC services, divided by the number of people born in non-English speaking countries aged 70 years or over, benchmarked against the rate at which the general population accesses the service
- the number of Indigenous people using residential services, CACP, EACH and HACC services, divided by the number of Indigenous people aged 50 years or over (because Indigenous people tend to require aged care services at a younger age than the general population) benchmarked against the rate at which the general population accesses the service
- the rate of contacts with Commonwealth Carelink Centres for Indigenous people compared with all people
- access to residential services for financially disadvantaged users, defined as the number of new residents classified as concessional or assisted divided by the number of new residents
- access to HACC services for people living in rural and remote areas — the number of hours of HACC service received (and, separately, meals provided) divided by the number of people aged 70 years or over plus Indigenous people aged 50–69 years for major cities, inner regional areas, outer regional areas, remote areas and very remote areas.

(Continued on next page)

Box 13.8 **(Continued)**

In general, usage rates for special needs groups similar to those for the broader aged care population are desirable, but interpretation of results differs for some special needs groups because:

- there is evidence that Indigenous people have higher disability prevalence rates than those of the general population, which suggests a greater level of need for services compared with those in the broader aged care population
- for financially disadvantaged users, Australian Government planning guidelines require that services allocate a minimum proportion of residential places for concessional or assisted residents. These targets range from 16 per cent to 40 per cent of places, depending on the service's region. Usage rates equal to or higher than the minimum rates are desirable.

Several factors need to be considered in interpreting the results for this set of indicators:

- Cultural differences may influence the extent to which people born in non-English speaking countries use different types of services.
- Cultural differences and geographic location may influence the extent to which Indigenous people use different types of services.
- The availability of informal care and support may influence the use of aged care services in different population groups.

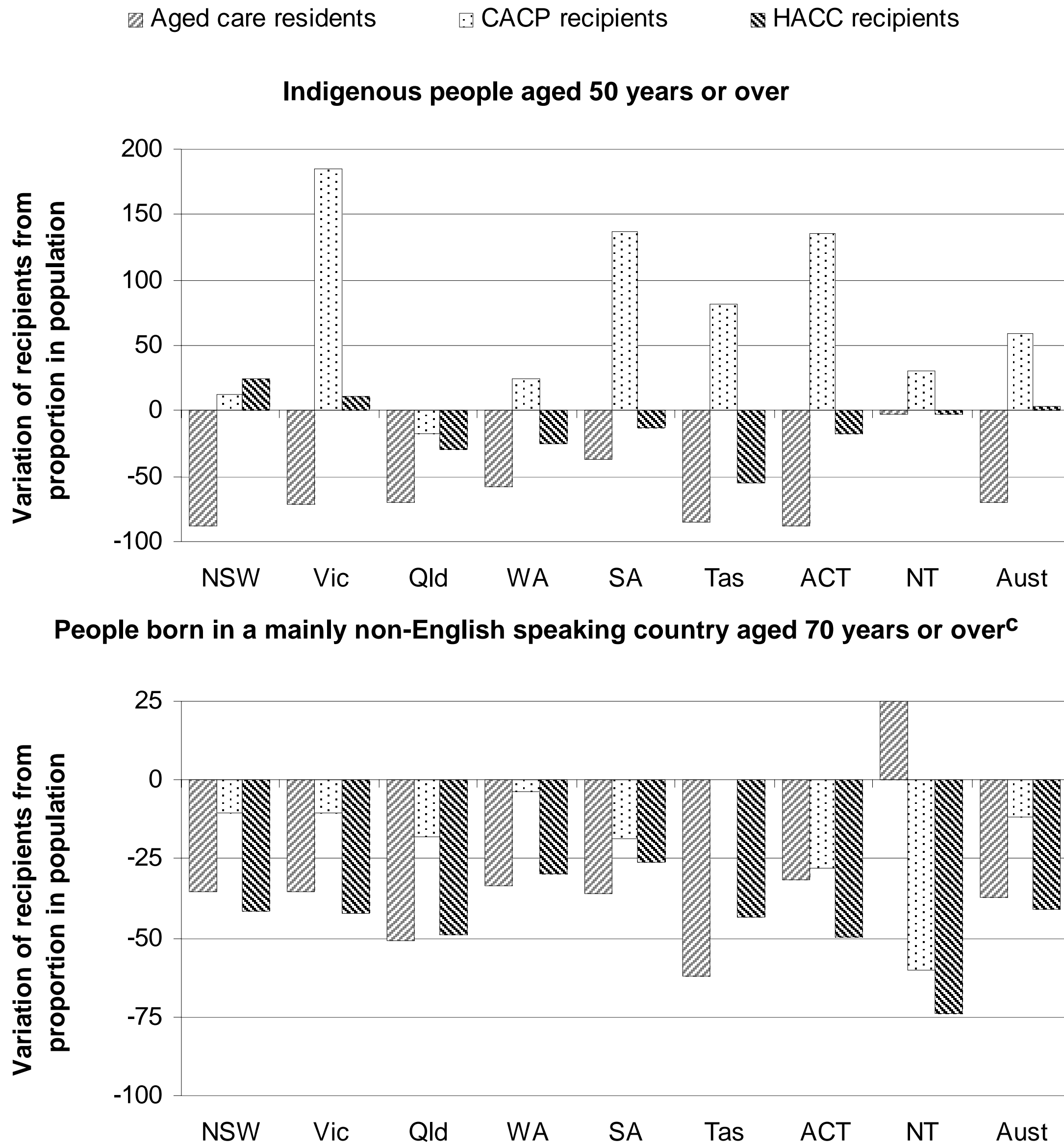
Data presented for this indicator are organised by the type of service provided, with sub-sections for the relevant special needs groups reported against that service.

Access to residential care services, CACP and HACC services by Indigenous people and people born in a mainly non-English speaking country

In general, Indigenous people and people born in a mainly non-English speaking country are under-represented in some aspects of access to residential care, CACP and HACC services in comparison to their proportion of the population as a whole. However, in relation to the CACP program in almost all jurisdictions and nationally, Indigenous people are over-represented, compared to the proportion of this group in the population. In relation to HACC services, Indigenous people are represented similarly to the total population on a national basis. Figure 13.13 demonstrates this over- and under-representation by reflecting the variation in the rate of access of the special needs target population from their proportion in the population as a whole. If the special needs group accessed services in proportion to their general representation in the population, no percentage variation would be observed. If they access services at a greater rate, a positive percentage from the

benchmark rate will be observed, or, if services are accessed at a lower rate, the bar would be negative (figure 13.13).

Figure 13.13 **Variation in the proportions of special needs target population accessing aged care services from their proportion in the population as a whole, June 2007 (per cent)[a, b]**

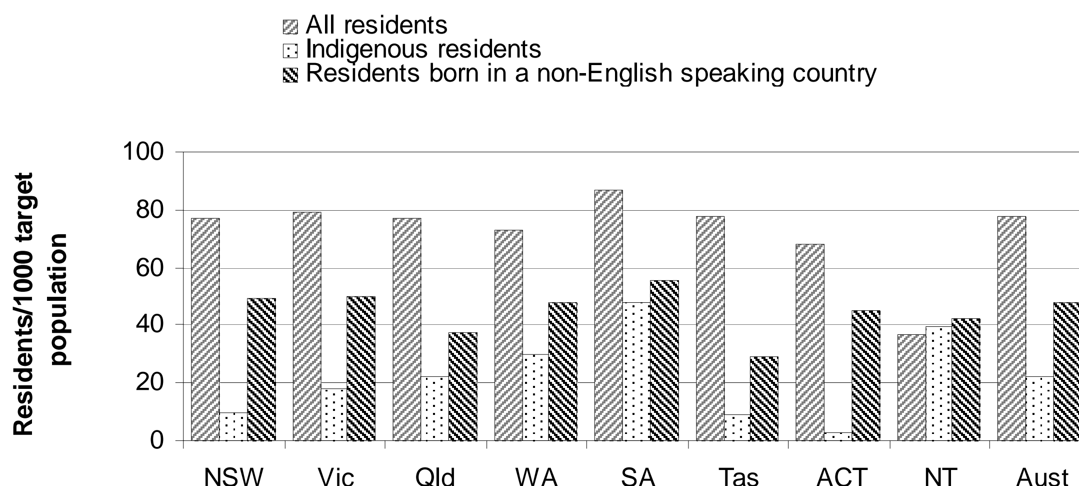


[a] The proportion of a HACC agencies that submitted data for the year varied between jurisdictions and actual service levels were higher than stated. [b] Reports provisional HACC data that have not been validated and may be subject to revision. [c] There is no variation between the proportion of Tasmanian CACP recipients for this group and their proportion in the population.

Source: DoHA (unpublished); tables 13A.19.

In all jurisdictions at 30 June 2007, on average, Indigenous people and people born in non-English speaking countries had lower rates of use of aged care residential services (22.2 and 48.1 per thousand of the relevant target populations respectively), compared with the population as a whole (77.7 per thousand) (figure 13.14).

Figure 13.14 **Residents per 1000 target population, 30 June 2007[a, b, c]**



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

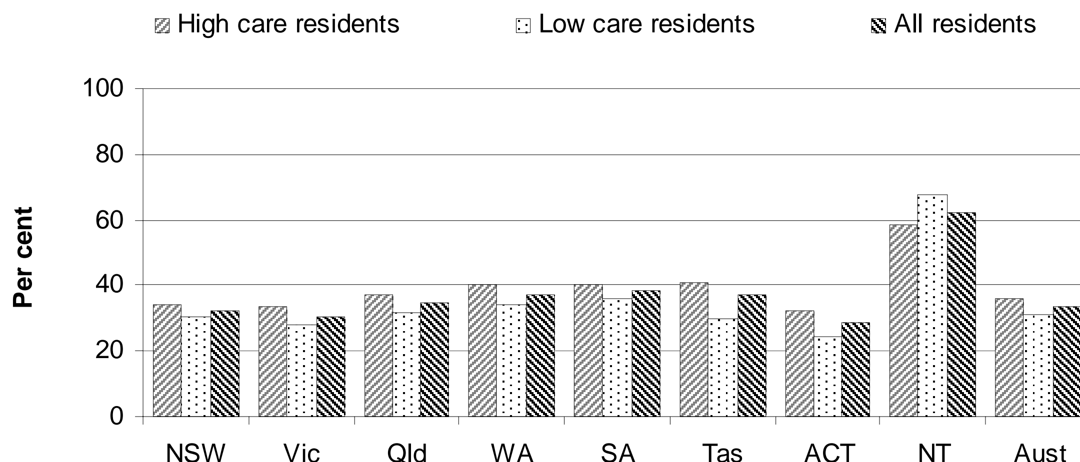
Source: DoHA (unpublished); tables 13A.13, 13A.15 and 13A.17.

Age specific usage rates for these services, by jurisdiction and remoteness are included in the Report. These data suggest there is significant variation in usage rates by remoteness area. In general, differences amongst jurisdictions are less marked than differences between remoteness area (tables 13A.14, 13A.16, 13A.18, 13A.59, 13A.61, 13A.62, 13A.64 and 13A.65).

Access to residential services by financially disadvantaged users

The proportion of all new residents classified as concessional or assisted residents during 2006-07 was 33.6 per cent nationally but varied across jurisdictions (figure 13.15).

Figure 13.15 **New residents classified as concessional or assisted residents, 30 June 2007[a]**



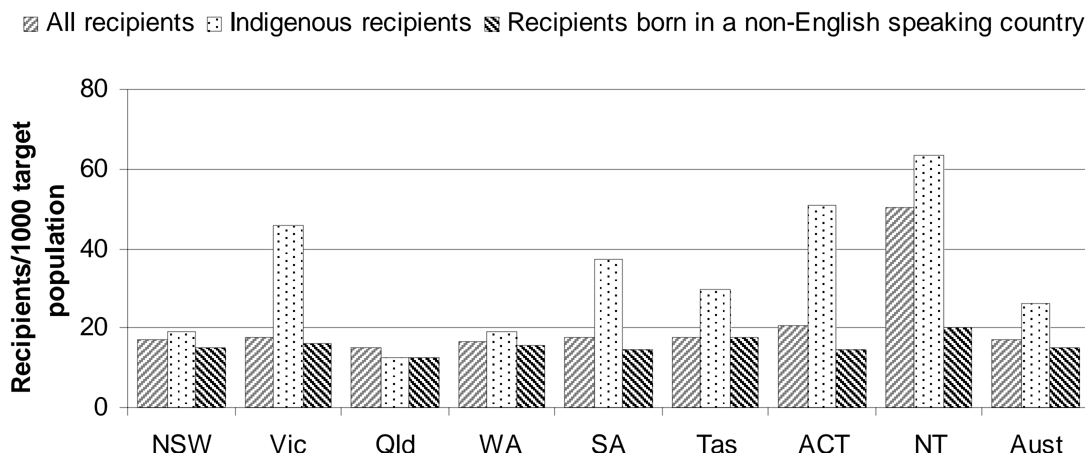
[a] Concessional residents are those who receive an income support payment and have not owned a home for the previous two or more years (or whose home is occupied by a 'protected' person, such as the care recipient's spouse or long term carer), and have assets of less than 2.5 times the annual single basic age pension. Assisted residents are those meeting the above criteria, but with assets between 2.5 and 4.0 times the annual single basic age pension.

