12 Aged care services

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

- high care, low care and mixed care residential services and residential respite services (box 12.1);
- community services, which include Home and Community Care (HACC) program services, Community Aged Care Package (CACP) program and home care support for veterans;
- respite services, which include HACC respite and centre day care and the Commonwealth National Respite for Carers Program; and
- assessment services, which are services provided by Aged Care Assessment Teams (ACATs).

A profile of aged care services appears in section 12.1, followed by a brief discussion of recent policy developments in section 12.2. Together, these 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 12.3, and data are discussed in section 12.4. Future directions in performance reporting are discussed in section 12.5. Jurisdictions' comments are reported in section 12.6. Definitions for data descriptors and indicators are provided in section 12.7.

A number of specific additions and improvements have been made to the chapter this year. These include descriptive information on targeting of HACC services, Indigenous specific and flexibly funded services, and compliance with standards for residential services. More detail on improvements to the framework can be found in section 12.3.

Box 12.1 **Interpreting residential care data**

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

- *Residential services data*: This Report groups residential services for reporting purposes based on the Resident Classification Scale (RCS) profile of their clients. Services are classified as either:
  - high care services: similar to nursing homes in the pre-1997 regime, these services cater primarily to meet the needs of high care residents. These services have 80 per cent or more residents classified as RCS 1–4.
  - low care services: similar to hostels in the pre-1997 regime, these services cater primarily to meet the needs of low care residents. These services have 80 per cent or more residents classified as RCS 5–8; or
  - mixed care services: these services meet the needs of both high and low care residents. They have less than 80 per cent residents classified as RCS 1–4 or more than 20 per cent of residents classified as RCS 5–8.

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

  Although there must be a needs match between residents entering vacant places (that is, vacant low care places must be filled by low care residents), this can change over time with ageing in place resulting in high care residents occupying low care places.
- *Locality data*: Geographical data areas are based on the Rural, Remote and Metropolitan Area (RRMA) classification (DPIE and DHSH 1994). Data are classified according to an index of remoteness which rates each Statistical Local Area (SLA) based on the number and size of towns, the distance to major towns and urban centres, and population densities. Areas are classified into three groups:
  - metropolitan areas: comprising State/Territory capital cities (based on the ABS capital city Statistical Division) and urban centres with 100 000 people more, such as Geelong, Gold Coast, Townsville, Newcastle and Wollongong;
  - rural areas: having several large towns with between 10 000 and 99 999 people; and
  - remote areas: having few large towns with more than 5000 people and where there are great distances between centres and other SLAs.

Older Australians also use many other mainstream health and community services. Other chapters cover outcomes for older people in some of these services — that is, acute health care services for older people in chapter 5 and housing services in chapter 16. There are interactions between these service areas; for example, the number of residential places may affect demand for public hospital beds.

Supporting tables

Supporting tables for chapter 12 are provided on the CD-ROM enclosed with the Report. The files are provided in *Microsoft Excel 97* format at \Publications\Reports\2001\Attach12A.xls or in Adobe PDF format at \Publications\Reports\2001\Attach12A.pdf. Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 12A.3 is table 3 in the electronic files). They may be subject to revision. The most up-to-date versions of these files can be found on the Review web page (www.pc.gov.au/service/gsp/2001/). Users without Internet access can contact the Secretariat to obtain up-to-date versions of these tables (see details on the inside front cover of the Report).

12.1 Profile of aged care services

Service overview

This chapter focuses on residential, community care and assessment services for older people. Services that are designed for the carers of older people are also within the scope of this chapter.

Services for older people 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 people aged 70 years and over as a proxy for the likelihood of a person in the general population requiring these services. Certain groups (notably Indigenous people) may require various services at a younger age. For Indigenous people, those aged 50 years and over are used as a proxy for the likelihood of requiring these services. The Commonwealth Government also uses these age proxies for planning residential care and CACPs.

Government funded aged care services covered in this chapter 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 also receive assistance from both formal aged care services and informal sources.

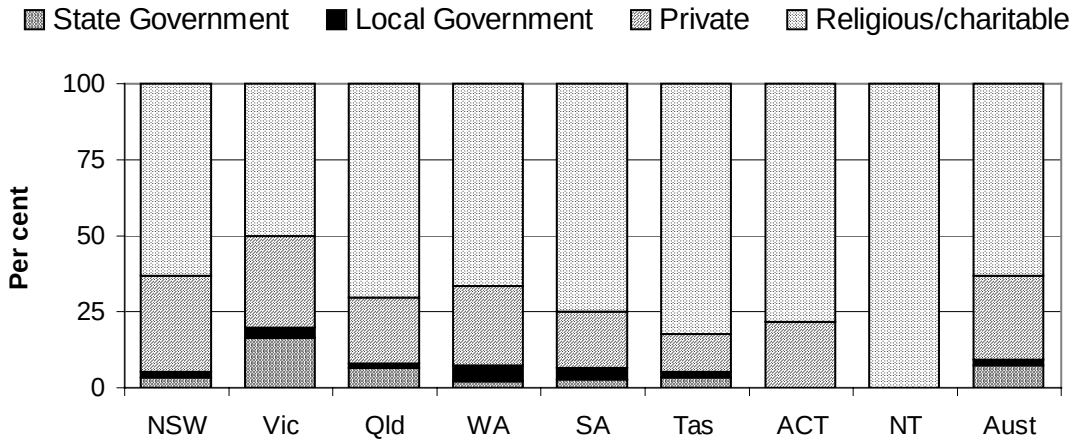
There is also a range of privately funded services that provide support for older Australians. These services do not receive government support and are not within the scope of services reported on in the chapter.

Roles and responsibilities

Residential care services

Residential care facilities are run mainly by private for-profit and religious/charitable not-for-profit organisations. Some State, Territory and local governments also operate some residential facilities (figure 12.1). The majority of places at June 2000 were in religious or charitable facilities (63 per cent). The private sector is mostly involved in high care facilities, managing about 46 per cent of places in these facilities (DHAC unpublished). The proportion of aged care services provided by government, private enterprise and charitable organisations varied significantly across jurisdictions at June 2000.

Figure 12.1 **Ownership of residential places, June 2000**



Source: table 12A.7.

The Commonwealth Government is responsible for most regulation of residential aged care facilities. State, Territory and local governments also have a regulatory

role in areas such as determining staffing and industrial awards, and monitoring compliance with building and fire safety regulations (box 12.2).

Box 12.2 **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 people in the population aged 70 years and over. In addition:

- services are expected to meet regional targets for places for concessional residents, ranging from 16 per cent to 40 per cent of places, to ensure residents who cannot afford to pay an accommodation bond or charge have equal access to care (with criteria for being deemed a concessional resident being based on 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.

Various Commonwealth, State and Territory laws govern regulatory arrangements for residential care. State and Territory legislation may prescribe matters such as staffing, the dispensing of medication and/or certain medical procedures, occupational health and safety, workers compensation requirements, building standards, and fire prevention and 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).

Assessment services

The Commonwealth established the Aged Care Assessment Program in 1984 based on the assessment processes used by State and Territory Area Health Services to determine eligibility for admission into residential care and the level of care required (and thus the subsidy paid to such services). Assessment and recommendation by ACATs is mandatory for admission to residential care or receipt of a CACP. ACATs may also refer people to other services such as those funded by the HACC program.

State and Territory governments are responsible for the day-to-day operation of ACATs. The role of the teams differ slightly between jurisdictions and within a jurisdiction, partly reflecting the service location (for example, whether the team is attached to a geriatric service, a hospital or a community service).

Community care services

The two types of community care program that are reported in this chapter — the HACC and CACP programs — fund services that aim to provide practical assistance to enable frail older people and people with disabilities to continue living in the community. The services are usually provided by State, Territory and local government organisations, charitable bodies, community organisations and commercial providers. The Department of Veterans' Affairs (DVA) and the National Respite for Carers Program also provide community services.

Indigenous specific and flexibly funded services

About 60–70 per cent of Indigenous Australians needing aged care services have their needs met through the mainstream services covered by this chapter (DHAC unpublished). Indigenous specific and flexibly funded services provide services for the majority of those people not in mainstream services (box 12.3).

Funding

Assessment

The Commonwealth, State and Territory governments jointly fund ACATs. Of the $25 million expended in 1997-98 on NSW ACATs, for example, the Commonwealth contributed 47 per cent, the NSW Area Health Services contributed 46 per cent, and the HACC program and other sources contributed 7 per cent (NDH 2000). In turn the HACC program is jointly funded by the Commonwealth and NSW in a ratio of 60:40.

Residential care services

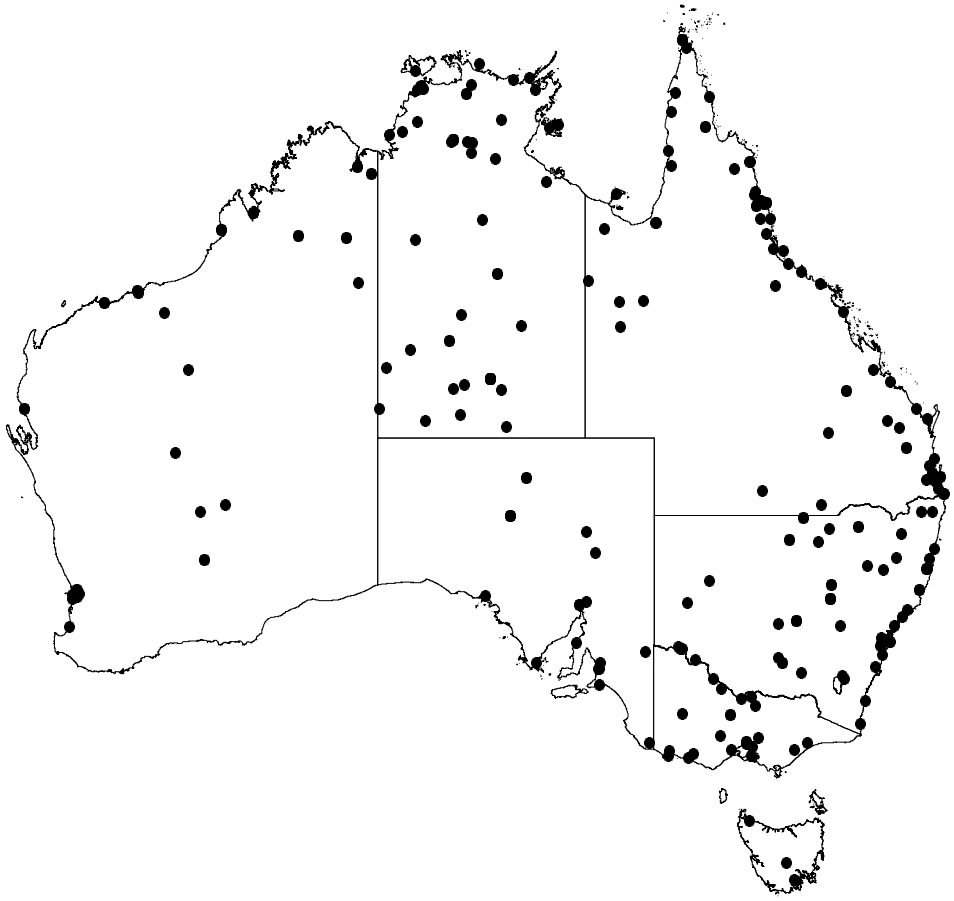
The aged care reforms introduced in October 1997 resulted in a government funding system that does not differentiate between nursing homes and hostels. One aim of this funding system is to promote 'ageing in place' — that is, enabling residents to remain in one aged care facility irrespective of their dependency level. Access to 'ageing in place' is subject to the decision of service providers to offer this option.

Box 12.3 **Indigenous specific and flexibly funded services**

Indigenous specific and flexibly funded services provide care for about 20 per cent of Indigenous Australians needing aged care services. These services are designed to allow Indigenous people to stay in their own communities, and may provide high levels of care for people who need continuous care, and/or middle to lower levels of help with daily tasks and personal care.

