# 13 Aged care services

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| Attachment tables |
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The aged care system comprises all services specifically designed to meet the care and support needs of older people living in Australia. This chapter focuses on government funded care and support services for older people and their carers, which are provided at home and in residential care facilities.

Improvements to the reporting of aged care services in this edition include:

* revisions to align reporting with current aged care policy and programs, including the removal of the distinction between residential high and low care
* significant revisions to the ‘Use by different groups’ indicator with new measures and data reported for Aboriginal and Torres Strait Islander people and for people from Culturally and Linguistically Diverse (CaLD) backgrounds
* a mini‑case study topic on the cost effectiveness of reablement in the WA Home and Community Care (HACC) program and a new approach to provide access to reablement interventions at entry to care through Regional Assessment Services (RAS).

All abbreviations used in this Report are available in a complete list in volume A: Approach to performance reporting.

## 13.1 Profile of aged care services

### Service overview

Government funded aged care services for older people are provided on the basis of frailty or disability. Services covered in this chapter are:

* information and assessment services, which seek to ensure that older people who need aged care, and their carers, know about and can access the appropriate support services to meet these needs
* home care and support services, which provide care and assistance to help older people remain, or return to, living independently in their home as long as possible, or which provide support to carers
* residential care services, which provide supported accommodation and care for older people who are unable to continue living independently in their own homes
* flexible care services, which address the needs of care recipients in ways other than that provided through mainstream services, such as support for older people leaving hospital to help them improve their functional capacity.

The Australian Government also funds activities related to workforce and service quality, and ageing and service improvement. Workforce activities seek to support the development and maintenance of an adequate and capable aged care workforce. Quality and service improvement activities are aimed at strengthening the capacity of the system (DSS 2014).

The formal government funded services covered in this Report represent only a small proportion of total assistance provided to older people. Many people receive assistance from both formal aged care services and informal sources. Extended family and partners are the largest source of emotional, practical and financial support for older people. Around 85 per cent of older people living in the community in 2012 who required help with self‑care, mobility or communication received assistance from the informal care network of family, friends and neighbours (Australian Bureau of Statistics [ABS] unpublished, *Survey of Disability, Ageing and Carers* [SDAC] *2012*, Cat. no. 4430.0). Older people also purchase support services in the private market, and these services are not covered in this Report.

Older Australians are also users of other government services covered in this Report. Understanding the relationship between the aged care and health systems is of particular importance as interactions are critical for the performance of both systems. The number of operational residential aged care places can affect demand for public hospital beds, for example; while the number of older patients in acute and subacute care and the amount of time they spend there can also have a substantial effect on the demand for aged care services. Health services are covered in sector overview E of this Report.

### Roles and responsibilities

The funding, regulation and policy oversight of aged care services are predominantly the role of the Australian Government. The *Aged Care Act 1997*, together with the accompanying Aged Care Principles, are the main regulatory instruments establishing the aged care framework, although some services are provided outside of the Act. Key provisions covered include service planning, user rights, eligibility for care, funding, quality assurance and accountability. During 2013, a package of bills amending the *Aged Care Act 1997* was passed into law to implement some major reforms to the aged care system. These reforms are being implemented progressively.

State, Territory and local governments do fund and/or deliver some aged care services. State and Territory governments main areas of involvement are the delivery of some residential and home care services (figures 13.1−2), the day‑to‑day operation and administration of Aged Care Assessment Teams (ACATs) and with the Australian Government, the joint administration and/or funding of HACC services in Victoria and WA (for older and younger clients), and the Transition Care and Multi‑Purpose Services (MPS) programs.

Services are largely delivered by non‑government organisations; for example, religious, private‑for‑profit and charitable organisations are the main providers of residential care (figure 13.1) and religious and charitable organisations are the main providers of Home Care (figure 13.2).

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| Figure 13.1 Ownership of operational residential places, by provider type, June 2015**a** |
| |  | | --- | | Figure 13.1 Ownership of operational residential places, by provider type, June 2015  More details can be found within the text surrounding this image. | |
| a See table 13A.14 for detailed footnotes and caveats. |
| *Source*: Department of Social Services (DSS) (unpublished); table 13A.14. |
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| Figure 13.2 Ownership of operational Home Care places, by provider type, June 2015**a** |
| |  | | --- | | Figure 13.2 Ownership of operational Home Care places, by provider type, June 2015  More details can be found within the text surrounding this image. | |
| a See table 13A.15 for detailed footnotes and caveats. |
| *Source*: DSS (unpublished); table 13A.15. |
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### Funding

Recurrent expenditure on aged care services covered in this Report was $15.8 billion in 2014‑15 (table 13.1). Expenditure on residential aged care of $10.8 billion accounted for the largest proportion of this expenditure (68.1 per cent). Expenditure on home care and support services accounted for much of the remainder ($4.1 billion), which included expenditure of $2.3 billion on HACC, $1.3 billion on Home Care and $220.7 million on the Department of Veterans’ Affairs (DVA) community nursing and Veterans’ Home Care (VHC) (table 13A.4). Further detailed expenditure data by program are contained in tables 13A.4−12.

The Australian Government provides most of the government funding for aged care services (approximately 95 per cent); however, State and Territory governments do contribute (table 13A.4). The Victorian and WA governments jointly fund HACC services in these jurisdictions, and the other State and Territory governments fund Home Care and residential aged care places for younger people. State governments also provide expenditure supplements for residential aged care facilities (table 13A.4). Other funding is contributed by clients and residents through fees and payments and some revenue is generated from charitable sources and donations (reporting on this expenditure is outside the scope of this Report).

Table 13.1 does not include all Australian, State and Territory government aged care expenditure; for example, the experimental estimates of expenditure on non‑HACC post‑acute packages of care (table 13A.9) and Australian, State and Territory governments’ capital expenditure are excluded (table 13A.10).

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| Table 13.1 Recurrent expenditure on aged care services, 2014‑15  ($ million)**a** |
| |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | NSW | Vic | Qld | WA | SA | Tas | ACT | NT | Aust | | Assessment and information | 36.1 | 26.0 | 18.5 | 10.8 | 9.6 | 2.8 | 1.2 | 1.4 | 133.7 | | Home care and support services | 1 151.7 | 1 097.5 | 805.2 | 489.7 | 320.2 | 109.7 | 75.6 | 39.1 | 4 091.3 | | Residential and flexible care | 3 735.5 | 2 992.8 | 2 085.9 | 978.2 | 1 085.6 | 288.2 | 115.0 | 45.0 | 11 331.3 | | Workforce and quality, and ageing and service improvement | 27.6 | 24.7 | 25.7 | 9.6 | 10.9 | 2.1 | 18.7 | 18.6 | 264.3 | | **Total** | **4 951.0** | **4 140.9** | **2 935.3** | **1 488.2** | **1 426.2** | **402.8** | **210.4** | **104.2** | **15 820.7** | |
| a See table 13A.4 for detailed footnotes and caveats. |
| *Source*: DSS (unpublished); DVA (unpublished); State and Territory governments (unpublished); table 13A.4. |
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### Size and scope of sector

#### Size and growth of the older population

The demand for aged care services is driven by the size and health of the older population. The Australian population is ageing rapidly, as indicated by the projected increase in the proportion of older people (aged 65 years or over) in the total population during this century (figure 13.3). The proportion of older people in the population at June 2015 was 14.9 per cent nationally (figure 13.4).

Higher life expectancy for females resulted in all jurisdictions having a higher proportion of older females than older males in the total population (except the NT) (table 13A.1). Females are more likely to utilise aged care services than males (partly because they are more likely to live alone). Based on the current age‑ and sex‑specific utilisation rates for residential and Home Care combined, and the projected growth in the size of the aged care planning population, it is estimated that the demand for these aged care services will more than treble by 2056 (Department of Social Services [DSS] unpublished estimate, based on ABS population projections series B in Cat. no. 3222.0).

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| Figure 13.3 People aged 65 years or over as a proportion of the total population**a** |
| |  | | --- | | Figure 13.3 People aged 65 years or over as a proportion of the total population  More details can be found within the text surrounding this image. | |
| a Population projections are derived from the ABS ‘B’ series population projections. |
| *Source*:ABS (2014) *Australian Historical Population Statistics, 2014*, Cat. no. 3105.0.65.001, Canberra; ABS (2013) *Population Projections, Australia, 2012 (base) to 2101*, Cat. no. 3222.0, Canberra. |
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| Figure 13.4 Estimated proportion of population aged 65 years or over, by sex, June 2015**a** |
| |  | | --- | | Figure 13.4 Estimated proportion of population aged 65 years or over, by sex, June 2015  More details can be found within the text surrounding this image. | |
| a See table 13A.1 for detailed footnotes and caveats. |
| *Source*:DSS (unpublished); table 13A.1. |
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##### Characteristics of older Aboriginal and Torres Strait Islander Australians

Although the Aboriginal and Torres Strait Islander population is also ageing, there are marked differences in the age profile of Aboriginal and Torres Strait Islander Australians compared with non‑Indigenous Australians (figure 13.5). Life expectancy at birth in the Aboriginal and Torres Strait Islander population is around 10.6 years less for males and 9.5 years less for females when compared with the total Australian population (ABS 2013). Aboriginal and Torres Strait Islander Australians aged 50 years or over are used in this Report as a proxy for the likelihood of requiring aged care services, compared to 65 years or over for the general population. The ABS estimates that 107 364 Aboriginal and Torres Strait Islander Australians were aged 50 years or over in Australia at 30 June 2015 (table 13A.2).

