13 Aged care services

CONTENTS

Attachment tables

Attachment tables are identified in references throughout this chapter by an 'A' suffix (for example, table 13A.3). A full list of attachment tables is provided at the end of this chapter, and the attachment tables are available on the CD-ROM enclosed with the Report or from the Review website at <www.pc.gov.au/gsp>.

The aged care system comprises all services specifically designed to meet the care and support needs of frail older people living in Australia. 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

- community care services and flexible services, which include Home and Community Care (HACC) program services, Community Aged Care Packages (CACP), the Extended Aged Care at Home (EACH) program, the EACH Dementia (EACH-D) program, the Transition Care Program (TCP), and the Department of Veterans' Affairs (DVA) Veterans' Home Care (VHC)[1] Community Nursing programs and Multi-purpose Service Program (MPS)
- respite services, which include HACC respite and centre-based day care and the National Respite for Carers Program (NRCP)
- assessment and information services, which are largely provided by the Aged Care Assessment Program (ACAP).

Additions and improvements made to the chapter this year include:

- inclusion of data for the first time on access to aged care residential services for veterans, within the indicator 'use by different groups'
- inclusion of additional data for the first time for EACH-D services including:
  - aged care recipients per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years as a proportion of all residents, by locality and recipients from a non-English speaking country
  - Indigenous aged care recipients per 1000 Indigenous people aged 50 years or over and as a proportion of all recipients and by locality
  - EACH-D recipients by age-sex specific usage rates per 1000 people by jurisdiction and remoteness
- replacing the measure 'average residents per room' with a more comprehensive measure 'percentage of compliant services' for the indicator 'compliance with service standards for residential care'
- redefining HACC services received per 1000 people to only include people aged 70 years and over plus Indigenous people aged 50 to 69. In previous years, all people in receipt of HACC services regardless of age were reported
- inclusion of an additional attachment table to summarise Government expenditure on aged care services and revisions to supporting attachment tables to report more comprehensive data and to better reflect expenditure categories for assessment and information services, residential care, community care and services delivered in mixed delivery settings.

Older Australians may also use other government services covered in this Report, including disability services (chapter 14), specialised mental health services

[1] Unless otherwise stated, HACC expenditure excludes the DVA expenditure on VHC.

(chapter 12), housing assistance (chapter 16) and services across the full spectrum of the health system (preface E and chapters 10–12). Interactions between these services 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.

This chapter also describes the characteristics and performance of residential aged care in terms of residential services, places and locality (box 13.1).

Box 13.1 Interpreting residential aged care data

Aged Care Funding Instrument and the characteristics of residents

On 20 March 2008, the Aged Care Funding Instrument (ACFI) was introduced to replace the Resident Classification Scale (RCS). Transition arrangements from the RCS to the ACFI are now complete.

The ACFI measures each resident's need for care (high, medium, low or nil) in each of three domains. This chapter classifies residents as 'high' or 'low' care based on their Aged Care Assessment Team (ACAT) assessment and their approved provider's appraisal of their care needs under the ACFI. Residents whose ACAT approval is not limited to low care are classified as high care if they have an ACFI appraisal of:

- medium or high in activities of daily living; or
- high in behaviour; or
- medium or high in complex health care.

All other ACAT approval and ACFI appraisal combinations result in a classification of low level care.

A residents care needs may change over time resulting in a change in classification from low to high level care (ageing in place).

Residential services data

- Aged care homes with 80 per cent or more residents classified as high care are described as high care services.
- Aged care homes with 80 per cent or more residents classified as low care are described as low care services.
- A service that is neither high care, nor low care, as defined above is called a mixed care service.

(Continued next page)

Box 13.1 **(continued)**

These categories have been used for descriptive purposes and do not have any legal foundation under the *Aged Care Act* 1997 (Cwlth) (the Aged Care Act). Similarly, the choice of 80 per cent as a cut-off point is arbitrary but considered appropriate for descriptive purposes.

Places data

The Aged Care Act (part 2.2) details the processes for planning and allocating Australian Government subsidised services to meet residential aged care needs and community care needs. Planning is based on a national ratio of places per 1000 people aged 70 years or over for both high and low care. High care places are planned to meet the needs of residents equivalent to high care. Low care places are planned to meet the needs of residents equivalent to low care.

Although a needs match is expected when residents enter vacant places (that is, for example, 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.

Locality data

Geographic data are based on the Australian Bureau of Statistics (ABS) Australian Standard Geographic Classification of Remoteness Areas (ABS 2006). 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.

13.1 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, as distinct from 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. Particular groups (notably Indigenous people) can 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 aged care places under the Act.

Government funded aged care services covered in this chapter relate to the three levels of government (Australian, State and Territory, and some local) involved in service funding and delivery. The formal, publicly funded services covered represent only a small proportion of total assistance provided to frail older people. Extended family and partners are the largest source of emotional, practical and financial support for older people: more than 90 per cent of older people living in the community in 2003 who required help with self-care, mobility or communications received assistance from the informal care network of family, friends and neighbours (ABS 2004). Many people receive assistance from both formal aged care services and informal sources. Older people also purchase support services in the private market, and these services are not covered in this chapter.

Roles and responsibilities

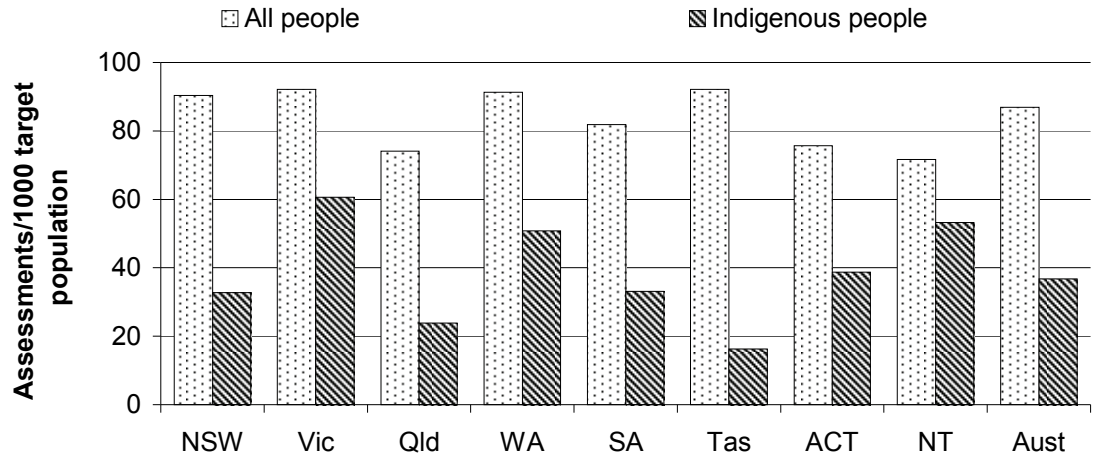
Aged Care Assessment Program

The Australian Government established the 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. The core objective of the ACAP is to assess the needs of frail older people and assist them to gain access to the most appropriate type of care. Assessment and approval by an ACAT is mandatory for admission to Australian Government subsidised residential care or to receive a CACP, EACH package, EACH-D package or TCP. People can also be referred by the ACAT to other services, such as those funded by the HACC program (although an ACAT referral is not mandatory for receipt of these other services).

State and Territory governments are responsible for the day to day operation and administration of the ACAP, and for provision of the necessary accommodation and support services. The scope and practice of the ACATs 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) and this has an effect on program outputs.

The number of assessments of people aged 70 years or over and Indigenous people aged 50-69 years per 1000 target population varied across jurisdictions in 2007-08. The national rate was 86.9 assessments per 1000 people aged 70 years or over and Indigenous people aged 50-69 years. The rate for Indigenous people aged 50 years and over was 36.8 per 1000 Indigenous people aged 50 years or over (figure 13.1).

Figure 13.1 **Aged Care Assessment Team assessment rates, 2007-08**[a, b, c, d, e]



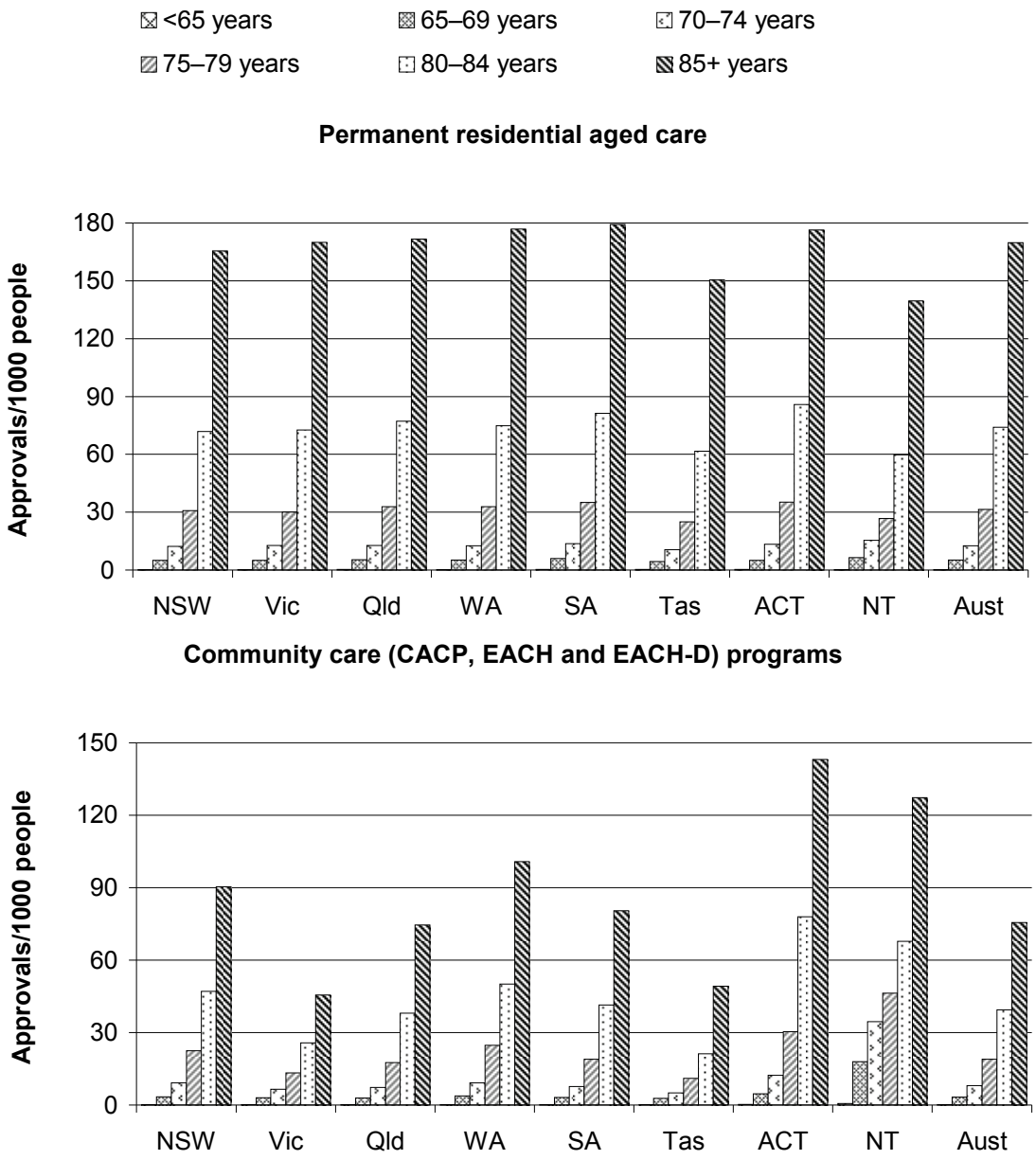
[a] Includes ACAT assessments for all services. [b] 'All people' includes all assessments of people aged 70 years or over and Indigenous people aged 50 years or over per 1000 people aged 70 years or over and Indigenous people aged 50 years or over. [c] 'Indigenous' includes all assessments of Indigenous people aged 50 years 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. [e] See table 13A.39 for further explanation of these data.

Source: Aged Care Assessment Program National Data Repository (unpublished); table 13A.39.

ACAT assessments which result in approvals of eligibility for various types of care can be shown by age-specific rates, for a series of age groups in the population. Data are provided for residential care and for community care (CACP, EACH and EACH-D).

The approval rates for both residential and community care services vary across jurisdictions and increase with age (figure 13.2). These data reflect the numbers of approvals, which are a subset of assessments, as some assessments will not result in a recommendation or an approval for a particular level of care.

Figure 13.2 **Age-specific approval rates, per 1000 people in the population, 2007-08[a, b]**



a Population numbers and the proportions of the population for older age groups in the ACT and the NT are smaller than other jurisdictions, and may show variation between years, so results should be interpreted with caution. **b** The age category population data for this table are derived from ABS estimated resident population figures as at 30 June 2008.

Source: DoHA (unpublished); table 13A.40.

The Council of Australian Governments (COAG) has agreed to improve aged care assessment services as part of its national health agenda (box 13.2).

Box 13.2 Improved performance and streamlining of assessment processes

In February 2006, COAG agreed to establish an initiative to simplify access to care services for the elderly, people with a disability and people leaving hospital.

The initiative consists of two components:

- ACAP — more timely and consistent assessments for frail older people by ACATs
- simplified entry and assessment processes for the HACC Program.

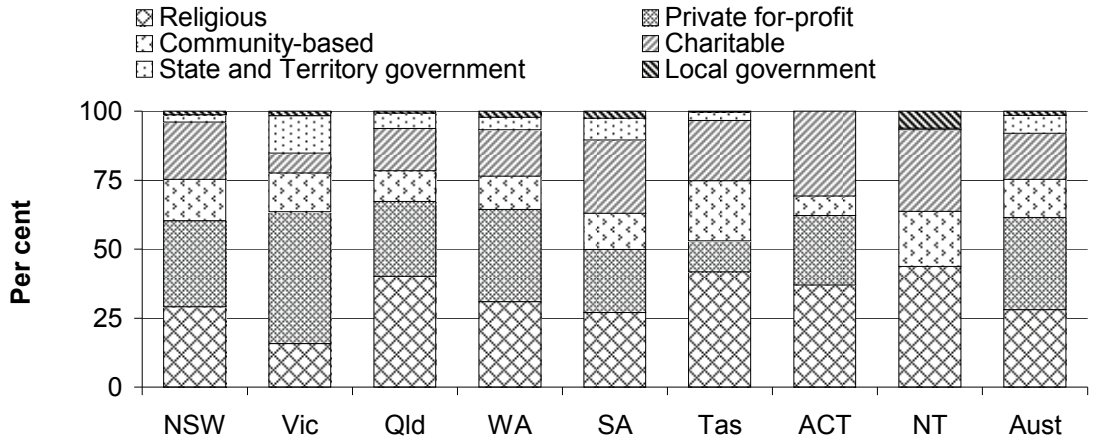
The ACAP component has enabled the implementation of a range of activities to improve the timeliness, quality and consistency of ACAT recommendations, at the national level and with the states and territories. Many of the national and State and Territory activities from earlier years of the measure were continued in 2008-09. Additional initiatives that were implemented include: the capacity for ACATs to electronically submit the Aged Care Client Record to Medicare Australia; the development of the National Training for ACAT Delegates workbook and e-learning site; national workshops to introduce the Delegates workbook and to provide training in administrative law for ACAT by the Senior Commonwealth Lawyer; a project to identify a set of comprehensive clinically validated assessment tools; the conduct of a national ACAP Conference in May 2010; the development of an overarching Implementation Plan for the recommendations of the National Review of ACAT; and improved communication to ACAT by enhancing the format and content of written communications with ACAT nationally. States and territories continue to undertake a range of projects to improve the management and operation of ACATs.

Source: DoHA (unpublished).

Residential care services

Religious and private for-profit organisations were the main providers of residential care at June 2009, accounting for 28.0 per cent and 33.5 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 13.7 per cent and 16.7 per cent respectively. State, Territory and local governments provided the remaining 8.1 per cent (figure 13.3).

Figure 13.3 **Ownership of operational residential places, June 2009**[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 13A.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 may also have a regulatory role in areas such as determining staffing and industrial awards, and monitoring compliance with building and fire safety regulations (box 13.3).

Box 13.3 Examples of regulatory arrangements for residential services

The Australian Government controls the number of subsidised places. In February 2007, the Australian Government announced an increase in the provision ratio from 108 (adopted in 2004 following a recommendation of the Review of Pricing Arrangements in Residential Aged Care) to 113 operational places per 1000 people aged 70 years or over, to be achieved by June 2011. The proportion of places offered has been adjusted from 20 to 25 places for community care (which includes CACP and EACH packages and other flexible care places), with 4 of these places to be for high level care. In residential care, the provision ratio for high level care was increased from 40 to 44 places, while the ratio for low level residential care was adjusted from 48 to 44 places.

Under the arrangements:

- services are expected to meet regional targets for places for concessional, assisted and supported residents. These targets range from 16 per cent to 40 per cent of places and are intended 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 the date of the resident's entry to care, home ownership and occupancy, receipt of income support and the level of assets held at entry. The criteria for being deemed a supported resident is based on the resident's entry date and 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, 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 bylaws may also apply (for example, waste disposal rules).

Source: DoHA (unpublished).

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 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. The number of operational places for CACP at 30 June 2009 was 40 195 (table 13A.36). There were 79 691 people approved for VHC services in 2008-09 (table 13A.48) and at least 862 488 HACC clients in 2008-09 (table 13A.33). High level community care is also available in the form of EACH and EACH-D.

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-D packages, innovative care places, MPS and the TCP. In addition, flexible models of care are provided under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. These services are funded and operate outside the regulatory framework of the Aged Care Act 1997.

- The EACH program provides high level care to people in their own homes, complementing CACPs, which provide low level care. EACH-D 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 4478 operational EACH places and 2036 operational EACH-D places at 30 June 2009 (table 13A.36).
- The Aged Care Innovative Pool is designed to test new approaches to providing aged care. It supports the development and testing of flexible models of service delivery in areas where mainstream aged care services might not appropriately meet the needs of a location or target group. For example, the TCP is built on the lessons learned from two pilot programs developed through the innovative pool, which addressed the interface between aged care and hospital care — the Innovative Care Rehabilitation Services and the Intermittent Care Services (DoHA unpublished).
- The MPS program supports the integration and provision of health and aged care services for small rural and remote communities. At 30 June 2009, there were 126 operational services with a total of 3076 operational 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. The TCP is intended to:

- enable a significant proportion of care recipients to return home, rather than prematurely 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.

The TCP is jointly funded by the Australian, State and Territory governments. Its operation is overseen by the Transition Care Working Group, which includes representatives from all states and territories and the Australian Government.

Transition care can be provided in either a home-like residential setting or in the community, and targets older people who would otherwise be eligible for residential care. A person may only enter the TCP directly upon discharge from hospital. The average duration of care is 7 weeks, with a maximum duration of 12 weeks that may in some circumstances be extended by a further 6 weeks.

The TCP operates with some differences across jurisdictions including differences in service systems, local operating procedures and implementation timetables, which are reflected in national data collections. An evaluation of the impact of the Transition Care Program on clients and systems and its cost effectiveness has been undertaken. Key findings of the evaluation were that functional improvement occurred and that older people who received Transition Care had fewer readmissions to hospital and were less likely to move into permanent residential aged care (DoHA 2008).

Transition care will expand up to 4000 places by 2010-11. At 30 June 2009, the Australian Government had allocated 2698 places to transition care, of which 2228 were operational, amongst 79 services across all jurisdictions. The average length of stay in 2008-09 was 58 days nationally (table 13A.51).

Long Stay Older Patient Initiative

As part of the COAG national health and aged care agenda the Long Stay Older Patient Initiative has been funded since 2006-07 (box 13.4).

Box 13.4 **Long Stay Older Patient Initiative**

From July 2006, a new four-year program commenced to assist older public patients who no longer require acute care or rehabilitation and are in hospital waiting for residential aged care by:

- providing more appropriate care for long-stay older patients in public hospitals, particularly in rural areas
- improving the capacity of rural hospitals to provide more age friendly services, including through making capital improvements such as establishing new multi purpose services
- reducing avoidable or premature admission of older people to hospitals
- assisting older public patients requiring long-term care to take up appropriate care options.

Source: COAG (2006).

