# 14 Aged care services

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| Attachment tables |
| Attachment tables are identified in references throughout this chapter by a ‘14A’ prefix (for example, table 14A.1) and are available from the website www.pc.gov.au/rogs/2017. |
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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.

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

## 14.1 Profile of aged care services

### Service overview

Government funded aged care services are provided on the basis of frailty or disability. Services covered are:

* information and assessment services
* home care and support services
* residential care services
* flexible care services.

The Australian Government also funds activities related to workforce and service quality, and ageing and service improvement.

Government funded aged care services represent around one‑quarter of the total assistance provided to older people with around three‑quarters coming from informal providers   
(ABS 2016). A spouse, partner or other family member are the largest source of care and support for older people (ABS 2016). Older people can also purchase care and support services in the private market.

### 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.

State, Territory and local governments fund and/or deliver some aged care services. State and Territory governments’ main areas of involvement are in 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 Home and Community Care (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 providers (tables 14A.10−11) such as religious, community‑based and charitable organisations. Governments subsidise only a portion of the cost of care, with clients and residents also contributing through fees and payments. Charitable sources and donations can also be a source of revenue for providers.

### Government expenditure

Government recurrent expenditure on aged care services was $16.8 billion in 2015‑16 or $4453 per older person (table 14A.3 and figure 14.1). Residential aged care services accounted for the largest proportion of expenditure in 2015‑16 ($11.5 billion, or 68.7 per cent). Home care and support services accounted for much of the remainder ($4.3 billion), which included expenditure of $1.6 billion on Home Support[[1]](#footnote-1), $1.0 billion on HACC (Victoria and WA only), $1.5 billion on Home Care and $233 million on the Department of Veterans’ Affairs (DVA) Community Nursing Program and Veterans’ Home Care (VHC) (table 14A.3).

The Australian Government provides most of the government funding for aged care services (around 95 per cent). State and Territory governments fund the remainder, with the largest contribution being from the Victorian and WA governments who with the Australian Government jointly fund HACC services in these jurisdictions (table 14A.3). Further detailed expenditure data by program are contained in tables 14A.3−8.

| Figure 14.1 Real recurrent expenditure on aged care services per older person**a** |
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| | Figure 14.1 Real recurrent expenditure on aged care services per older person  More details can be found within the text surrounding this image. | | --- | |
| a See table 14A.4 for detailed footnotes and caveats. |
| *Source*: Department of Health (unpublished); DVA (unpublished); State and Territory governments (unpublished); table 14A.4. |
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### Size and scope of sector

#### Aged care target population

The demand for aged care services is driven by the size and health of the older population. The Australian population is ageing rapidly, with the proportion of people aged 65 years or over in the total population projected to increase from 15.1 per cent in 2016 (table 14A.1) to 21.8 per cent in 2056 (ABS 2013). Although the Aboriginal and Torres Strait Islander population is also ageing, life expectancy at birth for Aboriginal and Torres Strait Islander people is lower when compared with the total Australian population (10.6 years less for males and 9.5 years less for females) (ABS 2013). In 2016, only 4.2 per cent of the Aboriginal and Torres Strait Islander population was aged 65 years or over (table 2A.14).

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

#### 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. For example, My Aged Care assists older people and their carers to access aged care information, and find Australian Government funded aged care services in their local area.

Assessment services determine the need and eligibility for government subsidised aged care services. A comprehensive assessment and approval by an ACAT, or Aged Care Assessment Services in Victoria, is mandatory for admission to residential care, to receive Home Care or enter Transition Care. ACATs also make recommendations regarding the most appropriate long‑term care arrangements for clients (table 14A.29). Assessments for other aged care programs are conducted by other agencies, such as Regional Assessment Services.

Some ACAT assessments will not result in an approval for care, whilst some clients can be approved for more than one type of care. In 2014‑15, there were 175 267 ACAT assessments undertaken for older people in the target population (equivalent to 48.0 per 1000 older people) and 218 569 approvals for people aged 65 years or over (table 14A.23 and Department of Health (unpublished)). ACAT approvals rates for Home Care and residential aged care significantly increase with age (figure 14.2).