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| Figure 13.5 Age profile and aged care target population differences between Aboriginal and Torres Strait Islander and other Australians, June 2011 |
| |  | | --- | | Figure 13.5 Age profile and aged care target population differences between Aboriginal and Torres Strait Islander and other Australians, June 2011  More details can be found within the text surrounding this image. | |
| *Source*:ABS (2013) *Australian Demographic Statistics, March 2013*, Cat. no. 3101.0, Canberra; ABS (2013) *Estimates of Aboriginal and Torres Strait Islander Australians, June 2011*, Cat. no. 3238.0.55.001. |
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#### Aged care target population

To align with the funding arrangements as specified under the National Health Reform Agreement, this Report defines the aged care target population as all people aged 65 years or over and Aboriginal and Torres Strait Islander Australians aged 50–64 years. This aged care target population differs in scope to the Australian Government’s aged care ‘planning population’ (people aged 70 years or over) used to allocate places for residential care and Home Care under the *Aged Care Act 1997*, and which for reporting purposes is combined with the population of Aboriginal and Torres Strait Islander Australians aged 50–69 years.

#### Aged care services

##### Information and assessment services

Information services provide older people, their families and carers with the information they need to ensure timely and appropriate access to care. My Aged Care assists older people, their families and carers to access aged care information, and find Australian Government funded aged care services in their local area. The My Aged Care website has service finders related to assessments, help at home and residential aged care. A contact centre phone line also operates across Australia. Other information services are available, such as those provided through Carers Information and Support services that distributed 216 140 items of information in 2014‑15 (table 13A.13). Further descriptive data on information services are available in the *Report on the Operation of the Aged Care Act 1997*.

Comprehensive assessment services are provided by ACATs, or Aged Care Assessment Services in Victoria. An ACAT assessment and approval is mandatory for admission to Australian Government subsidised residential care (including respite), to receive Home Care or enter Transition Care. People can also be referred by an ACAT to other services (such as HACC). Assessments for the other aged care programs are conducted by other assessment agencies (such as the VHC assessment agencies).

Nationally in 2013‑14, there were 179 200 ACAT assessments undertaken for all service types, equivalent to an assessment rate of 50.8per 1000 people aged 65 years or over and Aboriginal and Torres Strait Islander Australians aged 50–64 years (table 13A.33). Some ACAT assessments will not result in an approval for care, but one client can be approved for more than one type of care. In 2013‑14, there were 204 716 approvals for people aged 65 years or over (table 13A.34). Age‑specific ACAT approvals rates for Home Care and residential aged care are reported in figure 13.6.

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| Figure 13.6 ACAT assessment age‑specific approval rates, 2013‑14**a** |
| |  | | --- | | **Home care** | | Figure 13.6 ACAT assessment age-specific approval rates, 2013-14  Home care  More details can be found within the text surrounding this image. | | **Residential aged care** | | Figure 13.6 ACAT assessment age-specific approval rates, 2013-14  Residential aged care   More details can be found within the text surrounding this image. | |
| a See table 13A.34 for detailed footnotes and caveats. |
| *Source*:DSS (unpublished) Aged Care Data Warehouse; table 13A.34. |
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##### Home care and support

Home care and support services provide assistance to help older people remain, or return to, living independently in their home as long as possible, or provide respite support to carers. The distinctions between the main home care and support programs (HACC and Home Care) are summarised in table 13.2. The DVA VHC and community nursing services are also described below.

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| Table 13.2 Distinctions between HACC and Home Care, 2014‑15 |
| |  |  |  | | --- | --- | --- | |  | HACC | Home Care | | Type of servicesa | Basic maintenance and support services for people in the community whose independence is at risk. Services types include allied health care, centre‑based day care, domestic assistance, personal care, respite care, social support and meals. | Package of basic to low (levels 1−2) or intermediate to high (levels 3−4) level care that is tailored to client needs. Supplements for additional care needs (such as for dementia and cognition, and oxygen) are also available.  Services types include personal care (such as showering and meal preparation), support services (such as cleaning and transport for shopping) and clinical care (such as nursing and other health support ‒ for example, podiatry and physiotherapy). | | Relationship to residential care | Aims to prevent premature or inappropriate admission to residential aged care. | Substitutes for a residential aged care place. | | Eligibility | ACAT approval not required | ACAT approval mandatory | | Funding | Funded by the Australian Government and client contributions, except in Victoria and WA where funding is also provided by those jurisdictions’ governments. | Funded primarily by the Australian Government and client contributions — State and Territory governments fund younger people using these services (except in Victoria and WA). | | Target client groupsb | Available to frail older people with functional limitations as a result of profound, severe or moderate disability and their carers. Not age specific in Victoria and WA. | Older people with care needs similar to those in residential aged care.  Levels 1−2  Designed for people who are able to live at home with assistance.  Levels 3–4  Designed for people who have expressed a preference to live at home and are able to do so with assistance. | | Size of programc | $2.3 billion funding for older clients (includes funding for younger people in Victoria and WA)  At least 812 384 olderclients | $1.3 billion total funding  73 550 operational places, including flexible care places  86 302 older clients | |
| a HACC community nursing services can be supplied to someone receiving Home Care levels 1–2 when additional nursing services are required to support the consumer to remain living at home. b Most HACC clients with lower support needs would not be assessed as eligible for residential care; for example, an individual may receive only an hour of support per fortnight. However, some people have needs that would exceed the level available under a Home Care place. c See tables 13A.3–4 and 13A.13 for detailed footnotes and caveats. |
| *Source*:DSS (unpublished); tables 13A.3–4 and 13A.13. |
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During 2014‑15, the total number of older clients who used HACC and Home Care services per 1000 older people (aged 65 years or over and Aboriginal and Torres Strait Islander Australians aged 50–64 years) was 222.6 and 23.7 nationally (figure 13.7). At June 2015, the total number of Home Care operational places available was 73 550 (comprising 3.1 per cent at level 1, 71.8 per cent at level 2, 5.2 per cent at level 3 and 20.0 per cent at level 4) (table 13A.13) and 72 702 if flexible care places are excluded (DSS unpublished). Age‑specific usage rates for Home Care at 30 June 2015 are included in table 13A.25.

Centre‑based day care, domestic assistance and social support are the HACC service types with the most service hours, representing almost 70.0 per cent of total HACC service hours in 2014‑15 (table 13A.27). Further data on HACC service types, target population and client characteristics are included in tables 13A.22 and 13A.27‒32.

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| Figure 13.7 Older clients of HACC and home care services per 1000 older people, by program, 2014‑15**a** |
| |  | | --- | | Figure 13.7 Older clients of HACC and home care services per 1000 older people, by program, 2014-15  More details can be found within the text surrounding this image. | |
| a See table 13A.3 for detailed footnotes and caveats. |
| *Source*:DSS (unpublished); table 13A.3. |
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In 2014‑15, there were 156 087 veterans and war widows/widowers (who hold a Gold or White Repatriation Health Card) aged 65 years or over ‘eligible’ for DVA services (table 13A.12). However, access to VHC and community nursing services is not automatic for eligible veterans and war widows/widowers, but based on assessed need. VHC services are designed for those with low care needs, such as for domestic assistance, personal care, home and garden maintenance, and respite care; while community nursing services are designed for those with high level personal care needs or disability, such as for acute/post‑acute support and maintenance, medication management and palliative care.

There were 56 356 older clients (aged 65 years or over) approved for VHC services in 2014‑15 (table 13A.11) and 23 095 older clients received community nursing services (table 13A.11), representing 361.1 and 148.0 per 1000 older eligible veterans respectively (figure 13.8). In 2014‑15, the average number of hours provided per year for recipients of VHC services was 54 nationally and the average number of hours per 28 day period for recipients of community nursing services was 7.4 nationally (table 13A.11).

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| Figure 13.8 Clients of VHC and community nursing per 1000 older eligible veterans, by program, 2014‑15**a** |
| |  |  | | --- | --- | | Figure 13.8 Clients of VHC and community nursing per 1000 older eligible veterans, by program, 2014-15  More details can be found within the text surrounding this image. | | | a See tables 13A.11–12 for detailed footnotes and caveats. | | |
| *Source*:DVA (unpublished); tables 13A.11–12. |
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##### Residential and flexible care services

Residential care services provide permanent care and respite care (on a planned or emergency basis). The types of services provided depend on the needs of the resident. All residents receive services such as accommodation, support services (cleaning, laundry and meals) and personal care services, and those with greater needs might also receive nursing care, continence aids, basic medical and pharmaceutical supplies and therapy services.

All permanent residential aged care is provided on an ‘ageing in place’ basis. From 1 July 2014, new and continuing permanent residents are no longer classified as low/high care recipients, but continue to receive an Aged Care Funding Instrument (ACFI) classification. As respite residents receive short‑term care, they not appraised under the ACFI but continue to be classified as high or low care based on their level of ACAT approval.

The ACFI is used to appraise a permanent resident’s needs. The ACFI measures each resident’s need for care or level of dependency (high, medium, low or nil) in each of three domains: Activities of Daily Living, Behaviours and Complex Health Care. The Australian Government’s annual basic subsidy for each occupied place varies according to clients’ level of overall dependency. There are 64 combinations of care needs identified under the ACFI classification system. At 30 June 2015, the average annual subsidy per residential place was $56 084 nationally (table 13A.16). Residents’ care needs may change over time and residents are reappraised using the ACFI as required.

