11 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. Although the distinction between nursing homes and hostels has relaxed, nursing homes typically provide services for residents with high care nursing needs while hostels generally focus on care for residents with low care needs;
- community services — Home and Community Care program services, which incorporate Community Options Projects and Community Care Packages and support for veterans;
- respite services — Home and Community Care respite and centre day care and the Commonwealth National Respite for Carers program; and
- assessment services — services provided by Aged Care Assessment Teams.

A profile of aged care services is in section 11.1, followed by a brief discussion of recent policy developments in section 11.2. Together these provide a context for assessing the performance indicators presented later in the chapter. 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 11.3 and data are discussed in section 11.4. Future directions in performance reporting are discussed in section 11.5.

Three appropriateness of care indicators are reported for the first time this year. These are: recommended longer term living arrangements of Aged Care Assessment Teams clients; the number of nursing home-type patients in public hospitals; and length of stay for hostel and nursing home clients.

Box 11.1 **1999 – United Nations International Year of Older Persons**

The aims of declaring the International Year of Older Persons were to:

- increase awareness of the world's ageing population;
- recognise the roles older people play in all walks of life; and
- appreciate the need for intergenerational respect and support.

Each jurisdiction arranged activities and implemented programs around the theme.

One major initiative was the announcement that a National Strategy for an Ageing Australia would be developed. The initiative included the publication of discussion papers on the four key themes of the National Strategy: Independence and Self-Provision; Health Ageing; World Class Care; and Attitude, Lifestyle and Community Support. The papers were:

- *Background Paper* (April 1999) — outlined the scope of the work being undertaken on the four themes and the context of Australia's ageing population (Bishop 1999a);
- *Healthy Ageing* (October 1999) — examined how best to improve the physical, emotional and mental wellbeing of older people (Bishop 1999b);
- *Independence and Self-Provision* (November 1999) — examined the future sustainability of the age pension and discussed the choices and responsibilities confronting individuals in saving for retirement (Bishop 1999c); and
- *Employment for Mature Age Workers Issues Paper* (November 1999) — examined the value of mature age workers and the potential for further economic growth that can be produced by a larger cohort of mature age workers (Bishop 1999d).

Papers on World Class Care and Attitude, Lifestyle and Community Support are expected to be released in 2000.

The Productivity Commission, in conjunction with the Melbourne Institute of Applied Social and Economic Research, held a conference on the policy implications of the ageing of Australia's population (PCMI 1999). There were also joint Commonwealth/State initiatives throughout the year: for example, NSW's Ageing and Disability Department, in conjunction with the Commonwealth Department of Health and Aged Care, organised a 'Meeting of Generations' conference in 1999 to discuss the positive lessons learned so far, aspirations for the next century and means of achieving these. The Victorian Department of Human Services organised a major newspaper supplement on International Year of Older Persons, and distributed $2 million of grants for community projects on the theme 'Positive Wellbeing for Older People'.

Frail older people also use many other mainstream health and community services. Other chapters cover outcomes for older people of some of these services — that is, acute health care services for older people in chapter 4 and housing services for older people in chapter 15. There are interactions between these service areas; for

example, the number of residential places may affect demand for public hospital beds.

International Year of Older Persons

1999 was the International Year of Older Persons with the theme 'Towards a Society for All Ages' (box 11.1).

11.1 Profile of aged care services

This chapter focuses on residential and community care services for older people. These services are provided on the basis of the frailty or incapacity of the recipients rather than specific age criteria. 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, certain groups (notably Indigenous Australians) may require various services at a younger age on average than the general population. In addition, some aged care services are designed for the carers of older people.

Government funded aged care services covered in this Report relate to the three levels of government involved in 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.

Size and growth of the older population

The distribution of aged persons varied across jurisdictions in 1998 with relatively more older people in SA and Tasmania and relatively fewer in the NT (figure 11.1). The proportion of older females was higher than that of older males in all jurisdictions, as has been the historical trend.

Demographic profiles affect the demand for aged care services because females use aged care services, particularly residential services, more than males (table 11.1) — for example, 72.5 per cent of aged care residents at June 1999 were female (DHAC, unpublished data). 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. Additional factors are the greater incidences of incontinence, hip fractures and financial disadvantage among women.

Figure 11.1 **Males and females aged 70 years and over as a proportion of the total population, June 1998**

Source: table 11A.1.

Table 11.1 **Probability of future nursing home and hostel use, by gender and age, 1994-95**

	Age (years)							
	0	*65*	*70*	*75*	*80*	*85*	*90*	*95*
Nursing homes (permanent care)								
Males	0.20	0.25	0.28	0.32	0.39	0.48	0.56	0.60
Females	0.34	0.39	0.42	0.48	0.59	0.76	0.95	0.94
Persons	0.27	0.33	0.36	0.41	0.51	0.66	0.83	0.85
Hostels (permanent care)								
Males	0.09	0.12	0.14	0.17	0.22	0.31	0.39	0.38
Females	0.22	0.26	0.29	0.34	0.45	0.57	0.60	0.43
Persons	0.16	0.20	0.22	0.27	0.35	0.48	0.54	0.42

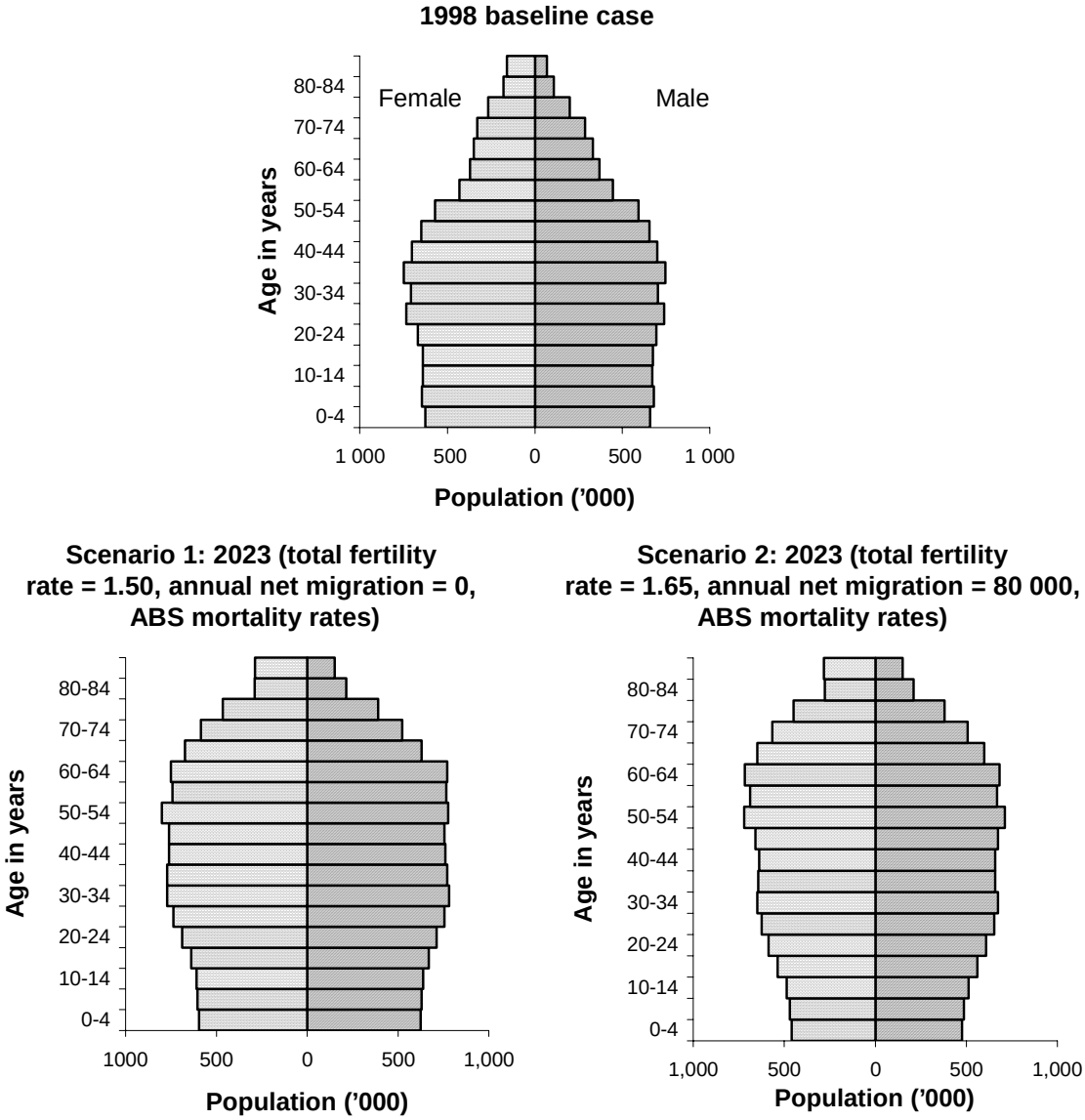
Source: table 11A.2.

The Australian population is ageing (as indicated by an increase in the proportion of older age groups in the total population). This trend is expected to continue and there is a general consensus that the proportion of older people will increase dramatically in the next century.

McDonald and Kippen (1999) estimated future population profiles using a number of plausible scenarios based on birth rates, net migration and mortality. All

scenarios examined suggested a significant increase in the number of older persons (particularly females aged 85 and over) will occur within three decades (figure 11.2). Such changes to Australia's demographic profile will influence the future care needs of older persons and the type of services required, and will have implications for the planning and financing of health services and long term care.

Figure 11.2 **Selected population pyramids, Australia, 1998–2023**



Source: McDonald and Kippen (1999); ABS (*Population by Age and Sex*, Cat. no. 3201.0).

Policy development needs to acknowledge the changing characteristics of the population. Those concerned with future delivery of services will need to consider issues such as the challenge of making the staffing of residential services responsive to the different needs of clients. Immigration policy will affect the size of the labour force which provides for older persons on pensions and those receiving government

subsidised services. Other policies that may affect the size of the labour force through influences on birth rates include those relating to child care and health services for mothers.

Aged care programs

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

Residential care services

The basis for reporting on residential care services has been revised since the 1999 report to take into consideration changes in the legal and pragmatic distinction between nursing homes and hostels (box 11.2).

Box 11.2 **Changes to the reporting of residential care services**

Before 1997, residential aged care services were called either 'nursing homes' or 'hostels', providing 24 hour nursing care or personal care services respectively. The *Aged Care Act 1997* removed the legal distinction between these kinds of services as part of the reforms to residential aged care. Services then became 'high care' or 'low care' services, which roughly equated with nursing homes and hostels. The practical distinction between former kinds of services was also blurred significantly as a result of service providers opting to provide for 'ageing in place' of their residents. Further, a number of services have added allocations of either high care places to a former hostel or low care places to a former nursing home, and/or sought approval to alter the mix of care provided by the service.

In recognition of these changes and the expected growth in the number of services offering both high and low care in the same service, this Report will focus on three types of residential aged care services, based on the types of residents in the service. One group of services — high care — primarily meets the needs of high care residents and has over 80 per cent of residents classified as Resident Classification Scale (RCS) 1–4. A second group of services — low care — primarily meets the needs of low care residents and has over 80 per cent of residents classified as RCS 5–8. The third group of services — mixed — meets the needs of both high and low care residents. The number of mixed services is expected to increase over time due to ageing in place, to the combination of co-located former nursing homes and hostels, and to an increasing number of new services designed to cater to the needs of a wide variety of residents.

The size and location of residential services — which may influence costs of delivery — vary across jurisdictions. Nationally, there were approximately 140 916 places (permanent and respite) in residential care facilities (72 335 in nursing homes

and 63 644 in hostels) at October 1999 (table 11.2). As the trend towards 'ageing in place' develops, one may expect an increase in the number of hostels categorised as 80 per cent high care services — that is, initially low level care residents in hostels will continue their stay even as their dependency levels rise over time.

Table 11.2 **Residential services and places, October 1999**

Type	*80% high care*[a]	*Mixed*	*80% low care*[b]	***Total***
Nursing Homes				
Services	1 395	23	0	**1 418**
Places	71 398	937	0	**72 335**
Hostels				
Services	12	455	1 021	**1 488**
Places	310	19 910	43 424	**63 644**
New services[c]				
Services	32	40	42	**114**
Places	1 223	2 011	1 703	**4 937**

[a] 80 per cent high care service refers to a service where 80 per cent or more of the residents are high care (RCS 1–4). [b] 80 per cent low care service refers to a service where 80 per cent or more of the residents are low care (RCS 5–8). [c] New services on payment system since 1 October 1997, when residential services ceased to be classified as either nursing homes or hostels.

