12 Aged care services

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

- residential services, which provide high care, low care and residential respite care (box 12.1)
- community care services, which include Home and Community Care (HACC) program services, Community Aged Care Packages (CACPs), the Extended Aged Care at Home (EACH) program and Veterans' Home Care (VHC)[1]
- respite services, which include HACC respite and centre-based day care and the National Respite for Carers Program (NRCP)
- assessment services, which are largely provided by Aged Care Assessment Teams (ACATs).

A profile of aged care services appears in section 12.1. A framework of performance indicators is outlined in section 12.2 and key performance results are discussed in section 12.3. Future directions in performance reporting are discussed in section 12.4. Jurisdictions' comments are reported in section 12.5. Section 12.6 contains a discussion of age standardisation of aged care data, and definitions for data and indicators are provided in section 12.7.

A number of additions and improvements have been made to the chapter this year:

- Reporting on access has been augmented with the addition of data on Indigenous people's access to Commonwealth Carelink Centres.
- New data are available for the indicator 'unmet need' from the Australian Bureau of Statistics (ABS) 2003 Survey of Disability, Ageing and Carers. (This survey is conducted every five years.)

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

- The indicator 'intensity of care' has been expanded to incorporate information on the impact of ageing in place on the residential care sector as a whole.
- Payroll tax on residential aged care has been separately identified in expenditure data for 2003-04.
- New outcome indicators have been identified and included in the performance indicator framework. Further development work is required, however, before data for these indicators can be reported.
- In the profile, experimental estimates of State and Territory expenditure on residential aged care services have been included.

Older Australians also use other government services covered in this Report, including disability services (see chapter 13), specialised mental health services (see chapter 11), public housing (see chapter 16) and services across the full spectrum of the health system (see the Health preface and chapters 9–11). There are also interactions among these services that are likely to affect performance results in this Report — for example, between residential aged care and public hospital services, the number of operational residential places may affect demand for public hospital beds, and changes in service delivery in the public hospitals sector may affect demand for residential aged care.

Supporting tables

Supporting tables for chapter 12 are provided on the CD-ROM enclosed with the Report. The files are provided in Microsoft Excel format as \Publications\Reports\2005\Attach12A.xls and in Adobe PDF format as \Publications\Reports\2005\Attach12A.pdf.

Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 12A.3 is table 3 in the electronic files). These files can be found on the Review web page (www.pc.gov.au/gsp). Users without Internet access can contact the Secretariat to obtain these tables (see details on the inside front cover of the Report).

Box 12.1 **Interpreting residential aged care data**

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

- *Residential services data*. This chapter groups residential services for reporting purposes based on the eight level Resident Classification Scale (RCS) profile of their clients.
  - Aged care homes with 80 per cent or more residents classified as RCS 1–4 are described as high care services.
  - Aged care homes with 80 per cent or more residents classified as RCS 5–8 are described as low care services.
  - A service that is not high care or low care as defined above is called a mixed service.

  These categories have been used for descriptive purposes and do not have any legal foundation under the *Aged Care Act 1997* (Cwlth). Similarly, the choice of 80 per cent as a cut-off is arbitrary but considered appropriate for descriptive purposes.
- *Resident data*. This chapter classifies clients as high care or low care based on their RCS assessment. High care residents have been assessed as RCS levels 1–4, and low care residents have been assessed as RCS levels 5–8.
- *Place data*. Part 2.2 of the Aged Care Act details the processes for planning and allocating subsidised services to meet residential aged care needs and community care needs. Planning is based on a national formula for people aged 70 years or over for high and low care. High care places are planned to meet the needs of residents with care needs equivalent to RCS levels 1–4. Low care places are planned to meet the needs of residents with care needs equivalent to RCS levels 5–8.

  Although there must be a needs match between residents entering vacant places (that is, vacant low care places should usually be filled by low care residents), this can change over time with 'ageing in place', which allows a low care resident who becomes high care within the same service to occupy a low care place until he or she is discharged.
- *Locality data.* Geographic data are based on the ABS Australian standard geographic classification of remoteness areas (ABS 2003). Data are classified according to an index of remoteness that rates each ABS Census district based on the number and size of towns, and the distance to major towns and urban centres.

12.1 Profile of aged care services

Service overview

Services for older people are provided on the basis of the frailty or functional disability of the recipients rather than specific age criteria. Nevertheless, without more specific information, this Report uses people aged 70 years or over as a proxy for the likelihood of a person in the general population requiring these services. Certain groups (notably Indigenous people) may require various services at a younger age. For Indigenous people, those aged 50 years or over are used as a proxy for the likelihood of requiring aged care services. The Australian Government also uses these age proxies for planning the allocation of residential care, CACPs and EACH packages.

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

Roles and responsibilities

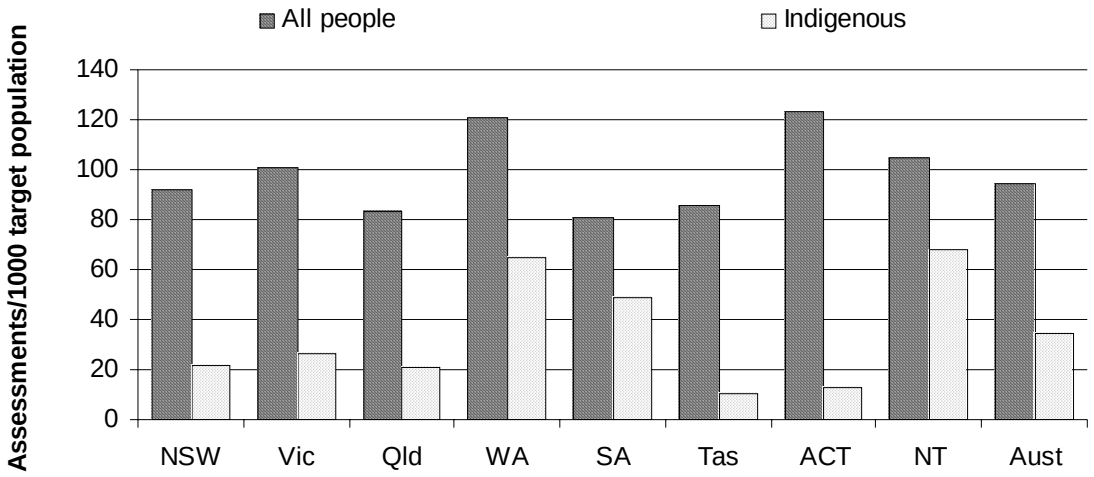
Assessment services

The Australian Government established the Aged Care Assessment Program (ACAP) in 1984, based on the assessment processes used by State and Territory health services to determine (1) eligibility for admission into residential care and (2) the level of care required (and thus the subsidy paid to such services). The core objective of the ACAP is to assess the needs of frail older people and recommend appropriate services. Assessment and recommendation by ACATs are mandatory for admission to residential care or receipt of a CACP or an EACH package. People may also be referred by ACATs to other services, such as those funded by the HACC program. An ACAT referral is not mandatory for receipt of other services, such as HACC and VHC services.

State and Territory governments are responsible for the day-to-day operation and administration of the ACAP and provide the necessary accommodation and support services. The role and scope of the teams differs across and within jurisdictions, however, partly reflecting the service location (for example, whether the team is attached to a residential service, a hospital or a community service).

The number of assessments per 1000 target population varied across jurisdictions in 2002-03. The ACT had the highest number of assessments of people aged 70 years or over per 1000 people aged 70 years or over (122.9) and the lowest rate of assessment was in SA (81.2). The NT had the highest rate of assessments for Indigenous people aged 50 years or over per 1000 Indigenous people aged 50 years or over (68.2) in 2002-03, and Tasmania had the lowest rate (10.6) (figure 12.1).

Figure 12.1 **Aged Care Assessment Team assessment rates, 2002-03[a, b, c]**



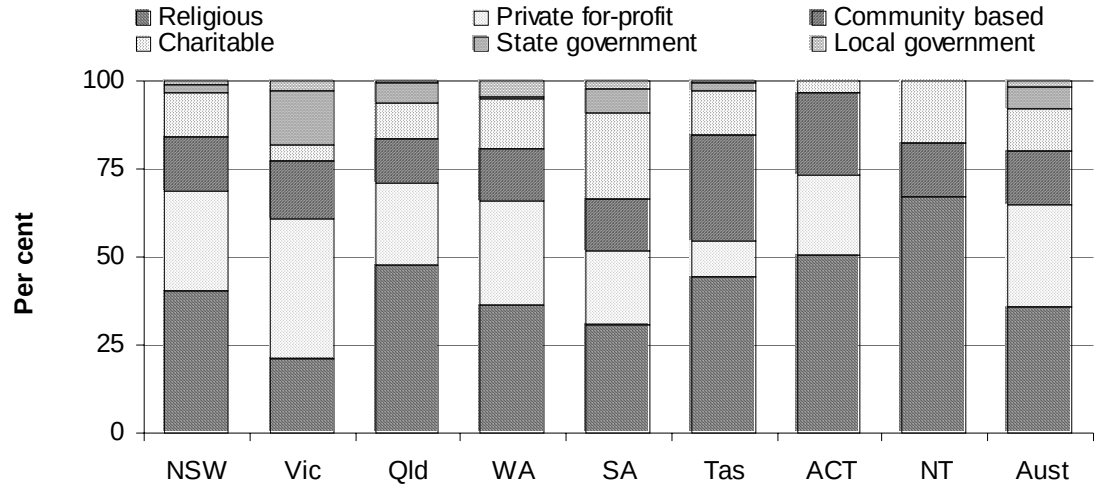
a Includes ACAT assessments for all services. **b** 'All people' includes all assessments of people aged 70 years or over per 1000 people aged 70 years or over. **c** 'Indigenous' includes all assessments of Indigenous people aged 50 or over per 1000 Indigenous people aged 50 years or over.

Source: Lincoln Centre for Ageing and Community Care Research (2004); table 12A.39.

Residential care services

Religious and private for-profit organisations were the main providers of residential care at June 2004, accounting for 35.7 per cent and 29.4 per cent respectively of all subsidised residential aged care places. Community-based organisations and not-for-profit charitable organisations accounted for a further 15.3 per cent and 11.4 per cent respectively. State, Territory and local governments provided the remaining 8.2 per cent (figure 12.2).

Figure 12.2 **Ownership of residential places, June 2004[a, b]**



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

Source: Department of Health and Ageing (DHA) (unpublished); table 12A.4.

The Australian Government is responsible for most of the regulation of Australian Government subsidised residential aged care services, including accreditation of the service and certification of the standard of the facilities. State, Territory and local governments also have a regulatory role in areas such as determining staffing and industrial awards, and monitoring compliance with building and fire safety regulations (box 12.2).

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 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.

Box 12.2 **Examples of regulatory arrangements for residential services**

The Australian Government controls the number of subsidised places. A target of 40 high care places, 50 low care places and 10 community care places (CACPs and EACH packages) per 1000 people aged 70 years or over applies to the data in this Report.

In May 2004, following a recommendation of the Review of Pricing Arrangements in Residential Aged Care, the Australian Government adopted a new ratio of 108 places for each 1000 people in the population aged 70 years or over. Of the 108 places, 88 are residential care places and 20 are community care places.

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

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

Flexibly funded services

Flexible care addresses the needs of care recipients in ways other than the care provided through mainstream residential and community care. Three types of flexible care are currently provided for under the Aged Care Act: EACH packages, Innovative Care places and Multipurpose Service program places. In addition, flexible models of care are provided under the National Aboriginal and Torres Strait Islander Aged Care Strategy (see below).

- The Multipurpose Service program supports the integration and provision of health and aged care services for small rural and remote communities. Nationally, the number of Multipurpose Services increased from 83 in June 2003 to 88 in June 2004.

- The Aged Care Innovative Pool provides flexible care subsidies for alternative care options. Nationally, there were 1351 Innovative Pool places at 30 June 2004.
- The EACH program provides high level aged care to people in their own homes, complementing CACPs, which provide low level care. There were 858 operational EACH places at 30 June 2004.

Indigenous-specific services

Under the Aged Care Act, 29 Indigenous aged care services are funded, providing approximately 700 places. Most of these places are available in Indigenous-specific aged care services, but some are available in aged care services catering to the broader community. In addition, 599 flexibly funded aged care places were provided at 30 June 2004 through the National Aboriginal and Torres Strait Islander Aged Care Strategy, often in remote areas where no aged care services are otherwise available. Services delivered under the strategy are outside the Aged Care Act.

The Australian Government actively targets community aged care places to Indigenous communities and contracts Aboriginal Hostels Ltd to provide ongoing assistance to ensure services in rural and remote areas remain viable.

Funding

Assessment services

The Australian Government provided grants to State and Territory governments to operate 119 ACATs (at 30 June 2004) and evaluation units. In 2003-04, the Australian Government provided funding of $47.1 million nationally for aged care assessment (table 12A.49). Expenditure per person aged 70 years or over, (plus per Indigenous person aged 50–69 years) was markedly higher in the NT ($82) than in the other jurisdictions where expenditure ranged from $23 to $25 per person during 2003-04 (table 12A.50). Some states and territories also contribute funding for ACATs.

Residential care services

The Australian Government provides the majority of annual funding for residential aged care services — $4.6 billion in 2003-04 (table 12A.45 and 12A.47). State and Territory governments also provide some funding for public sector beds. Residents

provide most of the remainder of service revenue, with some income derived from charitable sources and donations.

Experimental estimates of State and Territory government expenditure have been collected for some states and territories for the first time in this Report, for three categories (table 12.1). The categories are defined in section 12.7. The data definitions need further development, so comparisons across jurisdictions need to be made with care.

Table 12.1 **Experimental estimates of State and Territory government expenditure on residential aged care ($ million)**

	NSW	*Vic*[a]	*Qld*[b]	*WA*[c]	*SA*	*Tas*[d]	*ACT*	*NT*	*Total*
Adjusted subsidy reduction supplement	1.3	20.6	6.0	2.1	na	1.5	..	na	31.5
EBA supplement	..	30.4	14.7	na	na	..	..	na	45.1
Rural small nursing home supplement	na	3.4	na	2.4	na	8.0	..	na	13.8

EBA = enterprise bargaining agreement. **a** Victorian data are for 2002-03 for the adjusted subsidy reduction supplement, for the EBA supplement for 2003-04 and for 2003-04 rural small nursing home supplement. The EBA supplement includes $30.4 million in respect of generic aged care places, plus an amount of up to $5.0 million that could be determined for specialist mental health services. **b** Queensland Health's supplementation of $14.7 million to its 20 residential aged care facilities recognises the extra costs associated with public sector EBA, the different classification systems in place, and staffing numbers. **c** WA data are for 2002-03. **d** Tasmanian data are for 2003-04. **na** Not available. **..** Not applicable.

Source: State and Territory governments (unpublished).

The Australian Government annual RCS subsidy for each occupied place varies according to the client's level of dependency. At June 2004, the average RCS subsidy per residential place was $28 604 nationally. Across jurisdictions, it ranged from $30 075 in Tasmania to $27 712 in NT (table 12.2). Variations in average annual subsidies reflect differences in subsidy rates as well as differences in the dependency of residents. Low care subsidy rates (RCS levels 5–8) are the same in all states and territories. High care subsidy rates (RCS levels 1–4) are being adjusted towards a uniform national rate by July 2006, under the Australian Government's Funding Equalisation and Assistance Package.