Although the Commonwealth is in the process of developing a client based data collection there is limited information available on the services or the people who use them.

Information collected directly from jurisdictions indicates that in August 2000 there were about 225 Indigenous specific and flexibly funded services in operation (see below). These included 52 Commonwealth services across Australia that had 10 per cent or more Indigenous clients. Across jurisdictions, NSW (89), Queensland (48) and the NT (41) had the most services, followed by SA (26), WA (25) and Victoria (23) and Tasmania which had three.[a] The location of Indigenous specific and flexibly funded services in each jurisdiction is mapped below.



[a] The ACT does not have any Indigenous specific HACC services.

Source: Information provided by Commonwealth, State and Territory governments (unpublished).

The Commonwealth Government provides the majority of annual funding for residential aged care facilities — $3.5 billion in 1999-2000, or about 71 per cent of the cost of care (DHAC unpublished). State and Territory governments also provide some funding for public sector beds. Residents provide most of the remainder, with some income from charitable sources and donations.

Commonwealth Government funding of approximately $3.1 million in 1999-2000 was also provided through the Residential Care Development Scheme run by the DVA. The scheme aims to help ex-service and community based organisations to provide high quality residential aged care services and community care packages to the veteran community (table 12A.33).

The Commonwealth Government annual 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 12.1).

Table 12.1 **Average annual Commonwealth subsidy per occupied place and the dependency level of aged care residents, June 2000**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Average annual Commonwealth subsidy per residential place[a]										
All RCS levels	$	24 297	23 672	21 124	22 206	22 499	25 332	21 834	25 479	23 223
Proportion of high level of care residents[b]										
RCS 1 and 2	%	41.5	38.9	39.0	38.6	38.8	36.4	35.1	39.6	39.7
RCS 3 and 4	%	21.3	17.0	21.2	16.4	21.2	27.5	21.4	26.9	20.0
Proportion of low level of care residents										
RCS 5–8	%	37.2	44.1	39.8	45.0	40.0	36.1	43.5	33.4	40.3

[a] Only includes funding on the RCS; pensioner supplement and other supplements will add around $3000 a year for residents. On average, residents contribute $10 700 a 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 12A.32.

The average Commonwealth annual subsidy per residential place at June 2000 varied across jurisdictions, ranging from $21 124 in Queensland to $25 479 in the NT. Variations in average annual subsidies reflect differences in subsidy rates as well as differences in the dependency of residents (table 12.1). Low care subsidy rates RCS 5–8 are the same across all States and Territories, and high care subsidy rates RCS 1–4 are being adjusted towards uniform national rates by July 2006 under the Commonwealth Government's Funding Equalisation and Assistance Package, totalling $148 million over six years.

State and Territory governments contribute financially to the facilities they operate and these services receive lower Commonwealth subsidies than those received by other facilities. The NT Government also provides some funding to some private not-for-profit residential care facilities.

Residents' contributions, and income from charitable sources and donations are also used to fund residential aged care facilities.

Community care services

Total national expenditure on HACC and respite services was $908.5 million in 1999-2000, of which HACC expenditure represented $864.8 million. Commonwealth, State and Territory governments jointly fund the HACC program, with the Commonwealth Government contributing approximately 63 per cent and State and Territory governments funding the remainder (table 12A.30).

The CACP program is funded by the Commonwealth Government, which expended $150.4 million on the program in 1999-2000 (tables 12A.29 and 12A.2). Between 1998-99 and 1999-2000, expenditure per person aged 70 years and over receiving CACPs grew by about 17 per cent (table 12A.29). CACPs are also part-funded by client contributions.

The National Respite for Carers Program provides community care services and is funded by the Commonwealth. Expenditure on this program was $43.7 million in 1999-2000. In addition, the DVA provides funding for a similar range of community services targeted at veterans.

Size and scope of sector

Size and growth of the older population

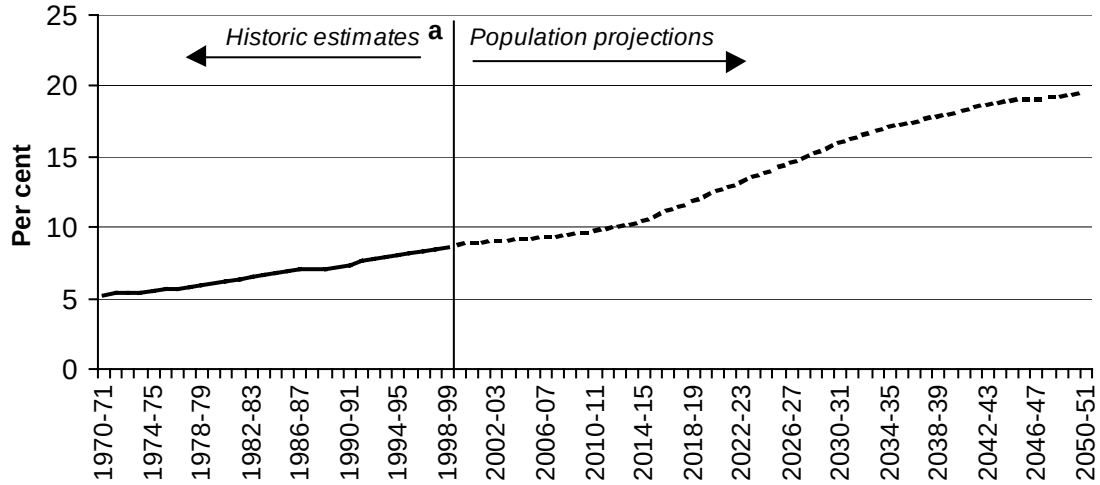
The Australian population is ageing (as indicated by an increase in the proportion of people aged 70 years and over in the total population). This trend is expected to continue and the proportion of older people is expected to increase dramatically in the twenty-first century (McDonald and Kippen 1999)(figure 12.2).

The distribution of aged people varied across jurisdictions at June 1999, with relatively more older people in SA and Tasmania and relatively fewer in the NT (figure 12.3). The proportion of older females was higher than that of older males in all jurisdictions.

Demographic profiles affect the demand for aged care services because females use aged care services, particularly residential services, more than males — for example, 72.4 per cent of aged care residents at June 2000 were female (DHAC unpublished). Females are more likely to use residential services partly because they tend to live longer (that is, there are more women than men in the older

population) and are less likely to have a partner to provide care. There are also greater incidences of incontinence, hip fractures and financial disadvantage among older women.

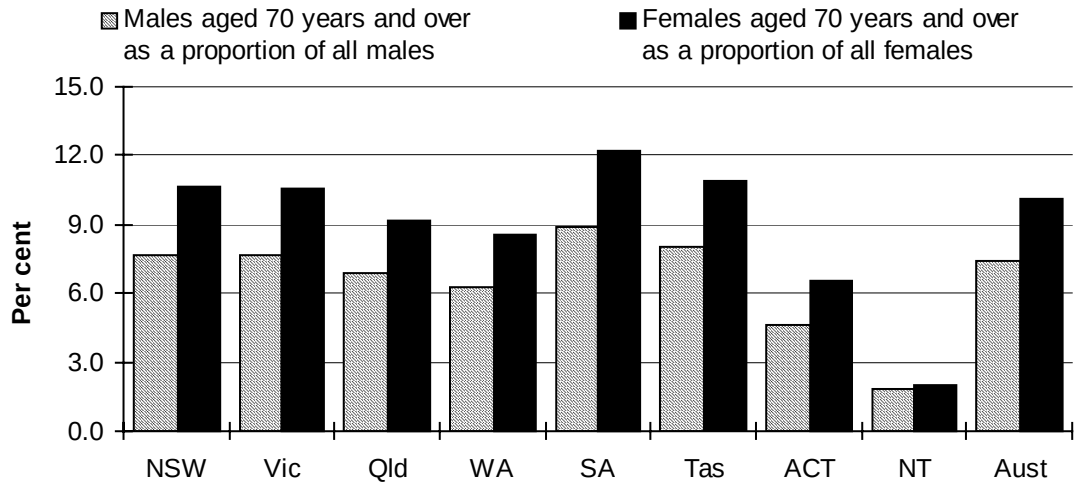
Figure 12.2 **Persons aged 70 years and over as a proportion of the total population — time series**



a Historic estimates are based on the population census that is held at five-year intervals.

Source: ABS (2000).

Figure 12.3 **People aged 70 years and over as a proportion of the total population by sex, June 2000 (estimated)**



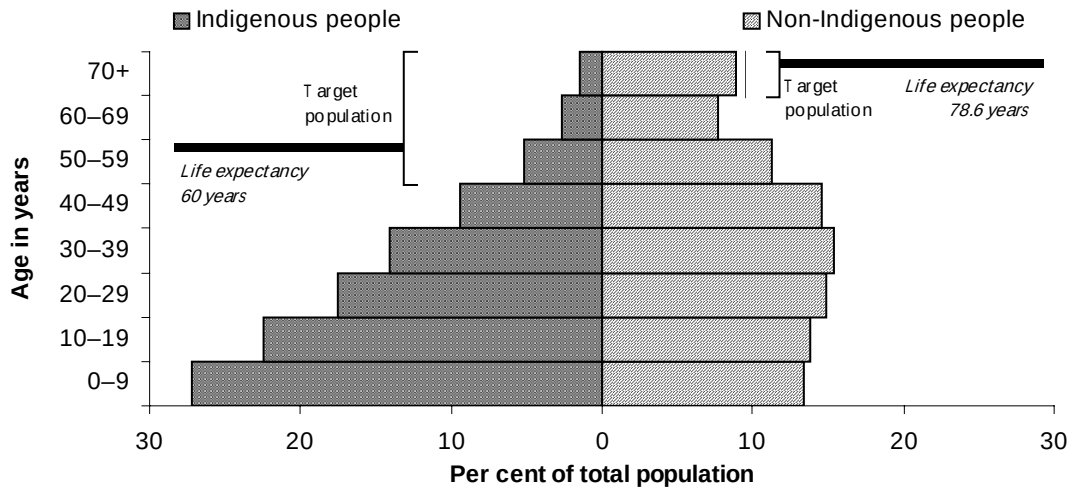
Source: table 12A.1.

Characteristics of older Indigenous people

The Australian Bureau of Statistics estimated that about 39 000 Indigenous people were aged 50 years or more in Australia at 30 June 2000. The majority were located in NSW (29 per cent), Queensland (27 per cent), and WA and the NT (14 per cent each) (ABS 1998).

Although the Indigenous population is also ageing, there are significant differences in the age profiles and life expectancies of Indigenous Australians compared with those of the non-Indigenous population (figure 12.4). The life expectancies of Indigenous males (57 years) and females (62 years) are nearly 20 years below those recorded for the total Australian population (ABS 1998). As a result of these population characteristics Indigenous people are likely to need aged care services earlier in life.

Figure 12.4 **Age profiles, target populations and life expectancy differences between Indigenous and other Australians, June 1999**



Sources: ABS (1998 and 2000).

Residential care services

The size and location of residential services — which may influence costs of service delivery — vary across jurisdictions. Nationally, there were approximately 141 237 places (permanent and respite) in residential care facilities (72 882 in high care services, 46 192 in low care services and 22 163 in mixed services) at June 2000 (tables 12A.3, 12A.4 and 12A.5). As the trend towards 'ageing in place' increases, it is expected that there will be an increase in the number of services categorised as mixed care; that is, the client profile of services that have predominantly low care

residents in 2000 will gradually change if low level care residents choose to stay in their current service as their dependency levels rise over time, and as aged care services expand.

The highest proportions of high care places in rural areas were in Tasmania (58 per cent) and Queensland (33 per cent), while the highest proportions in remote areas were in the NT (54 per cent) and WA (4 per cent) (table 12A.3). The distribution of regional residential places should be examined in terms of the number of potential users (that is, people aged 70 years and over) living in those areas. Tasmania, for example, had both the highest proportion of high care places in rural areas at June 2000 (58 per cent) and the highest proportion of people aged 70 years and over living in rural areas (57 per cent) (tables 12A.3 and 12A.6).

