10 Aged care services

The aged care system comprises all services specifically designed to meet the support needs of Australia's frail older people. The focus of this chapter is on government funded residential and community based services for older people, particularly:

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

This chapter reports data on the effectiveness and efficiency of publicly funded aged care services. Effectiveness is indicated by service quality, accessibility and equity, and efficiency is indicated by the unit cost of providing the service. A framework of performance indicators is outlined in section 10.3 and data are discussed in section 10.5. Waiting times data are included in this Report on a comparable basis for the first time.

Frail older people also use many mainstream health and community services. The outcomes for older people of some of these services are covered in other chapters — acute health care services for older people in chapter 4 and housing services for older people in chapter 14).

10.1 Profile of aged care services

This chapter focuses on residential and community care services for older people. Recipients of these services receive them on the basis of frailty or incapacity rather than age. Nevertheless, in the absence of more specific information, this chapter uses age (70 years and over) as a proxy for the likely requirement for services.

However, it should be noted that some aged care services are designed for the carers of older people. And certain groups, notably indigenous Australians, may require various services at a younger age on average than the general population.

The formal publicly funded services covered in this chapter represent only a small proportion of total assistance provided to frail older people. Most assistance is informal, delivered by family members, communities and other individuals. Extended family and partners are the largest source of emotional, practical and financial support for older people. Over 90 per cent of older people living in the community who required help with self care, mobility or communications received assistance from the informal care network of family, friends and neighbours (AIHW 1997).

Size and growth of the older population

The Australian population is ageing (as indicated by an increase in the proportion of the total population in the older age groups) and this trend is expected to continue. Such changes to Australia's demographic profile are particularly relevant to the planning and financing of health services and long term care.

The aged dependency ratio — a ratio of the number of people aged 65 years and over in the population to the number of people aged 15–64 years (that is, people of working age) — is one way of illustrating Australia's changing demographic profile. In 1995, there were approximately 18 people aged 65 years and over for every 100 persons of working age. This ratio is estimated to double over the next 50 years (table 10.1).

Table 10.1 **Aged dependency ratio (per cent)**

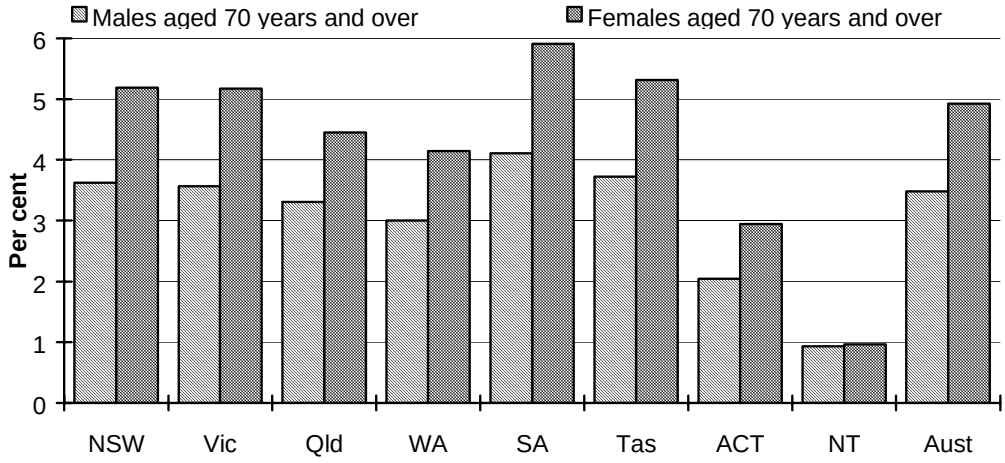
	1995	*2021*	*2051*
Dependency ratios	17.8	27.1[a]	38.4[a]

a Estimates of future dependency ratios.

Source: table 10A.1.

The distribution of aged persons varied significantly across jurisdictions in 1997 (figure 10.1). The proportion of older females was higher than that of older males in all jurisdictions, as has been the historical trend (table **10**.**1**).

Figure 10.2 **Males and females aged 70 years and over as a proportion of the total population, 1997**



Data source: table 10A.2.

Such demographic profiles affect the demand for aged care services because females use aged care services, particularly residential services, more than do males — for example, 73 per cent of age care residents were female in 1997-98. Females are more likely to use residential services, partly because they tend to live longer (that is, there are more older women in the population than older men) and are less likely to have a partner to provide care (table **10**.**2**).

Table 10.3 **Probability of future nursing home and hostel use, by gender and age 1994-95 (per cent)**

	Age (years)							
	0	65	70	75	80	85	90	95
*Nursing homes (*permanent care)								
Males	20	25	28	32	39	48	56	60
Females	34	39	42	48	59	76	95	94
Persons	27	33	36	41	51	66	83	85
*Hostels (*permanent care)								
Males	9	12	14	17	22	31	39	38
Females	22	26	29	34	45	57	60	43
Persons	16	20	22	27	35	48	54	42

Source: table 10A.3.

Aged care programs

The aged care services reported in this chapter can be categorised as residential services, community (or nonresidential) services or assessment services.

Residential care services

The Australian system of residential care has traditionally comprised two levels of care — nursing homes (for higher dependency residents) and hostels (for lower dependency residents).

The size and distribution of residential services — which may influence costs of delivery — vary across jurisdictions. Nationally, there were approximately 140 000 places (permanent and respite) in residential care facilities (76 000 in nursing homes and 64 000 in hostels) as at November 1998. The highest proportion of nursing home beds in rural areas were in Tasmania and Queensland, while the NT (54.5 per cent) and WA (3.9 per cent) had the highest proportion in remote areas (table **10**.**4**). However, the distribution of regional residential places should be examined with respect to the number of potential users (that is, persons aged 70 years and over) living in those areas (table 10A.6). Tasmania for example, has both the highest proportion of nursing home places in rural areas (55.6 per cent) and the highest proportion of people living in rural areas aged 70 years and over (57 per cent) (table **10**.**5**).

Table 10.6 **Size and scope of nursing home services, 1997-98[a, b]**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Number of nursing homes	No.	490	467	218	111	161	55	7	7	1 516
Nursing home places	No.	29 562	18 151	12 475	5 762	7 012	2 233	604	219	76 018
Occupancy rate	%	98.0	96.7	98.3	95.5	98.9	98.6	96.9	99.1	97.6
Proportion of nursing home places by geographic region:										
• capital cities	%	80.4	74.2	63.2	82.6	85.7	43.9	100.0	45.5	75.8
• rural	%	19.4	25.8	34.4	13.5	14.3	55.6	0.0	0.0	22.5
• remote	%	0.2	0.1	2.4	3.9	0.0	0.6	0.0	54.5	1.7
Size of nursing homes by number of beds:										
• 1 – 20	%	1.5	14.1	3.3	1.8	1.9	17.0	0.0	42.9	6.4
• 21 – 40	%	26.4	56.5	40.0	38.9	56.3	43.4	0.0	28.6	42.2
• 41 – 60	%	32.4	21.9	23.7	38.9	30.6	26.4	28.6	28.6	27.8
• 61 or more	%	39.5	7.6	33.0	20.4	11.3	13.2	71.4	0.0	23.6

a As at 1 November 1998. **b** New residential services (that is, beginning operation after 1 October 1997) were not classified as either nursing homes or hostels. These new services have been included in this table.

Source: table 10A.4.

Hostels were generally smaller (by number of beds) than nursing homes in 1997-98. Nationally 84.1 per cent of hostels had 60 beds or fewer compared with only 76.4 per cent of nursing homes (table **10**.**7**).

Table 10.8 **Size and distribution of hostel services, 1997-98[a]**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Number of hostels	No.	465	381	268	171	151	50	15	8	1 509
Hostel places	No.	19 976	16 406	12 670	5 921	6 411	1 535	812	143	63
Occupancy rate	%	94.4	93.2	96.2	93.6	94.8	97.3	94.7	93.0	94.5
Proportion of hostel places by geographic region:										
• capital cities and other metropolitan areas	%	70.6	70.0	57.8	78.3	75.8	45.1	100.0	47.7	68.6
• rural	%	28.5	30.0	38.2	17.9	23.9	54.3	0.0	0.0	29.8
• remote	%	0.9	0.0	4.0	3.8	0.2	0.6	0.0	52.3	1.6
Size of hostels by number of places:										
• 1 – 20	%	18.0	15.6	16.7	30.2	21.7	33.3	7.1	75.0	19.5
• 21 – 40	%	40.0	39.2	30.4	36.0	36.8	41.2	14.3	12.5	37.1
• 41 – 60	%	25.0	32.2	33.0	25.6	21.1	17.6	28.6	12.5	27.5
• 61 or more	%	17.0	13.1	20.0	8.1	20.4	7.8	50.0	0.0	15.9

a As at 1 November 1998.