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| Figure 14.2 ACAT assessment age‑specific approval rates, 2014‑15**a** |
| |  |  | | --- | --- | | **Home care** | **Residential aged care** | | Figure 14.2 ACAT assessment age-specific approval rates, 2014-15  Home care  More details can be found within the text surrounding this image. | Figure 14.2 ACAT assessment age-specific approval rates, 2014-15  Residential aged care  More details can be found within the text surrounding this image. | |
| a See table 14A.24 for detailed footnotes and caveats. |
| *Source*:Department of Health (unpublished); table 14A.24. |
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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. Most services were provided under the following programs in 2015‑16:

* CHSP (all jurisdictions except Victoria and WA) and HACC (Victoria and WA only) provide basic maintenance and support services for people in the community whose independence is at risk — centre‑based day care, domestic assistance and social support are some of the service types (tables 14A.21−22).
* Home Care — packages of care tailored to client needs, at basic to low levels (1−2) or intermediate to high levels (3−4), which can include personal care (such as showering), support services (such as cleaning) and clinical care (such as nursing and allied health support). At June 2016, the total number of Home Care operational places available was 79 819 (comprising 2.8 per cent at level 1, 66.7 per cent at level 2, 9.2 per cent at level 3 and 21.2 per cent at level 4) (table 14A.9). Usage rates for Home Care increase with age (table 14A.19).
* DVA community care for eligible veterans — VHC services are designed for those with low care needs, such as for domestic assistance, home and garden maintenance, and respite care; while DVA community nursing services are designed for those with high level personal care needs or disability, such as for acute/post‑acute support and maintenance and palliative care. There were 53 595 older clients (aged 65 years or over) approved for VHC services in 2015‑16 and 20 843 older clients received community nursing services, representing 363.2 and 141.3 per 1000 older eligible veterans respectively (tables 14A.7−8).

During 2015-16, the number of older clients who used HACC and Home Care was 76.0 and 24.2 per 1000 older people respectively (figure 14.3). CHSP client and activity data were not provided for this report due to under-reporting and a new data capturing system.

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| Figure 14.3 Older clients of HACC and home care services per 1000 older people, by program, 2015‑16**a, b** |
| |  | | --- | | Figure 14.3 Older clients of HACC and home care services per 1000 older people, by program, 2015-16  More details can be found within the text surrounding this image. | |
| a See table 14A.2 for detailed footnotes and caveats. b HACC is only applicable in Victoria and WA. |
| *Source*:Department of Health (unpublished); table 14A.2. |
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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 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.

The Aged Care Funding Instrument (ACFI) is used to appraise a permanent resident’s needs. The ACFI measures need based on the level of dependency in each of three domains: Activities of Daily Living, Behaviours and Complex Health Care. The Australian Government’s annual subsidy varies according to clients’ level of overall dependency. Residents’ care needs may change and residents are reappraised using the ACFI as required. Respite residents are not appraised under the ACFI but are classified as high or low care based on their ACAT approval.

During 2015‑16, the number of older clients who were in residential aged care nationally was 227 819 for permanent care and 55 146 for respite care, representing 60.4 and 14.6 older clients per 1000 older people respectively (figure 14.4). At 30 June 2016, the total number of residential aged care operational places available in mainstream services was 195 825 (table 14A.13); including flexible places, it was 199 449 (table 14A.10). Age‑specific usage rates for permanent residential aged care increased with age for both males and females, but more so for females (table 14A.19).

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| Figure 14.4 Older permanent and respite residential aged care clients per 1000 older people, 2015‑16**a** |
| |  | | --- | | Figure 14.4 Older permanent and respite residential aged care clients per 1000 older people, 2015-16  More details can be found within the text surrounding this image. | |
| a See table 14A.2 for detailed footnotes and caveats. |
| *Source*:Department of Health (unpublished); table 14A.2. |
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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 hospital care to help maximise independence and avoid premature entry to residential aged care. During 2015‑16, there were 23 796 older clients of Transition Care (table 14A.2) across the 4000 operational places (table 14A.46).
* The MPS program delivers flexible and integrated health and aged care services to small rural and remote communities. In 2015‑16, there was a total of 3592 operational MPS program places (includes residential and home care places) (Department of Health unpublished).
* 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. At 30 June 2016, there were 820 operational flexible aged care places under this program (Department of Health unpublished).

