13 Aged care services

CONTENTS

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

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

- residential services, which provide high care, low care and residential respite care (box 13.1)
- community care services and flexible services, which include Home and Community Care (HACC) program services, Community Aged Care Packages

(CACPs), the Extended Aged Care at Home (EACH) program, the EACH Dementia program, the Transition Care Program (TCP), and the Department of Veterans' Affairs (DVA) Veterans' Home Care (VHC)[1] and Community Nursing programs

- respite services, which include HACC respite and centre-based day care and the National Respite for Carers Program (NRCP)
- assessment services, which are largely provided by the Aged Care Assessment Program (ACAP).

Additions and improvements made to the chapter this year include:

- inclusion of data reflecting the Aged Care Funding Instrument (ACFI), which commenced in March 2008 and which will gradually replace the Resident Classification Scale (RCS) (box 13.1). ACFI and RCS subsidy data now include the Conditional Adjustment Payment (CAP)
- inclusion of numbers of clients for key aged care programs, in addition to existing data on the numbers of operational places and rates of service provision per 1000 of target populations
- inclusion of data relating to DVA community nursing services for veterans
- inclusion of an additional category of experimental expenditure data, for state and territory expenditure on non-HACC post acute packages of care
- inclusion of the results of the most recent round of appraisals of HACC agencies, conducted in most jurisdictions between 2004-05 and 2007-08, for the indicator 'compliance with service standards for community care'
- inclusion of a new measure for the indicator 'complaints', reflecting the introduction of the new complaints system — the Complaints Investigation Scheme
- reporting for the first time the outcome indicator 'maintenance of individual functioning', with data from the TCP.

Older Australians also use other government services covered in this Report, including disability services (chapter 14), specialised mental health services (chapter 12), housing assistance (chapter 16) and services across the full spectrum of the health system (preface E and chapters 10–12). There are also interactions between these services that are likely to affect performance results in this Report, for example, the number of operational residential aged care places may affect demand for public hospital beds, and changes in service delivery in the public hospital sector may affect demand for residential and community aged care.

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

Box 13.1 **Transition from the RCS to ACFI and the characteristics of residents**

On 20 March 2008, the ACFI was introduced and it will gradually replace the RCS.

The RCS is an eight level scheme of resident classification (RCS levels 1–8), and the level of subsidy provided varies according to the classification.

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). A subsidy is provided according to a formula which takes care needs in each domain into account.

Transition arrangements include the provision that when a resident is assessed for funding using the ACFI, if the new subsidy rate is either less than the RCS rate, or not $15 or more per day above the existing RCS rate, the RCS rate will continue to be paid. This will continue until the ACFI does provide a higher level of subsidy due to indexation, or there is an increase in the resident's care needs.

This chapter classifies residents as 'high' or 'low' care based on their RCS or ACFI classification. For this Report, under the RCS classification, high care residents have been assessed as RCS levels 1–4, and low care residents have been assessed as RCS levels 5–8. A resident assessed under ACFI is considered to be in receipt of high care (ACFI High) if they are assessed as:

- Medium or High in Activities of Daily Living; or
- High in Behaviour; or
- Medium or High in Complex Health Care.

All other residents assessed under ACFI are regarded as low care residents (ACFI Low).[a]

[a] This includes residents whose ACAT approval is limited to low care, but whose first ACFI appraisal rates them in a high care range. These residents 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.

This chapter also describes the characteristics and performance of residential aged care in terms of residential services, places and locality (box 13.2).

Box 13.2 **Interpreting residential aged care data**

Residential services data

This chapter groups residential services for reporting purposes based on both the eight level RCS profile of residential services' clients and the ACFI.

- Aged care homes with 80 per cent or more residents classified as RCS 1–4 or ACFI High are described as high care services.
- Aged care homes with 80 per cent or more residents classified as RCS 5–8 or ACFI Low are described as low care services.
- A service that is neither high care, nor low care, as defined above is called a mixed service.

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

Places data

The Aged Care Act (part 2.2) details the processes for planning and allocating subsidised services to meet residential aged care needs and community care needs. Planning is based on a national formula for people aged 70 years or over for high and low care. High care places are planned to meet the needs of residents with care needs equivalent to RCS levels 1–4 or ACFI High. Low care places are planned to meet the needs of residents with care needs equivalent to RCS levels 5–8 or ACFI Low.

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 until he or she is discharged.

Locality data

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

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) may require various services at a younger age. For Indigenous people, those aged 50 years or over are used as a proxy for the likelihood of requiring aged care services. The Australian Government also uses these age proxies for planning the allocation of residential care, CACP, EACH and EACH Dementia packages.

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

Roles and responsibilities

Assessment services

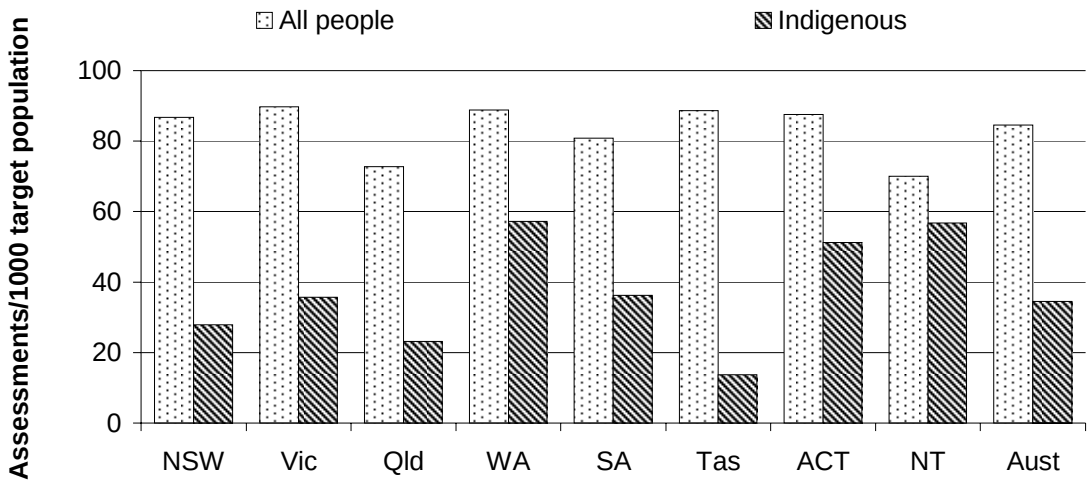
The Australian Government established the ACAP in 1984, based on the assessment processes used by State and Territory health services to determine (1) eligibility for admission into residential care and (2) the level of care required (and thus the subsidy paid to such services). The core objective of the ACAP is to assess the needs of frail older people and assist them to gain access to the most appropriate type of care. Assessment and approval by Aged Care Assessment Teams (ACATs) are mandatory for admission to Australian Government subsidised residential care or receipt of a CACP, EACH package, EACH Dementia package or TCP. People may also be referred by ACATs to other services, such as those funded by the

HACC program. An ACAT referral is not mandatory for receipt of other services, such as HACC and VHC services.

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

The number of assessments per 1000 target population varied across jurisdictions in 2006-07. The national rate was 84.5 assessments per 1000 people aged 70 years or over and Indigenous people aged 50 years or over and 34.5 per 1000 Indigenous people aged 50 years or over (figure 13.1).

Figure 13.1 **Aged Care Assessment Team assessment rates, 2006-07[a, b, c, d, e]**



a Includes ACAT assessments for all services. **b** 'All people' includes all assessments of people aged 70 years or over and Indigenous people aged 50 years or over per 1000 people aged 70 years or over and Indigenous people aged 50 years or over. **c** 'Indigenous' includes all assessments of Indigenous people aged 50 years or over per 1000 Indigenous people aged 50 years or over. **d** The number of Indigenous assessments is based on self-identification of Indigenous status. **e** See table 13A.39 for further explanation of these data.

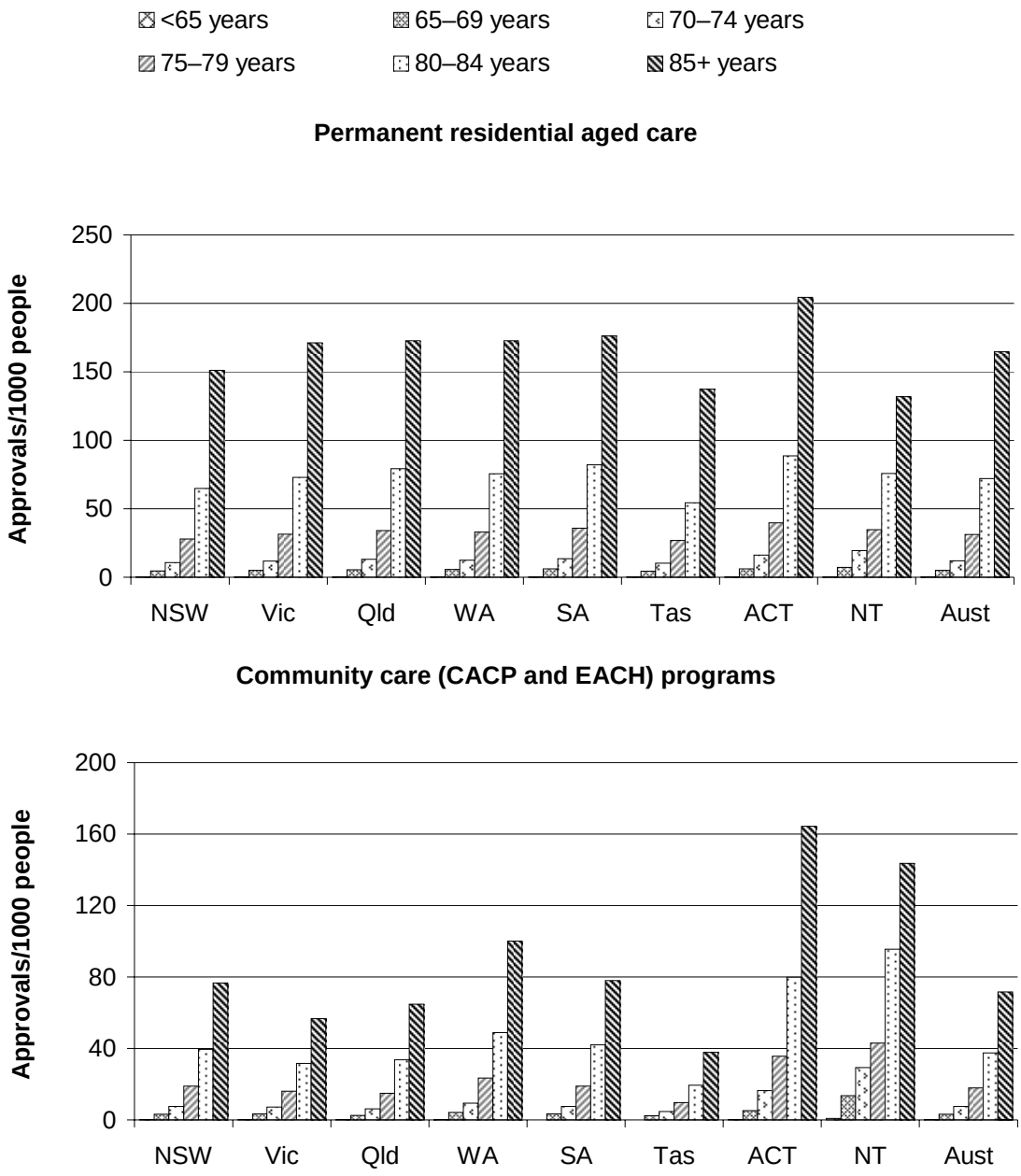
Source: Aged Care Assessment Program National Data Repository (unpublished); table 13A.39.

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

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. The numbers of places accepted cannot be identified from these data (see boxes 13.12 and 13.13 in relation to waiting time for residential and community care). As practices may vary across jurisdictions, data should be interpreted with care.

The approval rates for both residential and community care services vary across jurisdictions and increase with age (figure 13.2).

Figure 13.2 **Age-specific approval rates, per 1000 people in the population, 2006-07[a, b, c]**



a Population numbers and the proportions of the population for older age groups in the ACT and the NT are smaller than other jurisdictions, and may show variation between years, so results should be interpreted with caution. **b** The age category population data for this table are derived from ABS estimated resident population figures as at 30 June 2007. **c** EACH packages include EACH Dementia packages.

Source: Aged Care Assessment Program National Data Repository (unpublished); table 13A.40; table AA.1.

The Council of Australian Governments (COAG) has agreed to improve aged care assessment services as part of its national health agenda (box 13.3).

Box 13.3 **Improved performance and streamlining of assessment processes**

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

The initiative consists of two components:

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

The ACAP component provides for a range of activities to improve the timeliness, quality and consistency of ACAT recommendations, which will be implemented with the states and territories. In 2007-08, the initiatives implemented were: national and State and Territory projects undertaken to address the agreed priority areas; national training initiatives implemented under the National Training Strategy for ACATs; a project to determine the full cost of the ACAP by states and territories; release by the Minister for Ageing of the National ACAT Review Report and response paper by ACAP Officials; and improved communication to ACATs by enhancing the ACAT webpage on the Department of Health and Ageing (DoHA) internet site. States and territories continue to undertake a range of projects to improve the management and operation of ACATs.

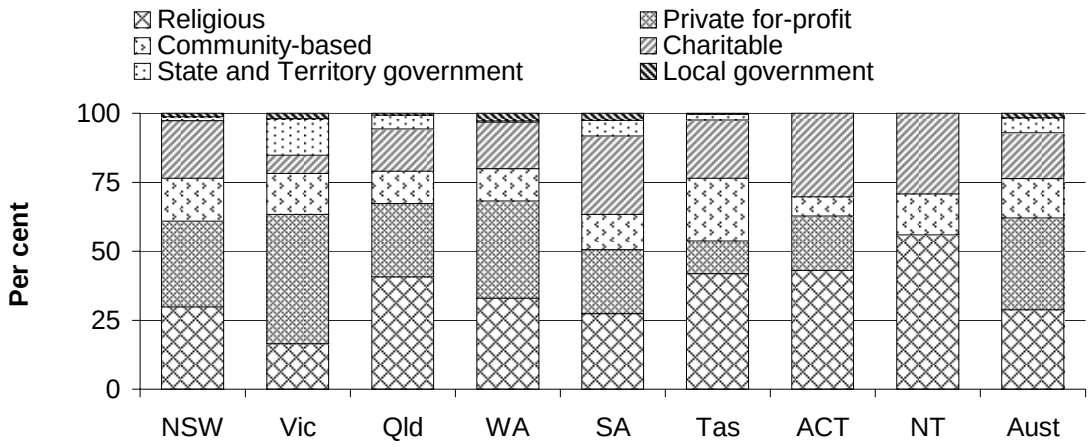
DoHA, in partnership with State and Territory governments and the community care sector has established Access Points Demonstration Projects in most states and territories. Access Points will simplify access and assessment processes for the HACC Program. Clients and carers will have their eligibility confirmed, their functional abilities and need for care assessed, and be prioritised for service referral. At the end of 2008, nine Access Point Demonstration Projects had been established in six states. They will be evaluated for approximately 12 months to inform further roll out.

Source: DoHA (unpublished).

Residential care services

Religious and private for-profit organisations were the main providers of residential care at June 2008, accounting for 28.8 per cent and 33.3 per cent respectively of all Australian Government subsidised residential aged care places. Community-based organisations and not-for-profit charitable organisations accounted for a further 14.2 per cent and 16.7 per cent respectively. State, Territory and local governments provided the remaining 7.1 per cent (figure 13.3).

Figure 13.3 **Ownership of operational mainstream residential places, June 2008[a, b]**



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

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

The Australian Government is responsible for most of the regulation of Australian Government subsidised residential aged care services, including accreditation of the service and certification of the standard of the facilities. State, Territory and local governments may also have a regulatory role in areas such as determining staffing and industrial awards, and monitoring compliance with building and fire safety regulations (box 13.4).

Box 13.4 **Examples of regulatory arrangements for residential services**

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

Under the arrangements:

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

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

Source: DoHA (unpublished).

Community care services

The main community care programs reported in this chapter — the HACC, CACP and VHC programs — fund services that aim to provide practical assistance to enable frail older people (HACC and CACP), people with a disability (HACC) and

veterans (VHC) to continue living in, or return to, the community. These services also provide assistance to carers. They are usually provided by State, Territory and local government organisations, charitable bodies, community organisations and commercial providers. The number of operational places for CACP (including community care places under the National Aboriginal and Torres Strait Islander Aged Care Program, Multipurpose Services and Innovative Care) at 30 June 2008 was 40 235 (table 13A.36). There were 80 742 people approved for VHC services in 2007-08 (table 13A.47) and at least 831 472 HACC clients in 2007-08 (table 13A.33).

Flexibly funded services

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

- The EACH program provides high level care to people in their own homes, complementing CACPs, which provide low level care. EACH Dementia provides high level care in the home to people with complex care needs associated with dementia, as an alternative to high level residential care. There were 4244 operational EACH places and 1996 operational EACH Dementia places at 30 June 2008 (table 13A.36).
- The Aged Care Innovative Pool is designed to test new approaches to providing aged care, either with time limited or ongoing flexible care allocations for innovative aged care services. It supports the development and testing of flexible models of service delivery in areas where mainstream aged care services may not appropriately meet the needs of a location or target group. For example, the TCP is built on the lessons learned from two pilot programs developed through the Innovative Pool, which addressed the interface between aged care and hospital care — the Innovative Care Rehabilitation Services and the Intermittent Care Services (DoHA unpublished).
- The MPS program supports the integration and provision of health and aged care services for small rural and remote communities. At 30 June 2008, there were 117 operational multi purpose services with a total of 2817 operational flexible aged care places. Some of the MPS serve more than one location (DoHA unpublished).

Transition care services

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

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

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

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

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

At 30 June 2008, the Australian Government had allocated 2228 places to transition care, of which 1963 were operational, amongst 76 services across all jurisdictions. The average length of stay in 2007-08 was 50 days nationally (table 13A.69).

Long Stay Older Patient Initiative

As part of the national health and aged care agenda, COAG has funded this program since 2006-07 (box 13.5).

Box 13.5 **Long Stay Older Patient Initiative**

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

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

Source: COAG (2006).

