# 14 Aged care services

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| Attachment tables are identified in references throughout this chapter by a ‘14A’ prefix (for example, table 14A.1) and are available from the website https://www.pc.gov.au/research/ ongoing/report-on-government-services. |
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This chapter reports on government funded care and support services (provided at home and in residential care facilities) for older people (and their carers).

Further information on the Report on Government Services including other reported service areas, the glossary and list of abbreviations is available at https://www.pc.gov.au/ research/ongoing/report-on-government-services.

## 14.1 Profile of aged care services

### Service overview

As people age they may need care and support to maintain health, social connectedness, wellbeing and the independence to remain in their homes and communities. Forty per cent of older people reported being in need of assistance as they aged (ABS 2016). Much of the care and support for older people is provided by family members, friends or neighbours (ABS 2016). But not everyone’s care needs can be fully met through this care and support and 80 per cent of older people will access some form of government funded aged care service before death (AIHW 2015).

Government funded aged care services are provided to those who both want them and have been assessed as being in need of them. Services assist people who can no longer live without support to access appropriate care in their home, in the community or in a residential care facility. Approved aged care service providers receive government funding to provide these services and are required to meet minimum standards as well as demonstrate commitment to continuous improvement in quality of care.

### Roles and responsibilities

Regulation and policy oversight of aged care services are predominantly the role of the Australian Government. The *Aged Care Act 1997* and the accompanying Aged Care Principles are the main regulatory instruments establishing the framework for aged care services in Australia. Provisions of the Act cover service planning, user rights, eligibility for care, funding, quality assurance and accountability and other matters. There are also a number of independent statutory bodies set up under the Act that have important responsibilities in relation to aged care services: the Aged Care Complaints Commissioner, National Aged Care Advocacy Program, Australian Aged Care Quality Agency (AACQA), and the Aged Care Pricing Commissioner.

State and Territory governments are funded by the Australian Government to provide comprehensive assessment services through the day‑to‑day operation and administration of Aged Care Assessment Teams (ACAT).[[1]](#footnote-2)

The Australian Government funds residential aged care, home care and home support, with State, Territory and local governments also funding and/or delivering some of these services directly. However, most services are delivered by non‑government providers (tables 14A.10−11) such as private-for-profit, religious and charitable organisations.

The Australian Government and State and Territory governments jointly administer/fund the Transition Care and Multi-Purpose Service (MPS) programs. The Australian Government with the WA government fund Home and Community Care (HACC) services (for older and younger clients) in WA.

Government subsidises a significant[[2]](#footnote-3) portion of the cost of providing aged care, but clients and residents are expected to contribute where they can and may be charged fees and payments by service providers.

### Government expenditure

Government recurrent expenditure on aged care services was $18.4 billion in 2017-18 or $4572 per older person (table 14A.4 and figure 14.1).

| Figure 14.1 Real recurrent expenditure on aged care services per older person (2017-18 dollars)**a** |
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| a See table 14A.4 for detailed footnotes and caveats. |
| *Source*: Department of Health (unpublished); Department of Veterans’ Affairs (unpublished); State and Territory governments (unpublished); table 14A.4. |
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Residential aged care services accounted for the largest proportion of expenditure in 2017‑18 ($12.4 billion, or 67.3 per cent). Home care and home support services accounted for much of the remainder $5.1 billion) (table 14A.3).

The Australian Government provides around 97 per cent of the government funding for aged care services. State and Territory governments provide the remainder, with the largest contribution being from the WA government (table 14A.3). Further detailed expenditure data by program are contained in tables 14A.3−8.

### Size and scope of sector

#### Aged care target population

Demand for aged care services is driven by the size and health of the older population. The Australian population is ageing rapidly, with the proportion of people aged 65 years or over in the total population projected (based on 2016 Census data) to increase from 15 per cent at 30 June 2017 to between 21 and 23 per cent in 2066 (ABS 2018a). Although the Aboriginal and Torres Strait Islander population is also ageing, life expectancy at birth for Aboriginal and Torres Strait Islander people is lower when compared with the non‑Indigenous population (ABS 2018b). (Population projections for Aboriginal and Torres Strait Islander people based on the 2016 Census are not yet available.)

The aged care target population is defined as all people aged 65 years or over and Aboriginal and Torres Strait Islander Australians aged 50–64 years (this aligns with the funding arrangements as specified under the National Health Reform Agreement). This aged care target population differs from the Australian Government’s aged care ‘planning population’ of people aged 70 years or over which is used, along with the population of Aboriginal and Torres Strait Islander Australians aged 50–69 years in some cases, to allocate places under the *Aged Care Act 1997*. See section 14.4 for a definition of the aged care planning population.

#### Types of care and support

##### Home care and home support

Governments provide services to help older people remain, or return to living independently, in their homes. Carers can also access respite care through home care and home support programs:

* the Commonwealth Home Support Program (CHSP) and HACC program[[3]](#footnote-4) provide basic maintenance and support services to people in the community whose independence is at risk — services include centre‑based day care, domestic assistance and social support (tables 14A.22−23)
* a limited number of Home Care Packages[[4]](#footnote-5) are available for people requiring higher levels of help to stay at home. There are four levels of care ranging from low level care needs (Home Care Package Level 1) to high care needs (Home Care Package Level 4). Services provided under these packages are tailored to the individual and might include personal care (such as showering), support services (such as cleaning) and/or clinical care (such as nursing and allied health support). As at 30 June 2018, 91 847 people were recipients of Home Care Packages, of which 56.1 per cent received a Home Care Package Level 2 (table 14A.9)
* Department of Veterans’ Affairs (DVA) community care for eligible veterans — Veteran Home Care (VHC) services provide domestic assistance, home and garden maintenance, and respite for people with low care needs; DVA community nursing services provide acute/post‑acute support and maintenance and palliative care for people with high care needs or disability. In 2017‑18, 47 449 older veterans were approved for VHC services and 17 253 older people received community nursing services, representing 36.0 and 13.1 per cent of older eligible veterans respectively (tables 14A.7−8).

In 2017‑18, there were 830 272 older clients of home support nationally (CHSP and HACC in WA), equivalent to around 206.4 older clients per 1000 older people (figure 14.2). There were a further 128 582 older clients of Home Care Packages, equivalent to around 32.0 older clients per 1000 older people (table 14A.2).