## 14.2 Framework of performance indicators

The framework of performance indicators for aged care services is based on governments’ objectives for the aged care sector (box 14.1).

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| Box 14.1 Objectives for aged care services |
| The aged care system aims to promote the wellbeing and independence of older people (and their carers), by enabling them to stay in their own homes or by assisting them in residential care. Governments seek to achieve this aim by subsidising aged care services that are:   * accessible — including, timely and affordable * planned effectively — targeted to areas of need and integrated with other services * appropriate to meet the needs of the recipients and their carers — with an emphasis on ageing in place and restorative approaches * person‑centred, taking into account individual goals, preferences and choices * high quality.   Governments aim for aged care services to meet these objectives in an equitable and efficient manner. |
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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 14.5).

The performance indicator framework shows which data are complete and comparable in the 2017 Report. For data that are not considered directly comparable, text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability, data completeness and information on data quality from a Report wide perspective. In addition to section 14.1, the Report’s statistical context chapter (chapter 2) contains data that may assist in interpreting the performance indicators presented in this chapter.

Improvements to performance reporting for aged care services are ongoing and will include identifying indicators to fill gaps in reporting against key objectives, improving the comparability and completeness of data and reviewing proxy indicators to see if more direct measures can be developed.

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| Figure 14.5 Aged care services performance indicator framework |
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## 14.3 Key performance indicator results

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

### 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). 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 aged care services in an equitable manner (box 14.2).

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| Box 14.2 Use by different groups |
| ‘Use by different 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 Culturally and Linguistically Diverse (CaLD) backgrounds). 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.  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.  There are nine special needs groups identified by the *Aged Care Act 1997* and its principles (see section 14.4 for details). Measures are reported for only two of these special needs groups. Measures for people who live in rural or remote areas, veterans (including widows and widowers of veterans) and financially and socially disadvantaged are currently under development (although data are available on the proportion of all permanent residents’ care days used by financially disadvantaged, see table 14A.20). Data are not available for reporting on the remaining special needs groups.  Several factors should be considered when interpreting the results for these measures:   * Higher disability rates can increase the use of services by different special needs groups. To account for higher disability rates, lower life expectancy and an increased likelihood of requiring aged care services at a younger age, the 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 other population groups. * Cultural differences and the availability of informal care and support can also affect the use of services across different population groups. Stronger informal support networks can reduce the need for formal aged care services, or for particular service types. |
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| Box 14.2 (continued) |
| Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * incomplete for the current reporting period. All required 2015‑16 data were not provided for CHSP. |
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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. Nationally:

* Aboriginal and Torres Strait Islander Australians were overrepresented in clients of Home Care levels 1−2, but underrepresented in clients of all other service types
* people from CaLD backgrounds were overrepresented in clients receiving Home Care levels 1−2 and Home Care levels 3−4, but underrepresented in clients of all other service types (table 14.1).

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| Table 14.1 Representation of special needs groups in the aged care target population, compared with their representation in older clients of aged care services (per cent)**a** |
| |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | NSW | Vic | Qld | WA | SA | Tas | ACT | NT | Aust | | **Aboriginal and Torres Strait Islander people** | | | | | | | | | | | *Aged care target population, June 2016* | 3.0 | 0.8 | 4.1 | 3.9 | 2.0 | 4.5 | 1.7 | 42.9 | 3.0 | | ACAT assessments, 2014‑15 | 1.2 | 0.5 | 1.8 | 2.0 | 1.0 | 0.9 | 0.9 | 40.1 | 1.4 | | Residential aged care, at 30 June 2016 | 0.7 | 0.2 | 1.5 | 1.8 | 0.5 | 0.6 | 0.5 | 38.9 | 0.9 | | Home care levels 1‒2, 30 June 2016 | 3.8 | 4.1 | 5.6 | 6.7 | 2.5 | 2.4 | 7.8 | 67.0 | 5.3 | | Home care levels 3‒4, 30 June 2016 | 1.6 | 1.8 | 2.5 | 2.4 | 1.5 | 1.2 | 0.3 | 27.8 | 2.1 | | CHSP, 2015-16 | np | np | np | np | np | np | np | np | np | | HACC, 2015‑16 | .. | 1.0 | .. | 3.0 | .. | .. | .. | .. | .. | | Transition Care, 2015‑16 | 0.8 | 0.1 | 1.9 | 1.7 | 0.6 | 1.3 | 1.7 | 21.1 | 1.1 | |
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| Table 14.1 (continued) |
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| a See box 14.2 and tables 14A.17–18 for detailed definitions, footnotes and caveats. .. Not applicable. **np** Not published. | |
| *Source*:Department of Health (unpublished); Victorian and WA governments (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); ABS (2014) *Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 2001 to 2026*, Cat. no. 3238.0;tables 14A.17–18. | |
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### Effectiveness

