PART F

COMMUNITY SERVICES

F Community services preface

Families are the principal providers of care for children, older people and people with a disability (ABS 2001). Community services aim to help families to undertake this role and can fulfil this role where families are not in a position to provide care. Community services covered by this Report encompass aged care services (chapter 12), services for people with a disability (chapter 13), children's services (chapter 14), and protection and support services (child protection, supported placements, and supported accommodation and assistance) (chapter 15).

Community service activities (box F.1) typically include those activities 'which assist or support members of the community in personal functioning as individuals or as members of the wider community' (ABS 2001). They may include financial assistance and relief to people in crisis, and housing assistance of a short term or transitional nature, but exclude acute health care services (see chapters 9–11), long term housing assistance (see chapter 16) and income support (such as social security pensions and allowances).

The definition of community service activities contained in this preface is based on the National Classification of Community Services, developed by the Australian Institute of Health and Welfare (AIHW 1997) (box F.1). Outputs measures for community services are based on ABS survey data and community services expenditure data were derived from the expenditure data collated for the individual chapters in the Report.

As in previous years, the preface includes descriptive data obtained from the Australian Institute of Criminology (AIC) on the number and detention rates of, juveniles in correctional facilities. In addition, this year's preface includes data on the number of juveniles on community based orders in each jurisdiction for the first time. It is anticipated that the Report will contain performance reporting on juvenile justice in future years.

Performance information on community services as a whole is not currently reported. While there are many interactions among the various community services, the services and their funding and delivery systems are too varied to enable aggregate community services reporting.

Box F.1 **Community service activities**

Child care — the provision of care, by persons other than the child's parents, under the supervision of a paid coordinator in a group setting or in another home.

Training and employment for people with disabilities — services that assist people with a disability in the labour market by providing training, job search skills, help in finding work, placement and support in open employment and, where appropriate, supported employment.

Financial and material assistance — provision of financial aid and goods (such as equipment, clothing and household items, food and vouchers) on a temporary emergency basis, to meet particular needs in times of crisis or disaster.

Residential care — services that help people who are disadvantaged (in terms of their capacity for independent living) to access suitable community housing arrangements and other appropriate community resources.

Foster care placement — placement of a child or young adult who lives apart from natural or adoptive parents in a private household with one or more adults who act as substitute parents.

Accommodation placement and support — services that assist disadvantaged people gain access to, and help maintain them in, suitable community housing arrangements (for example, State or Territory housing agency accommodation). These services include placement/outreach services for those leaving refuges.

Statutory protection and placement — services that include daily care, protective investigation, post-investigation intervention, removal to alternative care, statutory case management of out-of-home placements and/or application for a child protection order to the Children's Court and adoption placement.

Juvenile and disability corrective services — services that provide correctional and rehabilitative supervision and protection of public safety through corrective arrangements (for example, supervision of community-based orders and management of juvenile justice detention centres) and advice to courts and parole boards on juvenile offenders or offenders with intellectual or psychiatric disabilities. (Corrective activities for adults other than those with an intellectual or psychiatric disability are excluded.)

Other direct community service activities — other direct community service activities, such as preschool activities, recreation/leisure activities, community nursing services and other personal and social support.

Community service related activities — policy, community and service development and support, government administration of funding and monitoring of the licensing and regulating of service providers, retirement village self care units, and other community service related activities.

Source: Australian Bureau of Statistics (ABS) (2001).

Profile of community services

Roles and responsibilities

Government involvement in community services includes:

- funding non-government community service organisations (which then provide community services to clients);
- providing services to clients directly;
- regulating non-government providers; and
- undertaking policy development and administration.

The relative contribution of government to the direct provision of services varies across community service activities. Statutory protection and placement, and corrective services are provided primarily by government, while residential care and accommodation support, and other community services activities are provided primarily by non-government organisations.

Expenditure

Total expenditure by governments has been calculated based on the 2002-03 expenditure totals for aged care services, services for people with a disability, children's services and protection and support services. Community services expenditure in this preface, therefore, relates to only the activities as defined under these individual chapters.

Total expenditure on community services covered by this Report was estimated to be $12.4 billion in 2002-03. This was equivalent to 1.7 per cent of gross domestic product in that year, and 9.4 per cent of total government outlays (ABS 2003).

Between 1998-99 and 2002-03, community services expenditure increased by $3.0 billion, or 32.4 per cent in real terms (figure F.1). The biggest increases were in children's services and protection and support services for which expenditure rose by 44.8 and 44.2 per cent respectively over the period. The smallest increase was in aged care services, for which expenditure rose 24.3 per cent whilst disability services increased by 36.8 per cent over the period.

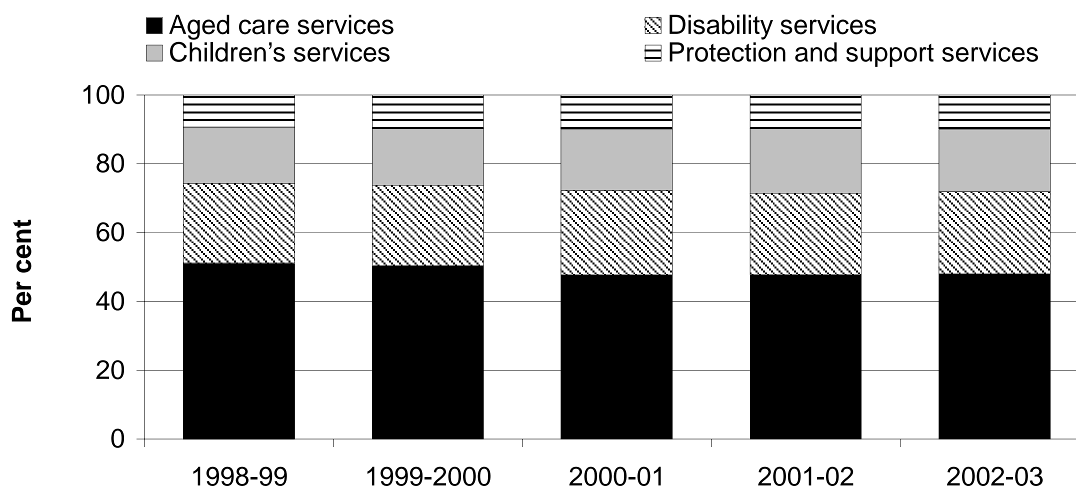
Table F.1 **Real recurrent expenditure on community services (2002-03 dollars) ($ million)**

	Aged care services	*Disability services*	*Children's services*	*Protection and support services*	***Total***
1998-99	4 801	2 179	1 541	869	**9 390**
1999-2000	5 019	2 329	1 638	971	**9 957**
2000-01	5 109	2 650	1 911	1 056	**10 726**
2001-02	5 645	2 811	2 221	1 150	**11 827**
2002-03	5 967	2 980	2 231	1 253	**12 431**

Source: Australian, State and Territory governments (unpublished); tables 12A.45–51,13A.21, 14.A.4, 15A.1 and 15A.163.

In 2002-03, close to half (48.0 per cent) of community services expenditure related to aged care services, 24.0 per cent related to disability services, 17.9 per cent related to children's services, and 10.1 per cent related to protection and support services (figure F.1).

Figure F.1 **Government recurrent expenditure on community services covered by the Report on Government Services**



Source: Australian, State and Territory governments (unpublished); tables 12A.45–51,13A.21, 14.A.4, 15A.1 and 15A.163.

Size and scope

Almost 9300 organisations were providing community services, covering the not-for-profit, government, and for-profit sectors, at 30 June 2000. The number of organisations increased by 15.3 per cent from the previous Australian Bureau of Statistics (ABS) Community Services Survey in 1995-96. The number of government organisations providing community services remained virtually

unchanged over this period, while the number of for-profit and not-for-profit organisations increased by 32.4 per cent and 9.9 per cent respectively (ABS 2001).

Across the three sectors at June 2000, these organisations employed 341 400 people (up 7.0 per cent from 1995-96), including 277 300 employed in direct service provision (up 24.2 per cent). A further 299 400 volunteers assisted in community service activities, representing a 25.4 per cent increase from the number of volunteers in 1995-96 (ABS 2001). Government organisations employed 59 200 people in providing community services (down 13.0 per cent from the number in 1995-96), who were assisted by almost 18 000 volunteers (down 18.5 per cent) (ABS 2001).

Table F.2 **Output measures for direct community services activities, 1999-2000[a]**

Direct community service activity	*Unit*	*Number ('000)*
Personal and social support		
Information, advice and referral	Contacts/year	7 612.1
Individual and family support	Cases/year	3 663.2
Independent and community living support	Cases/year	1 871.1
Support in the home	Clients/year	1 965.0
Child care		
Centre based long day care	children/day	140.0
Family day care	children/day	11.1
Occasional care	children/day	7.2
Before and after school hours care	children/day	35.8
Vacation care	children/day	23.2
Other child care	children/day	4.2
Training and employment for people with disabilities		
Pre-vocational/vocational training	trainees/year	9.6
Employment, job placement and support	clients/year	44.0
Supported employment/business services	employees/day	17.4
Financial and material assistance	Cases/year	1 749.1
Residential care		
Transitional accommodation	bed nights/year	2 587.2
Crisis accommodation	bed nights/year	2 796.5
Intensive residential care	residents/day	72.6
Hostel care	residents/day	66.8
Residential respite care	occupants/day	6.5
Residential rehabilitation	residents/day	2.4
Other residential care	residents/day	22.6
Foster care placement	placements/year	57.8
Statutory protection and placement	cases/year	139.8
Juvenile and disability corrective services	cases/year	37.0

a See definitions in box F.1

Source: ABS (2001).

The numbers and types of service provided in 1999-2000 varied across community service activities (table F.2).

- In personal and social support, 7.6 million contacts for information, advice and referral were made.
- In child care, around 140 000 children each day were in centre-based long day care.
- An average of 72 600 residents per day were in intensive residential care (such as nursing homes and residential support institutions for the aged or people with a disability).
- A total of 2.8 million bed nights of crisis accommodation were provided, in addition to 2.6 million bed nights of transitional accommodation.

An important issue for government is to determine how to assist community service clients in meeting their complex needs and how to assess performance in meeting these needs. Governments have introduced case management and policy coordination at a more central level to improve the delivery of services.

There are also links between community services and other government services. The performance of community services may influence outcomes for clients of education, health, housing and justice sector services; in turn, these other service areas, affect outcomes for clients of community services. A broader discussion of these links is contained in chapter 1.

Juvenile justice

The juvenile justice system is responsible for dealing with young people (predominantly aged 10–17 years) who have committed or allegedly committed an offence while considered by law to be a juvenile. Each jurisdiction has its own legislation which dictates the policies and practices of the juvenile justice system within its jurisdiction. While this varies in detail, the intent of the legislation is similar across jurisdictions. Key elements of juvenile justice systems in all jurisdictions, for example, include: diversion of young people from the more formal criminal justice system (court) where appropriate; incarceration as a last resort; victim's rights; the acceptance of responsibility by the offender for his or her behaviour; and community safety.

The juvenile justice system in each jurisdiction is comprised of several organisations, with each having a different primary role and responsibility in dealing with young offenders. These include:

- police, who are usually the young person's first point of contact with the system. Where considered appropriate, the police may administer warnings, cautions and in some jurisdictions use conferencing to divert the juvenile from proceeding to court;
- courts (usually a special Children's or Youth court), where matters relating to the charges against the young person are heard. The courts are largely responsible for decisions regarding bail (and remand) and sentencing options if the young person admits guilt or is found guilty by the court.
- juvenile justice departments, who are responsible for the supervision and case management of juveniles on a range of community based legal arrangements and in detention, and for the provision of a wide range of services aimed at crime prevention and diversion. Many of the services provided by juvenile justice departments are aimed at: rehabilitation; minimising the level of and future involvement of young people with the justice system; reducing the over-representation of Indigenous young people; maintaining the client's connection with family, culture and community; providing clients with an appropriate level of care and safety (duty of care); increasing client accountability to victims; and community safety.

Diversion of young offenders

In most jurisdictions the majority of young offenders are diverted through a range of mechanisms such as police caution, conferences and unsupervised orders, and do not become clients of juvenile justice departments. Informal warnings, police cautions, and community, family or youth justice conferences are now part of the spectrum of legislated responses to juvenile crime. Additionally, jurisdictions use infringement notices as a response to a wide range of regulatory, transport and environmental offences allegedly committed by juveniles. Responsibility for administering the options available for more minor offences — warnings (informal cautions), formal cautions, and a significant proportion of infringement notices — falls on police in all jurisdictions.

Responsibility for the administration of the diversionary processes available for generally more serious offences lies with juvenile justice authorities in departments ranging from Juvenile Justice (NSW) to Courts Administration (SA). Conference referrals can originate from both police and courts in most jurisdictions. Conditions of entitlement and eligibility and the range and/or definition of offences that can be dealt with by way of conference, vary from jurisdiction to jurisdiction.

While comparable national data are not yet available to illustrate the level of diversion, some data have been provided by individual jurisdictions. Diverting appropriate young offenders from the formal court system or minimising the involvement of young people with the justice system through a conferencing process can take considerable resources, depending on the judicial system in the jurisdiction and the number of young offenders involved. Examples of the number of young offenders dealt with by means of diversion are provided by the juvenile justice departments in NSW, Queensland and Tasmania (although data are not comparable across jurisdictions).

For 2002, NSW Police records show 1103 referrals to youth justice conferences, 9263 cautions were given and 33 952 warnings were administered to young offenders. The NSW Department of Juvenile Justice data show 1369 conferences were convened during the year for young offenders. In Queensland, 389 conferences were convened and completed for people aged 10–16 years during 2001-02. There were 359 conferences for young offenders aged 10–17 years in Tasmania over the same period.

In addition to conferences, juvenile justice departments in all jurisdictions provide pre-sentence reports for young people (who may or may not go on to become clients) to the courts as required. For example, during 2001-02 WA provided 1918 pre-sentence reports, whilst Queensland and Tasmania provided 578 and 507 pre-sentence reports respectively.

Clients of juvenile justice departments

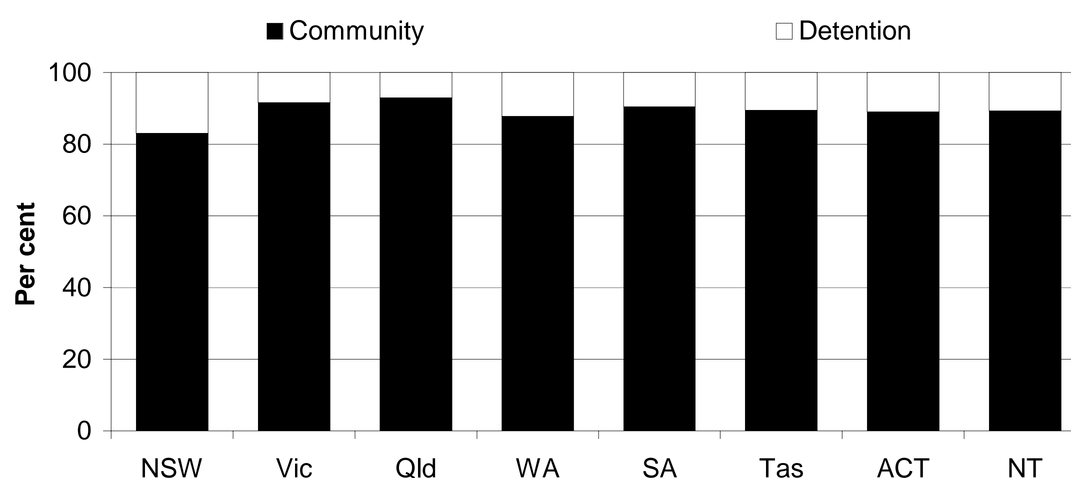
Detailed national data are currently only available on the number of young people held in juvenile detention centres, either on remand or sentenced, at the end of each quarter. Hence, this is the only data that are published in this Report.

Detention data, however, illustrates only one aspect of the juvenile justice system, and are not representative of the full workload or breadth of services provided by the juvenile justice system or even juvenile justice departments. The need for more representative data on a national basis has been one of the main factors driving the development of the Juvenile Justice National Minimum Data Set (JJNMDS). The JJNMDS has recently been successfully tested and data may be available for future reports.

Of those young offenders who do become clients of juvenile justice departments, most are diverted from detention through provision of a range of community based orders, including parole. Figure F.2 shows that the vast majority of young people who are supervised by juvenile justice departments — between 83 per cent and 93 per cent — are in the community, rather than in detention. As these data are

collected at a point in time, care should be taken in interpreting the data, particularly for jurisdictions with smaller populations where a small change to the number of young people in detention can make a significant difference to the proportion of the population.

Figure F.2 **Proportion of juvenile justice clients aged 10–17 years, supervised in the community and in detention centres, at 30 June 2002**[a, b, c, d, e, f, g, h, i]



[a] Only those young people who are under the supervision or case management of juvenile justice departments on a pre or post sentence legal arrangement or order are included (for example, young people on supervised bail, remand, a community services order, parole and in detention). [b] Juvenile justice departments also have additional clients in detention and community supervision who are over 17 years of age. The graph does not include those juvenile justice clients over 17 years of age at 30 June 2002. [c] Clients may be on multiple orders at any one time. The distribution in the graph is therefore not based on order type but where the client was located at 30 June 2002. [d] Children's court legislation in Victoria applies to persons aged 10–16 years. However, Victoria has a dual track system for persons aged 17–20 years at the time of sentencing in the adult court system. Such persons may be sentenced to the juvenile justice system but there is no provision for detaining persons aged 17 years and over who are only on remand. [e] In Queensland, juvenile justice legislation applies to those young people who were aged 10–16 years at the time of the offence. The data do however, include those 17 year olds who were still on supervision in the juvenile justice system at 30 June 2002. [f] SA data exclude juvenile justice clients who are on conditional release in the community, and include a small number of clients who are no longer under supervision of the department but where an exit date has not been recorded. [g] The NT community count is a slight over estimate of the actual number of clients in the community as a client with more than one community corrections program active is counted more than once. Also, clients who were in detention who also had a community correction order at 30 June 2002 are counted in both data sets. Age for clients in the community is based on age at the date the order began. The detention figures include all clients held in Don Dale juvenile justice facility, regardless of age. They may, therefore, include some clients over 17 years of age. [h] In WA juveniles subject to Juvenile Team Referrals Action Plans have been excluded from the data. [i] The number of diversions reported in the Juvenile Justice section may not match the numbers reported in the Police Chapter of the Report for several reasons. Firstly, police have their own diversionary processes that can be implemented before a young person becomes involved with the Juvenile Justice system. Second, police refer young people to the Juvenile system for conferencing, but are not the only source of referrals. Children's Court in some jurisdictions can refer young people to the Juvenile Justice system for conferencing or a form of diversion. Finally, as a consequence of time delays between referral date and conferencing date, the numbers may be different in a 12 month counting period.

