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## 9 AGED CARE SERVICES

### 9.1 Introduction

Broadly defined, the aged care system comprises services which provide for the wellbeing of older people.

This is the second Report to cover aged care services. The focus in this Report is on those services provided to frail older people. These services are:

- residential services in nursing homes, hostels and residential respite services;
- community services — Home and Community Care (HACC) program services, which incorporate Community Options Projects (COPs), and Community Aged Care Packages (CACPs);
- respite services — HACC respite and centre day care and the Commonwealth Respite for Carers (CRC) program; and
- assessment services — services provided by Aged Care Assessment Teams.

There are several other government funded, or part-funded, programs and services which are directed at or used by older people, but they are not reported here due to a lack of comparable data. These include programs for older people such as ‘seniors cards’, concessions, housing, recreational activities and health promotion, and an additional range of health services directed at or used by older people, including the Coordinated Care Trial.

### 9.2 Profile of aged care services

The main aged care services covered in this Report are residential and community care. Recipients of such services receive them on the basis of frailty or incapacity rather than age. But in the absence of more specific information, age is widely used as a proxy indicator of the likely requirement for services. Nonetheless, certain groups, notably indigenous Australians, may require various types of services at a younger age than the general population.

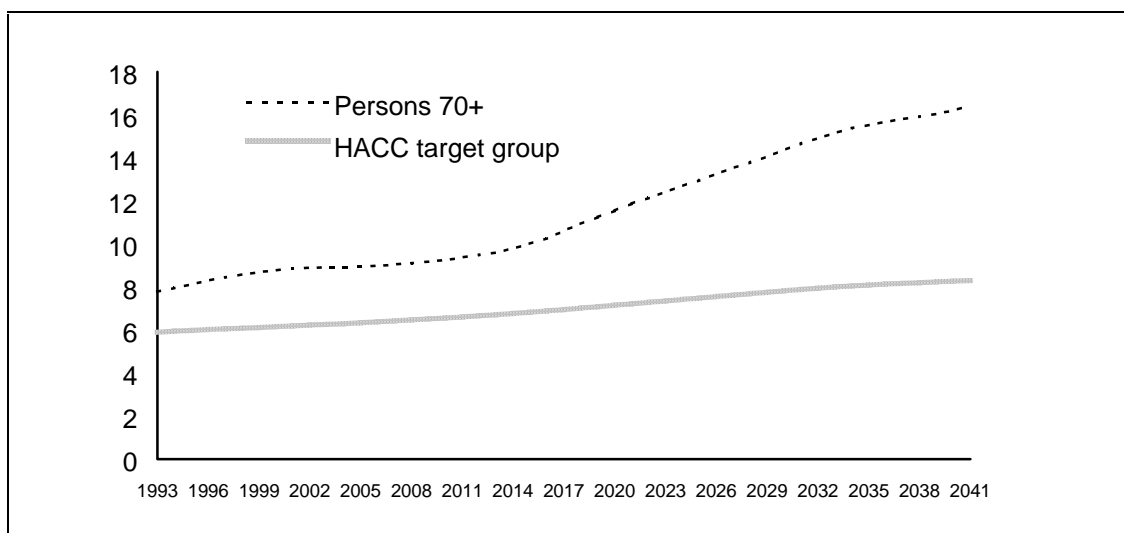
This Report focuses on formal government funded care services for frail older people. Governments deliver only the minority of these aged care services although they are responsible for a large share of the funding. Most care of frail

older people, in addition to these formal services, is delivered on an informal basis by family members, charities and benevolent individuals.

### 9.2.1 Size and growth rate of the older population

The older population in Australia is growing, not only in absolute terms but as a proportion of the total population. It is also projected to increase significantly in the future, with the proportion of people aged 70 years and over expected to double over the next 40 to 50 years (Figure 9.1).

Figure 9.1: Estimates of persons aged 70 years and over and HACC target persons as a proportion of the total population, 1993 to 2041 (per cent)

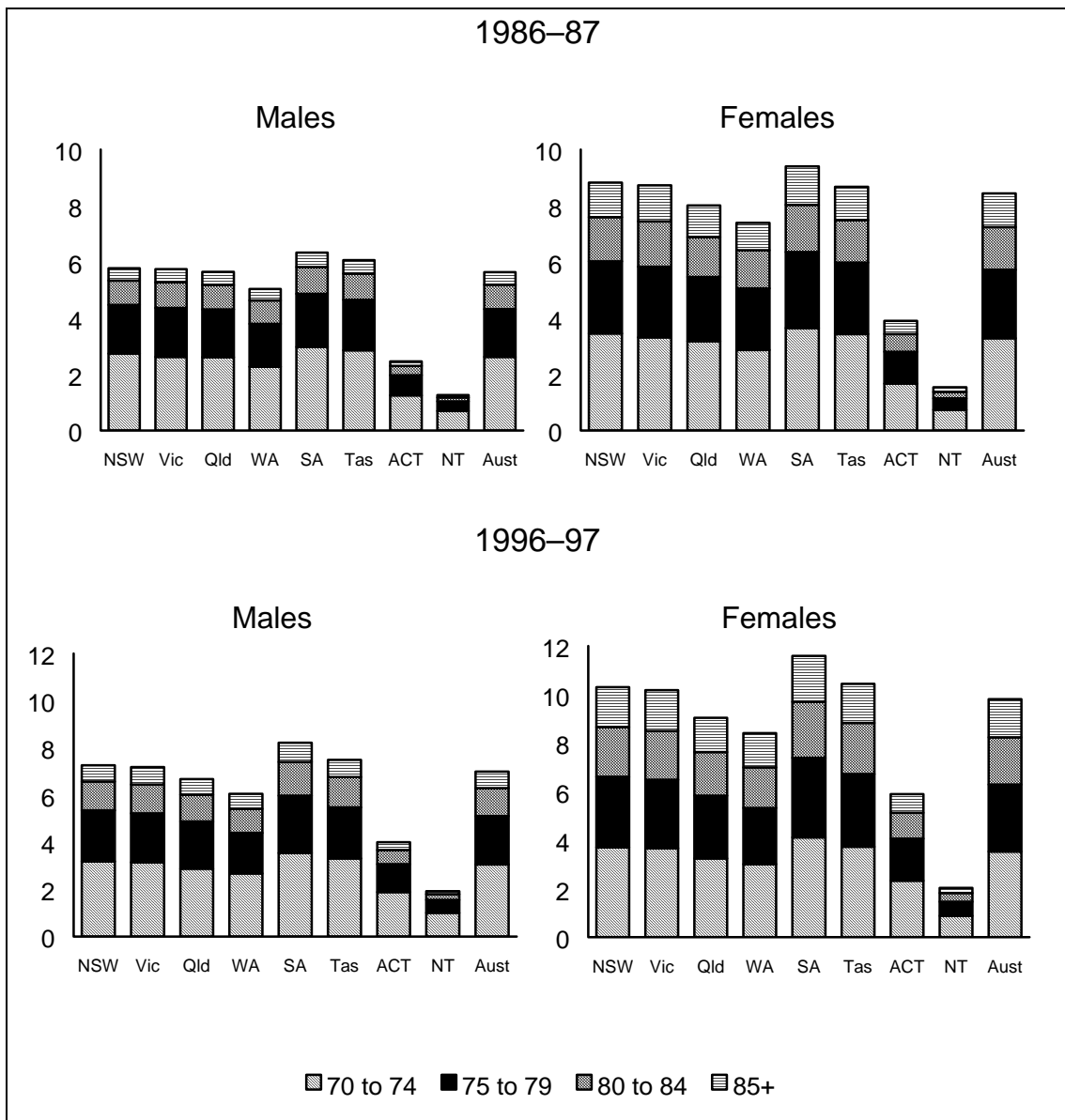


Source: Table 9A.29

The proportion of the population aged 70 years or over varied significantly across jurisdictions in 1996–97. The ACT and the NT had the lowest proportions of older people. Other jurisdictions had reasonably similar distributions, with SA having the highest proportion. The proportion of older females was higher than that of older males. Between 1986–87 and 1996–97, the proportion of older males and females in the population rose by several percentage points in almost all jurisdictions (Figure 9.1).

Gender is an important consideration in the provision of aged care services. Females are more financially disadvantaged in old age and rely more on social security support. Females also use aged care services at a higher rate than males, partly because they tend to live longer — that is, there are more older women in the population than older men — and because they are less likely to have a partner to serve as a carer.

