12 Aged care services

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

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

A profile of aged care services appears in section 12.1. A framework of performance indicators is outlined in section 12.2 and key performance results are discussed in section 12.3. Future directions in performance reporting are discussed in section 12.4. Jurisdictions' comments are reported in section 12.5. Section 12.6 contains a discussion of age standardisation of aged care data, and definitions for data and indicators are provided in section 12.7. Section 12.8 lists the supporting tables for this chapter. Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 12A.3 is table 3 in the attachment). Supporting tables are provided on the CD-ROM enclosed with the Report. Section 12.9 lists references used in this chapter.

Additions and improvements made to the chapter this year include:

- provision of age-sex specific usage rates (per 1000 of the population) by jurisdiction, and by remoteness category for high and low care residential

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

services, CACP and EACH. For Indigenous populations, these data are combined for high and low care residential services and for CACP

- reporting of outcomes of appraisals of HACC agencies over the three year period to 2003-04 for the indicator 'compliance with service standards for community care'.

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

Box 12.1 **Interpreting residential aged care data**

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

- *Residential services data*. This chapter groups residential services for reporting purposes based on the eight level Resident Classification Scale (RCS) profile of residential services' clients.
  - Aged care homes with 80 per cent or more residents classified as RCS 1–4 are described as high care services.
  - Aged care homes with 80 per cent or more residents classified as RCS 5–8 are described as low care services.
  - A service that is neither high care nor low care as defined above is called a mixed service.

  These categories have been used for descriptive purposes and do not have any legal foundation under the *Aged Care Act 1997* (Cwlth). Similarly, the choice of 80 per cent as a cut-off is arbitrary but considered appropriate for descriptive purposes.
- *Residents data*. This chapter classifies clients as high care or low care based on their RCS assessment. High care residents have been assessed as RCS levels 1–4, and low care residents have been assessed as RCS levels 5–8.
- *Places data*. Part 2.2 of the Aged Care Act details the processes for planning and allocating subsidised services to meet residential aged care needs and community care needs. Planning is based on a national formula for people aged 70 years or over for high and low care. 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.

(Continued on next page)

Box 12.1 **(Continued)**

Although there must be a needs match between residents entering vacant places (that is, vacant low care places should usually be filled by low care residents), this can change over time with 'ageing in place', which allows a low care resident who becomes high care to occupy a low care place within the same service until he or she is discharged.

- *Locality data.* Geographic data are based on the ABS Australian Standard Geographic Classification of Remoteness Areas (ABS 2003). Data are classified according to an index of remoteness that rates each ABS Census district based on the number and size of towns, and the distance to major towns and urban centres.

12.1 Profile of aged care services

Service overview

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

Government funded aged care services covered in this chapter relate to the three levels of government (Australian, State and Territory, and some local) involved in service funding and delivery. The formal publicly funded services covered represent only 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 2003 who required help with self-care, mobility or communications received assistance from the informal care network of family, friends and neighbours (ABS 2004). Many people receive assistance from both formal aged care services and informal sources. Older people also purchase support services in the private market, and these services are not covered in this chapter.

Roles and responsibilities

Assessment services

The Australian Government established the Aged Care Assessment Program (ACAP) in 1984, based on the assessment processes used by State and Territory health services to determine (1) eligibility for admission into residential care and (2) the level of care required (and thus the subsidy paid to such services). The core objective of the ACAP is to assess the needs of frail older people and recommend appropriate services. Assessment and recommendation by ACATs are mandatory for admission to residential care or receipt of a CACP or an EACH package. People may also be referred by ACATs to other services, such as those funded by the HACC program. An ACAT referral is not mandatory for receipt of other services, such as HACC and VHC services.

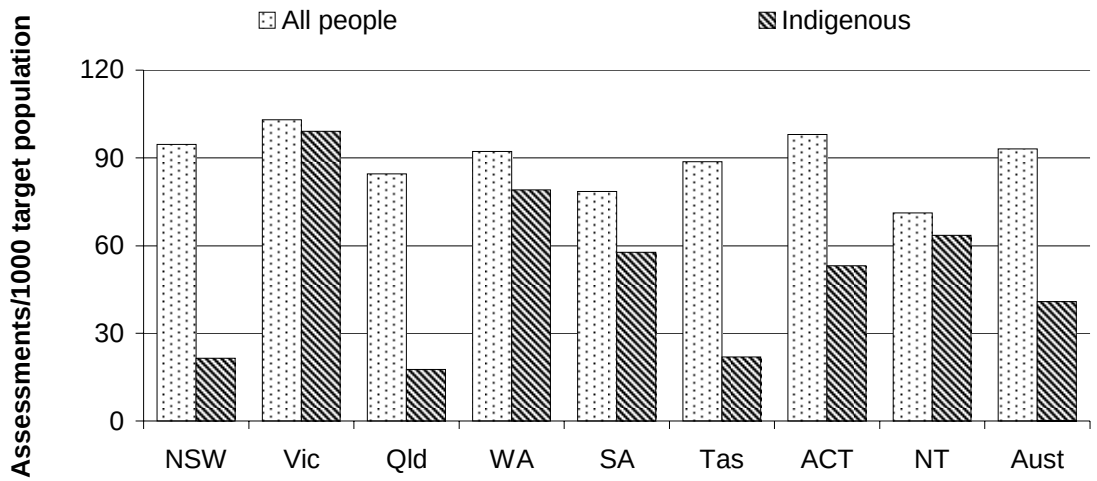
State and Territory governments are responsible for the day-to-day operation and administration of the ACAP and provide the necessary accommodation and support services. The scope and practice of the teams differ across and within jurisdictions, partly reflecting the service setting and location (for example, whether the team is attached to a residential service, a hospital, or a community service). This has an effect on program outputs.

The number of assessments per 1000 target population varied across jurisdictions in 2003-04. The national rate was 93.0 assessments per 1000 people aged 70 years or over and Indigenous people aged 50 years or over and 40.9 per 1000 Indigenous people aged 50 years or over (figure 12.1).

Residential care services

Religious and private for-profit organisations were the main providers of residential care at June 2005, accounting for 30.4 per cent and 31.2 per cent respectively of all subsidised residential aged care places. Community-based organisations and not-for-profit charitable organisations accounted for a further 14.7 per cent and 15.8 per cent respectively. State, Territory and local governments provided the remaining 7.8 per cent (figure 12.2).

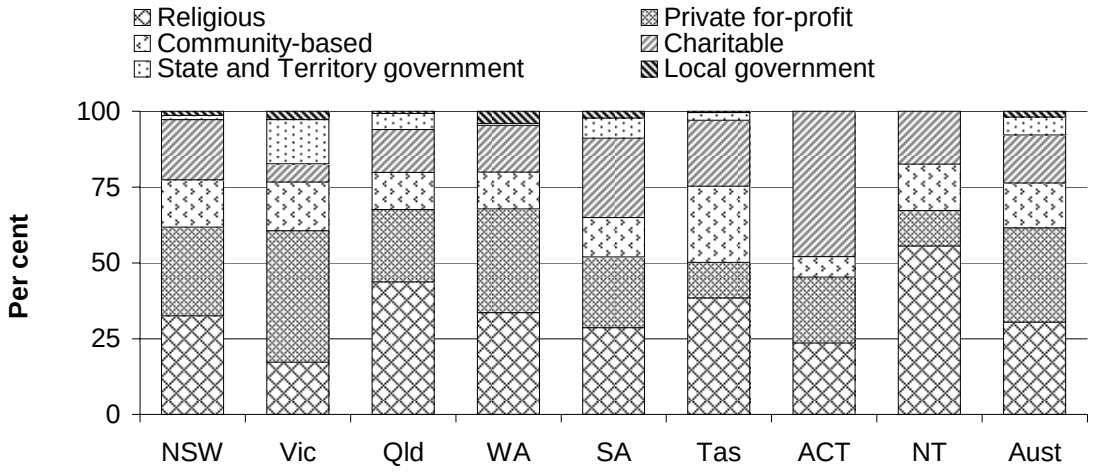
Figure 12.1 **Aged Care Assessment Team assessment rates, 2003-04[a, b, c, d]**



a Includes ACAT assessments for all services. **b** 'All people' includes all assessments of people aged 70 years or over and Indigenous people aged 50 years or over per 1000 people aged 70 years or over and Indigenous people aged 50 years or over. **c** 'Indigenous' includes all assessments of Indigenous people aged 50 or over per 1000 Indigenous people aged 50 years or over. **d** The number of Indigenous assessments is based on self-identification of Indigenous status.

Source: Lincoln Centre for Ageing and Community Care Research (unpublished); table 12A.38.

Figure 12.2 **Ownership of residential places, June 2005[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 (DoHA) (unpublished); table 12A.4.

The Australian Government is responsible for most of the regulation of Australian Government subsidised residential aged care services, including accreditation of the service and certification of the standard of the facilities. State, Territory and local

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

Community care services

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

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

The Australian Government controls the number of subsidised places. In May 2004, following a recommendation of the Review of Pricing Arrangements in Residential Aged Care, the Australian Government adopted a new ratio of 108 places for each 1000 people in the population aged 70 years or over. Of the 108 places, 88 are residential care places (40 high care and 48 low care) and 20 are community care places (CACP and EACH packages).

- Services are expected to meet regional targets for places for concessional residents. These targets range from 16 per cent to 40 per cent of places, and aim to ensure residents who cannot afford to pay an accommodation bond or charge have equal access to care. (The criteria for being deemed a concessional resident are based on home ownership and occupancy, receipt of income support and the level of assets held at entry.)
- Extra service places (where residents pay for a higher standard of accommodation, food and services) are restricted.
- To receive an Australian Government subsidy, an operator of an aged care service must be approved under the Aged Care Act as a provider of aged care.
- Principles (regulations) created under the Aged Care Act establish the obligations of approved providers relating to quality of care and accommodation.

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

Flexibly funded services

Flexible care addresses the needs of care recipients in ways other than the care provided through mainstream residential and community care. Three types of flexible care are currently provided for under the Aged Care Act: EACH packages, Innovative Care places and Multipurpose Service program places. In addition, flexible models of care are provided under the National Aboriginal and Torres Strait Islander Aged Care Strategy.

- The Multipurpose Service program supports the integration and provision of health and aged care services for small rural and remote communities. Nationally, the number of Multipurpose Services increased from 88 in June 2004 to 92 in June 2005 (DoHA unpublished).
- The Aged Care Innovative Pool provides flexible care subsidies for alternative care options. Nationally, there were 1344 Innovative Pool places at 30 June 2005 (DoHA, unpublished). Since it began in 2001, the Innovative Pool has focused on: Innovative Care Rehabilitation Services pilots and Intermittent Care Service pilots, both of which address the interface between aged care and hospital care; Disability pilots addressing the aged care and disability services interface; Dementia pilots providing services for people with dementia in alternative settings; and High Needs pilots for areas where the provision of aged care services presents a particular challenge.
- The EACH program provides high level aged care to people in their own homes, complementing CACPs, which provide low level care. There were 1672 operational EACH places at 30 June 2005 (table 12A.35).

Indigenous-specific services

Under the Aged Care Act, 30 Indigenous aged care services are funded, providing approximately 700 places. Most of these places are available in Indigenous-specific aged care services, but some are available in aged care services catering to the broader community. In addition, approximately 600 flexibly funded aged care places were provided at 30 June 2005 through the National Aboriginal and Torres Strait Islander Aged Care Strategy, often in remote areas where no aged care services are otherwise available. Services delivered under the strategy are outside the Aged Care Act (DoHA unpublished).

The Australian Government actively targets community aged care places to Indigenous communities and contracts Aboriginal Hostels Limited to provide ongoing assistance to ensure that services in rural and remote areas remain viable.

Funding

Assessment services

The Australian Government provided grants to State and Territory governments to operate 119 ACATs (at 30 June 2005) and seven evaluation units (DoHA unpublished). In 2004-05, the Australian Government provided funding of $51.7 million nationally for aged care assessment (table 12A.46). ACAT expenditure per person aged 70 years or over (plus per Indigenous person aged 50–69 years) was $27 nationally during 2004-05 (table 12A.47). Some States and Territories also contribute funding for ACATs.

Residential care services

The Australian Government provides the majority of annual funding for residential aged care services — $5.0 billion in 2004-05, comprising DoHA expenditure of $4.3 billion (table 12A.42) and Department of Veterans' Affairs (DVA) expenditure of $750.3 million (table 12A.44). State and Territory governments also provide some funding for public sector beds. Residents provide most of the remaining service revenue, with some income derived from charitable sources and donations.

Experimental estimates of State and Territory government expenditure have been collected for some states and territories, for three categories (table 12.1). The categories are defined in section 12.7. The data definitions need further development, so comparisons across jurisdictions need to be made with care.

Table 12.1 **Experimental estimates of State and Territory government expenditure on residential aged care 2004-05 ($ million)**

	NSW	*Vic*[a]	*Qld*[b]	*WA*	*SA*	*Tas*[c]	*ACT*	*NT*[d]	*Total*
Adjusted subsidy reduction supplement	2.5	13.1	6.0	2.6	na	1.5	..	..	25.7
EBA supplement	..	41.8	24.0	..	na	..	..	..	65.8
Rural small nursing home supplement	..	5.6	na	2.4	na	10.7	..	0.5	19.2

EBA = enterprise bargaining agreement. **a** Victorian data include payments for both generic aged care places and specialist mental health services. **b** Queensland Health provided approximately $24 million in supplementation. **c** Tasmanian data are for the adjusted subsidy reduction supplement and rural small nursing home supplement. Rural small nursing home supplement is an estimate based on the average bed day cost across all State operated small rural residential aged care services and recognises the extra cost of operating very small services in rural and remote areas, public sector EBA and staffing levels. **d** NT data are viability supplement grants given to small rural and remote residential aged care facilities. **na** Not available. .. Not applicable.

Source: State and Territory governments (unpublished).

The Australian Government annual RCS subsidy for each occupied place varies according to the client's level of dependency. At June 2005, the average annual RCS subsidy per residential place was $29 592 nationally (table 12.2). Variations in average annual subsidies reflect differences in subsidy rates as well as differences in the dependency of residents. Low care subsidy rates (RCS levels 5–8) are the same in all states and territories. High care subsidy rates (RCS levels 1–4) are being adjusted towards a uniform national rate by July 2006, under the Australian Government's Funding Equalisation and Assistance Package.

The combined number of operational high care and low care residential places per 1000 people aged 70 years or over at June 2005 was 41.8 and 43.4 respectively on a national basis (table 12.3). Nationally, the proportion of low care places relative to high care places rose between 2001 and 2004 (table 12A.10).

Table 12.2 **Average annual Australian Government RCS subsidy per occupied place, and the dependency levels high care and low care residents, June 2005**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Average annual Australian Government RCS subsidy per residential place[a]										
All RCS levels	$	29 839	29 582	28 994	28 522	30 414	30 748	29 825	30 784	29 592
Proportion of high care residents[b]										
RCS 1	%	22.4	25.2	17.9	23.7	23.7	18.1	28.7	20.8	22.5
RCS 2	%	26.7	21.6	25.3	20.6	25.7	26.5	17.8	32.6	24.5
RCS 3	%	14.3	12.7	18.3	13.2	16.1	20.4	15.6	17.1	14.9
RCS 4	%	5.4	5.3	6.1	5.8	5.4	7.2	6.3	4.2	5.6
Proportion of low care residents										
RCS 5	%	10.6	13.5	10.9	14.2	10.8	10.7	10.1	4.7	11.7
RCS 6	%	9.8	11.0	9.6	12.0	9.1	7.6	11.4	3.9	10.1
RCS 7	%	10.1	10.2	10.9	9.9	8.7	9.3	9.7	12.4	10.1
RCS 8	%	0.8	0.5	0.9	0.5	0.6	0.3	0.3	4.2	0.7

a Includes only subsidies based on the RCS. Average Australian Government payments, including subsidies and supplements totalled $39 336 per high care resident (RCS 1–4) and $14 109 per low care resident (RCS 5–8). **b** Differences in average annual subsidies reflect differences in subsidy rates as well as differences in the dependency of residents.