Source: State and Territory governments (unpublished).

Juvenile detentions

This Report includes descriptive data on the number and detention rates of juveniles in correctional facilities. The AIC has published these data, having obtained the data from juvenile justice agencies in each jurisdiction (AIC 2003). The following data relate to juvenile custodial services only and do not describe the operation of community-based services, which supervise the majority of juvenile offenders. Jurisdictions also have different definitions of a juvenile which may have an impact on the number and rates reported for people aged 10–17 years.

Data on the number of juveniles includes those on remand as well as those sentenced. In some jurisdictions, (for example, WA) juveniles that have been arrested and have not yet appeared before a court are also held in a detention centre.

The AIC uses ABS experimental projections for its estimates of the Indigenous population (ABS 1998). These data include a range of estimates (low, medium and high). The data in this Report are based on high level estimates.

Nationally, the average daily number of people aged 10–17 years detained in juvenile corrective institutions fell from 748 to 609 between 1997-98 and 2001-02 (table F.3).

Table F.3 **Average daily population of people aged 10–17 years in juvenile corrective institutions (number)[a]**

Year	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*[b]	*ACT*[c]	*NT*	*Aust*
1997-98	303	74	142	122	57	19	11	21	748
1998-99	285	72	133	125	42	29	9	23	716
1999-2000	251	63	112	116	47	31	11	15	647
2000-01	223	62	87	103	59	43	17	17	611
2001-02	217	62	89	106	56	27	18	16	609

a Average based on population of juvenile corrective institutions on the last day of each quarter of the financial year. **b** A review of data provided by Tasmania indicates that discrepancies in the number of young people reported in the data may result in higher numbers reported than the actual numbers in the detention centre. The proclamation of the *Tasmanian Youth Justice Act 1997* in February 2000 extended the upper range of the target group, resulting in an increased number of young people in detention. **c** ACT data for 2001-02 have been revised from data previously published by the AIC.

Source: AIC (2003).

Nationally, the rate of detention of people aged 10–17 years in juvenile corrective institutions fell by around one fifth between 1997-98 and 2001-02, although there were substantial differences across jurisdictions (table F.4).

The proportion of females detained as a proportion of the total population of juveniles in juvenile corrective institutions fluctuated between 6.4 and 10.4 per cent nationally over the five-year period to June 2002, and was 9.9 per cent at

30 June 2002. The proportion of males detained as a proportion of the total population of juveniles in juvenile corrective institutions varied from between 89.6 and 93.6 per cent over the period, and was 90.1 per cent at 30 June 2002 (table F.5).

Table F.4 **Average annual rate of detention per 100 000 people aged 10–17 years in juvenile corrective institutions (number)[a]**

Year	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*[b]	*ACT*[c]	*NT*	*Aust*
1997-98	43.5	14.8	35.4	56.7	35.5	26.8	30.8	86.3	35.5
1998-99	40.6	14.2	32.9	57.5	25.6	51.7	24.8	92.5	34.0
1999-2000	35.5	12.4	27.2	52.8	29.1	45.7	30.2	56.2	30.1
2000-01	31.1	11.9	20.9	46.2	36.4	61.8	46.6	60.6	28.1
2001-02	29.9	11.9	20.9	47.3	34.1	48.5	48.6	62.8	28.0

[a] Detention rates based on average population of juvenile corrective institutions on the last day of each quarter of the financial year. [b] A review of data provided by Tasmania indicates that discrepancies in the number of young people reported in the data may result in higher numbers reported than the actual numbers in the detention centre. The proclamation of the Tasmanian *Youth Justice Act 1997* in February 2000 extended the upper range of the target group, resulting in an increased number of young people in detention. [c] ACT data for 2001-02 have been revised from data previously published by the AIC.

Source: AIC (2003).

Table F.5 **Males and females aged 10–17 years in juvenile corrective institutions at 30 June as a proportion of total population aged 10–17 years in juvenile corrective institutions (per cent)**

Year	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*[a]	*ACT*[b]	*NT*	*Aust*
Males									
30 June 1998	95.5	92.5	92.1	90.4	92.0	94.7	90.9	100.0	93.6
30 June 1999	91.0	95.0	92.7	89.6	85.3	96.8	75.0	85.7	90.9
30 June 2000	91.6	82.7	91.2	89.6	83.1	91.9	93.3	100.0	90.0
30 June 2001	90.5	89.4	91.8	83.5	87.5	97.3	88.0	100.0	89.6
30 June 2002	92.1	93.0	84.5	89.9	85.1	96.2	80.8	100.0	90.1
Female									
30 June 1998	4.5	7.5	7.9	9.6	8.0	5.3	9.1	–	6.4
30 June 1999	9.0	5.0	7.3	10.4	14.7	3.2	25.0	14.3	9.1
30 June 2000	8.4	17.3	8.8	10.4	16.9	8.1	6.7	–	10.0
30 June 2001	9.5	10.6	8.2	16.5	12.5	2.7	12.0	–	10.4
30 June 2002	7.9	7.0	15.5	10.1	14.9	3.8	19.2	–	9.9

[a] A review of data provided by Tasmania indicates that discrepancies in the number of young people reported in the data may result in higher numbers reported than the actual numbers in the detention centre. The proclamation of the *Tasmanian Youth Justice Act 1997* in February 2000 extended the upper range of the target group, resulting in an increased number of young people in detention extended the upper range of the target group, resulting in an increased number of young people in detention. [b] ACT data for 2001-02 have been revised from data previously published by the AIC. – Nil or rounded to zero.

Source: AIC (2003).

The daily average number of Indigenous people aged 10–17 years detained in juvenile corrective institutions fluctuated between 1997-98 and 2001-02, from a

high of 315 in 1997-98 to a low of 246 in 2000-01, and averaged 266 in 2001-02 (table F.6).

Table F.6 **Average daily population of Indigenous people aged 10–17 years in juvenile corrective institutions (number)[a, b]**

Year	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*[c]	*ACT*[d]	*NT*	*Aust*[e]
1997-98	110	12	80	77	16	na	3	18	315
1998-99	96	9	77	80	14	na	2	17	295
1999-2000	91	8	60	77	13	na	2	10	261
2000-01	86	7	53	71	13	na	4	12	246
2001-02	92	7	53	71	19	na	5	12	266

[a] Average based on population of juvenile corrective institutions on the last day of each quarter of the financial year. [b] Jurisdictional comparisons need to be treated with caution, especially for those States and Territories with low Indigenous populations, where small number effects can introduce statistical variations that do not accurately represent trends over time or consistent differences from other jurisdictions. [c] A review of data provided by Tasmania indicates that discrepancies in the number of young people reported in the data may result in higher numbers reported than the actual numbers in the detention centre. The proclamation of the *Tasmanian Youth Justice Act 1997* in February 2000 extended the upper range of the target group, resulting in an increased number of young people in detention. [d] ACT data for 2001-02 have been revised from data previously published by the AIC. [e] The 2000-01 figure includes one Indigenous male held in detention for other reasons. **na** Not available.

Source: AIC (2003).

Nationally, the daily average detention rate for Indigenous people aged 10–17 years in 2001-02 was 287.5 per 100 000 Indigenous people (table F.7). This compares with a daily average detention rate of 15.7 per 100 000 people for the non-Indigenous population aged 10–17 years (figure F.3).

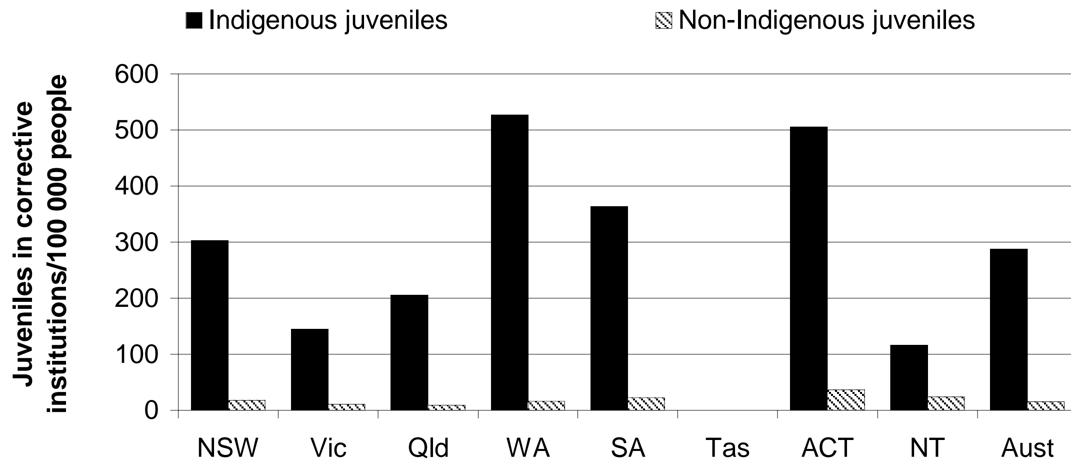
Table F.7 **Rate of detention per 100 000 Indigenous people aged 10–17 years in juvenile corrective institutions (number)[a, b]**

Year	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*[c]	*ACT*[d]	*NT*	*Aust*[e]
1997-98	490.0	283.6	383.2	690.1	367.0	na	397.3	189.3	430.5
1998-99	393.8	201.8	347.0	677.7	314.7	na	236.1	173.5	378.5
1999-2000	343.5	181.9	250.8	624.1	266.2	na	284.1	97.6	315.1
2000-01	300.8	146.0	208.9	548.3	258.9	na	460.3	119.6	280.4
2001-02	302.8	145.2	205.8	526.9	364.5	na	506.0	116.3	287.5

[a] Average based on population of juvenile corrective institutions on the last day of each quarter of the financial year. [b] Jurisdictional comparisons need to be treated with caution, especially for those States and Territories with low Indigenous populations, where small number effects can introduce statistical variations that do not accurately represent trends over time or consistent differences from other jurisdictions. [c] A review of data provided by Tasmania indicates that discrepancies in the number of young people reported in the data may result in higher numbers reported than the actual numbers in the detention centre. The proclamation of the *Tasmanian Youth Justice Act 1997* in February 2000 extended the upper range of the target group, resulting in an increased number of young people in detention. [d] ACT data for 2001-02 have been revised from data previously published by the AIC. [e] The 2000-01 figure includes one Indigenous male held in detention for other reasons. **na** Not available.

Source: AIC (2003).

Figure F.3 **Indigenous and non-Indigenous detention rates, 2001-02** [a, b, c, d]



[a] Jurisdictional comparisons need to be treated with caution, especially for those States and Territories with low Indigenous populations, where small number effects can introduce statistical variations that do not accurately represent trends over time or consistent differences from other jurisdictions. [b] Detention rate is based on the average population of juvenile corrective institutions on the last day of each quarter of the financial year. [c] A review of data provided by Tasmania indicates that discrepancies in the number of young people reported in the data may result in higher numbers reported than the actual numbers in the detention centre. The proclamation of the *Tasmanian Youth Justice Act 1997* in February 2000 extended the upper range of the target group, resulting in an increased number of young people in detention. [d] ACT data for 2001-02 have been revised from data previously published by the AIC.

Source: AIC (2003).

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12 Aged care services

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

- residential services, which include high care services, low care services, services providing a mixture of high and low care, and residential respite services (box 12.1)
- community care services, which include Home and Community Care (HACC) program services, the Community Aged Care Package (CACP) program, the Extended Aged Care at Home (EACH) program and Veterans' Home Care (VHC)[1]
- respite services, which include HACC respite and centre-based day care and the National Respite for Carers Program (NRCP)
- assessment services, which are provided by Aged Care Assessment Teams (ACATs).

A profile of aged care services appears in section 12.1, followed by a brief discussion of recent policy developments in section 12.2. Together, these sections provide a context for assessing the performance indicators presented later in the chapter. This chapter reports data on the effectiveness, efficiency and equity of publicly funded aged care services. Effectiveness is indicated by service quality and accessibility, equity is indicated by the levels of service granted to special needs groups, while efficiency is currently indicated by expenditure per head of target population. A framework of performance indicators is outlined in section 12.3, and key performance results are discussed in section 12.4. Future directions in performance reporting are discussed in section 12.5. Jurisdictions' comments are reported in section 12.6. A discussion of age standardisation of aged care data

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

appears in the appendix (section 12.7). Definitions for data and indicators are provided in section 12.8.

Box 12.1 **Interpreting residential aged care data**

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

- *Residential services data*. This chapter groups residential services for reporting purposes based on the eight level Resident Classification Scale (RCS) profile of their clients:
  - High care services are similar to nursing homes in the pre-1997 regime, catering primarily to the needs of high care residents. These services have 80 per cent or more residents classified as RCS levels 1–4.
  - Low care services are similar to hostels in the pre-1997 regime, catering primarily to the needs of low care residents. These services have 80 per cent or more residents classified as RCS levels 5–8.
  - Services with a mixture of high and low care aim to meet the needs of both high care and low care residents. They have less than 80 per cent residents classified as RCS levels 1–4 and more than 20 per cent of residents classified as RCS levels 5–8.

  These categories have been used for descriptive purposes and do not have any legal foundation in the *Aged Care Act 1997* (Cwlth). Similarly, the choice of 80 per cent as a cut-off is subjective but considered appropriate for descriptive purposes.
- *Resident data*. This Report classifies clients as high care or low care based on their RCS assessment. High care residents have been assessed as RCS levels 1–4. Low care residents have been assessed as RCS levels 5–8.
- *Place data*. Part 2.2 of the Aged Care Act details the processes for planning and allocating subsidised services to meet residential aged care needs and community care needs. Planning is done on the basis of high care and low care need. High care places are planned to meet the needs of residents with care needs equivalent to RCS levels 1–4. Low care places are planned to meet the needs of residents with care needs equivalent to RCS levels 5–8.

  Although there must be a needs match between residents entering vacant places (that is, vacant low care places should usually be filled by low care residents), this can change over time with ‘ageing in place’, which allows a low care resident who becomes high care within the same service to occupy a low care place until he or she is discharged.
- *Locality data.* Geographic data are based on the Australian Bureau of Statistics (ABS) Australian Standard Geographic Classification Remoteness Areas. Data are classified according to an index of remoteness that rates each ABS Census District based on the number and size of towns, and the distance to major towns and urban centres. For more information refer to the Australian Standard Geographic Classification (ABS 2003).

A number of additions and improvements have been made to the chapter this year. Data for the 'intensity of care' indicator are reported for the first time, using data on ageing in place. Data for the 'compliance with service standards for community care' indicator are partially reported for the first time, and some preliminary unit cost data are reported in the efficiency indicator section. Data from the HACC Minimum Data Set (MDS) are reported again this year.

Older Australians also use other mainstream government services covered in this Report, including disability services (chapter 13), specialised mental health services (chapter 11), housing (chapter 16) and services across the full spectrum of the health system (the Health preface and chapters 9–11). There are also interactions between these services that are likely to affect performance results in this Report; for example, between residential aged care and public hospital services — the number of residential places may affect demand for public hospital beds and changes in service delivery in the acute care sector may affect demand for residential aged care.

Supporting tables

Supporting tables for chapter 12 are provided on the CD-ROM enclosed with the Report. The files are provided in Microsoft Excel 97 format as \Publications\Reports\2004\Attach12A.xls and in Adobe PDF format as \Publications\Reports\2004\Attach12A.pdf.

Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 12A.3 is table 3 in the electronic files). These files can be found on the Review web page (www.pc.gov.au/gsp/2004/index.html). Users without Internet access can contact the Secretariat to obtain these tables (see details on the inside front cover of the Report).

12.1 Profile of aged care services

Service overview

Services for older people are provided on the basis of the frailty or functional disability of the recipients rather than specific age criteria. Nevertheless, without more specific information, the Report uses people aged 70 years or over as a proxy for the likelihood of a person in the general population requiring these services. Certain groups (notably Indigenous people) may require various services at a younger age. For Indigenous people, those aged 50 years or over are used as a proxy

for the likelihood of requiring aged care services. The Australian Government also uses these age proxies for planning the allocation of residential care and CACPs.

Government funded aged care services covered in this chapter relate to the three levels of government (Australian, State and Territory, and some local) involved in service funding and delivery. The formal publicly funded services covered in this chapter represent a small proportion of total assistance provided to frail older people. Extended family and partners are the largest source of emotional, practical and financial support for older people. More than 90 per cent of older people living in the community in 1998 who required help with self care, mobility or communications received assistance from the informal care network of family, friends and neighbours (ABS 1999). Many people receive assistance from both formal aged care services and informal sources.

A range of privately funded services also provide support for older Australians. These services do not receive government support and are not within the scope of reporting in the chapter.

Roles and responsibilities

Assessment services

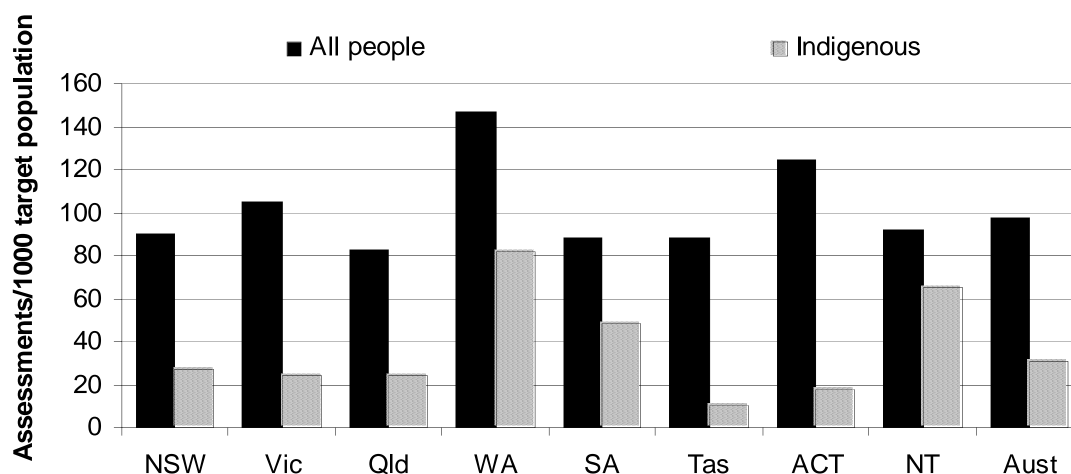
The Australian Government established the Aged Care Assessment Program (ACAP) in 1984, based on the assessment processes used by State and Territory Area Health Services to determine eligibility for admission into residential care and the level of care required (and thus the subsidy paid to such services).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

State and Territory governments are responsible for the day-to-day operation and administration of the ACAP and provide the necessary accommodation and support services. The role of the teams differs across and within jurisdictions, partly reflecting the service location (for example, whether the team is attached to a residential service, a hospital or a community service).