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| Figure 14.2 Older clients of home support (CHSP, HACC) services per 1000 older people, by program, 2017-18**a, b** |
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| a See table 14A.2 for detailed footnotes and caveats. b HACC is only applicable in WA. |
| *Source*:Department of Health (unpublished); table 14A.2. |
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##### Residential care services

Residential aged care is provided in aged care homes on a permanent or respite basis. Residents receive accommodation, support (cleaning, laundry and meals) and personal care services. Those with greater needs may also receive nursing care, continence aids, basic medical and pharmaceutical supplies and therapy services.

For permanent residents, the Aged Care Funding Instrument (ACFI) is used to appraise dependency and the annual subsidy available through the Australian Government. Residents can be reappraised as their care needs change. Respite residents are not appraised under the ACFI but are classified as high or low care based on their ACAT approval.

The planning framework for services provided under the *Aged Care Act 1997* aims to keep the growth in residential aged care places[[5]](#footnote-6) in line with growth in the older population, and to ensure a balance of services across Australia, including services for people with lower levels of need and in rural and remote areas. Nationally, at 30 June 2018, the number of residential care places was 75.9 per 1000 people in the aged care planning population  
(i.e., aged 70 years or over) (table 14A.14). If the population of Aboriginal and Torres Strait Islander Australians aged 50–69 years is taken into account, the rate is 74.4 per 1000 older people. This rate is higher in major cities 79.4 compared to regional areas 66.7 and remote/very remote areas 43.0 (tables 14A.15−16).

During 2017‑18, 234 798 older people were in permanent care (58.4 per 1000 older people) and 60 278 in respite care (15.0 per 1000 older people) (figure 14.3). At 30 June 2018, the occupancy rate for residential aged care was 90.3 per cent — the lowest rate over the 10 years of reported data (table 14A.13).

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| Figure 14.3 Older permanent and respite residential aged care clients per 1000 older people, 2017-18**a** |
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| a See table 14A.2 for detailed footnotes and caveats. |
| *Source*:Department of Health (unpublished); table 14A.2. |
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##### Flexible care services

Where mainstream residential or home care services are unable to cater for an older person’s specific needs, flexible care options are available:

* Transition Care assists older people in regaining physical and psychosocial functioning following an episode of inpatient hospital care to help maximise independence and avoid premature entry to residential aged care. During 2017‑18, there were 24 340 older clients of Transition Care (table 14A.2).
* Short-term restorative care (STRC) is similar to transition care, but is provided to people who have had a setback or decline in function without having been in hospital. In 2017‑18, 1574 people aged 65 years or over received STRC services, with 274 people receiving care at 30 June 2018 (Department of Health unpublished).
* The MPS program delivers flexible and integrated health and aged care services to small rural and remote communities. At 30 June 2018, there were 3624 operational MPS program places (Department of Health unpublished).
* The National Aboriginal and Torres Strait Islander Flexible Aged Care Program provides culturally appropriate aged care to older Aboriginal and Torres Strait Islander people close to home and their communities and delivers a mix of residential and home care services. At 30 June 2018, there were 860 operational flexible places under this program (Department of Health unpublished).

#### Supporting programs

Governments fund ‘Workforce and Quality’ and ‘Ageing and Service improvement’ programs to monitor compliance with the accreditation and quality frameworks, and ensure appropriately skilled staff are available to deliver home and residential care services and to address care issues associated with a predicted rise in the prevalence of dementia. Staff providing home and residential care, and the physical environment at residential facilities, are critical to the health, safety and client experience of care and support.

The *Aged Care Act 1997* does not prescribe the qualifications required by staff nor the number of staff required to be employed by an aged care service   
(Department of Health 2017b), but accreditation standards require aged care providers and residences to employ staff with the right skills and qualifications to look after clients and residents. In 2016, 28.5 per cent of full time equivalent (FTE) direct care staff at aged care homes were either nurses or allied health professionals, down from 31.8 per cent in 2012 (Department of Health 2017a). The physical environment at residential facilities is assessed as part of ongoing accreditation processes by the AACQA (tables 14A.34–37).

#### Accessing care

##### Information services

Services such as ‘My Aged Care’ provide older people, their families and carers with information to help them access timely and appropriate care, and find approved aged care services in their local area.

##### Assessment services

An assessment of need by an ACAT (Aged Care Assessment Service in Victoria), is mandatory for admission to residential care, to receive a Home Care Package, or enter STRC or Transition Care. ACATs also make recommendations regarding the most appropriate long‑term care arrangements for clients (table 14A.30). Since 2014, approvals for care from most assessments do not lapse. Assessments for other aged care programs are conducted by other assessment services (for example, Regional Assessment Services (RAS) for CHSP).

Not everyone assessed by an ACAT is approved for care, and some people are approved for more than one type of care. In 2017‑18, there were 180 493completed ACAT assessments (equivalent to 44.9 per 1000 older people) and 234 774 approvals for residential aged care and the Home Care Package program (tables 14A.24-25). ACAT approval rates for Home Care Packages and residential aged care significantly increase with client age (table 14A.25).

##### Elapsed times — time taken from ACAT approval to access care

The time between an ACAT approval and an older person’s access to an aged care service can be influenced by a range of factors (both service- and person-related) including:

* availability of places/packages and services (which can increase waiting times)
* an older person’s:
* preference to remain at home for as long as possible, going into approved residential aged care at a later date or not at all (choosing instead to access formal home care, or support from family, friends or the community)
* need to delay entry into residential aged care due to personal circumstances, such as selling their home
* decision to reject an offer due to the cost or location.

In 2017‑18, 44.7 per cent of older people entered residential aged care within 3 months of their ACAT approval (figure 14.4); the median elapsed time was 121 days, an increase from 105 days in 2016‑17 and 84 days in 2015-16 (table 14A.26). Further data on elapsed times are included in tables 14A.26–29.

| Figure 14.4 People entering residential care within specified elapsed time periods of their ACAT approval, 2017-18**a** |
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| a See table 14A.26 for detailed definitions, footnotes and caveats. |
| *Source*:Department of Health (unpublished); table 14A.26. |
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In 2017‑18, 42.3 per cent of older people commenced Home Care within 3 months of their ACAT approval under the new Increasing Choice in Home Care arrangements which commenced 27 February 2017 (figure 14.5). Only those approved under the new arrangements are included in the 2017-18 data (accounting for around two-thirds of people commencing Home Care in 2017-18 (Department of Health unpublished)). As approval processes for clients have changed significantly under the new arrangements, reporting has been restricted to this scope for 2017-18.

| Figure 14.5 People commencing Home Care via Increasing Choice in Home Care within one or three months elapsed time of their ACAT approval, 2017-18**a** |
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| a See table 14A.26 for detailed definitions, footnotes and caveats. |
| *Source*:Department of Health (unpublished); table 14A.26. |
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## 14.2 Framework of performance indicators

The framework of performance indicators for aged care services is based on governments’ objectives for the aged care sector (box 14.1).