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

Table 12.3 **Operational high care and low care residential places, 30 June 2005[a, b]**

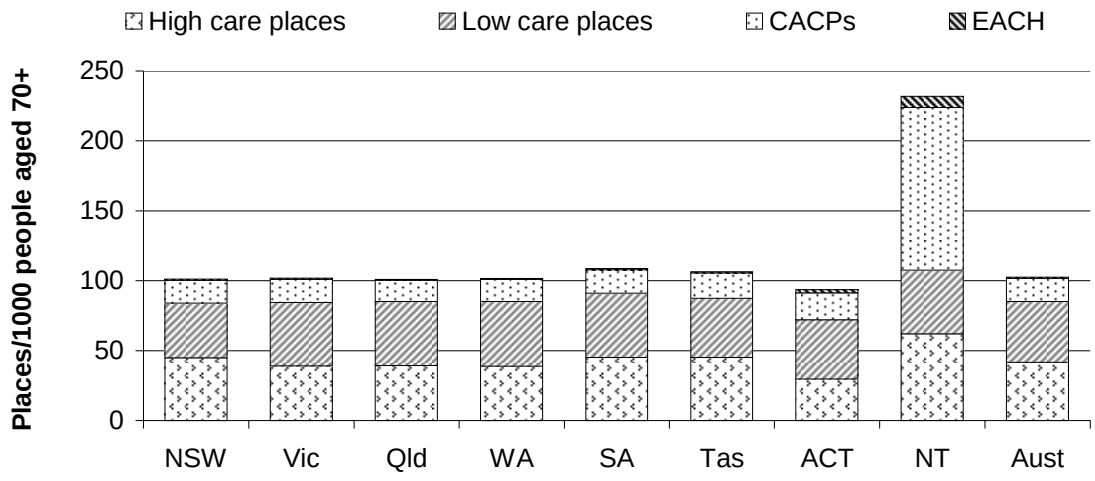
	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Number of places per 1000 people aged 70 years or over										
High care places	no.	44.9	39.1	39.3	38.7	45.2	45.3	29.6	62.2	41.8
Low care places	no.	39.2	45.4	45.9	46.5	46.0	42.1	42.5	45.3	43.4
Total places	**no.**	**84.1**	**84.5**	**85.2**	**85.2**	**91.2**	**87.4**	**72.1**	**107.5**	**85.2**
Proportion of places										
High care places	%	53.4	46.3	46.1	45.4	49.6	51.8	41.1	57.9	49.1
Low care places	%	46.6	53.7	53.9	54.6	50.4	48.2	58.9	42.1	50.9

a Excludes places that have been 'approved' but are not yet operational. Includes multipurpose and flexible services attributed as high care and low care places. **b** For this Report, Australian Government planning targets are based on providing 88 places per 1000 people aged 70 years or over. In recognition of poorer health among Indigenous communities, however, planning in some cases also takes account of the Indigenous population aged 50–69 years. This means that the provision ratio based on the population aged 70 years or over will appear high in areas with a high Indigenous population (such as the NT).

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

The combined number of high care residential places, low care residential places, CACPs and EACH packages is 102.4 per 1000 people aged 70 years and over (figure 12.3). The Australian Government's targets for the provision of residential places, CACPs and EACH packages were outlined previously (box 12.2).

Figure 12.3 **Operational residential places, CACPs and EACH packages, 30 June 2005[a, b, c, d]**



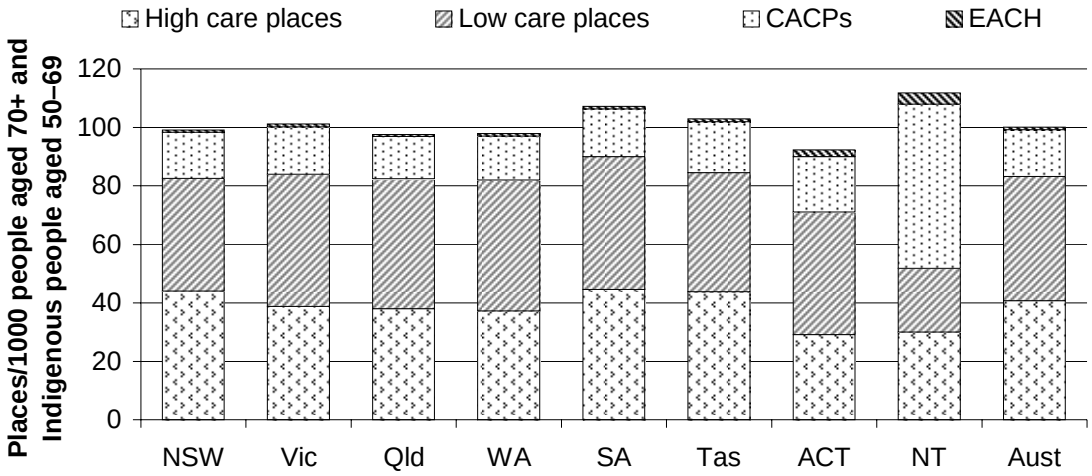
a Excludes places that have been approved but are not yet operational. **b** 'Ageing in place' may result in some low care places being filled by high care residents. **c** For this Report, Australian Government planning targets are based on providing 108 places per 1000 people aged 70 years or over. However, in recognition of poorer health among Indigenous communities, planning in some cases also takes account of the Indigenous population aged 50–69 years. This means that the provision ratio based on the population aged 70 years or over will appear high in areas with a high Indigenous population (such as the NT). **d** CACPs and EACH packages are not residential services but are included in the Australian Government planning targets (see boxes 12.1 and 12.2 for an interpretation of residential care data and Australian Government planning targets).

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

Age specific usage rates for these services, by jurisdiction and remoteness and for Indigenous usage at 30 June 2004 are reported in tables 12A.58 to 12A.64.

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

Figure 12.4 **Operational residential places, CACPs and EACH packages, 30 June 2005**[a, b, c, d]



[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 and EACH packages are not residential services but are included in the Australian Government planning targets (boxes 12.1 and 12.2 contain an interpretation of residential care data and Australian Government planning targets). [d] CACPs provide a more flexible model of care more suitable to remote Indigenous communities, so areas with a high Indigenous population (such as the NT) may have a higher proportion of CACPs.

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

Community care services

Total national government expenditure on HACC was $1.3 billion in 2004-05, consisting of $791.9 million from the Australian Government and $509.2 million from the State and Territory governments. The Australian Government contributed 60.8 per cent, while State and Territory governments funded the remainder (table 12A.43). Recipients may also contribute towards the cost of their care.

The NRCP provides community respite services and is funded by the Australian Government. Expenditure on this program was $99.2 million in 2004-05 (table 12A.46). The DVA also provided $80.5 million for the VHC program during

2004-05 (table 12A.45), which does not include expenditure for in-home and emergency respite home care.

The Australian Government funds the CACP and EACH programs, spending $323.3 million and $34.3 million respectively on the programs in 2004-05 (table 12A.46). Both CACPs and EACH packages are also part funded by client contributions. Australian Government expenditure data on a range of other community care programs targeting older people are contained in table 12A.46 and data on expenditure per head of the target population are contained in table 12A.47.

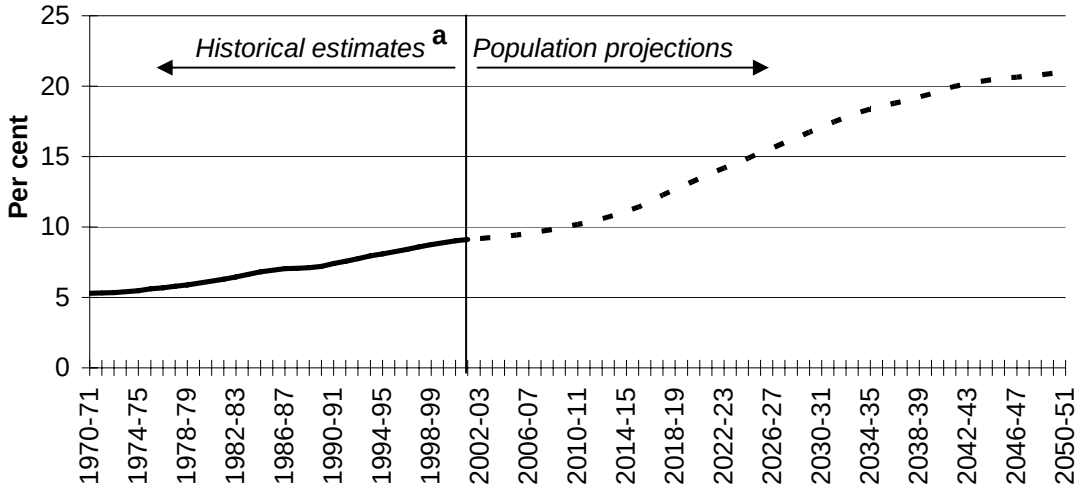
Size and scope of sector

Size and growth of the older population

The Australian population is ageing, as indicated by an increase in the proportion of people aged 70 years or over in the total population. This trend is expected to continue, and the proportion of older people is expected to increase dramatically in the 21st century (figure 12.5). The proportion of older people is 9.3 per cent nationally but varies across jurisdictions (figure 12.6). Higher life expectancy for females resulted in all jurisdictions having a higher proportion of older females than older males.

Demographic profiles affect the demand for aged care services because females use aged care services (particularly residential services) more than males. 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 they are less likely to have a partner to provide care.

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



a Historical estimates are based on the ABS Census of Population and Housing that is held at five year intervals.

Source: ABS States and Population by Age and Sex (unpublished); ABS Population Projections (unpublished).

Figure 12.6 **Estimated proportion of population aged 70 years or over, by gender, June 2005**

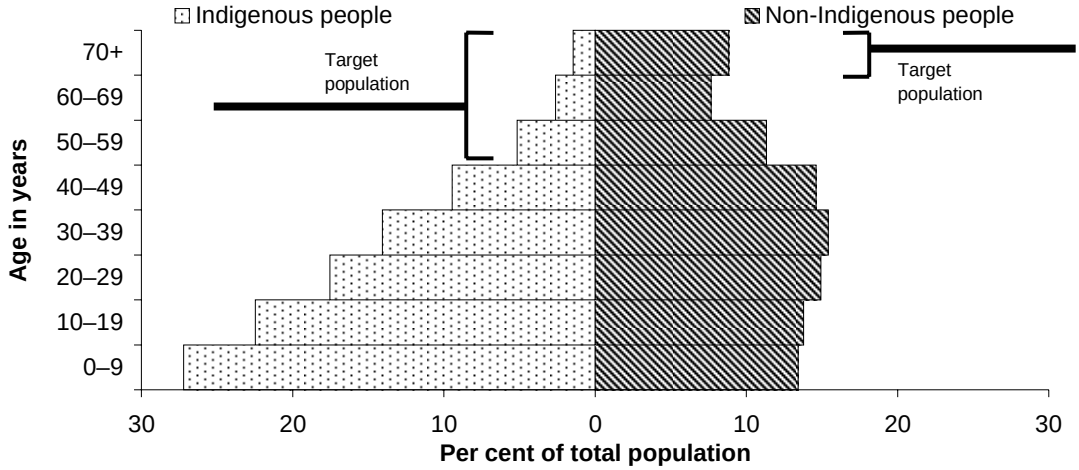
Source: ABS *Population* Projections by Statistical Local Area (SLA) 2002–2022 (unpublished); table 12A.1.

Characteristics of older Indigenous people

The ABS estimated that about 52 400 Indigenous people were aged 50 years or over in Australia at 30 June 2005 (table 12A.2). Although the Indigenous population is

also ageing, there are marked differences in the age profile of Indigenous Australians compared with the non-Indigenous population (figure 12.7). June 2001 ABS estimates of the life expectancy of Indigenous males and females suggested it was nearly 20 years below that recorded for the total Australian population. These figures indicate that Indigenous people are likely to need aged care services earlier in life, compared with the general population.

Figure 12.7 **Age profile and target population differences between Indigenous and other Australians, June 2001**



Source: ABS Estimated Residential Population (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 158 901 operational places (permanent and respite) in residential care services (72 268 in predominantly high care services, 23 689 in predominantly low care services and 62 944 in services with a mix of high care and low care residents) at June 2005 (tables 12A.6–9).

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 mix of high care and low care places. In June 2001, 25.2 per cent of all places were located in services offering both high care and low care places. This proportion increased to 30.5 per cent of places in June 2002 and 36.5 per cent of places in June 2003, then decreased to 33.4 per cent in June 2004 but increased to 39.6 per cent in June 2005 (tables 12A.6 and 12A.9; SCRCSSP 2002, 2003; SCRGSP 2004, 2005).

Box 12.3 **Ageing in place in residential care**

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

The Aged Care Act does not establish any 'program' or require any residential aged care service to offer ageing in place. Rather, it creates the opportunity for providers to choose to provide the full continuum of care, by removing the legislative and administrative barriers that prevented this outcome in the past.

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

Source: DoHA (unpublished).

The client profile of services that had predominantly low care residents in 2000 has changed over time, with low care residents staying in their current service as their dependency levels rise, and with aged care services expanding and diversifying. Low care services are generally smaller (as measured by number of places) than high care services. At June 2005, 64.2 per cent of low care services had 60 or fewer places (table 12A.8), compared with 47.3 per cent of high care services (table 12A.7).

Age specific usage rates for these services, by jurisdiction and remoteness and for Indigenous usage at 30 June 2004 are included in the Report at tables 12A.58 to 12A.64.

Community care services

Services provided under the HACC program include domestic assistance and home maintenance, personal care, food services, respite care, transport, allied health care and community nursing (box 12.4).

Box 12.4 **HACC Services**

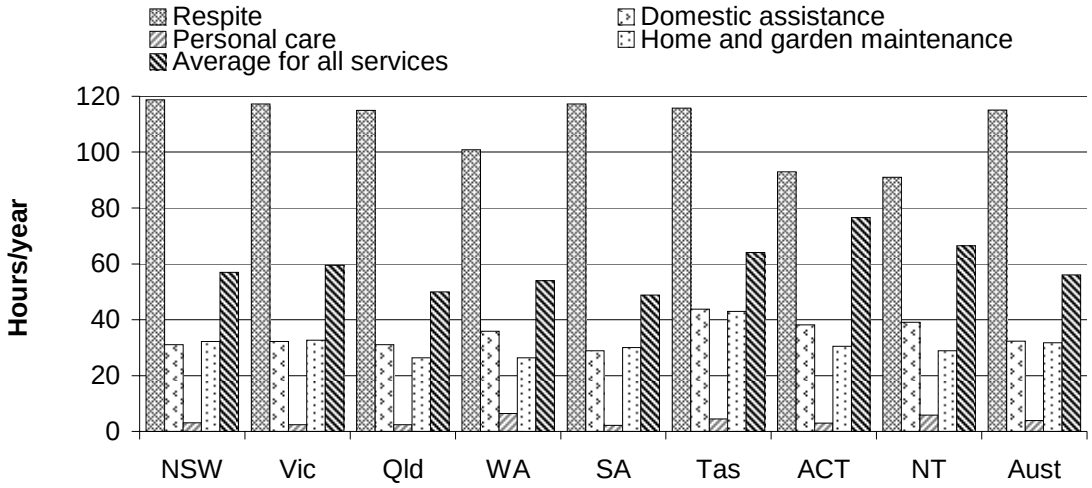
HACC services are basic maintenance and support services, including allied health care, assessment, case management and planning, centre-based day care, counselling, support, information and advocacy, domestic assistance, home maintenance, nursing, personal and respite care, social support, meals, home modification, linen service, goods and equipment, and transportation.

The target population is defined as people living in the community who are at risk, without these 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.

Not all HACC services are directed towards the ageing population described in this chapter. Figure 12.13 provides a more detailed breakdown of the age structure of HACC recipients. Approximately 68 per cent of the program's recipients are aged 70 years or over, but the program is also an important source of community care for younger people with a disability and their carers (table 12A.33). (Chapter 13 covers services for people with a disability, which manifests before the age of 65 years, that were provided under the Commonwealth State/Territory Disability Agreement.)

The services of the VHC program target veterans and war widows/widowers with low care needs. There were 74 620 people approved for VHC services in 2004-05 (table 12A.45). The program offers veterans and war widows/widowers who hold a Gold or White Repatriation Health Card 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. The average number of hours approved per year for veterans who were eligible to receive home care services was 56.12 nationally in 2004-05 (figure 12.8).

Figure 12.8 **Average number of hours approved for Veterans' Home Care, 2004-05[a]**



a VHC recipients fall into two categories: those veterans who transferred to the VHC program from the HACC program (transitional veterans) and those that did not (non-transitional veterans). The number of hours approved per year is for non-transitional veterans and relates to services that were approved to occur in 2004-05. The average for all services takes into account relative usage of each service.

Source: DVA (unpublished); table 12A.45.

Provision of CACPs is 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 EACH program is a mainstream program funded by the Australian Government. 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 15–20 hours of direct assistance each week. The main distinctions between the HACC, CACP and EACH programs are summarised in table 12.4.

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

	HACC	*CACPs*	*EACH*
Range of services[a]	Wide range of services available	Narrower range of services available	Narrower range of services available
Relationship to residential care	Aims to prevent premature or inappropriate admission	Substitutes for a low care residential place	Substitutes for a high care residential place
Eligibility	ACAT assessment not mandatory	ACAT assessment mandatory	ACAT assessment mandatory
Funding	Cost shared by the Australian, State and Territory governments and client contributions	Funded by the Australian Government and client contributions	Funded by the Australian Government and client contributions
Target client groups[b]	Available to people with a greater range of care needs	Targets people with care needs similar to low level residential care	Targets people with care needs similar to high level residential care
Size of program	$1.3 billion funding in 2004-05	$323.3 million funding in 2004-05	$34.3 million funding in 2004-05
	Approximately 744 197 clients in 2004-05[c]	30 426 operational places in 2004-05	1672 operational places at 30 June 2005

[a] HACC services such as community nursing, which are not available under CACPs, can be supplied to someone receiving a CACP. [b] Most HACC recipients at the lower end of the scale would not be assessed as eligible for residential care — for example, an individual may receive only an hour of home care per fortnight. At the higher end, some people have levels of need that would exceed the level available under CACPs and EACH. [c] Based on 82 per cent of HACC funded agencies that submitted Minimum Data Set data for 2004-05. Consequently, the total number of clients will be higher than those reported here.