Indigenous-specific services

Aboriginal and Torres Strait Islander people access mainstream services under the Aged Care Act, including those managed by Aboriginal and Torres Strait Islander organisations, and services funded outside the Act, including those funded under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. Some services managed by non-Indigenous approved providers also have a significant number of Aboriginal and Torres Strait Islander clients.

All aged care services that are funded under the Act are required to provide culturally appropriate care. Whether they are located in a community or residential setting, services may be subject to specific conditions of allocation in relation to the proportion of care to be provided to particular groups of people, including Aboriginal and Torres Strait Islander people.

At 30 June 2008, there were 640 flexible places for Indigenous clients allocated outside the *Aged Care Act 1997* under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. This flexible care helps to ensure that Aboriginal and Torres Strait Islander people can access culturally appropriate care services as close as possible to their communities, mainly in rural and remote locations. As part of the 1994 National Strategy, services were established to provide aged care using a flexible model. Communities are encouraged to participate in every aspect of service provision, from the very early planning stages right through to the operation of the services. These services are now funded under

the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (DoHA unpublished).

Funding

Recurrent expenditure on aged care services reported in this chapter was $9.2 billion in 2007-08 (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.68), or any Australian Government or State and Territory government capital expenditure (table 13A.72).

Table 13.1 **Expenditure on aged care services reported in the Aged care services chapter, 2007-08[a, b, c]**

Expenditure category	*$ million*
Assessment services	65.0
Residential care services	6 206.5
Community care services	2 970.7
Total	**9 242.2**

a Assessment services include only Australian Government expenditure. **b** Residential care services include DoHA, DVA (including payroll tax supplement) and State and Territory expenditure. **c** Community care services include HACC and TCP (State and Territory expenditure), VHC, DVA Community Nursing and a range of other DoHA expenditure listed in table 13A.48.

Source: tables 13A.44–48, 13A.68-69.

Assessment services

There were 116 ACATs (115 Australian Government funded) at 30 June 2008 (DoHA unpublished). In 2007-08, the Australian Government provided funding of $65.0 million nationally for aged care assessment (table 13.1). Australian Government ACAT expenditure per person aged 70 years or over plus Indigenous people aged 50–69 years was $31.6 nationally during 2007-08 (table 13A.49). States and territories also contribute funding for ACATs, but this expenditure is not included in the chapter.

The Australian Government provided grants to State and Territory governments to operate 115 ACATs in 2006-07 (table 13A.56).

Residential care services

The Australian Government provides most of the recurrent funding for residential aged care services. State and Territory governments also provide some funding for

public sector beds. Residents provide most of the remaining service revenue, with some income derived from charitable sources and donations.

Australian Government expenditure

Australian Government expenditure on residential aged care was $6.0 billion in 2007-08, comprising DoHA expenditure of $5.1 billion (table 13A.44) and Department of Veterans' Affairs (DVA) expenditure of $922.3 million (table 13A.46). Combined DoHA and DVA expenditure per person aged 70 years or over plus Indigenous people aged 50–69 years was $2923 nationally during 2007-08 (table 13A.51).

Australian Government basic subsidy (RCS or ACFI)

The Australian Government annual basic subsidy (RCS or ACFI) for each occupied place varies according to clients' levels of dependency. The CAP is included in the basic subsidy figures for the first time in this Report (box 13.6).

Box 13.6 **Conditional Adjustment Payment**

The CAP was introduced in 2004-05 and now constitutes a significant component of the Australian Government funding for residential aged care.

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

The amount of CAP payable is calculated as a percentage of the basic subsidy amount payable in respect of a resident. In 2004-05, the year of its introduction, this percentage was 1.75 per cent. It has risen annually and will be 8.75 per cent of the basic subsidy in 2008-09.

A review of the CAP was announced in the 2008-09 Federal Budget.

At June 2008, the average annual subsidy per residential place, including the CAP, was $33 969 nationally (table 13.2). Variations across jurisdictions in average annual subsidies reflect differences in the dependency of residents. The rates for aged care services by the level of high and low care places provided are at table 13A.5.

Table 13.2 **Average annual Australian Government basic subsidy (all RCS/ACFI levels) per occupied place at June 2008[a, b]**

		NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Subsidy level	$	34 392	33 270	33 024	33 248	36 373	34 627	34 468	35 665	33 969

a Includes CAP. Data in earlier reports have excluded the CAP. **b** The ACFI was introduced in March 2008 and will gradually replace the RCS as the method of determining residential aged care subsidies. See box 13.1 for further information.

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

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

Table 13.3 **Dependency levels of permanent residents, (RCS and ACFI), June 2008[a, b]**

		NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Proportions of residents										
(a) Resident classification scheme										
RCS 1-4 (High)	%	70.3	68.7	69.2	67.7	76.7	73.8	68.1	80.6	70.2
RCS 5-8 (Low)	%	29.7	31.3	30.8	32.3	23.3	26.2	31.9	19.4	29.8
Total	**%**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
(b) Aged Care Funding Instrument										
Activities of Daily Living										
High	%	36.2	32.7	31.6	32.8	35.3	31.2	31.3	41.0	34.0
Medium	%	25.4	31.5	27.1	31.4	25.7	29.0	28.5	24.8	28.0
Low	%	28.9	26.8	30.6	26.8	32.6	28.7	31.6	28.6	28.8
Nil	%	9.5	9.0	10.7	9.1	6.3	11.2	8.6	5.7	9.2
Total	**%**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Behaviours										
High	%	36.7	35.2	29.0	36.5	43.9	25.9	33.4	23.8	35.3
Medium	%	22.7	22.8	26.3	23.1	19.3	28.4	23.7	37.1	23.2
Low	%	25.0	26.6	25.1	26.2	25.8	21.8	28.8	24.8	25.6
Nil	%	15.6	15.4	19.7	14.3	11.1	23.9	14.2	14.3	15.9
Total	**%**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Complex Health Care										
High	%	14.4	13.9	10.9	12.7	17.5	12.8	13.5	8.6	13.8
Medium	%	38.1	38.4	41.3	40.6	38.4	39.6	38.5	41.0	39.0
Low	%	29.8	29.2	25.0	29.8	31.1	27.8	32.5	31.4	28.9
Nil	%	17.7	18.6	22.8	16.8	13.0	19.7	15.6	19.1	18.3
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.	38 655	27 881	19 794	9 170	11 976	3 061	1 105	305	111 947
Total Low	no.	14 554	11 927	8 209	3 915	3 303	1 082	463	67	43 520
All High/Low	**no.**	**53 209**	**39 808**	**28 003**	**13 085**	**15 279**	**4 143**	**1 568**	**372**	**155 467**

a The ACFI was introduced in March 2008 and will gradually replace the RCS as the method of determining residential aged care subsidies. See box 13.1 and footnotes to table 13A.5 for further information. **b** Totals may not add as a result of rounding.

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

State and Territory government recurrent expenditure

State and Territory government expenditure has been collected for three categories of residential care expenditure (adjusted subsidy reduction supplement, enterprise bargaining agreement supplement, and rural small nursing home supplement).

Reported expenditure in these three categories was $166.1 million in 2007-08 (table 13A.68).

Capital expenditure

Although capital expenditure is not regarded as part of the total recurrent expenditure in table 13.1, it is presented here to illustrate this aspect of expenditure on aged care services. The Australian Government provided $48.1 million in 2007-08 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.72). In addition, capital expenditure by some states and territories on residential aged care services in 2007-08 was $90.7 million (table 13A.72).

Community care services

Following is a summary of expenditure on community care programs. More detailed data may be found in the attachment tables referenced. Data on Australian Government expenditure per head of the target population by jurisdiction are contained in table 13A.49. Recipients of community care services may also contribute towards the cost of their care.

Expenditure on HACC, CACP, NRCP and DVA programs

Total government expenditure on HACC was $1.7 billion in 2007-08, consisting of $1.0 billion from the Australian Government and $645.3 million from the State and Territory governments. The Australian Government contributed 60.9 per cent, while State and Territory governments funded the remainder (table 13A.45). Recipients of HACC services may also contribute towards the cost of these services.

The Australian Government funds the CACP program, spending $447.8 million on the program in 2007-08 (table 13A.48). CACPs are also part funded by client contributions. The NRCP provides community respite services and is funded by the Australian Government. Expenditure on this program was $173.5 million in 2007-08 (table 13.4). The NRCP assisted 125 507 people in 2007-08 (table 13A.36). A disaggregation of Australian Government expenditure on the NRCP by State and Territory is provided in table 13.4.

Table 13.4 **Australian Government expenditure, National Respite for Carers Program, 2007-08 ($million)[a, b]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*National*	*Aust*
Commonwealth Carer Respite Centres										
	15.3	11.2	10.8	3.6	4.8	2.4	1.0	1.8	–	50.9
Respite services										
	35.4	26.5	18.3	10.1	10.7	3.2	2.8	3.0	–	110.0
National projects[c]										
	–	–	–	–	–	–	–	–	12.6	12.6
Total	**50.7**	**37.7**	**29.1**	**13.7**	**15.5**	**5.6**	**3.8**	**4.8**	**12.6**	**173.5**

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

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

The DVA also provided $98.3 million for the VHC program and $100.2 million for the Veterans Community Nursing program during 2007-08 (table 13A.47). VHC recipients may also contribute towards the cost of these services.

Flexibly funded services

The Australian Government funds the EACH and EACH Dementia programs, spending $141.1 million and $57.7 million respectively on these programs in 2007-08 (table 13A.48). EACH and EACH Dementia packages are also part funded by client contributions.

The Australian, State and Territory governments fund the TCP. In 2007-08 the Australian Government and the State and Territory governments spent $52.8 million and $59.1 million respectively (table 13A.69). The Australian Government also funds the MPS program and Indigenous specific services. In 2007-08, $78.3 million and $20.9 million were spent on these programs, respectively (table 13A.48).

Other aged care services

Australian Government expenditure data by jurisdiction on a range of other community care programs targeting older people are contained in table 13A.48. Australian Government expenditure on these programs was $89.1 million in 2007-08. These programs are Community Care Grants, Assistance with Care and Housing for the Aged, Day Therapy Centres, Continence Aids Assistance Scheme, Carers Information and Support, Commonwealth Carelink Centres, the National Continence Management Strategy, Dementia Education and Support and Additional Funding for ACATs (table 13A.48). In addition, Australian Government

expenditure on the Long Stay Older Patient Initiative (see box 13.5) was $37.5 million in 2007-08 (table 13A.44).

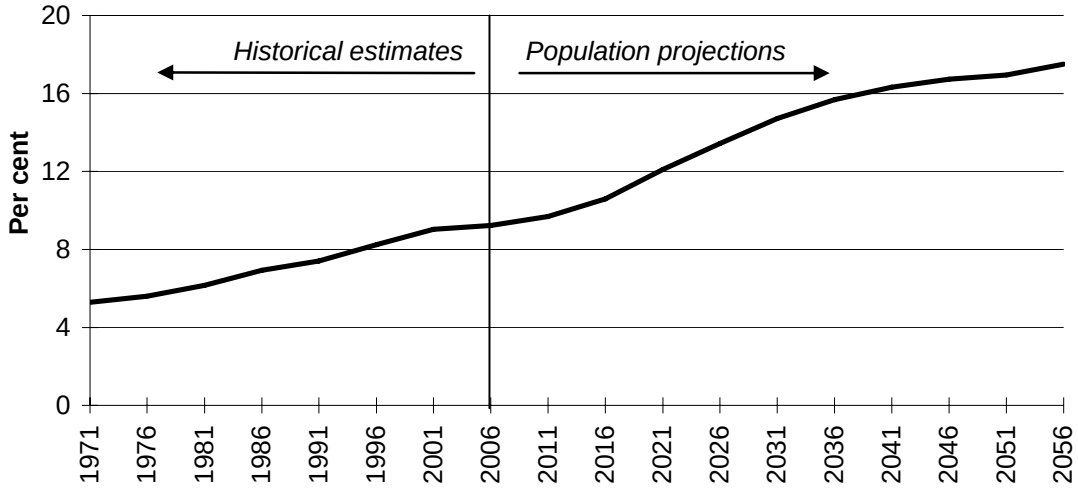
Size and scope of sector

Size and growth of the older population

The Australian population is ageing, as indicated by an increase in the proportion of people aged 70 years or over in the total population. This trend is expected to continue, and the proportion of older people is expected to increase dramatically in the 21st century (figure 13.4). The proportion of older people is 9.4 per cent nationally but varies across jurisdictions (figure 13.5). A disaggregation by remoteness categorisation is provided in table 13A.3. Higher life expectancy for females resulted in all jurisdictions (except the NT, where the rate was similar) having a higher proportion of older females than older males in the total population (table 13A.1).

Demographic profiles affect the demand for aged care services because females use aged care services (particularly residential services) more than males. Females are more likely to use residential services partly because they tend to live longer (that is, there are more women than men in the older population) and they are less likely to have a partner to provide them with care.

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



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

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

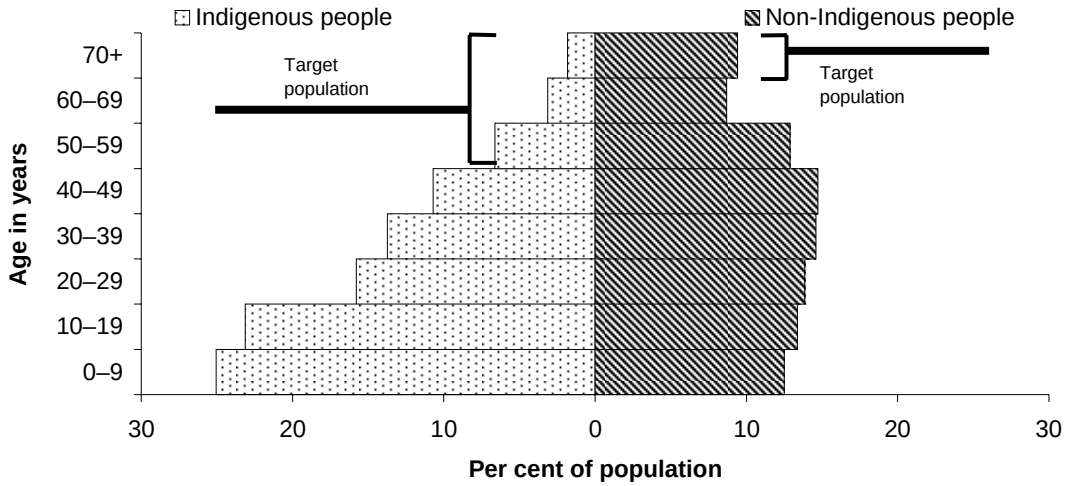
Figure 13.5 **Estimated proportion of population aged 70 years or over, by gender, June 2008**

Source: Population projections prepared by the ABS in 2007, using preliminary rebased estimated resident populations based on the 2006 Census according to assumptions agreed to by the Treasury and Department of Health and Ageing (unpublished); table 13A.1.

Characteristics of older Indigenous people

DoHA estimates that about 62 800 Indigenous people were aged 50 years or over in Australia at 30 June 2008 (table 13A.2). Although the Indigenous population is also ageing, there are marked differences in the age profile of Indigenous Australians compared with non-Indigenous Australians (figure 13.6). Estimates for both males and females show life expectancy at birth in the Indigenous population is around 17 years less than in the total Australian population (ABS 2004b). These figures indicate that Indigenous people are likely to need aged care services earlier in life, compared with the general population.

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



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

Residential care services

The size and location of residential services — which may influence the costs of service delivery — vary across jurisdictions. Nationally, there were up to 171 832 mainstream operational places in residential care services (71 036 in predominantly high care services, at least 10 870 in predominantly low care services and 89 866 in services with a mix of high care and low care residents) at June 2008 (tables 13A.6–9). These figures exclude flexible care places in a residential setting.

As the trend towards 'ageing in place' (box 13.7) increases, there has been a steady increase in the number of services categorised as providing a mix of high care and low care places. In June 2004, 33.4 per cent of all places were located in services offering both high care and low care places. This proportion increased to 52.3 per cent in June 2008 (table 13A.10).

Box 13.7 **Ageing in place in residential care**

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

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

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

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

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

Source: DoHA (unpublished).

The client profile of services that had predominantly low care residents in 2000 has changed over time, with low care residents staying in their current service as their dependency levels rise, and with aged care services expanding and diversifying. Low care services are generally smaller (as measured by number of places) than high care services. At June 2008, 68.2 per cent of low care services had 60 or fewer places (table 13A.8), compared with 41.3 per cent of high care services (table 13A.7).

The combined number of operational high care and low care residential places per 1000 people aged 70 years or over at June 2008 was 87.3 (42.8 high care and 44.5 low care) on a national basis (table 13.5). Nationally, the proportion of low care places relative to high care places rose slightly between 2004 and 2008 (table 13A.11).

Table 13.5 **Operational high care and low care residential places, 30 June 2008[a, b, c, d]**

	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	40.9	40.2	38.4	49.2	44.4	34.4	53.5	42.8
Low care places	no.	42.1	47.1	45.2	45.0	46.0	41.5	42.4	41.5	44.5
Total places	**no.**	**87.2**	**88.0**	**85.4**	**83.4**	**95.2**	**85.9**	**76.8**	**95.0**	**87.3**
Proportion of places										
High care places	%	51.6	46.5	47.1	46.0	51.9	51.7	44.8	56.3	49.0
Low care places	%	48.3	53.5	52.9	54.0	48.2	48.3	55.2	43.7	51.0

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', under either the ACFI or the RCS. See box 13.1 for more information. **d** See table 13A.11 for further information regarding the calculation of provision ratios, which vary from corresponding data published in the DoHA Annual Report 2007-08.

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

During 2007-08, the numbers of people (of all ages) who used permanent residential care services was 208 494 nationally (including both high and low care) and 39 580 nationally for respite residential care. These figures reflect the number of individuals who utilised these services during the year, for any length of time, rather than the number of places available (table 13A.71).

Age specific usage rates for these services, by jurisdiction and remoteness, at 30 June 2008 are included at tables 13A.59 and 13A.61, and 13A.62 and 13A.64 respectively. Indigenous usage by remoteness category is identified at table 13A.65.

Community care services

Services provided under the HACC program include domestic assistance, home maintenance, personal care, food services, respite care, transport, allied health care and community nursing (box 13.8).

