7 AGED CARE SERVICES

7.1 Introduction

The aged care system comprises all those services which are provided to enhance healthy ageing, however, the focus in this chapter is on those services provided to frail older people, particularly:

- residential or similar services, including nursing homes, hostels, nursing home-type patients in hospitals, and residential respite services;
- community care services, including the Home and Community Care (HACC) Program services, which incorporates Community Options (COPs) and respite services, and Community Aged Care Packages (CACPs); and
- assessment services by Aged Care Assessment Teams.

Several programs (for example HACC) deliver services to both frail older people, and to younger people with disabilities. It is not possible, at present, to identify the volume and type of services delivered to each group. Because the majority of its clients are frail older people the HACC program has been included in this chapter.

This is the first time aged care services are being reported on. Although a preliminary framework of indicators is presented, further work is required to more fully develop this framework and to define a set of indicators relating to each dimension of effectiveness and efficiency.

7.2 Profile of the sector

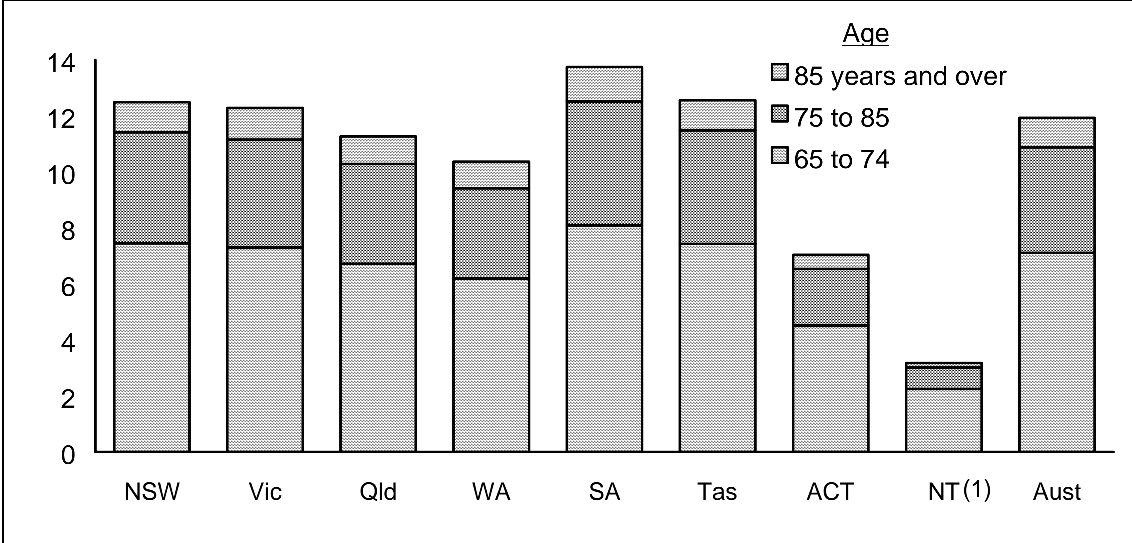
Aged care service may be narrowly defined as Commonwealth and State and Territory Government aged care programs which fund and/or provide residential and community based services for older people. It may be more broadly defined to include: acute and sub-acute health care provided to older persons; psychogeriatric and dementia care programs; non–health services such as transport concessions, medical services provided to older persons; support for carers; rehabilitation, and respite care. At the broadest level, housing, transport and other services for older people may also be included.

The focus in this chapter is on residential care and community care. It should be noted that the clients of aged care programs are not necessarily the older people themselves: another target group of aged care services is the carers of older people.

7.2.1 The older population

The distribution of aged persons varies significantly among jurisdictions. Both the ACT and the NT have a low proportion of older people. The other states and territories have similar distributions, although SA has the highest proportion of persons aged 65 years and over. SA also has the highest proportion of persons aged 85 years and over (Figure 7.1).

Figure 7.1: Older people, as a proportion of the total population, 1994–95 (per cent)



1 The NT has a higher proportion of indigenous people, who often require aged services at a younger age. Therefore the proportion of the population over 65 years of age is not necessarily a complete reflection of the care needs in the NT.

Source: ABS Cat. No. 3201.0.

7.2.2 Aged care programs

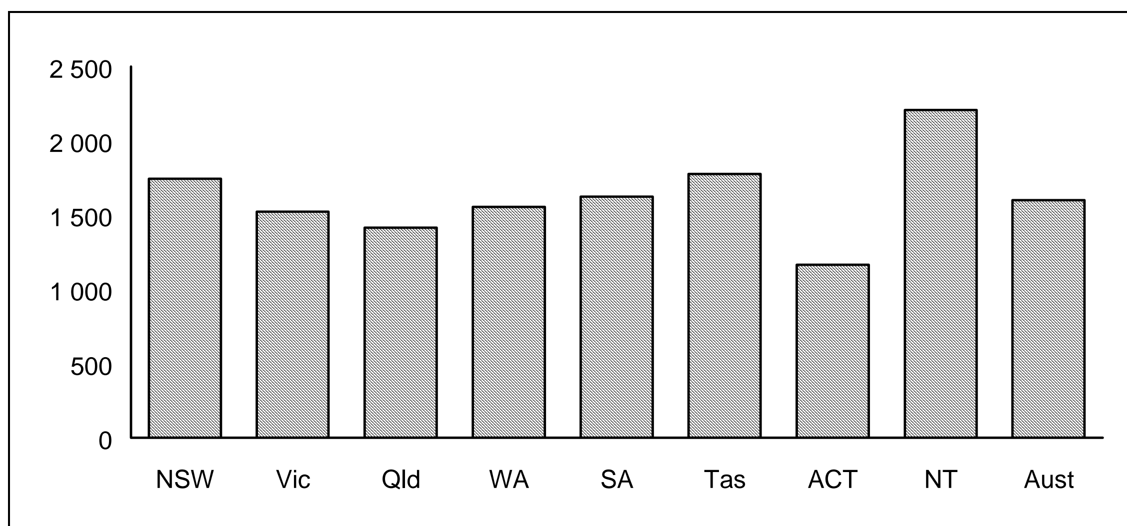
All three levels of government have a role in either funding, administering or providing services for older people, sometimes directly and sometimes jointly. Some services to older people are provided by programs which have a broader target group and others are provided under programs focused on older people.