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

‘Elapsed times for aged care services’ is a proxy indicator of governments’ objective to provide services that are accessible. Elapsed times are used as a proxy as waiting times cannot be measured accurately (box 14.3).

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| Box 14.3 Elapsed times for aged care services |
| ‘Elapsed times for aged care services’ is defined as the proportions of people who entered residential care or commenced Home Care, who did so within three months of their ACAT approval.  Higher proportions of admission to residential care or commencement of Home Care within three months of ACAT approval are desirable. |
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| Box 14.3 (continued) |
| 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’ (for example, hospital discharge policies and practices, or a client’s choice not to commence care immediately). 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.  The measure does not include clients who 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.  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 2015‑16 data are available for all jurisdictions. |
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Overall, 52.0 per cent of all people entering residential care during 2015‑16 did so within three months of their ACAT approval (figure 14.6), compared with 58.4 per cent in 2014‑15 (table 14A.25). The median time for entry into residential services was 84 days in 2015‑16 compared to 68 days in 2014‑15 (table 14A.25). Further data on elapsed time by specified time periods, remoteness, Socio‑Economic Indexes for Areas (SEIFA) and Indigenous status are included in tables 14A.25–28.

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| Figure 14.6 People entering residential care within specified time periods of their ACAT approval, 2015‑16**a** |
| |  | | --- | | Figure 14.6 People entering residential care within specified time periods of their ACAT approval, 2015-16  More details can be found within the text surrounding this image. | |
| a See box 14.3 and table 14A.25 for detailed definitions, footnotes and caveats. |
| *Source*:Department of Health (unpublished); table 14A.25. |
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Overall, 57.1 per cent of all people commencing Home Care during 2015‑16, received care within three months of being approved by an ACAT (figure 14.7). The median time for entry into Home Care was 73 days in 2015‑16 compared to 67 days in 2014‑15 (table 14A.25).

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| Figure 14.7 People commencing Home Care within one or three months of their ACAT approval, 2015‑16**a** |
| |  | | --- | | Figure 14.7 People commencing Home Care within one or three months of their ACAT approval, 2015-16  More details can be found within the text surrounding this image. | |
| a See box 14.3 and table 14A.25 for detailed definitions, footnotes and caveats. |
| *Source*:Department of Health (unpublished); table 14A.25. |
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#### Access – Unmet need

‘Unmet need’ is an indicator of governments’ objective of ensuring aged care services are accessible (box 14.4).

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| Box 14.4 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 2015 *Survey Disability Ageing and Carers* (SDAC) on older people with a need for assistance with at least one everyday activity (which could be met by formal or informal providers), and the extent to which that need was being met (fully, partly or not at all) are reported in table 14A.30. Although these data are included, this indicator is regarded as yet to be developed because further work is needed to define the scope and understand the impact of the caveats. |
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Nationally in 2015, 30.8 per cent of older people (aged 65 years and over) who were living in households and needed assistance, reported that their need was not fully met (table 14A.30). The proportion was higher for older people with a profound and severe disability (37.4 per cent) than for older people without a disability (20.8 per cent).

#### Access – 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 of ensuring aged care services are accessible (box 14.5).

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.