Figure 9.2: Males and females aged 70 years and over as a proportion of the total population, 1986–87 and 1996–97 (per cent)



Source: ABS 1996a

### **9.2.2 Aged care programs and changes in the structure of programs**

Programs which provide or fund services for older people are administered by the Commonwealth, State, Territory and Local Governments and community organisations, both independently and jointly. Programs focused on older people are supplemented by services that are provided through programs which have a broader target group. Indeed, the bulk of services provided to frail older people derive from generic services such as general practitioners, hospital and community health services.

Nursing homes were the dominant form of residential care until the late 1970s, and catered for a range of older people from those needing minimal personal care up to those needing intensive nursing care. But over the past twenty years, hostel accommodation has grown at the expense of nursing homes. This trend has resulted from government policies which have been directed at increasing hostel accommodation and other alternatives to nursing homes for example, CACPs.

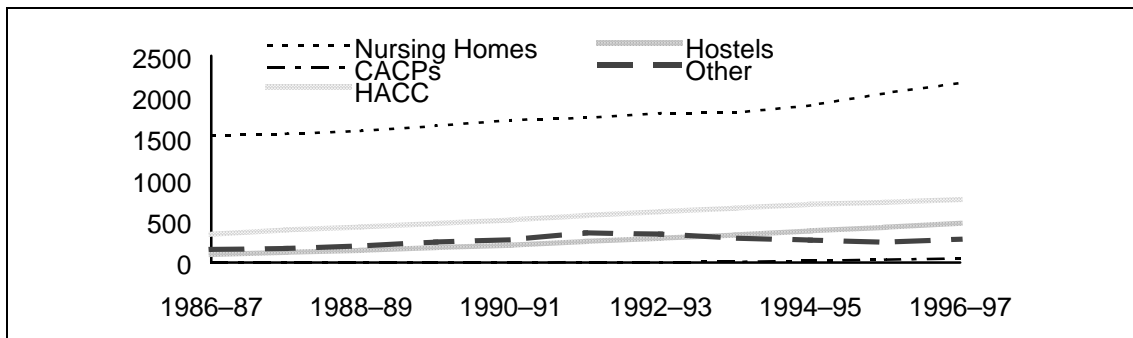
This shift in the balance of care has seen increased overlap in the type of care provided by the two types of residential facility, although nursing homes still cater for older people with the highest levels of dependency.

Differences in funding mechanisms applying to the two sectors have meant that residents with the same care requirements and financial means could receive differential funding by the Commonwealth Government. Recent changes to aged care legislation aim to break down any funding discrepancies between nursing homes and hostels.

Given the growth in the proportion of older people in the population, government expenditure on nearly all types of aged care services has risen steadily over the past ten years (Figure 9.3).

Although expenditure on nursing homes has grown the most, the number of permanent places in hostels and the availability of community-based care services (such as CACPs and the HACC program) has exhibited greater growth than permanent nursing home places.

Figure 9.3: Government expenditure on aged care services, 1986–87 to 1996–97 (\$ million, in 1996–97 dollars)<sup>a, b</sup>



a HACC expenditure was Commonwealth and State and Territory Government recurrent expenditure. For all other services expenditure was Commonwealth Government expenditure only. It did not include any State and Territory Government expenditure or Department of Veterans' Affairs expenditure on nursing homes (\$47.3 million in 1996–97).

b HACC services were provided to younger people as well as older people. In 1993, people aged 70 years and over received approximately 70 per cent of HACC services.

Sources: Tables 9A.21; 9A.22

### *Residential care*

There were about 132 500 residents (permanent and respite) in residential care facilities (72 500 in nursing homes and 60 000 in hostels) as at June 1997. The growth in persons in residential care between 1992 and 1997 was 12.7 per cent — places in nursing homes increased by 0.1 per cent (from 74 157 to 74 216) and places in hostels increased by 31.7 per cent (from 49 194 to 64 771). However, the proportion of the older population in residential care declined over the period.

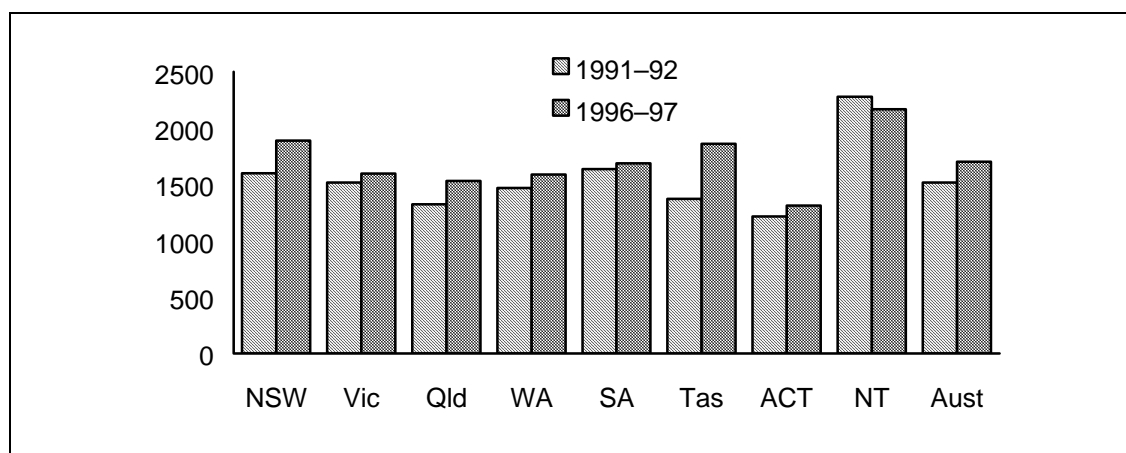
Females accounted for 71 per cent of nursing home residents and 75 per cent of hostel residents in 1997.

The Commonwealth Government is generally responsible for funding and regulating residential aged care facilities managed by private and religious/charitable sectors. However, some State and Territory Governments also provide funding to residential services and also operate a small number of facilities.

Commonwealth Government funding for long-term residential care services was about \$2.7 billion in 1996–97 (comprising \$2.2 billion for nursing homes and \$0.5 billion for hostels). Clients also contributed to the cost of residential care: the client contribution to nursing home costs was \$685 million in 1996–97 (DHFS 1997). Information was not available on the client contribution to hostel costs.

Commonwealth Government expenditure on residential care services per person aged 70 years or over was highest in the NT (\$2168) and lowest in the ACT (\$1312) in 1996–97. The Australian average was \$1703 (Figure 9.4).

Figure 9.4: Commonwealth Government expenditure on residential services, 1991–92 and 1996–97 (\$ per person aged 70 years and over in 1996–97 dollars)<sup>a,b</sup>



a Included expenditure on nursing home benefits, hostel subsidies and residential respite.

b Excluded the Department of Veterans' Affairs contribution to nursing home funding (\$47.3 million in 1996–97).

Source: Table 9A.7

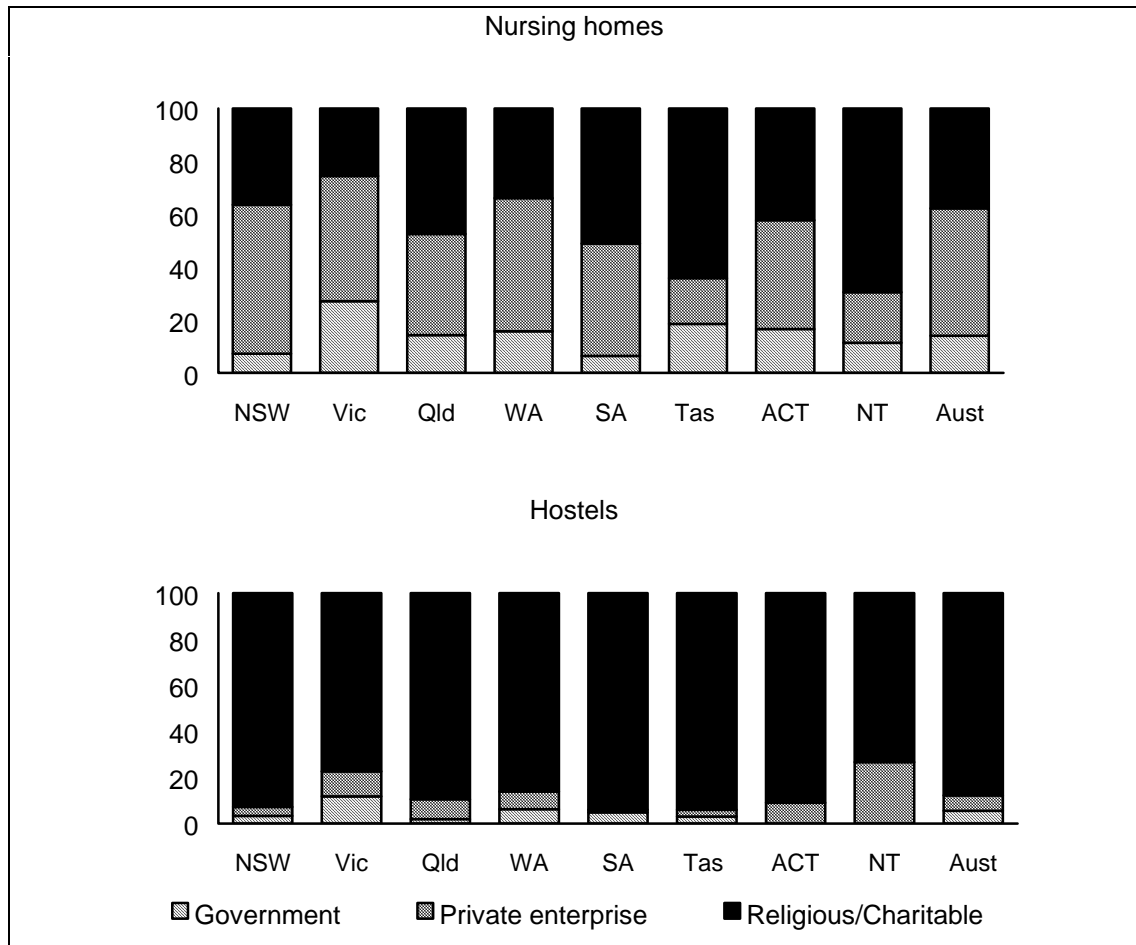
Over the past ten years, nursing home expenditure as a proportion of the total Commonwealth Government aged care budget has fallen but the budget share of expenditure on hostels and other types of aged care services, namely the HACC program and CACPs, has increased. In real terms, Commonwealth expenditure on nursing homes per person aged 70 years and over grew at an average annual rate of 0.4 per cent between 1986–87 and 1996–97. Expenditure on hostels grew at an average annual rate of 14 per cent over the same period.