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| Box 14.1 Objectives for aged care services |
| The aged care system aims to promote the wellbeing and independence of older people (and their carers), by enabling them to stay in their own homes or by assisting them in residential care. Governments seek to achieve this aim by subsidising aged care services that are:   * accessible — including timely and affordable * appropriate to meet the needs of clients — person-centred, with an emphasis on integrated care, ageing in place and restorative approaches * high quality.   Governments aim for aged care services to meet these objectives in an equitable and efficient manner. |
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The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of aged care services (figure 14.6).

The performance indicator framework shows which data are complete and comparable in the 2019 Report. For data that are not considered directly comparable, text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability, data completeness and information on data quality from a Report-wide perspective. In addition to section 14.1, the Report’s statistical context chapter (chapter 2) contains data that may assist in interpreting the performance indicators presented in this chapter. Chapters 1 and 2 are available from the website at https://www.pc.gov.au/research/ongoing/report-on-government-services.

Improvements to performance reporting for aged care services are ongoing and include identifying data sources to fill gaps in reporting for performance indicators and measures, and improving the comparability and completeness of data.

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| Figure 14.6 Aged care services performance indicator framework |
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## 14.3 Key performance indicator results

Different delivery contexts, locations and types of client may affect the effectiveness and efficiency of aged care services.

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|  |  |  | Data are comparable (subject to caveats) across jurisdictions and over time. |
|  |  |  | Data are either not comparable (subject to caveats) within jurisdictions over time or are not comparable across jurisdictions or both. |

The completeness of performance indicator results are shaded in indicator interpretation boxes, figures and chapter and attachment tables as follows:

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  | Data are complete (subject to caveats) for the current reporting period. All required data are available for all jurisdictions |
|  |  |  | Data are incomplete for the current reporting period. At least some data were not available. |

### Outputs

Outputs are the services delivered (while outcomes are the impact of these services on the status of an individual or group) (see chapter 1). Output information is also critical for equitable, efficient and effective management of government services.

### Equity

#### Access – Use by different groups

‘Use by different groups’ is an indicator of governments’ objective to subsidise aged care services in an equitable manner (box 14.2).

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| Box 14.2 Use by different groups |
| ‘Use by different groups’ is defined as the proportion of service clients who are from a special needs group, compared with the proportion of the aged care target population who are from that special needs group.  The proportion of service clients from a particular special needs group should be broadly similar to the proportion of the aged care target population who are from that special needs group.  There are nine special needs groups identified by the *Aged Care Act 1997* (see section 14.4 for details). Data are reported for three special needs groups (Aboriginal and Torres Strait Islander Australians; people from Culturally and Linguistically Diverse (CALD) backgrounds; and people receiving aged care services in outer regional, remote/very remote areas. People from CALD backgrounds are defined as those born overseas from countries other than the United Kingdom, Ireland, New Zealand, Canada, South Africa and the United States of America.  Measures for veterans (including widows and widowers of veterans) and for those who are financially and socially disadvantaged are currently under development (although data are available on the proportion of all permanent residents’ care days used by financially disadvantaged residents, see table 14A.21). Data are not available for reporting on the remaining special needs groups.  Several factors should be considered when interpreting these data.   * Special needs groups may have greater need for aged care services. Compared to the rest of the population Aboriginal and Torres Strait Islander Australians have higher rates of disability, lower life expectancy and an increased likelihood of requiring aged care services at a younger age. Because of these factors, the target population for Aboriginal and Torres Strait Islander Australians is people aged 50 years or over, compared to 65 years or over for other population groups. * Cultural differences and the availability of care and support from family, friends or neighbours can also affect the use of services across different population groups. Stronger support networks can reduce the need for government funded aged care services, or for particular government funded service types.   Data reported for this indicator are:  comparable (subject to caveats) across jurisdictions and over time  complete (subject to caveats) for the current reporting period. All required 2017‑18 data are available for all jurisdictions. |
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Differences in the representation of a special needs group in services compared to their representation in the aged care target population varied across service types and groups. Nationally:

* Aboriginal and Torres Strait Islander Australians are overrepresented for low level Home Care Packages (levels 1−2), similarly represented amongst those accessing CHSP, but are underrepresented in all other service types
* people from CALD backgrounds are overrepresented amongst those accessing both low and high level Home Care Packages, but underrepresented in all other service types
* people receiving aged care services in rural and remote areas are overrepresented amongst those accessing CHSP, but underrepresented in all other service types (table 14.1).

