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. This chapter focuses on government funded residential and community based services for older people, particularly:

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

A profile of aged care services appears in section 12.1, followed by a brief discussion of recent policy developments in section 12.2. Together, these 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, while efficiency is indicated by expenditure per head of target population. 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 and indicators are provided in section 12.7.

A number of additions and improvements have been made to the chapter this year. These include the reporting of expenditure for a number of community care programs and preliminary data from the HACC Minimum Data Set (MDS). The

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

indicator ‘waiting times for community care’ is also reported for the first time using CACP data.

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 eight level Resident Classification Scale (RCS) profile of their clients. Services are classified as:
  - high care services: similar to nursing homes in the pre-1997 regime, these services cater primarily to the needs of high care residents. These services have 80 per cent or more residents classified as RCS levels 1–4; or
  - low care services: similar to hostels in the pre-1997 regime, these services cater primarily to the needs of low care residents. These services have 80 per cent or more residents classified as RCS levels 5–8; or
  - services with a mixture of high and low care: these services meet the needs of both high care and low care residents. They have less than 80 per cent residents classified as RCS levels 1–4 and more than 20 per cent of residents classified as RCS levels 5–8.

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

  Although there must be a needs match between residents entering vacant places (that is, in general vacant low care places must be filled by low care residents), this can change over time with ‘ageing in place’ which allows a low care resident who becomes high care within the same service to occupy a low care place until they are discharged.
- *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.

(Continued on next page)

Box 12.1 **(Continued)**

Areas are classified into three groups:

- metropolitan areas: comprising State and Territory capital cities, based on the Australian Bureau of Statistics (ABS) capital city Statistical Division, and urban centres with 100 000 people or 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 — namely, acute health care services for older people in chapter 9 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 and changes in service delivery in the acute care sector may affect demand for residential aged care.

Supporting tables

Supporting tables for chapter 12 are provided on the CD-ROM enclosed with the Report. The files are provided in Microsoft Excel 97 format as \Publications\Reports\2003\Attach12A.xls and in Adobe PDF format as \Publications\Reports\2003\Attach12A.pdf.

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

12.1 Profile of aged care services

Service overview

This chapter focuses on residential care, community care and assessment services for older people. Services 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 functional disability of the recipients rather than specific age criteria. Nevertheless, in the absence of more specific information, people aged 70 years and over are used 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 aged care services. The Commonwealth Government also uses these age proxies for planning the allocation of residential care and CACPs.

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

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

Roles and responsibilities

Assessment services

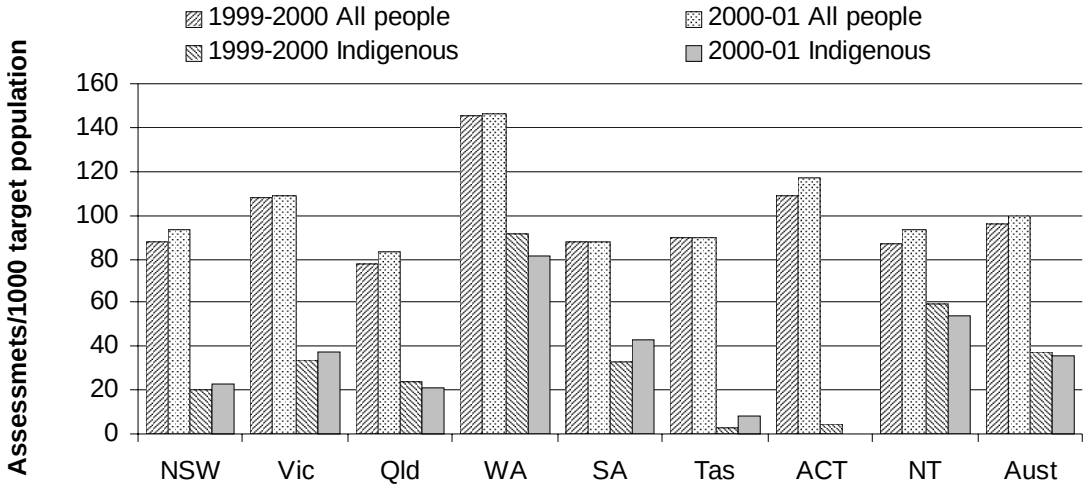
The Commonwealth established the Aged Care Assessment Program in 1984 based on the assessment processes used by State and Territory Area Health Services to determine eligibility for admission into residential care and the level of care required (and thus the subsidy paid to such services). The core objective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

State and Territory governments are responsible for the day-to-day operation and administration of ACATs and provide the necessary accommodation and support

services. The role of the teams differs across jurisdictions and within a jurisdiction, partly reflecting the service location (for example, whether the team is attached to a residential service, a hospital or a community service).

The number of assessments per 1000 target population varied across jurisdictions in 2000-01. Western Australia had the highest assessments of people aged 70 years and over per 1000 people aged 70 years and over (146.1) and the highest rate for Indigenous assessments per 1000 Indigenous people aged 50 years and over (81.8).[2] The lowest rate of assessment for all people during 2000-01 was in Queensland (83.4) while the ACT had no Indigenous assessments during the same period (figure 12.1).

Figure 12.1 **Assessments per 1000 target population[a, b]**



a 'All people' includes all assessments of people aged 70 and over per 1000 people aged 70 and over. **b** 'Indigenous' includes all Indigenous assessments per 1000 Indigenous people aged 50 and over.

Source: Lincoln Gerontology Centre (2001, 2002); table 12A.39.

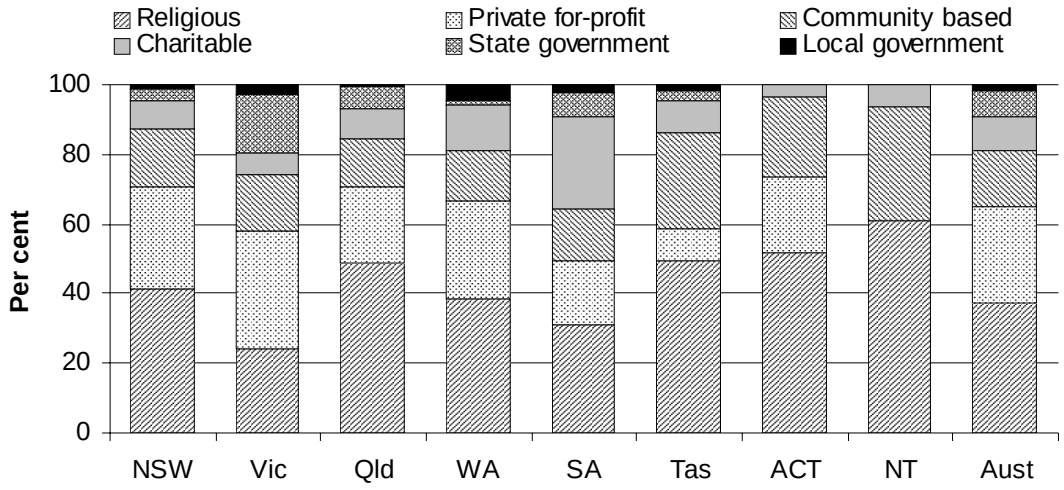
Residential care services

Residential care services are run mainly by private for-profit, religious, charitable and community based organisations. Some State, Territory and local governments also operate some residential services (figure 12.2). The largest providers of places at June 2002 were religious and private for-profit services (37.5 per cent and 27.4 per cent respectively). The private sector is mostly involved in high care services, managing about 46 per cent of places in these services

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

(DHA unpublished). The proportion of aged care services provided by government, private enterprise and charitable organisations varied markedly across jurisdictions in June 2002.

Figure 12.2 **Ownership of residential places, June 2002[a, b]**



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

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

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

Community care services

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

Box 12.2 **Examples of regulatory arrangements for residential services**

The Commonwealth Government controls the number of subsidised bed places, with a target of 40 high care places, 50 low care places and 10 community aged 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, receipt of income support and the level of assets held at entry); 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 firefighting 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: Productivity Commission (1999).

Indigenous specific and flexibly funded services

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

Funding

Assessment services

Under a cooperative arrangement, the Commonwealth provides grants to State and Territory governments to operate 123 ACATs and Evaluation Units. In 2001-02, the Commonwealth provided funding of $39.9 million nationally for aged care

assessment (table 12A.49). Expenditure per person aged 70 years and over plus Indigenous persons aged 50–69 years was highest in the NT ($71.4) during 2001-02 (table 12A.50).

Residential care services

The aged care reforms introduced in October 1997 resulted in a government funding system that does not differentiate between high care and low care services and incorporates high and low care services into a single funding system. 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.

The Commonwealth Government provides the majority of annual funding for residential aged care services — $4.0 billion in 2001-02, or approximately 71 per cent of the cost of care (DHA unpublished). State and Territory governments also provide some funding for public sector beds. Residents provide most of the remainder of service revenue, with some income derived from charitable sources and donations.

Commonwealth Government funding of approximately $5.6 million in 2001-02 was also provided through the Residential Care Development Scheme run by the Department of Veterans' Affairs (DVA). The scheme aimed 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.47).

The Commonwealth Government annual RCS subsidy for each occupied place varies according to the client's level of dependency. A high level of care is classified as RCS levels 1–4 and low level care is classified as RCS levels 5–8. The average Commonwealth annual RCS subsidy per residential place at June 2002 varied across jurisdictions, ranging from $29 187 in the NT to $23 998 in WA. 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 levels 5–8) are the same across all States and Territories, while high care subsidy rates (RCS levels 1–4) are being adjusted towards a uniform national rate by July 2006 under the Commonwealth Government's Funding Equalisation and Assistance Package, totalling $148 million over six years. The NT had the highest proportion of high care residents at June 2002 (table 12.1).

Table 12.1 **Average annual Commonwealth RCS subsidy per occupied place and the dependency level of aged care residents, June 2002**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Average annual Commonwealth RCS subsidy per residential place[a]										
All RCS levels	$	26 342	25 494	24 286	23 998	25 669	27 932	25 182	29 187	25 534
Proportion of high care residents[b]										
RCS 1	%	18.5	20.7	16.2	21.5	18.5	15.8	24.9	7.8	18.9
RCS 2	%	26.9	23.8	24.8	21.0	26.3	26.8	19.5	33.1	25.1
RCS 3	%	15.7	12.1	16.8	11.1	15.2	20.8	12.8	26.9	14.7
RCS 4	%	4.3	3.9	6.0	4.4	4.3	6.0	4.3	7.2	4.6
Proportion of low care residents										
RCS 5	%	9.5	11.8	9.8	12.6	9.9	10.6	11.0	6.6	10.5
RCS 6	%	9.9	11.8	10.3	13.8	10.4	8.2	12.0	9.9	10.8
RCS 7	%	13.4	14.4	14.2	14.3	14.2	10.9	13.4	8.4	13.8
RCS 8	%	1.9	1.5	1.9	1.2	1.1	0.8	2.1	0.3	1.6

a Includes only RCS funding; pensioner supplement and other supplements add around $4100 a year for residents. On average, residents contribute $11 400 per year to their care. **b** Differences in average annual subsidies reflect differences in subsidy rates as well as differences in the dependency of residents.

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

State and Territory governments contribute financially to the services they operate, and these services generally receive lower Commonwealth subsidies than those received by other services. Some States and Territories have made arrangements to continue supplementing former government services following the transfer of those services to the private sector. The NT Government also provides some funding to some private not-for-profit residential care services.

The combined number of operational high care and low care places per 1000 people aged 70 years and over at June 2002 ranged from 112.5 in the NT to 79.0 in Victoria. The ACT had proportionally more low care places (58.4 per cent) than those in other jurisdictions. There were proportionally more high care places in the NT (59.6 per cent) (table 12.2). The proportion of low care places relative to high care places rose between 1990 and 2002 (table 12A.10).