Residential care

The Commonwealth Government is principally responsible for funding and regulating residential aged care facilities managed by the private and not-for-profit sectors. However, some states and territories fund a small number of facilities, or top-up funding to some facilities. Commonwealth funding for long term residential care services was about $2.4 billion in 1995–1996 ($2.0 billion for nursing homes and $0.4 billion for hostels). Clients also contribute to the cost of residential care, in 1995–96 client fees totalled over $1.2 billion (DHFS 1996).

Commonwealth Government expenditure on residential care varied across states and territories. In 1995–96 expenditure per person aged 70 years and over on nursing home benefits and hostel subsidies (excluding respite) was highest in the NT ($2206) and lowest in the ACT ($1163) — the Australian average was $1600 (Figure 7.2).

Figure 7.2: Commonwealth government expenditure on residential services, 1995–96 ($ per person aged 70 years and over)[1]



1 Includes expenditure on nursing home benefits, hostel subsidies and residential respite.
Source: Table 7A.13.

Nursing homes mainly care for frail older people who require 24 hour nursing care and substantial assistance with personal care tasks. Hostels generally care for less frail older people, providing a wide range of accommodation, personal care and occasional nursing services to older people, the majority of whom require assistance with activities of daily living. There are also nursing home

type patients in public hospitals, some of whom have care needs similar to those of people in residential care.

Historically, nursing homes and hostels cared for different client groups, with hostels providing services for people with social or housing related needs but no significant care needs. Hostels maintain a residual housing role, but they have recently moved much closer to the type of services provided by nursing homes. There is now a considerable overlap between the care needs of residents in each sector.

There were approximately 137 300 clients in residential care facilities at 30 June 1995, compared with approximately 107 500 at 30 June 1985 (DHFS 1996) — a growth of approximately 28 per cent. It is estimated that the number of clients who received these services at any one time in 1995 amounted to around 10 per cent of all people aged 70 years and over, and more than a quarter of those aged 70 years and over with a moderate, severe or profound handicap (ABS 1993; DHSH 1995).

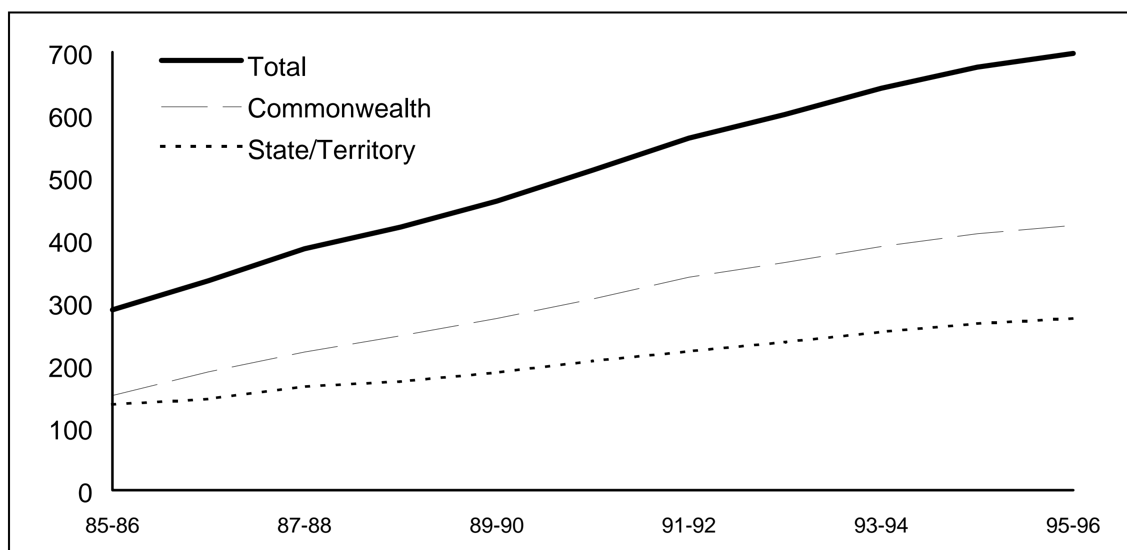
Community care

The Home and Community Care (HACC) program is jointly funded by the Commonwealth and State and Territory Governments, and managed by the State and Territory Governments. It provides community services for frail older people, younger people with disabilities and their carers. The aim of the program is to enable people to live in the community for as long as possible, minimising inappropriate entry to residential care. The HACC program funds a range of services including home help and maintenance, personal care, food services, respite care, transport, paramedical services and community nursing.

Expenditure on the HACC program, in 1995–96 prices, rose from $288 million in 1985–86 to $698 million in 1995–96 (DHFS 1996) (Figure 7.3). The increase has occurred in response to the policy of moving the balance of care from residential to community care. In addition, previously separately funded Commonwealth programs have been incorporated into HACC. As a result, the proportion of HACC expenditure provided by the Commonwealth Government increased from 50 per cent to around 61 per cent between 1985–86 and 1995–96.