Source: table **10**.**9**.

Residential care services — funding and service delivery

Nursing homes are provided by the for-profit and not-for-profit sectors directly, and by State and Territory Governments and local governments (figure **10**.**3**). The Commonwealth Government provides the majority of funds for residential aged care facilities, providing about 70 per cent of nursing home income on average and a smaller proportion of hostel income. Residents provide most of the remainder, with some income from charitable sources and donations. State and Territory Governments financially support the facilities they operate, and these homes receive lower Commonwealth subsidies than do other nursing homes. Commonwealth Government funding for long term residential care services was about $2.8 billion in 1997-98.

The Commonwealth Government subsidises all residential places. The subsidy for each place varies according to the client's level of dependency; high level care is classified as categories 1–4 on the 8-level Resident Classification Scale (RCS) (table **10**.**10**).

The average Commonwealth subsidy for nursing homes varied across jurisdictions in 1996-97, ranging from $26 413 in Queensland to $31 838 in Tasmania. Such differences in average annual subsidies reflect differences in subsidy rates as well as differences in the dependency of residents (table **10**.**11**).

Table 10.12 **Average annual Commonwealth subsidy per occupied nursing home place and the dependency level of aged care residents, 1996-97**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Average annual Commonwealth subsidy[a]										
	$	31 047	30 922	26 413	29 101	28 828	31 838	30 102	31 442	29 917
High level of care (proportion of residents)[b]										
RCS 1 and 2	%	32.3	34.0	31.2	26.6	28.4	26.8	25.5	39.4	31.5
RCS 3 and 4	%	27.4	21.6	24.5	24.6	27.0	31.0	24.0	29.6	25.3
Low level of care (proportion of residents)										
RCS 5 – 8	%	40.3	44.3	44.3	48.8	44.5	42.2	50.5	31.0	43.3

[a] Differences in average annual subsidies reflect differences in subsidy rates as well as differences in dependency of residents. [b] RCS = Residential Classification Scale.

Source: table 10A.7.

The aged care reforms introduced in October 1997 produced a government funding system which does not differentiate between nursing homes and hostels. The aim of this funding system is to enable residents to remain in one aged care facility irrespective of their dependency level.

The Commonwealth Government is responsible for most regulation of residential aged care facilities. State and Territory Governments and local governments also have a regulatory role in areas such as staff–resident ratios, industrial awards and compliance with building and fire safety regulations (box **10.1**).

Residential facilities are mainly run by private and religious/charitable organisations. However, some State and Territory Governments and local governments also operate a small number of residential facilities.

The ownership status of nursing homes and hostels varied in 1997-98. The majority of hostel places were in religious or charitable facilities (85 per cent) while for-profit enterprises were the major provider of nursing home places (48 per cent). The proportion of aged care services provided by government, private enterprise and charitable organisations also varied across jurisdictions in 1998 (figure **10.4**.)

Box 10.2 **Examples of regulatory arrangements for residential services**

The Commonwealth controls the number of subsidised bed places, with a target of 40 high care beds (generally in nursing homes) and 50 low care beds (hostels) for each 1000 persons of the population aged 70 years and over. In addition:

- services are expected to meet regional concessional resident targets, ranging from 16 per cent to 40 per cent of places; and
- extra service places (where residents pay for a higher standard of accommodation, food and services) are restricted.

To continue to receive Commonwealth funding after January 2001, services must be accredited as meeting all residential care standards. To ask residents to pay accommodation charges, a home must be certified as meeting specified building and care standards.

State and Territory legislation may prescribe matters such as staff–resident ratios, regulations about the dispensing of medication and/or certain medical procedures, occupational health and safety, workers compensation requirements, building standards, and fire prevention and fire fighting measures.

Staff wages and conditions are generally set by jurisdictional based awards.

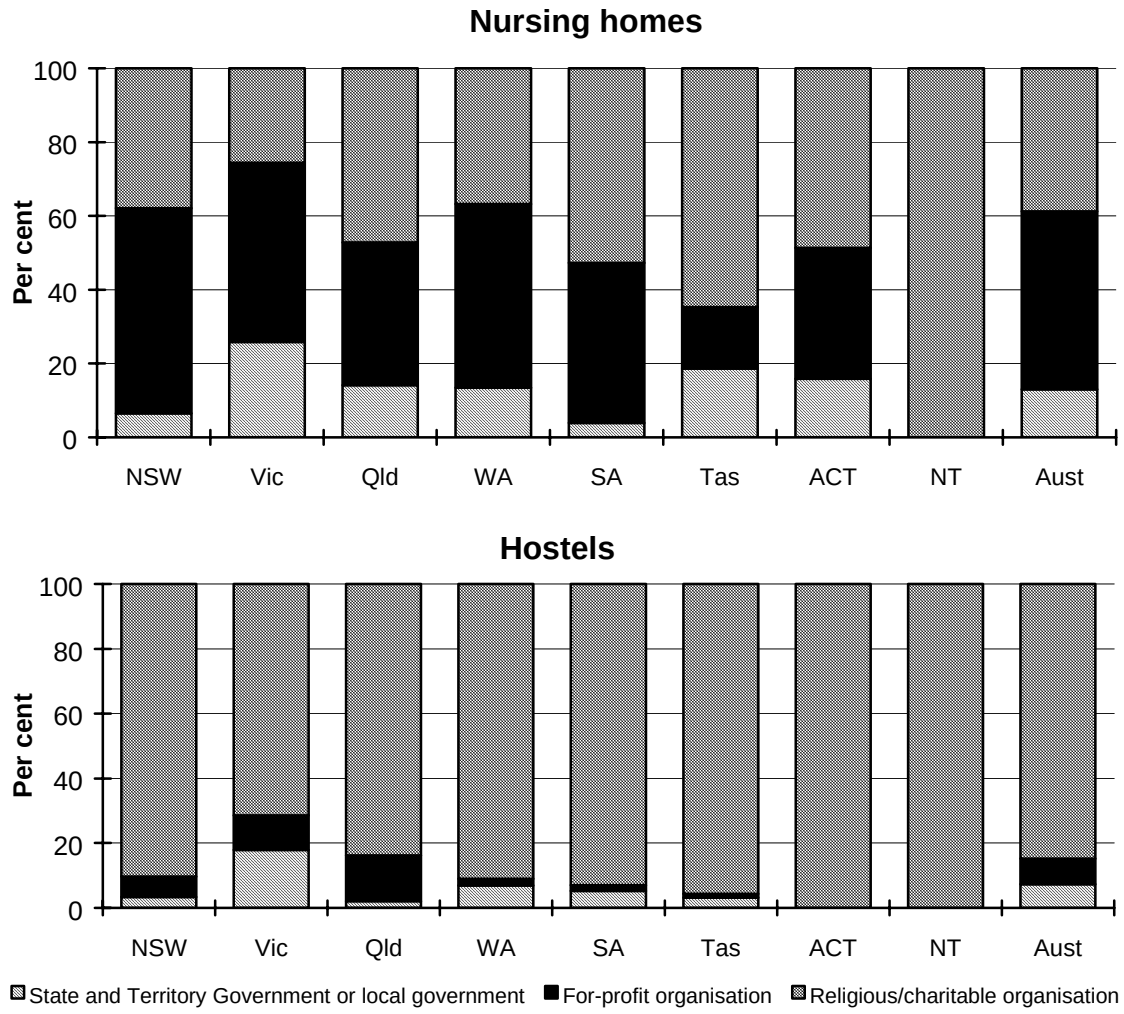
Local government by-laws may also apply (for example, waste disposal rules).

Source: PC (1998).