Table 12.2 **Operational high care and low care residential places, 30 June 2002[a]**

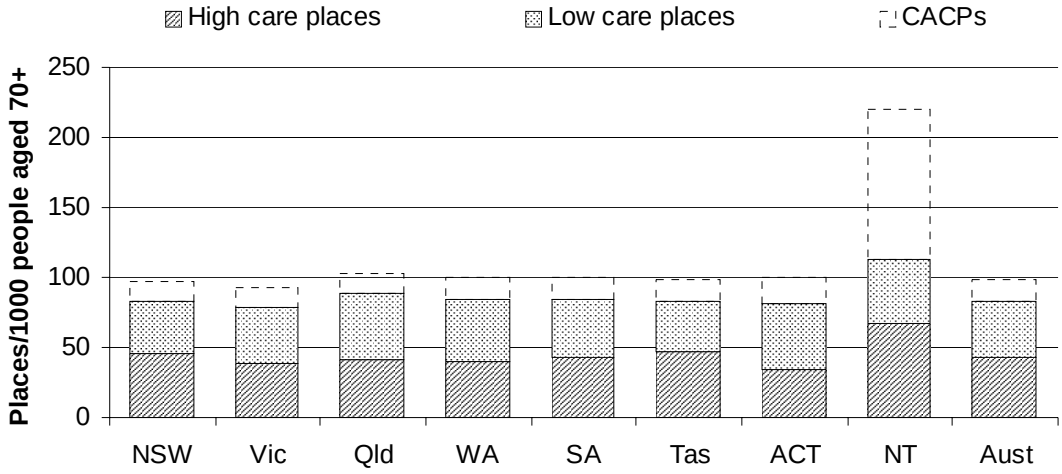
	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Number of places per 1000 people aged 70 years and over										
High care places	no.	46.2	38.2	41.5	39.7	43.5	47.0	33.6	67.1	42.4
Low care places	no.	36.3	40.8	46.5	44.9	41.1	36.4	47.2	45.4	40.5
Total places	**no.**	**82.5**	**79.0**	**88.0**	**84.6**	**84.6**	**83.4**	**80.8**	**112.5**	**82.9**
Proportion of places										
High care places	%	56.0	48.4	47.2	46.9	51.4	56.4	41.6	59.6	51.1
Low care places	%	44.0	51.6	52.8	53.1	48.6	43.6	58.4	40.4	48.9

a Excludes places that have been 'approved' but are not yet operational.

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

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

Figure 12.3 **Operational residential places and CACPs per 1000 people aged 70 years and over, June 2002[a, b, c, d]**



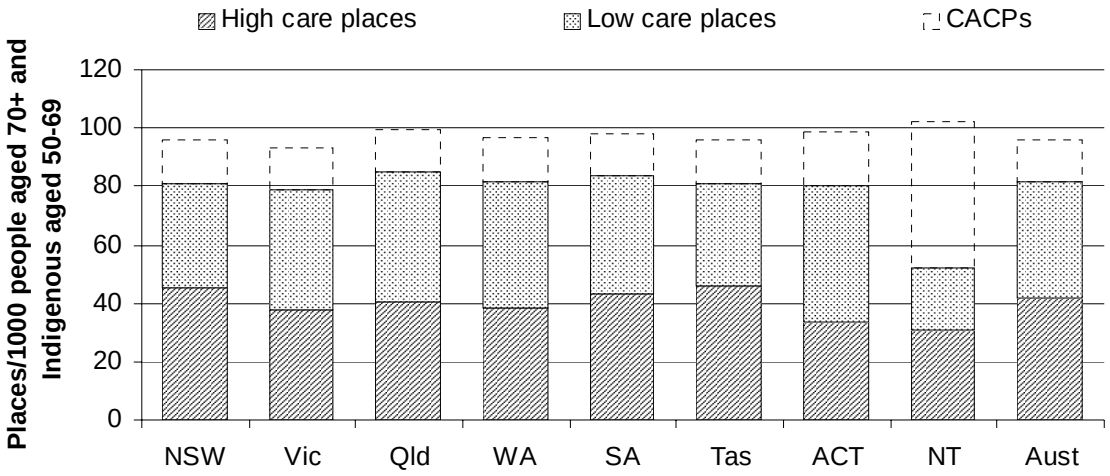
a Excludes places that have been 'approved' but are not yet operational. **b** 'Ageing in place' may result in some low care places being filled by high care residents. **c** Government planning targets are based on providing 100 places per 1000 people aged 70 years and over. However, in recognition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

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

The number of operational places can also be shown using a target population that incorporates Indigenous 50–69 year olds (figure 12.4). Using this 'adjusted' target

population has a noticeable effect on smaller jurisdictions with a large proportion of Indigenous people.

Figure 12.4 **Operational residential places and CACPs per 1000 people aged 70 years and over plus Indigenous people aged 50–69 years, June 2002[a, b, c]**



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

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

Community care services

Total national expenditure on HACC was just over $1 billion in 2001-02, which consisted of $615.6 million from the Commonwealth Government and $396.8 million from the State and Territory governments. This is equivalent to the Commonwealth Government contributing approximately 60.8 per cent and State and Territory governments funding the remainder (table 12A.46).

The NRCP provides community care services and is funded by the Commonwealth. Expenditure on this program was $72.9 million in 2001-02 (table 12A.49). Expenditure for in-home respite care from the DVA, including emergency home care, was $9.4 million in 2000-01 (DVA unpublished). The DVA also provided $61.6 million for the VHC program during 2001-02 (table 12A.48). This figure includes expenditure for in-home respite and emergency home care.

The CACP program is funded by the Commonwealth Government, which expended $246.0 million on the program in 2001-02 (table 12A.49). CACPs are also part funded by client contributions.

Expenditure data on a range of other community care programs targeting aged people are contained in tables 12A.49 and 12A.50.

Size and scope of sector

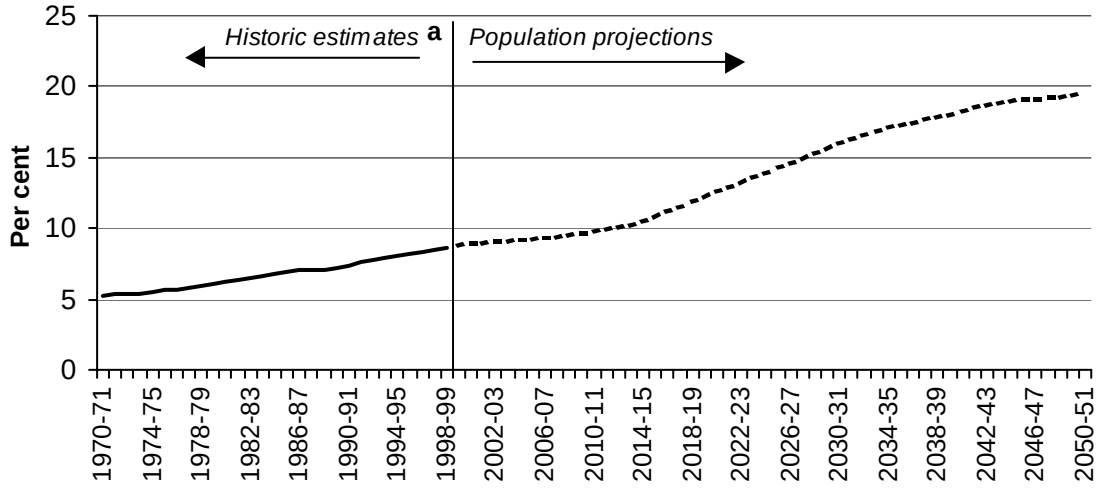
Size and growth of the older population

The Australian population is ageing as indicated by an increase in the proportion of people aged 70 years 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 (figure 12.5).

The distribution of older people varied across jurisdictions at June 2002, with relatively more older people in SA and relatively fewer in the NT (figure 12.6). Higher life expectancy for females is reflected in there being a higher proportion of older females than older males in all jurisdictions.

Demographic profiles affect the demand for aged care services because females use aged care services, particularly residential services, more than males do; for example, 72.4 per cent of aged care residents at June 2001 were female (DHA 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.

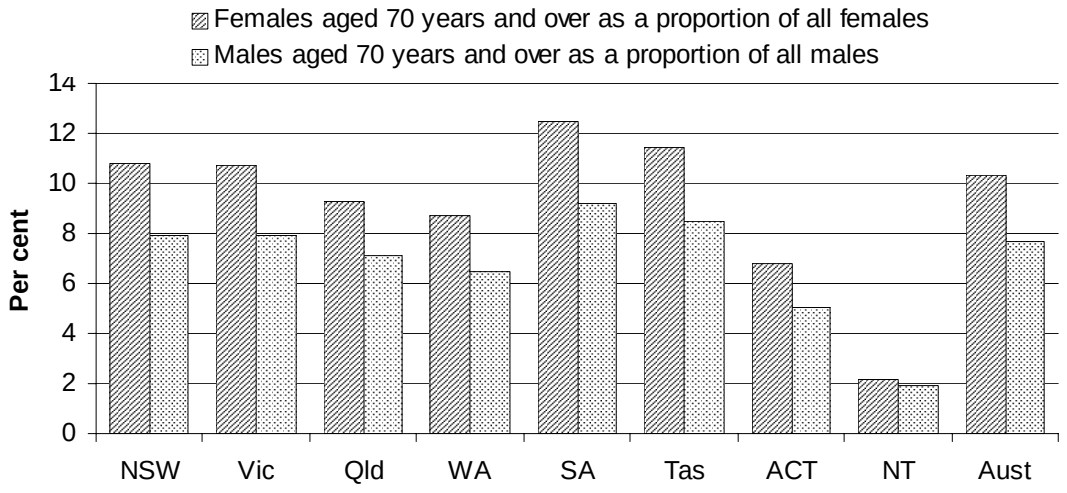
Figure 12.5 **Persons aged 70 years and over as a proportion of the total population — time series**



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

Source: ABS (2000).

Figure 12.6 **People aged 70 years and over as a proportion of males and females in the total population, by sex, June 2002 (estimated)**



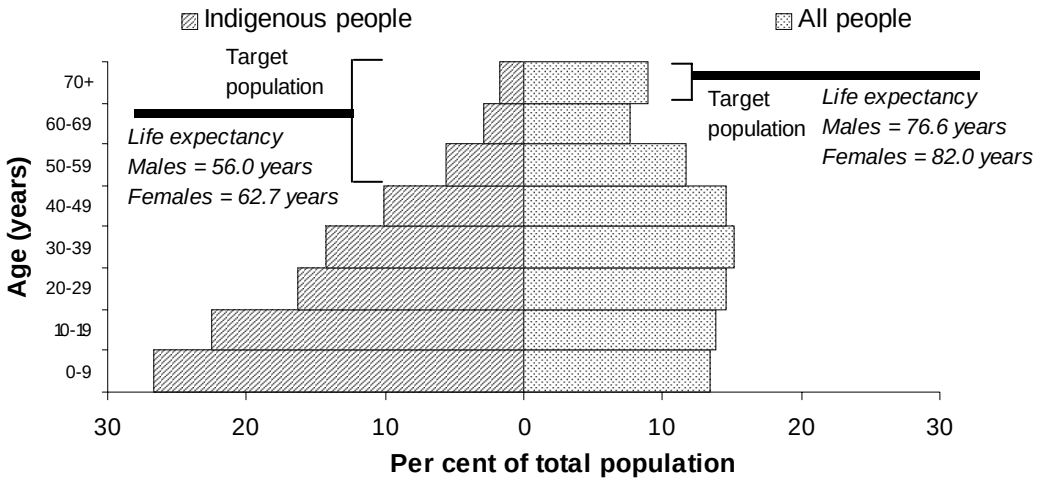
Source: DHA (unpublished); table 12A.1.

Characteristics of older Indigenous people

The ABS estimated that about 41 700 Indigenous people were aged 50 years or more in Australia at 30 June 2002. The majority were located in NSW (29.7 per cent), Queensland (26.6 per cent), WA (13.9 per cent) and the NT (13.7 per cent) (table 12A.2).