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| Box 14.5 Hospital patient days used by aged care type patients |
| ‘Hospital patient days used by aged care type patients’ is defined as 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).   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 acute care aimed at addressing serious illness or injury, or diagnosis. The needs of older people for maintenance care (particularly for extended periods of time) can be better met through residential aged care services than hospitals.  The indicator should be interpreted with caution, because:   * days for patients who have not completed their period of care in a hospital are not included * although the diagnosis codes reflect a care type, they may not reflect a person’s eligibility for residential 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 * the diagnosis codes may not be applied consistently across jurisdictions or over time.   Data reported for this indicator 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 2014‑15 data are available for all jurisdictions. |
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The proportion of all hospital patient days used by patients who are waiting for residential aged care was 10.0 per 1000 patient days nationally in 2014‑15 (figure 14.8). Proportions are higher for Aboriginal and Torres Strait Islander people compared to non‑Indigenous people and decrease as socioeconomic status of residence increases (table 14A.32).

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| Figure 14.8 Hospital patient days used by patients waiting for residential aged care**a** |
| |  | | --- | | Figure 14.8 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 14.5 and table 14A.32 for detailed definitions, footnotes and caveats. |
| *Source*:Australian Institute of Health and Welfare (unpublished); table 14A.32. |
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#### Appropriateness – Operational aged care places

‘Operational aged care places’ is an indicator of governments’ objective to plan aged care services effectively; that is, targeted to areas of need (box 14.6).

The planning framework for services provided under the *Aged Care Act 1997* aims to keep the growth in 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. See section 14.4 for a definition of the aged care planning population.

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| Box 14.6 Operational aged care places |
| ‘Operational aged care places’ is defined as the number of operational places (by type of place — residential aged care, Home Care levels 1–2 and Home Care levels 3–4) per 1000 people aged 70 years or over and Aboriginal and Torres Strait Islander Australians aged 50–69 years.  In general, provision ratios across states and territories, and across regions, that are broadly similar are desirable, as it indicates that services are planned effectively so 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 2016 data are available for all jurisdictions. |
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Nationally, the combined number of residential care and Home Care places at 30 June 2016 was 107.5 per 1000 people aged 70 years or over and Aboriginal and Torres Strait Islander Australians aged 50–69 years (figure 14.9) and 111.6 per 1000 people aged 70 years or over (table 14A.14). Transition Care adds an additional 1.6 places per 1000 people aged 70 years or over (table 14A.14).

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| Figure 14.9 Operational aged places per 1000 people aged 70 years or over and Aboriginal and Torres Strait Islander Australians aged 50–69 years, 30 June 2016**a** |
| |  | | --- | | Figure 14.9 Operational aged places per 1000 people aged 70 years or over and Aboriginal and Torres Strait Islander Australians aged 50–69 years, 30 June 2016  More details can be found within the text surrounding this image. | |
| a See box 14.6 and table 14A.15 for detailed definitions, footnotes and caveats. |
| *Source*:Department of Health (unpublished); table 14A.15. |
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Nationally, at 30 June 2016, 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 (115.1), than for inner and outer regional areas (99.3) or remote and very remote areas (77.4) (table 14A.16).

#### Quality – Compliance with service standards for residential care

‘Compliance with service standards for residential care’ is an indicator of governments’ objective to provide high quality aged care services (box 14.7).

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| Box 14.7 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.  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 service quality, than for those re‑accredited for a shorter period. Further information on the accreditation standards and process is available at www.aacqa.gov.au.  Data for this indicator do not include 22 new facilities that have not been re‑accredited as at  30 June (equal to 0.8 per cent of all residential care facilities).  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions (only one year of data are reported) * complete (subject to caveats) for the current reporting period. All required June 2016 data are available for all jurisdictions. |
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Of all re‑accredited residential aged care services (2655), 98.3 per cent had an accreditation status of a period of three years as at 30 June 2016 (table 14A.36). A re‑accreditation decision was made during 2015‑16 for 1053 services, of which 98.0 per cent were granted three year accreditation (table 14A.33). Data on re‑accreditation decisions during 2015‑16 by remoteness and size of facility are in tables 14A.34–35.