Low care services were generally smaller (by number of places) than high care at June 2000. Nationally, 85 per cent of low care services had 60 or fewer places (table 12A.4), compared with 75 per cent of high care services (table 12A.3).

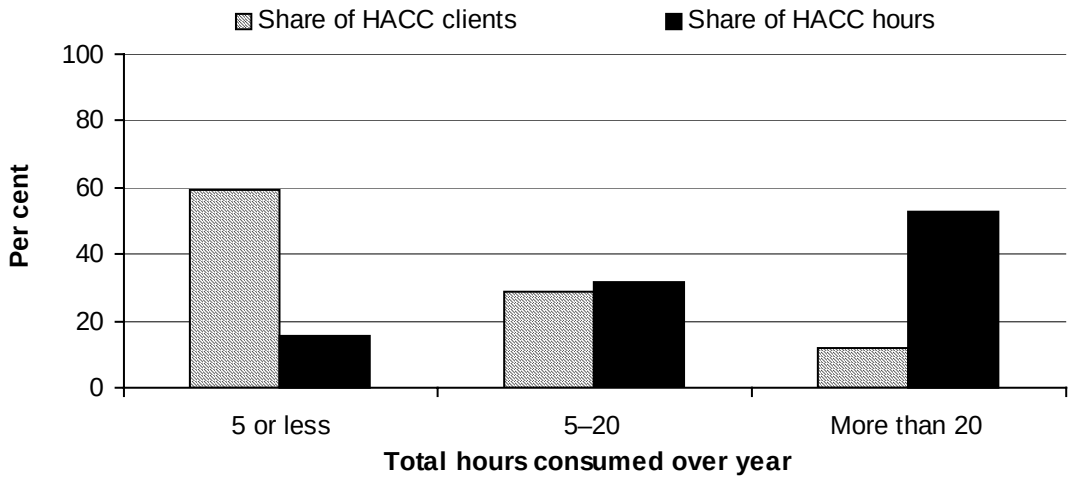
Community care services

HACC funding covers 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 program is also an important source of community care for younger people with disabilities (DHAC unpublished).

HACC clients receive differing levels of service. The majority of clients in 1997-98 (59 per cent) consumed five hours or less of HACC services each over the year and, in aggregate, accounted for a relatively small share (15 per cent) of the total HACC hours delivered (figure 12.5).

A relatively small proportion of recipients in 1997-98 (12 per cent) used the services intensively (more than 20 hours) and accounted for more than half (53 per cent) of all HACC service hours. More complete information on service use by individual HACC clients will be available from the HACC Minimum Data Set which is planned to be implemented in January 2001.

Figure 12.5 **Patterns of HACC service access for individual agencies, 1997-98[a]**



a Data refer to clients of individual services not individual clients. A client that receives services from more than one service will be counted as a separate client in each service. This may mean that for some clients the total number of hours of service received is understated.

Source: table 12A.36.

CACPs provide an alternative home based service for older people who ACATs assess as needing low level residential care (or RCS levels 5–8). The main distinctions between the HACC and CACP programs are summarised in table 12.2.

Two factors suggest community care will continue to play an increasing role in aged care services. First, 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. Second, 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 the HACC and CACP programs have become increasingly important components of the aged care system. The total number of HACC hours delivered per 1000 people aged 70 years and over grew by 0.5 per cent between 1998 and 1999, while the total number of CACP places per person aged 70 years and over increased by approximately 28 per cent between June 1999 and June 2000 (tables 12A.8 and 12A.17).

Table 12.2 **Distinctions between the HACC and CACP programs**

	HACC	*CACPs*
Range of services[a]	Wider range of services available	Narrower range of services available
Eligibility	ACAT assessment not mandatory	ACAT assessment mandatory
Funding	Cost shared by Commonwealth, State and Territory governments and client contributions	Funded by the Commonwealth and client contributions
	Mainstream HACC agency funding is increasingly tied to the delivery of service outputs	Fund holder can spread the available resources among high and lower need clients
Target client groups[b]	Available to people with a greater range of care needs	Targets people with low level care needs similar to residential low care
Size of program	$865 million funding in 1999-2000	$150 million funding in 1999-2000
	About 49 000 clients in 1997-98	About 16 600 clients in 1999-2000

[a] HACC services such as community nursing, which are not available under CACPs, can be supplied to someone receiving a CACP. [b] Most HACC recipients at the lower end of the scale would not be assessed as eligible for residential care; for example, an individual may only receive an hour of home care a fortnight. At the higher end, some people have levels of need that would exceed the level available under CACPs.

Source: tables 12A.2, 12A.9, 12A.29, 12A.30 and 12A.36.

12.2 Policy developments in aged care services

Extended Aged Care at Home (EACH) pilot

The EACH pilot program was established by the Commonwealth Government in 1993-94 to test the feasibility and cost effectiveness of providing care in a person's own home at the level provided in a high care residential facility. The program builds on CACPs, extending support to people eligible for high level residential care (RCS levels 1–4). Both programs reflect a policy response to community pressure for more care for older people to be provided in the home rather than in institutions.

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

The pilot program is cost-neutral to the Commonwealth. An EACH place does not become operational until an existing high level place has been closed by the service provider. The rate of subsidy is equivalent to the basic subsidy rate (in the State or Territory in which the project operates) for an RCS category 3 care recipient.

The EACH program 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 be assessed as requiring high level residential care (nursing home care) and express a preference for receiving care in their own home.

An evaluation of the pilot will be conducted to inform decisions about the future of the program. A report is expected in early 2001.

The Commonwealth Government is developing a *National Strategy for an Ageing Australia*. The National Strategy will deal with short, medium and long term policy responses to population ageing as part of a coordinated national framework. This will, for the first time, create a broad ranging framework to identify the challenges and possible responses for Government, business, the community and individuals to meet the needs of Australians as they age.

Reviews of aged care

Reviews of aged care during 2000 included:

- a two year review of aged services. A progress report, *Two Year Review of Aged Care Reforms: Report of the First Six Months* was released in 1999. A second progress report on the Review was provided in January 2000, followed by a national presentation tour;
- a DVA review of community services. The study compared diagnosis related group based funding and fee for service;
- a review of domiciliary care service in SA commenced in 2000 and is expected to be completed in early 2001; and
- a review of the NSW *Nursing Homes Act 1988*. A discussion paper was released in June 2000 for public consultation. Changes to the legislation are expected to be tabled in the NSW Parliament by the end of 2001. Other reviews include:
    - the HACC food services review in NSW, which is due to report in February 2001;
    - the HACC transport policy review in NSW, which is due to report June 2001; and
    - the HACC unit costing review in NSW, which is due to report early 2001.

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

12.3 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 12.6). These indicators relate to government objectives in the aged care sector (box 12.4).

Box 12.4 **Objectives for aged care services**

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

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

New and refined indicators

The performance indicator framework has been further refined for the 2001 Report. Efficiency data have also been improved by including DVA expenditure on residential services (table 12A.33).

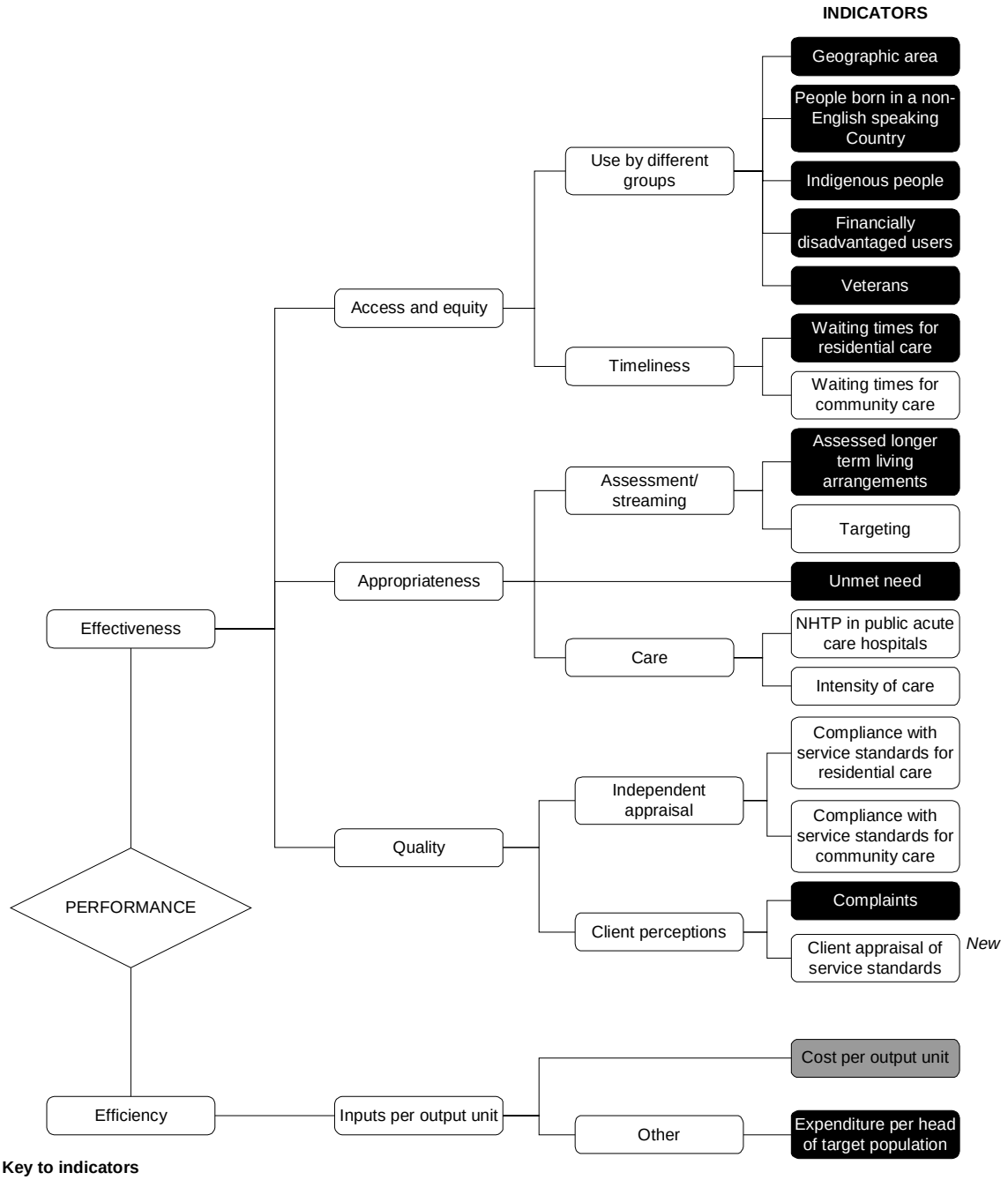
The chapter also foreshadows future reporting by including descriptive data on three areas that have been identified for future reporting: targeting of HACC services; Indigenous specific and flexibly funded services; and compliance with standards.

Ongoing work to provide a more comprehensive set of performance indicators, and to improve existing indicators and the data, is discussed in section 12.5.

