# 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 definitions for data and indicators. Section 12.7 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 12.8 lists references used in this chapter.

Additions and improvements made to the chapter this year include:

- provision of information on the Transition Care Program (TCP)
- reporting 'aged care recipients from special needs groups' as an indicator of equity of access

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

- Provision of information on EACH Dementia
- reporting of expenditure by jurisdiction on the National Respite for Carers Program (NRCP)
- relocation of the technical component of the age standardisation discussion to the Report Statistical Appendix and integration of descriptive material on age specific usage rates into the main body of the chapter.

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 a needs match is expected when residents enter 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 remain 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, in the absence of 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 2004a). 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, EACH package, EACH Dementia package or TCP. 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.

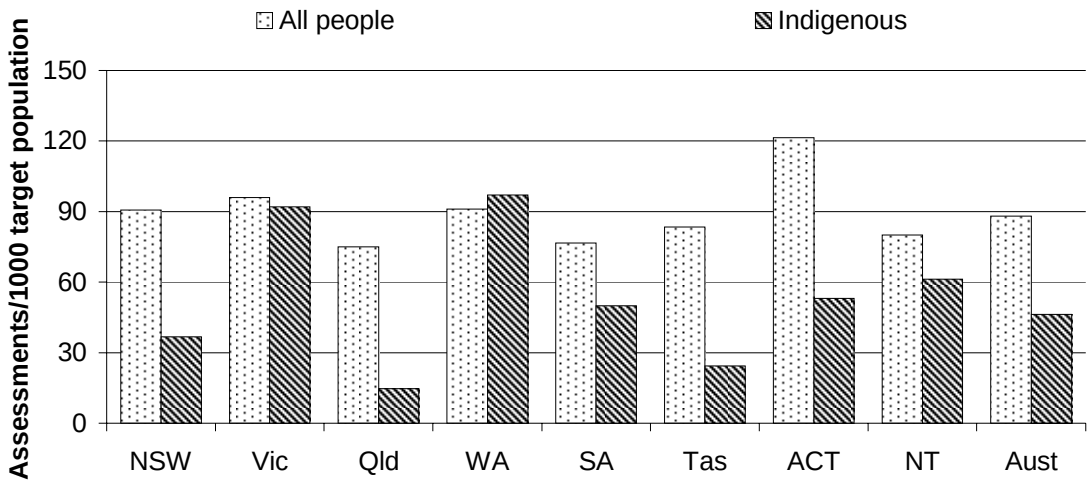
State and Territory governments are responsible for the day-to-day operation and administration of the ACAP and provide the necessary accommodation and support services. The scope and practice of the teams differ across and within jurisdictions, partly reflecting the service setting and location (for 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 2004-05. The national rate was 88.1 assessments per 1000 people aged 70 years or over and Indigenous people aged 50 years or over and 46.3 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 2006, accounting for 29.7 per cent and 32.0 per cent respectively of all Australian Government subsidised residential aged care places. Community-based organisations and not-for-profit charitable organisations accounted for a further 14.5 per cent and 16.1 per cent respectively. State, Territory and local governments provided the remaining 7.7 per cent (figure 12.2).

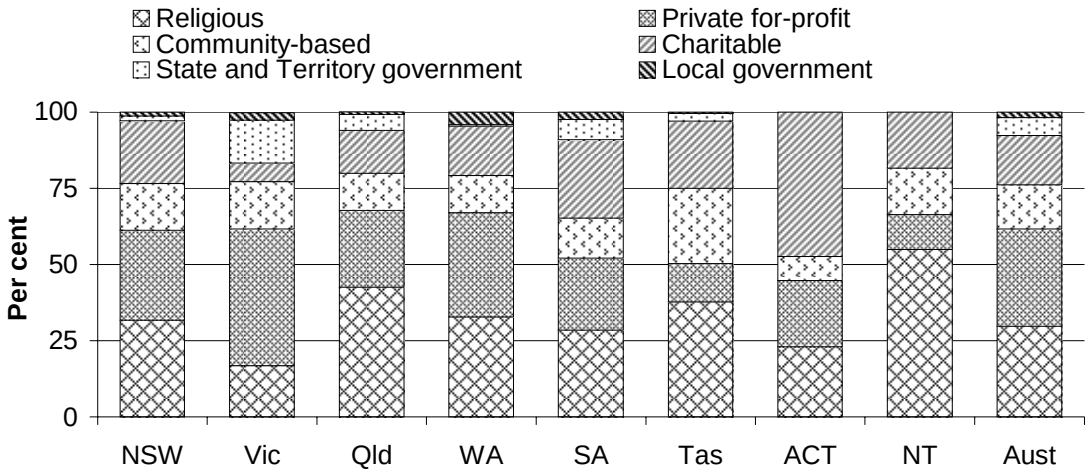
Figure 12.1 **Aged Care Assessment Team assessment rates, 2004-05[a, b, c, d]**




**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*: Department of Health and Ageing (DoHA) (unpublished); table 12A.38.

Figure 12.2 **Ownership of residential places, June 2006[a, b]**




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

*Source*: 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).

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).

### *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 or return to 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.

### *Flexibly funded services*

Flexible care addresses the needs of care recipients in ways other than that provided through mainstream residential and community care. Flexible care provided under the Aged Care Act includes EACH packages, EACH dementia packages, Innovative Care Places, Multi-purpose Service Aged Care and the TCP. In addition, flexible models of care are provided under the National Aboriginal and Torres Strait Islander Aged Care Strategy.

- The EACH program provides high level aged care to people in their own homes, complementing CACPs, which provide low level care. There were 2575 operational EACH places at 30 June 2006 (table 12A.35).
- EACH Dementia provides high level care in the home to people with complex care needs associated with dementia, as an alternative to high level residential care. There were 601 operational EACH Dementia places at 30 June 2006.
- The Aged Care Innovative Pool provides flexible care subsidies for alternative care options. Pilots have been conducted at the interface between aged care and other types of care. Evaluations of a number of the pilots were completed during 2005-06 and have, for example, informed the implementation of the Transition Care Program and the EACH Dementia program (DoHA unpublished).
- The Multi-purpose Service program supports the integration and provision of health and aged care services for small rural and remote communities. At 30 June 2006, there were 94 operational Multi-purpose Services with a total of 2259 flexible aged care places. Some of the MPS serve more than one location (DoHA unpublished).

### *Transition care services*

The TCP provides goal oriented, time limited and therapy focused care to help eligible older people complete their recovery after a hospital stay. Transition care is expected to:

- enable a significant proportion of care recipients to return home, rather than enter residential care
- optimise the functional capacity of those older people who are discharged from Transition Care to residential care
- reduce inappropriate extended lengths of hospital stay for older people.

Following a decision by health ministers in May 2004 and an announcement in the Australian Government's 2004-05 Budget, the Australian Government and the states and territories have collaborated in the design and implementation of the

program, which is jointly funded by the Australian Government and the states and territories.

Transition care can be provided in either a home-like bed based setting or in the community, and is for older people who would otherwise be eligible for residential care. A person may enter transition care only directly upon discharge from hospital. The average duration of care is expected to be 8 weeks, with a maximum duration of 12 weeks that may in some circumstances be extended by a further 6 weeks. When fully established, it is estimated that transition care will assist up to 13 000 people annually.

As there are significant service system differences between and within jurisdictions, different local operating circumstances, and different implementation processes and timetables, the TCP is likely to operate with some differences between jurisdictions that are likely to be reflected in national data collections.

By 30 June 2006 the Australian Government had allocated 1507 flexible aged care places to transition care, of which 595 were operational. A total of 2000 places will be allocated by June 2007. Most jurisdictions began delivering transition care services in 2005-06 (DoHA unpublished).

### *Indigenous-specific services*

Aboriginal and Torres Strait Islander people access mainstream services, as well as those managed by Aboriginal and Torres Strait Islander organisations. There are 29 services funded under the Aged Care Act that operate under the auspices of those organisations, providing 744 places at 30 June 2006. In addition, at 30 June 2006 there were 580 operational flexible aged care places, delivered under the National Aboriginal and Torres Strait Islander Aged Care Strategy. These flexible care places help ensure that Aboriginal and Torres Strait Islander people can access culturally appropriate care services as close as possible to their communities (DoHA unpublished). The Australian Government approved an additional 150 places to be allocated over three years.

## Funding

### *Assessment services*

The Australian Government provided grants to State and Territory governments to operate 119 ACATs in 2004-05 (table 12A.54). There were 115 ACATs at 30 June 2006. In 2005-06, the Australian Government provided funding of $55.5 million

nationally for aged care assessment (table 12A.46). ACAT expenditure per person aged 70 years or over (plus per Indigenous persons aged 50–69 years) was $28 nationally during 2005-06 (table 12A.47). Some States and Territories also contribute funding for ACATs.

### *Residential care services*

The Australian Government provides most of the recurrent funding for residential aged care services — $5.3 billion in 2005-06, comprising DoHA expenditure of $4.5 billion (table 12A.42) and Department of Veterans' Affairs (DVA) expenditure of $806.5 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 of residential care (table 12.1). The categories are defined in section 12.6. 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 2005-06 ($ million)**

| | *NSW* | *Vic*[a] | *Qld*[b] | *WA* | *SA* | *Tas*[c] | *ACT* | *NT* | *Total* |
|---|---|---|---|---|---|---|---|---|---|
| Adjusted subsidy reduction supplement | 4.3 | 15.3 | 5.8 | 2.3 | na | 1.5 | .. | .. | 29.2 |
| EBA supplement | .. | 54.0 | 25.7 | .. | na | .. | .. | .. | 79.7 |
| Rural small nursing home supplement | .. | 5.6 | na | 4.5 | na | 10.7 | .. | 0.4 | 21.1 |

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 $25.7 million in supplementation. [c] Tasmanian data are for 2005-06 for the adjusted subsidy reduction supplement and rural small nursing home supplement. Rural small nursing home supplement is an estimation based on the average bed day cost across all State operated small rural residential aged care services and recognises extra cost of operating very small services in rural and remote areas together with higher-cost public sector EBA and staffing levels. **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 2006, the average annual RCS subsidy per residential place was $31 009 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 2006 was 41.8 and 43.8 respectively on a national basis (table 12.3). Nationally, the proportion of low care places relative to high care places rose between 2002 and 2006 (table 12A.10).

Table 12.2 **Average annual Australian Government RCS subsidy per occupied place, and the dependency levels of high care and low care residents, June 2006**

| | *Unit* | *NSW* | *Vic* | *Qld* | *WA* | *SA* | *Tas* | *ACT* | *NT* | *Aust* |
|---|---|---|---|---|---|---|---|---|---|---|
| Average annual Australian Government RCS subsidy per residential place[a] | | | | | | | | | | |
| All RCS levels | $ | 31 347 | 30 673 | 30 401 | 30 046 | 32 480 | 31 426 | 31 472 | 31 472 | 31 009 |
| Proportion of high care residents[b] | | | | | | | | | | |
| RCS 1 | % | 23.7 | 26.1 | 17.8 | 23.7 | 26.2 | 18.8 | 30.6 | 20.7 | 23.4 |
| RCS 2 | % | 26.0 | 21.2 | 25.6 | 21.1 | 25.3 | 25.5 | 16.6 | 27.7 | 24.1 |
| RCS 3 | % | 14.5 | 13.4 | 19.0 | 13.6 | 16.5 | 21.6 | 16.0 | 21.2 | 15.4 |
| RCS 4 | % | 5.4 | 5.6 | 6.2 | 6.3 | 5.6 | 6.8 | 6.0 | 3.6 | 5.8 |
| Proportion of low care residents | | | | | | | | | | |
| RCS 5 | % | 11.2 | 13.9 | 11.1 | 15.4 | 10.6 | 10.4 | 13.3 | 6.0 | 12.2 |
| RCS 6 | % | 9.4 | 10.7 | 9.8 | 11.0 | 8.5 | 8.3 | 9.6 | 5.2 | 9.8 |
| RCS 7 | % | 9.3 | 8.6 | 9.7 | 8.7 | 7.1 | 8.5 | 7.8 | 10.9 | 8.9 |
| RCS 8 | % | 0.5 | 0.3 | 0.8 | 0.3 | 0.3 | 0.1 | 0.2 | 4.7 | 0.5 |

**a** Includes only subsidies based on the RCS. Average Australian government payments, including subsidies and supplements, totalled $43 952 per high care resident (RCS 1-4), $15 757 per low care resident (RCS 5-8) and $34 599 for all permanent residents. **b** Differences in average annual subsidies reflect 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 2006[a, b]**

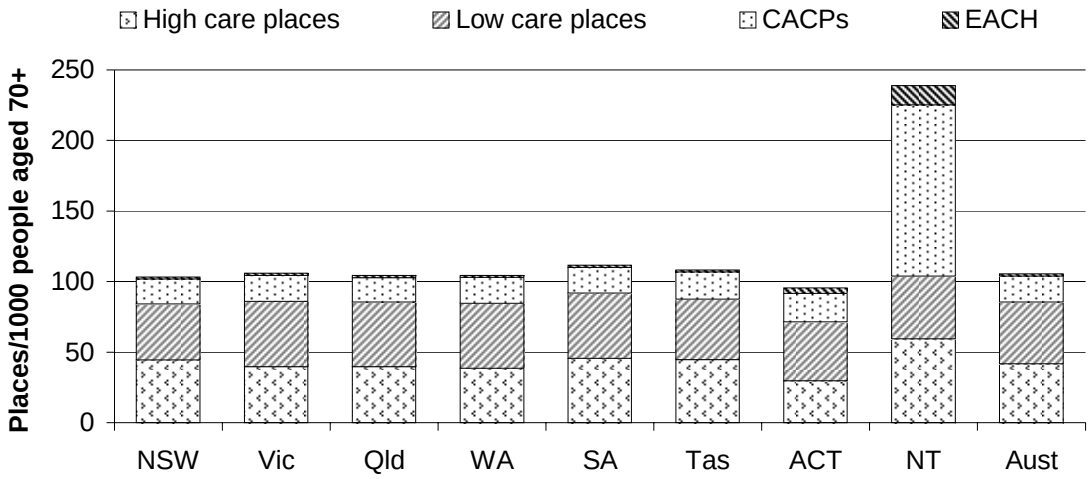
| | *Unit* | *NSW* | *Vic* | *Qld* | *WA* | *SA* | *Tas* | *ACT* | *NT* | *Aust* |
|---|---|---|---|---|---|---|---|---|---|---|
| Number of places per 1000 people aged 70 years or over | | | | | | | | | | |
| High care places | no. | 44.4 | 39.7 | 39.6 | 38.5 | 45.6 | 44.8 | 29.7 | 59.5 | 41.8 |
| Low care places | no. | 39.7 | 46.3 | 45.9 | 46.1 | 46.2 | 42.8 | 41.8 | 44.3 | 43.8 |
| **Total places** | **no.** | 84.1 | 86.0 | 85.5 | 84.7 | 91.8 | 87.6 | 71.5 | 103.8 | 85.6 |
| Proportion of places | | | | | | | | | | |
| High care places | % | 52.8 | 46.2 | 46.3 | 45.5 | 49.7 | 51.1 | 41.5 | 57.3 | 48.8 |
| Low care places | % | 47.2 | 53.8 | 53.7 | 54.5 | 50.3 | 48.9 | 58.5 | 42.7 | 51.2 |

**a** Excludes places that have been 'approved' but are not yet operational. Includes multi-purpose and flexible services attributed as high care and low care places. **b** For this Report, Australian Government planning targets are based on providing 108 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, EACH packages, EACH dementia packages, other flexible care places and TCP places at 30 June 2006 was 105.8 per 1000 people aged 70 years or older (figure 12.3). The Australian Government's targets for the provision of residential and community care places were outlined previously (box 12.2).