Although the Indigenous population is also ageing, there are significant differences in the age profile and life expectancy of Indigenous Australians compared with the non-Indigenous population. The life expectancy of Indigenous males (56.0 years) and females (62.7 years) at June 2001 was nearly 20 years below that recorded for the total Australian population (figure 12.7). As a result, Indigenous people are likely to need aged care services earlier in life, compared with the general population.

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



Source: ABS (2001 and unpublished).

Residential care services

The size and location of residential services — which may influence the costs of service delivery — vary across jurisdictions. Nationally, there were approximately 144 139 operational places (permanent and respite) in residential care services (71 570 in predominantly high care services, 28 596 in predominantly low care services and 43 973 in services with a mixture of high care and low care residents) at June 2002 (tables 12A.6, 12A.7, 12A.8 and 12A.9).

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

Box 12.3 **Ageing in place**

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

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

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

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

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

One possible proxy for measuring 'ageing in place' is the proportion of residential aged care service providers who are caring for residents whose care needs range across high care and low care. As noted there has been a steady increase in the number of services categorised as services providing a mixture of high and low care places.

Another possible measure is the proportion of residents who remain in the same home as their care needs increase (table 12.3). The main difficulty with measuring this is determining whether decreasing mobility between hostels and nursing homes reflects negatively or positively on the choice and flexibility of residential care available to residents.

Source: DHA (unpublished).

The client profile of services that had predominantly low care residents in 2000 has changed, with low care residents staying in their current service as their dependency levels rise over time, and with aged care services expanding. Low care services were generally smaller (as measured by number of places) than high care services at June 2002. Nationally, 84.4 per cent of low care services had 60 or fewer places (table 12A.8), compared with 73.8 per cent of high care services (table 12A.7).

The proportion of residents who remained in the same service as their care needs increased is illustrated in table 12.3. The 'ageing in place' policy has a clear

influence on the population of residential care facilities. While the planning ratio for residential aged care is 40 high care beds and 50 low care beds per 1000 people aged over 70 years, on average, over 60 per cent of the population of residents are high care residents (table 12.1).

Table 12.3 **'Ageing in Place' - resident movements for admissions during 1999-2000 after admission to permanent care**

Months after admission		*6 months*	*12 months*	*18 months*
Discharged or died	%	24.7	35.3	43.3
Remain high care	%	34.5	28.1	23.6
From high care to low care	%	0.5	0.6	0.7
From low care to high care	%	4.7	6.8	9.2
Remain low care	%	35.6	29.1	23.1
Total	**%**	**100**	**100**	**100**
Total admissions	no.	40 108	40 108	40 108

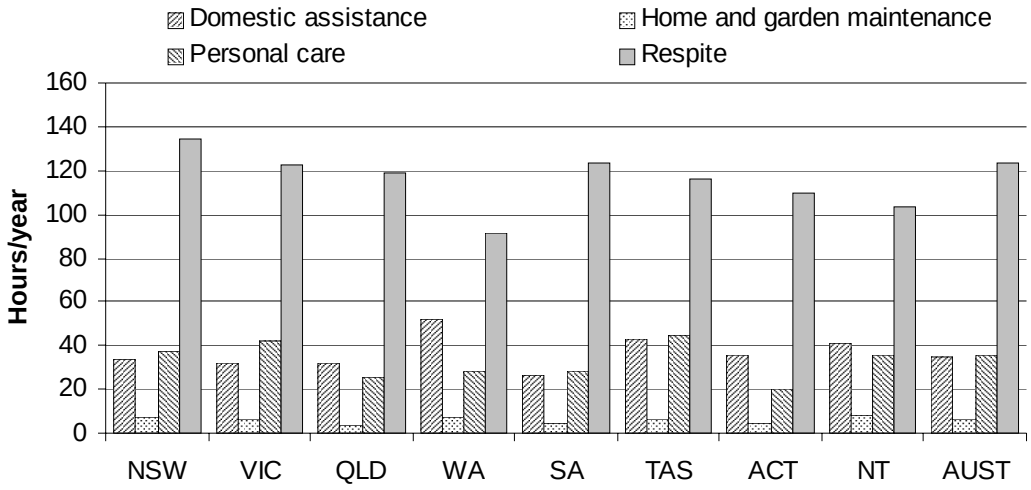
Source: DHA (unpublished); table 12A.56.

Community care services

A range of services are provided by HACC, such as domestic assistance and home maintenance, personal care, food services, respite care, transport, allied health care and community nursing. The target population is defined as people living in the community who are at risk, in the absence of basic maintenance and support services, of premature or inappropriate long term residential care. The target population comprises both frail aged people and younger people with a disability, and their carers. Approximately 70 per cent of the program's recipients are aged 70 years and over, but the program is also an important source of community care for younger people with a disability and their carers (DHA unpublished). (Chapter 13 covers younger people with a disability.)

The services of the VHC program target veterans and war widows/widowers with low care needs. There were 56 073 VHC recipients in 2001-02 (table 12A.48). The program offers veterans and war widows/widowers home support services, including domestic assistance, personal care, home and garden maintenance, and respite care. Other services, such as community transport, social support and delivered meals, are also available under the DVA's arrangements with State and Territory governments. Eligibility for VHC services is not automatic, but based on assessed need. Figure 12.8 shows the average number of hours approved per year for veterans who were approved to receive home care services between 1 July 2001 and 30 June 2002.

Figure 12.8 **Average number of hours approved for Veterans' Home Care, 2001-2002**



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

Community Aged Care Packages provide an alternative home-based service for older people who ACATs assess as eligible for care equivalent to low level residential care (RCS levels 5-8). The main distinctions between the HACC and CACP programs are summarised in table 12.4. Community care is likely to continue to play an increasing role in aged care services, given the longer term policy objective of improving the capacity of aged care services to support people at home, which reflects a strong consumer preference.

Table 12.4 **Distinctions between the HACC and CACP programs**

	HACC	*CACPs*
Range of services[a]	Wider range of services available	Narrower range of services available
Relationship to residential care	Prevents premature or inappropriate admission	Substitutes for a bed
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
Target client groups[b]	Available to people with a greater range of care needs	Targets people with care needs similar to low level residential care
Size of program	$1 billion funding in 2001-02	$246 million funding in 2001-02
	About 583 000 clients for the year 2001-02	About 26 400 places for the year 2001-02

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

Source: DHA (unpublished); tables 12A.30, 12A.45 and 12A.46.

Changing government policies over the past decade — shifting the balance of care away from the more intensive types of residential care towards home-based care — have meant that the HACC, EACH and CACP programs have become increasingly important components of the aged care system. During 2001-02, the HACC program delivered approximately 9023 hours per 1000 people aged 70 years and over plus Indigenous people aged 50–69 years (table 12A.20). The total number of CACP places per person aged 70 years and over plus Indigenous people aged 50–69 years increased by 5.0 per cent between June 2001 and June 2002, from 14.0 to 14.7 (table 12A.11).

12.2 Policy developments in aged care services

The Extended Aged Care at Home Program

The EACH program is a small program funded by the Commonwealth Government to provide a community alternative to high level residential aged care services. The program provides individually planned and coordinated packages of care, designed to meet older people's daily care needs in the community. The EACH program differs from the CACP program in that it targets frail older people who would otherwise be eligible for high level residential aged care. An EACH package typically provides between 15 and 20 hours of direct assistance each week.

Packages are flexible in content; the expectation, however, is that a package would include qualified nursing input, particularly in the design and ongoing management of the package and also where there are complex and technical nursing care needs.

The EACH program was introduced in 1993 at a single trial site in SA. The 1995 Commonwealth Budget expanded the program, which at that stage was called the Nursing Home Care Package pilot. By 1998, the trial had expanded to 10 pilot sites with 290 packages and had been renamed the EACH program. The pilot program was comprehensively evaluated over the three years from 1998 to 2001. This evaluation has been published by the DHA as a series of Aged and Community Care Service Development and Evaluation Reports: *Evaluation of the Extended Aged Care at Home (EACH) Pilot Program.*

In May 2002, the Minister for Ageing announced a further program expansion (160 new places). By early 2003, approximately 450 EACH packages are expected to be in place nationally. Work is being undertaken concurrently to move the program from its initial pilot status to a program consolidation stage which will focus on the development of a quality assurance and accountability framework. Expenditure data for the EACH program during 2001-02 are contained in table 12A.49.

Innovative Pool of aged care places

The national pool of flexible care places available for allocation to innovative services outside of the Aged Care Approvals Round was established in 2001-02. The 2002-03 Level 1 release of aged care places includes 550 flexible care places available to be allocated to innovative services. The national Innovative Pool allows for the development of pilots for innovative service provision, in partnership with other stakeholders (including State and Territory governments and approved providers).

The flexible care places through the Innovative Pool can be used to develop projects that will allow the Commonwealth to conduct an evidence-based test of alternative service models to address the Commonwealth's policy priorities. Evaluation will be an integral element of all projects involving alternative service models.

There are 550 places in the 2002-03 Innovative Pool, targeted at the following types of proposals:

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

An example of a pilot under the Innovative Pool is discussed in box 12.4.

Box 12.4 **The Home Rehabilitation and Support Service (HRSS) in SA**

A State funded Transition Care Project, which was the forerunner to the HRSS, ran successfully from January to December 2001. The Commonwealth Government agreed to contribute towards a similar but distinct joint project, with matching State and Commonwealth funding contributions. The Commonwealth contributes 50 Flexible Care Places from the Innovative Pool to the project (approximate value of $525 000 a year) with the State also contributing $525 000 a year. The Aged Care and Housing Group manages the project, which will run for an initial two year period.

The HRSS formally commenced on 21 December 2001. Thirteen residential and community care providers form the Acute Transition Care Alliance, which provides residential places for the purpose of the service, as well as home-based and community-based services. The target group for the project is older people who have either had an unnecessarily long stay or are at risk of an extended stay in the acute hospital system and who are also at risk of premature admission to a residential aged care facility. The Service provides short term rehabilitation and support services, including short term residential care, physiotherapy, occupational therapy, nursing and personal care and community based support services.

To 9 October 2002, 230 referrals had been received, of which 147 (about 64 per cent) were appropriate for the HRSS. Of these, 101 have made a transition from the program, with 18 per cent of clients going to residential care, 58 per cent of clients going home (receiving levels of support ranging from CACPs to family support, or refusing services) and 24 per cent being re-admitted to hospital.

Source: DHA and SA Government (unpublished).

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. These indicators relate to government objectives in the aged care sector (box 12.5).

Box 12.5 **Objectives for aged care services**

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

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

The performance indicator framework shows which data are comparable in the 2003 Report (figure 12.9). For data that are not considered strictly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report wide perspective (see section 1.6).

