13 Aged care services

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Attachment tables

Attachment tables are identified in references throughout this chapter by a '13A' 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 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.

Major improvements in reporting on aged care services this year include:

- reporting new measures for the indicator 'compliance with service standards in community care' for the Community Aged Care Packages (CACP), Extended

Aged Care at Home (EACH), EACH Dementia (EACH-D) and the National Respite for Carers Program (NRCP) programs

- inclusion of the following indicators/measures to align this Report with National Healthcare Agreement (NHA) aged care indicators:
  - operational aged care places
  - selected adverse events in residential aged care
  - hospital patient days (for overnight separations only) used by patients who are waiting for residential aged care
- expansion of time series data reporting in some attachment tables, in particular five years of data are now reported for most aged care expenditure and Home and Community Care (HACC) data
- inclusion of some 'data quality information' (DQI) documentation.

Older Australians are also users of other government services covered in this Report, including disability services (chapter 14), specialised mental health services (chapter 12), and housing assistance (chapter 16). Understanding the relationship between the health system and the aged care system is of particular importance (preface E and chapters 10–12), given that people aged 65 years or over account for around 50 per cent of all patient days in public hospitals (AIHW 2009). Interactions between health and aged care services are critical for the performance of both systems: for example, the number of operational residential aged care places can affect demand for public hospital beds, and throughput of older patients in acute and sub-acute care has a substantial effect on demand for residential and community aged care.

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. People aged 70 years or over plus Indigenous people aged 50–69 years are used as a proxy 'target' population for aged care services in this Report. The Australian Government uses

this population as a 'planning population' to allocate aged care places under the *Aged Care Act 1997*. Nationally, the proportion of the population who are in this category was 9.8 per cent, although the proportion varies across jurisdictions (tables 13A.1 and 13A.2).

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 services covered include:

- assessment and information services, which are largely provided by the Aged Care Assessment Program (ACAP)
- residential care services, which provide permanent high level and low level care, and respite high/low level care
- community care services, including home-based care and assistance to help older people remain, or return to, living independently in the community as long as possible. These services include:
  - HACC program services
  - CACP
  - flexible care services provided under the EACH and the EACH-D programs
  - services provided by the Department of Veterans' Affairs (DVA) under the Veterans' Home Care (VHC)[1] and Community Nursing programs
- community care respite services, which include HACC respite and centre-based day care services and services provided under the NRCP
- services provided in mixed delivery settings, which are designed to provide flexible care or specific support:
  - flexible care services, which address the needs of care recipients in ways other than that provided through mainstream residential and community care — services are provided under the Transition Care Program (TCP), Multi-purpose Service Program (MPS), Innovative Care Pool and National Aboriginal and Torres Strait Islander Flexible Aged Care Program
  - specific support services, which are provided to address particular needs such as those under the Long Stay Older Patients initiative and in Day Therapy Centres.

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

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

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

The funding and regulation of aged care services are predominantly the role of the Australian Government (although all three levels of government are involved). The *Aged Care Act 1997*, together with the accompanying *Aged Care Principles*, are the main regulatory instruments establishing the aged care framework. Key provisions covered include service planning, user rights, eligibility for care, funding, quality assurance and accountability (Productivity Commission 2010).

Aged Care Assessment Program

The Australian Government established the ACAP in 1984. An assessment and approval by an Aged Care Assessment Team (ACAT) is mandatory to be eligible for admission to Australian Government subsidised residential care (including respite) or to receive a CACP, EACH package, EACH-D package or enter the 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).

The Australian Government has oversight of policy and guidelines, and provides grants to State and Territory Governments specifically to operate ACATs. State and Territory governments are responsible for the day to day operation and administration of the ACAP, including the provision of the necessary accommodation and some 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 hospital or a community service) and this has an effect on program outputs.

The Council of Australian Governments (COAG) has agreed to improve aged care assessment services as part of its national health agenda (box 13.1).

Box 13.1 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 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 of the initiative has enabled the implementation of a range of Australian, State and Territory governments' activities to improve the timeliness, quality and consistency of ACAT recommendations. Many of the activities from earlier years were continued in 2009-10. Additional activities that were implemented include:

- the capacity for ACATs to electronically submit the Aged Care Client Record to Medicare Australia
- the development and delivery of the ACAP National Training Strategy
- national training resources (including national orientation and delegation training resources in administrative law for ACAT by the Senior Commonwealth Lawyer in hard and electronic formats)
- a national ACAP Conference held in May 2010
- legislation changes to reduce the amount of unnecessary reassessments by ACATs
- a project to identify a set of validated assessment tools
- the development of an overarching Implementation Plan for the recommendations of the National Review of ACATs
- improved communication to ACATs by enhancing the format and content of written communications with ACATs nationally.

State and Territory governments also continue to undertake a range of projects to improve the timeliness, consistency and quality of ACAT assessments.

Source: Department of Health and Ageing (DoHA) (unpublished).

Residential care services

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 13.2).

Box 13.2 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 to 113 operational places per 1000 people aged 70 years or over, to be achieved by June 2011. More detail is provided in box 13.10.

Under the arrangements:

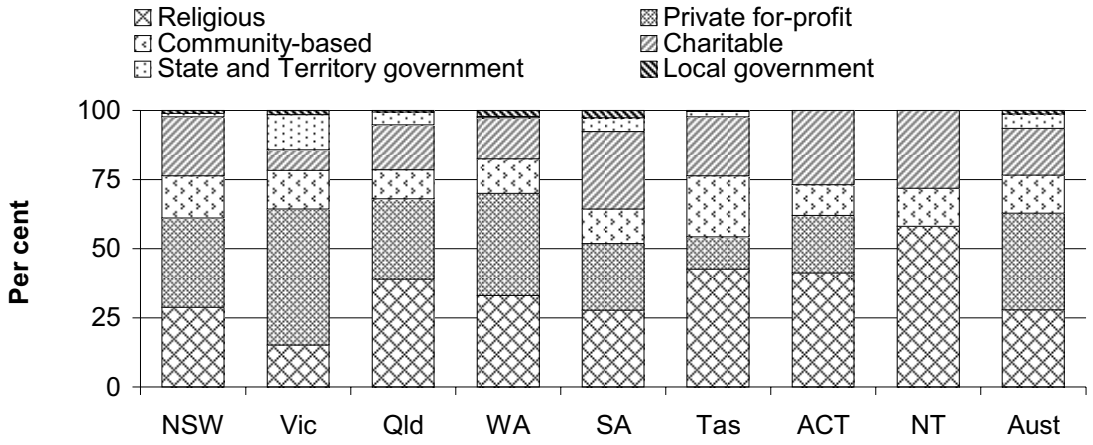
- services are expected to meet regional targets for places for concessional, assisted and supported residents. These targets range from 16 per cent to 40 per cent of places and are intended to ensure residents who cannot afford to pay an accommodation bond or charge have equal access to care. (The criteria 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 1997* as a provider of aged care
- principles (regulations) created under the *Aged Care Act 1997* 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 administration of medicines and/or certain medical procedures, occupational health and safety, workers compensation requirements, building standards, and fire prevention and firefighting measures. Industrial relations arrangements and outcomes vary between and within jurisdictions.

Source: DoHA (unpublished).

Religious and private for-profit organisations were the main providers of residential care at June 2010, accounting for 27.9 per cent and 35.0 per cent respectively of all Australian Government subsidised residential aged care places. Community-based organisations and charitable organisations accounted for a further 13.7 per cent and 16.9 per cent respectively. State, Territory and local governments provided the remaining 6.4 per cent (figure 13.1).

Figure 13.1 **Ownership of operational residential places, June 2010**[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.

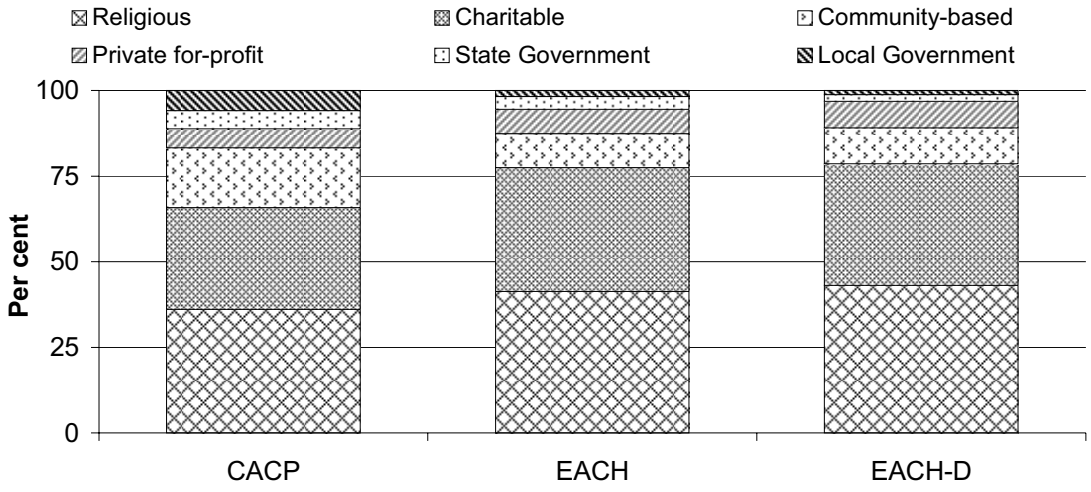
Source: Department of Health and Ageing (DoHA) (unpublished); table 13A.16.

Community care services

The main community care programs reported in this chapter are the HACC, CACP, EACH, EACH-D and the VHC programs. The HACC program is a joint Australian Government, and State and Territory governments' initiative administered under the *Home and Community Care Act 1985* (DoHA 2009). The State and Territory governments provide the day to day management and the Australian Government has a broad strategic policy role. HACC service providers vary from small community-based groups to large charitable and public sector organisations.

The Australian Government (Department of Health and Ageing [DoHA]) is primarily responsible for the policy oversight and regulation of the CACP, EACH and EACH-D programs. Religious and charitable organisations were the main providers of Australian Government subsidised community care places across the three programs at June 2010 (figure 13.2). EACH and EACH-D services are considered flexible care under the *Aged Care Act 1997*, but because of their nature are classified in this chapter as community care.

Figure 13.2 **Operational CACP, EACH and EACH-D places, by provider type, June 2010[a, b]**



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

Source: DoHA (unpublished).

The Australian Government (DVA) is primarily responsible for policy oversight and regulation of the VHC programs and community nursing services for veterans and war widows/widowers. These services are delivered either by organisations contracted by DVA or through arrangements with State and Territory governments. There were 78 304 people approved for VHC services in 2009-10 and 31 713 people receiving community nursing services (table 13A.13). This includes services provided to assist carers.

Services provided in mixed delivery setting — flexible care services

Flexible care provided under the *Aged Care Act 1997* includes EACH and EACH-D packages (described above), the TCP, MPS and innovative care places.

- 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 State and Territory governments and the Australian Government. Within the framework of the program, State and Territory governments as the approved providers develop their own service delivery models.
- MPS are a joint initiative between the Australian Government and State and Territory governments. Australian Government aged care funding is combined with State and Territory governments funding for health and aged care to bring a

flexible mix and range of aged care and health services together under one management structure. State and local governments are the major providers of MPS, which are primarily located in small rural hospital settings (DoHA 2009).

- The Aged Care Innovative Pool is designed to test new approaches to providing aged care. At the beginning of each financial year, the Australian Government's Minister for Ageing determines the flexible care subsidy rates for the Innovative Pool pilots. Innovative Pool program service providers are Approved Providers from the community care sector across five states (DoHA 2009). Further information on the TCP, MPS, and innovative care places is provided in box 13.3.

Box 13.3 **Flexible care programs**

Transition care

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.

Transition care can be provided either in 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 TCP 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).

Multi-purpose services (MPS)

The MPS Program supports the integration and provision of health and aged care services for small rural and remote communities. Some health, aged and community care services may not be viable in a small community if provided separately. By bringing the services together, economies of scale are achieved to support the services.

(Continued next page)

Box 13.3 **(continued)**

Innovative care

The Aged Care Innovative Pool 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.

National Aboriginal and Torres Strait Islander Flexible Aged Care Program

Flexible models of care are also 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*. Aboriginal and Torres Strait Islander people also access mainstream services under the *Aged Care Act 1997*, including those managed by Aboriginal and Torres Strait Islander organisations.

The National Aboriginal and Torres Strait Islander Flexible Aged Care 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.

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 1997* 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.

Services provided in mixed delivery setting — specific support

A range of programs designed to meet specific support needs of older people across care settings are funded and operate outside the regulatory framework of the *Aged Care Act 1997*. The Day Therapy Centre Program, for example, provides a wide range of therapy services to frail older people living in the community and to residents of Australian Government funded residential aged care facilities.

The Australian Government established, funds and oversights most of these programs. The Long Stay Older Patient Initiative is one exception. This program was established as part of the COAG national health and aged care agenda. The Australian Government has funded State and Territory governments to provide services under this initiative since 2006-07 (box 13.4).

Box 13.4 **Long Stay Older Patient Initiative**

From July 2006, a 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.

From July 2010, the initiative was extended for a further two years.

Source: COAG (2006); Federal Budget (2010-11).

Funding

Recurrent expenditure on aged care services reported in this chapter was $11.0 billion in 2009-10 (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.11), or any Australian Government or State and Territory government capital expenditure (table 13A.12).

Table 13.1 **Recurrent expenditure on aged care services reported in the Aged care services chapter, 2009-10**

Expenditure category	*$ million*
Assessment and information services[a]	96.7
Residential care services[b]	7 289.6
Community care services[c]	3 168.9
Services provided in mixed delivery settings[d]	458.4
Total	**11 013.6**

[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, EACH-D, NRCP, Community care grants, VHC, DVA Community Nursing and Assistance with Care and Housing for the Aged. [d] Services provided in mixed delivery settings include MPS, TCP, National Aboriginal and Torres Strait Islander Flexible Aged Care Program, 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: DoHA (unpublished); State and Territory governments (unpublished); table 13A.5.

Assessment services

There were 112 ACATs (111 Australian Government funded) at 30 June 2010 (DoHA unpublished). In 2009-10, the Australian Government provided funding of $75.6 million nationally for the aged care assessment program (table 13A.7). Australian Government ACAT expenditure per person aged 70 years or over plus Indigenous people aged 50–69 years was $35 nationally during 2009-10 (table 13A.7). 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 2008-09 are reported in table 13A.77.

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 $7.1 billion in 2009-10, comprising DoHA expenditure of $6.0 billion (table 13A.8) and DVA expenditure of $1.1 billion (table 13A.8).

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). 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 amount of CAP payable in respect of a resident is calculated as a percentage of the basic subsidy amount. Since 2008-09, the percentage has been set at 8.75 per cent.

At June 2010, the average annual subsidy per residential place, including the CAP, was $39 516 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.17.

Table 13.2 **Average annual Australian Government basic subsidy (all levels) per occupied place at June 2010[a]**

		NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Subsidy level (includes CAP)	$	39 624	39 419	38 256	39 164	42 534	38 139	38 452	39 672	39 516

a See footnotes to table 13A.17 for further information.

Source: DoHA (unpublished); table 13A.17.

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.17.

Table 13.3 **Dependency levels of permanent residents, June 2010**[a, b, c]

		NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Proportions of residents										
Aged Care Funding Instrument										
Activities of daily living										
High	%	37.4	32.7	31.6	32.8	35.3	31.2	31.3	41.0	34.0
Medium	%	28.8	31.5	27.1	31.4	25.7	29.0	28.5	24.8	28.0
Low	%	27.0	26.8	30.6	26.8	32.6	28.7	31.6	28.6	28.8
Nil	%	6.9	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	%	43.2	43.9	37.8	45.1	49.3	33.5	46.4	32.7	42.9
Medium	%	24.4	25.4	24.5	24.9	25.5	23.4	23.2	30.5	24.8
Low	%	19.6	19.5	21.8	19.5	17.5	24.8	17.8	24.9	19.9
Nil	%	12.8	11.2	15.9	10.6	7.7	18.3	12.6	12.0	12.4
Total	**%**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Complex health care										
High	%	17.1	18.0	14.2	15.3	23.5	17.9	16.4	19.8	17.3
Medium	%	30.3	31.4	27.3	32.7	32.0	25.8	33.1	24.6	30.3
Low	%	36.8	36.4	39.6	38.0	34.1	39.0	34.3	36.3	37.1
Nil	%	15.7	14.2	18.9	14.0	10.4	17.2	16.1	19.3	15.3
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.	39 975	29 588	20 170	9 532	11 937	2 807	1 222	316	115 547
Total Low	no.	17 339	13 413	9 754	4 326	3 856	1 451	588	121	50 848
All High/Low	**no.**	**57 314**	**43 001**	**29 924**	**13 858**	**15 793**	**4 258**	**1 810**	**437**	**166 395**

[a] See footnotes to table 13A.17 for further information. [b] Totals may not add as a result of rounding. [c] Information on the Aged Care Funding Instrument (ACFI) and the characteristics of residents is provided in box 13.5.

Source: DoHA (unpublished); table 13A.17.

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 $192.5 million in 2009-10 (table 13A.8).

Capital expenditure

The Australian Government provided $35.2 million in 2009-10 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.12). In addition, capital expenditure by some State and Territory governments on residential aged care services in 2009-10 was $13.6 million (table 13A.12).

Capital expenditure on aged care services in 2009-10 is summarised in table 13A.12. 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 (table 13.4). More detailed data are in the attachment tables referenced. Data on Australian, State and Territory governments' expenditure per person in the target population by jurisdiction are contained in table 13A.6. Recipients of community care services can also contribute towards the cost of their care.

Total government expenditure on HACC under the HACC Review Agreement was $1.9 billion in 2009-10, consisting of $1.2 billion from the Australian Government and $757.7 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.9). Recipients of HACC services can also contribute towards the cost of these services.

The Australian Government funds the CACP program, spending $508.7 million on the program in 2009-10 (table 13.4). CACPs are also partly funded by client contributions. The Australian Government also funds flexible care services under the EACH and EACH-D programs, spending $206.0 million and $99.6 million respectively on these programs in 2009-10 (table 13.4). EACH and EACH-D packages are also partly funded by client contributions.

The NRCP provides community respite services and is funded by the Australian Government. Expenditure on this program was $200.0 million in 2009-10 (table 13.4). The NRCP assisted 143 387 people in 2009-10 (table 13A.15). A breakdown of Australian Government expenditure on NRCP by State and Territory is reported in table 13.4.