Source: DoHA (unpublished); table 13A.20.

Access to community aged care packages by Indigenous people and people born in a mainly non-English speaking country

The number of Indigenous CACP recipients per 1000 Indigenous people aged 50 years or over was 25.9 nationally and the numbers of CACP recipients from non-English speaking countries per 1000 of the relevant target population was 15.1 nationally. These figures compare to a total of 17.1 per 1000 of the target population (people aged 70 years or over plus Indigenous people aged 50–69 years) (figure 13.16).

Figure 13.16 **Community Aged Care Package recipients per 1000 target population, 30 June 2007**[a, b, c, d, e]



[a] All recipients data are per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years. [b] Indigenous recipients data are per 1000 Indigenous people aged 50 years or over. [c] Data for recipients from non-English speaking countries are per 1000 people from non-English speaking countries aged 70 years or over. [d] The ACT has a very small Indigenous population aged 50 years or over (table 13A.2), and a small number of packages result in a very high provision ratio. [e] CACPs provide a more flexible model of care more suitable to remote Indigenous communities, so areas such as the NT have a higher rate of CACP recipients per 1000 people.

Source: DoHA (unpublished); tables 13A.13, 13A.15 and 13A.17.

Age-sex specific usage rates for CACP and EACH, by jurisdiction, remoteness and Indigenous usage vary between jurisdictions and remoteness categories for CACP. For EACH, the differences are less marked. However, the EACH program is small and growing rapidly (tables 13A.60-61 and 13A.63-65).

Access to the HACC program by Indigenous people and by remoteness area

HACC services are provided in the client's home or community for people with a moderate, severe or profound disability and their carers. The focus of this chapter is people 70 years and over and Indigenous people aged over 50. The proportion of HACC recipients aged 70 years or over during 2006-07 was 68.8 per cent (table 13A.33).

The number of service hours per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years was 18 599 nationally, and the number of meals provided per 1000 people aged 70 years or over plus Indigenous people aged 50–69 was 6126 nationally (table 13.8). HACC agencies that submitted the data as a proportion of all HACC agencies varies across jurisdictions and comparisons between jurisdictions should be made with care.

Table 13.8 **HACC services received, 2006-07 (per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years)[a, b, c]**

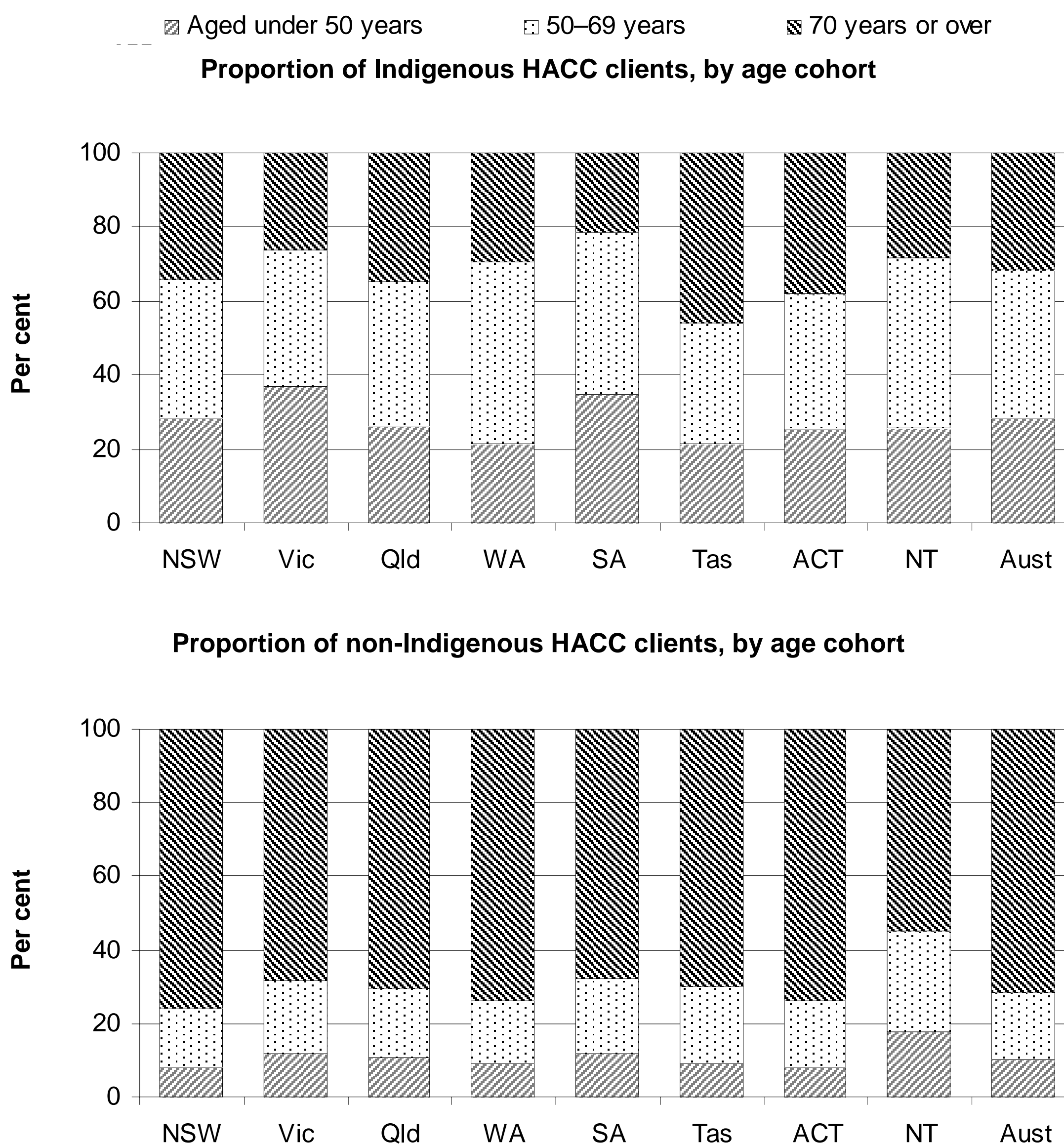
	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Percentage of agencies that reported Minimum Data Set data	%	75	89	92	91	94	81	100	92	83
Total hours[d]										
Major cities	hrs.	11 998	19 591	21 278	22 863	23 333	..	22 637	..	17 854
Inner regional	hrs.	11 736	23 601	17 357	20 749	17 009	17 022	..	..	17 063
Outer regional	hrs.	13 221	28 858	18 830	25 166	21 930	15 854	..	19 772	19 331
Remote	hrs.	22 774	34 353	20 912	23 563	25 066	20 750	..	32 606	24 037
Very remote	hrs.	16 276	..	19 926	20 935	30 629	33 975	..	35 463	25 502
All areas	**hrs.**	**12 847**	**21 446**	**20 304**	**23 852**	**23 328**	**17 333**	**23 110**	**28 852**	**18 599**
Total meals[e]										
Major cities	no.	4 379	5 247	6 696	6 599	7 042	..	5 229	..	5 453
Inner regional	no.	5 519	8 010	6 036	6 658	3 838	6 288	..	..	6 281
Outer regional	no.	7 259	7 292	7 467	7 841	7 770	7 903	..	8 272	7 493
Remote	no.	7 690	6 777	8 319	9 713	5 843	7 667	..	32 426	9 962
Very remote	no.	12 540	..	10 661	21 438	21 111	4 088	..	46 219	24 040
All areas	**no.**	**4 974**	**6 056**	**6 761**	**7 321**	**6 846**	**6 864**	**5 234**	**28 430**	**6 126**

[a] Data represent HACC services received divided by people aged 70 years or over, plus Indigenous people aged 50–69 years (tables 13A.21–13A.26) as distinct from HACC services received divided by HACC target population in all age groups (tables 13A.27–13A.32). [b] The proportion of HACC agencies that submitted data for the year varied between jurisdictions and actual service levels may be higher than stated. [c] Reports provisional HACC data that have not been validated and may be subject to revision. [d] See table 13A.21 for a full list of categories. [e] Includes home meals and centre meals. .. Not applicable.

Source: DoHA (unpublished); tables 13A.21–13A.26.

Reported use of HACC services showed a substantial difference between all users and Indigenous users across all age groups in 2006-07. This reflects the difference in morbidity and mortality trends between Indigenous people and the general population. The proportion of Indigenous HACC clients who are aged 70 years and over is 31.4 per cent and the proportion of non-Indigenous HACC clients who are aged 70 years and over is 71.2 per cent (figure 13.17).

Figure 13.17 **Recipients of HACC services by age and Indigenous status, 2006-07**[a]



[a] Reports provisional HACC data that have not been validated and may be subject to revision.

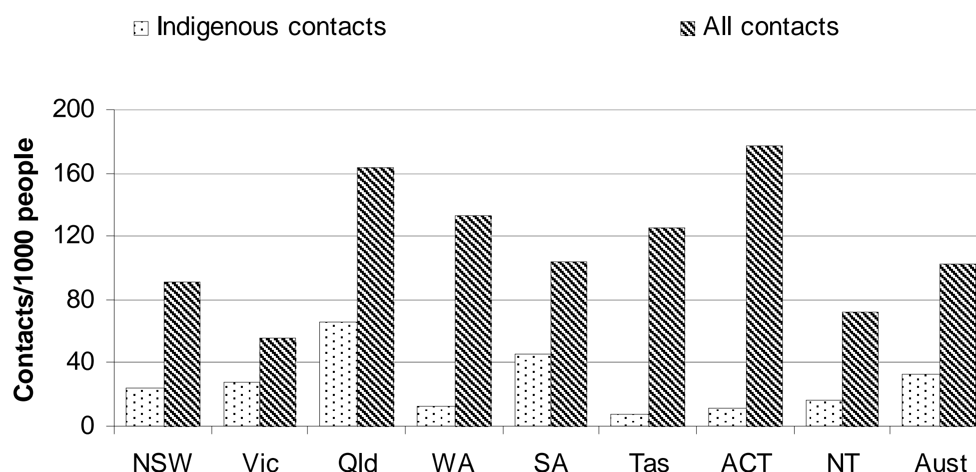
Source: DoHA (unpublished); table 13A.34.

Access by Indigenous people to Commonwealth Carelink Centres

Commonwealth Carelink Centres are information centres for older people, people with disabilities, carers and service providers. Information is provided on community services and aged care, disability and other support services available locally or anywhere in Australia, the costs of services, assessment processes and eligibility criteria. The national rate at which Indigenous people contacted Carelink

Centres at 30 June 2007, was 33.4 people per 1000 Indigenous people in the Indigenous target population (Indigenous people aged 50 years and over). The rate for all Australians was 102.2 per 1000 people in the target population (people aged 70 years and over plus Indigenous people aged 50–69). These figures varied across jurisdictions (figure 13.18). Data presented against this measure vary from previous Reports, where the entire population was used as the denominator. For this Report, the target populations for this chapter have been used, resulting in higher rates than in previous Reports.

Figure 13.18 **Commonwealth Carelink Centres, contacts per 1000 target population, by Indigenous status, 30 June 2007[a, b, c]**



[a] Contacts with Carelink include phone calls, visits, emails and facsimiles. [b] Indigenous contacts refer to contacts by Indigenous people per 1000 Indigenous people in the target population. [c] All contacts refers to contacts per 1000 target population.