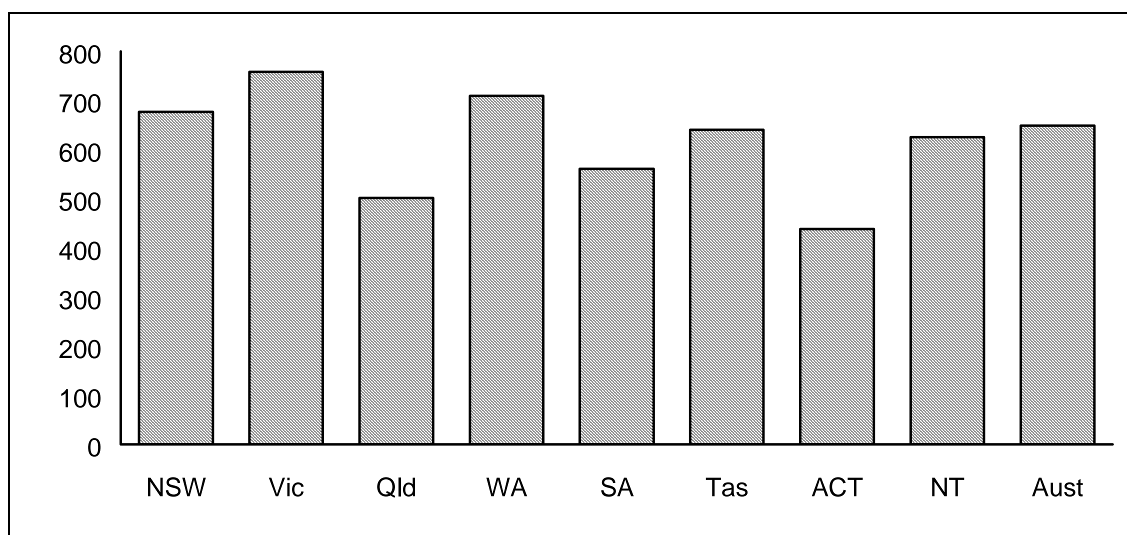
HACC expenditure per person with a moderate, severe or profound handicap, varied in 1995–96 from $438 in the ACT to $758 in Victoria, with an Australian average of $649 (Figure 7.4).

Figure 7.3: HACC expenditure at 1995–96 prices, 1985–86 to 1995–96 ($million)



Source: Table 7A.15.

Figure 7.4: Government expenditure on HACC, 1995-96 ($ per person with a moderate, severe or profound disability)[1]



1 Includes Commonwealth and State and Territory Government expenditure. Excludes community respite and COPs.
Source: Table 7A.14.

Other services

In addition to the community based services program, HACC also funds Community Options Projects, which provide coordinated care services in a

community setting. Similar services are also provided through Commonwealth funded Community Aged Care Packages.

An additional component of the aged care system is the Aged Care Assessment Teams, which are jointly funded by the Commonwealth and State and Territory Governments, and managed by State and Territory Governments. These provide formal assessments of older people to determine if it is appropriate for them to enter residential care. If such care is not appropriate they may refer clients to HACC services.

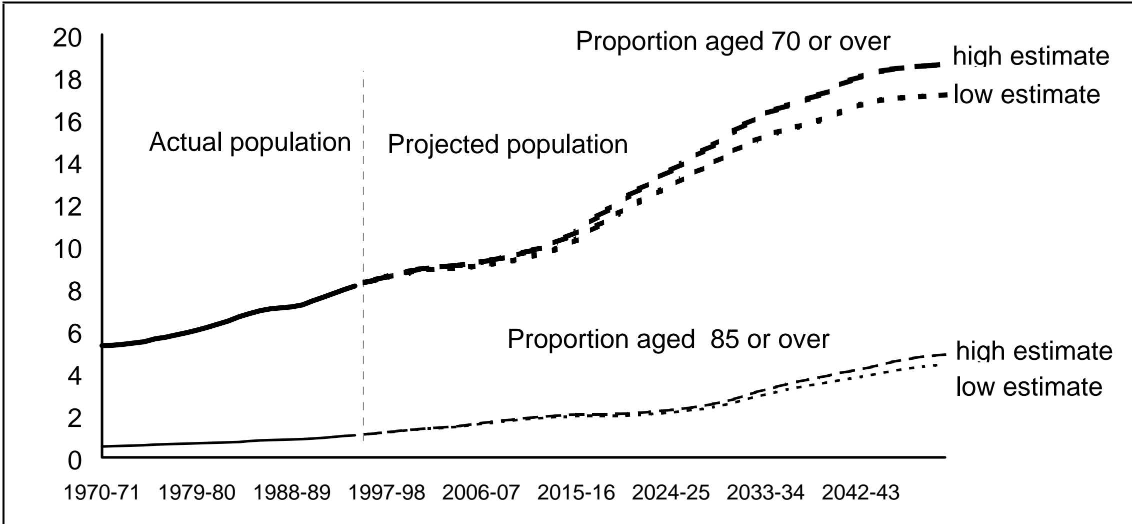
State and Territory Governments also fund a range of psychogeriatric services, sub acute geriatric in-patient services, and rehabilitation services.

7.3 Recent developments in the sector

7.3.1 Increasing demand for aged care services

The number of older persons in Australia is growing — not only in absolute terms, but also as a proportion of the total population — and it is projected to continue to increase in the future (Figure 7.5).

Figure 7.5: Persons aged 70 years and over, actual and projected, as a proportion of the total Australian population, 1970–71 to 2050–51 (per cent)[1]



1 Data up to 1994–95 was estimated resident population. After 1994–95 population projection series C and D were used. Series C assumed high fertility and high overseas migration, Series D assumed low fertility and low overseas migration. The 70 years and over age group was chosen because it was the common population used for demand estimation. A different distribution would occur if the 65 years or over age group was used.
Sources: ABS Cat No. 3201.0, ABS Cat. No. 3222.0.

The increase in the number of older persons is expected to change the level and composition of demand for aged care services, not only because people are living longer, but also because the pattern of frailty for older people is changing. This may occur because of changes in the period for which people are frail and the time at which they become frail.