Source: DoHA (unpublished); tables 12A.32, 12A.35, 12A.42 and 12A.43.

Changing government policies over the past decade — shifting the balance of care away from the more intensive types of residential care towards home-based care — have meant that the HACC, VHC, CACP and EACH programs have become increasingly important components of the aged care system. During 2004-05, the HACC program delivered approximately 10 653 hours per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years (table 12A.20). The total number of CACPs per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years increased between June 2001 and June 2005, from 14.0 to 16.0 (table 12A.11).

12.2 Framework of performance indicators

The framework of performance indicators aims to provide information on equity, efficiency and effectiveness, and to distinguish the outputs and outcomes of government aged care services. This approach is consistent with the general performance indicator framework and service process diagram outlined in chapter 1 (figures 1.2 and 1.3) that have been agreed by the Steering Committee. The performance indicators relate to government objectives in the aged care sector (box 12.5). At this stage, no outcome indicators are reported for aged care services.

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:

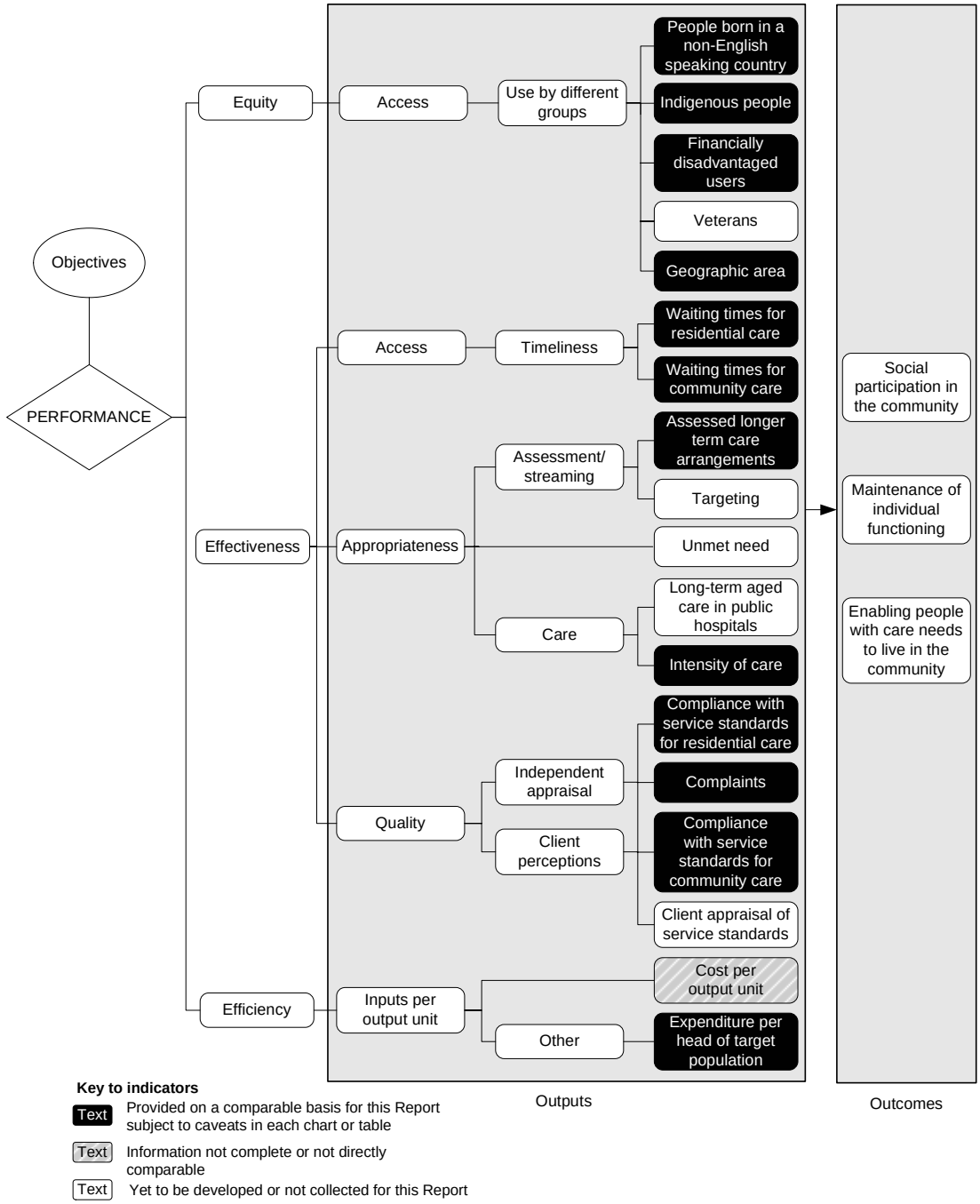
- accessible
- appropriate to needs
- high quality
- efficient.

The performance indicator framework shows which data are comparable in the 2006 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).

12.3 Key performance indicator results

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

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



Outputs

Equity

Access — use by different groups

'Use by different groups' has been included as an output indicator of equity (box 12.6).

Box 12.6 **Use by different groups**

A key national objective of the aged care system is to provide equitable access to aged care services for all people who require these services. 'Use by different groups' is a proxy indicator of equitable access. Various groups are identified by the Aged Care Act and its principles (regulations) as having special needs, including people from Indigenous communities, people born in non-English speaking countries, people who live in rural or remote areas, people who are financially or socially disadvantaged, and veterans (including widows and widowers of veterans). The indicator is reported for each special needs group except veterans, and the definitions are as follows:

- the number of people born in non-English speaking countries using residential services, CACPs, EACH and HACC services, divided by the number of people born in non-English speaking countries aged 70 years or over
- the number of Indigenous people using residential services, CACP, EACH and HACC services, divided by the number of Indigenous people aged 50 years or over (because Indigenous people tend to require aged care services at a younger age than the general population)
- for financially disadvantaged users — access to residential services is defined as the number of new residents classified as concessional or assisted divided by the number of new residential places
- for people living in rural and remote areas — the number of hours of HACC service received (and, separately, meals provided) divided by the number of people aged 70 years or over plus Indigenous people aged 50-69 years for major cities, inner regional areas, outer regional areas, remote areas and very remote areas
- the rate of contacts with Commonwealth Carelink Centres for Indigenous people compared with all people.

(Continued on next page)

Box 12.6 **(Continued)**

In general, usage rates for special needs groups similar to those for the broader aged care population are desirable, but interpretation of results differs for some special needs groups because:

- there is evidence that Indigenous people have higher disability prevalence rates than those of the general population, which suggests a greater level of need for services compared with those in the broader aged care population
- for financially disadvantaged users, Australian Government planning guidelines require that services allocate a minimum proportion of residential places for concessional residents. These targets range from 16 per cent to 40 per cent of new places, depending on the service's region. Usage rates equal to or higher than the minimum rates are desirable.

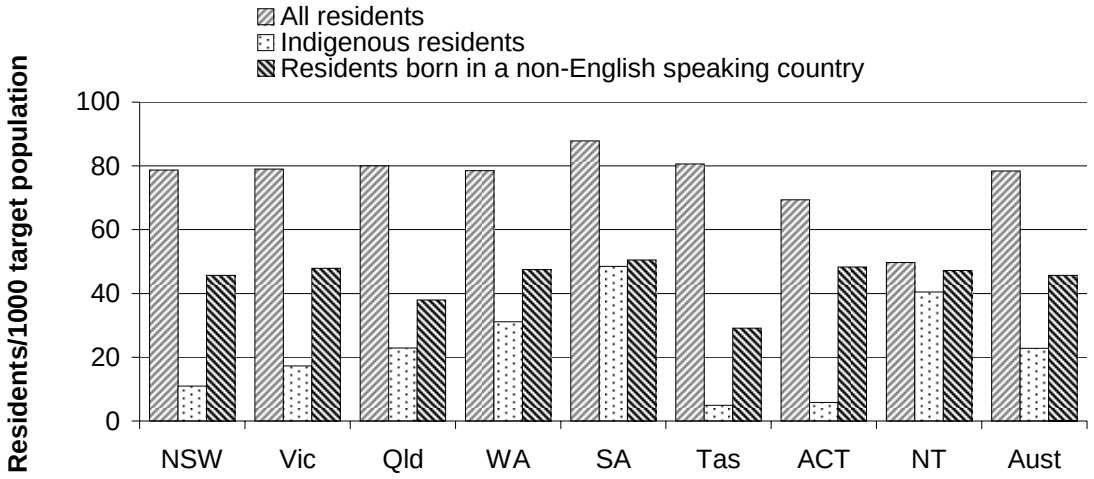
Several factors need to be considered in interpreting the results for this set of indicators:

- Cultural differences may influence the extent to which people born in non-English speaking countries use different types of services.
- Cultural differences and geographic location may influence the extent to which Indigenous people use different types of services.
- The availability of informal care and support may influence the use of aged care services in different population groups.

Access to residential services

In all jurisdictions at 30 June 2005, on average, Indigenous people and people born in non-English speaking countries had lower rates of use of aged care residential services (22.8 and 45.7 per thousand of the relevant target populations respectively), compared with the population as a whole (78.4 per thousand) (figure 12.10).

Figure 12.10 **Residents per 1000 target population, 30 June 2005**[a, b, c]



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

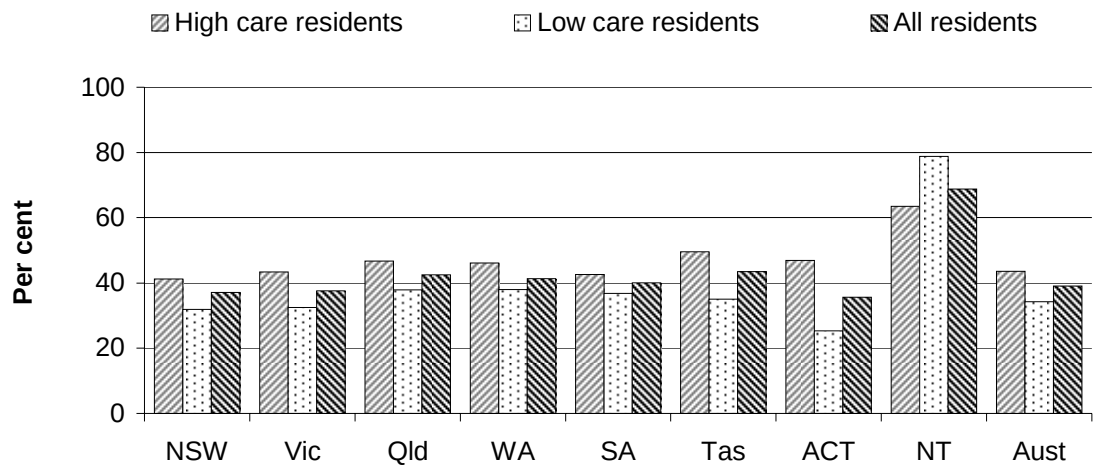
Source: DoHA (unpublished); tables 12A.12, 12A.14 and 12A.16.

Age specific usage rates for these services, by jurisdiction and remoteness and for Indigenous usage at 30 June 2004, are included in the Report. These data suggest there is significant variation in usage rates by remoteness area. In general, differences across jurisdictions are less marked than differences across remoteness areas (tables 12A.58, 12A.60, 12A.61, 12A.63 and 12A.64).

Access to services by financially disadvantaged users

The proportion of all new residents classified as concessional or assisted residents during 2004-05 was 39.1 per cent nationally but varied across jurisdictions (figure 12.11).

Figure 12.11 **New residents classified as concessional or assisted residents, 30 June 2005[a]**



a Concessional residents are those who receive an income support payment and have not owned a home for the previous two or more years (or whose home is occupied by a 'protected' person, such as, the care recipient's spouse or long term carer), and have assets of less than 2.5 times the annual single basic age pension. Assisted residents are those meeting the above criteria, but with assets between 2.5 and 4.0 times the annual single basic age pension.

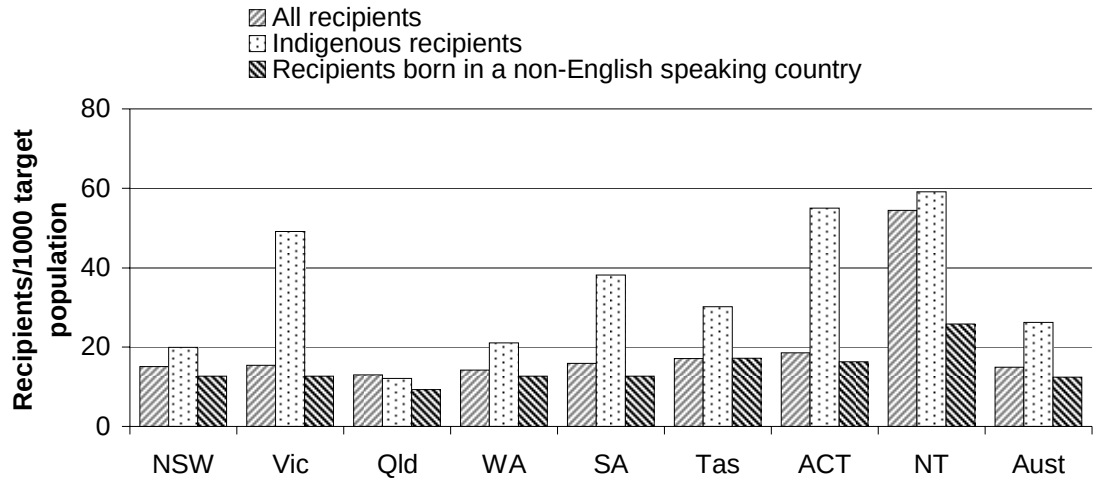
Source: DoHA (unpublished); table 12A.19.

Access to community aged care packages

The number of CACP recipients per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years has grown in recent years, but is still small relative to the number of recipients of residential care. At June 2005, 14.9 per 1000 of the target population received CACP services compared with 78.4 recipients of residential care, although this varied across jurisdictions (table 12A.12).

The number of Indigenous CACP recipients per 1000 Indigenous people aged 50 years or over was 26.2 nationally and the numbers of CACP recipients from non-English speaking countries per 1000 of the relevant target population was 12.4 nationally (figure 12.12). The Australian Government's allocation of CACPs in every jurisdiction at June 2005 exceeded 10 CACPs per 1000 of the overall target population.

Figure 12.12 **Community Aged Care Package recipients per 1000 target population, 30 June 2005**[a, b, c, d, e]



[a] All recipients data are per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years. [b] Indigenous recipients data are per 1000 Indigenous people aged 50 years or over. [c] Data for recipients from non-English speaking countries are per 1000 people from non-English speaking countries aged 70 years or over. [d] The ACT has a very small Indigenous population aged 50 years or over (table 12A.2), and a small number of packages will result in a very high provision ratio. [e] CACPs provide a more flexible model of care more suitable to remote Indigenous communities, so areas such as the NT have a higher rate of CACP recipients per 1000 people.

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

Age-sex specific usage rates for CACP and EACH, by jurisdiction, and remoteness and for Indigenous usage are included in the Report. Usage rates vary between jurisdictions and remoteness categories for CACP. For EACH, the differences are less marked. However, the EACH program is small but growing rapidly (tables 12A.59, 12A.60, 12A.62-64).

Access to the Home and Community Care program

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

The proportion of HACC recipients aged 70 years or over during 2004-05 was 67.7 per cent (table 12A.32). The number of service hours per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years was 10 653 nationally, and the number of meals provided per 1000 people aged 70 years or over plus Indigenous people aged 50–69 was 5269 nationally (table 12.5). HACC agencies that submitted the data as a proportion of all HACC agencies varies across jurisdictions so comparisons between jurisdictions should be made with care.