Assessment services

The Aged Care Assessment program was established in 1984 to control eligibility for admission into residential care and to determine the level of care required (and thus determine the subsidy paid to such services). Assessment by ACATs is mandatory for admission to residential care or receipt of CACPs. ACATs essentially coordinate the supply and demand of residential care services and CACPs; they may also refer people to other services such as the HACC program. The Commonwealth Government funds ACATs, with additional contributions from States and Territories. The latter are responsible for the day-to-day operation of ACATs.

Figure 10.5 **Ownership of residential places, 1998**[a, b]



[a] For the purposes of this analysis government ownership includes: residential facilities owned by State, Territory or local governments; and facilities owned by charitable organisations which used to be run by State Governments but still receive the same benefit rates as apply to State Government owned facilities. [b] As at 1 November 1998

Data source: table 10A.8.

Coordination of services

There are some concerns about the coordination of mainstream services used by older people, particularly health services such as general practitioners, hospitals and community health services. To better meet the needs of clients who require multiple services from various programs or different levels of government, Commonwealth and State and Territory Governments have jointly undertaken a series of coordinated care trials which began in October 1997 and will end in December 1999 (box **10**.**3**).

Box 10.4 **Coordinated care trials**

Coordinated care trials focus on consumers, with funding linked to individuals directly rather than to providers. The aim is to improve the matching of services to client needs. Nine national coordinated care trials are being run from October 1997 to December 1999. The trials vary in their aims and target groups. Three trials dealt with health issues of people aged over 65 years.

1. Care 21 (South Australia)

Target group: 800 persons over 65 years of age (over 55 years in the case of indigenous people) who have complex medical conditions (that is, they required at least one hospitalisation over the previous 12 months and/or are multiple users of HACC funded services)

Trial aim: to improve the outcomes for clients (who require community services which include home based domiciliary support, meals and home nursing services), such as minimising crises and enhancing their ability to remain in the community by encouraging early intervention and prevention responses. A particular focus is the ability to substitute between services while staying budget neutral.

2. TEAMCare Health (Queensland)

Target group: 1500 persons over 65 years of age who have complex needs as defined by using four or more services (such as pharmaceutical, community health and HACC type services) and who were hospitalised in the previous 12 months

Trial aim: to maximise clients' health and wellbeing and reduce institutional care, focusing on cooperation between general partitioners and community based providers

3. Careworks (Tasmania)

Target group: 800 persons over 65 years of age who have complex long term care needs (defined with reference to the person's medical condition and service use)

Trial aim: to improve outcomes for clients by improving the coordination and integration of care across the health and community care sectors. The focus is on improved management and preventative care in the community, reducing acute hospital admission and length of stay.

Community care services

Two types of community care programs are reported in this chapter: HACC and CACP.

The HACC program provides a range of community services (such as home help and maintenance, personal care, food services, respite care, transport, paramedical services and community nursing) to older people, to younger people with disabilities and to their carers. The target population is defined as people in households who have a moderate, severe or profound handicap; approximately 70 per cent of HACC

recipients are aged 70 years and over. The aim of the program is to provide high quality and cost effective care in the community, making services appropriate to the assessed need of the individual and avoiding inappropriate admission to residential care.

The CACP program provides an alternative home based service for older persons with complex care needs who would otherwise require admission to a hostel. The two main distinguishing features of the CACP and HACC programs are:

- the process of eligibility — an ACAT assessment is mandatory for receipt of CACPs but not for the HACC program; and
- the funding — CACP providers receive a subsidy in respect of an individual, whereas HACC service providers are funded to provide services to a number of individuals.

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 both programs (HACC and CACP) have become increasingly important components of the aged care system. The total number of HACC hours delivered between 1995 and 1998 grew by 9 per cent, for example, while the total number of CACP recipients grew by approximately 300 per cent over the same period.

Community care services — funding and service delivery

The Commonwealth and State and Territory Governments jointly fund the HACC program. Total national expenditure on the program was $808 million in 1997-98; the Commonwealth Government funded approximately 60 per cent and the State and Territory Governments and local governments funded the remainder (table **10**.**13**).

The CACP program is funded by the Commonwealth Government, and expenditure was $84 million in 1997-98. Over the four years to 1997-98, CACP expenditure per person aged 70 years and over grew by approximately 330 per cent (table **10**.**14**).

The Commonwealth is responsible for planning, coordinating and implementing national CACP policies. The Commonwealth, State and Territory Governments and local governments share responsibility for the HACC program, which is mainly delivered by community organisations.

10.2 Policy developments in aged care services

Structural reform package

The Aged Care Structural Reform Package, announced in the Commonwealth's August 1996 Budget, introduced a range of new funding, regulatory and monitoring mechanisms (SCRCSSP 1998a). Three reviews of this package occurred in 1998:

- the Nursing Home Subsidy Inquiry, in which the Productivity Commission examined the current and alternative method for setting nursing home subsidy rates and assessed whether the subsidy coalescence proposed by the *Aged Care Structural Reform Package* should proceed (PC 1998);
- a review of the Resident Classification Scale (RCS), examining funding under the new scale, its adequacy in funding dementia care, and the clarity of guidelines; and
- the two year review of the Act: assessing aspects of the Aged Care Structural Reform Package (including its effect on State and Territory aged care services).

10.3 Framework of performance indicators

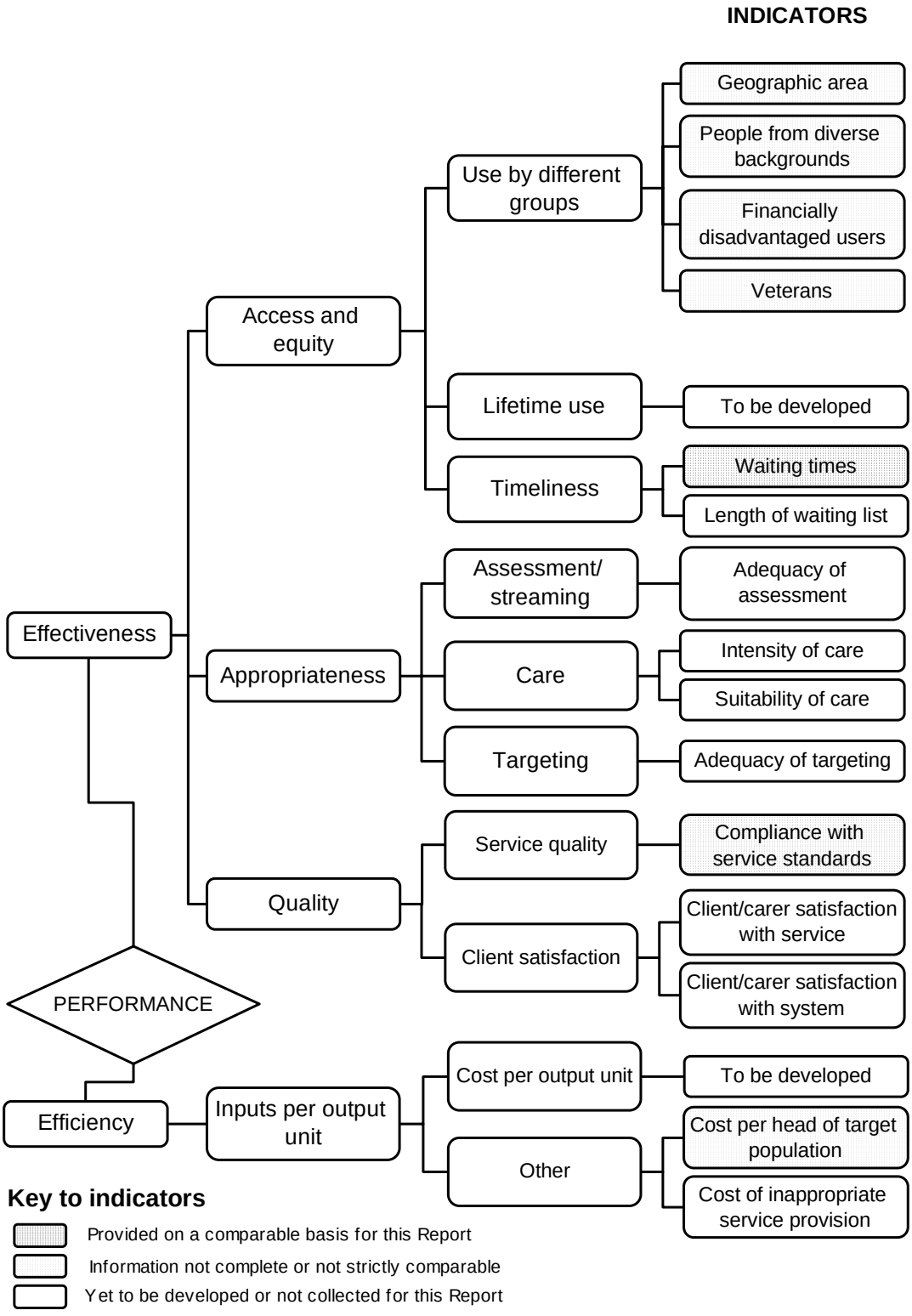
The aim of the indicators is to provide information on the efficiency and effectiveness of publicly funded aged care services. Effectiveness indicators focus on access to services and the appropriateness and quality of services. Efficiency indicators focus on the unit cost of providing a service (figure **10.6**). These indicators directly relate to the objectives of the aged care sector (box **10.5**).