Source: DoHA (unpublished); table 13A.57.

Effectiveness

Timeliness of access — waiting times for residential care

The indicator ‘waiting times for residential care’ is an indicator of the effectiveness of aged care services (box 13.9).

Box 13.9 **Waiting times for residential care**

'Waiting times for residential care' is an indicator of the timeliness with which people are able to access residential care.

The measure 'elapsed time between ACAT approval and entry into high care residential care service' measures the period between a client's approval for high care and his or her entry into care, and is defined as the percentage of people who are admitted to high care residential care within three months of their ACAT approval. Shorter elapsed times (measured by higher rates of admission to high care residential care within three months of ACAT approval) are desirable.

The relevant terms are defined as follows:

- ACAT approval — the approval date of an ACAT assessment
- entry into a residential care service — the date of admission to a residential care service.

This indicator needs to be interpreted with care. The measure of 'elapsed time' is utilised because the period of time between the ACAT assessment and entry into residential care may be due to factors which cannot be categorised as 'waiting' time. These include:

- clients with ACAT approvals who do not enter residential care (for example, who die before entering care)
- residential placement offers that are not accepted
- the availability of alternative community care, informal care and respite services
- the availability and distribution of operational residential care services
- building quality and perceptions about quality of care, which influence client choice of preferred service
- delays between the date of ACAT assessments and their approval
- priority allocations (for example, special needs groups)
- hospital discharge policies and practices
- impact on clients of programs which provide alternatives to residential care, such as EACH and EACH Dementia.

The measure focuses on high care services because, as a proxy for waiting time, the link between entry to residential care and elapsed time is stronger for high care residents than low care residents. This is due to the urgency for high care residents, and the greater number of alternatives for people with ACAT approvals for low care only. Waiting time measures for low care are included in the attachment tables.

The Steering Committee acknowledges the limitations of the current indicator (box 13.10) and supports redevelopment for improvement. The current indicator will continue to be reported until improved data are available.

Box 13.10 **Entry period for residential care**

The Australian Institute of Health and Welfare (AIHW) conducted a detailed study of 1999-2000 ACAT assessment data and entry into residential care (AIHW 2002*)*. The ‘entry period’ is the time between ACAT assessment of a person as eligible for residential aged care, and that person’s entry into a residential aged care service.

The study found that one of the main determinants of a short entry period is whether the resident has an ACAT assessment performed while in hospital rather than when living at home. A longer entry period is also strongly related to whether the resident used a CACP or residential respite care before admission.

Recommendations for residential care remain active for 12 months. Some people assessed by an ACAT and recommended for residential aged care may not take up a residential place within this period. People often do not act on the recommendation immediately. They may believe they are capable of continuing to manage at home and that they do not need admission. Others receive recommendations for both residential aged care and a CACP, and take up the latter.

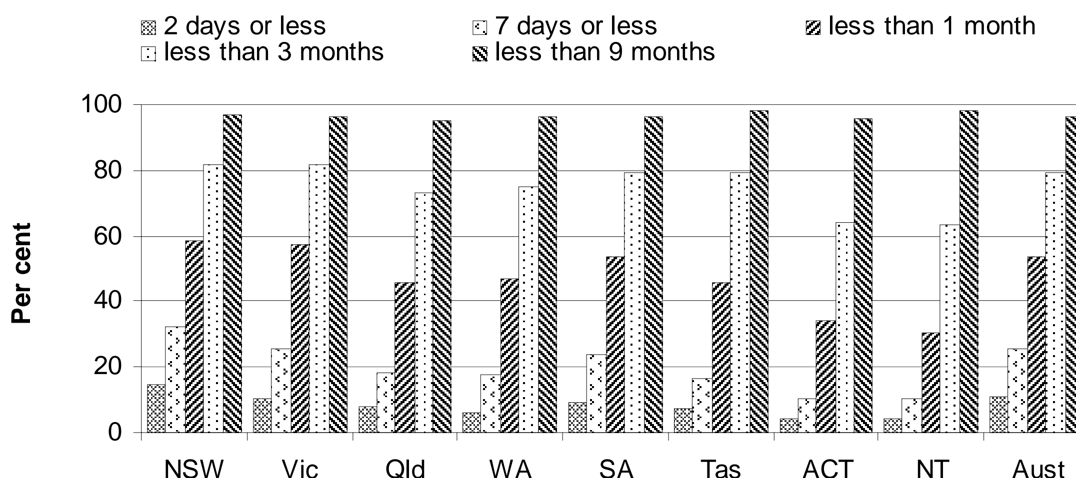
The AIHW found that many factors affect the entry period but are not linked to the performance of the aged care system. It recommended that the entry period for residential care not be used as a performance indicator.

Source: AIHW (2002).

Overall, 25.4 per cent of all people entering high care residential care during 2006-07 did so within seven days of being approved by an ACAT, 53.9 per cent entered within one month of their ACAT approval and 79.1 per cent entered within three months of their approval. These times varied across jurisdictions (figure 13.19). In the calculation of entry period, the most recent ACAT approval prior to entry is used. The median time for entry into high care residential care was 26 days (table 13A.37).

Nationally, a greater proportion of people entering high care residential services entered within three months of approval (79.1 per cent), compared with the proportion entering low care residential services within that time (60.4 per cent). These proportions varied across jurisdictions (table 13A.37).

Figure 13.19 **People entering high care residential care within specified time periods of their ACAT approval, 2006-07**



Source: DoHA (unpublished); table 13A.37.

Timeliness of access — waiting times for community care

'Waiting times for community care' is an indicator of the effectiveness of aged care services (box 13.11).

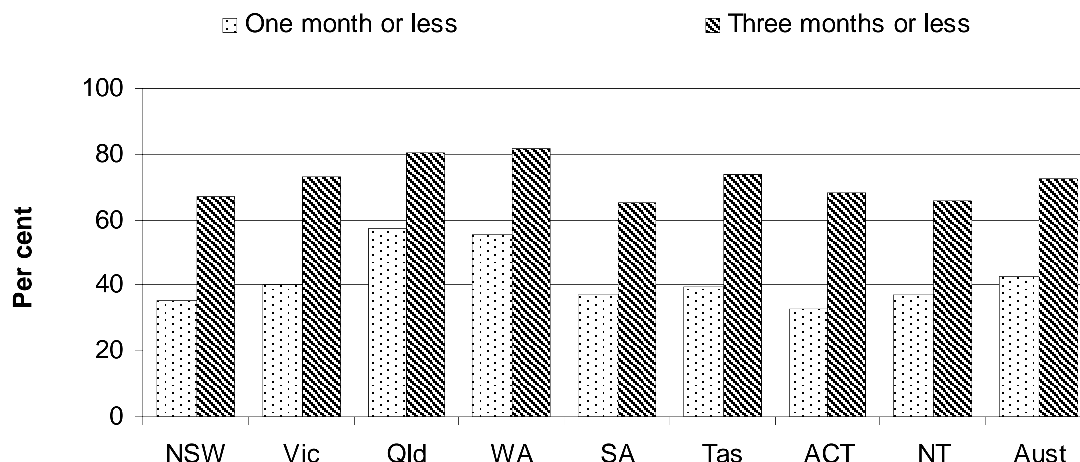
Box 13.11 **Waiting times for community care**

'Waiting times for community care' is an indicator of effectiveness and reflects the timeliness with which people are able to access CACPs. The indicator measures the period between a client's approval for care and his or her receipt of care, and is defined as the elapsed time between an ACAT approval and receipt of a CACP. Shorter waiting times (or higher rates of receipt of a CACP within one month or within three months of an ACAT approval) are considered desirable.

This indicator needs to be interpreted with care. Some ACAT assessed clients may choose not to receive a CACP, alternative community care options may be available, or varying fee regimes might influence choice.

Overall, 72.5 per cent of all people receiving a CACP during 2006-07 received it within three months of being assessed by an ACAT. This proportion varied across jurisdictions. On average, 42.9 per cent started receiving a CACP within one month of their ACAT assessment (figure 13.20).

Figure 13.20 **People commencing a CACP within one or three months of their ACAT assessment, 2006-07**



Source: DoHA (unpublished); table 13A.37.

Appropriateness — assessed longer term care arrangements

'Assessed longer term arrangements' is an indicator of the appropriateness of aged care services (box 13.12) and measures the proportion of clients referred to community care, compared with residential care.

Box 13.12 **Assessed longer term living arrangements**

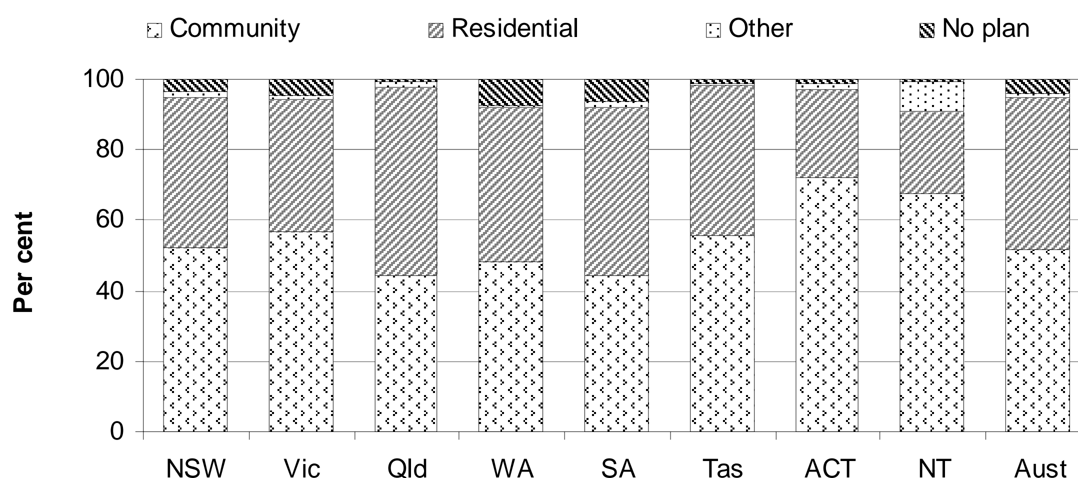
'Assessed longer term living arrangements' is an indicator of the appropriateness of aged care services in referrals. The indicator measures how effectively clients are allocated to the services that best meet their needs.

This indicator is defined as the proportion of ACAT clients recommended to remain at home or in residential care (permanent or respite). (Aged care assessments are mandatory for admission to residential care or for receipt of a CACP or an EACH package.)

The results for this indicator show the distribution of recommended living arrangements of ACAT clients in each jurisdiction. Differences in recommendations across jurisdictions may reflect external factors such as geographic dispersion of clients and service availability, but also client preferences and views on the types of client best served by community-based services. The distribution of ACAT recommendations for various living arrangements are influenced by the degree to which any pre-selection process refers people requiring residential care to ACATs for assessment. Jurisdictions with lower overall assessment rates may operate a filtering process to focus assessments on individuals who are more likely to require residential care.

The national proportion of ACAT clients approved for residential care in 2005-06 was 43.0 per cent and the proportion recommended to remain in the community was 51.8 per cent. No long term plan was made for 3.7 per cent, which included deaths, cancellations and transfers. These proportions varied across jurisdictions (figure 13.21).

Figure 13.21 **Recommended longer term living arrangements of ACAT clients, 2005-06[a]**



[a] 'No plan' includes deaths, cancellations and transfers.

Source: Aged Care Assessment Program National Data Repository (unpublished); table 13A.38.

Appropriateness — targeting

A 'targeting' indicator has not yet been developed (box 13.13).

Box 13.13 Targeting

The Steering Committee has identified 'targeting' as an indicator of appropriateness. It will be developed for reporting in the future.

Appropriateness — unmet need

'Unmet need' is an indicator of the appropriateness of aged care services in meeting clients needs (box 13.14).

Box 13.14 Unmet need

'Unmet need' is an indicator of the appropriateness of aged care services. The indicator measures the extent to which demand for services to support older people requiring assistance with daily activities is met.