Indigenous-specific services

Aboriginal and Torres Strait Islander people access mainstream services under the Aged Care Act, including those managed by Aboriginal and Torres Strait Islander organisations, and services funded outside the Act, including those funded under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program.

The National Aboriginal and Torres Strait Islander Flexible Aged Care Program (the Flexible Program) aims to provide quality, flexible, culturally appropriate aged care to older Aboriginal and Torres Strait Islander people close to their home and community. Flexible Aged Care services deliver a mix of residential and community aged care services to meet the needs of the community. At 30 June 2009, there were 29 aged care services funded to deliver over 650 flexible aged care places. These services are funded and operate outside the regulatory framework of the Aged Care Act 1997.

Some services managed by non-Indigenous approved providers also have significant numbers of Aboriginal and Torres Strait Islander clients. All aged care services that are funded under the Aged Care Act are required to provide culturally appropriate care. Whether they are located in a community or residential setting, services may be subject to specific conditions of allocation in relation to the proportion of care to be provided to particular groups of people, including Aboriginal and Torres Strait Islander people.

Funding

Recurrent expenditure on aged care services reported in this chapter was $10.1 billion in 2008-09 (table 13.1). Table 13.1 does not include all State and Territory government expenditure, for example, the experimental estimates of expenditure on non-HACC post acute packages of care (table 13A.46), or any Australian Government or State and Territory government capital expenditure (table 13A.73).

Table 13.1 Expenditure on aged care services reported in the Aged care services chapter, 2008-09

Expenditure category	*$ million*
Assessment and information services[a]	93.4
Residential care services[b]	6 653.7
Community care services[c]	2 935.0
Services provided in mixed delivery settings[d]	397.2
Total	**10 079.3**

[a] Assessment and information services include only Australian Government expenditure. [b] Residential care services include DoHA and DVA (including payroll tax supplement) and State and Territory governments expenditure. [c] Community care services include HACC, CACP, EACH and EACH-D, NRCP, Community care grants, VHC, DVA Community Nursing, Assistance with Care and Housing for the Aged. [d] Services provided in mixed delivery settings include the Transition Care Program, MPS and residential ATSI flexible services, Day Therapy Centres, Continence Aids Assistance Scheme, National Continence Management Strategy, Innovative Care Pool and Dementia Education and Support, Long Stay Older Patient Initiative, Community Visitors Scheme and Culturally and Linguistically Diverse expenditure.

Source: Table 13A.43.

Assessment services

There were 116 ACATs (115 Australian Government funded) at 30 June 2009 (DoHA unpublished). In 2008-09, the Australian Government provided funding of $74.5 million nationally for the aged care assessment program (table 13A.43). Australian Government ACAT expenditure per person aged 70 years or over plus Indigenous people aged 50–69 years was $35.3 nationally during 2008-09 (table 13A.52). State and Territory governments also contribute funding for ACATs, but this expenditure is not included in the chapter.

Aged care assessment program activities and costs for 2007-08 are reported in table 13A.59.

Residential care services

The Australian Government provides most of the recurrent funding for residential aged care services. 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.

Australian Government expenditure

Australian Government expenditure on residential aged care was $6.5 billion in 2008-09, comprising DoHA expenditure of $5.5 billion (table 13A.44) and Department of Veterans' Affairs (DVA) expenditure of $959.7 million (table 13A.45).

Australian Government basic subsidy

The Australian Government annual basic subsidy for each occupied place varies according to clients' levels of dependency and includes the Conditional Adjustment Payment (CAP) (box 13.5).

Box 13.5 **Conditional Adjustment Payment**

The CAP was introduced in 2004-05 as part of the Australian Government's initial response to the Review of Pricing Arrangements in Residential Aged Care.

The CAP is intended to provide medium term financial assistance to residential aged care providers, while encouraging them to implement improved management practices. Consequently, providers are only eligible to receive the CAP if they meet certain reporting conditions, such as preparing general purpose financial reports. All but a few providers currently meet these conditions and receive the payment.

The amount of CAP payable in respect of a resident is calculated as a percentage of the basic subsidy amount payable in respect of a resident. In 2004-05 this percentage was 1.75 per cent. It then rose annually in 1.75 per cent increments, to 3.5 per cent in 2005-06; 5.25 per cent in 2006-07; and 7.0 per cent in 2007-08.

In the 2008-09 Budget, the Australian Government provided $407.6 million over four years to increase the level of the CAP to 8.75 per cent ongoing.

Source: DoHA (unpublished).

At June 2009, the average annual subsidy per residential place, including the CAP, was $36 387 nationally (table 13.2). Variations across jurisdictions in average annual subsidies reflect differences in the dependency of residents. Rates for aged care services by the level of high and low care places are in table 13A.5.

Table 13.2 **Average annual Australian Government basic subsidy (all levels) per occupied place at June 2009**[a]

		NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Subsidy level (includes CAP)	$	36 903	35 751	35 203	35 721	39 231	35 638	35 658	37 369	36 387

[a] See footnotes to table 13A.5 for further information.

Source: DoHA (unpublished); table 13A.5.

The dependency levels of all residents are at table 13.3. Each resident has a dependency level for each of three domains. These dependency levels vary across jurisdictions. These data, categorised by the proportion of high and low care places provided are included in table 13A.5.

Table 13.3 **Dependency levels of permanent residents, June 2009**[a, b]

		NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Proportions of residents										
Aged Care Funding Instrument										
Activities of daily living										
High	%	34.9	32.7	31.6	32.8	35.3	31.2	31.3	41.0	34.0
Medium	%	27.8	31.5	27.1	31.4	25.7	29.0	28.5	24.8	28.0
Low	%	27.8	26.8	30.6	26.8	32.6	28.7	31.6	28.6	28.8
Nil	%	9.5	9.0	10.7	9.1	6.3	11.2	8.6	5.7	9.2
Total	**%**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Behaviours										
High	%	37.9	37.1	31.8	39.2	45.4	26.9	38.6	24.0	37.1
Medium	%	24.7	26.3	24.9	25.3	26.5	22.8	24.9	30.2	25.3
Low	%	22.1	22.5	24.5	22.1	18.8	26.7	22.1	29.9	22.5
Nil	%	15.2	14.2	18.8	13.5	9.3	23.6	14.4	15.9	15.1
Total	**%**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Complex health care										
High	%	12.9	13.0	10.3	10.6	17.6	13.6	11.3	10.0	12.7
Medium	%	28.2	28.3	24.0	28.7	30.4	23.7	27.1	21.8	27.6
Low	%	39.6	40.4	42.3	42.8	38.5	41.2	41.5	44.5	40.5
Nil	%	19.4	18.2	23.5	18.0	13.5	21.5	20.0	23.7	19.2
Total	**%**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Numbers of residents										
Total High	no.	40 428	28 993	20 751	9 524	12 284	2 931	1 138	309	116 358
Total Low	no.	15 253	13 023	8 246	3 995	3 449	1 269	564	105	45 904
All High/Low	**no.**	**55 681**	**42 016**	**28 997**	**13 519**	**15 733**	**4 200**	**1 702**	**414**	**162 262**

[a] See footnotes to table 13A.5 for further information. [b] Totals may not add as a result of rounding.

Source: DoHA (unpublished); table 13A.5.

State and Territory government recurrent expenditure

State and Territory government expenditure has been collected for three categories of residential care expenditure (adjusted subsidy reduction supplement, enterprise bargaining agreement supplement, and rural small nursing home supplement). Reported expenditure in these three categories was $179.7 million in 2008-09 (table 13A.46).

Capital expenditure

The Australian Government provided $40.6 million in 2008-09 to fund an ongoing program of targeted capital assistance to residential aged care services. This assistance is provided to services that, as a result of their rural or remote location or because the services target financially disadvantaged people, are unable to meet the cost of necessary capital works from the income they receive through resident accommodation payments and the general capital component of Australian Government recurrent funding (table 13A.73). In addition, capital expenditure by some State and Territory governments on residential aged care services in 2008-09 was $88.1 million (table 13A.73).

Capital expenditure on aged care services in 2008-09 is summarised in table 13A.73. These capital funds are in addition to the funding reported in table 13.1, which is total recurrent expenditure.

Community care services

Following is a summary of expenditure on community care programs. More detailed data is found in the attachment tables referenced. Data on Australian Government expenditure per person in the target population by jurisdiction are contained in table 13A.52. Recipients of community care services can also contribute towards the cost of their care.

Expenditure on HACC, CACP, NRCP and DVA programs

Total government expenditure on HACC was $1.8 billion in 2008-09, consisting of $1.1 billion from the Australian Government and $698.2 million from the State and Territory governments. The Australian Government contributed 61.0 per cent, while State and Territory governments funded the remainder (table 13A.49). Recipients of HACC services can also contribute towards the cost of these services.

The Australian Government funds the CACP program, spending $479.7 million on the program in 2008-09 (table 13A.47). CACPs are also part funded by client contributions. The NRCP provides community respite services and is funded by the Australian Government. Expenditure on this program was $193.3 million in 2008-09 (table 13.4). The NRCP assisted 127 504 people in 2008-09 (table 13A.36). A disaggregation of Australian Government expenditure on the NRCP by State and Territory is reported in table 13.4.

Table 13.4 **Australian Government expenditure, National Respite for Carers Program, 2008-09 ($million)**[a, b, c, d, e]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*National*	*Aust*
Commonwealth Carer Respite Centres										
	16.9	12.3	11.0	5.0	4.7	2.4	1.1	1.5	na	54.9
Respite services										
	39.1	27.7	21.3	10.2	10.3	3.6	2.9	3.1	na	118.2
Demonstration day respite										
	2.0	1.3	1.3	1.2	1.3	0.7	–	0.5	1.0	9.2
National projects										
	–	–	–	–	–	–	–	–	11.0	11.0
Total	**58.0**	**41.3**	**33.7**	**16.4**	**16.3**	**6.6**	**4.0**	**5.0**	**12.0**	**193.3**

[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] Demonstration day respite will add an extra 62 400 days of respite for carers of frail older people over the next four years. [d] National project is for Carers Australia. [e] Totals may not add as a result of rounding. **na** Not available. – Nil or rounded to zero.

Source: DoHA (unpublished); table 13A.47.

The DVA also provided $101.8 million for the VHC program and $106.0 million for the Veterans Community Nursing program during 2008-09 (table 13A.48). VHC recipients can also contribute towards the cost of these services.

Flexibly funded services

The Australian Government funds the EACH and EACH-D programs, spending $172.7 million and $83.6 million respectively on these programs in 2008-09 (table 13A.47). EACH and EACH-D packages are also part funded by client contributions.

The Australian, State and Territory governments fund the TCP. In 2008-09, the Australian Government spent $76.1 million and the State and Territory governments spent $74.8 million on TCP (table 13A.51). The Australian Government also funds the MPS program and Indigenous specific services. In 2008-09, $95.0 million and $23.0 million were spent on these programs, respectively (table 13A.50).

Services in mixed delivery settings

Australian Government expenditure data by jurisdiction on a range of other services provided in mixed delivery settings targeting older people are contained in table 13A.50. Australian Government expenditure on these programs was $113.7 million in 2008-09. These programs include Day Therapy Centres, Continence Aids Assistance Scheme, the National Continence Management Strategy, Dementia Education and Support, Community Visitors Scheme, Innovative Care Pool, Culturally and Linguistically Diverse aged care (CALD) and Indigenous specific services, (table 13A.50). In addition, Australian Government expenditure on the Long Stay Older Patient Initiative (see box 13.4) was $37.5 million in 2008-09 (table 13A.50).

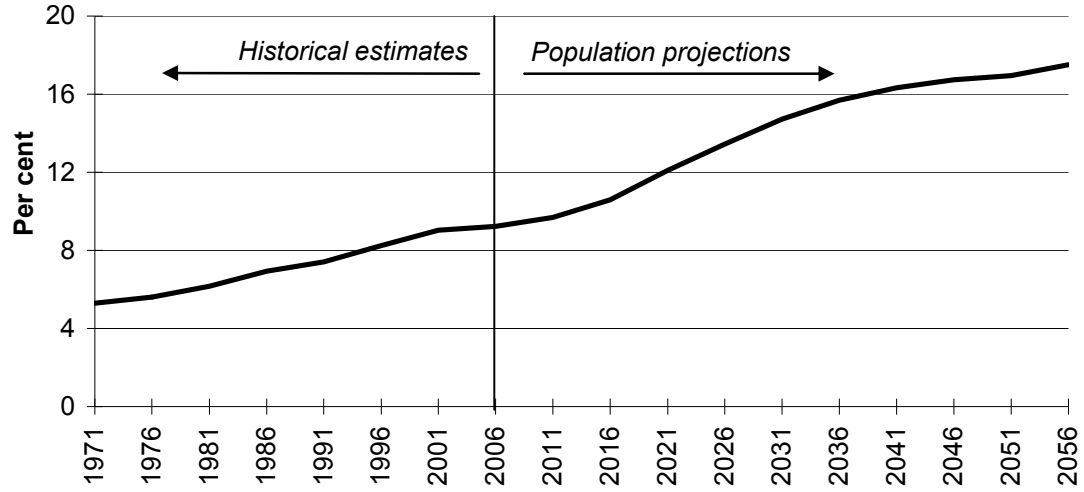
Size and scope of sector

Size and growth of the older population

The Australian population is ageing, as indicated by an increase in the proportion of people aged 70 years 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 13.4). The proportion of older people is 9.5 per cent nationally but varies across jurisdictions (figure 13.5). A disaggregation by remoteness categorisation is provided in table 13A.3. Higher life expectancy for females resulted in all jurisdictions (except the NT, where the rate was similar) having a higher proportion of older females than older males in the total population (table 13A.1).

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 them with care.

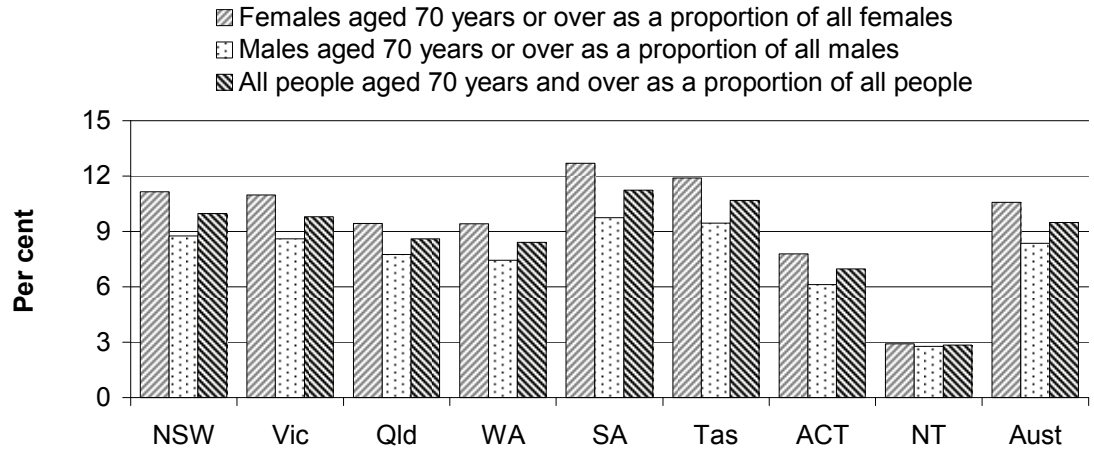
Figure 13.4 **People aged 70 years or over as a proportion of the total population[a]**



a Population projections are derived from the ABS 'B' series population projections.

Source: ABS *Australian Historical Population Statistics, 2008*, Cat. no. 3105.0.65.001, Canberra; ABS *Population Projections Australia 2006–2101*, Cat. no. 3222.0, Canberra.

Figure 13.5 **Estimated proportion of population aged 70 years or over, by gender, June 2009**

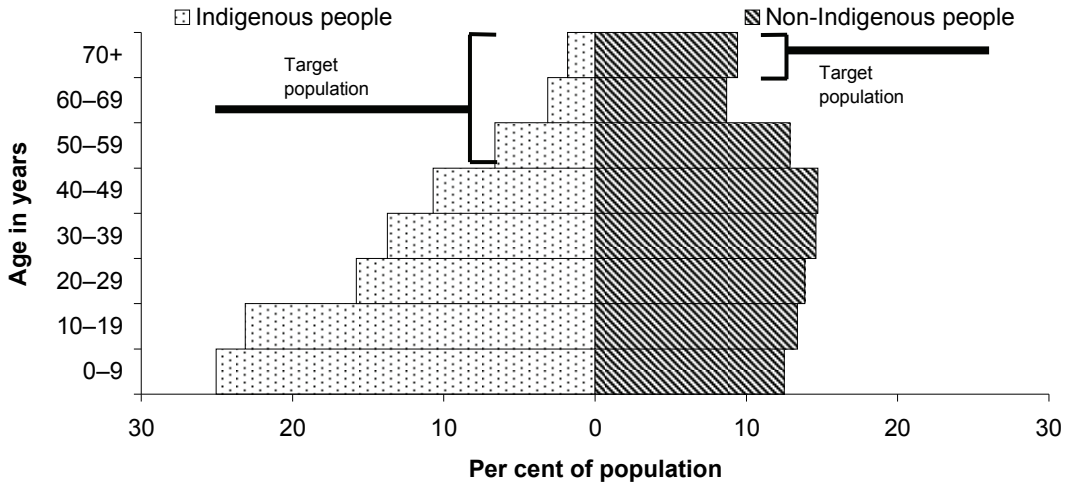


Source: Population projections prepared by the ABS using preliminary rebased estimated resident populations based on the 2006 Census according to assumptions agreed to by the Treasury and Department of Health and Ageing (unpublished); table 13A.1.

Characteristics of older Indigenous people

The DoHA estimates that about 65 300 Indigenous people were aged 50 years or over in Australia at 30 June 2009 (table 13A.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 13.6). Estimates show life expectancy at birth in the Indigenous population is around 11.5 years less for males and 9.7 years less for females when compared to the total Australian population (ABS 2009). These figures indicate that Indigenous people are likely to need aged care services earlier in life, compared with the general population.

Figure 13.6 **Age profile and target population differences between Indigenous and other Australians, June 2006**



Source: ABS *Experimental Estimates of Aboriginal and Torres Strait Islander Australians*, June 2006, Cat no. 3238.0.55.001, Canberra.

Residential care services

The size and location of residential services — which can influence the costs of service delivery — vary across jurisdictions. Nationally, there were 175 225 mainstream operational places in residential care services (75 145 in predominantly high care services, at least 5568 in predominantly low care services and 94 512 in services with a mix of high care and low care residents) at June 2009 (tables 13A.6–9). These figures exclude flexible care places in a residential setting.

Low care services are generally smaller (as measured by number of places) than high care services. At June 2009, 60.5 per cent of low care services had 60 or fewer

places (table 13A.8), compared with 39.7 per cent of high care services (table 13A.7).

As the trend towards 'ageing in place' in residential care (box 13.6) increases, there has been a steady increase in the number of services with a mix of high care and low care residents. In June 2005, 39.6 per cent of all places were located in services offering both high care and low care places. This proportion increased to 53.9 per cent in June 2009 (table 13A.10).

Box 13.6 **Ageing in place in residential care**

In its Objects, the Aged Care Act 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 combined number of all operational high care and low care residential places per 1000 people aged 70 years or over at June 2009 was 86.9 (42.6 high care and 44.2 low care) on a national basis (table 13.5). Nationally, the proportion of low care places relative to high care places has remained constant between 2005 to 2009 (table 13A.11).

Table 13.5 **Operational high care and low care residential places, 30 June 2009**[a, b, c, d, e]

	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.	45.0	41.2	39.5	37.3	49.4	45.2	33.2	54.3	42.6
Low care places	no.	42.3	46.8	45.1	44.0	44.3	41.1	39.7	43.3	44.2
Total places	**no.**	**87.3**	**88.0**	**84.6**	**81.3**	**93.7**	**86.3**	**72.9**	**97.6**	**86.9**
Proportion of places										
High care places	%	51.5	46.9	46.7	45.8	52.8	52.4	45.5	55.6	49.1
Low care places	%	48.5	53.1	53.3	54.2	47.2	47.6	54.5	44.4	50.9

[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 113 residential places per 1000 people aged 70 years or over. 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). [c] Includes residential places categorised as high care or low care. [d] See table 13A.11 for further information regarding the calculation of provision ratios, which vary from corresponding data published in the DoHA Annual Report 2008-09. [e] Data in this table may not add due to rounding

Source: DoHA (unpublished); table 13A.11.

