12 Aged care services

The aged care system comprises all services specifically designed to meet the needs of Australia's frail older people for care and support. This chapter focuses on government funded residential and community based services for older people, particularly:

- residential services, which include high care services, low care services, services providing a mixture of high and low care, and residential respite services (box 12.1);
- community services, which include Home and Community Care (HACC) program services, Community Aged Care Package (CACP) program and Veterans' Home Care (VHC);[1]
- respite services, which include HACC respite and centre based day care and the Commonwealth National Respite for Carers Program (NRCP); and
- assessment services, which are provided by Aged Care Assessment Teams (ACATs).

A profile of aged care services appears in section 12.1, followed by a brief discussion of recent policy developments in section 12.2. Together, these provide a context for assessing the performance indicators presented later in the chapter. This chapter reports data on the effectiveness and efficiency of publicly funded aged care services. Effectiveness is indicated by service quality, accessibility and equity; and efficiency is indicated by the unit cost of providing the service. A framework of performance indicators is outlined in section 12.3 and data are discussed in section 12.4. Future directions in performance reporting are discussed in section 12.5. Jurisdictions' comments are reported in section 12.6. Definitions for data descriptors and indicators are provided in section 12.7.

A number of additions and improvements have been made to the chapter this year. These include the reporting of a new effectiveness indicator — namely compliance with service standards for residential care. The chapter also includes descriptive data on intensity of care which has been identified for future reporting.

[1] Unless otherwise stated, HACC expenditure does not include the Department of Veterans' Affairs (DVA) expenditure on VHC.

Box 12.1 **Interpreting residential care data**

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

- *Residential services data*. This Report groups residential services for reporting purposes based on the eight level Resident Classification Scale (RCS) profile of their clients. Services are classified as:
  - high care services: similar to nursing homes in the pre-1997 regime, these services cater primarily to the needs of high care residents. These services have 80 per cent or more residents classified as RCS levels 1–4; or
  - low care services: similar to hostels in the pre-1997 regime, these services cater primarily to the needs of low care residents. These services have 80 per cent or more residents classified as RCS levels 5–8; or
  - services with a mixture of high and low care: these services meet the needs of both high care and low care residents. They have less than 80 per cent residents classified as RCS levels 1–4 and more than 20 per cent of residents classified as RCS levels 5–8.

  These categories have been used for descriptive purposes and do not have any legal foundation in the *Aged Care Act 1997* (Cwlth). Similarly, the choice of 80 per cent as a cut-off is subjective but considered appropriate for descriptive purposes.
- *Resident data*. This Report classifies clients as high care or low care based on their RCS assessment. High care residents have been assessed as RCS levels 1–4. 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 the planning and allocation of subsidised services to meet residential aged care needs and community care needs. Planning is done on the basis of high and low care need. 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 must be filled by low care residents), this can change over time with 'ageing in place' (box 12.3) which allows a low care resident who becomes high care within the same service to occupy a low care place until they are discharged.
- *Locality data*. Geographical data areas are based on the Rural, Remote and Metropolitan Area classification (DPIE and DHSH 1994). Data are classified according to an index of remoteness which rates each Statistical Local Area (SLA) based on the number and size of towns, the distance to major towns and urban centres, and population densities. Areas are classified into three groups:

(Continued on next page)

Box 12.1 **(Continued)**

- metropolitan areas: comprising State/Territory capital cities, based on the Australian Bureau of Statistics (ABS) capital city Statistical Division, and urban centres with 100 000 people more, such as Geelong, Gold Coast, Townsville, Newcastle and Wollongong;
- rural areas: having several large towns with between 10 000 and 99 999 people; and
- remote areas: having few large towns with more than 5000 people and where there are great distances between centres and other SLAs.

Older Australians also use many other mainstream health and community services. Other chapters cover outcomes for older people in some of these services — namely, acute health care services for older people in chapter 5 and housing services in chapter 16. There are interactions between these service areas; for example, the number of residential places may affect demand for public hospital beds, and changes in service delivery in the acute care 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 97 format at \Publications\Reports\2002\Attach12A.xls or in Adobe PDF format at \Publications\Reports\2002\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). They may be subject to revision. The most up-to-date versions of these files can be found on the Review's web page (www.pc.gov.au/gsp/). Users without Internet access can contact the Secretariat to obtain up-to-date versions of these tables (see details on the inside front cover of the Report).

12.1 Profile of aged care services

Service overview

This chapter focuses on residential care, community care and assessment services for older people. Services that are designed for the carers of older people are also within the scope of this chapter.

Services for older people are provided on the basis of the frailty or functional disability of the recipients rather than specific age criteria. Nevertheless, in the absence of more specific information, people aged 70 years and over are used 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 and over are used as a proxy for the likelihood of requiring aged care services. The Commonwealth Government also uses these age proxies for planning the allocation of residential care and CACPs.

Government funded aged care services covered in this chapter relate to the three levels of government (Commonwealth, State and Territory, and local) involved in service funding and delivery. The formal publicly funded services covered in this chapter represent 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 1998 who required help with self care, mobility or communications received assistance from the informal care network of family, friends and neighbours (ABS 1999). Many people also receive assistance from both formal aged care services and informal sources.

A range of privately funded services also provide support for older Australians. These services do not receive government support and are not within the scope of reporting in the chapter.

Roles and responsibilities

Assessment services

The Commonwealth established the Aged Care Assessment Program in 1984 based on the assessment processes used by State and Territory Area Health Services to determine eligibility for admission into residential care and the level of care required (and thus the subsidy paid to such services). The core objective of ACATs is to assess the needs of frail older people and recommend appropriate services. Assessment and recommendation by ACATs is mandatory for admission to residential care or receipt of a CACP. People may also be referred by ACATs to other services, such as those funded by the HACC program.

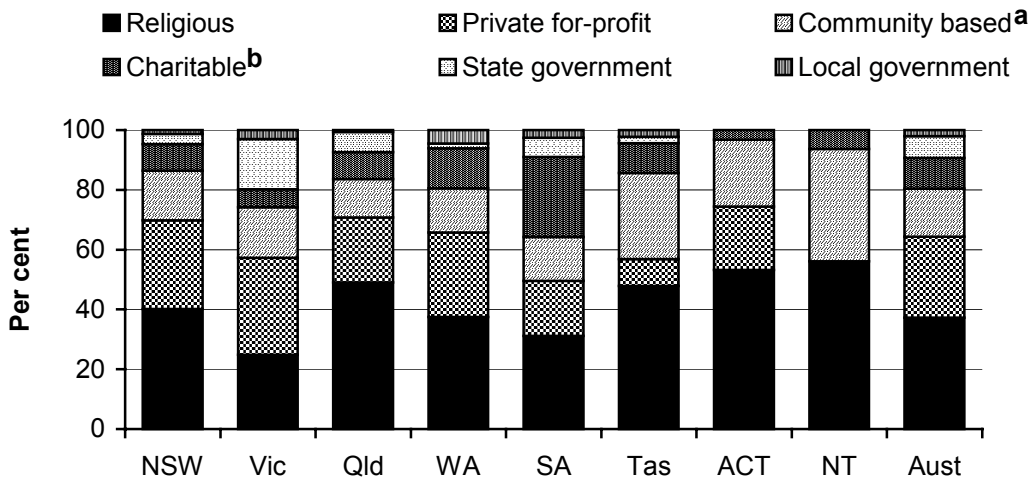
State and Territory governments are responsible for the day-to-day operation and administration of ACATs and provide the necessary accommodation and support services. The role of the teams differs slightly across jurisdictions and within a

jurisdiction, partly reflecting the service location (for example, whether the team is attached to a geriatric service, a hospital or a community service).

Residential care services

Residential care services are run mainly by private for-profit, religious, charitable and community based organisations. Some State, Territory and local governments also operate some residential services (figure 12.1). The largest providers of places at June 2001 were religious and private for-profit services (37.3 per cent and 27.0 per cent respectively). The private sector is mostly involved in high care services, managing about 46 per cent of places in these services (DHAC unpublished). The proportion of aged care services provided by government, private enterprise and charitable organisations varied significantly across jurisdictions in June 2001.

Figure 12.1 **Ownership of residential places, June 2001**



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: DHAC (unpublished); table 12A.7.

The Commonwealth Government is responsible for most of the regulation of residential aged care services, including accreditation (box 12.6). 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 two types of community care programs reported in this chapter — the HACC and CACP programs — fund services that aim to provide practical assistance to enable frail older people (HACC/CACP) and people with a disability (HACC) to continue living in the community. The services are usually provided by State, Territory and local government organisations, charitable bodies, community organisations and commercial providers. The Department of Veterans' Affairs (DVA) and the NRCP also provide community care services.

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

The Commonwealth Government controls the number of subsidised bed places, with a target of 40 high care places, 50 low care places and 10 community aged care packages for each 1000 people in the population aged 70 years and over. In addition:

- services are expected to meet regional targets for places for concessional residents, ranging from 16 per cent to 40 per cent of places, to ensure residents who cannot afford to pay an accommodation bond or charge have equal access to care (with criteria for being deemed a concessional resident being based on home ownership and occupancy, receipt of income support and the level of assets held at entry); and
- extra service places (where residents pay for a higher standard of accommodation, food and services) are restricted.

Various Commonwealth, State and Territory laws govern regulatory arrangements for residential care (box 12.6). 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 jurisdictional based awards. Local government by-laws may also apply (for example, waste disposal rules).

Source: PC (1999).

Indigenous specific and flexibly funded services

About 60–70 per cent of Indigenous Australians needing aged care services have their needs met through the mainstream services covered by this chapter (DHAC unpublished). Indigenous specific and flexibly funded services provide services for the majority of those people in services, but not in mainstream services.

Funding

Assessment services

Under a cooperative arrangement, the Commonwealth provides grants to State and Territory governments to operate 123 ACATs and Evaluation Units. In 2001-02, the Commonwealth provided funding of $39.9 million nationally (DHAC unpublished).

Residential care services

The aged care reforms introduced in October 1997 resulted in a government funding system that does not differentiate between nursing homes and hostels. One aim of this funding system is to promote 'ageing in place' — that is, enabling residents to remain in one aged care facility irrespective of their dependency level. Access to 'ageing in place' is subject to the decision of service providers to offer this option.

The Commonwealth Government provides the majority of annual funding for residential aged care services — $3.7 billion in 2000-01, or approximately 71 per cent of the cost of care (DHAC unpublished). 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.

Commonwealth Government funding of approximately $6.6 million in 2000-01 was also provided through the Residential Care Development Scheme run by the DVA. The scheme aims to help ex-service and community based organisations to provide high quality residential aged care services and community care packages to the veteran community (table 12A.33).

The Commonwealth Government annual RCS subsidy for each occupied place varies according to the client's level of dependency. A high level of care is classified as RCS levels 1–4 and low level care as RCS levels 5-8 (table 12.1). The average Commonwealth annual RCS subsidy per residential place at June 2001 varied across jurisdictions, ranging from $27 849 in the NT to $23 317 in Queensland. Variations in average annual subsidies reflect differences in subsidy rates as well as differences in the dependency of residents (table 12.1). Low care subsidy rates (RCS levels 5–8) are the same across all States and Territories, while high care subsidy rates (RCS levels 1–4) are being adjusted towards a uniform national rate by July 2006 under the Commonwealth Government's Funding Equalisation and Assistance Package, totalling $148 million over six years.

Table 12.1 **Average annual Commonwealth RCS subsidy per occupied place and the dependency level of aged care residents, June 2001**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Average annual Commonwealth RCS subsidy per residential place[a]										
All RCS levels	$	25 982	25 599	23 317	24 128	24 710	27 483	24 355	27 849	25 148
Proportion of high care residents[b]										
RCS 1 and 2	%	44.3	42.8	40.9	41.8	43.2	41.8	42.7	43.3	42.9
RCS 3 and 4	%	21.6	16.9	22.4	16.6	20.4	26.3	17.5	31.0	20.2
Proportion of low care residents										
RCS 5–8	%	34.0	40.3	36.6	41.6	36.4	31.9	39.8	25.7	36.9

[a] Only includes funding on the RCS; pensioner supplement and other supplements will add around $3000 per year for residents. On average, residents contribute $11 200 per year to their care. [b] Differences in average annual subsidies reflect differences in subsidy rates as well as differences in the dependency of residents.