The ownership status of residential care facilities varied between jurisdictions. For nursing homes, in 1997:

- the proportion of places in government facilities was highest in Victoria (27 per cent) and lowest in SA (6 per cent);
- the proportion of places in private enterprise facilities was highest in NSW (56 per cent) and WA (50 per cent) and lowest in Tasmania (17 per cent) and the NT (19 per cent); and
- the proportion of places in religious or charitable facilities was highest in the NT (70 per cent) and Tasmania (64 per cent) and lowest in Victoria (26 per cent) and WA (34 per cent) (Figure 9.5).

For hostels, the majority of places were in religious or charitable facilities in 1997. The proportion of places in government facilities was highest in Victoria (12 per cent) and the proportion of places in private facilities was highest in the NT (27 per cent) and Victoria (11 per cent) (Figure 9.5).

Figure 9.5: Ownership of residential places, January 1997 (per cent)



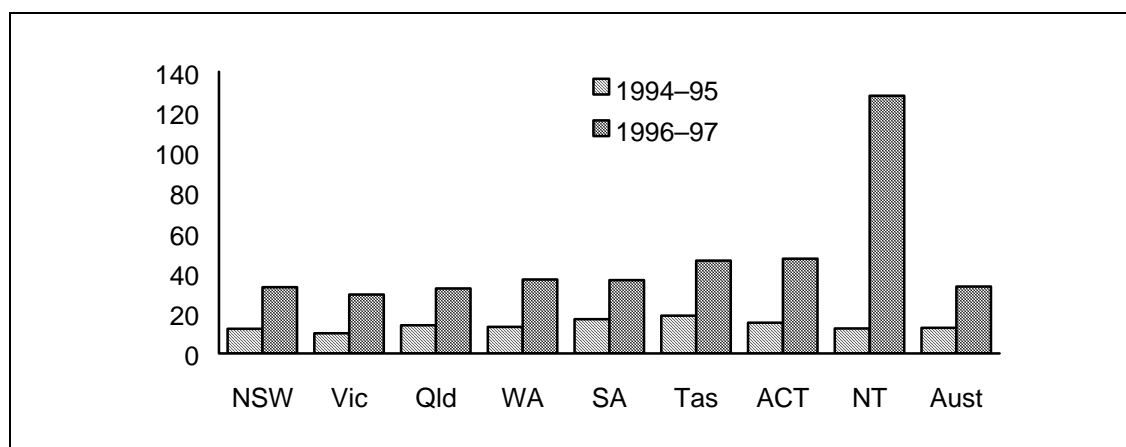
Source: Table 9A.28

### Community Aged Care Packages

CACPs, which provide up to hostel-level care in a community setting, are an alternative form of aged care (particularly to HACC care discussed below). They have been funded by the Commonwealth Government since 1992–93 and have become increasingly important as a setting for aged care services delivery.

The current target is 10 CACP places for every 1000 persons aged 70 years and over. CACP expenditure per person 70 years and over ranged from \$29 in Victoria to \$128 in the NT in 1996–97 (Figure 9.6).

Figure 9.6: Commonwealth Government expenditure on CACPs, 1994–95 and 1996–97 (\$ per person aged 70 years and over in 1996–97 dollars)



Source: Table 9A.7

### Home and Community Care

The HACC program, which is jointly funded and administered by the Commonwealth, State and Territory and Local Governments and community organisations, provides community services for older people, younger people with disabilities and their carers. The aim is to enable people to remain living in the community for as long as possible, minimising inappropriate entry to residential care.<sup>1</sup>

<sup>1</sup> 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.

The HACC target population is defined as people in households who have a moderate, severe or profound handicap. Planning for HACC uses this target group. However, to assist making comparisons with other areas of aged care, estimates of the expenditure on HACC services received by clients aged 70 years and over are used here.<sup>2</sup>

Total expenditure on the HACC program has grown at an annual average rate of 8.3 per cent in real terms over the past decade. It reached \$762 million nationally in 1996–97 (DHFS 1997). In 1993–94 it was estimated that close to 70 per cent of people catered for by the HACC program nationally were aged 70 years and over (DHFS 1994).

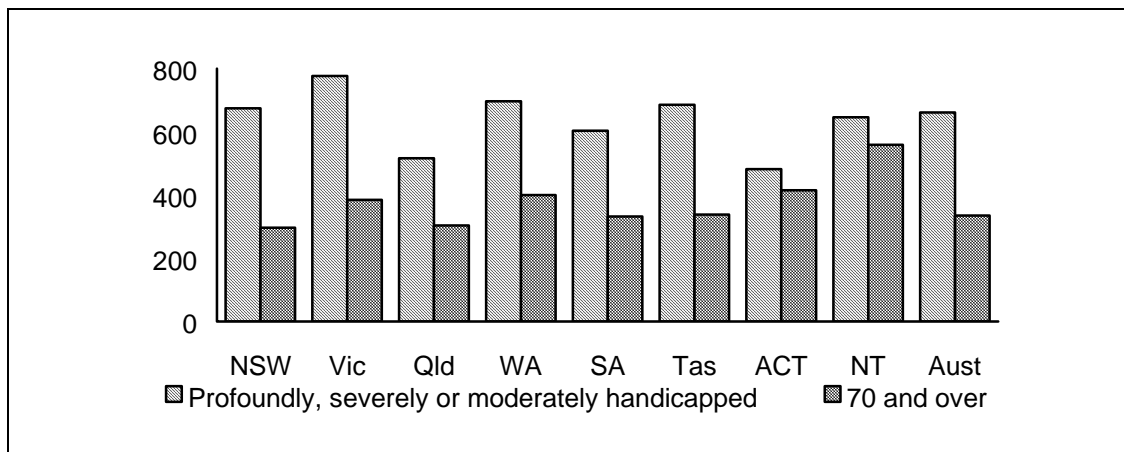
Estimated annual HACC expenditure per person aged 70 years and over in 1996–97 was highest in the NT (\$559) followed by the ACT (\$415) and WA (\$400). Expenditure was lowest in NSW (\$296). However, expressed as expenditure per person with a profound, severe or moderate handicap, the jurisdictions with the highest expenditure were Victoria (\$777), WA (\$696) and Tasmania (\$685). The lowest expenditures were in the ACT (\$482) and Queensland (\$516) (Figure 9.7).

The contrast between the HACC expenditure on older people and the expenditures on residential services in each jurisdiction suggests that an inverse relationship exists between the two types of care. For example, NSW had among the lowest HACC expenditure per person aged 70 years and over and among the highest expenditures on residential services per person aged 70 years and over. Conversely, the ACT had among the highest HACC expenditure per person aged 70 years and over and the lowest expenditures on residential services per person aged 70 years and over.