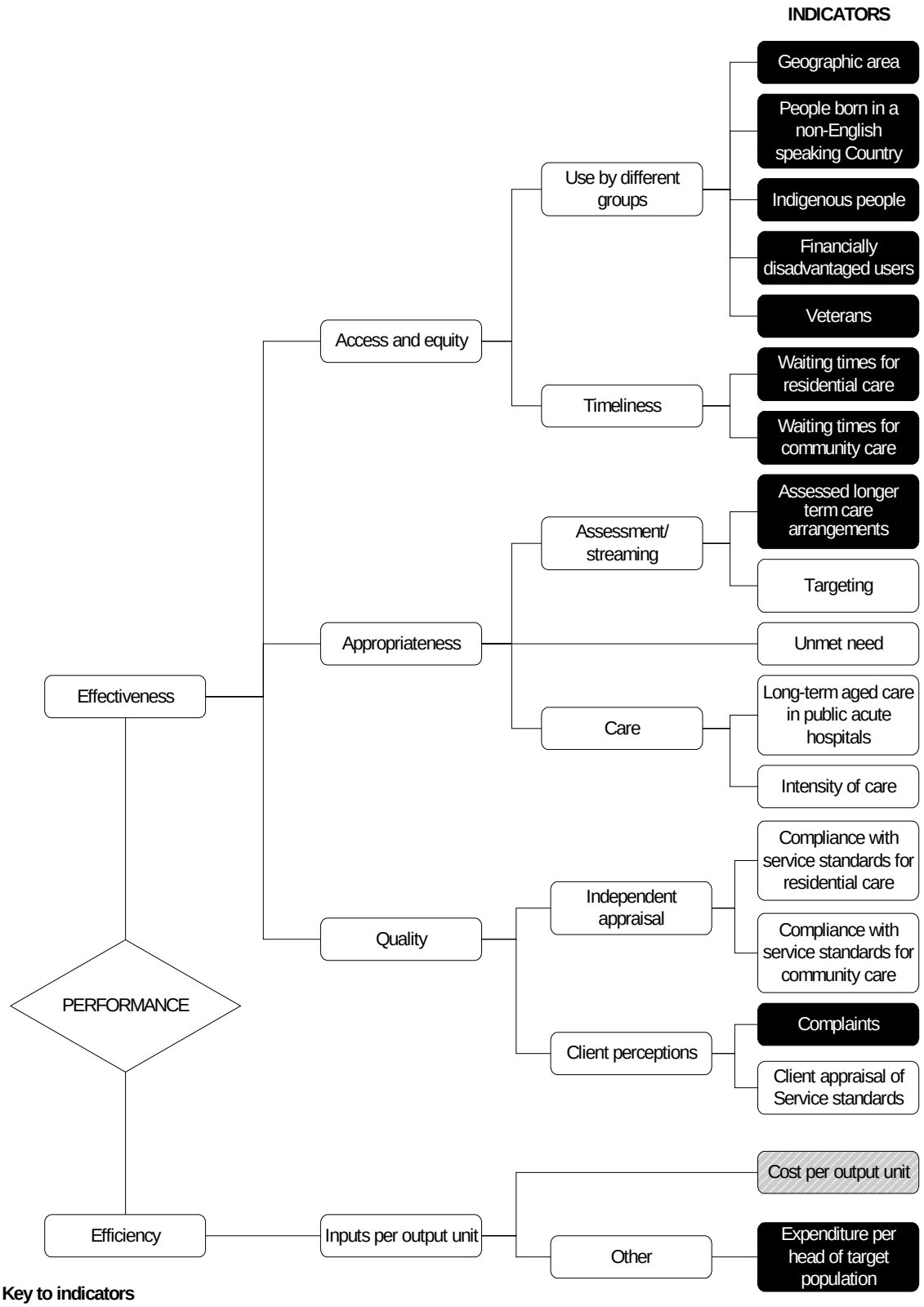
New and refined indicators

The performance indicator framework has been further refined for the 2003 Report. The indicator 'waiting times for community care' is reported for the first time using CACP data. Ongoing work to provide a more comprehensive set of performance indicators and to improve existing indicators and data is discussed in section 12.5.

12.4 Key performance indicator results

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

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



Access and equity — use by different groups

Residential services

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

In all jurisdictions, on average, Indigenous people and people from mainly non-English speaking countries have lower rates of use of aged care residential services, compared with the rest of the population, at June 2002 (figure 12.10).

Figure 12.10 **Residents per 1000 target population, June 2002**[a, b, c]

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

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

Commonwealth planning guidelines require that services allocate a minimum proportion of places for concessional residents. These targets range from 16 per cent of new places to 40 per cent, depending on the service's region. Most services exceed the minimum amount. All jurisdictions exceeded the minimum amount at 30 June 2002, with the NT reporting the highest proportion of concessional residents (79.1 per cent) (table 12.5).

Table 12.5 **New residents classified as concessional or assisted residents, 30 June 2002 (per cent)[a, b]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
High care residents	49.3	53.0	49.5	53.7	50.1	50.6	48.1	78.3	50.7
Low care residents	44.1	41.8	46.3	48.6	44.1	41.9	39.6	81.2	44.3
All residents	47.4	48.2	48.3	51.5	47.9	47.9	44.7	79.1	48.2

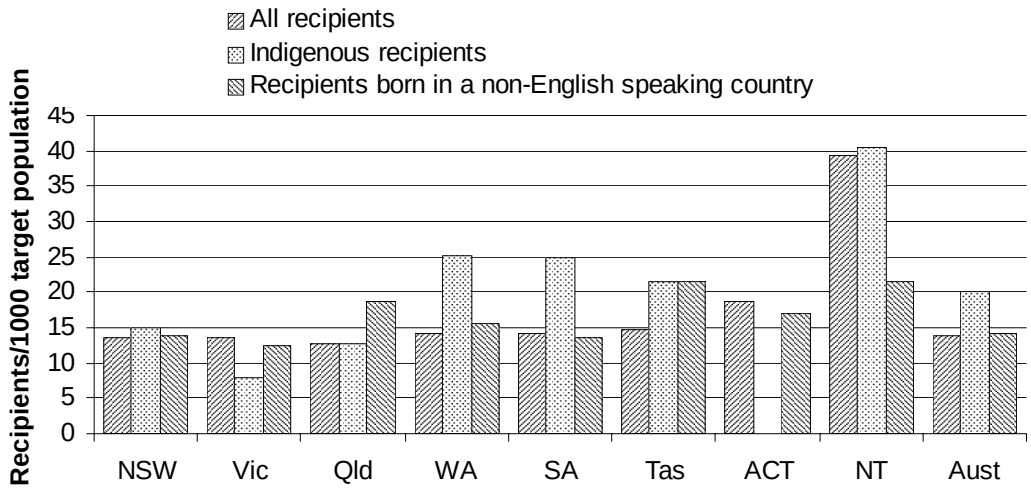
a Only new residents entering residential care post-October 1997 are eligible for either a concessional or assisted resident supplement. **b** Concessional residents are those who on entry to care were in receipt of an income support payment, who had not owned a home in the previous two years or whose home was occupied by a spouse or carer, and who had assets of less than $26 500. For married residents, half the couple's combined assets are counted. Assets include interest-free loans. Assisted residents are those meeting the above criteria with asset levels between $26 500 and $42 000. The asset levels are at 30 June 2002.

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

Community Aged Care Packages

The number of CACP recipients per 1000 people aged 70 years and over plus Indigenous people aged 50–69 years has grown in recent years but at June 2002 was small relative to the total number of recipients of residential care (13.8 compared with 78.5 recipients respectively per 1000 people aged 70 years and over plus Indigenous people aged 50–69 years) (table 12A.12). The jurisdictions with smaller populations had the highest proportion of CACP recipients per 1000 people aged 70 years and over plus Indigenous people aged 50–69 years at June 2002. The NT had the highest proportion of CACP recipients per 1000 Indigenous people aged 50 years and over (40.4) (table 12A.16). Tasmania and the NT had the highest proportion of CACP recipients from non-English speaking countries per 1000 people aged 70 years and over (figure 12.11). The Commonwealth's allocation of CACPs in every jurisdiction at June 2002 exceeded its target of ten CACPs per 1000 target population.

Figure 12.11 **CACP recipients per 1000 target population, June 2002[a, b, c, d]**



a All recipients data are per 1000 people aged 70 years and over plus Indigenous people aged 50–69 years. **b** Indigenous recipients per 1000 Indigenous people aged 50 and over. **c** Recipients from non-English speaking countries per 1000 people from non-English speaking countries aged 70 years and over. **d** The ACT has a very small Indigenous population aged over 50 years and a small number of packages will result in a very high provision ratio. Consequently, the ACT Indigenous CACP figures are not considered to be reliable and have not been reported.

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

Home and Community Care program

The services of the HACC program are provided in the client's home or community to frail older people with a severe, profound or moderate disability and to their carers. Around 69.8 per cent of HACC recipients are estimated to be aged 70 years and over (table 12A.30).

The HACC MDS will facilitate separate reporting of the three client groups (frail older people, young people with a disability and their carers), which previously has not been possible. Data from the MDS are reported for the first time this year and need to be interpreted with extreme caution. The items reported are broadly similar to estimated HACC data in previous editions of the Report, but they are not directly comparable. It should also be noted that the proportion of HACC funded agencies that submitted MDS data for 2001-02 differed across jurisdictions, and ranged from 94 per cent to 56 per cent (table 12.6). Consequently, actual service levels will be higher than those reported. Future data from the HACC MDS are expected to have wider coverage.

Table 12.6 **HACC services received, 2001-02 (per 1000 people aged 70 years and over, plus Indigenous people aged 50–69 years)[a]**

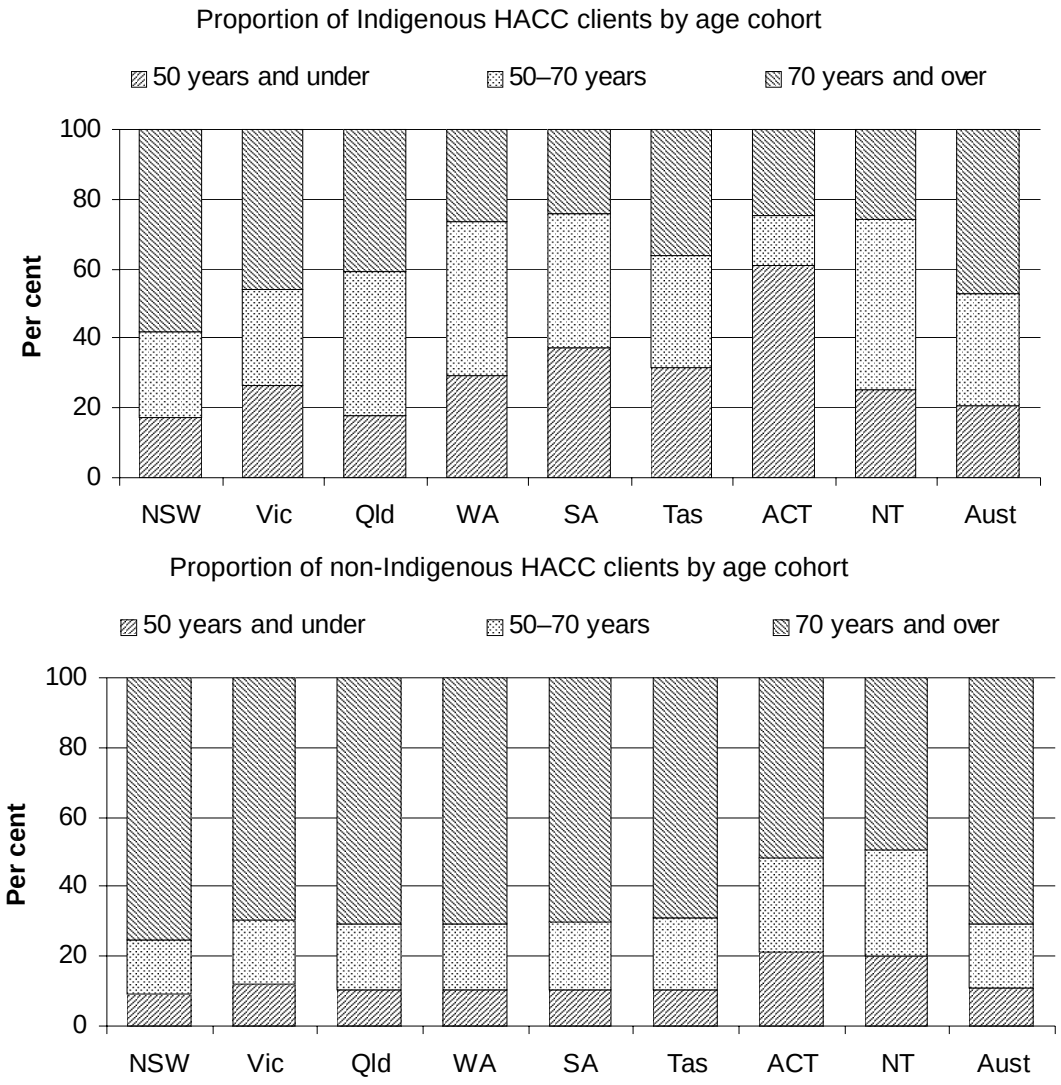
	NSW[b]	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*[c]	*NT*	*Aust*
Percentage of agencies who reported MDS data	66	70	85	94	78	73	89	56	74
Total hours[d]									
Capital city	4 909	8 816	11 000	13 112	9 681	5 604	11 263	7 314	8 311
Other major urban areas	6 022	9 107	8 039	–	–	–	–	–	6 985
Rural areas	5 629	11 900	10 102	12 061	9 181	8 039	–	20 401	8 964
Remote areas	9 118	12 797	15 224	16 979	9 428	15 339	–	11 698	13 889
All areas	**5 301**	**9 670**	**10 411**	**13 151**	**9 552**	**7 085**	**11 280**	**10 678**	**9 023**
Total meals[e]									
Capital city	2 931	3 961	7 583	5 401	846	4 723	5 274	4 716	3 907
Other major urban areas	3 837	3 645	4 736	–	–	–	–	–	4 092
Rural areas	4 706	4 381	6 789	7 317	1 109	6 800	–	17 690	5 079
Remote areas	4 498	1 342	8 258	13 649	3 523	6 497	–	19 994	10 244
All areas	**3 558**	**4 053**	**6 888**	**6 295**	**946**	**5 945**	**5 283**	**14 942**	**4 465**

a The proportion of HACC funded agencies that submitted MDS data for 2001-02 differed across jurisdictions, and ranged from 94 per cent to 56 per cent. Consequently, actual service levels will be higher than those reported here. **b** NSW advise that NSW data does not include a significant proportion of allied health and home nursing service data. **c** The ACT advise that nursing hours are significantly overstated. **d** See table 12A.20 for a full list of categories. **e** Includes home meals and centre meals. – Nil or rounded to zero.