Figure 12.3 **Operational residential places, CACPs and EACH packages, 30 June 2006[a, b, c, d, e]**



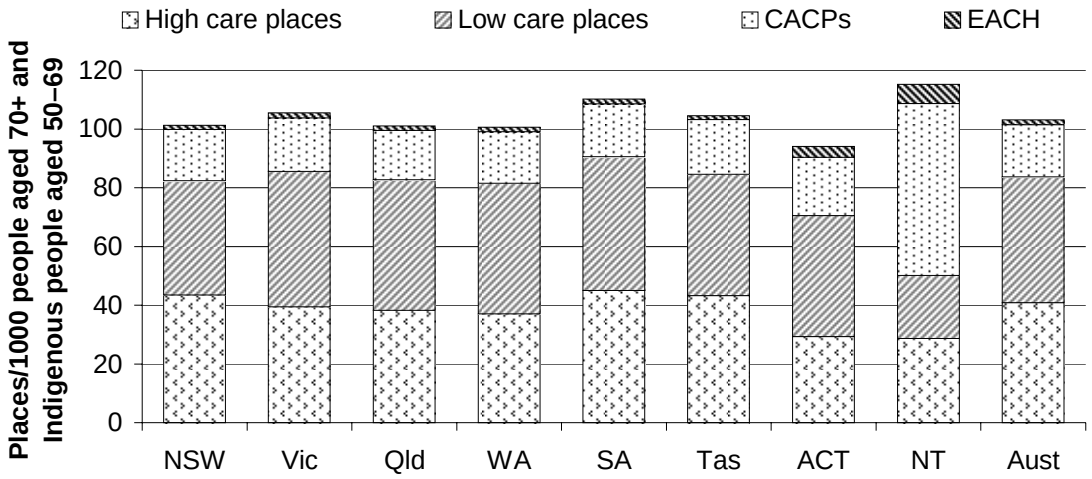

**a** Excludes places that have been approved but are not yet operational. **b** 'Ageing in place' may result in some low care places being filled by high care residents. **c** For this Report, Australian Government planning targets are based on providing 108 places per 1000 people aged 70 years or over. 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). **e** EACH Dementia places and TCP are not shown (table 12A.10).

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

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.

Age specific usage rates for these services, by jurisdiction and remoteness and for Indigenous usage at 30 June 2005 are reported in tables 12A.57 to 12A.63.

Figure 12.4 **Operational residential places, CACPs and EACH packages adjusted for Indigenous people age 50-69, 30 June 2006[a, b, c, d, e]**



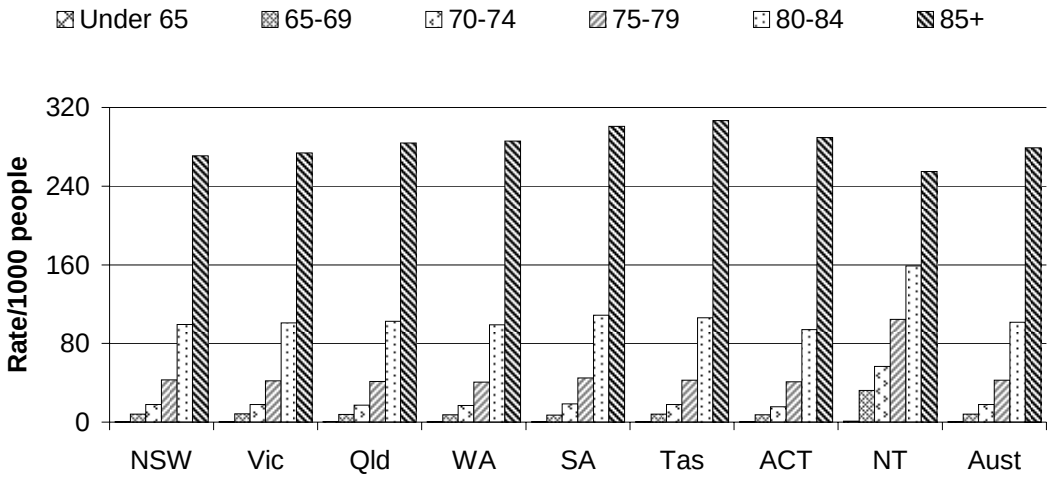

**a** Places do not include those that have been approved but are not yet operational. **b** 'Ageing in place' may result in some low care places being filled by high care residents. **c** CACPs and EACH packages are not residential services but are included in the Australian Government planning targets (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. **e** EACH Dementia places and TCP places are not shown (table 12A.11).

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

Presentation of age-specific usage rates raises particular data issues. In particular, if the numbers of people within a particular range for a given service are small, this may lead to apparently large fluctuations in growth rates. 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.

Age-specific rates in this Report are for 2005 due to data unavailability. The national age specific usage rates per 1000 persons for high and low residential care, CACP and EACH in combination at 30 June 2005 is 0.5 for people under 65 rising to 279.1 for people over 85. These rates vary across jurisdictions (figure 12.5).

Figure 12.5 **Permanent aged care residents, CACP and EACH recipients at 30 June 2005: age specific usage rates per 1000 persons by jurisdiction[a, b]**

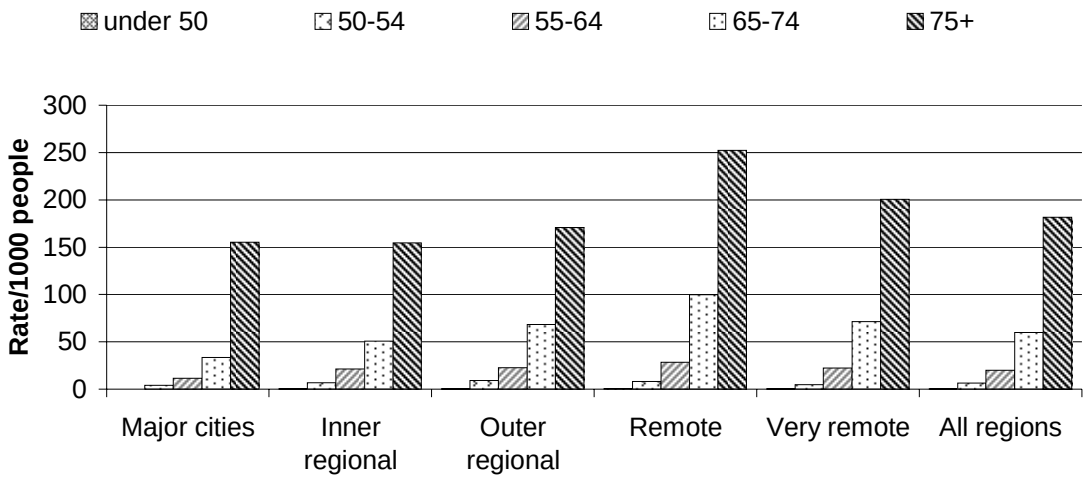



**a** Data based on AIHW analysis of the DoHA Australian Community Care Management Information System (ACCMIS) database and ABS population data. **b** Residents without a recorded RCS were omitted.

*Source*: AIHW (unpublished); table 12A.59.

The national age specific usage rates per 1000 Indigenous persons for high and low residential care and CACP in combination at 30 June 2005 is 0.3 for people under 50 rising to 181.6 for people over 75. The data show that Indigenous people tend to access these services at a younger age than the population as a whole. These rates vary by remoteness category (figure 12.6).

Figure 12.6 **Indigenous permanent residents classified as high or low care and Indigenous CACP at 30 June 2005: age specific usage rates per 1000 persons by remoteness[a, b]**




**a** Data based on AIHW analysis of ABS data and unpublished DoHA data. The Australian Standard Geographical Classification (ASGC) population figures for the Indigenous population at 30 June 2005 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.63.

### *Community care services*

Total government expenditure on HACC was $1.4 billion in 2005-06, consisting of $857.8 million from the Australian Government and $551.1 million from the State and Territory governments. The Australian Government contributed 60.9 per cent, while State and Territory governments funded the remainder (table 12A.43). Recipients of community care services may also contribute towards the cost of their care.

The Australian Government funds the CACP, EACH and EACH Dementia programs, spending $356.6 million, $65.3 million and $1.21 million respectively on the programs in 2005-06 (table 12A.46). CACPs, EACH and EACH Dementia packages are also part funded by client contributions. Australian Government expenditure data by jurisdiction 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 by jurisdiction are contained in table 12A.47.

The NRCP provides community respite services and is funded by the Australian Government. Expenditure on this program was $139.4 million in 2005-06 (table 12A.46). The DVA also provided $91.4 million for the VHC program during

2005-06 (table 12A.45), which does not include expenditure for in-home and emergency respite home care. In 2005-06:

- Commonwealth Carer Respite Centres provided an estimated 126 000 occasions of service to assist about 56 000 carers
- Commonwealth Carer Resource Centres assisted about 31 000 carers (DoHA unpublished).

A breakdown of Australian Government expenditure on the NRCP by state and territory is provided in table 12.4.

Table 12.4 **Australian Government expenditures, National Respite for Carers Program, by state and territory, 2005-06 ($million)[a, b]**

| | *NSW* | *Vic* | *Qld* | *WA* | *SA* | *Tas* | *ACT* | *NT* | *National* | *Total* |
|---|---|---|---|---|---|---|---|---|---|---|
| Commonwealth Carer Respite Centres | | | | | | | | | | |
| | 16.01 | 12.02 | 11.30 | 4.97 | 4.74 | 2.15 | 1.05 | 1.64 | – | 53.88 |
| Respite services | | | | | | | | | | |
| | 25.76 | 18.68 | 14.70 | 7.04 | 6.74 | 2.25 | 1.81 | 2.33 | – | 79.31 |
| National projects[c] | | | | | | | | | | |
| | – | – | – | – | – | – | – | – | 6.22 | 6.22 |
| Total | 41.77 | 30.70 | 26.00 | 12.01 | 11.48 | 4.40 | 2.86 | 3.97 | 6.22 | 139.41 |

**a** Commonwealth Carer Respite Centres coordinate respite services, help carers access them, and arrange individual respite when needed. **b** Respite services reports funding for services directly providing respite care. **c** National project is for Carers Australia.

– Nil or rounded to zero.

*Source*: DoHA (unpublished)

## Size and scope of sector

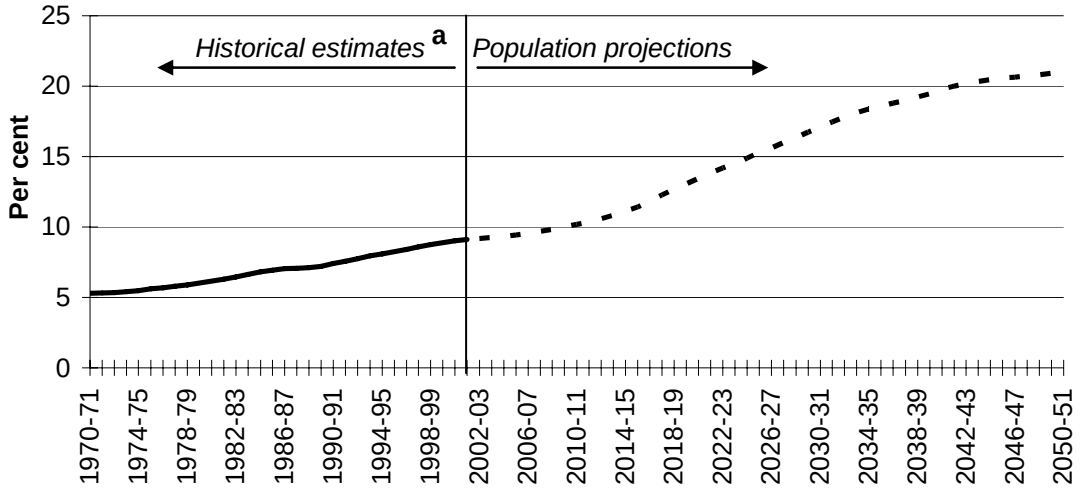
### *Size and growth of the older population*

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 12.7). The proportion of older people is 9.4 per cent nationally but varies across jurisdictions (figure 12.8). A breakdown by locality is provided in attachment table 12A.3. 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.