Source: DHAC (1999).

The highest proportions of nursing home places in rural areas were in Tasmania and Queensland, while the NT (49.2 per cent) and WA (3.8 per cent) had the highest proportions in remote areas (table 11.3). 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 11A.6). Tasmania, for example, had both the highest proportion of nursing home places in rural areas (55.2 per cent) at June 1999 and the highest proportion of people aged 70 years and over living in rural areas (57.2 per cent) (table 11A.6).

Low care services were generally smaller (by number of places) than high care at June 1999. Nationally 84 per cent of low care services had 60 places or fewer (table 11.4), compared with 76 per cent of high care services (table 11.3).

Table 11.3 **Size and distribution of services with over 80 per cent high care residents, June 1999**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Services	no.	478	431	207	111	149	47	7	6	1 436
Places	no.	28 610	17 063	11 990	5 756	6 615	2 095	614	193	72 936
Occupancy rate[a]	%	98.0	96.1	96.5	97.5	98.9	97.6	95.0	98.1	97.3
Places by locality										
Metropolitan	%	80.4	73.6	63.4	82.2	86.8	44.8	100.0	50.8	75.8
Rural	%	19.4	26.3	34.5	14.0	13.2	55.2	0.0	0.0	23.3
Remote	%	0.2	0.1	2.2	3.8	0.0	0.0	0.0	49.2	0.9
Service size										
1–20 places	%	2.7	12.8	4.3	1.8	1.3	8.5	0.0	33.3	6.1
21–40 places	%	26.4	56.4	39.1	38.7	55.0	46.8	0.0	33.3	41.7
41–60 places	%	32.2	21.8	22.2	39.6	31.5	29.8	28.6	33.3	28.1
61+ places	%	38.7	9.0	34.3	19.8	12.1	14.9	71.4	0.0	24.2

a The occupancy rate is defined as the number of residents in care as a proportion of available places.

Source: table 11A.3.

Table 11.4 **Size and distribution of services with over 80 per cent low care residents, June 1999**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Services	no.	355	301	121	139	110	37	7	4	1 074
Places	no.	16 086	13 274	5 396	5 022	4 710	1 139	420	58	46 105
Occupancy rate[a]	%	94.3	94.4	96.2	94.5	96.0	97.9	95.3	89.3	95.0
Places by locality										
Metropolitan	%	74.0	73.2	58.5	81.3	75.4	46.2	100.0	0.0	72.3
Rural	%	24.8	26.8	37.2	16.3	24.6	53.3	0.0	0.0	26.3
Remote	%	1.2	0.1	4.4	2.4	0.0	0.5	0.0	100.0	1.3
Service size										
1–20 places	%	14.6	12.3	19.8	24.5	22.7	29.7	0.0	75.0	17.3
21–40 places	%	38.3	38.9	29.8	41.7	36.4	43.2	14.3	25.0	37.7
41–60 places	%	28.2	35.9	33.1	24.5	20.9	21.6	28.6	0.0	29.3
61+ places	%	18.9	13.0	17.4	9.4	20.0	5.4	57.1	0.0	15.6

a The occupancy rate is defined as the number of residents in care as a proportion of available places.

Source: table 11A.4.

Mixed services (those with neither an 80 per cent majority of high care nor one of low care residents) include both nursing homes and hostels and accounted for about 16 per cent of residential service places at June 1999 (see table 11.5).

Table 11.5 **Size and distribution of mixed services with less than 80 per cent high care residents or less than 80 per cent low care residents, June 1999**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Services[a]	no.	127	109	160	31	48	21	9	5	510
Places	no.	5 198	4 310	8 008	1 054	2 194	562	438	111	21 875
Occupancy rate[b]	%	na	na	na	na	na	na	na	na	na
Places by locality										
Metropolitan	%	54.3	61.9	56.9	68.1	74.1	38.6	100.0	64.0	60.0
Rural	%	44.5	38.1	39.3	21.3	25.2	58.5	0.0	0.0	37.5
Remote	%	1.1	0.0	3.8	10.5	0.7	2.8	0.0	36.0	2.5
Service size										
1–20 places	%	21.3	20.2	10.6	35.5	14.6	57.1	33.3	80.0	20.2
21–40 places	%	41.7	44.0	31.9	22.6	41.7	19.0	0.0	0.0	35.9
41–60 places	%	22.0	22.9	35.0	35.5	20.8	14.3	33.3	20.0	26.9
61+ places	%	15.0	12.8	22.5	6.5	22.9	9.5	33.3	0.0	17.1

a Includes both nursing homes and hostels. **b** The occupancy rate is defined as the number of residents in care as a proportion of available places. **na** Not available.

Source: table 11A.5.

Residential care services — regulatory arrangements

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 11.3).

Residential care services — funding and service delivery

Residential facilities are run by mainly private for-profit or religious/charitable organisations. However, some State and Territory governments and local governments also operate a small number of residential facilities (figure 11.3). The majority of places at November 1999 were in religious or charitable facilities (62.5 per cent). The private sector is mostly involved in high care facilities (nursing homes), managing about 48 per cent of places in these facilities. The proportion of aged care services provided by government, private enterprise and charitable organisations varied significantly across jurisdictions.

The Commonwealth Government provides the majority of annual funding for residential aged care facilities, $3.3 billion in 1998-99 or about 72 per cent of the cost of care. Residents provide most of the remainder, with some income from charitable sources and donations. State and Territory governments contribute financially to the facilities they operate, and these services receive lower

Commonwealth subsidies than those received by other facilities. In Victoria, for example, the State Government met 17 per cent of the recurrent costs of nursing homes.

Box 11.3 **Examples of regulatory arrangements for residential services**

The Commonwealth Government controls the number of subsidised bed places, with a target of 40 high care places (generally in nursing homes), 50 low care places (hostels), and 10 community care packages 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, to ensure that residents who cannot afford to pay an accommodation bond or charge have equal access to care (with criteria to be deemed a concessional resident determined by home ownership and occupancy and receipt of income support); and
- extra service places (where residents pay for a higher standard of accommodation, food and services) are restricted.

The Commonwealth introduced an accreditation based quality assurance system for aged care in 1997. The Aged Care Standards and Accreditation Agency was established in October 1997. The agency's role is not only to assess performance against standards but also to assist industry to improve performance. It manages the accreditation process and has been assisting providers since January 1998 to improve service quality through education, training and information dissemination. The agency began accepting accreditation applications from 20 September 1999.

To continue to receive Commonwealth funding after January 2001, services must be accredited; all services must apply for accreditation before 31 December 1999. Services that meet a high standard will receive accreditation for three years, whereas those that achieve a satisfactory standard will receive accreditation for one year. This provides an administrative and financial incentive for services to maintain a high quality service. The fee for accreditation is $3050 plus $95 per place up to a maximum of $9500, with services with less than 25 places paying a reduced or no fee. About one third of services are ready to be accredited.

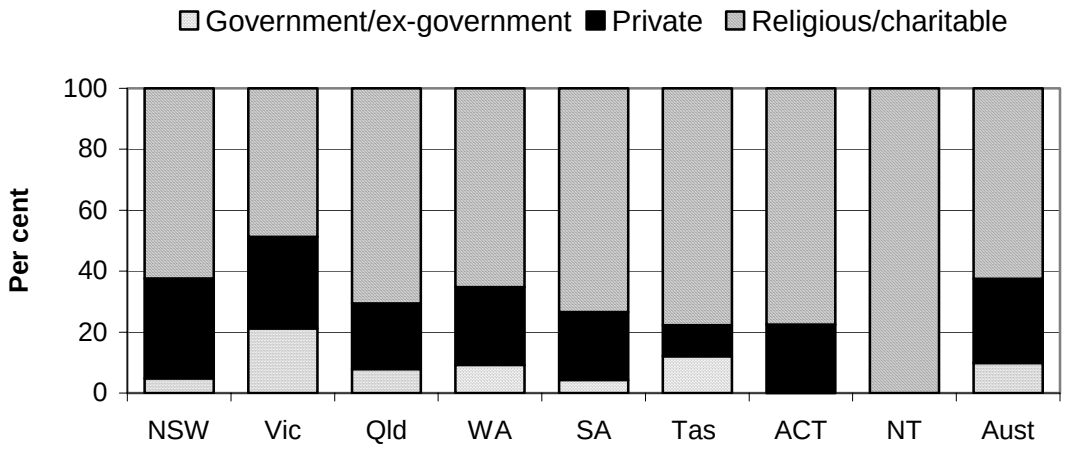
Before requiring residents to pay accommodation charges, a home must be certified as meeting specified building and care standards. Various Commonwealth and State and Territory laws govern regulatory arrangements for residential care. State and Territory legislation may prescribe matters such as staff–resident ratios, 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 (1999).

Commonwealth Government funding of approximately $10 million per year is also provided through the Department of Veterans' Affairs' Residential Care Development Scheme. The scheme aims to assist ex-service organisations and community based organisations to provide high quality residential aged care services and community care packages to the veteran community.

Figure 11.3 **Ownership of residential places, 1999[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 State Government owned facilities. **b** At 30 June 1999.

Source: table 11A.8.

The Commonwealth Government subsidy for each residential place varies according to the client's level of dependency; high level care is classified as categories 1–4 on the eight-level Resident Classification Scale (RCS) (table 11.6). The aged care reforms introduced in October 1997 produced a government funding system which does not differentiate between nursing homes and hostels. One aim of this funding system is to enable residents to remain in one aged care facility irrespective of their dependency level.

The average Commonwealth subsidy for residential places varied across jurisdictions at June 1999, ranging from $20 740 in Queensland to $25 201 in the NT. Variations in average annual subsidies reflect differences in subsidy rates as well as differences in the dependency of residents (table 11.6). Low care subsidy rates RCS 5–8 are the same across all States, and high care subsidy rates RCS 1–4 are being adjusted towards uniform national rates by July 2006.

Table 11.6 **Average annual Commonwealth subsidy per occupied place and the dependency level of aged care residents, June 1999**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Average annual Commonwealth subsidy[a]										
All RCS levels	$	23 909	23 318	20 740	21 392	21 542	24 231	21 855	25 201	22 742
Proportion of high level of care residents[b]										
RCS 1 and 2	%	39.9	37.9	39.7	36.4	34.7	33.9	36.1	43.7	38.4
RCS 3 and 4	%	24.0	18.7	21.1	18.6	24.4	27.4	21.6	23.8	21.9
Proportion of low level of care residents										
RCS 5–8	%	36.1	43.4	39.2	45.0	40.9	38.7	42.3	32.5	39.8

a Only includes funding on the RCS; pensioner supplement and other supplements will add around $3900 a year for high care residents and $3500 a year for low care residents. On average, residents contribute $10 000 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.

Source: table 11A.34.

Assessment services

The Aged Care Assessment program was established by the Commonwealth Government in 1984 to determine eligibility for admission into residential care and the level of care required (and thus the subsidy paid to such services). Assessment by Aged Care Assessment Teams is mandatory for admission to residential care or receipt of Community Care Packages. The teams may also refer people to other services such as the Home and Community Care program. (The exact level of resident subsidy is determined by the facility after assessing the person against the Resident Classification Scale.)

The role of the teams differs slightly among jurisdictions and within a jurisdiction, partly because of the service location (for example, whether they are attached to a geriatric service, a hospital or a community service). The Commonwealth Government funds the teams, with additional contributions from States and Territories; the latter are responsible for the day-to-day operation of the teams.

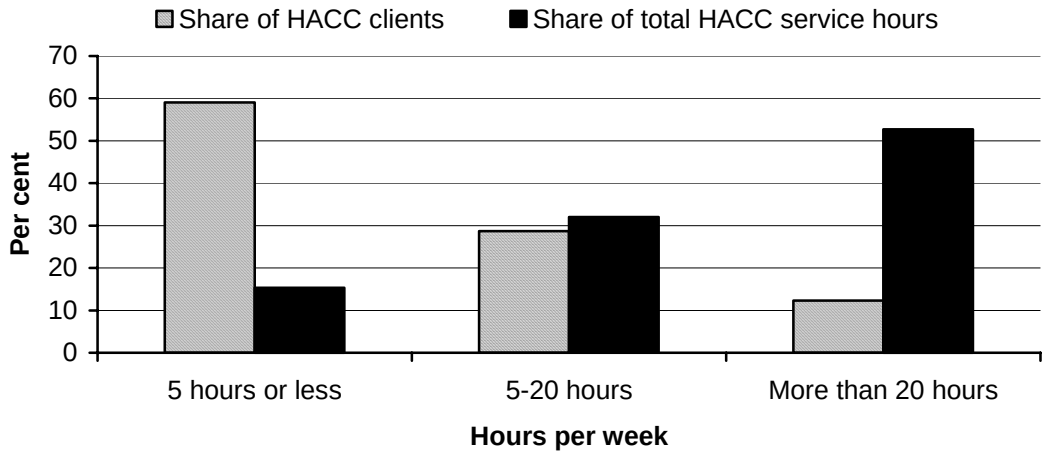
Community care services

Two types of community care programs are reported in this chapter: Home and Community Care (HACC) and Community Care Packages (CCP). The aim of both types of service is to provide practical assistance to enable frail aged and disabled people to continue living in the community. In addition, the Department of Veterans' Affairs provides funding for a similar range of community services targeted towards veterans.