Source: DHAC (unpublished); table 12A.32.

State and Territory governments contribute financially to the services they operate, and these services generally receive lower Commonwealth subsidies than those received by other services. Some States and Territories have made arrangements to continue supplementing ex-government services following transfer to the private sector. The NT Government also provides some funding to some private not-for-profit residential care services.

The combined number of operational high care and low care places per 1000 people aged 70 years and over was reasonably similar across most jurisdictions at June 2001 (ranging from 109.8 in the NT to 78.5 in Victoria). The ACT had proportionally more low care places and fewer high care places (58.3 per cent and 41.7 per cent respectively) than those in other jurisdictions. There were proportionally more high care places in NSW (57.6 per cent) (table 12.2).

Table 12.2 **Operational high care and low care residential places per 1000 people aged 70 years and over, 30 June 2001[a]**

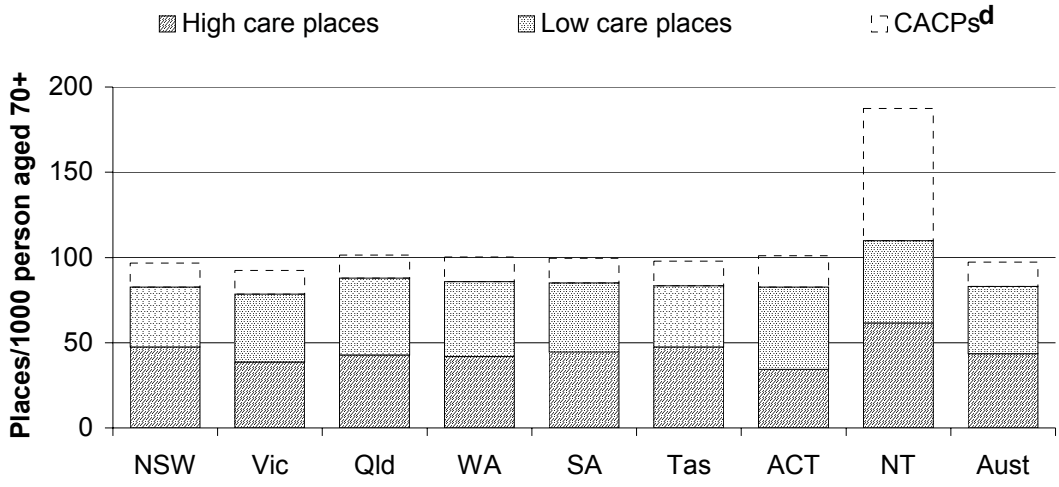
	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
High care places	no.	47.6	38.8	42.8	41.9	44.6	47.5	34.4	61.5	43.6
Low care places	no.	35.1	39.7	45.0	43.9	40.6	35.8	48.2	48.3	39.4
Total places	**no.**	**82.7**	**78.5**	**87.8**	**85.8**	**85.2**	**83.3**	**82.6**	**109.8**	**83.0**
Proportion of high care places	%	57.6	49.4	48.8	48.8	52.4	57.1	41.7	56.0	52.5
Proportion of low care places	%	42.4	50.6	51.2	51.2	47.6	42.9	58.3	44.0	47.5

[a] Places do not include those that have been 'approved' but are not yet operational.

Source: DHAC (unpublished); table 12A.8.

Figure 12.2 shows the combined number of high care residential places, low care residential places and CACPs. The proportion of low care places relative to high care places rose between 1988 and 2001 (table 12A.8).

Figure 12.2 **Balance of care: operational residential places and CACPs, June 2001**[a, b, c]



[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] Target population data exclude Indigenous people aged 50–70 years, which inflates the ratios for jurisdictions such as the NT which have a large proportion of Indigenous people in care. [d] CACPs are not residential services but are included in the Commonwealth planning targets of 100 places per 1000 residents in the target population. See box 12.1 for interpretation of residential care data.

Source: DHAC (unpublished); table 12A.8.

Community care services

Total national expenditure on HACC and respite services was $998.6 million in 2000-01, of which HACC expenditure represented $932.0 million. Commonwealth, State and Territory governments jointly fund the HACC program, with the Commonwealth Government contributing approximately 60.8 per cent and State and Territory governments funding the remainder (table 12A.30).

The National Respite for Carers Program provides community care services and is funded by the Commonwealth. Expenditure on this program was $66.6 million in 2000-01 (table 12A.30). Expenditure for in-home respite care from the DVA, including emergency home care, was $9.4 million in 2000-01 (DVA unpublished).

The CACP program is funded by the Commonwealth Government, which expended $194.6 million on the program in 2000-01 (tables 12A.29 and 12A.2). Community Aged Care Packages are also part funded by client contributions. Between

1999-2000 and 2000-01, CACP expenditure per person aged 70 years and over grew by about 24 per cent (table 12A.29).

Size and scope of sector

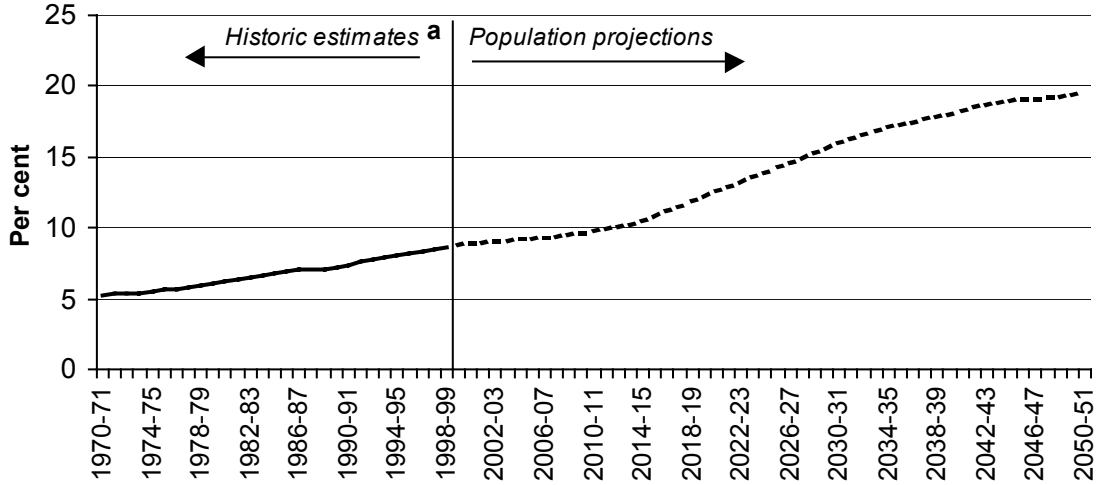
Size and growth of the older population

The Australian population is ageing (as indicated by an increase in the proportion of people aged 70 years and over in the total population). This trend is expected to continue and the proportion of older people is expected to increase dramatically in the twenty-first century (figure 12.3).

The distribution of older people varied across jurisdictions at June 2001, with relatively more older people in SA and Tasmania and relatively fewer in the NT (figure 12.4). The proportion of older females was higher than that of older males in all jurisdictions.

Demographic profiles affect the demand for aged care services because females use aged care services, particularly residential services, more than males do; for example, 72.4 per cent of aged care residents at June 2001 were female (DHAC unpublished). 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. There are also greater incidences of incontinence, hip fractures and financial disadvantage among older women.

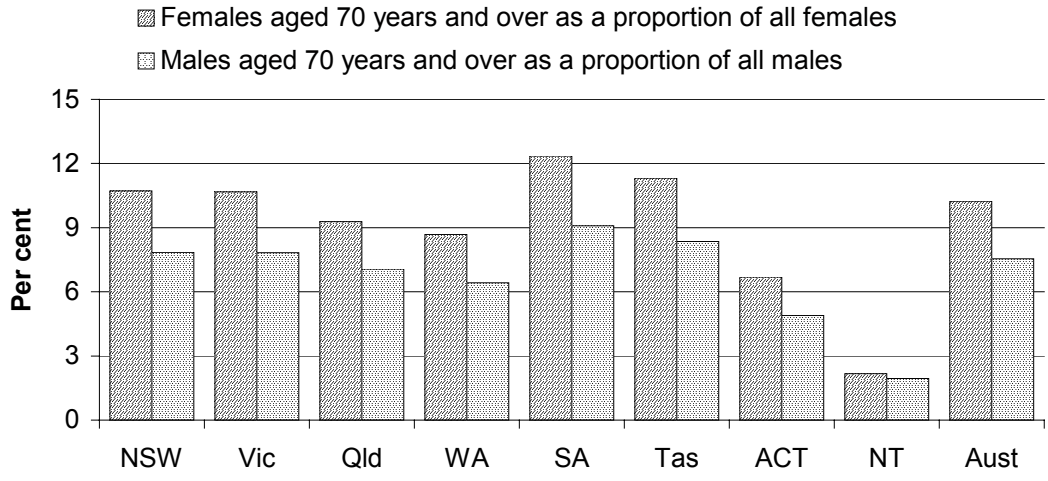
Figure 12.3 **Persons aged 70 years and over as a proportion of the total population — time series**



a Historic estimates are based on the population census that is held at five-year intervals.

Source: ABS (2000).

Figure 12.4 **People aged 70 years and over as a proportion of the total population, by sex, June 2001 (estimated)**



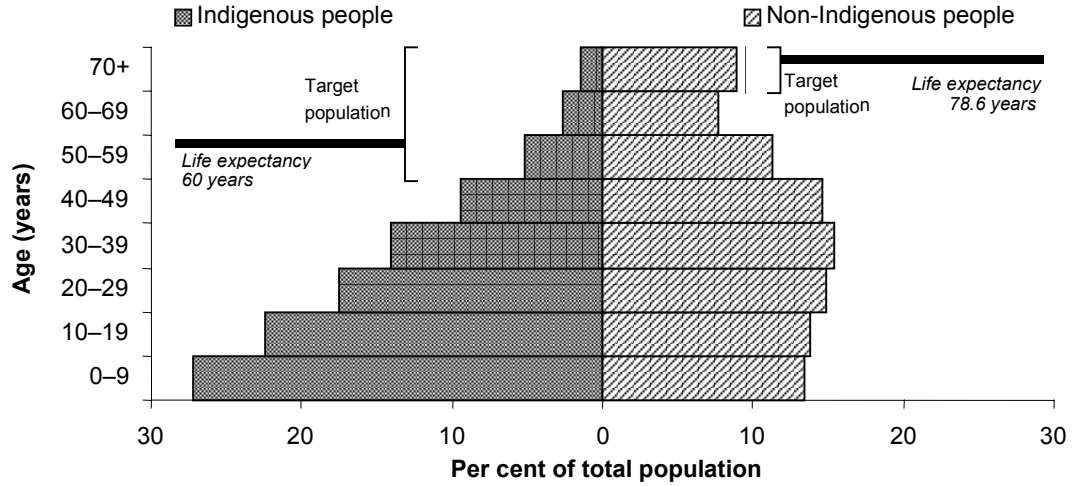
Source: DHAC (unpublished); table 12A.1.

Characteristics of older Indigenous people

The ABS estimated that about 40 500 Indigenous people were aged 50 years or more in Australia at 30 June 2001. The majority were located in NSW (30 per cent), Queensland (27 per cent), and WA and the NT (14 per cent each) (ABS 1998).

Although the Indigenous population is also ageing, there are significant differences in the age profile and life expectancy of Indigenous Australians compared with the non-Indigenous population (figure 12.5). The life expectancy of Indigenous males (57 years) and females (62 years) is nearly 20 years below that recorded for the total Australian population (ABS 1998). As a result, Indigenous people are likely to need aged care services earlier in life, compared with the general population.