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| Table 14.1 Representation of special needs groups in the aged care target population, compared with their representation in older clients of aged care services (per cent)**a** |
| |  |  |  | | --- | --- | --- | |  |  | Data are comparable (subject to caveats) across jurisdictions. | |  |  | Data are complete (subject to caveats) for the current reporting period. | |
| |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | NSW | Vic | Qld | WA | SA | Tas | ACT | NT | Aust | | **Aboriginal and Torres Strait Islander people** | | | | | | | | | | | *Aged care target population, June 2018* | *3.1* | *0.9* | *4.1* | *3.9* | *2.1* | *4.7* | *1.8* | *43.1* | *3.0* | | ACAT assessments, 2017‑18 | 2.5 | 0.7 | 2.2 | 1.9 | 1.4 | 1.5 | 1.3 | 34.2 | 1.9 | | Residential aged care, at 30 June 2018 | 0.9 | 0.2 | 1.5 | 1.8 | 0.5 | 0.9 | 0.4 | 36.0 | 1.0 | | Home Care Levels 1‒2, 30 June 2018 | 4.4 | 3.0 | 3.6 | 3.3 | 2.6 | 2.9 | 5.5 | 68.4 | 4.2 | | Home Care Levels 3‒4, 30 June 2018 | 3.7 | 2.0 | 3.1 | 3.1 | 2.5 | 2.6 | 2.8 | 33.8 | 3.2 | | CHSP, 2017‑18 | 3.1 | 1.6 | 3.2 | 8.9 | 2.2 | 2.3 | 1.1 | 45.4 | 2.8 | | HACC, 2017‑18 | .. | .. | .. | 3.0 | .. | .. | .. | .. | .. | | Transition Care, 30 June 2018 | 0.9 | 0.6 | 3.4 | 0.9 | 0.6 | 1.1 | – | 8.0 | 1.3 | | **CALD backgrounds** |  |  |  |  |  |  |  |  |  | | *Aged care target population, June 2016* | *26.5* | *31.1* | *12.5* | *20.8* | *19.8* | *8.0* | *25.6* | *20.9* | *23.3* | | ACAT assessments, 2017‑18 | 22.2 | 32.6 | 12.2 | 20.7 | 19.9 | 8.6 | 24.4 | 17.4 | 22.6 | | Residential aged care, 30 June 2018 | 21.2 | 25.5 | 10.5 | 17.9 | 18.1 | 6.9 | 22.1 | 14.3 | 19.5 | | Home Care Levels 1‒2, 30 June 2018 | 24.6 | 37.1 | 13.1 | 24.5 | 20.0 | 11.1 | 22.7 | 8.4 | 25.2 | | Home Care Levels 3‒4, 30 June 2018 | 26.7 | 41.3 | 15.0 | 26.1 | 22.6 | 10.8 | 25.4 | 19.8 | 26.2 | | CHSP, 2017‑18 | 21.8 | 30.4 | 11.1 | 17.9 | 20.8 | 8.5 | 27.7 | 16.5 | 21.2 | | HACC, 2017‑18 | .. | .. | .. | 20.4 | .. | .. | .. | .. | .. | | Transition Care, 30 June 2018 | 21.9 | 32.4 | 11.5 | 21.3 | 21.3 | 10.0 | 17.8 | 16.7 | 22.2 | |
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| Table 14.1(continued) |
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| |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **Rural and remote** |  |  |  |  |  |  |  |  |  | | *Aged care target population, June 2018* | *8.5* | *5.7* | *16.1* | *13.1* | *15.5* | *37.3* | *..* | *100.0* | *11.4* | | ACAT assessments, 2017‑18 | 8.3 | 6.2 | 13.2 | 10.3 | 14.7 | 29.7 | *..* | 100.0 | 10.1 | | Residential aged care, 30 June *2018* | 5.7 | 5.1 | 12.9 | 7.9 | 10.4 | 24.6 | *..* | 100.0 | 8.1 | | Home Care Levels 1‒4, 30 June *2018* | 3.7 | 4.4 | 11.8 | 8.1 | 12.6 | 14.1 | *..* | 100.0 | 7.4 | |  |  |  |  |  |  |  |  |  |  | | CHSP, 2017‑18 | 11.4 | 7.6 | 14.1 | 15.2 | 15.5 | 35.0 | *..* | 100.0 | 12.5 | | HACC, 2017‑18 | .. | .. | .. | 23.6 | .. | .. | .. | .. | .. | | Transition Care, 30 June 2018 | 4.9 | 1.5 | 9.6 | 5.0 | – | 18.1 | .. | 100.0 | 5.4 | |
| **a** See box 14.2 and tables 14A.17–19for detailed definitions, footnotes and caveats.  .. Not applicable. – Nil or rounded to zero. **b** The ACT does not have outer regional and remote/very remote areas. **c** The NT comprises only outer regional and remote/very remote areas. |
| *Source*:Department of Health (unpublished); Victorian and WA governments (unpublished); ABS, *Migration, Australia 2016-17*, data generated on 09/11/18 using ABS.Stat (http://stat.data.abs.gov.au/Index.aspx? DatasetCode=ABS\_ERP\_COB\_STATE#),tables 14A.17–19. |
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### Effectiveness

#### Access — Waiting times

‘Waiting times’ is an indicator of governments’ objective to subsidise aged care services that are accessible (box 14.3). The elapsed time between approval for care and commencement of care is reported earlier in the chapter as context.

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| Box 14.3 Waiting times |
| ‘Waiting times’ is defined as the proportion of older people who have an ACAT approval and are ready to take up care, who are able to enter residential care or commence Home Care within three months.  Higher proportions of admission to residential care or commencement of Home Care within three months are desirable.  Data for this indicator are not available. |
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#### Access – Unmet need

‘Unmet need’ is an indicator of governments’ objective of subsidising aged care services that are accessible (box 14.4).

| Box 14.4 Unmet need |
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| ‘Unmet need’ measures the need for aged care services relative to the access to services. Two measures of unmet need (one is a proxy) are reported.  Unmet need in the community  The ‘Unmet need in the community’ measure is the proportion of older people (aged 65 years or over) who were living in households and reported being in need of assistance, that also reported that their need was not fully met.  A low or decreasing proportion of people reporting their need as not fully met is desirable.  Data reported for this measure are:  comparable (subject to caveats) across jurisdictions (only one year of data are reported)  complete (subject to caveats) for the current reporting period. All required 2015 data are available for all jurisdictions.  Hospital patient days used by aged care type patients  The ‘Hospital patient days used by aged care type patients’ is a *proxy* measure of unmet need defined as the proportion of hospital patient days (for overnight separations only) that were for aged care type patients (see section 14.4 for further details).  Hospital inpatient services are geared towards shorter periods of acute care aimed at addressing serious illness or injury, or diagnosis. The needs of older people for maintenance care (particularly for extended periods of time) can be better met in residential aged care services than hospitals.  A low or decreasing proportion of patient days used by aged care type patients is desirable.  The data should be interpreted with caution, because:   * days for patients who have not completed their period of care in a hospital are not included * identification in hospital as aged care patient type may not reflect a person’s eligibility for residential care services (this is determined by an ACAT assessment) or reliably reflect access issues for residential aged care from the acute care sector — data (utilising appropriate linked hospital separations and ACAT approvals) are not available at this time * the diagnosis codes for aged care patient type may not be applied consistently across jurisdictions or over time * the denominator (all patient days for overnight separations) does not directly reflect the need for aged care services.   Data reported for this measure are:  comparable (subject to caveats) across jurisdictions and over time.  complete (subject to caveats) for the current reporting period. All required 2016-17 data are available for all jurisdictions. |
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##### Unmet need in the community

Nationally in 2015, 30.8 per cent of older people who were living in households and in need of assistance, reported that their need was not fully met (table 14A.31). The proportion was higher for those with a profound or severe disability (37.4 per cent) than for those without a disability (20.8 per cent).