Table 12.5 **HACC services received, 2004-05 (per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years)[a, b]**

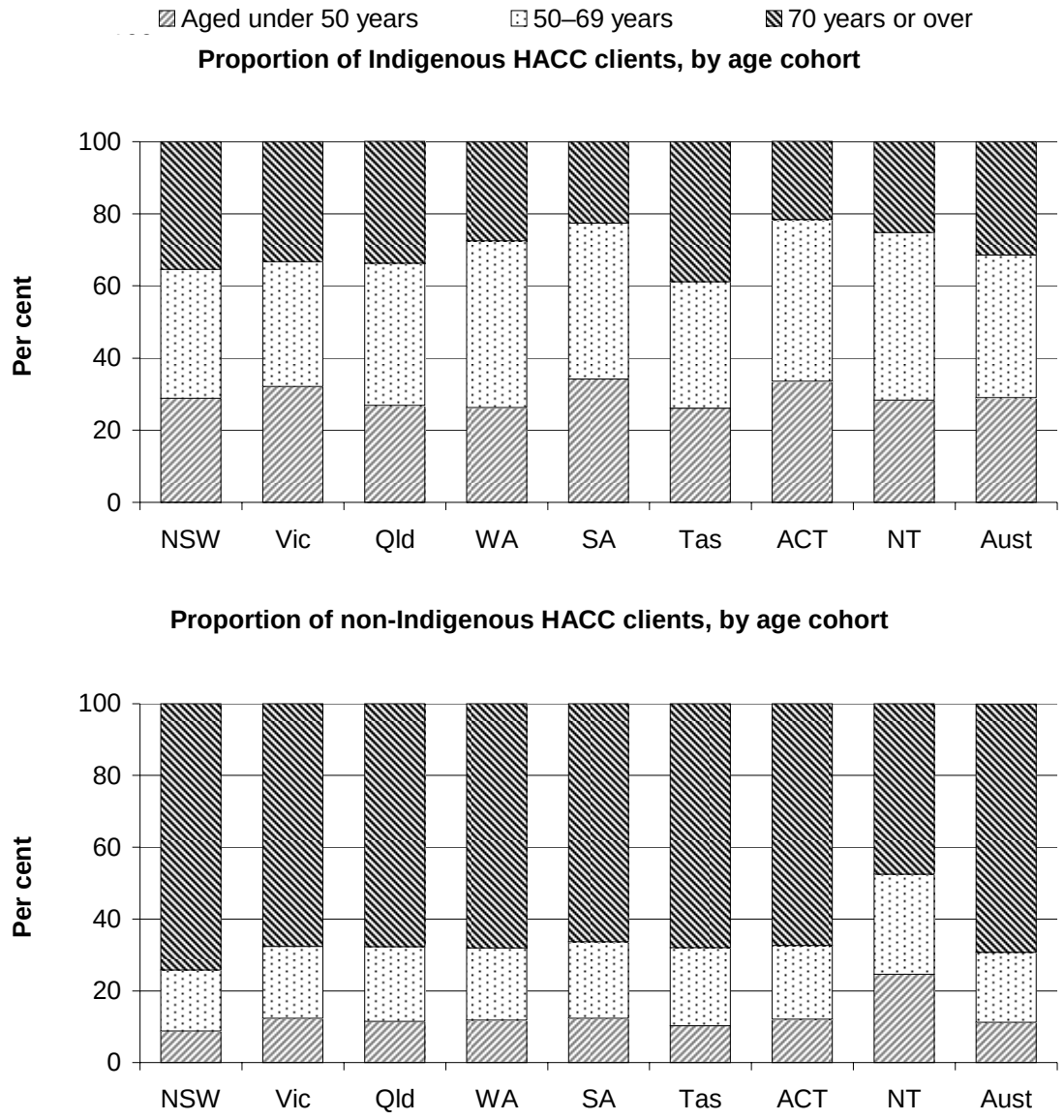
	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*[c]	*Tas*	*ACT*	*NT*	*Aust*
Percentage of agencies that reported MDS data	%	73	89	94	98	80	86	98	65	82
Total hours[d]										
Major cities	hrs.	5 766	12 510	12 954	17 182	8 622	..	11 446	..	10 163
Inner regional	hrs.	6 048	16 022	11 308	15 816	8 522	9 791	..	..	10 615
Outer regional	hrs.	7 841	19 795	13 226	18 868	10 329	10 490	..	8 646	12 496
Remote	hrs.	11 356	19 391	14 786	15 870	11 149	12 026	..	23 033	14 497
Very remote	hrs.	6 987	..	14 144	20 213	49 077	31 348	..	22 698	20 807
All areas	hrs.	**6 050**	**13 785**	**12 553**	**17 173**	**9 175**	**10 171**	**11 462**	**17 197**	**10 653**
Total meals[e]	no.									
Major cities	no.	3 890	5 196	6 699	6 247	3 652	..	3 487	..	4 849
Inner regional	no.	4 996	7 334	5 784	5 571	691	5 639	..	..	5 627
Outer regional	no.	5 393	6 684	6 582	9 060	2 181	7 488	..	3 898	6 025
Remote	no.	6 416	5 127	7 921	8 293	2 066	6 109	..	12 798	6 876
Very remote	no.	1 154	..	9 452	17 227	25 352	10 973	..	23 201	16 033
All areas	no.	**4 295**	**5 776**	**6 470**	**6 737**	**3 234**	**6 282**	**3 493**	**13 504**	**5 269**

a Data represent HACC services received by people aged 70 years or over plus Indigenous people aged 50–69 years (tables 12A.20–12A.25) as distinct from HACC services received by all age groups (tables 12A.26–12A.31). **b** The proportion of HACC funded agencies that submitted Minimum Data Set data for 2004-05 differed across jurisdictions, ranging from 65 per cent to 98 per cent. Consequently, actual service levels will be higher than those reported here. **c** The number of meals may be understated in SA due to slow implementation of the Minimum Data Set by Meals on Wheels. **d** See table 12A.20 for a full list of categories. **e** Includes home meals and centre meals. .. Not applicable.

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

Reported use of HACC services showed a substantial difference between all users and Indigenous users across all age groups in 2004-05. This reflects the difference in morbidity and mortality trends between Indigenous people and the general population. The proportion of Indigenous HACC clients aged 70 years and over is 31.5 per cent and the proportion of non-Indigenous HACC clients aged 70 years and over is 69.1 per cent (figure 12.13).

Figure 12.13 **Recipients of HACC services by age and Indigenous status, 2004-05**



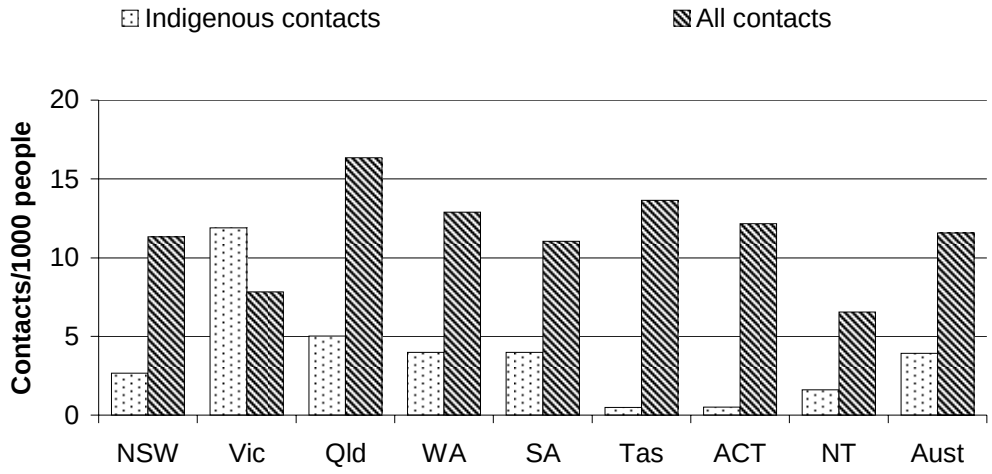
Source: DoHA (unpublished); table 12A.33.

Access by Indigenous people to Commonwealth Carelink Centres

Commonwealth Carelink Centres are information centres for older people, people with disabilities and those who provide care and services. Information is provided on community services and aged care, disability and other support services available locally or anywhere in Australia, the costs of services, assessment processes and eligibility criteria. The national rate at which Indigenous people contacted Carelink Centres at 30 June 2005, was 3.9 people per 1000 Indigenous

population. The rate for all Australians was 11.6 per 1000 people. These figures varied across jurisdictions (figure 12.14).

Figure 12.14 **Commonwealth Carelink Centres, contacts per 1000 people, by Indigenous status, 30 June 2005**[a, b, c]



a Contacts with Carelink include phone calls, visits, emails and facsimiles. **b** Indigenous contacts refer to contacts by Indigenous people per 1000 Indigenous population. **c** All contacts refers to contacts per 1000 total population.

Source: ABS Population Projections by SLA 2002–2022 (unpublished); table 12A.56.

Effectiveness

Timeliness of access — waiting times for residential care

The indicator 'waiting times for residential care' has been included as an output indicator of effectiveness (box 12.7).

Box 12.7 **Waiting times for residential care**

'Waiting times for residential care' is an output measure of effectiveness, reflecting the timeliness with which people are able to access residential care.

The indicator 'elapsed time between ACAT approval and entry into residential care service' measures the period between a client's approval for care and his or her entry into care and is defined as the percentage of people who are admitted to residential care within three months of their ACAT approval. The relevant terms are defined as follows:

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

Shorter waiting times (measured by higher rates of admission to residential care within three months of ACAT approval) are desirable.

This indicator needs to be interpreted with care. It may be influenced by a range of factors, such as:

- clients with ACAT assessments who do not enter residential care (for example, who die before entering care)
- residential placement offers that are not accepted
- the availability of alternative community care, informal care and respite services
- the availability and distribution of operational residential care services
- building quality and perceptions about quality of care, which influence client choice of preferred service
- delays between the date of ACAT assessments and their approval
- priority allocations (for example, special needs groups)
- hospital discharge policies and practices.

The Steering Committee acknowledges the limitations of the current indicator (box 12.8) and supports redevelopment for improvement. The current indicator will continue to be reported until improved data are available.

Box 12.8 **Entry period for residential care**

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

The study found that one of the main determinants of a short entry period is whether the resident has an ACAT assessment performed while in hospital rather than when living at home. A longer entry period is also strongly related to whether the resident used a CACP or residential respite care before admission.

Recommendations for residential care remain active for 12 months. Some people assessed by an ACAT and recommended for residential aged care may not take up a residential place within this period. People often do not act on the recommendation immediately. They may believe they are capable of continuing to manage at home and that they do not need admission. Others receive recommendations for both residential aged care and a CACP, and take up the latter.

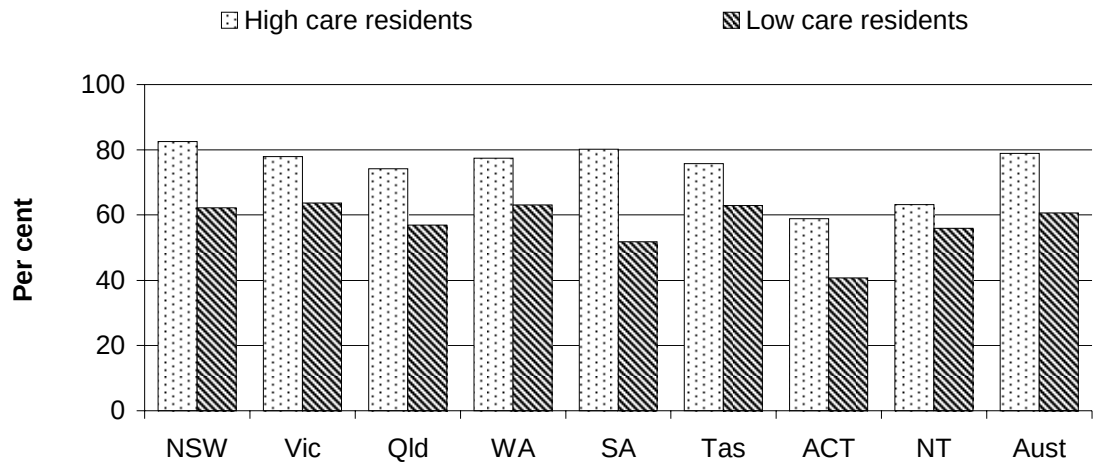
The AIHW found that many factors affect the entry period but are not linked to the performance of the aged care system. It recommended that the entry period for residential care not be used as a performance indicator.

Source: AIHW (2002).

On average, 71.7 per cent of all people entering residential care during 2004-05 did so within three months of being assessed by an ACAT, and 45.2 per cent entered within one month of their ACAT assessment (table 12A.36). In the calculation of entry period, the most recent ACAT assessment prior to entry is used.

Nationally, a greater proportion of people entering high care residential services entered within three months of assessment (78.9 per cent), compared with the proportion entering low care residential services within that time (60.6 per cent). The proportion of people entering high care residential services within three months of being assessed and the proportion of people entering low care residential services within three months of being assessed varied across jurisdictions (figure 12.15).

Figure 12.15 **People entering residential care within three months of their ACAT assessment, 2004-05**



Source: DoHA (unpublished); table 12A.36.

Timeliness of access — waiting times for community care

The indicator 'waiting times for community care' has been included as an output indicator of effectiveness (box 12.9) and reported using CACP data.

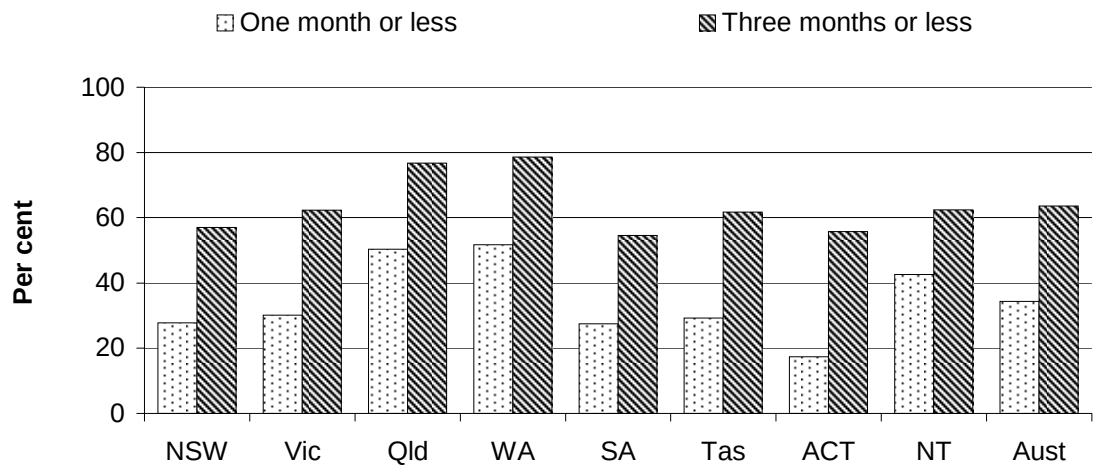
Box 12.9 **Waiting times for community care**

'Waiting times for community care' is an output measure of effectiveness and reflects the timeliness with which people are able to access CACPs. The indicator measures the period between a client's approval for care and his or her receipt of care, and is defined as the elapsed time between an ACAT approval and receipt of a CACP. Shorter waiting times (or higher rates of receipt of a CACP within one month or within three months of an ACAT approval) are desirable.

This indicator needs to be interpreted with care. Some ACAT assessed clients may choose not to receive a CACP, alternative community care options may be available, or varying fee regimes might influence choice.

On average, 63.6 per cent of all people receiving a CACP during 2004-05 received it within three months of being assessed by an ACAT. This proportion varied across jurisdictions (figure 12.16). On average, 34.4 per cent started receiving a CACP within one month of their ACAT assessment (table 12A.36).

Figure 12.16 **Elapsed time between ACAT approval and the receipt of a CACP service, 2004-05**



Source: DoHA (unpublished); table 12A.36.

Appropriateness — assessed longer term care arrangements

The indicator 'assessed longer term arrangements' has been included as an output indicator of effectiveness (box 12.10) and measures the proportion of clients referred to community care, compared to residential care.

Box 12.10 **Assessed longer term care arrangements**

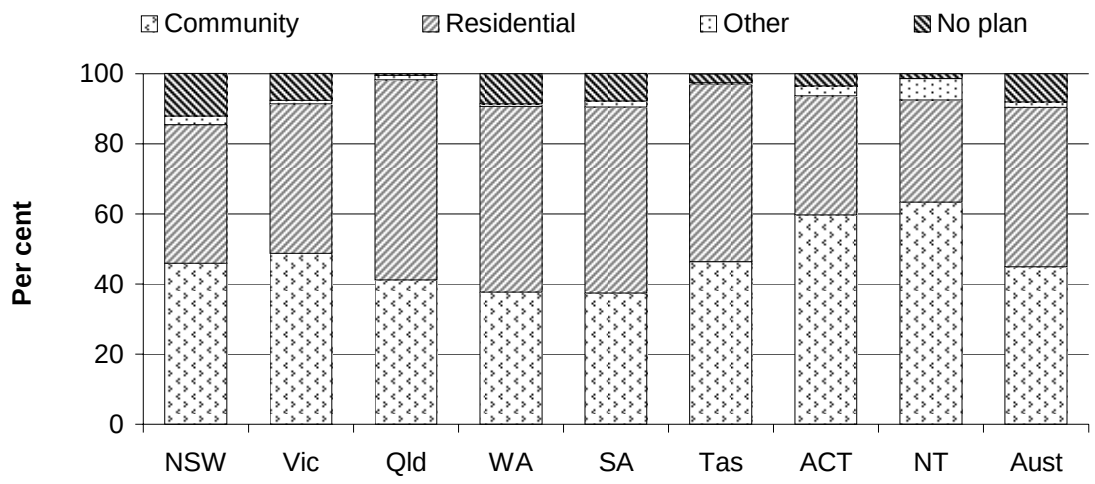
'Assessed longer term care arrangements' is an indicator of appropriateness. The purpose is to measure how effectively clients are allocated to the services that best meet their needs.