The number of assessments per 1000 target population varied across jurisdictions in 2001-02. WA had the highest assessments of people aged 70 years or over per 1000 people aged 70 years or over (146.9) and the highest rate for Indigenous

assessments per 1000 Indigenous people aged 50 years or over (81.5).[2] The lowest rate of assessment for all people during 2001-02 was in Queensland (82.9), while Tasmania had the lowest rate of Indigenous assessments per 1000 Indigenous people aged 50 years or over (10.0) during the same period (figure 12.1).

Figure 12.1 **ACAT assessment rates, 2001-02[a, b, c]**



[a] Includes ACAT assessments for all services. [b] 'All people' includes all assessments of people aged 70 or over per 1000 people aged 70 or over. [c] 'Indigenous' includes all Indigenous assessments per 1000 Indigenous people aged 50 or over.

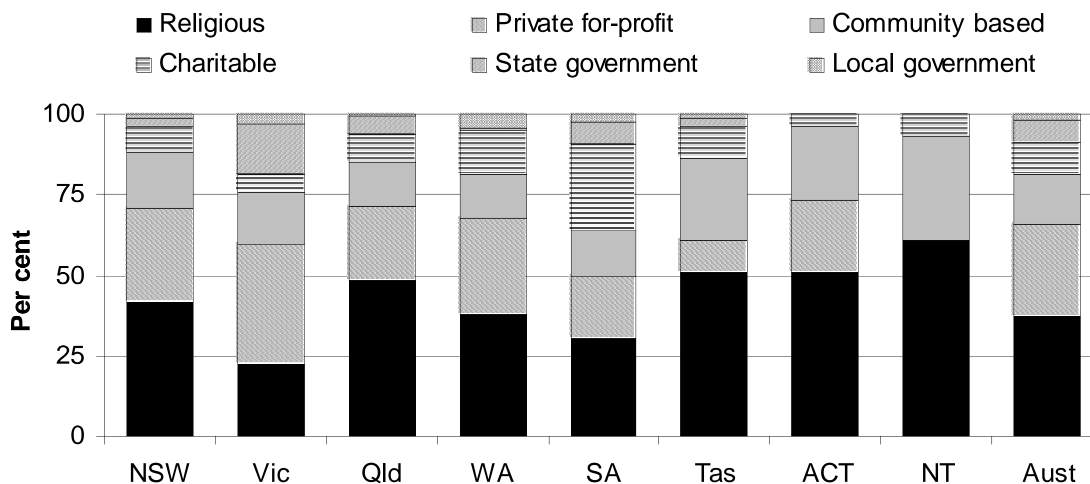
Source: Lincoln Gerontology Centre (2003); table 12A.39.

Residential care services

Religious and private for-profit organisations were the main providers of residential care services at June 2003, accounting for 37.1 per cent and 28.5 per cent respectively of all services. Community-based organisations and not-for-profit charitable organisations accounted for a further 16.0 per cent and 9.8 per cent respectively. State, Territory and local governments provided the remaining 8.6 per cent (figure 12.2).

[2] Remote areas of WA often do not have other agencies and services in a position to perform 'comprehensive assessments' for many groups, so a higher rate of referral to ACATs than in metropolitan areas may occur.

Figure 12.2 **Ownership of residential places, June 2003[a, b]**



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

Source: Department of Health and Ageing (DHA) (unpublished); table 12A.4.

The Australian Government is responsible for most of the regulation of residential aged care services, including accreditation of the service and certification of the standard of the facilities. State, Territory and local governments also have a regulatory role in areas such as determining staffing and industrial awards, and monitoring compliance with building and fire safety regulations (box 12.2).

Community care services

The main community care programs reported in this chapter — the HACC, CACP and VHC programs — fund services that aim to provide practical assistance to enable frail older people (HACC and CACP), people with a disability (HACC) and veterans (VHC) to continue living in the community. These services also provide assistance to carers of older people. The services are usually provided by State, Territory and local government organisations, charitable bodies, community organisations and commercial providers.

Box 12.2 Examples of regulatory arrangements for residential services

The Australian Government controls the number of subsidised bed places, with a target of 40 high care places, 50 low care places and 10 CACPs for each 1000 people in the population aged 70 years or over.

- Services are expected to meet regional targets for places for concessional residents. These targets range from 16 per cent to 40 per cent of places, and aim to ensure residents who cannot afford to pay an accommodation bond or charge have equal access to care. (The criteria for being deemed a concessional resident are based on home ownership and occupancy, receipt of income support and the level of assets held at entry.)
- Extra service places (where residents pay for a higher standard of accommodation, food and services) are restricted.

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

Source: PC (1999).

Indigenous specific and flexibly funded services

Flexible models of care are provided under the Aboriginal and Torres Strait Islander Aged Care Strategy. Services delivered under the Strategy are outside the Aged Care Act (DHA 2002). About 70 per cent of Indigenous Australians receiving residential aged care services have their needs met through the mainstream services covered by this chapter (DHA unpublished). A number of aged care residential services are targeted to Indigenous people, and these services are funded under the Aged Care Act. The Australian Government also actively targets CACPs to Indigenous communities and contracts Aboriginal Hostels Limited to provide ongoing assistance to ensure services in rural and remote areas remain viable (DHA 2002).

Funding

Assessment services

The Australian Government provides grants to State and Territory governments to operate 129 ACATs and Evaluation Units. The Australian Government provided funding of $41.8 million nationally for aged care assessment in 2002-03 (table 12A.49). Expenditure per person aged 70 years or over plus Indigenous persons aged 50–69 years was markedly higher in the NT ($89) than in the other jurisdictions (between $21 and $25) during 2002-03 (table 12A.50).

Residential care services

The Australian Government provides the majority of annual funding for residential aged care services — $4.3 billion in 2002-03 (table 12A.45 and 12A.47). State and Territory governments also provide some funding for public sector beds. Residents provide most of the remainder of service revenue, with some income derived from charitable sources and donations.

The Australian Government annual RCS subsidy for each occupied place varies according to the client's level of dependency. The national average Australian Government annual RCS subsidy per residential place at June 2003 was $27 678. Across jurisdictions, it ranged from $30 677 in the NT to $26 514 in WA (table 12.1). Variations in average annual subsidies reflect differences in subsidy rates as well as differences in the dependency of residents. Low care subsidy rates (RCS levels 5–8) are the same across all States and Territories. High care subsidy rates (RCS levels 1–4) are being adjusted towards a uniform national rate by July 2006 under the Australian Government's Funding Equalisation and Assistance Package.

The combined number of operational high care and low care places per 1000 people aged 70 years or over at June 2003 ranged from 113.9 in the NT to 79.4 in the ACT. There were proportionally more high care places in the NT (59.5 per cent), while the ACT had proportionally more low care places (58.9 per cent) than those in other jurisdictions (table 12.2). The proportion of low care places relative to high care places rose between 1999 and 2003 (table 12A.10).

Table 12.1 **Average annual Australian Government RCS subsidy per occupied place, and the dependency level of aged care residents, June 2003**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Average annual Australian Government RCS subsidy per residential place[a]										
All RCS levels	$	28 117	27 786	26 844	26 514	27 874	29 535	27 322	30 677	27 678
Proportion of high care residents[b]										
RCS 1	%	20.8	22.3	16.6	23.7	20.0	15.7	24.4	15.1	20.4
RCS 2	%	26.5	22.6	24.6	19.5	26.0	27.1	20.9	33.7	24.5
RCS 3	%	14.6	12.1	17.4	11.6	15.7	21.0	13.7	23.2	14.5
RCS 4	%	4.5	4.2	5.8	4.8	4.4	6.3	4.9	5.1	4.7
Proportion of low care residents										
RCS 5	%	9.7	13.1	10.3	13.9	10.4	10.4	9.5	7.8	11.1
RCS 6	%	10.1	11.7	10.3	13.2	10.4	8.6	10.4	6.3	10.8
RCS 7	%	12.5	13.2	13.4	12.3	12.3	10.2	15.0	8.7	12.8
RCS 8	%	1.4	1.0	1.6	0.9	0.7	0.6	1.2	–	1.2

[a] Includes only RCS funding; pensioner supplement and other supplements add around $3000 per year for residents. On average, residents contribute $11 500 per year to their care. [b] Differences in average annual subsidies reflect differences in subsidy rates as well as differences in the dependency of residents. – Nil or rounded to zero.

Source: DHA (unpublished); table 12A.5.

Table 12.2 **Operational high care and low care residential places, 30 June 2003[a]**

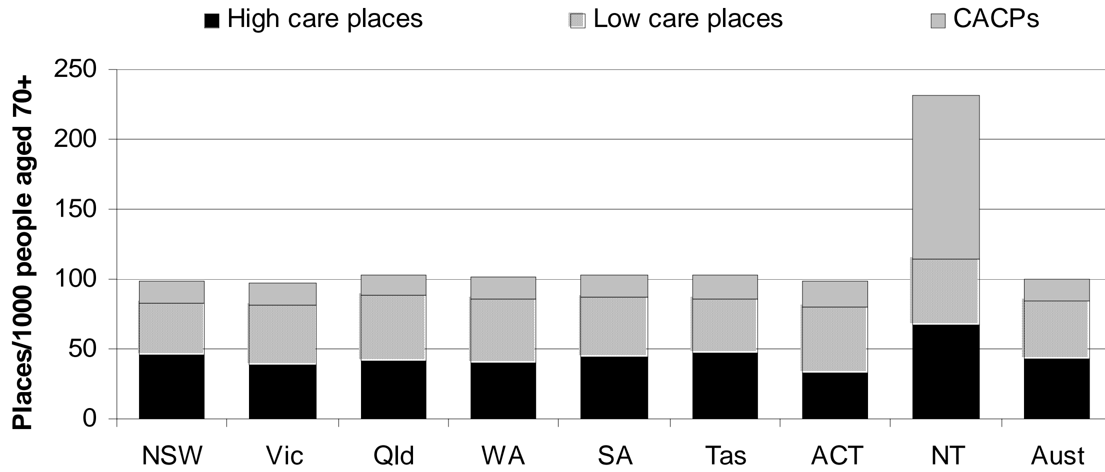
	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Number of places per 1000 people aged 70 years and over										
High care places	no.	45.9	38.1	40.8	39.3	44.4	47.2	32.6	67.8	42.2
Low care places	no.	37.1	43.2	47.4	45.9	43.3	38.8	46.8	46.1	42.0
Total places	**no.**	**83.0**	**81.3**	**88.2**	**85.2**	**87.7**	**86.0**	**79.4**	**113.9**	**84.2**
Proportion of places										
High care places	%	55.3	46.9	46.3	46.1	50.6	54.9	41.1	59.5	50.1
Low care places	%	44.7	53.1	53.7	53.9	49.4	45.1	58.9	40.5	49.9

[a] Excludes places that have been ‘approved’ but are not yet operational.

Source: DHA (unpublished); table 12A.10.

Figure 12.3 shows the combined number of high care residential places, low care residential places and CACPs. Box 12.2 sets out the Australian Government’s targets for the provision of residential places and CACPs.

Figure 12.3 **Operational residential places and CACPs per 1000 people aged 70 years or over, 30 June 2003[a, b, c, d]**

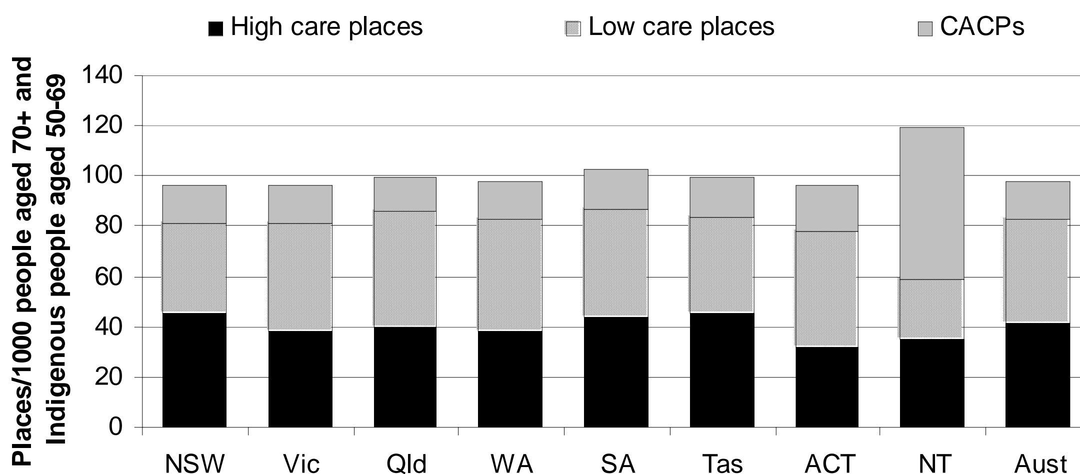


[a] Excludes places that have been approved but are not yet operational. [b] 'Ageing in place' may result in some low care places being filled by high care residents. [c] Australian Government planning targets are based on providing 100 places per 1000 people aged 70 years or over. However, in recognition of poorer health among Indigenous communities, planning in some cases also takes account of the Indigenous population aged 50–69 years. This means that the provision ratio based on the population aged 70 years or over will appear high in areas with a high Indigenous population (such as the NT). [d] CACPs are not residential services but are included in the Australian Government planning targets of 100 places per 1000 people in the target population. See boxes 12.1 and 12.2 for interpretation of residential care data.

Source: DHA (unpublished); table 12A.10.

The number of operational places can also be shown using a target population that incorporates Indigenous 50–69 year olds (figure 12.4). Use of this 'adjusted' target population has a noticeable effect on the NT, which has a large proportion of Indigenous people.

Figure 12.4 **Operational residential places and CACPs per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years, 30 June 2003[a, b, c]**



[a] Places do not include those that have been approved but are not yet operational. [b] 'Ageing in place' may result in some low care places being filled by high care residents. [c] CACPs are not residential services but are included in the Australian Government planning targets of 100 places per 1000 people in the target population. See boxes 12.1 and 12.2 for interpretation of residential care data.

Source: DHA (unpublished); table 12A.11.

Community care services

Total national expenditure on HACC was $1.1 billion in 2002-03, which consisted of $674.1 million from the Australian Government and $434.1 million from the State and Territory governments — equivalent to the Australian Government contributing 60.8 per cent and State and Territory governments funding the remainder (table 12A.46). Recipients may also contribute towards the cost of their care.

The NRCP provides community care services and is funded by the Australian Government. Expenditure on this program was $92.0 million in 2002-03 (table 12A.49). The Department of Veterans' Affairs (DVA) also provided $67.2 million for the VHC program during 2002-03 (table 12A.48) which does not include expenditure for in-home respite and emergency home care.

The Australian Government funds the CACP and EACH programs spending $287.9 million and $10.5 million respectively on the programs in 2002-03 (table 12A.49). CACPs are also part funded by client contributions. Expenditure data on a range of other community care programs targeting aged people are contained in tables 12A.49 and 12A.50.

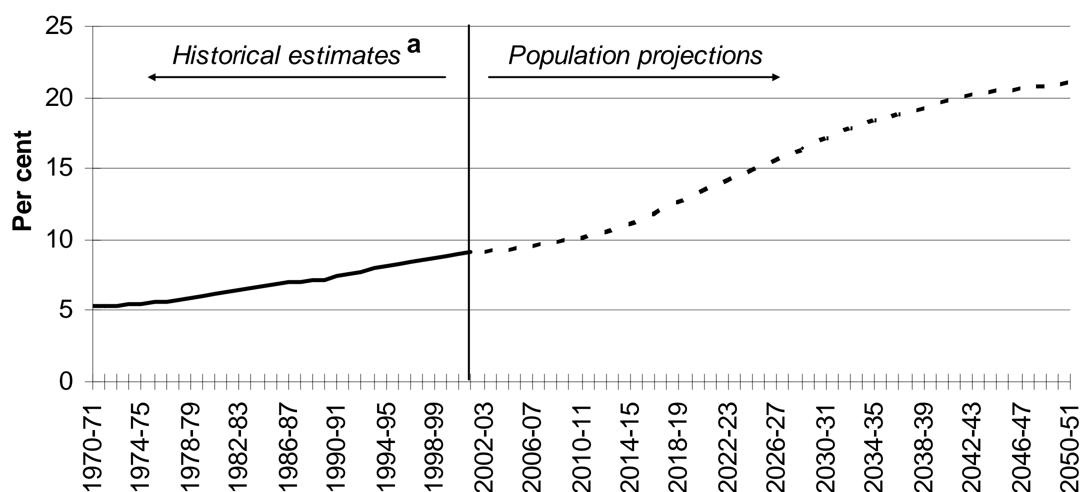
Size and scope of sector

Size and growth of the older population

The Australian population is ageing, as indicated by an increase in the proportion of people aged 70 years or over in the total population. This trend is expected to continue, and the proportion of older people is expected to increase dramatically in the 21st century (figure 12.5). The distribution of older people varied across jurisdictions at June 2003, with relatively more older people in SA and relatively fewer in the NT (figure 12.6). Higher life expectancy for females was reflected in there being a higher proportion of older females than older males in all jurisdictions.

Demographic profiles affect the demand for aged care services because females use aged care services (particularly residential services) more than males do. Females are more likely to use residential services partly because they tend to live longer (that is, there are more women than men in the older population) and are less likely to have a partner to provide care. There are also greater incidences of incontinence, hip fractures and financial disadvantage among older women.