Source: DHA (unpublished); tables 12A.20–12A.24.

Use of HACC services reported for all people compared with Indigenous people across all age groupings shows a substantial difference in the age profile for the two groups. This reflects the substantial difference in morbidity and mortality trends between Indigenous people and the general population (figure 12.12).

Figure 12.12 **HACC service by recipient age and Indigenous status, 2001-02**



Source: DHA (unpublished); table 12A.32.

Access and equity — timeliness

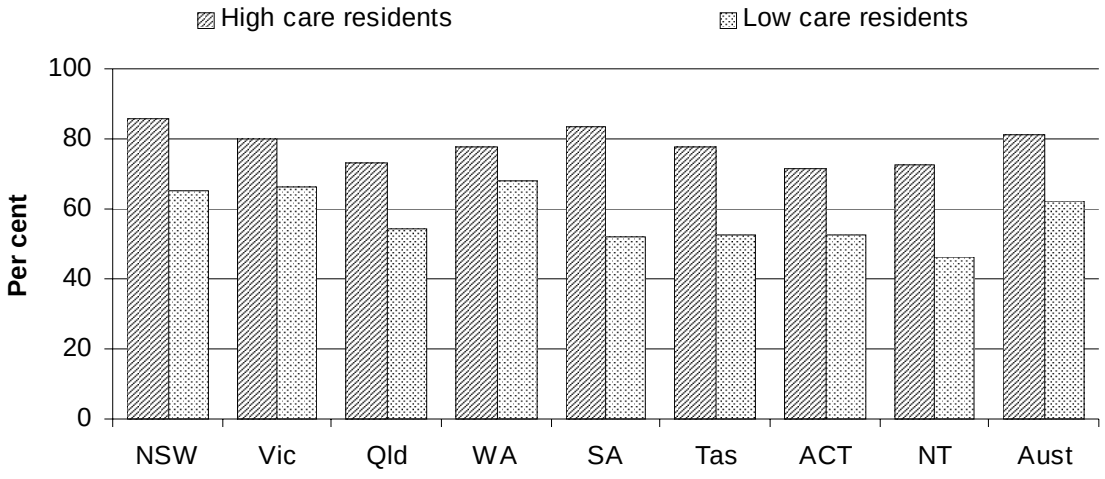
Elapsed time between ACAT assessment and entry into residential care service

The elapsed time between an ACAT assessment and entry into residential care partly reflects the extent to which aged care services meet the demand for residential services, but may also reflect applicants' willingness to wait for particular residential services or to defer entry. These data should therefore be viewed with care (boxes 12.6 and 12.7). The Steering Committee acknowledges the limitations of the current indicators and supports the need to improve them. Until improved data are available, the current indicators will continue to be reported.

On average, 72.1 per cent of all people entering residential care during 2001-02 did so within three months of being assessed by an ACAT, and almost half (44.1 per cent) entered within one month of their ACAT assessment. Across jurisdictions, the proportion of people who entered care within three months of assessment ranged from 77.1 per cent in NSW to 61.9 per cent in the ACT (table 12A.37).

Nationally, a greater proportion of people entering high care residential services entered within three months of assessment (81.1 per cent) compared with the population entering low care residential services within that time (62.3 per cent) (table 12A.37). Across jurisdictions, the proportion of people entering high care residential services within three months of being assessed ranged from 85.6 per cent in NSW to 71.6 per cent in the ACT. The proportion of people entering low care residential services within three months of being assessed ranged from 68.2 per cent in WA to 46.2 per cent in the NT (figure 12.13).

Figure 12.13 **People entering residential care in 2001-02 within three months of their ACAT assessment**



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

Box 12.6 **Interpretation of the elapsed time between ACAT approval and entry into residential care service indicator**

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

- ACAT approval — that is, the approval date of an ACAT assessment; and
- entry into a residential care service — that is, the date of admission to a residential care service.

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

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

Box 12.7 **Entry Period for Residential Care**

In 2002, the Australian Institute of Health Welfare (AIHW) released the report *Entry Period for Residential Care* (AIHW 2002*)*. The AIHW found that the 'entry period' for residential care, which is a measure often used as a performance indicator of timeliness of access for the residential aged care system, is often unrelated to actual waiting times for residential care.

The 'entry period' is the time between ACAT assessment of a person as being eligible for residential aged care, and that person's entry into a residential aged care service. In 1999-2000, the median entry period was 34 days, but it varied substantially between people admitted for low care (55 days) and those admitted for high care (24 days).

In recent years the entry period has been increasing, and concerns have been raised that this reflects decreasing accessibility of aged care in Australia, however, the AIHW found that the supply of services in any particular region has a negligible effect on the entry period.

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

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

Some people may want to enter a particular service and are prepared to wait a lengthy period for that opportunity. For others, personal circumstances may change, for the better or the worse, affecting the timing of their decision. The AIHW found that many factors affect the entry period, but are not linked to the performance of the aged care system. The AIHW recommended that the entry period for residential care not be used as a performance indicator.

The AIHW concluded that the 'waiting time' for residential aged care, as opposed to the entry period, is an important piece of information that is not currently collected. Before data can be collected, a definition of 'waiting time' needs to be agreed. The AIHW suggested that a starting point would be to define it as the time between a person actively seeking residential aged care and their actual entry to aged care.

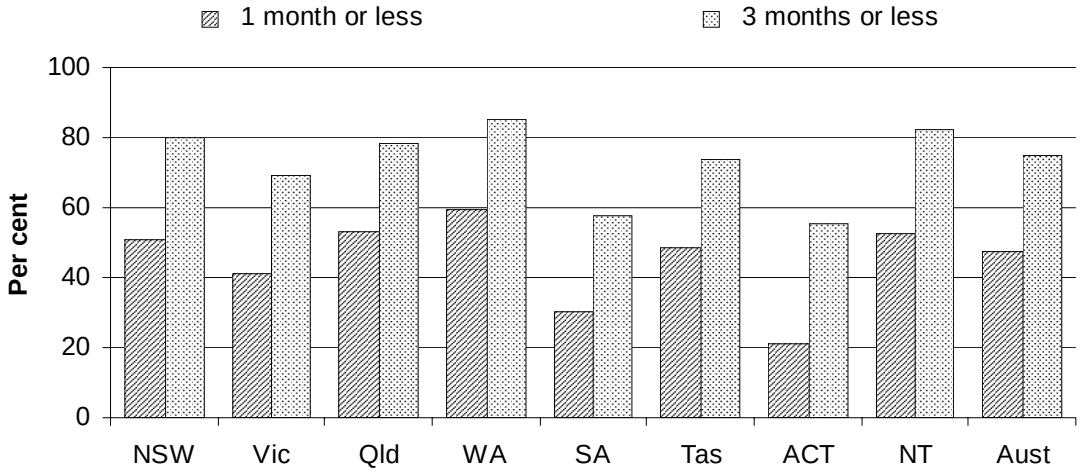
Source: AIHW (2002).

Elapsed time between ACAT assessment and the receipt of a CACP

The elapsed time between an ACAT assessment and the receipt of a community care service partly reflects the extent to which aged care services meet the demand for community care services. This indicator is reported using CACP data.

On average, 75.0 per cent of all people receiving a CACP during 2001-02 had received it within three months of being assessed by an ACAT, and 47.3 per cent had started receiving a CACP within one month of their ACAT assessment (table 12A.37). Across jurisdictions, the proportion of people who received a CACP within three months of assessment ranged from 85.3 per cent in WA to 55.2 per cent in the ACT (figure 12.14).

Figure 12.14 **Elapsed time between ACAT approval and the receipt of a CACP service, 2001-02**



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

Appropriateness — assessment/streaming

ACAT 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 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 a referral at that time for various reasons, or the local service provider may choose not to admit them or be unable to

do so at the time of application. (Service providers decide which eligible people are admitted to their service.)

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

Table 12.7 provides information on the proportion of assessed people referred to community or residential care. Queensland had the highest proportion of ACAT clients referred to residential care in 2000-01 (62.0 per cent), while the ACT had the highest proportion of clients referred to community care (63.8 per cent).

Table 12.7 **Recommended longer term care arrangements of ACAT clients, 2000-01[a]**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Community	%	51.9	53.0	36.5	58.5	34.0	36.2	63.8	52.5	49.2
Residential	%	37.7	39.0	62.0	36.7	52.6	61.0	29.4	28.2	43.0
Other	%	2.4	2.8	1.2	1.2	5.9	0.8	1.4	0.5	2.4
No long term plan made										
Died	%	0.6	0.7	0.1	1.0	1.8	0.2	0.1	1.6	0.7
Cancelled	%	2.0	1.0	0.2	–	4.6	1.4	0.3	0.5	1.4
Transferred	%	1.3	2.6	–	2.6	1.2	0.3	0.1	1.0	1.6
Unknown	%	4.1	0.9	–	–	–	–	4.9	15.8	1.8
Total	**no.**	**65 355**	**54 099**	**27 676**	**23 831**	**15 438**	**4 473**	**2 430**	**628**	**193 930**

a Includes deaths, cancellations and transfers. – Nil or rounded to zero.

Source: Lincoln Gerontology Centre (2002); table 12A.38.

The distribution of ACAT living arrangement recommendations will be influenced by the degree to which any pre-selection process refers a higher proportion of people requiring residential care to ACATs for assessment. Access to residential care requires an ACAT assessment, and jurisdictions with lower overall assessment rates may operate a filtering process to focus assessments on individuals who are more likely to require this level of care. In Queensland, for example, the high proportion of residential care assessments may partly reflect its low rate of use of ACATs other than for primarily residential assessments (table 12.7).

Appropriateness — unmet need

Defining and determining the level of need at an individual level, let alone at a population level, are complex tasks. The perceptions of need and unmet need are often subjective. Previous reports included discussion of unmet need from a

recipient's perspective based on the 1998 ABS Survey of Disability, Ageing and Carers concerning older people requiring assistance with daily activities (ABS 1999 and table 12A.40). Updated ABS data from the 2003 Survey of Disability, Ageing and Carers will be released during 2004 and will be included in the 2005 Report.