During 2008-09, the numbers of people (of all ages) who used permanent residential care services was 211 332 nationally (including both high and low care) and 41 864 nationally for respite residential care. These figures reflect the number of individuals who utilised these services during the year, for any length of time, rather than the number of places available (table 13A.72).

Age specific usage rates for these services, by jurisdiction and remoteness, at 30 June 2009 are included in tables 13A.62, 13A.64-65 and 13A.67 respectively. Indigenous usage by remoteness category is identified in table 13A.68.

Community care services

Services provided under the HACC program include domestic assistance, home maintenance, personal care, food services, respite care, transport, allied health care and community nursing (box 13.7).

Box 13.7 **Home and Community Care Services**

Home and Community Care (HACC) services are basic maintenance and support services, including allied health care, assessment, case management and client care coordination, 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.

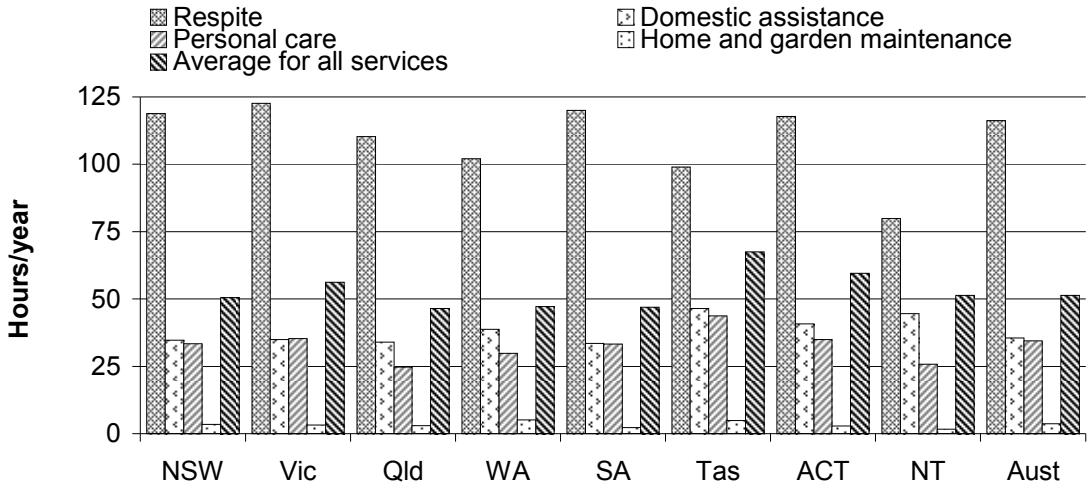
Not all HACC services are directed towards the ageing population described in this chapter. The HACC target population is defined as people living in the community who are at risk, without these services, of premature or inappropriate long term residential care. The target population comprises both frail aged people and younger people with disability. Carers may also receive HACC services.

Over 69 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 disability and their carers, with 11.0 per cent of recipients under 50 years of age (table 13A.34). (Chapter 14 reports on services for people with disability, which manifests before the age of 65 years, that were provided under the Commonwealth State/Territory Disability Agreement) and the National Disability Agreement from 1 January 2009.

The services of the VHC program target veterans and war widows/widowers with low care needs. There were 79 691 people approved for VHC services in 2008-09 (table 13A.48). 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.

Eligibility for VHC services is not automatic, but based on assessed need. The average number of hours provided per year for veterans who were eligible to receive home care services was 51.3 nationally in 2008-09 (figure 13.7).

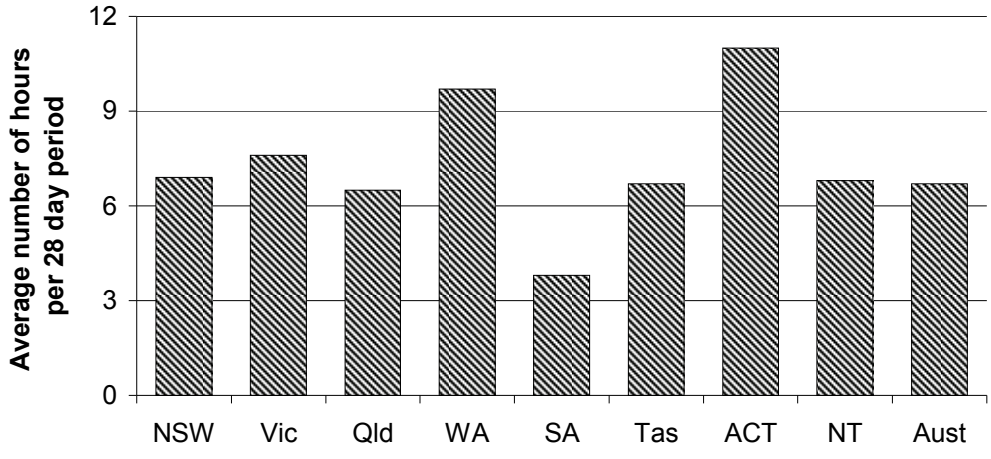
Figure 13.7 **Average number of hours approved for Veterans' Home Care, 2007-08**



Source: DVA (unpublished); table 13A.48.

The DVA also provides community nursing services to veterans and war widows/widowers. These services include acute/post acute, support and maintenance, personal care, medication management and palliative care. In 2008-09, 32 320 veterans received these services (table 13A.48), and the average number of hours provided for each recipient was 6.7 nationally per 28 day period (figure 13.8).

Figure 13.8 **Average number of hours provided for DVA Community Nursing, 2008-09**



Source: DVA (unpublished); table 13A.48.

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. A CACP typically provides 5 to 6 hours of direct assistance per week. The EACH program is similar to the CACP program but targets people who would be eligible for high level residential aged care. An EACH package typically provides 15 to 20 hours of direct assistance each week. The main distinctions between the HACC, CACP, EACH and EACH-D programs are summarised in table 13.6.

Table 13.6 **Distinctions between the HACC, CACP, EACH and EACH-D programs**

	HACC	*CACPs*	*EACH and EACH-D*
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	$1.79 billion funding in 2008-09 At least 862 488 clients in 2008-09[c]	$479.7 million funding in 2008-09 40 195 operational places in 2008-09	$256.3 million funding in 2008-09 6514 operational places in 2008-09

[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 needs that would exceed the level available under CACPs and EACH. [c] The proportion of HACC funded agencies that submitted Minimum Data Set data for 2008-09 differed across jurisdictions and ranged from 81 per cent to 100 per cent. Consequently, the total number of clients will be higher than those reported.

Source: DoHA (unpublished); tables 13A.33, 13A.36, 13A.47 and 13A.49.

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, EACH and EACH-D programs have become increasingly important components of the aged care system. During 2008-09, the HACC program delivered approximately 12 830 hours per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years (table 13A.21). The total number of CACPs per 1000 people aged 70 years or over

plus Indigenous people aged 50–69 years increased between June 2005 and June 2009, from 16.0 to 19.4 (table 13A.12).

The number of clients (of all ages) nationally for a range of community services are included in table 13.7. These figures reflect the number of individuals who utilised these services during the year, for any length of time, rather than the number of places available.

Combined residential and community care services rates

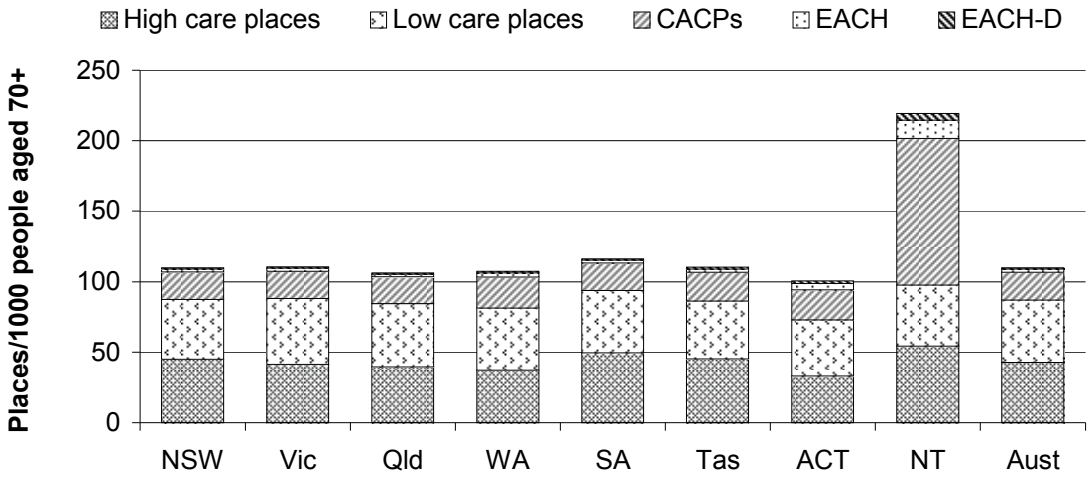
The combined number of high care residential places, low care residential places, CACPs, flexible care places excluding Transition Care places, and places under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program at 30 June 2009, was 110.0 per 1000 people aged 70 years or over (figure 13.9). Transition Care places add an additional 1.1 packages per 1000 people aged 70 years or over (table 13A.11). The Australian Government's targets for the provision of residential and community care places are outlined in box 13.4.

Table 13.7 **Number of clients, aged care programs, 2008-09**

Program	*Number of clients*
Residential Care – Permanent	211 322
Residential Care – Respite	41 864
CACP	54 354
EACH	6 449
EACH-D	3 296
TCP	12 631
HACC	862 488

Source: DoHA (unpublished); table 13A.72.

Figure 13.9 **Operational residential places, CACPs, EACH and EACH-D packages, 30 June 2009**[a, b, c, d, e, f, g, h]

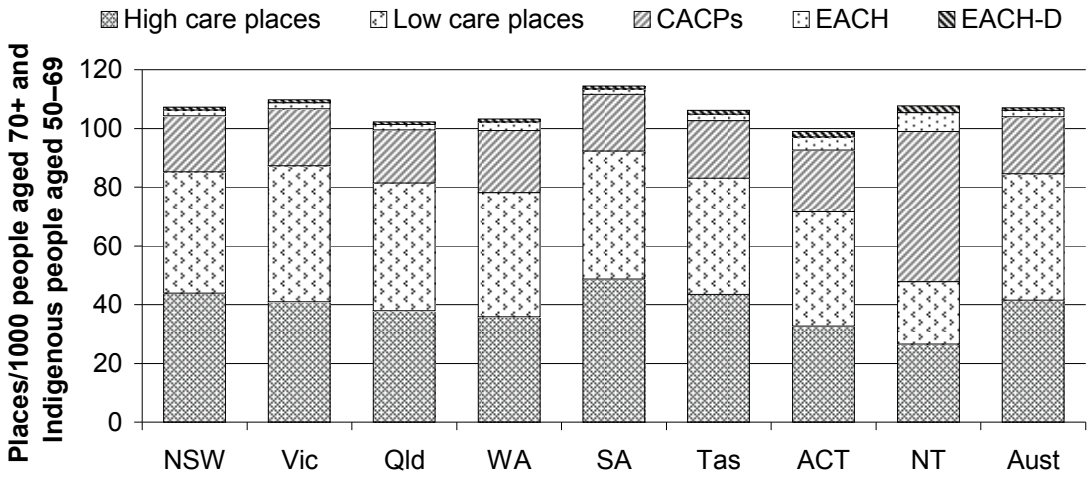


[a] Excludes places that have been approved but are not yet operational. [b] Ageing in place may result in some low care places being filled by high care residents. [c] For this Report, Australian Government planning targets are based on providing 113 places per 1000 people aged 70 years or over by 2011. 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] Includes residential places categorised as high care or low care. [e] CACPs, EACH and EACH-D packages are not residential services but are included in the Australian Government planning targets (see boxes 13.2 and 13.4 for an interpretation of residential care data and Australian Government planning targets). [f] CACPs include community care places under the National Aboriginal and Torres Strait Islander Aged Care Program, Multipurpose Services and Innovative Care. [g] TCP are not shown. [h] See table 13A.11 for further information regarding the calculation of provision ratios.

Source: DoHA (unpublished); table 13A.11.

The number of operational places can also be shown using the target population that incorporates Indigenous people aged 50–69 years (figure 13.10). Use of this 'adjusted' target population has a noticeable effect on the NT, which has a large proportion of Indigenous people.

Figure 13.10 **Operational residential places, CACPs, EACH and EACH-D packages adjusted for Indigenous people aged 50–69, 30 June 2009**[a, b, c, d, e, f, g]



[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] CACPs, EACH and EACH-D packages are not residential services but are included in the Australian Government planning targets (boxes 13.2 and 13.4 contain an interpretation of residential care data and Australian Government planning targets). [d] Includes residential places categorised as high care or low care [e] 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. [f] CACPs include community care places under the National Aboriginal and Torres Strait Islander Aged Care Program, Multipurpose Services and Innovative Care. [g] TCP places are not shown (table 13A.12).

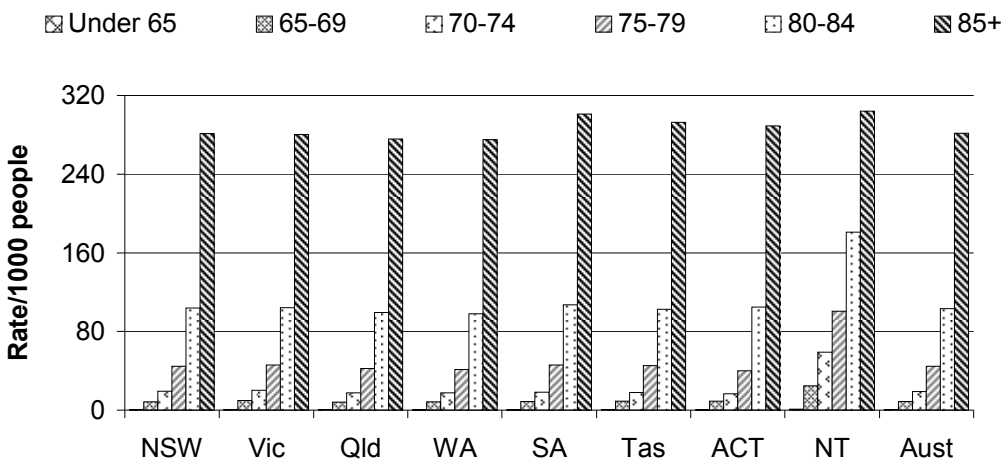
Source: DoHA (unpublished); table 13A.12.

Age-specific usage rates for these services, by jurisdiction and remoteness and for Indigenous usage, at 30 June 2009 are reported in tables 13A.62 to 13A.68.

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 can lead to apparently large fluctuations in growth rates. This can be seen from some of the usage rates identified for the EACH and EACH-D programs, which, whilst growing rapidly, are doing so from a relatively small base.

The national age specific usage rates per 1000 people for high and low residential care, CACP, EACH and EACH-D in combination at 30 June 2009 is 0.5 for people under 65 years of age and 281.7 for people aged 85 years or older. These rates vary across jurisdictions (figure 13.11).

Figure 13.11 **Permanent aged care residents, CACP, EACH and EACH-D recipients at 30 June 2009: age specific usage rates per 1000 people[a, b]**

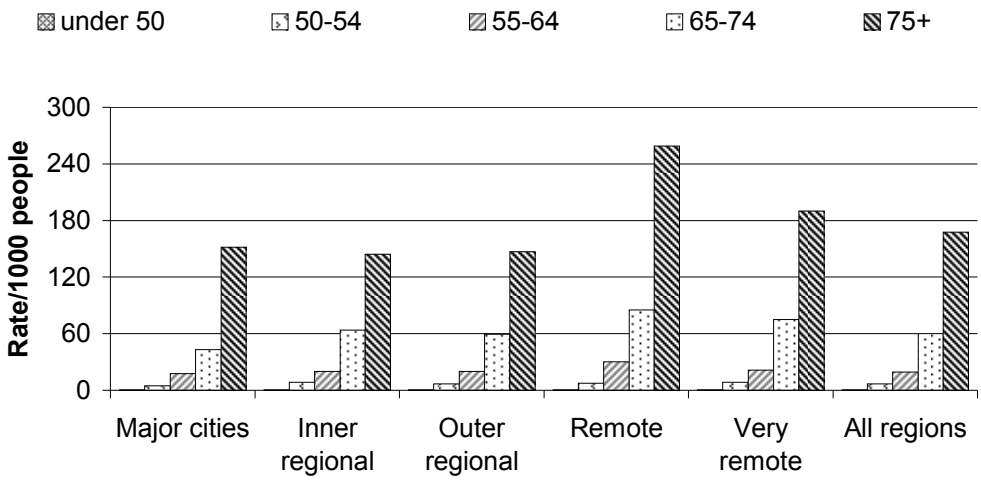


a Population data for June 2009 are population projections by SLA for 2007–2027 based on the 2006 Census prepared for DoHA by ABS according to assumptions agreed to by DoHA (see table 13A.2). **b** These figures exclude places funded by multi-purpose services and those provided by flexible funding under the Aboriginal and Torres Strait Islander Aged Care Program.

Source: DoHA (unpublished); table 13A.64.

The national age specific usage rates per 1000 Indigenous people for high and low residential care, CACP, EACH and EACH-D in combination at 30 June 2009 is 0.2 for people aged under 50 years and 167.7 for people aged over 75 years. 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 13.12).

Figure 13.12 **Indigenous permanent residents classified as high or low care and Indigenous CACP, EACH and EACH-D at 30 June 2009: age specific usage rates per 1000 people by remoteness[a, b, c, d]**



[a] Geographical data are based on the ABS Australian Standard Geographic Classification of Remoteness Areas. Data are classified according to an index of remoteness which rates each ABS census district based on the number and size of towns, the distance to major towns and urban centres. See table 13A.2 for more detail. [b] Historical rates in this figure may differ from those in previous Reports, as historical population data have been revised using Final Rebased Estimated Resident Population (ERP) data following the 2006 Census of Population and Housing (for 31 December 2002 to 2006). Similarly, new ABS Indigenous population estimates and projections have been used. [c] Includes residential places categorised as high care or low care [d] These figures exclude places and packages funded by Multi-purpose services and those provided by flexible funding under the Aboriginal and Torres Strait Islander Flexible Aged Care Program.

Source: DoHA (unpublished); table 13A.68.

13.2 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 13.8).

COAG has agreed six National Agreements to enhance accountability to the public for the outcomes achieved or outputs delivered by a range of government services (see chapter 1 for more detail on reforms to federal financial relations). The National Healthcare Agreement (NHA) covers the area of aged care services, while the National Indigenous Reform Agreement (NIRA) establishes specific outcomes

for reducing the level of disadvantage experienced by Indigenous Australians. The agreements include sets of performance indicators for which the Steering Committee collates annual performance information for analysis by the COAG Reform Council (CRC).

The measurement details of relevant National Agreement reporting were under development at the time of preparing this Report. It is anticipated that the performance indicator results reported in this chapter will be revised to align with the performance indicators in the National Agreements for the 2011 Report.

Box 13.8 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.