The combined number of operational high care and low care residential places per 1000 people aged 70 years or over at June 2004 ranged from 110.0 in the NT to 73.9 in the ACT. There were proportionally more high care places in the NT (57.8 per cent), while the ACT had proportionally more low care places (59.1 per cent) (table 12.3). In all jurisdictions except the NT, the proportion of low care places relative to high care places rose between 2000 and 2004 (table 12A.10).

Table 12.2 **Average annual Australian Government RCS subsidy per occupied place, and the dependency level of aged care residents, June 2004**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Average annual Australian Government RCS subsidy per residential place[a]										
All RCS levels	$	28 518	29 617	29 442	27 979	28 829	30 075	27 718	27 712	28 604
Proportion of high care residents[b]										
RCS 1	%	22.0	24.3	17.9	23.9	22.0	16.6	27.1	14.9	21.9
RCS 2	%	26.8	21.5	24.8	20.2	25.5	28.0	19.8	34.2	24.4
RCS 3	%	14.3	11.9	17.8	12.2	15.5	20.7	13.5	18.8	14.5
RCS 4	%	4.4	4.2	5.9	4.9	4.4	6.2	5.4	6.8	4.7
Proportion of low care residents										
RCS 5	%	10.8	14.1	10.8	14.7	11.6	10.0	10.1	6.8	12.0
RCS 6	%	9.8	11.8	9.9	12.7	9.9	8.9	11.7	5.0	10.6
RCS 7	%	10.9	11.6	11.7	10.5	10.5	9.3	11.5	12.0	11.1
RCS 8	%	0.9	0.6	1.1	0.8	0.7	0.3	0.9	1.6	0.8

a Includes only subsidies based on the RCS. Average Australian Government payments, including subsidies and supplements totalled $41 518 per high care resident (RCS 1–4) and $14 217 per low care resident (RCS 5–8). **b** Differences in average annual subsidies reflect differences in subsidy rates as well as differences in the dependency of residents.

Source: DHA (unpublished); table 12A.5.

Table 12.3 **Operational high care and low care residential places, 30 June 2004[a, b]**

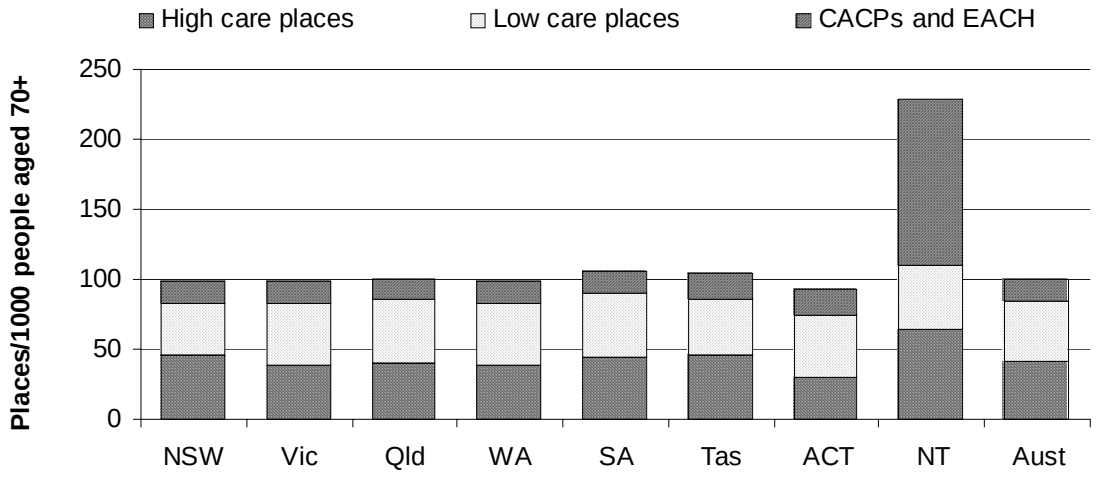
	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Number of places per 1000 people aged 70 years or over										
High care places	no.	45.2	38.0	39.8	38.2	44.2	45.4	30.2	63.6	41.6
Low care places	no.	37.7	44.5	46.0	45.2	45.2	41.0	43.7	46.4	42.4
Total places	**no.**	**82.9**	**82.5**	**85.8**	**83.4**	**89.4**	**86.4**	**73.9**	**110.0**	**84.0**
Proportion of places										
High care places	%	54.5	46.1	46.4	45.8	49.4	52.5	40.9	57.8	49.5
Low care places	%	45.5	53.9	53.6	54.2	50.6	47.5	59.1	42.2	50.5

a Excludes places that have been 'approved' but are not yet operational. Includes multipurpose and flexible services attributed as high care and low care places. **b** For this Report, Australian Government planning targets are based on providing 100 places per 1000 people aged 70 years or over. In recognition of poorer health among Indigenous communities, however, planning in some cases also takes account of the Indigenous population aged 50–69 years. This means that the provision ratio based on the population aged 70 years or over will appear high in areas with a high Indigenous population (such as the NT).

Source: DHA (unpublished); table 12A.10.

Figure 12.3 shows the combined number of high care residential places, low care residential places, CACPs and EACH packages. Box 12.2 sets out the Australian Government's targets for the provision of residential places, CACPs and EACH packages.

Figure 12.3 **Operational residential places, CACPs and EACH packages per 1000 people aged 70 years or over, 30 June 2004[a, b, c, d]**



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 100 places per 1000 people aged 70 years or over. However, in recognition of poorer health among Indigenous communities, planning in some cases also takes account of the Indigenous population aged 50–69 years. This means that the provision ratio based on the population aged 70 years or over will appear high in areas with a high Indigenous population (such as the NT). **d** CACPs and EACH packages are not residential services but are included in the Australian Government planning targets (see boxes 12.1 and 12.2 for an interpretation of residential care data and Australian Government planning targets).

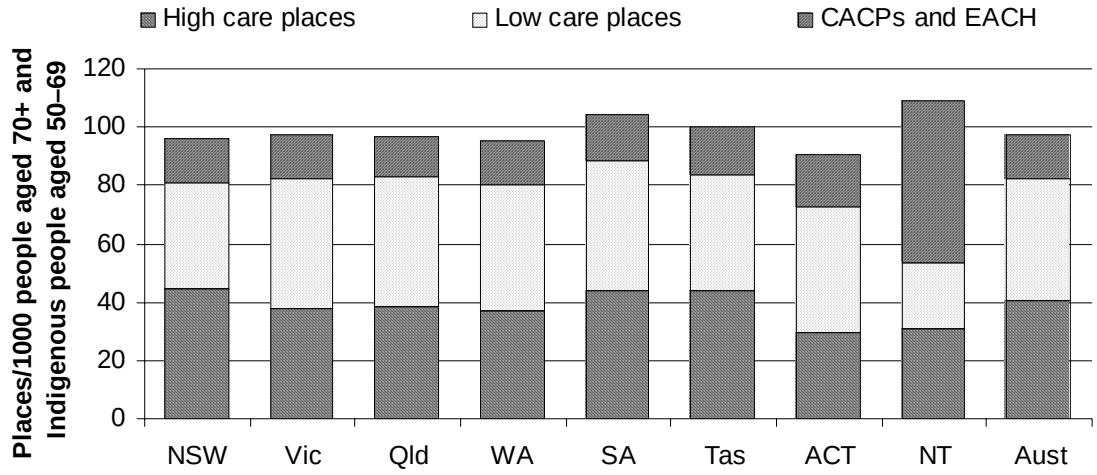
Source: DHA (unpublished); table 12A.10.

The number of operational places can also be shown using a target population that incorporates Indigenous 50–69 year olds (figure 12.4). Use of this 'adjusted' target population has a noticeable effect on the NT, which has a large proportion of Indigenous people.

Community care services

Total national expenditure on HACC was $1.2 billion in 2003-04 — consisting of $732.4 million from the Australian Government and $471.3 million from the State and Territory governments. The Australian Government contributed 60.8 per cent, while State and Territory governments funded the remainder (table 12A.46). Recipients may also contribute towards the cost of their care.

Figure 12.4 **Operational residential places, CACPs and EACH packages per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years, 30 June 2004[a, b, c, d]**



a Places do not include those that have been approved but are not yet operational. **b** 'Ageing in place' may result in some low care places being filled by high care residents. **c** CACPs and EACH packages are not residential services but are included in the Australian Government planning targets (see boxes 12.1 and 12.2 for an interpretation of residential care data and Australian Government planning targets). **d** CACPs provide a more flexible model of care more suitable to remote Indigenous communities, so areas with a high Indigenous population (such as the NT) may have a higher proportion of CACPs.

Source: DHA (unpublished); table 12A.11.

The NRCP provides community care services and is funded by the Australian Government. Expenditure on this program was $99.7 million in 2003-04 (table 12A.49). The Department of Veterans' Affairs (DVA) also provided $72.9 million for the VHC program during 2003-04 (table 12A.48), which does not include expenditure for in-home and emergency respite home care.

The Australian Government funds the CACP and EACH programs, spending $307.9 million and $15.5 million respectively on the programs in 2003-04 (table 12A.49). CACPs and EACH packages are also part funded by client contributions. Australian Government expenditure data on a range of other community care programs targeting older people are contained in tables 12A.49 and 12A.50.

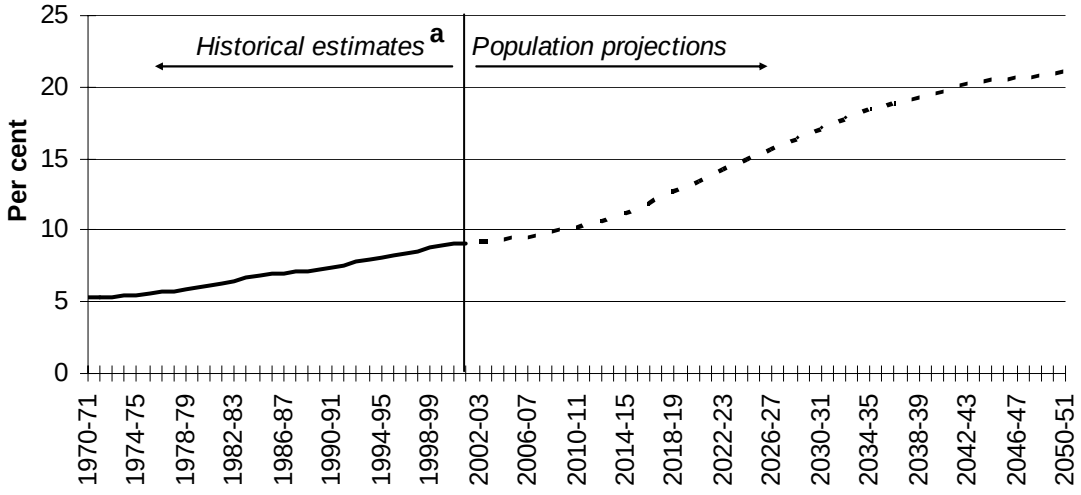
Size and scope of sector

Size and growth of the older population

The Australian population is ageing, as indicated by an increase in the proportion of people aged 70 years or over in the total population. This trend is expected to continue, and the proportion of older people is expected to increase dramatically in the 21st century (figure 12.5). The distribution of older people, however, varies across jurisdictions. At June 2004, SA recorded the highest proportion of older people (11.1 per cent), while the NT recorded the lowest (2.4 per cent) (figure 12.6). Higher life expectancy for females was reflected in all jurisdictions having a higher proportion of older females than older males.

Demographic profiles affect the demand for aged care services because females use aged care services (particularly residential services) more than males do. 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 are less likely to have a partner to provide care.

Figure 12.5 **Persons aged 70 years or over as a proportion of the total population**



a Historical estimates are based on the ABS Census of Population and Housing that is held at five year intervals.

Source: ABS (unpublished) Cat. no. 3201.0; ABS (unpublished) Cat. no. 3202.0.

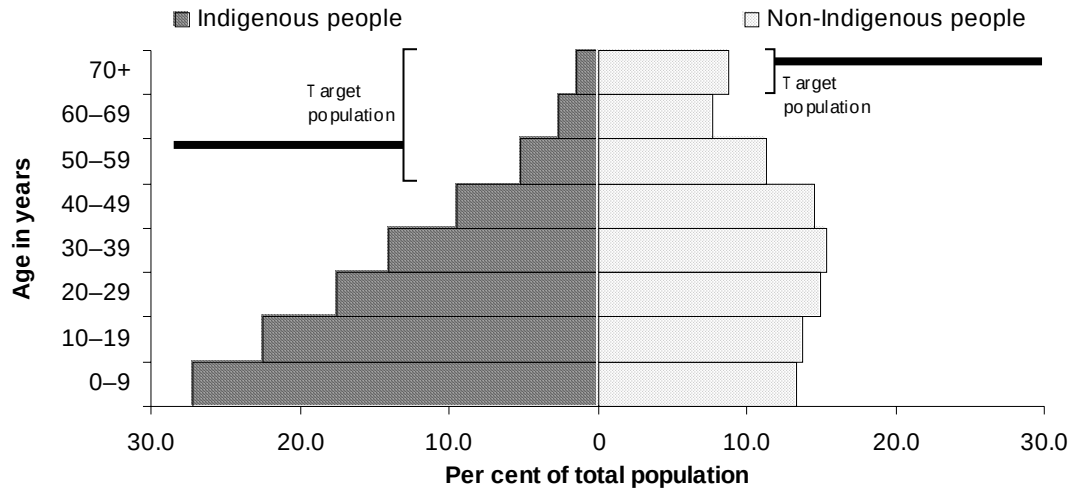
Figure 12.6 **Estimated proportion of population aged 70 years or over, by gender, June 2004**

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

Characteristics of older Indigenous people

The ABS estimated that about 50 800 Indigenous people were aged 50 years or more in Australia at 30 June 2004. The majority were located in NSW (30.9 per cent), Queensland (26.6 per cent), WA (14.6 per cent) and the NT (11.8 per cent) (table 12A.2). Although the Indigenous population is also ageing, there are marked differences in the age profile of Indigenous Australians compared with the non-Indigenous population (figure 12.7). Previous ABS estimates of the life expectancy of Indigenous males and females for June 2001 suggested it was nearly 20 years below that recorded for the total Australian population. (New methodology recently adopted by the ABS has led to revisions of these estimates — see the Health preface.) In any case, Indigenous people are likely to need aged care services earlier in life, compared with the general population.

Figure 12.7 **Age profile and target population differences between Indigenous and other Australians, June 2001**



Source: ABS (2001 and unpublished).

Residential care services

The size and location of residential services — which may influence the costs of service delivery — vary across jurisdictions. Nationally, there were approximately 153 963 operational places (permanent and respite) in residential care services (70 955 in predominantly high care services, 31 600 in predominantly low care services and 51 408 in services with a mix of high care and low care residents) at June 2004 (tables 12A.6, 12A.7, 12A.8 and 12A.9).

As the trend towards 'ageing in place' (box 12.3) increases, there has been a steady increase in the number of services categorised as services providing a mix of high care and low care places. In June 2000, 15.7 per cent of all places were located in services offering both high care and low care places; this proportion rose to 25.2 per cent of all places in June 2001, 30.5 per cent of places in June 2002 and 36.5 per cent of places in June 2003, then fell to 33.4 per cent in June 2004 (tables 12A.6 and 12A.9; SCRCSSP 2001, 2002, 2003; SCRGSP 2004).

Box 12.3 **Ageing in place**

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

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

Further, the Aged Care Act aims explicitly to encourage and facilitate 'ageing in place'. It 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. Over time, this may change the profile of people in services.