#### 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 provide high quality aged care services (box 14.8).

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| Box 14.8 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. * 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.   Data are reported for Australian Government home care and support providers combined, and separately for the WA HACC program. Data for 2015‑16 for Victorian HACC services are not available as no reviews were conducted.  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 for Australian Government home care and support providers and over time for WA HACC services * complete (subject to caveats) for the current reporting period. All required 2015‑16 data are available for all jurisdictions. |
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Nationally at 30 June 2016, of the reviews to be conducted over the three year cycle (2014–2017) for Australian Government home care and support service providers, 68.6 per cent had been (table 14A.38), as had 67.0 per cent of the reviews to be conducted for organisations providing HACC services in WA (table 14A.39). The proportion of Australian Government home care and support service providers reviewed that achieved all expected outcomes for each of the three standards are in table 14.2. Results for WA HACC services were similar (table 14A.39).

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| Table 14.2 Australian Government home care and support service providers that achieved all relevant expected outcomes, 2015‑16 (per cent)**a** |
| |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | *NSW* | *Vic* | *Qld* | *WA* | *SA* | *Tas* | *ACT* | *NT* | *Aust* | | Standard 1 | 94.2 | 98.5 | 92.7 | 100.0 | 90.7 | 96.8 | 96.3 | 83.6 | 94.1 | | Standard 2 | 95.9 | 99.0 | 97.9 | 100.0 | 89.9 | 100.0 | 100.0 | 90.2 | 96.6 | | Standard 3 | 99.2 | 100.0 | 99.2 | 100.0 | 98.4 | 100.0 | 100.0 | 93.4 | 99.1 | |
| a See box 14.8 and table 14A.38 for detailed definitions, footnotes and caveats. |
| *Source*: Australian Aged Care Quality Agency(unpublished); table 14A.38. |
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#### Quality – Complaints received

‘Complaints received’ is a proxy indicator of governments’ objective to provide high quality aged care services (box 14.9).

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| Box 14.9 Complaints received |
| ‘Complaints received’ is defined as the number of in‑scope complaints received per 1000 care recipients. Complaints within scope relate to Australian Government funded providers of residential, home care, Commonwealth Home Support or flexible care aged care services.  All else being equal, a low or decreasing rate of complaints can suggest higher quality services. However, a high or increasing rate of complaints may not necessarily mean lower quality services as it may reflect more effective complaints reporting and monitoring arrangements.  On 1 January 2016, the Aged Care Complaints Commissioner (Complaints Commissioner) replaced the Aged Care Complaints Scheme (the Scheme) and took over responsibility for the management of in‑scope complaints. The 2015‑16 data relate to complaints for six months of the former Scheme and six months of the Complaints Commissioner. Further information on the operation of the Complaints Commissioner is available at www.agedcarecomplaints.gov.au.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions but not comparable over time * complete (subject to caveats) for the current reporting period. All required 2015‑16 data are available for all jurisdictions. |
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During 2015‑16, 3936 in‑scope complaints were received, which equated to   
22.1 complaints per 1000 care recipients (table 14A.37).

#### Quality – Client experience of services

‘Client experience of services’ is yet to be defined, but will be an indicator of governments’ objective to provide high quality aged care services.

#### Quality – 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, but will be an indicator of governments’ objective to provide high quality aged care services.

### Efficiency

#### Cost per output unit

‘Cost per output unit’ is a proxy indicator of governments’ objective to deliver aged care services in an efficient manner (box 14.10).

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| Box 14.10 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 CHSP/HACC — Australian, Victorian and WA governments expenditure on services, divided by the number of hours of service provided.   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 CHSP/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 2014‑15 data are available for all jurisdictions.   Data reported for the ‘expenditure per hour of service for CHSP/HACC’ measure are:   * comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions * incomplete (subject to caveats) for the current reporting period. All required 2015‑16 data were not provided for CHSP. |
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Australian Government expenditure per aged care assessment during 2014‑15 averaged $586nationally (figure 14.10). In 2015‑16, Australian, Victorian and WA governments’ expenditure on HACC services per hour was higher for nursing and allied health than for domestic assistance and personal care (table 14A.41). CHSP client and activity data were not provided for this report due to under-reporting and a new data capturing system.