Figure 12.5 **Age profiles, target populations and life expectancy differences between Indigenous and other Australians, June 1999**



Source: ABS (1998, 2000).

Residential care services

The size and location of residential services — which may influence costs of service delivery — vary across jurisdictions. Nationally, there were approximately 142 013 operational places (permanent and respite) in residential care services (72 266 in predominantly high care services, 34 001 in predominantly low care services and 35 746 in services with a mixture of high and low care residents) at June 2001 (tables 12A.3, 12A.4 and 12A.5). As the trend towards 'ageing in place' (box 12.3) increases, there has been an increase in the number of services categorised as services with a mixture of high and low care, which rose from 15.7 per cent of all places in June 2000 to 25.2 per cent of all places in June 2001. The client profile of services that had predominantly low care residents in 2000 has changed, with low level care residents choosing to stay in their current service as their dependency levels rise over time, and with aged care services expanding.

Low care services were generally smaller (as measured by number of places) than high care services at June 2001. Nationally, 84.4 per cent of low care services had

60 or fewer places (table 12A.4), compared with 74.7 per cent of high care services (table 12A.3).

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 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 their care needs increase from low level to high level care. 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, and neither does it 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.

One possible proxy for measuring 'ageing in place' is the proportion of residential aged care service providers who are caring for residents whose care needs range across high and low care. Another possible measure is the proportion of residents who remain in the same home as their care needs increase. The main difficulty with the latter measure is determining whether decreasing mobility between hostels and nursing homes reflects negatively or positively on the choice and flexibility of residential care available to residents.

Future editions of the Report will include data on 'ageing in place', although it may not be possible to directly measure this concept.

Source: DHAC (unpublished).

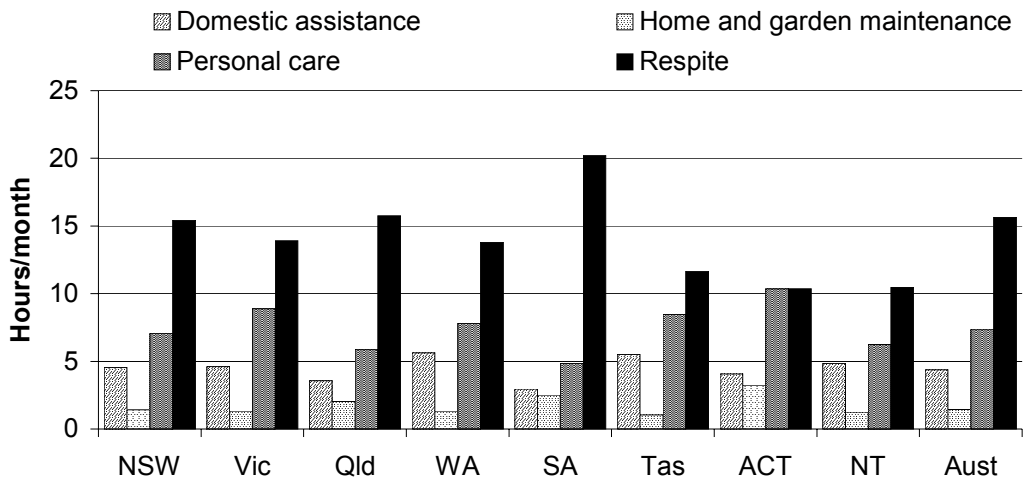
Community care services

Funding for HACC covers a range of services (such as home help and maintenance, personal care, food services, respite care, transport, paramedical services and community nursing). The target population is defined as people living in the community who are, in the absence of basic maintenance and support services, at

risk of premature or inappropriate long term residential care. The target population comprises both frail aged people and younger people with disabilities, and their carers. Approximately 70 per cent of the program's recipients are aged 70 years and over, but the program is also an important source of community care for younger people with a disability (DHAC unpublished).

Figure 12.6 shows the average number of hours approved per month for veterans who received home care services between 1 January 2001 and 30 June 2001. Veterans' Home Care services are targeted at veterans and war widows/widowers with low level care needs (DVA unpublished).

Figure 12.6 **Average number of hours approved per month for veterans, 1 January 2001 to 30 June 2001**[a]



[a] Average number of hours approved per month represents the average number of hours approved for each month of service rather than per veteran.

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

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 (or RCS levels 5–8). The main distinctions between the HACC and CACP programs are summarised in table 12.3.

Two factors suggest community care will continue to play an increasing role in aged care services. First, there is the longer term policy objective of improving the capacity of aged care services to support people at home, which reflects a strong consumer preference. Second, the 'technology' of community care is increasingly able to achieve this goal at higher levels of client dependency.

Table 12.3 **Distinctions between the HACC and CACP programs**

	HACC	*CACPs*
Range of services[a]	Wider range of services available	Narrower range of services available
Eligibility	ACAT assessment not mandatory	ACAT assessment mandatory
Funding	Cost shared by Commonwealth, State and Territory governments and client contributions Mainstream HACC agency funding increasingly tied to the delivery of service outputs	Funded by the Commonwealth and client contributions Fund holder able to spread the available resources among high and lower need clients
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
Size of program	$932 million funding in 2000-01 About 490 000 clients for the year 2000-01	$195 million funding in 2000-01 About 30 300 clients for the year 2000-01

[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 a fortnight. At the higher end, some people have levels of need that would exceed the level available under CACPs.

Source: DHAC (unpublished); tables 12A.2, 12A.9, 12A.29, 12A.30 and 12A.36.

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 both the HACC and CACP programs have become increasingly important components of the aged care system. The estimated number of HACC hours delivered per month per 1000 people aged 70 years and over grew by 2.2 per cent between 1999 and 2000 from 1048 to 1071 hours (table 12A.17). The estimated number of hours of HACC service per month increased by 4.8 per cent from 2.55 million in 1999 to 2.67 million in 2000 (DHAC unpublished). The total number of CACP places per person aged 70 years and over increased by approximately 31.2 per cent between June 2000 and June 2001 from 10.9 to 14.3 (table 12A.8).

12.2 Policy developments in aged care services

Veterans' Home Care

Veterans' Home Care is a 2000 Commonwealth Budget initiative implemented in January 2001. 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.

There are 54 VHC regions throughout Australia, with 34 agencies providing assessments to veterans and war widows/widowers, and approximately 300 organisations contracted to provide VHC services. Eligibility for VHC services is not automatic, but based on assessed need. Under the VHC national co-payment fees policy, veterans pay a co-payment for all VHC services except respite care. Separate co-payment arrangements apply for community transport, social support and delivered meals.

Accreditation

From 1 January 2001, all residential aged care services were required to be accredited by the Aged Care Standards and Accreditation Agency. This Report includes, for the first time, compliance with service standards for residential care as an indicator of quality to reflect the requirement for residential aged care services to gain accreditation (box 12.6 and table 12A.41)

12.3 Framework of performance indicators

The aim of the indicators is to provide information on the efficiency and effectiveness of publicly funded aged care services. Effectiveness indicators focus on access to services and the appropriateness and quality of services. Efficiency indicators focus on the unit costs of providing services (figure 12.7). These indicators relate to government objectives in the aged care sector (box 12.4).

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; and
- efficient.

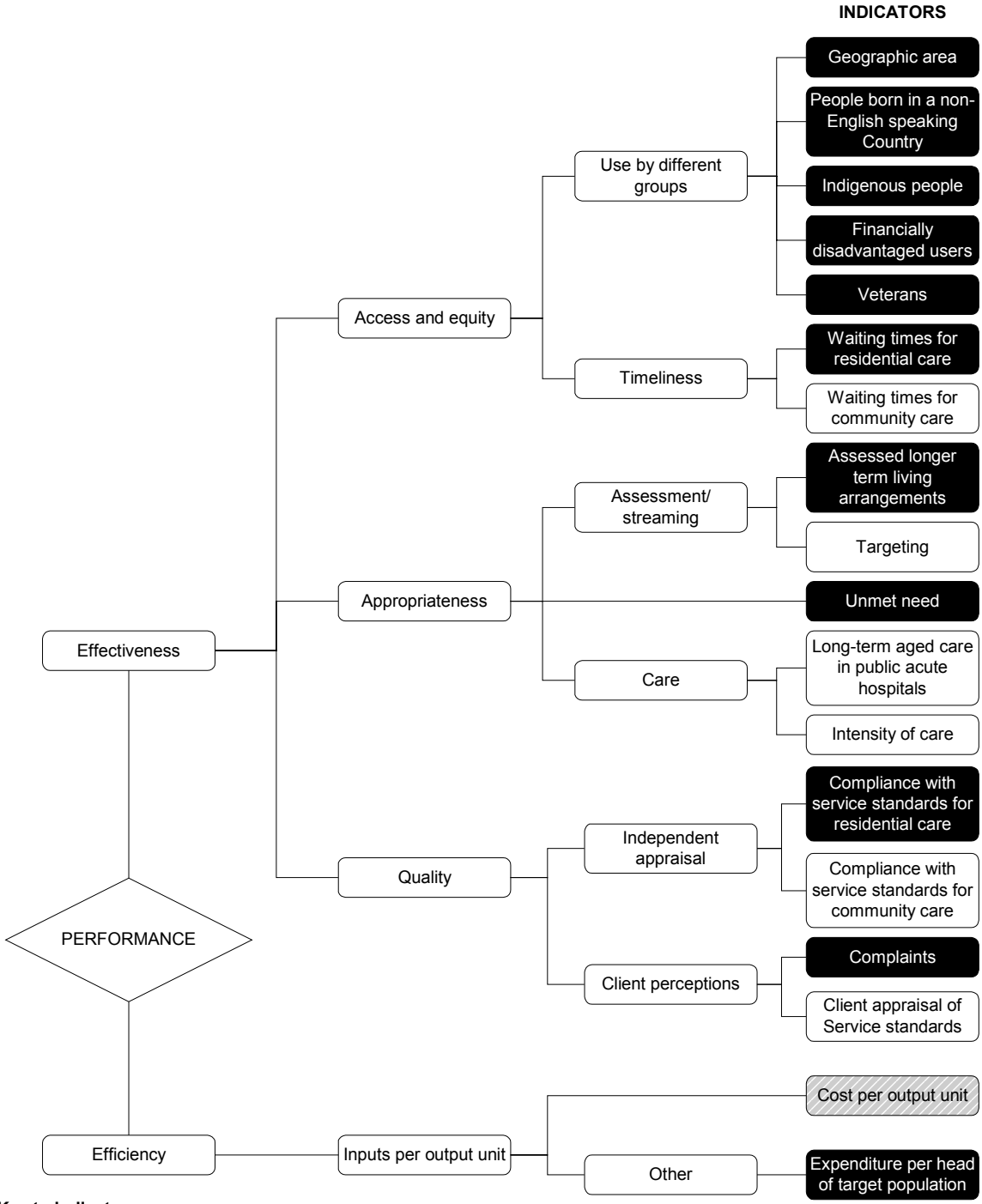
New and refined indicators

The performance indicator framework has been further refined for the 2002 Report. A new effectiveness indicator (compliance with standards for residential services) is reported (table 12.7 and table 12.8). Ongoing work to provide a more comprehensive set of performance indicators, and to improve existing indicators and data, is discussed in section 12.5.

12.4 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 12.7 **Performance indicators for aged care services**



Access and equity — use by different groups

Residential services

Special needs groups identified by the *Aged Care Act* are people from Indigenous communities, people from non-English speaking countries, people who live in rural or remote areas, people who are financially or socially disadvantaged and veterans. A key national objective of the aged care system is to provide equal access to residential services for all people who require those services. Indigenous people tend to require aged care services at a younger age than the general population. Thus, participation is based on Indigenous people aged 50 years and over.

One way of measuring accessibility is to compare the proportion of residents from a special needs group with their representation in the target population (which is all people aged 70 years and over, plus Indigenous people aged 50–69 years). However, factors such as cultural differences — which may influence the extent to which various special need groups use residential care services — need to be considered in the interpretation of such results.