During 2014‑15, the number of older clients who were in residential aged care nationally was 224 115 for permanent care and 51 411 for respite care, representing 61.4 and 14.1 older clients per 1000 people aged 65 years or over and Aboriginal and Torres Strait Islander Australians aged 50–64 years (figure 13.9). At 30 June 2015, the total number of residential aged care operational places available in mainstream services was 192 370 (table 13A.17); including flexible places, it was 195 953 (table 13A.18). Age‑specific usage rates for permanent residential aged care, by jurisdiction, at 30 June 2015 are included in table 13A.25.

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| Figure 13.9 Older permanent and respite residential aged care clients per 1000 older people, 2014‑15**a** |
| |  | | --- | | Figure 13.9 Older permanent and respite residential aged care clients per 1000 older people, 2014-15  More details can be found within the text surrounding this image. | |
| a See table 13A.3 for detailed footnotes and caveats. |
| *Source*:DSS (unpublished); table 13A.3. |
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Flexible care services address the needs of care recipients in ways other than that provided through mainstream residential and home care.

* Transition Care assists older people in regaining physical and psychosocial functioning following an episode of inpatient care to maximise independence and to help avoid premature entry to residential aged care. During 2014‑15, there were 24 009 clients of Transition Care (table 13A.3) across the 4000 operational places (table 13A.59), for which the average length of stay in 2014‑15 was 60 days (8.5 weeks) (table 13A.59).
* The MPS program delivers flexible and integrated health and aged care services to small rural and remote communities as some health, aged and community care services may not be viable in a small community if provided separately. In 2014‑15, there was a total of 3545 operational MPS program places (includes residential and home care places).
* The National Aboriginal and Torres Strait Islander Flexible Aged Care Program provides culturally appropriate aged care to older Aboriginal and Torres Strait Islander people close to home and their communities and delivers a mix of residential and   
  home care services. Services funded under this Program operate outside the regulatory framework of the *Aged Care Act 1997*. At 30 June 2015, there were 802 operational flexible aged care places under this program (DSS unpublished).

### Case study

Box 13.1 contains a case study on RAS and reablement in the WA HACC program.

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| Box 13.1 RAS and reablement in the WA HACC program |
| Reablement services focus on restoring a person’s independent functioning, rather than on simply doing things for them, which is the more conventional HACC approach. Reablement or restorative home care services provide intensive time‑limited interventions to assist the person maximise their capability to be independent in those aspects of their lives that they identify as most important to their quality of life. These services have been provided in WA since 1999 and are now well established, but until now have been provided on a limited opt‑in basis.  The cost effectiveness of the reablement approach was evaluated through an independent randomised controlled trial that compared the home care and healthcare service use and costs of older people receiving a restorative or a conventional service over a two‑year period from June 2005 to August 2007 (Lewin et al 2014). The study established that older people who received a reablement service had lower total home care costs and were less likely to be approved for a higher level of aged care, to have presented at an emergency department or to have had an unplanned hospital admission. These outcomes resulted in an average aggregated health and home care cost for restorative clients that was 18.5 per cent less ($19 090 compared to $23 428) than the conventional HACC approach.  HACC RASs were introduced in 2011 to provide a system‑wide approach to: determining whether an individual is eligible and a priority for services; conducting assessments; and providing support planning to maximise older people’s independence, wellbeing and connections to the community. Given the success of the reablement services, a reablement approach to RAS assessment was introduced in July 2013 to supplement established assessment approaches with access to evidence‑based reablement strategies at entry, before the need for ongoing support is determined.  The intensity of the reablement input from RAS varies greatly across clients and can be difficult to quantify. The input can be suggesting that clients adopt certain strategies to help them maintain or improve their independence, or in addition to this; the provision of basic equipment or other simple one‑off interventions. If additional follow‑up interventions are required after the RAS reablement assessment, then clients receive referrals to either reablement home support services or a restorative program, both of which guide and monitor the implementation of agreed strategies and remain involved for a six‑ to eight‑week period, before determining whether ongoing support is required. |
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| Box 13.1 (continued) |
| While the formal evaluation of the cost effectiveness of the RAS reablement approach has not been published, some initial results indicate it is a promising approach worth further examination. Initial analysis of 2014‑15 data shows that of the clients who received a RAS reablement assessment or re‑assessment, a lower proportion of clients had new or additional services put in place (75 per cent) when compared to those who received a non‑reablement assessment or re‑assessment (84 per cent). For new clients, those who were reablement clients had a higher proportion receiving no ongoing services than non‑reablement clients (21 per cent compared to 12 per cent). For existing HACC clients who were being reassessed, a lower proportion of reablement clients were referred for any additional HACC services (65 per cent compared to 79 per cent).  In addition, for new clients who had an initial assessment in the first quarter of 2014‑15, a slightly lower proportion of reablement clients were reassessed for additional services within nine months (34 per cent) than non‑reablement clients (39 per cent), indicating a lower proportion of reablement clients needing additional ongoing services. The initial results also indicate that the reduced service demand/use by reablement assessment clients is not at the expense of client outcomes. |
| *Source*: WA Government (unpublished); Lewin, G., Allan, J., Patterson, C., Knuiman, M., Boldy, D., Hendrie, D. (2014) ‘A comparison of the home‑care and healthcare service use and costs of older Australians randomised to receive a restorative or a conventional home‑care service’, *Health and Social Care in the Community,* vol. 22, no. 3, pp. 328–336. |
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## 13.2 Framework of performance indicators

The framework of performance indicators for aged care services is based on common objectives for the aged care sector (box 13.2).

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| Box 13.2 Objectives for aged care services |
| The aged care system aims to promote the wellbeing and independence of older people and their carers through the funding and delivery of care services that are: accessible, appropriate to needs, high quality, efficient and person centred.  These objectives are consistent with the Australian, State and Territory governments’ long‑term aged care objectives articulated under the National Healthcare Agreement that ‘older Australians receive appropriate high quality and affordable health and aged care services’ (COAG 2009). |
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The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of aged care services (figure 13.10). The performance indicator framework shows which data are complete and comparable in the 2016 Report. For data that are not considered directly comparable, text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability and data completeness from a Report wide perspective (section 1.6).

In addition to section 13.1, the Report’s statistical context chapter contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics (chapter 2).

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| Figure 13.10 Aged care services performance indicator framework |
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## 13.3 Key performance indicator results

Different delivery contexts, locations and types of client may affect the effectiveness and efficiency of aged care services.

Data Quality Information (DQI) is included where available for performance indicators in this Report. The purpose of DQI is to provide structured and consistent information about quality aspects of data used to report on performance indicators, in addition to material in the chapter or sector overview and attachment tables. All DQI for the 2016 Report can be found at www.pc.gov.au/rogs/2016.

### Outputs

Outputs are the services delivered (while outcomes are the impact of these services on the status of an individual or group) (see chapter 1, section 1.5). Output information is also critical for equitable, efficient and effective management of government services.

### Equity

#### Access – Use by different groups

‘Use by different groups’ is an indicator of governments’ objective to provide equitable access for all people, particularly those with special needs, to aged care services (box 13.3).

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| Box 13.3 Use by different groups |
| ‘Use by different groups’ has two measures:   * ‘Access to aged care services across special needs groups’ is defined as the proportion of service clients who are from a special needs group, compared with the proportion of the aged care target population who are from that special needs group. Data are reported for two special needs groups (Aboriginal and Torres Strait Islander Australians and people from CaLD backgrounds). Data availability varies across service types. People from CaLD backgrounds are defined as those born overseas from countries other than the United Kingdom, Ireland, New Zealand, Canada, South Africa and the United States of America. * ‘Access to residential aged care services for financially disadvantaged people’ is defined as the proportion of all permanent resident care days classified as for concessional, assisted, supported or low means residents. See section 13.5 for definitions of these concepts.   Interpretation of results across these measures varies:   * For the ‘Access to aged care services across special needs groups’, the proportion of service clients who are from a particular special needs group should be broadly similar to the proportion of the aged care target population who are from that special needs group. |
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| Box 13.3 (continued) |
| * For ‘Access to residential aged care services for financially disadvantaged people’, Australian Government planning guidelines require that services allocate a minimum proportion of residential places for concessional, assisted, supported or low means residents. These targets range from 16 per cent to 40 per cent of places, depending on the service’s region. Proportions of permanent resident care days equal to, or higher than, the minimum are desirable.   There are nine groups identified by the *Aged Care Act 1997* and its principles (regulations) as having special needs. Measures are available for only three of these special needs groups for this year’s Report — people from Aboriginal and Torres Strait Islander and CaLD backgrounds, and people who are financially or socially disadvantaged. Measures for people who live in rural or remote areas and veterans (including widows and widowers of veterans) are currently under development. Data are not available for reporting on people who are homeless or at risk of becoming homeless; people who are care leavers, parents separated from their children by forced adoption or removal and lesbian, gay, bisexual, transgender and intersex people.  Several factors need to be considered with the results for these measures:   * Cultural differences and higher disability rates, which suggest a greater level of need for services, can influence the extent to which the different special needs groups use different types of services. To account for higher disability rates, lower life expectancy and therefore an increased likelihood of requiring aged care services at a younger age, the aged care target population for Aboriginal and Torres Strait Islander Australians is people aged 50 years or over, compared to people aged 65 years or over for the general population and other population groups. * The availability of informal care and support can affect the use of aged care services across different population groups. Stronger informal support networks can reduce the need for formal aged care services, or for particular service types.   Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions for both measures and over time for the ‘Access to aged care services across special needs groups’ measure, but not comparable over time for the ‘Access to residential services by financially disadvantaged users’ measure (2014‑15 data are not comparable to earlier years as data on people of low means are not available) * complete (subject to caveats) for the current reporting period. All required latest year data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/rogs/2016. |
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##### Access to aged care services across special needs groups