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| Figure 14.10 Australian Government expenditure on aged care assessments, per assessment (2014‑15 dollars)**a** |
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| a See box 14.10 and table 14A.40 for detailed definitions, footnotes and caveats. |
| *Source*:Department of Health (unpublished); table 14A.40. |
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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 aged care services in an efficient manner (box 14.11).

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| Box 14.11 Expenditure per head of aged care target population |
| ‘Expenditure per head of aged care target population’ is defined as government expenditure per person aged 65 years or over and Aboriginal and Torres Strait Islander Australians aged  50–64 years. It is reported for Home Care, Home Support (including HACC expenditure in Victoria and WA), residential care and flexible services (comprising MPS, Transition Care and Aboriginal and Torres Strait Islander specific services).  This is a proxy indicator of efficiency as it measures expenditure per person in the target population, not cost per unit of service. As such it is a measure of system‑wide efficiency, rather than technical or service efficiency. |
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| Box 14.11 (continued) |
| While high or increasing expenditure per person can reflect deteriorating efficiency, it can also reflect changes in aspects of services (such as better quality of services) or in the characteristics of clients receiving services (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 across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required 2015‑16 data are available for all jurisdictions. |
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Governments’ expenditure in 2015‑16 on key aged care programs per person in the target population was $626 for Home Support (including HACC expenditure in Victoria and WA), $394 for Home Care, $3061 for residential care and $147 for flexible care (figure 14.11).

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| Figure 14.11 Governments’ expenditure on key aged care programs, per person in the aged care target population, 2015‑16**a** |
| |  | | --- | | Figure 14.11 Governments’ expenditure on key aged care programs, per person in the aged care target population, 2015-16   More details can be found within the text surrounding this image. | |
| a See box 14.11 and table 14A.42 for detailed definitions, footnotes and caveats. |
| *Source*:Department of Health (unpublished); State and Territory governments; table 14A.42. |
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### Outcomes

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

#### 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 14.12).

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| Box 14.12 Social participation in the community |
| ‘Social participation in the community’ has two 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 * 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 disability, 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.  High or increasing proportions of social participation in the community are desirable, as it indicates higher levels of wellbeing and independence.  Data reported for this measure are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required 2015 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. |
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Nationally in 2015, the estimated proportion of older people without disability who participated in any social or community activities away from home in the last three months was 95.9 per cent (table 14A.43). Participation in these activities was lower (82.9 per cent) for people with profound or severe disability (figure 14.12). Older people with profound or severe disability were also less likely than other older people without disability to have face‑to‑face contact with family or friends not living in the same household in the last week (74.5 per cent compared to 78.4 per cent) (table 14A.44).

Nationally in 2015, the estimated proportion of older people who did not leave home (or as frequently as they would like) was 14.5 per cent (table 14A.45) — this proportion was higher for those with profound or severe disability (45.6 per cent) than for other older people, especially those without disability (6.5 per cent) (figure 14.13).

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| Figure 14.12 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, 2015**a, b** |
| |  | | --- | | Figure 14.12 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, 2015  More details can be found within the text surrounding this image. | |
| a Error bars represent the 95 per cent confidence interval associated with each point estimate. b See box 14.12 and table 14A.43 for detailed definitions, footnotes and caveats. |
| *Source*: ABS (unpublished) *SDAC 2015,* Cat. no.4430.0 (derived using Table Builder);table 14A.43. |
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| Figure 14.13 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, 2015**a, b, c** |
| |  | | --- | | Figure 14.13 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, 2015  More details can be found within the text surrounding this image. | |
| a Error bars represent the 95 per cent confidence interval associated with each point estimate. b See box 14.12 and table 14A.45 for detailed definitions, footnotes and caveats. c NT data for people without disability are not published. |
| *Source*: ABS (unpublished) *SDAC 2015,* Cat. no.4430.0 (derived using Table Builder); table 14A.45. |
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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 wellbeing and independence of older people (box 14.13).