Box 13.8 **HACC Services**

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.

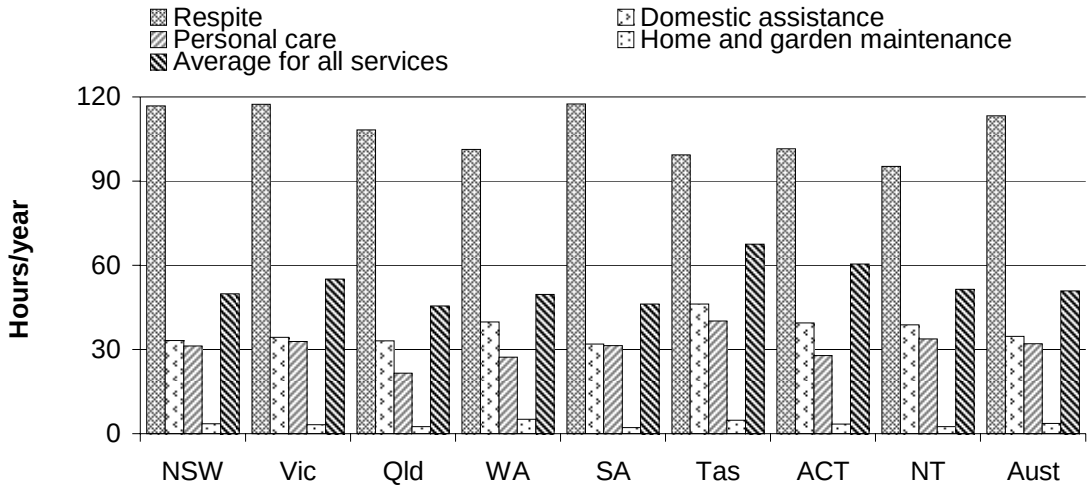
Not all HACC services are directed towards the ageing population described in this chapter. The target population is defined as people living in the community who are at risk, without these services, of premature or inappropriate long term residential care. The target population comprises both frail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

Over 68 per cent of the program's recipients are aged 70 years or over, but the program is also an important source of community care for younger people with a disability and their carers, with 11.3 per cent of recipients under 50 years (table 13A.34). (Chapter 14 covers services for people with a disability, which manifests before the age of 65 years, that are provided under the Commonwealth State/Territory Disability Agreement.)

The services of the VHC program target veterans and war widows/widowers with low care needs. There were 80 742 people approved for VHC services in 2007-08 (table 13A.47). The program offers veterans and war widows/widowers who hold a Gold or White Repatriation Health Card home support services, including domestic assistance, personal care, home and garden maintenance, and respite care. Other services, such as community transport, social support and delivered meals, are also available under the DVA's arrangements with State and Territory governments.

Eligibility for VHC services is not automatic, but based on assessed need. The average number of hours approved per year for veterans who were eligible to receive home care services was 50.9 nationally in 2007-08 (figure 13.7).

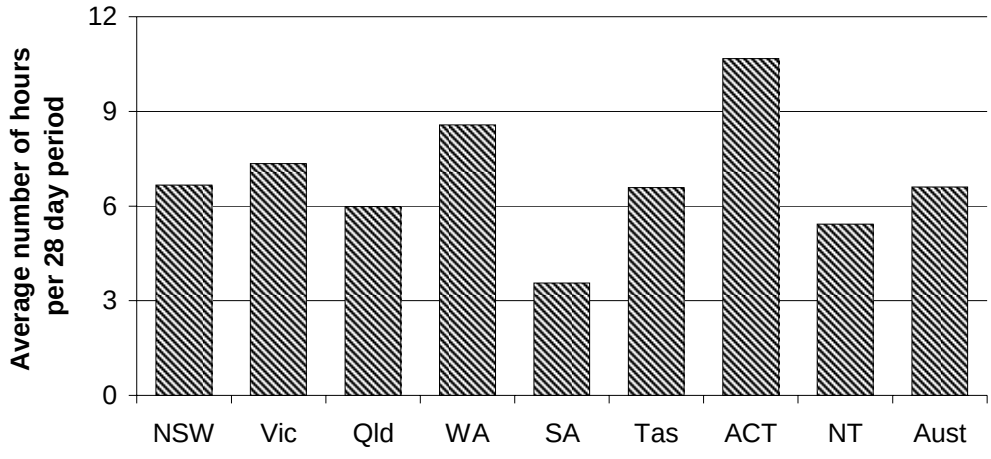
Figure 13.7 **Average number of hours approved for Veterans' Home Care, 2007-08**



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

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 2007-08, 32 263 veterans received these services (table 13A.47), and the average number of hours approved for each recipient was 6.6 nationally per 28 day period (figure 13.8).

Figure 13.8 **Average number of hours approved for DVA Community Nursing, 2007-08**



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

Provision of CACPs is an alternative home-based service for older people assessed by ACATs as eligible for care equivalent to low level residential care (RCS levels 5–8 or ACFI Low). A CACP typically provides 5 to 6 hours of direct assistance per week. The EACH program is similar to the CACP program but targets people who would be eligible for high level residential aged care. An EACH package typically provides 15 to 20 hours of direct assistance each week. The main distinctions between the HACC, CACP and EACH programs are summarised in table 13.6.

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

	HACC	*CACPs*	*EACH*
Range of services[a]	Wider range of services available	Narrower range of services available	Narrower range of services available
Relationship to residential care	Aims to prevent premature or inappropriate admission	Substitutes for a low care residential place	Substitutes for a high care residential place
Eligibility	ACAT assessment not mandatory	ACAT assessment mandatory	ACAT assessment mandatory
Funding	Cost shared by the Australian, State and Territory governments and client contributions	Funded by the Australian Government and client contributions	Funded by the Australian Government and client contributions
Target client groups[b]	Available to people with profound, severe and moderate disability and their carers. Not age specific.	Targets older people with care needs similar to low level residential care	Targets older people with care needs similar to high level residential care
Size of program	$1.7 billion funding in 2007-08 At least 831 472 clients in 2007-08[c]	$447.8 million funding in 2007-08 40 235 operational places at 30 June 2008[d]	For EACH and EACH Dementia: $198.8 million funding in 2007-08 6 240 operational places at 30 June 2008

[a] HACC services such as community nursing, which are not available under CACPs, can be supplied to someone receiving a CACP. [b] Most HACC recipients at the lower end of the scale would not be assessed as eligible for residential care, for example, an individual may receive only an hour of home care per fortnight. At the higher end, some people have needs that would exceed the level available under CACPs and EACH. [c] Based on 91 per cent of HACC funded agencies that submitted Minimum Data Set data for 2007-08. Consequently, the total number of clients will be higher than those reported here. [d] Includes community care places under the National Aboriginal and Torres Strait Islander Aged Care Program, Multipurpose Services and Innovative Care.

Source: DoHA (unpublished); tables 13A.33, 13A.36, 13A.45, 13A.48.

Changing government policies over the past decade — shifting the balance of care away from the more intensive types of residential care towards home-based care — have meant that the HACC, VHC, CACP and EACH programs have become increasingly important components of the aged care system. During 2007-08, the HACC program delivered approximately 19 319 hours per 1000 people aged

70 years or over plus Indigenous people aged 50–69 years (table 13A.21). The total number of CACPs per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years increased between June 2004 and June 2008, from 15.2 to 19.6 (table 13A.12).

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

Table 13.7 **Number of clients, aged care community care programs, 2007-08**

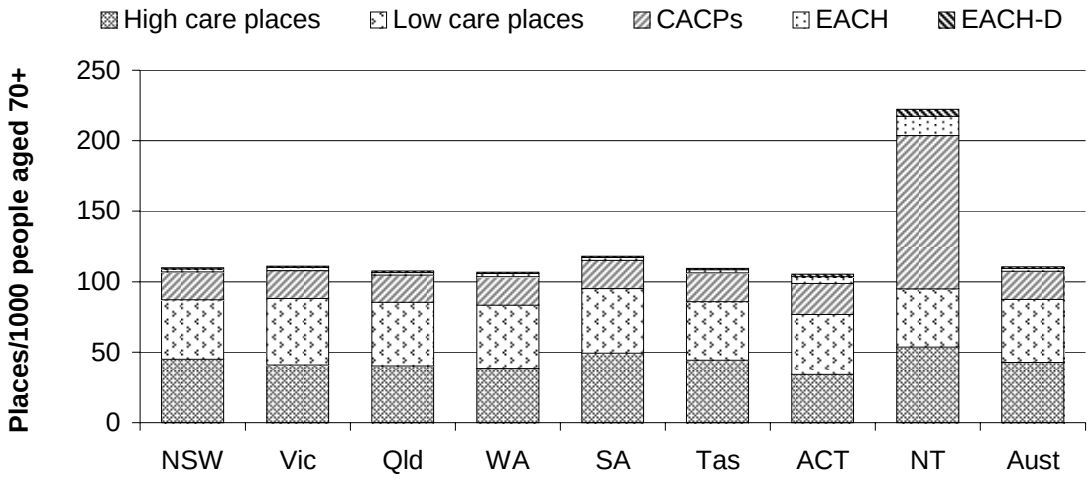
Program	*Number of clients*
CACP	53 224
EACH	5 907
EACH Dementia	2 659
Transition Care	10 355
Home and Community Care	831 472

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

Combined residential and community care services rates

The combined number of high care residential places, low care residential places, CACPs, EACH and EACH Dementia packages, at 30 June 2008, was 110.5 per 1000 people aged 70 years or over (figure 13.9). Transition Care places add an additional 1.0 package per 1000 people aged 70 years or over (table 13A.11). The Australian Government's targets for the provision of residential and community care places were outlined previously (box 13.4).

Figure 13.9 **Operational residential places, CACPs, EACH and EACH Dementia packages, 30 June 2008[a, b, c, d, e, f, g, h]**

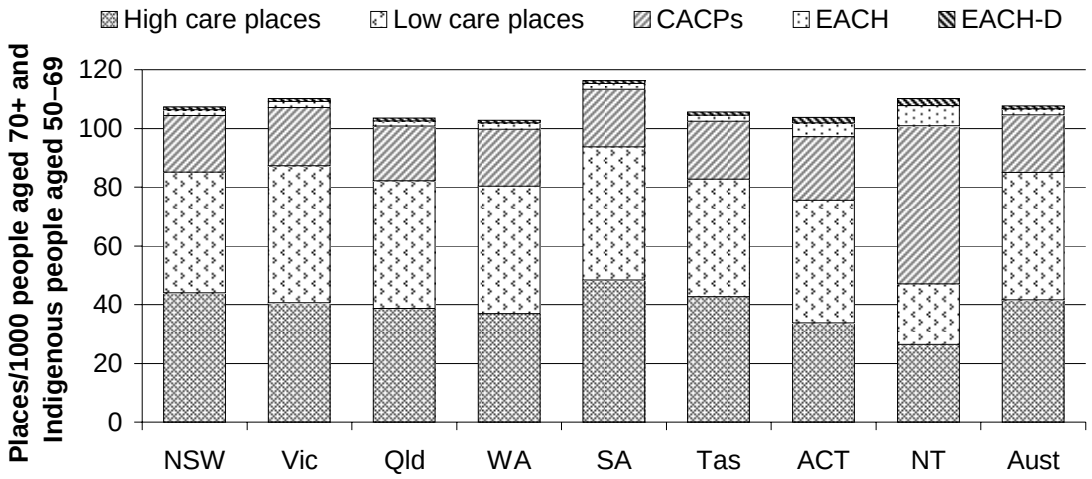


EACH-D = EACH Dementia. **a** Excludes places that have been approved but are not yet operational. **b** 'Ageing in place' may result in some low care places being filled by high care residents. **c** For this Report, Australian Government planning targets are based on providing 113 places per 1000 people aged 70 years or over by 2011. However, in recognition of poorer health among Indigenous communities, planning in some cases also takes account of the Indigenous population aged 50–69 years. This means that the provision ratio based on the population aged 70 years or over will appear high in areas with a high Indigenous population (such as the NT). **d** Includes residential places categorised as 'high care' or 'low care', under either the ACFI or the RCS. See box 13.1 for more information. **e** CACPs, EACH and EACH Dementia packages are not residential services but are included in the Australian Government planning targets (see boxes 13.2 and 13.4 for an interpretation of residential care data and Australian Government planning targets). **f** In this figure, CACPs include community care places under the National Aboriginal and Torres Strait Islander Aged Care Program, Multipurpose Services and Innovative Care. **g** TCP are not shown (table 13A.11). **h** See table 13A.11 for further information regarding the calculation of provision ratios.

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

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

Figure 13.10 **Operational residential places, CACPs, EACH and EACH Dementia packages adjusted for Indigenous people aged 50–69, 30 June 2008**[a, b, c, d, e, f, g]



EACH-D = EACH Dementia. **a** Places do not include those that have been approved but are not yet operational. **b** 'Ageing in place' may result in some low care places being filled by high care residents. **c** CACPs, EACH and EACH Dementia packages are not residential services but are included in the Australian Government planning targets (boxes 13.2 and 13.4 contain an interpretation of residential care data and Australian Government planning targets). **d** Includes residential places categorised as 'high care' or 'low care', under either the ACFI or the RCS. See box 13.1 for more information. **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** In this figure, CACPs include community care places under the National Aboriginal and Torres Strait Islander Aged Care Program, Multipurpose Services and Innovative Care. **g** TCP places are not shown (table 13A.12).

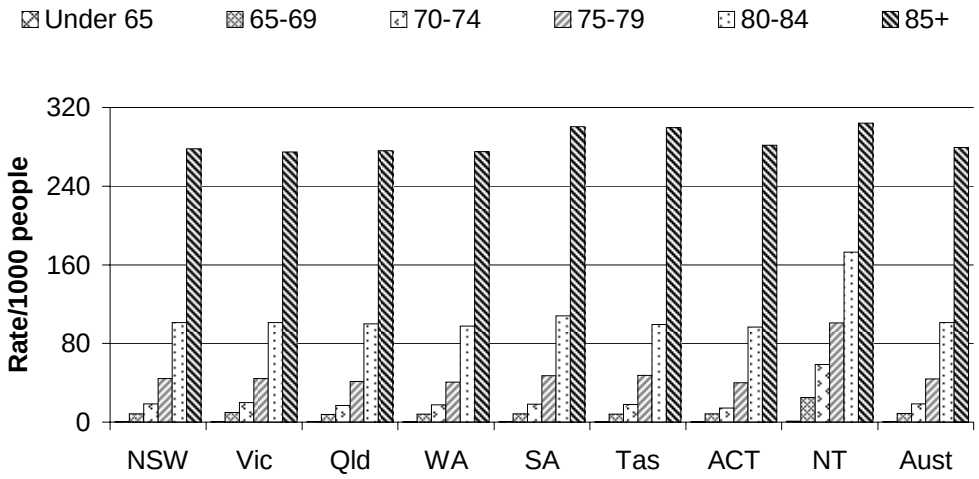
Source: DoHA (unpublished); table 13A.12.

Age-specific usage rates for these services, by jurisdiction and remoteness and for Indigenous usage, at 30 June 2008 are reported in tables 13A.59 to 13A.65.

Presentation of age-specific usage rates raises particular data issues. In particular, if the numbers of people within a particular range for a given service are small, this may lead to apparently large fluctuations in growth rates. This can be seen from some of the usage rates identified for the EACH program, which, whilst growing rapidly, are doing so from a relatively small base.

Age-specific rates in this Report are for 2007-08. The national age specific usage rates per 1000 people for high and low residential care, CACP, EACH and EACH Dementia in combination at 30 June 2008 is 0.5 for people under 65 years of age rising to 279.4 for people aged 85 years or older. These rates vary across jurisdictions (figure 13.11).

Figure 13.11 **Permanent aged care residents, CACP, EACH and EACH Dementia recipients at 30 June 2008: age specific usage rates per 1000 people[a, b, c]**

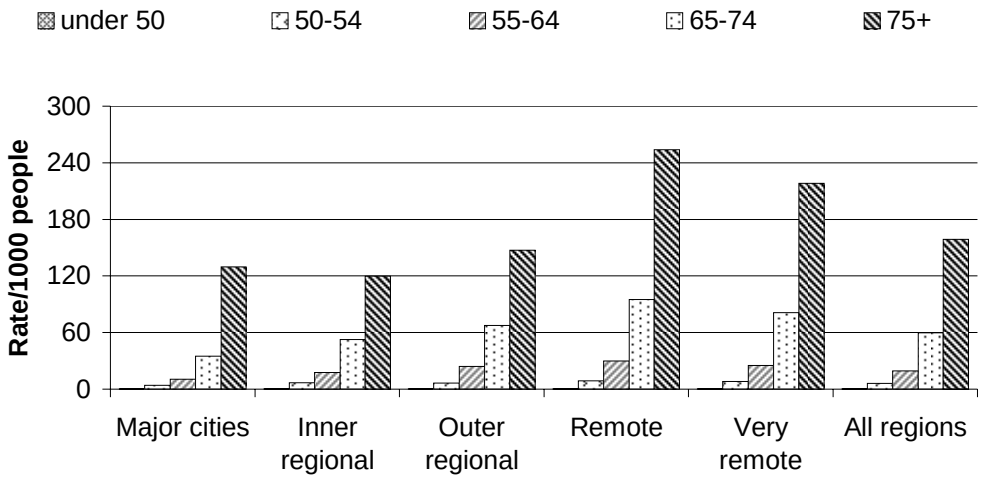


a Population data for June 2008 are preliminary population projections by SLA for 2006–2026 based on the 2006 Census prepared by ABS according to assumptions agreed to by DoHA (see table 13A.2). **b** Residents without a recorded RCS/ACFI were omitted. **c** These figures exclude places funded by Multi-purpose services and those provided by flexible funding under the Aboriginal and Torres Strait Islander Aged Care Strategy.

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

The national age specific usage rates per 1000 Indigenous people for high and low residential care, CACP and EACH in combination at 30 June 2008 is 0.2 for people under 50 rising to 158.7 for people over 75. The data show that Indigenous people tend to access these services at a younger age than the population as a whole. These rates vary by remoteness category (figure 13.12).