The Aged Care Act does not require any residential aged care service to offer ageing in place; or establish any 'program'. 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: DHA (unpublished).

The client profile of services that had predominantly low care residents in 2000 has changed, with low care residents staying in their current service as their dependency levels rise over time, 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 2004, 64.3 per cent of low care services had 60 or fewer places (table 12A.8), compared with 49.3 per cent of high care services (table 12A.7).

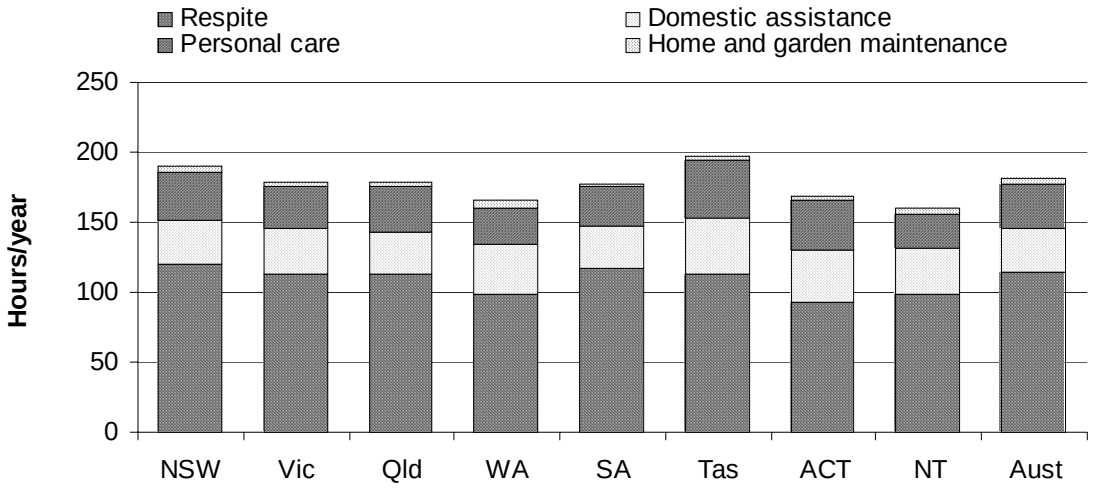
Community care services

Services provided under the HACC program include domestic assistance and home maintenance, personal care, food services, respite care, transport, allied health care and community nursing. The target population is defined as people living in the community who are at risk, without basic maintenance and support 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. Approximately 70 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 (DHA unpublished). (Chapter 13 covers services for people with a disability [which manifests before the age of 65 years] that were provided under the Commonwealth State/Territory Disability Agreement.)

The services of the VHC program target veterans and war widows/widowers with low care needs. There were 69 164 people approved for VHC services in 2003-04 (table 12A.48). The program offers veterans and war widows/widowers 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. Figure 12.8 shows the average number of hours approved per year for veterans who were eligible to receive home care services in 2003-04.

Figure 12.8 **Average number of hours approved for Veterans' Home Care, 2003-04[a]**



a VHC recipients fall into two categories: those veterans who transferred to the VHC program from the HACC program (transitional veterans) and those that did not (non-transitional veterans). The number of hours approved per year is for non-transitional veterans and relates to services that were approved to occur in 2003-04. The number of average hours actually provided will be lower.

Source: DVA (unpublished); table 12A.48.

Community Aged Care Packages provide an alternative home-based service for older people who ACATs assess as eligible for care equivalent to low level residential care (RCS levels 5–8). The main distinctions between the HACC, CACP and EACH programs are summarised in table 12.4. EACH is now a mainstream program funded by the Australian Government to provide a community alternative to high level residential aged care services. The program provides individually planned and coordinated packages of care designed to meet older people's daily

care needs in the community. The EACH program differs from the CACP program in that it targets frail older people who would otherwise be eligible for high level residential aged care. An EACH package typically provides 15–20 hours of direct assistance each week.

Community care is likely to continue to play an increasing role in aged care services, given the longer term policy objective of improving the capacity of aged care services to support people at home — an objective that reflects a strong consumer preference.

Table 12.4 **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 a greater range of care needs	Targets people with care needs similar to low level residential care	Targets people with care needs similar to high level residential care
Size of program	$1.2 billion funding in 2003-04	$307.9 million funding in 2003-04	$15.5 million funding in 2003-04
	Approximately 707 207 clients in 2003-04[c]	28 921 operational places in 2003-04	858 operational places at 30 June 2004

[a] HACC services such as community nursing, which are not available under CACPs, can be supplied to someone receiving a CACP. [b] Most HACC recipients at the lower end of the scale would not be assessed as eligible for residential care — for example, an individual may receive only an hour of home care per fortnight. At the higher end, some people have levels of need that would exceed the level available under CACPs. [c] Based on 83 per cent of HACC funded agencies that submitted Minimum Data Set data for 2003-04. Consequently, the total number of clients will be higher than those reported here.

Source: DHA (unpublished); tables 12A.32, 12A.35, 12A.45 and 12A.46.

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 2003-04, the HACC program delivered approximately 10 514 hours per 1000 people aged

70 years or over plus Indigenous people aged 50–69 years (table 12A.20). The total number of CACPs per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years increased between June 2000 and June 2004, from 10.7 to 15.2 (table 12A.11).

12.2 Framework of performance indicators

The framework of performance indicators aims to provide information on equity, efficiency and effectiveness, and to distinguish the outputs and outcomes of government aged care services. This approach is consistent with the revised general performance indicator framework and service process diagram outlined in chapter 1 (figures 1.2 and 1.3) that have been agreed by the Steering Committee. The performance indicators relate to government objectives in the aged care sector (box 12.4). At this stage, no outcome indicators are reported for aged care services.

Box 12.4 **Objectives for aged care services**

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

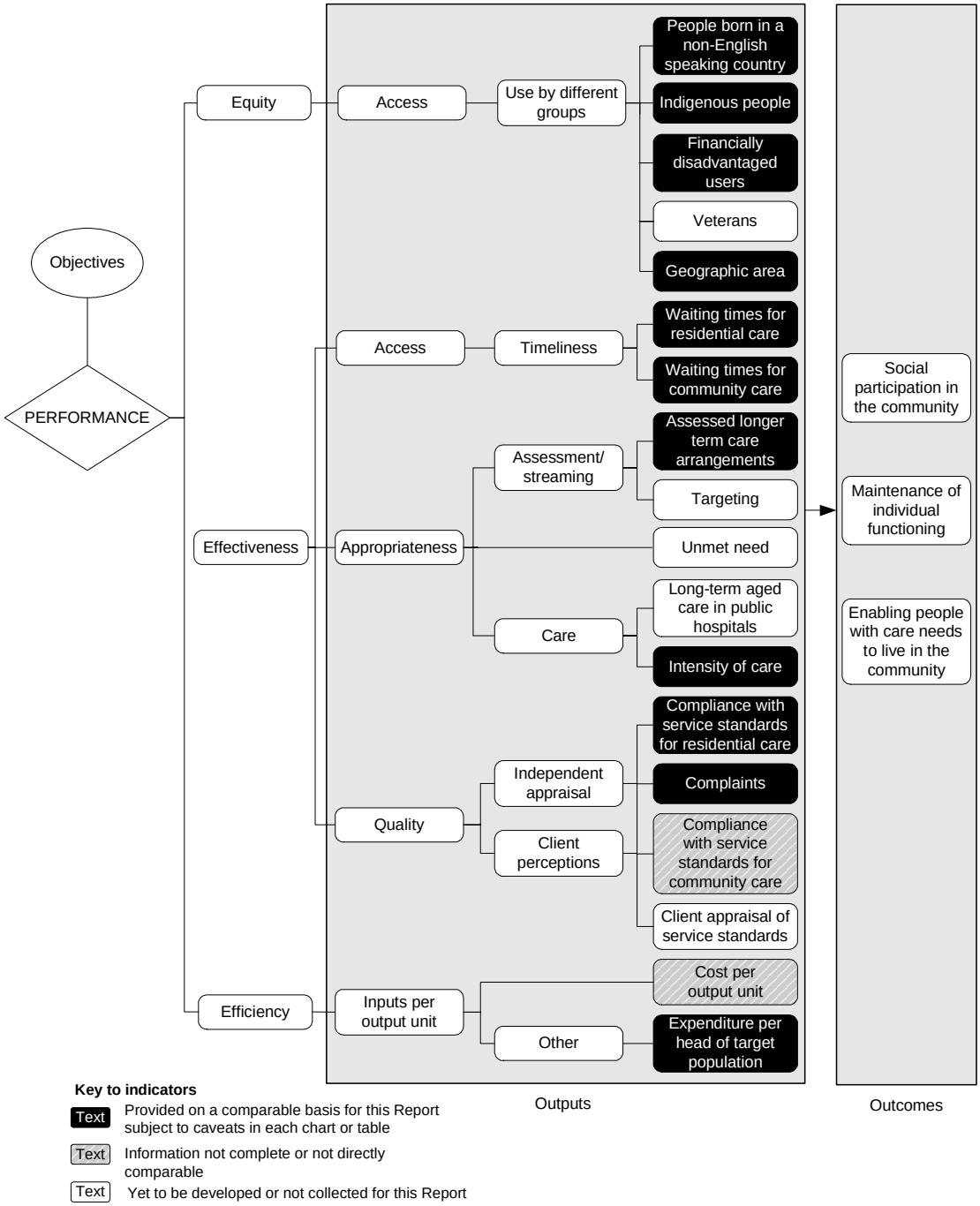
- accessible
- appropriate to needs
- high quality
- efficient.

The performance indicator framework shows which data are comparable in the 2005 Report (figure 12.9). For data that are not considered strictly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

12.3 Key performance indicator results

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

Figure 12.9 **Performance indicators for aged care services**



Outputs

Equity

Access — use by different groups

The access indicator 'use by different groups' is explained in box 12.5.

Box 12.5 **Use by different groups**

A key national objective of the aged care system is to provide equitable access to aged care services for all people who require these services. 'Use by different groups' is a proxy indicator of equitable access. Various groups are identified by the Aged Care Act and its principles (regulations) as having special needs, including people from Indigenous communities, people born in non-English speaking countries, people who live in rural or remote areas, people who are financially or socially disadvantaged, and veterans (including widows and widowers of veterans). The indicator is reported for each special needs group except veterans, and the definitions are as follows:

- 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.
- 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).
- for financially disadvantaged users: the indicator measures only access to residential services, and is defined as the number of new residents classified as concessional or assisted divided by the number of new residential places.
- for people living in rural and remote areas: the number of hours of HACC service received (and, separately, meals provided) divided by the number of people aged 70 years or over plus Indigenous people aged 50-69 years for major cities, inner regional areas, outer regional areas, remote areas and very remote areas.
- the rate of contacts with Commonwealth Carelink Centres for Indigenous people compared with all people.

(Continued on next page)

Box 12.5 **(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:

- There is evidence that Indigenous people have higher disability prevalence rates than those of the general population, which suggests a greater level of need for services compared with those in the broader aged care population.
- For financially disadvantaged users, Australian Government planning guidelines require that services allocate a minimum proportion of residential places for concessional residents. These targets range from 16 per cent to 40 per cent of new places, depending on the service's region. Use rates equal to or higher than the minimum rates are desirable.

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

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

Access to residential services

This indicator is explained in box 12.5. In all jurisdictions at 30 June 2004, on average, Indigenous people and people born in non-English speaking countries had lower rates of use of aged care residential services, compared with the rest of the population (figure 12.10).

Access to services by financially disadvantaged users

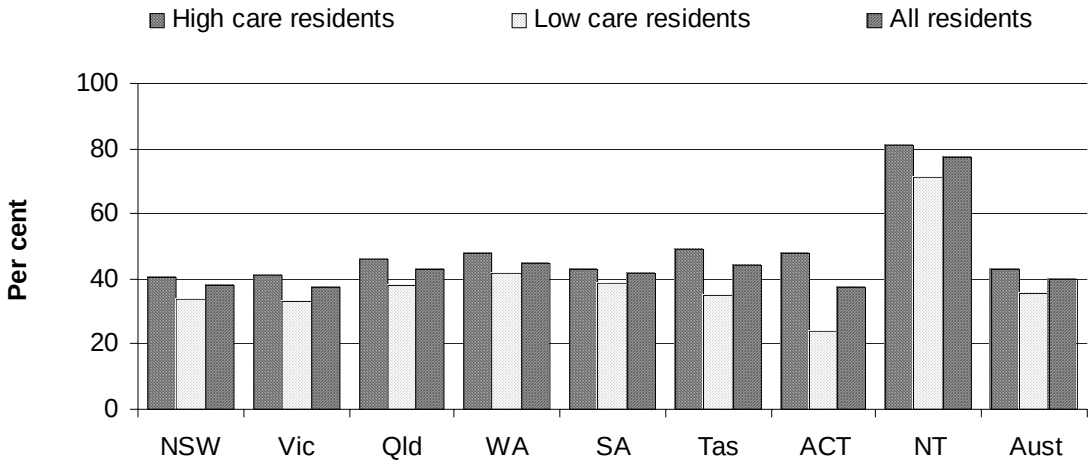
This indicator is explained in box 12.5. The NT had the highest proportion of all new residents classified as concessional or assisted residents during 2003-04 (77.3 per cent) and Victoria had the lowest (37.3 per cent) (figure 12.11).

Figure 12.10 **Residents per 1000 target population, 30 June 2004[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: DHA (unpublished); tables 12A.12, 12A.14 and 12A.16.

Figure 12.11 **New residents classified as concessional or assisted residents, 30 June 2004 (per cent)[a]**



a Concessional residents are those who receive an income support payment and have not owned a home for the previous two or more years (or whose home is occupied by a 'protected' person, such as, the care recipient's spouse or long term carer), and have assets of less than 2.5 times the annual single basic age pension. Assisted residents are those meeting the above criteria, but with assets between 2.5 and 4.0 times the annual single basic age pension.

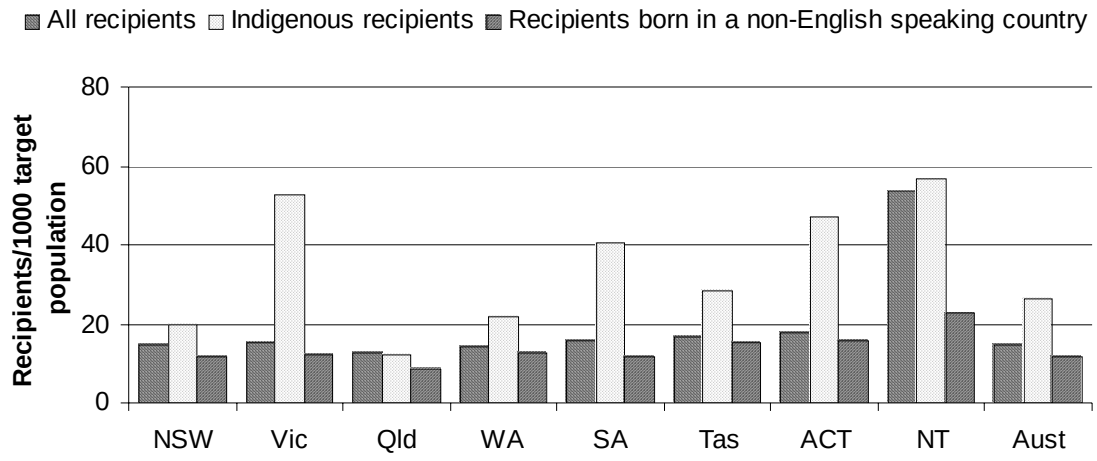
Source: DHA (unpublished); table 12A.19.