7.3.2 Changing structure of services

The Australian aged care system in the early 1980s emphasised intensive institutional care in nursing homes. Few alternatives were available for older people who wanted to remain living at home, or to have less intensive forms of care.

A number of subsequent changes have shifted the balance of care away from nursing home care. Expansion of the residential care sector has been restrained; the mix of residential care services has shifted towards greater hostel care, with nursing home care increasingly reserved for people with high levels of dependency. A national assessment system has been set up to ensure older people are properly assessed before entering residential care, so that they receive appropriate services.

A number of new methods of delivering alternatives to nursing home care have been trialed in both community care and residential care, and a number of new methods of organising and packaging community based services are being introduced. Community Aged Care Packages, for example, provide hostel level care in a community setting.

7.3.3 Greater focus on quality

There were also some concerns in the 1980s about apparent failings in the quality of care provided in some nursing homes.

The Commonwealth Government has since introduced outcome standards for nursing homes and hostels. Service quality measures, including consumer assessment, are being developed to ensure standards of service can be monitored in the HACC program.

7.3.4 COAG reform process

In June 1996, the Council of Australian Governments (COAG) agreed to broad directions for reform in the health and community services with long term arrangements for system-wide reform to be explored and developed (COAG 1996).

Australia's health and community services system works well for most of the people for most of the time, but a major weakness is its focus on providers and programs rather than on people and outcomes.

COAG aims to explore a better partnership between the Commonwealth and the State and Territory Governments, to deliver better outcomes for people.

7.3.5 Structural reform package

In the 1996–97 Commonwealth Budget (Costello 1996) a Structural Reform Package unified, under one regulatory framework, the nursing home and hostel systems into a single residential aged care system. The package and its associated legislation are due to commence on 1 July 1997. A single resident classification mechanism will assess dependency and allocate funding across the system. These reforms have significant implications for future reporting of residential care services. In addition, from 1 July 1997:

- recurrent subsidies will be income tested so that wealthier residents make a contribution towards the cost of their care; and
- incentives and funding for all providers to invest in building quality will improve by allowing them to charge resident entry contributions. This will be market driven, but subject to meeting minimum building and other standards, and with appropriate resident protections.

The package also incorporates a technical adjustment to funding arrangements which will transfer the payment of rent assistance for people in residential care, from the Social Security to the Health and Family Services portfolio (to be incorporated into recurrent subsidies).

7.4 Framework of performance measures

7.4.1 The objectives of the aged care system

There are some difficulties in developing a common definition for the aged care system because it is defined somewhat differently in each jurisdiction. Nonetheless it is possible to define a broad objective for aged care services.

For the purpose of developing performance indicators for this Report, the objective of the overall aged services system was considered to be: to ensure that older people are able to maximise their health, well-being, and independence.

However, the services covered in this Report are focused on services for frail older people, and the objective of these services are more appropriately defined as: to maximise the health, well-being and independence of frail older people and their carers through the provision of care services which are:

- accessible;
- appropriate to their needs;
- of a high quality; and
- cost–effective.

7.4.2 The indicators

Four groups of indicators, based on the more narrowly defined objectives of services for frail older people, are presented in this Report (Figure 7.6).

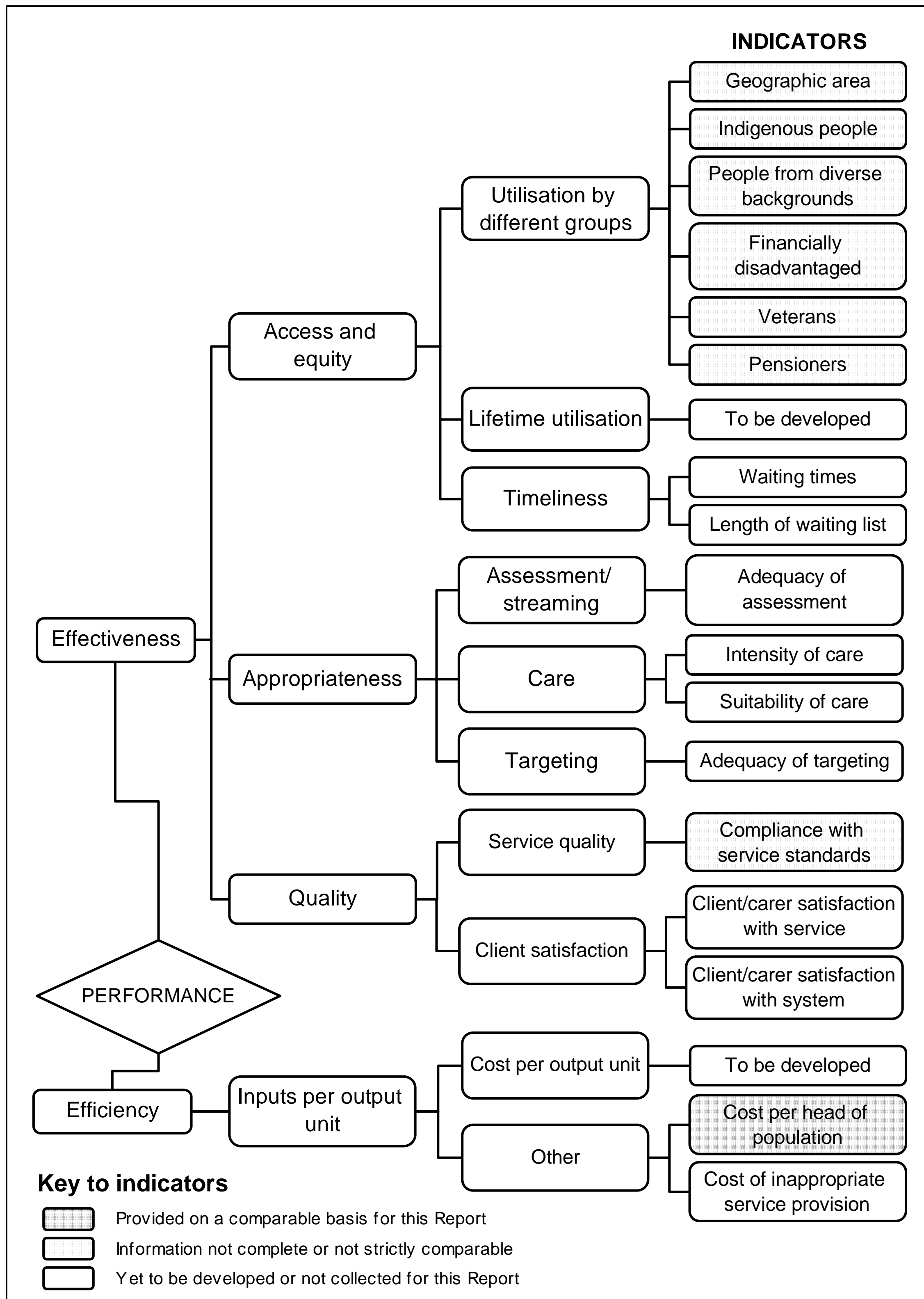
Access and equity indicators assess the amount of services provided and who consumes them. Within this group, most data is available on access and utilisation indicators. There is no comparable information on timeliness, but some case study material is available.