Figure 13.12 **Indigenous permanent residents classified as high or low care and Indigenous CACP and EACH at 30 June 2008: age specific usage rates per 1000 people by remoteness[a, b, c, d, e]**



a Geographical data are based on the ABS Australian Standard Geographic Classification of Remoteness Areas 2001. Data are classified according to an index of remoteness which rates each ABS Census District based on the number and size of towns, the distance to major towns and urban centres. **b** Indigenous population data for June 2008 are determined using DoHA unpublished projections. This is a different measure from those used for these age specific usage data in previous reports. See table 13A.65 for more detail. **c** Includes residential places categorised as 'high care' or 'low care', under either the ACFI or the RCS. See box 13.1 for more information. **d** Residents without a recorded RCS/ACFI were omitted. **e** These figures exclude places and packages funded by Multi-purpose services and those provided by flexible funding under the Aboriginal and Torres Strait Islander Aged Care Strategy.

Source: DoHA (unpublished); table 13A.65.

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 13.9).

Box 13.9 **Objectives for aged care services**

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

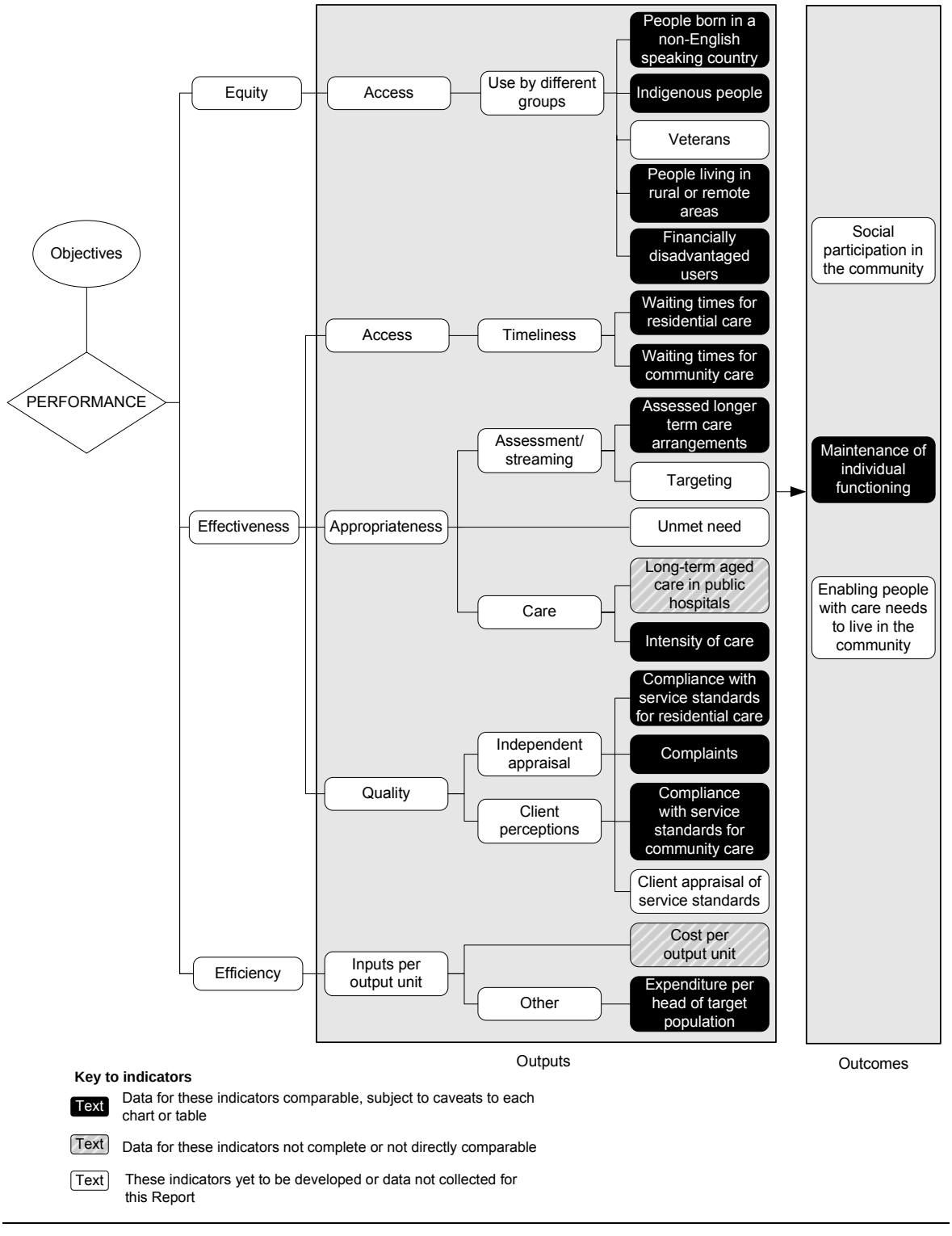
- accessible
- appropriate to needs
- high quality
- efficient.

The performance indicator framework shows which data are comparable in the 2009 Report (figure 13.13). For data that are not considered strictly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

13.3 Key performance indicator results

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

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



Outputs

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

Equity — Access

Use by different groups

'Use by different groups' is an indicator of governments' objective for the aged care system to provide equitable access to aged care services for all people who require these services (box 13.10).

Box 13.10 **Use by different groups**

'Use by different groups' is defined as:

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

Continued on next page

Box 13.10 (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, and veterans (including widows and widowers of veterans).

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

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

No data were available to report on veterans for this indicator.

Data reported for this indicator are comparable.

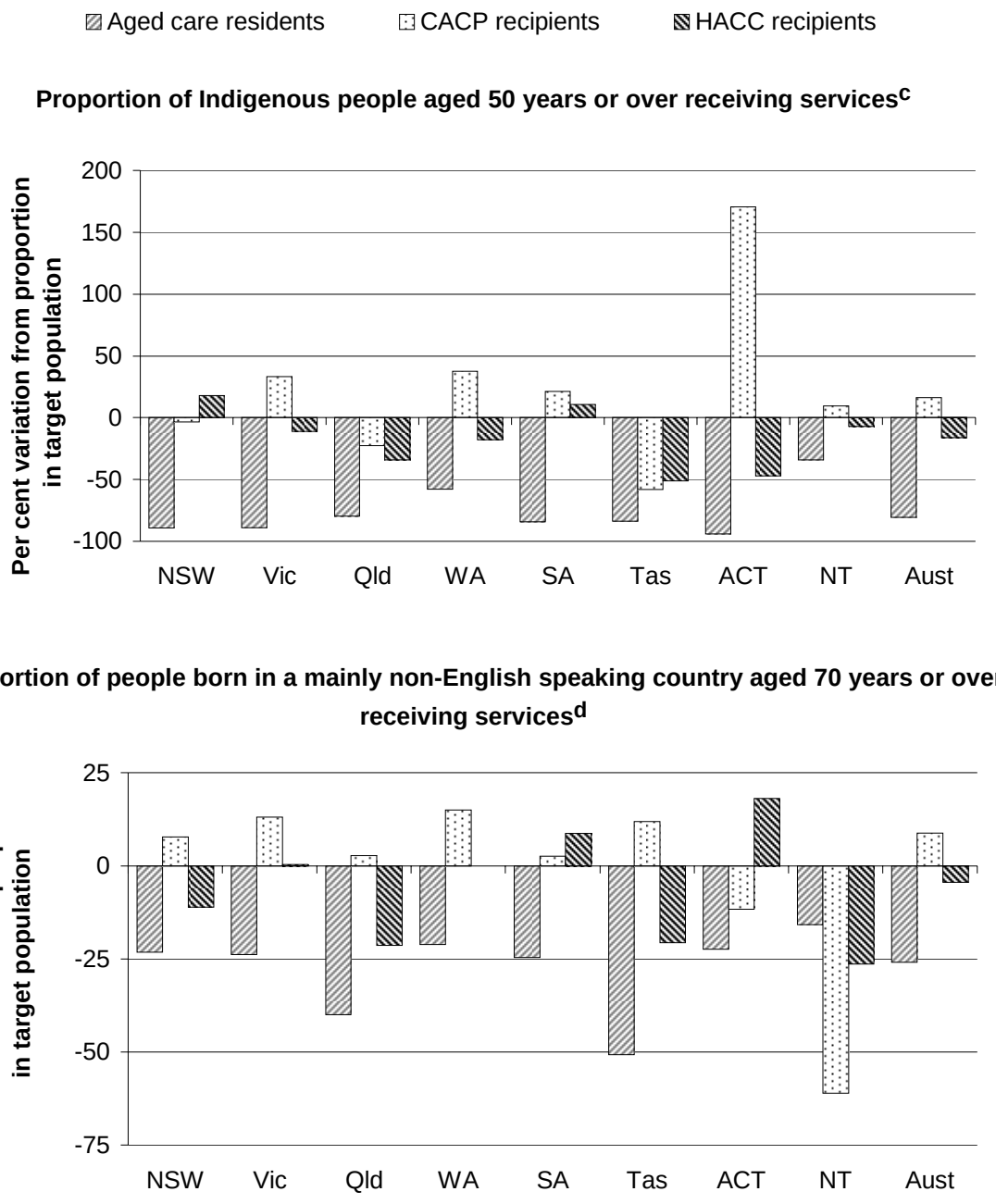
Data presented for this indicator are organised by the type of service provided, with sub-sections for the relevant special needs groups reported against that service.

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

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

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

Figure 13.14 **Variation in the proportions of special needs target populations accessing aged care services from their proportion in the target population as a whole, June 2008 (per cent)[a, b]**



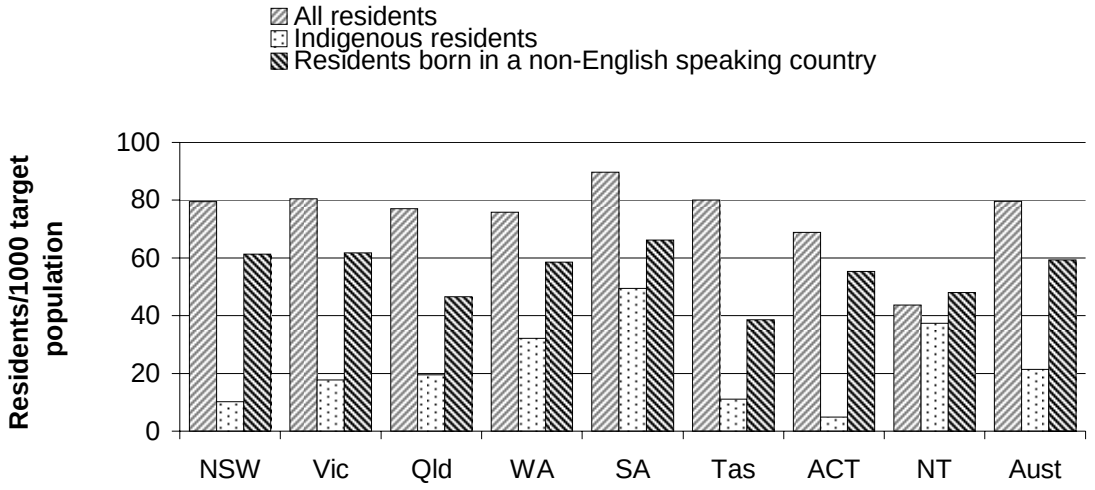
a The proportion of HACC agencies that submitted data for the year varied between jurisdictions and actual service levels were higher than stated. **b** Reports provisional HACC data that have not been validated and may be subject to revision. **c** The ACT has a very small Indigenous population aged 50 years or over (table 13A.2) and a small number of packages result in a very high provision ratio. **d** There is no variation between the proportion of WA HACC recipients for this group and their proportion in the target population.

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

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

In all jurisdictions at 30 June 2008, on average, Indigenous people and people born in non-English speaking countries had lower rates of use of aged care residential services (21.4 and 59.3 per 1000 of the relevant target populations respectively), compared with the population as a whole (79.6 per 1000) (figure 13.15).

Figure 13.15 **Residents per 1000 target population, 30 June 2008[a, b, c]**



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

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

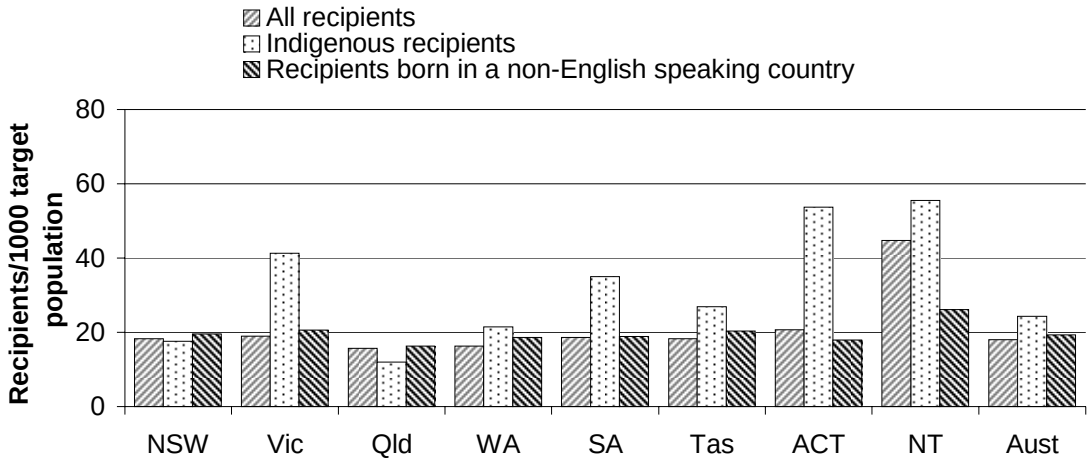
Age specific usage rates for these services, by jurisdiction and remoteness are included in the Report. These data suggest there is significant variation in usage rates by remoteness area. In general, differences amongst jurisdictions are less marked than differences between remoteness areas (tables 13A.14, 13A.16, 13A.18, 13A.59, 13A.61-62, 13A.64-65).

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

The number of Indigenous CACP recipients per 1000 Indigenous people aged 50 years or over was 24.3 nationally and the numbers of CACP recipients from non-English speaking countries per 1000 of the relevant target population was 19.3 nationally. These figures compare to a total of 18.0 per 1000 of the target

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

Figure 13.16 **Community Aged Care Package recipients per 1000 target population, 30 June 2008**[a, b, c, d, e]



[a] All recipients data are per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years. [b] Indigenous recipients data are per 1000 Indigenous people aged 50 years or over. [c] Data for recipients from non-English speaking countries are per 1000 people from non-English speaking countries aged 70 years or over. [d] The ACT has a very small Indigenous population aged 50 years or over (table 13A.2), and a small number of packages result in a very high provision ratio. [e] CACPs provide a more flexible model of care, more suitable to remote Indigenous communities, so areas such as the NT have a higher rate of CACP recipients per 1000 people.

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

Age–sex specific usage rates by jurisdiction, remoteness and Indigenous usage vary between jurisdictions and remoteness categories for CACP. For EACH, the differences are less marked. However, the EACH program is small and growing rapidly (tables 13A.60-61 and 13A.63–65).

Access to the HACC program by Indigenous people and by remoteness area

HACC services are provided in the client's home or community for people with a moderate, severe or profound disability and their carers. The focus of this chapter is all people 70 years or over and Indigenous people aged 50–69 years. The proportion of HACC recipients aged 70 years or over during 2007-08 was 68.9 per cent (table 13A.33).

The number of service hours per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years was 19 319 nationally, and the number of meals provided per 1000 people aged 70 years or over plus Indigenous people aged 50–69 was

6202 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, 2007-08 (per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years)[a, b, c]**