Access to community aged care packages

This indicator is explained in box 12.5. The number of CACP recipients per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years has grown in recent years, but was small relative to the total number of recipients of residential care at June 2004 (14.7 CACP recipients compared with 78.7 total recipients of residential care) (table 12A.12).

The NT had the highest number of CACP recipients per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years at June 2004 (53.8) and Queensland had the lowest (12.9). The NT had the highest number of Indigenous CACP recipients per 1000 Indigenous people aged 50 years or over (56.8) and Queensland had the lowest (12.2) (table 12A.16). The NT also had the highest number of CACP recipients from non-English speaking countries per 1000 people aged 70 years or over from non-English speaking countries (22.9) and Queensland had the lowest (8.6) (figure 12.12). The Australian Government's allocation of CACPs in every jurisdiction at June 2004 exceeded 10 CACPs per 1000 target population.

Figure 12.12 **Community Aged Care Package recipients per 1000 target population, 30 June 2004**[a, b, c, d, e]



[a] All recipients data are per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years. [b] Indigenous recipients data are per 1000 Indigenous people aged 50 years or over. [c] Data for recipients from non-English speaking countries are per 1000 people from non-English speaking countries aged 70 years or over. [d] The ACT has a very small Indigenous population aged 50 years or over (table 12A.2), and a small number of packages will result in a very high provision ratio. [e] CACPs provide a more flexible model of care more suitable to remote Indigenous communities, so areas such as the NT have a higher rate of CACP recipients per 1000 people.

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

Access to the Home and Community Care program

This indicator is explained in box 12.5. HACC services are provided in the client's home or community for frail older people with a severe, profound or moderate disability, and their carers.

Around 68.5 per cent of HACC recipients were aged 70 years or over during 2003-04 (table 12A.32). Nationally in 2003-04, 10 514 hours of HACC services were provided per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years. The number of service hours per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years ranged from 18 114 hours in the NT to 6295 hours in NSW. The number of meals provided per 1000 people aged 70 years or over, plus Indigenous people aged 50–69 years was highest in the NT (9348 meals) and lowest in SA (2929 meals) (table 12.5).

Table 12.5 **HACC services received, 2003-04 (per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years)[a, b]**

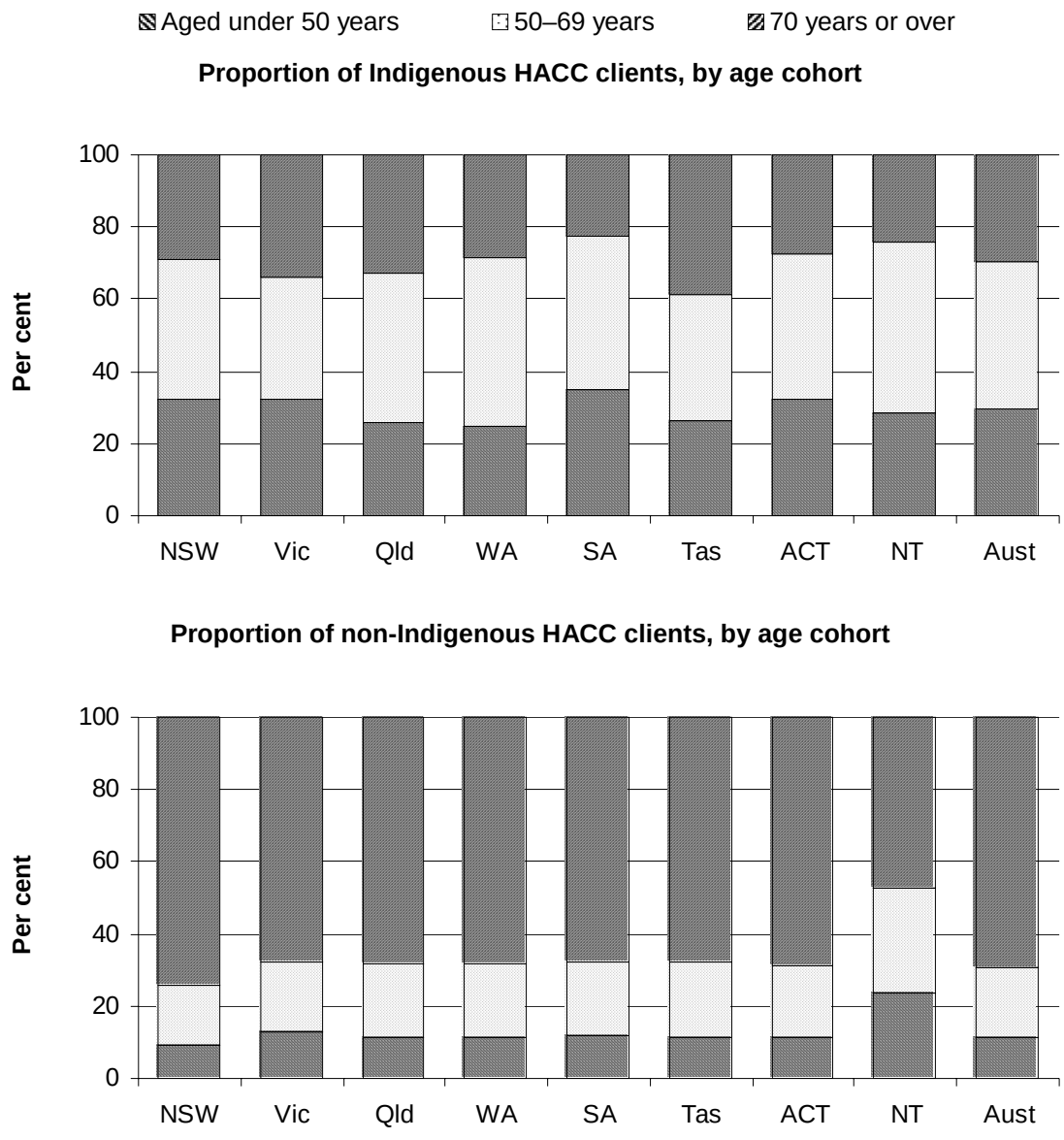
	NSW	*Vic*	*Qld*	*WA*	*SA*[c]	*Tas*	*ACT*	*NT*	*Aust*
Percentage of agencies that reported MDS data	77	86	93	99	85	83	99	77	83
Total hours[d]									
Major cities	5 885	12 082	12 576	17 400	8 160	..	9 894	..	9 966
Inner regional	6 571	15 865	10 345	14 579	8 856	9 898	na	..	10 496
Outer regional	8 226	19 381	13 196	15 991	10 179	12 225	..	17 862	12 623
Remote	11 663	22 355	15 575	16 730	10 003	15 319	..	16 546	14 401
Very remote	23 174	..	18 540	26 222	56 531	39 527	..	39 404	28 954
All areas	**6 295**	**13 429**	**12 084**	**17 003**	**8 853**	**10 885**	**9 924**	**18 114**	**10 514**
Total meals[e]									
Major cities	3 867	5 345	6 556	6 786	3 185	..	4 781	..	4 885
Inner regional	5 097	7 094	5 615	5 630	643	5 532	na	..	5 561
Outer regional	5 442	6 268	6 845	5 981	2 537	7 503	..	4 421	5 843
Remote	5 788	7 579	9 477	7 037	2 109	6 849	..	6 980	6 524
Very remote	1 866	..	13 070	21 181	39 500	7 315	..	46 976	23 569
All areas	**4 302**	**5 805**	**6 429**	**6 718**	**2 929**	**6 207**	**4 794**	**9 348**	**5 229**

a Data represents HACC services received by people aged 70 years or over plus Indigenous people aged 50–69 years (tables 12A.20–12A.25), rather than HACC services received by all age groups (tables 12A.26–12A.31). **b** The proportion of HACC funded agencies that submitted MDS data for 2003-04 differed across jurisdictions, ranging from 77 per cent to 99 per cent. Consequently, actual service levels will be higher than those reported here **c** SA advised that the number of meals may be understated due to slow implementation of the Minimum Data Set by Meals on Wheels. **d** See table 12A.20 for a full list of categories. **e** Includes home meals and centre meals. **na** Not available. **..** Not applicable.

Source: DHA (unpublished); tables 12A.20–12A.31.

Reported use of HACC services showed a substantial difference between all users and Indigenous users across all age groups in 2003-04. This reflects the difference in morbidity and mortality trends between Indigenous people and the general population (figure 12.13).

Figure 12.13 **Recipients of HACC services by age and Indigenous status, 2003-04**

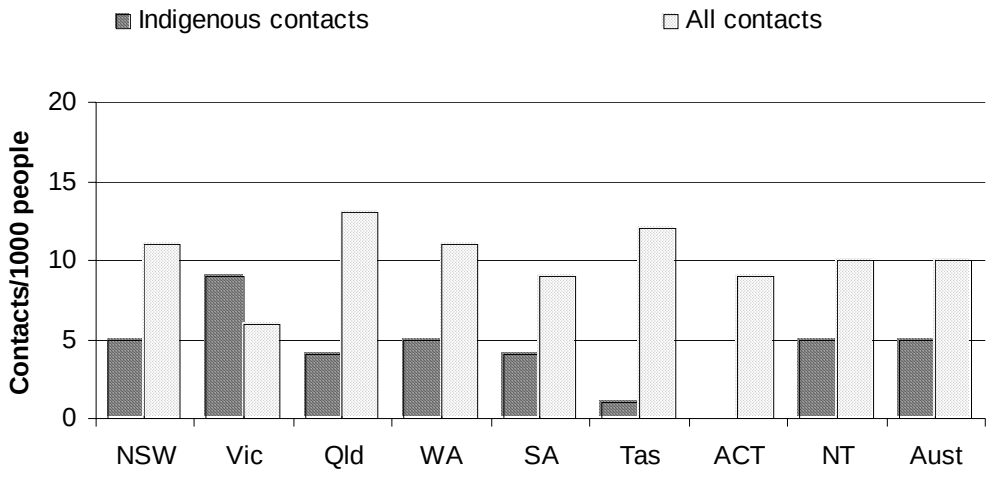


Source: DHA (unpublished); table 12A.33.

Access by Indigenous people to Commonwealth Carelink Centres

This indicator is explained in box 12.5. Commonwealth Carelink Centres are information centres for older people, people with disabilities and those who provide care and services. Information is provided on community services and aged care, disability and other support services available locally or anywhere in Australia, the costs of services, assessment processes and eligibility criteria. Figure 12.14 provides information on the rate at which Indigenous people contacted Carelink Centres at 30 June 2004, compared with the rate for all clients. The rate at which Indigenous people were able to access these centres was less than for all Australians except in Victoria. Victoria had the highest number of contacts by Indigenous people per 1000 Indigenous population in 2003-04 (8.7 per cent), while Tasmania had the lowest (1.3 per cent).

Figure 12.14 **Commonwealth Carelink centres, contacts per 1000 people, by Indigenous status, 30 June 2004**[a, b, c, d]



[a] Contacts with Carelink include phone calls, visits, emails and facsimiles. [b] Indigenous contacts refer to contacts by Indigenous people per 1000 Indigenous population. [c] All contacts refers to contacts per 1000 total population. [d] Data for the ACT for Indigenous clients were not available in 2003-04.

Source: Population Projections by SLA 2002-2022 (unpublished); table 12A.59.

Effectiveness

Timeliness of access — waiting times for residential care

The indicator 'waiting times for residential care' is explained in box 12.6. On average, 71.8 per cent of all people entering residential care during 2003-04 did so within three months of being assessed by an ACAT, and 44.6 per cent entered

within one month of their ACAT assessment. Across jurisdictions, the proportion of people who entered care within three months of assessment ranged from 75.0 per cent in NSW to 50.3 per cent in the ACT (table 12A.37).

Box 12.6 **Waiting times for residential care**

'Waiting times for residential care' is an output measure of effectiveness, reflecting the timeliness with which people are able to access residential care.

The indicator 'elapsed time between ACAT approval and entry into residential care service' measures the period between a client's approval for care and his or her entry into care and is defined as the percentage of people who are admitted to residential care within three months of their ACAT approval. The relevant terms are defined as follows:

- ACAT approval — the approval date of an ACAT assessment
- entry into a residential care service — the date of admission to a residential care service.

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

This indicator needs to be interpreted with care. It may be influenced by a range of factors, such as:

- 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
- hospital discharge policies and practices.

The Steering Committee acknowledges the limitations of the current indicator (box 12.7) and supports redevelopment for improvement. The current indicator will continue to be reported until improved data are available.

Box 12.7 **Entry period for residential care**

The Australian Institute of Health and Welfare (AIHW) conducted a detailed study of 1999-2000 ACAT assessment data and entry into residential care (AIHW 2002*)*. The 'entry period' is the time between ACAT assessment of a person as eligible for residential aged care, and that person's entry into a residential aged care service.

The study found that one of the main determinants of a short entry period is whether the resident has an ACAT assessment performed while in hospital rather than when living at home. A longer entry period is also strongly related to whether the resident used a CACP or residential respite care before admission.

Some people assessed by an ACAT and recommended for residential aged care may not take up a residential place. Others receive recommendations for both residential aged care and a CACP, and take up the latter. Recommendations for residential care remain active for 12 months. Some people assessed by an ACAT and recommended for residential aged care may not take up a residential place within this period. People often do not act on the recommendation immediately. They may believe they are quite capable of continuing to manage at home and that they do not need admission.

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

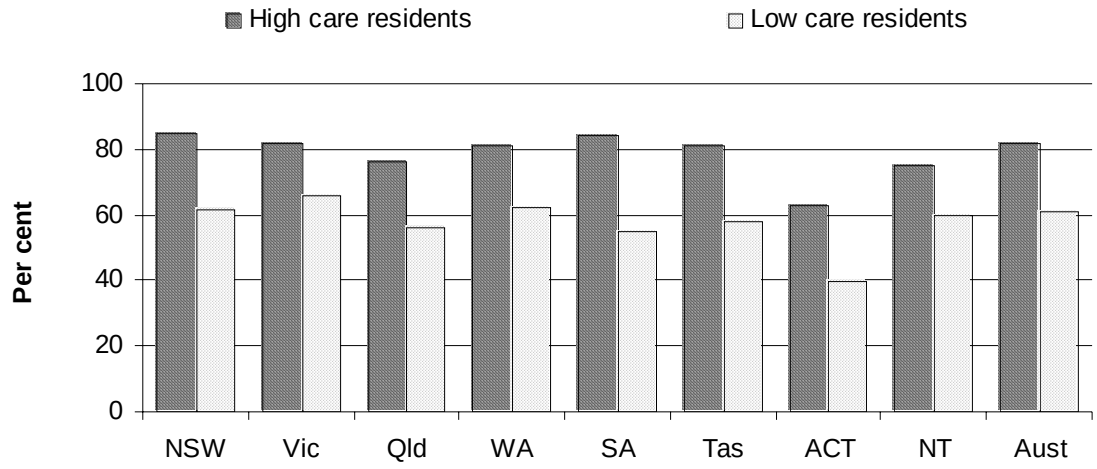
Source: AIHW (2002).