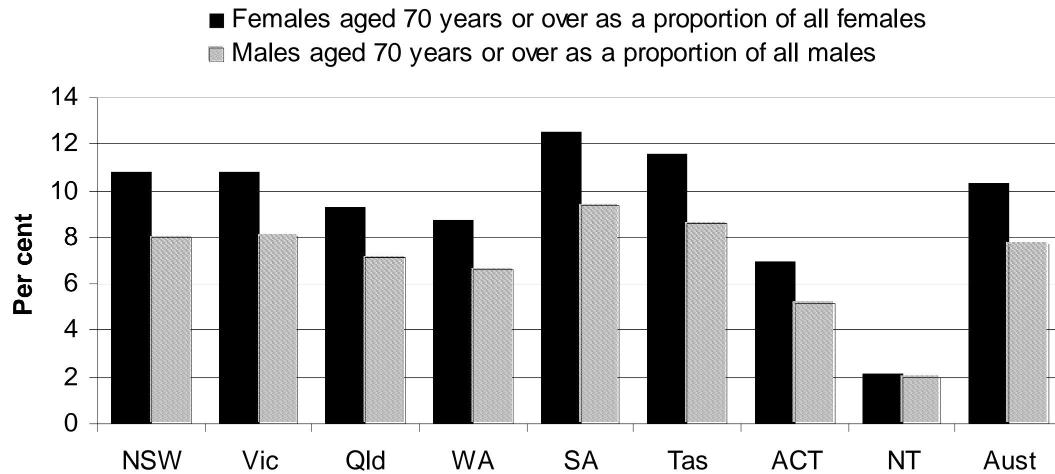
Figure 12.5 **Persons aged 70 years or over as a proportion of the total population**



[a] Historical estimates are based on the ABS Census of population and housing that is held at five year intervals.

Source: ABS *Population by Age and Sex, Australian States and Territories*, Cat. no. 3201.0 (unpublished); ABS *Population Projections, Australia*, Cat. no. 3202.0 (unpublished).

Figure 12.6 **Estimated population aged 70 years or over, by gender, June 2003**

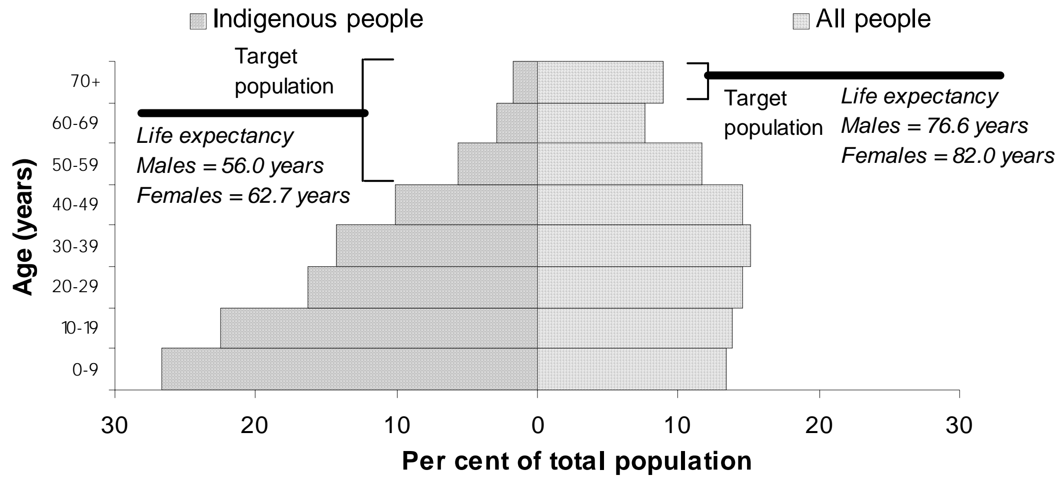


Source: ABS *Population Projections by SLA 1999–2019* (unpublished); table 12A.1.

Characteristics of older Indigenous people

The ABS estimated that about 43 700 Indigenous people were aged 50 years or more in Australia at 30 June 2003. The majority were located in NSW (32.7 per cent), Queensland (26.5 per cent), WA (12.8 per cent) and the NT (10.3 per cent) (table 12A.2). Although the Indigenous population is also ageing, there are marked differences in the age profile and life expectancy of Indigenous Australians compared with the non-Indigenous population. The life expectancy of Indigenous males and females at June 2001 was nearly 20 years below that recorded for the total Australian population (figure 12.7). Indigenous people are likely to need aged care services earlier in life, compared with the general population.

Figure 12.7 **Age profiles, target populations and life expectancy differences between Indigenous and other Australians, June 2001**



Source: ABS (2001 and unpublished).

Residential care services

The size and location of residential services — which may influence the costs of service delivery — vary across jurisdictions. Nationally, there were approximately 148 547 operational places (permanent and respite) in residential care services (71 392 in predominantly high care services, 22 978 in predominantly low care services and 54 177 in services with a mixture of high care and low care residents) at June 2003 (tables 12A.6, 12A.7, 12A.8 and 12A.9).

As the trend towards 'ageing in place' (box 12.3) increases, there has been a steady increase in the number of services categorised as services providing a mixture of high care and low care places. In June 2000, 15.7 per cent of all places were located in services offering high care and low care places; this proportion rose to 25.5 per cent of all places in June 2001, 30.5 per cent of places in June 2002 and 36.5 per cent in June 2003 (tables 12A.6 and 12A.9; SCRCSSP 2001, 2002, 2003).

Box 12.3 **Ageing in place**

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

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

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

The Aged Care Act does not require any residential aged care service to offer ageing in place; neither does it establish any 'program'. Rather, it creates the opportunity for providers to choose to provide the full continuum of care, by removing the legislative and administrative barriers that prevented this outcome in the past.

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

Source: DHA (unpublished).

The client profile of services that had predominantly low care residents in 2000 has changed, with low care residents staying in their current service as their dependency levels rise over time, and with aged care services expanding. Low care services were generally smaller (as measured by number of places) than high care services at June 2003. Nationally, 67.0 per cent of low care services had 60 or fewer places (table 12A.8), compared with 50.4 per cent of high care services (table 12A.7).

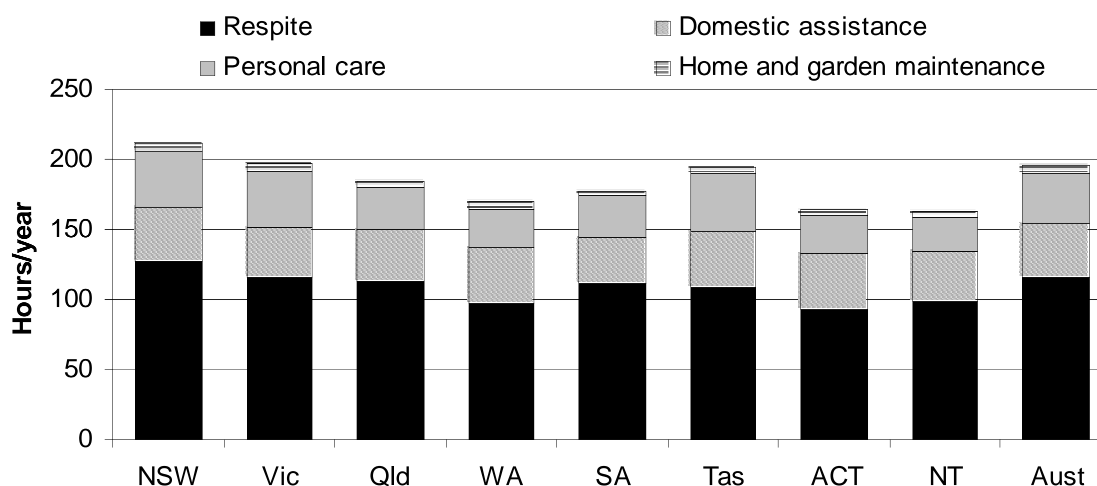
Community care services

Services provided under the HACC program include domestic assistance and home maintenance, personal care, food services, respite care, transport, allied health care and community nursing. The target population is defined as people living in the community who are at risk, without basic maintenance and support services, of premature or inappropriate long term residential care. The target population comprises both frail aged people and younger people with a disability, and their carers. Approximately 70 per cent of the program's recipients are aged 70 years or over, but the program is also an important source of community care for younger

people with a disability and their carers (DHA unpublished). (Chapter 13 covers services for people with a disability [usually aged less than 65 years] that were provided under the Commonwealth/State Disability Agreement.)

The services of the VHC program target veterans and war widows/widowers with low care needs. There were 66 221 people approved for VHC services in 2002-03 (table 12A.48). The program offers veterans and war widows/widowers home support services, including domestic assistance, personal care, home and garden maintenance, and respite care. Other services, such as community transport, social support and delivered meals, are also available under the DVA's arrangements with State and Territory governments. Eligibility for VHC services is not automatic, but based on assessed need. Figure 12.8 shows the average number of hours approved per year for veterans who were approved to receive home care services in 2002-03.

Figure 12.8 **Average number of hours approved for Veterans' Home Care, 2002-03[a, b]**



[a] VHC recipients fall into two categories, those veterans who transferred to VHC from the HACC program (transitional veterans) and those that did not (non-transitional veterans). [b] The number of hours approved per year is for non-transitional veterans and relates to services that were approved to occur in 2002-03. The number of average hours actually provided will be lower.

Source: DVA (unpublished); table 12A.48.

Community Aged Care Packages provide an alternative home-based service for older people who ACATs assess as eligible for care equivalent to low level residential care (RCS levels 5–8). The main distinctions between the HACC and CACP programs are summarised in table 12.3. The EACH program is a small program funded by the Australian Government to provide a community alternative to high level residential aged care services. The program provides individually planned and co-ordinated packages of care, designed to meet older people's daily care needs in the community. The EACH program differs from the CACP program

in that it targets frail older people who would otherwise be eligible for high level residential aged care. An EACH package typically provides 15–20 hours of direct assistance each week.

Community care is likely to continue to play an increasing role in aged care services, given the longer term policy objective of improving the capacity of aged care services to support people at home — an objective that reflects a strong consumer preference.

Table 12.3 **Distinctions between the HACC and CACP programs**

	HACC	*CACPs*
Range of services[a]	Wider range of services available	Narrower range of services available
Relationship to residential care	Aims to prevent premature or inappropriate admission	Substitutes for a bed
Eligibility	ACAT assessment not mandatory	ACAT assessment mandatory
Funding	Cost shared by the Australian, State and Territory governments and client contributions	Funded by the Australian Government and client contributions
Target client groups[b]	Available to people with a greater range of care needs	Targets people with care needs similar to low level residential care
Size of program	$1.1 billion funding in 2002-03	$287.9 million funding in 2002-03
	Approximately 661 062 clients in 2002-03[c]	27 996 places in 2002-03

[a] HACC services such as community nursing, which are not available under CACPs, can be supplied to someone receiving a CACP. [b] Most HACC recipients at the lower end of the scale would not be assessed as eligible for residential care; for example, an individual may receive only an hour of home care per fortnight. At the higher end, some people have levels of need that would exceed the level available under CACPs. [c] Based on 83 per cent of HACC funded agencies that submitted MDS data for 2002-03. Consequently, the total number of clients will be higher than those reported here.

Source: DHA (unpublished); tables 12A.32, 12A.35, 12A.45 and 12A.46.

Changing government policies over the past decade — shifting the balance of care away from the more intensive types of residential care towards home-based care — have meant that the HACC, VHC, CACP and EACH programs have become increasingly important components of the aged care system. During 2002-03, the HACC program delivered approximately 10 141 hours per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years (table 12A.20). The total number of CACPs per person aged 70 years or over plus Indigenous people aged 50–69 years increased by 3.4 per cent between June 2002 and June 2003, from 14.7 to 15.2 (table 12A.11).

12.2 Policy developments in aged care services

Innovative Pool of aged care places

A national Innovative Pool of flexible care places, available for allocation to innovative services outside of the Aged Care Approvals Round was established by the Australian Government in 2001-02. It allows for the development of pilots for innovative service provision, through collaboration among stakeholders (including governments and approved service providers).

The flexible care places provided through the Innovative Pool can be used to develop projects to conduct an evidence-based test of alternative service models. Evaluation will be an integral element of all projects involving alternative service models.

Places in the 2002-03 Innovative Pool were targeted at the following types of proposals:

- Innovative Care Rehabilitation Services pilots, which combine personal and nursing care and rehabilitation (Australian, State and Territory government funded)
- High Need and Specific Need proposals seeking residential, community or flexible care places for high need areas, alternative dementia care provision and projects addressing issues at the interface between disability and aged care services.

Table 12.4 **Innovative pool projects**

	New projects in 2002-03	*Total projects at 30 June 2003*	*Total places at 30 June 2003*
Innovative Care Rehabilitation Services pilots	5	13	407
Innovative Care Disability pilots	6	6	172
Innovative Care Dementia pilots	7	10	226
Innovative Care High Needs pilots	1	1	60
Total	**19**	**30**	**865**

Source: DHA (2003).

12.3 Framework of performance indicators

For the 2004 Report, the framework has been revised to provide information on equity, efficiency and effectiveness, and to distinguish the outputs and outcomes of government aged care services. This approach is consistent with the revised general

performance indicator framework and service process diagram outlined in chapter 1 (figures 1.2 and 1.3) that have been agreed by the Steering Committee. The performance indicators relate to government objectives in the aged care sector (box 12.4). At this stage, no outcome indicators have been developed for Aged care services.

Box 12.4 **Objectives for aged care services**

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

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

The performance indicator framework shows which data are comparable in the 2004 Report (figure 12.9). For data that are not considered strictly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

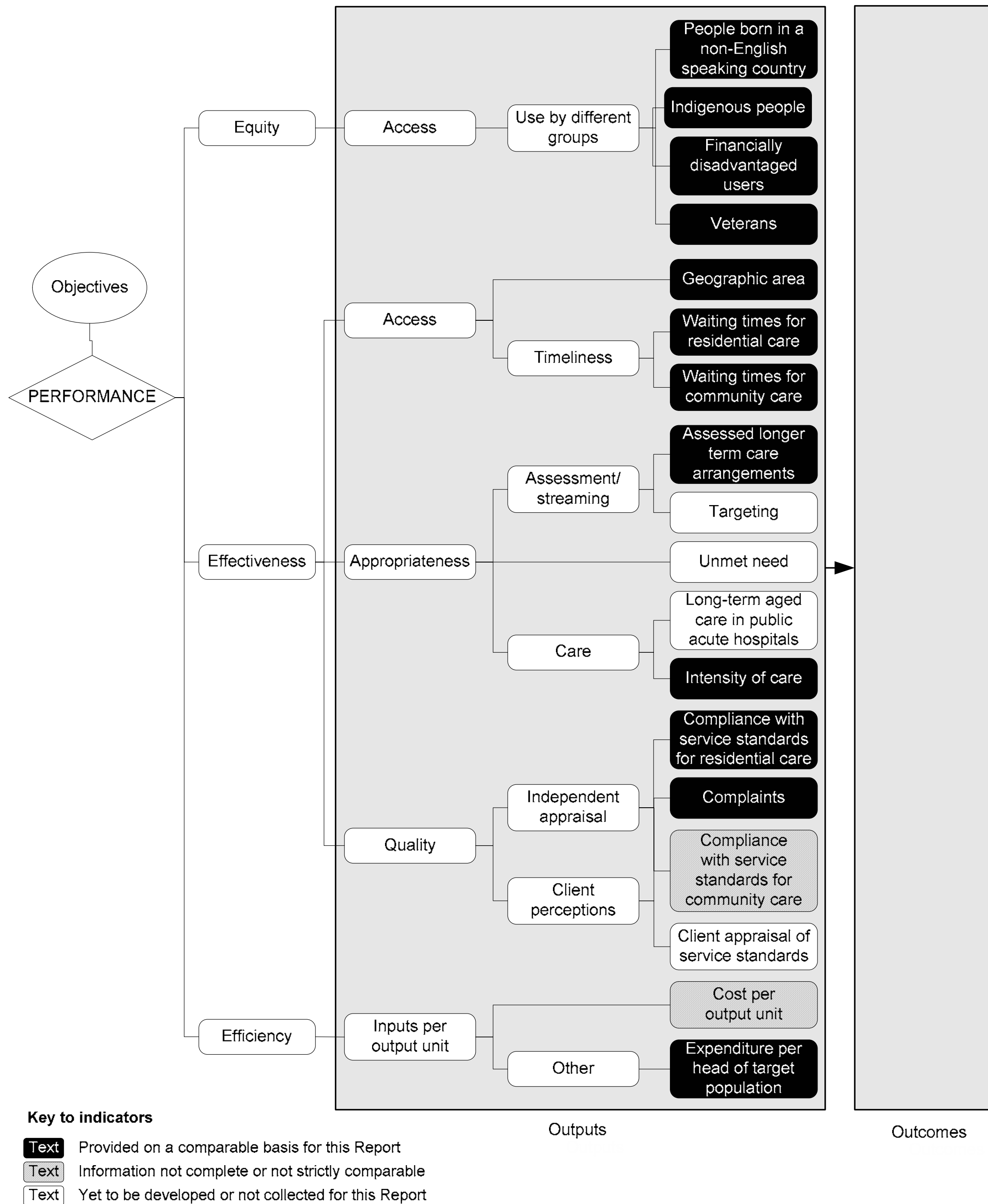
New and refined indicators

Data for the ‘intensity of care’ indicator are reported for the first time in the 2004 Report using data on ageing in place. Data for the ‘compliance with service standards for community care’ indicator are partially reported using data on the number of agencies assessed against the HACC service standards. Preliminary unit costs data are also included for aged care assessments. Ongoing work to provide a more comprehensive set of performance indicators, and to improve existing indicators and data is discussed in section 12.5.

12.4 Key performance indicator results

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

Figure 12.9 **Performance indicators for aged care services**



Outputs

Equity

Access to residential services by different groups

Special needs groups identified by the Aged Care Act are people from Indigenous communities, people from non-English speaking countries, people who live in rural or remote areas, people who are financially or socially disadvantaged, and veterans. A key national objective of the aged care system is to provide equitable access to residential services for all people who require these services. Indigenous people tend to require aged care services at a younger age than the general population. Participation is therefore based on Indigenous people aged 50 years or over.

One way of measuring accessibility is to compare the proportion of residents from a special needs group with their representation in the target population. However, factors such as cultural differences — which may influence the extent to which various special need groups use residential care services — need to be considered in the interpretation of such results. A discussion of age standardisation of aged care data appears in section 12.7.