This indicator is defined as the number of ACAT clients referred to community care (CACPs or EACH packages) or residential care (permanent or respite). (Aged care assessments are mandatory for admission to residential care or for receipt of a CACP or an EACH package.)

The results for this indicator show the distribution of recommended living arrangements of ACAT clients in each jurisdiction. Differences in recommendations across jurisdictions may reflect external factors such as geographic dispersion of clients and service availability, but also client preferences and views on the types of client best served by community-based services. The distribution of ACAT recommendations for various living arrangements are influenced by the degree to which any pre-selection process refers people requiring residential care to ACATs for assessment. Jurisdictions with lower overall assessment rates may operate a filtering process to focus assessments on individuals who are more likely to require residential care.

The national proportion of ACAT clients referred to residential care in 2003-04 was 45.5 per cent and the proportion referred to community care was 44.9 per cent. No long term plan was made for 8.0 per cent, which included deaths, cancellations and transfers. These proportions vary across jurisdictions (figure 12.17).

Figure 12.17 **Recommended longer term care arrangements of ACAT clients, 2003-04[a]**



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

Source: Lincoln Centre for Ageing and Community Care Research (unpublished); table 12A.37.

Appropriateness — targeting

The 'targeting' indicator has not yet been developed (box 12.11).

Box 12.11 **Targeting**

The Steering Committee has identified 'targeting' as an indicator of appropriateness. It will be developed for reporting in the future.

Appropriateness — unmet need

The indicator 'unmet need' has been included as an output indicator of effectiveness (box 12.12).

Box 12.12 **Unmet need**

'Unmet need' is an appropriateness indicator. The purpose of the indicator is to measure the extent to which demand for services to support older people requiring assistance with daily activities is met.

Defining and determining the level of need at an individual level, let alone at a population level, are complex tasks. Perceptions of need and unmet need are often subjective. Data for this indicator are drawn from the ABS 2003 Survey of Disability, Ageing and Carers and reflect people aged over 65 years who self-identified as having a need for assistance with at least one everyday activity, and the extent to which that need was met (fully, partly or not at all).

While low rates of unmet need are theoretically desirable, direct inferences about the demand for services from these data need to be made with care, because the data do not:

- reveal the intensity of care required by those who identify an unmet need — there is no indication of whether the need can readily be met informally or by formal home care, or whether the person may require residential care
- reflect the degree of unmet demand for a specific type of service. Differences across jurisdictions in the proportion of unmet need can reflect different policy approaches to targeting services. Some governments may choose to focus on those with the greatest degree of need for care and on fully meeting their needs. By contrast, other governments may choose to provide a lower level of service to a greater number of people, while only partly meeting the needs of those with the greatest need for care. Both policy approaches to the targeting of services are valid.
- reflect the past and possible future duration of the need — that is, whether it is long term or transitory
- reflect whether the need relates to a disability support service, aged care service or medical care, and thus whether it is a State, Territory or Australian Government responsibility.

The total number of persons aged 65 years or over living in households who needed assistance with at least one everyday activity in 2003 and whose needs for assistance were not met comprised over one third (35.7 per cent) of all those needing assistance (table 12.6).

Table 12.6 **Older persons needing assistance with at least one everyday activity: extent to which need was met, 2003[a]**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*[b]
Persons with a need not fully met	'000	108.0	98.8	76.3	29.0	30.1	9.6	na	na	358.6
All persons needing assistance	'000	306.9	269.8	214.7	80.8	92.2	27.8	na	na	1 005.2
Self-reported total or partial unmet need	%	35.2	36.6	35.5	35.9	32.6	34.5	na	na	35.7

a Aged 65 years or over, living in households. **b** Australian total includes data for the ACT and the NT. **na** Not available.

Source: ABS Survey of Disability, Ageing and Carers (unpublished).

Appropriateness — long term aged care in public hospitals

An indicator 'long term aged care in public hospitals' has not yet been developed (box 12.13).

Box 12.13 **Long term aged care in public hospitals**

'Long-term aged care in public hospitals' is an indicator of the appropriateness of care. Acute inpatient services are geared towards shorter periods of care aimed at addressing serious illness or injury, or diagnosis, and are a less effective form of care for older people who cannot live independently in the long term. Low incidence is desirable.

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

Appropriateness — intensity of care

The indicator 'intensity of care' has been included as an output indicator of effectiveness (box 12.14).

Box 12.14 **Intensity of care**

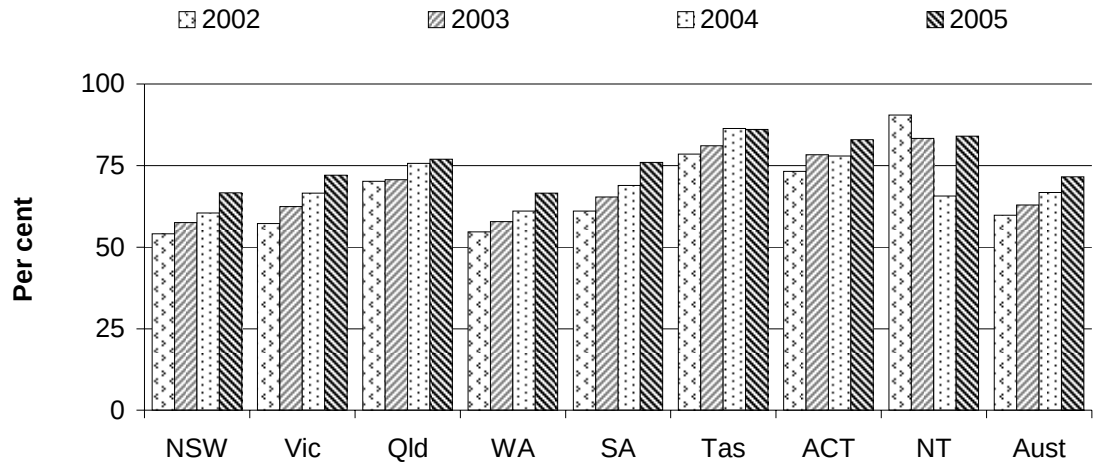
'Intensity of care' is an indicator of appropriateness, reflecting the proportion of residents who remain in the same residential aged care facility as their care needs increase from low care to high care. The Aged Care Act aims explicitly to encourage 'ageing in place' to increase choice and flexibility in residential aged care service provision (box 12.3).

This indicator needs to be viewed from the perspective of the system as a whole. The implication of ageing in place is that some places that were allocated for low care will be occupied by high care residents (or, conversely, allocated for high care and occupied by low care residents). Information about the use of operational residential aged care places is provided to demonstrate the impact of ageing in place on the aged care service system over time (figure 12.19).

Higher rates of ageing in place are desirable, in the context of a flexible system that meets the need for low level care either in residential facilities or in the community.

From June 2002 to June 2005, there was a steady increase in the proportion of people who stayed in the same residential aged care service when changing from low care to high care, from 59.7 per cent to 71.5 per cent nationally (figure 12.18). In June 2005, the proportion was higher in inner regional areas (76.3 per cent), outer regional areas (74.3 per cent) and remote areas (90.3 per cent) than in major cities (69.4 per cent) and very remote areas (59.1 per cent) (table 12A.53).

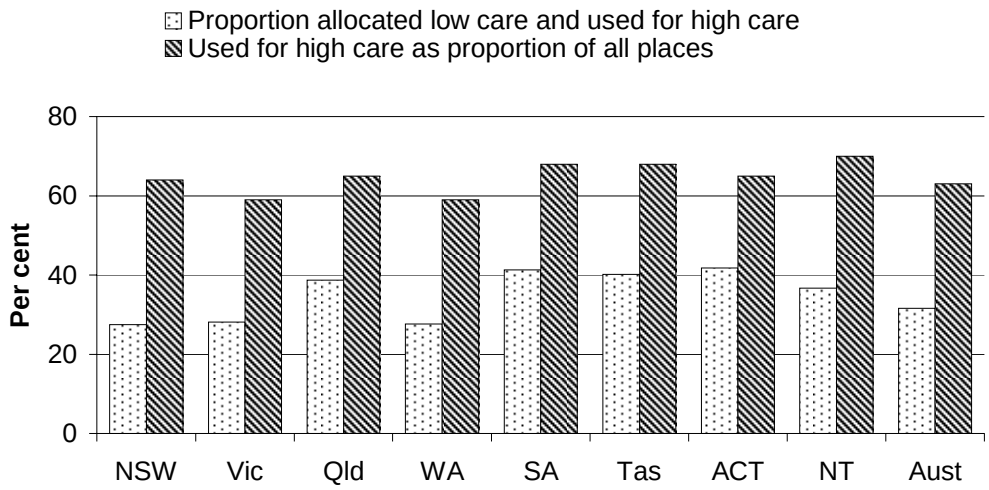
Figure 12.18 **Proportion of residents who changed from low care to high care and remained in the same aged care service, June**



Source: DoHA (unpublished); table 12A.53.

Nationally, 31.6 per cent of low care places in 2004-05 were occupied by residents with high care needs (figure 12.19). These data are provided by remoteness area in table 12A.57.

Figure 12.19 **Utilisation of operational residential places, 30 June 2005**



Source: DoHA (unpublished); table 12A.57.

Quality — compliance with service standards for residential care

The indicator 'compliance with service standards for residential care' has been included as an output indicator of effectiveness (box 12.15).

Box 12.15 **Compliance with service standards for residential care**

'Compliance with service standards for residential care' is an indicator of the quality of care. The purpose of the indicator is to monitor the extent to which residential care facilities are complying with accreditation or certification standards. The extent to which they comply implies a certain level of care and service quality.

Since 2001, Australian Government funded residential services have been required to meet accreditation standards (which comprise 44 expected outcomes), against which each residential service is assessed. The accreditation indicator reflects the period of accreditation granted. High rates of approval for accreditation for three years or more are desirable.

(Continued on next page)

Box 12.15 **(Continued)**

Residents per room and average certification safety scores are also output indicators of quality. Lower rates of residents per room are generally desirable because they imply a higher service quality of accommodation. Higher rates of safety certification are desirable because they imply a higher level of care and service quality. Average safety certification scores have been presented in previous Reports but are not included in the 2006 Report. This is because the data frequently do not represent the true condition of the buildings under consideration and in many cases are out of date. A replacement reporting regime is expected to arise from an evaluation of the accreditation process and changes in process in relation to reporting of fire safety.

There are three steps in the accreditation process.

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

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

At 30 June 2005, 92.3 per cent of residential aged care services had been granted an accreditation approval for a period of three years. This proportion varied across jurisdictions (table 12.7).

Table 12.7 **Accreditation decisions on residential aged care services, 30 June 2005**

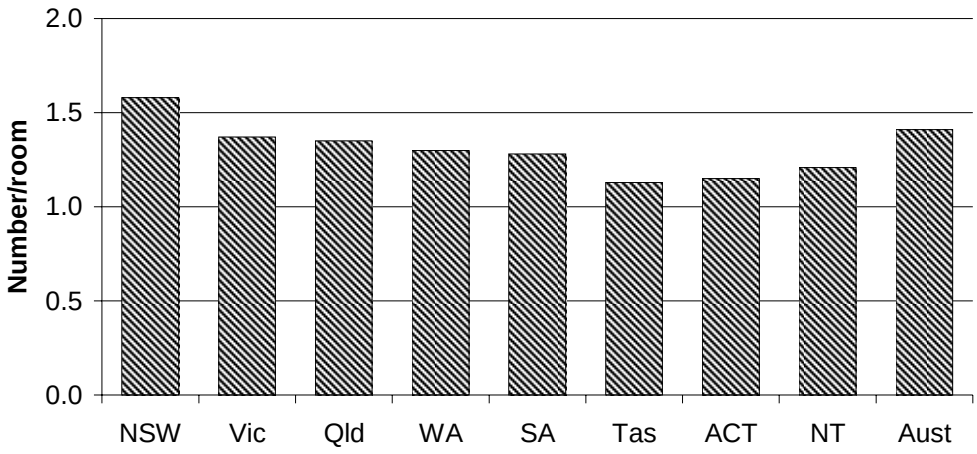
	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Accreditation period										
One year	%	1.4	2.6	1.4	1.9	0.7	–	–	–	1.6
Two years	%	4.7	4.4	12.6	4.7	6.0	5.4	4.3	6.7	6.1
Three years	%	93.9	93.1	86.0	93.4	93.3	94.6	95.7	93.3	92.3
Total	**%**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Accredited services	no.	935	821	494	257	298	92	23	15	2 935

– Nil or rounded to zero.

Source: ACSAA (unpublished); table 12A.39.

Existing services are required to meet privacy and space requirements by 2008. All new services must meet these targets from the time of construction. The average number of residents per room at July 2005 was 1.41 nationally (figure 12.20).

Figure 12.20 **Average residents per room, July 2005**



Source: DoHA (unpublished); table 12A.40.

Quality — complaints

The indicator 'complaints' is an output indicator of effectiveness (box 12.16).

Box 12.16 **Complaints**

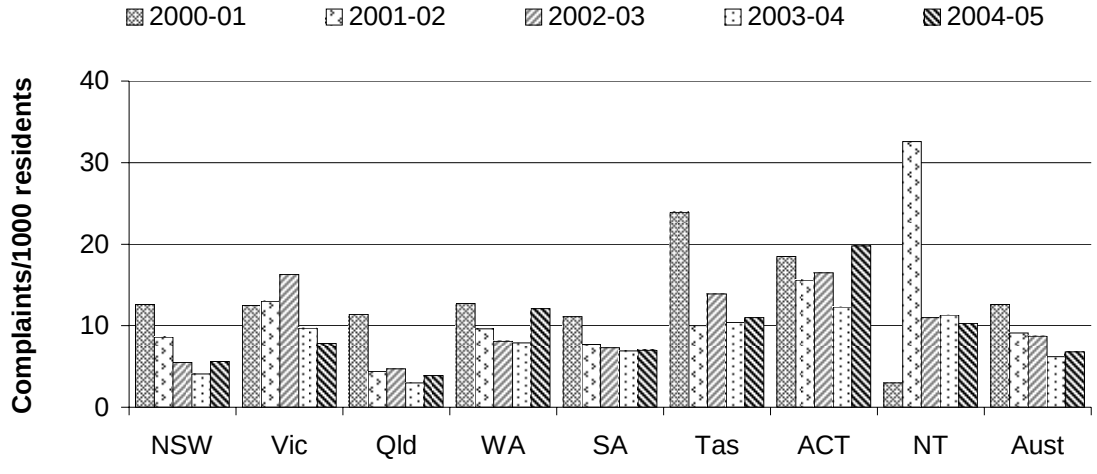
'Complaints' is an indicator of the quality of care. The purpose of the indicator is to monitor the level of complaints received by the Complaints Resolution Scheme in each State and Territory. If service recipients make official complaints, they may be dissatisfied with an element of the service provided and, therefore, dissatisfied with service quality.

All aged care services are required to have an internal complaints system. The Aged Care Complaints Resolution Scheme is a free complaints system run by the DoHA and overseen by an independent Commissioner for Complaints. The scheme is available to anyone who wishes to make a complaint about an Australian Government funded aged care service, including residents of aged care facilities and their families, staff and people receiving CACPs and EACH packages. The indicator measures the number of complaints per 1000 residents. A low rate of complaints is desirable.

The rate at which complaints occur is influenced by the propensity of clients and their families or service staff to complain, their knowledge of the complaints system, and perceptions of the effectiveness of the complaints system. In many cases, complaints may be resolved without the need to involve the Complaints Resolution Scheme.

In 2004-05, the Complaints Resolution Scheme received approximately 1004 new complaints, compared with 967 in 2003-04 (table 12A.41). Of these, 84 per cent were lodged as open complaints, 13 per cent as confidential and 3 per cent as anonymous. Of all complaints handled by the Scheme, 96 per cent related to residential aged care services (DoHA unpublished). The number of complaints registered per 1000 residents in 2004-05 was 6.8 nationally. This varied across jurisdictions (figure 12.21).

Figure 12.21 **Aged Care Complaints Resolution Scheme complaints per 1000 residents**



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

Quality — compliance with service standards for community care

The indicator 'compliance with service standards for community care' has been included as an output indicator of effectiveness (box 12.17).

Box 12.17 **Compliance with service standards for community care**

'Compliance with service standards for community care' is an output indicator of quality. The purpose of the indicator is to monitor the extent to which individual agencies are complying with service agreement standards.

The HACC national service standards provide HACC funded agencies with a common reference point for internal quality control, by defining aspects of service quality and expected outcomes for consumers. States and territories are required to include the standards in all service agreements. The HACC national service standards instrument has been developed to measure through a service appraisal process the extent to which individual agencies are complying with the standards. Monitoring and compliance with the standards are now a major part of service reviews.