Nationally, a greater proportion of people entering high care residential services entered within three months of assessment (82.0 per cent), compared with the proportion entering low care residential services within that time (60.9 per cent) (table 12A.37). Across jurisdictions, the proportion of people entering high care residential services within three months of being assessed ranged from 85.0 per cent in NSW to 62.6 per cent in the ACT. The proportion of people entering low care residential services within three months of being assessed ranged from 65.8 per cent in Victoria to 39.5 per cent in the ACT (figure 12.15).

Timeliness of access — waiting times for community care

The 'waiting times for community care' indicator is explained in box 12.8 and reported using CACP data. On average, 67.0 per cent of all people receiving a CACP during 2003-04 received it within three months of being assessed by an ACAT, and 36.6 per cent started receiving a CACP within one month of their ACAT assessment (table 12A.37). Across jurisdictions, the proportion of people who received a CACP within three months of assessment ranged from 77.5 per cent in WA to 55.7 per cent in SA (figure 12.16).

Figure 12.15 **People entering residential care within three months of their ACAT assessment, 2003-04**



Source: DHA (unpublished); table 12A.37.

Box 12.8 **Waiting times for community care**

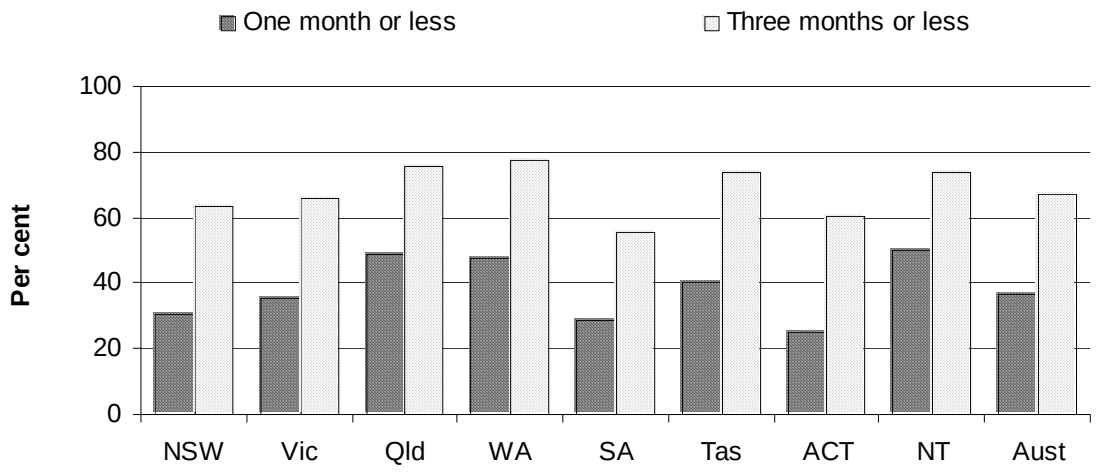
'Waiting times for community care' is an output measure of effectiveness and reflects the timeliness with which people are able to access CACPs. The indicator measures the period between a client's approval for care and his or her receipt of care, and is defined as the elapsed time between an ACAT approval and receipt of a CACP. Shorter waiting times are desirable (or higher rates of receipt of a CACP within one month or within three months of an ACAT approval).

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

Appropriateness — assessed longer term care arrangements

This indicator is explained in box 12.9. Information on the proportion of assessed people referred to community or residential care is provided in figure 12.17. Tasmania had the highest proportion of ACAT clients referred to residential care in 2002-03 (61.3 per cent), while the ACT had the highest proportion of clients referred to community care (68.4 per cent).

Figure 12.16 **Elapsed time between ACAT approval and the receipt of a CACP service, 2003-04**



Source: DHA (unpublished); table 12A.37.

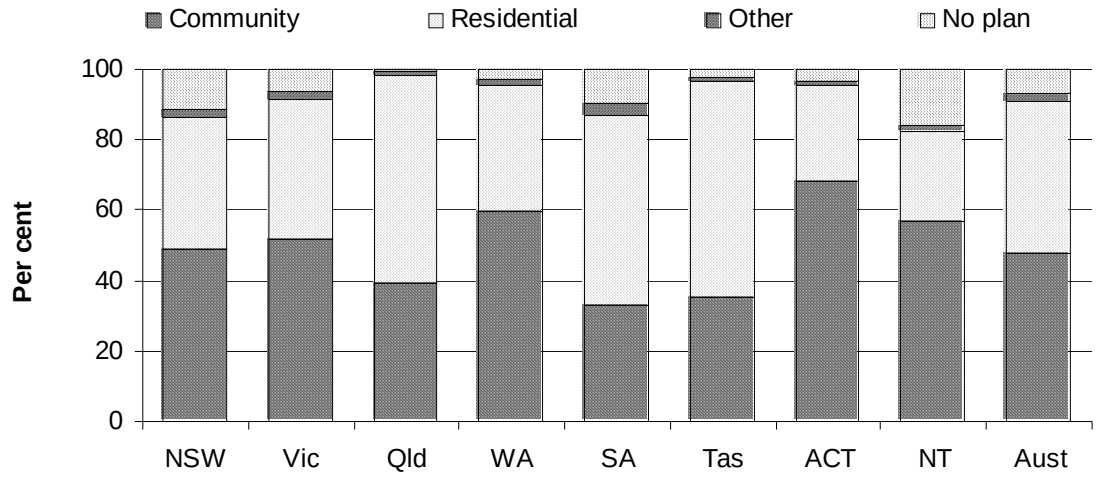
Box 12.9 **Assessed longer term care arrangements**

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

This indicator is defined as the number of ACAT clients referred to community care (CACPs or EACH packages) or residential care (permanent or respite). (Aged care assessments are mandatory for admission to residential care or for receipt of a CACP or an EACH package.)

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

Figure 12.17 **Recommended longer term care arrangements of ACAT clients, 2002-03[a]**



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

Source: Lincoln Centre for Ageing and Community Care Research (2004); table 12A.38.

Appropriateness — targeting

The 'targeting' indicator has not yet been developed (box 12.10).

Box 12.10 **Targeting**

The Steering Committee has identified 'targeting' as an indicator of appropriateness. It will be developed for reporting in future.

Appropriateness — unmet need

The indicator 'unmet need' is explained in box 12.11. The total number of persons aged over 65 years living in households who needed assistance with at least one everyday activity in 2003 are shown in table 12.6. Older people whose needs for assistance were not met comprised over one third (35.7 per cent) of all those needing assistance. Victoria reported the highest proportion of unmet need in 2003 and SA reported the lowest.

Box 12.11 **Unmet need**

'Unmet need' is an appropriateness indicator. The purpose of the indicator is to measure the extent to which demand for services to support older people requiring assistance with daily activities is met.

Defining and determining the level of need at an individual level, let alone at a population level, are complex tasks. Perceptions of need and unmet need are often subjective. Data for this indicator are drawn from the ABS 2003 Survey of Disability, Ageing and Carers and reflect people aged over 65 years who self-identified as having a need for assistance with at least one everyday activity, and the extent to which that need was met (fully, partly or not at all).

While low rates of unmet need is theoretically desirable, direct inferences about the demand for services from these data need to be made with care, because the data do not:

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

Table 12.6 **Older persons needing assistance with at least one everyday activity: extent to which need was met, 2003[a]**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*[b]
Persons with a need not fully met	'000	108.0	98.8	76.3	29.0	30.1	9.6	na	na	358.6
All persons needing assistance	'000	306.9	269.8	214.7	80.8	92.2	27.8	na	na	1005.2
Self - reported total or partial unmet need	%	35.2	36.6	35.5	35.9	32.6	34.5	na	na	35.7

a Aged 65 years or over, living in households. **b** Australian total includes data for the ACT and the NT. **na** Not available.

Source: ABS (unpublished); table 12A.40.

Appropriateness — long term aged care in public hospitals

An indicator 'long term aged care in public hospitals' has not yet been developed (box 12.12).

Box 12.12 **Long term aged care in public hospitals**

'Long-term aged care in public hospitals' is an indicator of the appropriateness of care. Acute inpatient services are geared towards shorter periods of care aimed at addressing serious illness or injury, or diagnosis, and are a less effective form of care for older people who cannot live independently in the long term. Low incidence is desirable.

The Steering Committee has identified this indicator for development and reporting in future.

Appropriateness — intensity of care

The indicator 'intensity of care' is explained in box 12.13. Figure 12.18 shows the proportion of people who stayed in the same residential aged care service when changing from low care to high care. From 2000-01 to 2003-04, there was a steady increase in this proportion, across the jurisdictions, with the exception of the NT (figure 12.18). In 2003-04, the highest proportion of residents who had 'aged in place' was in Tasmania (86.3 per cent) and the lowest was in NSW (60.4 per cent).

The proportion was higher in regional and remote areas than in major cities (table 12A.56).

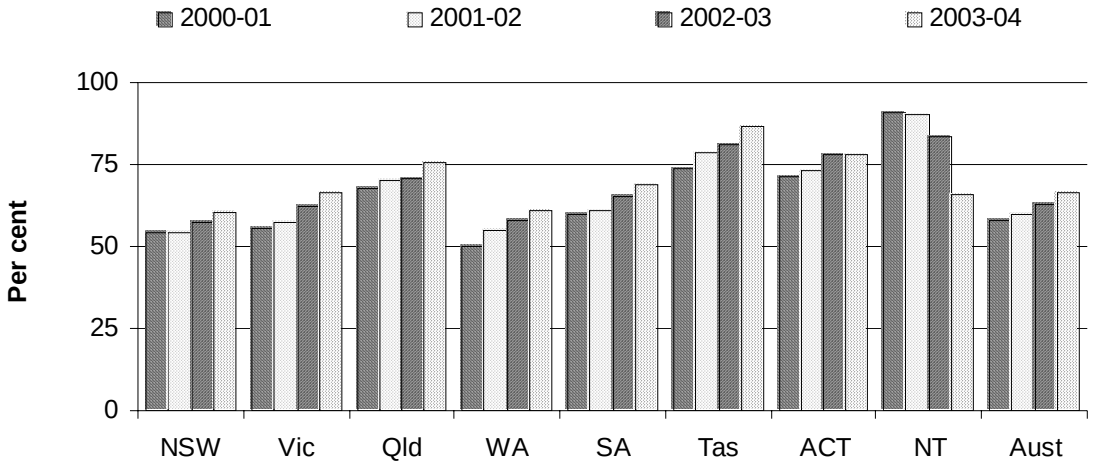
Box 12.13 **Intensity of care**

'Intensity of care' is an indicator of appropriateness, reflecting the proportion of residents who remain in the same residential aged care facility as their care needs increase from low care to high care. The Aged Care Act aims explicitly to encourage 'ageing in place' to increase choice and flexibility in residential aged care service provision (see box 12.3).

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

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

Figure 12.18 **Proportion of residents who changed from low care to high care and remained in the same aged care service**



Source: DHA (unpublished); table 12A.56.

Overall, 25.4 per cent of low care places in 2003-04 were occupied by residents with high care needs. Across jurisdictions, the proportion was highest in Tasmania (35.4 per cent) and lowest in Victoria (20.6 per cent) (table 12.7). These data are provided by remoteness area in table 12A.60.

Table 12.7 **Utilisation of operational residential places, 30 June 2004 (per cent)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Proportion of places allocated as low care and used for high care	22.0	20.6	33.8	22.9	32.0	35.4	35.2	30.8	25.4
Places used for high care as a proportion of all places	61.0	54.3	61.2	57.4	62.9	65.2	59.2	65.1	59.3

Source: DHA (unpublished); table 12A.60

Quality — compliance with service standards for residential care

The indicator 'compliance with service standards for residential care' is explained in box 12.14.

Box 12.14 **Compliance with service standards for residential care**

'Compliance with service standards' is an indicator of the quality of care. The purpose of the indicator is to monitor the extent to which residential care facilities are complying with accreditation or certification standards. The extent that they comply, implies a certain level of care and service quality.

Since 2001, Australian Government funded residential services have been required to meet accreditation standards (which comprise 44 expected outcomes), against which each residential service is assessed. The accreditation indicator reflects the period of accreditation granted. High rates of approval for accreditation for three years or more are desirable.

Average certification safety scores and residents per room are also presented as output indicators of quality. Higher rates are desirable because they imply a higher level of care and service quality.

There are three basic steps in the accreditation process.

- First, residential services apply for accreditation by completing a self-assessment of their performance against the accreditation standards, and submitting this with other relevant information to the Aged Care Standards and Accreditation Agency (ACSAA).
- Second, a team of registered quality assessors reviews the application (the 'desk audit') and then conducts an onsite assessment of the residential service (the site audit). During the site audit, the team observes the living environment and

practices of the residential service, reviews relevant documentation such as care plans, and interviews residents, relatives, staff and management. The team gives a draft report to the residential service at the end of the site audit, and a final 'site audit report' is prepared and submitted to the ACSAA within two weeks. During that two week period, the residential service has the opportunity to comment on the draft report or provide additional information.

- Third, an authorised decision maker from ACSAA (not the team) considers the site audit report, in conjunction with submissions from the residential service and any other relevant information (including information from DHA), and decides whether to accredit and, if so, for how long.

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). Table 12.8 summarises the accreditation decisions at 30 June 2004. The highest proportion of three year approvals was in the ACT (100.0 per cent) and the lowest was in Queensland (84.6 per cent).

Table 12.8 **Accreditation decisions on residential aged care services, 30 June 2004**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Accreditation approvals										
One year	%	3.8	4.6	3.6	2.7	5.4	1.1	–	6.7	3.9
Two years	%	4.1	5.2	11.8	8.1	7.1	3.3	–	–	6.3
Three years	%	92.1	90.1	84.6	89.2	87.5	95.6	100.0	93.3	89.8
Total	**%**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Accredited services	no.	943	820	499	260	297	92	23	15	2 949

– Nil or rounded to zero.

Source: ACSAA (unpublished); table 12A.41.

Certification aims to improve the physical quality of residential aged care services. The certification framework is underpinned by part 2.6 of the Aged Care Act and by the certification principles. Certified services gain access to accommodation payments and are eligible for Australian Government funding supplements for concessional and assisted residents. The certification program has established minimum standards of building quality, which the sector is to achieve progressively. To achieve certification, services are assessed against seven aspects of building quality.

All services were assessed for certification in 1997 and are now working to achieve continuous improvement targets, which were introduced in 1999 as part of a 10 year

plan to improve building quality. The targets require services to achieve a safety score of 19 out of 25 by the end of 2003, and an overall score of 60 out of 100. Existing services are also required to meet privacy and space requirements by 2008. All new services must meet these targets from the time of construction. The average number of residents per room at July 2004 varied from 1.6 in NSW to 1.1 in Tasmania. Average safety scores ranged from 21.4 in SA to 16.3 in the ACT (table 12.9).

Table 12.9 **Average certification safety score and residents per room, July 2004**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Safety score[a]	19.4	20.8	19.2	19.4	21.4	19.0	16.3	20.3	19.9
Residents per room	1.60	1.38	1.35	1.30	1.31	1.13	1.15	1.21	1.42

a Maximum score is 25; a target score of 19 was to be achieved by the end of 2003.

Source: DHA (unpublished); tables 12A.42 and 12A.43.

Quality — complaints

The indicator 'complaints' is explained in box 12.15. In 2003-04, the Complaints Resolution Scheme received approximately 967 new complaints, compared with 1227 in 2002-03. Of these, 73 per cent were lodged as open complaints, 16 per cent as confidential and 11 per cent as anonymous. Of all complaints handled by the Scheme, 97 per cent related to residential aged care services (DHA 2004). The number of complaints registered per 1000 residents in 2003-04 ranged from 12.3 in the ACT to 3.0 in Queensland (figure 12.19).