The HACC program provides a range of services (such as home help and maintenance, personal care, food services, respite care, transport, paramedical services and community nursing). The target population is defined as people living in the community who, in the absence of basic maintenance and support services, are at risk of premature or inappropriate long term residential care. The target population comprises both frail aged people and younger people with disabilities and their carers. Approximately 70 per cent of the program's recipients are aged 70 years and over, but the HACC program is also an important source of community care for younger people with disabilities.

The large majority of HACC users individually receive between one and two hours of care per week. However, about 10–15 per cent of clients receive significantly more care. HACC clients receive differing levels of services. The majority of clients (59 per cent) consume five hours or less of HACC services each, and in aggregate, account for a relatively small share of the total HACC hours delivered (15.3 per cent of hours) (figure 11.4). At the same time, a relatively small proportion of recipients (12 per cent) use the services intensively (more than 20 hours) and account for more than half of all HACC service hours (52.7 per cent). More complete information on service use by individual HACC clients will be available from the HACC Minimum Data Set in 2001.

Figure 11.4 **Patterns of HACC service access, 1997-98**



Source: 11A.37.

Within the HACC program is the Community Options or COPS sub-program (called 'Linkages' in Victoria). This is targeted at the more highly dependent end of the spectrum of HACC recipients, and delivers case-managed packages of care.

The CCP program provides an alternative home based service for older persons with at least a low level need (corresponding to levels 5–8 on the Resident Classification Scale). However, approval for hostel admission takes into account factors other than dependency level. Thus the CCP program is in reality targeted at a very similar group to the Community Options program. The main distinctions between HACC, its COPS sub-program, and CCPs are:

- *the range of services*: the 'menu' of possible services to a client is greater under the HACC program and the COPS sub-program; in particular, community nursing is not available under the CCP program;
- *the process of eligibility*: an ACAT assessment is mandatory for receipt of CCP but not for a COPS package or mainstream HACC services;
- *source of funds*: HACC and COPS are cost-shared by Commonwealth and State governments, but the CCP program is funded by the Commonwealth and by residents' contributions. The main function of COPS is to arrange packages of HACC funded services — they receive small amounts of top-up funding through HACC to fill gaps in existing services, whereas CCPs receive funds to provide or purchase hostel-like services (but many CCP recipients also receive HACC subsidised services);
- *client characteristics*: the CCPs were originally for people who would otherwise be eligible for hostel care. They are now aimed at people with at least a low level need for care (RCS 5-8) – approval for hostel admission takes into account factors other than dependency level. The HACC program delivers services to people with a greater range of care needs. Most HACC recipients at the lower end of the scale would not be assessed as eligible for residential care. For example, an individual may only receive an hour of home care a fortnight. At the higher end, some people have levels of need which would exceed the level available under CCP. Many of these people are referred to COPS;
- *funding arrangements:* the average CCP is tied to hostel subsidy levels and is worth about $10 300 per annum, but the fund-holder can spread the available resources among high and lower need clients. Holders of COPS packages have similar flexibility (in Victoria the average package is worth $10 500). Funds for mainstream HACC agencies are tied to the delivery of service outputs — whether in bulk or not; and
- *size of program*: the HACC program receives approximately 10 times more funding than the CCP program (see below) and provides services for significantly more people. Within HACC, COPS are about half the size of CCPs (based on funding).

Two factors suggest community care will continue to play an increasing role. Firstly, there is the longer term policy objective of improving the capacity of aged

care services to support people at home, which accords with strong consumer preferences. Secondly, the 'technology' of community care is increasingly able to achieve this goal at higher levels of client dependency.

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 CCP) have become increasingly important components of the aged care system. The total number of HACC hours delivered between 1995 and 1998 grew by 29 per cent, for example, while the total number of CCP recipients grew by approximately 295 per cent over the same period (tables 11A.9, 11A.18 and unpublished population estimates).

Total national expenditure on HACC and respite services was $855.3 million in 1998-99, of which HACC expenditure represented $823.4 million. The Commonwealth and State and Territory governments jointly fund the HACC program, with the Commonwealth Government contributing approximately 60 per cent and the State and Territory governments and local governments funding the remainder. The Commonwealth-only funded National Respite for Carers Program is not part of HACC, but it does provide community care services. The CCP program is funded by the Commonwealth Government, with expenditure of $121.8 million in 1998-99. Between 1995-96 and 1998-99, CCP expenditure per person aged 70 years and over grew by more than 226 per cent (or about $87 million) (table 11A.31).

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 2000 (box 11.4).

11.2 Policy developments in aged care services

Extended Aged Care at Home (EACH) pilot

The EACH packages pilot program aims to test the feasibility and cost effectiveness of providing nursing home-level care to people in their own homes. The program builds on the CCP program, which provides home based care to people with lower level dependency. Both programs reflect a policy response to community pressure for more care for older people to be provided in the home rather than in a residential

setting. The extended packages were first announced in the 1993-94 Federal Budget, and trialled in one service. Subsequent approval was given in the 1995-96 Budget for an expanded pilot to proceed. The current three year pilot period extends from 1 July 1998 to 30 June 2001. The 10 projects involved in the pilot are located in SA, WA, NSW, Victoria and the ACT, providing a total of 299 EACH packages (places).

Box 11.4 Coordinated care trials

Coordinated care trials link funding directly to individuals rather than to providers. The aim is to improve the matching of services to client needs. Nine nationally coordinated care trials were run from October 1997 to December 1999. The trials varied 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).

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.

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).

At the time of this Report, an interim evaluation (as at June 1999) had been conducted. There was insufficient evidence to conclude that the trials had had a positive effect on health status.

Source: DHAC (1999).

The pilot program is cost neutral to the Commonwealth. An EACH package (place) cannot become operational until an existing nursing home place has been closed. The rate of subsidy is equivalent to the basic subsidy rate (in the State or Territory in which the project operates) for a category 3 care recipient under the Resident Classification Scale.

An EACH package provides an individually tailored package of care and services, depending on the assessed needs of the client. Ongoing monitoring and review of care needs is an integral component of the package. To be eligible, clients must

have been assessed as requiring high level residential care (nursing home care) and have expressed a preference to receive care in their own home.

An evaluation of the pilot will be conducted to inform decisions about the future of the program. It will focus on quality of care (in terms of client satisfaction and clinical practice), cost compared to that of standard nursing home care, and which types of client are the best candidates for the EACH program (DHAC 1998).

Reviews in aged care

There were a number of reviews in aged care during 1999:

- a progress report on the two-year review of aged services was released (*Two Year Review of Aged Care Reforms: Report of the First Six Months* (Gray 1999)). The review is expected to be completed by June 2000;
- a review of HACC services commissioned by the Department of Veterans' Affairs started in 1999. The aim is to investigate access of the department's clients to HACC services;
- a review of community nursing was also commissioned by the Department of Veterans' Affairs. The study compares diagnosis related group (DRG) based funding and fee for service;
- a review of the *Nursing Home Act* was conducted in NSW. It is anticipated that a discussion paper will be released in early 2000 for public consultation. The changes to the legislation are expected to be implemented by the end of 2000; and
- the final report of the Productivity Commission's inquiry into nursing home subsidies (PC 1999) was released.

These reviews should be influential in the planning of aged care services.

11.3 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 costs of providing services (figure 11.5). These indicators directly relate to the objectives of the aged care sector (box 11.5).

Box 11.5 **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 and
- efficient.

New and refined indicators

Data are reported for the first time for three indicators of appropriateness. Data on the recommended longer term living arrangements of Aged Care Assessment Team clients are provided as an indicator of assessment arrangements (table 11.12). Data on the number of nursing home-type patients and the length of stay for hostel and nursing home clients are reported as indicators of appropriateness of care (table 11.13 and 11.14). However, further work in this area is required. Ongoing work to provide a more comprehensive set of performance indicators and to improve existing indicators and the data is discussed in section 11.5.

11.4 Key performance indicator results

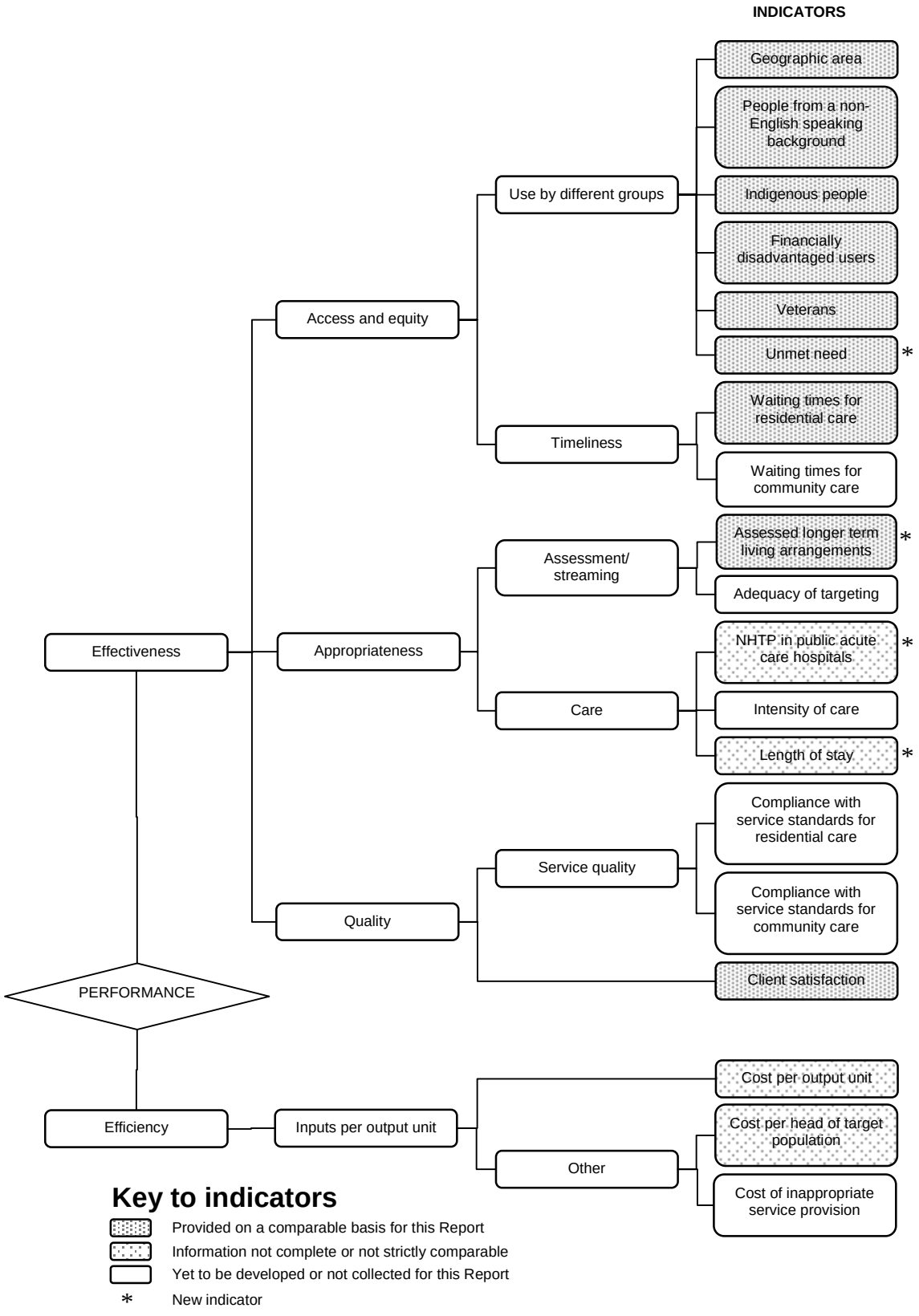
Different delivery contexts, locations and types of client may affect the effectiveness and efficiency of aged care services. Appendix A contains detailed statistics and short profiles on each State and Territory, which may assist in interpreting the performance indicators presented in this chapter.