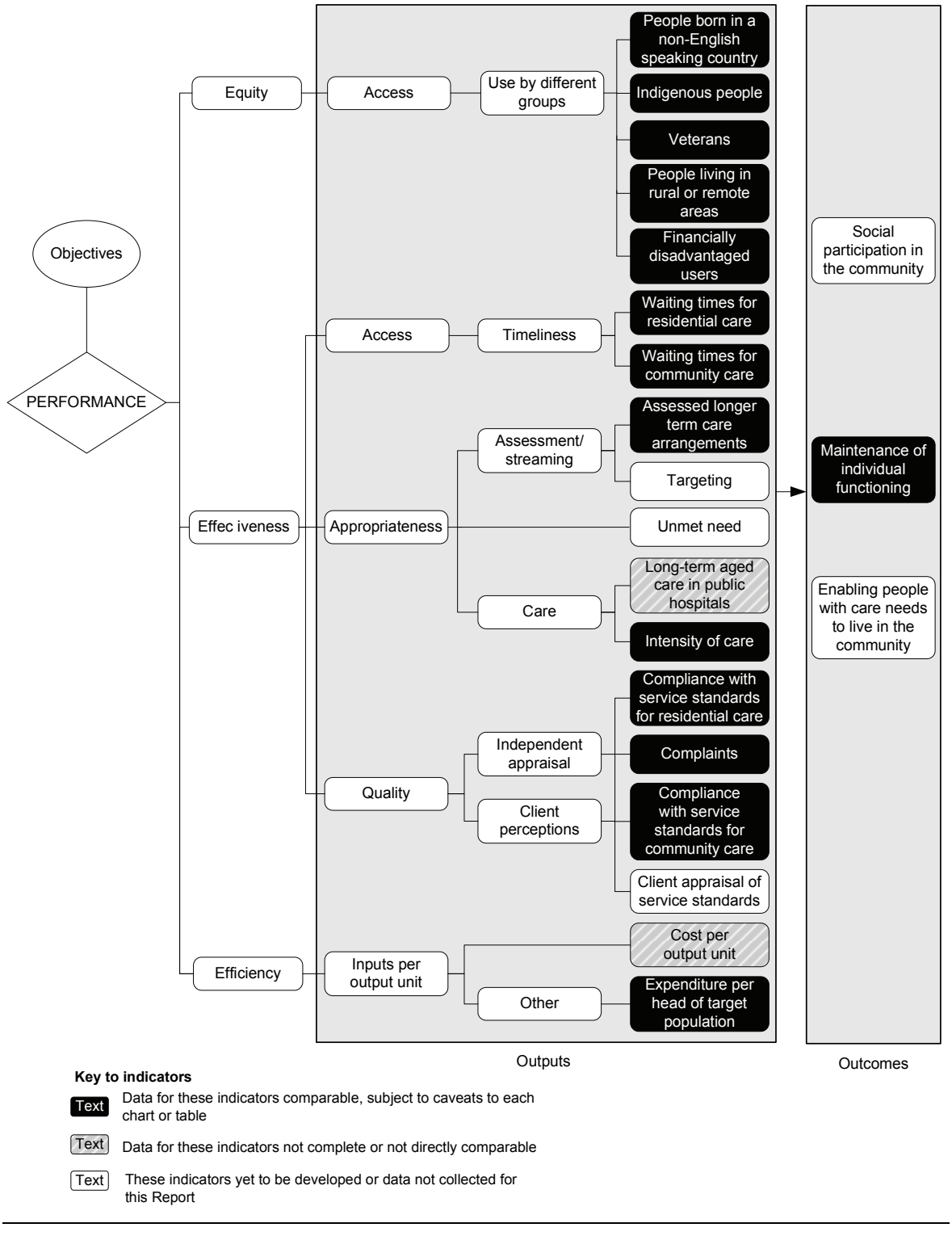
The performance indicator framework shows which data are comparable in the 2010 Report (figure 13.13). For data that are not considered strictly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

13.3 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 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).

Figure 13.13 **Performance indicators for aged care services**



Outputs

Outputs are the actual services delivered (while outcomes are the impact of these services on the status of an individual or group) (see chapter 1, section 1.5).

Equity — Access

Use by different groups

'Use by different groups' is an indicator of governments' objective for the aged care system to provide equitable access to aged care services for all people who require these services (box 13.9).

Box 13.9 **Use by different groups**

'Use by different groups' is defined as:

- the number of people born in non-English speaking countries using residential services, CACPs, EACH, EACH-D 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 (number of people aged 70 years or over plus Indigenous people aged 50–69 years) accesses the service
- the number of Indigenous people using residential services, CACP, EACH, EACH-D 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 (number of people aged 70 years or over plus Indigenous people aged 50–69 years) accesses the service
- the rate of contacts with Commonwealth Carelink Centres for Indigenous people benchmarked against the rate for all people
- the number of veterans aged 70 years and over in residential care divided by the total number of eligible veterans aged 70 years and over, where a veteran is defined as a DVA Gold or White card holder
- access to HACC services for people living in rural or 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 number of new residents classified as concessional or assisted or supported, divided by the number of new residents.

(Continued on next page)

Box 13.9 **(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 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, assisted or supported residents. These targets range from 16 per cent to 40 per cent of places, depending on the service's region. Usage rates equal to, or higher than, the minimum rates are desirable.

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).

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.

Data to report on veterans for this indicator has been included for the first time.

Data reported for this indicator are comparable.

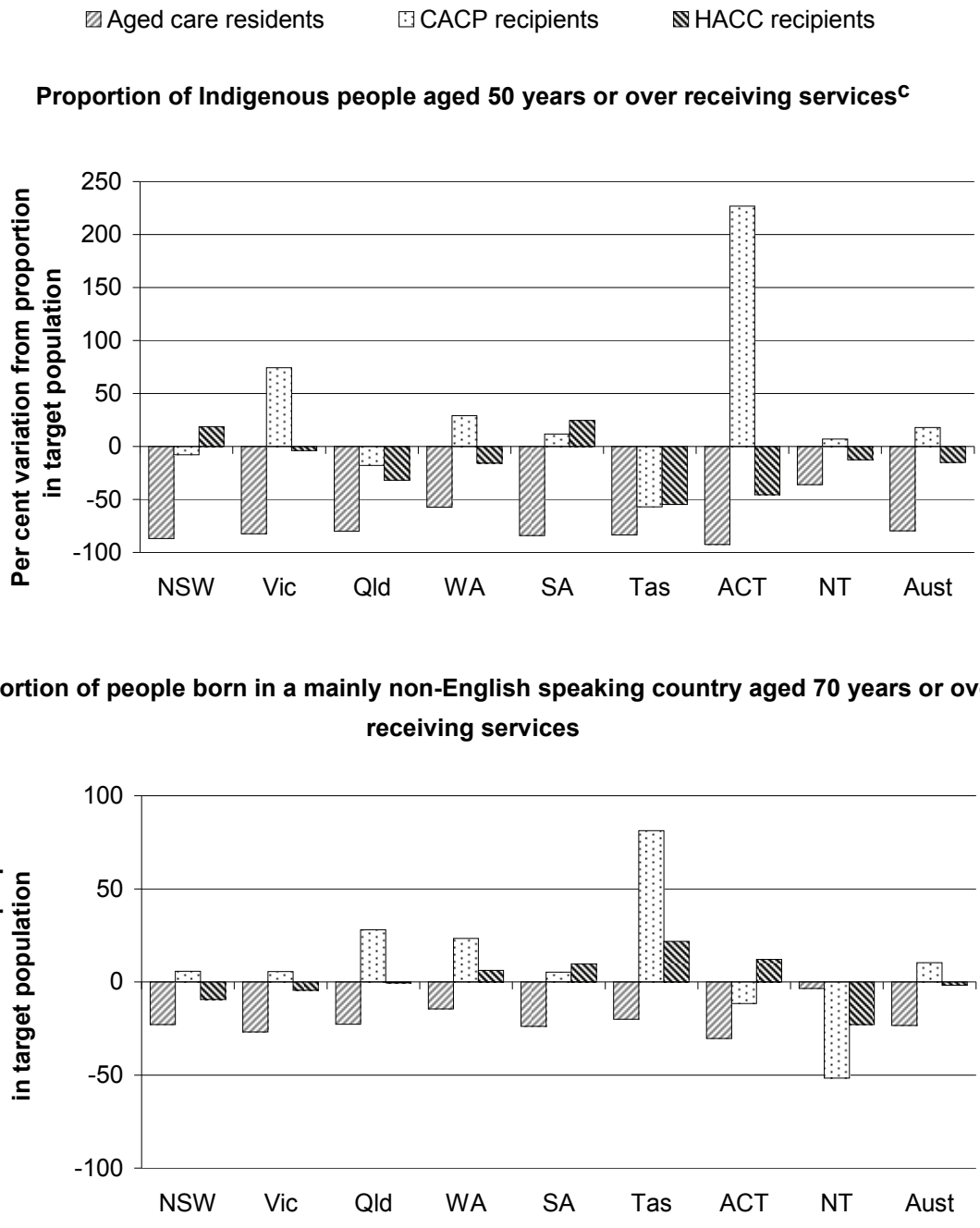
Data presented for this indicator are organised by the type of service provided, with sub-sections for the relevant special needs groups reported against that service.

Access to residential care services, CACP and HACC services by Indigenous people and people born in a mainly non-English speaking country

In general, Indigenous people and people born in a mainly non-English speaking country are under-represented in some aspects of access to residential care, CACP and HACC services in comparison to their proportion of the target population as a whole.

However, in relation to the CACP program in the majority of jurisdictions and nationally, Indigenous people and people born in a mainly non-English speaking country are over-represented, compared to the proportion of this group in the target population. Figure 13.14 demonstrates this over- and under-representation by reflecting the variation in the rate of access of the special needs target population from their proportion in the target population as a whole. If the special needs group accessed services in proportion to their general representation in the target population, no percentage variation would be observed. If they access services at a greater rate, a positive percentage from the benchmark rate will be observed, or, if services are accessed at a lower rate, the bar will be negative (figure 13.14).

Figure 13.14 **Variation in the proportions of special needs target populations accessing aged care services from their proportion in the target population as a whole, June 2009[a, b]**



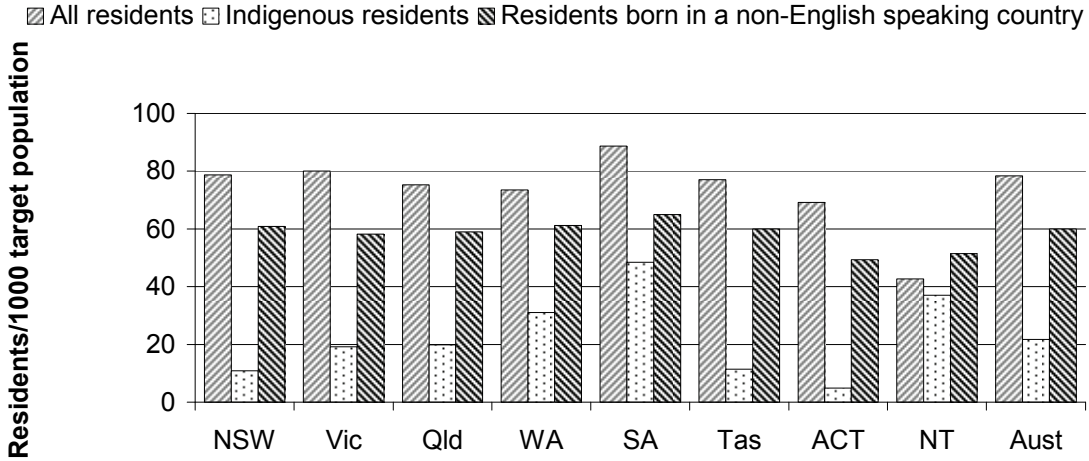
a The proportion of HACC funded agencies that submitted Minimum Data Set data for 2008-09 differed across jurisdictions and ranged from 89 per cent to 100 per cent. Consequently, actual service levels were higher than stated. **b** Reports provisional HACC data that have not been validated and may be subject to revision. **c** The ACT has a very small Indigenous population aged 50 years or over (table 13A.2) and a small number of packages result in a very high provision ratio.

Source: DoHA (unpublished); table 13A.19.

Access to residential aged care services by Indigenous people and people born in a mainly non-English speaking country

In all jurisdictions at 30 June 2009, on average, Indigenous people and people born in non-English speaking countries had lower rates of use of aged care residential services (21.7 and 60.0 per 1000 of the relevant target populations respectively), compared with the population as a whole (78.4 per 1000) (figure 13.15).

Figure 13.15 **Residents per 1000 target population, 30 June 2009**[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 13A.13, 13A.15 and 13A.17.

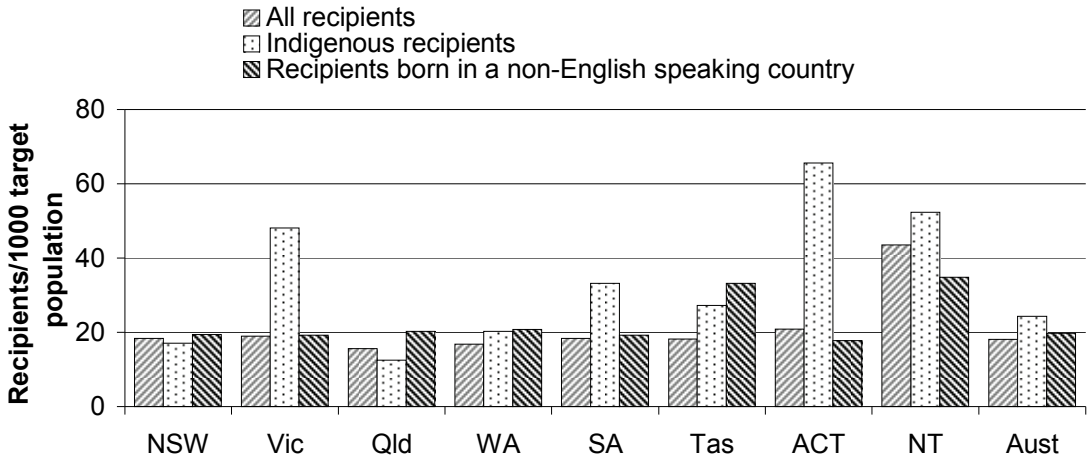
Age specific usage rates for these services, by jurisdiction and remoteness are included in the Report. These data suggest there is significant variation in usage rates by remoteness area. In general, differences amongst jurisdictions are less marked than differences between remoteness areas (tables 13A.14, 13A.16, 13A.18, 13A.62, 13A.64-65, 13A.67-68).

Access to aged care community programs by Indigenous people and people born in a mainly non-English speaking country

The number of Indigenous CACP recipients per 1000 Indigenous people aged 50 years or over was 24.3 nationally and the numbers of CACP recipients from non-English speaking countries per 1000 of the relevant target population was 19.7 nationally. These figures compare to a total of 18.1 per 1000 of the target

population (people aged 70 years or over plus Indigenous people aged 50–69 years) (figure 13.16).

Figure 13.16 **Community Aged Care Package recipients per 1000 target population, 30 June 2009**[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 13A.2), and a small number of packages 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.

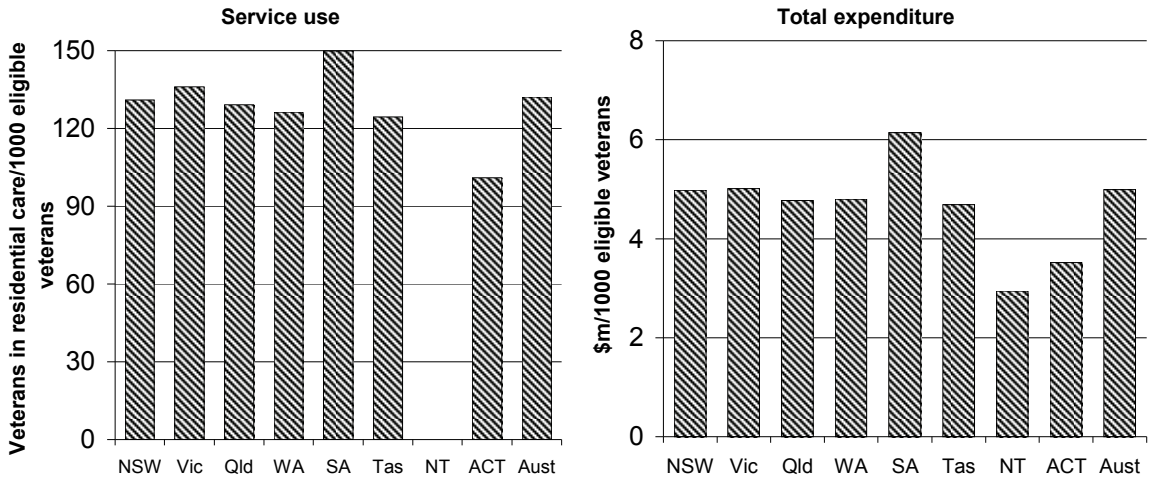
Source: DoHA (unpublished); tables 13A.13, 13A.15 and 13A.17.

Age–sex specific usage rates by jurisdiction, remoteness and Indigenous usage vary between jurisdictions and remoteness categories for CACP. For EACH and EACH-D, the differences are less marked. However, the EACH and EACH-D programs are small and growing rapidly (tables 13A.63-64 and 13A.66–68).

Access by veterans

The total number of veterans 70 years and over who were in the DVA treatment population at 30 June 2009 was 192 267. (table 13A.45) The number of veterans 70 years and over in residential care per 1000 eligible veterans 70 years and over at 30 June 2009 was 132.1 (figure 13.17). Nationally, total DVA expenditure for veterans 70 years and over was $467.3 (table 13A.45).

Figure 13.17 **Number of veterans aged 70 years and over in residential care and total expenditure on veterans aged 70 years and over per 1000 eligible veterans 70 years and over, 2008-09**[a, b, c, d]



[a] Data are subject to lag and may be subject to revision. [b] Number of veterans is the number of DVA Gold and White card holder residents as at June 2009. [c] Clients' data from the NT have been included with SA data due to the small number of clients. [d] Veterans 70 years and over includes those whose age is unknown.

Source: DVA (unpublished); DoHA (unpublished); table AA.26; table 13A.45.

Access to the HACC program

HACC services are provided in the client's home or community for people with a moderate, severe or profound disability and their carers. The focus of this chapter is all people 70 years or over and Indigenous people aged 50–69 years. The proportion of HACC recipients aged 70 years or over during 2008-09 was 69.1 per cent (table 13A.33).

The number of service hours per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years was 12 830 nationally, and the number of meals provided per 1000 people aged 70 years or over plus Indigenous people aged 50–69 was 5001 nationally (table 13.8). The proportion of HACC agencies that submitted the data vary across jurisdictions and comparisons between jurisdictions should be made with care.