Differences in the representation of a special needs group in services compared to their representation in the aged care target population varied across service types and groups (table 13.3):

* Nationally, Aboriginal and Torres Strait Islander Australians were 2.9 per cent of the aged care target population and were overrepresented in clients of Home Care   
  levels 1−2 (4.3 per cent) and similarly represented in clients of HACC services   
  (2.9 per cent), but underrepresented in clients of ACATs (1.3 per cent), residential aged care (1.1 per cent), Home Care levels 3−4 (1.6 per cent) and Transition Care   
  (0.8 per cent).
* Nationally, people from CaLD backgrounds were 22.6 per cent of the aged care target population and were therefore overrepresented in the group of clients receiving Home Care levels 1−2 (25.5 per cent) and Home Care levels 3−4 (25.8 per cent), but underrepresented in clients of residential aged care (18.3 per cent).

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| Table 13.3 Proportion of the aged care target population from special needs groups, compared with the proportion of service clients who are from special needs group (per cent)**a** |
| |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | NSW | Vic | Qld | WA | SA | Tas | ACT | NT | Aust | | **Aboriginal and Torres Strait Islander people** | | | | | | | | | | | *Aged care target population, June 2015* | 2.9 | 0.8 | 4.0 | 3.9 | 2.0 | 4.5 | 1.7 | 43.2 | 2.9 | | ACAT assessments, 2013‑14 | 1.1 | 0.6 | 1.7 | 1.8 | 0.8 | 0.8 | 0.6 | 33.2 | 1.3 | | Residential aged care, at 30 June 2015 | 0.7 | 0.3 | 1.6 | 2.2 | 1.2 | 0.6 | 0.4 | 53.8 | 1.1 | | Home care levels 1‒2, at 30 June 2015 | 2.6 | 3.2 | 4.1 | 4.7 | 3.0 | 5.3 | 4.8 | 57.8 | 4.3 | | Home care levels 3‒4, at 30 June 2015 | 1.4 | 1.5 | 1.3 | 1.6 | 1.0 | 1.2 | 0.6 | 22.6 | 1.6 | | HACC, 2014‑15 | 4.0 | 1.0 | 3.2 | 3.2 | 2.2 | 1.9 | 1.0 | 54.7 | 2.9 | | Transition Care,  2014‑15 | 0.7 | 0.3 | 0.9 | 0.6 | 1.1 | 1.1 | 1.0 | 16.7 | 0.8 | | **CaLD backgrounds** | | | | | | | | | | | *Aged care target population, June 2011* | 24.6 | 30.6 | 12.1 | 20.3 | 20.3 | 8.0 | 26.0 | 20.4 | 22.6 | | Residential aged care, at 30 June 2015 | 19.5 | 23.8 | 9.9 | 18.1 | 17.2 | 6.9 | 20.5 | 12.5 | 18.3 | | Home care levels 1‒2, at 30 June 2015 | 25.8 | 33.4 | 15.8 | 27.1 | 21.7 | 11.4 | 19.6 | 14.5 | 25.5 | | Home care levels 3‒4, at 30 June 2015 | 28.0 | 35.9 | 14.9 | 25.1 | 20.4 | 13.9 | 29.0 | 21.4 | 25.8 | |
| a See box 13.3 and tables 13A.2–3, 13A.23–24, 13A.30 and 13A.33 for detailed definitions, footnotes and caveats. |
| *Source*:DSS (unpublished); ABS (2014) *Estimated Resident Population, by Country of Birth by State, 1996−2011,* ABS.Stat (available at stat.abs.gov.au/Index.aspx?DataSetCode=ABS\_FFR\_COB\_STATE)*;* tables 13A.2–3, 13A.23–24, 13A.30 and 13A.33. |
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##### Access to residential services by financially disadvantaged users

The proportion of all permanent residents’ care days classified as concessional, assisted or supported during 2014‑15 was 37.7 per cent nationally (figure 13.11).

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| Figure 13.11 Permanent residents’ care days classified as concessional, assisted or supported**a** |
| |  | | --- | | Figure 13.11 Permanent residents’ care days classified as concessional, assisted or supported  More details can be found within the text surrounding this image. | |
| a See box 13.3 and table 13A.26 for detailed definitions, footnotes and caveats. |
| *Source*: Department of Health and Ageing/DSS (unpublished); table 13A.26. |
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### Effectiveness

#### Access – Operational aged care places

‘Operational aged care places’ is an indicator of governments’ objective to provide older Australians with access to a range of aged care services that can meet their care needs (box 13.4).

The planning framework for services provided under the *Aged Care Act 1997* aims to keep the growth in operational aged care places in line with growth in the older population, and to ensure a balance of services across Australia, including services for people with lower levels of need and in rural and remote areas. The national provision ratio is planned to increase to 125 places per 1000 people aged 70 years or over by 2021‑22. Within this provision ratio, the number of home care places is planned to increase to 45 (and residential care places will decrease to 80), reflecting a greater emphasis on assisting people to remain in their own home as they age.

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| Box 13.4 Operational aged care places |
| ‘Operational aged care places’ has two measures, the number of operational places (by type of place — residential aged care and Home Care levels 1–2 or Home Care levels 3–4) per 1000 people in the aged care planning population:   * aged 70 years or over * aged 70 years or over and Aboriginal and Torres Strait Islander Australians aged  50–69 years. (This second measure is in recognition of poorer health among Aboriginal and Torres Strait Islander communities and that planning in some cases also takes account of the Aboriginal and Torres Strait Islander population aged 50–69 years. A provision ratio based on the population aged 70 years or over will appear high in areas with a higher proportion of the population who are Aboriginal and Torres Strait Islander people.)   In general, provision ratios across states and territories, and across regions, that are broadly similar are desirable as it indicates that all older Australians have access to a similar level and mix of services to meet their care needs.  This indicator does not provide information on whether the overall target provision ratios are adequate or provide an appropriate mix of services relative to need.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required 30 June 2015 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/rogs/2016. |
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Nationally, the combined number of residential care and Home Care places at 30 June 2015, was 111.5 per 1000 people aged 70 years or over (figure 13.12). Transition Care places add an additional 1.7 per 1000 people aged 70 years or over (table 13A.19), however, these places are not included in the national provision ratio. The number of operational aged care places per 1000 people aged 70 years or over by care type was 81.1 places for residential care, 22.8 places for Home Care levels 1–2 and 7.7 places for Home Care levels 3–4 (figure 13. 12).

The number of operational aged care places can also be shown using an aged care planning population that incorporates Aboriginal and Torres Strait Islander Australians aged   
50–69 years (figure 13.13). Use of this ‘adjusted’ aged care planning population has a noticeable effect on the NT, which has a large proportion of Aboriginal and Torres Strait Islander Australians.

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| Figure 13.12 Operational residential and Home Care places per 1000 people aged 70 years or over, 30 June 2015**a** |
| |  | | --- | | Figure 13.12 Operational residential and Home Care places per 1000 people aged 70 years or over, 30 June 2015  More details can be found within the text surrounding this image. | |
| a See box 13.4 and table 13A.19 for detailed definitions, footnotes and caveats. |
| *Source*:DSS (unpublished); table 13A.19. |
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| Figure 13.13 Operational residential and Home Care places per 1000 people aged 70 years or over and Aboriginal and Torres Strait Islander Australians aged 50–69 years, 30 June 2015**a** |
| |  | | --- | | Figure 13.13 Operational residential and Home Care places per 1000 people aged 70 years or over and Aboriginal and Torres Strait Islander Australians aged 50–69 years, 30 June 2015  More details can be found within the text surrounding this image. | |
| a See box 13.4 and table 13A.20 for detailed definitions, footnotes and caveats. |
| *Source*:DSS (unpublished); table 13A.20. |
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Nationally, at 30 June 2015, the number of residential and Home Care operational aged care places per 1000 people aged 70 years or over and Aboriginal and Torres Strait Islander Australians aged 50–69 years was considerably higher in major cities at 113.3, than for inner and outer regional areas (97.8) or remote and very remote areas (80.9) (table 13A.21).

#### Access – Elapsed times for aged care services

‘Elapsed times for aged care services’ is a proxy indicator of governments’ objective to minimise the time people spend waiting to access aged care services. Elapsed times are used as a proxy as waiting times cannot be measured accurately (box 13.5).