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| Box 14.13 Maintenance of individual physical function |
| ‘Maintenance of individual physical function’ is defined as the improvement in the Transition Care Program (TCP) client’s level of physical function, measured as the difference between the average Modified Barthel Index (MBI) score on TCP entry and exit.  An increase in the score from entry to exit is desirable.  The MBI is a measure of functioning ranging from 0 (fully dependent) to 100 (fully independent). Data are reported for recipients who completed a TCP episode only. See section 14.4 for details on the TCP.  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 differences in client groups for the program across jurisdictions.  The TCP is a small program only available directly upon discharge from hospital. The average duration of care is around 8.5 weeks, with a maximum duration of 12 weeks (may be extended by a further 6 weeks in some circumstances).  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 2015‑16 data are available for all jurisdictions. |
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Nationally in 2015‑16, the average MBI score on entry to the TCP was 71 and on exit from the TCP was 81 (figure 14.14).

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| Figure 14.14 TCP — average MBI score on entry and exit, 2015‑16**a** |
| |  | | --- | | Figure 14.14 TCP — average MBI score on entry and exit, 2015-16  More details can be found within the text surrounding this image. | |
| a See box 14.13 and table 14A.46 for detailed definitions, footnotes and caveats. |
| *Source*: Department of Health (unpublished); table 14A.46. |
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#### 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, but will be an indicator of governments’ objective to promote the wellbeing and independence of older people, by enabling them to stay in their own homes.

## 14.4 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. |
| **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. |
| **Complaint** | A complaint by the affected care recipient or his or her representative, or anyone else, to the Complaints Commissioner about matters relevant to an approved provider’s responsibilities under the Aged Care Act 1997 or the Aged Care Principles. |
| **Disability** | In the ABS SDAC 2015, a person has a disability if they report they have a limitation, restriction or impairment, which has lasted, or is likely to last, for at least six months and restricts everyday activities. This includes: loss of sight (not corrected by glasses or contact lenses); loss of hearing where communication is restricted, or an aid to assist with, or substitute for, hearing is used; speech difficulties; shortness of breath or breathing difficulties causing restriction; chronic or recurrent pain or discomfort causing restriction; blackouts, seizures, or loss of consciousness; difficulty learning or understanding; incomplete use of arms or fingers; difficulty gripping or holding things; incomplete use of feet or legs; nervous or emotional condition causing restriction; restriction in physical activities or in doing physical work; disfigurement or deformity; mental illness or condition requiring help or supervision; long term effects of head injury, stroke or other brain damage causing restriction; receiving treatment or medication for any other long term conditions or ailments and still being restricted and any other long term conditions resulting in a restriction. |
| **Elapsed time** | The measure of the time elapsed between an ACAT approval and entry into a residential care service or commencement of Home 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). |
| **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. |
| **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)*. |

## 14.5 References

ABS 2016, *Disability, Ageing and Carers Australia: Summary of Findings 2015,* Cat. no. 4430.0,Canberra.

—— 2013, *Experimental Life Tables for Aboriginal and Torres Strait Islander Australians, Australia, 2010–2012*, Cat. no. 3302.0.55.003, Canberra.

Department of Health 2016, *2015-16 Report on the Operation of the Aged Care Act 1997,* www.agedcare.health.gov.au/sites/g/files/net1426/f/documents/12\_2016/2015-16\_report-on-the-operation-of-the-aged-care-act-1997.pdf(accessed 21 December 2016).

DoHA (the former Department of Health and Ageing) 2012, *Report on the Operation of the Aged Care Act 1997, 1 July 2011 — 30 June 2012*, Canberra, www.health.gov.au/internet/main/publishing.nsf/Content/ageing reports acarep 2012.htm (accessed 10 December 2012).

1. The Commonwealth Home Support Program (CHSP) officially replaced (except in Victoria and WA) four separate home care and support programs from 1 July 2015: Commonwealth HACC, National Respite for Carers (NRCP), Day Therapy Centres (DTC) and the Assistance with Care and Housing for the Aged (ACHA). However, Commonwealth HACC, DTC, NRCP and ACHA programs were extended from 1 July 2015 to 31 October 2015 to allow organisations to transition to the CHSP from 1 November 2015. Expenditure on home support is expenditure on all these programs during 2015-16. [↑](#footnote-ref-1)