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<sup>2</sup> Expenditure on HACC services received by clients aged 70 years and over was not available for 1997. It was estimated by DHFS by applying the average of the proportions of people aged 70 years and over accessing HACC services and the proportion of HACC hours of services received by this age group as reported by the 1993–94 HACC User Characteristics Survey to HACC funding for 1996–97 (DHFS 1994). More accurate data will be available when the 1997–98 HACC User Characteristics Survey is undertaken and when the HACC minimum data set is compiled in 1998–99.

Figure 9.7: Expenditure on HACC services, 1996–97  
(\$ per person with a profound, severe or moderate handicap and per person aged 70 years and over)<sup>a,b</sup>



a Expenditure was combined Commonwealth/State expenditure, except Commonwealth Respite for Carers (CRC) expenditure, which was Commonwealth Government expenditure only. Community respite was HACC respite and centre day care, and CRC. Handicapped persons data was estimated from the ABS Survey of Disability, Ageing and Carers (1993), and the proportion of people aged 70 and over receiving HACC services in each jurisdiction.

b Data taken from November 1994, 1995 and 1996, except for WA where all data was from September 1993 only, the ACT where 1994 data is from May 1995 and the NT where 1995 data was from May 1996.

Source: Table 9A.20

### Other services

In addition to residential and HACC services, the Commonwealth Government also funds the following services either alone or with State and Territory Governments:

- Community Options (HACC services arranged through a case manager for people with complex care needs); and
- Aged Care Assessment Teams (teams which formally assess older people to determine if it is appropriate for them to enter residential care and if not, may refer clients to HACC or other services).

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

## 9.3 Recent developments in the sector

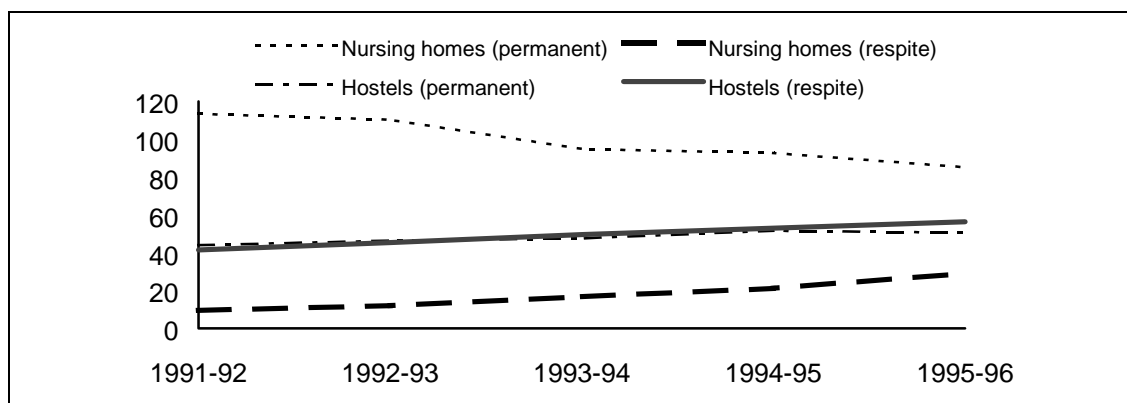
### 9.3.1 Reform directions

The Commonwealth and the State and Territory Governments are working to develop an improved partnership between levels of government to deliver better outcomes. The current step in reform is for the Commonwealth and State and Territory Governments to work cooperatively to develop practical proposals for reform — for example, to create opportunities for more flexibility and continuity of care, to ensure better planning and to improve quality of care.

### 9.3.2 Changes in accessibility of types of care

Nationally, accessibility of permanent nursing home care has fallen substantially between 1991–92 and 1995–96. But accessibility to hostels for permanent and respite care, nursing home respite care and other types of services, such as CACPs, has also risen over this period (Figure 9.8).<sup>3</sup>

Figure 9.8: Accessibility of nursing homes and hostels, 1991–92 to 1995–96 (admissions per 1000 persons with a profound/severe handicap aged 65 years and over)<sup>a</sup>



a Excluded CACPs.

Source: Table 9A.27

<sup>3</sup> Accessibility is defined as the number of admissions per number of persons with a profound/severe handicap who are aged 65 years and over, multiplied by 1000 (AIHW 1997).

### 9.3.3 Structural reform package

The aged care reforms legislated by the Commonwealth in 1997 aim to:

- break down the distinction between different types of residential care, that is, nursing homes and hostels, leading to funding being based on level of need (against an eight-level scale) rather than on the type of facility;
- introduce income testing in calculating care subsidies from 1 March 1998 for new residents. Full pensioners will pay 85 per cent of their pension, while others will contribute an extra income-tested charge of up to \$36.90 (indexed) per day or the full cost of their care (if lower);
- introduce an accommodation charge for nursing home care (excluding respite) to a maximum (indexed) of \$12 per day or \$4380 per year for up to five years. People with less than \$22 500 in assets will not be required to pay this charge. This, and the next reform, are designed to encourage nursing home owners to undertake capital improvements;
- introduce a new accreditation and certification system with the objective of ensuring quality assurance. Only certified facilities will be able to levy a capital charge, so encouraging owners to upgrade facilities to meet the standards; and
- remove some prescriptive regulations applying to residential care providers.

### 9.4 Framework of performance indicators

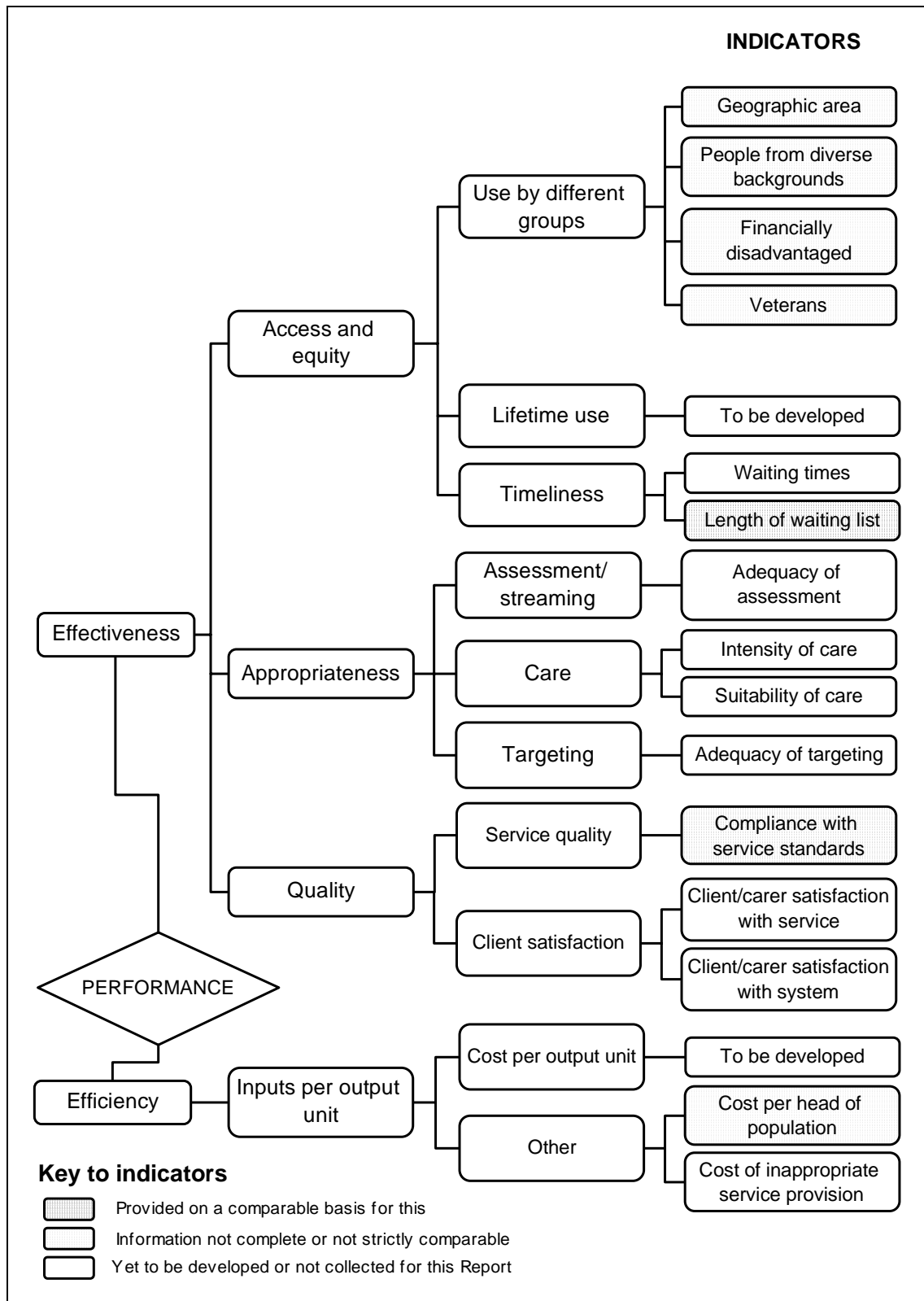
The performance indicators attempt to develop a consistent and comprehensive set of performance indicators for aged care services. The objectives of the aged care system are summarised in Box 9.1 and the indicator framework is presented in Figure 9.9.