Quality — compliance with service standards for community care

The indicator 'compliance with service standards for community care' is explained in box 12.16. The total number of HACC agencies operating and the number of appraisals undertaken over the three year cycle 2001-02 to 2003-04 are shown in table 12.10. Future reports are expected to include more detailed data on the outcomes of the service standards appraisals.

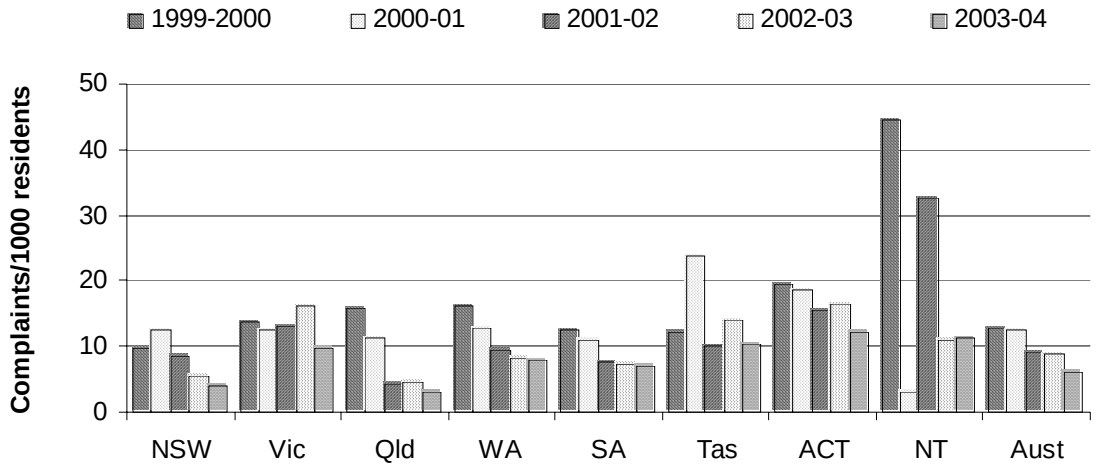
Box 12.15 **Complaints**

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

All aged care services are required to have an internal complaints system. The Aged Care Complaints Resolution Scheme is a free complaints system run by the DHA and overseen by an independent Commissioner for Complaints. The scheme is available to anyone who wishes to make a complaint about an Australian Government funded aged care service, including residents of aged care facilities and their families, staff and people receiving CACPs and EACH packages. The indicator measures the number of complaints per 1000 residents. A low rate of complaints is desirable.

The rate at which complaints occur is influenced by the propensity of clients and their families or service staff to complain, their knowledge of the complaints system, and perceptions of the effectiveness of the complaints system. In many cases, complaints may be resolved without the need to involve the Complaints Resolution Scheme.

Figure 12.19 **Aged Care Complaints Resolution Scheme complaints per 1000 residents**



Source: DHA (unpublished); table 12A.44.

Box 12.16 **Compliance with service standards for community care**

'Compliance with service standards for community care' is an output indicator of quality. The purpose of the indicator is to monitor the extent to which individual agencies are complying with service agreement standards.

The HACC national service standards provide HACC funded agencies with a common reference point for internal quality control, by defining aspects of service quality and expected outcomes for consumers. States and territories are required to include the standards in all service agreements. The HACC national service standards instrument has been developed to measure through a service appraisal process the extent to which individual agencies are complying with the standards. Monitoring and compliance with the standards are now a major part of service reviews.

In future, the indicator will measure the percentage of individual agencies that comply with the service standards, but data on the outcomes of service standard appraisals are not yet available. Meanwhile, the indicator is defined as the number of HACC agencies *appraised* against the standards divided by the total number of HACC agencies. It should be noted that the standards are not an accreditation system.

Table 12.10 **HACC national service standards appraisals over the three year cycle ending 2003-04[a, b]**

	Unit	*NSW*	*Vic*	*Qld*	*WA*[c]	*SA*[d]	*Tas*[e]	*ACT*	*NT*	*Aust*
Appraisals	no.	1 074	481	706	168	162	58	31	11	2 691
HACC agencies	no.	1 487	481	730	178	162	58	31	88	3215
Proportion of agencies assessed	%	72	100	97	94	100	100	100	21	84

a 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** Data in this table are preliminary and may be revised in the future. **c** The number of WA agencies appraised is lower than expected because some agencies amalgamated. **d** SA has an additional 21 exempt agencies. **e** Two agencies were exempt from the appraisal process in Tasmania.

Source: State and Territory governments (unpublished); table 12A.36.

Quality — client appraisal of service standards

The indicator 'client appraisal of service standards' has not yet been developed (box 12.17).

Box 12.17 **Client appraisal of service standards**

'Client appraisal of service standards' is an output indicator of quality. This indicator aims to monitor client satisfaction with services received. The Steering Committee has identified this indicator for development and reporting in future.

Efficiency

Inputs per output unit — cost per output unit

'Cost per output unit' is explained in box 12.18. Preliminary unit cost data have been calculated for aged care assessments. Cost per assessment during 2002-03 averaged $212 nationally, and was highest in the NT ($865) and lowest in the ACT ($156) (table 12.11).[2]

Box 12.18 **Cost per output unit**

A proxy efficiency indicator, 'cost per assessment', has been developed as work in progress in measuring efficiency for ACATs. It is defined as expenditure on ACATs divided by the number of ACAT assessments completed.

This indicator needs to be interpreted with care. While high or increasing expenditure per assessment may reflect deteriorating efficiency, it may also reflect changes in aspects of the service (such as greater time spent with clients) or changes in the characteristics of clients (such as their geographic location). Similarly, low or declining expenditure per assessment may reflect improving efficiency or less time spent with clients (for example).

Table 12.11 **Aged care assessment unit costs, 2002-03 (dollars)[a, b]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT[c]*	*Aust*
Cost per assessment	210	196	233	184	235	260	156	865	212

a Only includes Australian Government expenditure on ACAT. **b** ACAT referrals and operations vary across jurisdictions. **c** The high cost for each assessment in the NT may be influenced by the remoteness of people requiring assessments, clients having English as a second or third language, and a lack of supporting health and community services infrastructure to assist with assessments.

Source: DHA (unpublished), Lincoln Centre for Ageing and Community Care Research (2004); table 12A.57.

[2] Cost per assessment is calculated using the total number of assessments and includes clients aged less than 70 years.

Inputs per output unit — expenditure per head of target population

The indicator 'expenditure per head of target population' is explained in box 12.19. Australian Government expenditure (including expenditure by the DVA) on residential care services per person aged 70 years or over plus Indigenous people aged 50–69 years varied across jurisdictions in 2003-04, ranging from $2653 in SA to $1496 in the NT. Nationally, it increased from $2357 (in 2003-04 dollars) in 1999-2000 to $2416 in 2003-04 (figure 12.20).

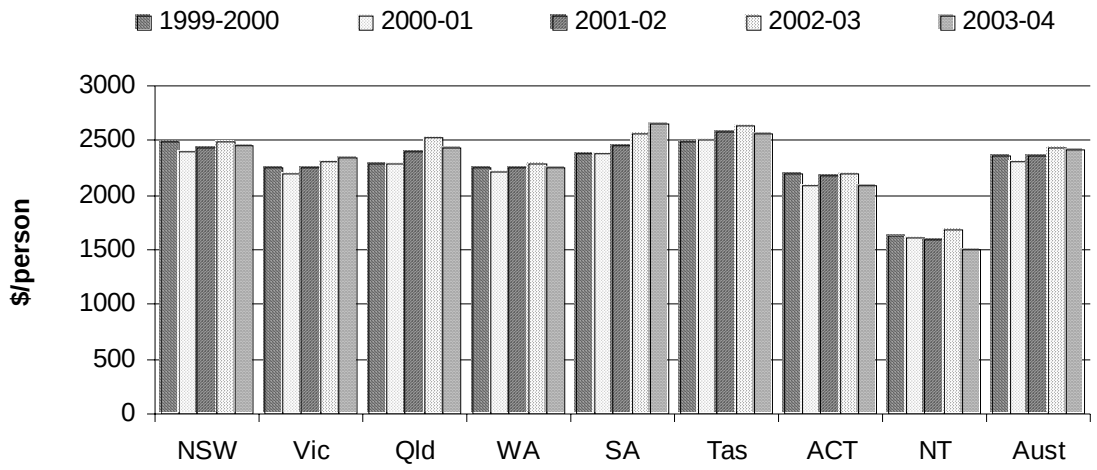
Box 12.19 **Expenditure per head of target population**

A proxy indicator of efficiency is 'expenditure per head of target population'. It reflects the objective to ensure services for frail older people are provided efficiently. The indicator is defined as government inputs (expenditure) divided by the number of people aged 70 years or over plus Indigenous people aged 50–69 years. Expenditure per person in the target population is reported for three main service types: residential services, CACP, EACH and HACC services.

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

Payroll tax has been separately identified in Australian Government DHA expenditure on residential aged care for the first time in this Report. Table 12.12 contains data including and excluding payroll tax for DHA expenditure on residential aged care per person aged 70 or over plus Indigenous people aged 50–69 years.

Figure 12.20 **Australian Government real expenditure on residential services per person aged 70 years or over plus Indigenous people aged 50–69 years (2003-04 dollars)[a, b]**



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

Source: DHA (unpublished); DVA (unpublished); table 12A.52.

Table 12.12 **Australian Government (DHA) expenditure on residential aged care, per person aged 70 years or over plus Indigenous people aged 50–69 years (2003-04 dollars)[a]**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Excluding payroll tax)	$/person	2 045	1 970	2 008	1 865	2 248	2 089	1 736	1 413	2 017
Including payroll tax	$/person	2098	2015	2043	1920	2289	2110	1774	1424	2062

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

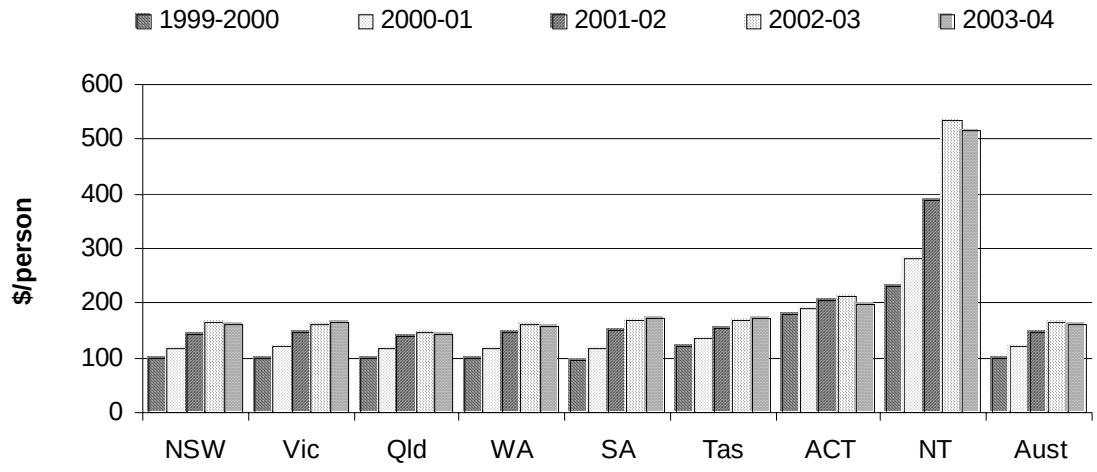
Source: DHA (unpublished), table 12A.51.

Australian Government expenditure on CACPs per person aged 70 years or over plus Indigenous people aged 50–69 years varied across jurisdictions in 2003-04, and was highest in the NT ($515) and lowest in Queensland ($142). Nationally, real expenditure per person aged 70 years or over plus Indigenous people aged 50-69 years increased from $100 (in 2003-04 dollars) in 1999-2000 to $162 in 2003-04 (figure 12.21).

Australian, State and Territory government expenditure on HACC services per person aged 70 years or over plus Indigenous people aged 50–69 years was highest in the ACT ($822) and lowest in NSW ($576). Nationally, real expenditure per person aged 70 years or over plus Indigenous people aged 50–69 years

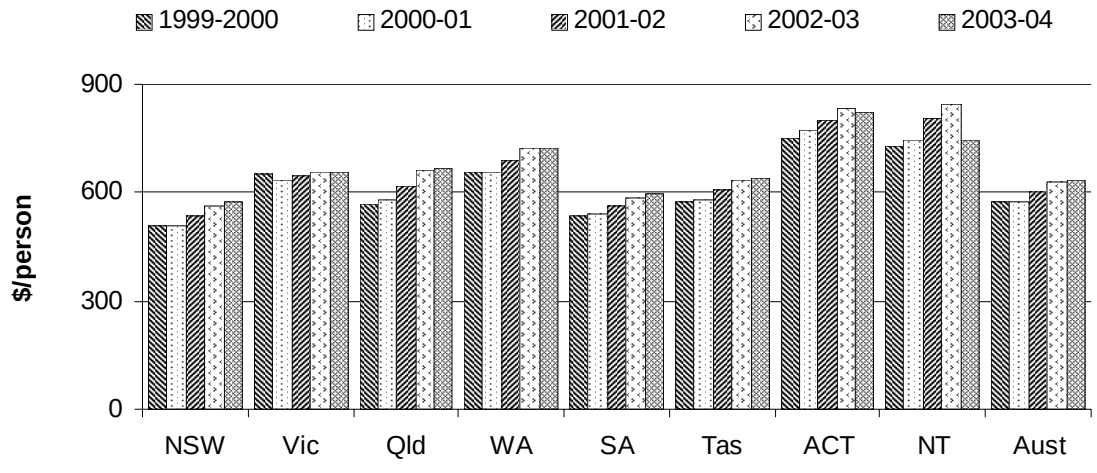
increased from $576 (in 2003-04 dollars) in 1999-2000 to $633 in 2003-04 (figure 12.22).

Figure 12.21 **Australian Government real expenditure on CACP services per person aged 70 years or over plus Indigenous people aged 50–69 years (2003-04 dollars)**



Source: DHA (unpublished); table 12A.55.

Figure 12.22 **Australian, State and Territory government real expenditure on HACC services per person aged 70 years or over plus Indigenous people aged 50–69 years (2003-04 dollars)[a]**



a People aged 70 years or over plus Indigenous people aged 50–69 years are not the HACC target population. Expenditure per person in the HACC target population is contained in table 12A.53.

Source: DHA (unpublished); table 12A.54.

Outcomes

New outcomes indicators have been identified this year for development and reporting in future (boxes 12.20, 12.21 and 12.22).

Social participation in the community

Box 12.20 **Social participation in the community**

'Social participation in the community' promotes the wellbeing and independence of frail older people. An indicator will be developed to show the extent to which older people participated in community, cultural or leisure activities. Higher rates of participation in the community are more desirable.

The Steering Committee has identified this indicator for development and reporting in future.

Maintenance of individual functioning

Box 12.21 **Maintenance of individual functioning**

'Maintenance of individual functioning' is an outcome indicator that reflects the objective for aged care services to promote the health, wellbeing and independence of frail older people. The Steering Committee has identified this indicator for development and reporting in future.

Two indicators would be reported:

- maintenance of, or minimised decline in residents' level of functioning reflected by a movement of clients to a higher level of need as indicated by a change in classification on the resident classification scale.
- length of stay in residential care for a given level of frailty or age at entry.

