# 13 Aged care services

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| Attachment tables |
| Attachment tables are identified in references throughout this chapter by a ‘13A’ prefix (for example, table 13A.1). A full list of attachment tables is provided at the end of this chapter, and the attachment tables are available from the Review website at www.pc.gov.au/gsp. |
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The aged care system comprises all services specifically designed to meet the care and support needs of older people living in Australia. This chapter focuses on government funded residential and community care for older people and services designed for the carers of older people. Some government expenditure on aged care is not reported, but continual improvements are being made to the coverage and quality of the data.

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

* inclusion of additional data for the ‘compliance with service standards for residential aged care’ indicator on the proportion of all re‑accredited services that are three year accredited
* data quality information (DQI) is available for the first time for the measures ‘use by different groups — access to Home and Community Care (HACC) services, by remoteness’, ‘cost per output unit — government funding per hour of HACC service’ and ‘expenditure per head of aged care target population — HACC’.

Older Australians are also users of other government services covered in this Report, including public hospitals (chapter 10), primary and community health services (chapter 11), specialised mental health services (chapter 12), disability services (chapter 14), and housing assistance (chapter 17). Understanding the relationship between the health system and the aged care system is of particular importance (sector overview E and chapters 10–12), given that people aged 65 years or over account for around 50 per cent of all patient days in public hospitals   
(AIHW 2013). Interactions between health and aged care services are critical for the performance of both systems; for example, the number of operational residential aged care places can affect demand for public hospital beds, and throughput of older patients in acute and sub‑acute care has a substantial effect on the demand for residential and community aged care.

## 13.1 Profile of aged care services

### Service overview

Services for older people are provided on the basis of frailty or disability. Government funded aged care services covered in this chapter include:

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

The formal publicly funded services covered represent only a small proportion of total assistance provided to older people. Extended family and partners are the largest source of emotional, practical and financial support for older people. Around 85 per cent of older people living in the community in 2012 who required help with self‑care, mobility or communications received assistance from the informal care network of family, friends and neighbours (ABS unpublished, *Survey of Disability, Ageing and Carers 2012*, Cat. no. 4430.0). Many people receive assistance from both formal aged care services and informal sources. Older people also purchase support services in the private market, and these services are not covered in this chapter.

### Roles and responsibilities

Under the *National Health Reform Agreement* (NHRA)*,* the roles and responsibilities that apply across the aged care and disability services’ systems changed from 1 July 2011 (for more details see the Community services sector overview F). The roles and responsibilities outlined in this chapter reflect the NHRA.

The funding and regulation of aged care services are predominantly the role of the Australian Government, although all three levels of government are involved. In September 2013, the Australian Government’s responsibility for Ageing and Aged Care moved from the Department of Health and Ageing (DoHA) to the Department of Social Services (DSS).

The *Aged Care Act 1997*, together with the accompanying *Aged Care Principles*, are the main regulatory instruments establishing the aged care framework. Key provisions covered include service planning, user rights, eligibility for care, funding, quality assurance and accountability (Productivity Commission 2010).

#### Aged Care Assessment Program

Aged Care Assessment Teams (ACATs) assess and approve clients as eligible for residential and community care[[2]](#footnote-2). An ACAT approval is mandatory for admission to Australian Government subsidised residential care (including respite) or to receive a CACP, EACH package, EACH‑D package or enter the TCP. People can also be referred by an ACAT to other services, such as those funded by the HACC program (although a referral under the ACAP is not mandatory for receipt of these other services).

The Australian Government has oversight of policy and guidelines, and engages State and Territory governments to operate ACATs who undertake the assessments. State and Territory governments are responsible for the day to day operation and administration of ACATs. The scope and practice of ACATs differ across and within jurisdictions, partly reflecting the service setting and location (for example, whether the team is attached to a hospital or a community service) and this has an effect on program outputs.

#### Residential care services

The Australian Government is responsible for most of the policy oversight and regulation of Australian Government subsidised residential aged care services, including:

* control over the number of subsidised residential care places through the provision ratio
* requirements that regulate the nature of the subsidised residential care places offered; for example services are expected to meet regional targets for places for concessional, assisted and supported residents and the number of extra service places are restricted
* accreditation of the service, certification of facilities and the ongoing monitoring of quality of care through the complaints scheme.

State, Territory and local governments may also have a regulatory role in areas such as work health and safety, workers compensation requirements, building standards, and fire prevention and firefighting measures. Industrial relations arrangements and outcomes vary between and within jurisdictions.

Religious and private for‑profit organisations are the main providers of residential care. At June 2013, they accounted for 27.2 per cent and 36.2 per cent respectively of all Australian Government subsidised residential aged care places.   
Community‑based organisations and charitable organisations accounted for a further 13.5 per cent and 17.6 per cent respectively. State and local governments provided the remaining 5.5 per cent (figure 13.1).

Figure 13.1 Ownership of operational residential places, June 2013**a, b, c**

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| Figure 13.1 Ownership of operational residential places, June 2013  More details can be found within the text surrounding this image. |

a Community‑based residential services provide a service for an identifiable community based on locality or ethnicity, not for financial gain. b Charitable residential services provide a service for the general community or an appreciable section of the public, not for financial gain. c Data exclude the flexible places provided under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program, Innovative Pool programs and care provided by Multi‑Purpose Services.

*Source*: DSS (unpublished); table 13A.16.

#### Community care services

The main community care programs reported in this chapter are the HACC, CACP, EACH, EACH‑D and the DVA VHC and Veterans’ community nursing programs. EACH and EACH‑D services are considered flexible care under the *Aged Care Act 1997*, but because of their nature are classified in this chapter as community care.

The Australian Government (DSS) is responsible for the policy oversight and regulation of HACC aged care services except in Victoria and WA where it is a joint Australian Government, and State governments’ initiative administered under the *Home and Community Care Review Agreement 2007*. HACC service providers vary from small community‑based groups to large charitable and public sector organisations.

The Australian Government (DSS) is responsible for the policy oversight and regulation of the CACP, EACH and EACH‑D programs. Religious and charitable organisations are the main providers of Australian Government subsidised community care places across the three programs (figure 13.2).

Figure 13.2 Operational CACP, EACH and EACH‑D places, by provider type, June 2013**a, b**

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| Figure 13.2 Operational CACP, EACH and EACH D places, by provider type, June 2013  More details can be found within the text surrounding this image. |

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

*Source*: DSS (unpublished).

The Australian Government (DVA) is primarily responsible for policy oversight and provision of the VHC and community nursing programs for veterans and war widows/widowers. These services are delivered by organisations contracted by DVA. There were approximately 66 000 people aged 65 years or over approved for VHC services in 2012‑13 and around 28 500 people aged 65 years or over receiving community nursing services (table 13A.13), including services provided to assist carers.

#### Services provided in mixed delivery setting

Two categories of services are defined in this Report as being provided in mixed delivery settings:

* flexible care services
* specific support services.

##### Flexible care services

Flexible care services comprise those provided under the *Aged Care Act 1997* (TCP, MPS innovative care places) and the National Aboriginal and Torres Strait Islander Flexible Aged Care Program.

* The TCP was established to assist older people in regaining physical and psychosocial functioning following an episode of inpatient care, to maximise independence and to help avoid premature entry to residential aged care. Services are delivered to patients in their own homes or in dedicated, home‑like residential facilities for a period of up to 12 weeks. To be eligible, patients must have been assessed by an ACAT as having the potential to benefit from Transition Care, be approved as eligible for residential aged care, and they must begin to receive Transition Care directly on discharge from hospital. The TCP is jointly funded by the Australian, State and Territory governments. Its implementation is overseen by the Transition Care Working Group, which includes representatives from all State and Territory governments and the Australian Government. State and Territory governments, as approved providers, develop their own service delivery models within the framework of the Program.
* The MPS program is a joint initiative between the Australian Government and State and Territory governments, which aims to deliver flexible and integrated health and aged care services to small rural and remote communities. Some health, aged and community care services may not be viable in a small community if provided separately. Australian Government aged care funding is combined with State and Territory governments’ health services funding. Services are primarily located in small rural hospital settings, where the MPS providers are State governments (DoHA 2012).
* The Aged Care Innovative Pool supports the development and testing of flexible models of service delivery in areas where mainstream aged care services might not appropriately meet the needs of a location or target group . At the beginning of each financial year, the Australian Government’s Minister for Ageing determines the flexible care subsidy rates for the Innovative Pool pilots.
* Under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program the Australian Government funds organisations to provide quality, flexible, culturally appropriate aged care to older Aboriginal and Torres Strait Islander people close to home and community. Flexible Aged Care services can deliver a mix of residential and community aged care services to meet the needs of the community. Services funded under this Program operate outside the regulatory framework of the *Aged Care Act 1997.*

##### Specific support services

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

The Australian Government is responsible for the funding and oversight of most of these programs. Programs focused on the care of long stay older patients (LSOP) in public hospitals are an exception. Since 2006, the Australian, State and Territory governments have had bilateral Agreements in place:

* The *Council of Australian Governments (COAG) LSOP Initiative ― 2006‑07 to 2011‑12* sought to ensure that older Australians at risk of unnecessary and prolonged hospital stays received appropriate and quality health care that better met their needs, and improved this group’s access to appropriate long‑term care options.
* Under the expiring *National Partnership Agreement (NPA) on Financial Assistance for LSOP ― 2011‑12 to 2013‑14,* the Australian Government provides funding to State and Territory governments to support a range of services relevant to their own service systems that improve care outcomes for older patients in public hospitals who no longer require acute or subacute care and who are eligible and waiting for a Australian Government‑subsidised aged care service.

Most State and Territory governments report that both the COAG Initiative and the NPA have enabled the introduction of valuable programs and strategies by hospitals, securing a successful decline in LSOP numbers over the life of those initiatives, including the number of very long stay patients (over 400 days).

### Funding

Recurrent expenditure on aged care services reported in this chapter was $13.6 billion in 2012‑13 (table 13.1). Table 13.1 does not include all Australian, State and Territory government expenditure on caring for older people, for example, the experimental estimates of expenditure on non‑HACC post‑acute packages of care and funding provided for older people in specialist disability services   
(table 13A.11), and Australian, State or Territory government capital expenditure are excluded (table 13A.12). Data on Australian, State and Territory governments’ expenditure per person in the aged care target population by program, jurisdiction and over time are in table 13A.6.

Table 13.1 Recurrent expenditure on aged care services, 2012‑13   
($ million)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | NSW | Vic | Qld | WA | SA | Tas | ACT | NT | Austa |
| Assessment and information servicesb | 39.0 | 27.6 | 21.0 | 12.6 | 10.4 | 3.4 | 1.4 | 1.8 | 120.8 |
| Residential care servicesc | 3 117.0 | 2 466.1 | 1 754.2 | 791.8 | 912.5 | 247.7 | 96.9 | 34.0 | 9 409.6 |
| Community care servicesd | 1 005.1 | 796.5 | 688.2 | 370.6 | 266.3 | 94.7 | 54.6 | 32.9 | 3 322.9 |
| Services provided in mixed delivery settingse | 189.7 | 140.6 | 127.6 | 81.4 | 90.3 | 24.0 | 8.8 | 13.1 | 776.4 |
| Total | **4 350.9** | **3 430.7** | **2 591.0** | **1 256.4** | **1 279.4** | **369.9** | **161.7** | **81.9** | **13 629.7** |

a Australian total includes ‘other’ Australian Government expenditure that cannot be attributed to individual states or territories. b Assessment and information services include only Australian Government expenditure on the ACAP, additional COAG funding for ACATs, Commonwealth Carelink Centres and Carers Information and Support. c Residential care services include DSS and DVA (including payroll tax supplement) and State and Territory governments’ expenditure and funding. d Community care services include HACC, CACP, EACH, EACH‑D, NRCP, VHC, DVA Community Nursing and Assistance with Care and Housing for the Aged. Expenditure on HACC in Victoria and WA is an estimate of that spent on older people under the HACC Review Agreement. e Services provided in mixed delivery settings include MPS, TCP, National Aboriginal and Torres Strait Islander Flexible Aged Care Program, Day Therapy Centres, Continence Aids Payment Scheme, National Continence Program, Innovative Care Pool, Dementia Education and Support, Financial Assistance for LSOP, Community Visitors Scheme and Support for older people from diverse backgrounds.

*Source*: DSS (unpublished); State and Territory governments (unpublished); table 13A.5.

#### Assessment and information services

In 2012‑13, the Australian Government provided funding of $102.2 million nationally for the ACAP, which includes $8.7 million of funding from the previous year (table 13A.7). Australian Government ACAP expenditure per person aged 65 years or over and Indigenous Australians aged 50–64 years was $30 nationally during 2012‑13 (table 13A.7). State and Territory governments also contribute funding for the ACAP, but this expenditure is not available for reporting. Aged care assessment program activities and expenditure for 2011‑12 and costs per person for 2005‑06 to 2011‑12 are reported in table 13A.84.

Expenditure on information services (Commonwealth Carelink Centres, and Carers Information and Support) was $18.3 million in 2012‑13 (table 13A.7).

#### Residential care services

The Australian Government provides most of the recurrent funding for residential aged care services. State and Territory governments provide funding for residential aged care for younger people and places provided by some public sector organisations. Residents provide most of the remaining service revenue, with some income derived from charitable sources and donations.

Total recurrent expenditure on residential aged care was $9.4 billion in 2012‑13 (table 13A.5). Australian Government expenditure (including payroll tax) on residential aged care was $9.0 billion in 2012‑13, comprising DoHA expenditure of $7.7 billion (table 13A.8) and DVA expenditure of $1.3 billion (table 13A.8). State and Territory government expenditure was $375.7 million from four categories of residential care expenditure/funding: adjusted subsidy reduction supplement ($20.7 million), enterprise bargaining agreement supplement ($179.6 million), rural small nursing home supplement ($17.2 million) and funding of younger people with disability in residential care (excluding for Victoria and WA) ($158.1 million).

##### Australian Government basic subsidy

The Australian Government annual basic subsidy for each occupied place varies according to clients’ levels of dependency. Each permanent resident has a dependency level for each of three domains (activities of daily living, behaviours and complex health care). The total average annual subsidy including the basic subsidy and the Conditional Adjustment Payment (CAP) is reported in table 13A.17. The amount of CAP payable in respect of a resident is calculated as a percentage of the basic subsidy amount (8.75 per cent since 2008‑09).

At 30 June 2013, the average annual subsidy per residential place, including the CAP, was $48 870 nationally (table 13A.17). The average annual subsidy per residential place varied across services with predominately high, mixed or low care, $55 357, $40 099 and $20 863 respectively. Detailed data on the dependency levels of permanent residents categorised by the proportion of high and low care places provided are shown in table 13A.17.

Capital expenditure

Capital expenditure on aged care services in 2012‑13 is summarised in table 13A.12. The Australian Government provided $40.9 million in 2012‑13 to fund programs that offer a range of financial assistance to address the capital needs (including for construction, expansion and upgrades) of services that are located in rural or remote areas, provide care to Aboriginal and Torres Strait Islander people or are in areas of special/high need. State governments also provided $42.1 million in 2012‑13 for capital expenditure on residential aged care services (table 13A.12). These capital funds are in addition to the total recurrent expenditure reported in table 13.1.

#### Community care services

Changing government policies over the past decade — shifting the balance of care away from the more intensive types of residential care towards community‑based care — have meant that the HACC, CACP, EACH, EACH‑D and DVA VHC and community nursing programs have become increasingly important components of the aged care system.

Total government expenditure on community care services for older people in   
2012‑13 was $3.3 billion (table 13A.5). Many recipients of these services also contribute to the costs.

* Total government expenditure on HACC services to older people was   
  $1.7 billion in 2012‑13 (table 13.2) ― consisting of $1.5 billion from the Australian Government and $247.3 million from the Victorian and WA governments (table 13A.5).
* Total government expenditure on community packaged care was $1.2 billion in 2012‑13, comprising $598.9 million on the CACP program, $372.6 million on EACH and $185.1 million on EACH‑D (table 13.2). This was largely funded by the Australian Government (99.0 per cent), with the remaining funding   
  ($12.0 million or 1.0 per cent) contributed by the State and Territory governments for younger people with disability (except in Victoria and WA) (table 13A.5).
* Expenditure on the NRCP was $206.6 million from the Australian Government (table 13.2).