In all jurisdictions at 30 June 2003, on average, Indigenous people and people from mainly non-English speaking countries had lower rates of use of aged care residential services, compared with the rest of the population (figure 12.10).

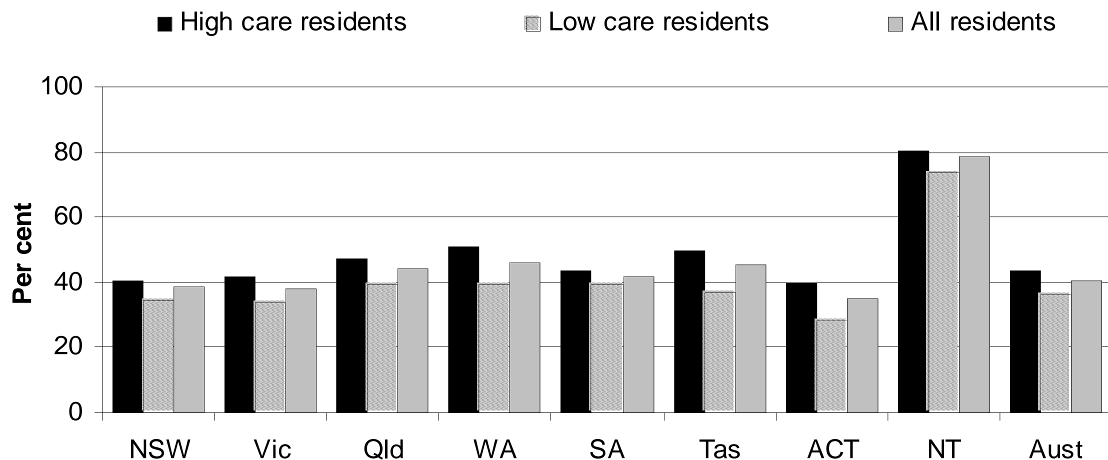
Australian Government planning guidelines require that services allocate a minimum proportion of places for concessional residents. These targets range from 16 per cent to 40 per cent of new places, depending on the service's region. All services exceeded the minimum amount during 2002-03 (DHA 2003). The NT had the highest proportion of all new residents classified as concessional or assisted residents during 2002-03 (78.3 per cent) and the ACT had the lowest (34.7 per cent) (figure 12.11).

Figure 12.10 **Residents per 1000 target population, 30 June 2003**[a, b, c]

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

Source: DHA (unpublished); tables 12A.12, 12A.14 and 12A.16.

Figure 12.11 **New residents classified as concessional or assisted residents, 30 June 2003 (per cent)**[a]



[a] Concessional residents are those who on entry to care were in receipt of an income support payment, who had not owned a home in the previous two years or whose home was occupied by a spouse or carer, and who had assets of less than $26 500. For married residents, half the couple's combined assets are counted. Assets include interest-free loans. Assisted residents are those meeting the above criteria with asset levels between $26 500 and $42 000. The asset levels are at 30 June 2003.

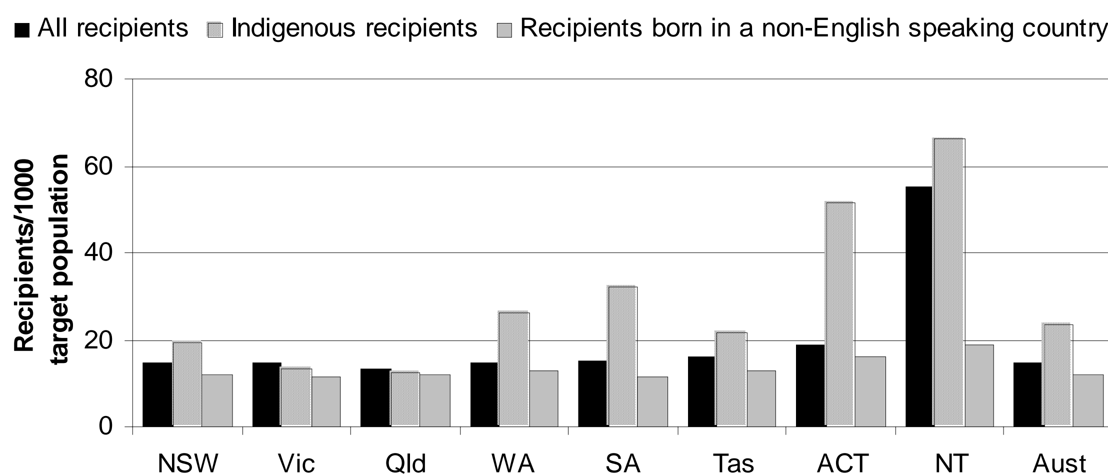
Source: DHA (unpublished); table 12A.19.

Access to CACPs by different groups

The number of CACP recipients per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years has grown in recent years, but was small relative to the total number of recipients of residential care at June 2003 (14.7 compared with 79.4 total recipients per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years) (table 12A.12).

Jurisdictions with smaller populations had higher proportions of CACP recipients per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years at June 2003. The NT had the highest proportion of Indigenous CACP recipients per 1000 Indigenous people aged 50 years or over (66.7 per cent) (table 12A.16). The NT also had the highest proportion of CACP recipients from non-English speaking countries per 1000 people aged 70 years or over from non-English speaking countries (figure 12.12). The Australian Government's allocation of CACPs in every jurisdiction at June 2003 exceeded its target of 10 CACPs per 1000 target population.

Figure 12.12 **CACP recipients per 1000 target population, 30 June 2003**[a, b, c, d]



[a] All recipients data are per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years. [b] Indigenous recipients data are per 1000 Indigenous people aged 50 years or over. [c] Data for recipients from non-English speaking countries are per 1000 people from non-English speaking countries aged 70 years or over. [d] The ACT has a very small Indigenous population aged 50 years or over (table 12A.2), and a small number of packages will result in a very high provision ratio.

Source: DHA (unpublished); tables 12A.12, 12A.14 and 12A.16.

Home and Community Care program

Home and Community Care program services are provided in the client's home or community to frail older people with a severe, profound or moderate disability and

to their carers. Around 69.3 per cent of HACC recipients were aged 70 years or over during 2002-03 (table 12A.32). Nationally in 2002-03, 10 141 hours of HACC services were provided per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years. The number of service hours per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years ranged from 18 870 hours in the NT to 6070 hours in NSW. The number of meals provided per 1000 people aged 70 years or over, plus Indigenous people aged 50–69 years in 2002-03 was highest in the NT (18 597 meals) and lowest in SA (2285 meals) (table 12.5).

Table 12.5 **HACC services received, 2002-03 (per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years)[a]**

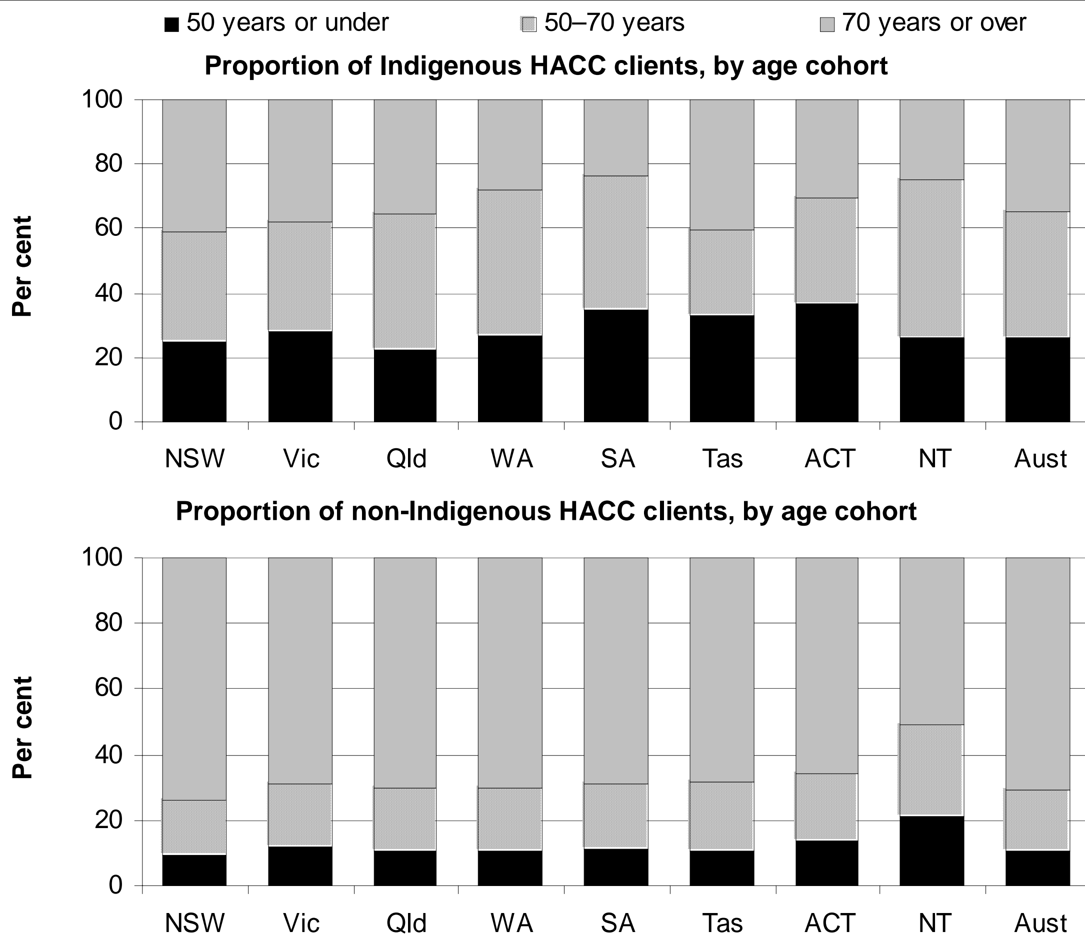
	NSW[b]	*Vic*	*Qld*	*WA*	*SA*[c]	*Tas*	*ACT*	*NT*	*Aust*
Percentage of agencies that reported MDS data	76	84	91	99	83	87	99	78	83
Total hours[d]									
Major Cities	5 815	10 973	12 387	16 637	8 871	–	8 329	–	9 563
Inner Regional	6 207	14 270	11 236	13 084	8 827	9 397	22 687	–	10 048
Outer Regional	7 299	18 471	14 310	15 899	10 997	11 724	–	15 201	12 479
Remote	11 237	40 643	16 828	18 278	9 591	14 482	–	21 959	15 840
Very Remote	13 480	–	15 605	25 630	45 552	26 404	–	21 140	22 185
All areas	**6 070**	**12 234**	**12 483**	**16 325**	**9 404**	**10 328**	**8 360**	**18 870**	**10 141**
Total meals[e]									
Major Cities	3 788	4 844	7 219	6 717	2 490	–	5 139	–	4 733
Inner Regional	5 435	7 027	6 454	6 429	484	5 162	5 486	–	5 848
Outer Regional	5 949	5 825	7 030	8 039	2 224	7 991	–	7 247	6 160
Remote	6 223	9 338	8 809	13 118	1 659	7 792	–	18 908	8 542
Very Remote	435	–	10 505	25 413	14 809	5 908	–	30 166	18 611
All areas	**4 360**	**5 399**	**7 049**	**7 362**	**2 285**	**6 125**	**5 140**	**18 597**	**5 277**

[a] Data represents HACC services received by people aged 70 years or over plus Indigenous people aged 50–69 years, rather than HACC services received by all age groups. The proportion of HACC funded agencies that submitted MDS data for 2002-03 differed across jurisdictions, ranging from 99 per cent to 76 per cent. Consequently, actual service levels will be higher than those reported here. [b] NSW advise that NSW data do not include a significant proportion of allied health and home nursing service data. [c] SA advise that the number of meals may be understated due to slow implementation of the MDS by Meals on Wheels. [d] See table 12A.20 for a full list of categories. [e] Includes home meals and centre meals. – Nil or rounded to zero.

Source: DHA (unpublished); tables 12A.20–12A.25.

Reported use of HACC services shows a substantial difference between all people and Indigenous people across all age groups in the age profile in 2002-03. This reflects the difference in morbidity and mortality trends between Indigenous people and the general population (figure 12.13).

Figure 12.13 **HACC service by recipient age and Indigenous status, 2002-03**



Source: DHA (unpublished); table 12A.33.

Effectiveness

Timeliness of access — waiting times for residential care

The elapsed time between an ACAT assessment and entry into residential care partly reflects the extent to which aged care services meet the demand for residential services, but may also reflect applicants' willingness to wait for particular residential services or to defer entry. These data therefore need to be viewed with care (boxes 12.5 and 12.6). The Steering Committee acknowledges the limitations of the current indicators and supports the need to improve them. Until improved data are available, the current indicators will continue to be reported.

Box 12.5 Interpretation of the elapsed time between ACAT approval and entry into residential care service indicator

The indicator 'elapsed time between ACAT approval and entry into residential care service' measures the time between the assessment of eligibility and admission to a service. The definitions used in this chapter are:

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

This indicator needs to be interpreted with care, because a range of factors may influence jurisdictional variations, such as:

- residential placement offers that are not accepted
- the availability of alternative community care, informal care and respite services
- the availability and distribution of operational residential care services
- building quality and perceptions about quality of care, which influence client choice of preferred service
- delays between the date of ACAT assessments and approval of assessments
- priority allocations
- hospital discharge policies and practices.

On average, 71.8 per cent of all people entering residential care during 2002-03 did so within three months of being assessed by an ACAT, and 44.6 per cent entered within one month of their ACAT assessment. Across jurisdictions, the proportion of people who entered care within three months of assessment ranged from 76.9 per cent in NSW to 50.1 per cent in the ACT (table 12A.37).

Box 12.6 **Entry Period for Residential Care**

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

One of the main determinants of a short entry period was whether the resident had an ACAT assessment performed while they were in hospital rather than when they were living at home. A longer entry period was also strongly related to whether the resident had used a CACP or residential respite care prior to admission.

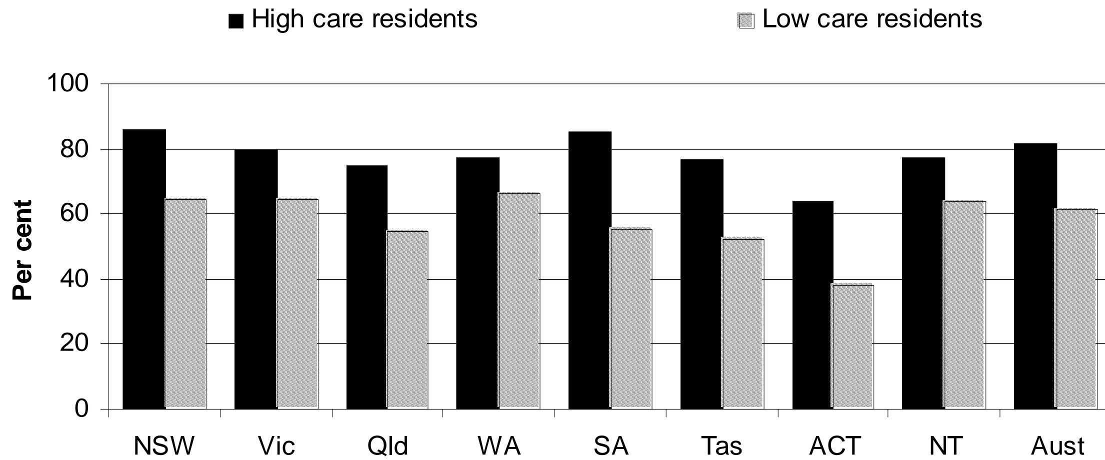
Many people assessed by an ACAT and recommended for residential aged care never enter a residential service. Others receive recommendations for both residential aged care and a CACP, and take up the latter. Recommendations for residential care remain active for 12 months; consequently, people often do not act on the recommendation immediately. They may believe they are quite capable of continuing to manage at home and that they do not need admission.

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

Source: AIHW (2002).

Nationally, a greater proportion of people entering high care residential services entered within three months of assessment (81.5 per cent), compared with the population entering low care residential services within that time (61.5 per cent) (table 12A.37). Across jurisdictions, the proportion of people entering high care residential services within three months of being assessed ranged from 86.0 per cent in NSW to 63.8 per cent in the ACT. The proportion of people entering low care residential services within three months of being assessed ranged from 66.1 per cent in WA to 38.0 per cent in the ACT (figure 12.14).

Figure 12.14 **People entering residential care within three months of their ACAT assessment, 2002-03**

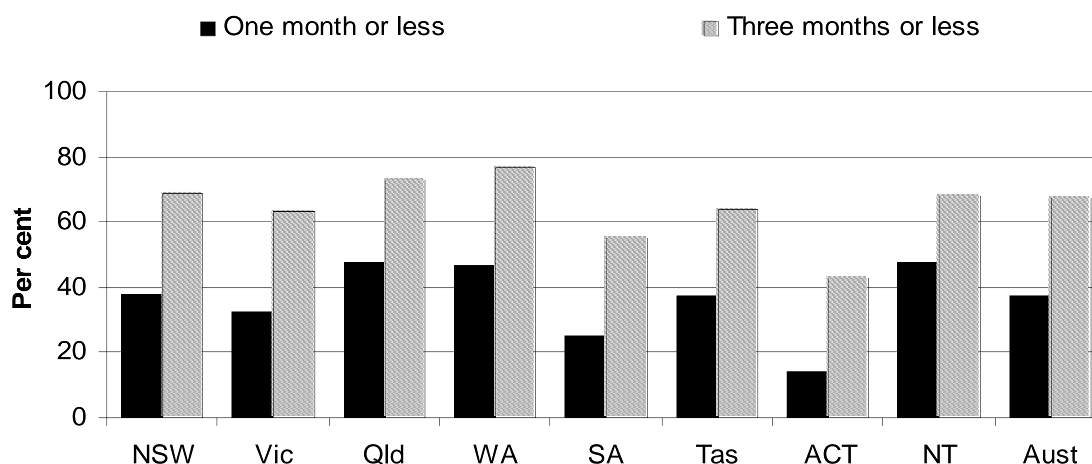


Source: DHA (unpublished); table 12A.37.