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| Box 13.5 Elapsed times for aged care services |
| ‘Elapsed times for aged care services’ has two measures, the proportions of people who:   * entered residential care that did so within three months of their most recent ACAT approval * commenced Home Care that did so within three months of their most recent ACAT approval.   Higher proportions of admission to residential care or commencement of Home Care within three months of ACAT approval are desirable.  This indicator needs to be interpreted with caution. The measure of ‘elapsed time’ is utilised, rather than ‘waiting times’ as the period of time between the ACAT approval and entry into residential care or commencement of Home Care can be affected by factors other than time spent ‘waiting’. Hospital discharge policies and practices or a client’s choice not to enter or commence care immediately but to take up the option at a later time for example, might delay entry or commencement of care. A client’s decision to take up care at a point in time can be affected by the availability of alternative care options (for example, informal care) or their preference for a particular service — a client’s perceptions of a service’s fee regimes or building quality may affect this preference. The measure does not include clients who may have spent time waiting, but did not enter residential care or commence Home Care (for example, who died before entering care) or who ultimately decided to delay or not take up a care placement offer during the relevant period.  It is recognised that this indicator has limitations and work is underway to review the data. This indicator will continue to be reported until improved data are available.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required 2014‑15 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/rogs/2016. |
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Overall, 9.8 per cent of all people entering residential care during 2014‑15 did so within seven days of being approved by an ACAT, compared with 16.0 per cent in 2013‑14 (table 13A.35). In 2014‑15, 30.6 per cent entered within one month of their ACAT approval and 58.4 per cent entered within three months of their approval (figure 13.14), compared with 41.2 per cent and 66.7 per cent respectively in 2013‑14 (table 13A.35). The median time for entry into residential services was 68 days in 2014‑15 compared to 45 days in 2013‑14 (table 13A.35). Further data on elapsed time by remoteness, Socio‑Economic Indexes for Areas (SEIFA) and Indigenous status are included in   
tables 13A.36–38.

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| Figure 13.14 People entering residential care within specified time periods of their ACAT approval, 2014‑15**a, b** |
| |  | | --- | | Figure 13.14 People entering residential care within specified time periods of their ACAT approval, 2014-15  More details can be found within the text surrounding this image. | |
| a NT data for ‘2 days or less’ and ‘7 days or less’ are not published. b See box 13.5 and table 13A.35 for detailed definitions, footnotes and caveats. |
| *Source*:DSS (unpublished); table 13A.35. |
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Overall, 58.6 per cent of all people commencing Home Care during 2014‑15, received care within three months of being approved by an ACAT. This proportion varied across jurisdictions. Nationally, 33.7 per cent started receiving Home Care within one month of being approved by an ACAT (figure 13.15).

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| Figure 13.15 People commencing Home Care within one or three months of their ACAT approval, 2014‑15**a** |
| |  | | --- | | Figure 13.15 People commencing Home Care within one or three months of their ACAT approval, 2014-15  More details can be found within the text surrounding this image. | |
| a See box 13.5 and table 13A.35 for detailed definitions, footnotes and caveats. |
| *Source*:DSS (unpublished); table 13A.35. |
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#### Appropriateness – Assessed long‑term care arrangements

‘Assessed long‑term care arrangements’ is an indicator of governments’ objective to meet clients’ needs through provision of appropriate aged care services (box 13.6).

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| Box 13.6 Assessed long‑term care arrangements |
| ‘Assessed long‑term care arrangements’ is defined as the proportions of ACAT clients recommended to reside in the community (private residence or other community). ACAT clients are also recommended for long‑term care in residential care or in another location (such as, other institutional care) and for some ACAT clients a recommendation was not made due to reasons such as death. A recommendation does not mean that the person will be approved for care and an approval does not mean that the person will take up care.  High or increasing proportions of clients recommended to remain in the community (assuming this is appropriate) are desirable.  Differences in recommendations across jurisdictions can reflect external factors such as geographic dispersion of clients and service availability, but also views on the types of client best served by home care and support services and client preferences. The distribution of ACAT recommendations for various care arrangements is also influenced by the degree to which any pre‑selection process refers people requiring residential care to an ACAT for an assessment. |
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| Box 13.6 (continued) |
| Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete for the current reporting period (subject to caveats). All required 2013‑14 data are available for all jurisdictions.   Data quality information for this indicator is under development. |
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The national proportion of ACAT clients recommended to remain in the community in 2013‑14 was 52.7 per cent and a further 36.6 per cent was recommended for residential care (figure 13.16). The remaining 9.9 per cent comprise those for whom the recommendation was another location (for example, other institutional care) or for whom reasons such as death, transfer or cancellation meant that no recommendation for long‑term care arrangements was made.

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| Figure 13.16 Recommended long‑term care arrangements of ACAT clients, 2013‑14**a** |
| |  | | --- | | Figure 13.16 Recommended long-term care arrangements of ACAT clients, 2013-14  More details can be found within the text surrounding this image. | |
| a See box 13.6 and table 13A.39 for detailed definitions, footnotes and caveats. |
| *Source*:DSS (unpublished) Ageing and Aged Care Data Warehouse from the Aged Care Assessment Program Minimum Data Set; table 13A.39. |
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#### Appropriateness – Unmet need

‘Unmet need’ is an indicator of governments’ objective of ensuring aged care services are allocated to meet clients’ needs (box 13.7).

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| Box 13.7 Unmet need |
| ‘Unmet need’ is defined as the extent to which demand for services to support older people requiring assistance with everyday activities is not met.  Low rates of unmet need are desirable; however, defining and determining the level of need at an individual level is complex and at a population level is highly complex. Perceptions of need and unmet need are often subjective.  Data from the ABS 2012 SDAC on older people with a need for assistance with at least one everyday activity, and the extent to which that need was being met (fully, partly or not at all) are reported in table 13A.40. Although these data are included, this indicator is regarded as yet to be developed because further work is needed to understand the extent of the caveats. |
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Of those people aged 65 years or over in 2012, who were living in households and who have a need for assistance with at least one everyday activity, 34.0 per cent reported that their need for assistance was not fully met (table 13A.40).

#### Appropriateness – Hospital patient days used by aged care type patients

‘Hospital patient days used by aged care type patients’ is a proxy indicator of governments’ objective to minimise the incidence of older people staying in hospitals for extended periods of time when their care needs can be met more appropriately through residential or home care and support services (box 13.8).

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| Box 13.8 Hospital patient days used by aged care type patients |
| ‘Hospital patient days used by aged care type patients’ has two measures:   * the proportion of completed aged care type public hospital separations for people aged 65 years or over and Aboriginal and Torres Strait Islander Australians aged 50–64 years for which the length of stay was 35 days or longer, where ‘aged care type’ hospital separations are defined as: * the care type was maintenance, and * the diagnosis (either principal or additional) was either a person awaiting admission to a residential aged care service or need for assistance at home and no other household member able to render care * the proportion of all patient days (for overnight separations only) used by patients who are waiting for residential aged care, where the: * care type was maintenance, and * diagnosis (either principal or additional) was a person awaiting admission to a residential aged care service, and * separation mode was not ‘other’ (includes discharge to place of usual residence or own accommodation/welfare institution). |
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| Box 13.8 (continued) |
| Low or decreasing proportions of hospital stays of ‘35 days or more’ and low or decreasing proportions of patient days used by people waiting for residential aged care are desirable.  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 long‑term care for older people who cannot live independently.  These measures should be interpreted with caution, because:   * patients who have not completed their period of care in a hospital are not included * although the diagnosis codes reflect a care type, they do not determine a person’s eligibility for residential or home care services (this is determined by an ACAT assessment) or reliably reflect access issues for residential aged care from the acute care sector — data (utilising appropriate linked hospital separations and ACAT approvals) are not available at this time * these diagnosis codes may not be applied consistently across jurisdictions or over time * reported hospital separations and patient days do not necessarily reflect the full length of hospital stay for an individual patient — if a change in the type of care occurs during a patient’s hospital stay (for example, from acute to maintenance) then two separations are reported for that patient * for the first measure, the code ‘need for assistance at home and no other household member able to render care’ may also be used for respite care for aged care residents or those receiving home care, and some jurisdictions may have higher proportions of this type — this is particularly relevant in some rural areas where there are few alternative options for these clients * they 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.   Data reported for the first measure are:   * comparable (subject to caveats) across jurisdictions but a break in series means that data from 2011‑12 are not comparable to data for earlier years * complete (subject to caveats) for the current reporting period. All required 2013‑14 data are available for all jurisdictions.   Data reported for the second measure are:   * comparable (subject to caveats) across jurisdictions and over time (except for Tasmania for 2008‑09 where two significant private hospitals are excluded) * complete (subject to caveats) for the current reporting period. All required 2013‑14 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/rogs/2016. |
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The proportion of separations for ‘aged care type’ patients aged 65 years or over and Aboriginal and Torres Strait Islander Australians aged 50–64 years whose separation was 35 days or longer was 11.5 per cent nationally in 2013‑14 (figure 13.17).

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| Figure 13.17 Proportion of separations for ‘aged care type’ public hospitals patients that were 35 days or longer**a** |
| |  | | --- | | Figure 13.17 Proportion of separations for ‘aged care type’ public hospitals patients that were 35 days or longer  More details can be found within the text surrounding this image. | |
| a See box 13.8 and table 13A.41 for detailed definitions, footnotes and caveats. |
| *Source*:Australian Institute of Health and Welfare (AIHW) (unpublished); table 13A.41. |
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The proportion of all hospital patient days used by patients who are waiting for residential aged care was 9.5 per 1000 patient days nationally in 2013‑14 (figure 13.18).