Table 13.2 Governments’ expenditure on selected community aged care programs, 2012‑13 ($million)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | NSW | Vic | Qld | WA | SA | Tas | ACT | NT | Aust |
| *HACC aged care services expenditure by the Australian, Victorian and WA governments*a | | | | | | | | | |
|  | 501.1 | 435.3 | 394.0 | 185.8 | 148.1 | 49.5 | 20.3 | 9.7 | 1 743.7 |
| *Aged care services expenditure*b | | | | | | | | | |
| CACP | 204.2 | 158.0 | 99.5 | 49.5 | 53.0 | 15.6 | 8.4 | 10.6 | 598.9 |
| EACH | 100.3 | 78.1 | 76.6 | 71.8 | 19.7 | 8.4 | 12.5 | 5.1 | 372.6 |
| EACH‑D | 47.6 | 39.3 | 43.2 | 32.3 | 11.0 | 5.1 | 4.7 | 1.9 | 185.1 |
| NRCPc | 62.9 | 44.9 | 34.5 | 17.1 | 17.6 | 6.3 | 4.3 | 5.4 | 206.6 |

HACC = Home and Community Care. CACP = Community Aged Care Packages. EACH = Extended Aged Care at Home. EACH‑D = EACH‑Dementia. a HACC aged care expenditure for each jurisdiction refers to the estimated funding from the Australian Government on all people aged 65 years or over and Indigenous Australians aged 50–64 years. The exceptions are Victoria and WA where the expenditure includes a component of funding ($247.3 million in total) from those two jurisdictions ($174.3 million spent by the Victorian Government in Victoria and $73.0 million spent by the WA Government in WA). b Includes total program expenditure, including expenditure on services provided for younger people with disability. c Australian total includes ‘other’ Australian Government expenditure that cannot be attributed to individual states or territories.

*Source*: DSS (unpublished); tables 13A.5 and 13A.9.

The DVA also provided $85.4 million for the VHC program and $125.1 million for veterans community nursing services during 2012‑13 (table 13A.9). VHC recipients also contribute towards the cost of these services. In 2012‑13, $8.3 million was also provided as grants to the State and Territory governments to facilitate access by veterans to HACC services (table 13A.11).

#### Services provided in mixed delivery settings

Five types of flexible care are provided under the *Aged Care Act 1997* (EACH and EACH‑D packages, TCP, MPS and innovative care places). Expenditure relating to EACH and EACH‑D is reported in table 13.2.

* The Australian, State and Territory governments fund the TCP. In 2012‑13, the Australian Government spent $224.7 million and the State and Territory governments spent $105.3 million on the TCP (table 13A.10).
* The Australian Government also funds the MPS program (in conjunction with State and Territory governments) and the Innovative Care Pool. In 2012‑13, the Australian Government spent $126.7 million and $2.8 million on these programs, respectively (table 13A.10).
* The Australian Government spent $30.7 million on Indigenous specific services delivered under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (table 13A.10).

Australian Government expenditure to support older people in hospitals (Financial Assistance for LSOP) was $120.6 million in 2012‑13 (table 13A.10). Australian Government expenditure data on a range of other services provided in mixed delivery settings targeting older people was $165.6 million in 2012‑13 (for more details see table 13A.10).

### Size and scope of sector

#### Aged care target population

To align with the funding arrangements as specified under the *National Health Reform Agreement*, this Report defines the aged care target population as all people aged 65 years or over and Indigenous Australians aged 50–64 years. This aged care target population differs in scope to the Australian Government’s aged care ‘planning population’ (people aged 70 years or over) used to allocate residential care places and community care packages under the *Aged Care Act 1997*, and which for reporting purposes is combined with the population of Indigenous Australians aged 50–69 years.

##### Size and growth of the older population

The Australian population is ageing, as indicated by an increase in the proportion of older people (aged 65 years or over) in the total population. This trend is expected to continue, and the proportion of older people is expected to increase dramatically during this century (figure 13.3). The proportion of older people in the population at June 2013 was 14.5 per cent nationally, but varies across jurisdictions (figure 13.4). A disaggregation by remoteness categorisation is provided in table 13A.3. Higher life expectancy for females resulted in all jurisdictions having a higher proportion of older females than older males in the total population (except the NT) (table 13A.1).

The demand for aged care services is driven by the size and health of the older population. Females comprise a larger proportion of the older population and are more likely to utilise aged care services than males (partly because they are more likely to live alone). Based on the current age‑sex specific utilisation rates for residential aged care and packaged community care combined, and projected growth in the size of the aged care planning population for these services, it is estimated that the demand for aged care services for people aged 70 years or over will more than treble by 2056 (DSS unpublished estimate, based on ABS population projections series B in Cat. no. 3222.0).

Figure 13.3 People aged 65 years or over as a proportion of the total population**a**

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| Figure 13.3 Peopole aged 65 years or over as a proportion of the total population  More details can be found within the text surrounding this image. |

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

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

Figure 13.4 Estimated proportion of population aged 65 years or over, by sex, June 2013

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| Figure 13.4 Estimated proportion of population aged 65 years or over, by sex, June 2013  More details can be found within the text surrounding this image. |

*Source*: Population projections prepared by the ABS based on the 2011 Census according to assumptions agreed to by DSS (unpublished); table 13A.1.

##### Characteristics of older Indigenous Australians

DSS estimates that about 83 959 Indigenous Australians were aged 50 years or over in Australia at 30 June 2013 (table 13A.2). Although the Indigenous population is also ageing, there are marked differences in the age profile of Indigenous Australians compared with non‑Indigenous Australians (figure 13.5). Estimates show life expectancy at birth in the Indigenous population is around 10.6 years less for males and 9.5 years less for females when compared with the total Australian population (ABS 2013). Indigenous Australians aged 50 years or over are used in this Report as a proxy for the likelihood of requiring aged care services, compared to 65 years or over for the general population.

Figure 13.5 Age profile and aged care target population differences between Indigenous and other Australians, June 2011

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| Figure 13.5 Age profile and aged care target population differences between Indigenous and other Australians, June 2011  More details can be found within the text surrounding this image. |

*Source*: ABS (2013) *Australian Demographic Statistics, March 2013*, Cat. no. 3101.0, Canberra; ABS (2013) *Estimates of Aboriginal and Torres Strait Islander Australians, June 2011*, Cat. no. 3238.0.55.001.

#### Aged Care Assessments

Aged care assessments are designed to assess the care needs of older people and assist them to gain access to the most appropriate type of care. There were 99 ACATs (98 Australian Government funded) at 30 June 2013   
(DSS unpublished). Nationally, there were 54.0 assessments per 1000 people aged 65 years or over and Indigenous Australians aged 50–64 years in 2011‑12. The rate for Indigenous Australians was 25.7 per 1000 Indigenous Australians aged 50 years or over (figure 13.6).

Figure 13.6 Aged Care Assessment Team assessment rates,   
2011‑12**a,** **b, c, d**, **e, f**

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| Figure 13.6 Aged Care Assessment Team assessment rates, 2011-12  More details can be found within the text surrounding this image. |

a Includes ACAT assessments for all services. b All Australians includes all assessments of people aged 65 years or over and Indigenous Australians aged 50–64 years per 1000 people aged 65 years or over and Indigenous Australians aged 50–64 years. c Indigenous includes all assessments of Indigenous Australians aged 50 years or over per 1000 Indigenous Australians aged 50 years or over. d The number of Indigenous assessments is based on self‑identification of Indigenous status. e Data are preliminary and were extracted from the *Ageing and Aged Care Data Warehouse* on 31 August 2013. Future extracts of these data may change. f See table 13A.64 for further explanation of these data.

*Source*: Aged Care Assessment Program National Data Repository (unpublished); table 13A.64.

Assessments that result in ACAT approvals of eligibility for various types of care can be reported by age‑specific rates, for a series of age groups in the population for residential care and for community care (CACP, EACH and EACH‑D) (see   
table 13A.65). These data reflect the numbers of approvals, which are a subset of assessments, as some assessments will not result in an approval for a particular level of care.

#### Residential care services

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

* high care combines services such as nursing care, continence aids, basic medical and pharmaceutical supplies and therapy services with the types of services provided in low care such as accommodation, support services (cleaning, laundry and meals) and personal care services
* low care focuses on personal care services, accommodation, support services (cleaning, laundry and meals) and some allied health services such as physiotherapy — nursing care can be given when required
* respite provides short term residential high/low care on a planned or emergency basis (DoHA 2012).

At June 2013, there were 2718 residential aged care services (table 13A.18). There were generally fewer places in low care services than high care services. At   
June 2013, 84.0 per cent of low care services had 60 or fewer places (table 13A.20), compared with 25.9 per cent of high care services (table 13A.19).

The size and location of residential services — which can influence the costs of service delivery — vary across jurisdictions. Nationally, there were   
186 278 mainstream operational places (excluding flexible care places) in residential care services (108 789 in predominantly high care services, 2022 in predominantly low care services, 75 467 in services with a mix of high care and low care residents) at June 2013 (tables 13A.18–21).Box 13.1 contains information on how the Aged Care Funding Instrument (ACFI) is used to appraise a resident’s needs as high or low care.

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| Box 13.1 The Aged Care Funding Instrument and the characteristics of residents |
| ACAT approvals for residential care may limit the approval for some residents to low care. Following an assessment, approved providers of aged care homes appraise the level of a resident’s care needs using the ACFI.  The ACFI measures each resident’s need for care (high, medium, low or nil) in each of three domains: Activities of Daily Living, Behaviours and Complex Health Care. The ACFI was introduced on 20 March 2008 and replaced the Resident Classification Scale (RCS).  Residents are classified as high or low care based on the resident’s level of approval for care (determined by an ACAT) and on the approved provider’s appraisal of the resident’s care needs against the ACFI, in the following manner:   * Residents who have not yet received an ACFI appraisal are classified using their ACAT assessment. |
| (Continued next page) |
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| --- |
| Box 13.1 (continued) |
| * Residents whose ACAT approval is not limited to low care, are classified as high care if they are appraised under the ACFI as: * High in Activities of Daily Living, or * High in Complex Health Care, or * High in Behaviour, together with low or medium in at least one of the Activities of Daily Living or Complex Health Care domains; or * Medium in at least two of the three domains. * All other residents appraised under the ACFI are classified as low care residents. * In addition, residents whose ACAT approval is limited to low care, but whose first ACFI appraisal rates them in a high care range are classified as ‘interim low’ until the ACAT low care restriction is removed, or the ACFI High status is confirmed by a subsequent assessment or review.   Residents’ care needs may change over time. Under ‘ageing‑in‑place’, a low care resident who becomes high care at a later date is able to remain within the same service. |
|  |
|  |

The combined number of all operational high care and low care residential places per 1000 people in the aged care planning population (aged 70 years or over) at   
June 2013 was 84.5 (42.3 high care and 42.2 low care) on a national basis   
(table 13.3). Nationally, the proportion of low care places relative to high care places has remained relatively constant between 2006 and 2013 (table 13A.24).

Table 13.3 Operational high care and low care residential places,  
30 June 2013**a, b, c, d, e**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Unit | | | NSW | | Vic | Qld | WA | SA | Tas | ACT | NT | Aust |
| Number of places per 1000 people aged 70 years or over | | | | | | | | | | | | | |
| High care places | no. | | 44.6 | | | 41.3 | 39.1 | 36.6 | 50.1 | 43.7 | 30.6 | 48.1 | 42.3 |
| Low care places | no. | | 41.8 | | | 43.9 | 42.3 | 40.3 | 42.8 | 37.2 | 42.8 | 39.1 | 42.2 |
| **Total places** | **no.** | | **86.4** | | | **85.2** | **81.4** | **77.0** | **92.9** | **80.9** | **73.4** | **87.2** | **84.5** |
| Proportion of places | | | | | | | | | | | | | |
| High care places | % | 51.6 | | | 48.5 | | 48.0 | 47.6 | 54.0 | 54.0 | 41.7 | 55.2 | 50.0 |
| Low care places | % | 48.4 | | | 51.5 | | 52.0 | 52.4 | 46.0 | 46.0 | 58.3 | 44.8 | 50.0 |

a Excludes places that have been ‘approved’ but are not yet operational. Includes multi‑purpose and flexible services attributed as high care and low care places. b Australian Government planning targets are based on providing 86 residential places per 1000 people aged 70 years or over. In recognition of poorer health among Indigenous communities, planning in some cases also takes account of the Indigenous population aged 50–69 years. This means that the provision ratio based on the population aged 70 years or over may appear high in areas with a high Indigenous population (such as in the NT). c Includes residential places categorised as high care or low care. d See table 13A.24 for further information regarding the calculation of provision ratios, which vary from corresponding data published in the DoHA Annual Report 2012‑13. e Data in this table may not add due to rounding.

*Source*: DSS (unpublished); table 13A.24.

Age specific usage rates for permanent residential aged care services, by jurisdiction and remoteness, at 30 June 2013 are included in tables 13A.35 and 13A.42, respectively. Age specific usage rates for these permanent residential services combined with community care program services (CACP, EACH and EACH‑D), by jurisdiction and remoteness are reported in tables 13A.40 and 13A.44. National, Indigenous age specific usage rates for all these services by remoteness category are in table 13A.45.

During 2012‑13, the number of older clients (aged 65 years or over and Indigenous Australians aged 50–64 years) who received either high or low care in a residential aged care facility was 218 906 nationally for permanent care and 46 792 nationally for respite care (table 13A.4). These figures reflect the number of older individuals who utilised these services during the year, for any length of time. Data on the number of younger people aged under 65 years who used permanent residential care during 2012‑13 are in table 13A.41.

#### Community care services

##### HACC, CACP, EACH and EACH‑D programs

The distinctions between the HACC, CACP, EACH and EACH‑D programs are summarised in table 13.4. DVA VHC and Veterans’ community nursing program services are described below.

Services provided under the HACC program are basic maintenance and support services, including allied health care, assessment, case management and client care coordination, centre‑based day care, counselling, support, information and advocacy, domestic assistance, home maintenance, nursing, personal care and respite care, social support, meals, home modification, linen service, goods and equipment and transport. During 2012‑13, the HACC program delivered approximately 10 100 hours per 1000 people aged 65 years or over and Indigenous Australians aged 50–64 years (table 13A.46).

CACPs provide community‑based low level care to older people who are assessed by ACATs as having complex low care needs, but who are able to live at home with assistance. The total number of CACPs per 1000 people aged 70 years or over and Indigenous Australians aged 50–69 years increased between June 2006 and   
June 2013, from 17.8 to 20.7 (table 13A.25).

EACH and EACH‑D provide community‑based high level care to older people who are assessed by ACATs as having complex high care needs, but who have expressed a preference to live at home and are able to do so with assistance (EACH‑D provides this care to people with the complex care needs associated with dementia). The total combined number of EACH and EACH‑D packages per 1000 people aged 70 years or over and Indigenous Australians aged 50–69 years increased between   
June 2006 and June 2013, from 1.6 to 5.7 (table 13A.25).

Table 13.4 Distinctions between the HACC, CACP, EACH and EACH‑D programs, 2012‑13

|  |  |  |  |
| --- | --- | --- | --- |
|  | HACC | CACPs | EACH and EACH‑D |
| Type of servicesa | Maintenance and support services for people in the community whose independence is at risk | Package of low level care tailored to client needs | Package of high level care tailored to client needs (including those with dementia) |
| Relationship to residential care | Aims to prevent premature or inappropriate admission | Substitutes for a low care residential place | Substitutes for a high care residential place |
| Eligibility | ACAT approval not required | ACAT approval mandatory | ACAT approval mandatory |
| Funding | Funded by the Australian Government and client contributions, except in Victoria and WA where funding is also provided by those jurisdictions. | Funded by the Australian, State and Territory governments and client contributions | Funded by the Australian State and Territory governments and client contributions |
| Target client groupsb | Available to older people with profound, severe and moderate disability and their carers. Not age specific in Victoria and WA | Targets older people with care needs similar to low level residential care | Targets older people with care needs similar to high level residential care |
| Size of program | $1.7 billion funding for older clients  At least 756 148 olderclientsc | $598.9 million total funding  47 937 operational placesd | $557.7 million total funding  13 150 operational places**e** |

a HACC services such as community nursing, which are not available under CACPs, can be supplied to someone receiving a CACP. b Most HACC clients at the lower end of the scale would not be assessed as eligible for residential care; for example, an individual may receive only an hour of home care per fortnight. At the higher end, some people have needs that would exceed the level available under CACPs and EACH. c The proportion of HACC funded agencies that submitted Minimum Data Set data for 2012‑13 differed across jurisdictions and ranged from 51 per cent to 100 per cent. Consequently, the total number of clients will be higher than those reported. **d** The number of operational places includes CACPs, low level consumer directed care (CDC) places and flexible community places. See notes to table 13A.15. **e** The number of operational places includes EACH, EACH‑D and high level CDC places.

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

Age specific usage rates for CACP, EACH and EACH‑D, by jurisdiction and remoteness, at 30 June 2013 are included in tables 13A.39 and 13A.43 respectively. Age specific usage rates for these community care program services (CACP, EACH and EACH‑D) combined with permanent residential services are in tables 13A.40 and 13A.44. National, Indigenous age specific usage rates for all these services by remoteness category are in table 13A.45.