Box 10.6 **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 provision of care services that are:

- accessible
- appropriate to needs
- high quality and
- cost effective.

Figure 10.7 **Performance indicators for aged care services**



New and refined indicators

Reporting for a number of indicators has been expanded or refined in this Report. However, performance information is still limited.

Access and equity indicators

Access to aged care services by special need groups (pensioners and concessional residents) is reported here for the first time.

Comparable waiting times data for all jurisdictions are also reported for the first time. Timeliness data in previous Reports have not been comparable because:

- data for only two jurisdictions were reported; and
- data were not presented in a comparable form.

10.4 Future directions

There are still several aspects of aged care services for which indicators are not fully developed and for which there is little performance reporting. Further development work is required to establish a full set of indicators.

Developing indicators and data

Appropriateness indicators

Further work is required to improve the definitions of the appropriateness indicators: adequacy of assessment, intensity and suitability of care and adequacy of targeting. A lack of data has also prevented progress in this area. However, two national HACC data developments — the HACC Minimum Data Set Project and the HACC National Service Standards Instrument — may provide useful data for these indicators in the future.

The HACC Minimum Data Set Project aims to provide a client centred data collection focusing on outputs and outcomes rather than process and inputs. The project will facilitate separate reporting of the three HACC client groups (frail older people, younger people with disabilities and carers), which is currently not possible. Consistent reporting by HACC funded agencies will allow more comprehensive and comparable reporting of the services both across jurisdictions and between community and residential services.

The HACC National Service Standards Instrument is designed to measure the extent to which agencies comply with national service standards. This instrument — developed in 1996-97 — will be the basis for monitoring, evaluating and reporting on the quality of HACC service provision. HACC officials approved national implementation of the instrument to commence in 1998; the data should be available for reporting in the 2001 Report. Data will facilitate the development of service quality indicators such as compliance with service standards.

Improving the treatment of superannuation

Next year's data collection will treat superannuation costs more consistently, in line with the Steering Committee's recommendations in *Superannuation in the Costing of Government Services* (SCRCSSP 1998a). This should improve the comparability and accuracy of cost information in future Reports.

10.5 Key performance indicator results

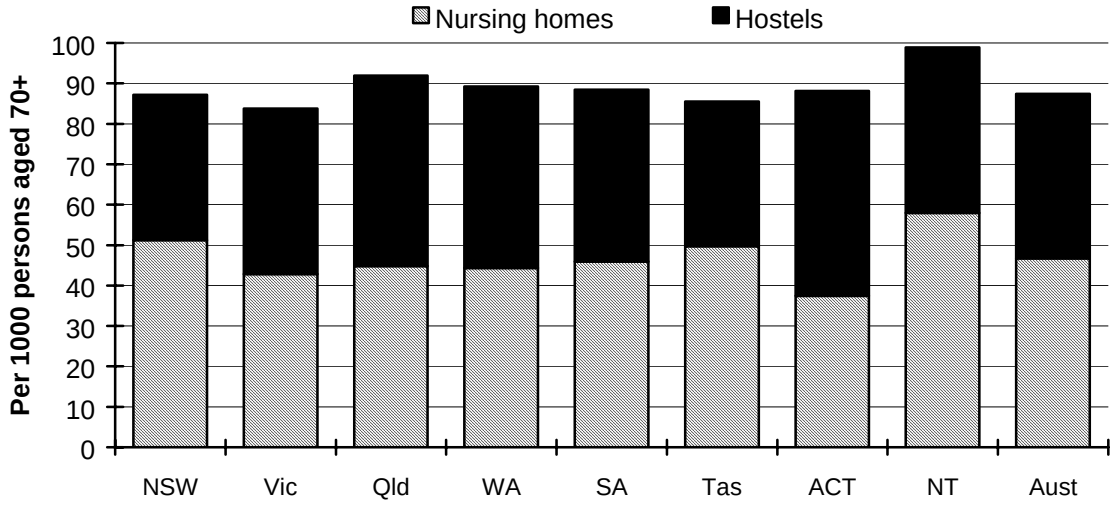
Appendix A contains detailed statistics and short profiles on each State and Territory, which may assist in interpreting the performance indicators presented in this chapter.

Access and equity — use by different groups

Residential services

The combined number of nursing home and hostel places per 1000 persons aged 70 years and over was reasonably similar across most jurisdictions in June 1998 (ranging from 83.7 in Victoria to 98.9 in the NT). The ACT had proportionally more hostel places and fewer nursing home places (57 per cent and 43 per cent respectively) than in other jurisdictions, and the NT had proportionally more nursing home places (59 per cent) (figure **10.8**). There was a general increase in the proportion of hostel places relative to nursing home places between 1988 and 1998 (table **10.15**).

Figure 10.9 **Residential places, June 1998**[a, b]



a Data for June 1988 were estimated. **b** Places do not include those places which have been 'approved in principle' but are not yet operational. If places 'approved-in-principle' were included, the overall ratio would be 97.8.

Data source: table **10**.**16**.

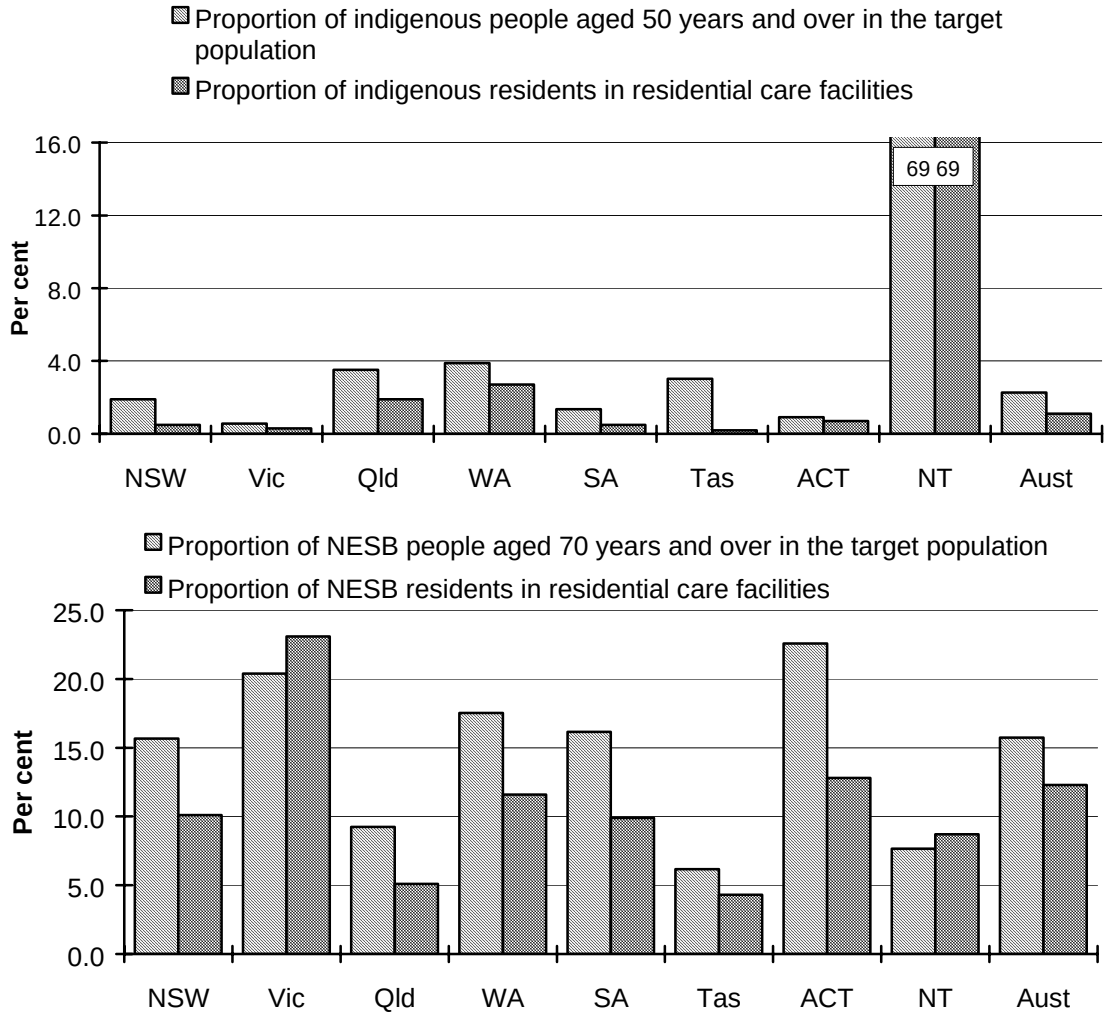
Three special need groups in the aged care sector are indigenous people, people from a non-English speaking background, and people with low incomes (pensioners).