The indicator measures the number of HACC agencies appraised against the standards divided by the total number of HACC agencies. This indicator also measures the percentage of individual agencies that comply with the service standards, through data on the outcomes of service standard appraisals. It should be noted that the standards are not an accreditation system.

The total number of HACC agencies identified for appraisal operating over the three year cycle 2001-02 to 2003-04 was 3207. The number of these agencies appraised was 2711 (85 per cent). This proportion varied across jurisdictions (table 12.8). The outcomes of these appraisals was a national average score of 16.0 out of 20 (table 12.9). In the course of the initial three year appraisal process, in the absence of detailed implementation guidelines, each State and Territory adopted individual approaches when assessing agencies against the National Service Standards Instrument (State and Territory governments unpublished).

Table 12.8 **HACC National Service Standards appraisals over the three year cycle ending 2003-04[a]**

	Unit	*NSW*[b]	*Vic*	*Qld*[c]	*WA*[d]	*SA*[e]	*Tas*[f]	*ACT*	*NT*	*Aust*
Appraisals	no.	1 095	481	706	168	161	58	31	11	2 711
HACC agencies	no.	1 487	481	730	178	161	58	31	81	3 207
Proportion of agencies assessed	%	74	100	97	94	100	100	100	14	85

a Not all HACC agencies were required to undergo external assessment, and some are exempt, so the number of HACC agencies may be higher than those reported. **b** The total number of agencies identified for NSW are those targeted in the appraisal plan as at 2001-02. The Integrated Monitoring Framework implemented by NSW in 2005-06 will cover new agencies since that time. NSW has completed all remaining appraisals in 2004-05. **c** Reviews in Queensland are conducted by an external agency on a three year contract. In Queensland, 730 is the number of agencies at the beginning of the contract period. There were 808 agencies in Queensland at the commencement of the 2004-05 contract. **d** The number of WA agencies appraised is lower than expected because some agencies amalgamated. **e** SA has an additional 21 exempt agencies. **f** Two agencies were exempt from the appraisal process in Tasmania.

Source: State and Territory governments (unpublished).

Table 12.9 **HACC National Service Standards results of appraisals over the three year cycle ending 2003-04[a, b, c]**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
High (17.5 – 20)	no.	607	157	276	108	51	12	25	na	1 236
Good (15 – 17.4)	no.	337	168	191	28	37	11	2	na	774
Basic (10 -14.9)	no.	132	123	142	34	50	24	3	na	508
Poor (less than 10)	no.	19	33	97	4	23	11	1	na	188
Average score	no.	17.2	15.5	14.8	17.0	14.5	13.2	17.9	na	16.0

a Not all HACC agencies were required to undergo external assessment, and some are exempt, so the number of HACC agencies may be higher than those listed. **b** The results of the appraisals will reflect different methodologies applied across each State and Territory. **c** For details about the method of determining the average score, see table 12A.65.

Source: State and Territory governments (unpublished); table 12A.65.

Quality — client appraisal of service standards

The indicator ‘client appraisal of service standards’ has not yet been developed (box 12.18).

Box 12.18 **Client appraisal of service standards**

'Client appraisal of service standards' is an output indicator of quality. This indicator aims to monitor client satisfaction with services received. The Steering Committee has identified this indicator for development and reporting in future.

Efficiency

Inputs per output unit — cost per output unit

The indicator 'cost per output unit' is an output indicator of efficiency (box 12.19).

Box 12.19 **Cost per output unit**

A proxy efficiency indicator, 'cost per assessment', has been developed as work in progress in measuring efficiency for ACATs. It is defined as expenditure on ACATs divided by the number of ACAT assessments completed.

This indicator needs to be interpreted with care. While high or increasing expenditure per assessment may reflect deteriorating efficiency, it may also reflect changes in aspects of the service (such as greater time spent with clients) or changes in the characteristics of clients (such as their geographic location). Similarly, low or declining expenditure per assessment may reflect improving efficiency or less time spent with clients (for example). States and territories also contribute to the cost of ACAT assessments and relative costs between jurisdictions may also reflect the impact of undertaking assessments in rural and remote areas.

Cost per aged care assessment during 2003-04 averaged $248 nationally. The cost per assessment is calculated using the total number of assessments and also includes clients aged less than 70 years (figure 12.22).

Figure 12.22 **Aged care assessment unit costs, 2003-04 (dollars)[a, b, c]**

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

Source: DoHA (unpublished); Lincoln Centre for Ageing and Community Care Research (unpublished); table 12A.54.

Inputs per output unit — expenditure per head of target population

The indicator 'expenditure per head of target population' is included as an output indicator of efficiency (box 12.20).

Box 12.20 **Expenditure per head of target population**

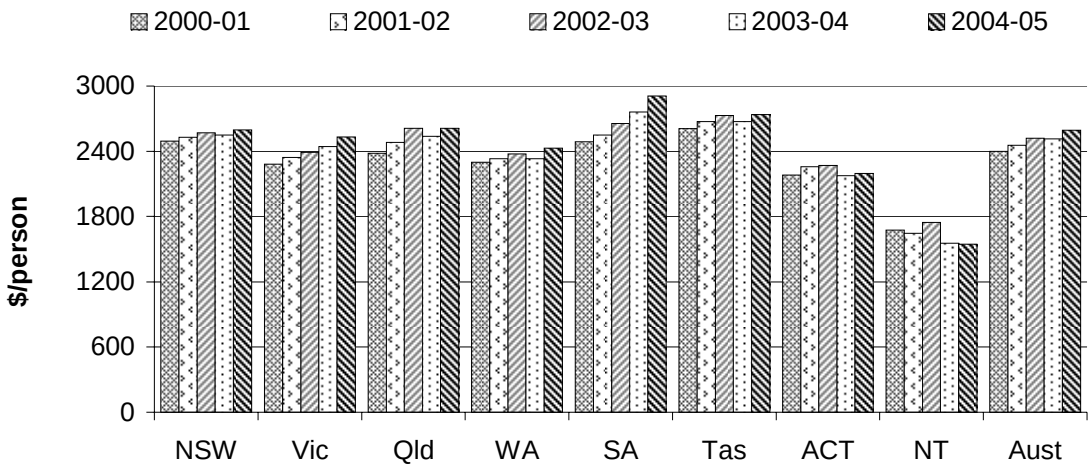
A proxy indicator of efficiency is 'expenditure per head of target population'. It reflects the objective to ensure services for frail older people are provided efficiently. The indicator is defined as government inputs (expenditure) divided by the number of people aged 70 years or over plus Indigenous people aged 50–69 years. Expenditure per person in the target population is reported for three main service types: residential services, CACP and HACC services.

This indicator needs to be interpreted with care. While high or increasing expenditure per person may reflect deteriorating efficiency, it may also reflect changes in aspects of the service (such as better quality of services) or in the characteristics of clients receiving the service (such as their geographic location or level of care need). Similarly, low or declining expenditure per assessment may reflect improving efficiency or a decrease in service standards.

Australian Government expenditure (including expenditure by the DVA) on residential care services per person aged 70 years or over plus Indigenous people

aged 50–69 years increased nationally from $2399 (in 2004-05 dollars) in 2000-01 to $2593 in 2004-05. This figure varied across jurisdictions (figure 12.23).

Figure 12.23 **Australian Government (DoHA and DVA) real expenditure on residential services per person aged 70 years or over plus Indigenous people aged 50–69 years (2004-05 dollars)[a, b]**

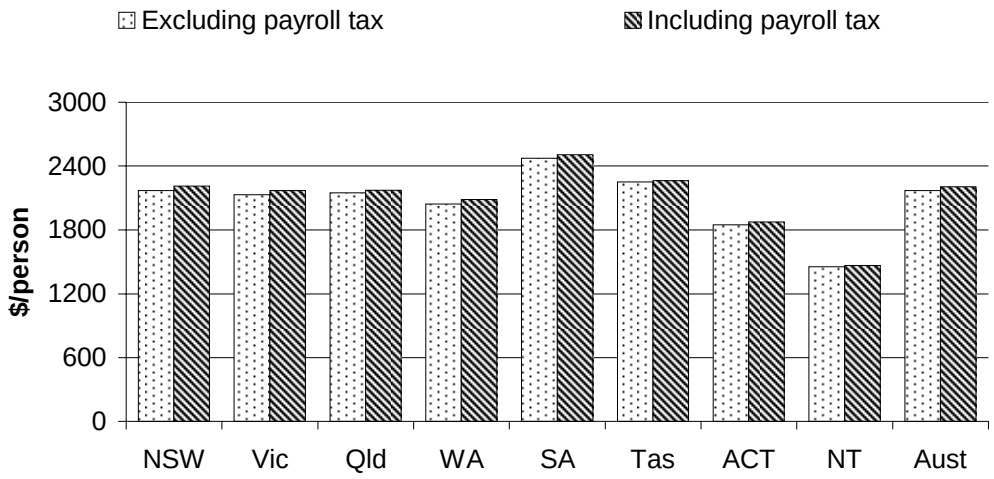


a Includes payroll tax. **b** Includes expenditure by DVA.

Source: DoHA (unpublished); DVA (unpublished); table 12A.49.

Payroll tax has been separately identified in Australian Government expenditure. DoHA expenditure on residential aged care per person aged 70 or over plus Indigenous people aged 50–69 years was $2206 nationally (including payroll tax) and $2170 nationally (excluding payroll tax) in 2004-05. These rates varied across jurisdictions (figure 12.24). DVA expenditure on residential aged care in 2004-05 was $750.3 million nationally (including payroll tax) and $737.8 million (excluding payroll tax) (table 12A.44).

Figure 12.24 **Australian Government (DoHA) expenditure on residential aged care, per person aged 70 years or over plus Indigenous people aged 50–69 years, 2004-05 (dollars)[a]**

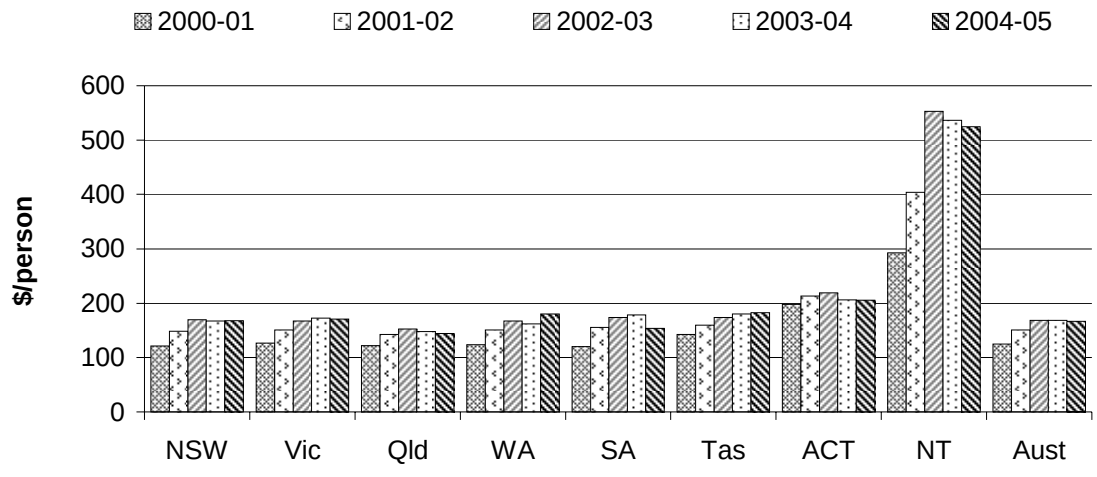


a Data in this table exclude DVA expenditure on residential aged care.

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

Australian Government expenditure on CACPs per person aged 70 years or over plus Indigenous people aged 50–69 years varied across jurisdictions in 2004-05. Nationally, real expenditure per person aged 70 years or over plus Indigenous people aged 50–69 years increased from $125 (in 2004-05 dollars) in 2000-01 to $167 in 2004-05 (figure 12.25).

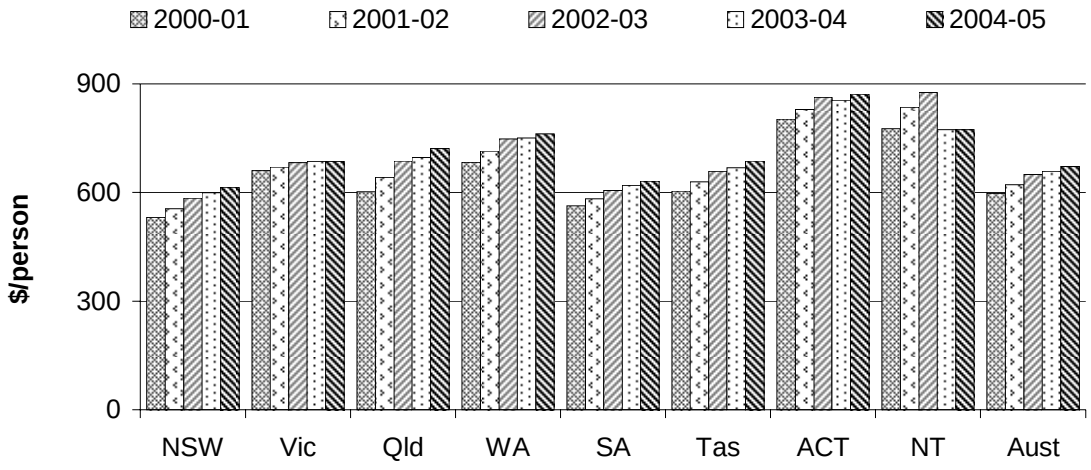
Figure 12.25 **Australian Government real expenditure on CACP services per person aged 70 years or over plus Indigenous people aged 50–69 years (2004-05 dollars)**



Source: DoHA (unpublished); table 12A.52.

Australian, State and Territory government expenditure on HACC services per person aged 70 years or over plus Indigenous people aged 50–69 years varied across jurisdictions. Nationally, real expenditure increased from $598 (in 2004-05 dollars) in 2000-01 to $672 in 2004-05 (figure 12.26). These figures reflect expenditure against the population regarded as the proxy for this chapter (see page 12.3), which is not the same as the HACC target population. Expenditure per person in the HACC target population is reported in table 12A.50.

Figure 12.26 **Australian, State and Territory government real expenditure on HACC services per person aged 70 years or over plus Indigenous people aged 50–69 years (2004-05 dollars)[a, b]**



a People aged 70 years or over plus Indigenous people aged 50–69 years are not the HACC target population. Expenditure per person and definition of the HACC target population is contained in table 12A.50. **b** This figure only represents expenditure under HACC Amending Agreements.

Source: DoHA (unpublished); table 12A.51.

Outcomes

Outcomes indicators have been identified this year for development and reporting in future (boxes 12.21, 12.22 and 12.23).

Social participation in the community

Box 12.21 **Social participation in the community**

'Social participation in the community' is an outcome indicator that measures the wellbeing and independence of frail older people. An indicator will be developed to show the extent to which older people participated in community, cultural or leisure activities. Higher rates of participation in the community are more desirable.

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

Maintenance of individual functioning

Box 12.22 **Maintenance of individual functioning**

'Maintenance of individual functioning' is an outcome indicator that reflects the objective for aged care services to promote the health, wellbeing and independence of frail older people. The indicator is defined as:

- maintenance of, or minimised decline in, residents' level of functioning reflected by a movement of clients to a higher level of need as indicated by a change in classification on the resident classification scale
- length of stay in residential care for a given level of frailty or age at entry.

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

Enabling people with care needs to live in the community

Box 12.23 **Enabling people with care needs to live in the community**

'Enabling people with care needs to live in the community' is an outcome indicator that reflects the objective of community care to delay entry to residential care and will measure levels of dependency on entry to residential care for those who have been receiving community care.

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

12.4 Future directions in performance reporting

For several aspects of aged care services, indicators are not fully developed and there is little performance reporting. Priorities for the future include:

- continued improvement of efficiency indicators, including for HACC services and assessment services
- further development of reporting of outcome indicators
- improved reporting of waiting times for residential aged care
- further work on reporting the indicator 'long term aged care in public hospitals'
- improved reporting of State and Territory expenditure on residential aged care.

12.5 Jurisdictions' comments

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

Australian Government comments

“In the 2004-05 Budget, the Australian Government responded to the report of Professor Warren Hogan’s Review of Pricing Arrangements in Residential Aged Care by announcing the $2.2 billion Investing in Australia’s Aged Care: More Places, Better Care package. Of the 31 new measures, 24 were implemented by the end of 2004-05 and three more by 1 July 2005. Implementation of the remaining four is well advanced. The package is providing for expanded provision of care; additional recurrent and capital funding for aged care services; improved quality of care; workforce initiatives; streamlined administration; more support in rural and remote areas; and improvements to the hospital/aged care interface through Transition Care.

In consultation with the states and territories, the Australian Government is also implementing The Way Forward, a blueprint announced in May 2004 for the future of community care.

The 2005-06 Budget provided $320.6 million over five years to make dementia an Australian Government National Health Priority and $207.6 million over four years to provide carers with more access to respite services. It provides for important new initiatives to help improve the quality of care.