##### Hospital patient days used by aged care type patients

Understanding the relationship between the aged care and health systems is of particular importance as interactions are critical for the performance of both systems. The number of operational residential aged care places can affect demand for public hospital beds, just as the number of older patients in acute and subacute care and the time they spend in hospital can affect demand for aged care services.

Nationally in 2016‑17, the proportion of all hospital patient days used by patients waiting for residential aged care was 11.4 per 1000 patient days (figure 14.7). Proportions were lower for Aboriginal and Torres Strait Islander people compared to other Australians, but higher for people from low socioeconomic areas compared to those from higher socioeconomic areas (table 14A.33). The proportion of separations for ‘aged care type’ patients[[6]](#footnote-7) waiting 35 days or longer was 11.2 per cent nationally in 2016‑17 (table 14A.32).

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| Figure 14.7 Hospital patient days used by patients waiting for residential aged care**a** |
| |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | |  |  |  | | --- | --- | --- | |  |  | Data are comparable (subject to caveats) across jurisdictions and over time. | |  |  | Data are complete (subject to caveats) for the current reporting period. | | |
| a See box 14.4 and table 14A.33 for detailed definitions, footnotes and caveats. |
| *Source*:Australian Institute of Health and Welfare (unpublished); table 14A.33. |
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#### Access – Affordability

‘Affordability’ is an indicator of governments’ objective to subsidise aged care services to make them affordable for those that need them (box 14.5).

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| Box 14.5 Affordability |
| ‘Affordability’ is defined as the out-of-pocket costs for aged care services (after subsidies) as a proportion of disposable income.  Low or decreasing out-of-pocket cost for aged care services as a proportion of disposable income represents more affordable aged care services and is desirable.  Data are not yet available for reporting against this indicator. |
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#### Appropriateness – Addressing client needs

‘Addressing client needs’ is an indicator of governments’ objective to subsidise aged care services that are appropriate to meet the needs of clients — person-centred, with an emphasis on integrated care, ageing in place and restorative approaches (box 14.6).

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| Box 14.6 Addressing client needs |
| ‘Addressing client needs’ will measure the extent to which:   * care recipients or their representatives had input into the planning of their care * the supports identified in the care planning process to address an individual’s needs were provided (match of needs) * individual interests, customs, beliefs and cultural and ethnic backgrounds were valued and fostered.   Data are not yet available for reporting against this indicator. |
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#### Quality – Compliance with service standards

‘Compliance with service standards’ is an indicator of governments’ objective to subsidise high quality aged care services (box 14.7).

| Box 14.7 Compliance with service standards |
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| ‘Compliance with service standards’ measures the extent to which approved aged care services are meeting expected standards. Measures are reported for residential care, and home care and home support.  Residential care  For residential aged care, the measure is the proportion of re-accredited facilities given  three‑year accreditation. Three years is the longest period for which re‑accreditation can be granted (in most cases), so if a service is re‑accredited for this period it implies a higher level of service quality than for those re‑accredited for a shorter period. Further information on the accreditation standards and process is available at www.aacqa.gov.au.  Data for this measure do not include 35 new facilities (1.3 per cent of all residential care facilities) that have not been re‑accredited as at 30 June 2018.  High or increasing proportions of services that are re-accredited for three years is desirable.  Data reported for this indicator are:  comparable (subject to caveats) across jurisdictions (only one year of data are reported)  complete (subject to caveats) for the current reporting period. All required June 2018 data are available for all jurisdictions.  Home care and home support  For Home care and support, the measure is the proportion of reviews that met all expected outcomes under each of the three Home Care Common Standards.   * Standard 1 — Effective management * Standard 2 — Appropriate access and service delivery * Standard 3 — Service user rights and responsibilities.   Data are reported for Australian Government Home care and support service providers combined, and separately for the WA HACC program.  High or increasing proportions of services that met all expected outcomes is desirable.  Data reported for this measure are:  comparable (subject to caveats) across jurisdictions for Australian Government home care and support providers, and over time for WA HACC services  complete (subject to caveats) for the current reporting period. All required 2017‑18 data are available for all jurisdictions. |
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As at 30 June 2018, 96.9 per cent of the 2669 re-accredited residential aged care services had been given three year accreditation (table 14A.37). During 2017‑18, 93.1 per cent of the 1561 services re-accredited were given three year accreditation status (table 14A.34), with disaggregations by remoteness and size of facility in tables 14A.35‑36.

For Australian Government home care and home support services, 24.5 per cent of the reviews scheduled to be done over the period 2017 to 2020 had been completed by 30 June 2018 (table 14A.39).

The proportions of home care and home support service providers reviewed during 2017‑18 that achieved all expected outcomes for each of the three standards are in table 14.2. Results for WA HACC services were similar (table 14A.40).

| Table 14.2 Australian Government home care and home support service providers that achieved all relevant expected outcomes, 2017‑18 (per cent)**a** |
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| |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | |  |  |  |  | | --- | --- | --- | --- | |  |  | Data are comparable (subject to caveats) across jurisdictions. | | |  |  | Data are complete (subject to caveats) for the current reporting period. | | |
| |  | NSW | Vic | Qld | WA | SA | Tas | ACT | NT | Aust | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Standard 1 | 95.5 | 96.3 | 92.2 | 91.7 | 79.3 | 92.0 | 84.6 | 81.8 | 92.3 | | Standard 2 | 95.5 | 96.9 | 97.7 | 100.0 | 82.8 | 92.0 | 92.3 | 81.8 | 94.5 | | Standard 3 | 99.1 | 99.0 | 96.9 | 100.0 | 93.1 | 100.0 | 100.0 | 81.8 | 97.3 | |
| a See box 14.7 and table 14A.39 for detailed definitions, footnotes and caveats. |
| *Source*: Australian Aged Care Quality Agency(unpublished); table 14A.39. |
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#### Quality – Adverse events

‘Adverse events’ is an indicator of governments’ objective to subsidise high quality aged care services (14.8).

| Box 14.8 Adverse events |
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| ‘Adverse events’ is defined as the number of adverse events that occur in the provision of aged care services expressed as a rate. No appropriate direct measure of adverse events in aged care is available; two potential measures have been identified for this indicator.  Low or decreasing rates of adverse events is desirable.  Adverse events in residential aged care  The National Aged Care Quality Indicator Program (NQIP) was piloted in 2015 and 2016 to report on pressure injuries, use of physical restraint and unplanned weight loss as indicators for residential facilities. The voluntary program was implemented in 2016. In October 2017 the Review of National Aged Care Quality Regulatory Processes recommended that all residential care services participate in the scheme. As NQIP data mature they may be suitable to report here, subject to developments following the Royal Commission into Aged Care Quality and Safety.  Data are not available for reporting against this measure. |
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| Box 14.8 (continued) |
| Hospital leave days from residential aged care for preventable causes  ‘Hospital leave days from residential aged care for preventable causes’ is being investigated as a proxy measure and would indicate the days that were spent out‑of‑residence due to preventable causes.  Data are not available for reporting against this measure. |
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#### Quality – Client and carer satisfaction

‘Client and carer satisfaction’ is an indicator of government’s objective to subsidise high quality aged care services (box 14.9).