12.4 Key performance indicator results

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

Figure 12.6 **Performance indicators for aged care services**

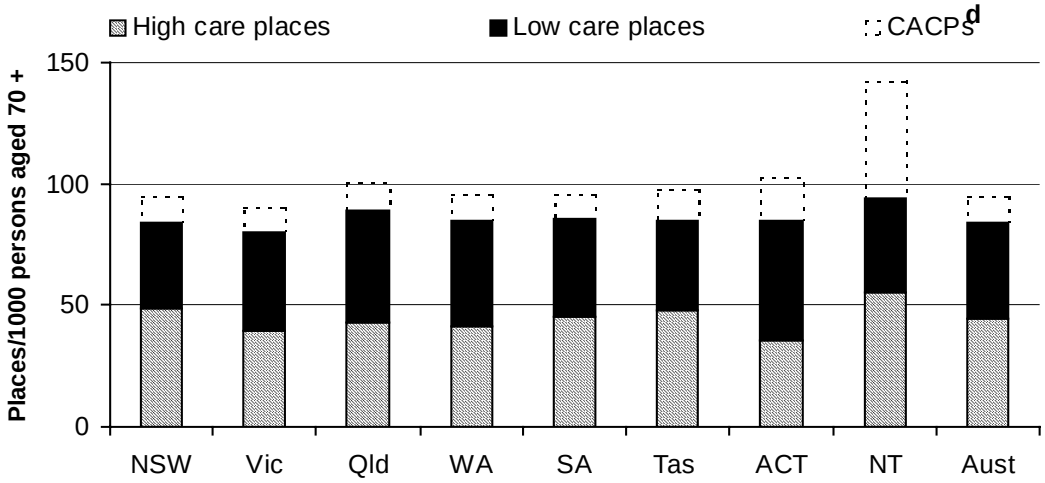


Access and equity — use by different groups

Residential services

The combined number of high care and low care places per 1000 people aged 70 years and over was reasonably similar across most jurisdictions at June 2000 (ranging from 80 in Victoria to 94 in the NT). The ACT had proportionally more low care places and fewer high care places (58 per cent and 42 per cent respectively) than those in other jurisdictions. The NT had proportionally more high care places (59 per cent) (figure 12.7). The proportion of low care places relative to high care places rose between 1988 and 2000 (table 12A.8).

Figure 12.7 **Balance of care: operational residential places and CACPs, June 2000[a, b, c]**



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 101.5. **b** 'Ageing in place' may result in some low care places being filled by high care residents. **c** Target population data excludes Indigenous people aged 50–70 years which inflates the ratios for jurisdictions like the NT which have a large proportion of Indigenous people in care. **d** CACPs are not residential services but are included in the Commonwealth planning targets of 100 places per 1000 residents in the target population. See box 12.1 for interpretation of residential care data.

Source: table 12A.8.

Special needs groups identified by the *Aged Care Act 1997 (Cwlth)* are people from Indigenous communities, people from non-English speaking countries, 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. Indigenous people tend to require aged care services at a younger age than the general

population. Thus, participation is based on Indigenous people aged 50 years and over.

One way of measuring accessibility is to compare the proportion of residents from a special needs group with their representation in the target population (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 — need to be considered in the interpretation of such results.

On average, Indigenous people and people from non-English speaking countries were underrepresented in residential care facilities (figure 12.8). This can be explained to some extent by the different age profiles of Indigenous and people from non-English speaking countries from other residents of aged care facilities. On average, residents of aged care facilities are typically 80 or more years of age. Indigenous people and people from non-English speaking countries in aged care facilities, however, tend to be much younger. There are also cultural characteristics that lead to a preference for community care over residential care for these groups.

Commonwealth planning guidelines require that services allocate a minimum number of places for concessional residents. These targets range from 16 per cent to 40 per cent of new places, depending on the service's region. Services can exceed the minimum amount if they wish. All jurisdictions exceeded the minimum amount, with the NT reporting the highest proportion of concessional residents (74 per cent) (table 12.3).

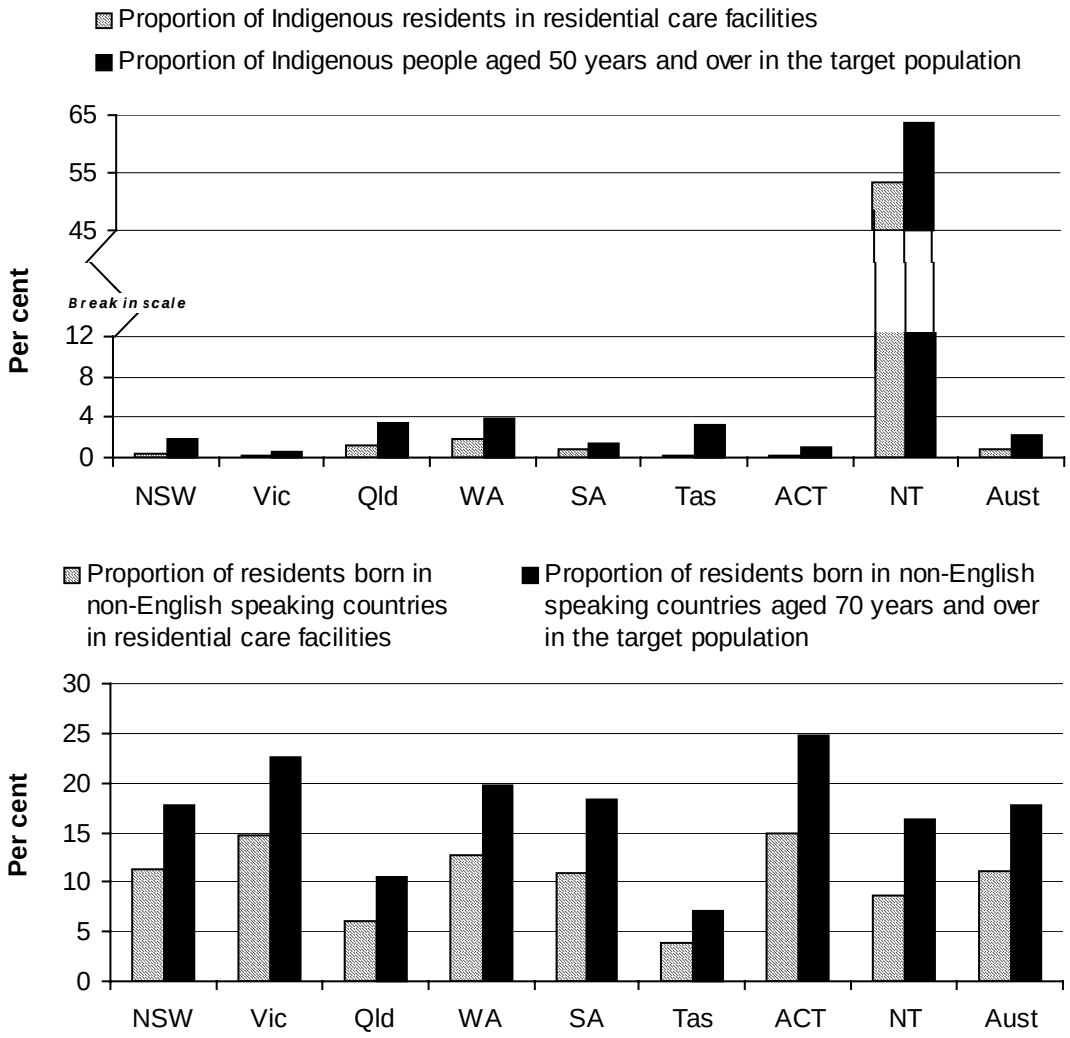
Table 12.3 **Proportion of new residents classified as concessional or assisted residents, 30 June 2000 (per cent)[a, b]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
High care residents	49.9	50.5	51.0	48.9	50.4	55.9	49.4	66.7	50.6
Low care residents	46.8	44.1	44.3	40.6	43.5	51.7	45.4	87.5	46.0
All residents	48.8	47.7	48.3	45.4	48.0	54.0	47.8	74.0	48.7

a Only new residents entering residential care post-October 1997 are eligible for either a concessional or assisted resident supplement. **b** Concessional residents are those who on entry to care were in receipt of an income support payment, who had not owned a home in the previous two years, or whose home was occupied by a spouse or carer, and who had assets of less than $24 000. For married residents, half the couple's combined assets are counted. Assets include interest free loans. Assisted residents are those meeting the above criteria with asset levels between $24 000 and $38 500. The asset levels are as at 30 June 2000.

Source: table 12A.15.

Figure 12.8 **Residential places used by special need groups, 2000[a]**



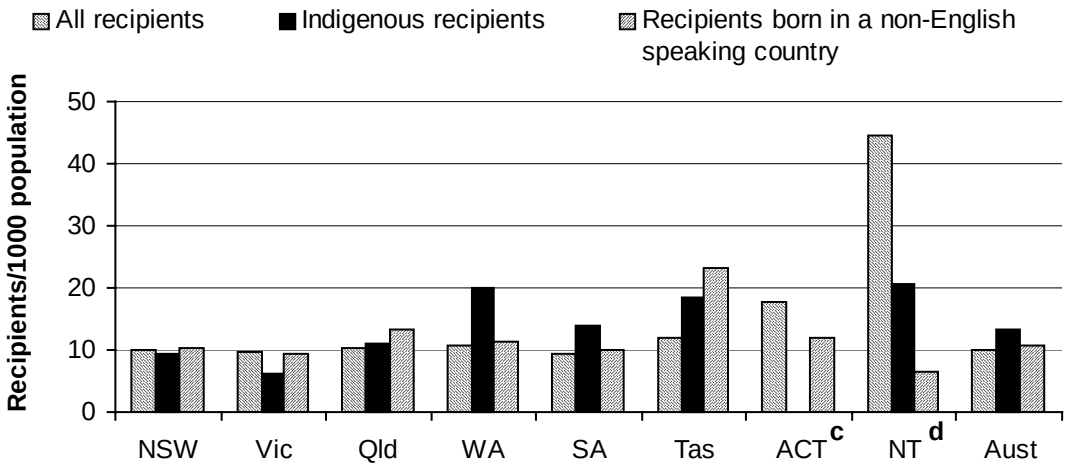
a The target population is Indigenous people aged 50–69 years plus all people aged 70 years and over.

Source: table 12A.14.

Community Aged Care Packages

The number of CACP recipients per 1000 people aged 70 years and over has grown in recent years but is small relative to the number of total recipients of residential care (11 compared with 84 recipients respectively per 1000 people aged 70 years and over at June 2000) (table 12A.8). The jurisdictions with smaller populations (Tasmania, the ACT and the NT) had the highest proportion of CACP recipients per person aged 70 years and over at June 2000. WA, SA, Tasmania and the NT had the highest proportion of CACP recipients per Indigenous person aged 50 years and over. Tasmania also had the highest proportion of CACPs per person aged 70 years and over for people from non-English speaking countries (figure 12.9).

Figure 12.9 **CACP recipients, June 2000[a, b]**



a Excludes unknown responses for Indigenous status. **b** All recipients data is per 1000 people aged 70 years and over; Indigenous recipients per 1000 Indigenous people aged 50 and over. Recipients from non-English speaking countries per 1000 people from non-English speaking countries aged 70 years and over. **c** The number of CACP recipients from an Indigenous background who were resident in the ACT was not reported for 1999-2000. **d** The NT data for all recipients is influenced by the high proportion of Indigenous people who received CACP. In 1999-2000, about 66 per cent of the NT CACPs recipients were Indigenous.

Sources: tables 12A.9, 12A.11 and 12A.13.

Home and Community Care Program

HACC services are provided in the client's home to people with a severe, profound or moderate handicap and to their carers. It is not yet possible to calculate the exact number of hours of HACC services consumed by people aged 70 years and over compared with those used by younger people with disabilities, and tables 12A.17–12A.21 provide estimates only. It is estimated that around 70 per cent of HACC recipients are aged 70 years and over.

The NT had the highest ratio of HACC service hours delivered per 1000 people 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 people aged 70 years and over in rural areas (table 12.4).