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 1999 (ranging from 81.6 in Victoria to 97.1 in the NT). The ACT and Queensland had proportionally more hostel places and fewer nursing home places (57 per cent and 43 per cent in the ACT and 51 per cent and 49 per cent in Queensland, respectively)

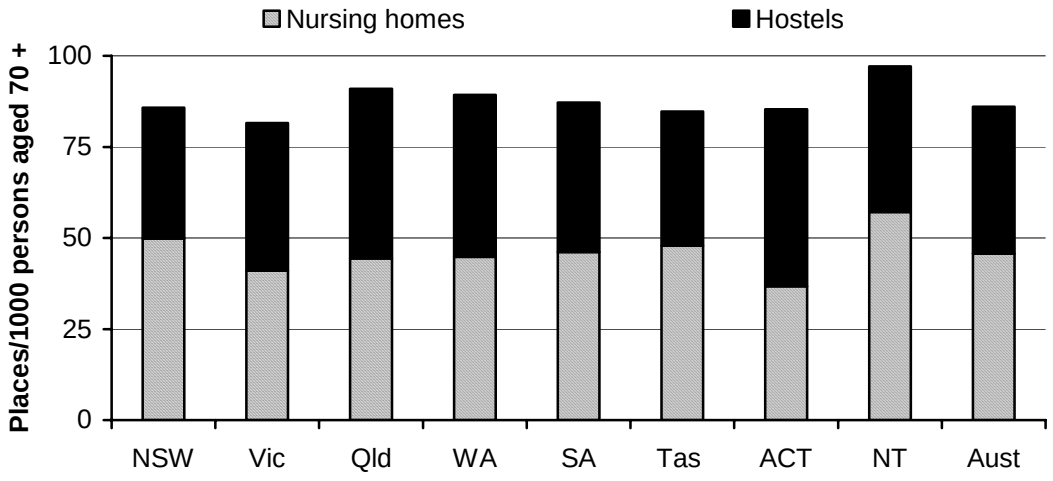
Figure 11.5 **Performance indicators for aged care services**



than in other jurisdictions. NT had proportionally more nursing home places (59 per cent) (figure 11.6). There was a general increase in the proportion of hostel places relative to nursing home places between 1988 and 1999 (table 11A.9).

Special needs groups identified by the *Aged Care Act 1997* are people from Aboriginal and Torres Strait Islander communities, people from non-English speaking backgrounds, people who live in rural or remote areas, and people who are financially or socially disadvantaged. 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 needs 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.

Figure 11.6 **Residential places, June 1999[a]**



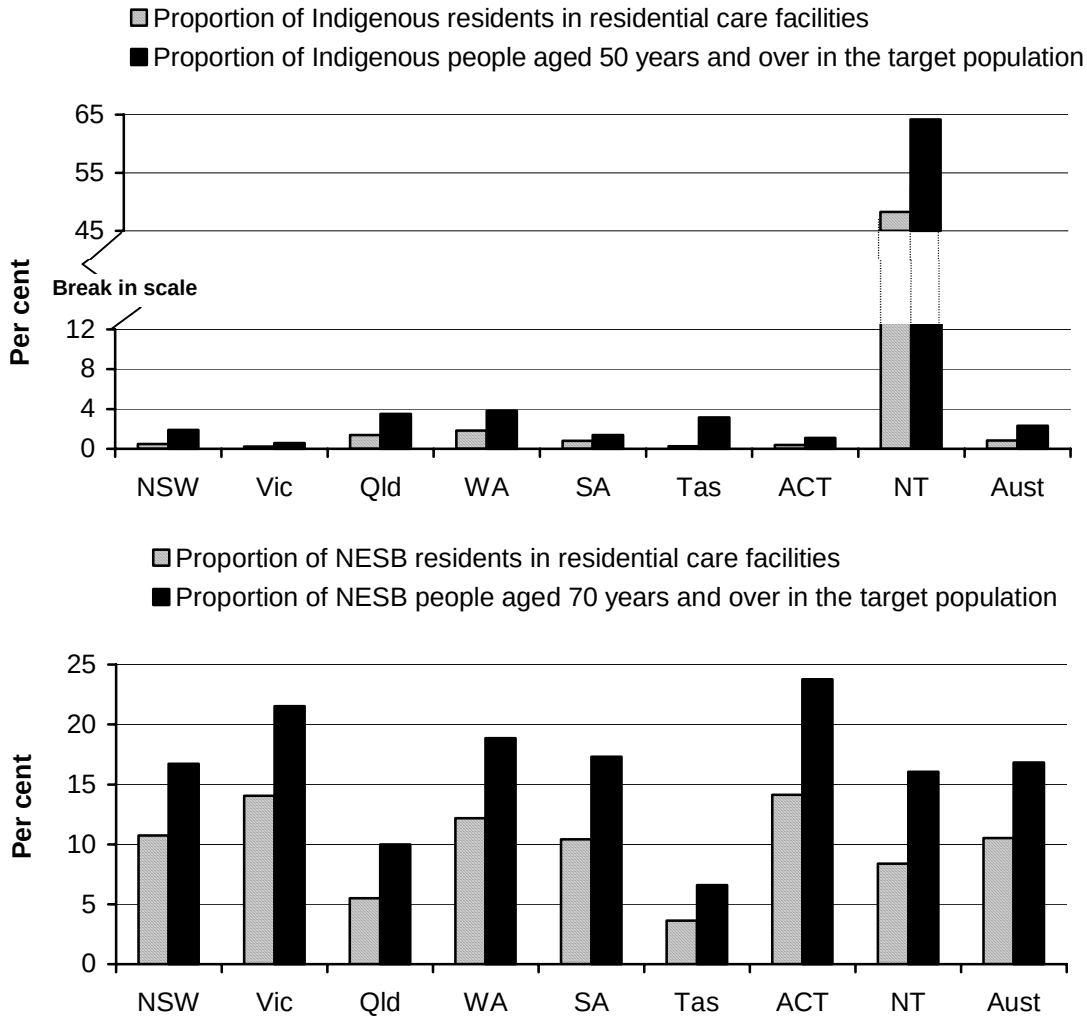
a Places do not include those that have been 'approved in principle' but are not yet operational. If places 'approved-in-principle' were included, the overall ratio would be 92.9.

Source: table 11A.9.

Indigenous people tend to require aged care services at a younger age than the general population. Thus, participation for 1999 was based on Indigenous people aged 50 years and over. On average, Indigenous people were underrepresented in residential care facilities (figure 11.7).

On average, people from non-English speaking backgrounds were under-represented in residential care facilities (figure 11.7).

Figure 11.7 **Proportion of residential places used by special need groups, 1999[a]**



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

Source: table 11A.15.

Commonwealth planning guidelines require that services allocate between 16 per cent and 40 per cent of new places to concessional residents, depending on the service's region. All jurisdictions exceeded this average, with the NT reporting the highest proportion of concessional residents (72.7 per cent) (table 11.7).

Table 11.7 **Proportion of new residents classified as concessional or assisted residents, 1998-99 (per cent)[a, b]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Nursing homes	55.8	55.9	55.1	60.5	56.7	57.7	59.9	69.4	56.3
Hostels	45.0	44.2	47.1	52.5	46.9	47.0	50.6	78.6	46.3
All residents	**51.2**	**49.5**	**51.1**	**56.3**	**52.3**	**53.0**	**55.3**	**72.7**	**51.5**

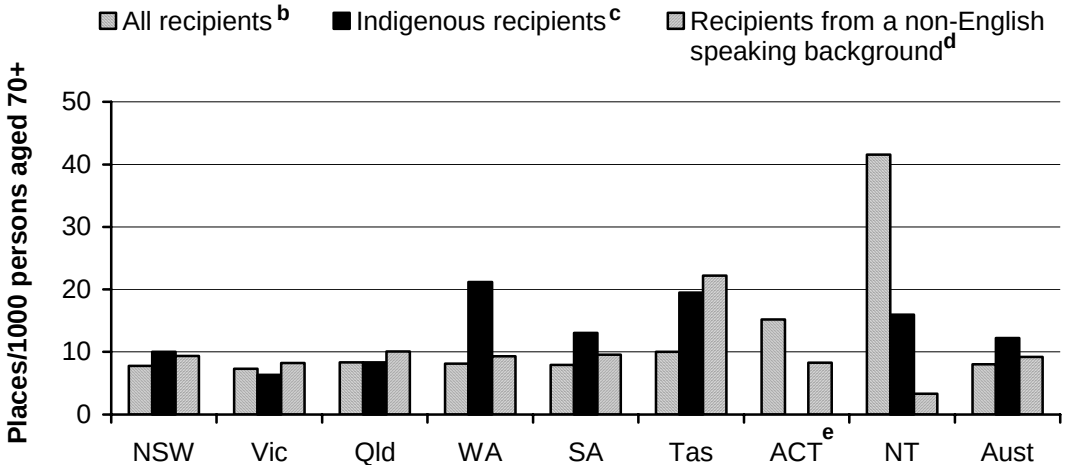
a Only new residents entering residential care post-October 1997 are eligible for either a concession or assistance. **b** Concessional residents are those who, on entry to care, were in receipt of an income support payment, had not owned a home in the last two years, or whose home was occupied by a 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.

Source: table 11A.16.

Community Care Packages

The number of CCP places per 1000 persons aged 70 years and over has grown in recent years but is small relative to the number of residential places (10 compared with 90 places per 1000 persons aged 70 years and over respectively). The jurisdictions with smaller populations (the NT, the ACT and Tasmania) had the highest proportion of CCP places per person aged 70 years and over at June 1999. WA, the NT, Tasmania and SA had the highest proportion of CCP places per Indigenous person aged 50 years and over. Tasmania also had the highest proportion of CCP places per person aged 70 years and over from a non-English speaking background (figure 11.8).

Figure 11.8 **CCP places, June 1999[a]**



a Unknown responses were distributed pro rata. **b** All recipients is per 1000 persons age 70 or over. **c** Indigenous recipients per 1000 Aboriginal and Torres Strait Islander persons aged 50 or over. **d** NESB recipients per 1000 NESB persons aged 70 or over. **e** There were no CCP recipients from an Indigenous background.

Sources: tables 11A.10,11A.12 and 11A.14.

Home and Community Care program

The HACC program provides services to people in households with a severe, profound or moderate handicap and their carers. It is not yet possible to calculate precisely the number of hours of HACC services consumed by persons aged 70 or over compared to those used by younger people with disabilities. Although persons aged 70 or over are not the HACC target group, it is estimated that around 70 per cent of HACC recipients are aged 70 and over.

The NT had the highest ratio of HACC service hours delivered per 1000 persons aged 70 years and over in capital cities and all areas in 1999. Victoria reported the highest ratio of HACC service hours delivered per 1000 persons aged 70 years and over in rural and remote areas (table 11.8).

Table 11.8 **Estimated level of HACC services received per month per 1000 persons aged 70 years and over, by region, 1999[a, b]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Total hours per month[c]									
Capital city	764	1 119	1 102	1303	970	727	876	1 339	989
Other major urban areas	935	1 648	714	0	0	0	0	0	950
Rural areas	1 024	1 742	1 191	823	898	1 034	0	0	1 220
Remote areas	2 341	3 247	2 065	2296	2 271	1 894	0	2 175	2 257
All areas	875	1 316	1 110	1257	971	910	876	1 594	1 072
Total meals per month[d]									
Capital city	359	590	655	564	510	376	278	814	500
Other major urban areas	428	571	454	0	0	0	0	0	452
Rural areas	545	639	646	573	816	579	0	0	615
Remote areas	1 028	922	1 218	1 461	1 722	609	0	2 976	1340
All areas	425	604	642	608	597	494	278	1 654	543

a Estimates based on the proportion of people aged 70 years and over receiving HACC services in each jurisdiction. **b** There is some overlap between jurisdictions in the definitions of home help, personal care, home nursing and paramedical services. **c** Includes home help, personal care, home nursing, paramedical care, respite care, centre day care, home maintenance. **d** Includes home meals and centre meals.

Sources: tables 11A.18, 11A.19, 11A.20, 11A.21 and 11A.22.

Indigenous persons tend to use HACC services more than residential services. Indigenous persons must meet the standard HACC criteria of 'people in households with a severe, profound or moderate handicap'. However, to reflect different morbidity and mortality trends, all people aged 70 years and over plus Indigenous people aged 50 to 69 years is used as a proxy (figure 11.9).