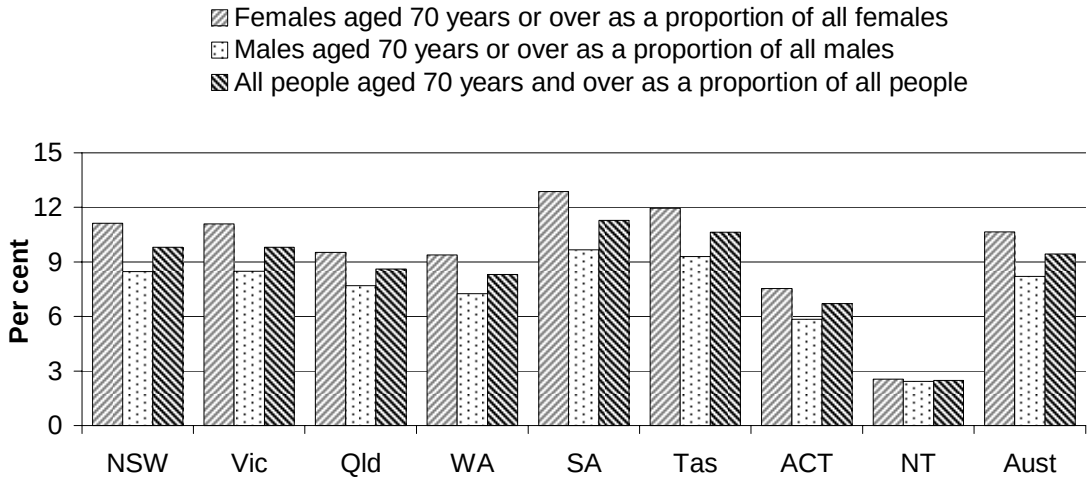
Figure 12.7 **Persons aged 70 years or over as a proportion of the total population**




**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 12.8 **Estimated proportion of population aged 70 years or over, by gender, June 2006**

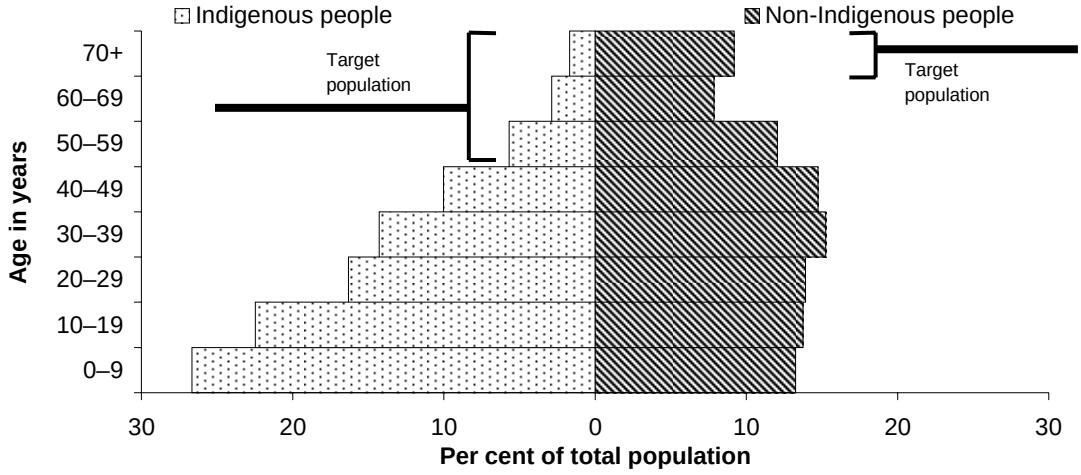



*Source*: ABS *Population* Projections by Statistical Local Area (SLA) 2002–2022 (unpublished); table 12A.1.

### *Characteristics of older Indigenous people*

The ABS estimates that about 54 100 Indigenous people were aged 50 years or over in Australia at 30 June 2006 (table 12A.2). Although the Indigenous population is also ageing, there are marked differences in the age profile of Indigenous Australians compared with non-Indigenous Australians (figure 12.9). The ABS estimates that for both males and females, life expectancy at birth in the Indigenous population is around 17 years less than in the total Australian population (2004b). These figures indicate that Indigenous people are likely to need aged care services earlier in life, compared with the general population.

Figure 12.9 **Age profile and target population differences between Indigenous and other Australians, June 2001**




*Source*: ABS (2004c).

### *Residential care services*

The size and location of residential services — which may influence the costs of service delivery — vary across jurisdictions. Nationally, there were 163 468 mainstream operational places in residential care services (72 886 in predominantly high care services, 19 293 in predominantly low care services and 71 289 in services with a mix of high care and low care residents) at June 2006 (tables 12A.6–9). These figures exclude flexible care places in a residential setting.

As the trend towards 'ageing in place' (box 12.3) increases, there has been a steady increase in the number of services categorised as providing a mix of high care and low care places. In June 2002, 30.5 per cent of all places were located in services offering both high care and low care places. This proportion increased to

36.5 per cent of places in June 2003 and then decreased to 33.4 per cent of places in June 2004, but increased to 39.6 per cent in June 2005 and 43.6 per cent in June 2006 (tables 12A.6 and 12A.9; SCRCSSP 2003; SCRGSP 2004, 2005, 2006).

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 2006, 64.9 per cent of low care services had 60 or fewer places (table 12A.8), compared with 46.9 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 2005 are included in the Report at tables 12A.57 to 12A.63.

*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**

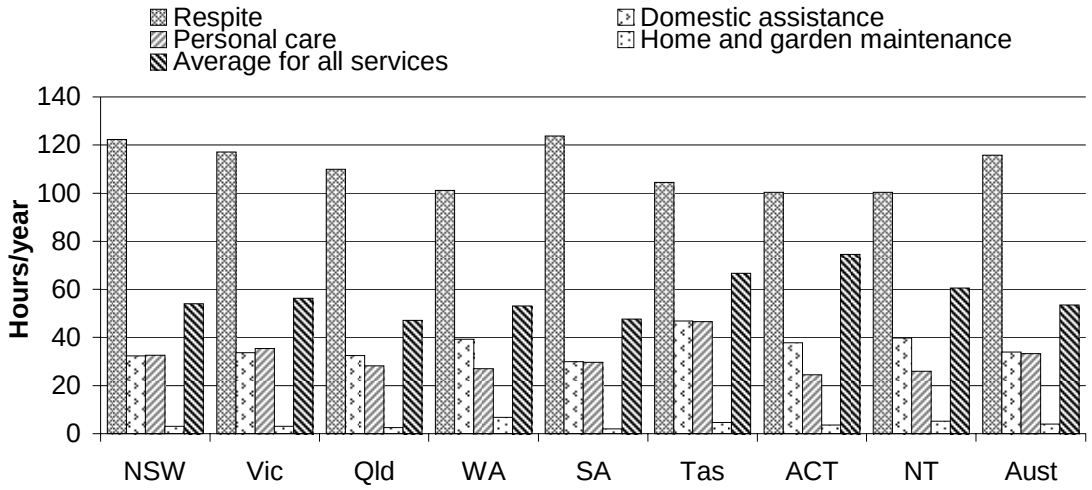
HACC services are basic maintenance and support services, including allied health care, assessment, case management and planning, centre-based day care, counselling, support, information and advocacy, domestic assistance, home maintenance, nursing, personal and respite care, social support, meals, home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

Not all HACC services are directed towards the ageing population described in this chapter. 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.

Figure 12.16 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 with nearly 12 per cent of recipients under 50 years (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 78 539 people approved for VHC services in 2005-06 (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 53.52 nationally in 2005-06 (figure 12.10).

Figure 12.10 **Average number of hours approved for Veterans' Home Care, 2005-06[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 2005-06. 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 assessed by ACATs as eligible for care equivalent to low level residential care (RCS levels 5–8). A CACP typically provides 5-6 hours of direct assistance per week. The EACH program is similar to the CACP program but targets 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 12.5.

Table 12.5 **Distinctions between the HACC, CACP and EACH programs**

| | *HACC* | *CACPs* | *EACH* |
|---|---|---|---|
| Range of services[a] | Wider 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 profound, severe and moderate disability and their carers. Not age specific. | Targets older people with care needs similar to low level residential care | Targets older people with care needs similar to high level residential care |
| Size of program | $1.4 billion funding in 2005-06 | $356.6 million funding in 2005-06 | $65.3 million funding in 2005-06 |
| | At least 793 472 clients in 2005-06[c] | 35 316 operational places at 30 June 2006 [d] | 2575 operational places at 30 June 2006 |

[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 83 per cent of HACC funded agencies that submitted Minimum Data Set data for 2005-06. Consequently, the total number of clients will be higher than those reported here. [d] Excludes flexible care delivered in a community setting.

*Source*: DoHA (unpublished).

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 2005-06, the HACC program delivered approximately 12 194 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 2002 and June 2006, from 14.7 to 17.8 (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 (see 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 wellbeing and independence of frail older people and their carers through the funding and delivery of care services that are:

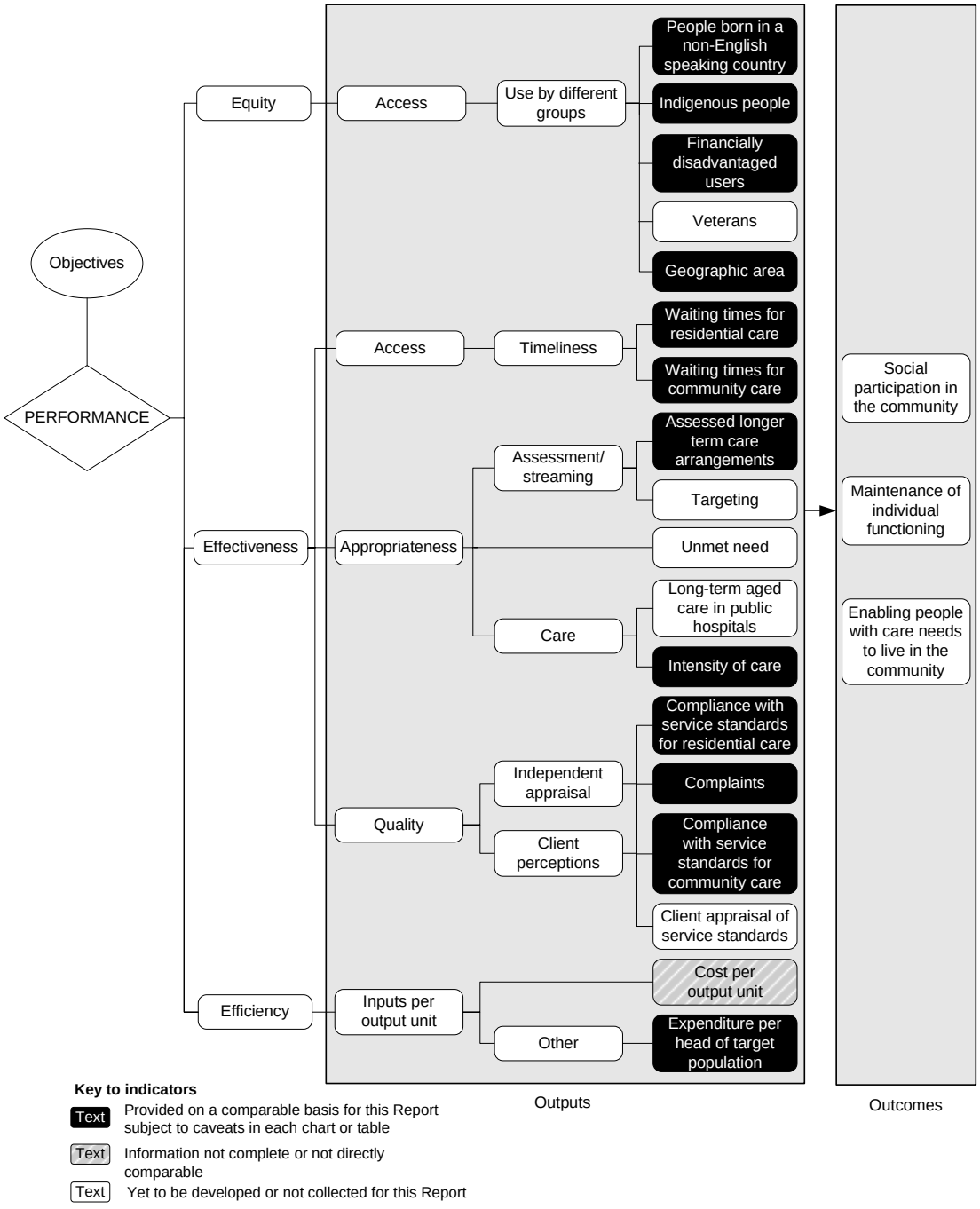
- accessible
- appropriate to needs
- high quality
- efficient.

The performance indicator framework shows which data are comparable in the 2007 Report (figure 12.11). 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 12.11 **Performance indicators for aged care services**



## Outputs

*Equity — Access*

*Use by different groups*

'Use by different groups' is 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, using the following definitions:

- 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 benchmarked against the rate at which the general population accesses the service
- 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) benchmarked against the rate at which the general population accesses the service
- 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.