Table 12.4 Estimated level of HACC services received per month per 1000 people aged 70 years and over, by region, June 1999[a, b]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Total hours per month[c]									
Capital city	797	1 078	1 183	1 414	940	828	1 014	2 258	1 012
Other major urban areas	873	1 545	1 004	–	–	–	–	–	990
Rural areas	1 018	1 851	1 157	1 315	936	987	–	–	1 266
Remote areas	1 264	1 194	2 021	2 391	1 206	2 342	–	4 166	1 945
All areas	**856**	**1 271**	**1 145**	**1 417**	**923**	**924**	**973**	**2 702**	**1 073**
Total meals per month[d]									
Capital city	395	514	603	533	495	435	311	640	480
Other major urban areas	384	553	429	–	–	–	–	–	417
Rural areas	562	688	614	650	878	538	–	–	633
Remote areas	612	–	1 161	1 652	1 292	1 299	–	4 388	1 273
All areas	**432**	**548**	**585**	**605**	**580**	**497**	**298**	**2 092**	**521**

[a] Estimates based on the proportion of people aged 70 years and over receiving HACC services in each jurisdiction. [b] The definitions of home help, personal care, home nursing and paramedical services varies across jurisdictions. [c] Includes home help, personal care, home nursing, paramedical care, respite care, centre day care and home maintenance. [d] Includes home meals and centre meals. – Nil or rounded to zero.

Sources: tables 12A.17, 12A.18, 12A.19, 12A.20 and 12A.21.

Indigenous people tend to use HACC services more than residential services. Indigenous people must meet the standard HACC criteria of 'people in households with a severe, profound or moderate handicap'. To reflect different morbidity and mortality trends, use of HACC services by all people aged 70 years and over, plus Indigenous people aged 50–69 years, is reported (figure 12.10).

Indigenous HACC clients aged 50 years and over received on average 1535 hours of HACC service per month in 1997-98, compared with 956 hour per month for non-Indigenous HACC clients aged 50 years and over (table 12A.37).

Access and equity — timeliness

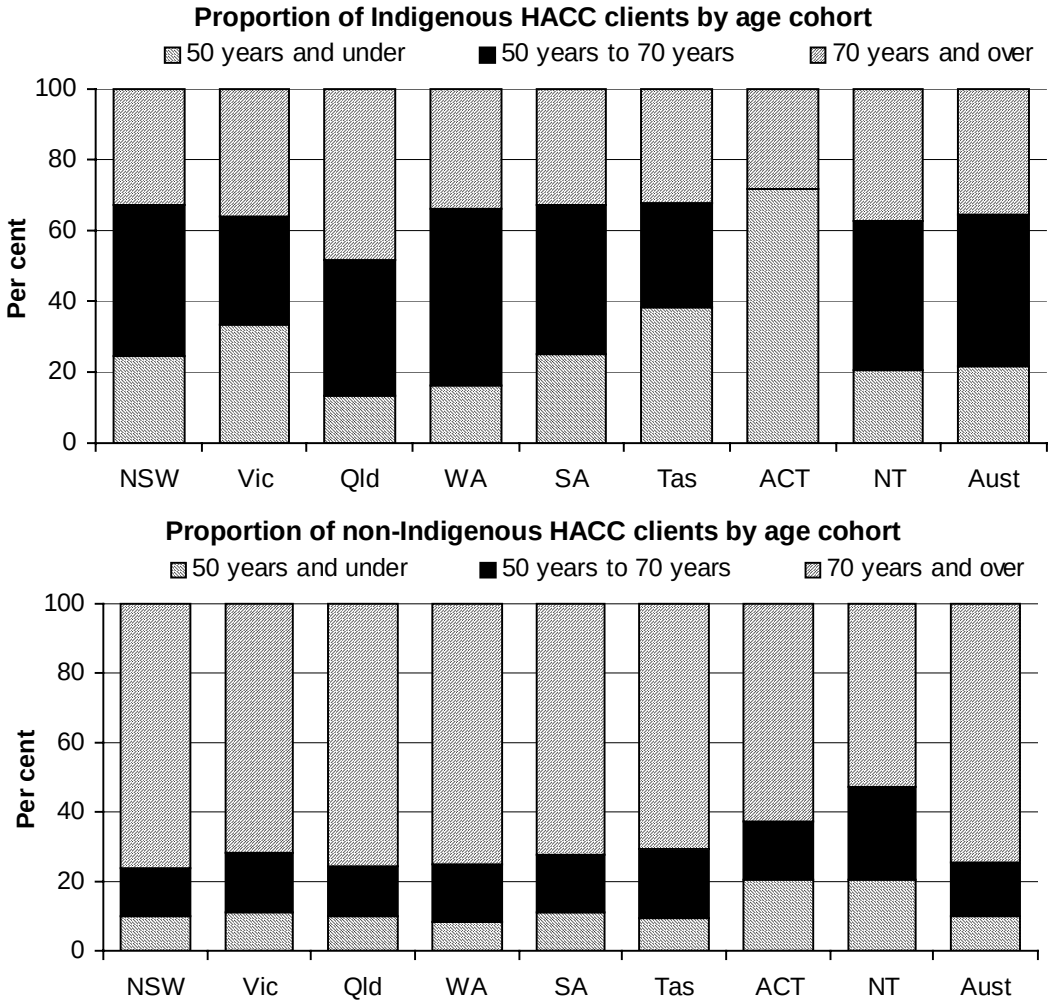
Elapsed time between ACAT assessment and entry into residential service

The elapsed time between ACAT assessment and entry into residential care partly reflects 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 12.5).

On average, 75 per cent of all people entering residential care during 1999-2000 were placed within three months of being assessed, and almost half (48 per cent) were placed within one month of ACAT assessment. Across jurisdictions, the

proportion of people who entered care within three months of assessment ranged from 61.5 per cent in the NT to 80.5 per cent in NSW (table 12A.27).

Figure 12.10 **HACC service by age and Indigenous status, 1997-98**



Source: table 12A.38.

With the exception of the NT, a greater proportion of people entering high care residential care were placed within three months of assessment (81 per cent nationally) than people entering low care residential care who were placed within that time (66 per cent nationally) (table 12A.27).

Across jurisdictions (excluding the NT), the proportion of people entering high care residential care within three months of being assessed ranged from 71 per cent in Queensland to 86 per cent in NSW. The proportion of people entering low care residential care within three months of being assessed ranged from 47.8 per cent in the ACT to 70.6 per cent in WA (excluding the NT) (figure 12.11). (The NT data for 1999-2000 were based on the experience of 72 high care and 37 low care

residents, and may not be representative of the experience of the NT residents over time (table 12A.27)).

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

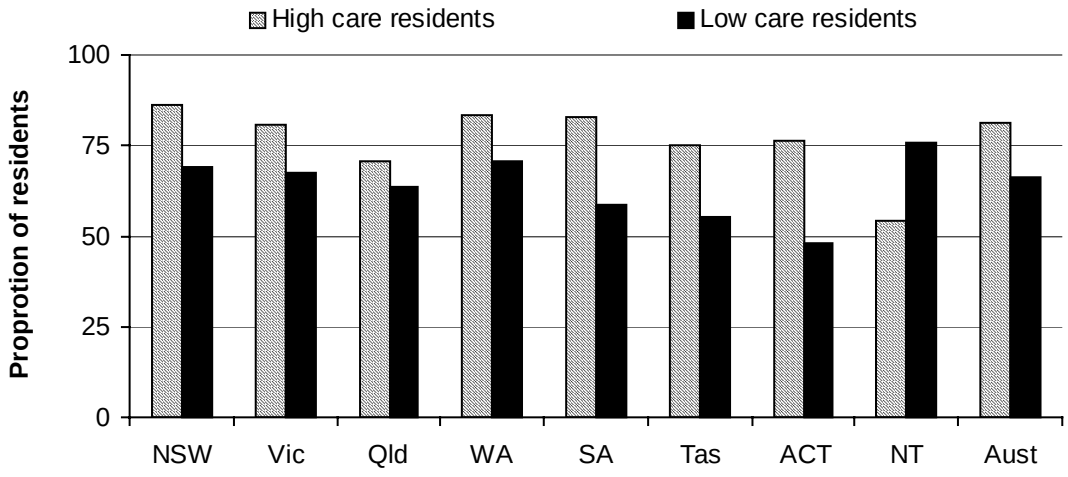
Broadly, the 'elapsed time between ACAT approval and entry into residential service' indicator measures the time between the application and receipt of a service. A robust and comparable indicator requires consistent definitions of when ACAT approval and entry into residential service occurs. The definitions used in this chapter are:

- ACAT approval — that is, the approval date of an ACAT assessment; and
- entry into residential service — that is, when a person is placed in a service.

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

- the classification of residential placement offers that are not accepted;
- the availability of community support services;
- hospital discharge policies and practices;
- distribution of operational residential care services;
- building quality and perceptions about quality of care;
- delays between physical ACAT assessments and approval of assessments; and
- priority allocations.

Figure 12.11 **Proportion of people entering residential care in 1999-2000 who were placed within three months of ACAT assessment**



Source: table 12A.27.

Appropriateness — assessment/streaming

ACATs recommendations of longer term living arrangements

Data on the recommended longer term living arrangements of people referred by ACATs to residential and community care provide information on the patterns and levels of use of aged care services, even though there is clearly no 'correct' mix. ACAT data provide information on referrals to aged care services, not necessarily on their use. Some people may choose not to take up the referrals for various reasons. In some instances people may be referred for a level of care (for example, low care), and the local service provider either does not admit them or takes a longer time to admit them. (Service providers decide which eligible people are admitted to their facility).

The differences in recommendations may reflect external factors such as geographic dispersion of clients and services availability, but also client preferences and views on the types of client best served by community based services. Since ACAT approvals are required for entry into residential care, the client mix is likely to be weighted towards those who have higher levels of dependency.

Table 12.5 provides information on the proportion of assessed people referred to community or residential care. Queensland had the highest proportion of ACAT clients referred to residential care (60 per cent), while the ACT had the highest proportion of clients referred to community care (69 per cent).

Table 12.5 **Recommended longer term living arrangements of ACAT clients, 1998-99[a]**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Community	%	52.6	49.1	35.0	54.9	32.5	43.8	69.0	33.1	47.5
Residential	%	39.9	38.0	60.2	39.1	54.2	53.3	13.8	44.9	43.4
Other	%	2.2	2.3	3.6	1.5	6.1	0.1	12.3	1.2	2.7
No long term plan made										
Died	%	0.6	0.7	0.4	1.3	2.0	0.2	0.1	0.2	0.8
Cancelled	%	0.9	2.0	0.6	–	4.3	0.9	0.7	0.3	1.3
Transferred	%	0.6	5.6	0.2	3.2	0.9	0.3	0.5	–	2.3
Unknown	%	3.2	2.3	–	–	–	1.4	3.7	20.4	2.0
Total	**no.**	**57 171**	**52 684**	**24 551**	**22 254**	**14 601**	**4 552**	**1 147**	**1 955**	**178 915**
Assessment rate[b]	no.	98.5	124.6	88.2	143.7	107.4	102.6	68.6	524.6	109.3

a Includes deaths, cancellations and transfers. **b** Number of assessments of people aged 70 years and over per thousand people aged 70 years and over in 1998-99.

Source: table 12A.35.

The distribution of ACAT living arrangement recommendations will be influenced by the degree to which any preselection process identifies a higher proportion of people 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 use of ACATs for other than residential assessments (table 12.5).

Home and community care targeting

Targeting strategies provide a means of concentrating resources on those in greatest need. Prior to July 1999 the only guidance available to service providers regarding targeting was the HACC Program National Guidelines. In response, the *Targeting of HACC Services* research study was commissioned in 1995. The final report released in July 1999 identified findings in four key areas: benefits of low levels of service use; three levels of service use; seven complementary targeting strategies; and the importance of client and carer involvement.

The focus of the report was a targeting strategies framework that service providers can use as a guide to resource allocation. As a result of the relationship between dependency, need and level of services used, an outcome based targeting approach has been developed. Seven broad types of targeting strategies were proposed to provide the flexibility to achieve different goals for different clients. These broad targeting strategies are designed to:

- reduce inappropriate use of nursing home or hostel care;
- reduce risk of premature or inappropriate admission to residential care;
- allow clients with high and complex care needs to remain in the community;
- improve functioning and support independence in the community;
- support carers;
- enhance quality of life; and
- reduce unmet need.