Table 13.4 **Governments' expenditure on selected community care programs, 2009-10 ($million)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
HACC expenditure by the Australian, State and Territory governments under the HACC Review Agreement									
	588.4	472.5	429.2	196.7	162.2	54.7	28.8	12.0	1 944.5
Australian Government expenditure									
CACP	175.2	131.8	83.9	44.2	45.0	13.5	6.8	8.4	508.7
EACH	67.2	53.4	32.5	21.8	16.3	5.9	5.4	3.6	206.0
EACH-D	33.3	24.7	16.0	10.2	8.5	3.5	2.1	1.2	99.6
NRCP	63.8	44.3	34.9	17.3	17.4	6.7	9.6	5.9	200.0

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

The DVA also provided $90.8 million for the VHC program and $109.6 million for veterans community nursing services during 2009-10 (table 13A.9). VHC recipients can also contribute towards the cost of these services.

Services provided in mixed delivery settings

Five types of flexible care are provided under the *Aged Care Act 1997* (EACH and EACH-D packages, TCP, MPS and innovative care places). Expenditure relating to EACH and EACH-D is reported above. The Australian, State and Territory governments fund the TCP. In 2009-10, the Australian Government spent $107.5 million and the State and Territory governments spent $84.6 million on the TCP (table 13A.10). The Australian Government also funds the MPS program (in conjunction with State and Territory governments) and the Innovative Care Pool. In 2009-10, the Australian Government spent $104.5 million and $3.2 million on these programs, respectively (table 13A.10). In addition to expenditure on these five flexible care programs, the Australian Government spent $23.4 million on Indigenous specific services delivered under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program.

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.10. Australian Government expenditure on these programs was $97.7 million in 2009-10. These programs include Day Therapy Centres, Continence Aids Assistance Scheme, the National Continence Management Strategy, Dementia Education and Support, Community Visitors Scheme and Culturally and Linguistically Diverse aged care (CALD) (table 13A.10). In addition, Australian Government expenditure on the Long Stay Older Patient Initiative (see box 13.4) was $37.5 million in 2009-10 (table 13A.5).

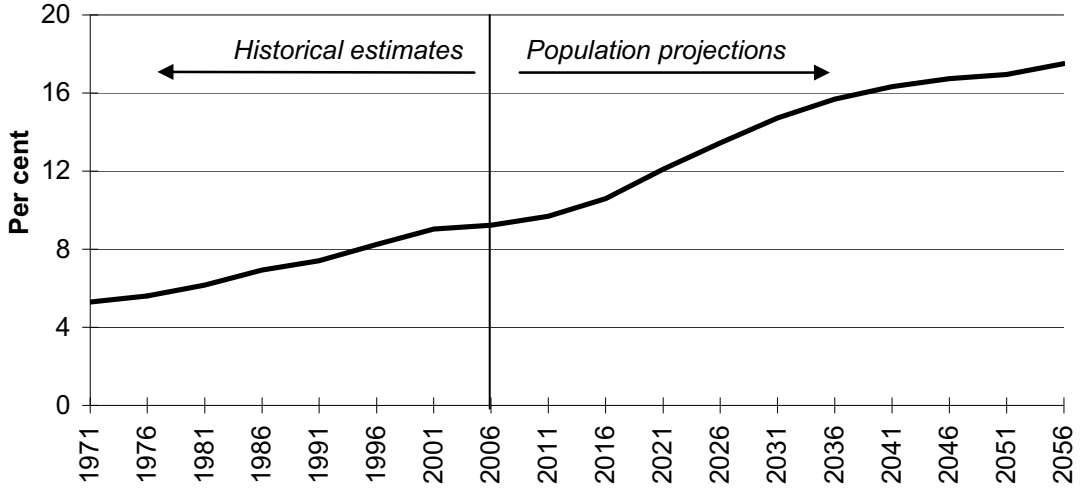
Size and scope of sector

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 13.3). The proportion of older people is 9.6 per cent nationally but varies across jurisdictions (figure 13.4). A disaggregation by remoteness categorisation is provided in table 13A.3. Higher life expectancy for females resulted in all jurisdictions having a higher proportion of older females than older males in the total population (except the NT) (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 more likely to live alone.

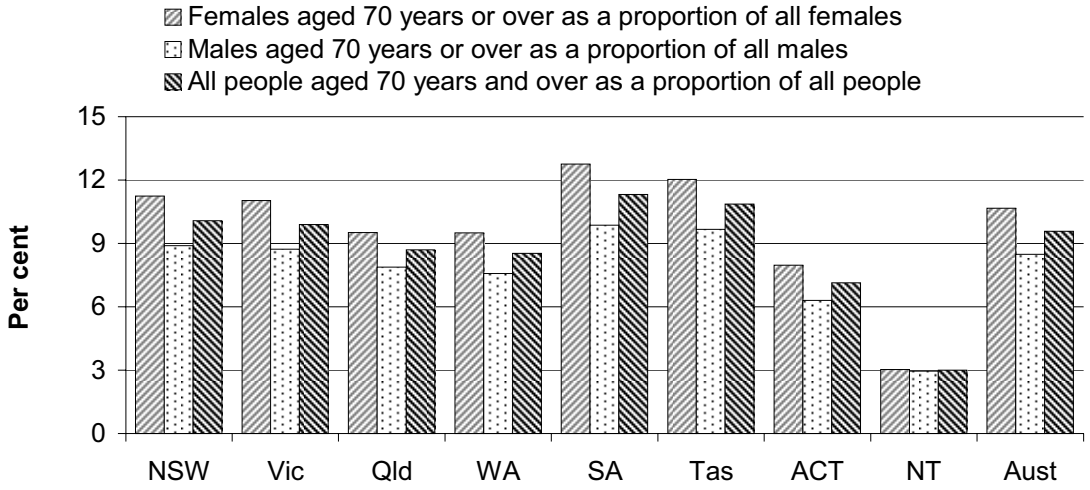
Figure 13.3 **People aged 70 years or over as a proportion of the total population[a]**



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

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

Figure 13.4 **Estimated proportion of population aged 70 years or over, by gender, June 2010**

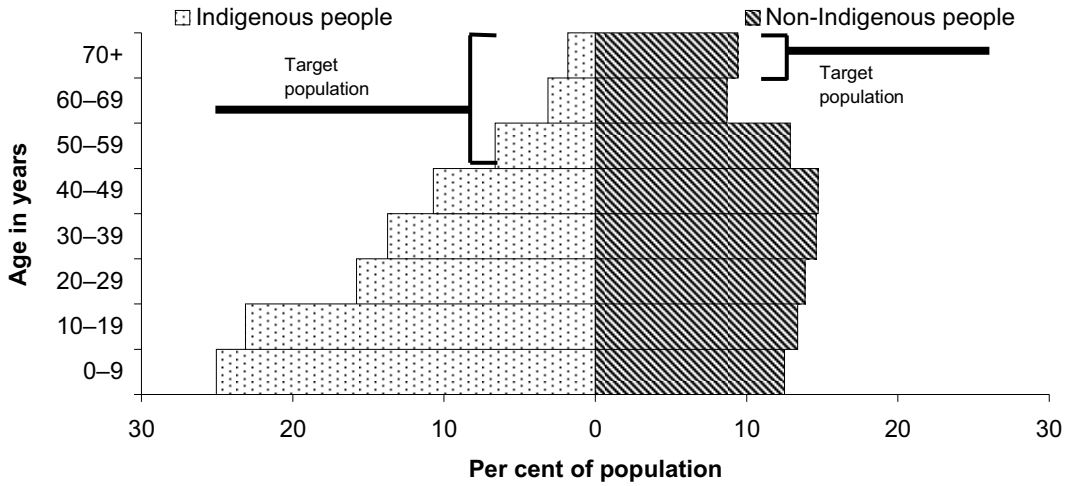


Source: Population projections prepared by the ABS using preliminary rebased estimated resident populations based on the 2006 Census according to assumptions agreed to by the Treasury and DoHA (unpublished); table 13A.1.

Characteristics of older Indigenous people

The DoHA estimates that about 67 107 Indigenous people were aged 50 years or over in Australia at 30 June 2010 (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 13.5). 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 with 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 13.5 **Age profile and target population differences between Indigenous and other Australians, June 2006**

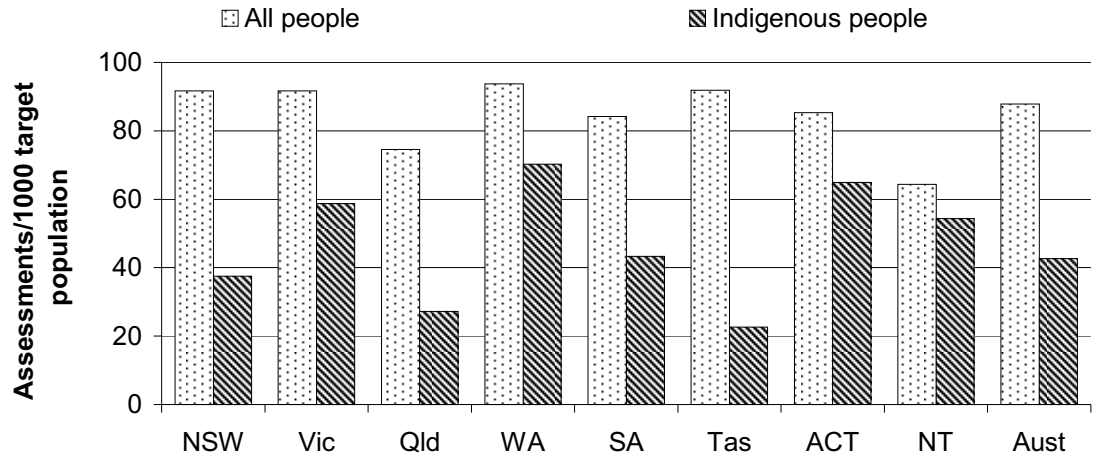


Source: ABS (2008) *Experimental Estimates of Aboriginal and Torres Strait Islander Australians*, June 2006, Cat. no. 3238.0.55.001, Canberra.

Aged Care Assessments

Aged care assessments are designed to assess the care needs of older people and assist them to gain access to the most appropriate type of care. 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 2008-09. The national rate was 87.8 assessments per 1000 people aged 70 years or over and Indigenous people aged 50-69 years. The rate for Indigenous people was 42.7 per 1000 Indigenous people aged 50 years or over (figure 13.6). Data on the numbers and rates of assessment for people of all ages by age group, Indigenous status, remoteness of residence and Socio-Economic Indexes for Areas (SEIFA), are in table 13A.65.

Figure 13.6 **Aged Care Assessment Team assessment rates, 2008-09**[a, b, c, d, e]

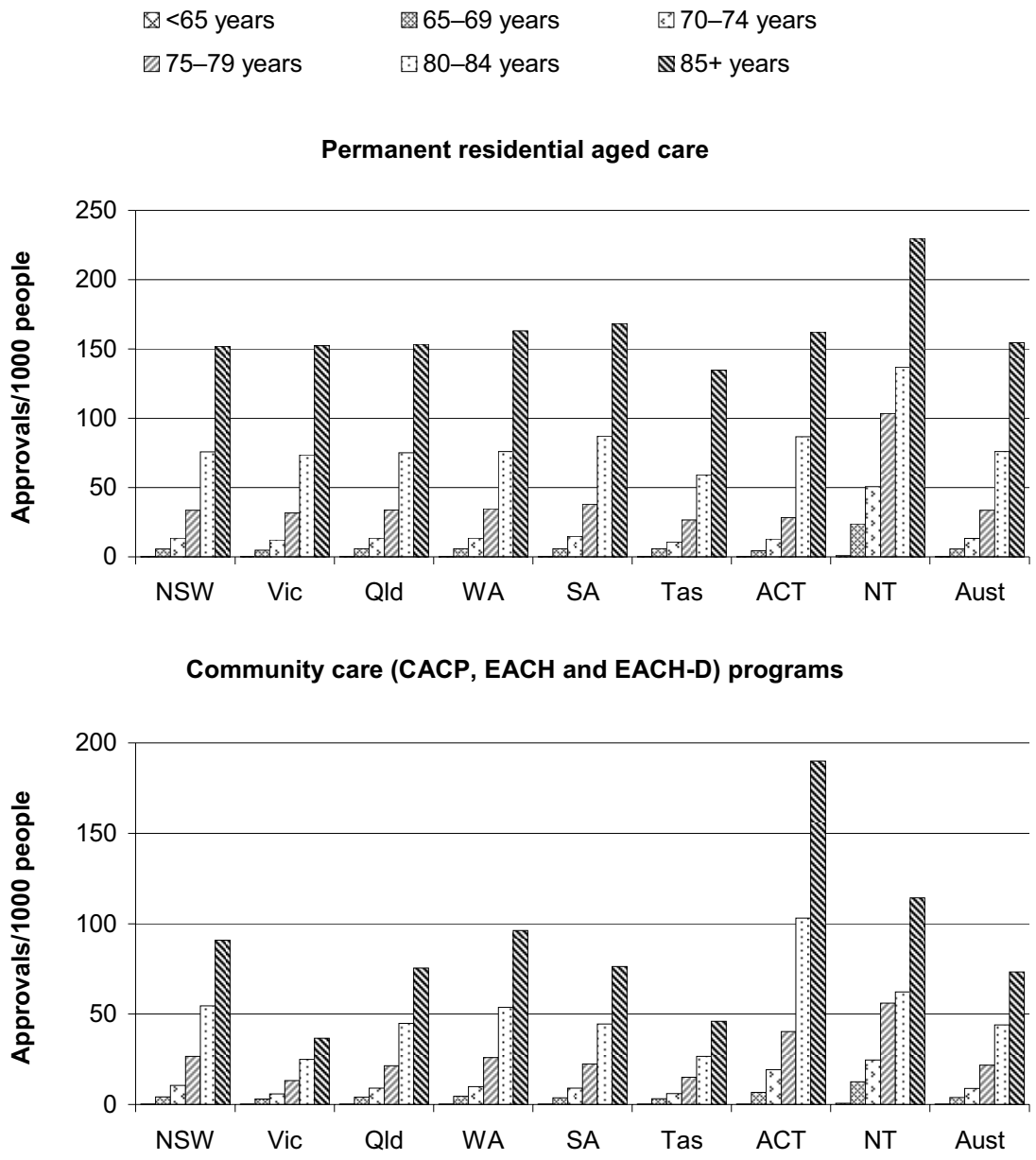


[a] Includes ACAT assessments for all services. [b] 'All people' includes all assessments of people aged 70 years or over and Indigenous people aged 50 years or over per 1000 people aged 70 years or over and Indigenous people aged 50 years or over. [c] 'Indigenous' includes all assessments of Indigenous 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.63 for further explanation of these data.

Source: Aged Care Assessment Program National Data Repository (unpublished); table 13A.63.

ACAT assessments that 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 (table 13A.64 and figure 13.7). 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 13.7 **Age-specific approval rates, per 1000 people in the population, 2008-09[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 figure are derived from ABS estimated resident population figures as at 30 June 2009.

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

Residential care services

Residential care services provide permanent high level and low level care and respite high/low level care:

- high care combines nursing care with the types of services provided in low care such as accommodation, support services (cleaning, laundry and meals) and personal care services
- low care focuses on personal care services, accommodation, support services (cleaning, laundry and meals) and some allied health services such as physiotherapy — nursing care can be given when required
- respite provides short term residential high/low care on a planned or emergency basis (DoHA 2009).

At June 2010, there were 2773 residential aged care services (table 13A.18). Low care services are generally smaller (as measured by number of places) than high care services. At June 2010, 62.1 per cent of low care services had 60 or fewer places (table 13A.20), compared with 31.4 per cent of high care services (table 13A.21).

The size and location of residential services — which can influence the costs of service delivery — vary across jurisdictions. Nationally, there were 179 749 mainstream operational places (excludes flexible care places) in residential care services (78 075 in predominantly high care services, 4377 in predominantly low care services and 97 297 in services with a mix of high care and low care residents) at June 2010 (tables 13A.18–21). Box 13.5 contains information on the planning and allocation of residential aged care places and how the Aged Care Funding Instrument is used to appraise a resident's needs as high or low care.

Box 13.5 Planning and allocation of residential aged care places and the Aged Care Funding Instrument

Planning and allocating of places

The *Aged Care Act 1997* (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.

Aged Care Funding Instrument and the characteristics of residents

Aged Care Assessment Teams (ACATs) assess and approve clients for residential and community care. ACAT approvals for residential care can limit the approval for some residents to low care. Following this, approved providers of age care homes appraise the level of a resident's care needs using the ACFI.

The ACFI measures each resident's need for care (high, medium, low or nil) in each of three domains: Activities of Daily Living, Behaviours and Complex Health Care. The ACFI was introduced on 20 March 2008 and replaced the Resident Classification Scale (RCS).

Residents are classified as high or low care based on the resident's level of approval for care (determined by an ACAT) and on the approved provider's appraisal of the resident's care needs against the ACFI, in the following manner:

- Residents who have not yet received an ACFI appraisal are classified using their ACAT assessment.
- Residents whose ACAT approval is not limited to low care, are classified as high care[a] if they are appraised under the ACFI as:
  - High in Activities of Daily Living, or
  - High in Complex Health Care, or
  - High in Behaviour, together with low or medium in at least one of the Activities of Daily Living or Complex Health Care domains; or
  - Medium in at least two of the three domains.
- All other residents appraised under the ACFI are classified as low care residents.

[a] From 1 January 2010, the definition for high care under the ACFI has changed to make it more like it was before the ACFI was introduced (see www.health.gov.au/internet/main/publishing.nsf/Content/ageing-acfi-factsheets.htm).

(Continued next page)

Box 13.5 **(continued)**

- In addition, residents whose ACAT approval is limited to low care, but whose first ACFI appraisal rates them in a high care range are classified as 'interim low' until the ACAT low care restriction is removed, or the ACFI High status is confirmed by a subsequent assessment or review.

Residents care needs may change over time. Under 'ageing-in-place', a low care resident who becomes high care at a later date is able to remain within the same service.

The combined number of all operational high care and low care residential places per 1000 people aged 70 years or over at June 2010 was 86.8 (42.8 high care and 44.0 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 2006 and 2010 (table 13A.24).