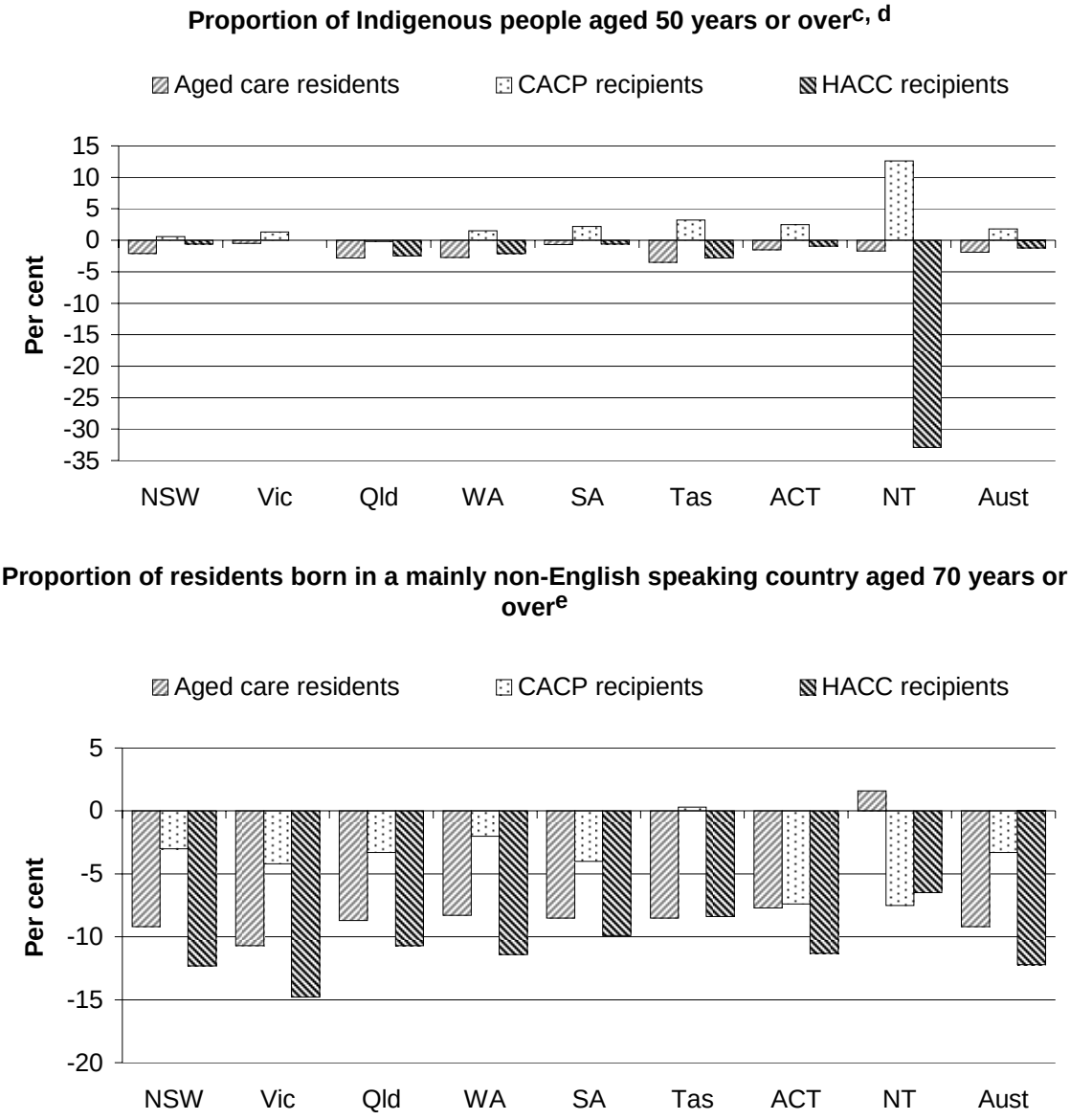
Several factors need to be considered in interpreting the results for this set of indicators:

- 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 by recipients from special needs groups*

The proportion of Indigenous aged care recipients and those born in a mainly non-English speaking country accessing aged care services at 30 June 2006, with the exception of the NT, was lower across the jurisdictions than their proportion of the population as a whole. Figure 12.12 reflects the variation in the rate of access of the special needs target population from their proportion in the population as a whole. If the special needs group accessed services at the same rate as the general population, all bars in the chart would be at zero. If they access services at a greater rate the bar would be positive, if they access services as a lower rate, the bar would be negative (figure 12.12). Care should be taken in interpreting this figure as the magnitude of variations are also influenced by the proportion of the special needs group in the population as a whole (table 12A.18).

Figure 12.12 **Variation in the rate of access of the special needs target population from their proportion in the population as a whole, June 2006 (per cent)[a, b]**



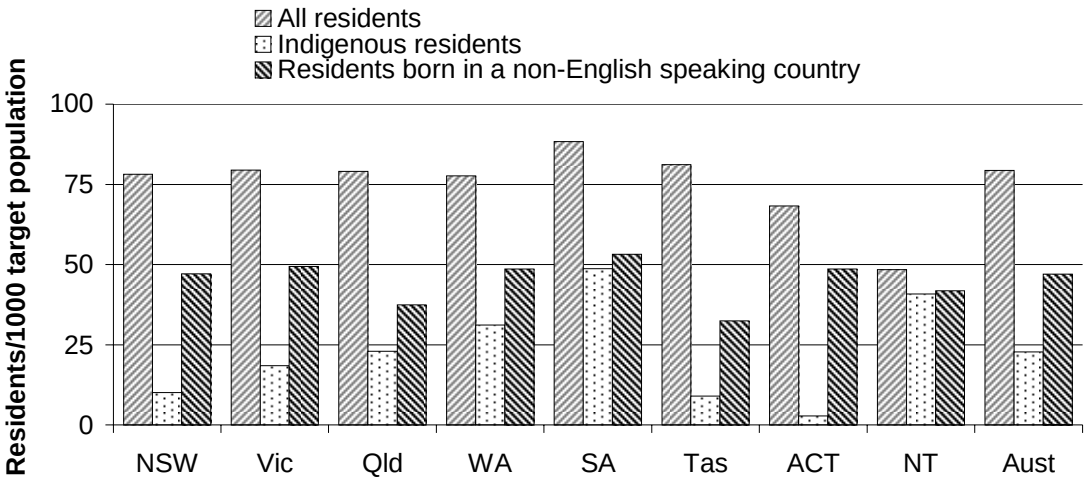

**a** The proportion of a HACC agencies that submitted data for the year varied between jurisdictions and actual service levels were higher than stated. **b** Reports provisional HACC data that have not been validated and may be subject to revision. **c** Charts Indigenous aged care residents, CACP recipients and HACC clients as a proportion of all aged care residents, CACP recipients and HACC clients respectively. **d** The magnitude of the variation in the NT partly reflects the relatively large proportion of Indigenous people in the population. **e** Charts aged care residents, CACP recipients and HACC clients from a non-English speaking country as a proportion of all aged care residents, CACP recipients and HACC clients respectively.

*Source*: DoHA (unpublished); tables 12A.18.

In all jurisdictions at 30 June 2006, 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 47.0 per thousand of the relevant target populations respectively), compared with the population as a whole (79.3 per thousand) (figure 12.13).

Figure 12.13 **Residents per 1000 target population, 30 June 2006**[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.

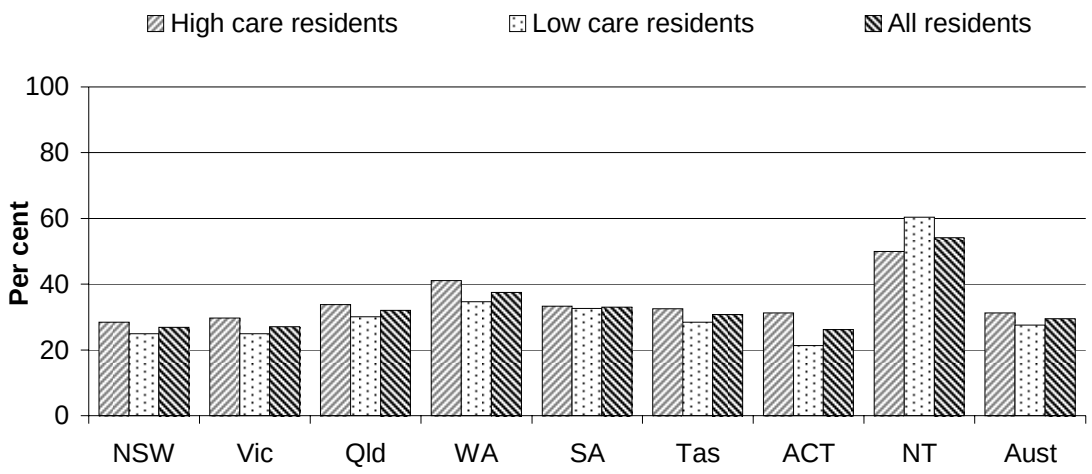
*Source*: DoHA (unpublished); tables 12A.12, 12A.14 and 12A.16.

Age specific usage rates for these services, by jurisdiction and remoteness are included in the Report. These data suggest there is significant variation in usage rates by remoteness area. In general, differences amongst jurisdictions are less marked than differences between remoteness area (tables 12A.13, 12A.15, 12A.17, 12A.57, 12A.59, 12A.60, 12A.62 and 12A.63).

*Access to services by financially disadvantaged users*

The proportion of all new residents classified as concessional or assisted residents during 2005-06 was 29.5 per cent nationally but varied across jurisdictions (figure 12.14). A decline in the proportion of concessional and assisted residents over the past few years is due to the Australian Government concessional validation program which finished on 30 June 2005 and since then to assets testing undertaken by Centrelink and the Department of Veterans' Affairs.

Figure 12.14 **New residents classified as concessional or assisted residents, 30 June 2006[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.

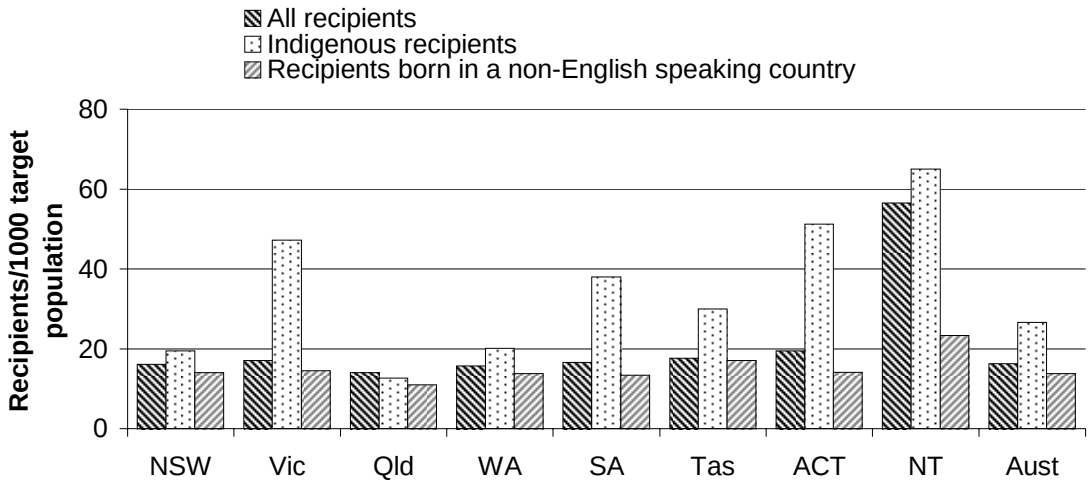
*Source*: DoHA (unpublished); table 12A.19.

### *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 2006, 16.3 per 1000 of the target population received CACP services compared with 79.3 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 26.6 nationally and the numbers of CACP recipients from non-English speaking countries per 1000 of the relevant target population was 13.8 nationally (figure 12.15).

Figure 12.15 **Community Aged Care Package recipients per 1000 target population, 30 June 2006**[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, remoteness and Indigenous usage 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.58–64).

*Access to the Home and Community Care program*

Home and Community Care services are provided in the client's home or community for people with a severe, profound or moderate disability and their carers. The focus of this chapter is people 70 years and over and Indigenous people aged over 50.

The proportion of HACC recipients aged 70 years or over during 2005-06 was 68.2 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 12 194 nationally, and the number of meals provided per 1000 people aged 70 years or over plus Indigenous people aged 50–69 was 5380 nationally (table 12.6). 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 12.6 **HACC services received, 2005-06 (per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years)[a, b, c]**

| | *Unit* | *NSW* | *Vic* | *Qld* | *WA* | *SA*[d] | *Tas* | *ACT* | *NT* | *Aust* |
|---|---|---|---|---|---|---|---|---|---|---|
| Percentage of agencies that reported MDS data | % | 81 | 90 | 91 | 97 | 89 | 83 | 100 | 94 | 86 |
| Total hours[e] | | | | | | | | | | |
| Major cities | hrs. | 8 582 | 13 950 | 11 940 | 16 797 | 9 083 | .. | 10 750 | .. | 11 621 |
| Inner regional | hrs. | 9 190 | 19 462 | 10 597 | 16 458 | 6 953 | 10 179 | .. | .. | 12 420 |
| Outer regional | hrs. | 10 888 | 27 887 | 11 004 | 17 906 | 6 927 | 9 852 | .. | 7 544 | 13 130 |
| Remote | hrs. | 13 963 | 27 675 | 11 736 | 16 934 | 13 430 | 12 538 | .. | 23 083 | 14 950 |
| Very remote | hrs. | 9 717 | .. | 16 052 | 21 404 | 26 886 | 26 721 | .. | 52 365 | 25 232 |
| **All areas** | hrs. | **8 522** | **16 114** | **11 533** | **16 976** | **8 840** | **10 216** | **10 770** | **20 625** | **12 194** |
| Total meals[f] | | | | | | | | | | |
| Major cities | no. | 4 491 | 5 328 | 5 289 | 5 686 | 957 | .. | 3 873 | .. | 4 637 |
| Inner regional | no. | 6 687 | 8 832 | 5 455 | 5 928 | 477 | 5 475 | .. | .. | 6 407 |
| Outer regional | no. | 8 089 | 8 879 | 5 419 | 5 376 | 1 435 | 7 040 | .. | 9 132 | 6 346 |
| Remote | no. | 7 605 | 5 028 | 5 493 | 7 405 | 1 875 | 5 826 | .. | 18 994 | 6 739 |
| Very remote | no. | 1 791 | .. | 8 844 | 19 769 | 8 456 | 7 813 | .. | 53 066 | 19 738 |
| **All areas** | no. | **5 295** | **6 333** | **5 430** | **6 064** | **1 041** | **6 022** | **3 882** | **20 866** | **5 380** |