Appropriateness indicators assess how well services and availability match client needs, but appropriateness data is not available at this stage. Some data is available for quality indicators (specifically, outcome standards information for nursing homes and hostels).

Some cost information is available for the major aged care services.

Descriptions of indicators are provided in Attachment 7A.

Figure 7.6: Framework of performance indicators for aged care services



7.4.3 Service areas covered

General information is available for all the service areas covered in this chapter. Reliable and comprehensive data is collected for residential care services (nursing homes and hostels). Some additional information is available on CACPs.

The information provided covers frail older people and younger people with disabilities because the HACC program, and to a lesser extent residential facilities, provide services to both client types.

7.5 Future directions

The framework contains many indicators which are not fully defined, and have no matching data. Ensuring a full and comprehensive set of indicators is presented in future Reports requires a large amount of development work. Other data development bodies will be consulted during this process.

7.5.1 Coverage of services

The Report should, as far as possible, cover all the important components of aged care services, including those services which are solely operated by State and Territory Governments.

To this end a complete 'scoping' review is planned for 1997. The aim is to identify all significant aged care services funded by the Commonwealth, State and Territory Governments, and the appropriateness of including them in this Report.

7.5.2 Improving the indicators

Identifying the relevant population

There are different target groups for residential care and HACC programs, and making comparisons of service delivery between them is difficult. It is hoped to develop a method for comparing service provision across programs.

Measuring appropriateness

The appropriateness of services is an important component of the performance of aged care services, however it is difficult to measure. For example, it is hard to determine when a service has been inappropriately provided, especially when there are many different service types and many service providers.

Further research is required to understand the many dimensions of appropriateness. There are a number of possible methods for determining the appropriateness of services. One approach is to examine the quality of assessments and the choices older people receive (so that they may match services to their particular requirements). Clients' views regarding their experiences with the system may also be a useful indicator of appropriateness.

Measuring quality

Some information is available on the quality of residential care, but very little information is available on the quality of the aged care system as a whole or on the clients' experiences of aged care services. For example, no information is available as to whether Aged Care Assessment Teams provide a high quality service to older people. Current data collections focus on the types of assessments undertaken, rather than the quality of those assessments. Further work is required for these aspects of quality to be adequately assessed.

Broader indicators

The data presented in this report is based on service types. Indicators which more fully capture the operation of the entire aged care system are needed to clearly describe the performance of the sector and whether the system is achieving its stated aims. Such indicators should focus on clients rather than on service providers. It is expected that some initial system wide indicators will be presented in the next Report.

The aged care system interacts with other parts of the health and community services system and it is intended that some indicators will be developed which provide information on these interactions.

7.5.3 Improving the data

A number of steps have been identified to improve the availability of data for the next Report.

Younger people with disabilities

Methodologies to separate data relating to services provided to older people and younger people with disabilities will be considered during 1997. Most services covered in this chapter, as noted earlier, provide services to younger people with disabilities, as well as to older people. This is particularly an issue with the HACC program, for which the target group is people with functional

disabilities. It is not currently possible to separate the two groups in data collections.

Data collections focussed on people

There are problems with the way in which data is currently collected in the aged care sector.

First, as the data collections have been based on services, they focus on the data needs of service providers and funding bodies. Much of the data is produced as part of the funding process, and, as such, is process oriented rather than outcome oriented.

Second, current data collections focus on the services provided by an individual service provider to an individual older person. There is very limited data on whether a person is consuming service from another provider, and on whether they received all the services they were assessed as needing. Thus it is difficult to assess the effectiveness and efficiency of aged care services overall.

Both of these problems hamper the development of useful performance indicators. Some information on services used is available from the current data collections, but they cannot provide more complex information — this is particularly important when considering more complex indicators, such as those for 'appropriateness'.

These indicators require information on all the services received by an individual. While some information is available from outside sources, such as the *ABS Survey of Disability, Ageing and Carers* (ABS 1993), much of the needed information requires data from different service providers to be coordinated. More work is required on this.