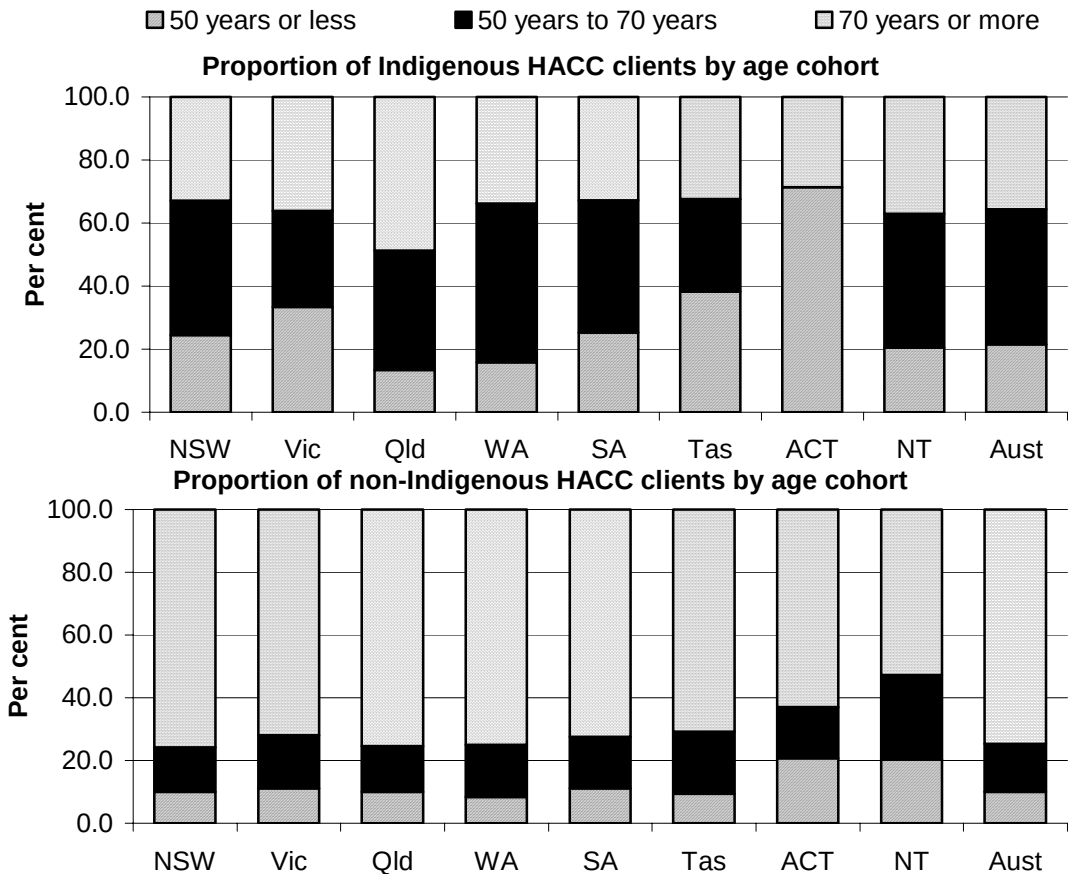
In 1997-98, Indigenous HACC clients aged 50 years and over received on average more than 1500 hours of HACC service per month compared with less than 1000 hour per month for non-Indigenous HACC clients aged 50 years and over (table 11A.38).

Access and equity — unmet need

Defining and determining the level of need at an individual level, let alone at a population level, is complex. Indicators of unmet need are often a subjective measure, based on the non-recipient's perceived level of need.

A survey of disability, ageing and carers was released in 1999 (ABS 1999), defining disability with reference to core activity restrictions (see box 12.2 in chapter 12). One objective of this study was to quantify unmet need for services. In total, 293 200 people aged 65 and over reported a need that was not fully met, out of a total of 887 900 persons aged 65 and over who reported needing assistance with everyday activities (table 11.9). Everyday activities include personal care (self care, mobility, communication and health care), transport, paperwork, housework, property maintenance, and meal preparation. The proportion of respondents reporting an unmet need varied from 29 per cent in NSW to 44 per cent in Tasmania.

Figure 11.9 **HACC service by age and Indigenous status**



Source: table 11A.39.Some recent studies have examined reasons for non-use of aged care services in older populations in general or specific sub-groups (box 11.6).

Box 11.6 Unmet need: reasons for non-use of aged care services

Dementia carers — NSW

In 1997, the NSW Ageing and Disabilities Department commissioned a research consultancy on dementia carers' non-use of community services. The main reasons for non-use of services were found to be:

- carer perception that services were not needed;
- reluctance to use services;
- service characteristics:
  - cost
  - inconvenient hours of service operation
  - lack of availability
  - inadequate information about eligibility
  - inappropriateness of existing services for particular needs; and
- lack of information.

Pathways project — South Australia

In 1998, the Office of the Ageing funded a project to identify how older people were assisted to access home based services either following assessment by an Aged Care Assessment Team or on application for one. The project found the following challenges to access:

- older people from non-English speaking backgrounds had little or no knowledge of home based services and frequently relied on friends or family members. They were more aware of services provided by professionals (for example, doctors, nurses, lawyers) and were more willing to use these services;
- people of Aboriginal and Torres Strait Islander descent may be reluctant to accept services because they feel a sense of shame;
- people living in rural or remote areas felt agencies were reluctant to provide services to them;
- cost is a barrier to receiving needed services such as physiotherapy and alarm system installation; and
- home help was the service most often needed but not received.

Source: Fine, Brodaty and Thomson (1997); ARAS (1998).

Table 11.9 Older persons needing assistance with at least one everyday activity: extent to which need is met, 1998[a, b]

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*[c]	*Aust*
Need not fully met	'000	91.0	75.5	59.0	25.8	25.1	12.0	4.0	0.8	293.2
All needing assistance	'000	312.4	226.4	153.9	72.6	82.7	27.0	10.9	2.0	887.9
Self reported unmet need	%	29.1	33.3	38.3	35.5	30.4	44.4	36.7	40.0	33.0

[a] Aged 65 years and over, living in households. [b] Totals may not add as a result of rounding. [c] Estimated as a residual.

Source: table 11A.35.

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 11.7).

Box 11.7 **Waiting time indicators**

Broadly, a 'waiting time' indicator measures the time between application and receipt of a service. A robust and comparable indicator requires consistent definitions of when the waiting time starts and finishes. The definitions used in this chapter are:

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

The choice of beginning and end points will partly depend on the data's intended use and its availability. The end of a waiting time, for example, could be based on when a person first receives a placement offer rather than the service.

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;
- delays for physical ACAT assessments;
- delays between physical ACAT assessments and approval of assessments; and
- priority allocations.

Two factors would tend to increase reported nursing home (or high care) waiting times, but are not related to changing service performance. First, more older people may be choosing to wait. The validity of nursing home level assessments was increased from 90 days to one year as part of the 1997 Aged Care Reform (bringing them in line with hostel approval periods). As a consequence, older people have more time to visit different facilities, consider their options, or wait for a place in a particular facility (for cultural or religious reasons for example). In addition, when ACAT assessments were only valid for 90 days, some ACAT teams may have delayed assessments until they were more confident that residents would find a place. With assessments valid for one year, some teams may be making assessments earlier, again making it more likely that some residents will have longer waits recorded, or choose to delay entry. Second, transfers from co-located hostels to nursing homes were recorded as nursing home admissions with very short waits. With ageing-in-place these admissions are likely to be reduced, increasing average waits.

People waited (between assessment and placement) an average 44 days for a high care residential placement in 1998-99. Eighty-five per cent of people waiting for a high care residential care were placed within 90 days of being assessed. Forty-one per cent of people in NSW were placed within seven days, compared with 17 per cent in the NT (table 11.10).

Table 11.10 **Waiting period between ACAT approval and permanent entry to high care residential placement, 1998-99[a, b]**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Proportion of high care clients placed in under										
2 days	%	25.1	14.2	10.3	15.4	17.7	11.4	10.1	5.6	18.3
7 days	%	41.2	28.7	20.5	29.9	34.3	20.8	22.6	16.7	32.8
30 days	%	67.6	63.7	47.9	63.6	64.6	49.6	48.7	33.3	62.3
60 days	%	79.7	80.8	65.4	80.4	78.9	69.3	70.4	47.2	77.3
90 days	%	87.2	88.0	76.4	87.8	86.9	78.7	79.9	66.7	85.4
120 days	%	90.8	91.5	82.4	92.1	90.9	86.5	85.4	72.2	89.6
Average wait	days	38.5	40.8	64.3	38.6	41.7	56.2	57.1	102.1	44.1

a The maximum period is 365 days, the ACAT approval period. **b** Differences in the way aged care entry periods are calculated mean that comparisons over time are not valid for a number of reasons. First, as part of the aged care reforms in 1997, an ACAT approval for nursing home admission is valid for one year, bringing it in line with the hostel approval period, rather than the 90 days which used to apply. This takes pressure off people entering nursing homes and gives them more time to make decisions. This gives older people time to visit different facilities, consider their options, settle their affairs and make arrangements with the facility of their choice before they enter care. Some older people may obtain ACAT assessment but choose not to proceed with entry to residential care for some time, while others may prefer to wait for a place in a particular facility, for religious preferences for example. It is therefore misleading to refer to this as a 'waiting period'. Second, the change in nursing home ACAT approval to one year also means that ACATs do not have to postpone an approval until they are sure the resident could find a place, as was sometimes the case in the past. Third, the increasing use of ageing-in-place also affects entry periods because, in the past, if a person moved from a hostel to a nursing home this would have been counted as a new admission, with a very short waiting time. Up to 40 per of hostel discharges in the past were to nursing homes, which would have reduced the average waiting time substantially. Since the aged care reforms fewer people have had to move from a hostel to a nursing home because they can receive higher levels of care in the low care service. This has a statistical effect on how entry periods are calculated.

Source: table 11A.28.

Low care clients waited 80 days on average — or about twice the waiting period of high care clients — for residential placement in 1998-99. Seventy-three per cent of low care clients in the NT were placed within 90 days, compared with 44 per cent in the ACT (table 11.11).

Table 11.11 **Waiting period between ACAT approval and permanent entry to low care residential placements, 1998-99**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Proportion of low care clients placed in under										
2 days	%	9.0	9.2	8.8	7.1	5.8	8.7	2.4	21.6	8.4
7 days	%	15.7	17.2	15.5	15.3	11.1	14.8	3.6	21.6	15.5
30 days	%	36.8	40.8	35.9	40.4	34.0	30.6	14.3	48.6	37.5
60 days	%	55.7	57.7	53.0	59.6	52.2	48.9	31.0	64.9	55.4
90 days	%	69.8	70.5	65.1	73.4	65.3	59.8	44.0	73.0	68.5
120 days	%	78.1	77.6	73.4	81.4	73.6	68.0	57.1	78.4	76.5
Average wait	days	76.9	76.0	87.5	69.6	86.5	94.3	132.8	76.0	79.8

Source: table 11A.29.

Appropriateness of assessment

This report provides for the first time information on assessed longer term living arrangements as reflected in the proportion of people that ACATs refer to residential and community care. These data can inform analysis of patterns and levels of use of aged care services, even though there is clearly no 'correct' mix. A similar situation arises in information on the appropriateness of acute health services.

The differences in the service mix may reflect external factors such as geographic dispersion of clients or views on the types of client who are best served by community based rather than residential services. Current mixes of services will also reflect historical patterns in service delivery.

Table 11.12 provides information on the proportion of assessed people referred to community or residential care. In Queensland, a higher proportion of ACAT clients were referred to residential care than to community care (66.8 per cent and 28.2 per cent respectively). In the NT, a higher percentage of clients were referred to community care than to residential care (57.9 per cent and 24.1 per cent respectively).

The distribution of ACAT living arrangement recommendations will be influenced by the degree to which any preselection process identifies a higher proportion of persons requiring residential care 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 assessment (table 11.12).