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

Data on the number of older clients (aged 65 years or over and Indigenous Australians aged 50–64 years) who received HACC, CACP, EACH and EACH‑D services in 2012‑13 are included in table 13.5. These data reflect the number of individuals who utilised these services during the year, for any length of time, as distinct from the number of places available. Data on the number of younger people aged under 65 years who used CACP, EACH and EACH‑D services during 2012‑13 are in table 13A.41.

Table 13.5 Number of community aged care older clients, by program, 2012‑13

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | NSW | Vic | Qld | WA | SA | Tas | ACT | NT | Aust |
| HACC | 220 597 | 213 495 | 150 094 | 56 494 | 80 567 | 23 090 | 10 187 | 1 624 | 756 148 |
| CACP | 21 558 | 15 401 | 10 835 | 5 712 | 5 454 | 1 558 | 922 | 844 | 62 232 |
| EACH | 3 428 | 2 480 | 2 522 | 2 621 | 664 | 251 | 446 | 154 | 12 558 |
| EACH‑D | 1 554 | 1 245 | 1 508 | 1 187 | 389 | 162 | 159 | 57 | 6 254 |

*Source*: DSS (unpublished); table 13A.4.

##### Veterans’ Home Care and Community Nursing programs

The services of the VHC program target veterans and war widows/widowers with low care needs. There were 67 471 people approved for VHC services in 2012‑13   
(table 13A.13)[[3]](#footnote-3). The program offers veterans and war widows/widowers who hold a Gold or White Repatriation Health Card home support services, including domestic assistance, personal care, home and garden maintenance, and respite care.

Eligibility for VHC services is not automatic, but based on assessed need. The average number of hours provided per year for veterans who were eligible to receive home care services was 51 nationally in 2012‑13 (figure 13.7).

The DVA also provides community nursing services to veterans and war widows/widowers. These services include acute/post‑acute support and maintenance, personal care, medication management and palliative care. In   
2012‑13, 28 585 veterans received these services (table 13A.13) and the average number of hours provided for each recipient was 8.9 per 28 day period   
(table 13A.13).

Figure 13.7 Average number of hours approved for Veterans’ Home Care, 2012‑13

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| Figure 13.7 Average number of hours approved for Veterans’ Home Care, 2012 13  More details can be found within the text surrounding this image. |

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

#### Services provided in mixed delivery setting

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

* At 30 June 2013, the Australian Government had allocated 4000 places to transition care, all of which were operational, across 93 services nationally. The average length of stay in 2012‑13 was 61 days (8‑9 weeks) nationally for completed episodes (table 13A.90).
* At 30 June 2013, there were 143 operational MPS program services with a total of 3483 operational flexible aged care places (includes residential and community places). Some of the MPS providers serve more than one location (DSS 2013).
* At 30 June 2013, there were 29 aged care services funded to deliver 679 flexible aged care places under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (DSS unpublished).
* In 2012‑13, 48 266 people received Day Therapy Centre Program services from   
  150 service outlets (table 13A.15 and DSS unpublished).
* During 2012‑13, 111 642 people were assisted through the Continence Aids Payment Scheme (table 13A.15).

## 13.2 Framework of performance indicators

The framework of performance indicators aims to provide information on equity, efficiency and effectiveness, and to distinguish the outputs and outcomes of government aged care services. This approach is consistent with the general performance indicator framework and service process diagram outlined in chapter 1 (see figures 1.2 and 1.3) that have been agreed by the Steering Committee. The performance indicator framework for aged care services is based on a set of shared government objectives in the aged care sector (box 13.2).

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| Box 13.2 Objectives for aged care services |
| The aged care system aims to promote the wellbeing and independence of older people and their carers through the funding and delivery of care services that are:   * accessible * appropriate to needs * high quality * efficient * person‑centred.   These objectives are consistent with the Australian, State and Territory governments’ long term aged care objectives articulated under the National Healthcare Agreement (NHA) that ‘older Australians receive appropriate high quality and affordable health and aged care services’ (COAG 2009). |
|  |
|  |

COAG has agreed six National Agreements to enhance accountability to the public for the outcomes achieved or outputs delivered by a range of government services (see chapter 1 for more detail on reforms to federal financial relations).

The National Healthcare Agreement (NHA) covers the areas of health and aged care services. The NHA includes sets of performance indicators, for which the Steering Committee collates performance information for analysis by the COAG Reform Council. Performance indicators reported in this chapter are aligned with the aged care‑related performance indicators in the NHA. The NHA was reviewed in 2011, 2012 and 2013 resulting in changes that have been reflected in this Report, as relevant.

The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of aged care services (figure 13.8). The performance indicator framework shows which data are complete and comparable in the 2014 Report. For data that are not considered directly comparable, text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report‑wide perspective (section 1.6).

The Report’s statistical context chapter contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and cultural status) (chapter 2).

Data quality information is being progressively introduced for all indicators in the Report. The purpose of DQI is to provide structured and consistent information about quality aspects of data used to report on performance indicators. DQI in this Report cover the seven dimensions in the ABS’ data quality framework (institutional environment, relevance, timeliness, accuracy, coherence, accessibility and interpretability) in addition to dimensions that define and describe performance indicators in a consistent manner, and key data gaps and issues identified by the Steering Committee. All DQI for the 2014 Report can be found at www.pc.gov.au/gsp/reports/rogs/2014.

Figure 13.8 Aged care services performance indicator framework

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| Figure 13.8 Aged care services performance indicator framework   More details can be found within the text surrounding this image. |

## 13.3 Key performance indicator results

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

### Outputs

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

#### Equity — Access

##### Use by different groups

‘Use by different groups’ is an indicator of governments’ objective for the aged care system to provide equitable access to aged care services for all people who require these services (box 13.3).

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| Box 13.3 Use by different groups |
| ‘Use by different groups’ has six measures defined as follows:   * the number of people born in non‑English speaking countries using residential services, CACPs, EACH, EACH‑D and HACC services divided by the number of people born in non‑English speaking countries aged 65 years or over, compared with the rates at which the total aged care target population (people aged 65 years or over and Indigenous Australians aged 50–64 years) access these services * the number of Indigenous Australians using residential services, CACP, EACH, EACH‑D and HACC services, divided by the number of Indigenous Australians aged 50 years or over (because Indigenous Australians tend to require aged care services at a younger age than the general population), compared with the rates at which the total aged care target population (people aged 65 years or over and Indigenous Australians aged 50–64 years) access these services * the number of veterans aged 65 years or over in residential care divided by the total number of eligible veterans aged 65 years or over, where a veteran is defined as a DVA Gold or White card holder * access to HACC services for people living in rural or remote areas — the number of hours of HACC service received (and, separately, meals provided) divided by the number of people aged 65 years or over and Indigenous Australians aged  50–64 years for major cities, inner regional areas, outer regional areas, remote areas and very remote areas |
| (Continued next page) |
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| Box 13.3 (continued) |
| * the rate of contacts with Commonwealth Respite and Carelink Centres for Indigenous Australians compared with the rate for all people * access to residential aged care services for financially disadvantaged people * the proportion of new residents classified as supported * the proportion of permanent resident care days classified as concessional, assisted or supported.   In general, usage rates for special needs groups similar to those for the broader aged care population are desirable, but interpretation of results differs for some special needs groups because:   * there is evidence that Indigenous Australians have higher disability rates than those of the general population, which suggests a greater level of need for services compared with those in the broader aged care population * for financially disadvantaged users, Australian Government planning guidelines require that services allocate a minimum proportion of residential places for concessional, assisted or supported residents. These targets range from 16 per cent to 40 per cent of places, depending on the service’s region. Usage rates equal to, or higher than, the minimum rates are desirable.   Use by different groups is a proxy indicator of equitable access. Various groups are identified by the *Aged Care Act 1997* and its principles (regulations) as having special needs, including people from Indigenous communities, people born in non‑English speaking countries, people who live in rural or remote areas, people who are financially or socially disadvantaged, veterans (including widows and widowers of veterans), people who are homeless or at risk of becoming homeless, or who are care leavers. A care leaver is a person who was in institutional care (such as an orphanage or mental health facility) or other form of out‑of‑home care, including foster care, as a child or youth (or both), at some time during their lifetime (DoHA 2012).  Several factors need to be considered in interpreting the results for this set of measures:   * Cultural differences can influence the extent to which people born in non‑English speaking countries use different types of services. * Cultural differences and geographic location can influence the extent to which Indigenous Australians use different types of services. * The availability of informal care and support can influence the use of aged care services in different population groups. |
| (Continued next page) |
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| Box 13.3 (continued) |
| Data reported for the six measures for this indicator are:   * comparable (subject to caveats) across jurisdictions but a break in series means that data for 2012‑13 are not comparable to data for earlier years (except for the ‘access to residential services by financially disadvantaged users’ measures that are comparable over time) * complete for the current reporting period (subject to caveats). All required 2012‑13 data are available for all jurisdictions.   Data quality information for five measures defined for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014. Data quality information for the other measures is under development. |
|  |
|  |

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

##### Access to residential aged care services by Indigenous Australians and people born in a non‑English speaking country

In all jurisdictions at 30 June 2013, on average, Indigenous Australians and people born in non‑English speaking countries had lower rates of use of aged care residential services (21.0 and 41.2 per 1000 of the relevant aged care target populations respectively), compared with the population as a whole (52.0 per 1000)   
(figure 13.9).

Age specific usage rates for these services, by jurisdiction (tables 13A.35 and 13A.40) and nationally by remoteness (tables 13A.42 and 13A.44‑45), suggest there is greater variation in usage rates by remoteness area than amongst jurisdictions.

Figure 13.9 Residents per 1000 aged care target population, 30 June 2013**a, b, c**

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| Figure 13.9 Residents per 1000 aged care target population, 30 June 2013  More details can be found within the text surrounding this image. |

a All residents data are per 1000 people aged 65 years or over and Indigenous Australians aged 50–64 years. b Indigenous residents data are per 1000 Indigenous Australians aged 50 years or over. c Data for residents from a non‑English speaking country are per 1000 people from non‑English speaking countries aged 65 years or over.

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

##### Access to CACP services by Indigenous Australians and people born in a non‑English speaking country

Nationally, the number of Indigenous CACP recipients per 1000 Indigenous Australians aged 50 years or over was 24.6 and the numbers of CACP recipients from non‑English speaking countries per 1000 of the relevant aged care target population was 14.0. These numbers compare to a total of 13.3 per 1000 of the aged care target population (people aged 65 years or over and Indigenous Australians aged 50–64 years) (figure 13.10).

Figure 13.10 Community Aged Care Package recipients per 1000 aged care target population, 30 June 2013**a, b, c, d, e**

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| Figure 13.10 Community Aged Care Package recipients per 1000 aged care target population, 30 June 2013  More details can be found within the text surrounding this image. |

a All recipients data are per 1000 people aged 65 years or over and Indigenous Australians aged 50–64 years.   
b Indigenous recipients data are per 1000 Indigenous Australians aged 50 years or over. c Data for recipients from non‑English speaking countries are per 1000 people from non‑English speaking countries aged 65 years or over. d The ACT has a very small Indigenous population aged 50 years or over (table 13A.2), and a small number of packages result in a very high provision ratio. e CACPs provide a more flexible model of care, more suitable to remote Indigenous communities, so areas such as the NT have a higher rate of CACP recipients per 1000 people.

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

Age–sex specific usage rates vary between jurisdictions (table 13A.39) and by remoteness categories nationally (table 13A.43) for CACP, EACH and EACH‑D.

##### Access to HACC aged care services by Indigenous Australians and people born in a non‑English speaking country

Nationally, the number of Indigenous HACC recipients per 1000 Indigenous Australians aged 50 years or over was 208.5 and the numbers of HACC recipients from non‑English speaking countries per 1000 people aged 65 years or over was 212.9. These numbers compare to a total of 222.8 per 1000 of the aged care target population (people aged 65 years or over and Indigenous Australians aged  
50–64 years) (figure 13.11).

Figure 13.11 HACC recipients per 1000 aged care target population,   
30 June 2013**a, b, c**

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| --- |
| Figure 13.11 HACC recipients per 1000 aged care target population, 30 June 2013  More details can be found within the text surrounding this image. |

a All recipients data are per 1000 people aged 65 years or over and Indigenous Australians aged 50–64 years. b Indigenous recipients data are per 1000 Indigenous Australians aged 50 years or over. c Data for recipients from non‑English speaking countries are per 1000 people from non‑English speaking countries aged 65 years or over.

*Source*: DSS (unpublished) *Home and Community Care Minimum Data Set*; table 13A.30.

##### Access by veterans

The total number of veterans 65 years or over who were in the DVA treatment population (that is, eligible veterans) at 30 June 2013 was 171 702 (table 13A.14). The number of veterans in residential care per 1000 eligible veterans aged 65 years or over at 30 June 2013 was 158.0 (figure 13.12). Nationally, total DVA expenditure on residential aged care subsidy per person aged 65 years or over was $393 (including payroll tax) in 2012‑13 (table 13A.14). Total DVA expenditure on residential aged care per 1000 eligible veterans aged 65 years or over was   
$7.6 million (figure 13.12).

Figure 13.12 Number of veterans aged 65 years or over in residential care and total DVA expenditure on residential aged care subsidy, per 1000 eligible veterans aged 65 years or over, 2012‑13**a, b, c**

|  |  |
| --- | --- |
| Figure 13.12 Number of veterans aged 65 years or over in residential care and total DVA expenditure on residential aged care subsidy, per 1000 eligible veterans aged 65 years or over, 2012-13   Service use   More details can be found within the text surrounding this image. | Figure 13.12 Number of veterans aged 65 years or over in residential care and total DVA expenditure on residential aged care subsidy, per 1000 eligible veterans aged 65 years or over, 2012 13   Total expenditure  More details can be found within the text surrounding this image. |

a Data are subject to a time lag and may be subject to revision. b The number of eligible veterans are veterans with a DVA Gold and White card holder residents as at June 2013. c Veterans 65 years or over includes those whose age is unknown.

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

##### Access to the HACC program, by location

HACC services are provided in the client’s home or community for people with moderate, severe or profound disability and their carers. The focus of this chapter is older people 65 years or over and Indigenous Australians aged 50–64 years. Nationally, the number of service hours per 1000 people aged 65 years or over and Indigenous Australians aged 50–64 years was 10 071 and the number of meals provided per 1000 people aged 65 years or over and Indigenous Australians aged 50–64 years was 2805 in 2012‑13 (table 13.6). The proportion of HACC agencies that submitted data vary across jurisdictions so comparisons between jurisdictions should be made with care.

Table 13.6 Selected HACC services received per 1000 people aged 65 years or over and Indigenous Australians aged   
50–64 years, 2012‑13**a, b, c**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| NSW | | Vic | Qld | WA | SA | Tas | ACT | NT | Aust |
| Percentage of agencies that reported Minimum Data Set data | | | | | | | | | |
|  | 100 | 97 | 98 | 100 | 96 | 99 | 100 | 51 | 98 |
| Total hours**d** | | | | | | | | | |
| Major cities | 8 836 | 10 526 | 11 579 | 10 258 | 11 308 | .. | 8 606 | .. | 10 130 |
| Inner regional | 7 438 | 11 973 | 9 211 | 10 922 | 7 667 | 11 201 | .. | .. | 9 414 |
| Outer regional | 9 136 | 15 364 | 11 004 | 12 296 | 10 655 | 8 685 | .. | 3 027 | 10 737 |
| Remote | 12 468 | 24 321 | 14 671 | 10 659 | 11 757 | 7 094 | .. | 4 518 | 11 591 |
| Very remote | 11 498 | .. | 13 536 | 15 225 | 22 582 | 14 476 | .. | 6 156 | 12 816 |
| **All areas** | **8 545** | **11 158** | **10 992** | **10 599** | **10 876** | **10 266** | **8 594** | **4 207** | **10 071** |
| Total mealse | | | | | | | | | |
| Major cities | 2 085 | 2 475 | 2 843 | 1 369 | 4 342 | .. | 2 385 | .. | 2 446 |
| Inner regional | 2 973 | 3 229 | 3 371 | 2 146 | 2 273 | 2 760 | .. | .. | 3 038 |
| Outer regional | 4 629 | 3 767 | 3 174 | 3 104 | 4 277 | 2 782 | .. | 1 934 | 3 689 |
| Remote | 8 524 | 6 987 | 5 528 | 4 587 | 4 473 | 2 747 | .. | 4 665 | 5 345 |
| Very remote | 21 911 | .. | 7 462 | 12 018 | 22 001 | 7 085 | .. | 12 470 | 11 987 |
| **All areas** | **2 562** | **2 728** | **3 119** | **1 879** | **4 223** | **2 792** | **2 382** | **5 406** | **2 805** |

a Data represent HACC services received by people aged 65 years or over and Indigenous Australians aged 50–64 years, divided by people aged 65 years or over and Indigenous Australians aged 50–64 years (tables 13A.46, 13A.48–52) as distinct from HACC services received by people aged 65 years or over and Indigenous Australians aged 50–64 years divided by the HACC target population aged 65 years or over and Indigenous Australians aged 50–64 years (tables 13A.54–59). b The proportion of HACC funded agencies that submitted Minimum Data Set data for 2012‑13 differed across jurisdictions and ranged from 51 per cent to   
100 per cent. Consequently, actual service levels were higher than stated. c Reports provisional HACC data that have not been validated and may be subject to revision. d See table 13A.48 for a full list of categories.   
e Includes home meals and centre meals. .. Not applicable.