#### Box 9.1: Objectives for aged care services

The aged care system aims to promote 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.

Figure 9.9: Performance indicators for the aged care services sector



Four groups of indicators, based on the objectives of aged care services, are presented in this Report. A description of all indicators is provided in Attachment 9A.

The *access and equity* indicators quantify the services available and their consumers. Most data for these indicators are available categorised into different groups of people.

*Appropriateness* indicators are an important component of the framework, but data are not available at this stage. Such indicators would cover adequacy of assessment, intensity and suitability of care, and adequacy of targeting.

Some limited data are available for *quality* indicators — specifically, outcome standards information for nursing homes and hostels.

*Unit cost* information remains unavailable for the major aged care services.

## **9.5 Future directions**

There are still several aspects of aged care services for which indicators are not fully developed and for which there is little performance reporting. Further development work is required to establish a full set of indicators. Progress on this over the past year has been slowed because of the focus by agencies on structural reforms to the aged care system. Further, even when specific indicators are identified, data for them may be difficult to collect or publish because it is confidential.

An important first step is to develop a strategy and timetable for addressing the current reporting gaps.

### **9.5.1 Improving the indicators**

Further work still needs to be done to improve the definitions of indicators for adequacy of assessment, intensity and suitability of care, adequacy of targeting and cost per unit of output.

#### *Identifying the relevant population*

Different reference populations exist for residential care and HACC services. HACC services to older people can only be estimated based on the number of people aged 70 years and over who are catered for by the services and the hours of services supplied (as opposed to actual services received by this age group). Thus, it is difficult to compare the effectiveness and efficiency of the alternative

settings delivering the required care packages. Development of a method for comparing service provision across service types is planned.

### *Measuring appropriateness*

It is difficult to measure appropriateness when the care package comprises a mix of many different service types provided simultaneously by a range of service providers.

Possible approaches to assessing the appropriateness of services provided are to review the quality of the assessment which establishes the care package, and to review the degree of choice in services and providers which older people receive. Appropriateness may also be measured by questioning clients about their experiences with the system.

Understanding the many dimensions of appropriateness requires further research. In particular, the development of statistical techniques to estimate service delivery across multiple providers will be pursued. No progress was able to be made for this Report in this area in 1997.

### *Measuring quality*

Some information is available on compliance with standards for residential care facilities, but little information is available on the quality of the aged care system as a whole or on client views on service quality, particularly for non-residential services. A national system for the assessment of quality in HACC services is due to commence in 1998. The Australian Institute of Health and Welfare (AIHW) is planning to undertake further investigation of methods for obtaining consumer feedback regarding HACC services in order to better inform this assessment process.

### *Broader indicators*

The data presented in this Report are based on service types. However, the aged care system closely interacts with other parts of the health and community services system. Thus, it is desirable to develop indicators which more fully capture the operation of the entire aged care system. In this sense, the indicators should focus on clients rather than on service providers.

## **9.5.2 Improving the data**

A broad range of indicators has been developed, but little data are available to report on these indicators. Steps were identified in the 1997 Report to improve the availability of data for this Report. Only limited new data have been

available this year but the projects being undertaken by the AIHW will provide some improvement for 1999. In particular, the HACC Minimum Data Set Project will provide a basis for consistent reporting of data by HACC funded agencies, allowing more comprehensive and comparable reporting against the indicators.

Some differences in indicator results for jurisdictions may reflect different counting and reporting rules for generating financial data. Differences may also reflect the treatment of various expenditure items (for example, superannuation). These issues are being addressed and this should allow the reporting of fully comparable data in future reports.

### *Younger people with disabilities*

Several services covered in this chapter provide services to younger people with disabilities, as well as to older people. A large proportion of HACC services are consumed by younger people with disabilities, and it is not yet possible to separate service provision to the two target groups in data collections. In providing information for this report, DHFS assumed that a certain percentage of all HACC services were received by people aged 70 years and over.<sup>4</sup> The compilation of the HACC minimum data set in 1998–99 will start to make it possible to report actual service use by age.

### *Data focused on people*

The current aged care data collection focuses on services and funding programs rather than on the people who use aged care facilities. There are no data on whether a person consumes services from several providers, nor on whether they receive all the services they are assessed as needing. There is also little information on outcomes, including measures of client satisfaction. Thus, it is difficult to assess the effectiveness and efficiency of aged care services.

## **9.6 Key performance results**

Only limited data were again available for reporting this year. Developments include data on the ownership of residential facilities across jurisdictions and information on the degree of targeting of HACC services.

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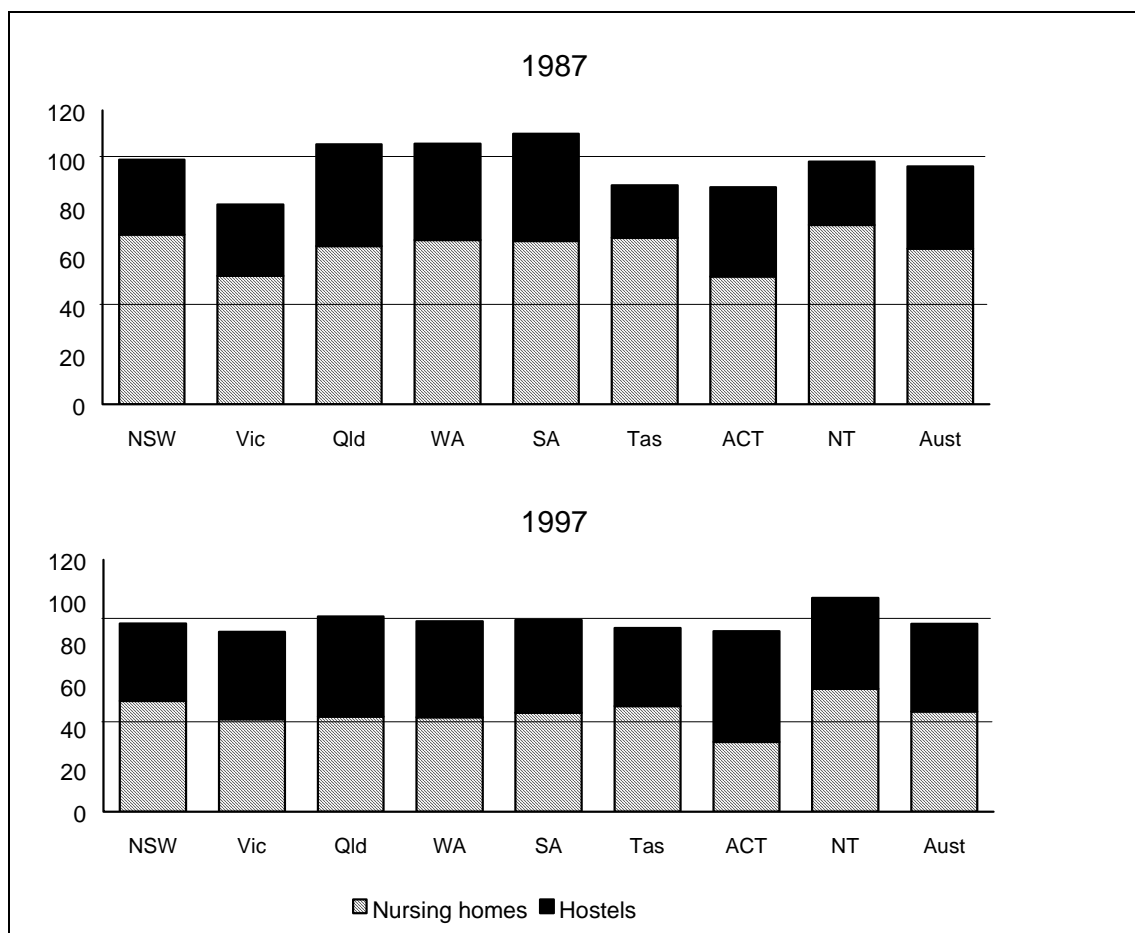
<sup>4</sup> The estimates of the percentages of HACC services received by people aged 70 and over were as follows: 66.7 in NSW; 71.6 in Victoria; 74.5 in Queensland; 71.0 in WA; 71.4 in SA; 63.7 in Tasmania; 63.7 in the ACT; 49.9 in the NT; and 69.5 for Australia (DHFS 1997).