Table 11.12 **Recommended longer term living arrangements of ACAT clients, 1997-98[a]**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Community	%	51.1	49.0	28.2	54.0	26.1	46.1	29.4	57.9	45.4
Residential	%	41.6	38.1	66.8	39.8	55.0	49.9	55.0	24.1	45.1
Other	%	2.3	2.5	3.9	1.5	13.1	2.7	1.3	9.8	3.4
No long term plan made										
Died	%	0.5	1.5	0.4	1.9	1.7	0.2	0.1	1.3	1.1
Cancelled	%	0.8	1.2	0.5	0.0	3.5	0.8	0.5	1.3	1.0
Transferred	%	0.6	5.5	0.2	2.7	0.7	0.3	0.3	1.2	2.3
Unknown	%	3.0	2.3	0.0	0.0	0.0	0.1	13.5	4.4	1.8
Total	**no.**	**55 664**	**50 923**	**23 320**	**20 692**	**13 438**	**4 718**	**1 724**	**1 181**	**171 660**
Assessment rate[b]	no.	91.7	116.6	82.3	148.7	86.5	102.3	188.2	105.5	101.3

a Includes deaths, cancellations and transfers. **b** Number of assessments of persons aged 70 years and over per thousand population aged 70 years and over in 1997-98.

Source: table 11A.36.

Appropriateness of care

Nursing home-type patients

Aged care services can be delivered in different ways. The mix of services can be examined in terms of the proportions provided in community versus institutional settings or in terms of different types of residential care arrangements.

One indicator of appropriateness is the number of patients in public acute care hospitals classified as nursing home-type patients. A nursing home type patient is a patient who has stayed 35 days or more and for whom an acute care certificate has not been provided at the time of discharge (AIHW 1999b). Classification as a nursing home-type patient does not imply eligibility for entry to residential care. Nursing home-type patient service funding is covered by the Commonwealth/State Health Care Agreements.

However, the geographic dispersion of older persons in some jurisdictions may be such that it is not feasible to have dedicated residential care facilities. Only a small number of people may require residential care, so care may be better provided in public acute care hospitals. It has been said that the shortage of nursing home beds in rural Australia 'has led to an inappropriate use of existing facilities, with nursing-home-type patients occupying 20 per cent of hospital beds' (VHA 1999). In NSW, rural area health services report that approximately one third of their hospital beds are occupied by nursing home-type patients as a result of shortages of places in nursing homes (IPART 1998).

Table 11.13 presents the number of nursing home-type patients by jurisdiction for 1996-97 and 1997-98, and their bed day use over that period.

Table 11.13 **Nursing home type patients**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Patient numbers									
1996-97	8 309	2 389	1 814	na	929	313	53	44	13 947
1997-98	5 354	1 841	2 096	na	771	253	70	38	10 548
Patient numbers per 1000 people aged 70 and over[b]									
1996-97	15.0	5.9	6.9	na	6.3	7.3	3.4	12.4	9.0
1997-98	9.4	4.5	7.7	na	5.1	5.8	4.3	10.3	6.6
Patient days									
1996-97	540 754	90 876	156 697	152 070	174 242	73 060	4 029	6 754	1 069 047
1997-98	712 639	74 147	168 848	129 575	132 119	31 694	2 081	1 559	1 147 142
Patient days per 1000 people aged 70 and over[b]									
1996-97	977.3	225.8	594.2	176.2	1 176.0	1 707.2	260.9	1 907.9	686.2
1997-98	1 255.9	179.4	619.1	181.9	869.2	726.3	127.6	421.9	716.3

a Data relate to separations from public acute and psychiatric hospitals occurring in the specified years. **b** Population estimates provided by the Department of Health and Aged Care.

Sources: AIHW (1998 and 1999a); information provided by Health Department of WA; Department of Health and Aged Care.

Length of stay

This Report provides for the first time information on the length of stay of people discharged from residential care. Data on variations in separation rates across jurisdictions are presented, although these data largely serve to stimulate investigation of the causes and (possibly more importantly) the effects of these differences, rather than to draw definitive conclusions. Three quarters of discharges from high care services are due to death.

Most residents discharged from residential care had stayed longer than six months, whether in low care (81.8 per cent) or high care (67.1 per cent) facilities (table 11.14). Around three-quarters of people who went into residential care for a period of respite stayed less than a month in any one facility (AIHW 1997).

A study of length of stay between 1991-92 and 1995-96 revealed a decline in accessibility for those requiring permanent care in a nursing home, with those already admitted staying longer (lower turnover) and thus fewer such people being admitted (AIHW 1997). However, it is difficult to draw conclusions from this finding. It is not problematic that people live in residential care longer unless it is to the detriment of others who are therefore denied access to needed residential care

services. Such a finding may also reflect a lack of adequate home based care as an alternative to residential care.

Table 11.14 **Permanent residents discharged from residential care service, 1998-99**[a]

Length of stay[b]	*Unit*	*High care*	*Low care*	*Total*
Less than 1 month	%	11.9	3.8	9.0
1–3 months	%	11.5	6.6	9.7
3–6 months	%	9.6	7.9	8.9
6–12 months	%	13.3	13.6	13.4
1–2 years	%	17.9	20.2	18.7
More than 2 years	%	35.9	48.0	40.2
Average months	no.	24.7	31.9	27.3

[a] Based on 52 400 permanent residents, of whom 9.3 per cent had more than one discharge. [b] Residents with more than one discharge have had their lengths of stay added together.

Source: Department of Health and Aged Care.

Quality — client satisfaction

Complaints data partly indicate 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 changed 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. Each jurisdiction has a variety of advocacy services which promote complaints mechanisms to varying degrees.

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. Nationally, approximately 86 per cent of complaint issues raised in 1998-99 were resolved by June 1999 (table 11.15).

Table 11.15 **Residential care complaints per 1000 residents, 1998-99[a]**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Total complaints received	**no.**	**305**	**608**	**379**	**191**	**160**	**40**	**29**	**13**	**1 725**
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[b]		14.0	37.9	26.4	31.9	31.4	17.3	41.2	69.6	25.8
Issues resolved[b]	%	81.5	84.3	79.1	94.8	97.3	90.6	96.4	50.0	85.5
Issues unresolved[b]	%	0.0	0.8	0.0	3.0	0.0	7.8	0.0	16.7	0.9
Issues unfinalised[b, c]	%	18.5	14.9	20.9	2.2	2.7	1.6	3.6	33.3	13.6

a Complaints received by Commonwealth Department's State Offices between 1 July 1998 and 30 June 1999. **b** A complaint may raise more than one issue. **c** As at 30 June 1999.

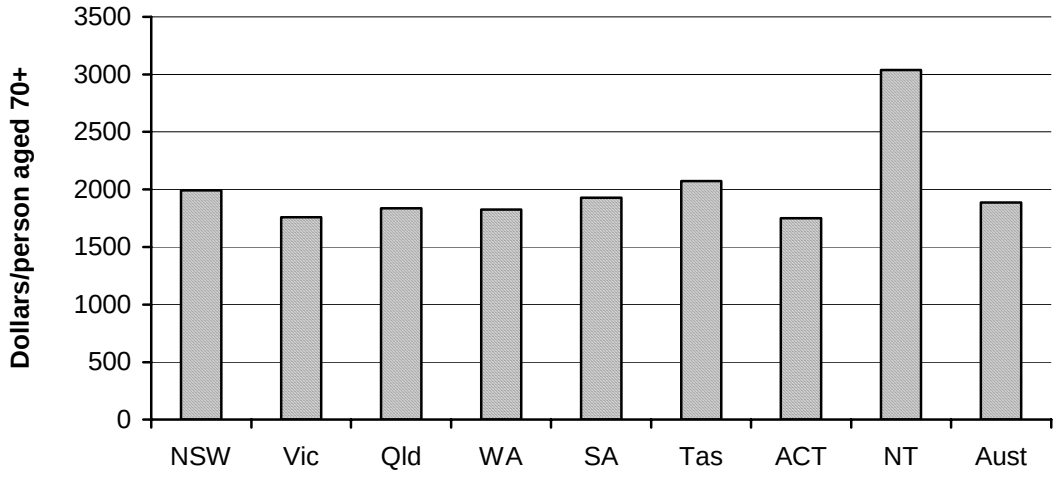
Source: table 11A.30.

Efficiency

This Report provides information on expenditure per person on the main types of aged care services. A proxy indicator of efficiency is cost per head of target population — that is, government inputs (expenditure) per person aged 70 years and over. Unit cost data for aged care services delivered by government do not yet contain capital costs.

Expenditure on residential care services per person aged 70 years and over varied across jurisdictions in 1998-99, ranging from $3037 in the NT to $1749 in the ACT (figure 11.10).

Figure 11.10 **Commonwealth Government expenditure on residential services, 1998-99[a, b]**



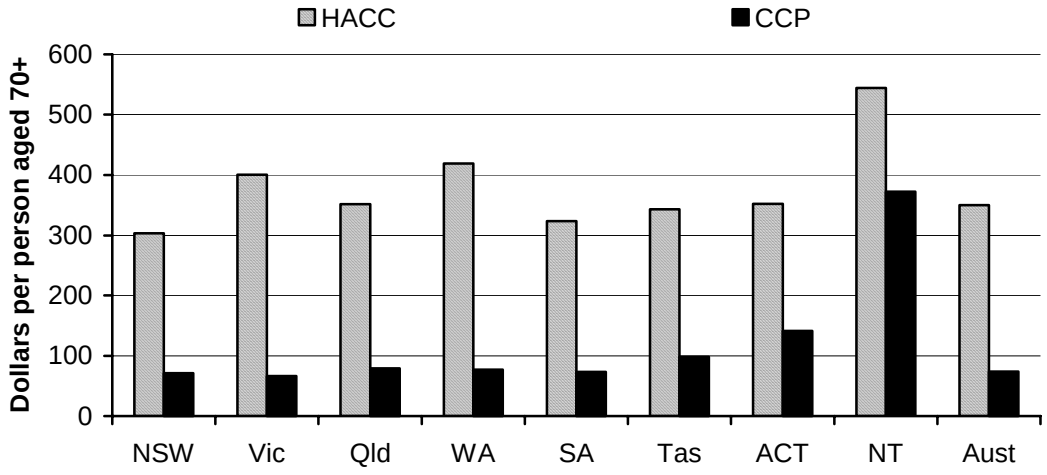
a Includes expenditure on nursing home benefits, hostel subsidies and residential respite. **b** Excludes funding from the Department of Veterans' Affairs ($367 million in 1998-99).

Source: table 11A.31.

Both the CCP expenditure and estimated annual HACC expenditure per person aged 70 years and over varied across jurisdictions in 1998-99. The NT reported the highest HACC expenditure ($544 per person) and the highest CCP expenditure ($372 per person) (figure 11.11). NSW reported the lowest HACC expenditure ($303 per person) and Victoria reported the lowest CCP expenditure ($67 per person).

In many areas of government services, there has been a move towards better measurement of unit costs as part of a strategy to promote efficiency improvements. It is difficult to measure the overall efficiency of the HACC program, given the heterogeneity of services. However, components can be identified and unit costs can be measured.

Figure 11.11 **Expenditure on community care services, 1998-99[a]**



a HACC expenditure includes expenditure on HACC (Commonwealth/State) and expenditure on National Respite for Carers (Commonwealth only).

Sources: tables 11A.31 and 11A.33.

It is anticipated that as jurisdictions move towards output based funding of aged care services, issues relating to the classification of outputs will need to be addressed. The Amending Agreement to the HACC Program, clause 10(3), requires the development of 'State Plans which specify measurable program outputs to be provided in each Region, including the mix, level and quality of services'. State program managers have generally interpreted this as requiring a move away from historical submission based funding, towards the introduction of some form of uniform pricing for a given service type. This is considered the most practical method of quantifying the outputs and service mix to be delivered in a given geographic area.

One approach is to identify service types so a classification system can be developed with corresponding unit costs, as is done with diagnosis related groups (DRGs) for the funding of public acute care hospitals. The development of a case mix style community care classification system remains a challenge. The problem is to define a meaningful episode of care and to show how client outcomes are related to the level and mix of resource inputs. Progress is being made in the fields of rehabilitation and palliative care in community settings, which should be useful models for HACC.

Victoria has implemented output based funding (or unit costing) for the delivery of HACC services (box 11.8). Victoria, having agreed to a national HACC output framework, developed its own framework, which is not comparable with any other State or Territory. The Victorian Department of Human Services will purchase services in 1999-2000 using a classification of service types and specified unit prices (table 11.16).

Table 11.16 **HACC service purchase prices in Victoria, 1999-2000**

HACC program activities 1999-2000	*Unit*	*Unit price*
Health care and support (nursing)	hour	$54.96
Health care and support (allied health)	hour	$60.98
Health care and support (delivered meals	delivered meal	$1.10
Home care	hour	$21.70
Property maintenance	hour	$34.00
Personal care	hour	$24.80
Respite (home and community)	hour	$22.60
Respite (overnight)	10-hour block	$101.97
Volunteer coordination	hour	$24.80
Planned activity group—core	person hour	$8.48
Planned activity group—high	person hour	$11.93
Linkages (community options)	package	$10 500.00

Source: Victorian Department of Human Services (unpublished).