It was recommended by HACC Officials at the May 2000 meeting in Darwin that the seven targeting strategies identified in the report form the basis of a targeting framework for the HACC Program and that these strategies should be reflected in the HACC National Program Guidelines. The HACC National Program Guidelines are being revised.

Box 12.6 **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 or on application for an ACAT assessment. The project found the following challenges to access:

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

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

Appropriateness — unmet need

Defining and determining the level of need at an individual level, let alone at a population level, is complex. The perceptions of need and unmet need are often subjective (box 12.6). The data reported in this section are based on the level of need from the recipient's perspective.

The ABS (ABS 1999), defines disability with reference to core activity restrictions (see chapter 13, box 13.1). One objective of this study was to quantify unmet need

for services. In total, 293 200 people aged 65 years and over living in households reported a need that was not fully met, out of a total of 887 900 people aged 65 years and over living in households who reported needing assistance with everyday activities (table 12.6). 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 in 1998 varied from 29 per cent in NSW to 44 per cent in Tasmania.

Table 12.6 **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 total or partial 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 12A.34.

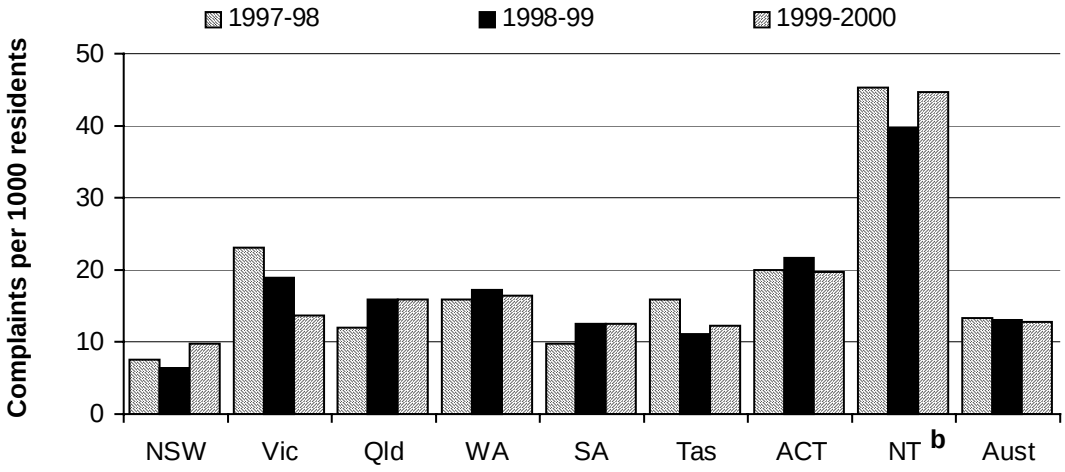
Quality — client perceptions

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 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 in 1999–2000 ranged from 9.7 in NSW to 16.3 in WA (excluding the ACT and the NT which are not directly comparable because the small number of residents in these jurisdictions exaggerates the number of complaints per 1000 residents) (figure 12.12 and table 12A.28).

Figure 12.12 **Residential care complaints per 1000 residents[a]**



[a] Complaints have been annualised for comparison. Estimates for 1997-98 are based on complaints received by Commonwealth Department's State and Territory offices between 1 October and 30 June for 1997-98. Estimates for 1997-98 are based on complaints received between 1 July and 30 June for 1998-99. Estimates for 1999-2000 are based on complaints received between 1 July 1999 and 30 June 2000. [b] A total of 15 complaints were registered in the NT 1999-2000. Most of these were against one NT facility and have been addressed.

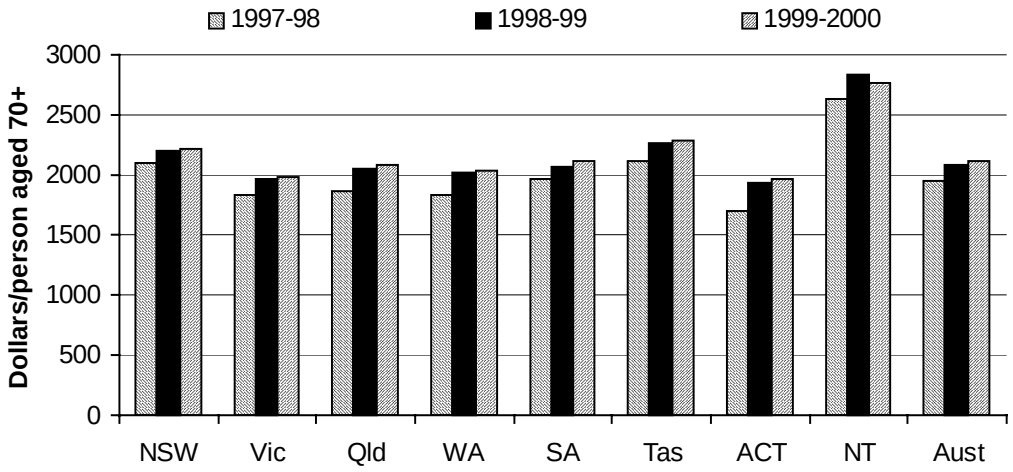
Source: table 12A.28.

Efficiency

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

Commonwealth Government expenditure (including expenditure by DVA) on residential care services per person aged 70 years and over varied across jurisdictions in 1999-2000, ranging from $1969 in the ACT to $2762 in the NT (figure 12.13).

Figure 12.13 **Commonwealth Government expenditure on residential services, per person aged 70 years and over[a, b]**



a Includes expenditure on nursing home benefits, hostel subsidies and residential respite. **b** Includes the Department of Veterans' Affairs contribution ($180 million in 1997-98, $367 million in 1998-99 and $387 million in 1999-2000).

Source: tables 12A.29 and 12A.33.

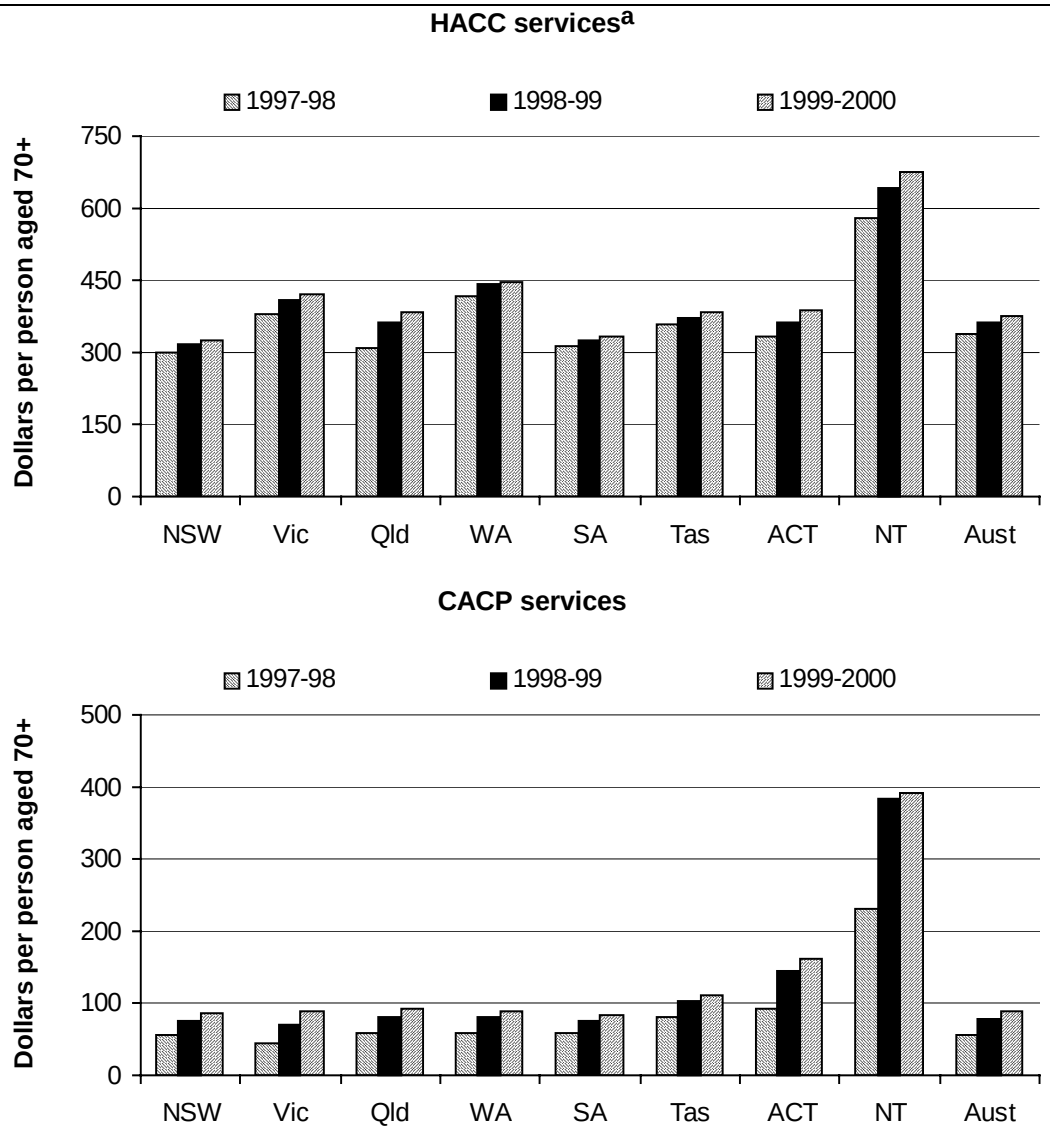
Both the CACPs expenditure and estimated annual HACC and National Respite for Carers Program (NRCP) expenditure per person aged 70 years and over varied across jurisdictions in 1999-2000. NSW reported the lowest expenditure on HACC and NRCP ($327 per person aged 70 years and over) and SA reported the lowest CACPs expenditure ($85 per person aged 70 years and over). The NT reported the highest HACC expenditure ($674 per person aged 70 years and over) and the highest CACPs expenditure ($392 per person aged 70 years and over) (figure 12.14).

For many 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 services, given their heterogeneity. However, components can be identified and unit costs can be measured. Nonetheless, cost comparisons may be affected where services are viewed as substitutes.

As jurisdictions move towards output based funding of aged care services, issues relating to the classification of outputs are likely to 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 and Territory program managers have generally interpreted this as requiring a move

away from historical submission based funding, towards the introduction of uniform pricing for a given service type.

Figure 12.14 **Expenditure on community care services, 1999-2000 dollars per person aged 70 year and over**



a Expenditure includes expenditure on HACC (Commonwealth, State and Territory) and expenditure on the National Respite for Carers Program (Commonwealth only).

Sources: tables 12A.29 and 12A.31.

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 for the funding of public acute care hospitals. The development of a casemix style community care classification system remains a challenge, including how to define a meaningful episode of care and 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 may provide models for HACC.

12.5 Future directions in performance reporting

There are 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. Developments that are relevant to all service areas are discussed in chapter 2.

Progressing work on the 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 people from a non-English speaking background, and Indigenous people in urban, rural and remote locations. An initial report was completed in July 2000 and the final supplementary report is due in early 2001.

The *National Satisfaction Survey of Clients of Disability Services Consultancy Report* (Equal and Donovan Research 2000), a joint publication by the Steering Committee for the Review of Commonwealth/State Service Provision and National Disability Administrators, was released in July 2000. The results of this survey were published in the 2000 Report (SCRCSSP 2000) and analysis of the method used will help address existing concerns about the use of satisfaction surveys of older people.

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 Data Set (MDS) project and the HACC national service standards instrument — may provide useful data for these indicators in the future.

The HACC MDS project aims to provide a client centred data collection that focuses on outputs 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 HACC MDS is scheduled for full implementation in January 2001. A pilot involving 104 HACC service providers in all States and Territories was undertaken in October 1999. The pilot aimed to ascertain the training, information and technical support requirements of the MDS, so they could be addressed before implementation. The pilot also tested 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 MDS will provide client based information about the distribution of HACC services for the first time. This will make 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. Some information on the early stages of implementation may be available for the 2002 Report, with more extensive information available in future Reports.