### 9.6.1 Access to services

#### *Residential services*

The combined number of nursing home and hostel places per 1000 persons aged 70 years and over was reasonably similar across most jurisdictions in June 1997. The ACT had proportionally more hostel places and fewer nursing home places than the other jurisdictions and the NT had proportionally more nursing home places than the other jurisdictions. There has been a general increase in the proportion of hostel places relative to nursing home places between 1987 and 1997 (Figure 9.10).

Figure 9.10: Residential places<sup>a</sup>, June 1987 and June 1997 (per 1000 persons aged 70 years and over)<sup>b</sup>



a Places do not include those places which have been 'approved in principle' but are not yet operational for Australia for June 1997.

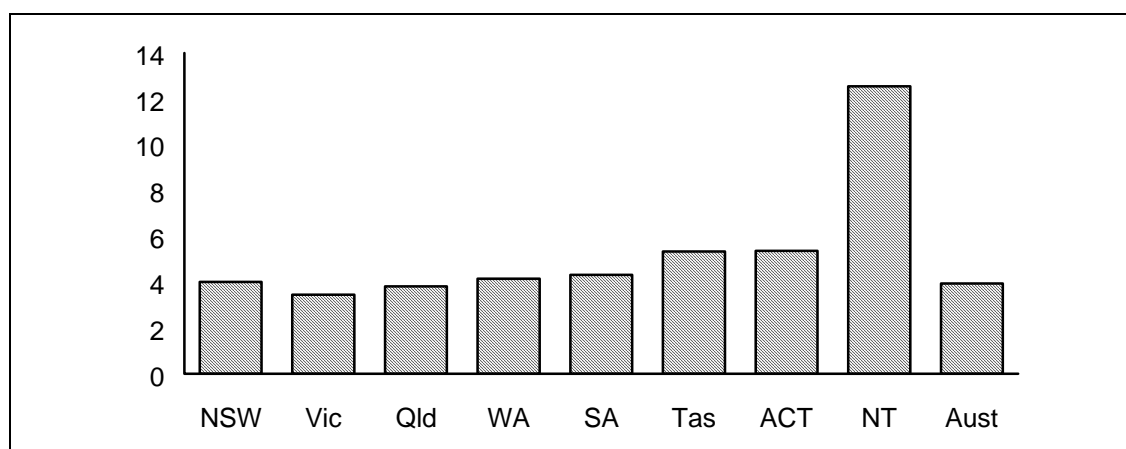
b The horizontal lines represent Commonwealth planning guidelines for the number of nursing home and hostel places per 1000 people aged 70 years and over.

Source and additional notes: Table 9A.23

### *Community Aged Care Packages*

The number of CACP places per 1000 persons aged 70 years and over has grown in recent years but still remains small relative to residential places. The smaller population jurisdictions (the NT, the ACT and Tasmania) had the highest proportion of CACP places relative to the target number, and Victoria, Queensland and NSW had the lowest as at June 1997 (Figure 9.11).

Figure 9.11: CACP places<sup>a</sup>, June 1997 (per 1000 persons aged 70 years and over)



a Places do not include those places which have been 'approved in principle' but are not yet operational for Australia for June 1997.

Source: Table 9A.23

### *Home and Community Care*

The NT had the highest quantity of HACC services delivered per 1000 persons aged 70 years and over for most services in 1996. Exceptions were home nursing and maintenance (which were highest in the ACT) and centre day care (which was highest in Queensland). NSW had the lowest quantities of paramedical services (with Tasmania) and home maintenance services; Victoria had the lowest quantity of personal care and respite care combined; SA had the lowest incidence of home help; and the NT had the lowest quantities of home nursing and centre day care. Home nursing was not HACC funded (or only minimally funded) in the NT (Table 9.1).

Eligibility for HACC services is determined by a potential provider's assessment of a person's needs, according to national guidelines.

**Table 9.1: Estimated level of HACC services received, 1996**  
(per month per 1000 persons aged 70 years and over)<sup>a, b</sup>

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
<i>Hours per month</i>									
Home help <sup>c</sup>	165	507	235	372	132	350	237	879	286
Personal care <sup>c</sup>	116	67	32	128	73	88	117	262	85
Home nursing <sup>c</sup>	71	145	146	147	65	151	239	7	112
Paramedical	8	23	16	15	24	8	9	57	16
Respite care	148	46	106	81	103	65	281	542	105
Centre day care	210	331	524	292	273	226	213	115	309
Home maintenance	24	34	26	42	30	40	65	33	30
<i>Meals per month</i>									
Home meals	417	526	545	527	535	485	382	1 528	491
Centre meals	53	82	74	186	67	29	19	317	76

a Estimates were based on the proportion of people aged 70 and over receiving HACC services in each jurisdiction.

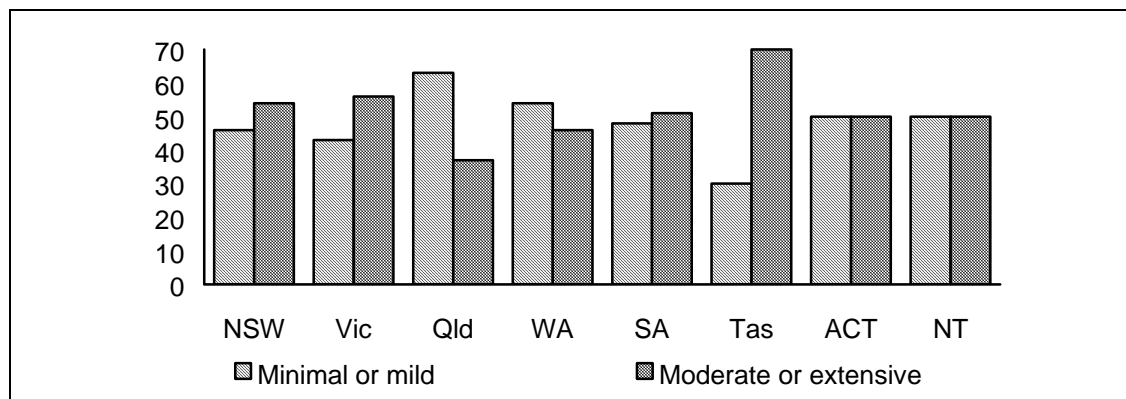
b Data were taken from November 1994, 1995 and 1996, except for WA where all data were from September 1993 only, the ACT where 1994 data were from May 1995 and the NT where 1995 data were from May 1996.

c There is some overlap between jurisdictions in the definitions of home help, personal care, home nursing and paramedical services.

Source: Table 9A.10

HACC targeting strategies can indicate the extent of rationing of HACC services and their subsequent allocation to those most in need of the service. In 1995, Tasmania, Victoria and NSW had the greatest percentage of HACC projects surveyed with 'moderate' or 'extensive' targeting strategies (Figure 9.12).

Figure 9.12: Existence of targeting strategies for HACC projects, 1996  
(per cent of projects)



Source: Table 9A.24

The survey on which these results are based also showed 60 per cent of the 400 HACC projects surveyed nationally in 1995 also reported taking further action to manage demand in excess of capacity (Howe *et al* 1996).

### 9.6.2 Timeliness

#### *Waiting times*

Waiting times data were not available on a consistent basis across jurisdictions. Some examples of the types of data available are shown in Box 9.2.

### 9.6.3 Quality indicators

Outcome standards for nursing homes and hostels targeted for assessment by the Commonwealth do not indicate the quality of care provided in a given year because inspectors target facilities considered to be high risk, not a random sample of facilities.<sup>5</sup> However, some interjurisdictional comparisons of the outcomes of the assessments can be made because there was similar targeting across jurisdictions.

<sup>5</sup> The shift to targeting of homes has caused the average score of visited homes to fall because most facilities assessed are those identified as being at risk of having poor standards.

### Box 9.2 Waiting times in Victoria and WA

Matching data across jurisdictions on waiting times for nursing homes and hostels remain unavailable. Data for two jurisdictions, Victoria and WA, are presented below to indicate the situation within these states and to illustrate some of the jurisdiction-specific information that exists. The data should not be used to compare performance across these jurisdictions.

Nursing home placement rates for Victoria were reported in a study by Butler *et al* (1997). The study considered the placement rates of Aged Care Assessment Team clients recommended for nursing home entrance during August 1996 at 30, 60, 90 and 120 day intervals. The overall placement rate was 58 per cent at 30 days, rising to 92 per cent at 120 days. The study also found that there was no statistically significant difference in the placement rates of metropolitan and non-metropolitan clients at the 30-day period.