*Source*: DSS (unpublished) *HACC Minimum Data Set 2011‑12*; DSS (unpublished) *HACC National Data Repository*; tables 13A.46, 13A.48–52.

There are substantial differences in the age profile across the Indigenous and   
non‑Indigenous populations. This reflects the difference in morbidity and mortality trends between Indigenous Australians and the general population. The proportion of older Indigenous HACC clients (aged 65 years or over) who are aged 80 years or over is 26.2 per cent and the proportion of non‑Indigenous HACC clients who are aged 80 years or over is 54.8 per cent (figure 13.13).

Figure 13.13 Older recipients of HACC aged care services by age and Indigenous status, 2012‑13**a, b, c**

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| **More details can be found within the text surrounding this image.Proportion of older Indigenous HACC clients, by age cohort**  Figure 13.13 Older recipients of HACC aged care services by age and Indigenous status, 2012-13  Proportion of older Indigenous HACC clients, by age cohort  More details can be found within the text surrounding this image. |
| **Proportion of older non‑Indigenous HACC clients, by age cohort**  Figure 13.13 Older recipients of HACC aged care services by age and Indigenous status, 2012-13  Proportion of older non-Indigenous HACC clients, by age cohort  More details can be found within the text surrounding this image. |

a Reports provisional HACC data that have not been validated and may be subject to revision. b The proportion of older HACC clients with unknown Indigenous status differed across jurisdictions. Nationally, the proportion of older HACC clients with unknown or null Indigenous status was 5.9 per cent (table 13A.60).   
c The Indigenous proportions are derived using data contained in table 13A.61.

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

##### Access by Indigenous Australians to Commonwealth Respite and Carelink Centres

Commonwealth Respite and Carelink Centres are information centres for older people, people with disabilities, carers and service providers. Information is provided on community services and aged care, disability and other support services available locally or anywhere in Australia, the costs of services, assessment processes and eligibility criteria. The national rate at which Indigenous Australians contacted Respite and Carelink Centres at 30 June 2013, was 31.7 people per 1000 Indigenous Australians in the Indigenous aged care target population (Indigenous Australians aged 50 years or over). The rate for all Australians was 163.3 per 1000 people in the aged care target population (people aged 65 years or over and Indigenous Australians aged 50–64 years). These figures varied across jurisdictions (figure 13.14).

Figure 13.14 Commonwealth Respite and Carelink Centres, contacts per 1000 aged care target population, by Indigenous status, 30 June 2013**a, b, c, d**

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| Figure 13.14 Commonwealth Respite and Carelink Centres, contacts per 1000 aged care target population, by Indigenous status, 30 June 2013  More details can be found within the text surrounding this image. |

a Contacts include phone calls, visits, emails and facsimiles. b Indigenous contacts refer to contacts by Indigenous Australians per 1000 Indigenous Australians aged 50 years or over. c All contacts refers to contacts per 1000 aged 65 years or over and Indigenous Australians aged 50–64 years. d Indigenous status is determined through people making contact self‑identifying themselves as Indigenous. Therefore, there is likely to be substantial under‑reporting of Indigenous status.

*Source*: DSS (unpublished); table 13A.63.

##### Access to residential services by financially disadvantaged users

New residents who are assessed as eligible to receive subsidised accommodation costs are known as supported residents. Residents who entered care prior to 20 March 2008 are still subject to the eligibility criteria for ‘concessional’ or ‘assisted’ resident status.

The proportion of all new residents classified as supported residents during 2012‑13 was 37.8 per cent nationally but varied across jurisdictions (figure 13.15). Targets for financially disadvantaged users range from 16 per cent to 40 per cent of places, depending on the service’s region.

Figure 13.15 New residents classified as supported residents, 2012‑13**a**

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| Figure 13.15 New residents classified as supported residents, 2012-13  More details can be found within the text surrounding this image. |

a Supported residents are those who have entered permanent residential care on or after 20 March 2008 (or who re‑entered care on or after 20 March 2008 after a break in care of more than 28 days) and have assets of up to a set value (from 20 March 2012 to 19 September 2012 — $108 266.40, from 20 September 2012 to   
19 March 2013 — $109 640.80 and from 20 March 2013 to 30 June 2013 — $112 243.20).

*Source*: DSS (unpublished); table 13A.36.

The proportion of all permanent resident care days classified as concessional, assisted or supported during 2012‑13 was 41.2 per cent nationally, but varied across jurisdictions (figure 13.16).

Figure 13.16 Permanent residents’ care days classified as concessional, assisted or supported, 2012‑13**a**

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| Figure 13.16 Permanent residents’ care days classified as concessional, assisted or supported, 2012-13  More details can be found within the text surrounding this image. |

a Concessional residents are those who entered permanent residential care before 20 March 2008, receive an income support payment and have not owned a home for the last two or more years (or whose home is occupied by a protected person, for example, the care recipient’s partner), and have assets of less than   
2.5 times the annual single basic age pension (or for a transfer from 20 September 2009 less than 2.25). Assisted residents are those meeting the above criteria, but with assets between 2.5 and 4.0 times the annual single basic age pension (or for a transfer from 20 September 2009 between 2.25 and 3.61). Supported residents are those who have entered permanent residential care on or after 20 March 2008 (or who re‑enter care on or after 20 March 2008 after a break in care of more than 28 days) and have assets of up to a set value (from 20 March 2012 to 19 September 2012 — $108 266.40, from 20 September 2012 to 19 March 2013 — $109 640.80 and from 20 March 2013 to 30 June 2013 — $112 243.20).

*Source*: DSS (unpublished); table 13A.36.

#### Effectiveness — level of access

##### Operational aged care places

‘Operational aged care places’ is an indicator of governments’ objective to provide older Australians with access to a range of aged care services that can meet their care needs (box 13.4). This indicator does not include places that have been approved, but are not yet operational.

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| Box 13.4 Operational aged care places |
| ‘Operational aged care places’ is defined by two measures, the number of operational places (by type) per 1000 people in the aged care planning population:   * aged 70 years or over * aged 70 years or over and Indigenous Australians aged 50–69 years.   The planning framework for services provided under the *Aged Care Act 1997* aims to keep the growth in the number of Australian Government subsidised aged care places in line with growth in the aged population, and to ensure a balance of services across Australia, including services for people with lower levels of need and in rural and remote areas. The current national provision ratio is 113 operational aged care places per 1000 of the population aged 70 years or overa. Within this overall target provision ratio of 113 places:   * 42 places (37 per cent) should be residential high care — designed to meet the needs of residents equivalent to high care * 44 places (39 per cent) should be residential low care — designed to meet the needs of residents equivalent to low care * 27 places (24 per cent) should be community care, with 6 of these places (around 5.3 per cent of total places) being for high level community care — designed to enable those with high/low care needs to continue living in, or return to, the community (DoHA unpublished)a.   In recognition of poorer health among Indigenous communities and that planning in some cases also takes account of the Indigenous population aged 50–69 years, the provision ratio is also reported for operational places per 1000 people aged 70 years or over and Indigenous Australians aged 50–69 years. A provision ratio based on the population aged 70 years or over will appear high in areas with a high Indigenous population (such as the NT).  In general, provision ratios across states and territories, and across regions, that are broadly similar to the overall target provision ratios are desirable as it indicates that older Australians have access to a similar level and mix of services to meet their care needs.  a The national provision ratio is planned to increase from 113 operational places per 1000 people aged  70 years or over to 125 places by 2021‑22. Within this provision ratio, the number of home care packages will increase from 27 to 45, reflecting a greater emphasis on assisting people to remain in their own home as they age. The absolute number of residential aged care places will also continue to increase, but at a rate more reflective of consumer demand (decreasing from 86 to 80 per 1000 of the population aged 70 years or over). |
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| Box 13.4 (continued) |
| This indicator does not provide information on whether the overall target provision ratios are adequate or provide an appropriate mix of services relative to need.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete for the current reporting period (subject to caveats). All required  30 June 2013 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014. |
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Nationally, the combined number of high care residential places, low care residential places, CACPs, flexible care places (including EACH and EACH‑D, but excluding Transition Care places) and places under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program at 30 June 2013, was   
111.7 per 1000 people aged 70 years or over (figure 13.17). Transition Care places add an additional 1.8 per 1000 people aged 70 years or over (table 13A.24), however, these places are not included in the target of 113 places (box 13.4). The number of operational aged care places per 1000 people aged 70 years or over by care type was:

* 42.3 places (37.8 per cent of total) for residential high care
* 42.2 places (37.8 per cent of total) for residential low care
* 27.2 places (24.4 per cent of total) for community care — 21.4 places for CACPs and 5.9 places for EACH and EACH‑D combined (5.2 per cent of total places)   
  (figure 13.17).

Figure 13.17 Operational residential places, CACPs, EACH and EACH‑D packages per 1000 people aged 70 years or over,   
30 June 2013**a, b, c, d, e, f, g**

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| Figure 13.17 Operational residential places, CACPs, EACH and EACH- D packages per 1000 people aged 70 years or over,  30 June 2013  More details can be found within the text surrounding this image. |

a Excludes places that have been approved but are not yet operational. b Ageing in place may result in some low care places being filled by high care residents. c For this Report, Australian Government planning targets are based on providing 113 places per 1000 people aged 70 years or over. However, in recognition of poorer health among Indigenous communities, planning in some cases also takes account of the Indigenous population aged 50–69 years. This means that the provision ratio based on the population aged 70 years or over will appear high in areas with a high Indigenous population (such as the NT). d Includes residential places categorised as high care or low care. e CACPs, EACH and EACH‑D packages are included in the Australian Government planning targets. f CACP data include flexible community low care places under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program, Multi‑Purpose Service Program and Innovative Pool Program (including CDC low care places). g See table 13A.24 for further information regarding the calculation of provision ratios.

*Source*: DSS (unpublished); table 13A.24.

The number of operational aged care places can also be shown using an aged care planning population that incorporates Indigenous Australians aged 50–69 years   
(figure 13.18). Use of this ‘adjusted’ aged care planning population has a noticeable effect on the NT, which has a large proportion of Indigenous Australians.

Figure 13.18 Operational residential places, CACPs, EACH and EACH‑D packages per 1000 people aged 70 years or over and Indigenous Australians aged 50–69 years, 30 June 2013**a, b, c, d, e, f, g**

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| Figure 13.18 Operational residential places, CACPs, EACH and EACH-D packages per 1000 people aged 70 years or over and Indigenous Australians aged 50–69 years, 30 June 2013  More details can be found within the text surrounding this image. |

a Excludes places that have been approved but are not yet operational. b Ageing in place may result in some low care places being filled by high care residents. c CACPs, EACH and EACH‑D packages are included in the Australian Government planning targets. d Includes residential places categorised as high care or low care. e CACPs provide a more flexible model of care more suitable to remote Indigenous communities, so areas with a high Indigenous population (such as the NT) may have a higher proportion of CACPs. f CACP data include flexible community low care places under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program, Multi‑Purpose Service Program and Innovative Pool Program (including CDC low care places). EACH data includes CDC high care places and EACH‑D data includes CDC high care dementia places. g TCP places are not shown, see table 13A.25.

*Source*: DSS (unpublished); table 13A.25.

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

#### Effectiveness — timeliness of access

##### Elapsed times for aged care services

‘Elapsed times for aged care services’ is an indicator of governments’ objective to maximise the timeliness with which people are able to access aged care services (box 13.5).

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| Box 13.5 Elapsed times for aged care services |
| ‘Elapsed times for aged care services’ is defined by two measures.   * The proportion of people who entered residential high care who did so within three months of their ACAT approval. Entry into a residential care service refers to the date of admission to a residential aged care service. ACAT approval refers to the approval date of the most recent assessment by an ACAT prior to admission into care. * The proportion of people who commenced a CACP who did so within three months of their ACAT approval. ACAT approval refers to the approval date of the most recent assessment by an ACAT prior to commencement of care.   Data are also presented for these service types on the proportions who enter/receive these services within other periods of time. Data on ‘elapsed’ times for EACH and EACH-D services are also included in table 13A.66.  Higher proportions of admission to residential high care or of commencement of a CACP service within three months of ACAT approval are desirable.  This indicator needs to be interpreted with care. The measure of ‘elapsed time’ is utilised, rather than ‘waiting times’, because the period of time between the ACAT approval and entry into residential care or commencement of a CACP may be affected by factors other than time spent ‘waiting’ to enter/receive a service, for example:   * hospital discharge policies and practices * client choice not to enter or commence care immediately, but to take up the option at a later time * variations in perceived quality of care, care fee regimes and building quality, which influence client choice of preferred service and delays their take up of care.   In addition, the measure does not include clients who have received an ACAT approval and who may have spent time waiting, but who:   * do not enter residential care or commence a CACP (for example, who die before entering care) * ultimately decide not to take‑up a care placement offer * choose to take‑up an alternative care option due to, for example, varying fee regimes.   Elapsed time needs to be interpreted locally and may vary in relevance according to individual circumstances. A client’s decision to take‑up care at a particular point in time can be influenced by the location of residential care services; the availability of alternatives to residential care, such as EACH and EACH‑D; and for community care, the availability of informal care and respite services. |
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| Box 13.5 (continued) |
| For residential aged care, this indicator focuses on high care services because the link between ‘elapsed time’ before entry to residential care and actual ‘waiting time’ is stronger for high care residents than for low care residents. This is due to the urgency of high care residents’ needs, and the greater number of alternatives for people with ACAT approvals for low residential aged care only. Where there is some urgency because of a client’s high care needs, it is clearly desirable to minimise the time elapsing between ACAT approval and entry to high level residential aged care. However, there is an equally strong argument for ensuring all options are explored, including Transition Care, to ensure that premature entry to residential aged care is avoided or at least postponed for as long as practical given individual circumstances.  It is recognised that this indicator has limitations and work is underway to review the data. This indicator will continue to be reported until improved data are available.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete for the current reporting period (subject to caveats). All required 2012‑13 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014. |
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Overall, 22.0 per cent of all people entering residential high care during 2012‑13 did so within seven days of being approved by an ACAT compared with 22.6 per cent in 2011‑12. In 2012‑13, 50.0 per cent entered within one month of their ACAT approval and 72.0 per cent entered within three months of their approval (figure 13.19), compared with 51.2 per cent and 73.2 per cent respectively in   
2011‑12 (table 13A.66). The median time for entry into high care residential services was 30 days in 2012‑13 compared to 28 days in 2011‑12 (table 13A.66).

Nationally in 2012‑13, a greater proportion of people entering high care residential services entered within three months of approval (72.0 per cent), compared with the proportion entering low care residential services within that time (64.9 per cent). Further data on elapsed time by remoteness, Socio Economic Indexes for Areas (SEIFA) and Indigenous status are included in table 13A.67–69.

Overall, 65.4 per cent of all people commencing a CACP during 2012‑13 received it within three months of being approved by an ACAT. This proportion varied across jurisdictions. On average, 35.1 per cent started receiving a CACP within one month of being approved by an ACAT (figure 13.20).

Figure 13.19 People entering high care residential care within specified time periods of their ACAT approval, 2012‑13**a, b**

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| -Figure 13.19 People entering high care residential care within specified time periods of their ACAT approval, 2012-13  More details can be found within the text surrounding this image. |

a Includes residential places categorised as high care. b NT data for people who entered high care residential care within ‘2 days or less’ and ‘7 days or less’ are not published due to small numbers.

*Source*:DSS (unpublished); table 13A.66.

Figure 13.20 People commencing a CACP within three months of their ACAT approval, 2012‑13

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| Figure 13.20 People commencing a CACP within three months of their ACAT approval, 2012 13  More details can be found within the text surrounding this image. |

*Source*: DSS (unpublished); table 13A.66.

#### Effectiveness — appropriateness

##### Assessed long‑term care arrangements

‘Assessed long‑term care arrangements’ is an indicator of governments’ objective to meet clients’ needs through provision of appropriate aged care services (box 13.6).