A key national objective of the aged care system is to provide equal access to residential facilities for all people who require those services. One way of measuring accessibility is to compare the proportion of residents from a special need group with their representation in the target population (which is all people aged 70 years and over, plus indigenous people aged 50–69 years). However, factors such as cultural differences — which may influence the extent to which various special need groups use residential care services — should be considered when interpreting such results.

On average people from non-English speaking backgrounds were underrepresented in residential care facilities. Victoria and the NT were the only jurisdictions to report that the proportion of residents from non-English speaking background was above their population share of this target group (figure **10**.**10**).

Indigenous people tend to require aged care services at a younger age than the general population. Thus, participation for 1998 was based on indigenous people aged 50 years and over. On average, indigenous people were well represented in residential care facilities. The NT reported a proportion of indigenous residents that was higher than the indigenous share of the target population (figure **10**.**11**).

‘Figure 10.12 **Proportion of residential places used by special need groups, 1998**[a]



a The target population is indigenous people aged 50–69 years plus all people aged 70 years and over.

Data source: tables **10**.**17**.

Commonwealth planning guidelines require that 27 per cent of residential places, on average, be allocated to concessional residents. All jurisdictions exceeded this average, with the NT reporting the highest proportion of concessional residents (72 per cent) (table **10**.**18**).

Table 10.19 **Proportion residents classified as concessional or assisted residents, 1997 (per cent)[a, b]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Concessional residents	48	40	46	48	54	50	53	72	46

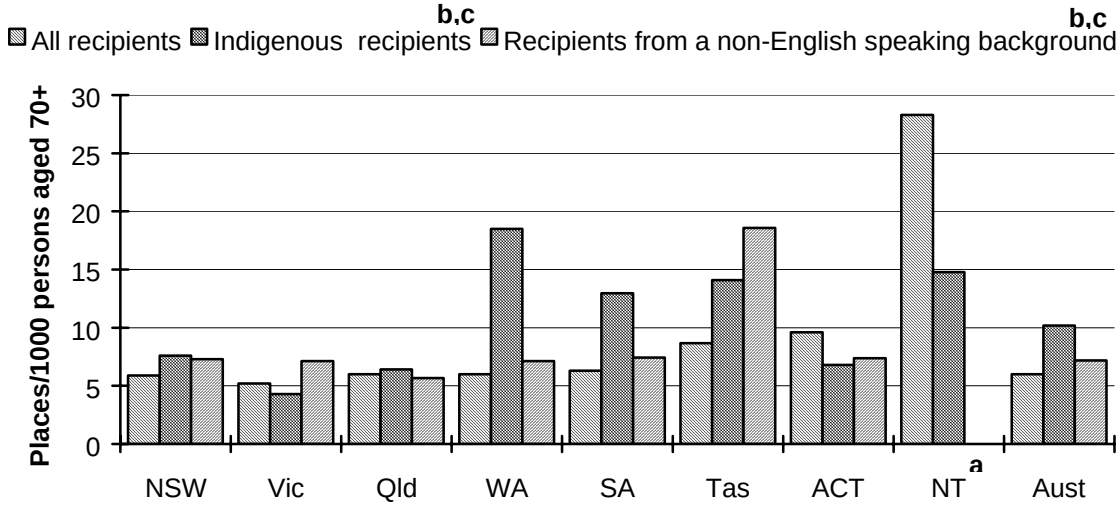
a Post-1 October 1997. **b** Concessional residents are those who, on entry to care, were in receipt of an income support payment, had not owned a home in the last 2 years, or whose home was occupied by a spouse or carer, and who had assets of less than $23 000. For married residents, half the couple's combined assets are counted. Assets include interest-free loans. Assisted residents have asset levels between $23 000 and $37 000.

Sources: tables **10**.**20**.

Community Aged Care Packages

The number of CACP places per 1000 persons aged 70 years and over has grown in recent years but still remains small relative to the number of residential places. The jurisdictions with smaller populations (the NT, the ACT and Tasmania) had the highest proportion of CACP places per person aged 70 years and over. WA, the NT, Tasmania and SA had the highest proportion of CACP places per indigenous person aged 50 years and over. Tasmania also had the highest proportion of CACP places per person aged 70 years and over from a non-English speaking background (figure **10**.**13**).

Figure 10.14 **CACP places, June 1998**



a There were no CACP recipients from a non-English speaking background. **b** Unknown responses were distributed pro-rata. **c** The 1996 population was taken from the census, while the 1995 and 1997 populations were estimated.

Data sources: tables **10**.**21** **10**.**22**, and **10**.**23**.

Home and Community Care program

The NT had the highest ratio of HACC service hours delivered per 1000 persons aged 70 years and over in remote areas, capital cities and all areas in 1997. Victoria reported the highest ratio of HACC service hours delivered per 1000 persons aged 70 years and over in rural areas (table **10**.**24**).

Table 10.25 **Estimated level of HACC services received per month per 1000 persons aged 70 years and over, by region, 1997** [a, b, c]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Total hours per month[d]									
Capital city	739	1 120	1 085	1 006	996	755	1 045	1 562	954
Other major urban areas	941	1 505	903	0	0	0	0	0	980
Rural areas	973	1 626	1 227	1 308	838	907	0	0	1 194
Remote areas	1 989	2 292	2 554	2 051	1 236	541	0	2 761	2 058
All areas	845	1 276	1 100	1 101	965	842	1 048	1 965	1 037
Total meals per month[e]									
Capital city	386	567	605	661	489	375	286	649	503
Other major urban areas	414	544	518	0	0	0	0	0	474
Rural areas	544	643	605	630	739	552	0	0	602
Remote areas	926	558	1 741	1 896	916	0	0	4 324	1 482
All areas	440	587	600	694	557	476	287	2 203	541

[a] Estimates based on the proportion of people aged 70 years and over receiving HACC services in each jurisdiction. [b] Data were taken from November 1994, 1995 and 1996, except for WA (where all data were from September 1993 only), the ACT (where 1994 data were from May 1995) and the NT (where 1995 data were from May 1996). [c] There is some overlap between jurisdictions in the definitions of home help, personal care, home nursing and paramedical services. [d] Includes home help, personal care, home nursing, paramedical care, respite care, centre day care, home maintenance. [e] Includes home meals and centre meals.

Sources: tables 10A.18, **10**.**26**, **10**.**27**, **10**.**28**, and **10**.**29**.

Access and equity — timeliness

Waiting times

Waiting times partly reflect the extent to which aged care services meet the demand for residential services, but they may also reflect applicants' willingness to wait for particular residential services (box 10.4). This Report contains consistent national data on this aspect of services for the first time.