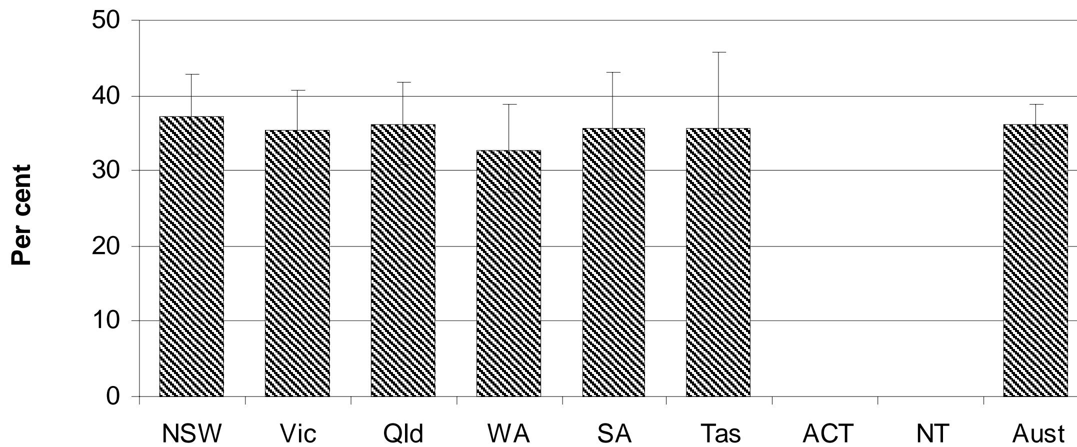
Defining and determining the level of need at an individual level, let alone at a population level, is complex. Perceptions of need and unmet need are often subjective. Data for this indicator are drawn from the ABS 2003 Survey of Disability, Ageing and Carers and reflect people aged over 70 years who self-identified as having a need for assistance with at least one everyday activity, and the extent to which that need was met (fully, partly or not at all).

While low rates of unmet need are desirable, direct inferences about the demand for services from these data need to be made with care, because the data do not:

- reveal the intensity of care required by those who identify an unmet need — there is no indication of whether the need can readily be met informally or by formal home care, or whether the person may require residential care
- reflect the degree of unmet demand for a specific type of service. Differences across jurisdictions in the proportion of unmet need can reflect different policy approaches to targeting services. Some governments may choose to focus on those with the greatest degree of need for care and on fully meeting their needs. By contrast, other governments may choose to provide a lower level of service to a greater number of people, while only partly meeting the needs of those with the greatest need for care. Both policy approaches to the targeting of services are valid
- reflect the past and possible future duration of the need — that is, whether it is long term or transitory
- reflect whether the need relates to a disability support service, aged care service or health care.

Of those persons aged 70 years or over in 2003, who were living in households and who self-identified as having a need for assistance with at least one everyday activity, over one third (36.1 per cent) reported that their needs for assistance were not fully met (figure 13.22).

Figure 13.22 **Percentage of older persons needing assistance with at least one everyday activity whose need was not fully met, 2003[a, b, c, d]**



[a] Aged 70 years or over, living in households. [b] Australian total includes data for the ACT and the NT. [c] Data for ACT and NT not available. [d] Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: ABS 2003 Survey of Disability, Ageing and Carers (unpublished); table 13A.67.

Appropriateness — long term aged care in public hospitals

'Long term aged care in public hospitals' is an indicator of the appropriateness of aged care services (box 13.15).

Box 13.15 **Long term aged care in public hospitals**

'Long term aged care in public hospitals' is an indicator of the appropriateness of care. Hospital inpatient services are geared towards shorter periods of care aimed at addressing serious illness or injury, or diagnosis, and are a less effective form of care for older people who cannot live independently in the long term.

The proxy measure for this indicator is defined as the proportion of completed hospital separations for people aged 70 years and over plus Indigenous people aged 50–69 years where:

- the care type was maintenance and
- the diagnosis (either principal or additional) was either 'awaiting admission to residential aged care' or 'no-one to provide care at home' and
- where the length of stay was 35 days or longer

as a proportion of all such separations.

A low proportion of stays of 35 days or more is desirable.

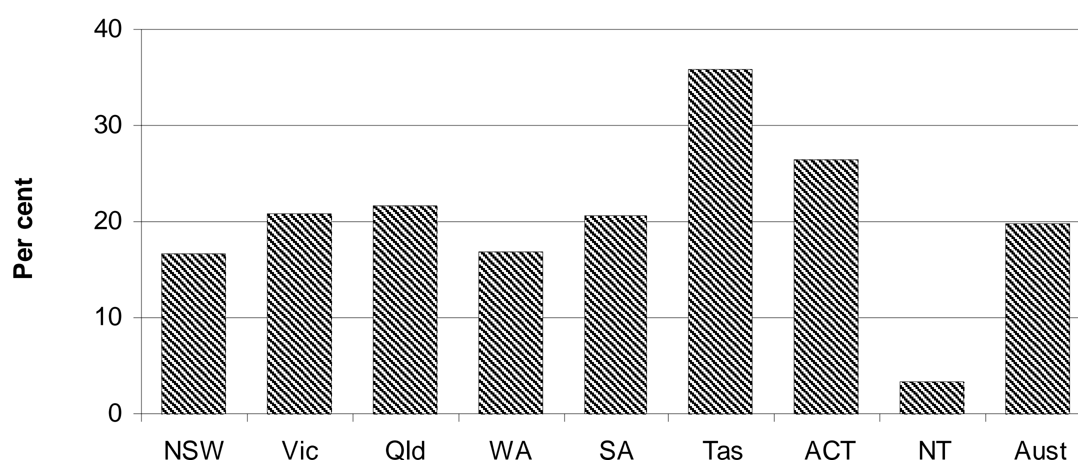
These data should be interpreted with care.

- Patients who have not completed their hospital stay are not reported in these data.
- Although the diagnosis codes reflect a care type, they do not determine a person's eligibility for residential aged care (this is determined by an ACAT assessment) or necessarily reliably reflect access issues for residential aged care from the acute care sector.
- Diagnosis codes may not be applied consistently across jurisdictions or over time.
- Data about hospital separations do not necessarily reflect the full length of hospital stay for any individual patient. If a change in the type of care occurs during a patient's hospital stay (for example, from acute to maintenance) then the data report two separations for that patient.
- The code 'no-one to provide care at home' may also be used for respite care for aged care residents or those receiving community care and some jurisdictions may have a high proportion of this type of use. This is particularly relevant in some rural areas where there are few alternative options for these clients.
- These data do not necessarily reflect alternative strategies in place by states and territories to manage the older person into appropriate residential aged care facilities from acute care hospitals.

The measure above is regarded as a proxy measure, as the desired measures (utilising appropriate linked hospital separations and ACAT approvals) are not available at this time. Work is underway to improve available data sets and the Steering Committee will continue to develop the indicator and associated measures for future Reports.

The proportion of separations for patients aged 70 years and over plus Indigenous people aged 50–69 years who had a care type of maintenance with a diagnosis (either principal or additional) of either ‘awaiting admission to residential aged care’ or ‘no-one to provide care at home’, and whose separation was 35 days or longer was 19.9 per cent nationally in 2005-06. This proportion varied across jurisdictions (figure 13.23). These data reflect only a small proportion of all public hospital separations for patients aged 70 years and over plus Indigenous people aged 50–69 years (11 222 separations of a total of 1.3 million nationally) (table 13A.70).

Figure 13.23 **Proportion of long term separations for aged care patients, in public hospitals, 2005-06**[a, b, c, d, e, f, g]



[a] Data are for hospital separations with a care type of maintenance and a diagnosis (either principal or additional) of either ‘awaiting admission to residential aged care’ or ‘no-one to provide care at home’ and where the separation lasted 35 days or longer. [b] Age of patients is 70 years and over, plus Indigenous patients 50–69 years. [c] Although the diagnosis codes reflect a care type, they do not determine a persons eligibility for residential aged care. [d] Diagnosis codes may not be applied consistently across jurisdictions or over time. [e] These data only account for completed unlinked separations. [f] The code ‘no-one to provide care at home’ may also be used for respite care for either residential or community care patients. [g] An individual patient may have multiple hospital separations during a single hospital stay – for example, if a change in the type of care occurs during a patient’s hospital stay. Data on length of stay relate to each separation and not the whole hospital stay.

Source: AIHW (unpublished); table 13A.70.

Appropriateness — intensity of care

‘Intensity of care’ is an indicator of the appropriateness of aged care services (box 13.16).

Box 13.16 **Intensity of care**

'Intensity of care' is an indicator of appropriateness, reflecting the proportion of residents who remain in the same residential aged care facility as their care needs increase from low care to high care. The Aged Care Act aims explicitly to encourage 'ageing in place' to increase choice and flexibility in residential aged care service provision (box 13.5).

This indicator needs to be viewed from the perspective of the system as a whole. The implication of ageing in place is that some places that were allocated for low care will be occupied by high care residents (or, conversely, allocated for high care and occupied by low care residents). Information about the use of operational residential aged care places is provided to demonstrate the impact of ageing in place on the aged care service system over time.

Higher rates of ageing in place are desirable, in the context of a flexible system that also meets the need for low level care either in residential facilities or in the community.

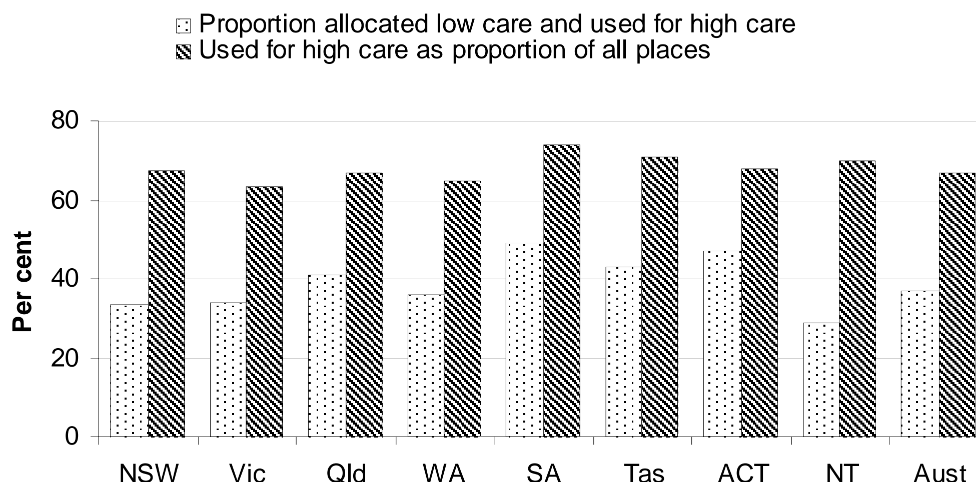
From June 2004 to June 2007 there was a steady increase in the proportion of people who stayed in the same residential aged care service when changing from low care to high care, from 66.7 per cent to 77.8 per cent nationally (figure 13.24). In June 2007 the proportion was higher in inner regional areas (81.5 per cent), outer regional areas (79.8 per cent) and remote areas (88.3 per cent) than in major cities (76.1 per cent) and very remote areas (39.3 per cent) (table 13A.55).

Figure 13.24 **Proportion of residents who changed from low care to high care and remained in the same aged care service, June**

Source: DoHA (unpublished); table 13A.55.

Nationally, 36.9 per cent of low care places in 2006-07 were occupied by residents with high care needs. The proportion of all operational places taken up by residents with high care needs made up 66.7 per cent (figure 13.25). These data are provided by remoteness area in table 13A.58.

Figure 13.25 **Utilisation of operational residential places, 30 June 2007**



Source: DoHA (unpublished); table 13A.58.

Quality — compliance with service standards for residential care

'Compliance with service standards for residential care' is an indicator of quality of aged care services (box 13.17).

Box 13.17 **Compliance with service standards for residential care**

'Compliance with service standards for residential care' is an indicator of the quality of care. The purpose of the indicator is to monitor the extent to which residential care facilities are complying with accreditation or certification standards. The extent to which they comply implies a certain level of care and service quality.

Two measures are reported against this indicator:

- the extent to which accreditation standards are met
- the number of residents per room.

(Continued on next page)

Box 13.17 **(Continued)**

Accreditation standards

Since 2001, each Australian Government funded residential service has been required to meet accreditation standards (which comprise 44 expected outcomes). The accreditation indicator reflects the period of accreditation granted. High rates of approval for three year accreditation are desirable.

The accreditation process is managed by the Aged Care Standards and Accreditation Agency (ACSAA). A Service must apply to ACSAA for accreditation and its application is based on a self-assessment of performance against the accreditation standards.