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| Box 13.6 Assessed long‑term care arrangements |
| ‘Assessed long‑term care arrangements’ is defined as the proportions of ACAT clients recommended to reside in the community (private residence or other community), or in residential care (high or low level), or in another location (such as, other institutional care) or for clients whom ACATs did not make a recommendation for long‑term care arrangements for reasons such as death, transfer or cancellation. A recommendation does not mean that the person will be approved for the care recommended, and an approval does not mean that the person will take up the care approved. Aged care assessments are mandatory for admission to Australian Government subsidised residential care or for receipt of a CACP, EACH, EACH‑D or TCP package.  High or increasing proportions of clients recommended to remain in the community (assuming this is appropriate) are desirable.  The results for this indicator show the distribution of long‑term care arrangements of ACAT clients in each jurisdiction. Differences in recommendations across jurisdictions can reflect external factors such as geographic dispersion of clients and service availability, but also views on the types of client best served by community‑based services and client preferences. The distribution of ACAT recommendations for various care arrangements are influenced by the degree to which any pre‑selection process refers people requiring residential care to an ACAT for an assessment.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete for the current reporting period (subject to caveats). All required 2011‑12 data are available for all jurisdictions.   Data quality information for this indicator is under development. |
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The national proportion of ACAT clients recommended for residential care in   
2011‑12 was 37.1 per cent and the proportion recommended to remain in the community was 50.7 per cent (figure 13.21). The remaining 12.2 per cent comprise those for whom the recommendation was another location (for example, other institutional care) or for whom reasons such as death, transfer or cancellation meant that no recommendation for long‑term care arrangements was made.

Figure 13.21 Recommended long‑term care arrangements of ACAT clients, 2011‑12**a, b, c**

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| Figure 13.21 Recommended long term care arrangements of ACAT clients, 2011-12  More details can be found within the text surrounding this image. |

a Other includes hospital and other institutional care. b No recommendation includes deaths, cancellations and transfers. c Data are preliminary and were extracted from the Ageing and Aged Care Data Warehouse on   
31 August 2013. Future extracts of these data may change and thus alter final numbers.

*Source*: DSS (unpublished) *Ageing and Aged Care Data Warehouse* from *Aged Care Assessment Program Minimum Data Set*; table 13A.70.

##### Unmet need

‘Unmet need’ is an indicator of governments’ objective of ensuring aged care services are allocated to meet clients’ needs (box 13.7).

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| Box 13.7 Unmet need |
| ‘Unmet need’ is defined as the extent to which demand for services to support older people requiring assistance with daily activities is not met.  Low rates of unmet need are desirable; however, defining and determining the level of need at an individual level is complex and at a population level is highly complex. Perceptions of need and unmet need are often subjective.  Data for this indicator are drawn from the ABS *2012 Survey of Disability, Ageing and Carers*. Data are for people aged 65 years or over who self‑identified as having a need for assistance with at least one everyday activity, and the extent to which that need was being met (fully, partly or not at all). |
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| Box 13.7 (continued) |
| Direct inferences about the demand for services need to be made with care, because the measure used does not:   * reveal the intensity of care required by those who identify an unmet need — there is no indication of whether the need can readily be met informally or by formal home care, or whether the person may require residential care * reflect the degree of unmet demand for a specific type of service. Differences across jurisdictions in the proportion of unmet need can reflect different policy approaches to targeting services. Some governments may choose to focus on those with the greatest degree of need for care and on fully meeting their needs. By contrast, other governments may choose to provide a lower level of service to a greater number of people, while only partly meeting the needs of those with the greatest need for care — both are valid policy approaches * reflect the past and possible future duration of the need — that is, whether it is long term or transitory * reflect whether the need relates to a disability support service, aged care service or health care.   Although data are included, this indicator is regarded as yet to be developed, because of the extent of the caveats. |
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Of those people aged 65 years or over in 2012, who were living in households and who self‑identified as having a need for assistance with at least one everyday activity, 34.0 ± 1.3 per cent reported that their need for assistance was not fully met   
(table 13A.71).

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

‘Hospital patient days used by aged care type patients’ is an indicator of governments’ objective to minimise the incidence of older people staying in hospitals for extended periods of time when their care needs may be met more appropriately through residential or community care services (box 13.8).

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| Box 13.8 Hospital patient days used by aged care type patients |
| ‘Hospital patient days used by aged care type patients’ has two measures:   * the proportion of completed aged care type public hospital separations for people aged 65 years or over and Indigenous Australians aged 50–64 years for which the length of stay was 35 days or longer, where ‘aged care type’ hospital separations are defined as: * the care type was maintenance, and * the diagnosis (either principal or additional) was either person awaiting admission to residential aged care service or need for assistance at home and no other household member able to render care * the proportion of all patient days (for overnight separations only) used by patients who are waiting for residential aged care, where the: * care type was maintenance, and * diagnosis (either principal or additional) was person awaiting admission to residential aged care service, and * separation mode was discharge/transfer to another acute hospital or to residential aged care (unless this is usual place of residence); statistical discharge, that is a change in care type; the patient died; discharge/transfer to other health care accommodation (including mother craft hospitals and another psychiatric hospital); left against medical advice/discharge at own risk or statistical discharge from leave.   Low or decreasing proportions of hospital stays of 35 days or more and low or decreasing proportions of patient days used by people waiting for residential aged care are desirable.  Hospital inpatient services are geared towards shorter periods of care aimed at addressing serious illness or injury, or diagnosis, and are a less effective form of care for older people who cannot live independently in the long term.  These measures should be interpreted with care, because:   * patients who have not completed their period of care in a hospital are not included * although the diagnosis codes reflect a care type, they do not determine a person’s eligibility for residential aged care (this is determined by an ACAT assessment) or necessarily reliably reflect access issues for residential aged care from the acute care sector * diagnosis codes may not be applied consistently across jurisdictions or over time * reported hospital separations and patient days do not necessarily reflect the full length of hospital stay for an individual patient. If a change in the type of care occurs during a patient’s hospital stay (for example, from acute to maintenance) then two separations are reported for that patient   (Continued next page) |
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| Box 13.8 (continued) |
| * for the first measure, the code ‘need for assistance at home and no other household member able to render care’ may also be used for respite care for aged care residents or those receiving community care, and some jurisdictions may have a high proportion of this type of use. This is particularly relevant in some rural areas where there are few alternative options for these clients * the measures do not necessarily reflect alternative strategies in place by states and territories to manage the older person into appropriate residential aged care facilities from acute care hospitals * the measures are regarded as proxies, as the desired measures (utilising appropriate linked hospital separations and ACAT approvals) are not available at this time. Further development is underway to improve available data sets and associated measures for future reports.   Data reported for the first measure are:   * comparable (subject to caveats) across jurisdictions but a break in series means that data for 2011‑12 are not comparable to data for earlier years * complete for the current reporting period (subject to caveats). All required 2011‑12 data are available for all jurisdictions.   Data reported for the second measure are:   * comparable (subject to caveats) across jurisdictions and over time (except Tasmanian data where two significant private hospitals are excluded in 2008‑09) * complete for the current reporting period (subject to caveats). All required 2011‑12 data are available for all jurisdictions.   Data quality information for one measure defined for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014. Data quality information for the other measure is under development. |
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The proportion of separations for ‘aged care type’ patients (as defined in box 13.8) aged 65 years or over and Indigenous Australians aged 50–64 years whose separation was 35 days or longer was 11.9 per cent nationally in 2011‑12   
(figure 13.22). The number of ‘aged care type’ patient separations for people aged 65 years or over and Indigenous Australians aged 50–64 years was 12 527, of a total   
2.2 million nationally (table 13A.72).

Figure 13.22 Proportion of separations for ‘aged care type’ public hospitals patients that were 35 days or longer**a, b, c, d, e, f, g, h**

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| Figure 13.22 Proportion of separations for ‘aged care type’ public hospitals patients that were 35 days or longer  More details can be found within the text surrounding this image. |

a Data are for hospital separations with a care type of maintenance and a diagnosis (either principal or additional) of either ‘person awaiting admission to residential aged care service’ or ‘need for assistance at home and no other household member able to render care’ and where the separation lasted 35 days or longer. b Age of patients is 65 years or over and Indigenous patients 50–64 years. c Although the diagnosis codes reflect a care type, they do not determine a person’s eligibility for residential aged care. d Diagnosis codes may not be applied consistently across jurisdictions or over time. e These data only account for completed unlinked separations. f The code ‘need for assistance at home and no other household member able to render care’ may also be used for respite care for either residential or community care patients. g An individual patient may have multiple hospital separations during a single hospital stay, for example, if a change in the type of care occurs during a patient’s hospital stay. Data on length of stay relate to each separation and not to the whole hospital stay. h Data for 2011‑12 include public patients in private hospitals, these patients were not included in 2009‑10 or 2010‑11.

*Source*: AIHW (unpublished); table 13A.72.

The proportion of all hospital patient days (for overnight separations only) used by patients who are waiting for residential aged care (as defined in box 13.8) was   
11.2 per 1000 patient days nationally in 2011‑12 (figure 13.23).

Figure 13.23 Hospital patient days used by patients waiting for residential aged care**a, b, c, d, e, f**

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| Figure 13.23 Hospital patient days used by patients waiting for residential aged care  More details can be found within the text surrounding this image. |

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

*Source*: AIHW (unpublished); table 13A.73.

##### Intensity of care

‘Intensity of care’ is an indicator of governments’ objective to encourage ‘ageing in place’ to increase choice and flexibility in residential aged care service provision (box 13.9). (See box 13.10 for background information on the ‘ageing in place’ policy.)

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| Box 13.9 Intensity of care |
| ‘Intensity of care’ is defined by two measures:   * the proportion of people who stayed in the same residential aged care service when changing from low care to high care * the proportion of low care places occupied by residents with high care needs, compared with the proportion of all operational places taken up by residents with high care needs.   High or increasing rates of ageing in place are desirable, in the context of a flexible system that also meets the need for low level care either in residential facilities or in the community.  These measures reflect the proportion of residents who remain in the same residential aged care facility as their care needs increase from low care to high care. The *Aged Care Act 1997* aims explicitly to encourage ageing in place to increase choice and flexibility in residential aged care service provision (box 13.10).  This indicator needs to be viewed from the perspective of the system as a whole. The implication of ageing in place is that some places that were allocated for low care will be occupied by high care residents (or, conversely, allocated for high care and occupied by low care residents). Information about the use of operational residential aged care places is provided to demonstrate the impact of ageing in place on the aged care services system over time.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete for the current reporting period (subject to caveats). All required  June 2013 data are available for all jurisdictions.   Data quality information for this indicator is under development. |
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Nationally, from 2004‑05 to 2012‑13, there was a steady increase in the proportion of people who stayed in the same residential aged care service when changing from low care to high care, from 71.5 per cent to 91.0 per cent (figure 13.24). For   
2012‑13, the proportion was highest in major cities (91.2 per cent), compared to other areas: inner regional areas (90.7 per cent), outer regional areas (90.3 per cent), remote areas (80.2 per cent) and very remote areas (83.3 per cent) (table 13A.37).

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| Box 13.10 Ageing in place in residential care |
| In its Objects, the *Aged Care Act 1997* aims to:  *… encourage diverse, flexible and responsive aged care services that:*  *(i) are appropriate to meet the needs of the recipients of those services and the carers of those recipients; and*  *(ii) facilitate the independence of, and choice available to, those recipients and carers.*  Further, the *Aged Care Act 1997* explicitly aims to encourage and facilitate ‘ageing in place’. The Act does not define ‘ageing in place’, but one useful definition is ‘the provision of a responsive and flexible care service in line with the person’s changing needs in a familiar environment’. In effect, ‘ageing in place’ refers to a resident remaining in the same residential aged care service as his or her care needs increase from low level to high level. This is changing the profile of people in services.  The *Aged Care Act 1997* does not establish any ‘program’ or require any residential aged care service to offer ageing in place. Rather, it creates the opportunity for providers to choose to provide the full continuum of care, by removing the legislative and administrative barriers that prevented this outcome in the past.  The concept of ‘ageing in place’ is linked to the outcomes of increasing choice and flexibility in residential aged care service provision. These are difficult outcomes to measure. |
| *Source*: DoHA (unpublished). |
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Nationally, 57.6 per cent of low care places in 2012‑13 were occupied by residents with high care needs. The proportion of all operational places taken up by residents with high care needs was 74.6 per cent (figure 13.25). These data are provided by remoteness area in table 13A.38.

Figure 13.24 Proportion of residents who changed from low care to high care and remained in the same aged care service**a**

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| Figure 13.24 Proportion of residents who changed from low care to high care and remained in the same aged care service  More details can be found within the text surrounding this image. |

a Ten years of annual data for this indicator are in table 13A.37.

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

Figure 13.25 Utilisation of operational residential places, 30 June 2013**a**

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| Figure 13.25 Utilisation of operational residential places, 30 June 2013  More details can be found within the text surrounding this image. |

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

*Source*: DSS (unpublished); table 13A.38.

#### Effectiveness — quality

##### Compliance with service standards for residential care

‘Compliance with service standards for residential care’ is an indicator of governments’ objective to ensure residential care services attain high levels of service quality, through compliance with certification and accreditation standards (box 13.11).

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| Box 13.11 Compliance with service standards for residential care |
| ‘Compliance with service standards for residential care’ is defined by two measures:   * the proportion of re‑accredited services which have received three year accreditation: * services re‑accredited in the financial year * all re‑accredited services * the proportion of aged care services that are compliant with building certification, fire safety and privacy and space requirements.   High or increasing proportions of approval for three year re‑accreditation and services that are compliant with building certification, fire safety and privacy and space requirements are desirable. The extent to which residential care services comply with service standards and other requirements implies a certain level of care and service quality.  Since 2001, each Australian Government funded residential service has been required to meet accreditation standards (which comprise 44 expected outcomes). The accreditation indicator reflects the period of accreditation granted. The accreditation process is managed by the Aged Care Standards and Accreditation Agency Ltd (ACSAA). A service must apply to ACSAA for accreditation and its application is based on a self‑assessment of performance against the accreditation standards. Following an existing residential service applying for accreditation, a team of registered quality assessors reviews the application, conducts an onsite assessment and prepares a report based on these observations, interviews with residents, relatives, staff and management, and relevant documentation. An authorised decision maker from ACSAA then considers the report, in conjunction with any submission from the residential service and other relevant information (including information from DoHA/DSS) and decides whether to accredit and, if so, for how long. Commencing services are subject to a desk audit only, and are accredited for one year. |
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| Box 13.11 (continued) |
| A home must be certified to be able to receive accommodation payments and extra service charges. Residents expect high quality and safe accommodation in return for their direct and indirect contributions. Certification provides a mechanism to encourage provision of safe and high quality accommodation within the regulatory frameworks for buildings legislated by State and Territory governments. Aged care homes are required to meet building certification, fire safety, privacy and space requirements to be eligible to receive the maximum level of the accommodation supplement.  Under the privacy and space requirements, all new buildings constructed since  July 1999, are required to have an average, for the whole aged care home, of no more than 1.5 residents per room. No room may accommodate more than two residents. There is also a mandatory standard of no more than three residents per toilet, including those off common areas, and no more than four residents per shower or bath.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete for the current reporting period (subject to caveats). All required  June 2013 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014. |
|  |

Accreditation decisions and further information relating to the accreditation standards and Aged Care Standards and Accreditation Agency Ltd (ACSAA) are publicly available (ACSAA 2009). Further information on the number of residential aged care facilities that had an audit in 2012‑13 and the outcomes of these audits is available in the latest *Report on the Operation of the Aged Care Act 1997*(DSS 2013). The accreditation process is summarised in box 13.11.

As at 30 June 2013, 1139 residential aged care services had a re‑accreditation decision in 2012‑13. Of these, 93.2 per cent were granted three years accreditation (table 13.7). Of all re‑accredited residential aged care services, 95.7 per cent had an accreditation status of a period of three years, as at 30 June 2013   
(table 13.7).

Table 13.7 Residential aged care services re‑accredited for three years, 30 June 2013**a, b**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | NSW | Vic | Qld | WA | SA | Tas | ACT | NT | Aust |
| *Services re‑accredited during 2012‑13* | | | | | | | | | |
| Total no. | 351 | 339 | 239 | 84 | 80 | 24 | 12 | 10 | 1 139 |
| % 3 year accredited | 95.7 | 95.9 | 90.8 | 89.3 | 93.8 | 100.0 | 66.7 | 20.0 | 93.2 |
| *All re‑accredited services* | | | | | | | | |  |
| Total no. | 876 | 751 | 445 | 241 | 264 | 78 | 26 | 15 | 2 696 |
| % 3 year accredited | 97.1 | 97.6 | 92.1 | 94.2 | 95.8 | 100.0 | 84.6 | 46.7 | 95.7 |

a Data as at 30 June 2013 relate only to re‑accredited services and do not include accreditation periods for   
27 commencing services. b Note that ‘accreditation period’ shows the decision in effect as at 30 June 2013.

*Source*: ACSAA (unpublished); tables 13A.74 and 13A.78.

Nationally, as at 30 June 2013, 100.0 per cent of residential aged care services were compliant with building certification, fire safety, and privacy and space requirements (table 13.8).