Box 10.7 **Waiting time indicators**

Broadly, a 'waiting time' indicator measures the time between application for a service and receipt of that service. A robust and comparable 'waiting time' indicator requires consistent definitions of when the waiting time starts and finishes.

The indicator reported in this chapter has been calculated from the following definitions:

- beginning of 'waiting time' — the approval date of an ACAT assessment; and
- end of 'waiting time' — when a person is placed in a service.

Choosing the relevant point in time is partly subjective and partly determined by data availability. The end of a waiting time, for example, could be based on when a person first receives a placement offer. The indicator reported here does not account for the time that people wait for an assessment.

'Waiting time' indicators need to be interpreted with care because a range of factors may influence jurisdictional variations, such as:

- non-acceptance of residential placement offers;
- intensity and frequency of waiting list reviews;
- availability of community support services;
- hospital discharge policies and practices;
- variations in ACAT assessments;
- time delays between the physical ACAT assessment and approval of the assessment; and
- priority allocations.

People waited (between assessment and placement) an average 31 days for a nursing home place in 1996-97. Ninety-two per cent of people waiting for a nursing home place were placed within 90 days of being assessed. Seventy-nine per cent of people in NSW were placed within 30 days, compared with 46 per cent in the NT (table **10.30**).

Table 10.31 **Waiting times — permanent nursing home residents, 1996-97**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Proportion of residents placed in under										
– 2 days	%	34	14	22	24	25	25	16	13	25
– 30 days	%	79	66	78	74	72	64	52	46	74
– 60 days	%	88	81	90	87	87	81	76	58	86
– 90 days	%	93	88	96	92	92	88	86	75	92
– 120 days	%	95	92	97	94	94	91	89	79	94
Average wait	days	26	41	22	31	32	42	57	82	31

Source: table **10.32**.

People waiting for hostel places waited 108 days on average — over three times longer than people waiting for nursing home places. Eighty-six per cent of people in the NT waiting for hostel places were placed within 90 days, compared with 49 per cent in the ACT (table **10**.**33**).

Table 10.34 **Waiting times — permanent hostel residents, 1996-97**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Proportion of residents placed in under										
– 2 days	%	9	9	10	7	6	12	4	16	9
– 30 days	%	52	49	39	50	43	43	24	58	47
– 60 days	%	66	64	54	66	56	57	40	79	61
– 90 days	%	73	72	61	75	64	63	49	86	69
– 120 days	%	77	77	67	80	71	73	61	86	75
Average wait	days	94	98	145	91	123	103	146	58	108

Source: table **10**.**35**.

Quality — client satisfaction

Client satisfaction with residential care

Complaints data indicate, to some extent, client satisfaction with service quality. Data collected from the residential care complaints program are reported against four main standards: management systems, staffing and organisational development; health and personal care; resident's lifestyle; and physical environment and safety of systems. These data record both the number of people complaining and the number of complaint issues.

The residential care complaints program is at a relatively early stage, and changes in data over time may not indicate declining quality. An increase in complaints may simply reflect greater preparedness to complain, more awareness of the rights and avenues of complaint, and/or a reduced fear of consequences.

The number of complaints registered per 1000 residents ranged from 5.6 in NSW to 32 in the NT. On average, residents or guardians complained about two or more issues except in the NT.

Nationally, approximately 80 per cent of complaint issues were resolved by the end of 1997-98. (table **10**.**36**)

Table 10.37 **Residential care complaints per 1000 residents, 1997-98[a]**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Total complaints received	**No.**	264	546	212	130	92	42	20	11	1317
Complaints	per 1000 residents	5.6	16.9	8.7	11.6	7.1	11.5	14.7	32.0	9.8
Issues raised	per 1000 residents	6.7	37.4	17.4	21.8	15.0	29.0	33.0	32.0	19.1
Issues resolved	%	84	81	79	79	78	61	76	27	79
Issues unresolved	%	1	5	5	5	13	8	0	73	6
Issues unfinalised at 30 June 1998[b]	%	15	14	16	16	9	31	24	0	15

a Complaints received by Commonwealth Department's State offices between 1 October 1997 and 30 June 1998. **b** As at 30 June 1998.

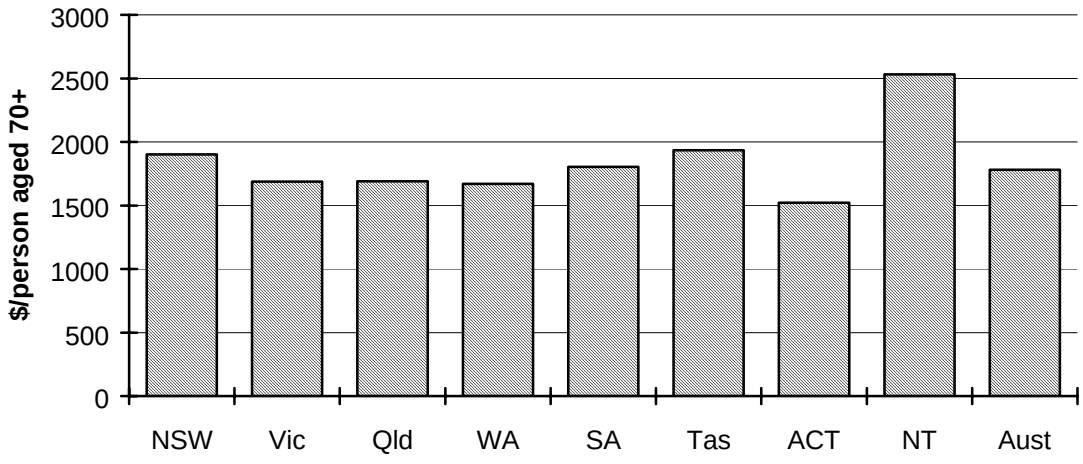
Source: table **10**.**38**.

Efficiency

This Report provides information on expenditure per person on the main types of aged care services. A proxy indicator of efficiency is government inputs (expenditure) per person aged 70 years and over.

Expenditure on residential care services per person aged 70 and over varied across jurisdictions in 1997-98, ranging from $2530 in the NT to $1522 in the ACT (figure 10.7).

Figure 10.15 **Commonwealth Government expenditure on residential services, 1997-98[a, b]**

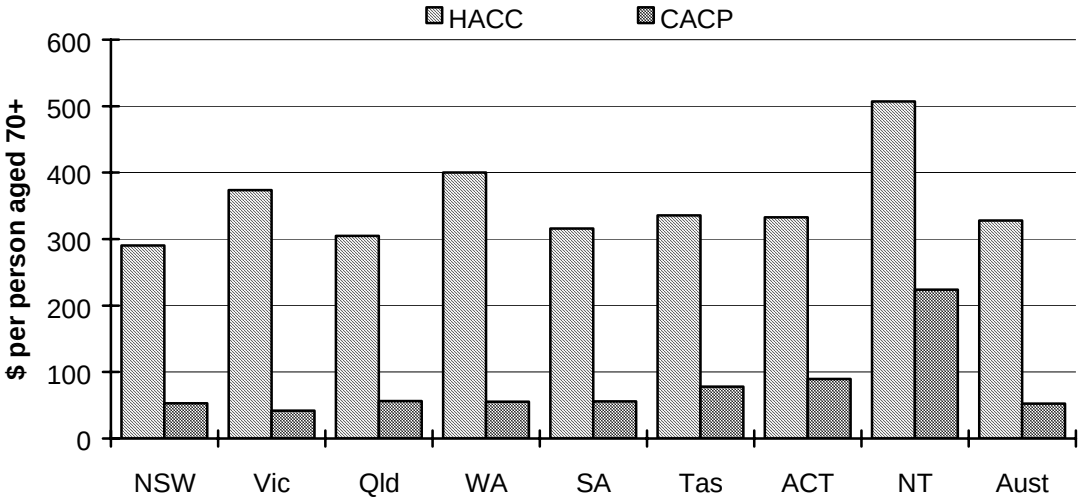


a Expenditure Includes: expenditure on nursing home benefits, hostel subsidies and residential respite. **b** Expenditure data do not include funding from the Department of Veterans' Affairs ($150 million in 1997-98).