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| Figure 13.18 Hospital patient days used by patients waiting for residential aged care**a** |
| |  | | --- | | Figure 13.18 Hospital patient days used by patients waiting for residential aged care  More details can be found within the text surrounding this image. | |
| a See box 13.8 and table 13A.42 for detailed definitions, footnotes and caveats. |
| *Source*:AIHW (unpublished); table 13A.42. |
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#### Appropriateness – Intensity of care

‘Intensity of care’ has been identified for development as an indicator of governments’ objective to provide flexible services that are appropriate to clients’ needs (box 13.9).

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| Box 13.9 Intensity of care |
| ‘Intensity of care’ is yet to be defined.  Data for this indicator were not available for this Report. |
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#### Quality – Compliance with service standards for residential care

‘Compliance with service standards for residential care’ is an indicator of governments’ objective to ensure residential care services meet minimum acceptable levels of service quality that include systems for continual improvement in the care provided to residents (box 13.10).

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| Box 13.10 Compliance with service standards for residential care |
| ‘Compliance with service standards for residential care’ is defined as the proportion of re‑accredited services that have received three‑year accreditation for both services re‑accredited within the financial year, and for all re‑accredited services.  High or increasing proportions of facilities with three‑year re‑accreditation is desirable. Three years is the longest period for which re‑accreditation can be granted (in most cases), so if a service is re‑accredited for this period it implies a higher level of care and service quality, than for those re‑accredited for a shorter period.  Australian Government funded residential services are required to meet accreditation standards (which comprise 44 expected outcomes). The accreditation process is managed by an accreditation agency (currently the Australian Aged Care Quality Agency). A service applying for accreditation undertakes an initial self‑assessment against the accreditation standards. A team of quality assessors review the application, conduct an onsite assessment and prepare a report based on their observations and interviews with residents, relatives, staff and management, and other relevant documentation. Based on this report and any submissions from the residential service and other relevant information (including information from DSS) an authorised decision maker considers whether to accredit and, if so, for how long. Commencing services are subject to a desk audit only, and are accredited for one year.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required June 2015 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/rogs/2016. |
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Of all re‑accredited residential aged care services, 97.6 per cent had an accreditation status of a period of three years as at 30 June 2015 (table 13.4). A re‑accreditation decision was made during 2014‑15 for 1237 services, of which 96.8 per cent were granted three year accreditation (table 13.4). Data on re‑accreditation decisions during 2014‑15 by remoteness and size of facility are in tables 13A.44–45.

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| Table 13.4 Residential aged care services re‑accredited for three years, 30 June 2015**a** |
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| a See box 13.10 and tables 13A.43 and 13A.46 for detailed definitions, footnotes and caveats. |
| *Source*: Australian Aged Care Quality Agency(unpublished); tables 13A.43 and 13A.46. |
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#### Quality – Compliance with service standards for home care and support

‘Compliance with service standards for home care and support’ is an indicator of governments’ objective to ensure that home care and support programs provide a minimum level of service quality and include systems for continuous improvement in the care provided to recipients (box 13.11).

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| Box 13.11 Compliance with service standards for home care and support |
| Compliance with service standards for home care and support’ is defined as the proportion of reviews of home care and support services that met all expected outcomes under each of the Home Care Common Standards:   * Standard 1 — Effective management — the service provider demonstrates effective management processes based on a continuous improvement approach to service management, planning and delivery. * Standard 2 — Appropriate access and service delivery — each service user (and prospective service user) has access to services and service users receive appropriate services that are planned, delivered and evaluated in partnership with themselves and/or their representatives. |
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| Box 13.11 (continued) |
| * Standard 3 — Service user rights and responsibilities — each service user (and/or their representative) is provided with information to assist them to make service choices and has the right (and responsibility) to be consulted and respected. Service users (and/or their representative) have access to complaints and advocacy information and processes and their privacy and confidentiality and right to independence is respected.   Services were required to appraise their performance against the Home Care Common Standards and complete a quality review at least once during the three year cycle. The number of reviews that were completed each year is provided for information. Data are reported for the Home Care Packages Program and National Respite for Carers Program (NRCP) combined, and separately for the HACC program.  A high or increasing proportion of reviews that met all expected outcomes under each of the Home Care Common Standards is desirable.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and overtime * complete (subject to caveats) for the current reporting period. All required 2014‑15 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/rogs/2016. |
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Nationally in 2014‑15, a total of 330 reviews of organisations providing Home Care and NRCP services were completed (table 13.5) and 382 reviews of organisations providing HACC (table 13.6). The proportion of these reviews that achieved all relevant expected outcomes was higher for Home Care/NRCP than HACC, across all three standards. These results varied across jurisdictions.

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| Table 13.5 Compliance with service standards for Home Care and NRCP, 2014‑15**a** |
| |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | *NSW* | *Vic* | *Qld* | *WA* | *SA* | *Tas* | *ACT* | *NT* | *Aust* | | *Number of reviews completed* (no.) | | | | | | | | |  | |  | 79 | 80 | 89 | 27 | 14 | 23 | 6 | 12 | 330 | | *Proportion of reviews achieving all relevant expected outcomes for the standard* (%) | | | | | | | | | | | Standard 1 | 82.1 | 93.2 | 82.7 | 80.6 | 100.0 | 86.7 | 100.0 | 76.9 | 86.0 | | Standard 2 | 83.2 | 98.9 | 89.8 | 83.9 | 100.0 | 90.0 | 100.0 | 38.5 | 88.6 | | Standard 3 | 95.8 | 100.0 | 99.0 | 90.3 | 100.0 | 100.0 | 100.0 | 84.6 | 97.4 | |
| a See box 13.11 and table 13A.48 for detailed definitions, footnotes and caveats. |
| *Source*: Australian Aged Care Quality Agency(unpublished); table 13A.48. |
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| Table 13.6 Compliance with service standards for HACC, 2014‑15**a** |
| |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | *NSW* | *Vic* | *Qld* | *WA* | *SA* | *Tas* | *ACT* | *NT* | *Aust* | | *Number of reviews completed* (no.) | | | | | | | | |  | |  | 131 | 52 | 80 | 43 | 37 | 12 | 12 | 15 | 382 | | *Proportion of reviews achieving all relevant expected outcomes for the standard* (%) | | | | | | | | | | | Standard 1 | 81.2 | 88.0 | 84.0 | 56.0 | 91.9 | 100.0 | 100.0 | 82.4 | 82.1 | | Standard 2 | 83.5 | 83.0 | 91.4 | 70.0 | 86.5 | 92.3 | 91.7 | 52.9 | 83.2 | | Standard 3 | 96.2 | 94.0 | 96.3 | 67.0 | 100.0 | 100.0 | 100.0 | 100.0 | 93.4 | |
| a See box 13.11 and table 13A.49 for detailed definitions, footnotes and caveats. |
| *Source*: Australian Aged Care Quality Agency(unpublished); table 13A.49. |
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#### Quality – Complaints resolution

‘Complaints resolution’ is a proxy indicator of governments’ objective to ensure aged care services provide a high quality of care (box 13.12).

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| Box 13.12 Complaints resolution |
| ‘Complaints resolution’ has two measures:   * the number of complaints received by the Aged Care Complaints Scheme (the Scheme) that are within the scope of the Scheme to handle (that is, relate to the responsibilities of an approved provider of residential or Home Care under the *Aged Care Act 1997* or under HACC funding agreements) per 1000 permanent care recipients * the proportion of complaints that were resolved without the need for a direction.   This indicator is a proxy of the quality of care and of the responsiveness of providers where issues about the quality of care or services are raised through complaints. A low or decreasing rate of complaints received and high proportion of complaints that were resolved without the need for a direction are desirable.  The Scheme encourages people to raise their concerns with the aged care provider in the first instance where possible. This can achieve a faster and more sustainable result through building relationships between all parties. If concerns are unable to be resolved directly with a service provider, then people can contact the Scheme. The Scheme assesses the risk associated with a complaint and the most appropriate method for resolving the complaint. This may mean encouraging resolution at a local provider level, conciliating an outcome between the complainant and the provider, or the Scheme investigating the complaint. Where the Scheme decides that an approved provider is not meeting its responsibilities, it has the power to issue the provider with directions. Prior to issuing a direction, the Scheme will typically give the provider other opportunities to remedy the issues, including responding to a notice of intention to issue directions. Where issues are addressed, directions may not be issued. |
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| Box 13.12 (continued) |
| Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions but a break in series means that data from 2012‑13 are not comparable to data for 2011‑12 * complete (subject to caveats) for the current reporting period. All required 2014‑15 data are available for all jurisdictions.   Data quality information for this indicator is under development. |
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During 2014‑15, the Scheme received 3725 complaints that were within the scope of the Scheme to handle (table 13A.47), which equated to 21.6 complaints per 1000 care recipients (figure 13.19). In 2014‑15, 80.9 per cent of complaints were resolved through early resolution and 19.1 per cent progressed to resolution (DSS unpublished). Of those complaints that progressed to resolution, 99.3 per cent were resolved without the need for a direction to the approved provider (table 13A.47).

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| Figure 13.19 Complaints received by the Aged Care Complaints Scheme that are within its scope to handle**a** |
| |  | | --- | | Figure 13.19 Complaints received by the Aged Care Complaints Scheme that are within its scope to handle  More details can be found within the text surrounding this image. | |
| a See box 13.12 and table 13A.47 for detailed definitions, footnotes and caveats. |
| *Source*:Department of Health and Ageing/DSS (unpublished); table 13A.47. |
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#### Quality – Client appraisal of service standards

‘Client appraisal of service standards’ is an indicator of governments’ objective to ensure high levels of client satisfaction with aged care services (box 13.13).