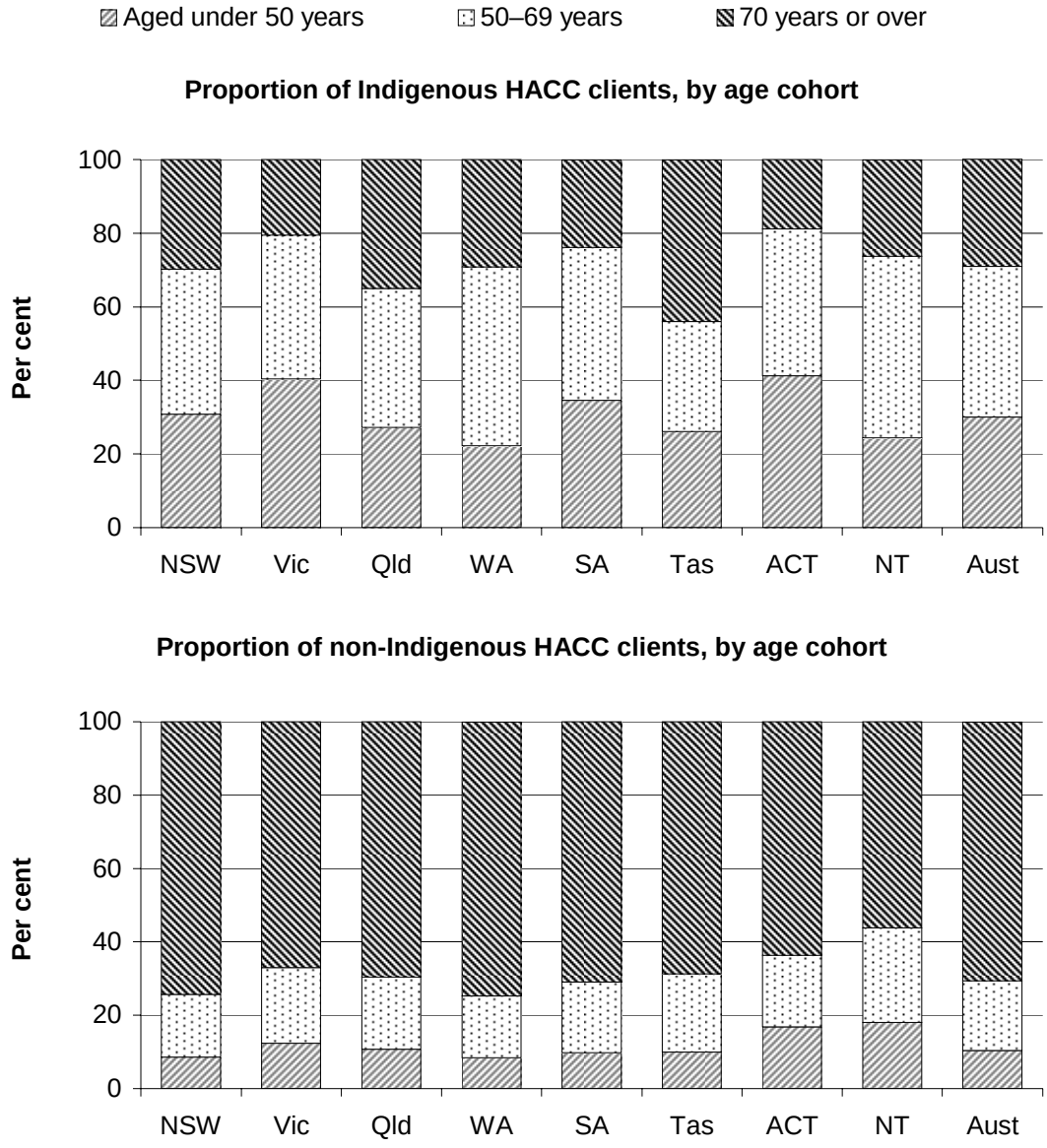
	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Percentage of agencies that reported minimum data set data	88	90	94	98	95	99	100	98	91
Total hours (no.)[d]									
Major cities	14 970	20 915	19 268	22 855	17 470	..	20 805	..	18 412
Inner regional	15 180	25 577	21 326	20 381	19 225	16 637	..	..	19 606
Outer regional	19 821	32 120	22 950	26 317	21 519	16 270	..	17 014	22 954
Remote	32 002	46 793	24 839	26 580	27 310	19 743	..	19 022	26 674
Very remote	38 614	..	24 388	34 844	27 992	26 803	..	32 438	30 143
All areas	**15 528**	**22 696**	**20 445**	**23 153**	**18 510**	**16 619**	**20 832**	**22 761**	**19 319**
Total meals (no.)[e]									
Major cities	4 256	5 985	5 359	6 364	7 811	..	5 125	..	5 477
Inner regional	5 645	8 490	7 394	5 753	5 246	4 755	..	..	6 619
Outer regional	7 938	8 147	8 370	8 400	10 235	5 356	..	4 844	8 060
Remote	10 470	11 315	8 663	12 087	7 464	6 190	..	19 799	10 771
Very remote	17 592	..	10 200	29 165	17 839	5 760	..	46 151	25 834
All areas	**4 936**	**6 687**	**6 398**	**7 063**	**7 858**	**4 979**	**5 126**	**22 478**	**6 202**

a Data represent HACC services received divided by people aged 70 years or over, plus Indigenous people aged 50–69 years (tables 13A.21–26) as distinct from HACC services received divided by HACC target population in all age groups (tables 13A.27–32). **b** The proportion of HACC agencies that submitted data for the year varied between jurisdictions and actual service levels may be higher than stated. **c** Reports provisional HACC data that have not been validated and may be subject to revision. **d** See table 13A.21 for a full list of categories. **e** Includes home meals and centre meals. .. Not applicable.

Source: DoHA Home and Community Care Minimum Data Set 2007-08 (unpublished); DoHA HACC National Data Repository (unpublished); tables 13A.21–26.

Reported use of HACC services showed a substantial difference between all users and Indigenous users across all age groups in 2007-08. 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 29.1 per cent and the proportion of non-Indigenous HACC clients who are aged 70 years or over is 70.5 per cent (figure 13.17).

Figure 13.17 **Recipients of HACC services by age and Indigenous status, 2007-08[a]**



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

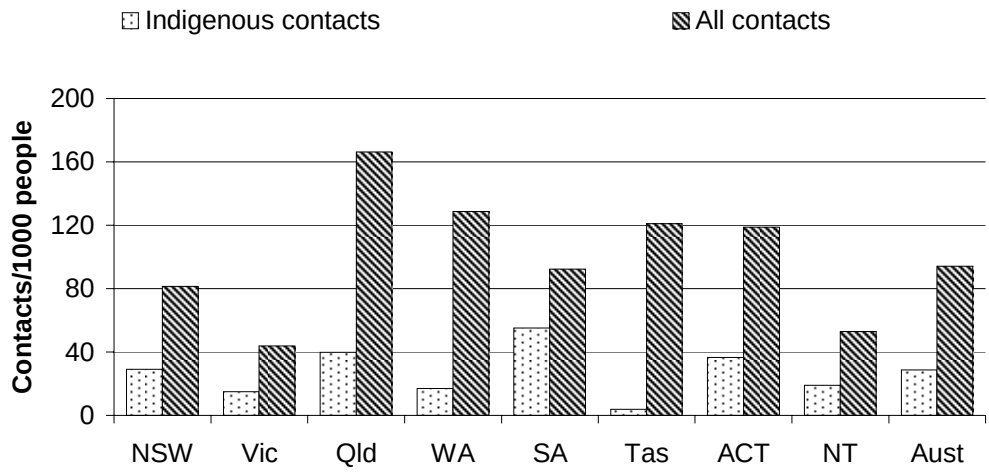
Source: DoHA (unpublished); table 13A.34.

Access by Indigenous people to Commonwealth Carelink Centres

Commonwealth Carelink Centres are information centres for older people, people with disabilities, carers and service providers. Information is provided on community services and aged care, disability and other support services available locally or anywhere in Australia, the costs of services, assessment processes and eligibility criteria. The national rate at which Indigenous people contacted Carelink

Centres at 30 June 2008, was 28.6 people per 1000 Indigenous people in the Indigenous target population (Indigenous people aged 50 years and over). The rate for all Australians was 94.1 per 1000 people in the target population (people aged 70 years or over plus Indigenous people aged 50–69). These figures varied across jurisdictions (figure 13.18).

Figure 13.18 **Commonwealth Carelink Centres, contacts per 1000 target population, by Indigenous status, 30 June 2008[a, b, c]**



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

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

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 13.11).

Box 13.11 **Supported residents**

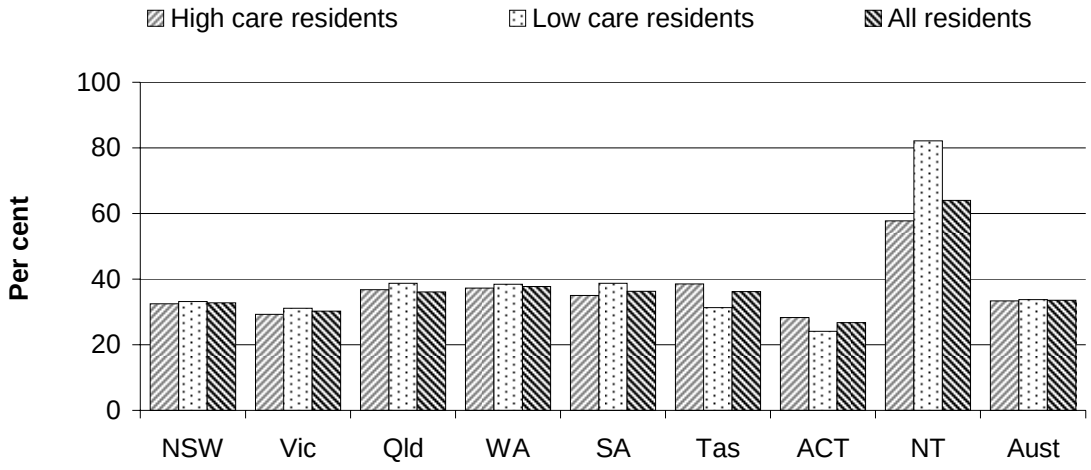
In 2008, new arrangements governing residents' contributions to their accommodation costs and the supplements the Australian Government pays for residents who cannot meet all or part of their own accommodation costs were introduced. These new arrangements only apply to residents who first enter permanent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

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

Data incorporating the new supported residents category are reported for the first time in the 2009 Report.

The proportion of all new residents classified as concessional, assisted or supported residents during 2007-08 was 33.6 per cent nationally but varied across jurisdictions (figure 13.19). Targets for financially disadvantaged users range from 16 per cent to 40 per cent of places, depending on the service's region.

Figure 13.19 **New residents classified as concessional, assisted or supported residents, 2007-08[a]**



a Concessional residents are those who receive an income support payment and have not owned a home for the previous two or more years (or whose home is occupied by a 'protected' person, such as the care recipient's partner), and have assets of less than 2.5 times the annual single basic age pension. Assisted residents are those meeting the above criteria, but with assets between 2.5 and 4.0 times the annual single basic age pension. Supported residents are those who have entered permanent residential care on or after 20 March 2008 (or who re-enter care on or after 20 March 2008 after a break in care of more than 28 days) and have assets of up to a set value ($90 410.40 as at 30 June 2008).

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

Effectiveness — timeliness of access

Waiting times for residential care

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

Box 13.12 **Waiting times for residential care**

'Waiting times for residential care' is defined as the percentage of people who are admitted to high care residential care within three months of their ACAT approval. The indicator measures the elapsed time between ACAT approval and entry into high care residential care service (the period between a client's approval for high care and his or her entry into care). ACAT approval refers to the approval date of an ACAT assessment. Entry into a residential care service refers to the date of admission to a residential care service.

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

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

- clients with ACAT approvals who do not enter residential care (for example, who die before entering care)
- residential placement offers that are not accepted
- the availability of alternative community care, informal care and respite services
- the availability and distribution of operational residential care services
- building quality and perceptions about quality of care, which influence client choice of preferred service
- delays between the date of ACAT assessments and their approval
- priority allocations (for example, special needs groups)
- hospital discharge policies and practices
- the impact on clients of programs which provide alternatives to residential care, such as EACH and EACH Dementia
- client choice not to enter residential care immediately but to take up the option later within the 12 month approval limit.

(Continued on next page)

Box 13.12 **(Continued)**

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

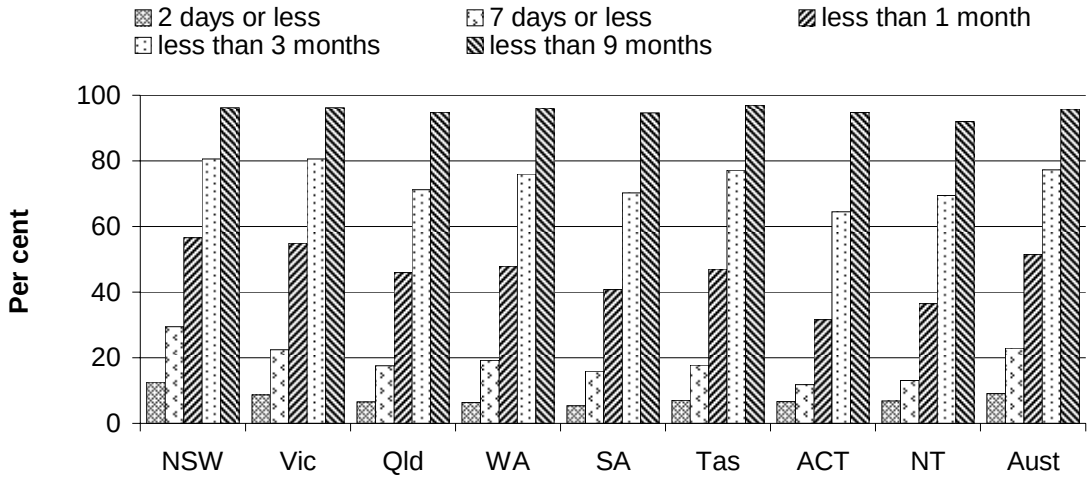
It is recognised that this indicator has limitations and work is underway to review the data. This indicator will continue to be reported until improved data are available.

Data reported for this indicator are comparable.

Overall, 22.9 per cent of all people entering high care residential care during 2007-08 did so within seven days of being approved by an ACAT, 51.5 per cent entered within one month of their ACAT approval and 77.3 per cent entered within three months of their approval. These times varied across jurisdictions (figure 13.20). In the calculation of waiting time, the most recent ACAT approval prior to entry is used. The median time for entry into high care residential care was 28 days (table 13A.37).

Nationally, a greater proportion of people entering high care residential services entered within three months of approval (77.3 per cent), compared with the proportion entering low care residential services within that time (60.9 per cent). These proportions varied across jurisdictions (table 13A.37).

Figure 13.20 **People entering high care residential care within specified time periods of their ACAT approval, 2007-08[a]**



a Includes residential places categorised as 'high care' under either the ACFI or the RCS. See box 13.1 for more information.

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

Waiting times for community care

'Waiting times for community care' is an indicator of governments' objective to maximise the timeliness with which people are able to access community care (box 13.13).

Box 13.13 **Waiting times for community care**

'Waiting times for community care' is defined as the elapsed time between an ACAT approval and receipt of a CACP. The indicator measures the period between a client's approval for care and his or her receipt of care.

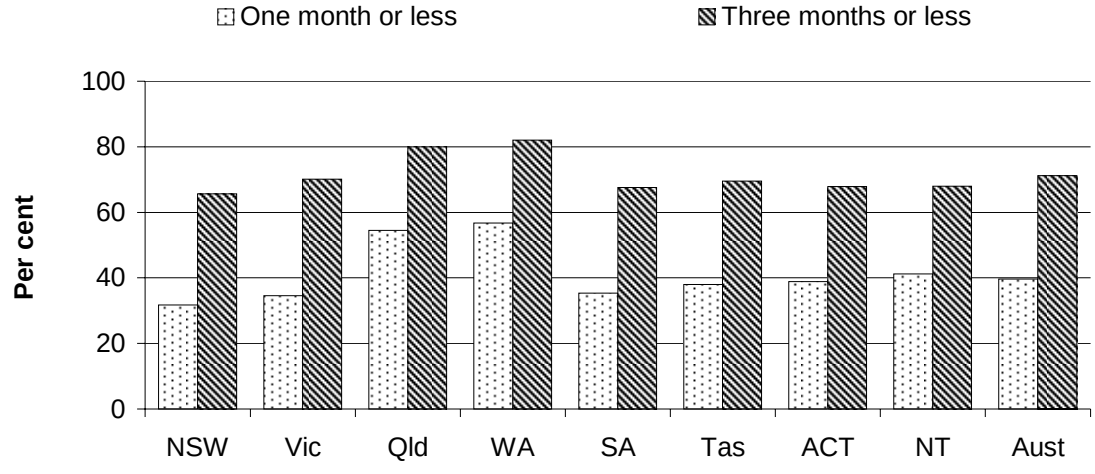
Shorter waiting times (or higher rates of receipt of a CACP within one month or within three months of an ACAT approval) are considered desirable.

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

Data reported for this indicator are comparable.

Overall, 71.2 per cent of all people receiving a CACP during 2007-08 received it within three months of being approved by an ACAT. This proportion varied across jurisdictions. On average, 39.6 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, 2007-08**



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

Effectiveness — appropriateness

Assessed longer term care arrangements

'Assessed longer term care arrangements' is an indicator of governments' objective to meet clients' needs through provision of appropriate aged care services (box 13.14).

Box 13.14 **Assessed longer term care arrangements**

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

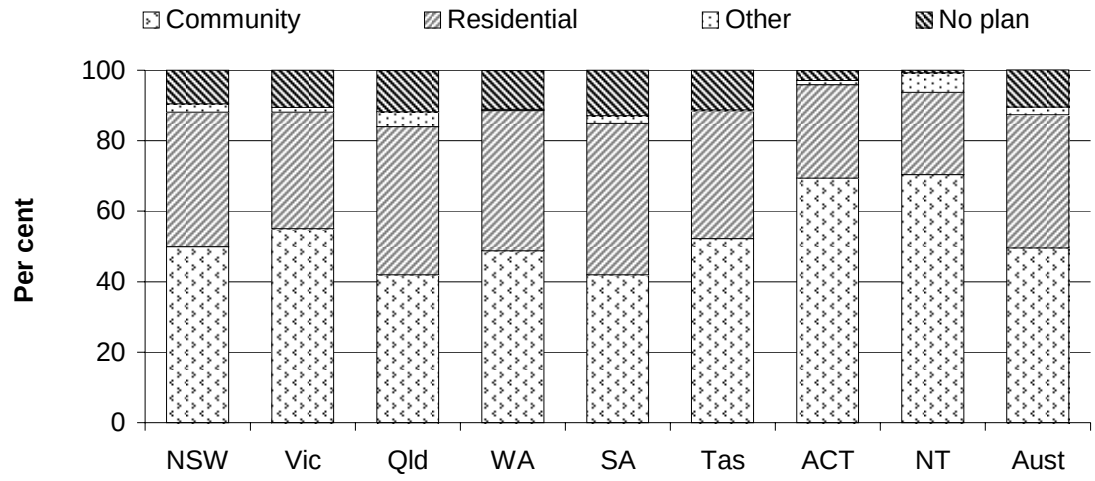
Higher proportions of clients remaining in the community are desirable.

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

Data reported for this indicator are comparable.

The national proportion of ACAT clients approved for residential care in 2006-07 was 37.8 per cent and the proportion recommended to remain in the community was 49.6 per cent. No long term plan was made for 10.5 per cent, which included deaths, cancellations and transfers. These proportions varied across jurisdictions (figure 13.22).

Figure 13.22 **Recommended longer term living arrangements of ACAT clients, 2006-07[a]**



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

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

Targeting

'Targeting' has been identified for development as an indicator of governments' objective to ensure that services are allocated to those people in greatest need (box 13.15).

Box 13.15 **Targeting**

'Targeting' has yet to be defined.

Data for this indicator were not available for the 2009 Report.

Unmet need

'Unmet need' is an indicator of governments' objective of ensuring aged care services are allocated to meet clients' needs (box 13.16).

Box 13.16 **Unmet need**

'Unmet need' is defined as the extent to which demand for services to support older people requiring assistance with daily activities is 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 is met (fully, partly or not at all).