The 2005-06 Budget established a framework for consultation with the community and the aged care industry on the long-term future of aged care, in particular the remaining medium term recommendations and long term options from the Review of Pricing Arrangements in Residential Aged Care.

The views of the community and the aged care sector will help the Government consider the best options to increase care recipients' choice of services that will meet their needs and to strengthen the sector's long-term sustainability.

The Department of Veterans’ Affairs held its second Veteran’s Home Care (VHC) program Assessment Agency Forum in Melbourne on 17-18 May 2005. The Forum provided an opportunity for contracted VHC assessment agencies and representatives from other organisations to review the first four years of the program, share experiences and provide directions and improvements for the future.

The Forum proved to be an outstanding success, with the overwhelming majority of the 80 delegates expressing enthusiasm and appreciation for the significant achievements that the VHC program has made to date.

The Australian Government provided an additional $52.4 million over four years during 2004-05 to enhance the VHC program. The funds have enabled the Department of Veterans’ Affairs to increase the number of eligible Veterans and War Widowers/s receiving services from around 60 000 to 66 000 during 2004-05.”

New South Wales Government comments

“

The NSW Government remains committed to assisting older people and their carers to maximise their independence and participation in community life, to promote their health and wellbeing, and to provide information and support to enable them to access appropriate services.

In 2004-05 NSW continued to expand the Home and Community Care (HACC) Program with the allocation of $32 million in additional funding, bringing the total HACC budget to more than $414 million. HACC services were expanded throughout NSW through the selection of providers to deliver $23 million of additional services, with a continuing emphasis on basic support including domestic assistance, personal care, transport, social support and respite care. The NSW Government continues its commitment to examining and addressing the needs of older people in disadvantaged communities, including Aboriginal and Torres Strait Islander peoples, rural, culturally diverse and public housing communities.

To meet the needs of the rapidly increasing numbers of people living with dementia, NSW Health has allocated $11 million over four years through its Future Directions for Dementia Care and Support in NSW (2001–2006). NSW Health is also the lead agency developing the National Framework for Action on Dementia (NFAD) as agreed by the Australian Health Ministers in January 2005. NSW Health has also committed $12.9 million to a four-year NSW Carers Program in 2004 to provide practical information, training and support for carers, many of whom are older people. Area Health Service Carer Support Officers are increasing the responsiveness of health services to meet the needs of carers.

An ‘Older People Framework Forum: Celebrating Improvements’ Forum is being held on 30 November 2005 to enable NSW Area Health Services to report on improved practices and systems change under the umbrella of the NSW Health Framework for Integrated Support and Management of Older People in the NSW Health Care System (2004–2006).

NSW is implementing the Transitional Aged Care program on a jointly funded basis with the Australian Government. The transition care model for older people aims to help reduce hospital length of stay and readmission rates and the premature admission to long-term residential aged care. Another evolving initiative is the Sub-Acute Fast Track Elderly Care (SAFTE Care) program designed to provide interventions for frail older people with emerging crisis and acute care needs in the community, thereby avoiding hospital presentation and admission. NSW funding of $4 million has been earmarked for this program to help meet the challenge of better integrating hospital aged care services, the hospital-community interface, general practice and community health services, so that older people receive the right care at the right time.

NSW has been actively engaged in COAG reforms during 2005 and continues to work with the Australian Government and other states and territories in activities associated with the Community Care Review.

”

Victorian Government comments

“During 2004-05 Victoria emphasised innovation in responding to the aged care challenges particular to the context in the State. Victoria has long had an emphasis on community-based care with a comprehensive sub-acute and rehabilitation system supported by an especially strong community care sector. However, with people delaying entry to residential care for as long as possible, there is pressure to both improve community care responses and to support the provision of higher levels of residential care.

Victoria is adopting an ‘active service model’; aiming to bring a more capacity focused and person centred approach to service delivery. It takes as its premise that the starting point needs to be promoting people’s independence rather than expecting them to continue to be dependent. A number of elements support this approach including pilot projects that are being conducted and documented in support of the model.

The ‘Well For Life’ program has been introduced to assist residential care and HACC Planned Activity Group workers implement change aimed at improving physical activity and nutrition of frail older people. It is hoped that people will achieve greater independence in activities of daily living such as eating, personal care, and personal mobility. Forty-eight projects have been funded across Victoria and an independent support and evaluation program is being conducted.

An Innovation Fund has also been introduced to support HACC service providers to develop innovation in service delivery and explore ways to do business more efficiently.

Measures are also being introduced to bolster residential aged care provision — both in terms of facilitating the development of services and in supporting quality care.

Development and redevelopment of residential aged care in inner and middle ring suburbs of Melbourne is being limited by economic factors including the price of suitable land. The Government announced in the ‘A Fairer Victoria’ social policy statement that it would explore options to assist not-for-profit residential aged care operators to develop new services in areas of high need.

Initiatives to further develop quality residential care include a business performance improvement project, development of quality of care indicators and a resource kit to assist services in the implementation of the Australian Pharmaceutical Advisory Council (APAC) ‘Guidelines for medication management in residential aged care facilities’.”

Queensland Government comments

“Queensland recognises that the preference for many older people and their carers is to live independently for as long as practicable and considers enabling people to act on that preference to be a key objective. Consumer and provider organisations support the need for a continuum of community care that enables older people to age in place with support increasing in direct proportion to need.

The Queensland Government achieves this through the HACC program, which is at the beginning of the aged care continuum, and is instrumental in helping older people to remain in their own homes. HACC is jointly funded by the Australian and Queensland Governments.

Planning for current and future generations has become essential as the Queensland population ages, with the number of older people expected to increase from 11.5 per cent in 2001 to more than 23 per cent in 2051.

Queensland has commenced implementation of Queensland Health’s Directions for Aged Care 2004–2011. This document provides a clear vision to guide Queensland Health and its partners towards providing even better health and support services to older people. Funding has recently been provided to support a number of one-off initiatives based around improving care for older people, ranging from improved discharge planning, training for staff at aged care facilities through the Hospital in the Nursing Home program, to trialling aged assessments in regional areas through telehealth facilities.

Queensland Health presently owns and operates 21 aged care facilities. In line with the recommendations of the Action Plan: Building a better health service for Queensland, a ‘case by case’ review will determine Queensland Health’s future involvement in each of these residential aged care homes.

Queensland Health has worked in close collaboration with the Australian Government to jointly fund and implement the new national Transition Care Program. This is a unique Program at the interface of the hospital and aged care sectors that will provide an opportunity for older people who are eligible to further improve their level of independence with therapy services and support services, for a period of up to 12 weeks. Transition care will also provide this group of clients additional time to consider their longer term care options.

Queensland welcomes the opportunity to work with the Australian Government and all State and Territory jurisdictions to continue the development of a new HACC Amending Agreement and to improve the delivery of aged care services in Australia through the review of the Community Care Sector.”

Western Australian Government comments

“Western Australia’s approach to programs and services for older people continues to be predicated on the vision of ‘independence, well-being and quality of life for older people through responsive health and aged care services and supports’ as articulated in the State Aged Care Plan for Western Australia 2003–2008. In line with the preference of older people to remain in their own homes for as long as possible, independence-promoting service models are a continuing focus for the Home and Community Care (HACC) program. These service models utilise multidisciplinary teams to deliver short-term packages of therapy-based care for clients assessed as being able and willing to improve/maintain their health status and functioning.

The *Carers’ Recognition Act 2004 (WA)*, formally recognising carers as key partners in the delivery of care, came into effect on 1 January 2005. The Act establishes a Carers’ Charter and provides a framework for involving carers in the assessment, planning and delivery of services. The HACC program will be promoting the Carers’ Charter across all HACC provider organisations and assisting them in fulfilling the requirements of the charter.

In a collaborative initiative with Carers WA, the HACC program is supporting a ‘Prepare to Care’ project run by Carers WA, which operates at the acute and community care interface. Carer Support officers work with hospital staff and family members to ensure ‘new’ carers are equipped to care for family members after discharge and have access to appropriate community-based services. Another recent focus of the HACC program is support for the establishment of the Alliance for the Prevention of Elder Abuse: WA to promote a whole-of-government policy framework that supports the rights of older people.

Western Australia continues to develop and refine its model of transition care for older people. The Transitional Care Service (TCS), providing a flexible model of care for older people at risk of premature admission to long-term services, provides short-term rehabilitation and support services either in the client’s home/hostel or temporarily in a residential aged care facility. Since the service began in November 2002, until 30 September 2005, 60 per cent of discharged clients returned home, with or without aged care support services. In February 2005, the Intermittent Care Service (ICS), a joint Australian Government and State program similar to the TCS, commenced. With a rehabilitative focus, the ICS provides short-term, flexible care options at the acute/subacute and residential care interface. It aims to reduce inappropriate extended hospital length of stay and premature admission to residential care.

In response to the national Transition Care Program announced by the Australian Government in the 2004-05 budget, Western Australia has developed a Transition Care Program Implementation Plan, which proposes to mainstream both the TCS and the recently commenced ICS pilot programs. Using efficiencies in the system, the intention is to further expand the community aspects of the program into selected rural areas.”

South Australian Government comments

“ The South Australian Government again fully matched the Australian Government growth offer for HACC in 2004-05, and has demonstrated its commitment to community care in planning for growth in HACC in the forward estimates.

Although the South Australian population is ageing more rapidly than the Australian population as a whole, HACC expenditure per person aged 70 years and over has been lower than the national average. The outcome of targeting HACC growth to frail older people over the last years is starting to be reflected in the data. Priority has been for people requiring low levels of care, especially those who live alone or are otherwise isolated, and for those people who have unstable accommodation arrangements, who age prematurely, or are in other ways vulnerable.

HACC services for people from culturally and linguistically diverse backgrounds continue to be fostered. Each year there have been more ethnic community organisations supported to provide services to their senior members.

Funding for Indigenous specific services has been maintained following concerted endeavours to establish services from the mid 1990s. The emphasis is increasingly on skills development for Aboriginal staff, and improving service delivery arrangements as required. Each year, two Indigenous HACC Workforce Forums are held for staff to network, share information and pursue training identified as needed across agencies.

In 2005, a Carer Support Project was conducted to better understand the current distribution and models of service. This will inform future developments for carer support, including in 2005-06.

The pilot Home Rehabilitation and Support Service was completed in June 2005. An on-going Transition Care Program is now jointly funded by the South Australian and Australian Governments to facilitate the transition of older people from acute care to more appropriate community options.

As the general population in South Australia has aged more quickly than for the nation as a whole, so too has the disabled population. This has provided an opportunity for the State and Australian Governments to explore innovative ways of supporting this group. Disability and aged care providers have come together to develop an ‘Interlink’ approach. The projects aim to support the increasing needs of people with disabilities which are due to their ageing. HACC and Innovative Pool funding are used respectively to top-up CSTDA funding, for people with lower and higher needs. ”

Tasmanian Government comments

“The State Government has recognised the challenges facing the State’s health and community services, which include the need to maintain the highest standards of client care in the face of the ageing of the population and increasing costs of new health technologies and recruiting and retaining specialist staff. The Government also acknowledges that pressures may be greater in Tasmania because the State’s population is ageing more rapidly than the rest of Australia, and because of the difficulties in servicing a dispersed population with the resulting diseconomies of scale.

Under the Better Hospitals Package a new 42 bed Transitional Care Unit is being established to complement the State’s Extended Rehabilitation Service. Additional investment has also been made in mental health; rural health; disability services; elective surgery; health workforce; ambulance services; and social housing.

The Tasmanian Department of Health and Human Services has identified Caring for Ageing Tasmanians as a high priority and will continue to invest significant effort in developing and improving a service system that deals with aged care needs in a flexible, fair and coordinated way.

Following a review of Community Options Services in the State, the service has been restructured and expanded. It is anticipated that a tripartite partnership agreement on population ageing, involving the Australian, Tasmanian and Local Governments, and aimed at addressing a range of specific aged care issues, will be implemented in 2006.

Tasmania is currently reviewing its Dementia Care Plan, with the aim that the updated plan will be consistent with and complement the National Framework for Action on Dementia 2006–2010. The State’s Seniors Bureau is also reviewing and updating the Tasmanian Plan for Positive Ageing.

The State Government is keen to work with the Australian Government on programs that address the needs of an ageing population, particularly in those areas at the interface between health services and aged care services.

The Pathways Home Program, Community Care Reforms, Transition Care Program and the new Home and Community Care Agreement will have significant implications for the State. Implementation of these programs needs to complement the State Government’s health service reforms to ensure continuing and appropriate support and care are provided to Tasmania’s ageing and regionally dispersed population.”

Australian Capital Territory Government comments

“ The ACT Government has undertaken a number of initiatives to support older Canberrans. Under the Transition Care Program, ACT Health has successfully applied to the Australian Government to receive 10 transition care places in 2005-06. These places will be jointly funded by the ACT and Australian Government and will provide additional support for older people leaving hospital to increase their level of physical functioning. In July 2006, the 25 Intermittent Care Service pilot places, which began in January 2005, will also become part of the Transition Care Program, resulting in 35 transition care places.

The ACT Government has also committed to construct a 40 bed rehabilitation/ convalescent service and 20 bed psychogeriatric facility at Calvary Hospital. This service will provide improved sub acute care for patients in need and where appropriate aid their transition back to independent living. Initially proposed construction dates have been extended. Architectural plans are now being finalised and construction will commence in early 2006.

In an Australian first, the ACT and Australian Governments collaborated to allocate aged care beds to a particular site. This will result in the establishment of a further 100-bed aged care complex that will also include 150 self-care/independent living units, and will be developed on the banks of Lake Ginninderra in Belconnen. This proposal will include 40 high and 60 low aged care places. Illawarra Retirement Trust has been selected to purchase and develop the site.

The ACT Government has approved an application from Calvary Hospital for an aged care complex consisting of a 100-bed aged care facility providing low, high and dementia care and 78 independent living units, 30 of which will be apartment style dwellings. The ACT Government has also approved the redevelopment of the Goodwin Aged Care facility in Ainslie, which includes a 108-bed residential aged care facility and 148 aged persons units.

The Elder Abuse Prevention Information Line has been actively promoted in the media and is receiving general enquiries as well as requests for assistance or referral to appropriate supports.

To improve the coordination and investigation of complaints, relating to older people in aged care homes in particular, a Memorandum of Understanding was signed on 28 June 2005 between the Secretary of the Department of Health and Ageing and the ACT Community and Health Services Complaints Commissioner. ”

Northern Territory Government comments

“Compared to other jurisdictions, the Northern Territory has unique socio-economic and environmental factors that necessitate flexible and creative ways of delivering specialist aged and community care services. These factors include relatively a younger population, a high proportion (30 per cent) of Aboriginal and Torres Strait Islander population, many of whom live in remote or very remote communities, and an environment as diverse as desert and wet tropics.

Free-standing, mainstream and traditional aged care service models are often not suitable, or viable or sustainable in remote Indigenous communities. It is for these reasons that the Northern Territory continued to provide aged care services through pooled resources across a range of health and community services sources.

The ‘trans-disciplinary’ approach to Allied Health service delivery was further expanded to assist more remote residents. Regular scheduled and agreed service visits by Allied Health and other Aged and Disability teams to rural and remote communities throughout the NT were conducted. These initiatives arose from the NT Government’s policy of supporting people in their home communities and strong commitment to also increasing the level of services available to remote communities.

Other initiatives maximise community participation and independence of senior Territorians, including the provision of concessions and subsidies related to costs associated with essential services and utilities; professional support services such as assessment, case management and community support for frail older people; expansion of HACC services to more Indigenous remote communities; the roll out of new respite services for older carers; a Darwin-based transitional care service; and the Aged Care Innovative Pool pilot. The Northern Territory Government is also planning to implement a ‘Return To Home’ Project, which coordinates the return of older people to their homes and community from hospital, through the provision of an intensive short term care package.

As noted in earlier reports, the NT potential population estimates need to be interpreted with caution. The small NT population yields a small sample size, and subsequently a high standard error.

The NT is committed to support national strategies to improve data collection and reporting particularly in relation Indigenous and rural and remote residents.”

12.6 Appendix: Age standardisation of aged care data

How age profiles can distort observed service usage patterns

The age profile of Australians varies across jurisdictions and across different cultural and linguistic backgrounds (see for example the different age profiles of Indigenous and non-Indigenous Australians — figure 12.7). Variations in age profiles are important because the likelihood of needing aged care services increases with age (figure 12.13). As a result, observed differences in service usage rates by different cohorts within the community may arise from different age profiles, rather than from different usage patterns. One method of eliminating this distortion from the data is to standardise for the age profiles of different groups.