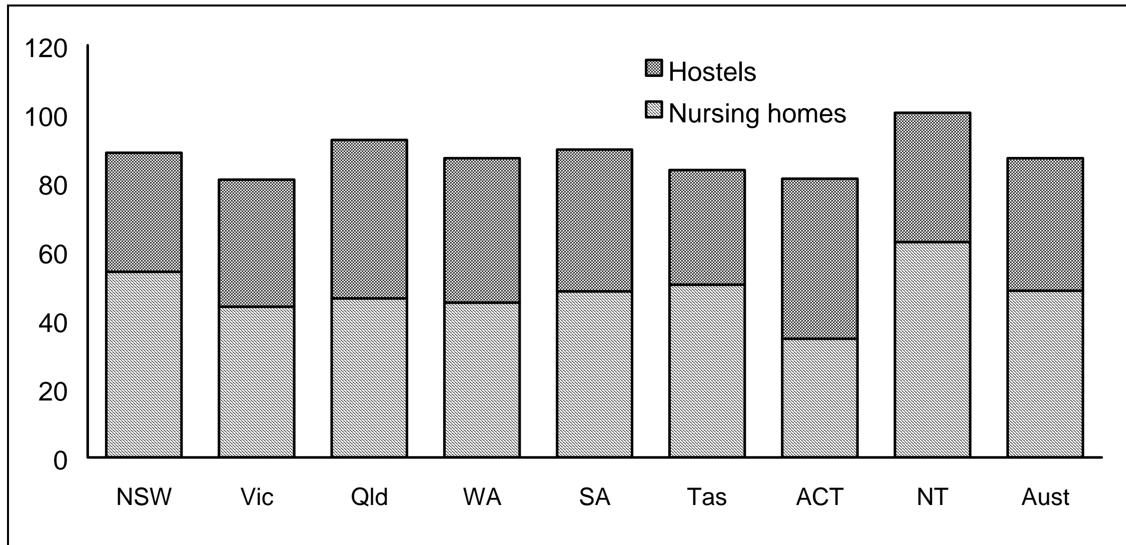
7.6 Key performance indicators

Only limited data is available for reporting this year, but there are plans to improve data collections in the future (Section 7.5).

7.6.1 Access to services

The number of residential services provided per person aged 70 years and over on 30 June 1996 was reasonably similar across jurisdictions (Figure 7.7). The highest proportion of people in care was in the NT where at 30 June 1996 approximately 100 persons were in residential care per 1000 persons aged 70 years and over.

Figure 7.7: People in nursing homes and hostels, 30 June 1996 (number per 1000 persons aged 70 years or over)[1]



1 Includes respite residents.
Source: Table 7A.1.

The distribution of HACC services provided was much more varied than for residential services, particularly the types of services (Table 7.1). For example, over 1000 hours per month of home help services were provided per 1000 persons with a moderate, severe, or profound handicap in Victoria, and nearly 900 hours were provided in the NT. However, the program in SA provided only 173 hours per month per 1000 persons with a moderate, severe, or profound handicap. This is to some degree explained by differences in definitions of services across jurisdictions (for example, between home help and personal care).

Around 500, 1000, and 1500 meals each month were provided in the ACT, SA and NT respectively, per 1000 persons with a moderate, severe, or profound handicap. Variations in the characteristics of the target population may or may not fully explain these variations in services provided, however further research is required to fully understand this relationship.

Table 7.1: Level of HACC service received, various periods 1993 to 1995 (number per month per 1000 persons with a moderate, severe or profound handicap)[1,2,3]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
hours of service received									
Home help[3]	460	1016	421	709	173	786	289	888	590
Personal care[3]	237	98	58	244	110	167	114	164	152
Home nursing[3]	173	313	287	281	169	337	294	0	244
Paramedical[3]	21	42	29	29	39	17	35	55	31
Home respite	368	146	168	154	93	150	309	280	220
Centre day care	536	678	854	556	440	265	232	60	607
Home maintenance/modification	63	77	39	79	9	75	52	32	58
meals received									
Home meals	1020	1054	964	1003	974	1068	507	1462	1007
Centre meals	131	139	130	354	91	39	23	169	144

1 HACC services were provided to both frail older people and younger people with disabilities. It is estimated that approximately three quarters of HACC clients were aged 70 years and over.

2 The collection months selected were those with the best coverage and editing rates. NSW and Queensland data were for November 1995; Victoria, SA, Tasmania, and ACT data were for May 1995; NT was for November 1994; and WA was for November 1993. The data was for a single month. Home Help was sometimes equivalent to Personal Care, depending on the practices of the service.

3 Excludes COPs.

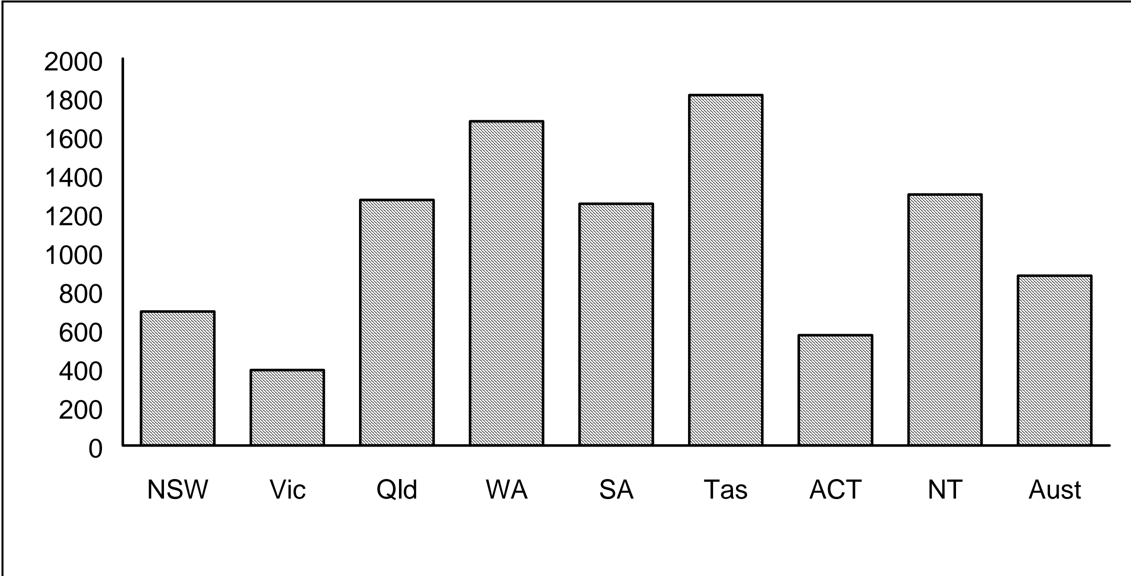
Source: Table 7A.2.