Table 13.5 **Operational high care and low care residential places, 30 June 2010**[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	41.6	40.2	37.6	49.0	45.0	34.5	50.7	42.8
Low care places	no.	42.5	46.3	44.6	43.4	43.4	39.6	45.9	40.4	44.0
Total places	**no.**	**87.5**	**87.9**	**84.8**	**81.1**	**92.4**	**84.5**	**80.3**	**91.1**	**86.8**
Proportion of places										
High care places	%	51.4	47.3	47.4	46.4	53.1	53.2	42.9	55.6	49.3
Low care places	%	48.6	52.7	52.6	53.6	46.9	46.8	57.1	44.4	50.7

[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 88 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.24 for further information regarding the calculation of provision ratios, which vary from corresponding data published in the DoHA Annual Report 2009-10. [e] Data in this table may not add due to rounding.

Source: DoHA (unpublished); table 13A.24.

Age specific usage rates for permanent residential aged care services, by jurisdiction and remoteness, at 30 June 2010 are included in tables 13A.35 and 13A.42 respectively. Age specific usage rates for these permanent residential services combined with community care program services (CACP, EACH and EACH-D) are in tables 13A.40 and 13A.44. Indigenous age specific usage rates for all these services by remoteness category are in table 13A.45.

During 2009-10, the number of older clients (aged 70 years or over plus Indigenous people aged 50–69 years) who received either high or low care in a residential aged care facility was 200 812 nationally for permanent care and 41 300 nationally for respite care. These figures reflect the number of older individuals who utilised these services during the year, for any length of time (table 13A.4). Data on the number of younger people aged under 65 years who used permanent residential care during 2009-10 are in table 13A.41.

Community care services

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, CACP, EACH, EACH-D and VHC programs have become increasingly important components of the aged care system. The distinctions between the HACC, CACP, EACH and EACH-D programs are summarised in table 13.6. VHC program services are described below.

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	$1.9 billion funding in 2009-10 At least 893 224 clients in 2009-10[c]	$508.7 million funding in 2009-10 43 360 operational places[d] in 2009-10	$305.5 million funding in 2009-10 8170 operational places in 2009-10

[a] HACC services such as community nursing, which are not available under CACPs, can be supplied to someone receiving a CACP. [b] Most HACC clients 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 2009-10 differed across jurisdictions and ranged from 91 per cent to 100 per cent. Consequently, the total number of clients will be higher than those reported. [d] The number of operational places includes CACPs and flexible community places. See note (d) to table 13A.15.

Source: DoHA (unpublished); tables 13A.4, 13A.5 and 13A.15.

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 13.6). During 2009-10, the HACC program delivered approximately 12 909 hours per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years (table 13A.46). Some further information on HACC services is contained in box 13.6.

Box 13.6 **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.

In 2009-10, 69.4 per cent of the program's recipients were aged 70 years or over, but the program was also an important source of community care for younger people with disability and their carers, with 10.7 per cent of recipients under 50 years of age (table 13A.59). (Chapter 14 reports on services for people with disability that 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.)

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. The total number of CACPs per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years increased between June 2006 and June 2010, from 17.8 to 20.0 (table 13A.25).

The EACH program is similar to the CACP program but targets people who would be eligible for high level residential aged care (EACH-D provides high level care to people with complex care needs associated with dementia). The total combined number of EACH and EACH-D packages per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years increased between June 2006 and June 2010, from 1.6 to 3.8 (table 13A.25).

Age specific usage rates for CACP, EACH and EACH-D, by jurisdiction and remoteness, at 30 June 2010 are included in tables 13A.39 and 13A.43 respectively. Age specific usage rates for these community care program services (CACP, EACH and EACH-D) combined with permanent residential services are in tables 13A.40 and 13A.44. Indigenous age specific usage rates for all these services by remoteness category are in table 13A.45.

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 number of older clients (aged 70 years or over plus Indigenous people aged 50–69 years) who received HACC, CACP, EACH and EACH-D services in 2009-10 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. Data on the number of younger of people aged under 65 years who used CACP, EACH and EACH-D services during 2009-10 are in table 13A.41.

Table 13.7 Number of community aged care older clients, by program, 2009-10

Program	*Number of clients*
HACC	625 765
CACP	53 802
EACH	6 989
EACH-D	3 487

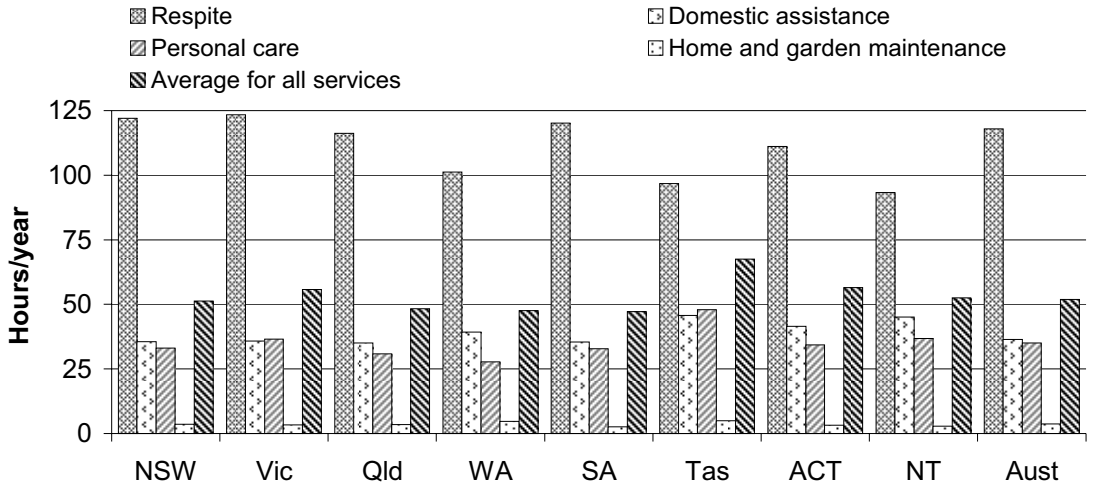
Source: DoHA (unpublished); table 13A.4.

The services of the VHC program target veterans and war widows/widowers with low care needs. There were 78 304 people approved for VHC services in 2009-10 (table 13A.13)[2]. 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 51.9 nationally in 2009-10 (figure 13.8).

2 DVA data include veterans of all ages.

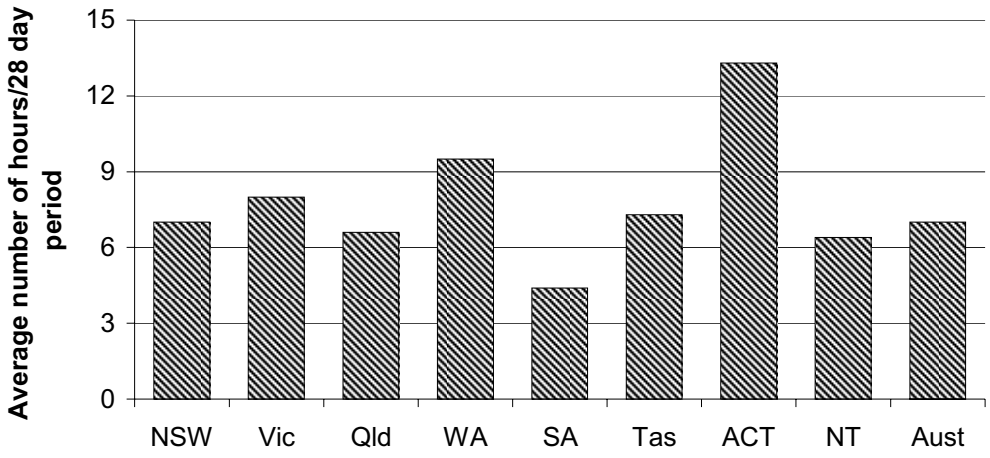
Figure 13.8 **Average number of hours approved for Veterans' Home Care, 2009-10**



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

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 2009-10, 31 713 veterans received these services (table 13A.13), and the average number of hours provided for each recipient was 7.0 nationally per 28 day period (figure 13.9).

Figure 13.9 **Average number of hours provided for DVA Community Nursing, 2009-10**



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

Services provided in mixed delivery setting

Information on the size/scope of a selection of the programs delivering services in mixed delivery settings is outlined below:

- At 30 June 2010, the Australian Government had allocated 3349 places to transition care, of which 2698 were operational, amongst 84 services across all jurisdictions. The average length of stay in 2009-10 was 60 days nationally (table 13A.82). Transition care will expand to up to 4000 places by 2011-12.
- At 30 June 2010, there were 129 operational MPS services with a total of 3120 operational flexible aged care places. Some of the MPS services serve more than one location (DoHA unpublished).
- At 30 June 2010, there were 29 aged care services funded to deliver over 650 flexible aged care places under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (DoHA unpublished).
- During 2009-10, 81 415 people were assisted through the Continence Aids Assistance Scheme (DoHA unpublished).
- During 2008-09, 160 026 people received Day Therapy Program services from 139 providers (DoHA unpublished).

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 13.7).

COAG has agreed six National Agreements (NAs) 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 NHA covers the area of health and aged care. The Agreement include sets of performance indicators, for which the Steering Committee collates annual performance information for analysis by the COAG Reform Council. Revisions have been made to the performance indicators reported in this chapter to align with the performance indicators in the NHA.

Box 13.7 **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
- person-centred.

These objectives are consistent with the Australian, State and Territory governments' long-term aged care objectives articulated under the NHA: that 'older Australians receive appropriate high quality and affordable health and aged care services' (COAG 2009).

The performance indicator framework shows which data are comparable in the 2011 Report (figure 13.10). 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).

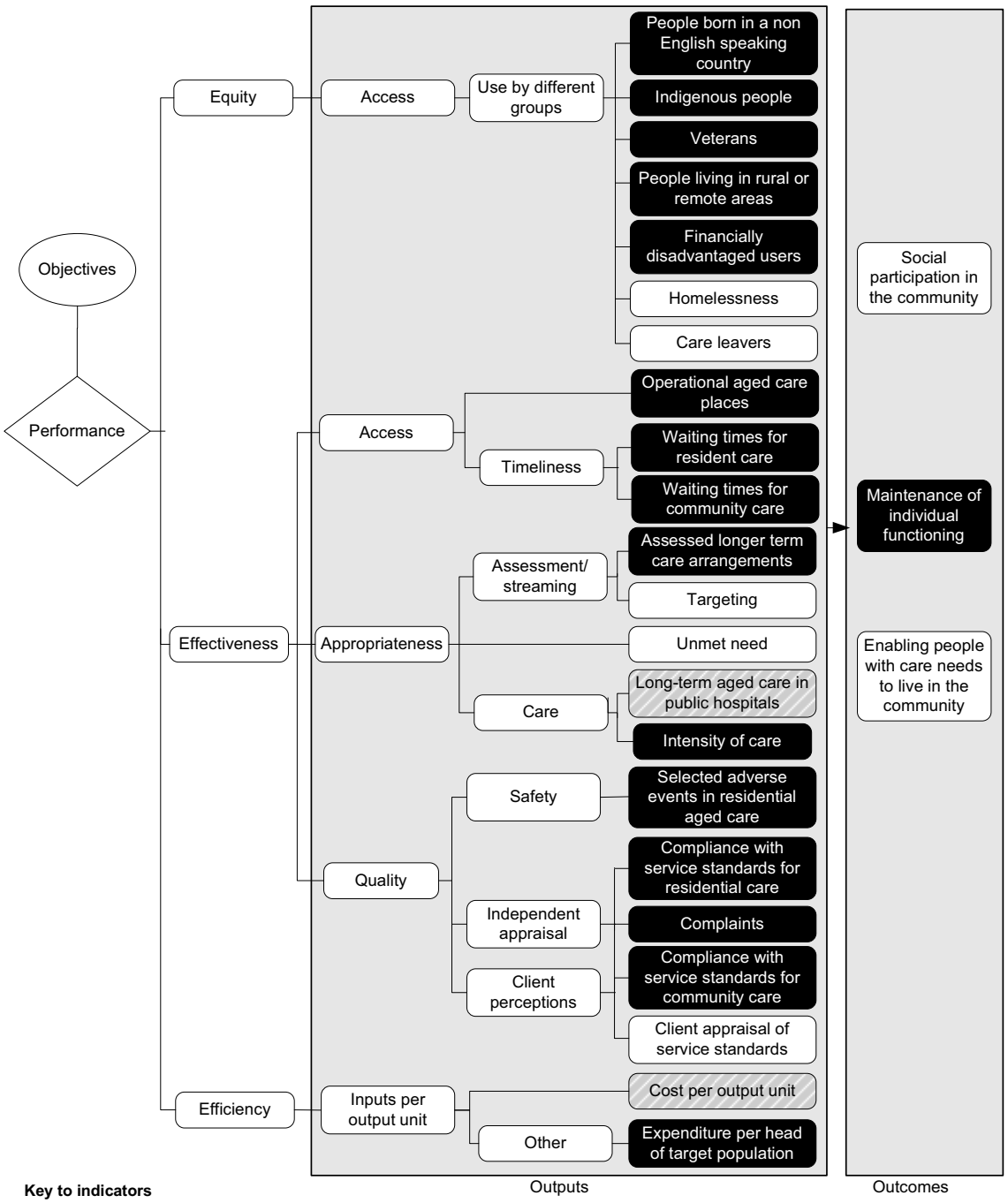
Some changes have been made to the aged care framework for the 2011 Report.

- Two measures have been added under the indicator on 'Use by different groups': 'homelessness' and 'care leavers'. These are additional special needs groups that have been defined under the *Aged Care Act 1997* and the Allocation Principles. Data will be included in future reports.
- Two new indicators have been added to the framework and data are reported for:
  - operational aged care places
  - selected adverse events in residential aged care.

Other changes to performance reporting for the 2011 Report include:

- additional measures under the indicators 'long-term aged care in public hospitals' and 'compliance with service standards for community care'
- additional time series data for the indicators 'intensity of care' and 'expenditure per head of target population'.

Figure 13.10 **Performance indicators for aged care services**



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).

Outputs

Outputs are the 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 13.8).

Box 13.8 **Use by different groups**

'Use by different groups' is defined by eight measures:

- variation in the proportion of people accessing residential services, HACC, CACPs, EACH and EACH-D services who are born in a non-English speaking country, from the proportion of people in the target population who are born in a non-English speaking country
- variation in the proportion of people accessing residential services, HACC, CACPs, EACH and EACH-D services who are Indigenous, from the proportion of people in the target population who are Indigenous
- the number of people born in non-English speaking countries using residential services, CACPs, EACH and EACH-D, 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, and EACH-D 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 number of veterans aged 70 years or over in residential care divided by the total number of eligible veterans aged 70 years or 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 rate of contacts with Commonwealth Respite and Carelink Centres for Indigenous people benchmarked against the rate for all people
- the number of new residents classified as concessional or assisted or supported, divided by the number of new residents.

(Continued next page)

Box 13.8 **(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 1997* 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, veterans (including widows and widowers of veterans), homelessness and care leavers.

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 reported for this indicator are comparable.

Data quality information for two measures (access to residential aged care services by Indigenous people and people born in a mainly non-English speaking country and access to aged care community programs by Indigenous people and people born in a mainly non-English speaking country) defined for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

Data quality information for the other measures is under development.

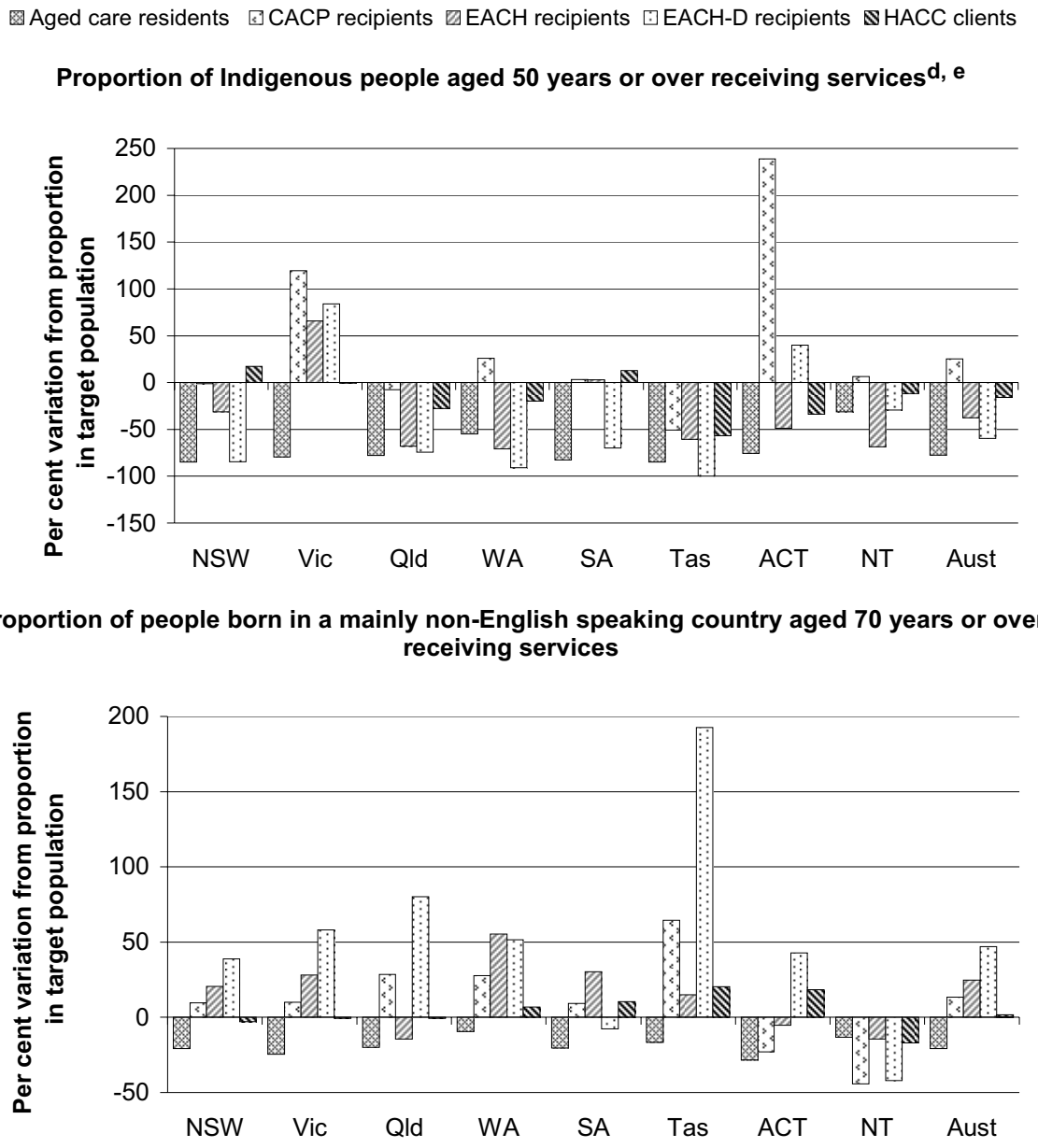
Data presented for this indicator are organised by the type of service provided, with sub-sections for the relevant special needs groups reported against that service.