Enabling people with care needs to live in the community

Box 12.22 **Enabling people with care needs to live in the community**

This outcome indicator reflects the objective of community care to delay entry to residential care and will measure levels of dependency on entry to residential care for those who have been receiving community care. The Steering Committee has identified this indicator for development and reporting in future.

12.4 Future directions in performance reporting

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

- continue improving efficiency indicators, including for HACC services and assessment services
- further develop reporting of outcome indicators
- improve reporting of waiting times for residential aged care
- continue working on reporting the indicator 'long term aged care in public hospitals'
- improve reporting of State and Territory expenditure on residential aged care
- examine whether to adjust data in the chapter for differences across jurisdictions in the age structure of the population. The appendix to this chapter (see section 12.6) provides some information on the impact of standardising some data in the chapter for age.

12.5 Jurisdictions' comments

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

Australian Government comments

“ Professor Warren Hogan presented the *Final Report*[1] of the Review of Pricing Arrangements in Residential Aged Care to the Australian Government on 5 April 2004. The Review examined the effectiveness of current and alternative funding arrangements, the level of efficiency of the industry and the long-term sustainability of current and alternative funding arrangements for the aged care sector.

In response to the Review, the Government announced a substantial package of measures,[2] providing $2.2 billion over 2003-04 and the four forward years. The package builds on the reforms of residential aged care from 1997 and addresses a number of short and medium term pressures facing aged care. It continues the provision of high quality aged care services for older Australians and positions Australia to meet the care needs of an ageing population by:

- expanding the provision of care;
- providing a significant increase in additional recurrent and capital funding for aged care services;
- supporting workforce initiatives;
- streamlining the administration of aged care;
- providing more support to services in rural and remote areas; and
- improving the hospital/aged care interface.

A review of community care was conducted during 2003-04 to develop an overarching framework within which all community care programs may operate. The framework will seek to develop greater consistency and common arrangements across community care programs in the key areas of assessment of need and eligibility, access to services, eligibility criteria, a common approach to determining consumer fees, accountability, quality assurance, information management and data collection, and planning.[3]

The Reviews complement the Australian Government’s focus on our ageing population, which is addressing issues such as retirement incomes, continuing workforce productivity, and the need to deliver affordable, equitable, flexible high quality aged care.

1. Review of Pricing Arrangements in Residential Aged Care. *Final Report.* Canberra, 2004.
2. *Investing in Australia’s Aged Care: More Places, Better Care.* Minister for Ageing. May 2004.
3. *A New Strategy for Community Care — The Way Forward.* Canberra, Department of Health and Ageing, 2004. ”

New South Wales Government comments

“ The NSW Government continues its commitment to improving the health and wellbeing of older people living in NSW and to enhancing services to respond to the increasing needs of an ageing population. The Home and Community Care program delivered more than $382 million of services in 2003-04 – an increase of $32 million from 2002-03. A significant proportion of this additional funding has been used to increase access to basic support services, including personal care, domestic assistance, centre-based day care and respite care.

NSW continues to improve services for people in rural and remote areas and for people from an Indigenous background. An example of this was the Wilcannia Polly Pineo Multi Service Outlet, which provides a range of services in the isolated township of Wilcannia. The local provision of culturally appropriate services has dramatically improved the wellbeing of the population — 95 per cent of which is Aboriginal — and strengthened Wilcannia’s unity and self-sufficiency.

The NSW Government hosted a Forum on Ageing during 2004. The aim of the Forum was to bring together key stakeholders to discuss issues around ageing and to identify current and emerging issues across the ageing spectrum, to stimulate public debate on ageing issues and proposed solutions, and to progress new directions in ageing policy, planning, practise and evaluation.

Dementia Awareness Week was again successful in raising awareness of issues for people with dementia and their carers, including a focus on Indigenous people with the release of a new set of resources for Indigenous communities.

The NSW health system is responding to the unique and complex needs of older people within an aged care policy framework. *The Framework for Integrated Support and Management of Older People in the NSW Health Care System*, released in 2004, is driving system-wide changes in policy and practice. A number of information sessions, workshops and inter-jurisdictional discussions have been conducted to support its objectives. Each Area Health Service is developing and implementing an aged care strategy. Developing new models of care for older people is part of a wider approach to develop sustainable management of the demand for hospital services via the Sustainable Access Plan developed by NSW Health. The NSW Government is also implementing transitional care models for older people, to assist at the interface between acute care, residential and community care services.

NSW Health continues to invest in innovative aged care services such as Aged Care Service Evaluation Teams in public hospitals, Emergency Medical Units and COMPACKS which broker packages of community care. This is in addition to the Aged Care Assessment Teams which receive funding from both Australian and NSW Governments, and the comprehensive range of acute, community, rehabilitation, mental health and geriatric services targeting older people. NSW also established the NSW Carers Program with $12.9 million over 4 years to provide practical information, training and support for carers, many of whom are older people. ”

Victorian Government comments

“ The data presented in chapter 12 sheds light on the workings of elements of the aged care system within their particular jurisdictional context. Victoria has a strong sub-acute and rehabilitation system, which assists older people to return to the community after acute health episodes. That is supported by a particularly strong community care system with higher expenditure per head of population than other jurisdictions. However, the strength of those parts of the system means that people tend to enter residential care at a higher level of need.

Victoria has the lowest rate of residential place provision and importantly, the lowest rate of high care places of any State. This is exacerbated by a lower rate of ageing in place than other jurisdictions. The resultant pressure on other parts of the system has encouraged Victoria to introduce its own system of interim care places. Victoria's response to the Australian Government's transition care initiative will reflect the needs and opportunities particular to this environment.

The Victorian Government has made a number of initiatives during 2003-04 in response to an older population growing twice as fast as the general Victorian population. The 85+ cohort is expected to grow at a rate of 4.2 per cent per annum to 2006. A linking theme in the initiatives is to ensure that older Victorians receive care in the most appropriate setting.

The recently launched Public Sector Residential Aged Care Policy confirms the Victorian Government commitment to public sector residential age care services and sets out the Government's role in residential aged care, signalling directions for public provision. Priorities include: access for rural Victorians to residential aged care; client groups with specialised care needs; better integration of health and aged care systems; responding to changing community care preference; quality of care; and good management and financial outcomes.

Supported Residential Services (SRS) are significant providers of supported accommodation services in Victoria, their role regulated and supported by the Victorian Government. The Government has introduced reform in the SRS industry based on five key directions: support to SRS residents and to SRS proprietors, facilitating sustainability within the pension-only segment of the industry, improved regulatory processes and building relationships with key stakeholders. Substantial funds have been committed to a range of research and pilot projects. A key objective is to facilitate industry sustainability in order to increase capacity of SRS to provide services to medium to higher care residents.

The Culturally Equitable Gateways Strategy aims to improve access to mainstream HACC services for people from Culturally and Linguistically Diverse backgrounds. Local governments and ethno specific agencies will work in local partnerships. In excess of $6 million of Victorian unmatched funding has been committed. ”

Queensland Government comments

“Queensland recognises that the preference for many older people and their carers is to live independently for as long as practicable and considers enabling people to act on that preference to be a key objective. Consumer and provider organisations support the need for a continuum of community care that enables older people to age in place with support increasing in direct proportion to need. The Queensland Government achieves this through the HACC program, which is at the beginning of the aged care continuum, and is instrumental in helping older people to remain in their own homes. HACC is jointly funded by the Australian and Queensland Governments.

Planning for current and future generations has become essential as the Queensland population ages, with the number of older people expected to increase from 11.5 per cent in 2001 to more than 23 per cent in 2051. Extensive Statewide consultation with aged care service providers and their staff, general practitioners, aged care advocacy and member organisations, individual consumers/carers and volunteers informed the development of Queensland Health's *Directions for Aged Care 2004-2011*. This document provides a clear vision to guide Queensland Health and its partners towards providing even better health and support services to older people.

Queensland has established a multi-disciplinary Peer Support Network to tackle elder abuse. The Network works directly with older people who are abused or are at risk of abuse and brings together social workers, counsellors, nurses and other professionals and volunteers in the ageing and family violence sectors. The Network ensures older Queenslanders have access to the best possible services to help them prevent or put an end to abusive situations.

A person's connection with their community can be influenced by individual, social, cultural and environmental factors; when the community fails to connect with someone the consequence can be social isolation. Queensland considers the reduction of social isolation of older people to be a priority and has commenced a project to identify practice models which reduce social isolation of older people.

The Queensland Government has also embarked on a capital works program for aged care. Construction of a new $13.6 million aged care centre at Kirwan in Townsville has begun and will provide a safe and comfortable environment for 70 residents in what is promised be one of the country's most modern aged care facilities.

Queensland is committed to improving the quality of life of older people and views the upcoming review of the community care sector, including the renegotiation of the HACC Amending Agreement, as a positive process with real opportunities to improve the ways in which older people in Australia receive care and assistance. Queensland welcomes the opportunity to work with the Australian Government and all State and Territory jurisdictions to develop a new HACC Amending Agreement and to improve the delivery of aged care services in Australia through the review of the Community Care Sector.”

Western Australian Government comments

“ Western Australia continues to refine its range of programs and services according to the principle of supporting older people in the community and recommending for residential care only when other support systems are not able to meet specific needs. In line with the expressed preference of older people to remain in their own homes for as long as possible, Western Australia has implemented a range of flexible options aimed at maximising the independence of the frail elderly while minimising the need for ongoing services.

The 18-month pilot of HACC-funded ‘Enablement Packages’ designed to provide a rapid response to HACC eligible clients who are ready for discharge from hospital has had successful outcomes, with demonstrated improvement in the health status of clients. Interventions were initiated within 24 to 48 hours of admission to the program and care plans and goals for independence were based on assessed needs and negotiation with the individual client, with 60 per cent achieving their goals for independence within eight weeks. The pilot demonstrated a reduced ongoing demand for HACC services: 72 per cent (84 of the 116 clients) who received HACC services both before and after the package required reduced services afterwards.

The WA Transitional Care Service, a flexible model of care for older people at risk of premature admission to long-term services, provides short-term rehabilitation and support services either in the client’s home/hostel or temporarily in a residential aged care facility. Of the 343 admissions until 30 September 2004, 60 per cent of discharged clients returned home, with or without aged care support services.

Innovative models of service delivery to better meet the needs of specific target groups continue to be initiated through the HACC program. In April 2004, a pilot program targeting homeless HACC eligible clients commenced, and early indications are that the service is meeting previously unmet basic support needs, and is also providing an important link to housing for many clients.

Considerable recent effort has been focused on streamlining assessment procedures. With the progressive implementation of the HACC Assessment Strategy through the roll-out of the HACC Needs Identification Instrument (HNI), HACC and Aged Care Assessment Program officers are collaborating to guide implementation of the next phase in which ACATs will be the preferred providers of comprehensive assessment for the HNI. The operations of the ACATs are now being supported by the *ACAT: Towards Best Practice Manual (2004)*, which is designed to support best possible outcomes for clients and consistent ACAT assessment practices across the State. ”

South Australian Government comments

“ The Report again highlights the relatively high proportion of people aged 70 years and over in SA compared with the rest of Australia (11.1 per cent in SA compared to 9.2 per cent in Australia). As people age, there is an increased likelihood of service use, either through community care or admission to residential care.

HACC in SA nevertheless continues to have a lower expenditure per person aged 70+ than the national average, even though the expenditure per 1000 HACC target population is on a par with the national figure. SA will therefore continue to focus on improving services for frail older people in 2005.

The effectiveness of prioritising Indigenous people in HACC over a considerable number of years is now better reflected in the data. In 2002, 1.4 per cent of HACC service recipients were Aboriginal, compared to 2.2 per cent in 2004. Despite a similar emphasis for older people born in mainly non-English speaking countries, this is not as yet well reflected in the data. The reasons for this would likely be the more recent service development, and less reliable data as small volunteer community organisations become proficient in recording their activity.

The Australian and SA governments have agreed to extend the jointly funded Home Rehabilitation and Support Service until June 2005. The service provides short-term rehabilitation and support for older people who have either had an unnecessarily long stay or are at risk of an extended stay in the acute hospital system, and who are assessed as eligible for residential care. To date, the project has resulted in a return home for 60 per cent of clients, with varying levels of support, and fewer than 17 per cent being discharged to residential aged care.

The SA Government has also significantly increased funding for the Hospital Avoidance and Demand Management Program. The program involves a range of strategies and interventions broadly aimed towards providing alternative care options to people who would otherwise be hospitalised. Whilst the program is not aged care per se, it will improve the quality of life for many older people by supporting their health and immediate daily living needs in their homes and communities. In addition, the program has established an Advanced Care in Residential Living program which provides alternative acute and primary care interventions within the residential care setting to avoid the disruption of hospital admission where this is appropriate. ”

Tasmanian Government comments

“ The Tasmanian Government has continued with its reform of the State's health system. The 2004-05 Budget for health and human services now exceeds $1 billion. In addition the State Government has announced additional funding under a $75 million 'Better Hospitals Package', nearly $60 million in the transfer back to State control of, and in upgrading services at, the Mersey Community Hospital and $47 million for Mental Health Services. In total the Government has committed well over $400 million extra to health services over the next four years with the promise that there is more to come.

The State Government has recognised the challenges facing the State's hospitals and community health services, which include the need to maintain the highest standards of patient care in the face of the ageing of the population and increasing costs of new health technologies and recruiting and retaining specialist staff. The Government also acknowledges that pressures may be greater in Tasmania because the State's population is ageing more rapidly than the rest of Australia, and because of the difficulties in serving a dispersed population with the resulting diseconomies of scale.

The 'Better Hospitals Package' includes funding to establish a new non-acute service in Hobart that will complement the State's Extended Rehabilitation Service pilot and contracted 'waiting placement beds' at private residential aged care services.

The development of a partnership agreement between the Australian, State and local governments is nearing completion. The agreement details agreed action items with specified timeframes for completion. The outcomes resulting from these actions are aimed at improving community capacity in addressing issues of an ageing population, providing greater access to information; and planning and implementation processes for aged care services, in context of bed readiness and land usage.

The State Government is keen to work with the Australian Government on programs that address the needs of an ageing population, particularly in those areas at the interface between health services and aged care services. The Department of Health and Human Services' projects within the Pathways Home Program have received final approval and are being implemented in line with the five-year strategic plan. The projects will increase step-down services, increase and improve rehabilitation services and provided additional health services for the elderly.

The implementation of the Australian Government's community care strategy, 'The Way Forward', the Transition Care Program and the new Home and Community Care Agreement will have significant implications for the State. These programs need to compliment and be coherent with the State Government's health service reforms and implemented in a framework that will ensure capacity and flexibility that enables appropriate support and care is provided to Tasmania's ageing and wide disbursed population. ”

Australian Capital Territory Government comments

“ The ACT Government has undertaken a number of initiatives to support older Canberrans to maximise their independence to remain in the community.

The ACT Transitional Care Program has been established to look at innovative ways to improve the interface between hospital and home for older people. This program now has eleven residential places and eight community packages and will continue to run as a pilot until June 2005.

Community Options Transitional Support Program was introduced in 2002 as a pilot and is now recurrently funded. This program provides integrated support services to people in need of assistance following discharge from hospital for a maximum of twelve weeks.

A new position of Residential Aged Care Liaison nurse has been valuable in improving the system wide management of people waiting in hospital for nursing home placement. The nurse has built relationships across the hospital, community and residential care sector and coordinates a centralised waiting list for residential care.