Following a residential service applying for accreditation, a team of registered quality assessors reviews the application, conducts an onsite assessment and prepares a report based on these observations, interviews with residents, relatives, staff and management, and relevant documentation.

An authorised decision maker from ACSAA then considers the report, in conjunction with any submission from the residential service and other relevant information (including information from DoHA) and decides whether to accredit and, if so, for how long.

Number of residents per room

The number of residents per room is an output indicator of quality. Lower rates of residents per room are generally desirable because they imply a higher service quality of accommodation.

As part of the Australian Government's certification requirements for residential aged care buildings, by 31 December 2008 every service that existed prior to July 1999 will be required to have no more than four residents accommodated in any room, no more than six residents sharing each toilet and no more than seven residents sharing each shower. For new buildings planned or built since July 1999, an average for the whole service of not more than 1.5 residents per room is required. No room may accommodate more than two residents, there must be no more than three residents per toilet and no more than four residents per shower or bath.

Accreditation decisions and other information relating to the accreditation standards, the aged care standards and ACSAA are publicly available via the ACSAA's web site (www.accreditation.aust.com). The accreditation process is summarised in box 13.17.

At 30 June 2007, 92.2 per cent of residential aged care services had been granted an accreditation approval for a period of three years or more. This proportion varied across jurisdictions (table 13.9).

Table 13.9 **Accreditation decisions on residential aged care services, 30 June 2007[a]**

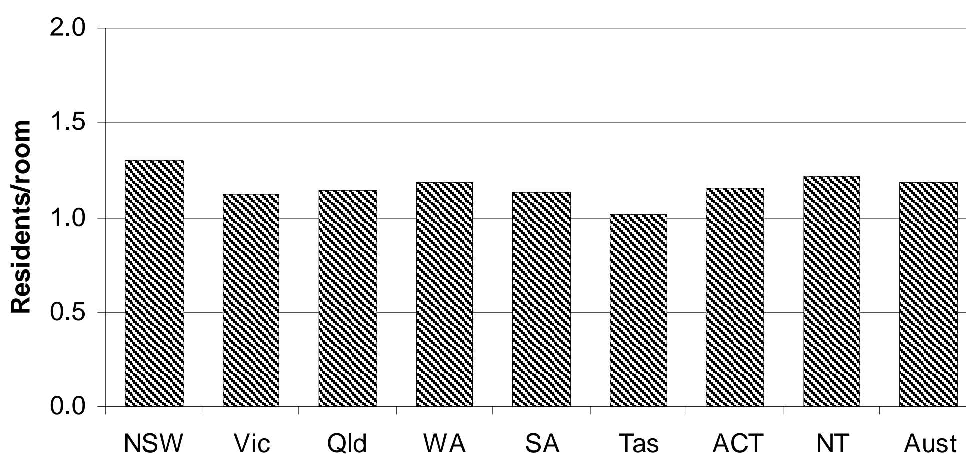
	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Accreditation period										
<2 years	%	2.0	4.1	8.0	3.9	4.2	4.5	8.7	–	4.1
2 years or more (but <3 years)	%	2.3	2.4	8.6	3.5	3.8	3.4	–	6.7	3.7
3 years or more	%	95.8	93.5	83.5	92.5	92.0	92.1	91.3	93.3	92.2
Total	%	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Accredited services	no.	918	805	490	255	288	89	23	15	2 886

[a] NT data will be variable due to small numbers. – Nil or rounded to zero.

Source: ACSAA (unpublished); table 13A.41.

Existing services are required to meet privacy and space requirements by 2008. Since 2001, all new services must meet these targets from the time of construction. The average number of residents per room at December 2006 was 1.19 nationally (figure 13.26).

Figure 13.26 **Average residents per room in residential aged care facilities, December 2006**



Source: DoHA (unpublished); table 13A.42.

Quality — complaints

'Complaints' is an indicator of the quality of aged care services (box 13.18).

Box 13.18 **Complaints**

‘Complaints’ is a proxy indicator of the quality of care. The indicator monitors the level of complaints received by the Complaints Resolution Scheme (after 30 April 2007, the Complaints Investigation Scheme) in each state and territory. If service recipients make official complaints, they may be dissatisfied with an element of the service provided.

All aged care services are required to have an internal complaints system. Until 30 April 2007, the Aged Care Complaints Resolution Scheme (ACCRS) was the Australian Government system for managing complaints. It was a complaints system run by the DoHA and overseen by the Commissioner for Complaints. The scheme was available to anyone who wished to make a complaint about an Australian Government funded aged care service, including residents of aged care facilities and their families, staff and people receiving CACPs and EACH packages. The indicator presented for this Report measures the number of complaints to the ACCRS per 1000 residents, for the period July 2006–April 2007, and for previous years. A low rate of complaints is desirable.

The rate at which complaints occur can be influenced by the propensity of clients and their families or service staff to complain, their knowledge of the complaints system, and perceptions of the effectiveness of the complaints system. In many cases, complaints may be resolved without the need to involve complaints systems.

From 1 July 2006 to 30 April 2007, the Complaints Resolution Scheme received approximately 1229 new complaints, compared with 1260 in 2005-06 (table 13A.43). The number of complaints registered per 1000 residents from 1 July 2006 to 30 April 2007 was 8.0 nationally. This varied across jurisdictions (figure 13.27).

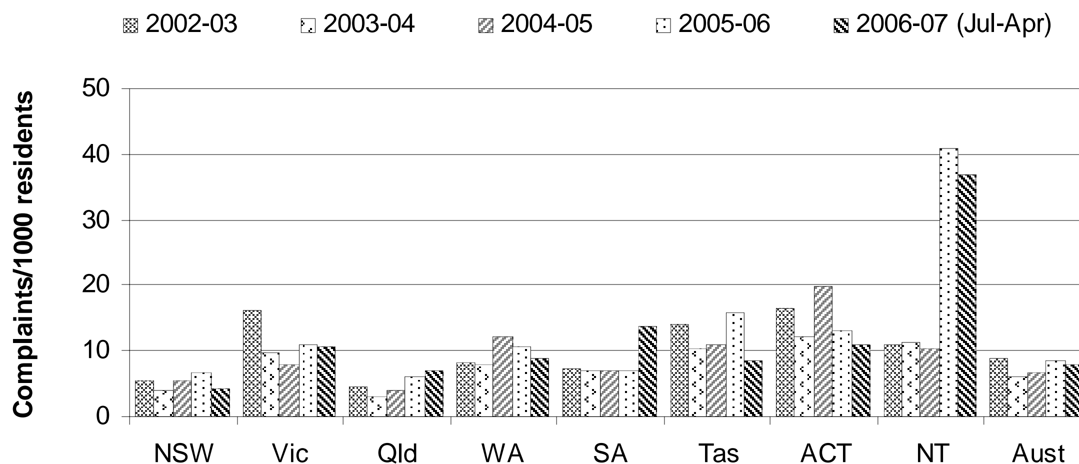
From 1 May 2007, the ACCRS was replaced by the Complaints Investigation Scheme (CIS), which has a greater capacity to accept complaints and other aged care related information. The CIS is a service which investigates any potential breach of an approved provider’s responsibilities in residential and community care; requires the service provider, where appropriate, to take action; and is able to refer issues that may be more appropriately dealt with by others (for example, police, nurses and medical registration boards).

Also from 1 May 2007 a new independent Aged Care Commissioner was appointed to examine certain decisions made by the CIS, to examine complaints made about the CIS’s process and the conduct of the Aged Care Standards and Accreditation Agency as well as any persons carrying out audits or making support contacts under the Accreditation Grant Principles 1999.

In the period 1 May–30 June 2007, DoHA dealt with 1170 matters which were within the scope of the CIS, not all of which were complaints. The increased

number of calls reflects the broader nature of the new scheme, which deals with information from a range of sources (DoHA, unpublished).

Figure 13.27 **Aged Care Complaints Resolution Scheme complaints per 1000 residents**[a, b]



[a] 2006-07 data represent complaints for the period July 2006 – April 2007. Therefore data for rates per 1000 residents for 2006-07 are not comparable with earlier years. [b] NT data will be variable due to small numbers. The number of complaints varied from 4 to 16 between 2002-03 and 2006-07.

Source: DoHA (unpublished); table 13A.43.

Quality — compliance with service standards for community care

The indicator 'compliance with service standards for community care' is an indicator of the quality of aged care services (box 13.19).

Box 13.19 **Compliance with service standards for community care**

'Compliance with service standards for community care' is an indicator of quality. The indicator monitors the extent to which individual agencies are complying with service agreement standards.

The HACC national service standards provide HACC funded agencies with a common reference point for internal quality control by defining aspects of service quality and expected outcomes for consumers. States and territories are required to include the standards in all service agreements. The HACC national service standards instrument has been developed to measure through a service appraisal process the extent to which individual agencies are complying with the standards. Monitoring and compliance with the standards are now a major part of service reviews.

(Continued on next page)

Box 13.19 **(Continued)**

The indicator measures the number of HACC agencies appraised against the standards divided by the total number of HACC agencies. This indicator also measures the percentage of individual agencies that comply with the service standards, through data on the outcomes of service standard appraisals. It should be noted that the standards are not an accreditation system.

A total of 3207 HACC agencies were identified for appraisal over the three year cycle 2001-02 to 2003-04. The number of these agencies appraised was 2711 (85 per cent). This proportion varied across jurisdictions (table 13.10). The outcomes of these appraisals was a national average score of 16.0 out of 20 (table 13.11). In the course of the initial three year appraisal process, in the absence of detailed national implementation guidelines, each State and Territory adopted individual approaches when assessing agencies against the National Service Standards Instrument (State and Territory governments unpublished).

The next appraisal cycle will cover the period 2005-06 to 2007-08. Data from this appraisal cycle are anticipated to be available for the 2009 Report.

Table 13.10 **HACC National Service Standards appraisals over the three year cycle ending 2003-04[a]**

	Unit	*NSW*[b]	*Vic*	*Qld*[c]	*WA*[d]	*SA*[e]	*Tas*[f]	*ACT*	*NT*[g]	*Aust*
Appraisals	no.	1 095	481	706	168	161	58	31	11	2 711
HACC agencies	no.	1 487	481	730	178	161	58	31	81	3 207
Proportion of agencies assessed	%	74	100	97	94	100	100	100	14	85

a Reports provisional data that have not been validated and may be subject to revision. Not all HACC agencies were required to undergo external assessment, and some are exempt, so the number of HACC agencies may be higher than those reported. **b** The total number of agencies identified for NSW are those targeted in the appraisal plan as at 2001-02. The Integrated Monitoring Framework implemented by NSW in 2005-06 will cover new agencies since that time. NSW completed all remaining appraisals in 2004-05. **c** Reviews in Queensland are conducted by an external agency on a three year contract. In Queensland there were 730 agencies at the beginning of the contract period. There were 808 agencies in Queensland at the commencement of the 2004-05 contract. **d** The number of WA agencies appraised is lower than expected because some agencies amalgamated. **e** SA has an additional 21 exempt agencies. **f** Two agencies were exempt from the appraisal process in Tasmania. **g** NT data are variable due to small numbers.

Source: State and Territory governments (unpublished).

Table 13.11 **HACC National Service Standards results of appraisals over the three year cycle ending 2003-04[a, b, c]**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
High (17.5 – 20)	no.	607	157	276	108	51	12	25	na	1 236
Good (15 – 17.4)	no.	337	168	191	28	37	11	2	na	774
Basic (10 -14.9)	no.	132	123	142	34	50	24	3	na	508
Poor (less than 10)	no.	19	33	97	4	23	11	1	na	188
Average score	no.	17.2	15.5	14.8	17.0	14.5	13.2	17.9	na	16.0

a Reports provisional data that have not been validated and may be subject to revision. Not all HACC agencies were required to undergo external assessment, and some are exempt, so the number of HACC agencies may be higher than those listed. **b** The results of the appraisals will reflect the individual approaches adopted by each State and Territory. **c** For details about the method of determining the average score, see table 13A.66. **na** Not available.

Source: State and Territory governments (unpublished); table 13A.66.

Quality — client appraisal of service standards

The indicator 'client appraisal of service standards' has not yet been developed (box 13.20).