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| Box 14.9 Client and carer satisfaction |
| ‘Client and carer satisfaction’ is defined by four measures:   * the proportion of people aged 65 years or over living in households, who are satisfied with the *range* of organised and formal service options available * the proportion of people aged 65 years or over living in households, who are satisfied with the *quality* of assistance received from organised and formal services in the last six months * the proportion of primary carers living in households (caring for people aged 65 years or over), who are satisfied with the *range* of formal service options available to help them in their caring role * the proportion of primary carers living in households (caring for people aged 65 years or over), who are satisfied with the *quality* of assistance received from formal services in the last six months to help them in their caring role.   A high or increasing proportion of clients and carers who are satisfied is desirable as it suggests that the service received was of a higher quality.  Data reported for this measure are:  comparable (subject to caveats) across jurisdictions and over time  complete (subject to caveats) for the current reporting period. All required 2015 data are available for all jurisdictions.  Comparability of the NT results against other jurisdictions for this indicator are affected by the scope of the Survey of Disability Ageing and Carers (SDAC) as it does not include people living in discrete Aboriginal and Torres Strait Islander communities or very remote areas. |
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Nationally in 2015, around three-quarters (76.1 per cent) of people aged 65 years or over who reported a need for, or received formal services in the previous six months, were satisfied with the *range* of services available (table 14A.42). Of people aged 65 years or over who received formal services in the previous six months, 89.2 per cent were satisfied with the *quality* of assistance they received (figure 14.8) – similar to 2012.

For primary carers of people aged 65 years or over, the proportion who were satisfied with the quality of services received to help them in their caring role was 77.2 per cent in 2015 compared to 84.7 per cent in 2012 (table 14A.43). Just under half (47.2 per cent) of primary carers were satisfied with the range of organised services available to help them in their caring role (table 14A.44) – similar to 2012.

Data disaggregated by remoteness area are available in tables 14A.45–48.

| Figure 14.8 Proportion of people aged 65 years or over who are satisfied with the quality of services receiveda |
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| a See box 14.9 and table 14A.41 for detailed definitions, footnotes and caveats. |
| *Source*: ABS (unpublished) SDAC; table 14A.41. |
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#### Quality – Complaints received

‘Complaints received’ is an indicator of governments’ objective to subsidise high quality aged care services (box 14.10).

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| Box 14.10 Complaints received |
| ‘Complaints received’ is defined as the number of in‑scope complaints received for residential aged care services per 1000 residential aged care residents (permanent and respite). Complaints within scope relate to Australian Government funded providers of residential care, Home Care, CHSP or flexible aged care services.  All else being equal, a low or decreasing rate of complaints can suggest higher quality residential care services. However, a high or increasing rate of complaints may not necessarily mean lower quality services as it may reflect more effective complaints reporting and monitoring arrangements.  Further information on the operation of the Complaints Commissioner is available at www.agedcarecomplaints.gov.au.  Data reported for this measure are:  comparable (subject to caveats) across jurisdictions and over time  complete (subject to caveats) for the current reporting period. All required 2017‑18 data are available for all jurisdictions. |
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During 2017‑18, a total of 5779 in‑scope complaints were received. Nationally, 4315 complaints were for residential care services (permanent and respite), which equated to 23.1 complaints per 1000 residential care residents (table 14A.38).

### Efficiency

#### Cost per output unit

‘Cost per output unit’ is an indicator of governments’ objective to subsidise aged care services in an efficient manner (box 14.11).

| Box 14.11 Cost per output unit |
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| ‘Cost per output unit’ is defined by two measures:   * Australian Government expenditure per ACAT assessment — Australian Government expenditure on the Aged Care Assessment Program divided by the number of completed assessments * expenditure per hour of service for CHSP/HACC — Australian and WA governments expenditure on services, divided by the number of hours of service provided.   While high or increasing cost per output unit may reflect deteriorating efficiency, it may also reflect changes in aspects of the service (such as greater time spent with clients) or differences in the characteristics of clients (such as their geographic location). Similarly, while low or declining cost per output unit may reflect improving efficiency it may also reflect declining quality (such as less time spent with clients). |
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| Box 14.11 (continued) |
| Not all expenditure is included in these measures. Expenditure by local governments and non‑government sources on services (for example, client fees for CHSP/HACC) and State and Territory governments’ contributions to the cost of ACAT assessments are not included.  Data reported for the ‘Australian Government expenditure per ACAT assessment’ measure are:  comparable (subject to caveats) across jurisdictions and over time  complete (subject to caveats) for the current reporting period. All required 2017‑18 data are available for all jurisdictions.  Data reported for the ‘expenditure per hour of service for CHSP/HACC’ measure are:  not comparable across jurisdictions, but are comparable (subject to caveats) within jurisdictions over time  complete (subject to caveats) for the current reporting period. All required 2017‑18 data were provided for all jurisdictions.  Efficiency (cost per unit) measures for residential care and home care are under development. |
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Nationally, the average Australian Government expenditure per ACAT assessment during 2017‑18 was $681(figure 14.9).

In 2017‑18, Australian and WA governments’ expenditure on CHSP and HACC services per hour was higher for nursing and allied health than for domestic assistance and personal care (table 14A.50).

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| Figure 14.9 Australian Government expenditure on aged care assessments, per assessment (2017-18 dollars)**a** |
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| a See box 14.11 and table 14A.49 for detailed definitions, footnotes and caveats. |
| *Source*:Department of Health (unpublished); table 14A.49. |
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### Outcomes

Outcomes are the impact of services on the status of an individual or group (see chapter 1).