Quality — independent appraisal

Compliance with service standards for residential care

Data showing compliance with standards for residential care were not available for this year's Report. Accreditation aims to promote the quality of life and quality of care of residents of government funded aged care services. Services are assessed against 44 'Expected Outcomes' under four main standards (management systems, staffing and organisational development; health and personal care; resident lifestyle; and physical environment and safe systems) to ensure they have internal processes conducive to quality outcomes and continuous improvement.

The accreditation process comprises a series of activities, including a self-assessment undertaken by the service and site audits. It results in a decision by the Aged Care Standards and Accreditation Agency (the Agency) on the period of accreditation to be granted. On the introduction of the accreditation process in 1999, services were rated on a four-level scale (commendable, satisfactory, unacceptable or critical) against each of the 'Expected Outcomes'. Following the completion of the first round of accreditation, the Agency revised the ratings scale and since December 2001 services are now assessed as either 'compliant' or 'non-compliant' against each 'Expected Outcome'. In cases where a serious risk is identified for an 'Expected Outcome' a rating of 'non-compliant with serious risk' is given.

The decision the Agency makes on a service's period of accreditation is based on desk and site audits and any other relevant information (box 12.8). Each decision is based on individual merits but services that are compliant with all 44 'Expected Outcomes' and that have demonstrated continuous improvement are generally awarded three-year accreditation. Services that are truly exceptional may be considered for a period of up to four years accreditation.

Services can seek reconsideration and review of decisions on accreditation, and are advised of any necessary improvements. Ongoing compliance is monitored through support contacts, and review audits may be conducted. Commencing services are assessed on the basis of a written application and, by law, can receive a maximum of only 12 months accreditation.

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

Box 12.8 **Accreditation**

The Aged Care Standards and Accreditation Agency takes into account the following factors, as required by the *Accreditation Grant Principles 1999*:

- the desk audit report;
- the site audit report;
- information received from the Secretary of the DHA about matters that must be considered under division 38 of the Aged Care Act for certification of the service;
- other information received from the Secretary;
- information received from the applicant in response to the statement of major findings presented to the applicant at the conclusion of the site audit (note that the site audit report may take into account this information from the applicant); and
- whether the agency is satisfied that the residential care service will undertake continuous improvement, measured against the Accreditation Standards, if it is accredited.

The following levels of accreditation are awarded on the basis of assessment standards.

Accreditation	*Criteria*
Three-year accreditation	Service is rated 'satisfactory' or 'commendable' on all four standards.
One-year accreditation	Service is: • rated 'unacceptable' on one or more standards but has an acceptable plan of address in place; and • rated 'satisfactory' or 'commendable' on the remaining standards.
Not accredited	Service is either: • rated 'critical' on any of the four standards; or • rated 'unacceptable' on one or more standards and does not have an acceptable plan of address in place.

Source: Aged Care Standards and Accreditation Agency (1998).

Certification aims to improve the physical quality of residential aged care services. The certification framework is underpinned by Part 2.6 of the Aged Care Act and by the Certification Principles. Certified services gain access to accommodation payments and are eligible for Commonwealth funding supplements for concessional and assisted residents.

The certification program has established minimum standards of building quality, which are to be achieved progressively by the industry. To achieve certification, services are assessed against seven aspects of building quality. All services were assessed for certification in 1997 and are now working to achieve continuous improvement targets, which were introduced in 1999 as part of a 10 year plan to improve building quality. Services are to achieve a safety score of 19 out of 25 and an overall score of 60 out of 100 by 2003, and to achieve privacy and space targets for residents by 2008. Timeframes for achievement of targets vary depending on whether the service is existing or new.

All services were required to be accredited by 1 January 2001. To achieve the second accreditation, all services must make a further application for accreditation approximately six months before their present period of accreditation expires. The process of desk audits and site audits is then repeated.

While data on accreditation decisions on residential care services were not available this year, data on safety scores and residents per room were provided. The average number of residents per room at July 2002 varied from 1.66 in NSW to 1.16 in Tasmania. Average safety scores ranged from 21.4 in SA to 17.4 in Tasmania (table 12.8).

Table 12.8 **Average certification safety score and residents per room, July 2002**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Fire score[a]	19.6	18.5	19.7	18.9	21.4	17.4	19.9	20.2	19.4
Residents per room	1.66	1.47	1.41	1.31	1.37	1.16	1.19	1.19	1.48

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

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

Quality — client perceptions

Complaints

The Aged Care Complaints Resolution Scheme was established in October 1997 under the Aged Care Principles. The Scheme is a free and accessible complaints system run by the DHA.

The Scheme is available to anyone who wishes to make a complaint about a Commonwealth funded aged care service. This can include residents of aged care facilities and their families, staff, and people receiving CACPs. Complaints can be

made verbally or in writing, and on a confidential or anonymous basis if necessary. All aged care services are required to have an internal complaints system and in many cases complaints may be resolved without the need to involve the Scheme.

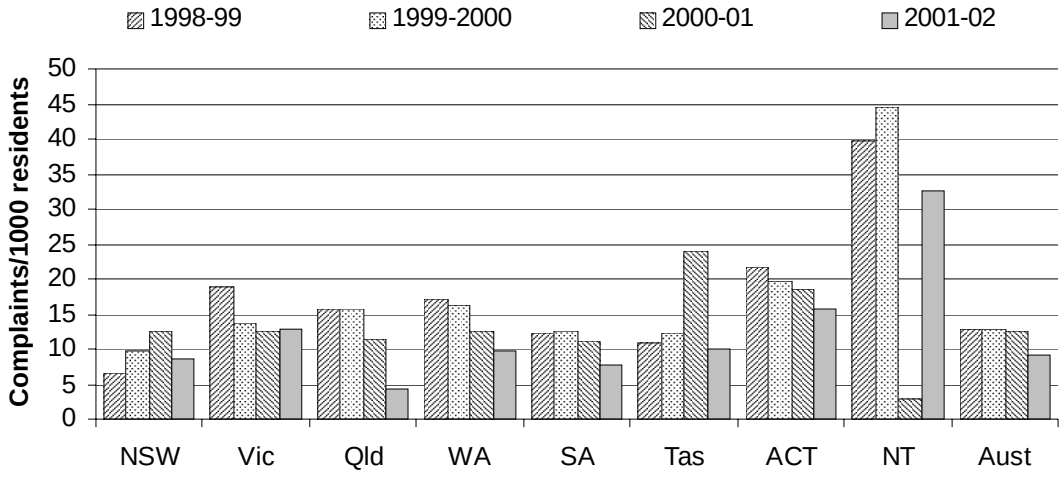
The Scheme is based on the intent that most complaints will be dealt with to the satisfaction of all parties through a resolution process. While approximately 90 per cent of cases have been resolved in this way since 1997, achieving this outcome can be resource intensive depending on the nature of the complaint and the attitudes of the parties.

Since the Scheme was introduced, it has handled over 7000 complaints. More than 95 per cent of these complaints have been dealt with through negotiation and mediation; only 1–2 per cent of cases proceeded to Committee for determination.

Many complaints are complex, raising one or more issues. Of the more than 7000 complaints dealt with, over 12 000 issues have been involved. The issues raised include care needs, financial matters, staff, catering, safety, environment, choice, continence, hygiene and security.

The number of complaints registered per 1000 residents in 2001-02 ranged from 13.0 in Victoria to 4.4 in Queensland (excluding Tasmania, 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 12.15).

Figure 12.15 **Aged Care Complaints Resolution Scheme complaints per 1000 residents**



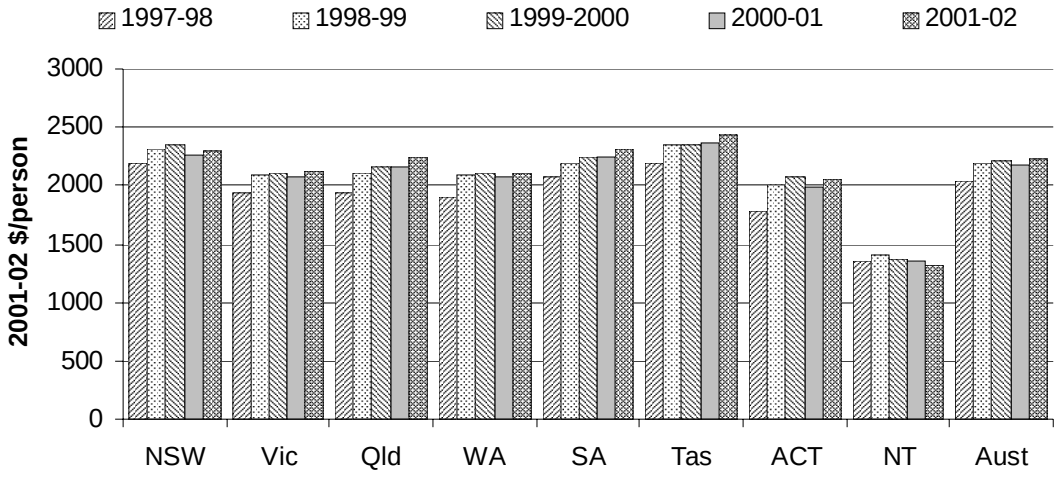
Source: DHA (unpublished); table 12A.44.

Efficiency

This section provides information on expenditure per person on the main types of aged care services. A proxy indicator of efficiency is cost per person in the target population — that is, government inputs (expenditure) per person aged 70 years and over plus Indigenous people aged 50–69 years. Unit cost data for aged care services delivered by government do not contain capital costs.

Commonwealth Government expenditure (including expenditure by the DVA) on residential care services per person aged 70 years and over plus Indigenous people aged 50–69 years varied across jurisdictions in 2001-02, ranging from $2428 in Tasmania to $1324 in the NT (figure 12.16).

Figure 12.16 **Commonwealth real expenditure on residential services — expenditure per person aged 70 years and over plus Indigenous people aged 50–69 years (2001-02 dollars)[a]**

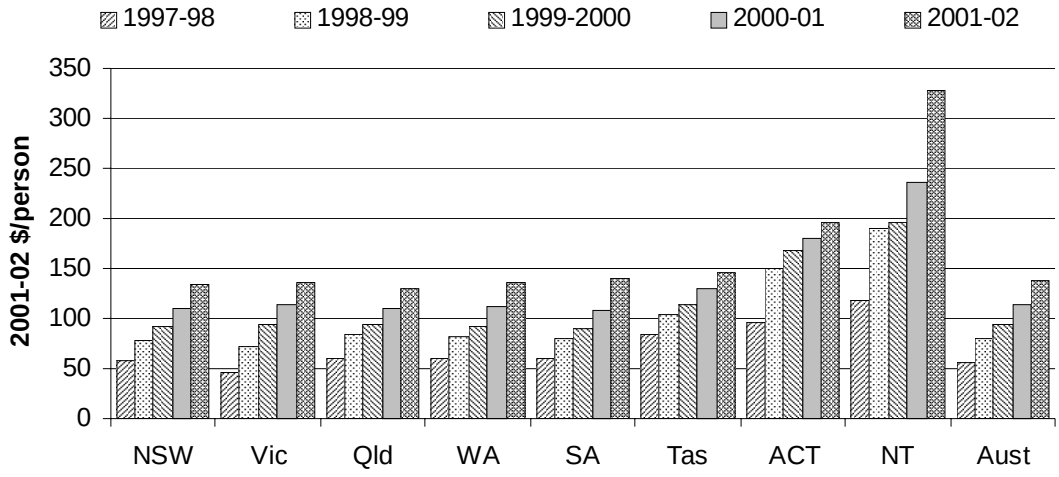


a Includes expenditure on nursing home benefits, hostel subsidies and residential respite. Includes the DVA's contribution (table 12A.47).

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

Expenditure on CACPs per person aged 70 years and over plus Indigenous people aged 50–69 years varied across jurisdictions in 2001-02, and was highest in the NT ($328) and lowest in Queensland ($130) (figure 12.17).