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

In comparison to their proportion of the target population as a whole, Indigenous people are under-represented in access to residential care, HACC, EACH and EACH-D services, whereas people born in a mainly non-English speaking country are under-represented in access to residential care (figure 13.11).

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 with the proportion of this group in the target population. People born in a mainly non-English speaking country are also over-represented in the EACH and EACH-D program compared with the proportion of the group in the target population. Figure 13.11 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 will 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, a negative percentage will be observed (figure 13.11).

Figure 13.11 **Variation in the proportions of special needs target populations accessing aged care services from their proportion in the target population as a whole, June 2010[a, b, c]**



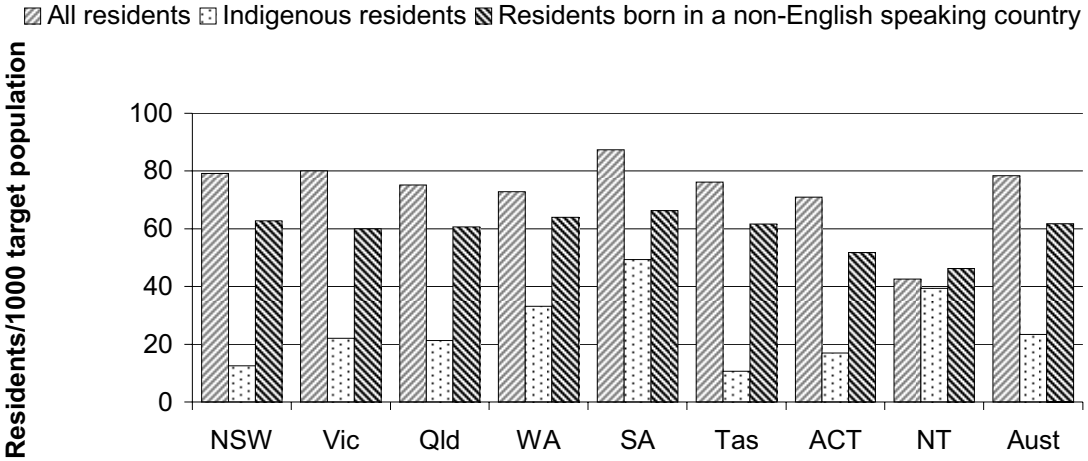
[a] The proportion of HACC funded agencies that submitted Minimum Data Set data for 2009-10 differed across jurisdictions and ranged from 91 per cent to 100 per cent. Consequently, actual service levels were higher than stated. [b] Reports provisional HACC data that have not been validated and may be subject to revision. [c] Some of these proportions are calculated using small numbers. In particular, this applies to the proportions for EACH and EACH-D. One example is the Tasmanian EACH-D proportion for people born in a mainly non-English speaking country which is calculated using a number between 10 and 20. See table 13A.30 for more details. [d] The ACT has a very small Indigenous population aged 50 years or over (table 13A.2) and a small number of CACP recipients results in a very high provision ratio. [e] Excludes National Aboriginal and Torres Strait Islander Flexible Aged Care Program recipients.

Source: DoHA (unpublished); table 13A.30.

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 2010, on average, Indigenous people and people born in non-English speaking countries had lower rates of use of aged care residential services (23.4 and 61.8 per 1000 of the relevant target populations respectively), compared with the population as a whole (78.4 per 1000) (figure 13.12).

Figure 13.12 **Residents per 1000 target population, 30 June 2010**[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.28, 13A.31 and 13A.33.

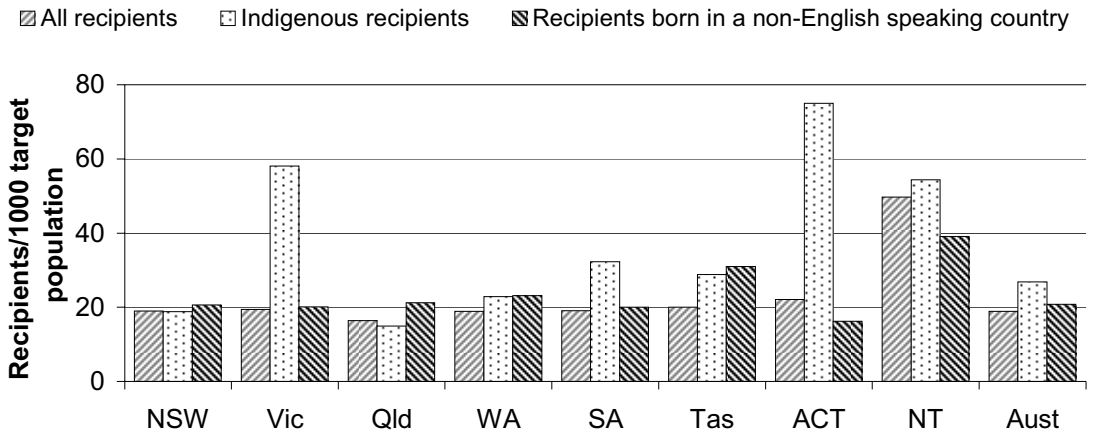
Age specific usage rates for these services, by jurisdiction and remoteness are included in the Report. These data suggest there is significant variation in usage rates by remoteness area. In general, differences amongst jurisdictions are less marked than differences between remoteness areas (tables 13A.29, 13A.32, 13A.34, 13A.35, 13A.40, 13A.42, 13A.44-45).

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 26.8 nationally and the numbers of CACP recipients from non-English speaking countries per 1000 of the relevant target population was 20.8 nationally. These figures compare to a total of 18.9 per 1000 of the target

population (people aged 70 years or over plus Indigenous people aged 50–69 years) (figure 13.13).

Figure 13.13 **Community Aged Care Package recipients per 1000 target population, 30 June 2010**[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.

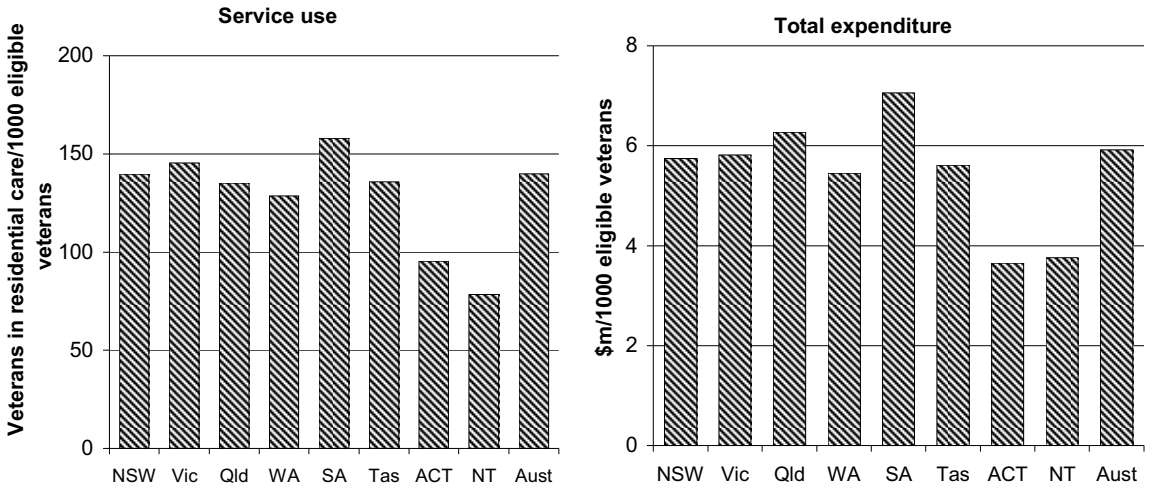
Source: DoHA (unpublished); tables 13A.28, 13A.31 and 13A.33.

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.39-40 and 13A.43–45).

Access by veterans

The total number of veterans 70 years or over who were in the DVA treatment population at 30 June 2010 was 180 803 (table 13A.14). The number of veterans in residential care per 1000 eligible veterans aged 70 years or over at 30 June 2010 was 139.8 (figure 13.14). Nationally, total DVA expenditure on residential aged care subsidy per person aged 70 years or over was $507 in 2009-10 (table 13A.14).

Figure 13.14 **Number of veterans aged 70 years or over in residential care and total DVA expenditure on residential aged care subsidy, per 1000 eligible veterans aged 70 years or over, 2009-10**[a, b, c]



[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 2010. [c] Veterans 70 years or over includes those whose age is unknown.

Source: DVA (unpublished); DoHA (unpublished); table 13A.14.

Access to the HACC program

HACC services are provided in the client's home or community for people with 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 clients aged 70 years or over during 2009-10 was 69.4 per cent (table 13A.59).

The number of service hours per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years was 12 909 nationally, and the number of meals provided per 1000 people aged 70 years or over plus Indigenous people aged 50–69 was 4703 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, 2009-10 (per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years)[a, b, c]

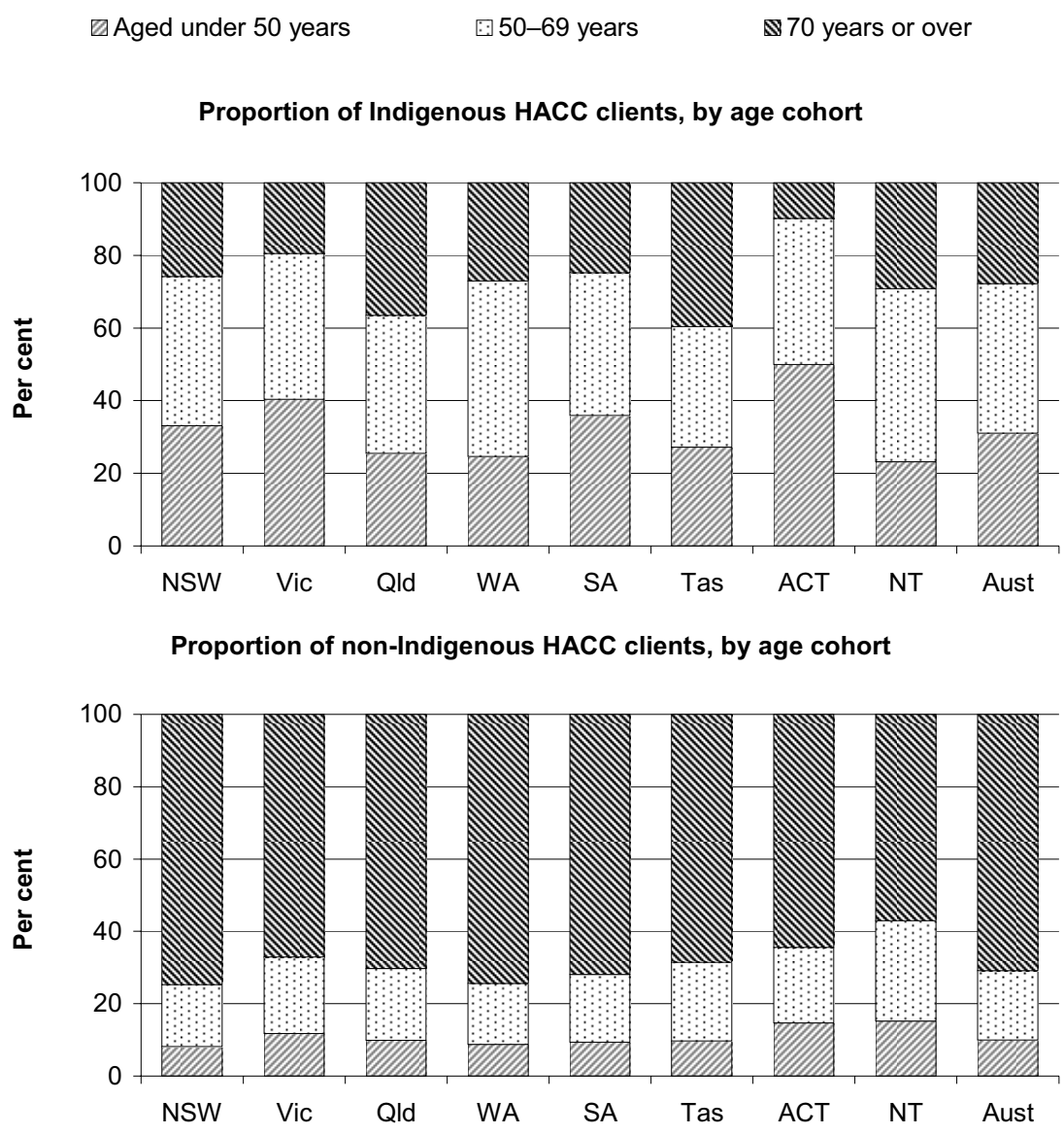
	NSW[d]	Vic	Qld	WA	SA[e]	Tas	ACT	NT	Aust
Percentage of agencies that reported Minimum Data Set data	96	96	96	91	99	98	100	96	96
Total hours (no.)[f]									
Major cities	10 538	14 019	14 394	15 230	13 277	..	12 002	..	12 882
Inner regional	8 820	16 686	11 783	12 935	11 373	12 260	..	..	12 009
Outer regional	11 382	20 794	13 501	18 374	13 257	10 081	..	9 076	14 051
Remote	15 314	31 544	19 151	16 397	17 585	10 908	..	10 266	16 737
Very remote	13 676	..	20 663	25 597	30 902	22 050	..	16 145	21 196
All areas	**10 217**	**15 076**	**13 781**	**15 403**	**13 281**	**11 565**	**12 002**	**11 722**	**12 909**
Total meals (no.)[g]									
Major cities	3 227	4 457	4 694	3 542	6 724	..	2 736	..	4 165
Inner regional	4 429	6 026	5 187	3 542	4 123	5 082	..	..	4 957
Outer regional	6 263	6 503	5 051	5 725	8 305	5 669	..	5 256	6 081
Remote	8 254	9 456	8 491	8 709	9 027	6 421	..	13 294	9 119
Very remote	10 791	..	9 681	19 831	15 099	9 472	..	29 462	18 300
All areas	**3 803**	**4 948**	**4 999**	**4 215**	**6 717**	**5 322**	**2 736**	**15 216**	**4 703**

[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.46–51) as distinct from HACC services received divided by HACC target population in all age groups (tables 13A.53–58). [b] The proportion of HACC funded agencies that submitted Minimum Data Set data for 2009-10 differed across jurisdictions and ranged from 91 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] NSW service levels for 2009-10 are higher than the service levels reported in this table. Processes causing the under reporting are being investigated. [e] Validation processes for SA and the HACC MDS differ. As a result, actual service levels may be up to 5 per cent higher or lower than stated. [f] See table 13A.46 for a full list of categories. [g] Includes home meals and centre meals. .. Not applicable.

Source: DoHA (unpublished) *Home and Community Care Minimum Data Set 2009-10*; DoHA (unpublished) *HACC National Data Repository*; tables 13A.46–51.

Reported use of HACC services showed a substantial difference between all users and Indigenous users across all age groups in 2009-10. 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 27.8 per cent and the proportion of non-Indigenous HACC clients who are aged 70 years or over is 70.8 per cent (figure 13.15).

Figure 13.15 **Recipients of HACC services by age and Indigenous status, 2009-10[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 unknown Indigenous status differed across jurisdictions. Nationally, the proportion of all HACC clients with unknown Indigenous status was 8.6 per cent (table 13A.59).

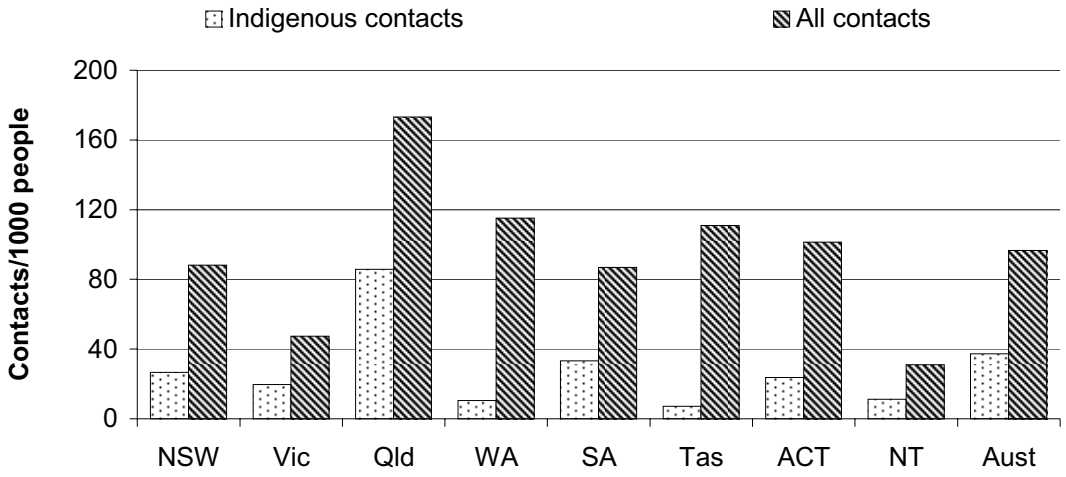
Source: DoHA (unpublished); table 13A.60.

Access by Indigenous people to Commonwealth Respite and Carelink Centres

Commonwealth Respite and 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 Respite and Carelink Centres at 30 June 2010, was 37.3 people per 1000 Indigenous people in the Indigenous target population (Indigenous people aged 50 years or over). The rate for all Australians was 96.6 per 1000 people in the target population (people aged 70 years or over plus Indigenous people aged 50–69 years). These figures varied across jurisdictions (figure 13.16).

Figure 13.16 **Commonwealth Respite and Carelink Centres, contacts per 1000 target population, by Indigenous status, 30 June 2010**[a, b, c, d]



[a] Contacts 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.62.

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 13.9).