Some jurisdictions have already standardised purchase prices for some services. In some jurisdictions, the State or Territory government contributes a fixed amount per delivered meal (table 11.17). Consumers also make some financial contribution (co-payment) towards the service in some jurisdictions.

Box 11.8 Output based purchasing of home and community care in Victoria

The Victorian Department of Human Services began implementing output based purchasing for HACC services in 1998. Prices paid were standardised by the type of activity (for example, an hour of home care) rather than varying according to any given agency's internal cost structure. The aim was to improve efficiency and equity in resource allocation.

Findings of 1995 unit cost survey

For most service types, 70–80 per cent of the unit cost was spent on direct costs, 5–8 per cent was spent on assessment, 3–8 per cent was spent on travel, and 4–17 per cent was spent on management and overheads. Metropolitan services generally reported higher unit costs than those of rural services, reflecting higher wage costs in metropolitan areas. Rural services reported higher costs for travel and consumables. A high use of volunteers was associated with lower unit costs, but this was partly an effect of having clients with lower needs.

Services with a high proportion of 'special needs' groups (dementia, cultural diversity, Indigenous) did not have consistently higher unit costs. But certain service types (day activity groups and in-home respite) showed higher unit costs associated with a high number of people with dementia.

Design and implementation, 1996–98

After extensive consultation with service providers, activities (service types) were redefined and assigned a unit price (that is, a fixed number of dollars per unit of output). Some other activities had a block grant. Costs of wages, travel and overheads were built into the fixed unit price for each activity.

The 'shadow budget' year began on 1 July 1998. Training sessions for providers were organised across the State. Although the level of funds to a given agency for 1998-99 was largely determined by its target output multiplied by the unit price, the shadow budget meant any payment would be based on actual expenditure, rather than the achievement of output targets.

All providers participated in a monthly data collection, comprising two basic data items for each service type — the aggregate number of hours and the number of clients seen that month. Analysis later confirmed that outputs were fairly close to target for the major service types.

Next phase, 1999–2000

Overall, implementation of output based purchasing appears to have been successful. Most services except nursing and allied health 'went live' on 1 July 1999. The underlying assumption — that a standard set of defined activities could be purchased at standard price — has been supported by feedback from service providers and by the level of activity against set targets. Further refinement to the model will continue to occur, including ongoing consultation with service providers and consumers.

Source: Victorian Department of Human Services.

Other approaches to measuring performance better may be used which may complement models based on separately defined services. The number of clients receiving a bundle of services (which will differ across clients) can be reported after adjusting for the varying levels of client need. This approach needs an objective measurement of client outcomes, because the quality of individual services cannot be assessed. This approach has some similarities to the models used to determine funding for schools and employment agencies.

Table 11.17 **Government purchase price and consumer co-payment per delivered meal, 1998-99 (dollars)**

NSW[a]	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*
Government payment							
na	1.10	1.35	1.20	1.35	2.30–3.10	2.74	na
Consumer co-payment							
na	3.00–6.00[b]	4.00[c]	3.00–5.00	4.00	3.69–4.30	4.80	na

a NSW does not have a subsidy price per meal because it funds administration, not the cost of a meal. **b** Department of Human Services' fees policy (for HACC) sets a scale of recommended fees. For delivered meals, the recommended fee is $3.00–$6.00 per meal. **c** On average. **na** Not available.

Source: State and Territory governments (unpublished).

11.5 Future directions in performance reporting

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.

Improving reporting of Aboriginal and Torres Strait Islander peoples' access to mainstream services

In May 1997 the Prime Minister requested that the Steering Committee give priority to developing indicators that measured the performance of mainstream services in meeting the needs of Indigenous Australians. This is an important task, but large gaps remain. Data are reported on the proportion of Indigenous persons aged 50 years and over in aged care facilities, and on the proportion of Indigenous persons receiving CCPs, which are indicators of access and equity. Data are also reported on the proportion of Indigenous persons receiving HACC services for different age groups. The availability and coverage of nationally consistent data on the delivery of services to Indigenous clients will improve in future Reports.

Progressing work on measurement of consumer satisfaction

The Australian Institute of Health and Welfare is examining methods for including consumer views in the assessment of HACC service quality. This project aims to establish a survey tool and method that will be useful to those assessing HACC agencies using the HACC National Service Standards Instrument. Consumers from more than 50 HACC funded agencies across Australia are participating in telephone interviews, focus groups and mail surveys to provide feedback about the services they receive. The survey is being conducted with consumers using a range of HACC services, with persons of a non-English speaking background, and with Indigenous people in urban, rural and remote locations. A report is expected to be available in 2000.

A major consultancy on client and carer views in disability services was completed in 1999, funded by the Commonwealth, States and Territories. The results of this survey (see chapter 12) and analysis of the method used will help address existing concerns over the use of satisfaction surveys of older persons.

Improving the measurement of unit costs

Further work is required to improve the comprehensiveness of expenditure data so they more fully reflect the cost to governments of providing services. Current data exclude, for example, an estimate of the administrative costs (at both the Commonwealth level and the State and Territory level) of maintaining aged care services. They also exclude recurrent and capital inputs provided by State and local governments for residential services.

The Steering Committee is working with the aged care sector to improve unit costs by introducing a more consistent treatment of:

- superannuation costs (see SCRCSSP 1998);
- payroll tax (see SCRCSSP 1999); and
- depreciation and the user cost of capital.

Accounting for these should improve the comparability and accuracy of unit cost information in future Reports.

Developing indicators and data

Further work is required to improve the definitions of the appropriateness indicators: adequacy of assessment, intensity and appropriateness of care**.** A lack of data has also prevented progress in this area. However, two national HACC data

developments — the HACC minimum dataset project and the HACC National Service Standards Instrument — may provide useful data for these indicators in the future.

The HACC minimum dataset 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 client groups (frail older people, younger people with disabilities, and carers), which is currently not possible. Consistent reporting by agencies will allow more comprehensive and comparable reporting of the services both across jurisdictions and between community and residential services.

The minimum dataset is scheduled for full implementation in July 2000. A pilot was undertaken in October 1999 involving 104 HACC service providers in all States and Territories. The pilot should indicate what training, information and technical support will be needed, so these can be addressed before July 2000. The pilot also tests the feasibility of a statistical record linkage key, which will enable the extraction of information on multiple service use by clients, while maintaining client confidentiality. Full implementation of the minimum dataset will provide client based information about the distribution of HACC services for the first time. This makes it a more accurate planning tool which will contribute to a framework for accountability.

The HACC National Service Standards Instrument measures the extent to which agencies comply with national service standards. Developed in 1996-97, the instrument is the basis for monitoring, evaluating and reporting on the quality of HACC services. It is being implemented in all States and Territories except the NT. The data should be available for reporting in the 2001 Report.

Measuring veterans' access to services

The Department of Veterans' Affairs commissioned a survey of veterans, war widows and their carers in late 1997. Just over 25 per cent of respondents reported that they needed more HACC services than currently available to them, with 50 per cent reporting difficulty with at least one activity of daily living. The department has since commissioned further research into the area of veteran use of community support services. The consultant's report was released in 1999.

Assessing the degree of social isolation

It has been demonstrated that social isolation may reduce quality of life for older people and has been associated with poorer health status, depression and the need

for residential care (Bishop 1999a) (box 11.9). Possible indicators of social isolation will be examined in future reports.

Box 11.9 **Social isolation among Australian veterans**

The Lincoln Gerontology Centre at La Trobe University conducted a study into the social isolation of war veterans between May 1996 and February 1998. It found that improving social activity may result in better health and lower use of health and aged care services.

People were defined as socially isolated 'if they reported low social participation combined with perceived inadequacy of social contact, and/or frequently felt bored, lonely, or unhappy. People reporting only low social participation were considered 'at risk of social isolation'. The results showed that approximately 10 per cent of respondents were socially isolated, with another 12 per cent at risk of social isolation.

Several factors that may have been thought to be predictors were found not to be significantly associated with social isolation; for example, old age, living alone and living in a rural/remote area. The strongest predictor of social isolation was poor health. It was also found that males were more likely to be socially isolated than females. War widows, for example, have more developed support networks which reduce the extent of social isolation experienced by this group compared with the general population.

The study identified four major areas of need in enhancing social networks:

- health (physical and mental);
- social support;
- transport; and
- information.

Source: Gardner *et a.* (1999).

Broadening the understanding of links between services

There has been a policy shift in the organisation of aged care services. The focus is now on individuals moving through the system, and on population based planning and funding mechanisms. This is in contrast to previous arrangements under which funds were more closely tied to particular programs rather than being flexible to allow greater response to individual needs.

There is an appreciation that older persons are significant users of sub-acute services, and that policy and planning need to recognise the link between these services and traditional aged care services as covered in this Report. A comprehensive framework for aged care services would indicate links to sub-acute health services. Appropriateness of care, for example, is best addressed with

reference to the acute care sector. This Report features data on the numbers of nursing home-type patients in public acute hospitals. However, while some of these people would be more appropriately cared for in a residential care setting, not all people who are classified as nursing home-type patients in public hospitals are eligible for entry to nursing homes. External factors such as geographic dispersion also affect the optimal mode of service delivery.

11.6 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 ageing of the Australian population creates opportunities, challenges and responsibilities for the Government, industry, the community and individuals. The Commonwealth has a major commitment to aged care: residential aged care is financed and regulated by the Commonwealth Government ($3.4 billion in 2000-01), with services largely provided by the non-Government sector, while the Commonwealth, together with States and Territories, funds and delivers community care ($0.9 billion in 2000-01), as well as providing services to carers. Funding will continue to increase in line with growth in the aged population and client dependency.

The 1999 International Year of Older Persons has been an opportunity to explore community attitudes to ageing and the aged, and issues related to an ageing society. A major essay on IYOP is in the Department of Health and Aged Care’s Annual Report.

The Commonwealth supports the collection and reporting of nationally consistent and comparable data items and performance indicators. Commonwealth data is nationally consistent, but work is still needed to ensure comparability across data collections. Where Commonwealth data is not available, e.g. with nursing home-type patients, the Commonwealth relies on States to report this data in a way that supports jurisdictional comparison.

The Commonwealth is progressing data development on three fronts:

- The Aged and Community Care Data Advisory Group was established by the National Community Services Information Management Group in June 1999. Its role is to review aged and community care data collections, data development needs and identify gaps in data development. The Group's aim is to ensure that consistent data definitions are used across aged and community care programs and follow the National Community Services Data Dictionary. The Aged Care Services Working Group for the Review of Commonwealth/State Service Provision has a participant on this Committee.
- The Community Care Branch has contracted the AIHW to undertake a review of the ACAT minimum dataset, to establish a CACP minimum dataset, and to develop performance indicators for community care services. The Branch is also establishing a data collection for carer respite centres and is reviewing the Client Information Assessment Referral Record (CIARR).
- The Home and Community Care minimum dataset was trialled in October 1999 and is to be introduced in July 2000, with all services collecting and reporting data from January 2001. ”

New South Wales Government comments

“NSW has used the International Year of Older Persons (IYOP) to promote a client centred focus to its service provision across aged care and an environment that enables all older people to lead satisfying and productive lives with maximum independence and well-being. During IYOP significant community partnerships have been forged with and between Government agencies and greater community awareness of the needs of older people has been advanced through numerous local and Statewide initiatives including a schools website, a health website, a dementia awareness campaign and a community grants scheme.

The Ageing and Disability Department and the NSW Health Department are directly responsible for providing acute and community care, and funding programs and services for older people. Over 20 government departments have reported how their Year 1 actions under the NSW Healthy Ageing Framework, have made mainstream services such as housing, transport and local government services, more responsive to the particular needs of older people across NSW. Additional resources have been made available to develop a framework of services for carers.

Planning for older people has been advanced through the Older People’s Health Survey 1999 and Population Group Planning (PGP). PGP is a NSW regional planning framework for mapping of service supply and demand, and for creating opportunities for better coordination across levels of government, for any given location. It has been promoted through sharing of data under a Memorandum of Understanding on Joint Planning between Commonwealth and NSW departments.

The NSW Government is implementing reforms to improve the efficiency and effectiveness of community care services. A community care assessment framework has been developed that is streamlining assessment processes across a range of community health, aged care and disability services. Implementation of National HACC reforms, such as the HACC Minimum Data Set and measurement of performance against HACC National Service Standards, are well advanced.