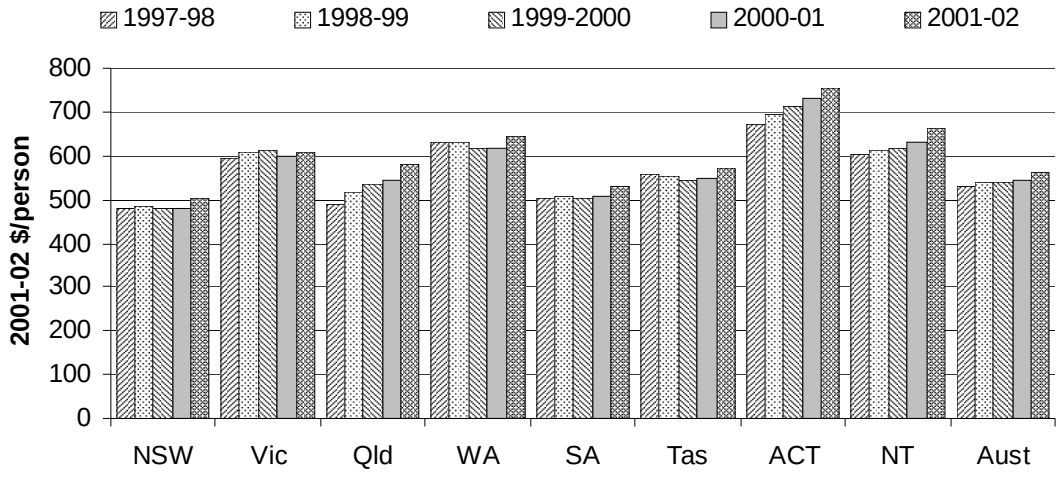
Figure 12.17 **Commonwealth real expenditure on CACP services — expenditure per person aged 70 years and over plus Indigenous people aged 50–69 years (2001-02 dollars)**



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

Commonwealth, State and Territory expenditure on HACC services per person aged 70 years and over plus Indigenous people aged 50–69 years was highest in the ACT ($756) and lowest in NSW ($504) (figure 12.18).

Figure 12.18 **Commonwealth and State Government real expenditure on HACC services — expenditure per person aged 70 years and over plus Indigenous people aged 50–69 years (2001-02 dollars)**



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

Many government services have moved towards better measurement of unit costs as part of a strategy to promote efficiency improvements. It is difficult to measure the

overall efficiency of community care services, given their heterogeneity, but components can be identified and unit costs can be measured. Where services are viewed as substitutes, cost comparisons may be affected.

One approach is to identify service types so a classification system can be developed with corresponding unit costs. The development of a community care classification system remains a challenge, including the question of how to define a meaningful episode of care and show how client outcomes are related to the level and mix of resource inputs.

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. Box 12.9 outlines the Retirement Villages Care Pilot.

Box 12.9 **Retirement Villages Care Pilot**

In the 2002-03 Budget, the Commonwealth Government provided $14.9 million over four years to pilot the provision of community care into retirement villages. The Retirement Villages Care Pilot initiative focuses on residents of retirement villages as a subgroup of those older Australians who require additional services to assist in their choice to stay at home for as long as possible.

The initiative will supplement the care already available in many villages. It should facilitate self provision of future care needs by supporting those who move to a retirement village — a choice that is becoming more common for older Australians.

Two hundred places are available for this initiative in 2002-03, comprising a mix of high care and low care equivalent places. Allocation will be on the basis of an expression of interest and the development of final proposals.

Source: DHA (unpublished).

Developing indicators and data

The AIHW has examined methods for including consumer views in the assessment of HACC service quality. The project developed a Consumer Survey Instrument (CSI), of which a number of versions have been produced to suit particular HACC service types, consumer groups and different ways of gathering consumer feedback. All States and Territories are committed to using the CSI and have agreed to

investigate methods of incorporating it into the National Service Standards Instrument.[3]

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. The HACC National Service Standards Instrument may provide useful data for these indicators in the future. Further work is also required to refine the timeliness indicators.

12.6 Jurisdictions' comments

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

[3] 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.

Commonwealth Government comments

“ The Commonwealth’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 almost 28 000 care packages will be in operation.

Commonwealth expenditure on aged and community care programs increased substantially between 1995-96 and 2001-02. Expenditure on:

- Community Aged Care Package increased sevenfold, from $33 million to $246 million;
- Home and Community Care (HACC) increased from $423 million to $616 million, an increase of 45 per cent;
- the National Respite for Carer’s Program increased from $15 million to $73 million, an increase of 402 per cent; and
- residential aged care increased from $2.4 billion to $4.0 billion, an increase of $1.6 billion.

In the last four years the Government has allocated more than 38 000 new places. In May, the Commonwealth Minister for Ageing announced the release of more than 8231 new aged care places for Aged Care, including 5737 residential care beds, 1150 Community Aged Care Packages and 1344 flexible care places.

The Australian Institute of Health and Welfare (AIHW) was commissioned to undertake a multivariate statistical analysis of entry periods to residential care. The AIHW’s Report confirms that people with the greatest health or social support needs enter care quickly, while people in receipt of other community care programs wait longer to enter residential care as they are receiving support services in the community in the interim. Significantly, the AIHW Report concludes that the supply of residential aged care places has marginal or no discernible effect on entry periods: for high care residents, a decrease in the provision ratio of 10 places per 1000 people aged 70 years and over was associated with only a two-day increase in entry period. The AIHW has now been asked to report on entry periods for Community Aged Care Packages.

The HACC Minimum Data Set (MDS) is being reported for the first time in this year's Report. Work is ongoing to improve reporting from the MDS and its accuracy. For 2001-02 it is estimated that approximately 74 per cent of HACC-funded agencies successfully submitted MDS data, ranging from 56 per cent in the Northern Territory and 66 per cent in New South Wales to 89 per cent in the ACT and 94 per cent in Western Australia. The Commonwealth will engage a consultant to undertake a comprehensive evaluation of the HACC MDS. It is expected that the Final Report of the consultancy will provide significant strategic direction for improving HACC MDS data quality for subsequent collections. Another community care data collection, the Carer Respite MDS, will be collected from January 2003. ”

New South Wales Government comments

“ The NSW Government is committed to providing services to older people and their carers to maximise their independence and participation in community life, to promote their health and wellbeing and to provide accurate and timely information to enable them to choose and access appropriate services as they need them.

The NSW Government established the Office for Ageing in March 2002 to enhance the quality of life of those in NSW who are ageing and to promote opportunities for older people who are active, healthy and contribute to their community. The Office has already progressed a number of strategies, such as Seniors On-Line, Future Directions for Dementia Care and Support (2001-2006) and the Seniors Information Service.

Additional funding for the Home and Community Care (HACC) program was more than $26.4 million in 2001-02, and significant additional funding was allocated to expansion in basic maintenance and support services, particularly domestic assistance, home maintenance, transport, and allied health. Improved service delivery to special needs groups was also a focus for HACC in 2001-02. In particular, resources were directed to services for Aboriginal and Torres Strait Islander people, people with dementia and their carers and people from non-English speaking backgrounds.

It should be noted that HACC data comparability across jurisdictions is complex, given the different data return rates from HACC providers in each jurisdiction, historically different service provision patterns, as well as the range and diversity of organisations funded. NSW makes a substantial investment in personal care services, one of the most significant services in preventing premature admission to institutional care. Improvements in data collection, together with the National HACC Equalisation Strategy that will ensure all jurisdictions receive a share of total HACC funding consistent with its share of the HACC target population, will mean that data comparability across jurisdictions will be improved.

Under the Government Action Plan (GAP) for Health, the NSW Minister for Health has established the Working Group on the Care of Older People in the NSW Health Care System to develop policy options for improving the interface between the acute, community and residential aged care sectors. An initial outcome of this work has been the allocation of an additional $5.5 million per annum for 34 multidisciplinary Aged care Services Emergency Teams across NSW to improve the care of older people who present to Emergency Departments. Other relevant GAP initiatives include improved discharge planning and the introduction of a personal health care record for people with chronic and complex care needs.

NSW is also continuing its planned and comprehensive response to the rapid increase in the number of people living with dementia through the allocation of an additional $11.043 million over four years for a range of dementia strategies. ”

Victorian Government comments

“Victoria is committed to enhancing the quality of life of seniors and to encouraging the community to plan for an ageing population through the establishment of the Office of Senior Victorians. The Office coordinates policy and action across the whole of Government to promote the wellbeing and social participation of older Victorians.

Over the past year, Victoria has faced increasing pressure on the health and community care system generally, and the HACC program in particular, to respond to a growing demand for aged care services.

In 2001-2002, Victoria has focused on the need to improve the interface between acute/sub-acute, residential aged care and the community-based sector. Initiatives included a HACC Workforce Development Strategy, recognising that quality service provision is critically dependent on quality staff. Development within the Primary Care Partnership Strategy, provides a common basis for HACC agencies to work together to ensure effective service delivery.

Victoria has continued to provide additional funds for HACC and HACC-like services over and above the requirements of the Commonwealth/State matched funding.

State funded programs provide additional services that assist Victorians to continue to live in their own homes. Further funds were made available for Personal Alert Victoria, which funded 14 915 personal alarm units across the State at June 2002. The Carers’ program also received new funds of $0.675m. and totalled $8.8m for 2001/02.

Victoria has made a strong commitment to improving access to services for, and better meeting the needs of, special needs groups in the community. The Ethnic Communities Council was funded to develop a range of strategies to assist small rural communities and emerging ethnic communities to understand the HACC service system. This initiative builds on Victoria’s high level of HACC service delivery for people living in rural and remote areas.

Victoria has a high proportion of state-owned residential aged care facilities. During the year 110 aged care beds were reopened in areas of high hospital demand and 60 aged care beds and 83 community aged care packages were reallocated to areas of need across the State. Capital works projects were completed at nine residential aged care facilities, contributing to quality accommodation for aged residents.”

Queensland Government comments

“In June 2002, the Queensland Government announced a new portfolio for Seniors. The Minister for Seniors has lead agency responsibility for issues relating to older people in Queensland. The Department of Families completed two suicide prevention projects targeting older people, both of which were evaluated as successful. These included a community awareness raising project and implementation of strategies to reduce social isolation of older people.

In 2002-2003, additional funding has been provided to support the Future Directions initiatives of the Department of Families. This includes the development of the “A Society for All Ages: Our Shared Future - 2020” framework, a long-range planning agenda to address the policy issues of the ageing population and the interconnected needs of other generations. Other Future Directions initiatives for older people include bridging the generation gap in multicultural communities, improving access to information technology for older people and elder abuse prevention.

The Queensland Government is committed to improving aged care. In 2002 Queensland Health’s draft Aged Care Strategy was released for public consultation. The Strategy outlined new directions in services for older people in inpatient services, mental health services (community and residential), State run residential aged care, dementia care and community services. The Government will consider the outcomes of the consultation in early 2003.

Queensland Health manages the Home and Community Care Program, Aged Care Assessment Program, State Government residential aged care facilities and a range of other services providing long term care for older people. The 2002/03 State Budget provided for the commencement of a major five year $120 million capital program to redevelop Queensland Health’s residential aged care facilities.

Queensland Health continues to address issues identified with the collocation of older mental health consumers in residential aged care facilities. These issue include accreditation, workforce and partnership arrangements between the mental health and aged care systems. Two memory clinics are now in operation.

A major priority for HACC in 2002/03 is to improve access to basic support services including personal care, domestic assistance and social support and home maintenance services. Other HACC priorities include extending access to Indigenous services; building on existing initiatives in continence management, and workforce training to better service the needs of clients suffering from dementia.

New approaches to assessment and client referral mechanisms are being trialled and evaluated. The aim is to reduce the burden of multiple comprehensive assessments for clients with complex needs, to promote consistency and ensure older people are able to access the most appropriate services based on their assessed need.”

Western Australian Government comments

“The Western Australian government’s commitment to aged care was reinforced early in 2002 with the formation of the WA Aged Care Advisory Council to oversee a whole-of-sector approach to the planning and provision of the State’s health and related aged care programs. The Advisory Council is taking a person-centred approach, considering the needs and preferences of individuals while building on the strengths of the existing system and the experience and expertise of service providers.