#### Victorian placement rates in nursing homes, August 1996

<i>Client placement status</i>	<i>Unit</i>	<i>30 days</i>	<i>60 days</i>	<i>90 days</i>	<i>120 days</i>
Placed in home of choice	%	44.2	57.0	63.8	66.5
Placed in home not of choice	%	6.6	9.8	11.0	12.8
Placed in home not of choice and awaiting transfer	%	2.4	3.8	4.4	4.9
Placed — no further information	%	4.9	6.4	6.6	7.4
Total placed	%	58.1	77.0	85.8	91.6
Sample	No	573	470	456	391

The WA data supplied was for the mean waiting times in days for nursing home entry over the past three financial years for all persons and various special needs groups. There was a substantial fall in the mean waiting time for all persons in 1996–97, with mixed results for the various special needs groups.

#### WA mean waiting times for nursing homes, 1994–95 to 1996–97 (days)

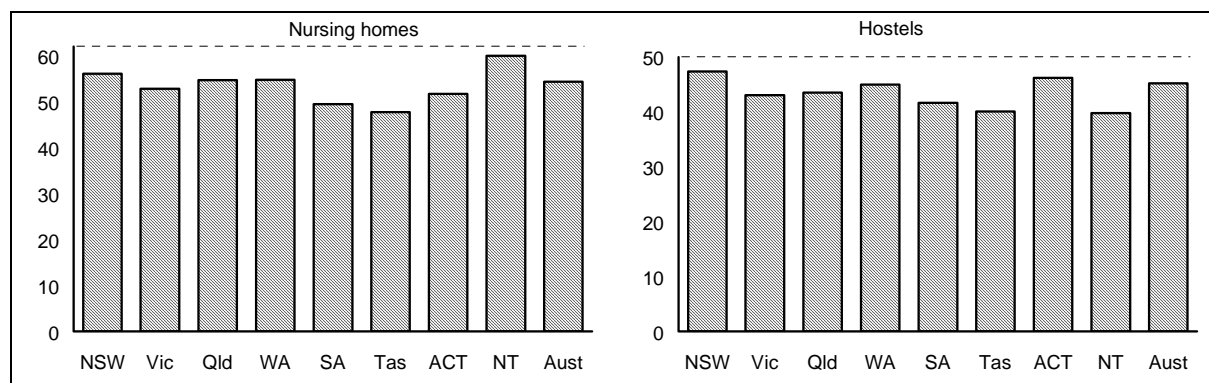
<i>Client group</i>	<i>1994–95</i>	<i>1995–96</i>	<i>1996–97</i>
Persons from culturally diverse backgrounds	30.5	25.2	29.5
Aboriginal and Torres Strait Islander people	22.0	20.6	28.8
Government pensioners	27.5	27.2	21.9
Veterans	41.9	27.9	23.6
All persons	28.1	28.4	23.1
Persons with unknown pension status	34.5	35.4	30.5

Sources: Butler *et al* 1997; UWA 1997 unpublished

Standards of those nursing homes targeted were highest in the NT (60.0) and NSW (56.1) and lowest in Tasmania (47.7) and SA (49.5). For hostels, the average standard was highest in NSW (47.4) and the ACT (46.2) and lowest in the NT (39.8) and Tasmania (40.1). However, it should be noted that performance assessment against outcome standards are mostly within the Commonwealth's jurisdiction (Figure 9.13).

Annual investment expenditure on nursing homes and hostels per resident over time indicate the extent to which the quality of the physical structure of facilities is being maintained. This information should become available in the future under the reporting requirements of the *Aged Care Act 1997*.

Figure 9.13: Average score of nursing homes and hostels assessed against outcome standards, 1996–97 (nursing homes out of 62; hostels out of 50)<sup>a,b</sup>



a The maximum score for nursing homes was 62 and the maximum for hostels was 50.

b Selection of facilities for inspection was on a risk management basis. Inspectors targeted facilities considered to be high risk, not a random sample of facilities. However, some interjurisdictional comparisons can be made, because the outcome assessments reflect similar targeting across jurisdictions.

Source: Table 9A.8

### 9.6.4 Access by special needs groups

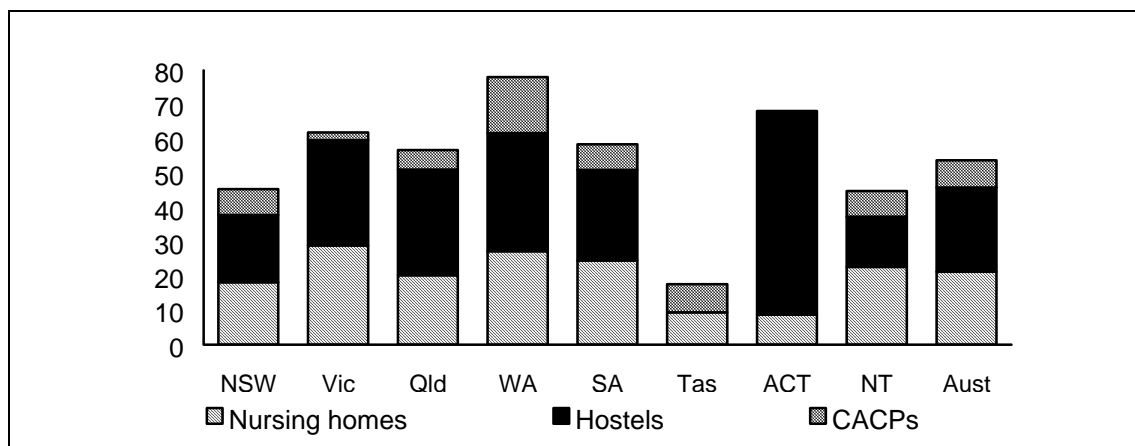
Two special needs groups in the aged care sector are indigenous people and people from a non-English speaking background. The receipt of aged care services by these people across jurisdictions can indicate:

- their relative need for aged care services — that is, demand; and
- how successfully their needs are being met — that is, supply of services.

When reporting receipt of services by these groups it is desirable to have indicators that could separate these two aspects. The extent to which people who have an assessed need for a service (for example, approval for residential care admission) choose not to take it up and people who may seek a service but not have an assessed need for it may also need to be taken into account. Another consideration is that the number and proportion of the population of indigenous people and people from a non-English speaking background varies by jurisdiction.

Indigenous people tend to require aged care services at a younger age than the general population. Thus participation for 1997 was measured against all indigenous people aged 50 years and over. The intensity of use of aged care services by indigenous people in this age group was highest in WA (78.1 per 1000 indigenous people) and lowest in Tasmania (17.6 per 1000 indigenous people) (Figure 9.14).

Figure 9.14: Indigenous aged care recipients, June 1997 (per 1000 indigenous people aged 50 years and over)<sup>a,b,c</sup>



a Unknown responses were distributed pro-rata.

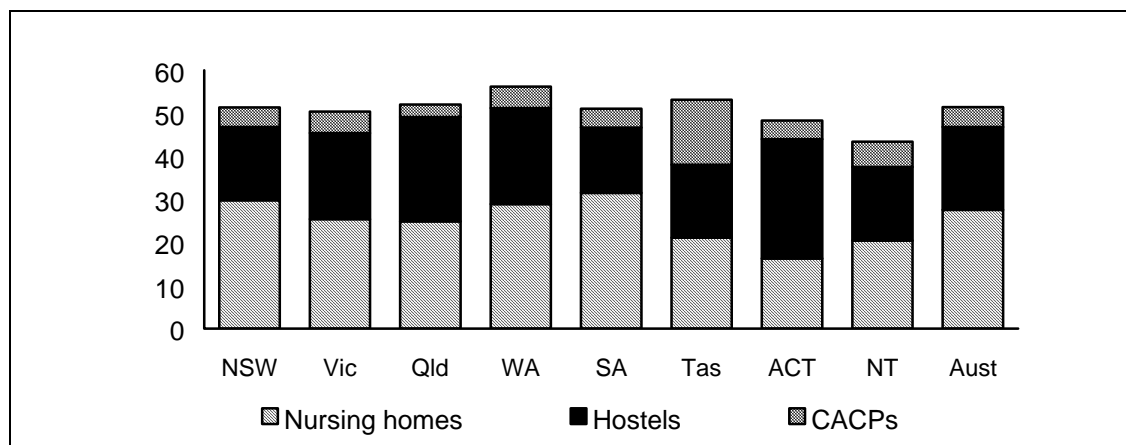
b Included flexibly funded and pilot ATSI projects (27 places 1996, 246 places 1997).

c The 1997 population was estimated.

Source and additional notes: Table 9A.5

In 1997, WA had the highest rate of participation in residential and equivalent services by people from a non-English speaking background, followed by Tasmania and Queensland. The lowest rates of participation were in the NT and the ACT (Figure 9.15). Compared with older people in general, older people from non-English speaking backgrounds had a substantially lower rate of use of aged care facilities in 1997.