In 1994–95 nursing home type patient bed days in hospitals per 1000 persons aged 70 and over was the lowest in Victoria (389) and the ACT (571) and the highest in Tasmania (1811). The Australian average for nursing home type patients was 878 bed days per 1000 persons aged 70 and over (Figure 7.8).

Nursing home type patients were those patients who stayed in acute care hospitals for longer than 35 days, and who no longer required acute care services. They included younger people receiving rehabilitation or psychiatric services as well as older people waiting for residential accommodation or who required higher than nursing home level care.

Waiting times have been identified as an important indicator of access. Nationally comparable data is not yet available, however a case study on information available is provided in Box 7.1.

Figure 7.8: Bed-days for nursing home type patients in hospitals, 1994–95 (number)[1]



1 NHTPs are patients who have been in hospital (public and private) for a continuous period exceeding 35 days and do not need acute care. Many people who do not require nursing home admission can meet this definition including accident and illness patients. Others may have been certified by a doctor as requiring hostel or nursing home care and are waiting placement.
Source: Table 7A.8.

Box 7.1: Waiting times in Queensland

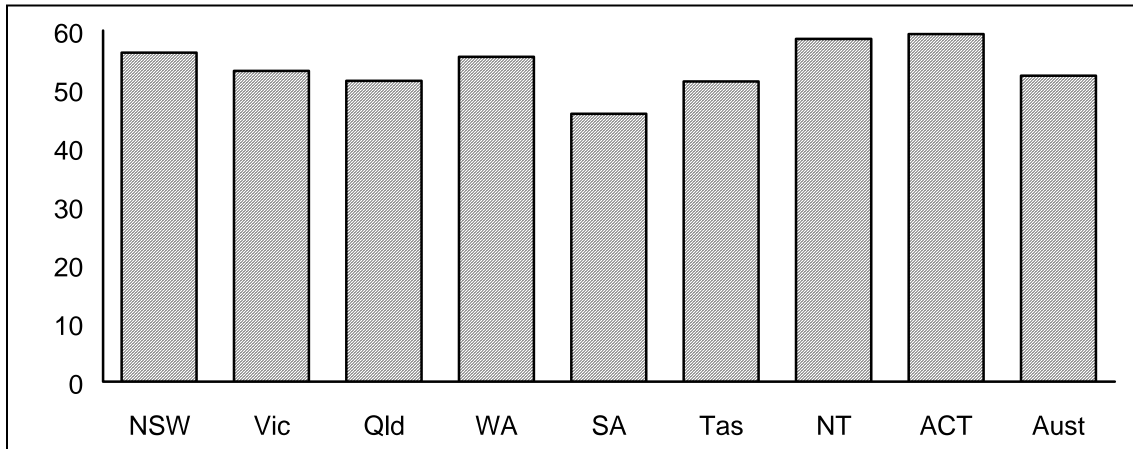
Information on waiting times for residential care is currently collected by Aged Care Assessment Teams in several states and territories, including Queensland and Tasmania. This information is maintained to monitor and analyse the factors influencing waiting times in particular areas.

At present, shortcomings in the data make it unsuitable for reporting. However it can provide a useful insight into the accessibility of some aged care services. For example, Queensland data for December 1995 showed that 17 per cent of people listed for nursing home or hostel admission were placed on the day of listing. Half of those waiting for nursing home were placed within 20 days, and half of those waiting for hostel within 40 days.

While the collection of data on waiting times has the potential to provide useful information on the performance of the system and the adequacy of current levels of care, there will need to be further development of collection methodology to address the inconsistencies in the data.

The extent to which nursing home outcome standards are met by homes targeted for assessment by the Commonwealth in a given year provides some indication of the quality of care (Figure 7.9).

Figure 7.9: Average score of nursing homes assessed against outcome standards, 1995–96 (score out of 62)[1]



1 Since October 1994 the Commonwealth Department of Health and Family Services has adopted a targeted approach to the selection of nursing homes for outcome standards assessments.
Source: Table 7A.11.

Results are not comparable between recent years as targeting has been on a risk management basis, with nursing homes at risk of having low standards being targeted for assessment. This shift to targeting has caused the average score of visited homes to fall.

Ratings against nursing home standards of those nursing homes targeted was high in all state and territories, and was highest in the ACT and NT. These results may reflect the number of assessments conducted in each state and territory, the effectiveness of targeting strategies, or actual differences in outcomes.

The introduction of outcome standards with targeted monitoring should have improved the quality of residential care services, and data indicates that standards initially judged as unmet have improved on subsequent follow-up visits. However data are not yet available to make authoritative comparisons either across time, or across states and territories. Further information on residential care outcome standards is provided in Box 7.2.

Box 7.2: Residential care outcome standards

Standards monitoring teams have visited nursing home facilities to assess their level of compliance with outcome standards from 1988. Similar standards for aged care hostels were implemented on 1 January 1991.