The principle of supporting people in their own homes, and recommending for residential care only when other support systems are not appropriate to meet specific needs, continues to inform the operations of the Aged Care Assessment Program (ACAP). Data derived from the ACAP Minimum Data Set (MDS) client-based data collection relating to recommended care plans resulting from an individual’s assessment, showed that, for 2001, 60.5 per cent of all ACAT assessments recommended that the person assessed returned to their home with or without community support services. Residential care was the recommended outcome for 35 per cent of all assessments. Remote ACATs recorded the greatest percentage of recommendations for returning home with or without support (71 per cent).

The Home and Community Care (HACC) program continues to expand in line with the commitment to improve the capacity of services to assist people to stay in their own homes. Planning for HACC services has been greatly enhanced by the availability of consistent and reliable data from the HACC MDS initiative. The State had close to 100 per cent compliance, well above the national average of 74 per cent, in the reporting of HACC services received in 2001-02.

The Care Awaiting Placement program encompasses the provision of 108 interim residential beds across the Perth metropolitan area to accommodate, in an appropriate environment, frail older people waiting for residential care. In the 12 months to June 2002, the number of older people waiting for residential care in an acute hospital setting decreased by 25 per cent.

Western Australia continues to implement a range of flexible care options for the frail elderly, including the provision of post-hospitalisation nursing and allied health support and home care services, to assist people to continue living in their own home. The Transitional Care Pilot (TCP), a collaborative State and Commonwealth project, is designed to provide rehabilitation for frail older people who have been hospitalised, to enable them to return home with appropriate support. The TCP, with an additional 50 places made available under the Commonwealth Innovations Pool, will be piloted for two years to determine whether it is a cost-effective and appropriate model of care for frail older people.

Western Australia is committed to further refinement of its range of programs and services in accordance with demographic changes, the geographic spread and diversity of the population, and the needs and preferences of older people.”

South Australian Government comments

“The 2001 ABS Census indicates that 10.8 per cent of South Australians were estimated to be aged 70 years and over in June 2002 compared with the national figure of 9.0 per cent. This continues to challenge the State in the provision of care and support, yet untapped opportunities remain to realise the contribution that senior residents can and do offer.

The Government which came into office in February 2002 has appointed a new Ministerial Advisory Board on Ageing. The Minister intends for the Board to oversight the development of a new State Plan on Ageing which builds on *Ageing – A Ten Year Plan* and *the National Strategy for an Ageing Australia.* Key considerations for the Board will be on working across Government and across generations.

Timely access to residential care remains an issue in South Australia. One issue has been the availability of funds to build newly allocated places. The Government is providing capital works funding and a loan facility to State health units which provide aged care. In addition, HomeStart has a loan facility for not-for-profit providers to access in establishing new beds, or moving places from areas of high to low supply.

A State funded Transition Care Project, which was the forerunner to the Home Rehabilitation and Support Service, ran successfully from January to December 2001. The Commonwealth Government agreed to contribute towards a similar but distinct joint project, with matching State and Commonwealth funding contributions. The target group is older people who have either had an unnecessarily long stay or are at risk of an extended stay in the acute hospital system, and who are assessed as eligible for residential care. The Service provides short-term rehabilitation and support services, including short-term residential care, therapy, nursing and personal care, and community based support. The project facilitated residential placement for 18 per cent of people completing their transition, and resulted in a return home for 58 per cent with varying levels of support. The outcomes of the project have challenged the thinking of aged care providers and program administrators in determining the appropriate balance between short-term or episodic support options compared with permanent placement.

The DHS has now released the document *Strategic Directions for Older People from Culturally and Linguistically Diverse Backgrounds*. This will influence priorities in many areas of work, including growth in the HACC Program. Services for Aboriginal people remain a priority. South Australia is actively contributing to the national HACC Best Practice Project in diverse areas across the State.”

Tasmanian Government comments

“ The Tasmanian Government is committed to promoting healthy ageing and providing a care system that has an appropriate focus on the health and care needs of older Tasmanians with adequate infrastructure to meet these needs.

Tasmania’s ageing population, along with the rurality of a small-dispersed population and its low socio-economic status, is increasingly becoming one of the major dominant influences on the planning and development of health services.

The State currently has a higher proportion of people aged 70 years or over, than the national average. It is rapidly moving towards a community where one third of its population will be aged 65 years or more, of which a significant proportion will be aged 85 years or more. In fact, the most rapid growth is predicted to be in the aged group of 85 years plus, which by 2050 will increase from 1.5 per cent to 6.8 per cent of the total population.

Tasmania continues to experience increasing numbers of people waiting for placement into residential aged care. Consequently, this significantly impacts upon the State’s community health and hospital services. Not only has the number of people waiting increased, but the percentage of these people needing to wait in hospital has more than doubled over the past 5 years.

In response to these challenges, the Government has relocated the Seniors Bureau to the Department of Premier and Cabinet to provide a stronger, more integrated and coordinated approach across the whole of government.

The Department of Health and Human Services is undertaking reviews of the Aged Care Assessment Program, Home Help & Home Maintenance Service and Community Transport systems and is developing a Community Nursing Strategic Plan. It is implementing reforms to statewide rehabilitation services. In addition, a new 25-bed unit under the Commonwealth’s Innovative Care Rehabilitation Service Pilots has been opened. Packages of care are being provided for people with complex care needs and efforts are being made to improve data collection and management information systems.

In order to address longer term needs, the Tasmanian Government is giving priority to developing a strategic plan that will provide a comprehensive understanding of the full extent of cost and demand pressures on health and human services created by an ageing population. This will also give strategic direction for the future development of health and community services.

Tasmania’s Department of Health and Human Services has identified the need to ensure that the services it provides are responsive to the needs of an ageing population and it recognises that the opportunity exists, in partnership with others, to undertake research and pilot new policies and models of service delivery to enable health services to meet the care needs of an ageing population. ”

Australian Capital Territory Government comments

“The ACT Government is committed to ensuring that older people in the ACT have access to timely and appropriate care services. The Government has developed a Health Action Plan that sets the directions for public health services in the ACT for the next three to five years. The Plan articulates an approach to older persons that is founded on the principles of independence, participation, care, self-fulfilment and dignity.

The ACT Government has undertaken a number of initiatives to improve the interface between acute care and aged care services. These include a joint initiative with the Commonwealth Government to fund 11 transitional care beds within a residential facility to assist elderly people to return home safely following a hospital stay. Other ACT Government funded services include transitional care packages in the community, and a convalescent service to assist people to restore function following discharge from hospital.

The ACT Government continues to work with the community sector and the Commonwealth Government to enhance services for elderly people. A priority for 2001-02 has been the commencement of a collaborative partnership between the Aboriginal community, the Commonwealth and the ACT Government to assess the aged care needs of Aboriginal people in the ACT. For the first time in 2001-02 an Aboriginal service provider was funded through the Home and Community Care (HACC) Program.

Steps are being taken to address the respite needs in the ACT in recognition of the vital role that carers play in supporting family members, friends and neighbours. The ACT Government is assessing the extent of met and unmet need for various client groups and individuals and plan for future respite services to ensure that carers and individuals are adequately supported.

Mental Health ACT has provided additional funds over the next three years to address the gap in services for people with dementia-related challenging behaviours. Negotiations have begun with a residential care provider and the Commonwealth regarding the provision of specialist psycho-geriatric residential beds. Negotiations also continue with the Commonwealth with regards to accessing funding for a Psycho-Geriatric Unit.

In the past twelve months the ACT Government has placed a strong emphasis on participating in and facilitating consultation in order to develop clear direction for the HACC Program in 2002-2003. Planning processes have included sector network meetings, planning sessions, reports and evaluations from services, consultation with relevant agencies and individuals. This has included consultation with consumers and regular contact with service providers. Particular emphasis has been given to listening and responding to consumers with a commitment to develop a consumer participation plan in 2002-2003.

The agreed vision for clients of HACC services includes the right to pursue lives of dignity and self-esteem, self-worth, independence and meaning, and a right to accurate information, and involvement in decision making.”

Northern Territory Government comments

“ The Northern Territory Government faces the challenge of providing services to an aged care target group that does not match the national norm. For instance, the NT currently has the smallest proportion of people aged 70 years and over, but it also has the fastest growing population in the target group. Additionally, over half of the target group for aged care services in the NT is Indigenous, in marked contrast with all other states/territories.

In the Territory, we are servicing a client group with higher support needs than the national average, and one that generally needs and accesses services at a much younger age than the national average. The aged care target group also includes many more indigenous, remote and non-English speaking background clients in all programs than any other jurisdiction in Australia; and has less capacity to share the cost of service delivery through co-payment systems such as residential aged care bonds.

Further, the diverse cultural mix of the Northern Territory population, remotely located communities, issues with recruitment, retention and training of staff, along with the harsh climatic conditions are all factors which challenge and encourage innovative approaches.

With this in mind, the Northern Territory has already developed a range of new responses to its unique client profile. Principally this is achieved through providing services to people in the community where they reside. Consequently, the NT has a higher number of very small, remote aged care services than any other jurisdiction. These services include CACP, HACC and indigenous pilots as well as a focus on integrating aged care with existing health and other community services.

Integration of HACC and ACAT assessment will be trialled in the Katherine district, as well as establishing links with other coordinated care and allied health trials under way in Katherine.

Current national projects which focus on the unique circumstances of remote indigenous service delivery include the documentation of good practice in remote HACC service delivery, and the development of an Indigenous HACC dependency tool.

These different types of services will ultimately ensure that ageing Territorians will be able to access service within their own communities. ”

12.7 Definitions

Table 12.9 **Terms**

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

(Continued on next page)

Table 12.9 **(Continued)**

Term	*Definition*
High/low care recipient	Recipient of a high level of residential care (that is, a level of residential care corresponding to RCS levels 1–4) or a recipient of a low level of residential care (that is, a level of residential care corresponding to RCS levels 5–8). If the person is approved as a recipient of a high level of care, that person can receive care at any care classification level (*Approval of Care Recipients Principles 1997*, s.5-9). A person approved as a recipient of a low level of care can be classified only as RCS 5–8. (*Classification Principles 1997*, s.9-19).
In-home respite	A short term alternative for usual care
People from non-English speaking countries	People who were born in non-English speaking countries. English-speaking countries are defined as Australia, New Zealand, the United Kingdom, Ireland, the United States, Canada and South Africa.
People with a moderate disability	Where a person does not need assistance, but has difficulty with self care, mobility or communication.
People with a profound disability	Where a person is unable to perform self care, mobility and/or communication tasks, or always needs assistance.
People with a severe disability	Where a person sometimes needs assistance with self care, mobility or communication.
Personal care	Assistance in undertaking personal tasks (for example, bathing).
Places	A capacity within an aged care service for the provision of residential care, community care or flexible care in the residential care context to an individual (*Aged Care Act 1997* (Cwlth)); also refers to 'beds' (*Aged Care (Consequential Provisions) Act 1997* (Cwlth), s.16).
Real expenditure	Actual expenditure adjusted for changes in prices, using the GDP(E) price deflator and expressed in terms of final year prices.
Resident	For the purposes of the *Aged Care Act 1997*, a person who is being provided with residential care through an aged care service conducted by an approved provider under the Act.
Respite care	Alternative care arrangements for dependent people living in the community, with the primary purpose of giving their carer a short term break from their usual caring commitments.
Special needs groups	Section 11-3 of the *Aged Care Act 1997* specifies the following people as people with special needs: people from Aboriginal and Torres Strait Islander communities; people from non-English speaking countries; people who live in rural or remote areas; people who are financially or socially disadvantaged; and veterans.
Veterans	Veterans and war widow(er)s who are entitled to treatment through the Department of Veterans' Affairs under the provisions of the *Veterans' Entitlements Act 1986*.

12.8 References

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