Table 13.8 Residential aged care services compliant with building certification, fire safety and privacy and space requirements, at 30 June 2013**a**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Unit | NSW | Vic | Qld | | WA | SA | Tas | | ACT | | NT | Aust |
| Total residential services | no | 884 | 756 | 454 | 242 | | 264 | 78 | 25 | | 15 | | 2 718 |
| Total compliant services | no | 884 | 756 | 453 | | 242 | 264 | 78 | | 25 | | 15 | 2 717 |
| Proportion of compliant services | % | 100.0 | 100.0 | 99.8 | | 100.0 | 100.0 | 100.0 | | 100.0 | | 100.0 | 100.0 |

a All operational residential care services are certified with the exception of one service located in Queensland. This service made application for certification on 3 September 2013 and is awaiting a site inspection.

*Source*: DSS (2013) *Report on the Operation of the Aged Care Act 1997, 1 July 2012 — 30 June 2013,* Canberra,www.health.gov.au/internet/main/publishing.nsf/Content/ageing‑reports‑acarep‑2013.htm (accessed 18December 2013) and table 13A.18.

##### Complaints resolution

‘Complaints resolution’ is an indicator of governments’ objective to ensure aged care services provide a high quality of care (box 13.12).

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| Box 13.12 Complaints resolution |
| ‘Complaints resolution’ has two measures:   * the number of complaints received by the Scheme that are within the scope of the Scheme to handle (that is, relate to the responsibilities of an approved provider of residential or community care under the *Aged Care Act 1997* or HACC funding agreements with the Australian Government) per 1000 permanent care recipients * the proportion of complaints that were resolved without the need for a direction.   This indicator is a proxy of the quality of care and of the responsiveness of approved providers where issues about the quality of care or services are raised through complaints. A low or decreasing rate of complaints received and high proportion of complaints that were resolved without the need for a direction are desirable.  The Scheme encourages people to raise their concerns with the aged care provider in the first instance where possible. This can achieve a faster and sustainable result through building relationships between all parties. If concerns are unable to be resolved directly with a service provider, then people can contact the Scheme. The Scheme assesses the risk associated with a complaint and the most appropriate method for resolving the complaint. This may mean encouraging resolution at a local provider level, conciliating an outcome between the complainant and the provider, or the Scheme investigating the complaint. Where the Scheme decides that an approved provider is not meeting its responsibilities, it has the power to issue the provider with directions. Prior to issuing a direction, the Scheme will typically give the provider other opportunities to remedy the issues, including giving the provider the opportunity to respond to a notice of intention to issue directions. Where issues are addressed, directions may not be issued.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions but a break in series means that data for 2012‑13 are not comparable to data for 2011‑12 * complete for the current reporting period (subject to caveats). All required  2012‑13 data are available for all jurisdictions.   Data quality information for this indicator is under development. |
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During 2012‑13, the Scheme received 3811 complaints that were within the scope of the Scheme to handle. The number of complaints per 1000 care recipients was 22.7 nationally in 2012‑13 (figure 13.26).

Figure 13.26 Complaints received by the Aged Care Complaints Scheme which are within its scope to handle**a**

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| Figure 13.26 Complaints received by the Aged Care Complaints Scheme which are within its scope to handle  More details can be found within the text surrounding this image. |

a Data for 2011‑12 are for the period 1 September 2011 to 30 June 2012.

*Source*: DoHA/DSS (unpublished); table 13A.79.

Of the complaints dealt with by the Scheme in 2012‑13, 89.2per cent related to residential care services, 7.4 per cent related to community/flexible care services (CACP, EACH and EACH-D) and 2.5 per cent related to HACC services   
(DSS unpublished).

In 2012‑13, 72.5 per cent of complaints were resolved through early resolution and 27.5 per cent progressed to resolution, utilising the range of techniques available to Scheme officers including approved provider resolution, conciliation, and investigation (DSS unpublished). Of those complaints that progressed to resolution, 99.1 per cent were resolved without the need for a direction to the approved provider (figure 13.27).

Figure 13.27 Proportion of in‑scope complaints that were resolved without the need for a direction

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| Figure 13.27 Proportion of in scope complaints that were resolved without the need for a direction  More details can be found within the text surrounding this image. |

*Source*: DoHA/DSS (unpublished); table 13A.79.

##### Compliance with service standards for community care

‘Compliance with service standards for community care’ is an indicator of governments’ objective to ensure that community aged care programs provide a high quality of service (box 13.13).

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| Box 13.13 Compliance with service standards for community care |
| ‘Compliance with service standards for community care’ is defined as the proportion of community aged care services which received ratings for:   * Outcome 1 — effective process and systems in place * Outcome 2 — some concerns about effectiveness of processes and systems in place * Outcome 3 — significant concerns about effectiveness of processes and systems in place.   The number of reviews against program standards for community aged care services that were completed is also provided for information. Data are reported for the CACP, EACH, EACH‑D and NRCP programs combined and separately for the HACC program. HACC review numbers and outcomes are reported separately as they may be undertaken at a different organisational level to the other programs. |
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| Box 13.13 (continued) |
| A high or increasing proportion of community aged care services reviewed and a high or increasing proportion reviewed who achieved an outcome 1 (effective processes and systems in place) are desirable.  The indicator monitors the extent to which agencies are being reviewed over a three year cycle by identifying what proportion of services targeted for review have been reviewed in a particular year. This indicator also measures the proportion of individual agencies that comply with the service standards, through the outcomes of service standard appraisals. It should be noted that a review against the standards is not an accreditation process.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and overtime * complete for the current reporting period (subject to caveats). All required  2012‑13 data are available for all jurisdictions.   Data quality information for this indicator is under development. |
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Nationally, a total of 424 reviews of HACC services were completed in 2012‑13 (table 13.9). Outcome 1 — effective processes and systems in place — was achieved in 71.2 per cent of these reviews (table 13.9).

Table 13.9 Compliance with service standards for HACC, 2012‑13**a**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | NSWb | Vicc | Qld | WA | SA | Tas | | ACT | NT | Aust |
| *Number of reviews completed* (no.) | | | | | | | | | |  |
|  | 78 | 157 | 76 | 64 | 43 | 5 | – | | 1 | 424 |
| *Proportion of reviews achieving relevant outcomes* (%) | | | | | | | | | | |
| Outcome 1d | 64.1 | .. | 63.2 | 82.8 | 81.4 | 60.0 | | .. | 100.0 | 71.2 |
| Outcome 2e | 26.9 | .. | 26.3 | 12.5 | 7.0 | 40.0 | | .. | – | 20.2 |
| Outcome 3f | 9.0 | .. | 10.5 | 4.7 | 11.6 | – | | .. | – | 8.6 |

a The HACC program for older people transitioned to the Commonwealth on 1 July 2012 for all states and territories (except Victoria and WA). b NSW data includes ACT quality reviews as these reviews are undertaken by the NSW office. c Victorian data are not available for the review Outcomes 1, 2 or 3 as this approach is not referred to, or specified in the National Community Care Common Standards (CCCS) Guide or supplementary material, and therefore has not been used by Victoria in undertaking CCCS reviews of HACC funded providers. d Outcome 1 ― effective processes and systems in place. e Outcome 2 ― some concerns about effectiveness of processes and systems in place. f Outcome 3 ― significant concerns about effectiveness of processes and systems in place. .. Not applicable. – Nil or rounded to zero.

*Source*: DSS (unpublished); tables 13A.82‑83.

Nationally, a total of 560 reviews of community aged care organisations providing CACP, EACH, EACH‑D and NRCP services were completed in 2012‑13   
(table 13.10). Outcome 1 — effective processes and systems in place — was achieved in 70.0 per cent of these reviews (table 13.10).

Table 13.10 Compliance with service standards for community aged care services — CACP, EACH, EACH‑D and NRCP, 2012‑13

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | NSW | Vic | Qld | WA | SA | Tas | ACT | NT | Aust |
| *Number of reviews completed* (no.) | | | | | | | | |  |
|  | 169 | 154 | 127 | 27 | 42 | 26 | 6 | 9 | 560 |
| *Proportion of reviews achieving relevant outcomes* (%) | | | | | | | | | |
| Outcome 1a | 67.5 | 83.8 | 47.2 | 80.8 | 92.9 | 76.9 | 66.7 | 50.0 | 70.0 |
| Outcome 2b | 25.4 | 11.0 | 36.2 | 19.2 | – | 19.2 | 33.3 | 30.0 | 21.6 |
| Outcome 3c | 7.1 | 5.2 | 16.5 | – | 7.1 | 3.8 | – | 20.0 | 8.4 |

a Outcome 1 ― effective processes and systems in place.b Outcome 2 ― some concerns about effectiveness of processes and systems in place. c Outcome 3 ― significant concerns about effectiveness of processes and systems in place. – Nil or rounded to zero.

*Source*: DSS (unpublished); tables 13A.80‑81.

##### Client appraisal of service standards

‘Client appraisal of service standards’ is an indicator of governments’ objective to ensure high levels of client satisfaction with aged care services (box 13.14).

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| Box 13.14 Client appraisal of service standards |
| ‘Client appraisal of service standards’ is yet to be defined.  Data for this indicator were not available for the 2014 Report. |
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#### Efficiency — inputs per output unit

##### Cost per output unit

‘Cost per output unit’ is an indicator of governments’ objective to deliver efficient aged care services (box 13.15).

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| Box 13.15 Cost per output unit |
| ‘Cost per output unit’ is defined by two measures:   * Australian Government expenditure per ACAT assessment — Australian Government expenditure on the ACAP divided by the number of assessments completed * expenditure per hour of service for HACC — State and Territory governments expenditure on services (some of this expenditure is funded by the Australian Government), divided by the number of hours of service provided (by service type domestic assistance, personal care, nursing and allied health service).   This is a proxy indicator of efficiency and needs to be interpreted with care. While high or increasing expenditure per assessment or hour of service may reflect deteriorating efficiency, it may also reflect changes in aspects of the service (such as greater time spent with clients) or changes in the characteristics of clients (such as their geographic location). Similarly, low or declining expenditure per assessment or hour of service may reflect improving efficiency or less time spent with clients, for example.  Australian Government expenditure per ACAT assessment and expenditure per hour of HACC service have been developed as proxies. For Australian Government expenditure per ACAT assessment, only Australian Government expenditure is included, although State and Territory governments also contribute to the cost of ACAT assessments. Similarly only State and Territory governments’ expenditure on HACC services is included and expenditure funded by non‑government sources is excluded.  Data reported for the ‘Australian Government expenditure per ACAT assessment’ measure are:   * comparable (subject to caveats) across jurisdictions and overtime * complete for the current reporting period (subject to caveats). All required  2011‑12 data are available for all jurisdictions.   Data reported for the ‘expenditure per hour of service for HACC’ measure are:   * comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions * incomplete for the current reporting period (subject to caveats). All required  2011‑12 data were not available for Queensland and the NT.   Data quality information for this indicator is under development. |
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Australian Government expenditure per aged care assessment during 2011‑12 averaged $502 nationally (figure 13.28).

Figure 13.28 Australian Government expenditure on aged care assessments, per assessment (2011‑12 dollars)**a, b, c, d, e**

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| Figure 13.28 Australian Government expenditure on aged care assessments, per assessment (2011-12 dollars)  More details can be found within the text surrounding this image. |

a Only includes Australian Government expenditure on ACATs. b The referrals and operations of ACATs vary across jurisdictions. c Data on the number of assessments used to derive this measure are preliminary extracted from the Ageing and Aged Care Data Warehouse on 31 August 2013. d Time series financial data are adjusted to 2011‑12 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2011‑12 = 100) (table 2A.53). The GGFCE replaces the Gross Domestic Product implicit price deflator used in previous editions. See chapter 2 (section 2.5) for details. e The high cost for each assessment in the NT may be influenced by the remoteness of people requiring assessments, clients having English as a second or third language, and a lack of supporting health and community services infrastructure to assist with assessments.

*Source*: DoHA/DSS (unpublished); table 13A.84.

Australian, Victorian and WA governments’ expenditure per hour of HACC service during 2011‑12 was higher for nursing and allied health than for domestic assistance and personal care across the states and territories for which data are available   
(figure 13.29).

Figure 13.29 State and Territory governments’ expenditure per hour of HACC service, by service type, 2011‑12**a, b**

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| Figure 13.29 State and Territory governments’ expenditure per hour of HACC service, by service type, 2011-12  More details can be found within the text surrounding this image. |

a WA contract by service group. Unit costs (includes government expenditure only) reported are an average across all services in the group. b Unit costs (includes government expenditure only) are not available for Queensland and the NT as they have not submitted the annual HACC business reports.

*Source*: DSS (unpublished), from State and Territory government estimates; table 13A.85.

##### Expenditure per head of aged care target population

‘Expenditure per head of aged care target population’ is an indicator of governments’ objective to deliver efficient aged care services (box 13.16).

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| Box 13.16 Expenditure per head of aged care target population |
| ‘Expenditure per head of aged care target population’ is defined as government inputs (expenditure) divided by the number of people aged 65 years or over and Indigenous Australians aged 50–64 years. Expenditure per person in the aged care target population is reported for residential care, selected community aged care programs (CACP, EACH and EACH‑D) and multi‑purpose and Indigenous specific services combined and reported separately for the three main service types: residential care services, HACC and CACP services. |
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| Box 13.16 (continued) |
| This is a proxy indicator of efficiency and needs to be interpreted with care as it measures cost per head of the aged care target population, not cost per unit of service. While high or increasing expenditure per person can reflect deteriorating efficiency, it can also reflect changes in aspects of the service (such as better quality of services) or in the characteristics of clients receiving the service (such as their geographic location or level of care need). Similarly, low or declining expenditure per assessment can reflect improving efficiency or a decrease in service standards.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions but a break in series means that data for 2012‑13 are not comparable to data before that year * complete for the current reporting period (subject to caveats). All required  2012‑13 data are available for all jurisdictions.   Data quality information for this indicator is under development. |
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Australian Government real expenditure on residential care, selected community care programs (CACP, EACH, EACH‑D), and on multipurpose and Indigenous specific services combined per person aged 65 years or over and Indigenous Australians aged 50–64 years was $3048 nationally in 2012‑13 (figure 13.30).

Figure 13.30 Australian Government (DoHA and DVA) real expenditure on selected programs, per person in the aged care target population, 2012‑13**a**

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| Figure 13.30 Australian Government (DoHA and DVA) real expenditure on selected programs, per person in the aged care target population, 2012-13  More details can be found within the text surrounding this image. |

a Results exclude State and Territory governments funding of younger people with disability (people aged under 65 years and Indigenous Australians aged under 50 years) in residential aged care.

*Source*: DSS (unpublished); tables 13A.8−10.

Nationally, Australian Government real expenditure by both DoHA and DVA on residential care services per person aged 65 years or over and Indigenous Australians aged 50–64 years was $2661 in 2012‑13 (figure 13.31). If the payroll tax supplement paid by the Australian Government is excluded, this expenditure nationally was $2609 in 2012‑13 (table 13A.86).

Nationally, DoHAexpenditure on residential care per person aged 65 years or over and Indigenous Australians aged 50–64 years in 2012‑13 was $2276 including the payroll tax supplement and $2231 excluding the payroll tax supplement   
(table 13A.8). DVA expenditure on residential care per person aged 65 years or over was $393 including the payroll tax supplement and $384 excluding the payroll tax supplement in 2012‑13 (table 13A.14).

Figure 13.31 Australian Government (DoHA and DVA) real expenditure on residential services per person in the aged care target population (2012‑13 dollars)**a, b, c**

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| Figure 13.31 Australian Government (DoHA and DVA) real expenditure on residential services per person in the aged care target population (2012-13 dollars)  More details can be found within the text surrounding this image. |

a Includes a payroll tax supplement provided by the Australian Government. Actual payroll tax paid may differ. b Results exclude State and Territory governments’ funding for younger people with disability (people aged   
64 years or under and Indigenous aged 49 years or under) in residential aged care (see tables 13A.5 and 13A.8 for details). c Time series financial data are adjusted to 2012‑13 dollars using the GGFCE chain price deflator (2012‑13 = 100) (table 2A.53). The GGFCE replaces the Gross Domestic Product implicit price deflator used in previous editions. See chapter 2 (section 2.5) for details.

*Source*: DoHA/DSS (unpublished); DVA (unpublished); table 13A.86.

Australian Government expenditure on CACPs per person aged 65 years or over and Indigenous Australians aged 50–64 years was similar in most jurisdictions except the NT. Nationally, expenditure was $176 per person aged 65 years or over and Indigenous Australians aged 50–64 years in 2012‑13 (figure 13.32).