In all jurisdictions, on average, Indigenous people and people from non-English speaking countries have lower rates of use of aged care services at June 2001 (figure 12.8). This can be explained to some extent by the younger age profiles of Indigenous people and people from non-English speaking countries compared with the rest of the population.

Commonwealth planning guidelines require that services allocate a minimum proportion of places for concessional residents. These targets range from 16 per cent to 40 per cent of new places, depending on the service's region. Services can choose to exceed the minimum amount. All jurisdictions exceeded the minimum amount at 30 June 2001, with the NT reporting the highest proportion of concessional residents (74.0 per cent) (table 12.4).

Figure 12.8 **Residents per 1000 target population, June 2001**

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

Source: DHAC (unpublished); tables 12A.9, 12A.11 and 12A.13.

Table 12.4 **New residents classified as concessional or assisted residents, 30 June 2001 (per cent)[a, b]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
High care residents	49.8	53.3	50.5	55.2	50.9	50.9	49.1	72.5	51.3
Low care residents	44.4	42.1	45.5	49.3	44.2	44.5	42.1	78.8	44.4
All residents	47.9	48.3	48.5	52.6	48.3	48.8	46.2	74.0	48.6

a Only new residents entering residential care post-October 1997 are eligible for either a concessional or assisted resident supplement. **b** Concessional residents are those who on entry to care were in receipt of an income support payment, who had not owned a home in the previous two years or whose home was occupied by a spouse or carer, and who had assets of less than $25 000. For married residents, half the couple's combined assets are counted. Assets include interest free loans. Assisted residents are those meeting the above criteria with asset levels between $25 000 and $40 000. The asset levels are as at 30 June 2001.

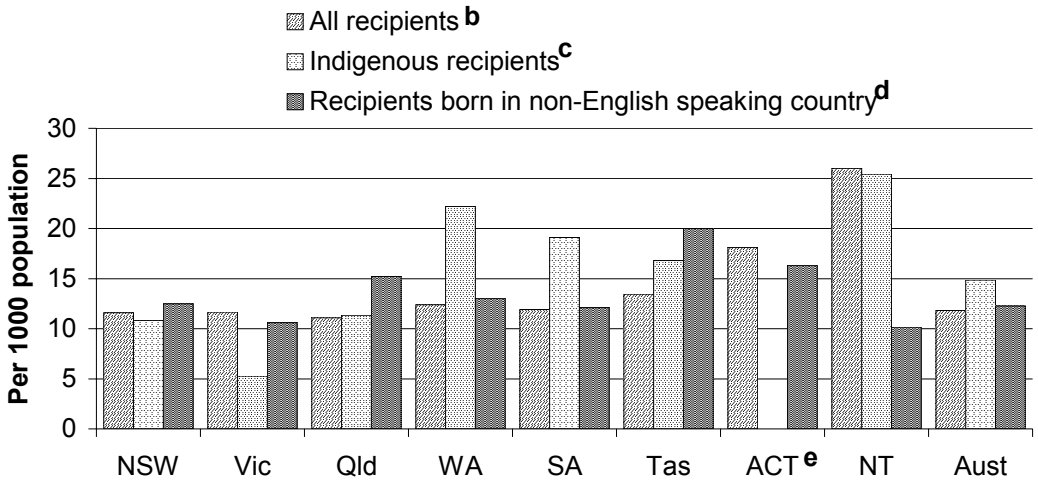
Source: DHAC (unpublished); table 12A.15.

Community Aged Care Packages

The number of CACP recipients per 1000 people aged 70 years and over has grown in recent years but at June 2001 was small relative to the total number of recipients of residential care (14.3 compared with 83.0 recipients respectively per 1000 people aged 70 years and over) (table 12A.8). The jurisdictions with smaller populations (the ACT and the NT) had the highest proportion of CACP recipients per person aged 70 years and over at June 2001. The NT had the highest proportion of CACP recipients per Indigenous person aged 50 years and over. Tasmania had the highest

proportion of CACP recipients from non-English speaking countries per person aged 70 years and over (figure 12.9).

Figure 12.9 **CACP recipients per 1000 target population, June 2001[a]**



a Excludes unknown responses for Indigenous status. **b** All recipients data are per 1000 people aged 70 years and over plus Indigenous people aged 50–69 years. **c** Indigenous recipients per 1000 Indigenous people aged 50 and over. **d** Recipients from non-English speaking countries per 1000 people from non-English speaking countries aged 70 years and over. **e** The number of CACP recipients from an Indigenous background who were resident in the ACT was not reported for 2000-01.

Sources: DHAC (unpublished); tables 12A.9, 12A.11 and 12A.13.

Home and Community Care program

Home and Community Care services are provided in the client's home or community to people with a severe, profound or moderate disability and to their carers. It is not yet possible to calculate the exact number of hours of HACC services consumed by people aged 70 years and over compared with the service hours used by younger people with disabilities, and tables 12A.17–12A.21 provide estimates only. Around 70 per cent of HACC recipients are estimated to be aged 70 years and over.

The NT had the highest number of estimated HACC service hours delivered per 1000 people aged 70 years and over in capital cities and all areas in 2000. Victoria reported the highest number of estimated HACC service hours delivered per 1000 people aged 70 years and over in rural areas (table 12.5).

Table 12.5 **Estimated level of HACC services received per month per 1000 people aged 70 years and over, by region, June 2000[a, b]**

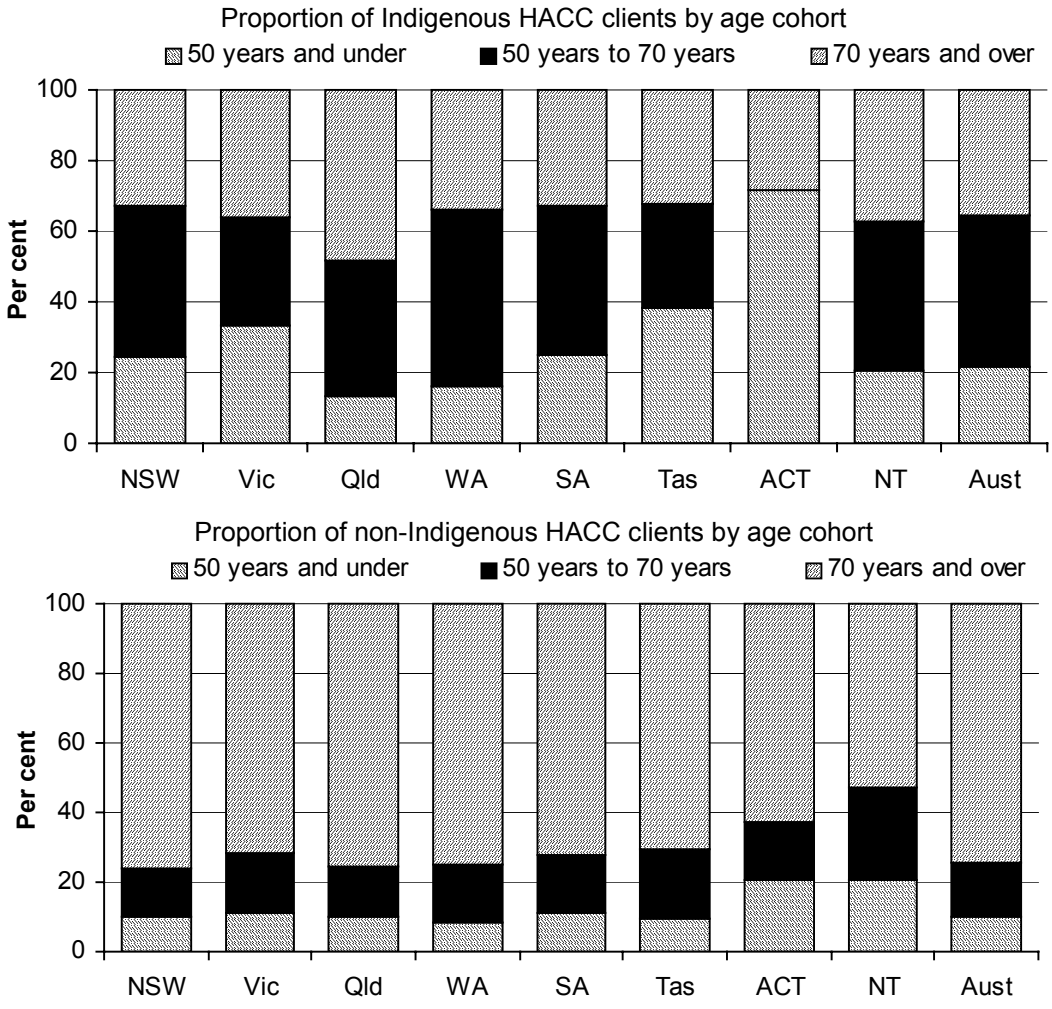
	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Total hours per month[c]									
Capital city	773	1 038	1 238	1 377	970	867	927	1 604	998
Other major urban areas	869	1 128	937	–	–	–	–	–	919
Rural areas	943	1 635	1 179	1 268	1 174	1 173	–	–	1 216
Remote areas	2 069	915	2 032	2 282	1 115	2 812	–	4 004	2 117
All areas	**844**	**1 198**	**1 200**	**1 412**	**1 020**	**1 060**	**927**	**2 418**	**1 071**
Total meals per month[d]									
Capital city	375	486	618	541	491	386	284	638	467
Other major urban areas	388	677	436	–	–	–	–	–	435
Rural areas	534	643	644	609	830	561	–	–	615
Remote areas	968	144	1 057	1 307	2 825	1 388	–	4 715	1 394
All areas	**426**	**534**	**616**	**600**	**596**	**495**	**284**	**2 257**	**521**

[a] Estimates based on the proportion of people aged 70 years and over receiving HACC services in each jurisdiction. [b] The definitions of home help, personal care, home nursing and paramedical services vary across jurisdictions. [c] Includes home help, personal care, home nursing, paramedical care, respite care, centre day care and home maintenance. [d] Includes home meals and centre meals. – Nil or rounded to zero.

Sources: DHAC (unpublished); tables 12A.17-12A.21.

Use of HACC services reported for all people compared with Indigenous people across all age groupings shows a substantial difference in the age profile for the two groups. This reflects the substantial difference in morbidity and mortality trends between Indigenous people and the general population (figure 12.10).

Figure 12.10 **HACC service by recipient age and Indigenous status, 1997-98**



Source: DHAC (1998); table 12A.38.

Access and equity — timeliness

Elapsed time between ACAT assessment and entry into residential care service

The elapsed time between an ACAT assessment and entry into residential care partly reflects the extent to which aged care services meet the demand for residential services, but may also reflect applicants' willingness to wait for particular residential services (box 12.5). On average, 73.7 per cent of all people entering residential care during 2000-01 had entered within three months of being assessed by an ACAT, and almost half (45.1 per cent) had entered within one month of their ACAT assessment. Across jurisdictions, the proportion of people who

entered care within three months of assessment ranged from 79.3 per cent in NSW to 63.2 per cent in the ACT (table 12A.27).

Nationally, a greater proportion of people entering high care residential services entered within three months of assessment (82.0 per cent) compared with the population entering low care residential services within that time (64.3 per cent) (table 12A.27). Across jurisdictions, the proportion of people entering high care residential services within three months of being assessed ranged from 87.1 per cent in NSW to 72.0 per cent in Queensland. The proportion of people entering low care residential services within three months of being assessed ranged from 67.7 per cent in NSW to 44.1 per cent in the ACT (figure 12.11).