#### Social participation in the community

‘Social participation in the community’ is an indicator of governments’ objective to encourage the wellbeing and independence of older people (box 14.12).

| Box 14.12 Social participation in the community |
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| ‘Social participation in the community’ is indicative of the wellbeing and independence of older people as defined by three measures, the estimated proportions of older people (aged 65 years or over) who:   * participated in social or community activities away from home in the last three months * had face‑to‑face contact with family or friends not living in the same household in the last week * did not leave home or did not leave home as often as they would like. |
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| Box 14.12 (continued) |
| These measures are reported by disability status (profound or severe disability, other disability, all disability, without disability) and for all older people. Disability status is used as a *proxy* to identify older people who might need more assistance to support their social participation.  High or increasing proportions of social participation in the community are desirable.  Data reported for these measures are:  comparable (subject to caveats) across jurisdictions (only one year of data is reported)  complete (subject to caveats) for the current reporting period. All required 2015 data are available for all jurisdictions.  Comparability of the NT results for this indicator are affected by the Survey of Disability Ageing and Carers (SDAC) survey instrument as it does not include data for people living in discrete Aboriginal and Torres Strait Islander communities and very remote areas. |
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Nationally in 2015:

* 93.6 per cent of older people reported having participated in social or community activities away from home in the last three months; the proportion was lower for older people with profound or severe disability (82.9 per cent) compared to those without disability (95.9 per cent) (table 14A.51)
* 77.4 per cent of older people reported having face‑to‑face contact with family or friends that were not living in the same household in the last week; the proportion was lower for older people with profound or severe disability (74.5 per cent) compared to those without disability (78.4 per cent) (table 14A.52)
* 14.5 per cent of older people reported they did not leave home or did not leave home as often as they would like; the proportion was higher for older people with profound or severe disability (45.6 per cent) compared to those without disability (6.5 per cent) (table 14A.53).

#### Enabling people with care needs to live in the community

‘Enabling people with care needs to live in the community’ is an indicator of governments’ objective to promote the wellbeing and independence of older people, by enabling them to stay in their own homes (box 14.13).

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| Box 14.13 Enabling people with care needs to live in the community |
| Enabling people with care needs to live in the community’ is defined as proportion of older people with care needs who are living in the community.  An increasing proportion of older people with care needs who are living in the community is desirable, where the older person wants to and their health and wellbeing are not compromised. This indicator should be considered alongside the outcome indicator on social participation.  Data are not yet available for reporting against this indicator. |
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#### Maintenance of individual function

‘Maintenance of individual function’ is an indicator of governments’ objective for aged care services to promote the wellbeing and independence of older people (box 14.14).

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| Box 14.14 Maintenance of individual function |
| ‘Maintenance of individual function’ is defined as the improvement in the level of physical function for Transition Care Program (TCP) clients from entry to exit, measured as the difference between the average Modified Barthel Index (MBI) score on TCP entry and exit.  An increase in the score from entry to exit is desirable.  The MBI is a measure of functioning ranging from 0 (fully dependent) to 100 (fully independent). Data are reported for recipients who completed a TCP episode only. See section 14.4 for details on the TCP.  This indicator needs to be interpreted with caution. The TCP operates with some differences across jurisdictions including differences in health and aged care service systems, local operating procedures and client groups. Variation in the average MBI scores on entry and exit from the program may reflect differences in client groups for the program across jurisdictions.  The TCP is a small program only available directly upon discharge from hospital (in 2017-18 there were 24 778 admissions to TCP (table 14A.54). The average duration of care is around 8.5 weeks, with a maximum duration of 12 weeks (may be extended by a further 6 weeks in some circumstances).  Data reported for this indicator are:  comparable (subject to caveats) across jurisdictions and over time  complete (subject to caveats) for the current reporting period. All required 2017-18 data are available for all jurisdictions. |
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Nationally in 2017‑18, the average MBI score for TCP clients improved from entry (70) to exit (81) (figure 14.10) – similar to scores over the last 10 years. At the jurisdictional level there is greater variability (table 14A.54).

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| Figure 14.10 TCP — average MBI score on entry and exit, 2017‑18**a** |
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| a See box 14.14 and table 14A.54 for detailed definitions, footnotes and caveats. |
| *Source*: Department of Health (unpublished); table 14A.54. |
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#### Wellbeing and independence in residential care

‘Wellbeing and independence in residential care’ is an indicator of governments’ objective to promote the wellbeing and independence of older people, by assisting them in residential care (box 14.15).

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| Box 14.15 Wellbeing and independence in residential care |
| ‘Wellbeing and independence in residential care’ is defined as the proportion of older people in residential aged care assessed as having a high quality of life. Quality of life is the degree to which an individual resident’s wellbeing meets their personal expectations and those of their carers.  A high or increasing proportion of older people in residential aged care with high quality of life is desirable.  Data are not yet available for reporting against this indicator. |
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## 14.4 Definitions of key terms