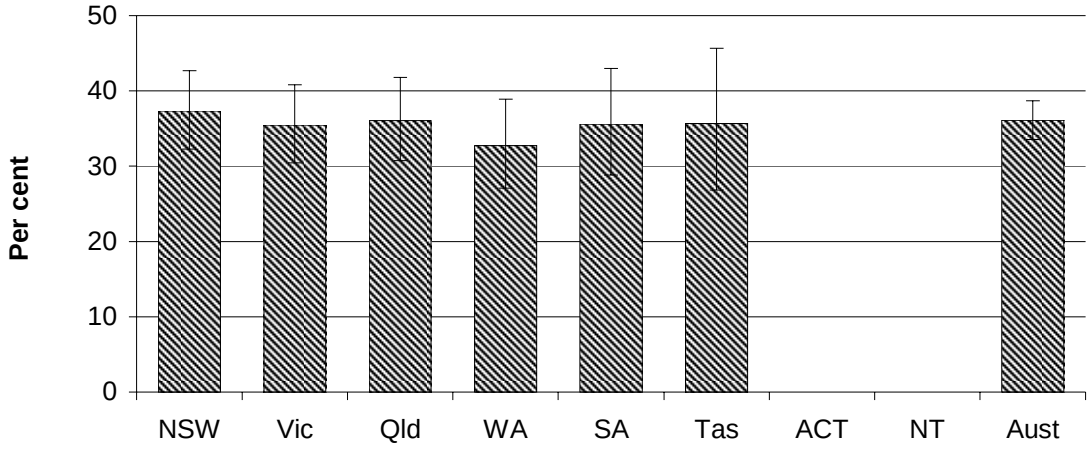
Direct inferences about the demand for services need to be made with care, because the measure used does not:

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

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

Of those people aged 70 years or over in 2003, who were living in households and who self-identified as having a need for assistance with at least one everyday activity, over one third (36.1 per cent) reported that their needs for assistance were not fully met (figure 13.23).

Figure 13.23 **Percentage of older people needing assistance with at least one everyday activity whose need was not fully met, 2003**[a, b, c, d]



a Aged 70 years or over, living in households. **b** Australian total includes data for the ACT and the NT. **c** Data for the ACT and the NT are not published separately. **d** Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: ABS *2003 Survey of Disability, Ageing and Carers* (unpublished); table 13A.67.

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 13.17).

Box 13.17 **Long term aged care in public hospitals**

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

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

as a proportion of all such separations.

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

(Continued on next page)

Box 13.17 **(Continued)**

Hospital inpatient services are geared towards shorter periods of care aimed at addressing serious illness or injury, or diagnosis, and are a less effective form of care for older people who cannot live independently in the long term.

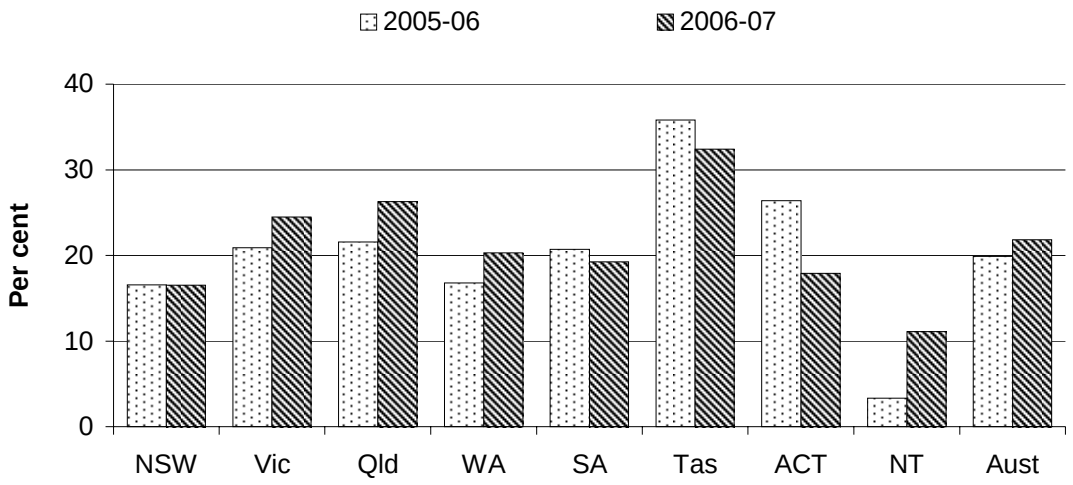
This measure should be interpreted with care.

- Patients who have not completed their hospital stay are not included.
- Although the diagnosis codes reflect a care type, they do not determine a person's eligibility for residential aged care (this is determined by an ACAT assessment) or necessarily reliably reflect access issues for residential aged care from the acute care sector.
- Diagnosis codes may not be applied consistently across jurisdictions or over time.
- Reported hospital separations do not necessarily reflect the full length of hospital stay for any individual patient. If a change in the type of care occurs during a patient's hospital stay (for example, from acute to maintenance) then two separations are reported for that patient.
- The code 'need for assistance at home and no other household member able to render care' may also be used for respite care for aged care residents or those receiving community care and some jurisdictions may have a high proportion of this type of use. This is particularly relevant in some rural areas where there are few alternative options for these clients.
- The measure does not necessarily reflect alternative strategies in place by states and territories to manage the older person into appropriate residential aged care facilities from acute care hospitals.
- The measure is regarded as a proxy, as the desired measures (utilising appropriate linked hospital separations and ACAT approvals) are not available at this time. Further development is underway to improve available data sets and associated measures for future reports.

Data reported for this indicator are not directly comparable.

The proportion of separations for patients aged 70 years or over plus Indigenous people aged 50–69 years who had a care type of maintenance with a diagnosis (either principal or additional) of either 'person awaiting admission to residential aged care service' or 'need for assistance at home and no other household member able to render care', and whose separation was 35 days or longer was 21.8 per cent nationally, in 2006-07. This proportion varied across jurisdictions (figure 13.24). These data reflect only a small proportion of all public hospital separations for patients aged 70 years or over plus Indigenous people aged 50–69 years (10 781 separations of a total of 1.4 million nationally) (table 13A.70).

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



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

Source: AIHW (unpublished); table 13A.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 13.18).

Box 13.18 **Intensity of care**

'Intensity of care' is defined by two measures:

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

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

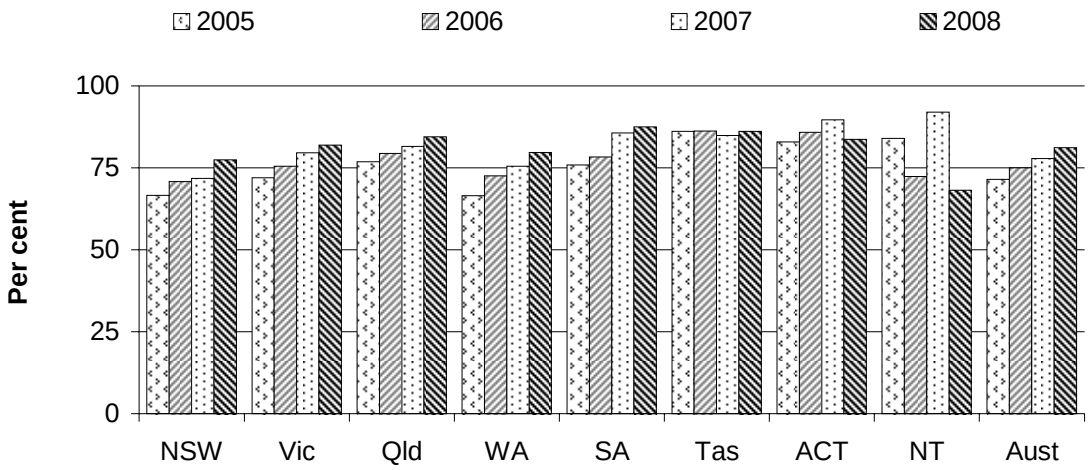
These measures reflect the proportion of residents who remain in the same residential aged care facility as their care needs increase from low care to high care. The Aged Care Act aims explicitly to encourage ageing in place to increase choice and flexibility in residential aged care service provision (box 13.7).

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

Data reported for this indicator are comparable.

Nationally, from June 2005 to June 2008 there was a steady increase in the proportion of people who stayed in the same residential aged care service when changing from low care to high care, from 71.5 per cent to 81.2 per cent (figure 13.25). In June 2008 the proportion was higher in inner regional areas (84.0 per cent), outer regional areas (83.5 per cent), remote areas (89.0 per cent) and very remote areas (84.0 per cent) than in major cities (79.7 per cent) (table 13A.55).

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

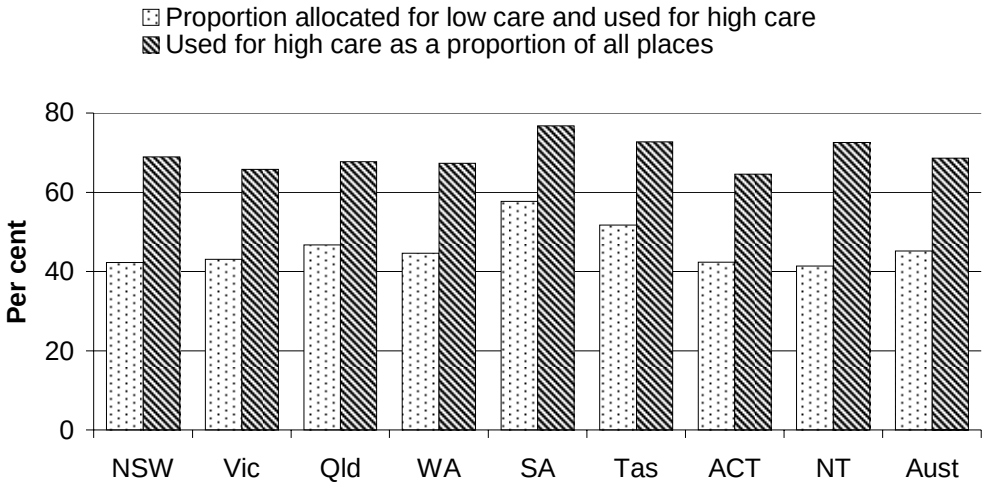


a For June 2008, includes residential places categorised as 'high care' or 'low care', under either the ACFI or the RCS. See box 13.1 for more information.

Source: DoHA (unpublished); table 13A.55.

Nationally, 45.1 per cent of low care places in 2007-08 were occupied by residents with high care needs. The proportion of all operational places taken up by residents with high care needs was 68.6 per cent (figure 13.26). These data are provided by remoteness area in table 13A.58.

Figure 13.26 **Utilisation of operational residential places, 30 June 2008[a]**



a Includes residential places categorised as 'high care' or 'low care', under either the ACFI or the RCS. See box 13.1 for more information.

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

Effectiveness — quality

Compliance with service standards for residential care

'Compliance with service standards for residential care' is an indicator of governments' objective to ensure residential care services attain high levels of service quality, through compliance with certification and accreditation standards (box 13.19).

Box 13.19 **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 three year re-accreditation, by meeting accreditation standards
- the average number of residents per room.

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

High 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 (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 a 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. New services are generally accredited for one year.

Lower rates of residents per room are generally desirable because they imply a higher service quality of accommodation.

(Continued on next page)

Box 13.19 **(Continued)**

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

Data reported for this indicator are comparable.

Accreditation decisions and other information relating to the accreditation standards, the aged care standards and ACSAA are publicly available via the ACSAA's web site (www.accreditation.aust.com). The accreditation process is summarised in box 13.19.

At 30 June 2008, 93.5 per cent of residential aged care services had been granted a re-accreditation approval for a period of three years or more. This proportion varied across jurisdictions (table 13.9).

Table 13.9 **Re-accreditation decisions on residential aged care services, 30 June 2008[a, b]**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Re-accreditation period										
<2 years	%	0.4	1.7	5.2	3.2	4.6	2.3	–	13.3	2.4
2 years or more (but <3 years)	%	1.9	3.2	10.1	3.2	3.9	4.5	8.3	–	4.1
3 years or more	%	97.7	95.1	84.7	93.6	91.4	93.2	91.7	86.7	93.5
Total	**%**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total re-accredited services	**no.**	**894**	**783**	**477**	**249**	**280**	**88**	**24**	**15**	**2 810**

a Excludes services being accredited for the first time, of which there were 36 in the year to June 2008. **b** NT data will be variable due to small numbers. – Nil or rounded to zero.

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

Existing services are required to meet privacy and space requirements by 2008. From 2004, the number of residents per room nationally has been gradually decreasing. The average number of residents per room at December 2006 was 1.19 nationally (table 13A.42).

Complaints

'Complaints' is an indicator of governments' objective to ensure aged care services provide a high quality of care (box 13.20).

Box 13.20 **Complaints**

'Complaints' is defined as the number of breaches under the *Aged Care Act 1997* per 1000 residents.

A low proportion of breaches is desirable.

This indicator is a proxy of the quality of care. It counts the number of breaches identified nationally by the Complaints Investigation Scheme (CIS), which replaced the Complaints Resolution Scheme (CRS) on 1 May 2007. 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, police, nursing and medical registration boards). An independent Aged Care Commissioner has been appointed to review decisions made by the CIS in relation to the investigation of complaints, to examine complaints made about CIS processes and the conduct of the Aged Care Standards and Accreditation Agency as well as any people carrying out audits or making support contacts under the Accreditation Grant Principles 1999.

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

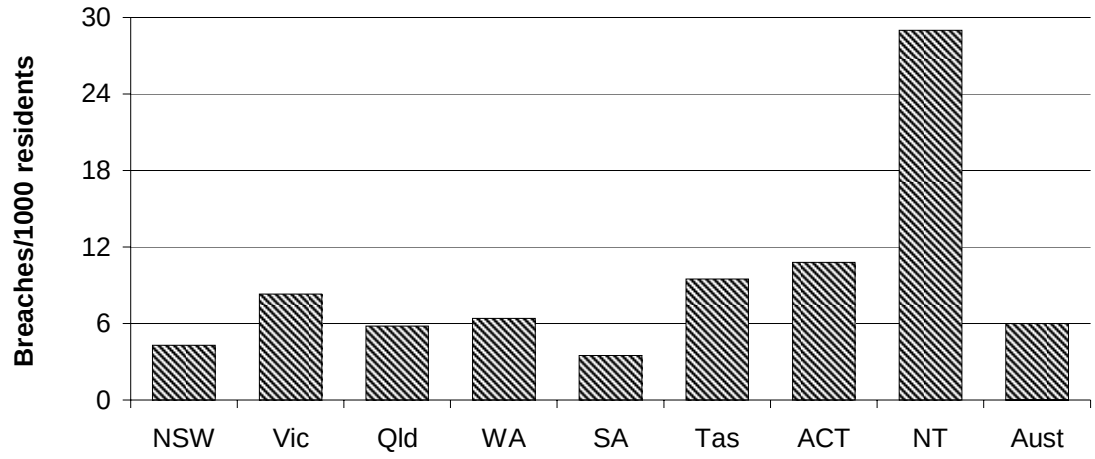
Data reported for this indicator are comparable.

From 1 July 2007 to 30 June 2008, the CIS identified 930 breaches under the Aged Care Act (table 13A.43). The number of breaches identified per 1000 residents from 1 July 2007 to 30 June 2008 was 6.0 nationally. This varied across jurisdictions (figure 13.27).

In the period 1 July 2007 to 30 June 2008, DoHA also dealt with 11 323 matters of which 7496[2] were within the scope of the CIS to investigate, although not all of these were complaints. The increased number of calls reflects the broader nature of the new scheme, which deals with information from a range of sources (DoHA unpublished).

[2] Of the 7496 in scope cases dealt with by the CIS, 89 per cent related to residential care services.

Figure 13.27 **Complaints Investigation Scheme breaches, 2007-08[a, b]**



a Outcomes of the CRS are included in earlier reports. **b** NT data will be variable due to small numbers.

Source: DoHA (unpublished); table 13A.43.

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 13.21).

Box 13.21 **Compliance with service standards for community care**

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

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

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

The indicator monitors the extent to which individual agencies are complying with service agreement standards. The HACC national service standards provide HACC funded agencies with a common reference point for internal quality control by defining aspects of service quality and expected outcomes for consumers. States and territories are required to include the standards in all service agreements. The HACC national service standards instrument has been developed to measure through a service appraisal process the extent to which individual agencies are complying with the standards. Monitoring and compliance with the standards are now a major part of service reviews. This indicator also measures the percentage of individual agencies that comply with the service standards, through the outcomes of service standard appraisals. It should be noted that the standards are not an accreditation system.

Data reported for this indicator are comparable.

A total of 3504 HACC agencies were identified for appraisal over the second appraisal cycle (the four year cycle 2004-05 to 2007-08). The number of these agencies appraised was 2915 (83.2 per cent). This proportion varied across jurisdictions (table 13.10). The outcomes of these appraisals was a national average score of 17.5 out of 20 (table 13.11).

The ACT will complete this cycle in 2008-09 and updated outcomes from the second appraisal cycle will be available for the 2010 Report.

Table 13.10 HACC National Service Standards appraisals over the four year cycle ending 2007-08[a]

	Unit	*NSW*[b]	*Vic*[c]	*Qld*[d]	*WA*	*SA*	*Tas*	*ACT*[e]	*NT*[f]	*Aust*[d]
Appraisals	no.	1 411	338	963	123	179	53	..	10	2 915
HACC agencies	no.	1 785	460	801	135	179	53	..	91	3 504
Proportion of agencies assessed	%	79.0	73.5	100.0	91.1	100.0	100.0	..	11.0	83.2

[a] Reports provisional data that have not been validated and may be subject to revision. Not all HACC agencies were required to undergo external assessment, and some are exempt, so the number of HACC agencies may be higher than those reported. [b] Validation of 343 HACC services auspiced and/or administered by NSW Health occurred from February–October 2005. Monitoring of all other NSW HACC services commenced in November 2005 under the Integrated Monitoring Framework, and is due for completion by December 2008. The total number of HACC agencies is the number of HACC services funded in 2007-08. The proportion of agencies appraised is indicative only, as agencies may equate to services or outlets. In NSW, the appraisal methodology differs slightly under the Integrated Monitoring Framework, though is closely aligned to the HACC Standards Instrument. Scores are derived from equivalent performance questions. [c] Victoria has completed appraisals for 338 agencies. The remaining 122 agencies are Quality Improvement Council or Australian Council on Healthcare Standards accredited. Victoria has contracted with the licensee of these systems to conduct appraisals against HACC standards as part of their major review. These appraisals will be finalised by mid 2010. [d] In Queensland the number of appraisals exceeds the number of agencies because some service providers were reviewed twice in the four year period. Therefore calculation of the Australian total of appraisals and the proportion of agencies assessed only includes 801 Queensland agencies. [e] Quality Assessments in the ACT will occur in 2008-09. [f] NT data are variable due to small numbers. .. Not applicable.