There are 31 nursing home standards and 25 hostel standards. They are grouped into objectives such as health care, social independence, privacy and dignity, homelike environment, variety of experience and safety. For example:

- the health objective, which includes: 'All residents are adequately nourished and adequately hydrated'; and 'Sensory losses are identified and corrected so that residents are able to communicate effectively' (nursing home standard);
- the social independence objective, which includes: 'Residents have freedom of movement within and from nursing homes, restricted only for safety reasons'; and 'Provision is made for residents with differing religious, personal and cultural customs' (nursing home standard);
- the privacy and dignity objective, including: 'Personal effects of a resident must not be used by other persons without the consent of the resident' (hostel standard); and
- the objective of homelike environment, which includes: 'each resident must be provided with a comfortable and homelike environment' (hostel standard).

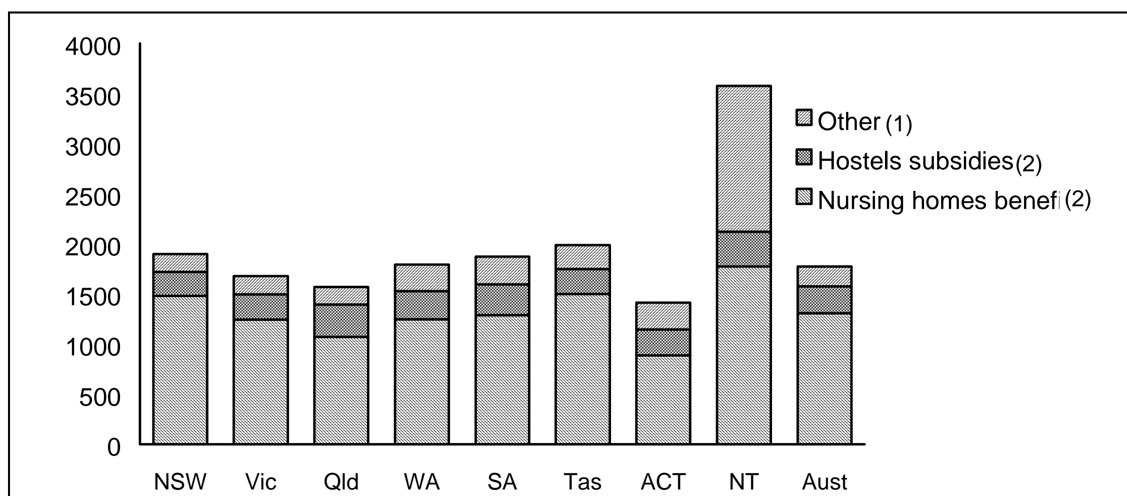
Sources: CSWPNHS 1987, DHFS unpublished.

7.6.2 Expenditure

There has been a trend towards community care over the last decade. Residential and community care have different target groups, but some indication of the distribution of care types can be gained by examining expenditure per person in the respective target populations. Victoria, for example, makes the greatest use of community care services.

Governments provide a number of different residential and community care services for aged persons. Both the composition of government expenditure and the levels of expenditure per person in target groups vary across jurisdictions. Government expenditure on residential aged care per 1000 persons aged 70 years and over was dominated by nursing homes expenditure although not all persons utilising residential aged care facilities are aged 70 years and over (Figure 7.10). On a per head basis, for persons aged 70 years and over, expenditure on residential services was highest in the NT and lowest in the ACT. The above average expenditure in the NT may be due to its isolation and larger population of Aboriginal and Torres Strait Islanders (Figure 7.10).

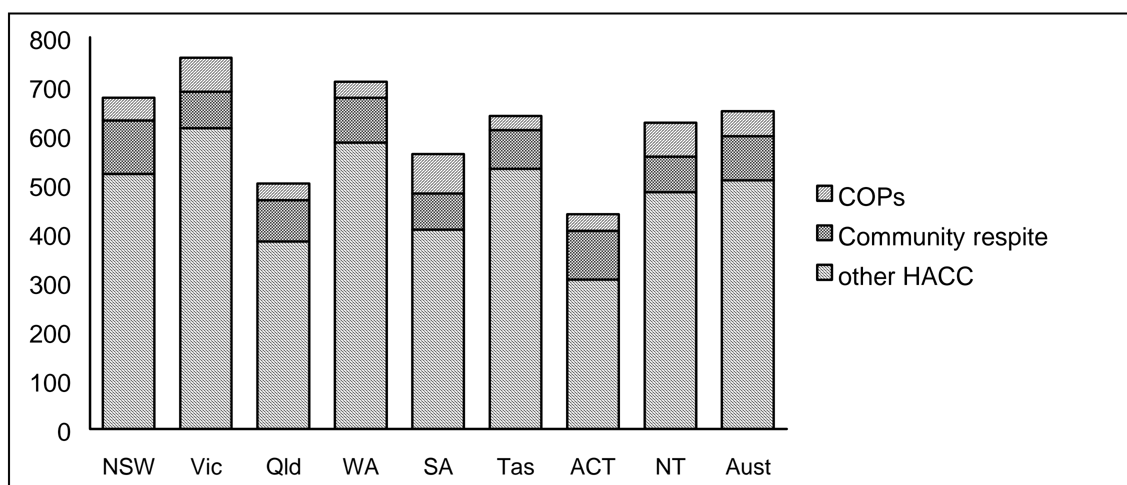
Figure 7.10: Commonwealth expenditure on residential care, 1995–96 ($ per person aged 70 years and over)[1]



1 Other expenditure included top-up funding for residential facilities, planning/development, projects, schemes, other services, capital funding, CACPs expenditure and residential respite.
2 The 'hostel subsidies' and 'nursing home benefits' classification excluded residential respite services.
Source: Table 7A.13.

Expenditure on HACC services per person aged 70 years and over with a moderate to profound handicap was highest in Victoria and lowest in the ACT. In all jurisdictions it was predominantly for HACC services other than COPs and community respite (Figure 7.11).

Figure 7.11: Government expenditure on home and community services, 1995–96 ($ per person with a moderate, severe or profound handicap)[1]



Source: Table 7A.14.