Figure 13.32 Australian Government real expenditure on CACP services per person in the aged care target population   
(2012‑13 dollars)**a, b**

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| Figure 13.32 Australian Government real expenditure on CACP services per person in the aged care target population  (2012-13 dollars)  More details can be found within the text surrounding this image. |

a Time series financial data are adjusted to 2012‑13 dollars using the GGFCE chain price deflator   
(2012‑13 = 100) (table 2A.53). The GGFCE replaces the Gross Domestic Product implicit price deflator used in previous editions. See chapter 2 (section 2.5) for details. b Results include State and Territory governments’ funding for younger people with disability (people aged under 65 years and Indigenous aged under 50 years) receiving CACP (see tables 13A.5 and 13A.9 for details).

*Source*: DoHA/DSS (unpublished); table 13A.89.

Nationally, in 2012‑13, Australian, Victorian and WA governments’ real expenditure on HACC services was $514 per person aged 65 years or over and Indigenous Australians aged 50–64 years (figure 13.33). These data reflect expenditure against the aged care target population (see section 13.2), which is not the same as the HACC target population for older people. Expenditure per person in the HACC target population for older people is reported in table 13A.87.

Figure 13.33 Australian, Victorian and WA governments’ real expenditure on HACC services per person in the aged care target population (2012‑13 dollars)**a, b, c, d**

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| Figure 13.33 Australian, Victorian and WA governments’ real expenditure on HACC services per person in the aged care target population (2012-13 dollars)  More details can be found within the text surrounding this image. |

a These data represent expenditure on those people aged 65 years or over and Indigenous Australians aged 50–64 years. Victorian and WA governments’ HACC expenditure was around $247 million in total in 2012‑13, equivalent to $207 per person spent by the Victorian Government in Victoria and $225 per person spent by the WA Government in WA. b Expenditure per person in the older HACC target population (people aged 65 years or over and Indigenous Australians aged 50‑64 years) is contained in table 13A.87. c Reports provisional HACC data that have not been validated and may be subject to revision. d Time series financial data are adjusted to 2012‑13 dollars using the GGFCE chain price deflator (2012‑13 = 100) (table 2A.53). The GGFCE replaces the Gross Domestic Product implicit price deflator used in previous editions. See chapter 2   
(section 2.5) for details.

*Source*: DoHA/DSS (unpublished); table 13A.88.

### Outcomes

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

#### Social participation in the community

‘Social participation in the community’ has been identified for development as an indicator of governments’ objective to encourage the wellbeing and independence of older people (box 13.17).

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| Box 13.17 Social participation in the community |
| ‘Social participation in the community’ is yet to be defined.  High or increasing rates of participation in the community are desirable.  When developed for future reports, this indicator will show the extent to which older people participated in community, cultural or leisure activities. |
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#### Maintenance of individual physical function

‘Maintenance of individual physical function’ is an indicator of governments’ objective for aged care services to promote the health, wellbeing and independence of older people and is measured using data for the TCP only (box 13.18).

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| Box 13.18 Maintenance of individual physical function |
| ‘Maintenance of individual physical function’ is defined as the improvement in the TCP client’s level of physical function, reflected in the difference between the average Modified Barthel Index (MBI) score on entry to the TCP to the average MBI score on exit from the TCP. The minimum MBI score is 0 (fully dependent) and the maximum score is 100 (fully independent).  This indicator needs to be interpreted with care. The TCP operates with some differences across jurisdictions including differences in health and aged care service systems, local operating procedures and client groups. Variation in the average MBI scores on entry and exit from the program may reflect a range of target client groups for the program across jurisdictions. An increase in the score from entry to exit is desirable.  The TCP is a small program at the interface of the health and aged care systems. A person may only enter the TCP directly upon discharge from hospital. The average duration of care is around 8 weeks (62 days for completed episodes), with a maximum duration of 12 weeks that may in some circumstances be extended by a further 6 weeks. It may be possible to develop measures for other aged care programs such as residential aged care and community aged care services which would be indicators of maintenance of individual physical function.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and overtime * complete for the current reporting period (subject to caveats). All required  2012‑13 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014. |
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The average Modified Barthel Index (MBI) score on entry to the TCP in 2012‑13 was 72.3 nationally. The average MBI score on exit from the TCP was 82.9 nationally (figure 13.34). This was an average increase in the score of 10.6 nationally.

Figure 13.34 Transition Care Program — average MBI score on entry and exit, 2012‑13**a, b**

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| Figure 13.34 Transition Care Program - average MBI score on entry and exit, 2012-13  More details can be found within the text surrounding this image. |

MBI = Modified Barthel Index. a The MBI is a measure of functioning in the activities of daily living, ranging from 0 (fully dependent) to 100 (fully independent). Data are reported for TCP recipients who completed a transition care episode. b Different health and aged care service systems, local operating procedures and client groups can affect the outcomes of the Transition Care Program across jurisdictions.

*Source*: DSS (unpublished); table 13A.90.

#### Hospital leave days from residential aged care for preventable causes

‘Hospital leave days from residential aged care for preventable causes’ has been identified for development as an indicator of governments’ objective to provide high quality and safe residential aged care services (box 13.19).

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| Box 13.19 Hospital leave days from residential aged care for preventable causes |
| ‘Hospital leave days from residential aged care for preventable causes’ is yet to be defined.  Low or decreasing proportions of residential aged care days on hospital leave due to selected preventable causes are desirable.  When developed for future reports, this indicator will show the proportion of residential aged care days that are taken as hospital leave for selected preventable causes. |
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#### Enabling people with care needs to live in the community

‘Enabling people with care needs to live in the community’ has been identified for development as an indicator of governments’ objective to delay entry to residential care when a person’s care needs can be met in the community (box 13.20).

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| Box 13.20 Enabling people with care needs to live in the community |
| ‘Enabling people with care needs to live in the community’ is yet to be defined.  High or increasing rates of people with care needs remaining and participating in the community are desirable.  When developed for future reports, this indicator will show the extent to which older people’s entry to residential care is delayed. |
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## 13.4 Future directions in performance reporting

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

* continued improvement of efficiency indicators
* improved reporting of elapsed times for aged care
* improved reporting of hospital patient days used by aged care type patients
* inclusion of data on hospital leave days for preventable causes as they become available
* development of performance indicators relevant to the aged care reforms
* further development of outcome indicators.

In 2012, the Australian Government announced a package of reforms to aged care. On 28 June 2013, to implement these reforms, a package of Bills amending the *Aged Care Act 1997* was passed into law. The key reforms implemented since   
30 June 2013 that will have a significant effect on reporting in the next version of this Report are outlined in box 13.21.

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| Box 13.21 Aged care reforms |
| The Australian Government’s aged care reforms were developed in response to the Productivity Commission’s *Inquiry into Caring for Older Australians*. The focus of the reforms is to make the structural changes needed to ensure the future sustainability of Australia’s aged care system. The key elements of the new aged care system are designed to provide for:   * greater choice and control over aged care arrangements for consumers * new and more equitable ways of meeting the ever increasing costs of aged care * ensuring that the most vulnerable in our society are fully protected * the aged care sector working more closely with the wider health system to tackle key health challenges in particular, the increasing prevalence of dementia, and support for end‑of‑life care * a single identifiable entry point for consumers, called the Aged Care Gateway * access to aged care based on need and not the ability to pay.   The key reforms implemented after 30 June 2013 are the:   * introduction of the Home Care Packages Program with four levels of packages, two replacing CACP and EACH * requirement that all new Home Care Packages allocated to providers are offered to care recipients on a Consumer Directed Care basis * establishment of the My Aged Care website and a national call centre * operation of a centralised data clearing house at the AIHW * introduction of a funding supplement for veterans receiving aged care through a Home Care Package or residential care, who have an accepted eligible mental health condition * introduction of dementia supplements for people receiving aged care through a Home Care Package or residential care, who have dementia and other conditions. |
| *Source*: DSS (unpublished). |
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## 13.5 Jurisdictions’ comments

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

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| **“** | Australian Government comments |  |
| The Australian Government is committed to reforming the aged care system in a way that balances the needs and expectations of older people as consumers, and those of industry. The Government has a vision of a flexible aged care system that is focussed on providing high‑quality care for older Australians.  This year’s report shows the early signs of changes to Australia’s aged care system. As the reforms move forward, the aged care system will become more affordable and sustainable by striking a balance between individual responsibility, affordability for the taxpayer and a safety net for those who need it. It will also be made more accessible as My Aged Care, the systems entry point, grows and develops.  The Government will work in partnership with stakeholders to prioritise future reform to the aged care system through a Healthy Life, Better Ageing Agreement, guided by the Productivity Commission Report, Caring for Older Australians.  The Australian Government is also very conscious of the need to ensure the aged care and disability systems work together, and has taken important steps to enhance this interface by ensuring both sets of reforms are overseen by the same Ministerial team.  The Government is committed to working to ensure these changes improve the system, and are complemented by a reduction in red tape and an increase in flexibility in the sector. | **”** |

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| **“** | New South Wales Government comments |  |
| The NSW Government continues to implement its 2012 Ageing Strategy, a whole of government response to the challenges of an ageing population. A key priority has been to prevent and address abuse against older people. An Elder Abuse Helpline and Resource Unit was established in early 2013 as a central point for information, advice, referral and data collection. Concerned older people and carers, as well as friends, family, support workers and service providers, are able to access a range of services, including advice and referral to support agencies or service providers as and when appropriate. The Unit is also providing education and training for frontline workers, including police and care workers, as well as engaging in community awareness and education.  The NSW Government launched its ‘Get it in black & white’ campaign in October 2013 as an Australian‑first initiative aimed at increasing the number of people completing Wills, Powers of Attorney and Enduring Guardianship. The media and advertising campaign aims to encourage people to seek out the right information, have information with their loved ones and take control of their own plans for later life while they have the capacity to do so. A range of resources are available for community education purposes and tailored for different age groups, life stages, cultural backgrounds and interests.  NSW Health has lead agency responsibility for a range of actions related to the strategic goal of keeping people healthy and out of hospital. Priorities include promoting integrated health service delivery to support older people living in their communities; improving building design of health facilities to be aged friendly; building aged care expertise in the health system workforce; promoting healthy ageing strategies; and developing service measures to reflect how well the health system meets the needs of an ageing population.  NSW Health continues to maintain ACAT service delivery through to 30 June 2014 when the Commonwealth assumes full funding and policy responsibility for aged care. Significant improvements have been made to ACAT seen on time performance indicators to ensure timely responses to referrals for a comprehensive ACAT eligibility assessment across NSW.  NSW Health has operationalised all 1378 Transition Care places allocated to NSW. As at September 2013, there are 45 Transition Care services across NSW providing 148 (11 per cent) residential places and 1213 (88 per cent) community places and 17 (1 per cent) ‘mixed setting’ places.  The NSW Government committed $30 million in its 2013‑14 budget to support ‘integration’ initiatives in recognition of the importance of integrated care, which better connects those parts of the healthcare system outside of hospitals, such as primary, aged and community healthcare providers. The Agency for Clinical Innovation, one of the NSW Health pillars, is leading the development of a Framework for the integrated care of older people with complex health needs.  NSW Health continues to improve the experiences of people with dementia and their carers through the NSW *2010‑15 Dementia Services Framework*. | **”** |

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| **“** | Victorian Government comments |  |
| In 2012‑13, Victoria again strengthened its work in promoting the health, wellbeing and participation of older people. This year there have been many achievements that will benefit older people.  For the first time in Victoria, people in care relationships are formally recognised by law. Under the Carers Recognition Act 2012, state government departments, local governments and funded organisations must acknowledge, inform, support, promote and value people in care relationships.  Improving responses to people with dementia and their carers underpinned a project in collaboration with the Royal District Nursing Service, where two dementia resources were developed to improve awareness of how to connect people to the dementia and carer support services across the health system.  Funds of $1.6 million have been provided over the past three years for staff training to public health and aged care services (including district nursing) in the comprehensive health assessment of older Victorians, which has benefited over 1200 clinicians and care staff. The program aims to train aged care and district nurses to identify and address people at clinical risk, thereby avoiding potential hospital admissions.  The Home and Community Care (HACC) Diversity Planning and Practice Initiative was implemented across all HACC‑funded organisations this year. It ensures a more comprehensive and better‑coordinated approach to responding to different needs and disadvantage experienced within the HACC target population.  A successful pilot investigated whether short‑term case management could help HACC clients who have complex needs to live more independently at home, and avoid escalation to more intensive levels of care such as hospital admission.  As part of the NDIS agreement, Victoria agreed that responsibility for HACC services for people aged sixty‑five and over will be transferred to the Commonwealth from July 2015.  The agreement provides that the Commonwealth and Victoria will work together to retain the benefits of Victoria’s current Home and Community Care service system. Victoria and the Commonwealth have begun a cooperative process to ensure that this is achieved.  There is strong consensus amongst peak provider, consumer and advocacy groups in Victoria that the fundamental features of our system should remain in place.  These include the strong and effective linkages between community care services and health services, including acute and post‑acute, as well as community nursing, and primary care, including allied health. | **”** |
|  | Queensland Government comments |  |
| **“** | The Queensland Government is continuing to implement the National Health Reform Agreement through focusing on its role in providing a quality health system for all Queenslanders.  In April 2013, the Queensland Government released its response to the Independent Commission of Audit’s Final Report. As part of the response, the Queensland Government agreed that its primary role in the health system is to deliver public hospital and health services such as elective surgery and emergency department services. In recognition of its primary role, the Queensland Government agreed to examine options to transfer residential aged care places to non‑government providers having regard to local circumstances and capacity. This recognises that non‑government providers of residential aged care already provide over 95 per cent of residential aged care places in Queensland and have the necessary expertise and capacity to provide high quality services.  During 2013, various Queensland Hospital and Health Services (HHSs) began examining their role in providing residential aged care services and whether these could be more appropriately delivered by non‑government providers. In addition, HHSs also assessed their role in providing community services under the Commonwealth Home and Community Care (HACC) Program and where appropriate, relinquished funding to the Commonwealth for reallocation to  non‑government providers. This process has allowed HHSs to focus on the provision of public hospital services, whilst strengthening the capacity of the non‑government sector.  The Queensland Government will continue to be a provider of residential aged care services and Commonwealth HACC Program services in circumstances where no other alternative providers are willing or able to provide services or for people who have high and complex care needs that are unable to be met by other providers.  As part of the Queensland Health Reforms, HHSs have been working closely with Medicare Locals, as well as primary health and aged care providers to improve the integration of services for older people between the different sectors. This work has resulted in a downward trend in the number of longer stay older patients remaining in public hospitals who are in need of aged care services.  Queensland provided 733 transition care places across the state assisting approximately 4700 older people in 2012‑13 to regain or maximise their level of independence following discharge from hospital.  Queensland also operated 31 Multi‑purposes Health Services in 2012‑13 which provided a mix of health and aged care services appropriate to the needs of communities in rural and remote locations. | **”** |