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| Box 13.13 Client appraisal of service standards |
| ‘Client appraisal of service standards’ is yet to be defined.  Data for this indicator were not available for the 2016 Report. |
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### Efficiency

#### Cost per output unit

‘Cost per output unit’ is a proxy indicator of governments’ objective to deliver efficient aged care services (box 13.14).

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| Box 13.14 Cost per output unit |
| ‘Cost per output unit’ is defined by two measures:   * Australian Government expenditure per ACAT assessment — Australian Government expenditure on the Aged Care Assessment Program divided by the number of completed assessments * expenditure per hour of service for HACC — Australian, Victorian and WA governments expenditure on services, divided by the number of hours of service provided (by service type domestic assistance, personal care, nursing and allied health service).   This is a proxy indicator of efficiency and needs to be interpreted with caution. While high or increasing cost per output unit may reflect deteriorating efficiency, it may also reflect changes in aspects of the service (such as greater time spent with clients) or differences in the characteristics of clients (such as their geographic location). Similarly, while low or declining cost per output unit may reflect improving efficiency it may also reflect declining quality (such as less time spent with clients).  Not all expenditure is included in these measures. Expenditure by non‑government sources on services (for example, client fees for HACC) and State and Territory governments’ contributions to the cost of ACAT assessments are not included.  Data reported for the ‘Australian Government expenditure per ACAT assessment’ measure are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required 2013‑14 data are available for all jurisdictions.   Data reported for the ‘expenditure per hour of service for HACC’ measure are:   * comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions * complete (subject to caveats) for the current reporting period. All required 2013‑14 data were available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/rogs/2016. |
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Australian Government expenditure per aged care assessment during 2013‑14 averaged $537.40nationally (figure 13.20). Australian, Victorian and WA governments’ expenditure per hour of HACC service during 2013‑14 was higher for nursing and allied health than for domestic assistance and personal care across the states and territories for which data are available (table 13A.51).

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| Figure 13.20 Australian Government expenditure on aged care assessments, per assessment (2013‑14 dollars)**a** |
| |  | | --- | | Figure 13.20 Australian Government expenditure on aged care assessments, per assessment (2013-14 dollars)  More details can be found within the text surrounding this image. | |
| a See box 13.14 and table 13A.50 for detailed definitions, footnotes and caveats. |
| *Source*:Department of Health and Ageing/DSS (unpublished); table 13A.50. |
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#### Expenditure per head of aged care target population

‘Expenditure per head of aged care target population’ is a proxy indicator of governments’ objective to deliver efficient aged care services (box 13.15).

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| Box 13.15 Expenditure per head of aged care target population |
| ‘Expenditure per head of aged care target population’ is defined as government expenditure divided by the number of people aged 65 years or over and Aboriginal and Torres Strait Islander Australians aged 50–64 years. Expenditure per person in the aged care target population is reported for Home Care, HACC, residential care and flexible services (comprising MPS, Transition Care and Aboriginal and Torres Strait Islander specific services). |
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| Box 13.15 (continued) |
| This is a proxy indicator of efficiency and needs to be interpreted with caution as it measures expenditure per head of the aged care target population, not cost per unit of service. While high or increasing expenditure per person can reflect deteriorating efficiency, it can 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 level of care need). Similarly, low or declining expenditure per person can reflect improving efficiency or a decrease in service standards.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions but a break in series means that data from 2012‑13 are not comparable to data for earlier years * complete (subject to caveats) for the current reporting period. All required 2014‑15 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/rogs/2016. |
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Governments’ expenditure on HACC, Home Care, residential and flexible care per person aged 65 years or over and Aboriginal and Torres Strait Islander Australians   
aged 50–64 years was $4023.22 nationally in 2014‑15 (figure 13.21), comprising $571.09 on HACC, $351.00 on Home Care, $2951.11 on residential care and $150.02 on flexible care. Expenditure per person in the HACC target population for older people is reported in table 13A.53.

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| Figure 13.21 Governments’ expenditure on key aged care programs, per person in the aged care target population, 2014‑15**a** |
| |  | | --- | | Figure 13.21 Governments’ expenditure on key aged care programs, per person in the aged care target population, 2014-15  More details can be found within the text surrounding this image. | |
| a See box 13.15 and tables 13A.8, 13A.52, 13A.54–55 for detailed definitions, footnotes and caveats. |
| *Source*:DSS (unpublished); tables 13A.8, 13A.52 and 13A.54–55. |
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### Outcomes

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

#### Social participation in the community

‘Social participation in the community’ is an indicator of governments’ objective to encourage the wellbeing and independence of older people (box 13.16).

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| Box 13.16 Social participation in the community |
| ‘Social participation in the community’ has three measures, the estimated proportions of older people (aged 65 years or over) who:   * participated in social or community activities away from home in the last three months * had face‑to‑face contact with family or friends not living in the same household in the last week, month or three months * did not leave home or did not leave home as often as they would like.   These measures are reported by disability status (profound or severe, other disability, all disability, without disability) and for all older people. Disability status is used as a ‘proxy’ to identify those older people who might need more assistance to support their social participation in the community.  High or increasing proportions of social participation in the community are desirable, as it indicates higher levels of wellbeing and independence.  Data for this/these measure/s include 95 per cent confidence intervals (in the form of error bars in figures).  Data reported for this measure are:   * comparable (subject to caveats) across jurisdictions (no time series data are reported) * complete (subject to caveats) for the current reporting period. All required 2012 data are available for all jurisdictions.   The SDAC does not include people living in discrete Aboriginal and Torres Strait Islander communities and very remote areas, which affects the comparability of the NT results.  Data quality information for this indicator is at www.pc.gov.au/rogs/2016. |
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Nationally in 2012, the estimated proportion of people aged 65 years or over who participated in any social or community activities away from home in the last three months was 93.2 per cent (table 13A.56). Participation in these activities was lower (82.7 per cent) for people with profound or severe disability (figure 13.22).

Nationally in 2012, older people without disability were more likely than those with profound or severe disability to have face‑to‑face contact with family or friends not living in the same household in the last week (78.9 per cent compared to 74.8 per cent) (table 13A.57). Data on face‑to‑face contact with family or friends not living in the same household, in the last month and last three months are in table 13A.57.

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| Figure 13.22 Participation of people aged 65 years or over in any social or community activities away from home in the last three months, by disability status, 2012**a** |
| |  | | --- | | Figure 13.22 Participation of people aged 65 years or over in any social or community activities away from home in the last three months, by disability status, 2012  More details can be found within the text surrounding this image. | |
| a See box 13.16 and table 13A.56 for detailed definitions, footnotes and caveats. |
| *Source*: ABS (unpublished) *SDAC 2012,* Cat. no.4430.0 (derived using Table Builder product);table 13A.56. |
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Nationally in 2012, the estimated proportion of people aged 65 years or over who did not leave home (or as frequently as they would like) was 16.2 per cent (figure 13.23) – this proportion was higher for those with profound or severe disability (46.8 per cent) than for other older people, especially those without disability (6.4 per cent).

Nationally, two of the main reasons older people did not leave home as frequently as they would like was their own disability/condition or they could not be bothered/nowhere to go (table 13A.58).

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| Figure 13.23 People aged 65 years or over who did not leave home or did not leave home as often as they would like, by disability status, 2012**a** |
| |  | | --- | | Figure 13.23 People aged 65 years or over who did not leave home or did not leave home as often as they would like, by disability status, 2012  More details can be found within the text surrounding this image. | |
| a See box 13.16 and table 13A.58 for detailed definitions, footnotes and caveats. |
| *Source*: ABS (unpublished) *SDAC 2012,* Cat. no.4430.0 (derived using Table Builder product); table 13A.58. |
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#### Maintenance of individual physical function

‘Maintenance of individual physical function’ is an indicator of governments’ objective for aged care services to promote the health, wellbeing and independence of older people and is measured using data for the Transition Care Program (TCP) only (box 13.17).

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| Box 13.17 Maintenance of individual physical function |
| Maintenance of individual physical function’ is defined as the improvement in the TCP client’s level of physical function, reflected in the difference between the average Modified Barthel Index (MBI) score on entry to the TCP to the average MBI score on exit from the TCP. The MBI is a measure of functioning in the activities of daily living, ranging from 0 (fully dependent) to 100 (fully independent). Data are reported for recipients who completed a Transition Care episode only.  This indicator needs to be interpreted with caution. The TCP operates with some differences across jurisdictions including differences in health and aged care service systems, local operating procedures and client groups. Variation in the average MBI scores on entry and exit from the program may reflect a range of target client groups for the program across jurisdictions. An increase in the score from entry to exit is desirable. |
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| Box 13.17 (continued) |
| The TCP is a small program at the interface of the health and aged care systems. A person may only enter the TCP directly upon discharge from hospital. The average duration of care is around 8.5 weeks (60 days for completed episodes), with a maximum duration of 12 weeks that may in some circumstances be extended by a further 6 weeks.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and overtime * complete for the current reporting period (subject to caveats). All required 2014‑15 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/rogs/2016. |
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The average MBI score on entry to the TCP in 2014‑15 was 71 nationally, and the average MBI score on exit from the TCP was 82 nationally (figure 13.24), an average increase in the average MBI score of 11 nationally.