Timeliness of access — waiting times for community care

The elapsed time between an ACAT assessment and the receipt of a community care service partly reflects the extent to which aged care services meet the demand for community care services. This indicator is reported using CACP data. On average, 67.2 per cent of all people receiving a CACP during 2002-03 received it within three months of being assessed by an ACAT, and 37.7 per cent started receiving a CACP within one month of their ACAT assessment (table 12A.37). Across jurisdictions, the proportion of people who received a CACP within three months of assessment ranged from 76.8 per cent in WA to 42.9 per cent in the ACT (figure 12.15).

Figure 12.15 **Elapsed time between ACAT approval and the receipt of a CACP service, 2002-03**



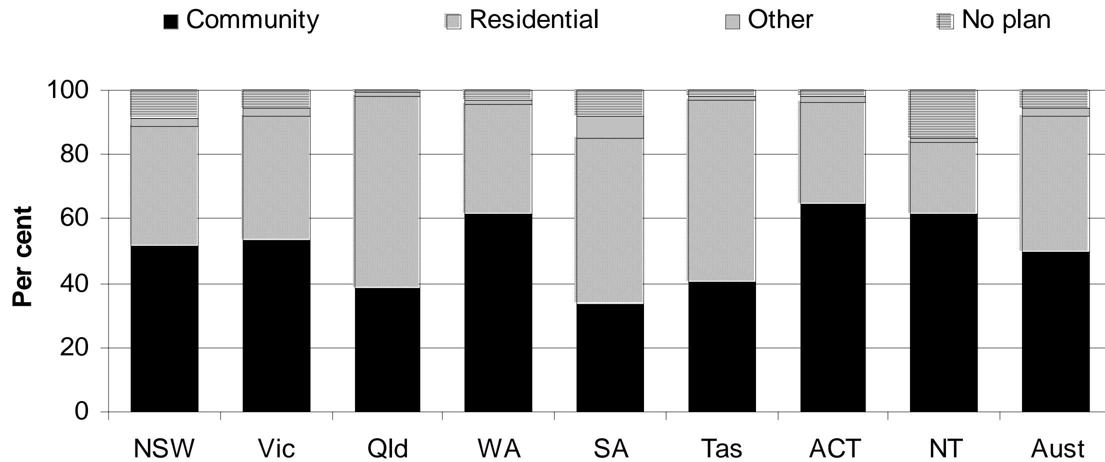
Source: DHA (unpublished); table 12A.37.

Appropriateness — assessed longer term care arrangements

Data from ACAT assessments provide information on referrals to residential and community care services, not necessarily on their use. Some people may choose not to take up a referral at that time for various reasons, or the local service provider may choose not to admit them or be unable to do so at the time of application. (Service providers decide which eligible people are admitted to their service.)

The differences in recommendations may reflect external factors such as geographic dispersion of clients and services availability, but also client preferences and views on the types of client best served by community-based services. ACAT approvals are required for entry into residential care and for CACPs. Figure 12.16 provides information on the proportion of assessed people referred to community or residential care. Queensland had the highest proportion of ACAT clients referred to residential care in 2001-02 (59.6 per cent), while the ACT had the highest proportion of clients referred to community care (64.7 per cent).

Figure 12.16 **Recommended longer term care arrangements of ACAT clients, 2001-02[a]**



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

Source: Lincoln Gerontology Centre (2003); table 12A.38.

The distribution of ACAT living arrangement recommendations will be influenced by the degree to which any pre-selection process refers a higher proportion of people requiring residential care to ACATs for assessment. Access to residential care requires an ACAT assessment, and jurisdictions with lower overall assessment rates may operate a filtering process to focus assessments on individuals who are more likely to require this level of care. In Queensland, for example, the high proportion of residential care assessments may partly reflect its low rate of use of ACATs other than for primarily residential care assessments (figure 12.16).

Appropriateness — targeting

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

Appropriateness — unmet need

Defining and determining the level of need at an individual level, let alone at a population level, are complex tasks. The perceptions of need and unmet need are often subjective. Previous reports included discussion of unmet need from a recipient's perspective based on the ABS 1998 *Survey of Disability, Ageing and Carers* concerning older people requiring assistance with daily activities (ABS 1999 and table 12A.40). Updated ABS data from the 2003 *Survey of Disability, Ageing and Carers* will be released during 2004 and included in the 2005 Report.

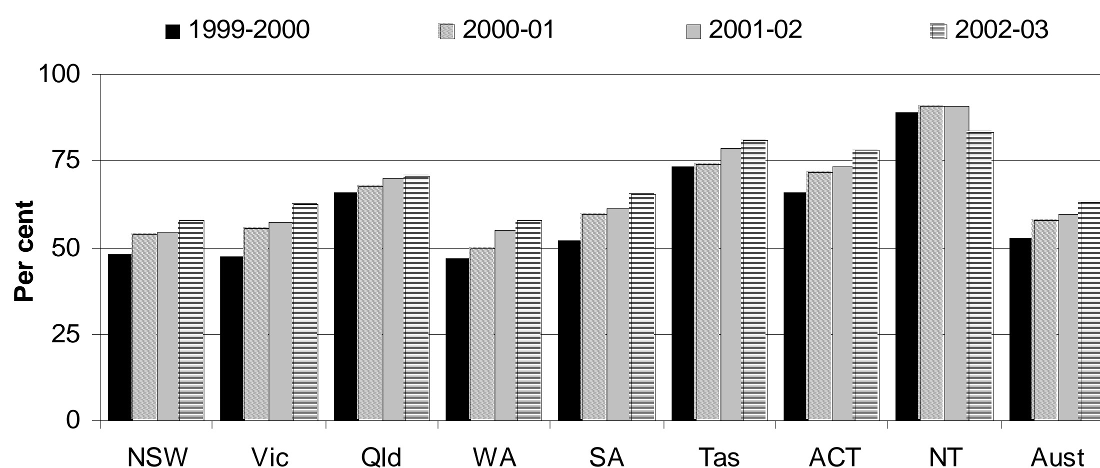
Appropriateness — long term aged care in public acute hospitals

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

Appropriateness — intensity of care

Ageing in place refers to residents remaining in the same residential aged care service as their care needs increase from low level to high level care (box 12.3). The indicator 'intensity of care' is reported for the first time this year using data on ageing in place. Figure 12.17 shows the proportion of people who stayed in the same residential aged care service when changing from low care to high care. From 1999-2000 to 2002-03, there was a steady increase in the proportion of residents who moved from low care to high care and remained in the same aged care service (figure 12.17). During 2002-03, the highest proportion was in the NT (83.3 per cent) and the lowest was in NSW (57.6 per cent). The proportion of residents who had 'aged in place' during 2002-03 was higher in remote areas than in major cities or regional areas (table 12A.56).

Figure 12.17 **Proportion of residents who changed from low care to high care and remained in the same aged care service**



Source: DHA (unpublished); table 12A.56.

Quality — compliance with service standards for residential care

All Australian Government funded residential services have been required to meet accreditation standards to receive residential care subsidies since 1 January 2001. The Aged Care Standards and Accreditation Agency (ACSAA) is the 'accreditation

body' under the Aged Care Act and is responsible for managing the accreditation process and monitoring residential services for continued compliance with the Accreditation Standards. The Accreditation Standards comprise 44 expected outcomes, against which each residential service is assessed.

The first round of accreditation occurred from September 1999 to December 2000, and approximately 90 per cent of residential services received three year accreditations. The measurements applied by the ACSAA in that round were 'commendable', 'satisfactory', 'unacceptable' and 'critical'. These ratings were applied to each expected outcome and then aggregated to a finding for each of the four Accreditation Standards.

The second round introduced a new application and a new method of reporting on findings, although the Standards themselves remained the same. Expected outcomes are now found 'compliant', 'non-compliant' or 'non-compliant with serious risk'. (There is no aggregation of expected outcomes to 'rate' the four Standards.) Results of the second round of accreditation are being collected and will be analysed following completion of the round in early 2004. The results will not be directly comparable with the results from the first round.

There are three basic steps in the accreditation process.

- First, residential services apply for accreditation by completing a self-assessment of their performance against the Accreditation Standards, and submitting this with other relevant information to the ACSAA.
- Second, a team of registered quality assessors reviews the application (the 'desk audit') and then conducts an onsite assessment of the residential service (the 'site audit'). During the site audit, the team observes the living environment and practices of the residential service, reviews relevant documentation such as care plans, and interviews residents, relatives, staff and management. The team gives a draft report to the residential service at the end of the site audit, and a final 'site audit report' is prepared and submitted to the ACSAA within two weeks. During that two week period, the residential service has the opportunity to comment on the draft report or provide additional information.
- Third, an authorised decision maker from the ACSAA (not the team) considers the site audit report, in conjunction with submissions from the residential service and any other relevant information (including information from the DHA), and decides whether or not to accredit, and if so, for how long.

Accreditation decisions and other information relating to the Accreditation Standards, the Aged Care Standards and the ACSAA are publicly available via the ACSAA's web site (www.accreditation.aust.com).

Table 12.6 summarises the accreditation decisions at 30 June 2003. The highest proportion of three year approvals was in NSW and Tasmania (96.7 per cent) and the lowest was in WA (87.8 per cent).

Table 12.6 **Accreditation decisions on residential aged care services, 30 June 2003**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Accreditation approvals										
One year	%	2.1	2.9	2.6	1.9	4.1	2.2	4.3	6.7	2.6
Two years	%	1.2	3.1	5.4	10.3	6.1	1.1	–	–	3.7
Three years	%	96.7	94.0	92.0	87.8	89.9	96.7	95.7	93.3	93.6
Total	**%**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Accredited services	no.	935	818	503	262	296	92	23	15	2 944

– Nil or rounded to zero.

Source: ACSAA (unpublished); table 12A.41.

Certification aims to improve the physical quality of residential aged care services. The certification framework is underpinned by Part 2.6 of the Aged Care Act and by the Certification Principles. Certified services gain access to accommodation payments and are eligible for Australian Government funding supplements for concessional and assisted residents. The certification program has established minimum standards of building quality, which the sector is to achieve progressively. To achieve certification, services are assessed against seven aspects of building quality.

All services were assessed for certification in 1997 and are now working to achieve continuous improvement targets, which were introduced in 1999 as part of a 10 year plan to improve building quality. The targets require services to achieve a safety score of 19 out of 25 by the end of 2003, and an overall score of 60 out of 100. Existing services are also required to meet privacy and space requirements by 2008. All new services must meet these targets from the time of construction. The average number of residents per room at July 2003 varied from 1.62 in NSW to 1.12 in Tasmania. Average safety scores ranged from 21.3 in SA to 16.3 in the ACT (table 12.7).

Table 12.7 **Average certification safety score and residents per room, July 2003**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Safety score[a]	19.2	20.4	19.0	19.2	21.3	19.0	16.3	20.2	19.7
Residents per room	1.62	1.40	1.35	1.28	1.32	1.12	1.14	1.19	1.44

[a] Maximum score is 25; a target score of 19 was to be achieved by the end of 2003.

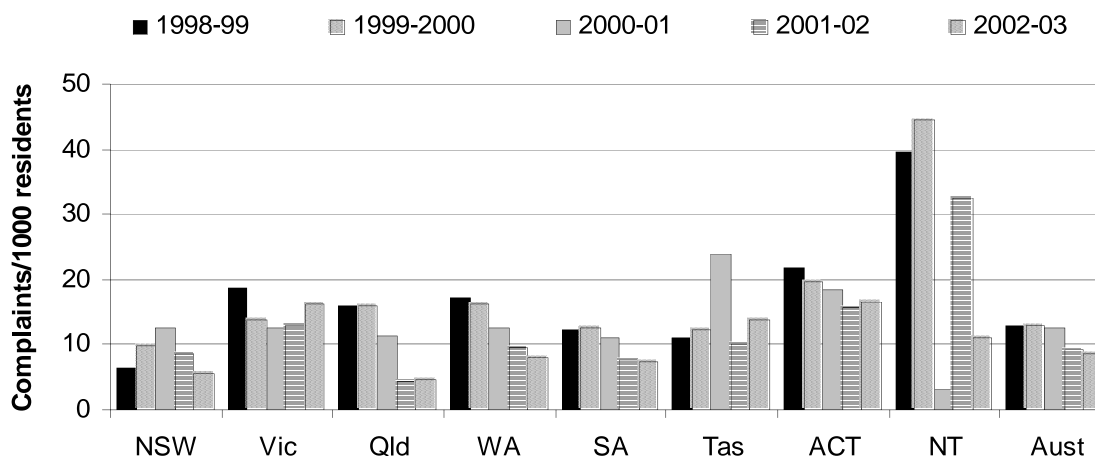
Source: DHA (unpublished); tables 12A.42 and 12A.43.

Quality — complaints

The Aged Care Complaints Resolution Scheme was established in October 1997. The Scheme is a free and accessible complaints system run by the DHA and is overseen by an independent Commissioner for Complaints. The Scheme is available to anyone who wishes to make a complaint about an Australian Government funded aged care service. This can include residents of aged care facilities and their families, staff and people receiving CACPs. Complaints can be made verbally or in writing, and on a confidential or anonymous basis if necessary. All aged care services are required to have an internal complaints system; in many cases, complaints may be resolved without the need to involve the Scheme.

Since the Scheme was introduced, it has handled more than 7000 complaints. Over 1200 complaints were received in 2002-03, of which 66 per cent were lodged as open complaints, 18 per cent as confidential and 16 per cent as anonymous. Of all complaints handled by the Scheme, 97 per cent related to residential aged care services (DHA 2003). The number of complaints registered per 1000 residents in 2002-03 ranged from 16.5 in the ACT to 4.7 in Queensland (figure 12.18).

Figure 12.18 **Aged Care Complaints Resolution Scheme complaints per 1000 residents**



Source: DHA (unpublished); table 12A.44.

Quality — compliance with service standards for community care

The HACC National Service Standards provide HACC funded agencies with a common reference point for internal quality control by defining aspects of service quality and expected outcomes for consumers. States and Territories are required to include the standards in all service agreements. The HACC National Service Standards Instrument has been developed to measure the extent to which individual agencies are complying with the standards through a service appraisal process. Monitoring and compliance with the standards is now a major part of service reviews, however it should be noted that the standards are not an accreditation system.

Data on the outcomes of service standards appraisals are not yet available, however the total number of appraisals undertaken during 2001-02 was 620. The number of HACC agencies operating and the number of appraisals undertaken during 2002-03 are shown in table 12.8. Future reports are expected to include more detailed data on the outcomes of the service standards appraisals.

Table 12.8 **HACC National Service Standards appraisals, 2002-03[a, b, c]**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT[d]	NT	Aust
Appraisals	no.	435	36	377	14	20	15	–	19	949
HACC agencies	no.	1 399	470	730	175	144	72	31	79	3 060
Proportion of agencies assessed	%	31	8	52	8	14	21	–	24	31

[a] Only includes HACC Agencies registered to submit data to the HACC MDS data collection. [b] Data in this table are preliminary and may be revised in the future. [c] HACC service standards appraisals operate on a three year cycle, with the first cycle finishing in June 2004. Consequently data for one year may not be representative of a jurisdiction's performance over time and need to be interpreted with caution. [d] The ACT commenced assessments in 2003-04. – Nil or rounded to zero.

Source: State and Territory governments (unpublished); table 12A.36.

Quality — client appraisal of service standards

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

Efficiency

Inputs per output unit — cost per output unit

Many government services have moved towards better measurement of unit costs as part of a strategy to promote efficiency improvements. Although it is difficult to measure the overall efficiency of community care services (given their diversity) some components can be identified and some unit costs can be approximated. Where services are viewed as substitutes, cost comparisons may be affected.

Preliminary unit cost data have been calculated for aged care assessments using 2001-02 expenditure and activity data. These data need to be interpreted with care. Cost per assessment during 2001-02 averaged $202 nationally and was highest in the NT ($867) and lowest in WA ($147).[3] Victoria had the highest cost per team during 2001-02 ($573 278) and the NT had the lowest ($106 167) (table 12.9).

[3] Cost per assessment is calculated using the total number of assessments and will include clients aged less than 70 years.

Table 12.9 **Aged care assessment unit costs, 2001-02 (dollars)[a, b]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT[c]*	*Aust*
Cost per assessment (all people)	205	191	230	147	225	245	149	867	202
Cost per team	255 302	573 278	442 133	232 438	209 412	373 333	410 000	106 167	309 519

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

Source: DHA (unpublished), Lincoln Gerontology Centre (2003); table 12A.57.

The DVA has contracted authorised service providers to deliver VHC services across the country.[4] The rates paid by DVA for these services are a set price, however they may indicate of an approximate unit cost for the delivery of community care services. Table 12.10 shows the rates paid by DVA for each category of VHC service.

Table 12.10 **Veterans' Home Care service costs, 2002-03 (dollars)**

Type of VHC service	*Co-payment by recipient*	*$ per hour*
Domestic assistance	$5 per hour to a maximum of $5 in any week	30
Home and garden maintenance	$5 per hour for each hour of service	35
Personal care	$5 per hour to a maximum of $10 per week	30
Respite care	No co-payment for respite care	25

Source: DVA (unpublished).

Inputs per output unit — expenditure per head of target population

This section provides information on expenditure per person on the main types of aged care services. A proxy indicator of efficiency is cost per person in the target population — that is, government inputs (expenditure) per person aged 70 years or over plus Indigenous people aged 50–69 years. Preliminary unit cost data are also included.

Australian Government expenditure (including expenditure by the DVA) on residential care services per person aged 70 years or over plus Indigenous people aged 50–69 years varied across jurisdictions in 2002-03, ranging from $2550 in Tasmania to $1633 in the NT. Nationally, expenditure per person aged 70 years or

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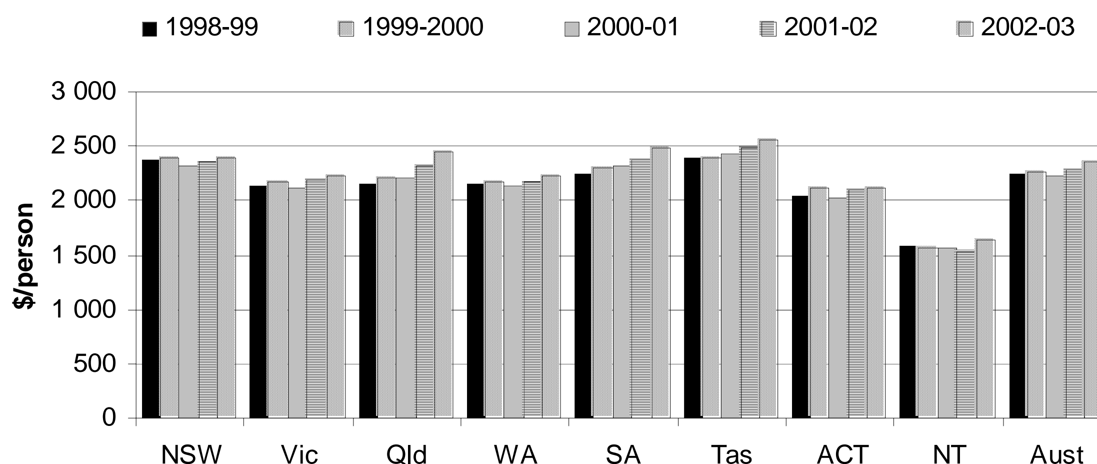
4 A number of these contracted VHC service providers also provide home care services under the HACC program.

over plus Indigenous people aged 50–69 years increased from $2237 (2002-03 dollars) in 1998-99 to $2353 in 2002-03 (figure 12.19).