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| **“** | Western Australian Government comments |  |
| During the past 12 months the Western Australian (WA) Aged Care Advisory Council has continued to support a WA Dementia Working group to focus on dementia as a priority for the health and community care sectors in WA. Hospital emergency departments, impatient settings , geriatrician led memory clinics and Home ad Community Care (HACC) assessment and service delivery are specific target areas in relation to achieving the broad objective of better outcomes and quality of life for people with dementia. This work aligns with the national Framework for Action on Dementia and is an extension of the WA models of care for dementia and delirium.  In 2012‑2013 WA delivered a growth rate of 15 per cent in subacute care service delivery across approximately 50 projects. In addressing the gaps in subacute care service provision, increased service provision across rural and remote areas was addressed. The major focus being the strengthening services across WA with the establishment of dedicated subacute resources centres in all major regional centres. The State‑wide Subacute Training and Development Centre (TRACS WA) is now fully integrated into the WA subacute care sector as well as creating links with the non‑government sector to enhance the provision of subacute services in WA. TRACS WA is currently focusing on the development of a “Subacute Care Core Curriculum” designed to form part of the orientation of the workforce in the WA Health subacute care sector.  The National Transition Care Program (TCP) Quality Improvement Framework commenced on 1 July 2012 and having previously conducted quality review audits based on the WA Quality improvement Framework, WA was well placed to progress with this initiative. All current TCP service agreements are due to expire on 30 June 2014 and the Department of Health is currently undertaking a tendering process for the delivery of TCP for the next 7 years.  WA continues to operate a very effective Continence Management and Support Scheme in partnership with the Disability Services Commission. The scheme delivers assessment and clinical support through a Continence Management and Advice Service managed by Silver Chain and a product subsidy managed by Independence Australia.  The role out of the WA Assessment Framework across the state has commenced and the partnership between HACC and the Aged Care Assessment Program has been strengthened, to support a streamlined client journey and referral pathways to prevent duplication of assessments. A Professional Development Framework for all assessors in currently being developed that will continue to support the focus on strengthening client independence in support planning.  The Long Stay Older Patient Initiative has continued to support Care Coordination Teams to improve the flow of older patients through the emergency department with the outcome of preventing avoidable admissions and early care planning in the acute environment. | **”** |
| **“** | South Australian Government comments |  |
| In 2012‑13 South Australia continued to consolidate the transition of responsibility for Ageing Policy from the Department for Communities and Social Inclusion (DCSI) to SA Health, including the Aged Care Assessment Program (ACAP) and the Adelaide Aged Care Assessment Teams (AACAT).  This transition presented an opportunity to evaluate the ACAP in South Australia, with an external evaluation conducted through August‑December 2012. The Final report contained 39 recommendations across five key areas:  1. Improving documentation  2. Improving the consumer experience  3. ACAT Structure, roles and responsibilities  4. Enhancing capacity for hospital assessments  5. Enabling funding and capacity building  Major progress was also made towards enhancing the e‑business capability of all South Australian ACATs, with implementation of the eACAT System scheduled for 2013‑14.  South Australia has continued to build the interface between Access2HomeCare (A2HC) and the ACATs, with the rollout of this service to all country ACATs during 2012‑13. A2HC is now the state‑wide single entry point for South Australian ACAT referrals.  South Australia has continued collaboration with the Commonwealth on advancing the national Living Longer. Living Better reform agenda in aged care including piloting the Assessment Framework Tool proposed as part of the National Aged Care Gateway initiative.  SA Health has been considering the ways of integrating the *Living Longer, Living Better* reform agenda complementing a range of state based initiatives underway. This work continues with a focus on developing protocols that ensure high quality care at the acute care‑aged care interface.  SA Health continues to strengthen the Transition Care program (TCP) demonstrating the second highest National average for occupancy levels for 2012‑13 with over 2000 people receiving services through TCP. SA Health has established a new provider panel based on a high level of quality service provision.  Work on the preparation of the new state‑wide ageing plan for South Australia began during 2012‑13. Prosperity Through Longevity: South Australia’s Ageing Plan: our vision was launched in October 2013.  A steering committee was established to review and update the existing Our Actions to Prevent the Abuse of Older People framework 2007, leading to the development draft for consultation of the South Australian Strategy for Safeguarding Older People 2014–2021. It is anticipated that the strategy will be completed during 2013‑14. | **”** |
| **“** | Tasmanian Government comments |  |
| * Tasmania’s population is ageing more rapidly than any other Australian jurisdiction. The median age is the highest in the nation and it is anticipated that future demand for aged care services will increase at a significantly faster rate than currently planned increases in their supply. Tasmania is also likely to have more people per capita with dementia than any other state or territory, growing from 6000 in 2010 to 15 000 by 2030. * Population ageing will continue to have a significant impact on hospitalisation rates in Tasmania. While the Australian Government has assumed full funding and management responsibility for the provision of aged care services to people over 65 years of age, the Tasmanian Government retains a strong interest in those services and their impact on the broader health and human services system. * It is likely that there will continue to be a degree of complexity at the interface between aged care and health services for older people and their families. With increasing demand associated with the ageing of the population, it is important that avoidable hospitalisations and long‑stays by older people are minimised and well managed. Accordingly, in 2012‑13, the Tasmanian Government has continued to make a considerable investment in the jointly‑funded Transition Care Program. * Since 2007, the Australian Government funded Long Stay Older Patients (LSOP) initiatives have also underpinned effective programs in Tasmania diverting older people away from, or reducing their necessary stay in hospital care. Tasmania’s hospitals have also implemented their own strategies, such as purchasing temporary beds in private aged care facilities to facilitate the transition for older people from hospital to home or into residential care. * The current funding provided through the *National Partnership Agreement (on Financial Assistance for LSOP ― 2011‑12 to 2013‑14,* has enabled Tasmania to support older patients in public hospitals who no longer require acute or subacute care and who are waiting for residential aged care. As noted in the body of this chapter, most State and Territory governments report that this Commonwealth funding has enabled the implementation of valuable interventions to mitigate the LSOP problem. * This has certainly been the case in Tasmania where the number of long stay older patients has more than halved between 2006 and 2013. Even so, over the course of 2012‑13, Tasmania’s public hospitals still had 595 long stay older patients waiting an aggregate of just under 18 000 days between ACAT approval and discharge. * The Tasmanian Government is concerned that, following the expiry of the current funding arrangement in June 2014, the successful programs now in place will be at risk and that the numbers of older people ‘stranded’ in hospital will, unfortunately, again increase due to an unavailability of safe and appropriate aged care services. | **”** |
| **“** | Australian Capital Territory Government comments |  |
| * Older citizens and their carers continue to be the focal point of the  *ACT Strategic Plan for Positive Ageing 2010‑14: Towards an Age‑Friendly City*. The Plan provides a framework of social inclusion and encompasses the United Nations Principles for Older Persons: independence, participation, care, self‑fulfilment and dignity. * This year has seen the launch of a new *Palliative Care Services Plan:  2013‑17*, to provide strategic direction for the development of palliative care in the ACT to best meet current and projected population needs. The Plan signals the need to develop greater capacity to respond to the needs of people and their families for end of life care in the community. * The *ACT Chronic Conditions Strategy – Improving Care and Support:  2013‑18*, also launched this year, sets a direction for the care and support of those living with chronic conditions in the ACT. The prevalence of chronic conditions is increasing significantly and currently accounts for nearly 80 per cent of the total burden of disease and injury in the ACT. The Strategy provides a basis for improving the quality of support and management of chronic conditions in the ACT through a person centred approach. * The recent 2012‑13 Aged Care Approvals Round provided the ACT with 180 new residential aged care places. This allocation comprised:  120 places (60 high care and 60 low care) for Ngunnawal Aged Care, a new facility planned for the north of Canberra; and 60 places (30 high care and 30 low care) for Calwell Community Aged Care, a new facility planned for the south of Canberra. * The Respecting Patient Choices Program continues to provide consumers with a means to discuss and record their choices around future health care, in the event that they can no longer make decisions for themselves. It works closely with ACT public hospitals, the Chronic Care Program, palliative care, residential aged care facilities, the Public Advocate and community organisations. | **”** |
| **“** | Northern Territory Government comments |  |
| * On 1 July 2012, the Australian Government assumed funding and administration responsibility for the Home and Community Care (HACC) Program providing services to people 65 years of age and over and Indigenous people 50 years and over. * The Northern Territory Department of Health was funded to continue to provide HACC dementia nurses and community care nurses as part of the transition. A new HACC program was also established, the HACC Equipment Program for Older Territorians, which is delivered by the Northern Territory Department of Health. The equipment program conducts assessments and provides equipment for eligible HACC clients. * The Northern Territory continued to provide comprehensive aged care assessments, under the Aged Care Assessment Program (ACAP) during 2012‑13. In the period from 1 July 2012 to 30 June 2013, the Northern Territory Aged Care Assessment Team (ACAT) received 1220 referrals. A total of 942 referrals resulted in delegated assessments for subsidised care. * During 2012‑13, work was undertaken to enable the transition of the Aged Care Units to the Health Services under the Department of Health’s New Service Framework. The transition occurred on 1 July 2013. * In May 2013 the first successful electronic transfer of the Aged Care Client Record (ACCR) was achieved in Darwin. Considerable work and collaboration between the ACAP Section, Access Reform Branch in Canberra, La Trobe University and ACAT teams in the Northern Territory from the commencement of 2013 saw the successful installation of Aged Care Evaluation and the transition from a paper‑based program to eACCR. * During 2012‑13, the Transition Care Program provided services to frail aged persons. Transition Care Program is goal oriented, time‑limited and therapy focussed care for older persons following a hospital stay. There were 29 allocated places under the Transition Care Program in the Northern Territory. Eight places were managed flexibly through a non‑government service provider in the Katherine region as either residential or community packages depending on demand. Six residential packages were managed by a non‑government service provider in Darwin and Alice Springs. The remaining 15 places were Northern Territory wide community based places administered by the Northern Territory Department of Health. * Due to facility problems and reduced regional uptake, by the end of the year all packages were Department managed and could be used across the Territory. Ninety‑three clients were managed by the Transition Care Team during 2012‑13. | **”** |

## 13.6 Definitions of key terms

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| **Adjusted subsidy reduction supplement** | An adjusted subsidy reduction supplement is a payment made by State governments to some public sector residential care operators to offset the effect of the Australian Government’s adjusted subsidy reduction. The adjusted subsidy reduction reduces the daily rate of Residential Care Subsidy paid by the Australian Government in respect of certain residential aged care places owned by State governments or State public sector organisations. The rate of the reduction is determined by the relevant Commonwealth Minister from 1 July each year, in accordance with section 44‑19 of the *Aged Care Act 1997*. |
| **Accreditation** | Accreditation is a key component of the Australian Government’s quality framework for federally funded residential aged care and is a quality assurance system for residential aged care services — based on the principle of continuous improvement.  Accreditation requires assessment against the 44 expected outcomes used for accreditation assessment — grouped into four standards: management systems, staffing and organisational development; health and personal care; residential lifestyle; and physical environment and safety systems. |
| **Aged care** | Formal services funded and/or provided by governments that respond to the functional and social needs of older people, and the needs of their carers. Community aged care services aim to optimise independence and to assist older people to stay in their own homes, while residential care services provide accommodation and care for those who can no longer be assisted to stay at home. Assessment of care needs is an important component of aged care.  The majority of aged care services assist in activities of daily living such as personal care (for example, bathing and dressing), housekeeping and meal provision. Other services aim to promote social participation and connectedness. These services are delivered by trained aged care workers and volunteers. However, aged care services may also be delivered by health professionals such as nurses and occupational therapists.  Aged care services generally aim to promote wellbeing and foster function rather than to treat illness. Although some aged care services such as transition care have a specific restorative role, they are distinguished from the health services described in Part E of this Report.  Aged care services may be funded through programs specifically or mainly directed to older people, or through programs that address the needs of people of different ages. |
| **Aged care target population** | The Aged Care target population is defined as all people (Indigenous and non‑Indigenous) aged 65 years or over and Indigenous Australians aged 50–64 years. This is the population specified in the *National Health Reform Agreement* who are within the scope of, and funded for services under, the national aged care system (except in Victoria and WA). |
| **Aged care planning population** | The Aged care planning population is defined as people aged  70 years or over. This is the population used by the Australian Government for its needs‑based planning framework to ensure sufficient supply of both low‑level and high‑level residential and community care places by matching the growth in the number of aged care places with growth in the aged population. It also seeks to ensure balance in the provision of services between metropolitan, regional, rural and remote areas, as well as between people needing differing levels of care (DoHA 2012).  Under the framework, the Australian Government seeks to achieve and maintain a specified national provision level of subsidised operational aged care places for every 1000 people aged 70 years or over. This provision level is known as the aged care provision ratio (DoHA 2012). |
| **Ageing in place in residential care** | An approach that aims to provide residents with appropriate care and increased choice by allowing them to remain in the same facility regardless of changes in their level of care needs. It also allows couples with different levels of care needs to be cared for in the same facility. The main facet of ‘ageing in place’ is that funding is tied to the assessed care needs of the client rather than to the services provided by the facility.  One of the objectives of Australian Government aged care legislation is ‘to promote ageing in place through the linking of care and support services to the places where older people prefer to live’ (*Aged Care Act 1997* (Cwlth), s.2‑1 [1j]). |
| **Capital expenditure on residential services** | Expenditure on building and other capital items, specifically for the provision of Australian government funded residential aged care. |
| **Care leaver** | A care leaver is a person who was in institutional care (such as an orphanage or mental health facility) or other form of out‑of‑home care, including foster care, as a child or youth (or both) at some time during their lifetime (DoHA 2012). |
| **Centre day care** | Respite care provided from a facility such as a day care or health centre. Respite care is usually combined with social support services to maintain the functional capabilities of the person receiving care. |
| **Complaint** | A complaint by the affected care recipient or his or her representative, or anyone else, to the Secretary of the Department of Social Services about matters relevant to an approved provider’s responsibilities under the *Aged Care Act 1997* or the Aged Care Principles or a service provider’s responsibilities under the Commonwealth HACC funding agreement. |
| **Dementia services program** | Includes flexible and innovative support, respite, counselling, information and referral services, education and leisure. The program includes meeting individual and immediate needs which cannot be met by other services, through carer respite services and other carer support agencies. Inpatient services are excluded. |
| **Disability** | A limitation, restriction or impairment that has lasted, or is likely to last, for at least six months and restricts everyday activities. |
| **EBA supplement** | Payments made to supplement services for the extra costs associated with public sector enterprise bargaining agreements over and above those required by other wage Awards. |
| **Elapsed time** | The measure of the time elapsed between ACAT approval and entry into a residential care service. It has been used in past years as an indicator of access to residential care. |
| **High/low care recipient** | On entry, a resident is classified as high or low care based on their assessment by an ACAT and their approved provider’s appraisal of their care needs under the ACFI.  Residents whose ACAT approval is not limited to low care are classified as high care if they have an ACFI appraisal of:   * high in Activities of Daily Living, or * high in Complex Health Care, or * high in Behaviour, together with low or medium in at least one of the Activities of Daily Living or Complex Health Care domain, or * medium in at least two of the three domains.   All other ACAT approval and ACFI appraisal combinations result in a classification of low level care.  A resident’s care needs may change over time resulting in a change in classification from low to high level care (ageing in place). |
| **In‑home respite** | A short term alternative for usual care. |
| **People from non‑English speaking countries** | People who were born in non‑English speaking countries. English‑speaking countries are defined as Australia, New Zealand, the United Kingdom, Ireland, the United States, Canada and South Africa. |
| **People with a moderate disability** | Where a person does not need assistance, but has difficulty with self‑care, mobility or communication. |
| **People with a profound disability** | Where a person is unable to perform self‑care, mobility and/or communication tasks, or always needs assistance. |
| **People with a severe disability** | Where a person sometimes needs assistance with self‑care, mobility or communication. |
| **Personal care** | Assistance in undertaking personal tasks (for example, bathing). |
| **Places** | A capacity within an aged care service for the provision of residential care, community care or flexible care in the residential care context to an individual (*Aged Care Act 1997 (Cwlth)*); also refers to ‘beds’ (*Aged Care (Consequential Provisions) Act 1997 (Cwlth)*, s.16). |
| **Real expenditure** | Actual expenditure adjusted for changes in prices, using the GDP(E) price deflator and expressed in terms of final year prices. |
| **Resident** | For the purposes of the *Aged Care Act 1997*, a person who is being provided with residential care through an aged care service conducted by an approved provider under the Act. |
| **Respite care** | Alternative care arrangements for dependent people living in the community, with the primary purpose of giving a carer or a care recipient a short term break from their usual care arrangement. |
| **Rural small nursing home supplement** | Payments made by states and territories to small sized high care public sector residential aged care facilities (up to 30 places) that are located in rural areas. Three levels of supplement are paid to facilities varying in size from 10 to 20 and 30 places. |
| **Special needs groups** | Section 11‑3 of the *Aged Care Act 1997*, specifies the following people as people with special needs: people from Aboriginal and Torres Strait Islander communities; people from culturally and linguistically diverse backgrounds; veterans; people who live in rural or remote areas; people who are financially or socially disadvantaged; people who are homeless or at risk of becoming homeless; care‑leavers; parents separated from their children by forced adoption or removal; and lesbian, gay, bisexual, transgender and intersex (LGBTI) people. |
| **Veterans** | Veterans, war widows, widowers and dependants who hold a Repatriation Health Card and are entitled to medical and other treatment at the Department of Veterans’ Affairs’ expense under the *Veterans’ Entitlement Act 1986*, the *Social Security and Veterans’ Entitlements Amendment (No2) Act 1987*, the *Veterans’ Entitlement (Transitional Provisions and Consequential Amendments) Act 1986* and the *Military Rehabilitation and Compensation Act 2004*. |

## 13.7 List of attachment tables

Attachment tables are identified in references throughout this chapter by a ‘13A’ prefix (for example, table 13A.1). Attachment tables are available on the Review website (www.pc.gov.au/gsp).

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| **Table 13A.1** | Older people as a share of the total population, by gender, June 2013 |
| **Table 13A.2** | Aged care target population data, by location (‘000) |
| **Table 13A.3** | Proportion of all people who are older, by region, June 2013 |
| **Table 13A.4** | People receiving aged care services, 2012‑13 |
| **Table 13A.5** | Government expenditure on aged care services, 2012‑13 ($ million) |
| **Table 13A.6** | Government real expenditure on aged care services, by program type  (2012‑13$) |
| **Table 13A.7** | Australian Government (DoHA) real expenditure on assessment and information services (2012‑13$) |
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## 13.8 References

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1. Unless otherwise stated, HACC expenditure excludes the DVA expenditure on VHC. [↑](#footnote-ref-1)
2. In Victoria, an ACAT is referred to as an Aged Care Assessment Service (ACAS). Where this Report refers to an ACAT, it intends the Victorian term ACAS to be read as interchangeable. [↑](#footnote-ref-2)
3. DVA data include veterans of all ages. [↑](#footnote-ref-3)