Table 13.8 **HACC services received, 2008-09 (per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years)[a, b, c]**

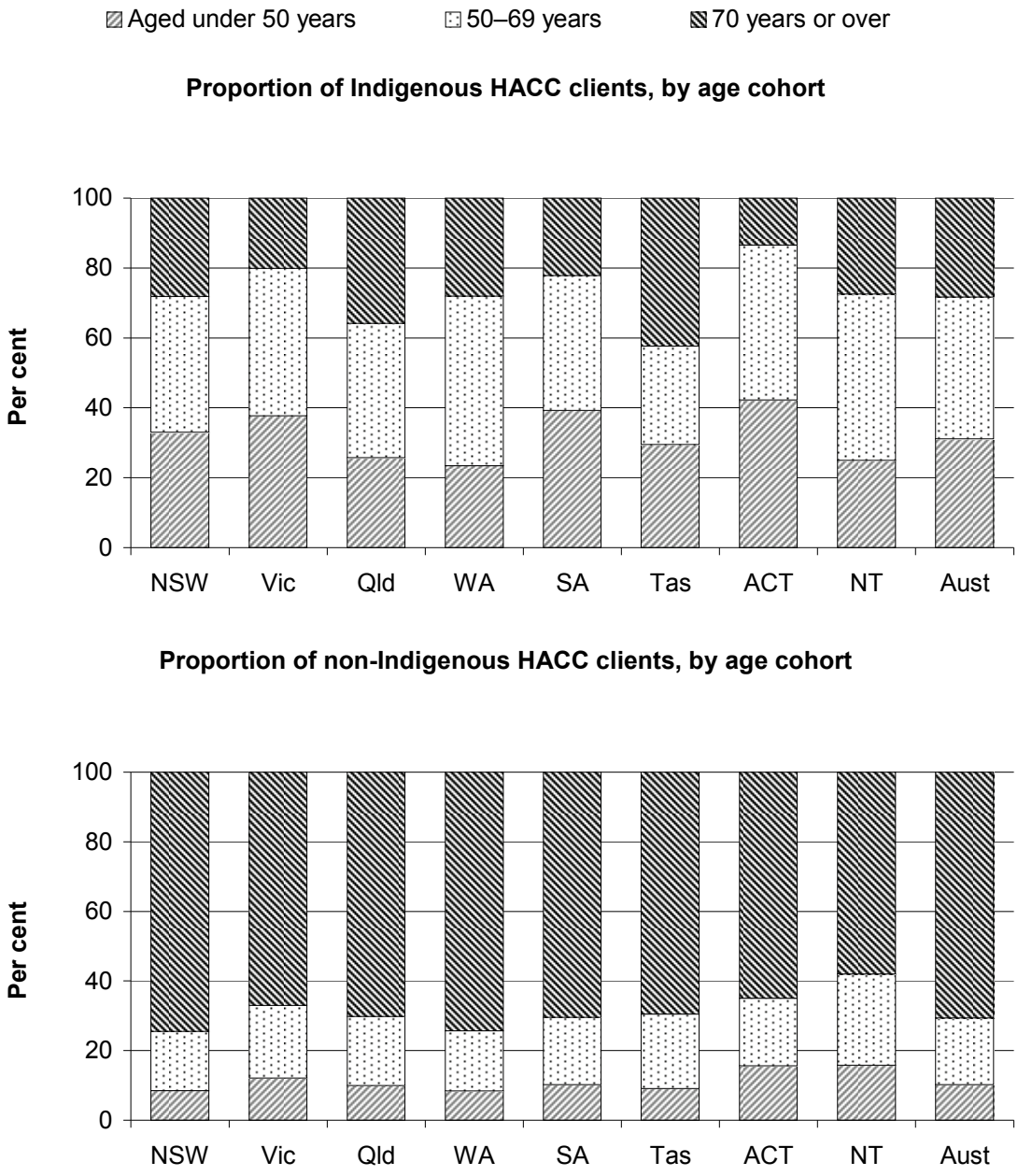
	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Percentage of agencies that reported minimum data set data	89	95	95	99	98	99	100	99	93
Total hours (no.)[d]									
Major cities	9 941	14 200	14 790	15 943	12 435	..	10 114	..	12 739
Inner regional	9 068	15 927	12 013	13 355	11 321	12 350	..	..	11 987
Outer regional	12 320	19 007	13 789	19 476	12 705	10 111	..	8 943	14 144
Remote	16 821	24 827	19 876	17 872	16 292	11 717	..	9 912	17 058
Very remote	16 030	..	19 576	29 384	32 613	21 279	..	16 473	21 965
All areas	**9 968**	**14 912**	**14 113**	**16 194**	**12 581**	**11 646**	**10 114**	**11 733**	**12 830**
Total meals (no.)[e]									
Major cities	3 517	4 766	5 093	4 230	6 752	..	3 563	..	4 503
Inner regional	4 636	6 360	5 365	4 240	4 612	4 721	..	..	5 194
Outer regional	6 038	6 464	5 419	6 374	8 617	5 444	..	4 390	6 158
Remote	7 528	8 105	7 613	9 491	8 184	6 296	..	14 860	8 937
Very remote	6 826	..	8 628	23 446	30 361	7 733	..	33 536	21 022
All areas	**4 021**	**5 238**	**5 297**	**4 956**	**6 926**	**5 001**	**3 563**	**16 747**	**5 001**

[a] Data represent HACC services received by people aged 70 years or over, plus Indigenous people aged 50-69 years, divided by people aged 70 years or over, plus Indigenous people aged 50–69 years (tables 13A.21–26) as distinct from HACC services received divided by HACC target population in all age groups (tables 13A.27–32). [b] The proportion of HACC funded agencies that submitted Minimum Data Set data for 2008-09 differed across jurisdictions and ranged from 89 per cent to 100 per cent. Consequently, actual service levels were higher than stated. [c] Reports provisional HACC data that have not been validated and may be subject to revision. [d] See table 13A.21 for a full list of categories. [e] Includes home meals and centre meals. .. Not applicable.

Source: DoHA Home and Community Care Minimum Data Set 2008-09 (unpublished); DoHA HACC National Data Repository (unpublished); tables 13A.21–26.

Reported use of HACC services showed a substantial difference between all users and Indigenous users across all age groups in 2008-09. 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 or over is 28.3 per cent and the proportion of non-Indigenous HACC clients who are aged 70 years or over is 70.6 per cent (figure 13.18).

Figure 13.18 **Recipients of HACC services by age and Indigenous status, 2008-09**[a, b]



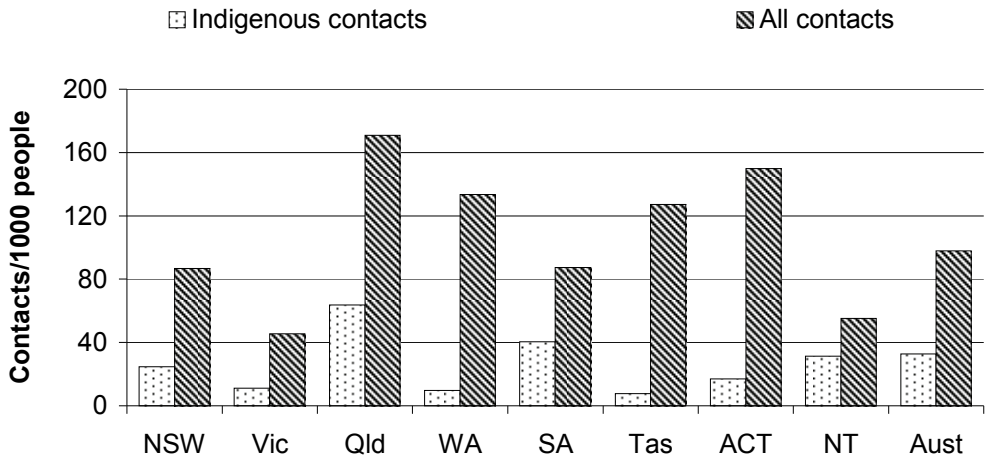
[a] Reports provisional HACC data that have not been validated and may be subject to revision. [b] The proportion of HACC clients with 'nil' and 'not stated' Indigenous status differed across jurisdictions and ranged from 6.3 per cent to 14.8 per cent. Nationally, the proportion of HACC clients with 'nil' and 'not stated' Indigenous status was 9.7 per cent

Source: DoHA (unpublished); table 13A.34.

Access by Indigenous people to Commonwealth Carelink Centres

Commonwealth Carelink Centres are information centres for older people, people with disabilities, carers and service providers. 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 2009, was 32.8 people per 1000 Indigenous people in the Indigenous target population (Indigenous people aged 50 years and over). The rate for all Australians was 97.9 per 1000 people in the target population (people aged 70 years or over plus Indigenous people aged 50–69). These figures varied across jurisdictions (figure 13.19).

Figure 13.19 **Commonwealth Carelink Centres, contacts per 1000 target population, by Indigenous status, 30 June 2009**[a, b, c, d]



[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. [d] People making contact self identify as Indigenous. Therefore, there is likely to be substantial under-reporting of Indigenous status.

Source: DoHA (unpublished); table 13A.60.

Access to residential services by financially disadvantaged users

The financial assistance arrangements for financially disadvantaged users were changed on 20 March 2008, to include a new category known as supported residents (box 13.10).

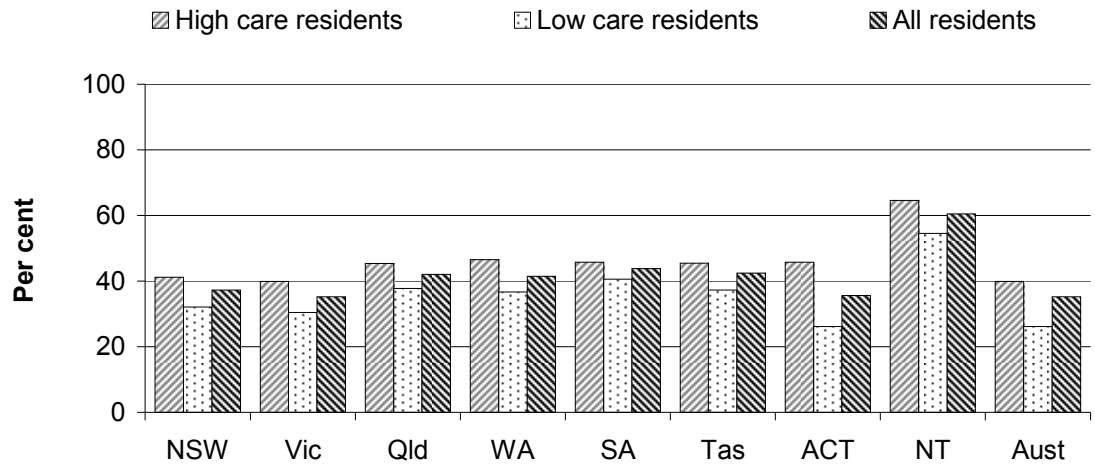
Box 13.10 **Supported residents**

In 2008, new arrangements governing residents' contributions to their accommodation costs and the supplements the Australian Government pays for residents who cannot meet all or part of their own accommodation costs were introduced. These new arrangements only apply to residents who first enter permanent residential care on or after 20 March 2008, or who re-enter care on or after 20 March 2008, after a break in care of more than 28 days.

New residents who are assessed as eligible to receive subsidised accommodation costs are known as supported residents. Residents who entered care prior to 20 March 2008 are still subject to the eligibility criteria for 'concessional' or 'assisted' resident status.

The proportion of all new residents classified as supported residents during 2008-09 was 35.2 per cent nationally but varied across jurisdictions (figure 13.20). Targets for financially disadvantaged users range from 16 per cent to 40 per cent of places, depending on the service's region.

Figure 13.20 **New residents classified as supported residents, 2008-09**[a]



[a] Supported residents are those who have entered permanent residential care on or after 20 March 2008 (or who re-enter care on or after 20 March 2008 after a break in care of more than 28 days) and have assets of up to a set value ($90 910.40 as at 30 June 2009).

Source: DoHA (unpublished); table 13A.20.

Effectiveness — timeliness of access

Waiting times for residential care

'Waiting times for residential care' is an indicator of governments' objective to maximise the timeliness with which people are able to access residential care (box 13.11).

Box 13.11 **Waiting times for residential care**

'Waiting times for residential care' is defined as the number of people who are admitted to residential high care within three months of their ACAT approval as a proportion of the total number of people with an ACAT approval to enter high care. ACAT approval refers to the approval date of the most recent ACAT assessment prior to admission into care. Entry into a residential care service refers to the date of admission to a residential care service. In the calculation of waiting time, the most recent ACAT approval prior to entry is used.

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

This indicator needs to be interpreted with care. The measure of 'elapsed time' is utilised because the period of time between the ACAT approval and entry into residential care may be due to factors which cannot be categorised as 'waiting' time. These include:

- clients with ACAT approvals 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 impact on clients of programs which provide alternatives to residential care, such as EACH and EACH-D
- client choice not to enter residential care immediately but to take up the option at a later time.

(Continued on next page)

Box 13.11 **(Continued)**

The measure focuses on high care services because, as a proxy for waiting time, the link between entry to residential care and elapsed time is stronger for high care residents than for low care residents. This is due to the urgency for high care residents' needs, and the greater number of alternatives for people with ACAT approvals for low care only. Waiting time measures for low care are included in the attachment tables.

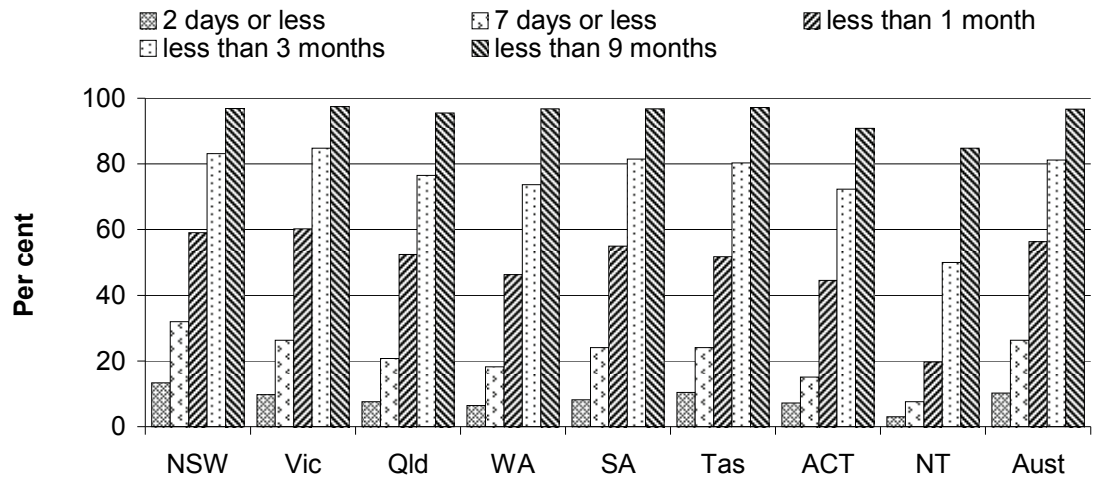
It is recognised that this indicator has limitations and work is underway to review the data. This indicator will continue to be reported until improved data are available.

Data reported for this indicator are comparable.

Overall, 26.3 per cent of all people entering residential high care during 2008-09 did so within 7 days of being approved by an ACAT compared with 22.9 per cent in 2007-08. In 2008-09, 56.3 per cent entered within one month of their ACAT approval and 81.2 per cent entered within 3 months of their approval compared with 51.5 per cent and 77.3 per cent respectively in 2007-08. These proportions varied across jurisdictions (figure 13.21) (SCRGSP 2009, table 13A.37). The median time for entry into high care residential services was 23 days in 2008-09 compared with 28 days in 2007-08 (table 13A.37) (SCRGSP 2009, table 13A.37).

Nationally, a greater proportion of people entering high care residential services entered within 3 months of approval (81.2 per cent), compared with the proportion entering low care residential services within that time (61.4 per cent). These proportions varied across jurisdictions (table 13A.37).

Figure 13.21 **People entering high care residential care within specified time periods of their ACAT approval, 2008-09[a]**



a Includes residential places categorised as high care.

Source: DoHA (unpublished); table 13A.37.

Waiting times for community care

'Waiting times for community care' is an indicator of governments' objective to maximise the timeliness with which people are able to access community care (box 13.12).

Box 13.12 **Waiting times for community care**

'Waiting times for community care' is defined as the number of people who are commencing a CACP within one month or within three months of their ACAT approval as a proportion of the total number of people with an ACAT approval to commence a CACP. ACAT approval refers to the approval date of the most recent ACAT assessment prior to admission into care. Entry into a CACP service refers to the date of commencement of a CACP service. In the calculation of waiting time, the most recent ACAT approval prior to entry is used.

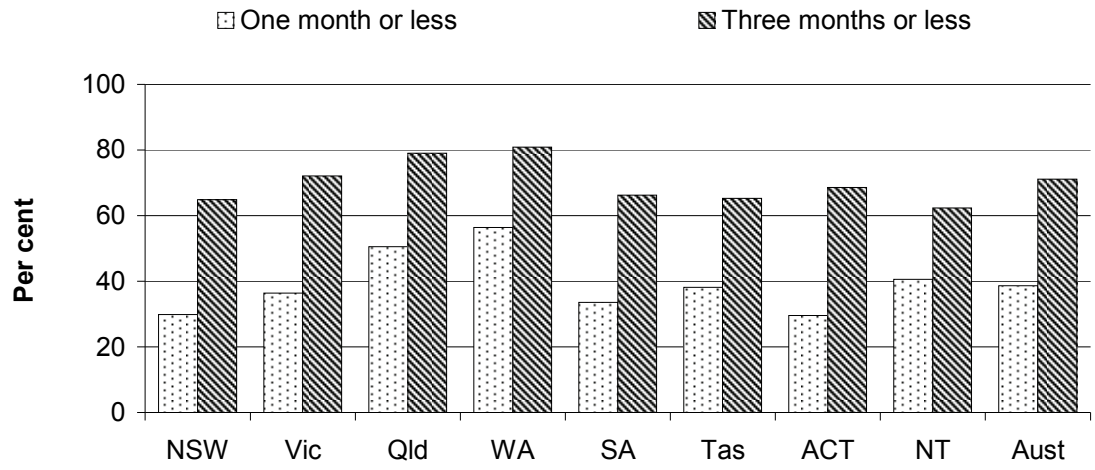
Shorter waiting times (measured by higher rates of commencement of a CACP service within one or three months of ACAT approval) are desirable.

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

Data reported for this indicator are comparable.

Overall, 71.1 per cent of all people receiving a CACP during 2008-09 received it within three months of being approved by an ACAT. This proportion varied across jurisdictions. On average, 38.6 per cent started receiving a CACP within one month of their ACAT approval (figure 13.22).

Figure 13.22 **People commencing a CACP within one or three months of their ACAT approval, 2008-09**



Source: DoHA (unpublished); table 13A.37.

Effectiveness — appropriateness

Assessed longer term care arrangements

'Assessed longer term care arrangements' is an indicator of governments' objective to meet clients' needs through provision of appropriate aged care services (box 13.13).

Box 13.13 **ACAT recommended longer term living arrangements**

'Assessed longer term care arrangements' is defined as the proportions of ACAT clients recommended to remain at home or in residential care (permanent or respite), as aged care assessments are mandatory for admission to Australian Government subsidised residential care or for receipt of a CACP, EACH, EACH-D or TCP package.

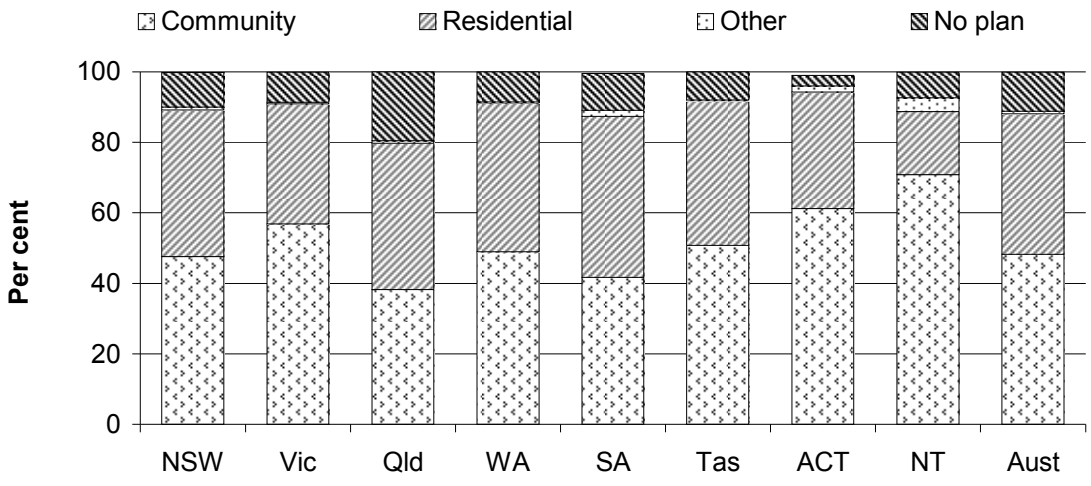
Higher or increasing proportions of clients remaining in the community are desirable.

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.

Data reported for this indicator are comparable.

The national proportion of ACAT clients approved for residential care in 2007-08 was 39.8 per cent and the proportion recommended to remain in the community was 48.3 per cent (13A.38). No long term plan was made for 11.0 per cent, which included deaths, cancellations and transfers. These proportions varied across jurisdictions (figure 13.23).

Figure 13.23 **Recommended longer term living arrangements of ACAT clients, 2007-08**[a]



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

Source: Aged Care Assessment Program National Data Repository (unpublished); table 13A.38.

Targeting

'Targeting' has been identified for development as an indicator of governments' objective to ensure that services are allocated to those people in greatest need (box 13.14).

Box 13.14 **Targeting**

'Targeting' has yet to be defined.

Data for this indicator were not available for the 2010 Report.

Unmet need

'Unmet need' is an indicator of governments' objective of ensuring aged care services are allocated to meet clients' needs (box 13.15).

Box 13.15 **Unmet need**

'Unmet need' is defined as the extent to which demand for services to support older people requiring assistance with daily activities is not met.

While low rates of unmet need are desirable, defining and determining the level of need at an individual level, let alone at a population level, is complex. 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. Data are for people aged 70 years or over who self-identified as having a need for assistance with at least one everyday activity, and the extent to which that need was being met (fully, partly or not at all).

Direct inferences about the demand for services need to be made with care, because the measure used does 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 are valid policy approaches
- 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 health care.