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| **Accreditation** | Accreditation is a key component of the Australian Government’s quality framework for federally funded residential aged care and is a quality assurance system for residential aged care services — based on the principle of continuous improvement.  Accreditation requires assessment against the 44 expected outcomes used for accreditation assessment — grouped into four standards: management systems, staffing and organisational development; health and personal care; residential lifestyle; and physical environment and safety systems. |
| **Aged care** | Services funded and/or provided by governments that respond to the functional and social needs of older people, and the needs of their carers. Home care and home support services aim to optimise independence and to assist older people to stay in their own homes, while residential care services provide accommodation and care for those who can no longer be cared for 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. |
| **Aged care target population** | The Aged Care target population is defined as all people (Aboriginal and Torres Strait Islander and non‑Indigenous) aged 65 years or over and Aboriginal and Torres Strait Islander Australians aged 50–64 years. This is the population within the scope of, and funded for services under, the national aged care system (except in WA). |
| **Aged care type patient (unmet need indicator)** | Aged care type patients are those who are waiting for residential aged care where the care type is *Maintenance*, a diagnosis was reported as *Person awaiting admission to residential aged care service* and the separation mode was not *Other (includes discharge to place of usual residence)*. Includes overnight separations only. |
| **Aged care planning population** | The Aged care planning population is defined as people aged 70 years or over. This is the population used by the Australian Government for its needs‑based planning framework to ensure sufficient supply of both places by matching the growth in the number of aged care places with growth in the aged population. It also seeks to ensure balance in the provision of services between metropolitan, regional, rural and remote areas, as well as between people needing differing levels of care.  Under the framework, the Australian Government seeks to achieve and maintain a specified national provision level of subsidised operational aged care places for every 1000 people aged 70 years or over. This provision level is known as the aged care provision ratio (DoHA 2012). |
| **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. |
| **Capital expenditure on residential services** | Expenditure on building and other capital items, specifically for the provision of Australian Government funded residential aged care. |
| **Care leaver** | A care leaver is a person who was in institutional care (such as an orphanage or mental health facility) or other form of out‑of‑home care, including foster care, as a child or youth (or both) at some time during their lifetime (DoHA 2012). |
| **Centre day care** | Respite care provided from a facility such as a day care or health centre. Respite care is usually combined with social support services to maintain the functional capabilities of the person receiving care. |
| **Complaint** | A complaint by the affected care recipient or his or her representative, or anyone else, to the Complaints Commissioner about matters relevant to an approved provider’s responsibilities under the *Aged Care Act 1997* or the Aged Care Principles. |
| **Disability** | In the ABS SDAC 2015, a person has a disability if they report they have a limitation, restriction or impairment, which has lasted, or is likely to last, for at least six months and restricts everyday activities. This includes: loss of sight (not corrected by glasses or contact lenses); loss of hearing where communication is restricted, or an aid to assist with, or substitute for, hearing is used; speech difficulties; shortness of breath or breathing difficulties causing restriction; chronic or recurrent pain or discomfort causing restriction; blackouts, seizures, or loss of consciousness; difficulty learning or understanding; incomplete use of arms or fingers; difficulty gripping or holding things; incomplete use of feet or legs; nervous or emotional condition causing restriction; restriction in physical activities or in doing physical work; disfigurement or deformity; mental illness or condition requiring help or supervision; long term effects of head injury, stroke or other brain damage causing restriction; receiving treatment or medication for any other long term conditions or ailments and still being restricted and any other long term conditions resulting in a restriction. |
| **Elapsed time** | The measure of the time elapsed between an ACAT approval and entry into a residential care service or commencement of Home Care. |
| **Home Care Common Standards** | Standard 1 — Effective management — the service provider demonstrates effective management processes based on a continuous improvement approach to service management, planning and delivery.  Standard 2 — Appropriate access and service delivery — each service user (and prospective service user) has access to services, and service users receive appropriate services that are planned, delivered and evaluated in partnership with themselves and/or their representatives.  Standard 3 — Service user rights and responsibilities — each service user (and/or their representative) is provided with information to assist them to make service choices and has the right (and responsibility) to be consulted and respected. Service users (and/or their representative) have access to complaints and advocacy information and processes and their privacy and confidentiality and right to independence is respected. |
| **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 profound, severe and moderate disability** | A person with a profound disability is unable to do, or always needs help with, a core activity task.  A person with a severe disability: sometimes needs help with a core activity task, and/or has difficulty understanding or being understood by family or friends, or can communicate more easily using sign language or other non‑spoken forms of communication.  A person with a moderate disability needs no help, but has difficulty with a core activity task. |
| **Older people** | All people (Aboriginal and Torres Strait Islander and non‑Indigenous) aged 65 years or over and Aboriginal and Torres Strait Islander Australians aged  50–64 years. |
| **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). |
| **Primary carer** | In the ABS SDAC, a primary carer is defined as a person who provides the most informal assistance, in terms of help or supervision, to a person with disability with one or more of the core activities of mobility, self care or communication. The assistance has to be ongoing, or likely to be ongoing, for at least six months.  Where the primary carer has more than one recipient of care, the main recipient of care is the one receiving the most help or supervision. A sole recipient is also classed as a main recipient.  Where the care recipient lives in the same household, the assistance is for one or more of the following core and non‑core activities (cognition/emotion, communication, health care, household chores, meal preparation, mobility, property maintenance, reading or writing, self care, transport (ABS 2016). |
| **Respite care** | Alternative care arrangements for dependent people living in the community, with the primary purpose of giving a carer or a care recipient a short term break from their usual care arrangement. |
| **Special needs groups** | Section 11‑3 of the *Aged Care Act 1997*, specifies the following people as people with special needs: people from Aboriginal and Torres Strait Islander communities; people from culturally and linguistically diverse backgrounds; veterans; people who live in rural or remote areas; people who are financially or socially disadvantaged; people who are homeless or at risk of becoming homeless; care‑leavers; parents separated from their children by forced adoption or removal; and lesbian, gay, bisexual, transgender and intersex people. |
| **Veterans** | Veterans, war widows, widowers and dependants who hold a Repatriation Health Card and are entitled to health services and treatment under the *Veterans’ Entitlements Act 1986 (VEA), Safety, Rehabilitation and* *Compensation Act 1988 (SRCA)* or the *Military Rehabilitation and Compensation Act 2004 (MRCA)*. |

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DoHA (the former Department of Health and Ageing) 2012, *2011‑2012* *Report on the Operation of the Aged Care Act 1997,* Canberra, www.health.gov.au/internet/main/ publishing.nsf/Content/ageing reports acarep 2012.htm (accessed 10 December 2012).

1. While ACAT undertake comprehensive assessment for services under the Aged Care Act, lower entry-level services needs are assessed by Australian Government funded Regional Assessment Services (RAS). An ACAT is referred to as an Aged Care Assessment Service in Victoria. [↑](#footnote-ref-2)
2. In 2015-16, the Commonwealth Government contribution to aged care of $12.9 billion\* covered approximately 75 per cent of total expenditure in the aged care sector (\*excludes CHSP and HACC contribution of $2.2 billion) (Aged Care Financing Authority 2017). [↑](#footnote-ref-3)
3. The CHSP now operates fully in all states and territories, except for WA (transition to occur from 1 July 2018) where similar levels of home support to the community are provided through some CHSP services and the HACC program. [↑](#footnote-ref-4)
4. From 27 February 2017, Home Care Packages are attached to consumers and allocated according to consumer need (rather than being allocated to providers on the basis of assumed need). [↑](#footnote-ref-5)
5. Up until February 2017, Home care places were also allocated under this framework. Under the Increasing Choices initiative introduced 27 February 2017, Home Care Packages are allocated to consumers rather than providers (consumers then choose a provider). At the same time, short-term restorative care places were introduced and are important in ensuring access to services across geographic locations. [↑](#footnote-ref-6)
6. Scope of these aged care type patients is slightly different to that defined for the indicator. See table 14A.32 for details. [↑](#footnote-ref-7)