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| Figure 13.24 TCP — average MBI score on entry and exit, 2014‑15**a** |
| |  | | --- | | Figure 13.24 TCP — average MBI score on entry and exit, 2014-15  More details can be found within the text surrounding this image. | |
| a See box 13.17 and table 13A.59 for detailed definitions, footnotes and caveats. |
| *Source*: DSS (unpublished); table 13A.59. |
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#### Hospital leave days from residential aged care for preventable causes

‘Hospital leave days from residential aged care for preventable causes’ has been identified for development as an indicator of governments’ objective to provide high quality and safe residential aged care services (box 13.18).

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| Box 13.18 Hospital leave days from residential aged care for preventable causes |
| ‘Hospital leave days from residential aged care for preventable causes’ is yet to be defined.  Low or decreasing proportions of residential aged care days on hospital leave due to selected preventable causes are desirable.  When developed for future reports, this indicator will show the proportion of residential aged care days that are taken as hospital leave for selected preventable causes. |
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#### Enabling people with care needs to live in the community

‘Enabling people with care needs to live in the community’ has been identified for development as an indicator of governments’ objective to delay entry to residential care when a person’s care needs can be met in the community (box 13.19).

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| Box 13.19 Enabling people with care needs to live in the community |
| ‘Enabling people with care needs to live in the community’ is yet to be defined.  High or increasing rates of people with care needs remaining and participating in the community are desirable.  When developed for future reports, this indicator will show the extent to which older people’s entry to residential care is delayed. |
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## 13.4 Future directions in performance reporting

On 28 June 2013, the Australian Government passed into law a package of Bills amending the *Aged Care Act 1997* to implement the national aged care reforms. These aged care reforms are being implemented in three phases over 10 years. The key reforms implemented during 2015 that may have a significant influence on reporting in future versions of this Report are that:

* all Home Care is now delivered on a Consumer Directed Care basis
* the functionality of the My Aged Care website and contact centre has significantly increased
* the pilot of national voluntary quality indicators for aged care commenced
* the Commonwealth Home Support Program and RAS have been introduced
* the Regulatory Performance Framework has been implemented.

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

* continued improvement of equity and efficiency indicators
* improved reporting of elapsed times for aged care
* improved reporting of hospital patient days used by aged care type patients
* inclusion of data on hospital leave days for preventable causes as they become available
* development of performance indicators relevant to the aged care reforms.

## 13.5 Definitions of key terms

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| **Accreditation** | Accreditation is a key component of the Australian Government’s quality framework for federally funded residential aged care and is a quality assurance system for residential aged care services — based on the principle of continuous improvement.  Accreditation requires assessment against the 44 expected outcomes used for accreditation assessment — grouped into four standards: management systems, staffing and organisational development; health and personal care; residential lifestyle; and physical environment and safety systems. |
| **Aged care** | Formal services funded and/or provided by governments that respond to the functional and social needs of older people, and the needs of their carers. Home care and support services aim to optimise independence and to assist 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. Assessment of care needs is an important component of aged care.  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. Other services aim to promote social participation and connectedness. These services are delivered by trained aged care workers and volunteers. However, aged care services may also be delivered by health professionals such as nurses and occupational therapists.  Aged care services generally aim to promote wellbeing and foster function rather than to treat illness. Although some aged care services such as transition care have a specific restorative role, they are distinguished from the health services described in Part E of this Report. 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. |
| **Aged care target population** | The Aged Care target population is defined as all people (Aboriginal and Torres Strait Islander and non‑Indigenous) aged 65 years or over and Aboriginal and Torres Strait Islander Australians aged 50–64 years. This is the population specified in the *National Health Reform Agreement* who are within the scope of, and funded for services under, the national aged care system (except in Victoria and WA). |
| **Aged care planning population** | The Aged care planning population is defined as people aged 70 years or over. This is the population used by the Australian Government for its needs‑based planning framework to ensure sufficient supply of both residential and home care places by matching the growth in the number of aged care places with growth in the aged population. It also seeks to ensure balance in the provision of services between metropolitan, regional, rural and remote areas, as well as between people needing differing levels of care.  Under the framework, the Australian Government seeks to achieve and maintain a specified national provision level of subsidised operational aged care places for every 1000 people aged 70 years or over. This provision level is known as the aged care provision ratio (DoHA 2012). |
| **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. |
| **Care leaver** | A care leaver is a person who was in institutional care (such as an orphanage or mental health facility) or other form of out‑of‑home care, including foster care, as a child or youth (or both) at some time during their lifetime (DoHA 2012). |
| **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. |
| **Comparability** | Data are considered comparable if (subject to caveats) they can be used to inform an assessment of comparative performance. Typically, data are considered comparable when they are collected in the same way and in accordance with the same definitions. For comparable indicators or measures, significant differences in reported results allow an assessment of differences in performance, rather than being the result of anomalies in the data. |
| **Complaint** | A complaint by the affected care recipient or his or her representative, or anyone else, to the Secretary of DSS about matters relevant to an approved provider’s responsibilities under the *Aged Care Act 1997* or the Aged Care Principles or a service provider’s responsibilities under the Commonwealth HACC funding agreement. |
| **Completeness** | Data are considered complete if all required data are available for all jurisdictions that provide the service. |
| **Concessional, assisted supported or low means residents** | Concessional residents are those who entered permanent residential care before 20 March 2008, receive an income support payment and have not owned a home for the last two or more years (or whose home is occupied by a protected person, for example, the care recipient’s partner), and have assets of less than 2.5 times the annual single basic age pension (or for a transfer from 20 September 2009 less than 2.25). Assisted residents are those meeting the above criteria, but with assets between 2.5 and 4.0 times the annual single basic age pension (or for a transfer from 20 September 2009 between 2.25 and 3.61). Supported residents are those who have entered permanent residential care on or after 20 March 2008 (or who re‑enter care on or after 20 March 2008 after a break in care of more than 28 days) and have assets of up to a set value at the date that they enter care (from 20 March 2014 to 19 September 2014 — $116 136.00, from  20 September 2014 to 19 March 2015 — $116 636.00 and from 20 March 2015 to 19 September 2015 — $118 363.20, from 20 September 2015 — $118 966.40). Low means residents are those who have entered permanent residential care on or after 1 July 2014 (or who re‑enter care on or after 1 July 2014 after a break in care of more than 28 days; or who re‑enter care on or after 1 July 2014 and choose to ‘opt in’ to the new means testing arrangements) and have a daily means tested amount (assessed under the combined assets and income means test) at the date they enter care that is less than the maximum daily rate of accommodation supplement, from 1 July 2014 to 19 September 2014 – $52.49, from 19 September 2014 to 19 March 2015 – $53.04, from 20 March 2015 to 19 September 2015 – $53.39, from 20 September 2015 –‑ $53.84. |
| **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. |
| **Enterprise Bargaining Agreement 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** | The measure of the time elapsed between an ACAT approval and entry into a residential care service or commencement of Home 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 older and frail people with moderate, severe or profound disabilities. The HACC Target Population is estimated by applying the proportion of all people with moderate, severe or profound disability in households, by sex and five year age groups, from the ABS 2012 SDAC to Population projections by Statistical Local Area for 2012–2027 (prepared by ABS according to assumptions agreed to by DSS) in each jurisdiction. To calculate the Indigenous 50‑64 year component of the HACC target population for older people, the proportion of all people aged 50‑64 years in households with moderate, severe or profound disability was multiplied by an additional Indigenous factor of 1.9 (from ABS unpublished analysis) and then applied to DSS Indigenous population projections in the 50‑64 years age groups in each jurisdiction. The HACC target population from 2013‑14 is based on the SDAC 2012 while HACC target populations for previous years are based on SDAC 2009. See table 13A.2 for details about the total population projections and the Aboriginal and Torres Strait Islander population used in these calculations. |
| **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 profound, severe and moderate disability** | A person with a profound disability is unable to do, or always needs help with, a core activity task.  A person with a severe disability:   * sometimes needs help with a core activity task, and/or * has difficulty understanding or being understood by family or friends, or * can communicate more easily using sign language or other non‑spoken forms of communication.   A person with a moderate disability needs no help, but has difficulty with a core activity task. |
| **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 General Government Final Consumption Expenditure chain price deflator. |
| **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 a carer or a care recipient a short term break from their usual care arrangement. |
| **Rural small nursing home supplement** | Payments made by states and territories to small sized 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 1997*, specifies the following people as people with special needs: people from Aboriginal and Torres Strait Islander communities; people from culturally and linguistically diverse backgrounds; veterans; people who live in rural or remote areas; people who are financially or socially disadvantaged; people who are homeless or at risk of becoming homeless; care‑leavers; parents separated from their children by forced adoption or removal; and lesbian, gay, bisexual, transgender and intersex people. |
| **Veterans** | Veterans, war widows, widowers and dependants who hold a Repatriation Health Card and are entitled to health services and treatment under the *Veterans’ Entitlements Act 1986* (VEA), *Safety, Rehabilitation and Compensation Act 1988* (SRCA) or the *Military Rehabilitation and Compensation Act 2004* (MRCA). |

## 13.6 List of attachment tables

Attachment tables are identified in references throughout this chapter by a ‘13A’ prefix (for example, table 13A.1). Attachment tables are available on the website (www.pc.gov.au/rogs/2016).

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| **Table 13A.1** | People aged 65 and over, by sex and remoteness, 30 June 2015 |
| **Table 13A.2** | Aged care target population, by remoteness areas (‘000) |
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## 13.7 References

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