Figure 9.15: Aged care recipients from a non-English speaking background, 1997 (per 1000 people aged 70 years and over from a non-English speaking background)<sup>a,b</sup>



a Unknown responses were distributed pro-rata.

b The 1997 population was estimated.

Source: Table 9A.3

Data will be available on use of HACC services by special needs groups from the 1997–98 HACC User Characteristics Survey.

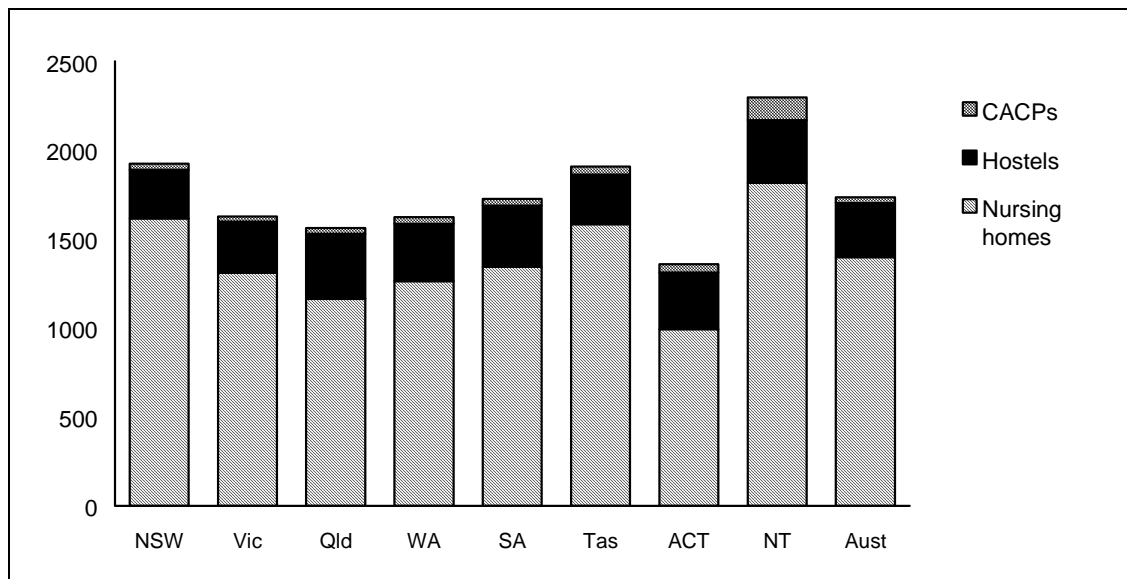
### 9.6.5 Expenditure and efficiency

A number of different services are provided in both residential and community care. This Report provides information on expenditure per person on the main types of aged care services.

Some differences in indicator results for jurisdictions may reflect different counting and reporting rules for generating financial data. Differences may also reflect the treatment of various expenditure items (for example, superannuation).

Expenditure on residential (and equivalent) care services per person aged 70 and over in 1996–97 was dominated by nursing home expenditure, with a smaller but substantial amount of expenditure on hostels. Expenditure per person aged 70 years and over on nursing homes was highest in the NT (\$1815) and it was highest for hostels in Queensland (\$366). CACP absorbed a small amount of the aged care budget, but its importance has grown over the past several years. It is included with residential services in this Report because it is funded alongside these services by the Commonwealth Government (Figure 9.16).

Figure 9.16: Commonwealth Government expenditure on residential services, 1996–97 (dollars per person aged 70 years and over)<sup>a,b</sup>



a Not included is \$283 million of ‘other’ expenditure that could not be allocated specifically to the three service categories in the figure. The major components of this expenditure (together making up around 70 per cent of the ‘other’ expenditure) were the Domiciliary Nursing Care Benefit, capital funding, Aged Care Assessment Teams, Day Therapy Centres and multipurpose services.

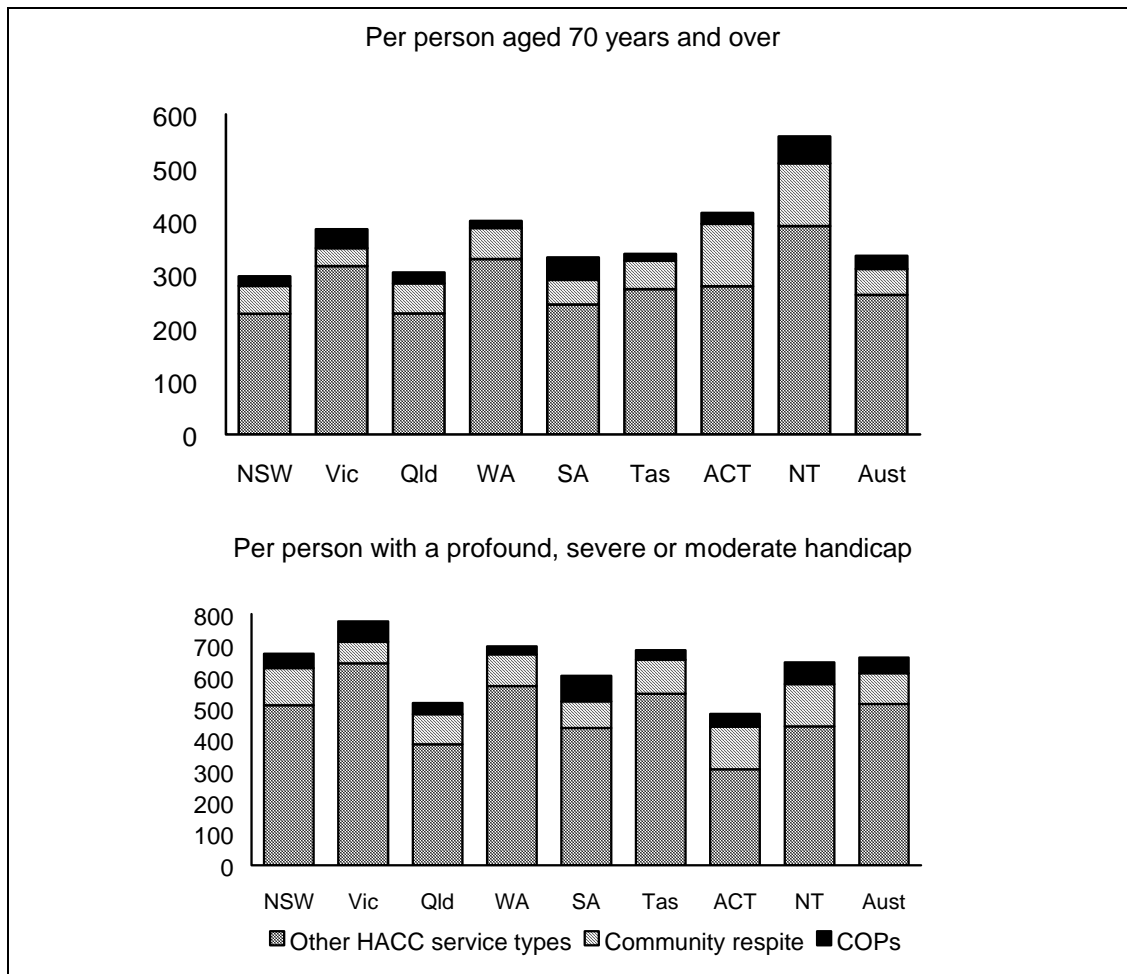
b CACPs expenditure excluded establishment grants.

Source: Table 9A.7

Commonwealth Government expenditure on other non-residential services amounted to a further \$283 million in 1996–97. Major components of this non-residential expenditure were the Domiciliary Nursing Care Benefit, capital funding, Aged Care Assessment Teams, Day Therapy Centres and multipurpose services which collectively made up around 70 per cent of this expenditure.

Expenditure on HACC services also varied across jurisdictions in 1996–97. HACC expenditure per person aged 70 years and over tended to display an inverse relationship with residential expenditure across jurisdictions. For example, it was lowest in NSW (\$296) but residential expenditure in this state was among the highest. The jurisdiction with the highest HACC expenditure per person aged 70 years and over was the NT (\$559). The NT expenditure possibly reflects the special factors that apply to service delivery in this jurisdiction, plus the large proportion of indigenous residents with special aged care needs (Figure 9.17). A more rigorous analysis of unit costs would be required to fully explore the reasons for higher per capita expenditure in the NT.

Figure 9.17: Expenditure on HACC services, 1996–97 (dollars per person aged 70 and over)<sup>a</sup>



<sup>a</sup> HACC services for older people were estimates based on the proportion of people aged 70 years and over receiving HACC services in each jurisdiction.

Source: Table 9A.20