12.6 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this chapter and attachment 12A on the CD-ROM. 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. In addition, detailed statistics covering aspects such as age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (such as Indigenous and ethnic status) are included in the appendix.

Commonwealth Government comments

“ The Commonwealth Government’s emphasis on community care continued over the last year with increased funding for carers and respite services and increasing availability of Community Aged Care Packages. By the end of this financial year some 24 000 care packages will be in operation.

Commonwealth expenditure on Community Aged Care Packages increased fivefold from 1995-96 to 1999-2000, up from $33 million in 1995-96 to $165 million in 1999-2000. The Commonwealth’s funding for Home and Community Care (HACC) has increased from $423 million in 1995-96 to $565 million this year, an increase of 34 per cent. The Commonwealth’s funding for residential aged care has increased from $2.5 billion in 1995-96 to $3.9 billion this year — an increase of $1.4 billion.

After the Commonwealth Government came into office in 1996, the Auditor-General found there was a 10,000 aged care place deficit left by the previous government. The 1999 Aged Care Approvals Round, together with the places advertised in the round for this year, amounts to 22 000 places to make up for this deficit and to meet the need for growth. In June, the Minister announced the release of more than 14,000 new aged care places worth $173 million a year, in the largest–ever Approvals Round.

The elapsed time between ACAT approval and entry into a residential care service is provided in this Report. However this is no longer considered a reliable indicator of access into residential care and is now under review by the Department of Health and Aged Care. There is significant evidence that it measures changes in provision of community and respite care. The more community and respite is provided to individuals, the longer the elapsed time to permanent entry to residential care, demonstrating the efficacy of community care and respite in delaying entry into nursing homes.

The Commonwealth has provided national leadership in important data developments in the last year, including:

- the establishment in June 1999 of the Aged and Community Care Data Advisory Group (ACCDAG) as a sub-committee of the National Community Services Information Management Group. This provides a forum for reviewing and improving data development activities of a number of government and non-government organisations.
- the development of data dictionaries for HACC, aged care assessments, Community Aged Care Packages, and the National Respite for Carers Program;
- commencement of a stocktake of aged and community care data resources; and
- implementation of the HACC Minimum Data Set in July 2000. The first collection will commence in January 2001 and data reports will be available from June 2001. ”

New South Wales Government comments

“ NSW considers that accurate and current data supports effective resource allocation and empowers governments to promote improvements in access to, and quality of, services. Two significant data projects are welcomed, which will significantly enhance NSW's capacity in this regard:

1. The expansion of the Population Group Planning Data Model (PGP) in NSW has enabled the aggregation of output data from 5 State and Commonwealth Government agencies and the analysis of service supply and demand. PGP has been used as the basis for 1999-2000 HACC allocation across local planning areas in NSW. The HACC Program will grow by over 5 per cent in NSW in 2001-2002, with new expenditure of approximately $21 million, $8.297 million of which is contributed by NSW for growth and indexation.
2. The new HACC Minimum Data Set (MDS) to be introduced in 2001 will provide more accurate and comparative data for this Report than do the current HACC data collections. However, the new HACC MDS is requiring significant additional resources from the HACC Program.

NSW has developed a number of initiatives that foster the health and well being of older people. The NSW Government's funding commitment to the HACC Program sits within a wider context, especially the NSW Government's Social Justice Statement, NSW Disability Policy Framework, NSW Healthy Ageing Framework, the NSW Government's Action Plan for Health, the NSW Action Plan on Dementia, and the NSW Care For Carers Program. The unique needs of Indigenous people and people from culturally and linguistically diverse backgrounds are being recognised in all programs, policies and services.

The NSW Government's Action Plan for Health in particular reflects recommendations from independent reviews of the NSW health system and rural services. Over the next 3 years, $45 million is committed to improve health services in the community for people with chronic and complex care conditions, improve their quality of life and prevent crises and urgent, unplanned admissions to hospital. State and Commonwealth departments are jointly developing strategies to ensure that older people have access to appropriate aged care accommodation, particularly in rural NSW. NSW Health will build and redevelop 34 small rural facilities over the next 3 years; 15 of these sites have been approved by NSW Health and the Commonwealth to be progressed as Multi Purpose Services.

The NSW Healthy Ageing Framework, designed to assist older people to remain active and independent participants in their communities, includes a range of special services and information for older people if their health deteriorates. A comprehensive range of projects under the NSW Action Plan on Dementia includes practical information for carers, good practice models, and dementia awareness programs for the general community and for professionals. The Care for Carers Program will provide support in 3 priority areas for carers in NSW, including counselling, support groups, training, respite, transport and building better responses to carers among health and community care workers. ”

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.

The Victorian Government recognises that a full range of accessible and responsive health and aged care services are required across the State to meet the needs of older people. To this end sub-acute services will continue to be expanded over the next three years. Further work will also occur to improve the interface between hospitals and the community and residential care sectors. The Primary Care Partnership (PCP) Strategy will provide important benefits for older people, particularly those with chronic or complex conditions, by enhancing the coordination of care, developing a more integrated system which is easier for people to use, and improving service planning for the primary care sector, including for community-based aged care services. Each partnership will be working within a common framework which will enable more effective links with hospitals and general practice.

Expansion and development of home and community care services will continue to be a priority. Work to improve the level of equity in HACC resource distribution within the State was undertaken during 2000-01 and will continue. The Victorian Government believes it would be an opportune time to review the national formula for resource allocation in the HACC Program, given the dynamic relationship between demand for community care and demand for residential care services. Unmet demand for HACC services in Victoria is affected by the lower levels of per capita residential care funding relative to other States and the maldistribution of residential care services within Victoria.

The Victorian Government is making a major commitment to improving the building quality of State managed residential care facilities to meet national standards. However, the distribution of Commonwealth funds for operational residential care services continues to disadvantage Victoria in comparison to other States and Territories. In particular, the Victorian Government is concerned that a significant boost in new high care places is needed on an ongoing basis in Victorian to address a situation where the ratio of operational high carer places has now fallen below the planning ratio of 40 places per 1,000 people aged 70 and over. A significant expansion of an appropriately skilled workforce is also necessary to keep pace with an anticipated ongoing expansion of residential and community based services.

Victoria will explore with the Commonwealth opportunities to improve the planning and coordination of services for older people from resource distribution through to coordinated service delivery. The Victorian Government is also committed to a high level of consultation with key stakeholders and local communities to inform the development of new policies and services. A Peak Council of Older Victorians is also being established to help older Victorians to have a voice in the development of a society which values the contribution of older people. ”

Queensland Government comments

“The Queensland Government maintains a whole of Government focus on older people, encompassing a wide range of issues which contribute to health and well-being.

The Minister for Families, Youth and Community Care has lead agency responsibility across the Queensland Government on issues related to older people. A Ministerial advisory council, the Council for Older Persons, was established in 2000 to advise the Minister on issues affecting older Queenslanders. The Council has 14 members, 12 of whom are older people representing a diverse range of interests and backgrounds. The Council advises on a wide range of issues relating to all portfolio areas within the Queensland Government.

Responsibility for aged care within the Queensland Government rests with Queensland Health, which manages the Home and Community Care Program, the Aged Care Assessment Program, State Government residential aged care facilities, and various other services providing long-term care for older people.

Queensland Health has worked towards improving the quality of its residential aged care facilities, and all 21 facilities are now accredited. This has involved a substantial investment both of capital and of human resources.

Psychogeriatric services have been collocated with four aged care facilities, and two further collocations are planned. This facilitates better integration of aged care and mental health services to meet the range of needs experienced by many older people.

Following signing of the HACC Amending Agreement last year, Queensland is progressing new accountability, contracting and standards measurement initiatives. Action is in train for the implementation of the Minimum Data Set in 2001. Current service priorities in the program include improving access for Indigenous people, strengthening the availability of domestic assistance and support; support for carers; regional equity; coordinated assessment; and improved information collection and utilisation.

Queensland Health has focussed on dementia this year, and is in the process of developing strategies and partnerships which will improve the quality and accessibility of dementia services in the State.

Queensland is participating in a joint project with Western Australia and the Northern Territory to investigate appropriate ways of interpreting assessment data from rural and remote Aged Care Assessment Teams to provide a framework for future analysis of Indigenous assessment data.”

Western Australian Government comments

“Compared to most other States and Territories, Western Australia has a relatively young population. However, compared to most other States and Territories, Western Australia is experiencing a faster rate of growth of its elderly population. For example, Western Australia's Home and Community Care (HACC) program target population is projected to grow by 30 per cent from now to 2011, compared to 23 per cent growth nationally.

The State is closely monitoring the effects that aged population growth is having on the demand for aged care services. For example, there are signs that the rapid growth of the State's elderly population is stretching the capacity of available residential care services. Over the past twelve months many elderly people living in the Perth metropolitan area have been experiencing considerable difficulties in gaining timely access to permanent residential care.

One effect of this situation has been higher numbers than previously of people waiting in metropolitan public hospitals for a nursing home bed vacancy. This is in turn is placing pressure on the capacity of public hospital departments of rehabilitation and aged care to adequately meet the rehabilitative care needs of elderly people.

Further work will be done to analyse the factors in addition to aged population growth that are contributing to the difficulties being experienced by elderly people gaining access to permanent residential care when required.

The State has given high priority to the development and expansion of community care services for older people as part of a range of initiatives to meet a projected escalating growth in the need for aged care services. For example, particular emphasis is being given to improved models of community based post acute and transitional care for older people. Other initiatives include:

The establishment of a single rehabilitation and aged care integrated clinical service to improve the coordination of state funded aged care services across the metropolitan area.

The expansion in funding of geriatric day therapy services and the highly successful community based Parkinson's Nurse Specialist service.

As well the State Government has committed to ensuring that there is adequate growth in the capacity of the state's specialist geriatric medical services . The first stage of a five year geriatric medical services development plan has been implemented.

Western Australia is putting considerable effort into the development of improved models of health and related health service delivery in rural areas. For example, there are now 19 Multi-Purpose Services (MPSs) in rural Western Australia and more are planned. An important element of rural MPSs is the ability to improve aged care services in small rural communities by the use of more flexible and relevant service delivery arrangements.”

South Australian Government comments

“ The South Australian population includes the highest proportion of older people of any State or Territory in Australia, a trend which is expected to continue for some time. To this end significant planning has been undertaken by the South Australian Government, initially in the development of *Ageing — A Ten Year Plan for South Australia* released in 1996, and more recently in the development of *Moving Ahead — A Five Year Strategic Plan for Human Services for Older People 1999–2004*.

A review of Domiciliary Care Services will also be finalised in 2000 and review of rehabilitation services, including for older people, commenced in 2000. Both reviews indicate a continuing State Government commitment to the development of community-based and, where appropriate, specialist, services that support people in the communities of their choice.

The implementation process for Moving Ahead is well underway, with the first year annual report indicating continuing high levels of commitment and activity both within the Department and in the sector.

The Department of Human Services has placed a particular emphasis on the development of integrated human services throughout rural South Australia. Joint work is currently being undertaken with the Commonwealth Department of Health and Aged Care and with several rural communities in the continuing development of rural health services. A seminar on rural ageing in November 1999 provided an opportunity for community leaders, older people, and service providers from throughout the State to discuss issues and opportunities for older people in rural areas. The report of those proceedings is now available and has provided a useful basis for continued whole of Government effort in rural areas.

Consistent with other States and Territories, Indigenous people in SA do not yet enjoy the additional years of life which have become increasingly more likely for non-Indigenous people. A particular focus on both the development of Indigenous specific services and on improving access to mainstream services has lead to an improved coverage of services for Indigenous people, including in remote areas of the State.