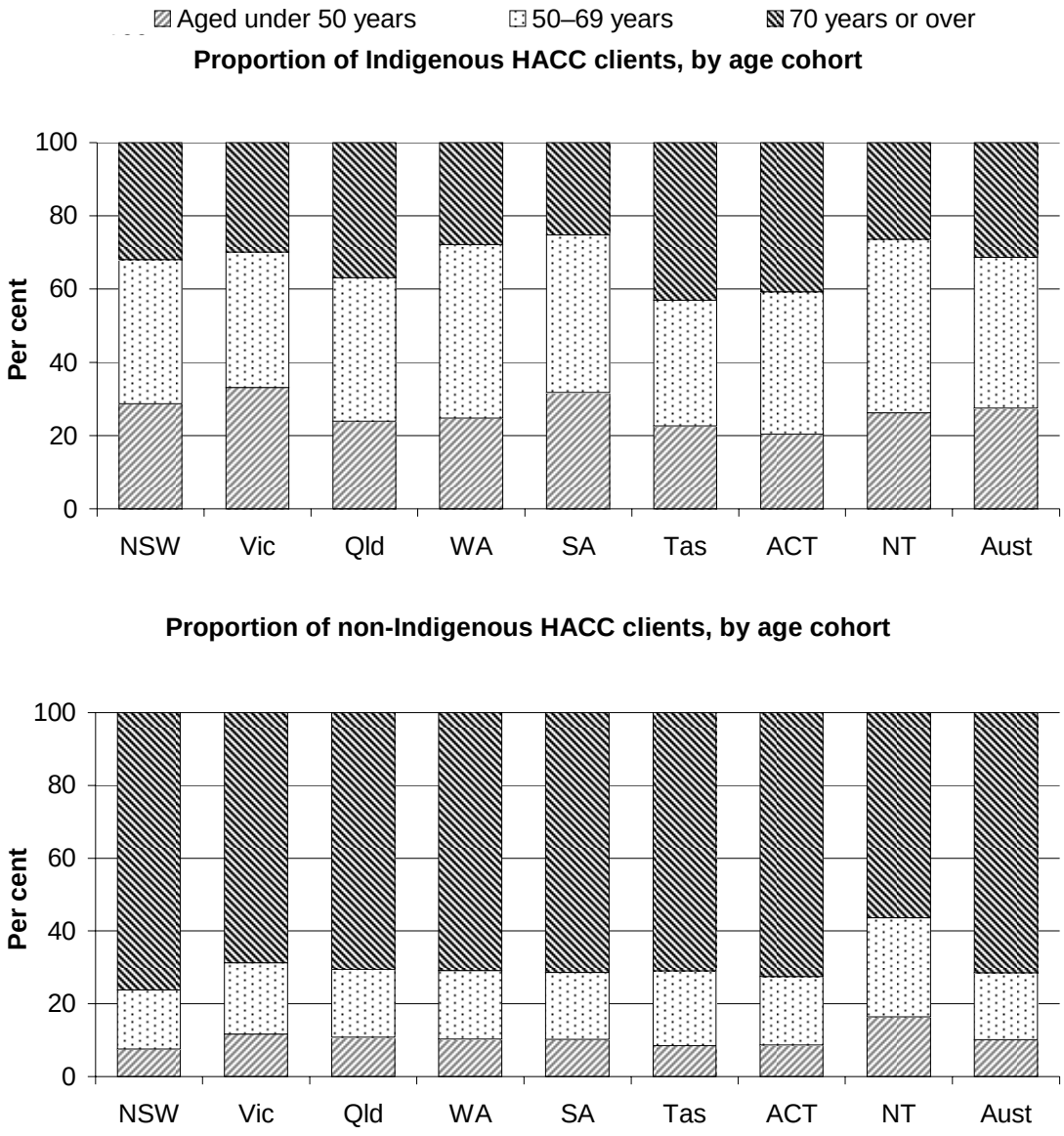
**a** Data represent HACC services received by people aged 70 years or over plus Indigenous people aged 50–69 years (tables 12A.20–12A.25) as distinct from HACC services received by HACC target population in all age groups (tables 12A.26–12A.31). **b** The proportion of HACC agencies that submitted data for the year varied between jurisdictions and actual service levels were higher than stated. **c** Reports provisional HACC data that have not been validated and may be subject to revision. **d** The number of meals may be understated in SA due to slow implementation of the Minimum Data Set by Meals on Wheels. **e** See table 12A.20 for a full list of categories. **f** 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 2005-06. This reflects the difference in morbidity and mortality trends between Indigenous people and the general population. The proportion of Indigenous HACC clients who are aged 70 years and over is 31.3 per cent and the proportion of non-Indigenous HACC clients who are aged 70 years and over is 71.5 per cent (figure 12.16). The high rate of missing data for Indigenous people will also inflate the figures presented.

Figure 12.16 **Recipients of HACC services by age and Indigenous status, 2005-06[a]**




**a** Reports provisional HACC data that have not been validated and may be subject to revision.

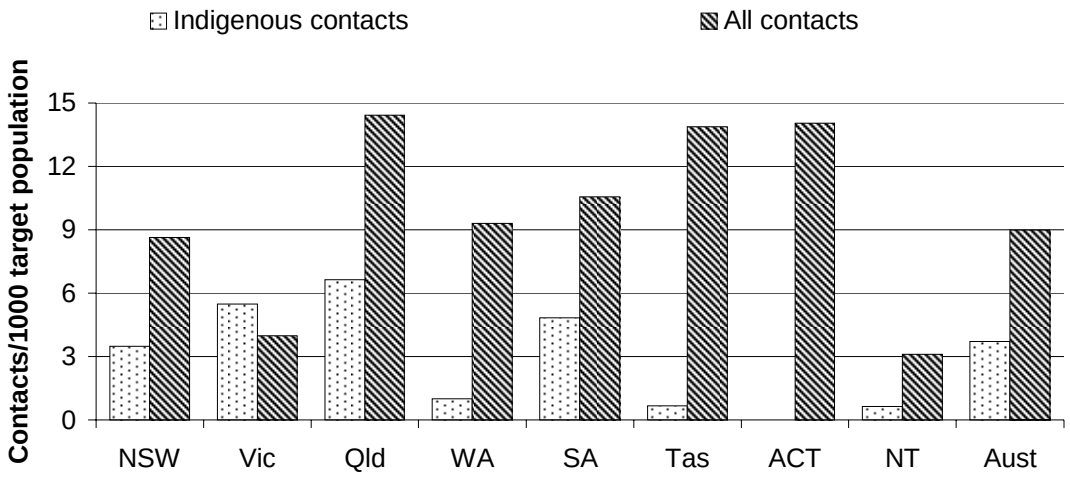
*Source*: DoHA (unpublished); table 12A.33.

## *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 2006, was 3.7 people per 1000 Indigenous people in the target population. The rate for all Australians was 9.0 per 1000 people in the target population. These figures varied across jurisdictions (figure 12.17).

Figure 12.17 **Commonwealth Carelink Centres, contacts per 1000 target population, by Indigenous status, 30 June 2006[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 people in the target population. **c** All contacts refers to contacts per 1000 target population.

*Source*: DoHA (unpublished); table 12A.55.

### *Effectiveness*

#### *Timeliness of access — waiting times for residential care*

The indicator 'waiting times for residential care' is 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.

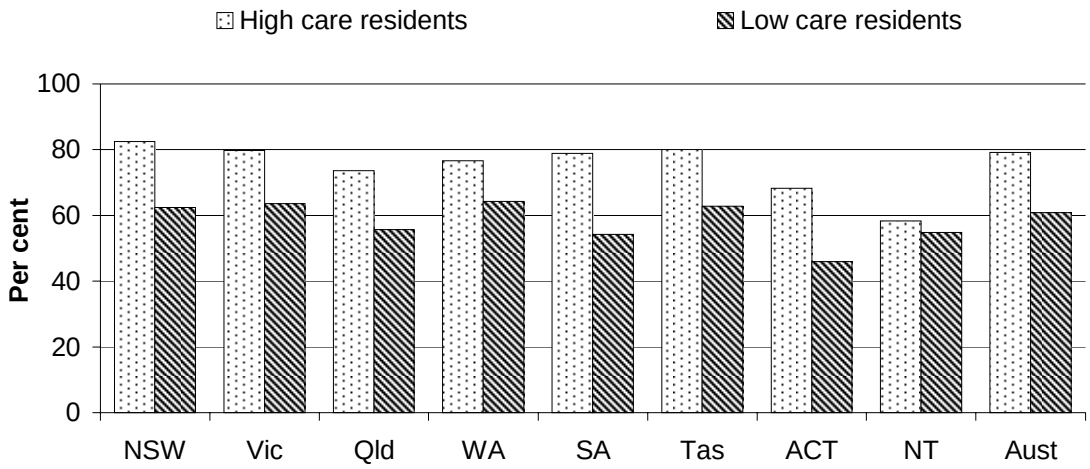
The AIHW found that many factors affect the entry period but are not linked to the performance of the aged care system. It recommended that the entry period for residential care not be used as a performance indicator.

*Source*: AIHW (2002).

Overall, 72.0 per cent of all people entering residential care during 2005-06 did so within three months of being assessed by an ACAT, and 45.8 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 (79.2 per cent), compared with the proportion entering low care residential services within that time (60.9 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 12.18).

Figure 12.18 **People entering residential care within three months of their ACAT assessment, 2005-06**




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

*Timeliness of access — waiting times for community care*

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

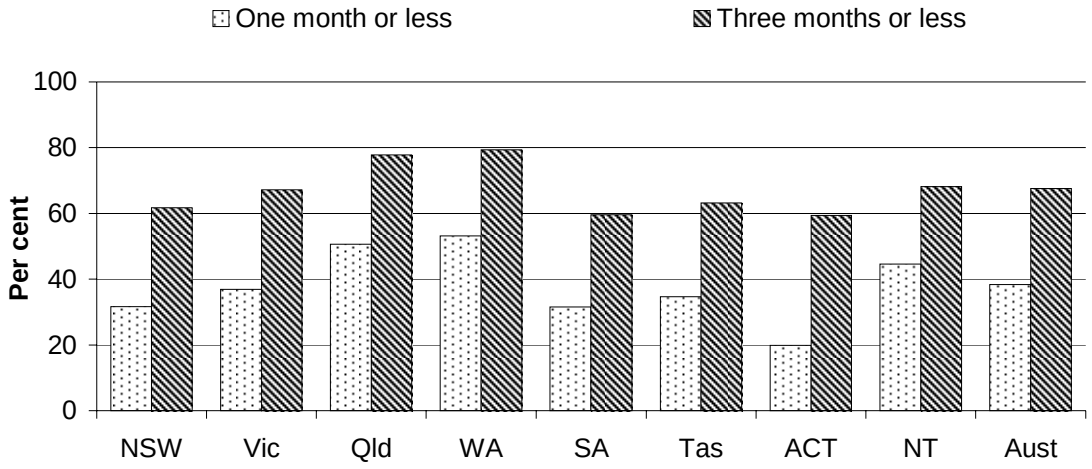
Box 12.9 **Waiting times for community care**

'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 considered 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.

Overall, 67.6 per cent of all people receiving a CACP during 2005-06 received it within three months of being assessed by an ACAT. This proportion varied across jurisdictions (figure 12.19). On average, 38.4 per cent started receiving a CACP within one month of their ACAT assessment (table 12A.36).

Figure 12.19 **People commencing a CACP within one or three months of their ACAT assessment, 2005-06**




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

*Appropriateness — assessed longer term care arrangements*

The indicator 'assessed longer term arrangements' is an output indicator of effectiveness (box 12.10) that measures the proportion of clients referred to community care, compared to residential care.

Box 12.10 **Recommended longer term living arrangements**

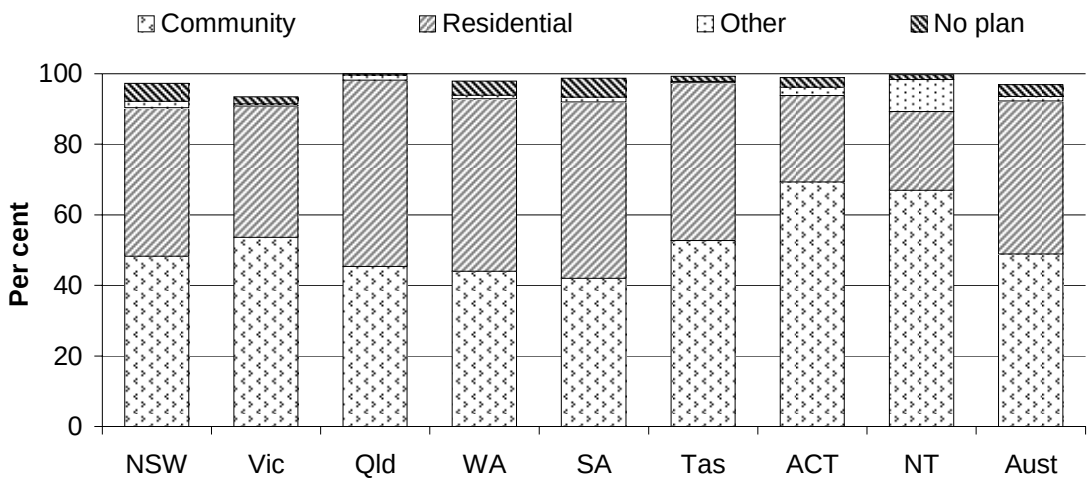
'Assessed longer term living arrangements' is an indicator of appropriateness. The purpose is to measure how effectively clients are allocated to the services that best meet their needs.