Source: State and Territory governments (unpublished).

Table 13.11 HACC National Service Standards results of appraisals over the four year cycle ending 2007-08 (number)[a, b, c]

	NSW	*Vic*	*Qld*[d]	*WA*	*SA*	*Tas*[e]	*ACT*[f]	*NT*	*Aust*
High (17.5 – 20)	997	162	682	88	89	29	..	1	2 048
Good (15 – 17.4)	226	74	175	11	42	9	..	4	541
Basic (10 -14.9)	167	71	85	16	34	10	..	4	387
Poor (less than 10)	21	31	21	8	14	5	..	1	101
Average score	17.7	16.0	18.3	17.0	16.1	16.2	..	15.0	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.66. [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 will occur in 2008-09. .. Not applicable.

Source: State and Territory governments (unpublished); table 13A.66.

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 13.22).

Box 13.22 **Client appraisal of service standards**

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

Data for this indicator were not available for the 2009 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 13.23).

Box 13.23 **Cost per ACAT assessment**

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

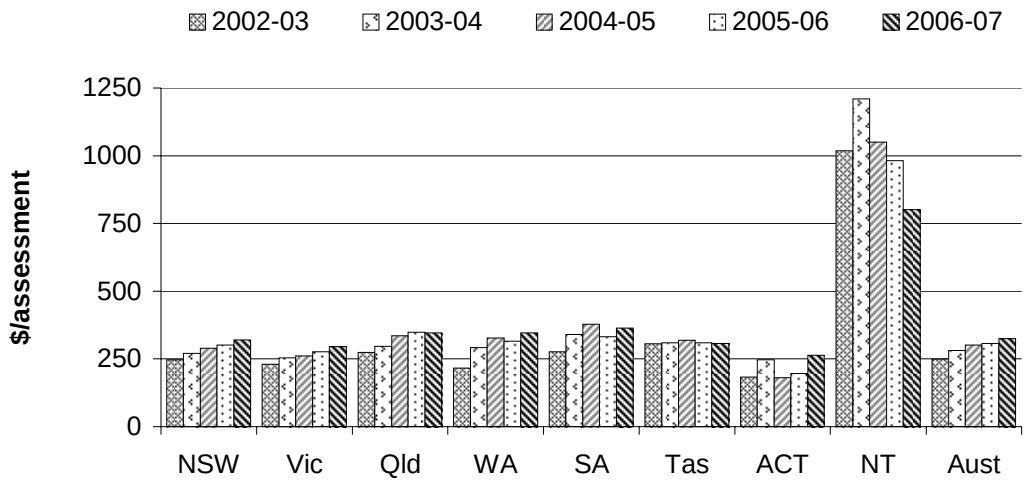
This is a proxy indicator of efficiency and needs to be interpreted with care. While high or increasing expenditure per assessment may reflect deteriorating efficiency, it may also reflect changes in aspects of the service (such as greater time spent with clients) or changes in the characteristics of clients (such as their geographic location). Similarly, low or declining expenditure per assessment may reflect improving efficiency or less time spent with clients, for example. This indicator includes only Australian Government expenditure, although states and territories also contribute to the cost of ACAT assessments.

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

Data reported for this indicator are not directly comparable.

Australian Government expenditure per aged care assessment during 2006-07 averaged $325 nationally (figure 13.28). Nationally, real expenditure increased from 2002-03 to 2006-07. The cost per assessment is calculated using the total number of assessments and therefore includes clients aged less than 70 years.

Figure 13.28 **Australian Government expenditure on aged care assessments, per assessment (2006-07 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.56.

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 13.24).

Box 13.24 **Expenditure per head of target population**

'Expenditure per head of target population' is defined as government inputs (expenditure) divided by the number of people aged 70 years or over plus Indigenous people aged 50–69 years. Expenditure per person in the target population is reported for three main service types: residential services, CACP and HACC services.

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

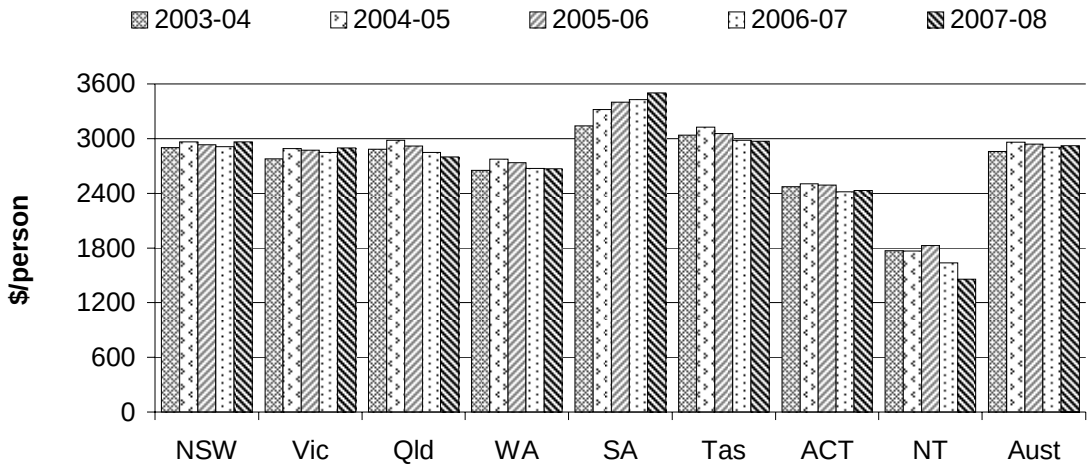
Data reported for this indicator are comparable.

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 nationally from 2003-04 ($2859) to 2007-08 ($2923) (figure 13.29). If the payroll tax supplement paid by the Australian Government is excluded, this expenditure increased nationally from $2819 in 2003-04 to $2875 in 2007-08 (table 13A.51).

DoHA expenditure on residential care per person aged 70 years or over plus Indigenous people aged 50–69 years in 2007-08 was $2474 including the payroll tax supplement and $2434 excluding the payroll tax supplement (table 13A.50). DVA expenditure on residential care per person aged 70 years or over plus Indigenous people aged 50–69 years in 2006-07 was $449 including the payroll tax supplement and $441 excluding the payroll tax supplement (table 13A.46).

Figure 13.29 **Australian Government (DoHA and DVA) real expenditure on residential services per person aged 70 years or over plus Indigenous people aged 50–69 years (2007-08 dollars)[a, b]**

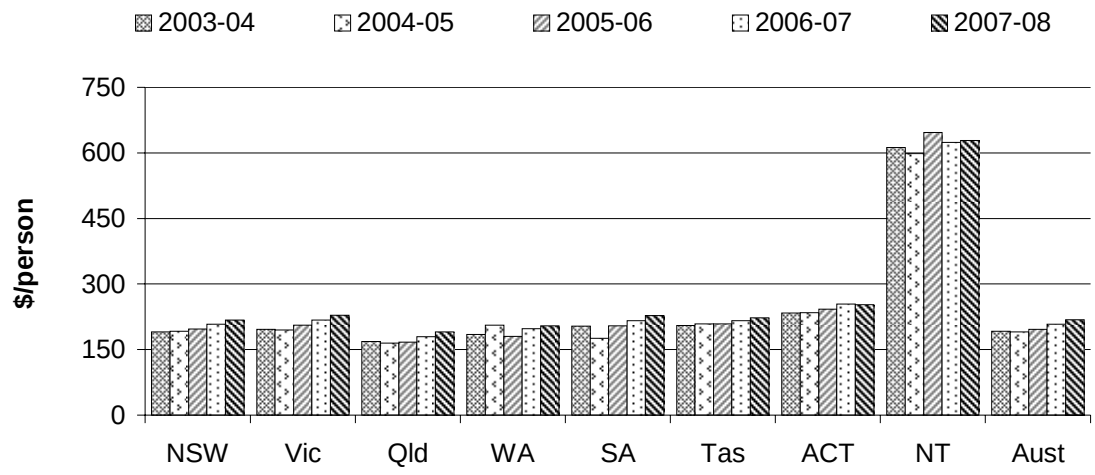


a Includes a payroll tax supplement provided by the Australian Government. Actual payroll tax paid may differ. **b** Population data for 2007-08 are based on 2006 Census data. Population data for earlier years are based on 2001 Census data. See footnotes to table 13A.2 for more information.

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

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 2007-08. Nationally, real expenditure per person aged 70 years or over plus Indigenous people aged 50–69 years increased from $192 in 2003-04 to $218 in 2007-08 (figure 13.30).

Figure 13.30 **Australian Government real expenditure on CACP services per person aged 70 years or over plus Indigenous people aged 50–69 years (2007-08 dollars)[a]**

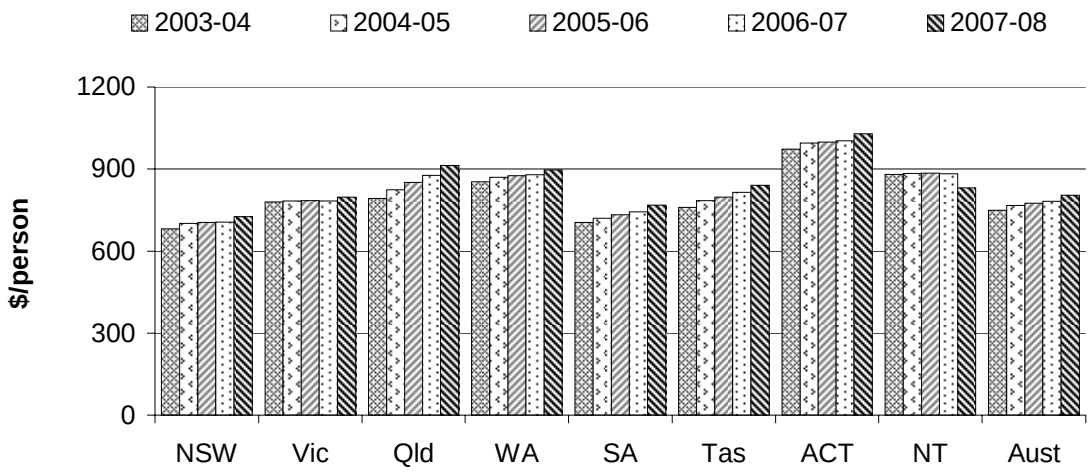


a Population data for 2007-08 are based on 2006 Census data. Population data for earlier years are based on 2001 Census data. See footnotes to table 13A.2 for more information.

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

Australian, State and Territory government expenditure on HACC services per person aged 70 years or over plus Indigenous people aged 50–69 years varied across jurisdictions. Nationally, real expenditure increased from $749 in 2003-04 to $804 in 2007-08 (figure 13.31). These figures reflect expenditure against the population used as the proxy in this chapter (see section 13.1), which is not the same as the HACC target population. Expenditure per person in the HACC target population is reported in table 13A.52.

Figure 13.31 **Australian, State and Territory government real expenditure on HACC services per person aged 70 years or over plus Indigenous people aged 50–69 years (2007-08 dollars)[a, b, c, d, e]**



a People aged 70 years or over plus Indigenous people aged 50–69 years are not the HACC target population. Expenditure per person and the definition of the HACC target population are contained in table 13A.52. **b** This figure only represents expenditure under HACC Amending Agreements. **c** Reports provisional HACC data that have not been validated and may be subject to revision. **d** Expenditure reflects an equalisation strategy. See notes to table 13A.53 for more detail. **e** Population data for 2007-08 are based on 2006 Census data. Population data for earlier years are based on 2001 Census data. See footnotes to table 13A.2 for more information.

Source: DoHA (unpublished); table 13A.53.

Outcomes

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

Social participation in the community

'Social participation in the community' has been identified for development as an indicator of governments' objective to encourage the wellbeing and independence of frail older people (box 13.25).

Box 13.25 **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 13.26).

Box 13.26 **Maintenance of individual functioning**

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

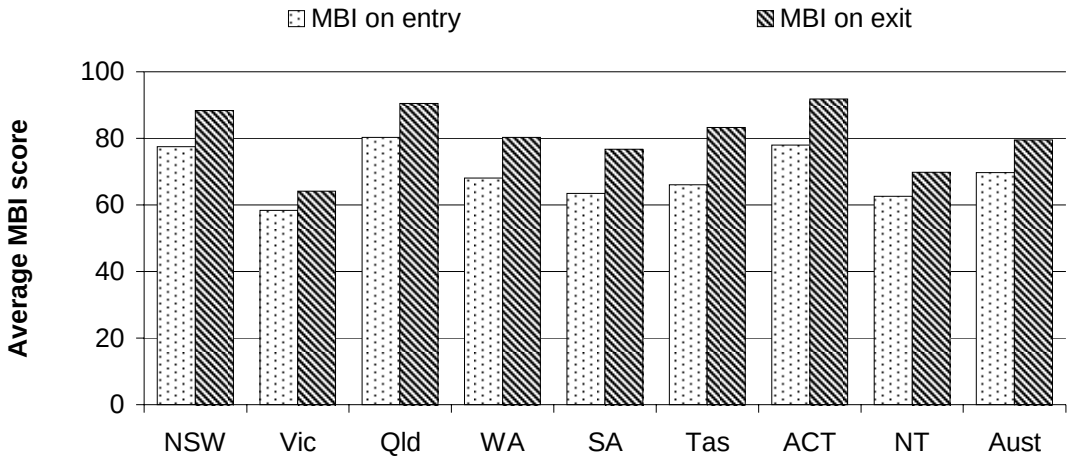
This indicator needs to be interpreted with care. The TCP is one aged care program where it is possible to measure a change in a client's level of functioning. Variation in the average MBI scores on entry and exit from the program may reflect a range of target client groups for the program across jurisdictions.

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

Data reported for this indicator are comparable.

The average MBI score on entry to the TCP in 2007-08 was 69.7 nationally. The average MBI score on exit from the TCP was 79.5 nationally. These results varied across jurisdictions (figure 13.32).

Figure 13.32 **Transition care program — average Modified Barthel Index score on entry and exit, 2007-08[a]**



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

Source: DoHA (unpublished); table 13A.69.

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 13.27).

Box 13.27 **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
- further development of outcome indicators.

Reform of Specific Purpose Payments

In December 2007, COAG agreed to reform Specific Purpose Payments (SPPs). SPPs are financial agreements between the Australian Government and State and Territory governments involving a contribution by the Australian Government to the funding of services which are considered a joint Australian and State and Territory government responsibility. Aged care assessment and Home and Community Care payments were such SPPs.

At its 29 November 2008 meeting, COAG agreed to six new National Agreements, (none specific to aged care services, although the National Healthcare Agreement may have implications for aged care services). Five of the new agreements are associated with a National SPP. The performance of governments in achieving these mutually agreed outcomes will be assessed by the COAG Reform Council (CRC). The Steering Committee has been requested by COAG to provide the SPP performance information to the CRC (COAG July 2008).

The National Agreements/SPPs will be supplemented by a range of National Partnerships (NPs): project, facilitation and reward agreements. Funding for NPs may be conditional on states and territories meeting agreed milestones and performance benchmarks.

The Steering Committee and the Aged Care Working Group will ensure that reporting in this chapter reflects the COAG priorities identified in the relevant NPs.

13.5 Jurisdictions' comments

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

Australian Government comments

“There have been a number of changes to this year’s Report, reflecting recent policy changes. In 2007-08, the Australian Government implemented significant reforms in the funding of residential aged care. These reforms included a new, fairer income test and accommodation supplement that provide more equitable treatment for all residents, as well as a new funding instrument, the Aged Care Funding Instrument (ACFI).

On March 20 2008, new arrangements governing residents’ contributions to their accommodation costs and the supplements the Government pays for residents who cannot meet all or part of their own accommodation costs were introduced. The new arrangements combine the Concessional Resident Supplement and the Pensioner Supplement into a single Accommodation Supplement paid to the residential aged care providers on behalf of supported residents. The amount of Accommodation Supplement paid for supported residents is based on the assessed value of their assets.

The ACFI measures residents’ needs for care rather than care being provided. This is a more objective measure of resident care needs. This new system has three funded levels for personal care and includes two new funding supplements. The new supplements will better target funding towards residents with dementia and challenging behaviours, and residents who have complex health care needs, including those who need palliative care.

These changes have affected the data presented in the 2009 Report and are documented in relevant areas of the 2009 Report.

This year’s Report includes, for the first time, data on the Department of Veterans’ Affairs Community Nursing program. This is one of a suite of DVA programs to assist veterans and war widows/widowers to continue to live safely and independently in their own homes and avoid early admission to hospital or residential care.

An independent review of the Veterans’ Home Care program was completed in early 2008 and is currently under consideration.”

New South Wales Government comments

“ The NSW Government continues to be committed to providing quality services for older people and their carers which promote their health and wellbeing, optimise their independence and participation in community life, and facilitate their timely access to appropriate care and support.

NSW Health has had a busy and constructive year with the implementation and review of a range of aged and chronic care services both within NSW hospitals and at the interface between acute care and community care services.

Additional resources have been made available to assist older people across the full spectrum of acute care. This has included enhancement of specialist aged care services in Emergency Departments to better coordinate the care of older patients as well as the commissioning of Medical Assessment Units attached to Emergency Departments across NSW. New positions have been established in inpatient ward settings to assist older people access long term support services from hospital as well as the expansion of a range of short-term post-acute care options for older people after hospitalisation. A total of 674 Transition Care places were operational across NSW by 30 June 2008.

The NSW Protocols and Procedures Manual for Aged Care Assessment Teams (ACATs) in NSW was published and the ongoing review and structural reform of the Aged Care Assessment Program (ACAP) in NSW continues with the use of Australian Government COAG funds. The goal of these reforms is to improve the quality, efficiency and consistency of ACAT assessments across NSW.

Further development of services for older people with mental health issues and support for carers has also been an important focus of activity in NSW.

In 2007-08 the NSW HACC program continued to expand with the allocation of $35 million in additional funding, bringing the total budget to $510 million.