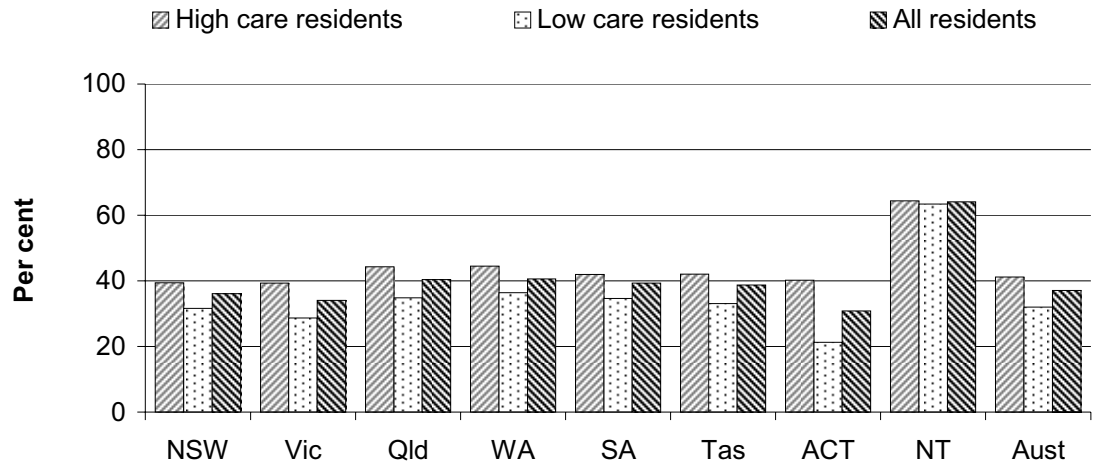
Box 13.9 **Supported residents**

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 entered permanent residential care on or after 20 March 2008, or who re-entered 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 2009-10 was 37.1 per cent nationally but varied across jurisdictions (figure 13.17). Targets for financially disadvantaged users range from 16 per cent to 40 per cent of places, depending on the service's region.

Figure 13.17 **New residents classified as supported residents, 2009-10[a]**



a Supported residents are those who have entered permanent residential care on or after 20 March 2008 (or who re-entered 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 (20 March 2008 to 19 March 2010 — $91 910.40 and from 20 March 2010 — $93 910.40).

Source: DoHA (unpublished); table 13A.36.

Effectiveness — level of access

Operational aged care places

'Operational aged care places' is an indicator of governments' objective to provide frail older Australians with access to a range of aged care services that can meet their care needs (box 13.10). The 2011 Report is the first time this indicator has been reported. This indicator does not include places that have been approved, but are not yet operational.

Box 13.10 **Operational aged care places**

'Operational aged care places' is defined by two measures, the number of operational places (by type) per 1000 people:

- aged 70 years or over
- aged 70 years or over plus Indigenous people aged 50–69 years.

The planning framework for services provided under the *Aged Care Act 1997* aims to keep the growth in the number of Australian Government subsidised aged care places in line with growth in the aged population, and to ensure a balance of services across Australia, including services for people with lower levels of need and in rural and remote areas. The framework aims to achieve and maintain a national provision ratio of 113 operational aged care places per 1000 of the population aged 70 years or over by June 2011. Within this overall target provision ratio of the 113 places per 1000 people aged 70 years or over:

- 44 places (39 per cent) should be residential high care — designed to meet the needs of residents equivalent to high care[a]
- 44 places (39 per cent) should be residential low care — designed to meet the needs of residents equivalent to low care
- 25 places (22 per cent) should be community care, with 4 of these places (around 3.5 per cent of total places) being for high level community care — designed to enable those with high/low care needs to continue living in, or return to, the community (DoHA unpublished)[a].

[a] In 2010, the target for high level community care was temporarily increased from 4 to 5 places, while the target for high level residential care was temporarily adjusted to 43 places per 1000 people aged 70 years or over. This was to ensure that the overall target ratio is achieved in 2011, together with the balance of 48 high care and 65 low care places (DoHA 2010).

(Continued next page)

Box 13.10 **(continued)**

For this Report, in recognition of poorer health among Indigenous communities and that planning in some cases also takes account of the Indigenous population aged 50–69 years, the provision ratio is also reported in terms of operational places per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years. A 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).

In general, provision ratios across state and territories, and across regions, that are broadly similar to the overall target provision ratios are desirable as it indicates that all frail older Australians have access to a similar level and mix of services to meet their care needs.

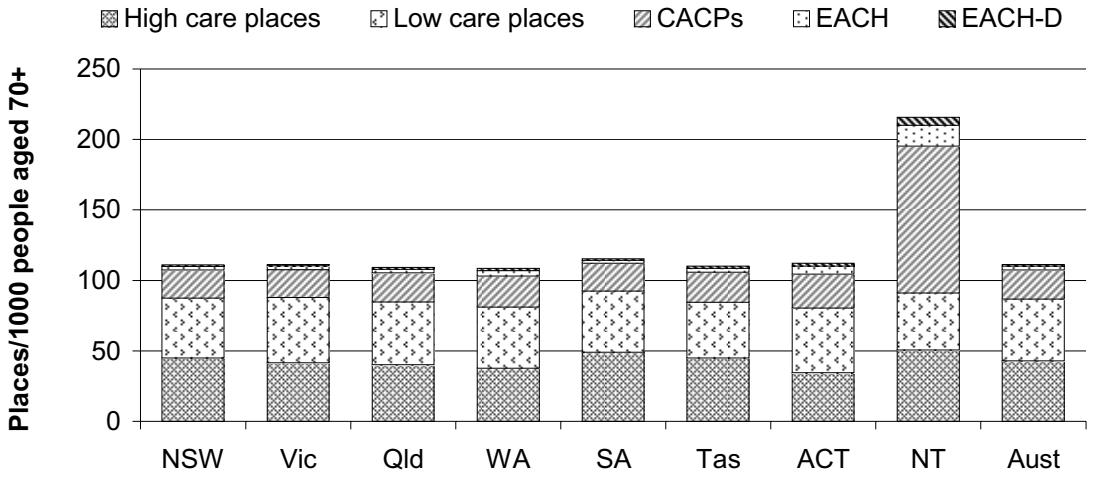
This indicator does not provide information on whether the overall target provision ratios are adequate or provide an appropriate mix of services relative to need.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

Nationally, the combined number of high care residential places, low care residential places, CACPs, flexible care places (including EACH and EACH-D, but excluding Transition Care places) and places under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program at 30 June 2010, was 111.3 per 1000 people aged 70 years or over (figure 13.18). Transition Care places add an additional 1.3 per 1000 people aged 70 years or over; however, these places are not included in the target of 113 places (table 13A.24). The number of operational aged care places per 1000 people aged 70 years or over by care type was:

- 42.8 places (38.5 per cent of total) for residential high care
- 44.0 places (39.5 per cent of total) for residential low care
- 24.5 places (22.0 per cent of total) for community care — 20.6 places for CACPs and 3.9 places for EACH and EACH-D combined (3.5 per cent of total places) (figure 13.18).

Figure 13.18 **Operational residential places, CACPs, EACH and EACH-D packages per 1000 people aged 70 years or over, 30 June 2010**[a, b, c, d, e, f, g, h]

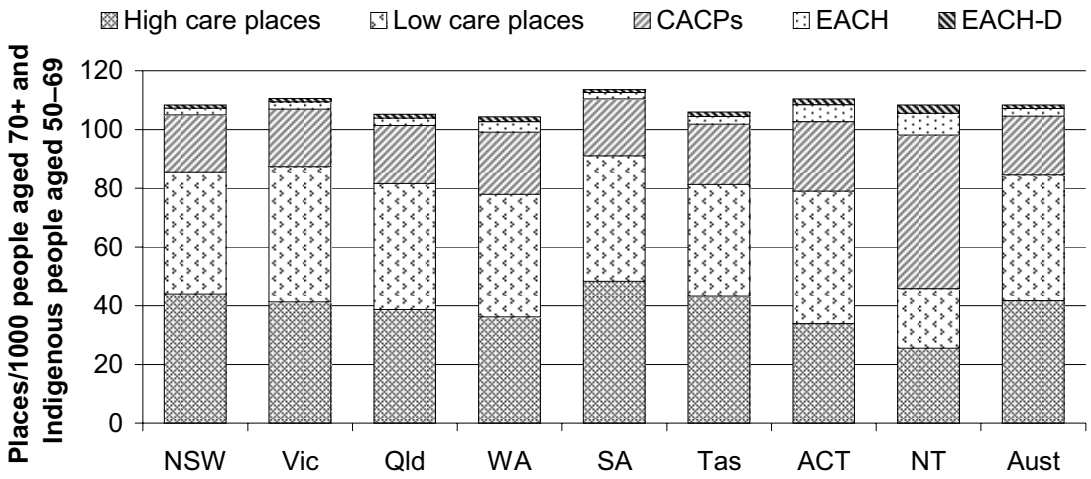


[a] Excludes places that have been approved but are not yet operational. [b] Ageing in place may result in some low care places being filled by high care residents. [c] For this Report, Australian Government planning targets are based on providing 113 places per 1000 people aged 70 years or over by June 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 included in the 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 places are not included in the provision ratio. [h] See table 13A.24 for further information regarding the calculation of provision ratios.

Source: DoHA (unpublished); table 13A.24.

The number of operational aged care places can also be shown using a population that incorporates Indigenous people aged 50–69 years (figure 13.19). Use of this 'adjusted' population has a noticeable effect on the NT, which has a large proportion of Indigenous people.

Figure 13.19 **Operational residential places, CACPs, EACH and EACH-D packages per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years, 30 June 2010**[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 included in the 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, see table 13A.25.

Source: DoHA (unpublished); table 13A.25.

Data on the number of residential and community care operational aged care places per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years by planning region and remoteness are in tables 13A.26-27.

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 proportion of people who entered residential high care within three months of their ACAT approval. 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 influenced by factors that cannot be categorised as 'waiting' time and not all 'waiting' time is included. Some examples 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.

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.

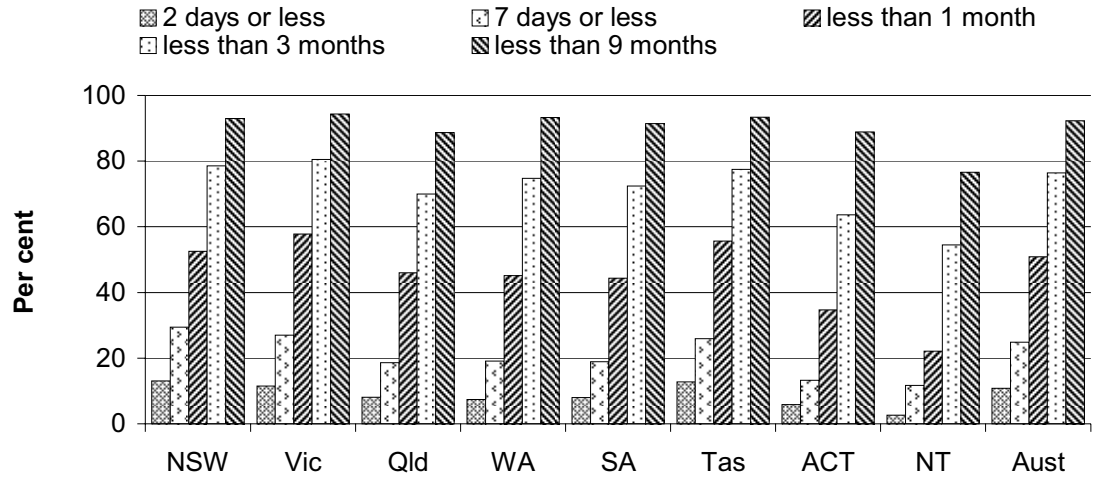
Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Overall, 24.9 per cent of all people entering residential high care during 2009-10 did so within 7 days of being approved by an ACAT compared with 26.3 per cent in 2008-09. In 2009-10, 50.9 per cent entered within one month of their ACAT approval and 76.4 per cent entered within 3 months of their approval compared with 56.3 per cent and 81.2 per cent respectively in 2008-09. These proportions varied across jurisdictions (figure 13.20 and table 13A.66). The median time for entry into high care residential services was 29 days in 2009-10 compared with 23 days in 2008-09 (table 13A.66).

Nationally, a greater proportion of people entering high care residential services entered within 3 months of approval (76.4 per cent), compared with the proportion entering low care residential services within that time (63.3 per cent). These proportions varied across jurisdictions (table 13A.66).

Figure 13.20 **People entering high care residential care within specified time periods of their ACAT approval, 2009-10[a]**



a Includes residential places categorised as high care.

Source: DoHA (unpublished); table 13A.66.

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.

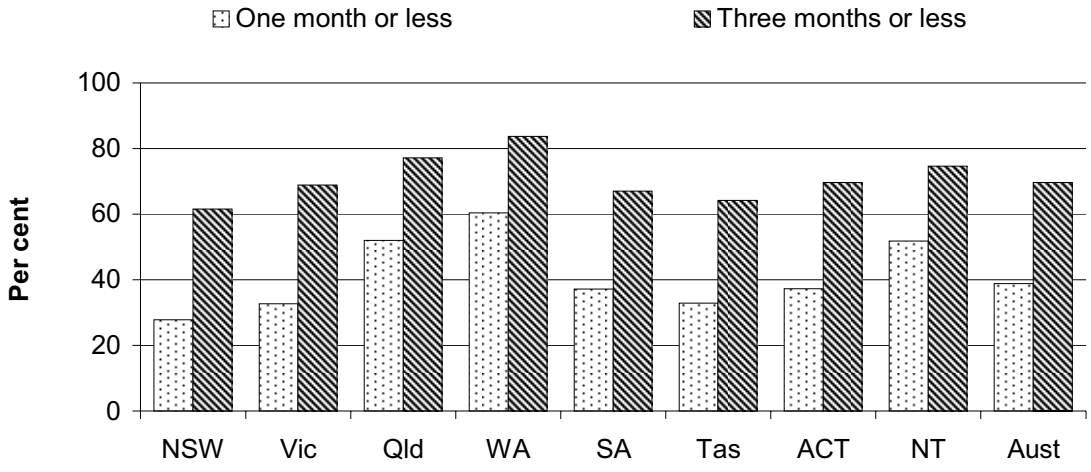
This indicator needs to be interpreted with care. Some ACAT approved clients may choose not to receive a CACP, alternative community care options may be available, or varying fee regimes might influence choice.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Overall, 69.7 per cent of all people receiving a CACP during 2009-10 received it within three months of being approved by an ACAT. This proportion varied across jurisdictions. On average, 38.8 per cent started receiving a CACP within one month of their ACAT approval (figure 13.21).

Figure 13.21 **People commencing a CACP within one or three months of their ACAT approval, 2009-10**



Source: DoHA (unpublished); table 13A.66.

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.

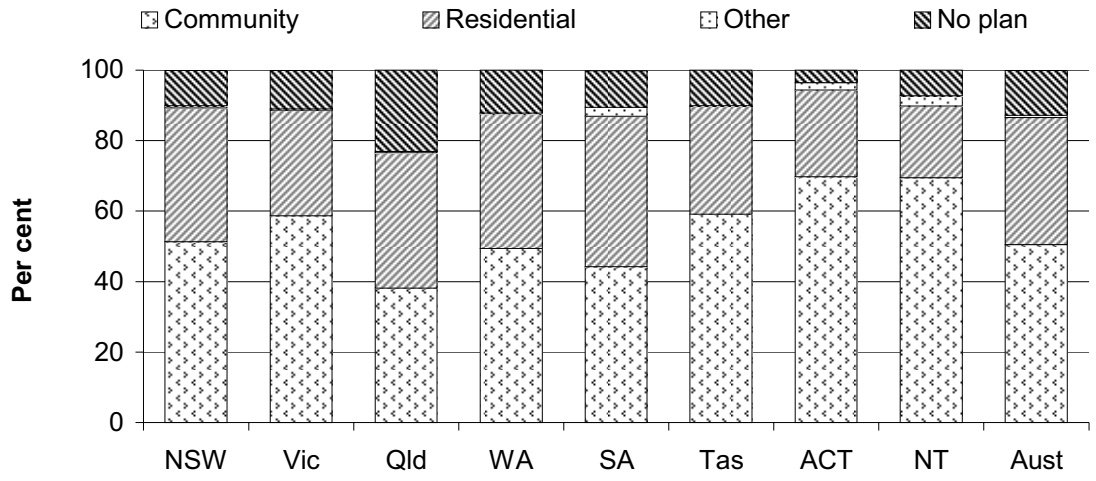
The results for this indicator show the distribution of recommended living arrangements of ACAT clients in each jurisdiction. Differences in recommendations across jurisdictions may reflect external factors such as geographic dispersion of clients and service availability, but also client preferences 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.

Data quality information for this indicator is under development.

The national proportion of ACAT clients approved for residential care in 2008-09 was 36.0 per cent and the proportion recommended to remain in the community was 50.5 per cent (figure 13.22). No long term plan was made for 12.8 per cent, which included deaths, cancellations and transfers.

Figure 13.22 **Recommended longer term living arrangements of ACAT clients, 2008-09**[a]



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

Source: DoHA (unpublished) *Ageing and Aged Care Data Warehouse* from *Aged Care Assessment Program Minimum Data Set*; table 13A.67.

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 2011 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, 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 need for assistance was not fully met (table 13A.68 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). A new measure for this indicator is reported for the first time in the 2011 Report

'proportion of all patient days (for overnight separations only) used by patients who are waiting for residential aged care'.

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

'Long term aged care in public hospitals' is defined by two measures:

- the proportion of completed 'aged care type' hospital separations for people aged 70 years or over plus Indigenous people aged 50–69 years for which the length of stay was 35 days or longer, where 'aged care type' hospital separations are defined as:
  - 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.
- the proportion of all patient days (for overnight separations only) used by patients who are waiting for residential aged care, where the:
  - care type was maintenance, and
  - diagnosis (either principal or additional) was person awaiting admission to residential aged care service, and
  - separation mode was discharge/transfer to another acute hospital or to residential aged care (unless this is usual place of residence); statistical discharge, that is a change in care type; the patient died; discharge/transfer to other health care accommodation (including mother craft hospitals and another psychiatric hospital); left against medical advice/discharge at own risk or statistical discharge from leave (for more detail see note (b) figure 13.24).

Lower proportions of hospital stays of 35 days or more and lower proportions of patient days used by people waiting for residential aged care are 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.

These measures should be interpreted with care.

- Patients who have not completed their period of acute care in a hospital 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.

(Continued next page)

Box 13.16 **(continued)**

- Reported hospital separations and patient days 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.
- For the first measure, 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.
- The measures do 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 measures are regarded as proxies, 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.