Although data are included here, this indicator is regarded as yet to be developed, because of the extent of the caveats.

Of those people aged 70 years or over in 2003, who were living in households and who self-identified as having a need for assistance with at least one everyday activity, over one third (36.1 per cent) reported that their needs for assistance were not fully met (table 13A.70 and SCRGSP 2009).

Long term aged care in public hospitals

'Long term aged care in public hospitals' is an indicator of governments' objective to minimise the incidence of older people staying in public hospitals when their care needs may be met through residential or community care services (box 13.16).

Box 13.16 **Long term aged care in public hospitals**

Long term aged care in public hospitals' is defined as the proportion of completed hospital separations for people aged 70 years or over plus Indigenous people aged 50–69 years where:

- the care type was maintenance, and
- the diagnosis (either principal or additional) was either 'person awaiting admission to residential aged care service' or 'need for assistance at home and no other household member able to render care', and
- where the length of stay was 35 days or longer.

A low proportion of stays of 35 days or more is desirable.

Hospital 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.

This measure should be interpreted with care.

- Patients who have not completed their hospital stay are not included.
- Although the diagnosis codes reflect a care type, they do not determine a person's eligibility for residential aged care (this is determined by an ACAT assessment) or necessarily reliably reflect access issues for residential aged care from the acute care sector.
- Diagnosis codes may not be applied consistently across jurisdictions or over time.
- Reported hospital separations do not necessarily reflect the full length of hospital stay for an individual patient. If a change in the type of care occurs during a patient's hospital stay (for example, from acute to maintenance) then two separations are reported for that patient.
- The code 'need for assistance at home and no other household member able to render care' may also be used for respite care for aged care residents or those receiving community care, and some jurisdictions may have a high proportion of this type of use. This is particularly relevant in some rural areas where there are few alternative options for these clients.

(Continued on next page)

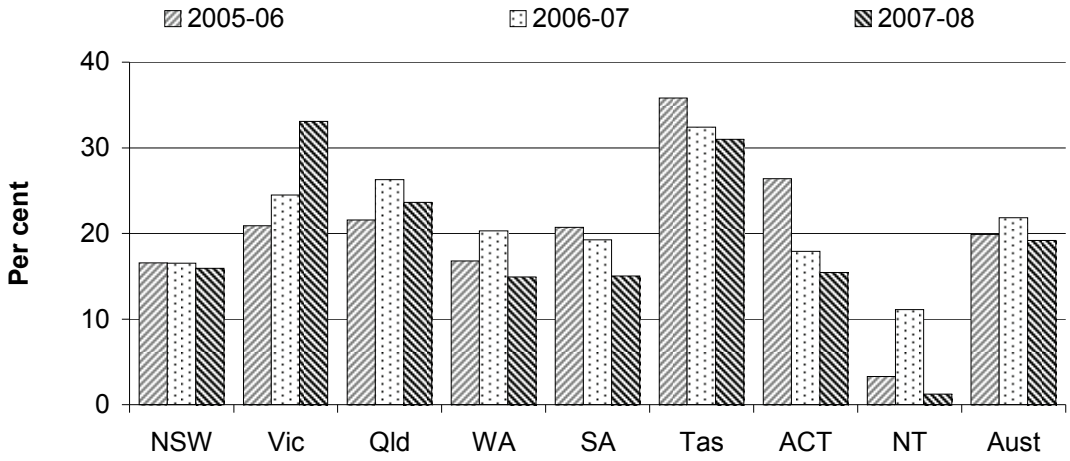
Box 13.16 **(Continued)**

- The measure does not necessarily reflect alternative strategies in place by states and territories to manage the older person into appropriate residential aged care facilities from acute care hospitals.
- The measure is regarded as a proxy, as the desired measures (utilising appropriate linked hospital separations and ACAT approvals) are not available at this time. Further development is underway to improve available data sets and associated measures for future Reports.

Data reported for this indicator are not directly comparable.

The proportion of separations for patients aged 70 years or over plus Indigenous people aged 50–69 years who had a care type of maintenance with a diagnosis (either principal or additional) of either 'person awaiting admission to residential aged care service' or 'need for assistance at home and no other household member able to render care', and whose separation was 35 days or longer was 19.2 per cent nationally, in 2007-08. This proportion varied across jurisdictions (figure 13.24). These data reflect only a small proportion of all public hospital separations for patients aged 70 years or over plus Indigenous people aged 50–69 years (10 843 separations of a total of 1.4 million nationally) (table 13A.71).

Figure 13.24 **Proportion of long term separations for aged care patients, in public hospitals**[a, b, c, d, e, f, g]



[a] Data are for hospital separations with a care type of maintenance and a diagnosis (either principal or additional) of either 'person awaiting admission to residential aged care service' or 'need for assistance at home and no other household member able to render care' and where the separation lasted 35 days or longer. [b] Age of patients is 70 years or over, plus Indigenous patients 50–69 years. [c] Although the diagnosis codes reflect a care type, they do not determine a person's eligibility for residential aged care. [d] Diagnosis codes may not be applied consistently across jurisdictions or over time. [e] These data only account for completed unlinked separations. [f] The code 'need for assistance at home and no other household member able to render care' may also be used for respite care for either residential or community care patients. [g] An individual patient may have multiple hospital separations during a single hospital stay, for example, if a change in the type of care occurs during a patient's hospital stay. Data on length of stay relate to each separation and not to the whole hospital stay.

Source: AIHW (unpublished); table 13A.71.

Intensity of care

'Intensity of care' is an indicator of governments' objective to encourage 'ageing in place' to increase choice and flexibility in residential aged care service provision (box 13.17).

Box 13.17 **Intensity of care**

'Intensity of care' is defined by two measures:

- the proportion of people who stayed in the same residential aged care service when changing from low care to high care
- the proportion of low care places occupied by residents with high care needs, compared with the proportion of all operational places taken up by residents with high care needs.

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

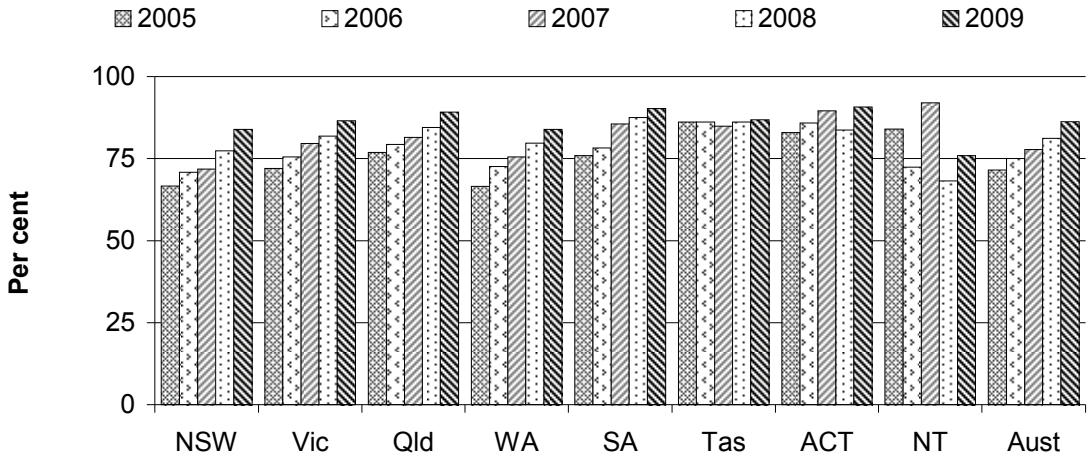
These measures reflect the proportion of residents who remain in the same residential aged care facility as their care needs increase from low care to high care. The Aged Care Act aims explicitly to encourage ageing in place to increase choice and flexibility in residential aged care service provision (box 13.6).

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 services system over time.

Data reported for this indicator are comparable.

Nationally, from June 2005 to June 2009, 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 71.5 per cent to 86.2 per cent (figure 13.25). In June 2009 the proportion was higher in inner regional areas (88.1 per cent), outer regional areas (86.8 per cent), remote areas (93.3 per cent) and very remote areas (95.0 per cent) than in major cities (85.4 per cent) (table 13A.58).

Figure 13.25 **Proportion of residents who changed from low care to high care and remained in the same aged care service, June[a]**

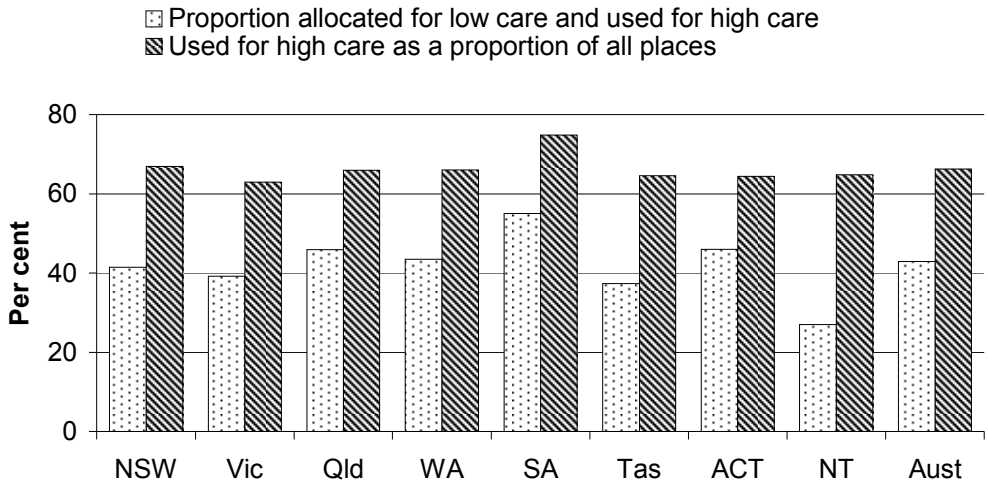


a For June 2009, includes residential places categorised as high care or low care.

Source: DoHA (unpublished); table 13A.58.

Nationally, 42.9 per cent of low care places in 2008-09 were occupied by residents with high care needs. The proportion of all operational places taken up by residents with high care needs was 66.3 per cent (figure 13.26). These data are provided by remoteness area in table 13A.61.

Figure 13.26 **Utilisation of operational residential places, 30 June 2009[a]**



a Includes residential places categorised as high care or low care.

Source: DoHA (unpublished); table 13A.61.

Effectiveness — quality

Compliance with service standards for residential care

'Compliance with service standards for residential care' is an indicator of governments' objective to ensure residential care services attain high levels of service quality, through compliance with certification and accreditation standards (box 13.18).

Box 13.18 **Compliance with service standards for residential care**

'Compliance with service standards for residential care' is defined by two measures:

- the proportion of accredited services which have received 3 year re-accreditation, by meeting accreditation standards
- the percentage of aged care services that are compliant with building certification, fire safety and privacy and space requirements.

The extent to which residential care services comply with service standards implies a certain level of care and service quality.

High or increasing rates of approval for three year re-accreditation are desirable.

Since 2001, each Australian Government funded residential service has been required to meet accreditation standards (which comprise 44 expected outcomes). The accreditation indicator reflects the period of accreditation granted. The accreditation process is managed by the Aged Care Standards and Accreditation Agency Ltd (ACSAA). A service must apply to ACSAA for accreditation and its application is based on a self-assessment of performance against the accreditation standards. Following an existing residential service applying for accreditation, a team of registered quality assessors reviews the application, conducts an onsite assessment and prepares a report based on these observations, interviews with residents, relatives, staff and management, and relevant documentation. 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. Commencing services are subject to a desk audit only, and are accredited for one year.

A home must be certified to be able to receive accommodation payments and extra service charges. Residents expect high quality and safe accommodation in return for their direct and indirect contributions, therefore all aged care homes are required to meet fire safety and privacy and space targets to be eligible to receive the maximum level of the accommodation supplement.

(Continued on next page)

Box 13.18 **(Continued)**

While certification is not time limited, it is based on the principle of continuous improvement and an agreed 10-year plan, introduced in 1999, provides homes with a clear framework for improving safety, privacy and space standards. Every aged care home that was constructed prior to July 1999 is 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 or bath.

Under the privacy and space requirements, all new buildings constructed since July 1999, are required to have an average, for the whole aged care home, of no more than 1.5 residents per room. No room may accommodate more than two residents. There is also a mandatory standard of no more than three residents per toilet, including those off common areas, and no more than four residents per shower or bath.

Data reported for this indicator are comparable.

Accreditation decisions and further information relating to the accreditation standards and ACSAA are publicly available (ACSAA 2009). The accreditation process is summarised in box 13.18.

At 30 June 2009, 92.9 per cent of residential aged care services had been granted a re-accreditation approval for a period of three years. This proportion varied across jurisdictions (table 13.9).

Table 13.9 **Re-accreditation decisions on residential aged care services, 30 June 2009[a, b]**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Re-accreditation period										
<2 years	%	1.1	2.7	6.6	3.7	5.6	–	4.2	14.3	3.2
2 years or more (but <3 years)	%	2.5	3.9	7.4	1.6	3.0	8.3	4.2	7.1	3.9
3 years	%	96.4	93.4	86.0	94.7	91.5	91.7	91.7	78.6	92.9
Total	**%**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total re-accredited services	**no.**	**880**	**770**	**471**	**244**	**270**	**84**	**24**	**14**	**2 757**

a Data for 2007-08 relate only to re-accreditations, and do not include accreditation periods for commencing services (37 in 2008-09). Earlier reports included both initial accreditations and re-accreditations. **b** Note that 'accreditation period' shows the decision in effect at 30 June 2009. The figures in this table will not necessarily agree with the accreditation decisions made in 2008-09, because those decisions may not yet have taken effect, or may have been superseded. – Nil or rounded to zero.

Source: ACSAA (unpublished); table 13A.41.

The measure 'average residents per room' has been replaced with the more comprehensive measure 'the percentage of aged care services that are compliant

with building certification, fire safety and privacy and space requirements' (box 13.18).

Nationally, as at 30 June 2009, 98.5 per cent of aged care services were compliant as outlined in table 13.10.

Table 13.10 **Residential aged care services compliant with building certification, fire safety and privacy and space requirements at 30 June 2009**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*[a]	*Aust*
Total residential services	no	889	780	477	245	271	82	25	14	2783
Total compliant services	no	867	776	468	243	270	81	24	14	2 743
Proportion of compliant services	**%**	**97.5**	**99.4**	**98.1**	**99.1**	**99.6**	**98.7**	**96.0**	**100.0**	**98.5**

[a] NT data are variable due to small numbers.

Source: DoHA Report on the Operation of the Aged Care Act 1997 – 1 July 2008 to 30 June 2009.

Complaints

'Complaints' is an indicator of governments' objective to ensure aged care services provide a high quality of care (box 13.19).

Box 13.19 **Complaints**

'Complaints' is defined as the number of breaches under the Aged Care Act identified by the Complaints Investigation Scheme (CIS) per 1000 residents.

A low or decreasing rate of breaches is desirable.

This indicator is a proxy of the quality of care. It counts the number of breaches identified by the CIS. Official complaints may indicate dissatisfaction about an element of the service provided, but do not always result in the finding of a breach.

The CIS investigates any potential breach of an approved provider's responsibilities in residential and community care; requires the service provider, where appropriate, to take action; and is able to refer issues that may be more appropriately dealt with by others (for example, the Aged Care Standards and Accreditation Agency, police, nursing and medical registration boards). The CIS is able to issue Notices of Required Action where an approved provider is found to be in breach of their responsibilities under the Aged Care Act and where the breach has not been rectified immediately.

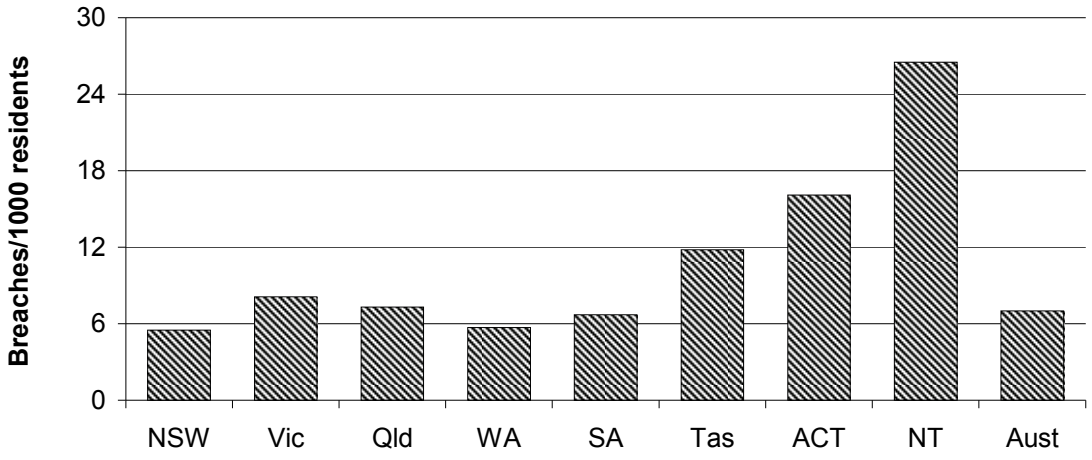
The rate at which complaints occur can be influenced by the propensity of clients and their families or service staff to complain, their knowledge of the complaints system and perceptions of the effectiveness of the complaints system.

Data reported for this indicator are comparable.

From 1 July 2008 to 30 June 2009, the CIS identified 1093 breaches under the Aged Care Act (table 13A.42). The number of breaches identified per 1000 residents from 1 July 2008 to 30 June 2009 was 7.0 nationally. This varied across jurisdictions (figure 13.27).

In the period 1 July 2008 to 30 June 2009, DoHA also dealt with 12 573 matters of which 7962 were within the scope of the CIS to investigate, although not all of these were complaints. Of the 7962 in scope cases dealt with by the CIS, 94 per cent related to residential care services. The increased number of calls reflects the broader nature of the new scheme, which deals with information from a range of sources (DoHA unpublished).

Figure 13.27 **Complaints Investigation Scheme breaches, 2008-09**[a, b]



a Data for NT and ACT will be variable due to small numbers. **b** Data relate to permanent residents as at 31 December 2008.

Source: DoHA (unpublished); table 13A.42.

Compliance with service standards for community care

'Compliance with service standards for community care' is an indicator of governments' objective to ensure that community aged care programs provide a high quality of service (box 13.20).

Box 13.20 **Compliance with service standards for community care**

'Compliance with service standards for community care' is defined by two measures:

- the number of HACC agencies appraised against the standards as a percentage of the total number of HACC agencies
- the proportions of agencies which achieve high, good, basic, or poor ratings, and the average score in each jurisdiction.

A high proportion of agencies appraised, higher ratings and high average scores are desirable.

The indicator monitors 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. This indicator also measures the percentage of individual agencies that comply with the service standards, through the outcomes of service standard appraisals. It should be noted that the standards are not an accreditation system.

Data reported for this indicator are comparable.

A total of 3534 HACC agencies were identified for appraisal over the second appraisal cycle (the four year cycle 2004-05 to 2007-08). The ACT completed this four year cycle in 2008-09. The number of these agencies appraised was 3390 (95.9 per cent). This proportion varied across jurisdictions (table 13.11). The outcomes of these appraisals was a national average score of 17.3 out of 20 (table 13.12).

Table 13.11 HACC National Service Standards appraisals over the four year cycle ending 2007-08[a]

	Unit	NSW[b]	Vic[c]	Qld[d]	WA	SA	Tas	ACT[e]	NT[f]	Aust[d]
Appraisals	no.	1 692	338	965	123	179	53	30	10	3 390
HACC agencies	no.	1 785	460	801	135	179	53	30	91	3 534
Proportion of agencies assessed	%	94.8	73.5	100.0	91.1	100.0	100.0	100.0	11.0	95.9

[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] Validation of 343 HACC services auspiced and/or administered by NSW Health occurred from February–October 2005. Monitoring of all other NSW HACC services commenced in November 2005 under the Integrated Monitoring Framework, and was completed by June 2009. The total number of HACC agencies is the number of HACC services funded in 2007-08. The proportion of agencies appraised is indicative only, as agencies may equate to services or outlets. In NSW, the appraisal methodology differs slightly under the Integrated Monitoring Framework, though is closely aligned to the HACC Standards Instrument. Scores are derived from equivalent performance questions. [c] Victoria has completed appraisals for 338 agencies. The remaining 122 agencies are Quality Improvement Council or Australian Council on Healthcare Standards accredited. Victoria has contracted with the licensee of these systems to conduct appraisals against HACC standards as part of their major review. These appraisals will be finalised by mid 2010. [d] In Queensland the number of appraisals exceeds the number of agencies because some service providers were reviewed twice in the four year period. Therefore calculation of the Australian total of appraisals and the proportion of agencies assessed only includes 801 Queensland agencies. [e] Quality Assessments in the ACT occurred in 2008-09 with data being included in the four year cycle ending 2007-08. [f] NT data are variable due to small numbers.