Figure 12.19 **Australian Government real expenditure on residential services per person aged 70 years or over plus Indigenous people aged 50–69 years (2002-03 dollars)**

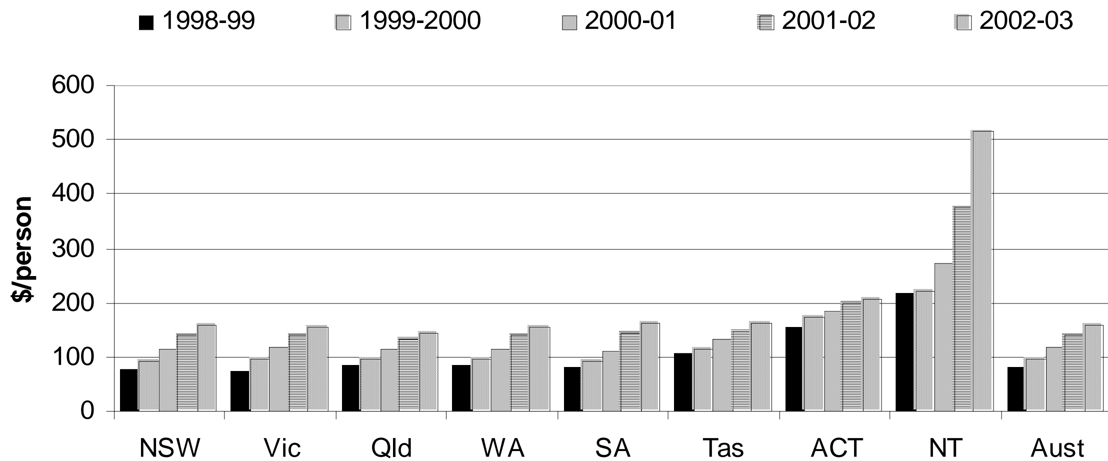


Source: DHA (unpublished); DVA (unpublished); table 12A.52.

Australian Government expenditure on CACPs per person aged 70 years or over plus Indigenous people aged 50–69 years varied across jurisdictions in 2002-03, and was highest in the NT ($516) and lowest in Queensland ($142). Nationally expenditure per person aged 70 years or over plus Indigenous people aged 50–69 years increased from $82 (2002-03 dollars) in 1998-99 to $158 in 2002-03 (figure 12.20).

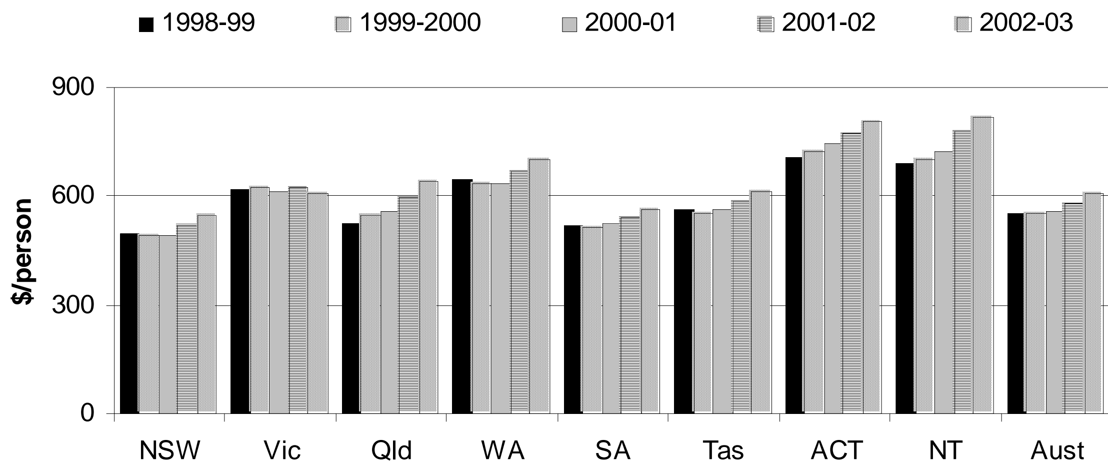
Australian, State and Territory government expenditure on HACC services per person aged 70 years or over plus Indigenous people aged 50–69 years was highest in the NT ($818) and lowest in NSW ($546). Nationally, expenditure per person aged 70 years or over plus Indigenous people aged 50–69 years increased from $552 (2002-03 dollars) in 1998-99 to $607 in 2002-03 (figure 12.21).

Figure 12.20 **Australian Government real expenditure on CACP services per person aged 70 years or over plus Indigenous people aged 50–69 years (2002-03 dollars)**



Source: DHA (unpublished); table 12A.55.

Figure 12.21 **Australian, State and Territory government real expenditure on HACC services per person aged 70 years or over plus Indigenous people aged 50–69 years (2002-03 dollars)[a]**



[a] People aged 70 years or over plus Indigenous people aged 50–69 years are not the HACC target population. Expenditure per head of HACC target population is contained in table 12A.53.

Source: DHA (unpublished); table 12A.54.

Outcomes

No outcome indicators have been developed for aged care services.

12.5 Future directions in performance reporting

For several aspects of aged care services indicators are not fully developed and there is little performance reporting. Further development work is required to establish a full set of indicators. At this stage, no outcome indicators have been developed for Aged care services. Developments that are relevant to all service areas are discussed in chapter 2. Box 12.7 outlines the Retirement Villages Care Pilot.

Interface between aged care and health services

The Care of Older Australians Working Group (COAWG) has been established under the auspice of the Australian Health Ministers' Conference to work across jurisdictions on issues affecting the care of older people. As a way of stimulating broader discussion, reports commissioned by COAWG are available on the Department of Health and Ageing web site (www.health.gov.au/minconf.htm). These include: *Mapping of Services at the Interfaces of Acute and Aged Care* (which gives an account of recent developments in both acute and aged care services that address the transfer of older people into and out of acute care) and *Service Provision for Older People in the Acute — Aged Care System* (which examined services relevant to the care of older people with acute illness, chronic illness and disability, and that operate in some way within hospitals or at the interface between hospitals and other care delivery systems). A third report, *Examination of Length of Stay for Older Persons in Acute Care and Sub-Acute Sectors,* relates to a national census of older people in hospital in 2002 and contains information on situations where another form of care was considered more clinically appropriate. In addition, the AIHW was commissioned to produce the report, *Feasibility study on linking hospital morbidity and residential aged care data to examine the interface between the two sectors.* Issues at the aged/acute care interface are being addressed through the development of a national framework for the care of older persons.

The Steering Committee has also been aware of the importance of examining the performance implications of interactions between services and is researching ways to report interface issues into the future.

Box 12.7 **Retirement Villages Care Pilot**

The Retirement Villages Care Pilot was announced in the 2002-03 Budget as part of a set of initiatives entitled *Staying at Home — Care and Support for Older Australians*. Its focus is on older residents of retirement villages who require additional aged care services to assist their choice to stay at home for as long as possible.

The initiative will supplement any care already available, take advantage of the well designed environment in many retirement village settings and encourage the self-provision that people have made for their future care needs by moving to a retirement village — a choice that is becoming more common for older Australians.

Ten sites have been selected for pilot participation, and the approved providers will be allocated a total of 280 flexible care places comprising a mix of high and low care equivalent places. The pilots commenced operation from 1 October 2003 and will continue until the pilot is completed in June 2006. All pilot sites will participate in a national evaluation that will inform decision making to determine the future of the initiative.

Source: DHA (unpublished).

12.6 Jurisdictions' comments

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

Australian Government comments

"In line with population growth the Australian Government continued to support the expansion of the aged care program. Australian Government expenditure on aged and community care programs increased substantially between 1995-96 and 2002-03. Expenditure on:

- CACPs increased eightfold, from $33 million to $287 million;
- residential aged care increased from $2.4 billion to $4.3 billion, an increase of $1.9 billion; and
- HACC increased from $423 million to $626 million, an increase of 45 per cent.

The Australian Government released 8666 new aged care places across Australia for allocation in 2003-04, bringing the total number made available in the last five years to more than 52 700. The 2003 release includes 5237 residential aged care places, 861 CACPs, 550 EACH and 702 places for national priorities, including restructuring.

The AIHW was commissioned to undertake a multivariate statistical analysis of entry periods to residential care. The AIHW's Report finds that people assessed in hospital enter aged care more quickly than those assessed in other settings, while people in receipt of other community care programs wait longer to enter residential care as they are receiving support services in the community in the interim. Significantly the AIHW Report concludes that the supply of residential aged care places has marginal or no discernible effect on entry periods.

The quality and comprehensiveness of HACC MDS data has continued to improve. For 2002-03 it is estimated that around 83 per cent of HACC agencies successfully submitted MDS data. This represents a significant improvement over the national participation rate of 74 per cent for 2001-02."

New South Wales Government comments

“

The NSW Government is committed to assisting older people and their carers to live independently and participate in community life, and NSW allocates substantial resources to positive ageing programs, home and community care services and other services for older people to achieve this goal.

NSW spent more than $350 million on HACC services in 2002-03, an increase of $32 million. A significant proportion of this additional funding was allocated to increasing access to basic support services, particularly personal care and domestic assistance. The allocation of funding was guided by community consultation and analysis of local need and service gaps to achieve similar access to services regardless of where a person lives.

NSW also made a significant investment in 2002-03 in building HACC service system capacity, including developing new and innovative service models, and building the capacity of providers to deliver services more efficiently and to better respond to the needs of the changing population.

A number of positive ageing programs have been implemented in NSW to facilitate older people’s participation in the community. Initiatives include Seniors Card, which provides a range of transport and other concessions for people over 60; Seniors Online, which assists older people in accessing the internet, and the Seniors Information Service, which provides information and referral on such things as Centrelink entitlements, retirement accommodation, and access to health care and other services.

NSW is also continuing its comprehensive response to the rapid increase in the number of people living with dementia through the allocation of an additional $11.0 million over four years for a range of dementia strategies.

A key NSW initiative has been the establishment of the NSW Care of Older People Committee, an industry representative forum that is developing *A Framework for the Integrated Support and Management of Older People in the NSW HealthCare System*. It seeks to achieve integrated support and management of older people and carers through co-ordinated hospital aged care services, strengthening the hospital-community interface and community health services, and linking the acute, post-acute and chronic and complex care of older people with general practitioners. Programs implemented include Agedcare Services Emergency Teams in public hospital emergency departments; and Community Packages (ComPacks) and Community Acute/Post Acute Care (CAPAC), which provide care and support services in one’s own home, including acute care services, thus avoiding hospital admission or reducing the need to remain in hospital.

Other achievements include the launch of the NSW Clinical Service Frameworks on chronic respiratory disease, heart failure and cancer; and the development of 60 chronic care programs that have enhanced the care of people with chronic conditions, many of whom are aged.

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Victorian Government comments

“During 2002-03, Victoria has undertaken a number of initiatives to enhance services and develop policies that will respond to the future challenges of a rapidly ageing population.

A Health and Active Living Strategy has been introduced with funding of $1.9 million over four years being allocated to work with local communities to increase the participation of senior Victorians in existing sport recreation and leisure facilities and also to increase the range of available activities. The strategy will focus on supporting activity in local communities including older people receiving HACC services, and those in residential care settings. The Office of Senior Victorians will co-ordinate the multi-pronged strategy, combining State-level promotional activity, information services, and referral systems with locally developed strategies.

Victoria has contributed to the Australian Government’s Community Care Review, making recommendations on reorganising community care in terms of principles for better information, intake, assessment and referral arrangements, as well as the design of basic and more intensive forms of community care.

Analysis underpinning the recommendations shows that 99 per cent of the 200 000 Victorian HACC clients receive less than $10 000 of services per annum and account for about 80 per cent of recurrent expenditure. Most of these clients receive services costing less than $5000 per annum.

The *Better Planning and Funds Allocation for the HACC Program in Victoria* reforms were launched in April 2003 benefiting over 500 providers of HACC services. Simplified funding round processes facilitate more equitable distribution of HACC funds across local government areas, increase consistency and transparency in funding decisions, give greater certainty to providers and focus Ministerial Priorities for HACC growth funds towards the expansion of HACC basic services delivered by local government, community health centres and nursing services.

The Reforms also deliver consistent three year planning through the development of Regional Plans, more diverse means of funds allocation including direct allocation and invited submissions and automatic allocation of minor capital via a formula.

Victoria also sees a need to focus on policy responses to the changing demand for residential care places and the interplay with the need for community care resources. Victoria’s continuing undersupply of operational residential care places measured against the planning ratios, particularly in high care, combines with extreme demand for high care places and diminishing demand for low-care built places. Accompanying strong consumer preference for CACPs, EACH packages and other community care services, suggest the need for an urgent system wide examination of planning arrangements including provision ratios.”

Queensland Government comments

“The Minister for Families and Minister for Seniors has lead agency responsibility for issues relating to older people. In 2003, the Department of Families maintained its investment in social participation and fear of crime. The Department has taken the lead in developing a cross-government project to address social isolation of older people. The Department also co-ordinated production of a major public discussion paper - *Queensland 2020: A State for All Ages*, situating ageing of the population in a positive cultural context as an issue for all age groups.

The Queensland Government finalised an extensive consultation on Queensland Health's draft aged care strategy. The strategy focuses on six key issues: hospital services, psychogeriatric services, indigenous issues, residential aged care, dementia care and community services. The Strategy recognises the Australian Government has primary responsibility for aged care and calls for significant systemic improvements that will allow greater choice for frail older people and their carers.

Queensland Health manages the HACC, ACAP, State Government residential aged care facilities and other long-term care services for older people. The Aged Care Capital Works Program is expending $120 million over five years to redevelop eighteen residential facilities.

Changes to one part of the system such as residential aged care (Australian Government responsibility) can have consequences for other parts of the system that older people rely on (eg. acute care). In 2003 Queensland Health worked with consumer organisations, providers and other jurisdictions on improving interfaces between the acute, community and residential care systems.

A major priority for HACC in 2002-03 was to enhance Home Help services, which received a 13 per cent increase in funding to purchase an additional 118 000 hours of service across the state. Other priorities included:

- The development of the HACC Aboriginal and Torres Strait Islander Service Development Plan and the allocation of $468 000 to purchase additional services specifically for HACC eligible Aboriginal and Torres Strait Islander people.
- Ongoing implementation of the HACC Continence Management Strategy with $1.12 million allocated for information, advice and support services.
- Completion of the Resident Support Program with $400 000 allocated to provide support staff for HACC eligible people living in supported and unsupported accommodation.
- Assessment within the HACC Program has been targeted for improvement and reform. A new model incorporating a consistent screening assessment and client referral tool was trialed in 20 community organisation and Queensland Health sites.”

Western Australian Government comments

"Western Australia continues to refine its programs and services for older people in line with demographic trends, the State's population diversity and geographic size, and the expressed preference of older people to continue to reside in their own homes for as long as possible.

In June 2003, the government endorsed a new State aged care plan to enable health and related aged care services for older people to be drawn together within a comprehensive strategic framework. The State Aged Care Plan for Western Australia 2003–2008 is predicated on a vision of 'independence, well-being and quality of life for older people through responsive health and aged care services and supports.'

In a complementary initiative centred on active ageing in an era of population ageing, an across-government taskforce provided recommendations on the development of sustainable social policy for the next 10–15 years, with high-level focus on the promotion of positive ageing and on the development of a policy framework to address major resource and social implications of the 'baby-boomer' generation retiring from the paid workforce.

Western Australia continues to implement a range of flexible options for the frail elderly. Innovative models of service delivery to better meet the needs of target groups continue to be initiated through the HACC program, for example, programs to assist older Aboriginal men in the remote Kimberley region to participate in valued chosen activities thus reducing their need to leave family and country.

With the development and state-wide implementation of a single assessment tool, the Needs Identification Instrument, the HACC program is continuing to improve the targeting of clients on the basis of their needs, taking into account levels of dependency and existing supports.

In January 2003, an 18-month pilot of an 'Enablement Package' commenced to provide a rapid response to HACC eligible clients who are ready for discharge from hospital. The short-term enabling process assists clients to maximise their independence while reducing or eliminating the need for ongoing services.

The WA Transitional Care Service, a flexible model of care for older people at risk of premature admission to long-term services commenced in November 2002. The service provides short-term rehabilitation and support services either in the client's home/hostel or temporarily in a residential aged care facility. Of the 175 admissions until 28 September 2003, 50 per cent of discharged clients returned home, with or without aged care support services.

The principle of supporting people in their own homes, and recommending for residential care only when other support systems are not appropriate continues to inform the ACAP. In 2002-03, 76.8 per cent of people received a CACP within three months of assessment."

South Australian Government comments

The ABS Census indicates that SA has the oldest population of all States and Territories. In June 2002, 10.9 per cent of South Australians were estimated to be aged 70 years or over compared with the national figure of 9.1 per cent. SA also has a significantly higher proportion of people aged 80 years or over.

The SA Government has recently received the *Generational Health Review* and released *First Steps Forward*, the blueprint for systemic health reform.

SA continues to take up the challenge of the ageing population, focusing on improving accessibility to and the quality of community based support services and providing greater opportunities for inclusion and participation of seniors.

There is a significant and growing demand for community based services. Timely access to CACPs remains an issue. The SA Government has responded by providing increased growth funding for the HACC Program. Priorities focus on expanding the provision of basic home and community care services, especially domestic assistance and personal care for frail older people, Indigenous people, people in isolated geographic pockets and vulnerable adults.