Box 13.20 **Client appraisal of service standards**

'Client appraisal of service standards' is an indicator of the quality of aged care services. This indicator aims to monitor client satisfaction with services received. The Steering Committee has identified this indicator for development and reporting in future.

Efficiency

Inputs per output unit — cost per ACAT assessment

'Cost per ACAT assessment' is an indicator of the efficiency of aged care services (box 13.21).

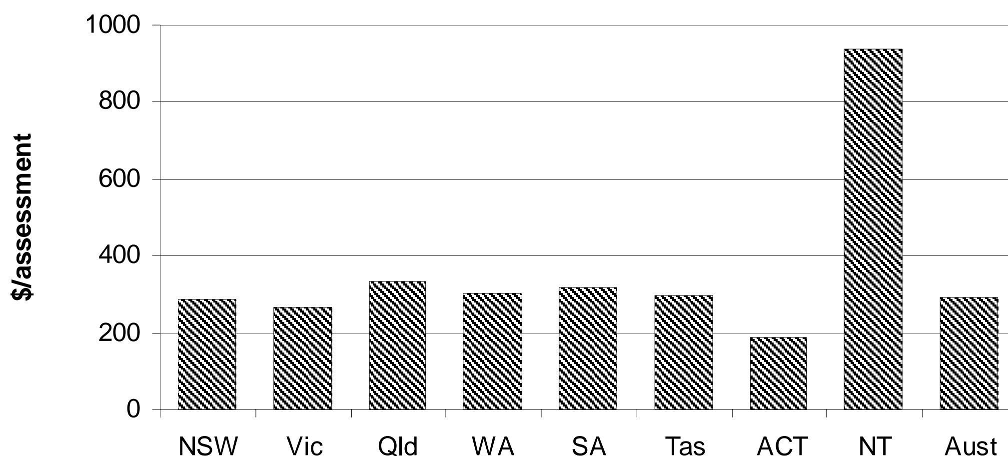
Box 13.21 **Cost per ACAT assessment**

A proxy efficiency indicator, 'cost per ACAT assessment', has been developed as work in progress to measure efficiency for ACATs. It is defined as expenditure on ACATs divided by the number of ACAT assessments completed.

This indicator needs to be interpreted with care. While high or increasing expenditure per assessment may reflect deteriorating efficiency, it may also reflect changes in aspects of the service (such as greater time spent with clients) or changes in the characteristics of clients (such as their geographic location). Similarly, low or declining expenditure per assessment may reflect improving efficiency or less time spent with clients (for example). This indicator includes only Australian Government expenditure, although states and territories also contribute to the cost of ACAT assessments.

Australian Government expenditure per aged care assessment during 2005-06 averaged $294 nationally (figure 13.28). The cost per assessment is calculated using the total number of assessments and therefore includes clients aged less than 70 years.

Figure 13.28 **Australian Government expenditure on aged care assessments, per assessment, 2005-06 (dollars)**[a, b, c]



[a] Only includes Australian Government expenditure on ACAT. [b] ACAT referrals and operations vary across jurisdictions. [c] The high cost for each assessment in the NT may be influenced by the remoteness of people requiring assessments, clients having English as a second or third language, and a lack of supporting health and community services infrastructure to assist with assessments.

Source: DoHA (unpublished); table 13A.56.

Inputs per output unit — expenditure per head of target population

'Expenditure per head of target population' is a proxy indicator of the efficiency of aged care services (box 13.22).

Box 13.22 Expenditure per head of target population

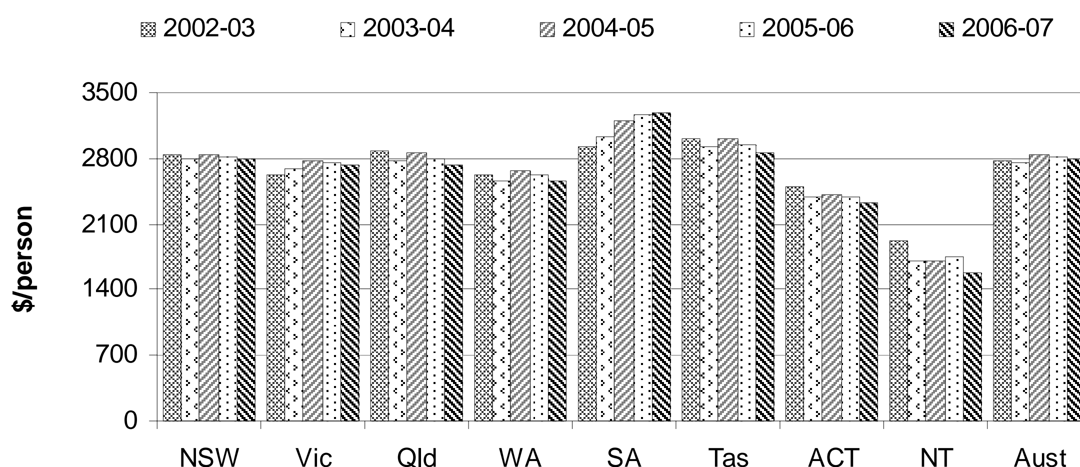
A proxy indicator of efficiency is 'expenditure per head of target population'. The indicator is defined as government inputs (expenditure) divided by the number of people aged 70 years or over plus Indigenous people aged 50–69 years. Expenditure per person in the target population is reported for three main service types: residential services, CACP and HACC services.

This indicator needs to be interpreted with care. While high or increasing expenditure per person may reflect deteriorating efficiency, it may also reflect changes in aspects of the service (such as better quality of services) or in the characteristics of clients receiving the service (such as their geographic location or level of care need). Similarly, low or declining expenditure per assessment may reflect improving efficiency or a decrease in service standards.

Australian Government real expenditure by both DoHA and DVA on residential care services per person aged 70 years or over plus Indigenous people aged 50–69 years was little changed between 2002-03 ($2775) and 2006-07 ($2788) (figure 13.29). If the payroll tax supplement paid by the Australian Government is excluded, this expenditure decreased nationally from $2800 in 2004-05 (the earliest year the payroll tax supplement is included in the Report for this service) to $2734 in 2006-07 (table 13A.51).

DoHA expenditure on residential care per person aged 70 years or over plus Indigenous people aged 50–69 years in 2006-07 was $2359 including the payroll tax supplement and $2312 excluding the payroll tax supplement (table 13A.50). DVA expenditure on residential care per person aged 70 years or over plus Indigenous people aged 50–69 years in 2006-07 was $429 including the payroll tax supplement and $422 excluding the payroll tax supplement (table 13A.46).

Figure 13.29 **Australian Government (DoHA and DVA) real expenditure on residential services per person aged 70 years or over plus Indigenous people aged 50–69 years (2006-07 dollars)**[a]

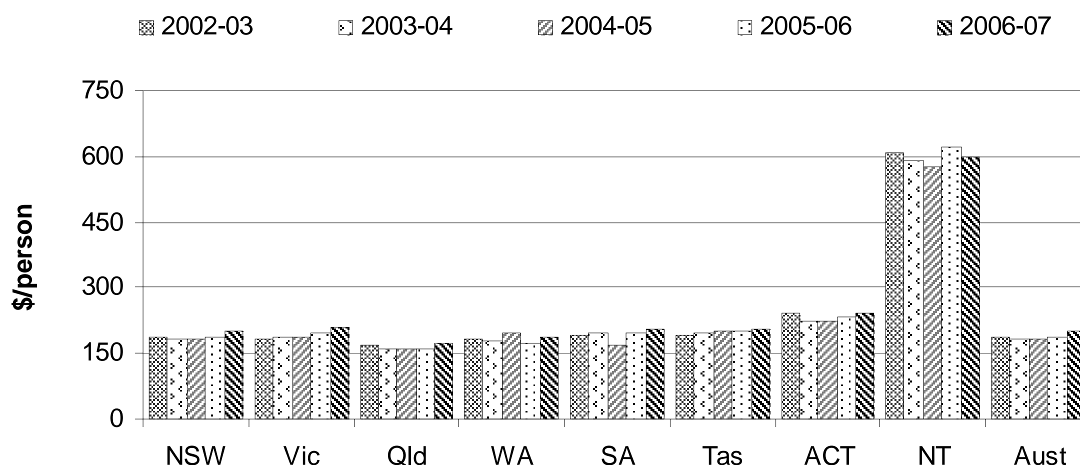


[a] Includes a payroll tax supplement provided by the Australian Government. Actual payroll tax paid may differ.

Source: DoHA (unpublished); DVA (unpublished); table 13A.51.

Australian Government expenditure on CACPs per person aged 70 years or over plus Indigenous people aged 50–69 years was similar in most jurisdictions except the NT in 2006-07. Nationally, real expenditure per person aged 70 years or over plus Indigenous people aged 50–69 years increased from $186 in 2002-03 to $200 in 2006-07 (figure 13.30).

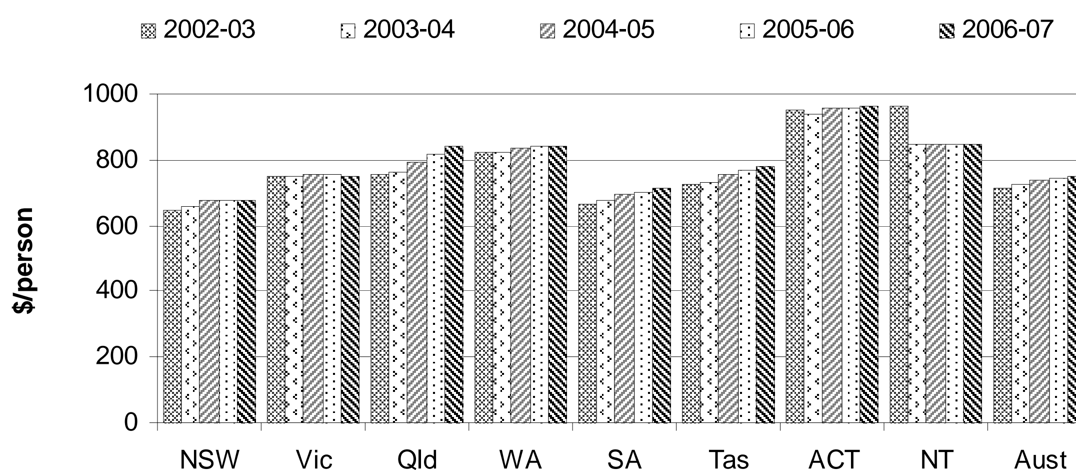
Figure 13.30 **Australian Government real expenditure on CACP services per person aged 70 years or over plus Indigenous people aged 50–69 years (2006-07 dollars)**



Source: DoHA (unpublished); table 13A.54.

Australian, State and Territory government expenditure on HACC services per person aged 70 years or over plus Indigenous people aged 50–69 years varied across jurisdictions. Nationally, real expenditure increased from $715 in 2002-03 to $751 in 2006-07 (figure 13.31). These figures reflect expenditure against the population regarded as the proxy for this chapter (see section 13.1), which is not the same as the HACC target population. Expenditure per person in the HACC target population is reported in table 13A.52.

Figure 13.31 **Australian, State and Territory government real expenditure on HACC services per person aged 70 years or over plus Indigenous people aged 50–69 years (2006-07 dollars)[a, b, c]**



[a] People aged 70 years or over plus Indigenous people aged 50–69 years are not the HACC target population. Expenditure per person and definition of the HACC target population are contained in table 13A.52. [b] This figure only represents expenditure under HACC Amending Agreements. [c] Reports provisional HACC data that have not been validated and may be subject to revision.

Source: DoHA (unpublished); table 13A.53.

Outcomes

Outcomes are the impact of services on the status of an individual or group (while outputs are the actual services delivered) (see chapter 1, section 1.5).

Three outcomes indicators have been identified for development and reporting in future:

- social participation in the community (box 13.23)
- maintenance of individual functioning (box 13.24)
- enabling people with care needs to live in the community (box 13.25).

Social participation in the community

Box 13.23 Social participation in the community

'Social participation in the community' is an indicator of the wellbeing and independence of frail older people. An indicator will be developed to show the extent to which older people participated in community, cultural or leisure activities. Higher rates of participation in the community are more desirable.

The Steering Committee has identified this indicator for development and reporting in future.