This indicator is defined as the proportion of ACAT clients recommended to remain at home or in 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 2004-05 was 43.4 per cent and the proportion remaining in the community was 48.9 per cent. No long term plan was made for 3.3 per cent, which included deaths, cancellations and transfers. These proportions vary across jurisdictions (figure 12.20).

Figure 12.20 **Recommended longer term living arrangements of ACAT clients, 2004-05[a]**




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

*Source*: DoHA (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' is 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.

Persons aged 65 years or over and who were 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 12.7).

Table 12.7 **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 2003 Survey of Disability, Ageing and Carers.

*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' is an output indicator of effectiveness (box 12.14).

Box 12.14 **Intensity of care**

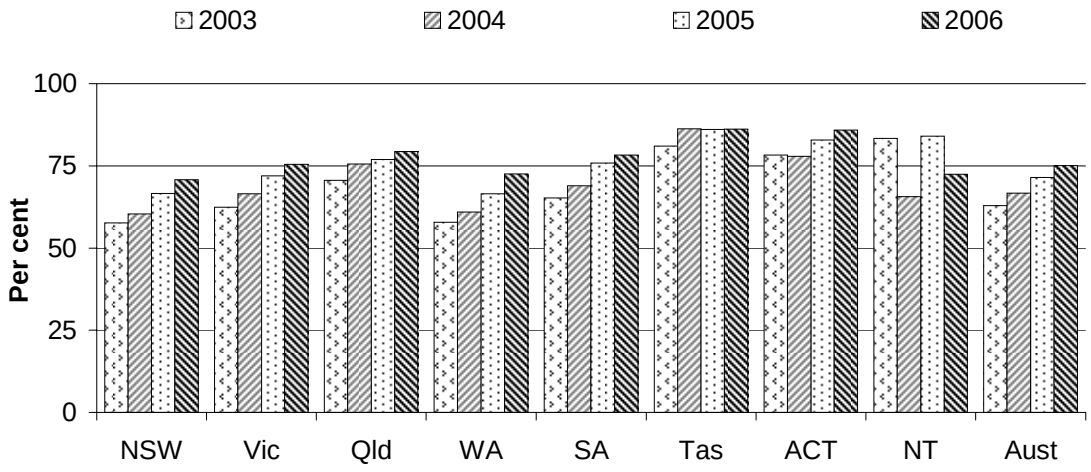
'Intensity of care' is an indicator of appropriateness, reflecting the proportion of residents who remain in the same residential aged care facility as their care needs increase from low care to high care. The Aged Care Act aims explicitly to encourage 'ageing in place' to increase choice and flexibility 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 12.22).

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 2003 to June 2006, 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 62.9 per cent to 75.0 per cent nationally (figure 12.21). In June 2006, the proportion was higher in inner regional areas (79.8 per cent), outer regional areas (78.2 per cent) and remote areas (86.1 per cent) than in major cities (72.6 per cent) and very remote areas (68.0 per cent) (table 12A.53).

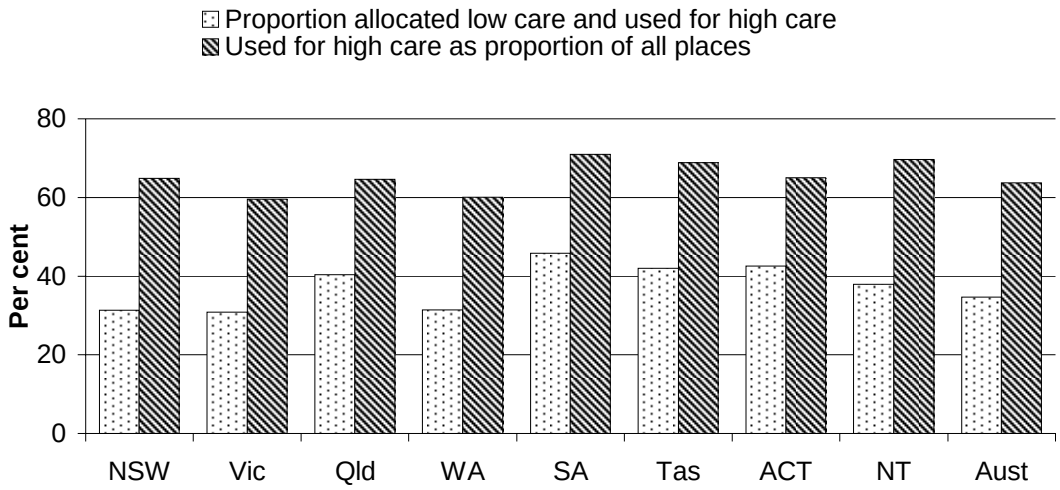
Figure 12.21 **Proportion of residents who changed from low care to high care and remained in the same aged care service, June**




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

Nationally, 34.7 per cent of low care places in 2005-06 were occupied by residents with high care needs (figure 12.22). These data are provided by remoteness area in table 12A.56.

Figure 12.22 **Utilisation of operational residential places, 30 June 2006**




*Source*: DoHA (unpublished); table 12A.56.

*Quality — compliance with service standards for residential care*

The indicator 'compliance with service standards for residential care' is 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 three year accreditation are desirable.

(Continued on next page)

Box 12.15 **(Continued)**

There are three steps in the accreditation process.

- A residential service applies for accreditation to the Aged Care Standards and Accreditation Agency (ACSAA), based on a self-assessment of performance against the accreditation standards.
- A team of registered quality assessors reviews the application, conducts an onsite assessment of the residential service and prepares a report based on observations of the living environment, care practices and relevant documentation such as care plans. Residents, relatives, staff and management are also interviewed.
- An authorised decision maker from ACSAA then considers the report, in conjunction with any submission from the residential service and other relevant information (including information from DoHA) and decides whether to accredit and, if so, for how long.

The number of residents per room is also an output indicator of quality. Lower rates of residents per room are generally desirable because they imply a higher service quality of accommodation.

As part of the Australian Government's certification requirements for residential aged care buildings, by 31 December 2008 every service that existed prior to July 1999 will be required to have no more than four residents accommodated in any room, no more than six residents sharing each toilet and no more than seven residents sharing each shower. For new buildings since July 1999, an average for the whole service of not more than 1.5 residents per room is required. No room may accommodate more than two residents, there must be no more than three residents per toilet and no more than four residents per shower or bath.

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). The accreditation process is summarised in box 12.15.

At 30 June 2006, 92.8 per cent of residential aged care services had been granted an accreditation approval for a period of three years or more. This proportion varied across jurisdictions (table 12.8).

Table 12.8 **Accreditation decisions on residential aged care services, 30 June 2006[a]**

| | *Unit* | *NSW* | *Vic* | *Qld* | *WA* | *SA* | *Tas* | *ACT* | *NT* | *Aust* |
|---|---|---|---|---|---|---|---|---|---|---|
| Accreditation period | | | | | | | | | | |
| <2 years | % | 1.6 | 3.5 | 5.2 | 1.4 | 5.8 | 3.3 | – | 6.7 | 3.2 |
| 2 years or more but <3years) | % | 3.2 | 2.7 | 5.8 | 2.5 | 6.5 | 5.6 | 13.0 | 13.3 | 3.9 |
| 3 years or more | % | 95.2 | 93.8 | 89.0 | 96.0 | 87.7 | 91.1 | 87.0 | 80.0 | 92.8 |
| **Total** | **%** | **100.0** | **100.0** | **100.0** | **100.0** | **100.0** | **100.0** | **100.0** | **100.0** | **100.0** |
| Accredited services | no. | 936 | 818 | 501 | 278 | 276 | 90 | 23 | 15 | 2 937 |

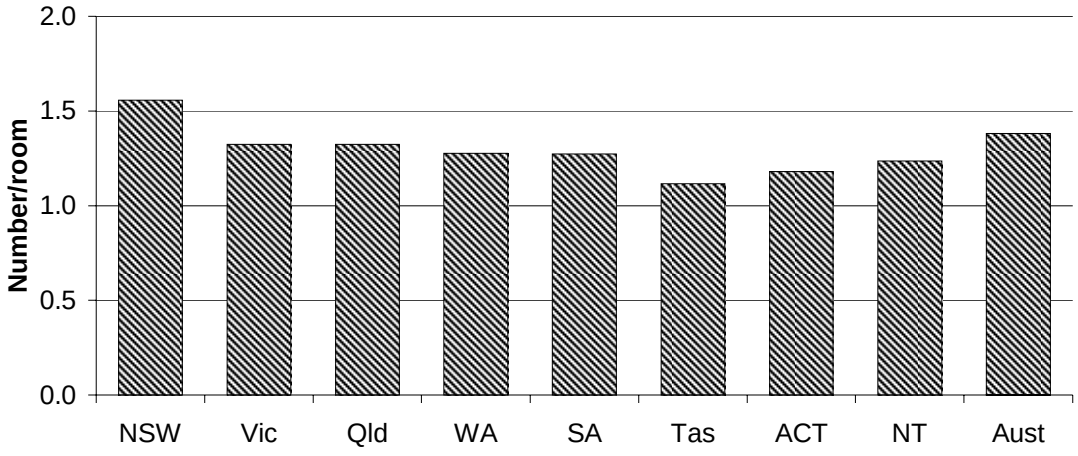
**a** NT data will be variable due to small numbers.

– Nil or rounded to zero.

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

Existing services are required to meet privacy and space requirements by 2008. Since 2001 all new services must meet these targets from the time of construction. The average number of residents per room at July 2006 was 1.38 nationally (figure 12.23).

Figure 12.23 **Average residents per room in residential aged care facilities, July 2006**




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

*Quality — complaints*

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

Box 12.16 **Complaints**

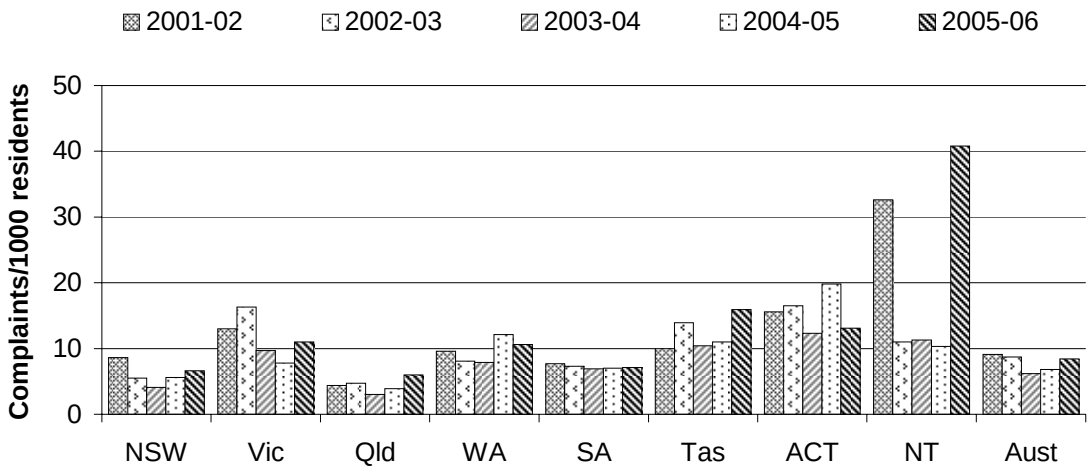
'Complaints' is used in this report as an indicator of the quality of care. The purpose of the indicator is to monitor the level of complaints received by the Complaints Resolution Scheme in each State and Territory. If service recipients make official complaints, they may be dissatisfied with an element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

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 2005-06, the Complaints Resolution Scheme received approximately 1260 new complaints, compared with 1004 in 2004-05 (table 12A.41). The number of complaints registered per 1000 residents in 2005-06 was 8.4 nationally. This varied across jurisdictions (figure 12.24).

Figure 12.24 **Aged Care Complaints Resolution Scheme complaints per 1000 residents[a]**




**a** NT data will be variable due to small numbers. The number of complaints varied from 4 to 16.

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

*Quality — compliance with service standards for community care*

The indicator 'compliance with service standards for community care' is 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.

A total of 3207 HACC agencies were identified for appraisal over the three year cycle 2001-02 to 2003-04. The number of these agencies appraised was 2711 (85 per cent). This proportion varied across jurisdictions (table 12.9). The outcomes of these appraisals was a national average score of 16.0 out of 20 (table 12.10). 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 12.9 **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*[g] | *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] Reports provisional data that have not been validated and may be subject to revision. 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 there were 730 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. [g] NT data are variable due to small numbers.

*Source*: State and Territory governments (unpublished).

Table 12.10 **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] Reports provisional data that have not been validated and may be subject to revision. 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.64.

*Source*: State and Territory governments (unpublished); table 12A.64.

### *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).

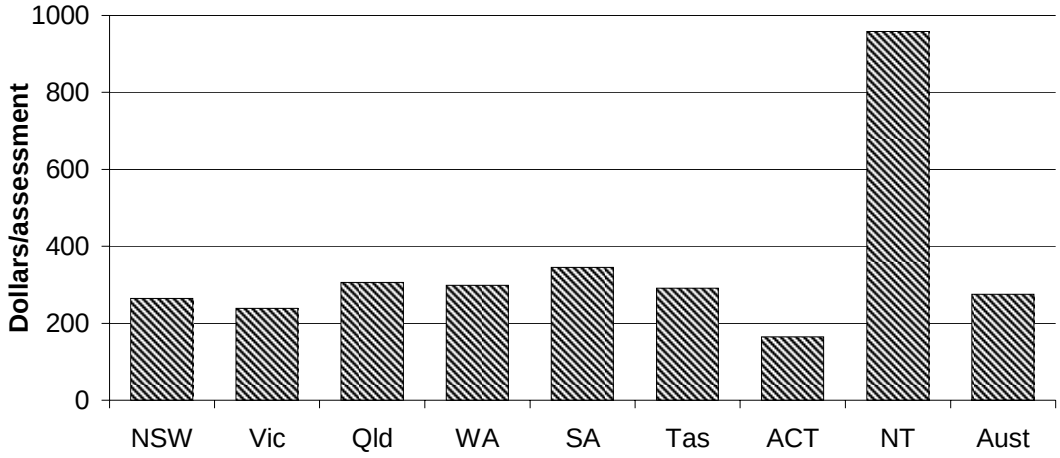
Box 12.19 **Cost per output unit**

A proxy efficiency indicator, 'cost per assessment', has been developed as work in progress to measure 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). This indicator includes only Australian Government expenditure, although states and territories also contribute to the cost of ACAT assessments.