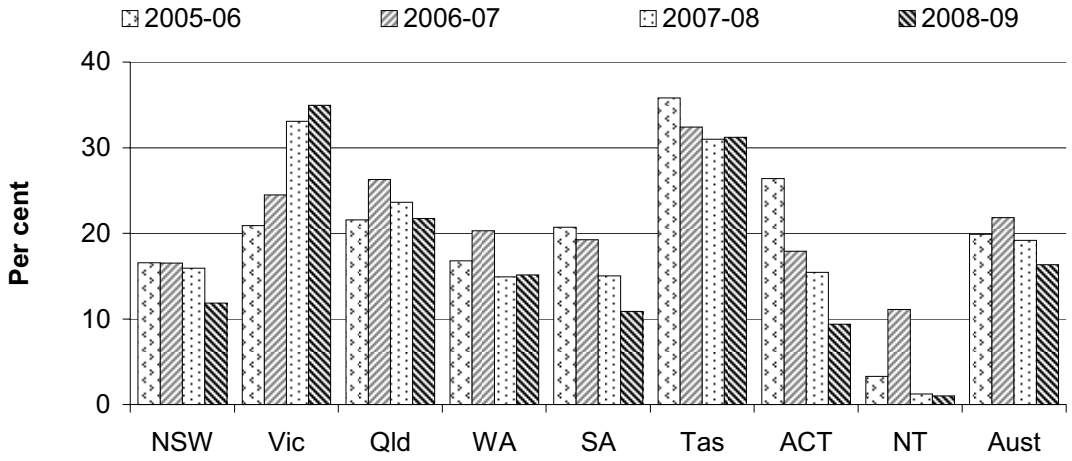
Data reported for this indicator are not directly comparable.

Data quality information for one measure (proportion of all patient days used by patients who are waiting for residential aged care) is at www.pc.gov.au/gsp/reports/rogs/2011.

Data quality information for the other measure is under development.

The proportion of separations for 'aged care type' patients (as defined in box 13.16) aged 70 years or over plus Indigenous people aged 50–69 years whose separation was 35 days or longer was 16.3 per cent nationally, in 2008-09. The proportions varied across jurisdictions (figure 13.23). 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 (10 968 separations of a total of 1.5 million nationally) (table 13A.69).

Figure 13.23 **Proportion of separations for 'aged care type' public hospitals patients that were 35 days or longer**[a, b, c, d, e, f, g]

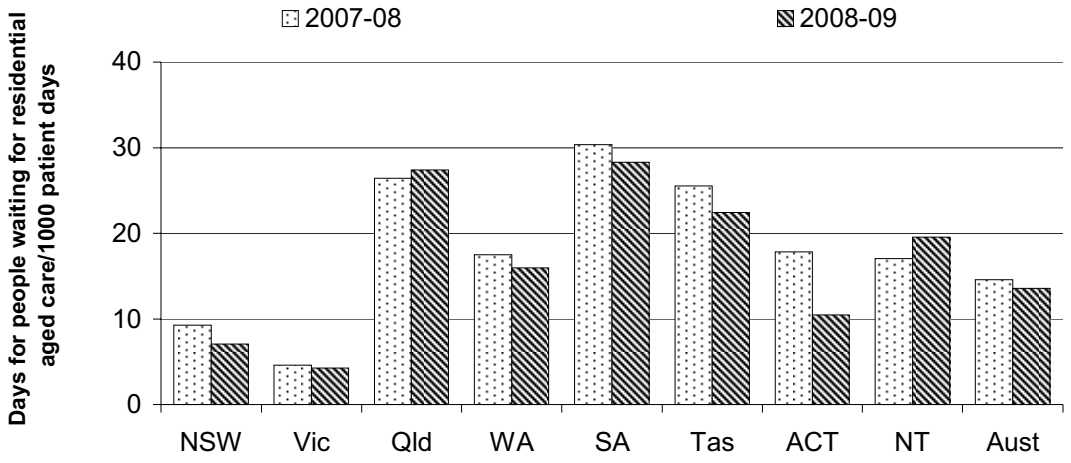


[a] Data are for hospital separations with a care type of maintenance and a diagnosis (either principal or additional) of either 'person awaiting admission to residential aged care service' or 'need for assistance at home and no other household member able to render care' and where the separation lasted 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.69.

The proportion of all hospital patient days (for overnight separations only) used by patients who are waiting for residential aged care (as defined in box 13.16) was 13.6 per 1000 patient days nationally, in 2008-09 (figure 13.24).

Figure 13.24 **Hospital patient days used by patients waiting for residential aged care**[a, b, c, d, e, f]



[a] Data include overnight hospital separations only. [b] Numerator data include patients with a care type of maintenance, and diagnosis (either principal or additional) was 'person awaiting admission to residential aged care service', and separation mode was 'discharge/transfer to another acute hospital'; 'discharge, transfer to residential aged care (unless this is usual place of residence); 'statistical discharge—type change'; 'died'; 'discharge/transfer to other health care accommodation (including mother craft hospitals)' or 'left against medical advice/discharge at own risk; statistical discharge from leave; discharge/transfer to (an)other psychiatric hospital'. [c] Includes patients of all ages. [d] Although the diagnosis codes reflect a care type, they do not determine a person's eligibility for residential aged care. [e] Diagnosis codes may not be applied consistently across jurisdictions or over time. [f] These data only account for completed unlinked separations. 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 patient days relate to the defined separations and not to the whole hospital stay.

Source: AIHW (unpublished); table 13A.70.

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). (See box 13.18 for background information on the 'ageing in place' policy.)

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 1997* aims explicitly to encourage ageing in place to increase choice and flexibility in residential aged care service provision (box 13.18).

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.

Data quality information for this indicator is under development.

Nationally, from June 2002 to June 2010, there was a steady increase in the proportion of people who stayed in the same residential aged care service when changing from low care to high care, from 59.7 per cent to 86.1 per cent (figure 13.25). In June 2010, the proportion was higher in major cities (86.0 per cent), inner regional areas (86.6 per cent), outer regional areas (84.9 per cent), remote areas (90.1 per cent), than in very remote areas (81.8 per cent) (table 13A.37).

Box 13.18 **Ageing in place in residential care**

In its Objects, the *Aged Care Act 1997* 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.*

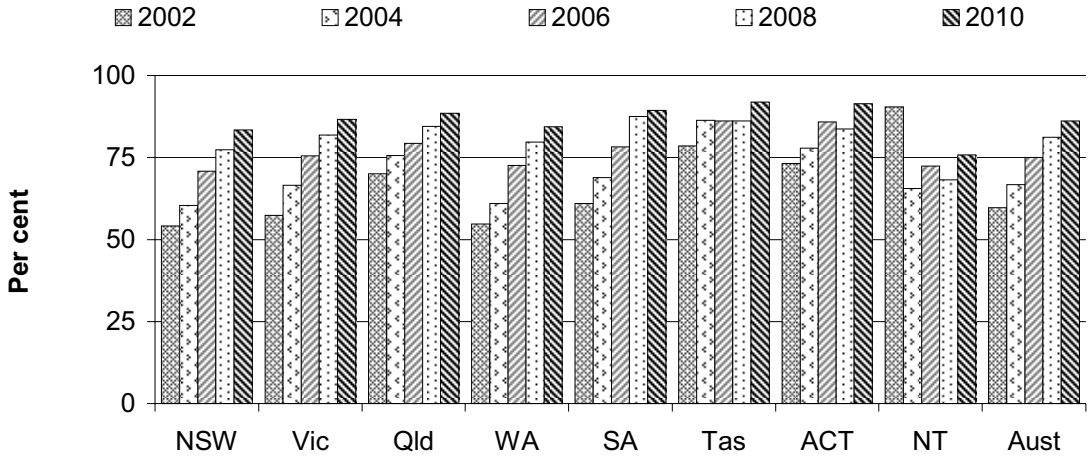
Further, the *Aged Care Act 1997* explicitly aims to encourage and facilitate 'ageing in place'. The Act does not define 'ageing in place', but one useful definition is 'the provision of a responsive and flexible care service in line with the person's changing needs in a familiar environment'. In effect, '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 1997* 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.

Source: DoHA (unpublished).

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

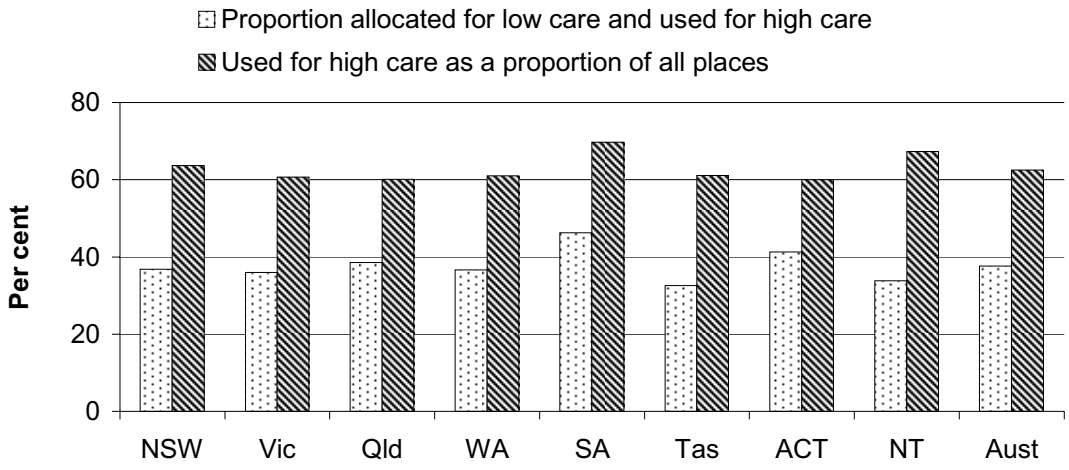


a Full ten years of data for this indicator are in attachment 13A.37.

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

Nationally, 37.6 per cent of low care places in 2009-10 were occupied by residents with high care needs. The proportion of all operational places taken up by residents with high care needs was 62.5 per cent (figure 13.26). These data are provided by remoteness area in table 13A.38.

Figure 13.26 **Utilisation of operational residential places, 30 June 2010[a]**



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

Source: DoHA (unpublished); table 13A.38.

Effectiveness — quality

Selected adverse events in residential aged care

'Selected adverse events in residential aged care' is an indicator of governments' objective to provide residential care services that are safe and of high quality by preventing and minimising the harm associated with adverse events in residential aged care (box 13.19). Falls in residential aged care that resulted in a hospital admission are the only adverse events reported on for the 2011 Report. (See box 13.20 for background information on falls in residential aged care.) As data for other adverse events (such as pressure ulcers) become available they will also be included.

Box 13.19 **Selected adverse events in residential aged care**

'Selected adverse events in residential aged care' is defined by the number of hospital separations for falls in residential aged care services per 10 000 resident occupied place days. Falls that occurred in residential aged care, but did not result in hospitalisation are not included.

Low or decreasing rates of hospital separations for falls in residential aged care services per 10 000 resident occupied place days are desirable.

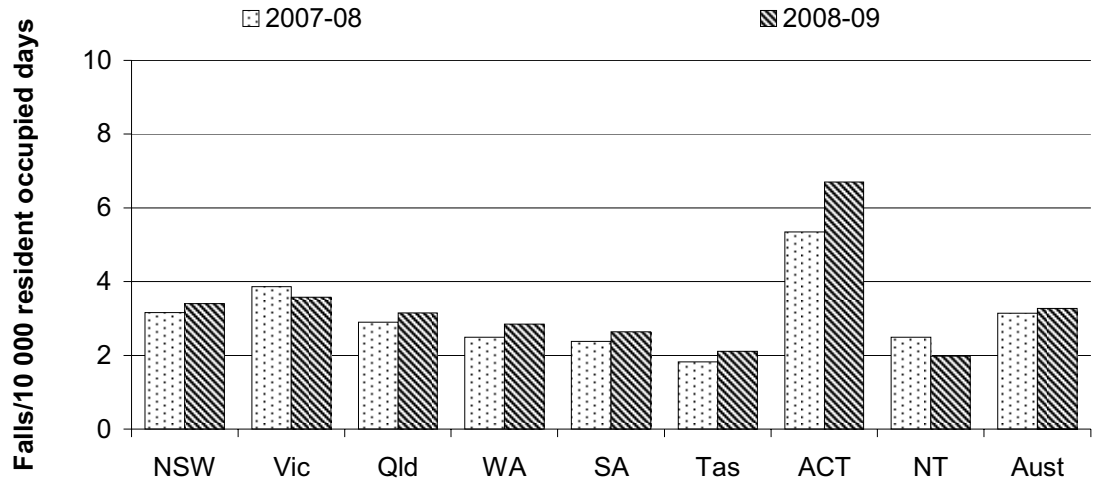
Not all falls are preventable. An excessively custodial and risk-averse approach to preventing falls that infringes on a older person's autonomy and limits rehabilitation is also not appropriate. Interventions that prevent falls or mitigate harm from falls, but do not limit autonomy or rehabilitation are the most desirable.

Data reported for this indicator are comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

Nationally, in 2008-09 there were 3.3 hospital separations for falls in residential aged care services per 10 000 resident occupied place days (figure 13.27). These data are provided by Indigenous status, remoteness area and SEIFA in table 13A.71.

Figure 13.27 **Hospitalisations for falls in residential aged care[a]**



a Number of hospital separations involving one or more falls in an aged care facility, not the number of falls.

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

Box 13.20 **Falls in residential aged care**

Falls are the most common cause of serious injury among older Australians and the most common reason for injuries that result in hospital admission (Pointer S, Harrison J and Bradley C 2003; AIHW 2007). For older people who are hospitalised, the largest proportion of injuries are to the hip and thigh. Of these hip and thigh injuries, a significant proportion are fractures. The second most common injuries are to the head (Bradley C and Pointer S 2009).

Analysis of data for 2005-06 on hospitalisations for falls of people aged 65 years or over shows that the rate was more than five times higher for people in aged care facilities than for those who lived in the community (Bradley C and Pointer S 2009). There were differences and similarities in the types of falls experienced by older people in these settings. A high proportion of falls for both groups were from slipping, tripping, stumbling and other falls on the same level. However, the proportion of falls from beds in aged care facilities was twice that of falls from beds in the home. In comparison, the proportion of falls in the home attributed to falls on and from stairs or steps was nearly ten times the proportion for those living in aged care facilities (Bradley C and Pointer S 2009).

There are a number of risk factors for residents falling in aged care facilities (many of these risks will also apply in other settings). A person's risk of falling increases as their number of risk factors accumulate. Risk factors can be related to:

- a person's behaviour or condition — some examples include wandering behaviour, cognitive impairment and multiple drug use
- the environment or a person's interaction with the environment — relocation between settings and environmental hazards (ACSQHC 2009).

The Australian Commission on Safety and Quality in Health Care (ACSQHC) have identified four components for best practice for fall prevention and harm minimisation in residential aged care: (1) implementing standard falls prevention strategies; (2) identifying falls risks; (3) implementing interventions targeting these risks to prevent falls and (4) preventing injury to those people who do fall (ACSQHC 2009). According to the ACSQHC, while the body of knowledge about the risk of falls and how to reduce these falls is growing, a combination of interventions tailored to the individual appear to be effective for reducing the risk of falls. In the residential aged care setting, there is also evidence that certain single interventions, such as hip protectors, vitamin D and calcium supplementation, or medication reviews, prevent fractures or reduce the risk of falls in some residents (ACSQHC 2009).

Source: ACSQHC (2009); Pointer S, Harrison J and Bradley C (2003); AIHW (2007); Bradley C and Pointer S (2009).

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 13.21).

Box 13.21 **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.

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Box 13.21 **(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.

Data quality information for this indicator is under development.

Accreditation decisions and further information relating to the accreditation standards and ACSAA are publicly available (ACSAA 2009). The accreditation process is summarised in box 13.21.

At 30 June 2010, 90.4 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 2010[a, b]**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Re-accreditation period										
<2 years	%	4.0	4.6	4.8	4.7	8.1	–	20.0	37.5	5.0
2 years or more (but <3 years)	%	1.9	3.7	6.8	8.2	8.1	3.8	–	12.5	4.6
3 years	%	94.1	91.7	88.4	87.1	83.7	96.2	80.0	50.0	90.4
Total	**%**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total re-accredited services	**no.**	**324**	**350**	**249**	**85**	**86**	**26**	**10**	**8**	**1 138**

a Data at 30 June 2010 relate only to re-accreditations, and do not include accreditation periods for 28 commencing services. Earlier reports (up to June 2007 data) included both initial accreditations and re-accreditations. **b** Note that 'accreditation period' shows the decision in effect at 30 June 2010. Data in this table will not necessarily be consistent with the accreditation decisions made in 2009-10, because those decisions may not yet have taken effect, or may have been superseded. – Nil or rounded to zero.

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

Nationally, as at 30 June 2010, 99.5 per cent of residential aged care services were compliant with building certification, fire safety, and privacy and space requirements (table 13.10).

Table 13.10 **Residential aged care services compliant with building certification, fire safety and privacy and space requirements at 30 June 2010**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*[a]	*Aust*
Total residential services	no	886	774	480	244	267	82	26	14	2 773
Total compliant services	no	880	774	474	243	267	82	26	14	2 760
Proportion of compliant services	**%**	**99.3**	**100.0**	**98.8**	**99.6**	**100.0**	**100.0**	**100.0**	**100.0**	**99.5**

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

Source: DoHA (2010) *Report on the Operation of the Aged Care Act 2007, 1 July 2009 – 30 June 2010*, Canberra.

Complaints

'Complaints' is an indicator of governments' objective to ensure aged care services provide a high quality of care (box 13.22).

Box 13.22 **Complaints**

'Complaints' is defined as the number of breaches under the *Aged Care Act 1997* 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 1997* 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.