Data source: table **10**.**39**

Both the CACP expenditure and estimated annual HACC expenditure per person aged 70 years and over varied across jurisdictions in 1997-98. The NT reported the highest HACC and CACP expenditure per person aged 70 years and over ($507 and $224 respectively). NSW reported the lowest HACC expenditure ($291 per person) and Victoria reported the lowest CACP expenditure ($42 per person) (figure **10.16**).

Figure 10.17 **Expenditure on HACC and CACP services, 1997–98[a]**



a HACC expenditure includes combined Commonwealth/State expenditure, except Commonwealth National Respite for Carers (NRCP), (which was Commonwealth Government expenditure only).

Data sources: tables **10.40** and **10.41**.

10.6 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this chapter. 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. The information covers aspects such as: age profile; geographic distribution of the population; income levels; education levels; tenure of dwellings; and cultural heritage (such as aboriginality and ethnicity).

Commonwealth Government comments

“ The Commonwealth has a substantial commitment to aged care in Australia, with responsibility for funding and managing the residential aged care program and jointly funding and managing the Home and Community Care Program with States and Territories. Total Commonwealth funding on aged care is expected to reach $3.8 billion in 1998-99. This will continue to increase in line with growth in the aged population, which is growing at a much faster rate than the population in general. For example, over the next 10 years the over 70 population will grow 2.1 times faster than the total population and the over 80 population will grow 4.2 times faster.

The development of national performance indicators and comparison of services across jurisdictions are strongly supported by the Commonwealth. The present data collections provide a range of useful indicators of comparative performance across States and Territories and at a national level, but more work is required to improve data integration, coverage, consistency and use.

The continued implementation of structural reforms has provided additional data on services received by pensioners, veterans and war widows, and financially disadvantaged ‘concessional residents’, as well as information on improved care standards and building quality.

Four data development activities in 1998-99 are of note:

- annual reporting to Parliament on the implementation of the *Aged Care Act* will report on an expanded range of data items; the first report is expected to be tabled in early 1999;
- discussions are underway within the National Community Services Information Management Group to establish an Aged Care Data Working Group to focus on data collected in residential aged care and Aged Care Assessment Teams;
- the HACC Minimum Data Set was accepted by HACC Officials in May 1998 and a technology review is being undertaken to see how the MDS can be implemented, with a proposed implementation date of July 1999; and
- HACC is working on a community care classification system to assess the care needs of individuals. ”

New South Wales Government comments

“ The NSW Government has a broad and holistic view of ageing, which is reflected in its approach to service provision and planning for older people.

The NSW Government has recently launched its whole-of-government NSW Healthy Ageing Framework, which seeks, among other things, to address the linkages between service systems which older people use. The five year Framework is based on the belief that all older people have the right to lead satisfying and productive lives with maximum independence and wellbeing. The strategies outlined in the framework address a range of issues, and are based around the following key objectives: improving community attitudes to ageing and older people; participation in community life; information and informed decision making; accessible and supportive neighbourhoods and communities; independence, wellbeing and health of older people; and making the best use of resources. Aged care is considered within this broader context, and improvements to the broader service systems will also improve the care and wellbeing of frail older people.

The framework builds on the innovative policy and program activities which the Government has been involved in over the last few years, including the Community Care Demonstration Projects, which seek to integrate community care services; the Transport Demonstration Projects, which have improved access to transport for frail older people and people with disabilities in 23 local communities; the NSW Action Plan on Dementia, which has funded a range of initiatives aimed to improve the accommodation, care and treatment for people with dementia and their carers; and Prevention of Elder Abuse initiatives, in which all areas across NSW have been trained in elder abuse and have in place local inter-agency protocols to improve the management of abuse cases. In addition, the NSW Government has developed the Population Group Planning resource allocation model, which plans for whole-of-life needs of the population groups of older people, people with disabilities and their carers, rather than around programs.

The ability to deliver improved HACC services has been hampered by the Commonwealth’s limited funding offers, due to the Commonwealth’s decision to base funding offers on the States’ fees policies in 1996. The NSW Government has taken the view it is unreasonable for the Commonwealth to shift funding responsibility from Governments to frail older people and people with disabilities. Despite these funding issues, the 1996 User Characteristics demonstrate increased numbers of older people receiving HACC services. ”

Victorian Government comments

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The Victorian Government is continuing to develop a comprehensive and accessible aged care system. In the past twelve months, attention has concentrated on the following: reforming the State’s purchasing policy in aged care; reducing the size of the State-managed residential care sector to redistribute and upgrade services through increased participation by the private and non-profit sectors; planning for a more extensive and equitable distribution of sub-acute services for older people; and setting up pilot projects to bring together a range of non-institutional health and community services, so as to improve continuity of care from the consumer’s point of view.

Figures in this chapter show that Victoria’s aged care system has some distinctive features, some positive and some negative: the state appears to have a high proportion of small sized residential services, and the overall amount of residential care is lower than Other states, while the provision of community care is much higher than average. If comparative data on access to sub-acute care for older people were available, they would be expected to show the positive effects of Victoria’s concentration on developing this field.

Victorian purchasing policy for Home and Community Care Services is in the midst of a transition to output based funding. This will have the effect of clarifying the resources devoted to a given product mix at the local level; it is also expected to lead to a significant improvement in data quality as providers become more conscious of the importance of accurately measuring outputs.

Victoria’s strategy to improve primary health and community services (PHACS) through pilot projects will integrate intake and assessment functions across HACC and other aged care services. The result will be to streamline and simplify this process for both the users and deliverers of services. Partners in the pilot projects are being encouraged to integrate their client data management systems in the interest of greater continuity of care.

As the figures in this report demonstrate, Victoria has sustained a very high proportion of State sector ownership of nursing homes. To upgrade these services, redistribute services which are in excess supply, identify areas of need and develop a system of care for particular needs, State sector beds which are no longer central to the health status of older Victorians are being transferred to the private and non-government sectors. Hostels have now been included in the transfer. Stage 3 of the transfer project has now commenced and will involve the transfer of a further 800 beds.

Our commitment to the expansion of Multi Purpose Services has been crucial in maintaining the viability of aged care services in smaller rural settings.

We look forward to continuing collaboration on the production of these comparative indicators.

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Queensland Government comments

“Since this chapter was first included in the 1997 Report, there have been major changes in Commonwealth residential aged care policy and financing, and further reforms in other areas are under consideration. States have responded to these changes in various ways. Queensland continues to affirm its status as a provider of residential aged care, and its role in strategic policy, funding, purchasing and delivery of other aged care services.

In future years, major developments in services for older people are likely to relate to healthy ageing, with emphasis on prevention of illness and injury and minimisation of its impact through improved primary and acute care. Much of this work is beyond the scope of this chapter as it is currently defined, though in time the outcomes of such initiatives would be expected to be reflected in a decrease in demand for support services.

Care will be required to ensure that the aged care chapter, and the Report as a whole, move to reflect the increasing emphasis on outcomes in government and non-government activities. Residential and nonresidential support services and assessment represent one part of a spectrum of government activities relating to the health and wellbeing of older people. While they account for substantial government expenditure, they represent only a fraction of the government expenditure on acute hospital, medical, pharmaceutical and other health services for older people.

Queensland continues to develop a broad approach which will address the health needs of older people across the spectrum of services, focusing both on improved preventive, treatment and support services for older people, and on coordination across the broader sphere of government and non-government activities which affect the health and wellbeing of older people.

The inclusion of aged care in this report has provided an opportunity to compare services across jurisdictions, and to examine the roles of individual jurisdictions and of the Commonwealth in different jurisdictions. This has proved valuable in identifying variations, and in focusing on issues of equity and efficiency

Queensland is hopeful that funding equity issues explored by the Commission will be resolved, and that additional Commonwealth resources will be available to support nursing home service provision and development in Queensland.

It is now time to consider taking a broader approach, focusing on outcomes for older people and encompassing not only the outcomes of aged care, but aged care as an outcome of other government programs and services.”

Western Australian Government comments

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The Western Australian Government gives high priority to the support and development of an aged care system which provides older people with the necessary balance of care services regardless of the part of the State in which they live.

Growth of the State’s elderly population is approximately twice the State's overall rate of population growth. As a result there is increasing demand across all areas of aged care services.

As the State’s population ages, the incidence of age related disabling disease, including stroke, hip and other bone factures, and dementia, increases. Older people with these conditions typically have a relatively high need for government funded aged care services.