People from ageing ethnic communities continue to be a high priority for HACC funding in SA, and a substantial amount of funding has been approved in recent years for new ethno-specific services. There is also a range of service development initiatives that are currently being implemented to improve accessibility to and responsiveness of mainstream services for older people from ethnic backgrounds.

There have been significant community development and inter-governmental funding initiatives to improve the situation of Aboriginal people, especially for Aboriginal people in the very remote Anangu Pitjantjatjara lands.

The Australian and SA governments have agreed to continue to jointly fund the Home Rehabilitation and Support Service. The service provides short-term rehabilitation and support for older people who have either had an unnecessarily long stay or are at risk of an extended stay in the acute hospital system, and who are assessed as eligible for residential care. To date, the project has resulted in a return home for 60 per cent, with varying levels of support.

The HACC funded *Equity, Responsiveness, Access* project aims to promote more flexible home based service responses for older people in the Wakefield, Mid North and Gawler areas by streamlining entry, screening, assessment and service co-ordination processes. The service improvement model has increased the capacity of older people to access available services through improved system responses.

Tasmanian Government comments

“The Tasmanian Government through the Department of Health and Human Services is enhancing service delivery structures to ensure that the Government is appropriately placed to meet the health needs of the Tasmanian community well into the future. In the six years since coming into office, the Government has increased health spending by $200 million. This year there has been an increase of $49.5 million in recurrent funding alone.

All residential aged care services operated by the State Government have been upgraded to meet the Australian Government’s 2008 certification requirements. The State Government has also allocated funds to enable major capital upgrade of its rural health and aged care services. In all nearly $25 million has been allocated to these services. This does not include more than $15 million to be expended on the State’s major hospitals and smaller capital works projects.

The State is rapidly moving towards a community where one third of its population will be aged 65 years or over, with the most rapid growth being predicted to be in the aged group of 85 years plus. Projected population data for Tasmania indicates that the percentage of the population aged 70 years or over that are aged 85 years or older will increase from 15.8 per cent currently to 27.5 per cent by 2051. This will have significant implications for the State as people aged 85 years or over are more likely to need a range of aged care services.

Tasmania’s changing demographics within its older population is not recognised in the current targeting of aged care resources and there is a real possibility that Tasmania will have a significant shortage of residential aged places within the next ten years.

Non-operational residential aged care places continues to be an issue within the State with the number representing a significant percentage of the people waiting placement and who need to have their care needs met in a hospital.

Following concern expressed by the Australian Government that local government processes had resulted in delays in bringing beds online, the State Government took the initiative and, through the Premier’s Local Government Council, invited the Australian and local governments to join the State in developing a tripartite partnership agreement on an ageing population. One of the primary objectives of the tripartite agreement will be to ensure there are no unnecessary hurdles in the way of the provision of aged care places.

The Tasmanian Government is giving priority to developing a strategic plan that will provide a comprehensive understanding of the full extent of cost and demand pressures on health and community services created by an ageing population. In response a number of reviews have been undertaken with recommendations being progressively implemented to ensure policies and models of service delivery are in place to meet the care needs of an ageing population.”

Australian Capital Territory Government comments

The ACT Government has continued to see the needs of older people as a key area within health and community care. The ACT Government has provided $5.5 million to cover capital costs associated with building a new sub-acute facility for the ACT. The new facility will provide 20 rehabilitation beds, 20 psychogeriatric beds and 20 convalescent/transitional care beds. Service modelling around the facility is currently being developed.

The HACC program has been enhanced through the provision of a $1.5 million funding allocation, representing 100 per cent of growth funding, to community organisations. Additional outputs will be provided for: Allied Health Care; Case Co-ordination; Case Management; Centre-based Day Care; Counselling/support, information & advocacy; Domestic Assistance; Home Maintenance; Home Modification; Nursing Care; Personal Care; Provision of goods and equipment; Social Support and Transport.

In 2002-03 the ACT Government allocated $1 million to improve respite care services in the ACT. A review of the respite sector in the ACT highlighted a number of areas that require development to respond to the needs of the community. These include:

- Appropriateness of models of care (ie traditional respite service versus family support models)
- Skills and training (workforce development and support)
- Fragmentation of respite services (across funding bodies, community sector and mainstream services, co-ordination point to facilitate access)
- Adequate data collections to demonstrated need
- Access issues for specific client groups.

The ACT Government is in the process of responding to these issues through a cross agency working group.

In 2002-03 the ACT Government continued to support the ACT Transitional Care Program funded as part of the Innovative Care Rehabilitation Services Pilots. The program provides post hospital care in a residential setting, as well as in community based packages. The program has been valuable in assisting frail older people to return home following an acute episode.

Timely access to residential aged care services continues to be a concern to the ACT Government and community members. A Residential Aged Care Liaison Nurse has been appointed as a two year project to address system wide issues in accessing residential care. The nurse has been successful in building relationships across the hospital, community and residential care sector, and is currently working to develop a centralised waiting list for residential care.

Northern Territory Government comments

“The NT government is committed to providing appropriate services to older Territorians to maximise their independence and participation in their communities.

The proportion of the NT population aged 70 years or over is comparatively low, but the rate of increase is higher than other jurisdictions. For a jurisdiction that is more familiar with a young age structure this presents a challenge to develop appropriate responses to the changing age and needs profile.

The Territory is monitoring the impact of the increasing aged population on health expenditure and the acute/aged care interface. As in other jurisdictions this interface is currently a key focus area. The Katherine Transitional Care Unit will utilise flexible care places from the National Innovative Pool. The interaction between this pilot and other approaches to remote service provision such as co-ordinated care and a new health zone will be of particular interest.

Older people are not a homogenous group and the NT epitomises this. The population profile and the profile of aged care service users reflects considerable diversity, both within the NT and in comparison to national data. With a diverse ethnic mix along wih a significant rural and remote population (26 per cent compared to 14 per cent nationally), providing appropriate care services is challenging and resource intensive. The cost of service provision in aged care across the NT is therefore somewhat higher than the national average. Further, the majority of older Territorians do not have the capacity to contribute to the cost of their care, reflected in the high proportion of concessional residents (78 per cent).

The NT recognises that innovative and flexible approaches to provision of care are required to meet the needs of such a diverse population. The Territory’s higher proportion of CACPs and fewer low care places is largely due to expanded allocation of CACPs to Indigenous people in remote communities. The NT government and the local office of the Department of Health and Ageing are considering the development of the Territory’s first Multipurpose Services as a model to address the aged care needs in two remote locations.

Some NT data in this report needs to be interpreted with caution due to small sample sizes and the exclusion of data for Indigenous people aged 50–69 for some services. The NT welcomes the implementation of the ACAP MDS version two and future improvements in data quality and comparability.”

12.7 Appendix: Age standardisation of aged care data

Age profiles can distort observed usage patterns

The age profiles of Australians varies across jurisdictions and across different cultural and linguistic backgrounds. (See for example the different age profiles of Indigenous and non-Indigenous Australians, figure 12.7). Variations in age profiles are important because the likelihood of needing aged care services increases with age (table 12.11). As a result, observed differences in usage rates by different cohorts within the community may arise from different age profiles, rather than from different usage patterns. One method of eliminating this distortion from the data is to standardise for the age profiles of different groups.

Method of standardisation

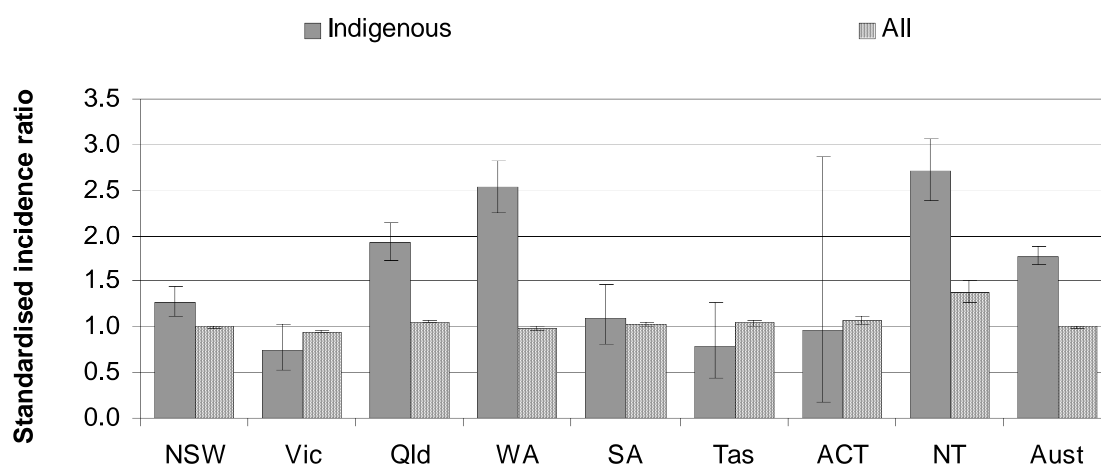
Either direct or indirect standardisation can be used; indirect standardisation is presented here because it is more appropriate when comparing small populations. This method applies standard age-specific usage rates (in this case, average Australian rates) to actual populations (different groups within States and Territories), and compares observed numbers of clients with the numbers that would have been expected if average rates had applied. Comparisons are made via the standardised incidence ratio. A value greater than 1.0 in this ratio means that use was higher than expected if the particular group had the same usage rates as that of the Australian population as a whole. A value below 1.0 means use was lower than expected. Age standardisation generally covers use by all age groups, and therefore the resulting standardised incidence ratios compare use by complete population groups, not just by those aged 70 years or over.

Application of indirect standardisation

In the following illustration, 2001 data are used. Within each State and Territory, the combined use of permanent residential aged care and CACPs by Indigenous people is compared with average service use by all Australians. The resulting standardised incidence ratios are presented in figure 12.22. The error bars in the figure show how accurate the comparisons are; if an error bar goes across the value of 1.0 then the usage rate by that population group is not significantly different from the average use by all Australians. It should be noted that people, and Indigenous people in particular, also use long-stay hospital beds, flexible places and other services not covered in the analysis; consequently, these results do not represent all the services available to people.

Figure 12.22 shows that, overall, Indigenous people had a higher than average combined use of CACPs and permanent residential aged care — nationally, about 80 per cent higher. This result reflects the higher age-specific usage rates of CACPs for Indigenous people at all ages, and of permanent residential aged care among those aged under 75 years (table 12.11). The picture, however, changes from State to State: combined use of the services is not significantly different from the national average for Indigenous people in Victoria, SA, Tasmania and the ACT, but is higher than average in NSW (about 25 per cent higher), Queensland (90 per cent higher), WA (250 per cent higher) and the NT (270 per cent higher). Looking at both Indigenous and non-Indigenous people, Victorians generally use residential aged care at a slightly lower rate than the national average, while people from Queensland, SA, Tasmania and the NT have slightly higher than average usage rates.

Figure 12.22 **Standardised incidence ratio for CACP and permanent residential aged care (combined), 30 June 2001[a]**



[a] Uses indirect age standardisation against use by all people Australia-wide.

Source: AIHW (unpublished); table 12A.58.

Table 12.11 **Age-specific usage rates of CACPs and permanent residential aged care (per 1000 people), 30 June 2001[a, b]**

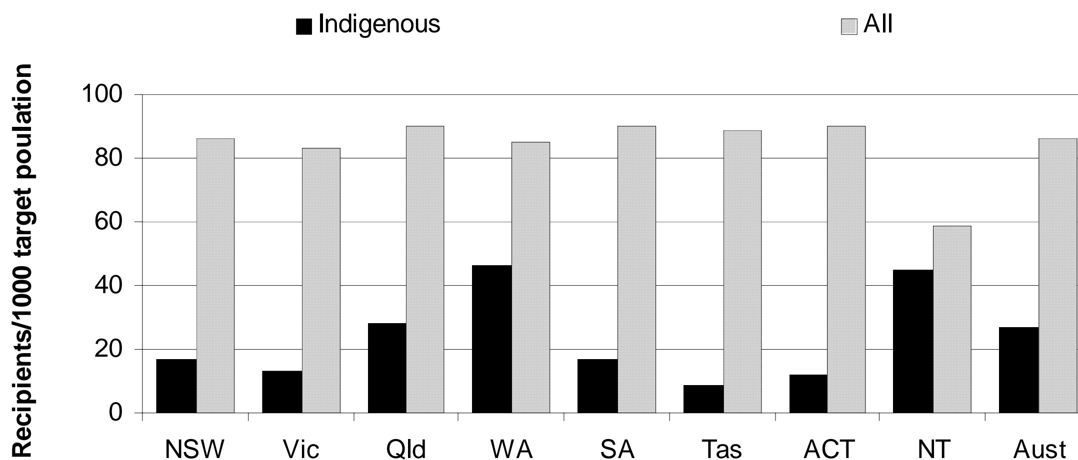
	CACP recipients		*Permanent aged care residents*	
Age (years)	*Indigenous*	*Non-Indigenous*	*Indigenous*	*Non-Indigenous*
50–54	1.7	0.1	1.7	0.7
55–59	4.1	0.3	4.1	1.4
60–64	8.6	0.7	8.6	2.9
65–69	16.3	1.5	16.3	6.1
70–74	30.1	3.2	30.1	14.5
75–79	33.7	7.1	33.7	35.3
80+	36.7	20.7	116.3	160.8

a Excludes clients of multipurpose and flexible services. **b** Cases with missing data on Indigenous status have been pro rated within gender/age groups.

Source: AIHW (unpublished).

The above picture is quite different from that given when comparing use with the target group population (clients per 1000 in the target group — figure 12.23); also used in figures 12.10 and 12.12. This measure suggests that in all jurisdictions except the NT, combined use of CACPs and permanent residential aged care is much lower for Indigenous people than others, and even in the NT for Indigenous people the ratio of clients to target population is about 25 per cent lower than that for all people from the NT. Figure 12.23 also suggests that combined use of the two services in the NT is generally much lower than in other jurisdictions; this difference is not apparent after age-standardisation (figure 12.22), indicating that the difference in this measure is the result of the relatively young age structure of the NT.

Figure 12.23 **Ratio of CACP recipients and permanent residents (combined) to 1000 persons in target population, 30 June 2001[a]**



[a] Indigenous ratio is per 1000 Indigenous people aged 50 or over, all ratio is per 1000 Indigenous people aged 50 or over and non-Indigenous people aged 70 or over.

Source: AIHW (unpublished); table 12A.58.

12.8 Definitions

Table 12.12 **Terms**

Term	*Definition*
Aged care	Formal services funded and/or provided by governments, that respond to the functional and social needs of frail older people, and the needs of their carers. Community aged care services are aimed to optimise independence and to assist frail older people to stay in their own homes. Residential care services provide accommodation and care for those who can no longer be assisted to stay at home. The majority of aged care services assist in activities of daily living such as personal care (eg. bathing and dressing), housekeeping and meal provision, and are delivered by trained aged care workers. However, aged care services may also be delivered by health professionals such as nurses and occupational therapists. These services are generally aimed to maintain function rather than treat illness or to rehabilitate, and are distinguished from the health services described in Part E of this report. Assessment of care needs is also an important component of aged care. Aged care services may be funded through programs specifically or mainly directed to older people, or through programs that address the needs of people of different ages. Generally, the target groups of aged care services are people over the age of 70 years and Indigenous people aged over 50 years.
Ageing in place	An approach that aims to provide residents with appropriate care and increased choice by allowing them to remain in the same facility regardless of their levels of care needs. It also allows couples with different levels of care needs to be cared for in the same facility. The main facet of 'ageing in place' is that funding is tied to the assessed care needs of the client rather than to the services provided by the facility. One of the objectives of Commonwealth aged care legislation is 'to promote ageing in place through the linking of care and support services to the places where older people prefer to live' (*Aged Care Act 1997* (Cwlth), s.2-1 [1j]).
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	The affected care recipient or his or her representative, or anyone else, may make a complaint to the Secretary about anything that: • (a) may be a breach of the relevant approved provider's responsibilities under the *Aged Care Act 1997* or the Aged Care Principles • (b) the complainant thinks is unfair or makes the affected care recipient dissatisfied with the service.
Disability	A limitation, restriction or impairment which has lasted, or is likely to last, for at least six months and restricts everyday activities.
Elapsed time between ACAT approval and entry into a residential care service	The measure of the elapsed time between ACAT approval and entry into a residential care service. It has been used in past years as an indicator of access to residential care.

(Continued on next page)

Table 12.12 **(Continued)**

Term	*Definition*
High/low care recipient	Recipient of a high level of residential care (that is, a level of residential care corresponding to RCS levels 1–4) or a recipient of a low level of residential care (that is, a level of residential care corresponding to RCS levels 5–8). If the person is approved as a recipient of a high level of care, that person can receive care at any care classification level (*Approval of Care Recipients Principles 1997*, s.5-9). A person approved as a recipient of a low level of care can be classified only as RCS 5–8. (*Classification Principles 1997*, s.9-19).
In-home respite	A short term alternative for usual care
People from non-English speaking countries	People who were born in non-English speaking countries. English-speaking countries are defined as Australia, New Zealand, the United Kingdom, Ireland, the United States, Canada and South Africa.
People with a moderate disability	Where a person does not need assistance, but has difficulty with self care, mobility or communication.
People with a profound disability	Where a person is unable to perform self care, mobility and/or communication tasks, or always needs assistance.
People with a severe disability	Where a person sometimes needs assistance with self care, mobility or communication.
Personal care	Assistance in undertaking personal tasks (for example, bathing).
Places	A capacity within an aged care service for the provision of residential care, community care or flexible care in the residential care context to an individual (*Aged Care Act 1997* (Cwlth)); also refers to 'beds' (*Aged Care (Consequential Provisions) Act 1997* (Cwlth), s.16).
Real expenditure	Actual expenditure adjusted for changes in prices, using the GDP(E) price deflator and expressed in terms of final year prices.
Resident	For the purposes of the *Aged Care Act 1997*, a person who is being provided with residential care through an aged care service conducted by an approved provider under the Act.
Respite care	Alternative care arrangements for dependent people living in the community, with the primary purpose of giving their carer a short term break from their usual caring commitments.
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 non-English speaking countries; people who live in rural or remote areas; people who are financially or socially disadvantaged; and veterans.
Veterans	Veterans and war widow(er)s who are entitled to treatment through the Department of Veterans' Affairs under the provisions of the *Veterans' Entitlements Act 1986*.

12.9 References

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