Cost per aged care assessment during 2004-05 averaged $275 nationally (figure 12.25). The cost per assessment is calculated using the total number of assessments and also includes clients aged less than 70 years.

Figure 12.25 **Aged care assessment unit costs, 2004-05 (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); table 12A.54.

*Inputs per output unit — expenditure per head of target population*

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

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

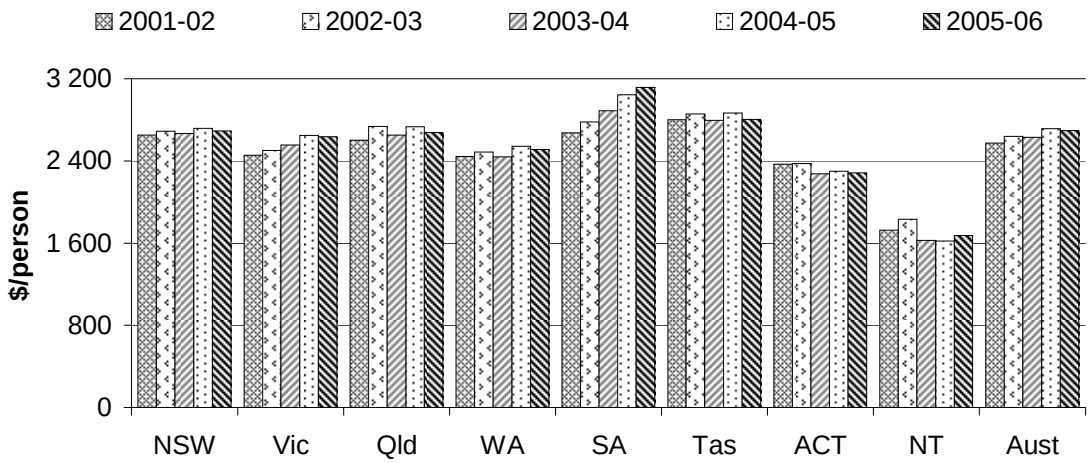
A proxy indicator of efficiency is 'expenditure per head of target population'. It reflects the objective of ensuring services for frail older people are provided efficiently. The indicator is defined as government inputs (expenditure) divided by the number of people aged 70 years or over plus Indigenous 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 $2574 (in 2005-06 dollars) in 2001-02 to $2694 in 2005-06. This figure varied across jurisdictions (figure 12.26).

Figure 12.26 **Australian Government (DoHA and DVA) real expenditure on residential services per person aged 70 years or over plus Indigenous people aged 50–69 years (2005-06 dollars)[a, b]**

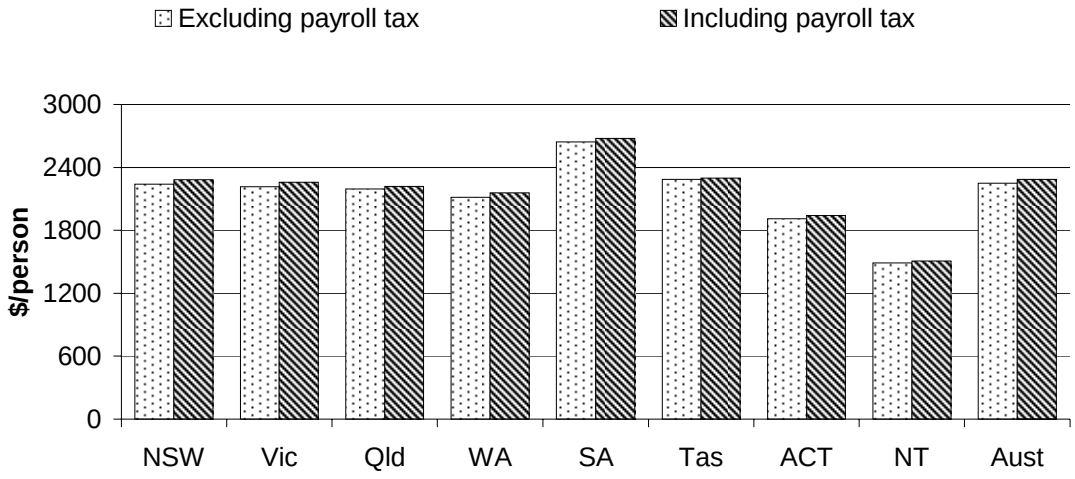



**a** Includes payroll tax. **b** Includes expenditure by DVA.

*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 $2287 nationally (including payroll tax) and $2250 nationally (excluding payroll tax) in 2005-06. These rates varied across jurisdictions (figure 12.27). DVA expenditure on residential aged care in 2005-06 was $806.5 million nationally (including payroll tax) and $792.3 million (excluding payroll tax) (table 12A.44).

Figure 12.27 **Australian Government (DoHA) expenditure on residential aged care, per person aged 70 years or over plus Indigenous people aged 50–69 years, 2005-06[a]**

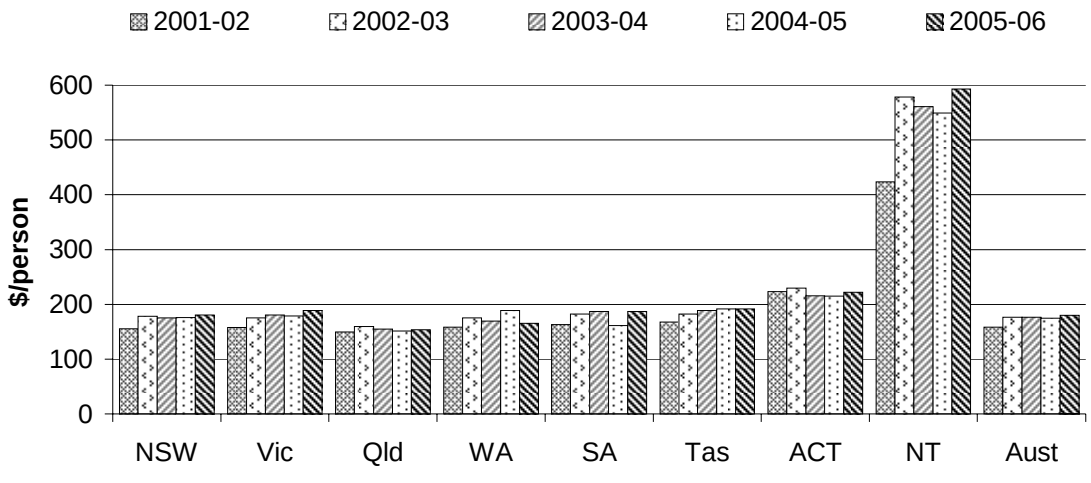



**a** Data in this table exclude DVA expenditure on residential aged care.

*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 2005-06. Nationally, real expenditure per person aged 70 years or over plus Indigenous people aged 50–69 years increased from $158 (in 2005-06 dollars) in 2001-02 to $180 in 2005-06 (figure 12.28).

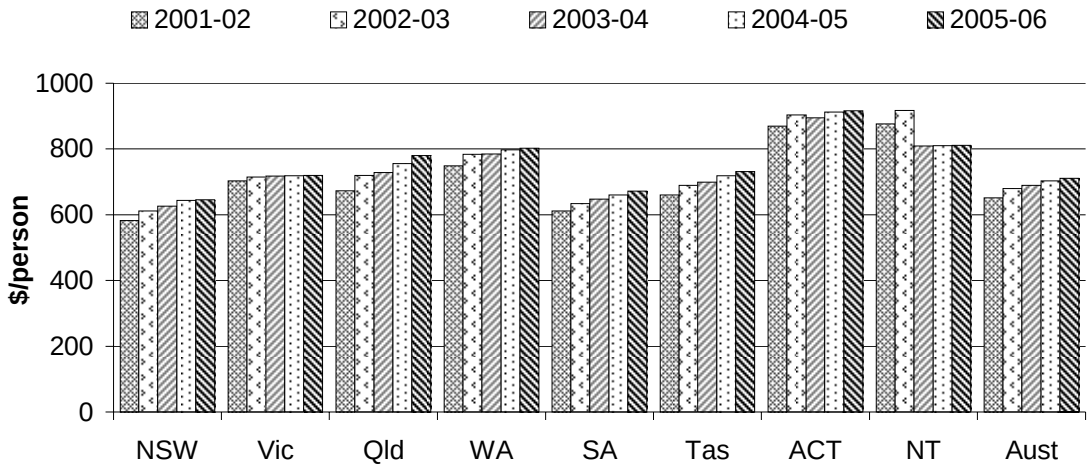
Figure 12.28 **Australian Government real expenditure on CACP services per person aged 70 years or over plus Indigenous people aged 50–69 years (2005-06 dollars)**




*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 $652 (in 2005-06 dollars) in 2001-02 to $711 in 2005-06 (figure 12.29). 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 12.29 **Australian, State and Territory government real expenditure on HACC services per person aged 70 years or over plus Indigenous people aged 50–69 years (2005-06 dollars)[a, b, c]**




**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. **c** Reports provisional HACC data that have not been validated and may be subject to revision.

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

## Outcomes

Three outcomes indicators have been identified for development and reporting in future:

- social participation in the community (box 12.21)
- maintenance of individual functioning (box 12.22)
- enabling people with care needs to live in the community (box 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 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

“Access to and appropriateness of aged care services continued to improve during 2005-06. At 30 June 2006 there were 204 869 operational aged care places, exceeding the Australian Government’s target of 200 000 places in 2006, set in 2001. This represents 105.8 places for every 1 000 people aged 70 and over, up from 102.4 in June 2005. Growth is on track to reach 108 operational places per 1 000 people aged 70 and over in 2007.

Growth was fastest in community care with an 18 per cent increase during the year. This reflects the Australian Government’s response to older people’s preference to remain at home while receiving care, wherever possible. The 2005-06 financial year also saw the introduction of the Extended Care at Home Dementia (EACH-D) program, which provides care packages to those at the highest end of the community care continuum. EACH-D packages assist people with dementia who experience difficulties in their daily life because of behavioural and psychological symptoms associated with their dementia.

The Transition Care Program commenced delivery of services during 2005-06. The program is a collaborative undertaking between the Australian Government and states and territories that provides time limited support and therapy focused care to older people who have just completed a hospital stay. 2000 Transition Care places will be allocated by June 2007.

During 2005-06 providers undertook some $2.2 billion worth of improvements to building quality in residential aged care, involving 25 per cent of all homes. Of this, $771 million was spent on new buildings. 95 per cent of aged care homes now meet the 2008 Certification privacy and space standards.

Quality in residential care will be further improved through a $90.2 million package of reforms that includes more robust complaints and compliance arrangements and a new Office for Aged Care Quality and Compliance, with enhanced powers and responsibilities. With other initiatives announced in the 2006-07 Budget, the value of the Australian Government’s response to allegations of abuse of the elderly in aged care will be more than $100 million over 4 years.

The Australian Government’s Veterans’ Home Care (VHC) program has been enormously successful since it was established in 2001. However, the veteran cohort is ageing and becoming frailer and an increasing number of war widows are entering the program. To address these issues, the Australian Government will be conducting an independent review of the VHC program in 2007 to identify any changes necessary to ensure that the program continues to meet the needs of veterans and war widows/widowers over the coming years.”

## New South Wales Government comments

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- The NSW Government continues its commitment to providing services to older people and their carers which maximise their independence and participation in community life, promote their health and wellbeing and provide information and support to enable them to access appropriate services.
- In 2005-06 NSW continued to expand the Home and Community Care (HACC) Program with the allocation of $30 million in additional funding, bringing the total HACC budget to more than $448 million. This included $21 million for additional services, of which 10 per cent were designed for people with dementia and 30 per cent were for older people in disadvantaged communities. These additional services had a continuing emphasis on basic support including domestic assistance, personal care, transport, centre-based day care and respite.
- The NSW government has been providing high quality services to the people in need. A recent customer satisfaction survey by an independent market research company of Home Care Services the largest HACC service providers in NSW, found that 94 per cent of those surveyed were satisfied with the service they received, with 67 per cent highly satisfied.
- NSW has commenced the Transitional Aged Care program, which aims to help reduce hospital length of stay and readmission rates for older people, and the premature admission to long-term residential aged care.
- The Clinical Services Redesign program has seen a number of clinical service systems undergo significant redesign to provide a better focus on patients. Integrating models of care and management of older people and people with chronic disease will be particularly addressed in the coming year.
- NSW Health continues to invest in innovative aged care services such as Aged Care Service Evaluation Teams (ASETS) in public hospitals, Emergency Medical Units (EMUs) and COMPACKS, brokering packages of community care. These are in addition to the comprehensive range of acute, community, rehabilitation, mental health and geriatric services targeting older people. During 2005, ASETs assessed 42 369 older people in NSW Emergency Departments enabling the identification of health and social issues that informed care planning and risk minimisation, 39 per cent of these people could be discharged directly from the Emergency Department.
- NSW also promotes active participation of carers in the health service through continued funding of the NSW Carers Program. The program has funded 71 Non Government Organisations (NGOs) to provide direct education and support through one off local carer grants of 1–3 years duration, with some specifically targeting carers of older people.