A number of innovative respite care models have been introduced to support families in very flexible ways. One of these projects provides overnight respite care for aged and younger people with a disability from culturally and linguistically diverse backgrounds.

A new intermittent care service has been allocated 25 places from the Australian Government’s Aged Care Innovative Pool for 2003-04. ACT Health will provide 25 community-based packages to provide a restorative, therapeutic and social model of care for older people to improve their physical functioning and mobility to assist them to regain and maintain their activities of daily living.

A specialist stroke unit opened in November 2004 and provides intensive support to clients in a multidisciplinary team for seven days.

The Home and Community Care program will be enhanced by an additional $1.6 million in 2004-05 to support people to remain at home with access to a broad range of community-based based services.

The ACT Legislative Assembly’s Standing Committee on Health and Community Care conducted an inquiry into the prevalence of and options to prevent elder abuse in the ACT. In response to the recommendations that ACT Government has allocated $411 000 over four years to provide for a single contact telephone number to report incidences of elder abuse. The service has also developed an information and education resource kit concerning elder abuse prevention and has completed an extensive community-based based education program. ”

Northern Territory Government comments

“ The Northern Territory Government faces a major challenge in providing community care services to the most remote and most sparsely populated areas in Australia. However, the NT continues to deliver some innovative services to frail aged Territorians. Some of these innovative services models include restructuring services and pooling resources from various program sources such as Home and Community Care, Community Aged Care Packages (CACP), Allied Health Services and the Commonwealth State & Territory Disability Agreement.

New Trans-disciplinary Allied Health services for the frail aged and people with disabilities have been established in rural and remote communities in Katherine, East Arnhem and Darwin regions. A similar service model is currently being rolled out in Central Australia.

The Katherine Transitional Care Unit was launched in March 2003. The restructured Aged and Disability Team in the Katherine region now provides specialist allied health services to the Unit and has increased services to residents of remote communities in the region.

The Northern Territory is developing plans for a Multi Purpose Service (MPS) in Nhulunbuy, East Arnhem Land, which is one of the most isolated regions in Australia. The MPS will provide support and coordination to existing Aged and Disability programs in the region. Greater coordination and support between the visiting and existing services will improve the overall care in the region. A community-based based forensic disability service has been established to meet the needs of people with disabilities that had serious involvement with the criminal justice system.

It is worth noting that the report reveals major achievements that these innovations have delivered. These include the NT having the highest rate of HACC service hours and Indigenous recipients of CACPs in all jurisdictions.

It is also worth noting that Australian Government expenditure on residential care services per person in the target group in the NT is almost half that of SA. Most of the residential aged care facilities in the Northern Territory have a small number of places and are facing critical viability problems. The NT is establishing a project officer position to assist service providers in Tennant Creek to consolidate ancillary services of various providers and assist with viability issues. It is crucial that the Australian Government address the serious viability problems faced small facilities in remote and rural areas.

The NT Government is committed to working with local service providers, other jurisdictions and the Australian Government on improving outcomes for the frail aged and people with disabilities in the Northern Territory. ”

12.6 Appendix: Age standardisation of aged care data

How age profiles can distort observed service usage patterns

The age profile of Australians varies across jurisdictions and across different cultural and linguistic backgrounds, (see for example the different age profiles of Indigenous and non-Indigenous Australians — figure 12.7). Variations in age profiles are important because the likelihood of needing aged care services increases with age (table 12.13). As a result, observed differences in service usage rates by different cohorts within the community may arise from different age profiles, rather than from different usage patterns. One method of eliminating this distortion from the data is to standardise for the age profiles of different groups.

Method of standardisation

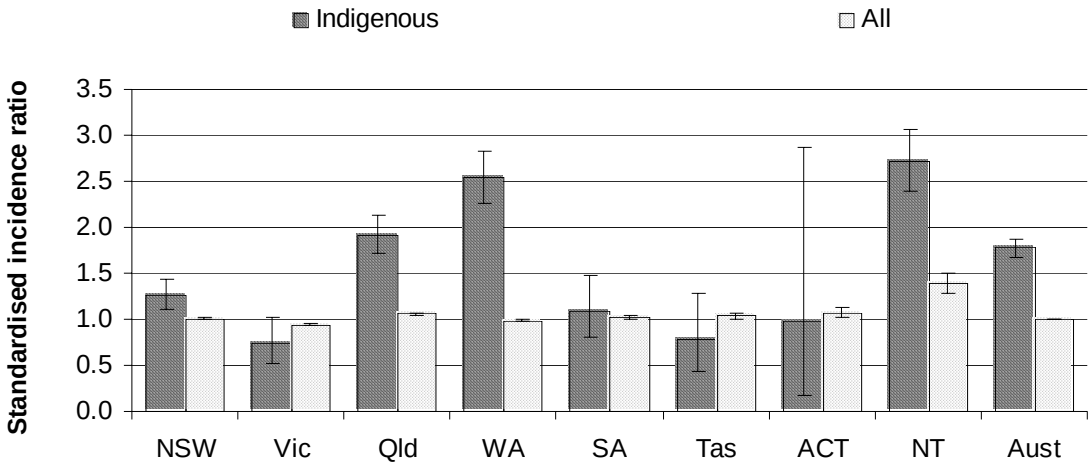
Either direct or indirect standardisation can be used; indirect standardisation is presented here because it is more appropriate when comparing small populations. This method applies standard age-specific usage rates (in this case, average Australian rates) to actual populations (different groups within states and territories), and compares observed numbers of clients with the numbers that would have been expected if average rates had applied. Comparisons are made via the standardised incidence ratio. A value greater than 1.0 in this ratio means that use is higher than expected if the particular group has the same usage rate as that of the Australian population as a whole; a value below 1.0 means use is lower than expected. Age standardisation generally covers use by all age groups, so the resulting standardised incidence ratios compare use by complete population groups, not just by those aged 70 years or over.

Application of indirect standardisation

In the following illustration, 2001 data are used. Within each State and Territory, the combined use of permanent residential aged care and CACPs by Indigenous people is compared with average service use by all Australians. The resulting standardised incidence ratios are presented in figure 12.23. The error bars in the figure show how accurate the comparisons are; if an error bar goes across the value of 1.0, then the usage rate by that population group is not significantly different from the average use by all Australians. People (Indigenous people in particular) also use long stay hospital beds, flexible places and other services not covered in the analysis; consequently, these results do not represent all the services available to people.

Figure 12.23 shows that, Indigenous people had a higher than average combined use of CACPs and permanent residential aged care — nationally, about 80 per cent higher. This result reflects the higher age-specific usage rates of CACPs for Indigenous people at all ages, and of permanent residential aged care for those Indigenous people aged under 75 years (table 12.13). The picture, however, changes from State to State: combined use of the services is not significantly different from the national average for Indigenous people in Victoria, SA, Tasmania and the ACT, but is higher than the average in NSW (about 25 per cent higher), Queensland (90 per cent higher), WA (150 per cent higher) and the NT (170 per cent higher). Looking at both Indigenous and non-Indigenous people, Victorians generally use residential aged care at a slightly lower rate than the national average, while people from Queensland, SA, Tasmania, the ACT and the NT have slightly higher than average usage rates.

Figure 12.23 **Standardised incidence ratio for use of CACP and permanent residential aged care (combined), 30 June 2001[a, b]**



a Indigenous ratio is per 1000 Indigenous people aged 50 or over, all ratio is per 1000 Indigenous people aged 50 or over and non-Indigenous people aged 70 or over **b** Uses indirect age standardisation against use by all people Australia-wide.

Source: AIHW (unpublished); table 12A.58.

Table 12.13 **Age-specific usage rates of CACPs and permanent residential aged care (per 1000 people), 30 June 2001[a, b]**

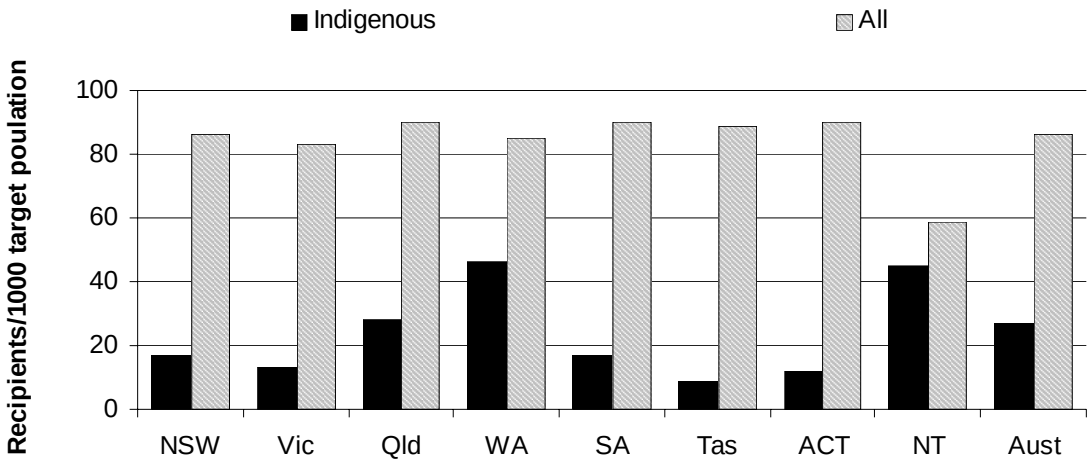
	CACP recipients		*Permanent aged care residents*	
Age (years)	*Indigenous*	*Non-Indigenous*	*Indigenous*	*Non-Indigenous*
50–54	1.7	0.1	3.3	0.7
55–59	4.1	0.3	4.2	1.4
60–64	8.6	0.7	9.5	2.9
65–69	16.3	1.5	11.4	6.1
70–74	30.1	3.2	25.2	14.5
75–79	33.7	7.1	66.3	35.3
80+	36.7	20.7	116.3	160.8

a Excludes clients of multipurpose and flexible services. **b** Cases with missing data on Indigenous status have been pro rated within gender/age groups.

Source: AIHW (unpublished).

The above picture is quite different from that given when comparing use with the target group population (clients per 1000 in the target group — figure 12.24; also used in figures 12.10 and 12.12). This measure suggests that, combined use of CACPs and permanent residential aged care is much lower for Indigenous people than for all people in all jurisdictions except the NT; even in the NT, for Indigenous people the ratio of clients to target population is about 25 per cent lower than that for all people from the NT. Figure 12.24 also suggests that combined use of the two services is generally much lower in the NT than in other jurisdictions; this difference is not apparent after age standardisation (figure 12.24), indicating that the difference in this measure is the result of the relatively young age structure of the NT.

Figure 12.24 **Ratio of CACP recipients and permanent residents (combined) to 1000 persons in target population, 30 June 2001[a]**



a Indigenous ratio is per 1000 Indigenous people aged 50 years or over, 'all' ratio is per 1000 Indigenous people aged 50 years or over and non-Indigenous people aged 70 years or over.

Source: AIHW (unpublished); table 12A.58.

12.7 Definitions of key terms and indicators

Adjusted subsidy reduction supplement

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

Aged care

Formal services funded and/or provided by governments, that respond to the functional and social needs of frail older people, and the needs of their carers. Community aged care services aim to optimise independence and to assist frail older people to stay in their own homes, while residential care services provide accommodation and care for those who can no longer be assisted to stay at home.

The majority of aged care services assist in activities of daily living such as personal care (for example. bathing and dressing), housekeeping and meal provision, and are delivered by trained aged care workers. However, aged care services may also be delivered by health professionals such as nurses and occupational therapists. These services generally aim to maintain function rather than treat illness or rehabilitate, and are distinguished from the health services described in Part E of this report. Assessment of care needs is also an important component of aged care.

Aged care services may be funded through programs specifically or mainly directed to older people, or through programs that address the needs of people of different ages. Generally, the target groups of aged care services are people over the age of 70 years and Indigenous people aged over 50 years.

Ageing in place

An approach that aims to provide residents with appropriate care and increased choice by allowing them to remain in the same facility regardless of their levels 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 Commonwealth aged care legislation is 'to promote ageing in place through the linking of care and support services to the places where older people prefer to live' (*Aged Care Act 1997* (Cwlth), s.2-1 [1j]).

Centre day care

Respite care provided from a facility such as a day care or health centre. Respite care is usually combined with social support services to maintain the functional capabilities of the person receiving care.

Complaint

A complaint by the affected care recipient or his or her representative, or anyone else, to the Secretary about anything that:

- may be a breach of the relevant approved provider's responsibilities under the *Aged Care Act 1997* or the Aged Care Principles
- the complainant thinks is unfair or makes the affected care recipient dissatisfied with the service.

Disability	A limitation, restriction or impairment that has lasted, or is likely to last, for at least six months and restricts everyday activities.
EBA supplement	Payments made to supplement services for the extra costs associated with public sector enterprise bargaining agreements over and above those required by other wage Awards.
Elapsed time between ACAT approval and entry into a residential care service	The measure of the elapsed time between ACAT approval and entry into a residential care service. It has been used in past years as an indicator of access to residential care.
High/low care recipient	Recipient of a high level of residential care (that is, a level to RCS levels 1–4) or a recipient of a low level of residential care (that is, a level corresponding to RCS levels 5–8). If the person is approved as a recipient of a high level of care, that person can receive care at any care classification level (*Approval of Care Recipients Principles 1997*, s.5-9). A person approved as a recipient of a low level of care can be classified only as RCS 5–8 (*Classification Principles 1997*, s.9-19).
In-home respite	A short term alternative for usual care.
People from non-English speaking countries	People who were born in non-English speaking countries. English-speaking countries are defined as Australia, New Zealand, the United Kingdom, Ireland, the United States, Canada and South Africa.
People with a moderate disability	Where a person does not need assistance, but has difficulty with self care, mobility or communication.
People with a profound disability	Where a person is unable to perform self-care, mobility and/or communication tasks, or always needs assistance.
People with a severe disability	Where a person sometimes needs assistance with self-care, mobility or communication.
Personal care	Assistance in undertaking personal tasks (for example, bathing).
Places	A capacity within an aged care service for the provision of residential care, community care or flexible care in the residential care context to an individual (*Aged Care Act 1997* (Cwlth)); also refers to 'beds' (*Aged Care (Consequential Provisions) Act 1997* (Cwlth), s.16).
Real expenditure	Actual expenditure adjusted for changes in prices, using the GDP(E) price deflator and expressed in terms of final year prices.
Resident	For the purposes of the *Aged Care Act 1997*, a person who is being provided with residential care through an aged care service conducted by an approved provider under the Act.
Respite care	Alternative care arrangements for dependent people living in the community, with the primary purpose of giving their carer a short term break from their usual caring commitments.
Rural small nursing home supplement	Payments made by states and territories to small sized high care public sector residential aged care facilities (up to 30 places) that are located in rural areas. Three levels of supplement are paid to facilities varying in size from 10 to 20 and 30 places.
Special needs groups	Section 11-3 of the Aged Care Act, specifies the following people as people with special needs: people from Aboriginal and Torres Strait Islander communities; people from non-English speaking countries; people who live in rural or remote areas; and people who are financially or socially disadvantaged. Principles (Regulations) made under s. 11-3 also specify veterans as a special needs group.

Veterans	Veterans, their war widows, widowers and dependents who are eligible for treatment through the Department of Veterans' Affairs under the provisions of the *Veterans' Entitlements Act 1986* (Cwlth).

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