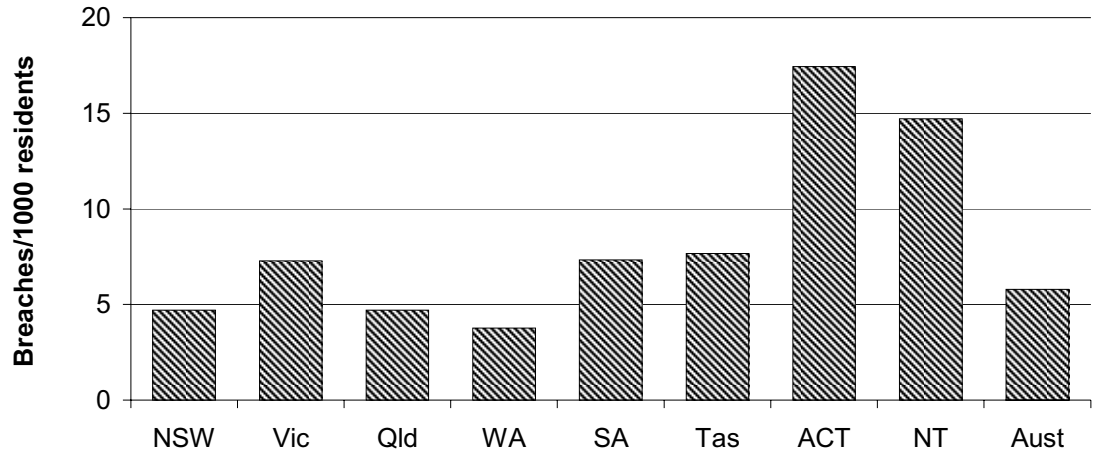
Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

From 1 July 2009 to 30 June 2010, the CIS identified 931 breaches under the *Aged Care Act 1997* (table 13A.73). The number of breaches identified per 1000 residents from 1 July 2009 to 30 June 2010 was 5.8 nationally. This varied across jurisdictions (figure 13.28).

In the period 1 July 2009 to 30 June 2010, DoHA received 13 166 contacts of which 8055 were within the scope of the CIS to investigate, although not all of these were complaints. Of the 8055 in scope cases dealt with by the CIS, 96.5 per cent related to residential care services (DoHA unpublished).

Figure 13.28 **Complaints Investigation Scheme breaches, 2009-10[a, b]**



a Data for NT and ACT are variable due to small numbers. **b** Data relate to permanent residents as at 31 December 2009.

Source: DoHA (unpublished); table 13A.73.

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 13.23). Measures for compliance with service standards for community care are reported for the first time for CACP, EACH, EACH-D and NRCP services.

Box 13.23 **Compliance with service standards for community care**

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

- the number of HACC agencies appraised against the standards as a percentage of the total number of HACC agencies
- the proportions of HACC agencies which achieve high, good, basic, or poor ratings, and the average score in each jurisdiction
- the number of reviews against program standards for community aged care services (CACP, EACH, EACH-D and NRCP) as a proportion of total services to be reviewed
- the proportion of community aged care services (CACP, EACH, EACH-D and NRCP) which received ratings for:
  - Outcome 1 — effective process and systems in place
  - Outcome 2 — some concerns about effectiveness of processes and systems in place
  - Outcome 3 — significant concerns about effectiveness of processes and systems in place.

A high proportion of HACC agencies appraised, higher ratings and high average scores are desirable. A high proportion of community aged care services reviewed and a high proportion reviewed who achieved an outcome 1 (effective processes and systems in place) are desirable.

The indicator monitors the extent to which individual agencies are complying with service agreement standards/program 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.

Data quality information for this indicator is under development.

A total of 3469 HACC agencies were identified for appraisal over the four year period 2006-07 to 2009-10. The number of these agencies appraised was 3285 (94.7 per cent). This proportion varied across jurisdictions (table 13.11). The outcomes of these appraisals was a national average score of 17.5 out of 20 (table 13.12).

Table 13.11 HACC National Service Standards appraisals over the four year period ending 2009-10[a]

	Unit	NSW[b]	Vic	Qld[c]	WA	SA	Tas	ACT[d]	NT[e]	Aust[c]
Appraisals	no.	1 527	437	917	225	195	72	30	16	3 285
HACC agencies	no.	1 610	461	783	278	195	72	30	40	3 469
Proportion of agencies assessed	%	94.8	94.8	100.0	80.9	100.0	100.0	100.0	40.0	94.7

[a] Reports provisional data that have not been validated and may be subject to revision. Not all HACC agencies were required to undergo external assessment, and some are exempt, so the number of HACC agencies may be higher than those reported. [b] The NSW Health reviews undertaken during 2009-10 were a representative sample of all NSW Health HACC funded services and covered all service types and geographic areas to determine any variations. This sample was used to validate the self-assessment completed by 100 per cent of NSW Health HACC funded services. All HACC services were reviewed using a comprehensive monitoring tool between November 2005 and June 2009. That monitoring activity verified non-government organisations self-assessment against the HACC instrument. Remaining services to be appraised are mainly community transport services due to complete in December 2010. [c] 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 783 Queensland agencies. [d] Quality Assessments in the ACT occurred in 2008-09 only. [e] 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 period ending 2009-10 (number)[a, b, c]

	NSW	Vic	Qld[d]	WA	SA	Tas[e]	ACT[f]	NT	Aust
High (17.5 – 20)	1 065	237	703	88	114	30	18	3	2 258
Good (15 – 17.4)	227	92	145	40	43	11	9	4	571
Basic (10 -14.9)	202	77	60	87	30	16	3	7	482
Poor (less than 10)	33	31	9	10	8	15	–	2	108
Average score	17.7	16.5	18.6	15.0	17.0	14.9	17.6	14.3	17.5

[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.76. [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 only. – Nil or rounded to zero.

Source: State and Territory governments (unpublished); table 13A.76.

Nationally, a total of 618 community aged care organisations providing CACP, EACH, EACH-D and NRCP services were to be reviewed in 2009-10 (table 13A.74). Of these services, 98.8 per cent were reviewed nationally and this proportion varied across jurisdictions (table 13.13). The proportion of the reviews for which an outcome 1 — effective processes and systems in place — was achieved was 78.7 per cent (table 13.13).

Table 13.13 **Compliance with service standards for community aged care services — CACP, EACH, EACH-D and NRCP, 2009-10 (per cent)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Proportion of services reviewed[a]									
	103.8	131.5	85.0	105.0	50.0	96.5	60.0	141.6	98.8
Proportion of reviews achieving relevant outcomes									
Outcome 1[b]	73.8	86.3	80.3	76.2	70.6	92.9	100.0	64.7	78.7
Outcome 2[c]	7.5	8.2	16.1	14.3	17.6	7.1	–	35.3	12.1
Outcome 3[d]	18.7	5.5	3.6	9.5	11.8	–	–	–	9.2

[a] In some states and territories, more services were reviewed than the annual target for 2009-10. [b] Outcome 1 is effective processes and systems in place. [c] Outcome 2 is some concerns about the effectiveness of processes and systems in place. [d] Outcome 3 is significant concerns about the effectiveness of processes and systems in place. – Nil or rounded to zero.

Source: DoHA (unpublished); tables 13A.74-75.

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 13.24).

Box 13.24 **Client appraisal of service standards**

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

Data for this indicator were not available for the 2011 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 13.25).

Box 13.25 **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.

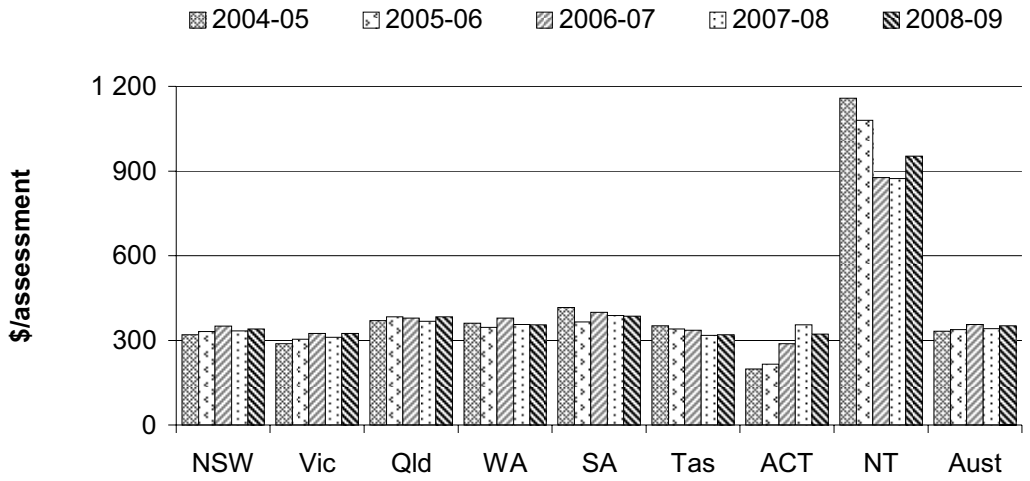
Cost per ACAT assessment has been developed as a proxy and work is in progress to measure efficiency for ACATs.

Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

Australian Government expenditure per aged care assessment during 2008-09 averaged $352 nationally (figure 13.29). Nationally, real expenditure increased between 2004-05 to 2008-09. The cost per assessment is calculated using the total number of assessments and therefore includes clients aged less than 70 years.

Figure 13.29 **Australian Government expenditure on aged care assessments, per assessment (2008-09 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.77.

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 13.26).

Box 13.26 **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 care services, HACC and CACP 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.

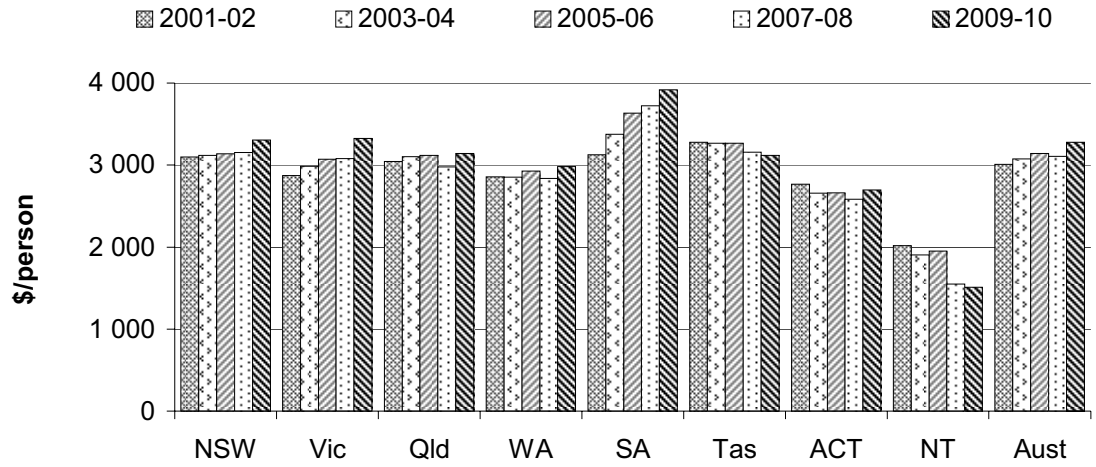
Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

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 increased from $3010 in 2001-02 to $3280 in 2009-10 (figure 13.30). If the payroll tax supplement paid by the Australian Government is excluded, this expenditure nationally was $3228 in 2009-10 (table 13A.78).

DoHA expenditure on residential care per person aged 70 years or over plus Indigenous people aged 50–69 years in 2009-10 was $2785 including the payroll tax supplement and $2742 excluding the payroll tax supplement (table 13A.8). DVA expenditure on residential care per person aged 70 years or over in 2009-10 was $507 including the payroll tax supplement and $500 excluding the payroll tax supplement (table 13A.14).

Figure 13.30 **Australian Government (DoHA and DVA) real expenditure on residential services per person aged 70 years or over plus Indigenous people aged 50–69 years (2009-10 dollars)[a, b, c]**

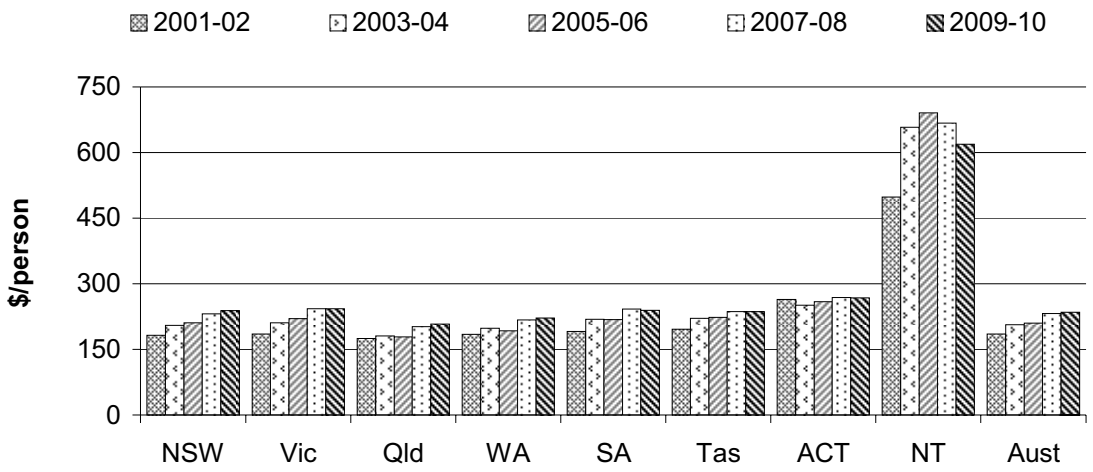


a Includes a payroll tax supplement provided by the Australian Government. Actual payroll tax paid may differ. **b** Population data for years prior to 2008, are from population projections by SLA for 2002–2022 based on 2001 Census prepared for DoHA by the ABS according to assumptions agreed by DoHA. Population data for June 2008, are from preliminary population projections by SLA for 2006–2026 based on 2006 Census prepared by the ABS for DoHA according to assumptions agreed by DoHA. Population data for years from June 2009, are from population projections by SLA for 2007–2027 based on 2006 Census prepared by the ABS for DoHA according to assumptions agreed by DoHA. See footnotes to table 13A.2 for more information. **c** Full ten years of data for this indicator are in attachment 13A.78.

Source: DoHA (unpublished); DVA (unpublished); table 13A.78.

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 2009-10. Nationally, real expenditure per person aged 70 years or over plus Indigenous people aged 50–69 years increased from $185 in 2001-02 to $235 in 2009-10 (figure 13.31).

Figure 13.31 **Australian Government real expenditure on CACP services per person aged 70 years or over plus Indigenous people aged 50–69 years (2009-10 dollars)[a, b]**

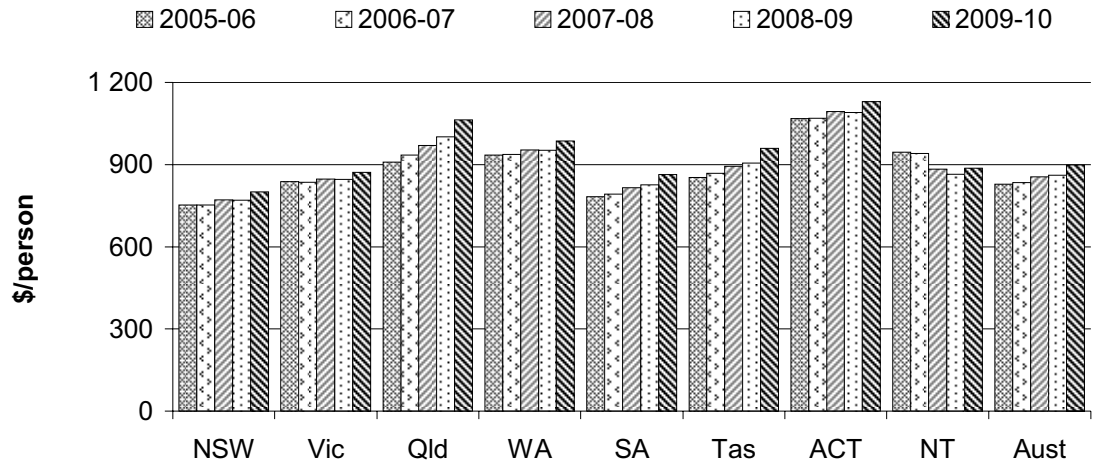


a Population data for years prior to 2008, are from population projections by SLA for 2002–2022 based on 2001 Census prepared for DoHA by the ABS according to assumptions agreed by DoHA. Population data for June 2008, are from preliminary population projections by SLA for 2006–2026 based on 2006 Census prepared by the ABS for DoHA according to assumptions agreed by DoHA. Population data for years from June 2009, are from population projections by SLA for 2007–2027 based on 2006 Census prepared by the ABS for DoHA according to assumptions agreed by DoHA. See footnotes to table 13A.2 for more information. **b** Full ten years of data for this indicator are in attachment 13A.81.

Source: DoHA (unpublished); table 13A.81.

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 was $899 in 2009-10, higher than expenditure in 2005-06 which was $829 (figure 13.32). 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.79.

Figure 13.32 **Australian, State and Territory government real expenditure on HACC services per person aged 70 years or over plus Indigenous people aged 50–69 years (2009-10 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 in the HACC target population is contained in table 13A.79. HACC target population data are in table 13A.52. [b] These data represent expenditure under the HACC Review Agreement only. [c] Reports provisional HACC data that have not been validated and may be subject to revision. [d] Expenditure reflects an equalisation strategy. [e] Population data for years prior to 2008, are from population projections by SLA for 2002–2022 based on 2001 Census prepared for DoHA by the ABS according to assumptions agreed by DoHA. Population data for June 2008, are from preliminary population projections by SLA for 2006–2026 based on 2006 Census prepared by the ABS for DoHA according to assumptions agreed by DoHA. Population data for years from June 2009, are from population projections by SLA for 2007–2027 based on 2006 Census prepared by the ABS for DoHA according to assumptions agreed by DoHA. See footnotes to table 13A.2 for more information.

Source: DoHA (unpublished); table 13A.80.

Outcomes

Outcomes are the impact of services on the status of an individual or group (while outputs are the 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 13.27).

Box 13.27 **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 13.28).

Box 13.28 **Maintenance of individual functioning**

'Maintenance of individual functioning' is defined as improvement in TCP client's level of functioning, reflected in the movement from the average Modified Barthel Index (MBI) score on entry to the TCP 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.

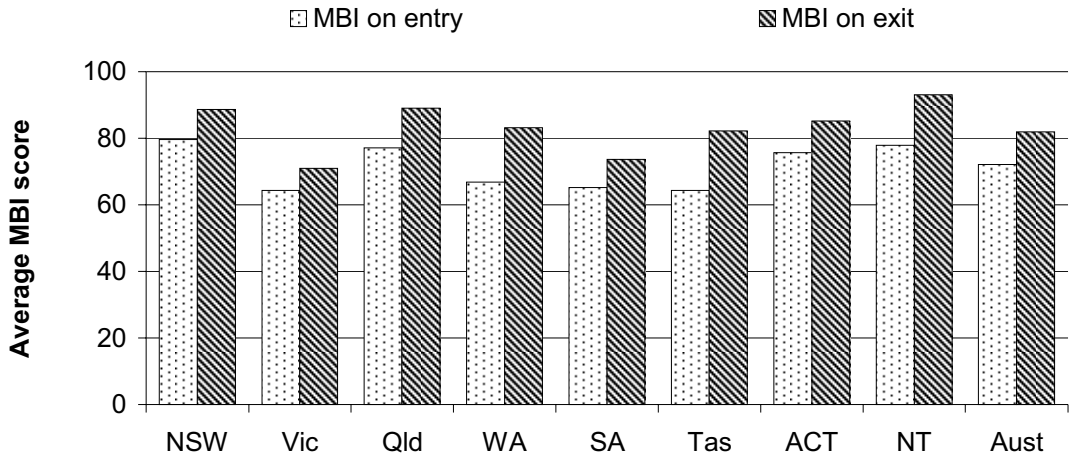
The TCP is a small program at the interface of the health and aged care systems. It may be possible to develop measures for other aged care programs such as residential aged care and community aged care services which would be indicators of maintenance of individual functioning.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

The average MBI score on entry to the TCP in 2009-10 was 72.1 nationally. The average MBI score on exit from the TCP was 82.0 nationally. These results varied across jurisdictions (figure 13.33).