Planning for the HACC program in 2007-08 continued toward a more strategic approach with the identification of regional priorities and strategies over the long, medium and short term. NSW priorities for growth funding in 2007-08 included an emphasis on basic support services and improved delivery to the HACC special needs groups. Growth funding highlights include increases in social support, centre based day care, respite support and transport services to improve clients’ and carers’ access to the community and reduce social isolation. Initiatives were introduced to improve access for Aboriginal people, people from CALD backgrounds and people with dementia.

As part of the national Community Care reforms, the HACC Access Points Demonstration Project started in March 2008. This project streamlines and simplifies access to HACC and other community care services, using standardised intake assessment approaches and tools. ”

Victorian Government comments

“Victoria continued to lead innovation during 2007-08, in the development of programs and services that provide support for older people.

In February 2008, Victoria hosted the HACC National Promoting Independence Forum 2008. Almost 400 people attended the participative policy focused forum which brought key stakeholders together from amongst academics, researchers, service providers and governments to explore the evidence base and implications for more thoroughly adopting a wellness, capacity building and restorative care approach to HACC service provision, and to test whether a consensus can be developed about future directions and next steps. Invited papers were presented from Australia and elsewhere in the world, including on Victoria's *Active Service Model*.

The forum was judged to be highly successful and will undoubtedly influence future directions in Australian community care.

In April, Victoria launched the Seniors Rights Victoria, a state-wide service providing telephone support and advice to respond to the abuse, mistreatment or neglect of older people. Seniors Rights Victoria works closely with professionals who regularly deal with the financial, medical and legal affairs of older people to ensure they understand the issues and can respond appropriately. The service combines the resources and experience of the Council on the Ageing Victoria, two community legal centres and the Public Interest Law Clearing House. The service is one element of the Government's response to the 2006 report of the Elder Abuse prevention Project. Other elements are in development.

An evaluation was completed of the *Well for Life in Public Housing* program. The program takes to public housing settings, a health promotion program focussed on physical activity and nutrition among older people. Well for Life challenges established attitudes and practices about what is possible and achievable in improving functional capacity and quality of life for frail older people.

Well for Life complements other Victorian initiatives including; Older Persons High Rise Support Program, Housing Support for the Aged program, Supported Residential Services Service Coordination Program, Community Connections Service Program and Aged Care Support for Carers program.

Substantial financial support was provided during the year for a consortium of 14 local councils that is establishing a regional kitchen for the preparation of delivered meals ('Meals on Wheels'). This innovative response will provide significant economies and drive quality in a niche market not responded to by the mainstream food industry, assuring sustainable services for HACC clients.”

Queensland Government comments

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

The Queensland HACC Program progressed reform initiatives arising from the Common Arrangements agreed under the HACC Review Agreement 2007. The most notable initiative was the Community Care Access Point demonstration project in the Central Queensland area. The project simplifies the process for determining eligibility and priority of access for people requiring community care services, including HACC services. Extensive consultation and planning was also undertaken in the development of the first Triennial Plan for the Queensland HACC Program for the 2008–11 period.

Queensland continued to operationalise the 351 places approved under the first phase of the Transition Care Program. As at 30 June 2008, 347 of these places were operational across both residential and community settings.

With funding provided by the Australian Government through COAG, Queensland Health implemented a number of local based initiatives through the Long Stay Older Patients Program. These initiatives included continuation of existing and new capital works at the Herberton, Gordonvale, Gladstone and Boonah hospitals, interim care at Cairns, Townsville, Bundaberg, Gold Coast, Toowoomba and Princess Alexandra hospitals, and Hospital in the Nursing Home at Bundaberg and Cairns. Significant planning and capital works has also been undertaken in a number of sites across Queensland to expand the Multi-Purpose Health Service (MPHS) program.

Queensland continues to support 21 State owned and operated residential aged care facilities. In 2007-08, the State government contribution to the operations of these facilities was over $70 million from an overall expenditure of $146.7 million. Other revenue was received from the Australian Government, resident charges and other miscellaneous sources to supplement the Queensland Government contribution.

In addition as part of its $120 million redevelopment program, $6.4 million was expended on the upgrade of residential aged care facilities.

During 2007-08, 31 776 aged care assessments were undertaken in Queensland through the Aged Care Assessment Teams jointly funded by both levels of government.

In addition, in 2007-08, six projects have been progressed through COAG funding aimed at improving the consistency and timeliness of aged care assessments. These projects are the continuation of the information technology, Indigenous assessments projects commenced in 2006-07 and new projects around central coordination of the COAG initiatives, ACAT education support and coordination, the development of a locum assessment model and support for the attendance of ACATs at the national conference in 2008.”

Western Australian Government comments

“The WA Aged Care Network has continued to promote a continuum of care approach to the planning and delivery of services for older people in WA through the development of a range of *Aged Care Models of Care* across the WA Health system. An overarching policy document: ‘Model of Care for the Older Person in WA’ has been strengthened by the development of a range of service delivery models of care endorsed by the State Health Executive Forum:

- Geriatric Evaluation and Management
- Amputees Services and Rehabilitation
- Ortho-geriatric care services
- Parkinson’s Disease Services
- Rehabilitation and Restorative Care Services.

A ‘Models of Care’ Forum attended by over 100 people from across WA provided an opportunity to bring together a diverse range of stakeholders to provide feedback on individual draft service delivery level models of care and identify practical steps to progress the implementation at the local area health service level. Progress towards the development of additional service delivery models of care including delirium and dementia will continue to support and improve the quality of care for the older person across the continuum of care.

Through the COAG, Long Stay Older Patient initiative, area health services across WA have continued to work on implementation of an eldercare pathway that has strengthened existing hospital strategies, including emergency departments’ capacity to risk screen elderly patients and facilitate further assessment of those identified at risk. All area health services now use the best practice clinical resources developed as a part of the National Action Plan.

The WA Transitional Care program has a total of 160 operational places and in 2007-08, 597 older people were assisted by the program with on average 53 per cent returning home to the community with or without the support of aged care services.

The WA ACAP has moved forward with the COAG initiatives to formalise and develop a specific ACAT training schedule which has been implemented. ACAT Education Officers have been established at various locations across the state and provide orientation and education to team members.

To support the National community care reform agenda and development of the HACC sector in WA, Access Network demonstrations commenced operating in Esperance, Derby/Broome and the Local Government Area of Swan to support the provision of information, initial eligibility screening and data collection with the goal of assisting clients/carers to access the most appropriate community care services.”

South Australian Government comments

“ The Department for Families and Communities through the Office for the Ageing (OFTA) has continued to lead the development and implementation of ‘*Improving with Age — Our Ageing Plan for South Australia*’. Since its launch in February 2006, OFTA has provided over $6 million to kick-start over 60 innovative projects to implement the Ageing Plan. There are now over 135 State Government initiatives operating across the state, which are making a significant difference to the lives of older South Australians.

South Australia is a partner in the reform of Community Care Common Arrangements across Australia, including:

- the implementation of the Community Care Access Points, a COAG initiative to improve access to community care and the development and implementation of the Common Standards for Community Care
- development of Information Management and Data Collection strategies in Community Care and the development of the National Fees Framework.

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:

- building on the earlier review of assessment practices across South Australian Aged Care Assessment Teams (ACATs) resulting in the development of Best Practice Protocols
- the Mobile Assessment Response (MAR) aims to provide support and back-up for ACAT teams, especially in unforseen circumstances. The MAR Project has been further developed in 2007-08 with an increased range of responses, including the commencement of an annual visiting service to the Anangu Pitjantjatjara Yankunytjatjara Lands to complete assessments and provide education for suitably qualified staff on the Lands to enable them to undertake assessments between visits.

OFTA successfully developed a Triennial Plan (2008-09 to 2010-11) for the HACC Program in SA. The plan outlines the strategic directions and funding priorities for the HACC Program in SA over the next three years.

OFTA continued to implement reforms in the way that it allocates growth funding to services for frail older people, people with disabilities and carers through the HACC Program. In addition to the new funding allocation processes including direct allocation and invited submission implemented in the country regions in 2007-08, these reforms were further expanded in 2008-09 to metropolitan regions resulting in more appropriate and targeted methods of funding disadvantaged groups. The implementation of new funding allocation processes across SA has further streamlined and simplified administrative processes with benefits to both OFTA and the ageing and community services sector. ”

Tasmanian Government comments

“ ‘*Tasmania’s Health Plan*’ provides a blueprint for the integrated development of primary and acute health services. It draws together the recommendations of the Primary Health Services Plan and the Clinical Services Plan, both of which were developed following comprehensive processes of stakeholder consultation and data analysis. The Plan was initially released in May 2007 and an update was released in May 2008, recognising the impact of changes resulting from the Australian Government taking control of the Mersey Community Hospital. The Plan is the cornerstone for planning for health services into the future, including aged care services.

‘*Tasmania’s Health Plan*’ recognises that health care and support for older people is increasingly being delivered in community settings rather than in acute hospitals. A need has been acknowledged in the Plan to redesign systems so that care provided across different settings is integrated seamlessly and that communities can access a comprehensive mix of services in appropriate settings.

The establishment of Clinical Networks is a key component of the Tasmanian Health Plan, mirroring the experience of most Australian states and territories. The establishment of an Aged Care and Rehabilitation Clinical Network in 2008-09 will form the basis for greater involvement of clinicians and consumers in the planning, delivery, evaluation and improvement of health services across the interface between acute and aged care in Tasmania, and enhance collaboration and coordination in the delivery of services across organisational boundaries in order to improve outcomes for older patients and clients.

The Home and Community Care (HACC) Triennial plan details funding priorities relating to service delivery, asset purchases, pilot and research projects and program development. Over the triennium the Tasmanian HACC Program will continue its current strategy of rolling priorities over a number of years, and the most significant investments will be in the provision of HACC basic services. In 2007-08, the Central Contact Point Trial (Tasmanian CAREpoint Pilot Project) tested a central, telephone-based point of contact for consumers to access selected HACC services provided in the southern region by DHHS and non-government service providers. CAREpoint provided initial contact, referral, screening and intake processes for community care services (community nursing, personal care, home help and home maintenance). The trial is now being evaluated to help inform arrangements for a wider Access Point Demonstration Project, commencing in 2008-09. The Access Point service will provide Tasmanians with easier access to information about, or referral to, community services. ”

Australian Capital Territory Government comments

“ The ACT is committed to assist older people and their carers by providing better support and access to appropriate services that promote health and wellbeing and optimise independence and participation in community life. The ACT continues to pursue strategies to improve the planning and delivery of services to meet the challenge of growing care needs of frail older people.

Three ACAP projects developed under the COAG initiative of improving timeliness and consistency of aged care assessments were progressed. These projects included the development of an education and training program and the provision of infrastructure to improve the collection and quality of data.

Additional resources were allocated to the Older Persons Mental Health Unit to enhance the service delivery for older people with a mental illness. The service provides specialist mental health assessment and treatment services and also gives support and assistance to families and carers.

With funding provided by the Australian Government though the Long Stay Older Patients initiative, the ACT continued to reduce avoidable hospital admissions through the Rapid Assessment of the Deteriorating Aged at Risk (RADAR) program and improve care outcomes for older persons by providing additional support during the transition from hospital to appropriate long-term care.

During 2007-08, 157 new residential aged care places were made operational in the ACT, representing a 9.6 per cent increase. In cooperation with the Australian Government, industry and service providers, the ACT continued to review land planning and allocation processes to provide a more effective, streamlined process and significantly improve the timeliness of delivering high quality aged persons’ accommodation.

The Community Partners Program, funded through the Australian Government, delivered training programs for Culturally and Linguistically Diverse volunteers on dementia and palliative care. The training enhanced their skills to support residential aged care residents and helped to ensure that older people with dementia or receiving palliative care continue to be part of their communities. ”

Northern Territory Government comments

“The unique environment and socio-economic factors in the NT create specific challenges in the provision of human services including aged care services for both the NT and Australian Government. This is particularly so in the provision of appropriate, cost effective and sustainable aged care services in remote Indigenous communities. The high proportion of people living in remote settings and lack of a major metropolitan centre creates increased cost structures for all services.

Enhancing Indigenous remote residents access to aged care services and equitable allocation of resources remained a priority to the NT Government.

Data quality remains an ongoing challenge for providers in the NT, given that most are small non-government agencies that receive funds from multiple sources and for multiple purposes. In addition, the relatively small numbers of aged care clients in the NT results in distorted or misleading proportions in the data analysis.

A major reform in the NT was the planning for the amalgamation of community councils to larger shire councils. From 1 July 2008, fewer and larger providers will replace the current large numbers of small and dispersed aged care providers.

In 2007-08 a number of projects were implemented with the focus of improving service planning and quality. These included a new resources allocation policy to distribute available funds to targeted services closer to home for aged people.

Transition Care services, piloted in Katherine before it was extended to Darwin and Alice Springs and planning for new common access points for aged care services was undertaken during the reporting period. The NT is trialling this approach in all areas outside Darwin and Alice Springs.

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

13.6 Definitions of key terms and indicators

Adjusted subsidy reduction supplement

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

Accreditation

Accreditation is a key component of the Australian Government's quality framework for federally funded residential aged care and is a quality assurance system for residential aged care services — based on the principle of continuous improvement.

Accreditation requires compliance with the 44 expected outcomes used for accreditation assessment — grouped into four standards: management systems 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.
Certification	The aim of certification is to improve the physical quality of federally funded residential aged care buildings through access to ongoing streams of funding from bonds, charges and supplements to finance construction and improvement in aged care services.
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.
Elapsed time between ACAT approval and entry into a residential care service	The measure of the elapsed time between ACAT approval and entry into a residential care service. It has been used in past years as an indicator of access to residential care.
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; and the unpaid Carers of people assessed as being within the National Program's target population. 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	This chapter classifies residents as 'high' or 'low' care based on their RCS or ACFI classification. For the purpose of this Report, under the RCS classification, high care residents have been assessed as RCS levels 1–4, and low care residents have been assessed as RCS levels 5–8. A resident assessed under ACFI is considered to be in receipt of high care (ACFI High) if they if they are assessed as: • Medium or High in Activities of Daily Living; or • High in Behaviour; or • Medium or High in Complex Health Care All other residents assessed under ACFI are regarded as low care residents (ACFI Low). If the person is approved as a recipient of a high level of care, that

	person can receive care at any care classification level (Approval of Care Recipients Principles 1997, s.5 9). A person approved as a recipient of a low level of care can be classified on entry only as RCS 5–8 (Classification Principles 1997, s.9-19).
In-home respite	A short term alternative for usual care.
People from non-English speaking countries	People who were born in non-English speaking countries. English-speaking countries are defined as Australia, New Zealand, the United Kingdom, Ireland, the United States, Canada and South Africa.
People with a moderate disability	Where a person does not need assistance, but has difficulty with self care, mobility or communication.
People with a profound disability	Where a person is unable to perform self-care, mobility and/or communication tasks, or always needs assistance.
People with a severe disability	Where a person sometimes needs assistance with self-care, mobility or communication.
Personal care	Assistance in undertaking personal tasks (for example, bathing).
Places	A capacity within an aged care service for the provision of residential care, community care or flexible care in the residential care context to an individual (*Aged Care Act 1997 (Cwlth)*); also refers to 'beds' (*Aged Care (Consequential Provisions) Act 1997 (Cwlth)*, s.16).
Real expenditure	Actual expenditure adjusted for changes in prices, using the GDP(E) price deflator and expressed in terms of final year prices.
Resident	For the purposes of the *Aged Care Act 1997*, a person who is being provided with residential care through an aged care service conducted by an approved provider under the Act.
Respite care	Alternative care arrangements for dependent people living in the community, with the primary purpose of giving their carer a short term break from their usual caring commitments.
Rural small nursing home supplement	Payments made by states and territories to small sized high care public sector residential aged care facilities (up to 30 places) that are located in rural areas. Three levels of supplement are paid to facilities varying in size from 10 to 20 and 30 places.
Special needs groups	Section 11-3 of the Aged Care Act, specifies the following people as people with special needs: people from Aboriginal and Torres Strait Islander communities; people from non-English speaking countries; people who live in rural or remote areas; and people who are financially or socially disadvantaged. Principles (Regulations) made under s. 11-3 also specify veterans as a special needs group.
Veterans	Veterans, their war widows, widowers and dependents who are eligible for treatment through the Department of Veterans' Affairs under the provisions of the *Veterans' Entitlements Act 1986 (Cwlth)*.

13.7 Attachment tables

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

Table 13A.1	Males and females aged 70 years or over, June 2008
Table 13A.2	Target population data, by location ('000)
Table 13A.3	Proportion of people aged 70 years and over by locality, June 2008
Table 13A.4	Ownership of operational mainstream aged care residential places, June 2008
Table 13A.5	Average annual Australian Government RCS subsidy per occupied place and the dependency level of aged care residents, June 2008
Table 13A.6	Size and distribution of all residential aged care services, June 2008
Table 13A.7	Size and distribution of residential aged care services with over 80 per cent high care residents, June 2008
Table 13A.8	Size and distribution of residential aged care services with over 80 per cent low care residents, June 2008
Table 13A.9	Size and distribution of mixed residential aged care services, June 2008
Table 13A.10	Proportion of residential aged care places, by location in high care, low care and mixed care services
Table 13A.11	Operational number of aged care places per 1000 people aged 70 years or over, 30 June
Table 13A.12	Operational number of aged care places per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years, 30 June
Table 13A.13	Aged care recipients per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years, 30 June (c),
Table 13A.14	Aged care recipients per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years by locality, 30 June
Table 13A.15	Aged care recipients from a non-English speaking country, 30 June
Table 13A.16	Aged care recipients from a non-English speaking country per 1000 people from a non-English speaking country aged 70 years and over by locality, 30 June
Table 13A.17	Indigenous aged care recipients per 1000 Indigenous people aged 50 years or over and as a proportion of all recipients, 30 June
Table 13A.18	Indigenous aged care recipients per 1000 Indigenous people aged 50 years or over by locality, 30 June
Table 13A.19	Aged care recipients from special needs groups, June 2008 (per cent)
Table 13A.20	Proportion of new residents classified as concessional, assisted or supported residents, 2007-08 (per cent)
Table 13A.21	HACC services received per 1000 people aged 70 years or over plus

13.8 References

ABS (Australian Bureau of Statistics) 2003, *Australian Standard Geographic Classification*, Cat no. 1216.0, Canberra.

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