Box 12.5 Interpretation of the elapsed time between ACAT approval and entry into residential care service indicator

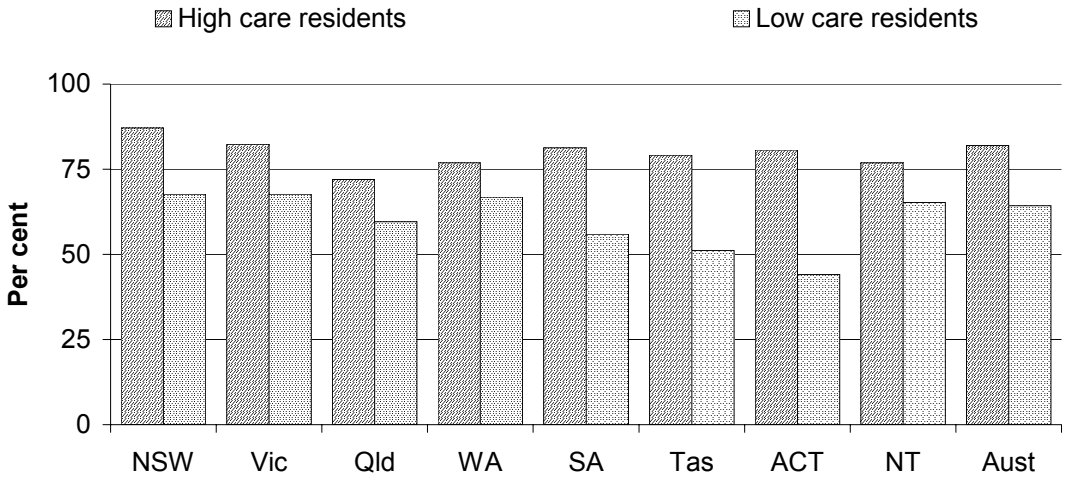
Broadly, the 'elapsed time between ACAT approval and entry into residential care service' indicator measures the time between the assessment of eligibility and admission to a service. A robust and comparable indicator requires consistent definitions of when ACAT approval and entry into a residential care service occurs. The definitions used in this chapter are:

- ACAT approval — that is, the approval date of an ACAT assessment; and
- entry into a residential care service — that is, the date of admission to a residential care service.

This indicator needs to be interpreted with care, because a range of factors may influence jurisdictional variations, such as:

- the classification of residential placement offers that are not accepted;
- the availability of alternative community care and respite services;
- hospital discharge policies and practices;
- 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 approval of assessments; and
- priority allocations.

Figure 12.11 **People entering residential care in 2000-01 who entered within three months of their ACAT assessment**



Source: DHAC (unpublished); table 12A.27.

Appropriateness — assessment/streaming

ACAT recommendations of longer term living arrangements

Data on the recommended longer term living arrangements of people referred by ACATs to residential and community care provide information on the patterns and levels of use of aged care services, even though there is no 'correct' mix. Aged Care Assessment Team data provide information on referrals to aged care services, not necessarily on their use. Some people may choose not to take up a referral at that time for various reasons, or the local service provider may choose not to admit them or be unable to do so at the time of application. (Service providers decide which eligible people are admitted to their service.)

The differences in recommendations may reflect external factors such as geographic dispersion of clients and services availability, but also client preferences and views on the types of client best served by community based services. Aged Care Assessment Team approvals are required for entry into residential care, so the client mix is likely to be weighted towards those who have higher levels of dependency.

Table 12.6 provides information on the proportion of assessed people referred to community or residential care. Queensland had the highest proportion of ACAT clients referred to residential care in 1999-2000 (61.0 per cent), while WA had the highest proportion of clients referred to community care (57.0 per cent).

Table 12.6 **Recommended longer term living arrangements of ACAT clients, 1999-2000[a]**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Community	%	53.2	50.1	36.9	57.0	33.7	37.5	44.3	56.3	48.5
Residential	%	38.9	38.8	61.0	37.9	52.8	60.1	37.4	22.6	43.4
Other	%	2.4	2.6	1.6	1.5	6.1	0.8	1.1	17.8	2.5
No long term plan made										
Died	%	0.5	0.9	0.2	1.1	1.8	0.3	–	0.2	0.8
Cancelled	%	0.9	0.9	0.3	–	4.7	0.8	0.2	0.6	1.0
Transferred	%	0.7	5.0	–	2.5	0.9	0.2	–	0.2	2.1
Unknown	%	3.4	1.6	–	–	–	0.3	16.9	2.4	1.8
Total	**no.**	**59 965**	**52 665**	**25 273**	**23 341**	**15 100**	**4 484**	**2 127**	**629**	**183 584**
Assessment rate[b]	no.	100.8	120.9	88.2	166.3	95.2	98.8	120.6	159.6	109.0

[a] Includes deaths, cancellations and transfers. [b] Number of assessments of people aged 70 years and over per 1000 people aged 70 years and over in June 2000. – Zero or close to zero.

Source: Lincoln Gerontology Centre (2001); table 12A.35.

The distribution of ACAT living arrangement recommendations will be influenced by the degree to which any pre-selection process refers a higher proportion of people requiring residential care to ACATs for assessment. Access to residential care requires an ACAT assessment, and jurisdictions with lower overall assessment rates may operate a filtering process to focus assessments on individuals who are more likely to require this level of care. In Queensland, for example, the high proportion of residential care assessments may partly reflect its low rate of use of ACATs other than for primarily residential assessments (table 12.6).

Home and Community Care targeting

Targeting strategies provide a means of concentrating resources on those in greatest need. Prior to July 1999, the HACC Program National Guidelines were the only guidance available to service providers regarding targeting. In response, the *Targeting of HACC Services* research study was commissioned in 1995. The final report released in July 1999 identified findings in four key areas: the benefits of low levels of service use; three levels of service use; seven complementary targeting strategies; and the importance of client and carer involvement.

The focus of the report was a targeting strategies framework that service providers can use as a guide to resource allocation. As a result of the relationship among dependency, need and the level of services used, an outcome based targeting approach has been developed. Seven broad types of targeting strategy were proposed to provide the flexibility to achieve different goals for different clients.

These broad targeting strategies are designed to:

- reduce the use of residential and acute care;
- reduce the risk of premature or inappropriate admission to residential and acute care;
- allow clients with high and complex care needs to remain in the community;
- improve functioning and support independence in the community;
- support carers;
- enhance quality of life; and
- reduce unmet need.

It was recommended by HACC Officials at the May 2000 meeting in Darwin that the seven targeting strategies identified in the report form the basis of a targeting framework for the HACC program and that the HACC National Program Guidelines reflect these strategies. Veterans' Home Care was also built upon this research study, with the targeting strategies forming the basis of the VHC framework for determining levels of service provision.

Appropriateness — unmet need

Defining and determining the level of need at an individual level, let alone at a population level, are complex tasks. The perceptions of need and unmet need are often subjective. Previous reports included discussion of unmet need from a recipient's perspective based on ABS 1998 data concerning older people requiring assistance with daily activities (ABS 1999 and table 12A.34). Further work is required to progress this issue for future reports.

Quality — independent appraisal

Compliance with standards for residential care

Compliance with standards for residential care is reported for the first time this year. 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 Commonwealth funding supplements for concessional and assisted residents.

The certification program has established minimum standards of building quality which are to be achieved progressively by the industry. 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. Services are to achieve a safety score of 19 out of 25 and an overall score of 60 out of 100 by 2003, and to achieve privacy and space targets for residents by 2008.

Accreditation aims to promote the quality of life and quality of care of residents of government funded aged care services. Services are assessed against 44 'expected outcomes' under four main standards (management systems, staffing and organisational development; health and personal care; resident lifestyle; and physical environment and safe systems) to ensure they have internal processes conducive to quality outcomes and continuous improvement.

The accreditation process begins with a self assessment by the service, which is later validated by an assessment team via desk and site audits (box 12.6). Services are rated on a four-level scale ('commendable', 'satisfactory', 'unacceptable' or 'critical') against each of the 44 expected outcomes. These results are then consolidated to provide a similar four-level rating for each of the service standards. The four-level rating scale is being revised by the Aged Care Standards and Accreditation Agency.

The Aged Care Standards and Accreditation Agency then makes an accreditation decision, based on the audits and other relevant information. Each decision is made based on individual merits but, generally, three-year accreditation is awarded to services that are performing well and to services that have some minor non-compliance but have plans in place to rectify it. Services that have a greater degree of non-compliance, but that can demonstrate plans to rectify the non-compliance, will receive shorter periods of accreditation. Accreditation is not awarded to poorly performing services.

Services can seek reconsideration and review of decisions on accreditation, and are advised of any necessary improvements. Ongoing compliance is monitored through support contacts, and review audits may be conducted. Commencing services are assessed on the basis of a written application, and by law can receive a maximum of only 12 months accreditation.

Accreditation decisions and other information relating to the Accreditation Standards and the Aged Care Standards and Accreditation Agency are publicly available via the agency's web site (www.accreditation.aust.com).

Box 12.6 **Accreditation**

The Aged Care Standards and Accreditation Agency takes into account the following factors, as required by the *Accreditation Grant Principles 1999*:

- the desk audit report;
- the site audit report;
- information received from the Secretary of the Department of Health and Aged Care about matters that must be considered under division 38 of the *Aged Care Act 1997* for certification of the service;
- other information received from the Secretary;
- information received from the applicant in response to the statement of major findings presented to the applicant at the conclusion of the site audit (note that the site audit report may take into account this information from the applicant); and
- whether the agency is satisfied that the residential care service will undertake continuous improvement, measured against the Accreditation Standards, if it is accredited.

The following levels of accreditation are awarded on the basis of assessment standards.

Accreditation	*Criteria*
Three-year accreditation	Service is rated 'satisfactory' or 'commendable' on all four standards.
One-year accreditation	Service is: • rated 'unacceptable' on one or more standards but has an acceptable plan of address in place; and • rated 'satisfactory' or 'commendable' on the remaining standards.
Not accredited	Service is either: • rated 'critical' on any of the four standards; or • rated 'unacceptable' on one or more standards and does not have an acceptable plan of address in place.

Source: ACSA (1998).

All services were required to be accredited by 1 January 2001. To achieve the second accreditation, all services must make a further application for accreditation approximately six months before their present period of accreditation expires. Then, the process of desk audits and site audits is repeated. Table 12.7 summarises the accreditation decisions at 31 December 2000. The highest proportion of three-year approvals was in the ACT (100 per cent), while the lowest was in Victoria (91.8 per cent).

Table 12.7 **Accreditation decisions on residential aged care services, to 31 December 2000[a]**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Proportion of services reaching commendable or satisfactory										
Management systems, staffing and organisational development										
	%	98.0	97.7	97.7	98.1	97.7	100.0	100.0	86.7	97.9
Health and personal care										
	%	97.5	94.3	94.0	94.4	95.7	99.0	95.7	86.7	95.6
Residential lifestyle										
	%	99.0	97.9	98.8	100.0	97.7	100.0	100.0	93.3	98.7
Physical environment and safe systems										
	%	96.2	96.3	94.3	99.6	97.4	97.0	100.0	100.0	96.4
Accreditation approvals										
Three-year	%	97.0	91.8	92.4	92.9	93.8	97.0	100.0	93.3	94.1
One-year	%	2.7	6.5	7.6	5.6	3.9	1.0	0.0	6.7	4.9
Nil	%	0.1	0.7	0.0	0.0	0.3	1.0	0.0	0.0	0.3
Total	**%**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Number of services[b]	no.	928	814	487	266	304	99	23	15	2 936

[a] Accreditation period as at August 2001. [b] The number of services differs from that shown in other tables because the time period is different and, in a number of cases, the Aged Care Standards and Accreditation Agency treated co-located services as a single entity.

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

The average number of residents per room at September 2001 varied from 1.8 in the NT to 1.2 in both Tasmania and the ACT. Average safety scores ranged from 21 in SA to 16 in Tasmania (table 12.8).

Table 12.8 **Average certification safety score and residents per room, September 2001**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Fire score[a]	19	18	20	19	21	16	20	18	19
Residents per room	1.7	1.5	1.4	1.3	1.4	1.2	1.2	1.8	1.5

[a] Maximum score is 25; score of 19 to be achieved by 2003.