Figure 13.33 **Transition Care Program — average Modified Barthel Index score on entry and exit, 2009-10[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 TCP recipients who successfully completed a transition care episode.

Source: DoHA (unpublished); table 13A.82.

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 13.29).

Box 13.29 **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

For several 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
- inclusion of additional data on adverse events in residential aged care as they become available
- further development of outcome indicators.

COAG Developments

Report on Government Services alignment with National Agreement reporting

Further alignment between the Report and NA indicators might occur in future reports as a result of developments in NA reporting.

Outcomes from review of Report on Government Services

COAG endorsed recommendations of a review of the RoGS in December 2009. Those recommendations implemented during 2010 are reflected in this Report.

Further recommendations will be reflected in future Reports, including implementation of Independent Reference Group and Steering Committee recommendations arising from the 'Review of the general performance indicator framework' and the 'Review of the performance indicators and their associated measures'. The 2012 Report and later editions will continue:

- lengthening time series data in attachment tables
- developing data quality information documents for performance indicators
- developing mini-case studies.

13.5 Jurisdictions' comments

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

Australian Government comments

“During 2009-10, the Commonwealth commenced work on the development of a national aged care system that will provide better support for older Australians including training for aged care workers, more aged care places and choice, improved health care services and protection for older Australians. The Council of Australian Governments agreed to major reforms to the funding and operational roles and responsibilities in the aged care sector. Under this system the Commonwealth will become the sole funder and regulator of aged care services, including Home and Community Care services (with the exception of Victoria and Western Australia) through to high level residential care.

The Commonwealth also commenced work to implement improved information and access to services for older Australians and their families and providing $300 million in loans to support the development of an additional 2500 aged care places supporting an estimated 3600 people per year once fully implemented. Work has commenced to provide assistance over four years to improve the viability of rural and regional community care providers by increasing the viability supplement for eligible providers. More than 280 sub-acute beds, or their equivalents, are being constructed, in new and existing Multi-Purpose Services, supporting up to 5400 people a year and increasing the availability of more appropriate care options for long stay older patients in rural and remote areas. Funding is being provided to help states and territories meet the cost of long stay older patients in public hospitals, through the allocation of 2000 time-limited flexible aged care places to states and territories to support older people in hospitals. The Commonwealth is also improving consumers quality of life, independence and satisfaction with opportunities for care recipients and carers to be more active in shaping their care and services through 1200 Consumer Directed Care packages in Commonwealth-funded community care programs. The Aged Care Complaints Investigation Scheme is expanding the means through which complaints can be resolved by working with the aged care sector to establish alternate methods of resolution.

The Australian Government recognises that there are challenges facing the aged care sector and that reform is essential to build a more sustainable system that older Australians can rely on, providing high quality, affordable care into the future. The reforms the Government are introducing are the first step. The Prime Minister, the Hon Julia Gillard MP, has identified continued reform of the aged care system as a second term priority for the Government. This is why it asked the Productivity Commission to examine all aspects of Australia’s aged care system, and to develop detailed options to ensure it can meet the challenges facing it in coming decades. The Government is looking forward to the conclusions from the Productivity Commission’s inquiry and to working with the industry and older people to reform aged care so that older people can continue to receive the quality care they deserve.”

New South Wales Government comments

“All NSW Government agencies continue to work on strategic priority activities identified in the *NSW Towards 2030: planning for our changing population*. This is facilitating a coordinated approach to population ageing and demographic change by the NSW Government, together with business and the community.

As part of the National Health and Hospitals Reform, NSW Health is working with the Commonwealth on opportunities to improve the integration of specialist health services for older people within the national aged care system. This includes managing the transition of full funding and policy responsibility for the Aged Care Assessment Program to the Commonwealth by July 2012. Major progress is also being made towards enhancing the e-business capability of all 38 Aged Care Assessment Teams in NSW through implementation of the electronic Aged Care Client Record (eACCR).

NSW Health is successfully expanding its jointly-funded Transition Care Program designed to provide time-limited low intensity therapy and support to older people following hospitalisation. At 30 June 2010, NSW had 934 Transitional Aged Care places operating in NSW in both residential and community settings.

Funding under the 2006 COAG Long Stay Older Patients program continues to enable AgedCare Services in Emergency Teams to improve the clinical care and management of older people who present to a NSW public hospital Emergency Department. It also supports the provision of Acute to Aged-Related Care Services targeting early and appropriate identification of the discharge support needs of older people admitted to hospital.

In 2009-10, the NSW Home and Community Care (HACC) program continued to expand with a total budget of $588 million, an increase of $42 million, or 7.7 per cent, over 2008-09. The *Better Practice Project* was established as part of the commitment by NSW to introduce client focused service delivery and independence models of support within the HACC program. Under this initiative, NSW piloted four regional demonstrations and partnered with Aged and Community Services NSW and ACT to deliver an Awareness Raising Education Program with a focus on innovation and better practices in HACC.

The Home Care Service, a major HACC service provider in NSW, achieved a 95 per cent satisfaction rating in its 2010 Client Satisfaction Survey. This high level of satisfaction was found across all client groups and all survey participants expressed high levels of satisfaction with the attitude of staff, service standards and reliability.

In March 2010, the Community Care Access Centre celebrated two years of operation for the people of the Hunter Local Government Area. During the two-year period, the Access Centre received 20 978 new referrals, performed 20 684 community care assessments and made 22 599 e-referrals to HACC services on behalf of clients and carers.”

Victorian Government comments

“ This year has seen important discussion and negotiation between jurisdictions on alternatives for future policy and funding responses and responsibilities in aged care.

COAG discussion of health reform led to very significant changes including the transfer of all funding and policy responsibility for the Home and Community Care (HACC) Program to the Commonwealth in every jurisdiction that has agreed to the health and aged care reforms, other than Victoria. The Victorian Government will retain responsibility for jointly funding and managing HACC Services for older people, younger people with disabilities and their carers, recognising the strength of and unique characteristics of the program in this State.

Victoria will continue to work with the Commonwealth on advancing the national reform agenda in aged care, noting that models proposed to be put in place such as 'one stop shops' would need to provide demonstrably improved navigation of the service system and enhanced assessment processes for older people to be supported.

The Productivity Commission’s inquiry into the challenges facing Australia’s aged care system is a further important milestone in establishing an optimal framework to meet future aged care needs. Victoria has made a submission outlining a variety of concerns regarding the current structure of the Commonwealth aged care system.

Key issues from Victoria’s perspective include:

- aged care system integration — across the range of community-based and residential service types and with other systems (such as hospital and disability)
- importance of state/local governments as system managers — for example HACC
- rural viability of aged care services
- funding and regulation, particularly of residential aged care and especially high care.

Supported residential services (SRS) provide privately-run care and accommodation to people who need support in everyday life. New legislation has been introduced to improve the protection, safety and wellbeing of people living in SRS.

A Victorian charter supporting people in care relationships was launched in June 2010. The charter recognises and respects the vital role all carers play in the Victorian community.

Three guides have been developed to support older Victorians: *Living at home, your choices*, and *Residential care, your choices*, provide information and options for older Victorians and their families and carers, and *On my terms ... alone at home with care needs*, is a resource for services service providers. ”

Queensland Government comments

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- Queensland has continued to support the programs and services that improve the quality of life of older people and their carers.
- The Department of Communities has led the development of “Positively Ageless – Queensland Seniors Strategy 2010–2020” and the “10-year plan for supporting Queenslanders with a disability”. These plans identify priority areas and key initiatives for older people, particularly those who are vulnerable, disadvantaged or socially isolated, and people with a disability.
- In 2009-10, Queensland continued to address priorities identified in the HACC Triennial Plan 2008–2011 including improving service accessibility and delivery for Aboriginal and Torres Strait Islander people, people with dementia, carers, people who are homeless or living in boarding houses and hostels and people from culturally and linguistically diverse communities.
- The Queensland Community Services Skilling Plan has delivered expanded training and skill development for HACC workers, volunteers and clients in Queensland. A pilot program, Nutrition for One or Two, helped frail aged men and women to reignite their interest in eating and preparing nutritious food.
- A review of the Access Point program in Rockhampton identified that improved efficiency would be gained by changing to a single regional service provider model. Queensland now plans to expand the program state-wide.
- Queensland has continued to implement places approved under the Transition Care Program. As at 30 June 2010, 606 places were operational. During 2009-10, Queensland Health contributed over $16 million towards the cost of Transition Care.
- Queensland Health continued to implement local based initiatives under the Long Stay Older Patients’ Program. Initiatives include capital works at 22 rural sites and Hospital in the Home and Nursing Home, Interim Care, Early Intervention and Hospital Avoidance across metropolitan and major provincial sites.
- Queensland supports 20 State owned and operated residential aged care facilities. In 2009-10, the State Government contributed nearly $90 million of an overall expenditure of over $162 million. Capital expenditure of nearly $10 million was made to upgrade these facilities and Multi Purpose Health Services.
- During 2009-10, Queensland rolled-out the electronic submission of all aged care assessments undertaken by 17 Aged Care Assessment Teams across Queensland.
- Queensland also contributed $10 million in 2009-10 for the Healthier Ageing Program aimed at addressing lifestyle factors impacting on the health of older people. Funding of $800 000 was provided for the Strengthening Aged Care initiative.

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Western Australian Government comments

Western Australia's approach to the development and implementation of services for older people continues to focus on the vision of independence, wellbeing and quality of life.

The WA Home and Community Care (HACC) Program "Assessment Framework Service Redesign" framework released in 2009 was followed by a series of consultation forums and in early 2010; Reference Groups were established to support the development and implementation of the Assessment Framework. An expression of interest has been called to identify the service providers that will take on the role of Regional Assessment Services.

The Friend In Need–Emergency (FINE) scheme is a metropolitan based partnership between public hospitals and community care that targets older and chronically-ill patients and gives them an alternative to an emergency department presentation or admission to hospital. As well as keeping people at home the FINE scheme assists in timely, safe and effective discharge of patients from public hospitals. It supports a range of services including the Silver Chain Home Hospital; a strengthened network of care coordination; and community based home care packages. The WA Health Residential Care Line Outreach has been integrated into the FINE scheme and, together with Silver Chain Home Hospital services, provides enhanced clinical support options to Residential Aged Care Facilities in metropolitan Perth.

There has also been a focus on the growth of sub-acute care services across the state, especially in rural and remote geographical areas where services are minimal or undeveloped. This work has included expansion of consultant geriatric visiting services and the establishment of a consultant psycho-geriatric visiting service in rural areas. The establishment of Day Therapy Units and outreach community based physiotherapy in key regional centres is also an important development. The work has also included a particular emphasis on Rehabilitation in the Home (RITH) in metropolitan regions, establishment of outreach multidisciplinary rehabilitation clinics for specialist clinical groups such as Amputee and Parkinson's Disease patients and the establishment of regional secondary stroke units.

The 'Long Stay Older Patients' initiative (LSOPI) has continued to operate across the state with a focus on strengthening existing hospital strategies through the continued funding of the emergency department Care Coordination Teams (CCT). The major focus of the CCTs includes screening for any condition associated with ageing that may impact on the person's functional wellbeing which could lead to admission to hospital. Early identification of these risks assists with care planning and early introduction of support services and treatment interventions to prevent future emergency department attendance, hospital admission and functional decline. The LSOPI has also provided the catalyst for raising awareness and changing the culture of aged care in emergency departments and raised the profile of aged care service delivery along the Eldercare Pathway.

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’.

In keeping with the national community care reforms and COAG’s initiative to improve access to community care, SA 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 SA Home and Community Care (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 SA HACC program continued to expand, with $12.5 million in additional funding bringing the total budget to $162.2 million in 2009-10.

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
- older people from culturally and linguistically diverse (CALD) backgrounds and their carers
- 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 $8.9 million in 2009-10. Funding was also allocated for specific projects for carers and to implement the State-wide Dementia Action Plan. ”

Tasmanian Government comments

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- Under the national health reforms, the Australian Government will take over full responsibility for the planning, funding and provision of aged care. States and territories, however, will still be required to make a significant contribution to hospital and other services providing care to older people.
- Both the direct and the broader service demand issues posed by population ageing are now a central focus of social and economic planning within Australia and internationally. Those issues are of particular concern for Tasmania, with current projections by the Australian Bureau of Statistics indicating that, by 2021, this state will have 20.8 per cent of its population aged 65 years or older, a considerable 3.6 per cent higher than the national average of 17.2 per cent.
- While demand for community services is increasing, evidence confirms better outcomes for older people and lower costs to governments through enabling older people to live independently and as long as possible in their own homes. The Tasmanian Government is committed to that principle, and in 2010 it fully matched the Australian Government’s growth offer of 8.37 per cent in the Home and Community Care (HACC) Program.
- While longer term service reform planning is essential, existing service models must be recurrently resourced and where necessary enhanced, in the short to medium term. Tasmania has continued to make a considerable investment in 2009-10 with both the jointly-funded Transition Care and the Long Stay Older Patients programs, aimed at diverting older people away from, or reducing their stay, in acute care.
- 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.
- The subacute care element of the National Partnership Agreement (NPA) on Hospital and Health Workforce Reform requires Tasmania to implement strategies to grow subacute services by 20 per cent over the life of the NPA. The State has already made solid progress in the first year of the Agreement and has completed a number of projects under its implementation plan. Both the Statewide Aged Care and Rehabilitation and the Palliative Care Clinical Networks have been successfully established with ongoing project support. Palliative care services have been expanded and innovative models of other subacute care have been implemented, or are being developed, across the three service regions.
- Tasmania has also signed up to a two-year funding and implementation plan with the Australian Government, under the NPA on Health Services, to improve existing services, develop arrangements for a one-stop shop model and to consider the future arrangements for the Aged Care Assessment Teams in the context of the broader national health and aged care reforms.

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Australian Capital Territory Government comments

“

- The ACT has one of the fastest growing populations of people aged 60 years or over in Australia. Growth of the ACT population is expected to rise from 15.8 per cent in 2020 to 22 per cent by 2030. The ACT Government has implemented a Strategic Plan for Positive Ageing (2010–2014) with the vision that Canberra will be an age-friendly city.
- Ageing of the ACT and the regional population has influenced the planning of infrastructure through the Capital Asset Development Project. *Your health — our priority* is a $1 billion plus redevelopment of our health infrastructure. The aim is to revitalise and ready the ACT health system to respond to growing health service demand through to 2022 and beyond.
- As part of the forward design, ACT Health is working with our consumers, clinicians and staff to develop the way forward for our health services and to design the facilities needed to deliver them. Plans developed to date are the critical care, Cancer Services, Mental Health Services, Diabetes, Corrections health and Surgical Services plans. Other services plans are currently underway including the Rehabilitation and Aged Care Plan 2010–2015.
- In recognition of General Practitioner (GP) access difficulties, a GP in-hours locum service to support GPs and residents of residential aged care facilities is to be implemented. The service will operate from 8am to 6pm Monday – Friday (excluding public holidays). The service will receive referrals from GPs to the locum service who will provide primary care to patients in residential aged care facilities or to those clients who are home bound.
- In 2009-10, an additional $2.3 million was provided to support people to remain independent in the community through the Home and Community Care program. Services expanded included domestic assistance, personal care and home modifications.
- The Australian Government commitment to work with the States and Territories to improve transition from hospital to aged care allocates an additional 2000 transition care places for older Australians, including Aboriginal and Torres Strait Islander people. This initiative has enabled the expansion of the ACT transition care program to 41 places in 2009-10.

”

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 Northern Territory is the largest in Australia. The NT's projected growth rate for people aged 65 years or 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 2009-10, the benefits in streamlined reporting, as a result of the amalgamation of Community Government Councils to larger Shire Councils, began to be realised. There was minimal impact on service delivery under the new arrangements.

In 2009-10, the numbers of allocated places under the Transition Care Program were increased by seven to bring the NT's total allocation to 29. The additional seven places are community based, increasing the flexibility of the program in the NT. There are now 13 community based places and 16 residential based places (four each in Darwin and Alice Springs and eight in Katherine).

The NT operated six Aged Care Assessment Teams (ACATs) during 2009-10. 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 Home and Community Care (HACC) funding pool of $12.0 million for 2009-10. A mix of Non-Government, Local Government and State Government providers delivered support to the frail aged and younger people with disabilities and their carers through fifty three different 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

An adjusted subsidy reduction supplement is a payment made by State governments to some public sector residential care operators to offset the effect of the Australian Government's adjusted subsidy reduction. The adjusted subsidy reduction reduces the daily rate of Residential Care Subsidy paid by the Australian Government in respect of certain residential aged care places owned by State governments or State public sector organisations. The rate of the reduction is determined by the relevant Commonwealth Minister from 1 July each year, in accordance with section 44-19 of the *Aged Care Act 1997*.

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: • high in Activities of Daily Living, or • high in Complex Health Care, or • high in Behaviour, together with low or medium in at least one of the Activities of Daily Living or Complex Health Care domain, or • medium in at least two of the three domains. All other ACAT approval and ACFI appraisal combinations result in a classification of low level care. A resident's 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 List of attachment tables

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

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Table 13A.78 Australian Government (DoHA and DVA) real expenditure on residential services, per person aged 70 years or over plus Indigenous people aged 50–69 years (2009-10 dollars)

Table 13A.79 Australian, State and Territory governments' real expenditure on HACC services per person in the HACC target population (2009-10 dollars)

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Table 13A.81 Australian Government real expenditure on CACPs, per person aged 70 years or over plus Indigenous people aged 50–69 years (2009-10 dollars)

Table 13A.82 Transition Care Program

13.8 References

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