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## Victorian Government comments

“During 2005-06 Victoria has continued to emphasise innovation in responding to age care challenges. New initiatives and enhancements have built on the foundations of Victoria’s long-standing emphasis on community-based care, supported by public sector involvement in residential aged care.

In assessment, a framework for assessment in HACC has been developed that aims to improve the consistency and quality of assessments in the HACC Program. The framework incorporates the agreed ‘common arrangements’ that are part of the Commonwealth’s community care reforms and aims to ensure assessments are responsive to special needs groups such as CALD clients, Aboriginal clients and younger people with disabilities. Victoria has also commenced the pilot of an electronic comprehensive assessment tool for older people, the InterRAI Home Care. ACAS managers in Victoria have identified the use of a common assessment tool as a key factor in improving the quality and consistency of ACAS assessments.

The Victorian dementia framework Pathways to the Future, 2006 and Beyond — Dementia Framework for Victoria, and an Implementation Plan 2006–08 were launched in April 2006. This was accompanied by expanded funding for dementia services and projects.

The DHS policy framework Recognising and supporting care relationships was launched in August 2006, supported by three action plans from Disability Services, Mental Health, and for older people.

New programs to assist supported residential services and people in insecure accommodation were introduced during the year including assertive outreach, HACC, dental and mental health services targeted to people who are homeless or living in insecure housing.

Following a report on responses to elder abuse, a range of measures is to be implemented in community and provider education, legal services and other responses to raise the awareness of and assist in the prevention of elder abuse.

In residential care, a pilot program offering surplus government land sites to not-for-profit aged care providers will proceed, to facilitate the establishment of high-care aged care places in inner-Melbourne, where development has been limited by the price of suitable land.

A suite of quality initiatives aimed at building a quality of care focus into the strategic management and day-to-day operation of public sector residential aged care facilities has been introduced.”

## Queensland Government comments

“Queensland has continued to support the programs and services that improve the quality of life of older people and has worked closely with the Australian Government and all State and Territory jurisdictions to renegotiate the HACC Amending Agreement. This program is important because it provides services at the beginning of the aged care continuum, and is instrumental in helping older people to remain in their own homes.

Planning for future services for older people has been based on the initiatives outlined in Queensland Health's Directions for Aged Care 2004–2011 and will continue to align with the Statewide Health Services Plan.

Queensland has received provisional approval for 273 transition care places, with a further 78 expected to be offered in 2006-07. Plans to operationalise all places are well underway, with 103 places already approved. The remainder are expected to receive approval by the end of 2006. Queensland has developed a hub and spoke model with services being provided through a mix of Queensland Health and non-government organisations. The program has been well received by the community with places experiencing high occupancy levels.

In response to a number of national incidents involving abuse of elderly residents in aged care facilities, the Queensland Government has developed a number of measures to address the issue for State Government facilities. These have focused on:

- improved training and support for all staff so that they fully understand the components of physical, sexual and financial abuse and are able to identify other symptoms of abuse of older people;
- protocols and mechanisms to improve reporting of abuse through enhanced training programs of all staff and volunteers to increase awareness of the process for acting on elder abuse incidents.

Since 2001, Queensland Health has embarked on a $120 million redevelopment program which has resulted in the replacement of a number of the State's Residential Aged Care Facilities.

Over the past 5 years, Queensland Health has provided new replacement facilities at Roma, Dalby, Townsville, Redland, Maryborough, Redcliffe, Warwick, replacement accommodation for 80 residents at Sandgate, with new facilities at Wondai under construction and Nambour in the design phase. In addition the program has provided air conditioning Oakey and Zillmere.”

## Western Australian Government comments

“ In February 2006, the Department of Health Western Australia launched the Clinical Network for Aged Care (CNAC). The CNAC has been formed through integration of the WA Aged Care Ministerial Advisory Committee (WAACMA), the Clinical Advisory Committee (CAC) and the WA Community Care Reform Advisory Group (WACCRAG).

The CNAC provides a forum to support multi sectorial and multi disciplinary relationships to be strengthened, with an emphasis on partnerships and collaboration, while supporting a new approach to the planning and delivery of aged care services that is responsive, flexible and focused on the real needs of the older person.

The WACCRAG will continue to provide advice to the WA Department of Health's Aged Care Policy Directorate (ACPD) in regard to working towards common arrangements in community care as outlined in the Australian Government's A New Strategy for Community Care: The Way Forward and the February 2006 Council of Australian Governments (COAG) decision to improve access to services for frail older people by strengthening the performance of the Aged Care Assessment Program (ACAP), and simplifying entry points for the Home and Community Care Program (HACC).

Carers WA have been contracted to develop and pilot a training program for all HACC funded agencies to raise awareness of the Carers' Recognition Act 2004 (WA), and to support agencies to formally recognise carers as key partners in the delivery of care.

In March 2006 the WA HACC Program adopted a Wellness Approach to Community Home Care (WATCH) philosophy as its policy position for future growth in service delivery. The aim of WATCH is to support a move towards maximising physical and psychosocial function for people accessing HACC services, resulting in optimal levels of functional and social independence.

The Northern Transition Care Service commenced operating on January 1st 2006. This service, which provides 50 flexible care places to elderly clients living in the North Metropolitan Area Health Service Region, mainstreamed the pilot program, which successfully operated since 2002. Work is currently underway to mainstream the Intermittent Care Service pilot operating in the South Metropolitan Area Health Service Region to enable a metropolitan area wide Transition Care Program. ”

## South Australian Government comments

“ Improving with Age – Our Ageing Plan for South Australia was officially launched by the Minister for Ageing in February 2006. The Plan serves as a policy framework for implementation across Government and reinforces the ongoing commitment to ageing in SA. In brief, the Plan focuses on maximising the citizenship and independence of older people and ensuring they have opportunities and choices to remain connected to their communities. The Plan highlights five key action areas:

- Enabling Choice and independence
- Valuing and recognising contribution
- Providing safety, security and protection
- Delivering the right services and the right information
- Staying in front

A number of Kick-Start initiatives have already been identified as part of implementing the Plan. These include mapping of ageing services across SA to improve planning, and an elder abuse conference held in June 2006 on World Elder Abuse Awareness Day. Another Kick-Start initiative was funded to research ways of supporting Aboriginal Elders by services following them as they move for cultural, family or climatic reasons. Delivering services in remote and mobile communities remains a challenge, and will continue to be a focus of service development, in the HACC and ACAP programs.

The Carers Recognition Act commenced in SA in December 2005. It requires Government organisations and Government funded services to report annually on the action they take to ensure that those whom they employ are aware of, and understand the Carers Charter, and take action to reflect the principles of the Carers Charter in how services are provided. Additionally such organisations must consult carers or those people or organisations that represent carers in policy and program development, or in strategic or operational planning which is relevant to carers and those they care for.

A review of the processes of planning, funding, contracting, monitoring, reporting and evaluating the provision of services under the HACC program in SA commenced in 2005-06. The goal of this review is to recommend and implement process improvements that meet the needs of key partners and stakeholders, increase efficiency, ensure value for money in the provision of HACC services, and expedite reporting. Some of the processes are being introduced in 2006-07, and it is anticipated that improvements will occur as community care reform continues to progress at the national level. ”

## Tasmanian Government comments

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- Service demand issues posed by population ageing have become a central focus of social and economic planning within Australia and internationally. Those issues are of particular concern for Tasmania, with current projections indicating that by 2021, this state will have the highest proportion in Australia (22 per cent) of its population aged 65 years or more. A Tripartite Agreement for Population Ageing in Tasmania, signed by Tasmania's three spheres of government in August 2006, will offer the opportunity to work together on common issues to improve the coordination of planning for aged care services and healthy ageing programs.
- While demand for community services is increasing, evidence confirms better outcomes for older people and lower costs to governments through enabling older people to live independently and as long as possible in their own homes. The Tasmanian Government is committed to that principle and in 2006 it again fully matched the Australian Government's growth offer in the Home and Community Care (HACC) Program. Greater demand means that HACC services must increasingly be targeted at high-needs clients and this can result in fewer, but more complex and longer, home visits.
- While longer-term service reform planning is essential, existing service models must be resourced and, where necessary, enhanced in the shorter term. The Tasmanian Department of Health and Human Services is responding to that challenge by implementing a comprehensive management reform strategy to develop better processes and systems to support frontline service delivery. Improvements in achievement, quality and access are critical to ensure sustainable services, both in terms of resources and outcomes for clients. Fundamental to the continued provision of sustainable health and human services is the development of a flexible and skilled workforce and investment in new infrastructure.
- Tasmania made a considerable investment in 2005-06 with an expansion in transition care services and the establishment of a new geriatric evaluation and management unit. Sub-acute planning work is continuing with a review of rehabilitation services and the development of psycho-geriatric service pathways. Tasmania is also continuing to implement the major service changes outlined in the Palliative Care in Tasmania: Current Situation and Future Directions report (2004).

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## Australian Capital Territory Government comments

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The ACT Government remains committed to assisting older people and their carers by providing better access to appropriate services and promoting independence and participation in community life.

The Home and Community Care (HACC) program was enhanced by an additional $1.64 million in 2005-06 to assist people to remain in the community. The focus of additional HACC funding provided additional community transport, centre based day care, personal care, domestic assistance, counselling, podiatry and respite care. The enhanced service delivery of HACC services in the ACT has provided more options for older people and their carers, and helps avoid premature entry into residential aged care.

The ACT Transitional Therapy and Care Program is jointly funded by the Australian and ACT Governments to provide a restorative, therapeutic and social model of care for older people leaving hospital to improve their physical functioning. In December 2005, 10 places where allocated under the Transition Care Program. From 1 July 2006, an additional 25 places were allocated and operationalised in the Transitional Therapy and Care Program. The ACT now has 15 residential and 20 community transitional places.

The ACT Government is constructing a 60 bed facility comprised of 28 sub-acute and post acute beds, 12 Geriatric Evaluation Management beds and a 20 bed psycho-geriatric unit at Calvary Hospital. This facility will enhance the care options provided to older Canberrans by the Aged Care and Rehabilitation Service. Construction is expected to be complete by January 2007.

The Australian Government has made available 174 new residential and 35 community aged care places in 2006-07. In response to the Australian Government’s increased allocation, the ACT Government through its Land Development Agency has released land in Nicholls on the north side of Canberra, to accommodate an additional 100 aged care beds and 150 independent living units. The Chief Minister’s Department has recently completed a ‘Retirement Accommodation and Residential Aged Care in the ACT 2006 – 2026, Demand and Supply Report’. The report provides the framework for planning for an ageing population and includes a targeted land release strategy and improved planning processes.

The Minister for Health, Katy Gallagher officially launched an Elder Abuse Awareness Campaign for the ACT on the 16 May 2006. The awareness campaign is being promoted through television, print and electronic media and is supported by information kits containing fact sheets. A comprehensive elder abuse web page has been developed with links to the fact sheets. A summary of the information is available at http://www.ageing.act.gov.au/elderabuse.

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## Northern Territory Government comments

“ The unique environmental and socio-economic factors in the NT create specific challenges in the provision of aged care services for both the NT and Australian Government, particularly in providing appropriate and sustainable aged care services to remote Indigenous communities. The high proportion of people living in remote settings and lack of a major metropolitan centre creates increased cost structures for all services, particularly due to the cost of travel, staff retention and recruitment.

Data quality remains an ongoing challenge for providers in the NT, given the need to integrate funds across aged care and disability programs to create viable services, especially in remote communities. Data quality issues can distort results in individual programs. During 2005-06 the NT put a lot of effort in improving the participation rates as well as the quality of the Home and Community Care (HACC) National Minimum Data Set (MDS) from providers. This involved working collaboratively with HACC service agencies and providing them with ongoing training and support and the role out of web based data entry system throughout the NT. There remains an ongoing challenge of ensuring good data quality from the large number of small and dispersed providers, particularly given that these providers receive funds from multiple funding sources.

In 2005-06 quality initiatives have improved including commencement of the second round of quality reviews of the HACC services.

During 2005-06 the NT Government placed great emphasis on supporting carers of the frail aged, people with a disability, those with a chronic disease and people with mental illness. A new Carers Recognition Act with specific Carers' Charter was developed. This is in recognition of carer's contribution to the community. The Act will come into effect in 2006-07. In addition, subsidies and concessions on cost of essential services similar to those available to pensioners was extended to carers in the NT and $1.05 million was allocated by NT Government for these concessions in 2006-07.

NT potential population estimates in the report are based on small sample sizes and subsequently have high standard error rates. Indicators based on these estimates need to be interpreted with caution. In addition small variations in NT aged care data appears in magnified proportions in the report. ”

## 12.6 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.

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|---|---|
| **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).

## 12.7 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\2007\Attach12A.xls and in Adobe PDF format as \Publications\Reports\2007\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).

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|---|---|
| **Table 12A.1** | Males and females aged 70 years or over, June 2006 (estimated) |
| **Table 12A.2** | Target population data, by location ('000) |
| **Table 12A.3** | Proportion of people aged 70 years and over by locality, June 2006 |
| **Table 12A.4** | Ownership of aged care residential places, June 2006 |
| **Table 12A.5** | Average annual Australian Government RCS subsidy per occupied place and the dependency level of aged care residents, June 2006 |
| **Table 12A.6** | Size and distribution of all residential aged care services, June 2006 |
| **Table 12A.7** | Size and distribution of residential aged care services with over 80 per cent high care residents, June 2006 |
| **Table 12A.8** | Size and distribution of residential aged care services with over 80 per cent low care residents, June 2006 |
| **Table 12A.9** | Size and distribution of mixed residential aged care services, June 2006 |
| **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, June 2006 (per cent) |
| **Table 12A.19** | Proportion of new residents classified as concessional or assisted residents, 2005-06 (per cent) |
| **Table 12A.20** | HACC services received per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years, 2005-06 |
| **Table 12A.21** | HACC services received within major cities per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years, 2005-06 |

## 12.8 References


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