Source: State and Territory governments (unpublished).

Table 13.12 HACC National Service Standards results of appraisals over the four year cycle ending 2007-08 (number)[a, b, c]

	NSW	Vic	Qld[d]	WA	SA	Tas[e]	ACT[f]	NT	Aust
High (17.5 – 20)	1 166	162	683	88	89	29	18	1	2 236
Good (15 – 17.4)	276	74	176	11	42	9	9	4	601
Basic (10 -14.9)	217	71	85	16	34	10	3	4	440
Poor (less than 10)	33	31	21	8	14	5	–	1	113
Average score	17.6	16.0	18.3	17.0	16.1	16.2	17.6	15.0	17.3

[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 the individual approaches adopted by each State and Territory. [c] For details about the method of determining the average score, see table 13A.69. [d] In Queensland some agencies were reviewed twice in the four year period. This table includes outcomes of all appraisals during the cycle. [e] One agency in Tasmania declined to participate in the appraisal process and was therefore scored as zero. [f] Quality Assessments in the ACT occurred in 2008-09 with data being included in the four year cycle ending 2007-08. – Nil or rounded to zero.

Source: State and Territory governments (unpublished); table 13A.69.

Client appraisal of service standards

'Client appraisal of service standards' is an indicator of governments' objective to ensure high levels of client satisfaction with aged care services (box 13.21).

Box 13.21 Client appraisal of service standards

'Client appraisal of service standards' is yet to be defined.

Data for this indicator were not available for the 2010 Report.

Efficiency — inputs per output unit

Cost per ACAT assessment

'Cost per ACAT assessment' is an indicator of governments' objective to deliver efficient ACAT assessment services (box 13.22).

Box 13.22 Cost per ACAT assessment

'Cost per ACAT assessment' is defined as Australian Government expenditure on ACATs divided by the number of ACAT assessments completed.

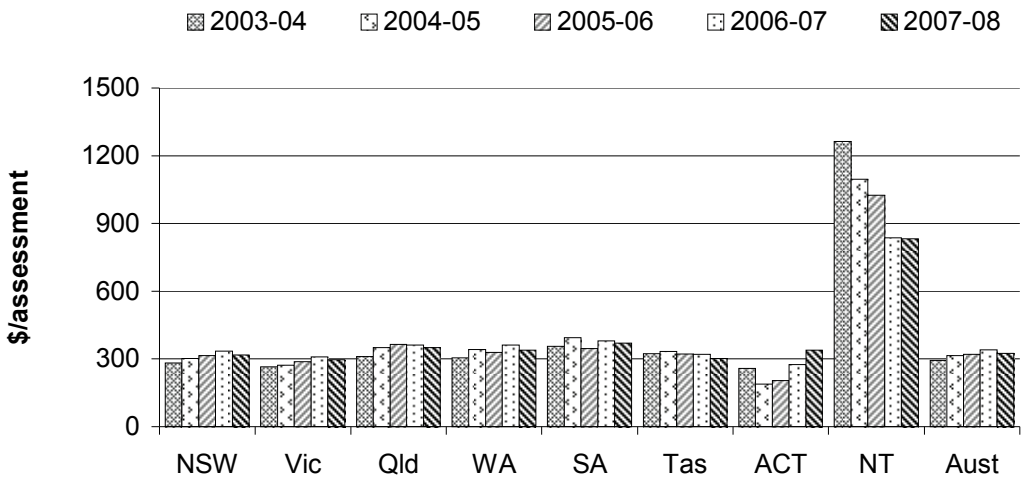
This is a proxy indicator of efficiency and needs to be interpreted with care. This indicator includes only Australian Government expenditure, although states and territories also contribute to the cost of ACAT assessments. While high or increasing expenditure per assessment may reflect deteriorating 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.

Cost per ACAT assessment has been developed as a proxy and work is in progress to measure efficiency for ACATs.

Data reported for this indicator are not directly comparable.

Australian Government expenditure per aged care assessment during 2007-08 averaged $325 nationally (figure 13.28). Nationally, real expenditure increased from 2003-04 to 2007-08. The cost per assessment is calculated using the total number of assessments and therefore includes clients aged less than 70 years.

Figure 13.28 **Australian Government expenditure on aged care assessments, per assessment (2007-08 dollars)[a, b, c]**



a Only includes Australian Government expenditure on ACATs. **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 13A.59.

Expenditure per head of target population

'Expenditure per head of target population' is an indicator of governments' objective to deliver efficient aged care services (box 13.23).

Box 13.23 **Expenditure per head of target population**

'Expenditure per head of target population' 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.

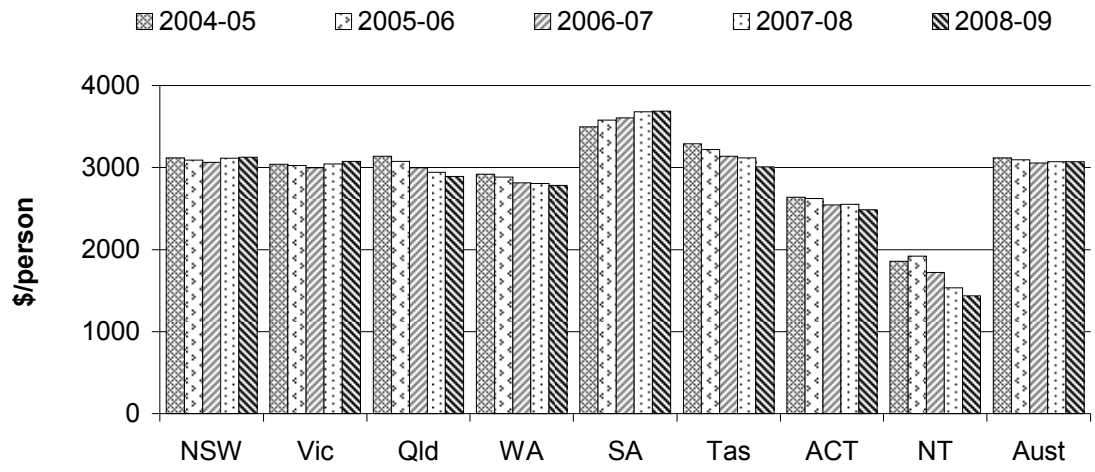
This is a proxy indicator of efficiency and needs to be interpreted with care as it measures cost per target population, not cost per unit of service. While high or increasing expenditure per person can reflect deteriorating efficiency, it can also reflect changes in aspects of the service (such as better 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 can reflect improving efficiency or a decrease in service standards.

Data reported for this indicator are comparable.

Nationally, Australian Government real expenditure by both DoHA and DVA on residential care services per person aged 70 years or over plus Indigenous people aged 50–69 years decreased slightly from $3117 in 2004-05 to $3070 in 2008-09 (figure 13.29). If the payroll tax supplement paid by the Australian Government is excluded, this expenditure decreased nationally from $3127 in 2004-05 to $3082 in 2008-09 (table 13A.54).

DoHA expenditure on residential care per person aged 70 years or over plus Indigenous people aged 50–69 years in 2008-09 was $2615 including the payroll tax supplement and $2573 excluding the payroll tax supplement (table 13A.53). DVA expenditure on residential care per person aged 70 years or over in 2008-09 was $467 including the payroll tax supplement and $459 excluding the payroll tax supplement (table 13A.45).

Figure 13.29 **Australian Government (DoHA and DVA) real expenditure on residential services per person aged 70 years or over plus Indigenous people aged 50–69 years (2008-09 dollars)[a, b]**

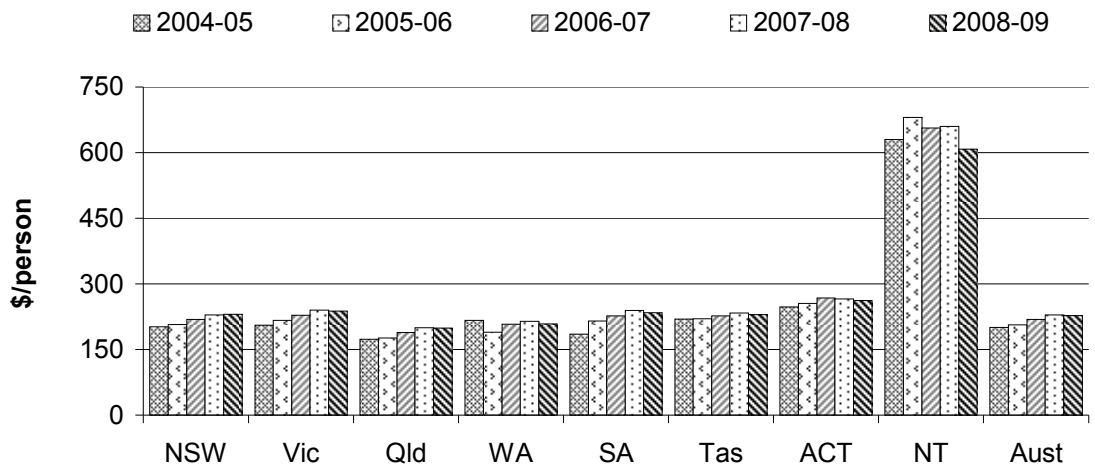


a Includes a payroll tax supplement provided by the Australian Government. Actual payroll tax paid may differ. **b** Population data for June 2008 and June 2009 are based on ratios from ABS 2006 Census data applied to population projections by SLA 2006–2026 and 2007–2027, respectively. Population data for earlier years are based on 2001 Census data applied to population projections by SLA 2002–2022. See footnotes to table 13A.2 for more information.

Source: DoHA (unpublished); DVA (unpublished); table 13A.54.

Australian Government expenditure on CACPs per person aged 70 years or over plus Indigenous people aged 50–69 years was similar in most jurisdictions except the NT in 2008-09. Nationally, real expenditure per person aged 70 years or over plus Indigenous people aged 50–69 years increased from $201 in 2004-05 to $227 in 2008-09 (figure 13.30).

Figure 13.30 **Australian Government real expenditure on CACP services per person aged 70 years or over plus Indigenous people aged 50–69 years (2008-09 dollars)[a]**

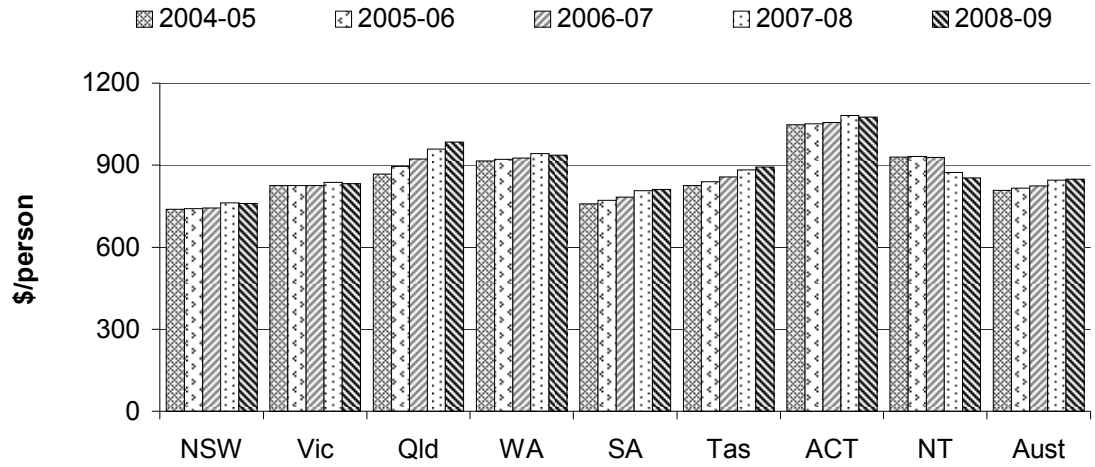


a Population data for June 2008 and June 2009 are based on ratios from ABS 2006 Census data applied to population projections by SLA 2006–2026 and 2007–2027, respectively. Population data for earlier years are based on 2001 Census data applied to population projections by SLA 2002–2022. See footnotes to table 13A.2 for more information.

Source: DoHA (unpublished); table 13A.57.

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 $808 in 2004-05 to $850 in 2008-09 (figure 13.31). These figures reflect expenditure against the population used as the proxy in this chapter (see section 13.1), which is not the same as the HACC target population. Expenditure per person in the HACC target population is reported in table 13A.55.

Figure 13.31 **Australian, State and Territory government real expenditure on HACC services per person aged 70 years or over plus Indigenous people aged 50–69 years (2008-09 dollars)[a, b, c, d, e]**



[a] People aged 70 years or over plus Indigenous people aged 50–69 years are not the HACC target population. Expenditure per person and the definition of the HACC target population are contained in table 13A.55. [b] This figure only represents expenditure under HACC Agreements. [c] Reports provisional HACC data that have not been validated and may be subject to revision. [d] Expenditure reflects an equalisation strategy. See notes to table 13A.56 for more detail. [e] Population data for June 2008 and June 2009 are based on ratios from ABS 2006 Census data applied to population projections by SLA 2006–2026 and 2007–2027, respectively. Population data for earlier years are based on 2001 Census data applied to population projections by SLA 2002–2022. See footnotes to table 13A.2 for more information.

Source: DoHA (unpublished); table 13A.56.

Outcomes

Outcomes are the impact of services on the status of an individual or group (while outputs are the actual services delivered) (see chapter 1, section 1.5).

Social participation in the community

'Social participation in the community' has been identified for development as an indicator of governments' objective to encourage the wellbeing and independence of frail older people (box 13.24).

Box 13.24 **Social participation in the community**

'Social participation in the community' is yet to be defined.

Higher rates of participation in the community are more desirable.

When developed for future Reports, this indicator will show the extent to which older people participated in community, cultural or leisure activities.

Maintenance of individual functioning

'Maintenance of individual functioning' is an indicator of governments' objective for aged care services to promote the health, wellbeing and independence of frail older people (box 13.25).

Box 13.25 **Maintenance of individual functioning**

'Maintenance of individual functioning' is defined as improvement in Transition Care Program (TCP) clients level of functioning, reflected in the movement from the average Modified Barthel Index (MBI) score on entry to the average MBI score on exit from the TCP. The minimum MBI score is 0 (fully dependent) and the maximum score is 100 (fully independent).

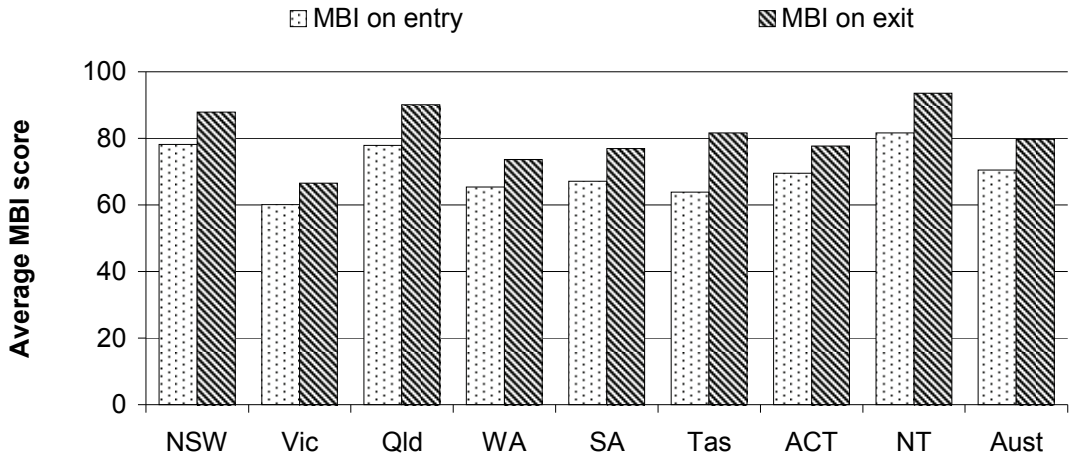
This indicator needs to be interpreted with care. The TCP is one aged care program where it is possible to measure a change in a client's level of functioning. Variation in the average MBI scores on entry and exit from the program may reflect a range of target client groups for the program across jurisdictions.

The TCP is a small program at the interface of the health and aged care systems. It may be possible to develop measures for other aged care programs such as residential aged care and community aged care services which would be indicators of maintenance of individual functioning.

Data reported for this indicator are comparable.

The average MBI score on entry to the TCP in 2008-09 was 70.5 nationally. The average MBI score on exit from the TCP was 79.7 nationally. These results varied across jurisdictions (figure 13.32).

Figure 13.32 **Transition care program — average Modified Barthel Index score on entry and exit, 2008-09[a]**



MBI: Modified Barthel Index. **a** The MBI is a measure of activities of daily functioning, ranging from 0 (fully dependent) to 100 (fully independent). Data are reported for Transition Care Program recipients who successfully completed a Transition Care episode.

Source: DoHA (unpublished); table 13A.51.

Enabling people with care needs to live in the community

'Enabling people with care needs to live in the community' has been identified for development as an indicator of governments' objective to delay entry to residential care (box 13.26).

Box 13.26 **Enabling people with care needs to live in the community**

'Enabling people with care needs to live in the community' is yet to be defined.

Higher rates of people with care needs remaining and participating in the community are more desirable.

When developed for future Reports, this indicator will show the extent to which older people's entry to residential care is delayed and the extent to which older people participate in community, cultural or leisure activities.

13.4 Future directions in performance reporting

States and Territories began reporting on five agreed Key Performance Indicators (KPIs) for HACC in 2007-08. In 2008-09 an additional two KPIs will be reported on, they are:

- percentage of HACC funded organisations that have supplied acquittals, and
- unit cost to refer to the full cost of delivering a service for key service types.

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

- continued improvement of efficiency indicators, including for HACC services and assessment services
- improved reporting of waiting times for residential aged care
- improved reporting of long term aged care in public hospitals
- further development of outcome indicators.

COAG Developments

Report on Government Services alignment with National Agreement reporting

It is anticipated that future editions of the Aged care services chapter will align with applicable NHA indicators, and the NIRA. Further alignment between the Report and NA indicators, and other reporting changes, might result from future developments in NA and National Partnership reporting.

Outcomes from review of Report on Government Services

COAG agreed to Terms of Reference for a Heads of Treasuries/Senior Officials review of the Report in November 2008, to report to COAG by end-September 2009. The review examined the ongoing usefulness of the Report in the context of new national reporting under the Intergovernmental Agreement on Federal Financial Relations.

No significant changes from this review are reflected in the 2010 Report. Any COAG endorsed recommendations from the review are likely to be implemented for the 2011 Report.

13.5 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this chapter.

Australian Government comments

“A major achievement in 2008-09 was the implementation of the first round of zero real interest loans to residential aged care providers. This initiative aims to improve the affordability of capital works in high need regions by providing low cost finance to encourage care providers to make places available sooner than would otherwise be the case. The Department assessed the first round of loan applications in September 2008, which resulted in offers of loans for 1348 residential aged care places around the country. The Department will seek applications for a second round of loans next financial year, in conjunction with the 2009-10 Aged Care Approvals Round.

Work also commenced on the Australian Government's commitment to double the number of transition care places available from 2000 to 4000 places by 2011-12. The implementation of this initiative is progressing well with the first batch of 228 additional transition care places becoming operational during 2008-09 and the second batch of 470 places being allocated to states and territories in March 2009.

Another major achievement was the implementation of changes to make the income test for residents fairer and simpler. Previously, self-funded retirees paid higher income-tested fees because most of their income was counted under the income test. These changes ensure that pensioners and self-funded retirees are now treated in the same way, irrespective of whether they are on a pension or private income.