Maintenance of individual functioning

Box 13.24 Maintenance of individual functioning

'Maintenance of individual functioning' is an indicator that reflects the objective for aged care services to promote the health, wellbeing and independence of frail older people. The indicator is defined as:

- maintenance of, or minimised decline in, residents' level of functioning reflected by a movement of clients to a higher level of need as indicated by a change in classification on the resident classification scale
- length of stay in residential care for a given level of frailty or age at entry.

The Steering Committee has identified this indicator for development and reporting in future.

Enabling people with care needs to live in the community

Box 13.25 Enabling people with care needs to live in the community

'Enabling people with care needs to live in the community' is an indicator that reflects the objective of community care to delay entry to residential care and will measure levels of dependency on entry to residential care for those who have been receiving community care.

The Steering Committee has identified this indicator for development and reporting in future.

13.4 Future directions in performance reporting

For several aspects of aged care services, indicators are not fully developed and there is little performance reporting. Priorities for the future include:

- continued improvement of efficiency indicators, including for HACC services and assessment services
- improved reporting of waiting times for residential aged care
- improved reporting of long term aged care in public hospitals
- development of outcome measures.

13.5 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this chapter. Appendix A contains data about each jurisdiction that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status).

Australian Government comments

“The Commonwealth is keen to develop a stronger focus in the Review on the people for whom services are provided. In round numbers, 800 000 older people received aged care services in 2006-07. Of these, over half a million received support while still living at home through the HACC Program, jointly funded by the Commonwealth, states and territories. HACC also provided services to another quarter of a million people aged less than 70, most of whom are younger people with disabilities. These are not counted in the 800 000 people receiving aged care.

Some 55 373 people received Commonwealth CACPs or EACH packages – equivalent to 2.9 per cent of people aged 70 years or over (as at 30 June 2006 from the 2006 Census).

A further 202 502 people received permanent residential aged care at some stage during 2006-07 — equivalent to 10.6 per cent of people aged 70 years or over. 38 806 people received residential respite care during 2006-07 — equivalent to 2.0 per cent of people aged 70 years or over.

Some 6511 people received care in 2006-07 under the Transition Care Program, jointly funded by the Commonwealth and the states and territories.

During the 2006-07 financial year, over 80 000 veterans and war widows/widowers received either domestic assistance, personal care, home and garden maintenance, respite care or a combination of these services through the VHC program.

In accordance with the Commonwealth Procurement Guidelines, and to ensure the continuation of VHC services, the Department of Veterans’ Affairs conducted an open procurement processes in 2006 for the selection of assessment agencies and service providers, with the result that the Department now contracts with over 190 organisations around Australia to assess clients for VHC services or deliver those services.

The Department also contracted with the University of Wollongong in early 2007 to conduct an independent review of the VHC program to identify what adjustments, if any, may be necessary to ensure the program continues to meet the needs of veterans and war widows/widowers over the coming years. In addition to VHC, eligible veterans, serving and former defence force members, their war widows/widowers and dependents have access to a wide range of health and other care services that promote and maintain self-sufficiency, wellbeing and quality of life.”

New South Wales Government comments

" The NSW Government is committed to providing quality services for older people and their carers which promote their health and wellbeing, optimise their independence and participation in community life, and facilitate their timely access to appropriate care and support.

This commitment is strongly reflected in both the State Plan and the State Health Plan ('A New Direction for NSW — Towards 2010') which were developed after extensive community consultation.

NSW is pursuing a number of strategies to improve the planning and delivery of care for frail older people. A key priority is to strengthen the integration of services across a range of providers and settings to improve the older person's journey through the health and aged care continuum.

An *Interagency Protocol for Responding to Abuse of Older People* was developed which emphasised the principle that older people are entitled to the same level of protection as any other member of the community. The Protocol details a framework and provides information and resources for agencies and staff to assist them to better respond to the abuse of older people.

Additional resources have been allocated to services that enable older people with multiple care needs to return home from hospital safely and without unnecessary delay. These same services also provide support in the home to minimise the risk of avoidable re-admission to hospital.

The specialised aged care services that have been established in public hospital Emergency Departments continue to support the appropriate care and management of older people in these busy, high pressured settings.

The NSW Carers Program funds Non Government Organisations Grants, Carers Support Services in Area Health Services, services for carers of people with mental illness, peak body funding to Carers NSW through NSW Department of Health and a young carers project through the NSW Department of Ageing Disability and Home Care.

In 2006-07 the NSW HACC program continued to expand with the allocation of over $31 million in additional funding, bringing the total budget to more than $479 million.

Planning for the HACC program in 2006-07 continued toward a more strategic approach with the identification of regional priorities and strategies over the long, medium and short term. NSW priorities for growth funding in 2006-07 included an emphasis on basic support services and improved delivery to the HACC special needs groups. Growth funding highlights included increases in social support and transport services to improve clients' and carers' access to the community and reduce social isolation.

Following major reviews, guidelines for the HACC service types of case management, social support, respite, centre-based day care, home maintenance and home modification were developed. "

Victorian Government comments

“In 2006-07, Victoria has emphasised the individual at the centre of the care domain in further developing innovative approaches to meeting the challenges of providing aged care across the State. As in the past, Victoria continues to build its community-based services to meet the growing care needs of frail older people.

Victoria has been working with the Commonwealth to implement the 2006 COAG agreement *to simplify entry and assessment processes for the HACC Program*. Two Access Point Demonstration Projects have been established. The Access Point capacity in Victoria will be an easily identifiable and highly visible and well recognised point of contact for those frail older people, younger people with disabilities, their carers, families and friends who do not know where to go for initial information and assistance, including (if required) a referral for an assessment.

Younger people in residential aged care will benefit from alternative accommodation and support through the *my future my choice* initiative. A 10-bed unit to give younger people with a disability an alternative to living in residential aged care will be the first specialist home to be provided under this initiative.

Residents in Victoria’s public sector residential aged care facilities are being supported to maintain their social connections with their community through the Victorian Government’s *Count Us In!* initiative. This initiative promotes social inclusion for people living in residential aged care, helping to ensure that older citizens who move into this type of care can continue throughout their lives as valued members of their communities.

Residential aged care residents also benefited from new legislation and guidelines for medication management. The provisions extend coverage to all high care residents without regard to the type of facility, providing protection to a wider group while at the same time making better use of professional resources.

A number of innovative programs that provide outreach services have been funded. Outreach eye care and oral health services for people living in Supported Residential Services (SRS) facilities will be provided in a van fitted out with optometrical equipment to enable vision tests to be done on location at each SRS facility. Oral health services will involve local community health centre staff, with oral assessments, being completed on site at SRS facilities.

Innovation has continued to occur in the area of support for people with dementia and their families and carers. Funds have been made available for projects to develop dementia care information and/or services to meet the needs of people from Aboriginal and culturally and linguistically diverse backgrounds.”

Queensland Government comments

“Queensland has continued to support the programs and services that improve the quality of life of older people and has worked closely with the Australian Government and negotiated the HACC Amending Agreement during 2006-07.

Queensland received its final provisional approval of 78 transition care places bringing its allocation of places to 351. As at 30 June 2007, 249 of these places were operational across both residential and community settings. State government expenditure for the Transition Care Program in 2006-07 was $2.4 million.

With funding provided by the Australian Government through COAG, Queensland Health implemented a number of local based initiatives through the Long Stay Older Patients Program. These initiatives included capital works at the Gatton Hospital, interim care at Cairns and Townsville and Hospital in the Nursing Home at Bundaberg. Significant planning has also been undertaken in a number of sites across Queensland to expand the Multi-Purpose Health Service (MPHS) program.

Queensland continues to support 21 State owned and operated residential aged care facilities. In 2006-07, the State government contribution to the operations of these facilities was $48.4 million from an overall expenditure of $121.8 million. Other revenue was received from the Australian Government, resident charges and other miscellaneous sources to supplement the Queensland Government contribution. In addition as part of its $120 million redevelopment program, $20.7 million was expended on the upgrade of 10 of its residential aged care facilities.

During 2006-07, 37 365 aged care assessments were undertaken in Queensland through the Aged Care Assessment Teams jointly funded by both levels of government. In addition four projects have been progressed under funding provided through COAG in relation to the improvement of consistency and timeliness of aged care assessments. These projects are the development of a business case model for ACATs, supporting the ACAT workforce, developing of protocols to improve access by Indigenous and people from culturally and linguistically diverse background to ACAT assessments and the provision of infrastructure to improve the collection and quality of data.

In recognition of the need to protect older residents in residential aged care facilities from elder abuse, Queensland Health has ensured that criminal history checks are undertaken on all staff in these facilities. A training program including protocols and mechanisms to improve the identification and reporting of cases of elder abuse in residential aged care facilities is being developed.”

Western Australian Government comments

“The approach to services for older people continues to develop in line with the ongoing reform agenda occurring across the WA health system. The WA health system change and redesign incorporates the shared principles outlined in *A Healthy Future for Western Australians: Report of the Health reform Committee.*

In response to the change in policy direction an Aged Care Network has been set up to develop the *Model of Care for Older Persons* that relates to the continuum of care service delivery across the WA health system and beyond. The conceptual and strategic framework for the State Aged Care Plan for WA 2003–2008 has guided the work of the Aged Care Network since its inception in February 2006.

The *Model of Care for Older Persons* focuses on the need to promote independence, well-being and quality of life for the older person with a greater emphasis on prevention and promotion programs that encourage self management. It includes a partnership approach across the community, acute and residential aged care sectors, including improved coordination and communication processes. It is also being used to inform the development of the service specific models with the initial focus on Dementia, Delirium, Falls, Parkinson’s, Amputees, Rehabilitation, Ortho-Geriatrics and Geriatric Evaluation Management.

Implementation of the National Action Plan (NAP), (Health Care of Older Australians Standing Committee) in WA is another key component of work being undertaken to progress system wide coordination for older people accessing aged care services thorough the establishment of an eldercare pathway. This work is being supported in part by strengthening existing hospital strategies, including safe and effective discharge from emergency departments, improved patient and carer health outcomes, early identification, assessment and care planning for older people at risk and implementing best practice clinical resources developed as part of the NAP.

The WA HACC Program continues to progress development of Access Networks in Esperance (rural), Derby (remote) and the Swan Local Government Area (metropolitan) that will simplify client access, eligibility and assessment processes into community care. Agencies that form part of the Access Network will provide information, initial screening and data collection, with the goal of assisting clients/carers to access the most appropriate referral and support into community care services. Access Network agencies will form part of an interconnected network of community care agencies that deliver services and/or support to frail aged and younger people with disabilities living in the community.

An ‘ACAP Quality Framework’ has been developed and implemented along with some work around strengthening communication with ACATs and ACAT management. These initiatives are expected to provide an effective environment to progress the ACAP COAG initiatives.”

South Australian Government comments

" The Department for Families and Communities through the Office for the Ageing (OFTA) has led the development and implementation of *Improving with Age: Our Ageing Plan for South Australia*. *Improving with Age* is the State Government's blueprint for its response to an increasingly ageing population. Since its launch in February 2006, OFTA has provided over $4 million to kick-start over 40 innovative projects to implement the Ageing Plan. Currently, over 135 State Government initiatives are operating across the state, which are making a difference to the lives of older South Australians.

SA actively participated in the trialling of the Australian Community Care Needs Assessment and the Carers Eligibility Needs Assessment in 2006, with the involvement of non-government and government, country and metropolitan agencies. In 2007, SA identified two sites, one country and one metropolitan, to demonstrate access points for community care. The demonstration sites build on existing infrastructure, but will expand their role across the broader sector.

ACAP projects developed under the COAG initiative of improving timeliness and consistency of assessments have included a review of assessment practices across ACATs, and the development of a Mobile Assessment Response (MAR). The MAR aims to provide support and back-up to teams especially in unforseen circumstances, to improve the availability of particular areas of expertise, and to respond to assessment needs in remote communities.

OFTA is reforming the way that it allocates growth funding to services for frail older people, people with disabilities and carers through the HACC Program. In 2007-08, new funding allocation processes including invited submission and direct allocation were introduced in country regions and for Aboriginal and culturally and linguistically diverse community organisations. The new funding allocation processes have introduced more appropriate and targeted methods of funding disadvantaged groups and have streamlined and simplified administrative processes with benefits to both OFTA and the sector. In 2008-09, new funding allocation processes will be rolled out to metropolitan regions.