NSW continues to approximate the national average for HACC expenditure per head of the total HACC target population (i.e. including younger people with disabilities). The HACC service provision for 70+ is an estimate only and as such provides a poor basis for comparison across jurisdictions. NSW has the lowest proportion (29 per cent) of older people with unmet needs for HACC services. However, NSW continues to be disadvantaged by reduced Commonwealth Government growth offers for the HACC Program as a result of the 1996 Federal Budget decision on fees.”

Victorian Government comments

“The Victorian Government recognises the vital contribution that older people make to the creation of a stable and mature society. It is committed to addressing the special needs of older people and ensuring that its policies and programs reflect the diversity of their lives. An adequate income and access to good quality health and aged care services are essential.

The Government is committed to upgrading the current stock of State-managed nursing homes to meet national standards. However, the distribution of Commonwealth funds for residential care has been to the disadvantage of Victoria. As the figures in this chapter illustrate, Victoria continues to be substantially under-supplied with residential care places compared to other States, when measured on the basis of beds per thousand people aged 70-plus.

Shortages in sub-acute care will be addressed by a systematic growth in expenditure over the next four years. The focus will be on rehabilitation and on geriatric medical care. Health promotion programs will be developed for older people, including programs in such areas as falls prevention, continence, diabetes and arthritis.

A stronger emphasis will be given to the problem of improving the interface between the hospital and the community. This will help ensure that public hospitals can continue to meet the demographic demands of an ageing population. A comprehensive Hospital to Home Program for patients discharged from hospital is being implemented. Its major beneficiaries are likely to be older people.

Expansion and development of home and community care services will be a priority. Many HACC service providers are known to be under continued pressure to ration, because demand is higher than they can satisfy. The level of growth in the program is still being hampered by the limited funding made available by the Commonwealth.

Assessment of individual older people’s needs for particular packages of health services and community services at critical stages in their lives is recognised to be the key to the rational allocation of resources. Models to streamline the assessment process are therefore being developed, and improved methods of coordinating services for the frail aged and people with chronic illness are being considered.”

Queensland Government comments

“This year has seen considerable attention focussed on older people, primarily on healthy ageing. The International Year of Older Persons 1999 has provided an opportunity for older people to express their views, and for the community as a whole to review its perceptions of older people and their roles. Queensland is committed to ensuring that the impetus of the Year is not lost, and that there is a continuing emphasis on the views, preferences and needs of older people.

The development of a whole-of-government five-year strategy in Queensland has provided an opportunity for all departments to work together to develop a platform for initiatives for the new millennium. The strategy, “Our Shared Future: Queensland’s Framework for Ageing 2000-2004”, will provide an overview of Government achievements and initiatives, and ongoing monitoring of progress will ensure its continued relevance.

Queensland Health has confirmed its continuing involvement in the provision of residential aged care, and has completed a program of upgrading infrastructure in State Government nursing homes to enable their certification. Further, all 21 facilities are expected to achieve accreditation by 2001. This reform strategy will ensure that the quality of care for residents meets industry standards.

Queensland remains the most disadvantaged State in relation to the level of the residential care subsidy paid by the Commonwealth. Residential aged care providers, including the Queensland Government, continue to seek equity in line with the recommendations of the Productivity Commission Inquiry Report on Nursing Home Subsidies.

The Queensland Government has signed the HACC Amending Agreement. The Agreement provides an important lever for reform within the Program, simplifying administrative arrangements between the Commonwealth and the State and strengthening the basis for needs based planning, contracting arrangements between the State and providers and accountability. Queensland continues to support national initiatives in assessment, targeting, standards measurement and the adoption of a minimum data set.”

Western Australian Government comments

“An important aged care services planning issue for the State is the widening geographic spread of the State’s rapidly growing elderly population. This change in the distribution of the State's aged population follows a sustained period of residential expansion in Perth and the south west of the State.

Residential care facilities are still relatively concentrated in the inner suburbs of Perth. However, new and existing residential care providers are being encouraged, in accordance with residential care planning guidelines, to relocate and develop new facilities in areas of high aged population growth. Over time this will significantly improve the distribution of residential care facilities in the metropolitan area.

An even more important long term trend is the growing preference of older people to remain in the community for as long as possible. While this is recognised as a very desirable development for older people and the community and should be encouraged, it is placing substantial added pressure on community care and carer support services. For example, in Western Australia, notwithstanding the continued growth in the number of Commonwealth funded community care packages as a substitute for hostel care, there are often waiting lists for these packages.

In its planning of aged care services the State is placing increased emphasis on the development of services which will support the trend to less institutional care including the growth in the need for carer support and respite care and specialised services for people with dementia. There is also a growing requirement for appropriate aged care services which meet the needs of people with disabilities who are ageing.

The State is introducing improved options for community rehabilitation, improved assessment and treatment services for older people with disabilities and chronic illness and improved post acute care services to assist older people to regain independence after acute illness. The continued development of specialist geriatric assessment and rehabilitation services for the early diagnosis and treatment of chronic disease and disability in older people, together with targeted health promotion initiatives for older people such as the State’s “Stay on Your Feet Program”, are seen as important strategies to improve the health status of older people and to enable older people to retain their independence to the maximum extent possible.

Other important aged care service developments in Western Australia are the progressive upgrading and re-development of State Government nursing home services in non-metropolitan areas and the expansion of multi purpose services. Where practical, non-metropolitan State Government nursing homes are being transferred to non-government operation.”

South Australian Government comments

“

South Australia continues to support the work of the Steering Committee for the Review of Commonwealth/State Service Provision in the development each year of better performance indicators and better source data about services.

The Minister for the Ageing, Hon Robert Lawson, released *Moving Ahead — A 5 Year Strategic Plan for Human Services for Older People 1999–2004* in 1999.

Moving Ahead is in it's first year of implementation, steered by a Reference Group comprising representatives from the Department of Human Services, the Commonwealth Department of Health and Aged Care, and service providers and consumer peak bodies. The Plan will bring about significant strategic change in Human Services for older people in South Australia.

Reforms will see a greater emphasis on maintaining people in their own communities, an exploration of the substitution of expensive acute services, a reduction of acute outlay through early intervention and prevention, and an emphasis on pre-admission, discharge planning, post-acute care and rehabilitation. The Strategic Plan also envisages more extensive roles in the future for the non-government and private sectors.

The directions of *Moving Ahead* resulted from wide consultation throughout South Australia. It reflects the aspirations of all stakeholders to create more stream-lined and integrated services, which emphasise, among other things, improved access to information and support, a sharper focus on the benefits of rehabilitation, the development of common entry processes linked to the primary care and community support system, the co-ordination of care for people with complex/chronic needs and greater priority on developing system responses for Aboriginal people.

The Plan also includes strategies which will promote integrated planning (including with the Commonwealth), more effective resource allocation and an emphasis on management for quality performance.

Within this framework, the State Government will continue to pursue opportunities for collaborative effort with and between service providers and explore with the Commonwealth approaches which will improve the planning and coordination of services from resource allocation through to coordinated service delivery.

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Tasmanian Government comments

“ The Tasmanian Government is committed to the development of policies and the provision of health services to ensure that all older Tasmanians have access to appropriate health and support services.

Tasmania has a large ageing, but dispersed rural population, which creates a complex environment for the delivery of health services. In response the Government has forged ahead with the development of partnerships, between governments and local communities. In these communities health services are being restructured at a local level to provide a responsive and flexible range of services. Local partnership groups are being established to assist providers in identifying service priorities.

The pressure on small rural, residential aged care facilities to maintain viability is well documented and the view of the Government is that the expansion of Multi-Purpose Services throughout the State is critical if aged care services are to be maintained in rural communities.

A priority for the Tasmanian Government has been the provision of services to people with dementia. This year the Government has undertaken wide community consultation in the development of the Tasmanian Dementia Care Plan. The Plan provides direction for policy and service development in the care of people with dementia and for the support of their carers.

Tasmania has an increasing number of aged, or prematurely ageing, people with a disability, or suffering from a mental disorder and the Government is committed to ensuring that mainstream services are providing equity of access and appropriate responsive services to these people. The Government has invested heavily in the provision of a number of new and appropriate accommodation facilities for aged people with highly complex and challenging behaviours.

Tasmanian has also seen a significant increase in demand for community based health services and an increasing number of aged clients with complex care needs. The Department has responded with additional individual programs to support these people while they wait residential aged care placement or to maintain them in the community if that is their wish. Home and Community Care program has also responded by ensuring services are targeted to areas of greatest need.

The Government’s Aged Care Rehabilitation Unit in partnership with St Johns Private Hospital and the Kingston Rehabilitation Centre in Victoria is establishing a specialist treatment unit for best practice management of Parkinson’s Disease. In another partnership the Unit and the Department’s Emergency Medicine Services are developing strategies to improve outcomes in the reoccurrence of falls through the Falls Prevention Clinic. The Department has also expanded rehabilitation programs within day centres for aged people with chronic conditions.

The Tasmanian Government is committed to a whole-of-government approach to aged care and seeks to work collaboratively with all levels of government in the provision of appropriate and accessible aged care services. ”

Australian Capital Territory Government comments

“The ACT Government is committed to promoting and protecting the health of its older citizens as part of its broad commitment to leading Australia in maximising both community and individual health and wellbeing.

The ACT population is ageing at a faster rate than any other jurisdiction. In 1998, one person in five in the ACT was aged 50 years or over. By 2013, it will be one person in three. Similarly, the proportion of people aged 65 or more in the ACT will triple by 2051. Older people in the ACT are generally healthier than their counterparts in other jurisdictions. Seventy five per cent of ACT residents over 50 years of age rate their health as good to excellent, compared with 71 per cent nationally. This data highlights the need to ensure that appropriate services are in place to meet the future needs of the ageing population.

As part of its commitment to the International Year of the Older People (IYOP), the ACT Government has established an Aged Health Care Services Advisory Council. The role of the Council is to provide advice to the Minister for Health and Community Care and the Department of Health and Community Care in matters concerning the planning and provision of health care services for the aged in the ACT with a strong consumer focus.

As part of IYOP, the ACT Government also recently released a discussion paper *Towards a Society for All Ages: A Forward Plan for Older People in the ACT 2000-2003*, which provides a framework for the development of a new Forward Plan for Older People in the ACT. It is designed to seek responses from the general community, from older people, from service providers and from government agencies.

The ACT Government has undertaken a number of service delivery reviews and consumer surveys over the past eighteen months in relation to aged care and home and community care to assess service gaps and unmet need. These have included HACC needs profile, HACC case management practices, community transport review, taxi subsidy scheme review and an epidemiological review of the health status of older people in the ACT.

The outcomes of the reviews and surveys are being utilised in the development of a revised model for aged care and home and community care service purchasing, which will be based on the principles of coordinated care, shared service provision and consumer centred services.”

Northern Territory Government comments

“The Northern Territory has diverse regional, cultural and economic characteristics, which continue to pose problems for Government in the provision of effective aged care services.

Although the aged population represents a significantly smaller percentage of the NT population than nationally, the number of aged people is growing faster in the NT than in Australia as a whole. By 2031 the number of Australians aged 65 years and over is expected to increase by 100 per cent, while in the NT the number of people in this age group is expected to increase by over 300 per cent. Clearly this will impact on the demand for care services, both residential and community based.

These increases require a strategic approach to the planning for services taking into consideration a number of distinctive features. Specifically these features include a much higher proportion of Aboriginal people (28 per cent compared to 2 per cent nationally), a higher proportion of people living in rural and remote areas (27 per cent compared to 14 per cent nationally, 12 per cent in NSW and Victoria). Further, there is a higher proportion of younger people residing in nursing homes in the NT and a significantly higher proportion of Aboriginal people in high level facilities (42 per cent compared to 1 per cent nationally). In the Home & Community Care Program, 26 per cent of people accessing HACC services were under 65 compared to 14 per cent nationally.

The Commonwealth has recognised the unique characteristics of this jurisdiction and has included an age limit of 50 years and over in the planning of services and in the allocation of residential and Community Care Packages for Aboriginal people. This has assisted in improving the equity of access to services across the NT. However, issues such as remoteness, the subsequent cost of service delivery, the lack of infrastructure and the difficulties in providing stand alone residential care options impact heavily on the ability of rural and remote communities to provide appropriate services.

The Northern Territory is however, cognisant of the fact that aged care services are an intricate part of the broader health and community services system and is committed to an approach, which will address the health needs of older Territorians across the spectrum of services. This will require the development of innovative approaches to service delivery including flexible funding options like transitional care step down facilities and slow stream rehabilitation services which can assist people to stay in their communities.”