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

Quality — client perceptions

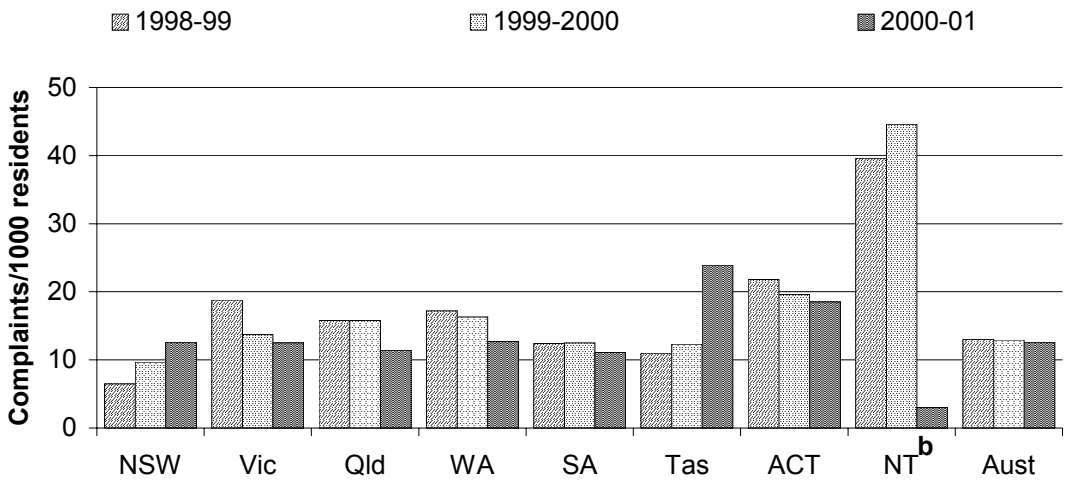
Complaints data partly indicate client satisfaction with service quality. Data collected from the residential care complaints program are reported against four main standards: management systems, staffing and organisational development; health and personal care; resident's lifestyle; and physical environment and safety

of systems. These data record both the number of people complaining and the number of complaint issues.

The residential care complaints program is at a relatively early stage, so changes in data over time may not indicate changed quality. An increase in complaints may reflect greater preparedness to complain, more awareness of the rights and avenues of complaint, and/or a reduced fear of consequences. Each jurisdiction has a variety of advocacy services which promote complaints mechanisms to varying degrees.

The number of complaints registered per 1000 residents in 2000-01 ranged from 12.7 in WA to 11.1 in SA (excluding Tasmania, the ACT and the NT, which are not directly comparable because the small number of residents in these jurisdictions exaggerates the number of complaints per 1000 residents) (figure 12.12).

Figure 12.12 **Residential care complaints per 1000 residents[a]**



[a] As at 30 June. [b] A total of 15 complaints were registered in the NT in 1999-2000. Most of these were against one NT facility and have been addressed.

Source: DHAC (unpublished); table 12A.28.

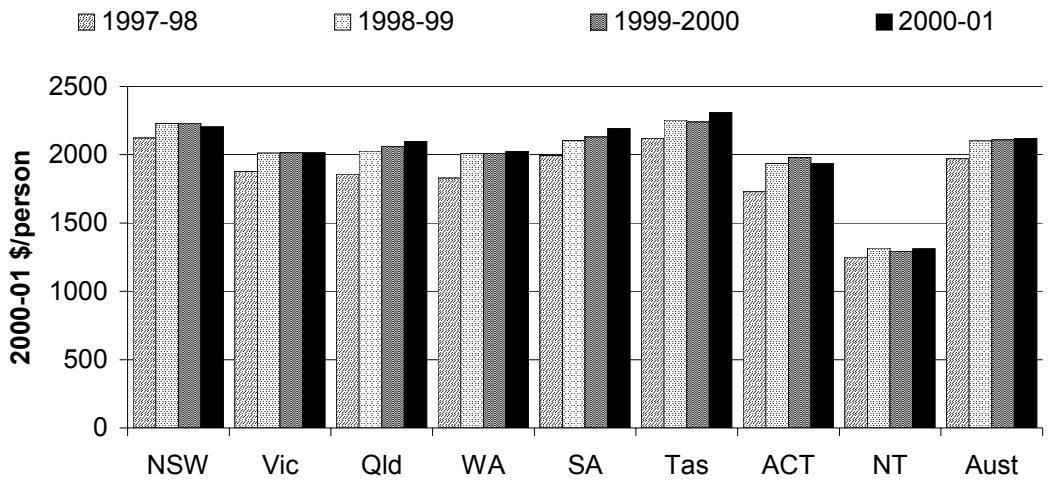
Efficiency

This section provides information on expenditure per person on the main types of aged care services. A proxy indicator of efficiency is cost per person in the target population — that is, government inputs (expenditure) per person aged 70 years and over plus Indigenous people aged 50–69 years. Unit cost data for aged care services delivered by government do not yet contain capital costs.

Commonwealth Government expenditure (including expenditure by the DVA) on residential care services per person aged 70 years and over plus Indigenous people

aged 50–69 years varied across jurisdictions in 2000-01, ranging from $2309 in Tasmania to $1313 in the NT (figure 12.13). The data in this year's Report are different from last year's data as a result of the inclusion of Indigenous people aged 50–69 years in the target population.

Figure 12.13 **Commonwealth Government expenditure on residential services, per person aged 70 years and over plus Indigenous persons aged 50–69 years (2000-01 dollars)[a, b]**



[a] Includes expenditure on nursing home benefits, hostel subsidies and residential respite. [b] Includes the Department of Veterans' Affairs contribution ($180 million in 1997-98, $367 million in 1998-99, $387 million in 1999-2000 and $417 million in 2000-01).

Source: DHAC (unpublished); DVA (unpublished); table 12A.44.

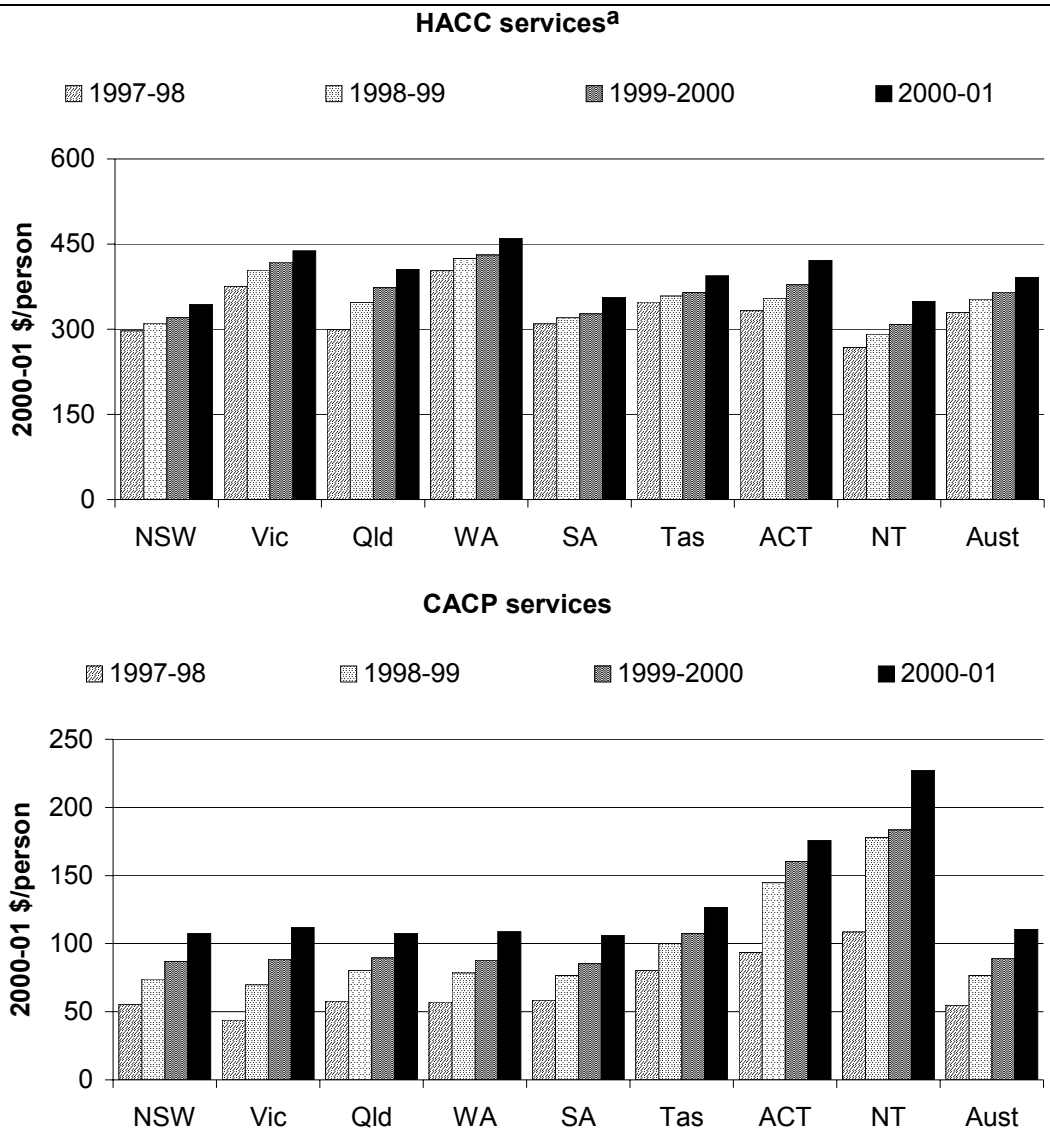
Both CACP expenditure and estimated annual HACC and NRCP expenditure per person aged 70 years and over plus Indigenous persons aged 50–69 years varied across jurisdictions in 2000-01. Western Australia reported the highest HACC expenditure ($460 per person) and the NT reported the highest CACP expenditure ($227 per person) (figure 12.14). New South Wales reported the lowest expenditure on HACC and the NRCP ($343 per person) and SA reported the lowest CACP expenditure ($106 per person).

Many government services have moved towards better measurement of unit costs as part of a strategy to promote efficiency improvements. It is difficult to measure the overall efficiency of the HACC services, given their heterogeneity, but components can be identified and unit costs can be measured. Where services are viewed as substitutes, cost comparisons may be affected.

As jurisdictions move towards output based funding of aged care services, output classification issues are likely to need to be addressed. The *Amending Agreement to the HACC Program*, clause 10(3), requires the development of 'State plans which

specify measurable program outputs to be provided in each region, including the mix, level and quality of services'. State and Territory program managers have generally interpreted this clause as requiring a move away from historical submission based funding, towards the introduction of uniform pricing for a given service type.

Figure 12.14 **Expenditure on community care services, 2000-01 dollars per person aged 70 years and over, plus Indigenous persons aged 50–69 years (2000-01)**



[a] Includes expenditure on HACC (Commonwealth, States and Territories) and the National Respite for Carers Program (Commonwealth only). Excludes DVA expenditure.

Sources: DHAC (unpublished); tables 12A.31 and 12A.45.

One approach is to identify service types so a classification system can be developed with corresponding unit costs, as is done with diagnosis related groups

for the funding of public hospitals. The development of a casemix-style community care classification system remains a challenge, including how to define a meaningful episode of care and show how client outcomes are related to the level and mix of resource inputs.

12.5 Future directions in performance reporting

There are several aspects of aged care services for which indicators are not fully developed and for which there is little performance reporting. Further development work is required to establish a full set of indicators. Developments that are relevant to all service areas are discussed in chapter 2. Box 12.7 outlines the report of the Two Year Review of Aged Care Reforms by Professor Len Gray.

Developing indicators and data

The Australian Institute of Health and Welfare has examined methods for including consumer views in the assessment of HACC service quality. The project developed a Consumer Survey Instrument (CSI), of which a number of versions have been produced to suit particular HACC service types, consumer groups and different ways of gathering consumer feedback. All States and Territories are committed to using the CSI and have agreed to investigate methods of incorporating it into the National Service Standards Instrument.

Further work is required to improve the definitions of the appropriateness indicators (adequacy of assessment, intensity and appropriateness of care). A lack of data has also prevented progress in this area. Two national HACC data developments — the HACC Minimum Data Set (MDS) project and the HACC national service standards instrument — may provide useful data for these indicators in the future.