SA is currently developing a Triennial Plan for the HACC Program which will commence in 2008-09. The Plan will outline the agreed Australian Government and State Government strategic directions, priorities and allocation of funds for the HACC Program over the triennium. SA has undertaken extensive consultation processes to inform the Triennial Plan, including with peak bodies, key stakeholders, special needs groups, service providers and consumers at a regional and sub-regional level. In particular, the Council on the Ageing SA has been engaged by OFTA to facilitate statewide consumer consultations with older people. "

Tasmanian Government comments

Tasmania's Health Plan, released in May 2007, is an integrated strategy incorporating both acute health services and primary health services. The key focus and objective of *Tasmania's Health Plan* is sustainability. This seeks to ensure that health services are safe, effective and accessible and make the best use of available resources. Aged care and rehabilitation are a defined area for development in the Plan.

A separate and interlinking statewide Rehabilitation Services Review was also commissioned and conducted during 2006-07. It is anticipated that the reforms will enhance specialised health service delivery for older people.

Tasmania's Health Plan includes a greater focus on primary health, increasing health promotion and better management of chronic illnesses. It establishes a new tiered service structure for both primary and acute health, with a change of role for some facilities including reconfiguring under-used and unsustainable district hospital and residential aged care services, with resources redirected to primary health care and home based care services.

Service development and redesign initiatives during 2007 have included:

- ongoing management of the *Tasmanian Post Acute Support Program* providing services to eligible HACC clients
- projects funded under the *Pathways Home Program* supporting education, step down and rehabilitation services
- ongoing implementation of recommended service changes from the *Palliative Care in Tasmania: Current Situation and Future Directions Report*
- implementation of the national Transition Care Program and the COAG Long Stay Older Patient initiative have supported quality development of age friendly principles and practices
- development of a HACC data repository which will include a range of service and client data and be capable of linking and communicating with HACC service providers
- the establishment of a demonstration site, in collaboration with the Australian Government, for simplified entry to community care, including HACC.

The removal of the legacy requiring State governments to supplement non-government operators in respect of former State operated residential aged care places is a welcome initiative. The Tasmanian Government looks forward to continuing to work with the Australian Government in removing the burden associated with those beds that the Tasmanian Government itself continues to operate. The reduced subsidy and consequent need by the Tasmanian Government to top-up funding, increases the financial pressures on those services that, due to their small size and remote location, make them non-viable for other providers.

Australian Capital Territory Government comments

During 2006-07 the ACT Government has remained committed to assisting older people and their carers by providing better access to appropriate services and promoting independence and participation in community life.

access health was launched in 2006-07 by the Minister for Health as a key document to set the future direction of ACT health services for the next three years. *access health* is about ensuring that people have access to the right type of health care. The ACT Government identified priorities include:

- timely access to care
- aged care
- mental health
- chronic disease management
- early childhood and vulnerable families
- Aboriginal & Torres Strait Islander health.

A new purpose built sub and non-acute and psycho-geriatric facility was officially opened in February 2007 boosting the bed and service capacity of ACT public hospitals. The new facility added 28 new sub and non-acute beds to the existing 12 geriatric evaluation management beds at the Calvary Hospital. The facility also provides 20 new psycho-geriatric beds to meet the needs of older people with a mental illness in the ACT and enhance care options.

The Medical Assessment and Planning Unit opened in May 2007. The new Unit aims to improve the older persons experience through the Emergency Department by streamlining admission and intervention processes, facilitating early consultant review, expediting multidisciplinary review and providing better access to more appropriate services.

The ACT also added the Rapid Assessment of the Deteriorating Aged at Risk (RADAR) program to support older people in the community in 2006-07. RADAR provides short term assistance with medical management to an older persons own GP to prevent a hospital admission.

The HACC program was enhanced by an additional $1.8 million in 2006-07 to provide support services to assist people to remain in the community. The focus of additional HACC funding provided additional levels of personal care, social support, home maintenance and domestic assistance. The enhanced service delivery of HACC services in the ACT has provided more options for older people and their carers, and helps avoid premature entry into residential aged care.

Northern Territory Government comments

The unique environmental and socio economic factors in the Northern Territory create specific challenges in the provision of aged care services for both the Northern Territory and Australian Governments, particularly in providing appropriate and sustainable aged care services to remote Indigenous communities. The high proportion of people living in remote settings creates increased cost structures for all services, particularly due to the cost of travel, staff retention and recruitment, and in providing a service to small numbers over large geographical areas.

Data quality remains an ongoing challenge for providers in the Northern Territory, given the need to integrate funds across aged care and disability programs to create viable services, especially in remote communities. Data quality issues can distort results in individual programs. During 2006-07 the Northern Territory consolidated the effort of the previous year in improving the participation rates as well as the quality of the HACC National Minimum Data Set (MDS) from providers. There remains an ongoing challenge of ensuring good data quality from the large number of small and dispersed providers, particularly given that these providers receive funds from multiple funding sources.

In 2006-07 the quality focus was the development of a number of standardised initiatives supporting Territory-wide approaches, while retaining flexibility in region specific HACC services.

During 2006-07 the new *Carers' Recognition Act* with a specific Carers' Charter came into effect. Subsidies and concessions on cost of essential services similar to those available to pensioners was extended to carers in the Northern Territory and $1.05 million was allocated for this purpose by the Northern Territory Government in 2006-07. The Pensioner Concession and Carer's Scheme was further consolidated by the linking of the Northern Territory Senior's Card administratively with the above schemes.

Aged care services in remote areas face real challenges in terms of sustainability and viability of service contributed by remoteness, limited economies of scale, staff recruitment and retention issues. Innovative service models, which include pooling resources from a range of programs, and closer links with health services, provide opportunities for addressing these issues.

Projections of future Northern Territory potential population estimates in the report are based on small sample sizes and subsequently have high standard error rates.

Indicators based on these estimates need to be interpreted with caution. Similarly small variations in Northern Territory aged care data appear magnified in the report.

13.6 Definitions of key terms and indicators

Adjusted subsidy reduction supplement
Payments made to equalise the recurrent funding paid by the Australian Government as adjusted subsidy reduction places to public sector residential care operators. The states and territories provide top-up funding for residential aged care places at a rate set by the Minister for Health from 1 July each year.

Aged care
Formal services funded and/or provided by governments, that respond to the functional and social needs of frail older people, and the needs of their carers. Community aged care services aim to optimise independence and to assist frail older people to stay in their own homes, while residential care services provide accommodation and care for those who can no longer be assisted to stay at home.

The majority of aged care services assist in activities of daily living such as personal care (for example, bathing and dressing), housekeeping and meal provision, and are delivered by trained aged care workers. However, aged care services may also be delivered by health professionals such as nurses and occupational therapists. These services generally aim to maintain function rather than treat illness or rehabilitate, and are distinguished from the health services described in Part E of this Report. Assessment of care needs is also an important component of aged care.

Aged care services may be funded through programs specifically or mainly directed to older people, or through programs that address the needs of people of different ages. Generally, the target groups of aged care services are people over the age of 70 years and Indigenous people aged over 50 years.

Ageing in place in residential care
An approach that aims to provide residents with appropriate care and increased choice by allowing them to remain in the same facility regardless of changes in their level of care needs. It also allows couples with different levels of care needs to be cared for in the same facility. The main facet of 'ageing in place' is that funding is tied to the assessed care needs of the client rather than to the services provided by the facility.

One of the objectives of Australian Government aged care legislation is 'to promote ageing in place through the linking of care and support services to the places where older people prefer to live' (*Aged Care Act 1997* (Cwlth), s.2-1 [1j]).

Capital expenditure on residential services
Expenditure on building and other capital items, specifically for the provision of Australian government funded residential aged care.

Centre day care
Respite care provided from a facility such as a day care or health centre. Respite care is usually combined with social support services to maintain the functional capabilities of the person receiving care.

Complaint
A complaint by the affected care recipient or his or her representative, or anyone else, to the Secretary about anything that:

- may be a breach of the relevant approved provider's responsibilities under the *Aged Care Act 1997* or the Aged Care Principles
- the complainant thinks is unfair or makes the affected care recipient dissatisfied with the service.

Dementia services program	Includes flexible and innovative support, respite, counselling, information and referral services, education and leisure. The program includes meeting individual and immediate needs which cannot be met by other services, through carer respite services and other carer support agencies. Inpatient services are excluded.
Disability	A limitation, restriction or impairment that has lasted, or is likely to last, for at least six months and restricts everyday activities.
EBA supplement	Payments made to supplement services for the extra costs associated with public sector enterprise bargaining agreements over and above those required by other wage Awards.
Elapsed time between ACAT approval and entry into a residential care service	The measure of the elapsed time between ACAT approval and entry into a residential care service. It has been used in past years as an indicator of access to residential care.
HACC target population	The HACC Target population is people in the Australian community who, without basic maintenance and support services provided under the scope of the HACC Program, would be at risk of premature or inappropriate long term residential care, including (i) older and frail people with moderate, severe or profound disabilities; (ii) younger people with moderate, severe or profound disabilities; and (iii) such other classes of people as are agreed upon, from time to time, by the Commonwealth Minister and the State Minister; and the unpaid Carers of people assessed as being within the National Program's target population. The HACC Target Population is estimated by applying the proportion of people in households with a moderate, severe, or profound disability as reported in the ABS 2003 Survey of Disability, Ageing and Carers to the ABS Population Projections by SLA 2002–2022.
High/low care recipient	Recipient of a high level of residential care (that is, a level to RCS levels 1–4) or a recipient of a low level of residential care (that is, a level corresponding to RCS levels 5–8). If the person is approved as a recipient of a high level of care, that person can receive care at any care classification level (*Approval of Care Recipients Principles 1997*, s.5-9). A person approved as a recipient of a low level of care can be classified on entry only as RCS 5–8 (*Classification Principles 1997*, s.9-19).
In-home respite	A short term alternative for usual care.
People from non-English speaking countries	People who were born in non-English speaking countries. English-speaking countries are defined as Australia, New Zealand, the United Kingdom, Ireland, the United States, Canada and South Africa.
People with a moderate disability	Where a person does not need assistance, but has difficulty with self care, mobility or communication.
People with a profound disability	Where a person is unable to perform self-care, mobility and/or communication tasks, or always needs assistance.
People with a severe disability	Where a person sometimes needs assistance with self-care, mobility or communication.
Personal care	Assistance in undertaking personal tasks (for example, bathing).
Places	A capacity within an aged care service for the provision of residential care, community care or flexible care in the residential care context to an individual (*Aged Care Act 1997* (Cwlth)); also refers to 'beds' (*Aged Care (Consequential Provisions) Act 1997* (Cwlth), s.16).
Real expenditure	Actual expenditure adjusted for changes in prices, using the GDP(E)

price deflator and expressed in terms of final year prices.

Resident	For the purposes of the *Aged Care Act 1997*, a person who is being provided with residential care through an aged care service conducted by an approved provider under the Act.
Respite care	Alternative care arrangements for dependent people living in the community, with the primary purpose of giving their carer a short term break from their usual caring commitments.
Rural small nursing home supplement	Payments made by states and territories to small sized high care public sector residential aged care facilities (up to 30 places) that are located in rural areas. Three levels of supplement are paid to facilities varying in size from 10 to 20 and 30 places.
Special needs groups	Section 11-3 of the Aged Care Act, specifies the following people as people with special needs: people from Aboriginal and Torres Strait Islander communities; people from non-English speaking countries; people who live in rural or remote areas; and people who are financially or socially disadvantaged. Principles (Regulations) made under s. 11-3 also specify veterans as a special needs group.
State-only HACC expenditure	Additional to state matching amount already reported but not including local government.
Veterans	Veterans, their war widows, widowers and dependents who are eligible for treatment through the Department of Veterans' Affairs under the provisions of the *Veterans' Entitlements Act 1986* (Cwlth).

13.7 Attachment tables

Attachment tables are identified in references throughout this chapter by an 'A' suffix (for example, table 13A.3 is table 3 in the attachment). Attachment tables are provided on the CD-ROM enclosed with the Report and on the Review website (www.pc.gov.au/gsp). On the CD-ROM, the files containing the attachment tables are provided in Microsoft Excel format as \Publications\Reports\2008\Attach13A.xls and in Adobe PDF format as \Publications\Reports\2008\Attach13A.pdf. Users without access to the CD-ROM or the website can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

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13.8 References

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