Method of standardisation

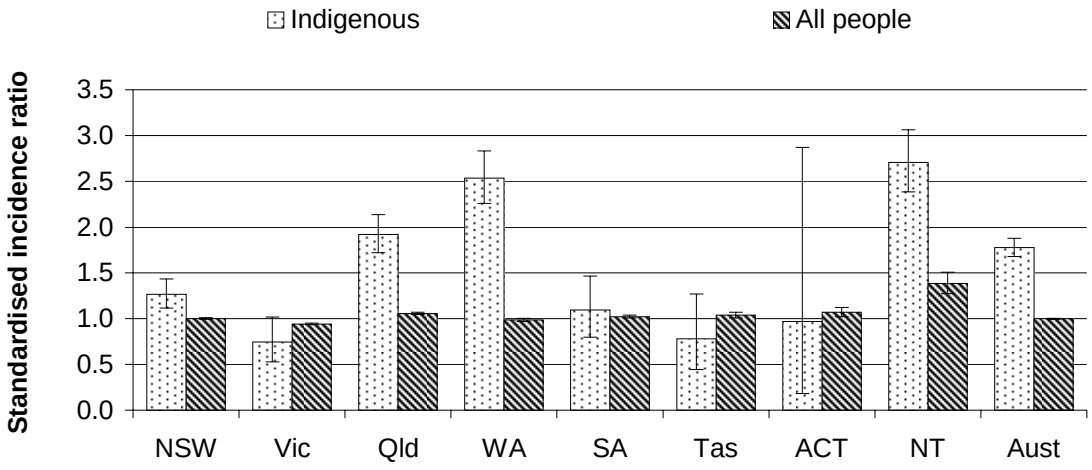
Either direct or indirect standardisation can be used. Indirect standardisation is presented here because it is more appropriate when comparing small populations. This method applies standard age-specific usage rates (in this case, average Australian rates) to actual populations (different groups within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

Application of indirect standardisation

In the following illustration, 2001 data are used. Within each State and Territory, the combined use of permanent residential aged care and CACPs by Indigenous people is compared with average service use by all Australians. The resulting standardised incidence ratios are presented in figure 12.27. The error bars in the figure show how accurate the comparisons are-if an error bar goes across the value of 1.0, then the usage rate by that population group is not significantly different from the average use by all Australians. People (Indigenous people in particular) also use long stay hospital beds, flexible places and other services not covered in the analysis, and consequently, these results do not represent all the available services.

Figure 12.27 shows that Indigenous people had a higher than average combined use of CACPs and permanent residential aged care — nationally, about 80 per cent higher. This result reflects the higher age-specific usage rates of CACPs for Indigenous people at all ages, and of permanent residential aged care for those Indigenous people aged under 75 years (table 12.10). Results vary across jurisdictions. The combined use of the services is not significantly different from the national average for Indigenous people in Victoria, SA, Tasmania and the ACT, but is higher than the average in other jurisdictions.

Figure 12.27 **Standardised incidence ratio for use of CACP and permanent residential aged care (combined), 30 June 2001[a, b, c]**



a The Indigenous ratio is per 1000 Indigenous people aged 50 or over, the all people ratio is per 1000 Indigenous people aged 50 or over and non-Indigenous people aged 70 or over **b** The calculations use indirect age standardisation against use by all people Australia-wide. **c** ACT data are based on a very small Indigenous population and have high standard errors.

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

Table 12.10 **Age-specific usage rates of CACPs and permanent residential aged care (per 1000 people), 30 June 2001[a, b]**

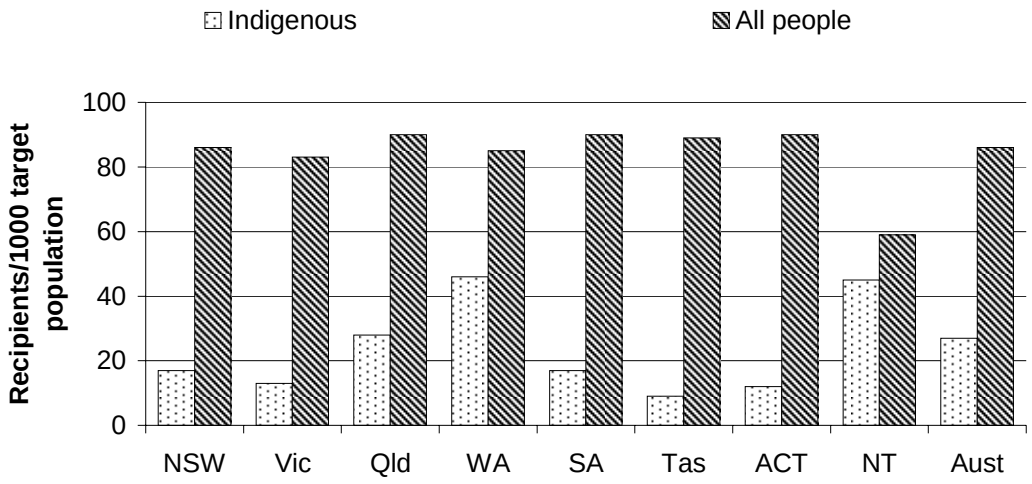
	CACP recipients		*Permanent aged care residents*	
Age (years)	*Indigenous*	*Non-Indigenous*	*Indigenous*	*Non-Indigenous*
50–54	1.7	0.1	3.3	0.7
55–59	4.1	0.3	4.2	1.4
60–64	8.6	0.7	9.5	2.9
65–69	16.3	1.5	11.4	6.1
70–74	30.1	3.2	25.2	14.5
75–79	33.7	7.1	66.3	35.3
80+	36.7	20.7	116.3	160.8

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

Source: AIHW (unpublished).

The age standardised rates are quite different from those that will result from comparing use with the target group population (clients per 1000 in the target group). The target group measure (figure 12.28) suggest that combined use of CACPs and permanent residential aged care is much lower for Indigenous people than for all people in all jurisdictions. Figure 12.28 also suggests that combined use of the two services is generally much lower in the NT than in other jurisdictions; this difference is not apparent after age standardisation (figure 12.28), indicating that the difference in this measure is the result of the relatively young age structure of the NT (even within the two subgroups of people 70 years and over and Indigenous people 50 years and over).

Figure 12.28 **Ratio of CACP recipients and permanent residents (combined) to 1000 persons in target population, 30 June 2001[a]**



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

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

Age-specific usage rates prepared for the 2006 Report

Preparation of age-specific usage rates is a necessary requirement before any age standardisation, either direct or indirect, can be undertaken. The 2006 Report includes some age specific usage rates per 1000 persons, against the following categories of data for 30 June 2004:

- permanent aged care residents, (both high care and low care); CACP; and EACH, by jurisdiction and by remoteness. These are also provided as total figures for the three services. These are each broken down into male, female and all persons across six age ranges.

- the total of Indigenous permanent aged care residents (both high and low care) and CACP, by remoteness. These data are broken down into male, female and all persons across five age ranges.

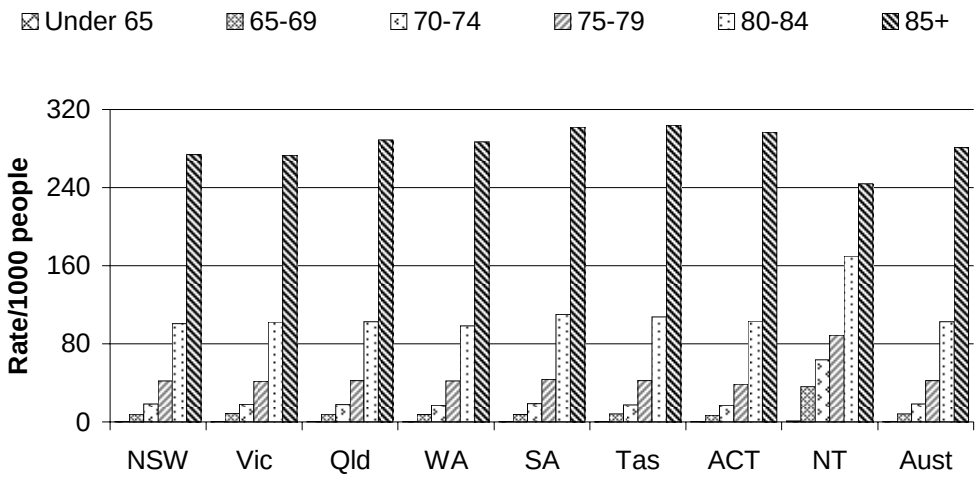
These data are included in tables 12A.58–12A.64.

Presentation of age-specific usage rates raises particular data issues which would have further implications for age standardisation, if undertaken. In particular, if the numbers of people within a particular range for a given service are small, this may lead to instability in the data and the possibility of data which do not provide meaningful information. This can be seen from some of the usage rates identified for the EACH program, which, whilst growing rapidly, is doing so from a relatively small base and is likely to fluctuate in future before stabilising.

The development of age-specific usage rates has intrinsic value, as a snapshot or when mapped over time. The data included in the 2006 Report provide some insights into these issues and identify some significant variations in rates between jurisdictions and remoteness areas.

The national age specific usage rates per 1000 persons for high and low residential care, CACP and EACH in combination at 30 June 2004 is 0.5 for people under 65 rising to 280.9 for people over 85. These rates vary across jurisdictions (figure 12.29).

Figure 12.29 **Permanent aged care residents, CACP and EACH recipients at 30 June 2004: age specific usage rates per 1000 persons by jurisdiction** [a, b]

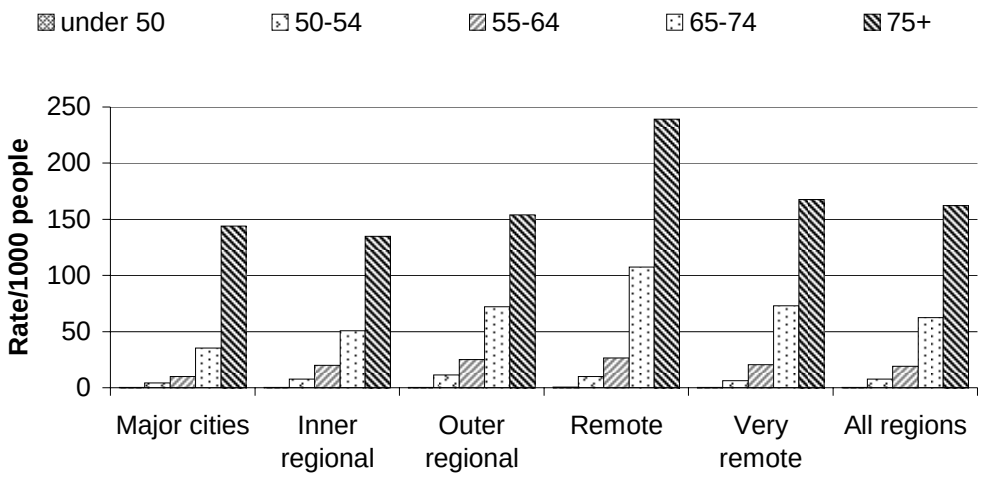


[a] Data based on AIHW analysis of the DoHA Australian Community Care Management Information System (ACCMIS) database and ABS population data. [b] Residents without a recorded RCS were omitted.

Source: AIHW (unpublished); table 12A.60.

The national age specific usage rates per 1000 Indigenous persons for high and low residential care and CACP in combination at 30 June 2004 is 0.3 for people under 50 rising to 162.3 for people over 75. These rates vary by remoteness category (figure 12.30).

Figure 12.30 **Indigenous permanent residents classified as high or low care and Indigenous CACP at 30 June 2004: age specific usage rates per 1000 persons by remoteness [a, b]**



a Data based on AIHW analysis of the DoHA ACCMIS database and ABS data. The Australian Standard Geographical Classification (ASGC) population figures for the Indigenous population at 30 June 2004 were derived by the AIHW from the 2001 Census ASGC data and the experimental estimates and projections of the Indigenous population which includes age and sex breakdowns by states and territories. **b** Residents without a recorded RCS were omitted.

Source: AIHW (unpublished); table 12A.64.

12.7 Definitions of key terms and indicators

Adjusted subsidy reduction supplement

Payments made to equalise the recurrent funding paid by the Australian Government as adjusted subsidy reduction places to public sector residential care operators. The states and territories provide top-up funding for residential aged care places at a rate set by the Department of Health and Ageing from 1 July each year.

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 aim to optimise independence and to assist frail older people to stay in their own homes, while 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 (for example, 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 generally aim to maintain function rather than treat illness or 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 in residential care

An approach that aims to provide residents with appropriate care and increased choice by allowing them to remain in the same facility regardless of changes in their level 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 Australian Government aged care legislation is 'to promote ageing in place through the linking of care and support services to the places where older people prefer to live' (*Aged Care Act 1997* (Cwlth), s.2-1 [1j]).

Centre day care

Respite care provided from a facility such as a day care or health centre. Respite care is usually combined with social support services to maintain the functional capabilities of the person receiving care.

Complaint

A complaint by the affected care recipient or his or her representative, or anyone else, to the Secretary about anything that:

- may be a breach of the relevant approved provider's responsibilities under the *Aged Care Act 1997* or the Aged Care Principles
- the complainant thinks is unfair or makes the affected care recipient dissatisfied with the service.

Disability	A limitation, restriction or impairment that has lasted, or is likely to last, for at least six months and restricts everyday activities.
EBA supplement	Payments made to supplement services for the extra costs associated with public sector enterprise bargaining agreements over and above those required by other wage Awards.
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.
High/low care recipient	Recipient of a high level of residential care (that is, a level to RCS levels 1–4) or a recipient of a low level of residential care (that is, a level 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.
Rural small nursing home supplement	Payments made by states and territories to small sized high care public sector residential aged care facilities (up to 30 places) that are located in rural areas. Three levels of supplement are paid to facilities varying in size from 10 to 20 and 30 places.
Special needs groups	Section 11-3 of the Aged Care Act, 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; and people who are financially or socially disadvantaged. Principles (Regulations) made under s. 11-3 also specify veterans as a special needs group.

Veterans Veterans, their war widows, widowers and dependents who are eligible for treatment through the Department of Veterans' Affairs under the provisions of the *Veterans' Entitlements Act 1986* (Cwlth).

12.8 Supporting tables

Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 12A.3 is table 3 in the attachment). Supporting tables are provided on the CD−ROM enclosed with the Report. The files containing the supporting tables are provided in Microsoft Excel format as \Publications\Reports\2006\Attach12A.xls and in Adobe PDF format as \Publications\Reports\2006\Attach12A.pdf. The files containing the supporting tables can also be found on the Review web page (www.pc.gov.au/gsp). Users without access to the CD-ROM or Internet can contact the Secretariat to obtain the supporting tables (see contact details on the inside front cover of the Report).

Table 12A.1	Males and females aged 70 years or over, June 2005 (estimated)
Table 12A.2	Target population data, by location ('000)
Table 12A.3	Proportion of people aged 70 years and over by locality, June 2005
Table 12A.4	Ownership of aged care residential places, June 2005
Table 12A.5	Average annual Australian Government RCS subsidy per occupied place and the dependency level of aged care residents, June 2005
Table 12A.6	Size and distribution of all residential aged care services, June 2005
Table 12A.7	Size and distribution of residential aged care services with over 80 per cent high care residents, June 2005
Table 12A.8	Size and distribution of residential aged care services with over 80 per cent low care residents, June 2005
Table 12A.9	Size and distribution of mixed residential aged care services, June 2005
Table 12A.10	Operational number of aged care places per 1000 people aged 70 years or over
Table 12A.11	Operational number of aged care places per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years
Table 12A.12	Aged care recipients per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years
Table 12A.13	Aged care recipients per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years by locality
Table 12A.14	Aged care recipients from a non-English speaking country
Table 12A.15	Aged care recipients from a non-English speaking country per 1000 people from a non-English speaking country aged 70 years and over by locality
Table 12A.16	Indigenous aged care recipients per 1000 Indigenous people aged 50 years or over and as a proportion of all recipients
Table 12A.17	Indigenous aged care recipients per 1000 Indigenous people aged 50 years or over by locality
Table 12A.18	Aged care recipients from special needs groups, (per cent) 30 June 2005
Table 12A.19	Proportion of new residents classified as concessional or assisted residents, 2004-05 (per cent)

12.9 References

ABS (Australian Bureau of Statistics) 2001, *Estimated Residential Population, by Age and Sex,* Cat no. 3101.0, Canberra.

—— 2003, *Australian Standard Geographic Classification,* Cat no. 1216.0, Canberra.

—— 2004, *Survey of Disability, Ageing and Carers, 2003,* Cat no. 4430.0, Canberra.

AIHW (Australian Institute of Health and Welfare) 2002, *Entry Period for Residential Aged Care*, Cat. no. AGE 24, AIHW Aged Care Series no. 7, Canberra.

SCRCSSP (Steering Committee for the Review of Commonwealth/State Service Provision) 2002, *Report on Government Services 2002*, Productivity Commission, Canberra.

—— 2003, *Report on Government Services 2003*, Productivity Commission, Canberra.

SCRGSP (Steering Committee for the Review of Government Service Provision), 2004, *Report on Government Services 2004*, Productivity Commission, Canberra.

—— 2005, *Report on Government Services 2005*, Productivity Commission, Canberra.