2000-01 marks the end of the period in which the Commonwealth Government’s HACC fees policy has reduced growth funding for South Australia. There is considerable unmet need for HACC services in SA and this year the State Government has committed $2.5 million in new funding for the HACC Program in anticipation of the Commonwealth’s offer for growth. ”

Tasmanian Government comments

“ The Tasmanian Government's commitment to ensuring that all older Tasmanians have access to appropriate health and support services has resulted in a major review of service delivery policies across all Districts. The review will ensure that standards in equity of access, availability and service provision will be applied to future business planning and service development.

The development of partnerships, between governments and local communities has continued with several communities well advanced in the creation of new service delivery models. A number of other rural communities are actively participating in health service reviews. Rural communities recognise the need to restructure health services at a local level to ensure that services are appropriate and relevant to the needs of the community.

The majority of Tasmania's large ageing population resided outside the metropolitan areas of the State creating a complex environment for the delivery of health services. This together with the well documented pressures on residential aged care facilities in rural communities provides a significant challenge in meeting the major objectives of the *Aged Care Act 1997* — to ensure that aged care services are provided towards people with the greatest needs; to provide flexible and responsive aged care services; to provide equity in access and to ensure access regardless of geographic location.

A priority for the Tasmanian Government has been the implementation 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. The Government has established a clinical reference group and a community reference group to oversee the implementation, evaluation and updating of the Plan on an annual basis.

Tasmania has an increasing number of people with a disability, or suffering a mental disorder where their aged related disability is becoming the primary diagnosis and health need. The Government is committed to ensuring that mainstream services are providing equity of access to these people. The Government's heavy investment in the provision of new accommodation facilities for aged people with highly complex and challenging behaviours is nearing completion.

There also has been a significant increase in the number of people waiting placement into residential aged care within the State and this has created an increasing demand for community based health services particularly aged clients with complex care needs.

The Home and Community Care program has responded to increase demand for services by ensuring that services are targeted to areas of greatest need. The implementation of the Home and Community Care program reforms are well advanced throughout the State as is the development of a Single Entry Point Assessment Project.

The Government is pursuing a whole-of-government approach to aged care and seeks to work collaboratively with all levels of government. ”

Australian Capital Territory Government comments

“ The ACT Government recognises the valuable contribution older people make to the social fabric of the ACT community. It is committed to continue to build a community with strong social capital with well developed networks based on shared interests, enduring relationships and trust.

The age profile of the Canberra population is still much younger than the overall Australian average, but the pace of ageing of the Canberra population is already occurring and will quickly accelerate. In 1998, only 7.8 per cent of Canberra's population were aged 65 and over, but by 2013, this is projected to nearly double to 12.4 per cent.

Over the past 12 months there has been a strong emphasis on improving access to information with the progress of key initiatives including the Consumer Access Centre, Health Information Networking Project; and CanberraConnect. The intention is to fully integrate user-friendly computer assisted telephone and internet based consumer access to provide information on health issues enabling consumers to make better decisions at the point of care.

The ACT Government released Towards a Society for All Ages: Forward Plan for Older People in the ACT 2000–2003. The Plan outlines strategies and programs to be undertaken during the next three years to ensure that older people in the ACT are able to lead productive and fulfilling lives as valued members of our community.

The ACT Aged Care Planning Advisory Committee's recommendations regarding the Aged Care Approvals round identified as priorities residential respite care for carers of people with dementia and Community Aged Care packages for people from Aboriginal and Torres Strait Islander communities.

The ACT Aged Health Care Services Advisory Council was established last year to provide advice to the Minister for Health, Housing and Community Care on a range of aged care issues including dementia, health promotion, assessment models and respite care.

The ACT Legislative Assembly Standing Committee on Health and Community Care Report on Respite Care Services was released in March 2000 and Government is now considering the recommendations. The same committee also announced an inquiry into elder abuse issues in the ACT.

A stronger emphasis will be given to improving the interface between the hospital and the community for aged care health services. The ACT Department of Health and Community Care is investigating models of care to guide the purchase of post-discharge services.

The planning of services for older people will be advanced through the findings from a Computer Assisted Telephone Interview (CATI) survey and a proposed survey by the ACT Aged Health Care Services Advisory Council. This will strengthen the development of the ACT Department of Health, Housing and Community Care Seniors Purchasing Strategy 2001–2003. ”

Northern Territory Government comments

“ The Northern Territory has a relatively young population profile, which impacts on aged care service data. In 1997, the average age of Territorians was 28 years compared to a national average of 34 years. However, this profile is changing. During the next 30 years, the number of people aged 65 and over is projected to increase by 300 per cent, while the proportion of this group to the total NT population will grow from 3.3 per cent in 1997 to 7.7 per cent in 2031.

One of the main challenges for the Northern Territory Government continues to be the provision of aged care services to a diverse range of older people, many of whom live in rural and remote areas. (27 per cent of the NT population lives in rural and remote areas, compared to 14 per cent nationally).

Issues such as remoteness, the high costs of service provision, lack of infrastructure on many communities and relative small numbers of older people spread across large geographical areas, all impact on service viability and appropriateness.

Further, Indigenous people make up 28 per cent of the NT population, compared to 2 per cent nationally, which highlights the need to ensure aged care services are culturally appropriate.

The Commonwealth recognises the health issues, lower life expectancy and subsequent need for aged care services at an earlier age for Indigenous people in its planning ratio for aged care services. While the age benchmark for non-Indigenous people is 70 years and over, the benchmark for Indigenous people is 50 years and over.

However, the data used in this report includes only those people aged 70 years and over. This impacts significantly on NT data representation as Indigenous people aged 50–69 years comprise over 50 per cent of our target ‘aged’ population. This means that the data reporting on actual residential care places, Community Aged Care Packages and associated costs should be halved to present an accurate picture for the NT.

It is recognised that a collaborative approach between various government sectors, community groups, older people and their carers is required to ensure appropriate aged care services and improve the health and wellbeing of all senior Territorians.

Examples of collaboration and a flexible approach to service provision include innovative options such as slow stream rehabilitation and transitional care models. These services assist people to maximise their independence, prevent premature admission to residential care and allow people to return to their homes and communities.

The NT Government has also demonstrated its commitment to the philosophy of Health Ageing by signing the ‘Commonwealth, State and Territory Strategy on Healthy Ageing’. Local NT strategies are currently being developed to implement recommendations from this report. ”

12.7 Definitions

Table 12.7 **Terms**

Term	*Definition*
Aged Care	Care of one or more of the following types: residential care; community care; flexible care (*Aged Care Act 1997* (Cwlth)). Residential care is personal care and/or nursing care provided to a person in a residential service in which the person is also provided with accommodation that includes appropriate staffing to meet the nursing and personal care needs of the person, meals and cleaning services, and furnishings, furniture and equipment for the provision of that care and accommodation (*Aged Care Act 1997* (Cwlth), s.41-3). Community care is care consisting of a package of personal care services and other personal assistance provided to a person who is not being provided with residential care (*Aged Care Act 1997* (Cwlth), s.41-3). Flexible care means care provided in a residential or community setting through an aged care service that addresses the needs of care recipients in alternative ways to the care provided through residential care services and community care services. Examples of the kinds of care that might be specified are care for people with special needs, care provided in small or rural communities, care provided through a pilot program for alternative means of providing care, and care provided as part of coordinated service and accommodation arrangements directed at meeting several health and community service needs (*Aged Care Act 1997* (Cwlth), s.49-3 and s.50-2).
Ageing in place	An approach that aims to provide residents with appropriate care and increased choice by allowing them to remain in the same facility regardless of their levels of care needs. It also allows couples with different levels of care needs to be cared for in the same facility. The main facet of ageing in place is that funding is tied to the assessed care needs of the client rather than the services provided by the facility. One of the objectives of Commonwealth aged care legislation is '... to promote ageing in place through the linking of care and support services to the places where older people prefer to live' (*Aged Care Act 1997* (Cwlth), s.2-1 [1j]).
Centre day care	Respite care provided from a facility such as a day care or health centre. Respite care is usually combined with social support services to maintain the functional capabilities of the person receiving care.
Complaint	A query or grievance that any member of the public makes to the Commonwealth Department of Health and Aged Care about any services provided by a Commonwealth funded nursing home and/or hostel
Elapsed time between ACAT approval and entry into a residential care service	The measure of the elapsed time between ACAT approval and entry into a residential care service. Used in past years as an indicator of access into residential care.
Handicap	A limitation in performing certain tasks associated with daily living. The limitation has to result from a disability and affect one or more of the following areas: self care, mobility, verbal communication, schooling, or employment.

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Table 12.7 **(Continued)**

Term	*Definition*
High/low care recipient	High level of residential care means a level of residential care corresponding to RCS levels 1–4. Low level of residential care means a level of residential care corresponding to RCS levels 5–8. If the person is approved as a recipient of a high level of care, that person can receive care at any care classification level, (*Approval of Care Recipients Principles 1997*, s.5-9), while a person approved as a recipient of a low level of care can only be classified as RCS 5–8. (*Classification Principles 1997*, s.9-19).
Home help	Assistance provided to clients in undertaking household tasks (for example, household cleaning).
Home maintenance/ modification	Assistance provided to clients in undertaking home maintenance tasks that the client is unable to undertake themselves, or the modification of the home for care purposes (for example, installation of hand rails)
Home meals/centre meals	Meals provided to persons either in their own home or at a separate facility (including 'meals on wheels').
Home nursing	Nursing care provided in a person's home (for example, assistance with taking medication).
Home respite	A short term substitute for usual care. Home respite could be provided in the home of either the person requiring care or the person providing care, and could be for up to a day, overnight or for longer periods.
Hostel	Residential facilities for older people that provide accommodation, personal care and occasional or limited nursing services.
Nursing home	Residential facilities for frail older people that provide accommodation, 24-hour nursing care and personal care.
Paramedical services	Services to help people maintain their independence and mobility (for example, physiotherapy, podiatry, speech therapy and occupational therapy).
People from non-English speaking countries	People who were born in non-English speaking countries. English-speaking countries are defined as Australia, New Zealand, United Kingdom, Ireland, the US, Canada and South Africa.
People with a moderate handicap	Those people with a disability who do not require help or supervision with tasks relevant to self care, mobility and verbal communication, but who have difficulty performing one or more of these tasks.
People with a profound handicap	Those people with a disability who always require help or supervision in self care, mobility and/or verbal communication.
People with a severe handicap	Those people with a disability who sometimes require help or supervision with tasks relevant to self care, mobility and verbal communication.
Personal care	Assistance in undertaking personal tasks (for example, bathing)
Places	A capacity within an aged care service for the provision of residential care, community care or flexible care in the residential care context to an individual (*Aged Care Act 1997* (Cwlth)); also refers to 'beds' (*Aged Care (Consequential Provisions) Act 1997* (Cwlth), s.16).
Real expenditure	Actual expenditure adjusted for changes in prices, using the GDP(E) price deflator, and expressed in terms of final year prices.

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Table 12.7 **(Continued)**

Term	*Definition*
Resident	A person is an aged care resident for the purposes of the *Aged Care Act 1997* if the person is being provided with residential care through an aged care service conducted by an approved provider under the Act (*Aged Care (Consequential Provisions) Act 1997*, s.5).
Respite care	Alternative care arrangements for dependent people living in the community, with the primary purpose of giving their carer a short term break from their usual caring commitments.
Services	An aged care/residential care/community care/flexible care service means an undertaking through which aged care/residential care/community care/flexible care is provided. (*Aged Care Act 1997*).
Special needs groups	Section 11-3 of the *Aged Care Act 1997* specifies the following people as people with special needs: people from Aboriginal and Torres Strait Islander communities, people from non-English speaking backgrounds, people who live in rural or remote areas, and people who are financially or socially disadvantaged.
Veterans	Veterans and war widow(er)s who are entitled to treatment through the Department of Veterans' Affairs under the provisions of the *Veterans' Entitlement Act 1986*.