The HACC MDS project provides a client centred data collection that focuses on outputs rather than process and inputs. The project facilitates separate reporting of the three client groups (frail older people, young people with a disability and their carers), which previously has not been possible. Consistent reporting by agencies allows more comprehensive and comparable reporting of the services both across jurisdictions and between community and residential services.

The HACC national service standards instrument measures the extent to which agencies comply with national service standards. Developed in 1996-97, the instrument is the basis for monitoring, evaluating and reporting on the quality of HACC services. Some information on the early stages of implementation may be

available for the 2003 Report, with more extensive information to be available in future reports.

Box 12.7 **The Two Year Review of Aged Care Reforms**

In July 1998, Professor Len Gray was appointed to undertake an independent review of the *Aged Care Act 1997* and implementation of the related structural reforms. The report, *Two Year Review of Aged Care Reforms,* was subsequently released in May 2001.

Professor Gray reported against the eight areas of interest defined in the terms of reference (access, affordability, quality, efficiency, industry viability, State and Territory programs, choice and appropriateness, and other considerations including dementia) and concluded, in relation to the eight areas, that the reforms have delivered improvements to the aged care system.

In summary, the report recommended that:

- the Department of Health and Aged Care (DHAC) review and enhance indicators of supply and demand for residential and community care to ensure the adequacy and reliability of these measures;
- the Commonwealth and the States and Territories jointly undertake a critical analysis of current measures of care, and work cooperatively to ensure appropriate care options are available across the full range of settings;
- a more detailed analysis of respite care be undertaken;
- further investigation be undertaken into the needs and care options for people with dementia;
- discussion occur among stakeholders to explore simple administrative changes that could improve the information available to intending residents and reduce the complexity of admissions procedures;
- the Aged Care Standards and Accreditation Agency examine its assessment protocol to ensure its consistency between assessments, and continue to take particular care in monitoring medication and nursing care standards in aged care services that have a low proportion of high care residents; and
- DHAC and the Aged Care Standards and Accreditation Agency consider the introduction of objective measures of continuous improvement and further consider processes and outcomes of accreditation following the first round of assessments to assist in the development of future monitoring of care quality.

The Commonwealth Government has accepted all the recommendations in the Report. It is likely that some of the Government's response to the Gray Report will affect future data and indicators published by the Review. The specific nature of the implications for the Review will be discussed in future editions of the *Report on Government Services*.

Source: Gray (2001)

12.6 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this chapter and attachment 12A on the CD-ROM. 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. The information covers aspects such as age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (such as Indigenous and ethnic status).

Commonwealth Government comments

“The Commonwealth’s emphasis on community care continued over the last year with increased funding for carers and respite services and increasing availability of Community Aged Care Packages. By the end of this financial year some 30 000 care packages will be in operation. Commonwealth expenditure on Community Aged Care Packages increased sixfold from 1995-96 to 2000-01, up from $33 million to $195 million. The Commonwealth’s funding for Home and Community Care (HACC) has increased from $423 million in 1995-96 to $567 million in 2000-01, an increase of 34 per cent. The Commonwealth’s funding for residential aged care has increased from $2.5 billion in 1995-96 to $3.9 billion in 2000-01 — an increase of $1.4 billion.

In the last three years the government has allocated almost 31 000 places to meet the need for growth. In April, the Commonwealth Minister announced the release of more than 9 500 new aged care places for Aged Care, including 2 479 new residential high care beds, more than four times the number of residential high care places ever released in a single year for the past 15 years.

In May 2001 the independent Two Year Review of Aged Care Reforms conducted by Professor Len Gray, a leading aged care expert, was released. The report concluded that the Federal Government’s reforms have been successful in improving the standard of care and the quality of aged care homes. Professor Gray concluded that the industry was viable and able to achieve at least a 12 per cent return on investment; that the aged care reforms provided a substantial increase in the Commonwealth funding available to the residential aged care industry; that there have been improvements in access to care for people living in regional and rural areas; and that considerable progress has been made towards improving the quality and quantity of residential buildings.

The Commonwealth has provided national leadership in important data developments in the last few years, including:

- the establishment of the Aged and Community Care Data Advisory Group to provide a forum for reviewing and improving the aged care data development activities of a number of government and non-government organisations;
- the development of data dictionaries for ACATs, Community Aged Care Packages and the National Respite for Carers Program;
- a stocktake of residential aged care data resources and commencement of a project to develop performance indicators and data definitions for residential aged care; and
- implementation of the HACC Minimum Data Set in July 2000. The first collection commenced in January 2001 and by September 2001 over 75 per cent of services were providing data to the National Data Repository.”

New South Wales Government comments

“ The NSW Government is committed to facilitating older people's capacity to live independently, to promote their health and wellbeing and to provide accurate and timely information to enable them to choose and access appropriate services as they need them.

The NSW Government's funding commitment to the HACC Program sits within a wider context, especially the NSW Government's Social Justice Statement, the NSW Disability Policy Framework, the NSW Healthy Ageing Framework, the NSW Government's Action Plan for Health, the NSW Action Plan on Dementia, and the NSW Care For Carers Program. The unique needs of indigenous people and people from culturally and linguistically diverse backgrounds are being recognised in all programs, policies and services.

The NSW Government is developing policies for dynamic, innovative and flexible services to meet the needs of older people over the next two to three decades. The NSW Health Department has released a proposed policy framework on Improving the Aged/Acute Care Interface in NSW. This policy framework outlines the proposed role of Area Health Services and the non-government sector in the provision of residential aged care services. It also proposes policy options for reform of the interface between aged and acute care services for negotiation between the NSW and Commonwealth Governments. One major proposal being advanced by NSW is the development and expansion of new models of transitional (or stepdown) care options for older people. Transitional care is intended to provide an alternative care option for older people who may be waiting for residential care or people who require slow stream rehabilitation in a non-acute setting, with the intention in both cases of improving the functional dependence of older people. NSW is continuing its planned and comprehensive response to the rapid increase in the number of people living with dementia through the allocation of over $10 million to the development of a second, five-year Dementia Action Plan.

In 2000-01, NSW HACC services have targeted the provision of services in rural and remote areas to ensure more equitable service access. This is reflected in the high levels of personal care and respite care being received by older people in rural areas, as well as the highest level of service provision in remote areas to the total target group.

It should be noted that data comparability across jurisdictions remains complex caused by factors such as different per capita funding in each State and historically different service provision patterns, as well as the range and diversity of organisations funded. NSW makes a substantial investment in personal care services, one of the most significant services in preventing premature admission to institutional care. However, because they have high unit costs (often delivered out of hours and needing two people), fewer outputs are produced for a given expenditure compared with lower unit cost services. The Population Group Planning Model and the HACC Minimum Data Set will enable the HACC service estimates provided in this report to be replaced over time by more robust data. ”

Victorian Government comments

“ The Victorian Government is committed to recognising older peoples contribution to society and to directly hear their views through the recently established Ministerial Advisory Council of Senior Victorians.

Over the past year, the Victorian Government has faced significant service delivery challenges as a result of pressures building in the health and aged care sector. System pressures have resulted from continued low levels of operational residential care places approved by the Commonwealth, an increase in demand for Home and Community Care (HACC) services and management of increased complexity within the population served by HACC services.

One of the impacts of low levels of operational residential care places has been pressure in the community care, sub-acute and acute sectors. In order to respond to these pressures, the Victorian Government has implemented a range of initiatives to respond appropriately to the care needs of older Victorians. These initiatives include a State funded pilot of interim care places in metropolitan health services and strong involvement in progressing the work of the AHMAC Working Group on Care of Older Australians. The Victorian Government has provided additional funds for HACC and HACC-like services, over and above the requirements for Commonwealth/State funds matching.

Victoria is keen to continue to seek bilateral discussions with the Commonwealth to discuss issues related to residential care and the relationship between residential care and HACC.

In the community care sector, a range of initiatives have been undertaken to more effectively and efficiently use resources for delivery of direct care for older people. The Victorian Government’s Primary Care Partnerships (PCP) initiative has seen all PCPs submit their first annual community health plan. This represents a significant achievement in the community sector by a range of community based services including HACC agencies. Projects that relate to streamlining community care services include the trial of an initial needs identification tool and a project to improve electronic connectivity. These projects will allow service providers to more efficiently transmit client information and reduce the administrative burden on providers.

Developments in the HACC program include implementation of a revised Relative Resource Equity (RREF) formula and implementation of the HACC minimum data set. The revised RREF allows more responsive resource allocation by taking into account factors affecting demand such as socioeconomic status, rurality and health status.

Development of policy frameworks is also occurring in relation to the role of the State Government as a provider of residential care and provision of sub-acute services. ”

Queensland Government comments

“The Minister for Families, Youth and Community Care retains lead agency responsibility for issues relating to older people. In 2001, the Ageing Branch in the Department of Families was granted funding under the National Suicide Prevention Strategy to undertake two suicide prevention projects targeting older people. In addition, the Department provided additional funding for services to increase the social participation of older people, through addressing barriers such as social isolation and the effects of fear of crime.

The Queensland Government's commitment to aged care has been reinforced this year, with the development of Queensland Health Strategic Directions for Older People's Health Services 2001–2006, focusing on five main areas: hospital services, psychogeriatric services in community and residential settings, residential aged care, dementia care and community services.

Queensland Health's responsibility for aged care within the Queensland Government is reflected through its management of the Home and Community Care program, Aged Care Assessment Program, State Government residential aged care facilities and a range of other services providing long-term care for older people. Queensland Health's Aged Care Capital Works Program, has committed $120 million over the next five years to redevelop 18 of Queensland Health's State Government Nursing Homes.

Queensland Health is still fine-tuning some of the issues identified with the collocation of mental health consumers in nursing homes. Nearly all the capital works projects for older peoples' mental health are now completed. The recent budget allocation has facilitated the increase of older peoples community mental health teams in line with the Ten Year Mental Health Strategy for Queensland, 1996. The development of the Implementation Plan for older people will underpin the Queensland Health Strategic Directions for Older People's Health Services 2001–2006 policy framework.

A major priority for HACC in 2001-02 was to enhance Home Help services, which achieved a 40 per cent increase in funding. Other HACC priorities included the implementation of a service development framework to improve Indigenous services; completion of a continence management project, the implementation of education and advisory services coordinated with the MASS Scheme and, the establishment of key support services for people who are living in supported/unsupported accommodation.

A range of assessment models will be trialed and evaluated throughout the State to ensure that a network of independent assessors is established throughout Queensland, to reduce the burden of multiple comprehensive assessments for clients with complex needs and ensure they are able to access the most appropriate services based on assessed need.”

Western Australian Government comments

“In the coming decades, more Western Australians than ever before are likely to survive into old age. These projected changes are bringing new challenges to government since many of our societal institutions have evolved over time to meet the needs of a much younger population structure.

The State is monitoring the effects that aged population growth is having on the demand for aged care services and is actively engaged in developing aged care pathways to integrate and coordinate the transfer of care for the frail aged across the boundaries between primary, acute, community and residential care.

The implementation of the Care Awaiting Placement (CAP) program has seen a significant decrease in the number of patients in acute metropolitan hospitals who are awaiting transfer to residential aged care accommodation. As well as the provision of beds, the CAP program has developed consistent definitions and protocols and a data collection methodology which is now operating in all metropolitan health services and will be used to evaluate the current program.

The State is also developing longer term strategies to provide finite term residential care and community packages for post-hospitalisation support. The Department of Health, in collaboration with the Commonwealth Government, is exploring this option in terms of a Transitional Care Pilot which will utilise up to 90 flexible places from the National Innovations Pool to provide a combination of finite term residential care and enhanced therapy based home care packages. It is envisaged that the Transitional Care Pilot will assist in developing a more sustainable option for the provision of care awaiting placement.