There is increasing demand for home care services as a substitute for nursing home or hostel care. This trend is expected to continue, which will place greater demands on the Home and Community Care program, particularly in regard to respite care services and carer support

In addition to analysing trends in the need for aged care services, the Health Department consults widely in its year-by-year planning and setting of aged care service priorities. These consultations have identified high priority needs for increased home care services in regard to respite, dementia care and support, carer support, and transport.

As well, the Health Department has established special initiatives in community based rehabilitation, improved hospital discharge planning for older people and community based psychogeriatric services.

Also, the restructuring of State Government nursing home services is enabling the transfer of beds from State Government nursing homes in metropolitan areas, where there are relative surpluses of beds, to other metropolitan and country areas where there is a relative shortage of nursing home beds because of growth in the elderly population. This action is significantly improving access to nursing home services in the State.

A significant number of State Government nursing home beds have been converted to funding for multipurpose services in small rural centres. This has enabled these small rural communities to develop and maintain a more flexible mix of aged care services for their local community.

As well, the State Government is sponsoring the redevelopment and refurbishment of a number of its larger country nursing homes which will substantially improve the quality of existing State Government nursing home facilities and services in these rural areas.

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South Australian Government comments

“In October 1997, the newly re-elected SA Government announced the formation of a new Department of Human Services, combining the former health, housing and community services portfolios. The new Department signalled a desire on the part of the Government to improve the integration and flexibility of human services provision in SA.

Aged care has developed as a shared responsibility between the Commonwealth Government, the State and Territory Governments and numerous local governments, the private sector and not-for-profit providers. Further, the outcomes for older people using aged care are integrally linked with the performance of other related sectors, such as housing, health and transport.

It is these relationships which the SA Government has focused upon in the formation of the new Department, and in the development of one of its major initiatives, an integrated human services strategic plan for older people. The planning process, which is known as *Moving Ahead*, involves all the major stakeholders in trying to achieve a more responsive system for older people.

The draft plan addresses service design, access, funding, quality and partnerships. It includes strategies for more seamless relationships from a user point of view between the acute and post acute care sectors, and between the various providers of aged care services. There is also new recognition of the possibilities which prevention, rehabilitation and early intervention strategies may offer older people not only in reducing illness but also in maximising quality of life. The plan aims to identify ways in which these approaches may be funded and delivered more systematically.

This Report offers considerable potential for the development of national benchmarks, although this potential continues to be limited by the lack of useable client and service data in the community care sector and of funding information across the spectrum of services.

SA continues to suffer a funding disadvantage in aged care, both as a result of the Commonwealth funding formula for aged care and because the target date for achieving equity of funding between the States for the Home and Community Care (HACC) Program is still some years away.

The SA Government has nevertheless welcomed the Commonwealth’s continuing commitment to this Report, as well as its partnership (with other funder, provider, consumer and carer stakeholders) in the *Moving Ahead* process.”

Tasmanian Government comments

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Tasmania values the contribution of older people within our community and strives to achieve quality, accessible, coordinated service delivery, within a climate of decreasing financial resources and increasing human need. The Department has adopted a whole-of-government approach in the form of developing a Healthy Ageing Plan and a Statewide Health and Wellbeing Survey to assist in planning for future service delivery.

The key issues for Tasmania are the provision of services to rural and remote areas of the State and the need to provide a range of flexible services to the increasing ageing population.

In comparison with other States and Territories, Tasmania has a very dispersed population, with the lowest proportion of people living within the capital city. The number of older people living within these dispersed centres is increasing, thus providing the challenge to deliver accessible services across the State. To assist addressing equity and access issues that exist in rural and remote areas, the Department has established a Rural Health Unit which aims to provide a strategic, coordinated approach to service delivery across these localities.

The shift away from residential care to receiving care and support within the older person’s own home has resulted in the expansion of community based services. Given these factors, there is increased pressure on the community sector. The Home and Community Care (HACC) program in particular has responded by adopting improved targeting of services as a major initiative for the next financial year. The Tasmanian Government funds a wide range of programs with a primary focus on providing services to older people, and particularly to older people with multiple care needs. These programs include generic community support services, rehabilitation and therapy, psychogeriatric care and residential facilities. Tasmania is also participating in the national Coordinated Care Trials, through the Careworks project.

To achieve optimum client outcomes, the Tasmanian Government consults with the community and works closely with the non-government sector to inform planning processes for future service delivery.

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Australian Capital Territory Government comments

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The ACT Government values the contribution made by older citizens to the richness, diversity and wellbeing of the community.

Expenditure by the ACT Government and Commonwealth Government on aged care services in the ACT is $18.9 million (1998-99). Expenditure by the ACT Government on aged care concessions (for example, public transport, water and sewerage) is $12.8 million (1998-99).

The ACT population is ageing at almost twice the national average. Between the years 1997 and 2011, the ACT's population is predicted to rise by 38 300 – an increase of 12.4 per cent. The proportion of people aged 65 years or more will increase from 7.3 per cent of the population in 1997 to 10.2 per cent in the year 2011.

Work has commenced on developing an Aged Care Services Strategic Plan for the ACT. The plan will address, among other things, the need for the improved planning and coordination of services across the range of consumer need. The plan will also address the important issue of elder abuse. A separate but related strategy on detecting and preventing abuse is being developed.

The ACT Government is planning to review the current Three Year Plan for Older People in the ACT and to launch a new plan during the International Year of Older Persons.

The Minister for Health and Community Care has agreed to the restructuring of some Ministerial advisory councils. This will give the Minister more focused advice on issues of aged care and aged care services. It will also give older people more capacity to influence the development of aged care services.

The ACT Department of Health and Community Care and the ACT Office of the Commonwealth Department of Health and Aged Care have agreed to explore options for establishing a joint services development framework to assist the planning and development of services for the aged. It is anticipated that progress on this will be made in the early part of 1999.

Other initiatives which will improve the quality of life of older people include the current review of special needs transport and the associated objective of making transport more accessible to older people.

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Northern Territory Government comments

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The NT has diverse regional, cultural and economic characteristics which pose many challenges for the NT Government in providing effective services to the aged population. Issues such as remoteness and the young age structure, part of which is attributed to a higher than average proportion of Aboriginal and Torres Strait Islander people in the population (28 per cent compared with 2.0 per cent for the rest of Australia — as sourced from ABS 1997 data), require the development of flexible and innovative approaches to service delivery.

The NT has the most rapidly increasing aged population of any jurisdiction. For example, over the next 20 years, the number of people aged 65 years and over will increase from 6 000 to approximately 18 000 (or 6.2 per cent of the total population).

The population of the NT is distributed over a large land area, with 27 per cent of the population living in rural and remote areas compared with 12 per cent in NSW and Victoria. (ABS 1997, Australian demographic statistics). Many of the remote Aboriginal communities have populations ranging between 100 and 1000 people and are often comprised of small family groups. With the high degree of mobility between communities, it is difficult to provide mainstream services.

The national benchmark adopted by the Commonwealth when allocating aged care places (nursing home, hostel and community aged care packages) for people in Australia is 70 years and over. However, recognising the unique population within the NT (specifically the Aboriginal people living in many remote communities), the reduced life expectancy and higher rates of illness and frailty, often requires the provision of aged care services at a young age. The Commonwealth Government has acknowledged that an age limit of 50 years and over should be used in the planning services for Aboriginal people. This has assisted in the planning of aged care services across the NT. However, issues such as the cost of service delivery and lack of infrastructure in remote communities inhibit appropriate planning for care. This can also lead to the separation of families from their aged people because communities are unable to provide appropriate services.

The NT has a total of 73 recurrently funded HACC services of which 67 per cent are located outside the two major centres of Darwin and Alice Springs. National figures clearly indicate that the frail aged are the prime target group for the HACC program. It is interesting to note when analysing NT figures that this jurisdiction has a higher percentage of younger people accessing HACC services compared with the frail aged.

The challenge for the NT Government is the development of a strategic and innovative approach to service delivery, based on the belief that older people should have the same access as other people in the community to community services. An Aged Care Strategy is currently being developed which will encourage the preservation of independent lifestyle where possible, and raise the standards of community and residential care options. The strategy will also provide people with meaningful choices which recognise and respond to cultural, locational and socioeconomic differences.

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