A new federal financial framework began on 1 January 2009. The changes include a major rationalisation of the number of payments to the states for Specific Purpose Payments, reducing the number of such payments from over 90 to 5. Under these arrangements Australian Government payments to state and territory governments for the home and community care and aged care assessment programs are now paid by the Commonwealth Treasury to state and territory treasuries. These payments are recorded as payments by the Department of Health and Ageing in this report.”

New South Wales Government comments

“Towards 2030: Planning for our changing population is the whole of government strategy to manage demographic change. All NSW Government agencies are responsible for implementing actions under this strategy, which include building workforce, capacity to respond to changing demographics and improving service delivery to ensure that NSW continues to offer the quality care and support needed by an ageing population.

NSW Health is successfully developing the joint State and Commonwealth Transitional Aged Care Program which provides time-limited, low intensity therapy and support to older people in order to reduce unnecessary extended stays in hospital and/or premature admission to residential aged care. Implementation of the Long Stay Older Patients (LSOP) program in partnership with the Australian Government Department of Health and Ageing (DoHA) has also enabled NSW Health to enhance its Aged Care Services in Emergency Team (ASET) services and to implement a new Acute to Aged-Related Care Service (AARCS) across the State to coordinate effective and timely discharge planning for older inpatients in accordance with their needs.

NSW Health continues to pursue a range of COAG Aged Care Assessment Program (ACAP) structural reforms. These include: standardising ACAT business practices; developing a NSW ACAT Assessor Accreditation System to improve the consistency and quality of ACAT assessments statewide; and working with DoHA to enhance the e-business capability of all ACATs in NSW through implementation of an electronic Aged Care Client Record (eACCR).

In 2008-09 the NSW Home and Community Care program continued to expand with a total budget of $546 million, an increase of $36 million or 7.1 per cent over 2007-08. The increased funds provided a significant boost to Home and Community Care services across NSW, with expansion of services to improve independence at home, access to community transport and the availability of centre based day care programs for frail older people, young people with disability and their carers. Services for special needs groups also received a substantial increase in funding.

New and innovative ‘independence’ models of service delivery for Home and Community Care clients are being explored which are responsive to individual need and focus on early intervention and building client abilities.

Key strategic directions for the Home and Community Care program in NSW include the simplification of access and pathways, developing a streamlined, risk based approach to the monitoring of performance and quality assurance for providers and building the evidence base to support ongoing development of the HACC program. The NSW Community Care Access Point demonstration project in the Hunter Local Planning Area is the most comprehensive and extensive of its type and is leading the way in promoting clearer pathways to Home and Community Care services and visible access points for people seeking services.”

Victorian Government comments

“ The rapid ageing of our population is driving focused activity in Victoria's aged care portfolio to ensure that service systems are shaped to meet future needs. Examination of alternatives for future policy and funding responsibilities has been a subject of discussion this year. It will be important that the model finally adopted facilitates integration with primary health services and promotes continuity of care.

It is becoming increasingly clear that providing services that substitute for a person’s own effort as that person experiences an 'inevitable' decline in function associated with ageing is both unsustainable and may be detrimental to the person's wellbeing. We are turning to a 'reablement' approach to shape future services. That approach encourages independence and motivates improvement by providing positive expectations, opportunities for development and positive experiences. Reablement involves improving health and functional capacity together with reconnecting people into community involvement and social relationships.

The summer of 2008-09 brought extraordinary heatwave conditions and Victoria's Aged Care Program acted quickly to help providers of community and residential aged care to prepare and to support vulnerable older people. Authoritative public health information was distributed by a range of media, incorporating advice on strategies to maintain hydration and control body temperature. On particularly hot days, there was direct targeting to providers of services to the most vulnerable clients. Some funds were also provided to assist older people plan for future heatwave events, such as by installing shade cloths.

An assessment of health impacts of the heatwave of January 2009 showed 374 excess deaths, of which the greatest number were among people aged over 75 years. During extremely high temperatures over the period Wednesday 28 January to Sunday 1 February 2009, the Personal Alert Victoria service increased staff resources to respond to increased demand. Capacity was also provided to enable call centre staff to remind clients who made telephone contact to drink water and keep cool. Personal Alert Victoria reported an increase in missed daily calls, significantly increased numbers of medical emergencies, and higher than average number of cancellations as a result of clients being deceased during the heatwave.

Ongoing work between the Department's Health Protection and Aged Care program areas will provide heatwave information and resources for older Victorians and service providers in preparation for next summer. ”

Queensland Government comments

Queensland has continued to support the programs and services that improve the quality of life of older people and their carers and has worked closely with the Australian Government in implementing national programs.

In 2008-09, the State Government contributed over $135 million to the HACC program. The priorities for the HACC Queensland Triennial Plan 2008–2011 include a particular focus on improving service accessibility and delivery for Aboriginal and Torres Strait Islander people, people living with dementia, people from culturally and linguistically diverse backgrounds, and carers.

New services funded in 2008-09 included: seven regional HACC Multicultural Advisory Services – to help break down cultural and language barriers to improve access to HACC services for people from diverse backgrounds; and seven regional HACC Dementia Advisory and Support Services – designed to support both HACC-eligible people who have dementia, their carers and also through education and training to HACC service providers.

The Rockhampton Access Point Demonstration Project catchment area was expanded in early 2009, which resulted in a usage increase of 50 per cent.

Queensland has continued to implement places approved under the Transition Care Program under the first and second phases. As at 30 June 2009, 389 of these places were operational. During 2008-09, Queensland Health contributed over $16 million towards the cost of Transition Care.

Queensland Health is implementing local based initiatives under the Long Stay Older Patients' Program. These initiatives include capital works at 12 rural sites. Activities such as Hospital in the Home, Interim Care, Early Intervention and Hospital Avoidance are also being implemented across metropolitan and major provincial sites.

Queensland supports 20 State owned and operated residential aged care facilities. In 2008-09, the State Government contributed in excess of $79 million of an overall expenditure of over $152 million. Further capital expenditure of $5 million was expended on the upgrade of these facilities.

During 2008-09, over 35 000 aged care assessments were completed by the Aged Care Assessment Teams operating across Queensland. Four projects were progressed from funding provided by COAG to address the timeliness and consistency of aged care assessments.

Queensland also contributed $10 million in 2008-09 for the Healthier Ageing Program aimed at addressing lifestyle factors impacting on the health of older people. In excess of $800 000 was also provided for the Strengthening Aged Care initiative.

Western Australian Government comments

“The Western Australian Government continued to progress reforms outlined in the WA Health Clinical Services Framework 2005–2015 relating to the health needs of older people. An overarching policy document, ‘Models of Care for the Older Person in WA’ outlines the service redesign, aimed at developing a service system that provides clients with a coordinated pathway to a range of care.

The WA Home and Community Care (HACC) Program ‘Assessment Framework Service Redesign’ document was developed in April 2009 as an outcome of the ongoing implementation of the ‘Wellness Approach’ and the National evaluation of the Access Network Demonstration Projects. The ‘Assessment Framework’ advocates the need for service redesign within HACC to facilitate the emerging thinking and trends in access and assessment in community care.

At the Council of Australian Governments meeting in December 2008, the WA Premier and the Federal Minister for Health and Ageing signed an agreement for the improved delivery of subacute care services under the National Health Partnership Agreement. As part of the agreement, WA has committed to increase subacute care services in the areas of rehabilitation, geriatric evaluation and management, psychogeriatric care and palliative care.

Work has also commenced on the development and implementation of the Friend In Need – Emergency (FINE) scheme that aims to deliver care and support to people in need enabling them to remain in their own home (including residential aged care). Most importantly, for the person ‘at risk’ and their carer, benefits of the FINE scheme will include maintaining quality of life, addressing challenges of functional decline, and receiving care at home rather than presenting to an emergency department or being admitted to hospital.

The expansion of the Transitional Care Program has continued across WA with a total of 178 transition care places being operational. On average, 53 per cent of transition care clients have been discharged home with or without the support of community care services and 14 per cent discharged to permanent residential aged care.

On a foundation of work aimed at implementing the Age-friendly principles and practices of the Australian Health Ministers’ Advisory Committee’s National Action Plan, WA continues to support the implementation of the ‘Long Stay Older Patients’ initiative. A key component of the WA COAG ‘Long Stay Older Patients Initiative’ is to strengthen multidisciplinary Care Coordination Teams in metropolitan hospital emergency departments and for WA Country Health Services the strategy focuses on strengthening rural hospital emergency departments’ capacity to risk screen and access allied health in a timely fashion.”

South Australian Government comments

“ The Department for Families and Communities through the Office for the Ageing continues to lead the development and implementation of ‘Improving with Age — Our Ageing Plan for South Australia’. State of the Ageing in South Australia brought together researchers and academic expertise to collaborate on understanding the implications of the rapidly ageing population in South Australia. The report was launched in September 2009.

In keeping with the national community care reforms and COAG’s initiative to improve access to community care, South Australia established Access2HomeCare, a community care access point demonstration project. The project covers a metropolitan (western Adelaide) and a country site (Gawler, Barossa, Lower North and Yorke Peninsula communities). A screening tool was developed for consistency across the two sites. A database has been developed to assist in the allocation of referrals to providers who have the capacity to accept clients and provide the services required.

The Aged Care Assessment Program projects are developed under the COAG initiative. These projects aim to improve timeliness and consistency of assessments. Specific initiatives undertaken in SA include:

- decreasing the number of clients on Aged Care Assessment Team (ACAT) waitlists by providing additional assessment staff and support
- streamlining ACAT business processes and improving data quality and the consistency and timeliness of ACAT assessments across South Australia through a State-wide approach to change management.

The South Australian HACC program continues to take a strategic approach to funding allocation, with the introduction of a number of new initiatives aimed at improving the evidence base for funding planning and allocation. The South Australian HACC program continued to expand, with $11.1 million in additional funding bringing the total budget to $149.7 million in 2008-09. This funding was distributed according to priorities documented in the Triennial Plan (2008-09 to 2010-11), which included target group priorities of:

- people with dementia including younger onset and their carers
- frail older people including those with complex needs and their carers
- older people living in supported residential facilities
- frail older people from culturally and linguistically diverse (CALD) backgrounds and their carers
- frail older Aboriginal people and their carers.

Additional funding was allocated for services for Aboriginal people and people from CALD backgrounds, with CALD-specific funding increasing from $2.5 million in 2001-02 to $7.25 million in 2008-09. Funding was also allocated to specific projects for carers and to implement the State-wide Dementia Action Plan. ”

Tasmanian Government comments

“ The Tasmanian Government is building a health and human services system that will withstand the impact of demographic change, and provide the care and assistance Tasmanians need. The Government’s reform agenda is vital to the future health and wellbeing of the Tasmanian community. It includes putting Tasmania’s Health Plan into action and implementing changes to children and family services, disability services and housing, with the aim of increasing social inclusion and improving health and social outcomes in the State.

Implementation of Tasmania’s Health Plan involves more than 100 projects, many of which have already commenced and others which will commence within 5 years.

Service development and redesign initiatives during 2009 have been implemented in a restructured Department of Health and Human Services aimed at better integrating and strengthening acute, primary and community health services within three newly-established regional area health services.

The establishment of an Aged Care and Rehabilitation Clinical Network is also anticipated to promote the involvement of clinicians, service providers, and consumers in the State-wide planning, delivery, evaluation and improvement of aged care and rehabilitation services in Tasmania.

The joint-funded Transition Care Program for older patients in hospitals has achieved over 40 per cent growth across Tasmania during 2009, offering valuable alternative care to older people in hospital requiring slow stream rehabilitation and waiting for discharge either to residential aged care or home.

In addition to the Transition Care Program, the co-funded Long Stay Older Patients Initiative supports aged care liaison teams and augments State funded aged care services such as geriatric evaluation and management units, rehabilitation services and transition care for older people.

Hospitals have also employed a number of other State funded strategies to provide for improved transition of older people who are assessed and approved for residential aged care, including the purchase of beds in private aged care facilities to provide transition type care for patients awaiting permanent transfer to residential aged care.

Considerable progress has also been achieved over 2009, in commissioning a centralised contact, referral, filtering, and screening contact point for older Tasmanians into aged and community care services across the State. ”

Australian Capital Territory Government comments

“The ACT continues to support older people and their carers through programs and services that promote health and wellbeing, optimise independence and improve the quality of life of older people. The ACT is committed to working closely with the Australian Government in the implementation of national programs.

Additional resources were made available in 2008-09 to expand a range of health-care services offered to older people in the ACT. The Rapid Assessment of the Deteriorating Aged at Risk service developed into a multidisciplinary team with the addition of allied health support. The service has been successful in reducing avoidable hospital admissions and was the winner of the ‘Innovative Model of Care’ category of the ACT Health Quality Awards, as well as being the overall winner for 2008.

The ACT Equipment Loan Service was enhanced in 2008-09 to improve client outcomes and an Older Person’s Dietetic Service was established to identify and treat malnutrition in the elderly and to provide post-discharge guidance and support.

On 1 July 2008, the ACT Transition Care Program expanded to 37 operational places. During 2008-09 219 older people were assisted by the service and over 70 per cent were able to return to their own homes with or without the support of aged care or Home and Community Care (HACC) program services.

2008-09 was the commencement of the first Triennial Plan for the ACT HACC Program. The plan outlines the strategic directions and funding priorities for the HACC Program in the ACT over 3 years to June 2011. ACT priorities for growth funding in 2008-09 were directed to expanding direct client service provision. Promotion of continuous quality improvement across the community care sector continued in 2008-09 with all ACT HACC agencies being evaluated by external evaluators using the HACC National Service Standards Instrument and Guidelines.

In 2008-09 the ACT Aged Care Assessment Team (ACAT) progressed four COAG funded projects to improve the quality, efficiency and consistency of ACAT assessments in the ACT. These projects included new information technology, dementia training, development of the ACAT Education Officer role to support ACAT training needs and attendance of ACT ACAT members at the national conference.”

Northern Territory Government comments

“The NT is committed to supporting people as they age and encouraging them to take responsibility for their own health and financial wellbeing. As part of this commitment, the NT has continued to progress issues of ageing under the Active Ageing Framework (the Framework). The Framework focuses on how people can maintain their good health, continue to remain mentally and physically active and retain their independence regardless of their age.

Though the aged population numbers in the NT are not as high in comparison to other jurisdictions, the prospective increase of growth in this population across the NT is the largest in Australia. The NT's projected growth rate for people aged 65 years and over is 4.5 per cent per annum over the next 20 years. In addition to this, the NT experiences unique constraints that affect the servicing of the aged population. These constraints include geographic, climatic and cultural barriers, as well as the recruitment and retaining of an aged trained workforce.

During 2008-09 the NT implemented changes that were introduced as part of the amalgamation of community government councils to larger shire councils. There was minimal impact on service delivery under the new arrangements. Work commenced on streamlining the reporting requirements for remote communities to a shire based model which will come into effect in 2009-10.

In 2008-09 the number of allocated places under the Transition Care Program were increased by 6 to bring the NT's total allocation to 22. The additional 6 places are community based, increasing the flexibility of the program in the NT. The other 16 places continued to be residential based with 4 places each in Darwin and Alice Springs and 8 places in Katherine.

The NT operated 6 Aged Care Assessment Teams (ACATs) during 2008-09. These teams undertook assessments across the NT including in remote communities. The ACATs are jointly funded by the NT and Australian governments, with the NT providing a significant investment to ensure that the frail aged in regional and remote areas receive this service. This investment is also ensuring that clients receive comprehensive aged care assessment and case coordination where considered necessary as part of a best practice.

The NT had a combined HACC funding pool of $11 0 million for 2008-09. 90 non-government providers were funded to provide services to the frail aged and younger people with disabilities, and their carers.

The Community Development Employment Projects Program for positions in HACC services in remote communities was managed by the NT during 2008-09. This initiative provided the NT with $6.2 million in funding for wages for 304 Aboriginal and/or Torres Strait Islander people to work in part time positions in HACC services.

As in previous years, indicators based on the estimated number of people with severe, profound and/or core activity limitations in the NT need to be interpreted with caution. Small variations in service and population data appears in magnified proportions to the small population in the NT.”

13.6 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 Minister for Health from 1 July each year
Accreditation	Accreditation is a key component of the Australian Government's quality framework for federally funded residential aged care and is a quality assurance system for residential aged care services — based on the principle of continuous improvement. Accreditation requires assessment against the 44 expected outcomes used for accreditation assessment — grouped into four standards: management systems, staffing and organisational development; health and personal care; residential lifestyle; and physical environment and safety systems.
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. Assessment of care needs is an important component of aged care. 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. Other services aim to promote social participation and connectedness. These services are delivered by trained aged care workers and volunteers. However, aged care services may also be delivered by health professionals such as nurses and occupational therapists. Aged care services generally aim to promote wellbeing and foster function rather than to treat illness. Although some aged care services such as transition care have a specific restorative role, they are distinguished from the health services described in Part E of this Report. 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 aged 70 years or over and Indigenous people aged 50 years or over.
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]).
Capital expenditure on residential services	Expenditure on building and other capital items, specifically for the provision of Australian government funded residential aged care.

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 of the Department of Health and Ageing 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.
Dementia services program	Includes flexible and innovative support, respite, counselling, information and referral services, education and leisure. The program includes meeting individual and immediate needs which cannot be met by other services, through carer respite services and other carer support agencies. Inpatient services are excluded.
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.
HACC target population	The HACC Target population is people in the Australian community who, without basic maintenance and support services provided under the scope of the HACC Program, would be at risk of premature or inappropriate long term residential care, including (i) older and frail people with moderate, severe or profound disabilities; (ii) younger people with moderate, severe or profound disabilities; and (iii) such other classes of people as are agreed upon, from time to time, by the Commonwealth Minister and the State Minister. The HACC Target Population is estimated by applying the proportion of people in households with a moderate, severe, or profound disability as reported in the ABS 2003 *Survey of Disability, Ageing and Carers* to the ABS Population Projections by SLA 2002–2022.
High/low care recipient	On entry, a resident is classified as high or low care based on their ACAT assessment and their approved provider's appraisal of their care needs under the ACFI. Residents whose ACAT approval is not limited to low care are classified as high care if they have an ACFI appraisal of: • medium or high in activities of daily living • high in behaviour or • medium or high in complex health care. All other ACAT approval and ACFI appraisal combinations result in a classification of low level care. A residents care needs may change over time resulting in a change in classification from low to high level care (ageing in place).
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)*.
Waiting times	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.

13.7 Attachment tables

Attachment tables are identified in references throughout this chapter by an '13A' suffix (for example, table 13A.3). Attachment tables are provided on the CD-ROM enclosed with the Report and on the Review website (www.pc.gov.au/gsp). Users without access to the CD-ROM or the website can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

Table 13A.1 Males and females aged 70 years or over, June 2009

Table 13A.2 Target population data, by location ('000)

Table 13A.3 Proportion of people aged 70 years and over by locality, June 2009

Table 13A.4 Ownership of operational aged care residential places, June 2009

Table 13A.5 Average annual Australian Government basic subsidy amount, including Conditional adjustment payment, per occupied place and the dependency level of aged care residents, June 2009

Table 13A.6 Size and distribution of all residential aged care services, June 2009

Table 13A.7 Size and distribution of residential aged care services with over 80 per cent high care residents, June 2009

Table 13A.8 Size and distribution of residential aged care services with over 80 per cent low care residents, June 2009

Table 13A.9 Size and distribution of mixed residential aged care services, June 2009

Table 13A.10 Proportion of residential aged care places, by location in high care, low care and mixed care services

Table 13A.11 Operational number of aged care places per 1000 people aged 70 years or over, 30 June

Table 13A.12 Operational number of aged care places per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years, 30 June

Table 13A.13 Aged care recipients per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years, 30 June

Table 13A.14 Aged care recipients per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years by locality, 30 June

Table 13A.15 Aged care recipients from a non-English speaking country, 30 June

Table 13A.16 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, 30 June

Table 13A.17 Indigenous aged care recipients per 1000 Indigenous people aged 50 years or over and as a proportion of all recipients, 30 June

Table 13A.18 Indigenous aged care recipients per 1000 Indigenous people aged 50 years or over by locality, 30 June

Table 13A.19 Aged care recipients from special needs groups, June 2009 (per cent)

Table 13A.20 Proportion of new permanent residents classified as supported residents, 2008-09 (per cent)

13.8 References

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