Western Australia has been actively involved in the development and implementation of software for the ACAP Minimum Data Set Version 2.0. Other ACAP initiatives include the development of a WA-specific ACAT Orientation Manual which provides ACAT staff with a consistent orientation to policies and procedures and the drafting of an ACAT Best Practice Manual.

The Home and Community Care (HACC) program continues to expand in line with the commitment to improve the capacity of aged care services to support people in their own homes, and additional HACC services have been purchased based on regional priorities. Planning for the HACC program will be enhanced by the availability of reliable and consistent data following the commencement of data collection under the HACC Minimum Data Set (MDS) in January 2001.

Western Australia continues to develop improved models of service delivery for rural areas — for example, the development of a policy of equitable access to ambulatory oxygen for people living in all regional and remote areas of the State.”

South Australian Government comments

“The SA Government continues to take up the challenge of an ageing population, focusing on improving support and recognising the contribution of seniors. *Ageing — A Ten Year Plan for South Australia* remains the overarching State Government commitment to a whole-of-government approach to older people living in the community, participating in the community and independence in the community. The vision and principles of the plan have changed the focus of the Government's policy and practice from a narrow aged care approach to a broader attitude to ageing and wellbeing.

Many of the directions set by the *Ten Year Plan* have now formed the basis of *Moving Ahead — a Strategic Plan for Human Services for Older People in South Australia 1999–2004. Moving Ahead* was developed by DHS to improve health and community services for older people. The Office for the Ageing has taken an active role in its second year of implementation, in collaboration with other DHS Divisions, industry groups and consumer and carer peak bodies.

The implementation of *Moving Ahead* has included address of the interface between the acute, residential and aged care sectors. An Acute Transition Care pilot funded by the State Government identified older people in hospital who no longer required acute care but who were waiting for residential placement. The program was successful in providing transition care and moving people within a short period to appropriate residential or community care with required support. The Commonwealth and the SA governments have now agreed to build on this and to jointly fund a national pilot as an Innovative Care (Rehabilitation) Project.

In 1996, an estimated 17.1 per cent of the SA population aged 65 years and over were migrants born in a non-English speaking country, and it is projected that this will increase to 21.1 per cent in 2006. The Office for the Ageing has funded the development of *Strategic Directions for Older People of Culturally and Linguistically Diverse Backgrounds*. The project forms part of the DHS commitment under *Moving Ahead,* and involves stakeholders from across Government, service providers and various culturally diverse communities. The document will include strategies and actions to be implemented by the DHS over a three-year timeframe.

Life expectancy at birth for indigenous Australians remains considerably lower than the all Australian estimates of 76 years for males and 82 years for females. In addition, access to community services for indigenous people has been lower than their representation in the population. There has been significant community development and funding initiatives to improve this situation. Further, the HACC program has established and funded the Council of Aboriginal Elders to provide:

- a coordinated voice for Aboriginal communities in the development of State and Commonwealth policies impacting on Aboriginal older people; and
- advocacy, support, advice, leadership and guidance in policy and services development for older Aboriginal people.”

Tasmanian Government comments

“ Unlike other States and Territories over 58 per cent of Tasmania’s large ageing population reside outside the metropolitan areas of the State. This creates a unique and complex environment for the delivery of appropriate health services.

The State Government is working with local rural communities to coordinate delivery and management of health services. The process is being undertaken within the national framework ‘Healthy Horizons’ and is aimed at ensuring a model of service delivery that meets the specific needs of a particular community. The development of Multi-Purpose Services is a major strategy being actively implemented to address this issue. Included in this strategy has been the formation of local community partnership groups. The State Government has provided training to these groups in strategic and health planning to enable them to have the skills to help their communities.

The national shortage of nurses has had a significant impact on Tasmania, particularly in rural areas of the State. This has serious implications for residential aged care services operated by the State, the majority of which are located in rural areas, both in their capacity to attract and the cost of maintaining skilled staff. In response the State Government established a Workforce Planning Project involving the public and private health sectors, the aged care industry, the University of Tasmania and unions. The project has completed their report that is due for release before the end of 2001.

During 2001 the State Government commenced a program that will ensure that all State operated residential aged care services will meet the Commonwealth’s current certification requirements by end of July 2002. In addition the State Government has continued with major capital upgrades of rural health services. The State Government is also working with the local office of the Department of Health and Aged Care and other key stakeholders to identify and address issues in respect to certification requirements on residential aged care services in the State.

Tasmania has this year again experience record numbers of people waiting for placement into residential aged care. This is a significant issue creating its own set of problems and additional pressure on the State’s hospitals and community health services. Tasmania’s public hospitals and community health services have established programs specifically to develop strategies to assist alleviate the negative impact created. The Aged Care Rehabilitation Unit continues to provide best practice multi-disciplinary rehabilitation for aged people.

The State Government is currently developing individualised Packages of Care for people with complex care needs through the HACC program. Five priorities have been identified, people with disability, people with mental illness, frail aged, people with dementia and people requiring short term post-acute care. It is anticipated that the first packages will be implemented in January 2002. ”

Australian Capital Territory Government comments

“ The ACT Government supports the continuing improvement of nationally consistent data capture for aged care and HACC services.

The ACT Government continues to work with the ACT Home and Community Care (HACC) sector to implement HACC reforms in areas such as Minimum Data Set and Standard implementation. This work has involved sector consultation and development and the ACT Government looks forward to more robust planning due to the availability of more consistent data.

The ACT has also focused on improving the interface between hospital and community particularly in the area of post-hospitalisation services. A transitional care project will start shortly for people who no longer require acute care but who require some restorative care before returning to their homes. This project will be co-funded with the Commonwealth Government.

The ACT Aged Health Care Services Advisory Council has continued to provide advice to the Minister of Health and Community Care on a range of issues, particularly in the area of convalescent care. The Council has also approached the Council of The Ageing ACT to survey the health needs of older ACT residents. The final report of this survey should be released in the near future.

The ACT Mental Health Service (ACT MHS) has negotiated provision of 10 beds in the Sir Leslie Morshead Nursing Home for older persons with mental illness. The ACT MHS provides top-up funding to ensure the extra support needs of residents are met. The Older Persons Mental Health Service is responsible for admission to and discharge from these beds, and they provide consultation and liaison services to, and training for, the Sir Leslie Morshead staff.

The ACT Government has developed a whole-of-government approach to the provision of aged care services in the ACT and has met regularly with the Territory office of the Commonwealth Department of Health and Aged Care.

The ACT Government also looks forward to the outcomes of the AHMAC Working Group on Care of Older Australians. These outcomes should guide future improvements in the interface between hospital and community for older people and provide a focus for policy and service provision. ”

Northern Territory Government comments

“ The Northern Territory Government has a strong commitment to continuing to improve the range and accessibility of aged care services to senior Territorians. It recognises that to meet the diverse needs of this group will require an increasing emphasis on new and flexible approaches to the provision of care.

While the current NT aged population is relatively small, it is culturally diverse (28 per cent of the NT's population is Indigenous, 21 per cent speak a language other than English at home) and is spread across a vast area, with 27 per cent of the population living in rural and remote areas.

Indigenous Australians suffer high levels of chronic disease and disability at much younger ages than other Australians. The Commonwealth recognises this 'premature ageing' in the planning ratios, which now include Indigenous people aged 50–65. As a result, Indigenous people comprise more than half of the target group for aged care services in the NT. A large proportion of this target group resides in remote areas.

This creates an increasing imperative to find appropriate ways of delivering care in remote Aboriginal communities. To do so means overcoming many hurdles, including the high cost of service provision in remote areas, lack of infrastructure, problems with staff recruitment, retention and training, and the difficulty of establishing viable services when there are only small numbers of older people spread across large geographic areas.

It should be noted that the inclusion of Indigenous people aged 50–69 in the target groups is not reflected in all of the data used in this report. As a result the tables based only on the population aged 70 and over can be misleading. In particular the provision rates for residential care places, and the level of HACC services, appear much higher than they actually are.

The age profile of the NT is rapidly changing. By 2031, the number of people aged 65 and over is projected to increase by over 300 per cent, while their proportion of the total population will grow from 3.3 per cent in 1997 to 7.7 per cent in 2031.

With this in mind the Northern Territory Government is committed not only to the development and provision of flexible and innovative aged care services but also to the provision of services which maximise the health, independence and well being of ageing Territorians to ensure that they remain in their homes and communities longer. ”

12.7 Definitions

Table 12.9 **Terms**

Term	*Definition*
Aged care	Care of one or more of the following types: residential care; community care; flexible care (*Aged Care Act 1997* (Cwlth)). Residential care is personal care and/or nursing care provided to a person in a residential service in which the person is also provided with accommodation that includes appropriate staffing to meet the nursing and personal care needs of the person, meals and cleaning services, and furnishings, furniture and equipment for the provision of that care and accommodation (*Aged Care Act 1997* (Cwlth), s.41-3). Community care is care consisting of a package of personal care services and other personal assistance provided to a person who is not being provided with residential care (*Aged Care Act 1997* (Cwlth), s.41-3). Flexible care means care provided in a residential or community setting through an aged care service that addresses the needs of care recipients in alternative ways to the care provided through residential care services and community care services. Examples of the kinds of care that might be specified are care for people with special needs, care provided in small or rural communities, care provided through a pilot program for alternative means of providing care, and care provided as part of coordinated service and accommodation arrangements directed at meeting several health and community service needs (*Aged Care Act 1997* (Cwlth), s.49-3 and s.50-2).
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 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 query or grievance that any member of the public makes to the Commonwealth Department of Health and Aged Care about any services provided by a Commonwealth funded nursing home and/or hostel.
Disability	A limitation in performing certain tasks associated with daily living. The limitation has to result from a disability and affect one or more of the following areas: self care, mobility, verbal communication, schooling or employment.
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 into residential care.

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Table 12.9 **(Continued)**

Term	*Definition*
High/low care recipient	Recipient of a high level of residential care (that is, a level of residential care corresponding to RCS levels 1–4) or a recipient of a low level of residential care (that is, a level of residential care 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).
Home help	Assistance provided to clients in undertaking household tasks (for example, household cleaning).
Home maintenance/ modification	Assistance provided to clients in undertaking home maintenance tasks that the client is unable to undertake themselves, or the modification of the home for care purposes (for example, installation of hand rails).
Home meals/centre meals	Meals provided to persons either in their own home or at a separate facility (including 'meals on wheels').
Home nursing	Nursing care provided in a person's home (for example, assistance with taking medication).
Home respite	A short term substitute for usual care. Home respite could be provided in the home of either the person requiring care or the person providing care, and could be for up to a day, overnight or for longer periods.
Hostel	Residential services for older people that provide accommodation, personal care and occasional or limited nursing services.
Nursing home	Residential services for frail older people that provide accommodation, 24-hour nursing care and personal care.
Paramedical services	Services to help people maintain their independence and mobility (for example, physiotherapy, podiatry, speech therapy and occupational therapy).
People from non-English speaking countries	People who were born in non-English speaking countries. English-speaking countries are defined as Australia, New Zealand, United Kingdom, Ireland, the United States, Canada and South Africa.
People with a moderate disability	Those people with a disability who do not require help or supervision with tasks relevant to self care, mobility and verbal communication, but who have difficulty performing one or more of these tasks.
People with a profound disability	Those people with a disability who always require help or supervision in self care, mobility and/or verbal communication.
People with a severe disability	Those people with a disability who sometimes require help or supervision with tasks relevant to self care, mobility and verbal 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.

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Table 12.9 **(Continued)**

Term	*Definition*
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.
Services	An aged care/residential care/community care/flexible care service means an undertaking through which aged care/residential care/community care/flexible care is provided (*Aged Care Act 1997*).
Special needs groups	Section 11-3 of the *Aged Care Act 1997* specifies the following people as people with special needs: people from Aboriginal and Torres Strait Islander communities; people from non-English speaking countries; people who live in rural or remote areas; people who are financially or socially disadvantaged; and veterans.
Veterans	Veterans and war widow(er)s who are entitled to treatment through the Department of Veterans' Affairs under the provisions of the *Veterans' Entitlement Act 1986*.