# 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.

Improvements to the reporting of aged care services in this edition include:

* addition of a measure on ‘access to Transition Care services by Indigenous status’ for the ‘use by different groups’ indicator
* improved reporting on the ‘compliance with service standards for community care’ indicator to revise the measure to report on ‘the proportion of reviews of community aged care services that met all expected outcomes under each of the Home Care Common Standards’
* development of the ‘social participation in the community’ indicator to report three measures, ‘the estimated proportions of older people (aged 65 years or over) who:
* participated in social or community activities away from home in the last three months’
* ‘had face‑to‑face contact with family or friends not living in the same household in the last week, month or three months’
* ‘did not leave home or did not leave home as often as they would like’
* improving, simplifying and streamlining the attachment table set
* data quality information (DQI) available for the first time for a further two measures ‘use by different groups — access by veterans’ and ‘hospital patient days used by aged care type patients – proportion of completed hospital separations for which the length of stay was 35 days or longer’.

In addition to these improvements, reporting on aged care services this year has been revised to reflect program changes for community and flexible aged care. From 1 August 2013, the new Home Care Packages Program replaced the former community and flexible packaged care programs — Community Aged Care Packages (CACPs), Extended Aged Care at Home (EACH) packages, and EACH Dementia (EACH‑D) packages.

Older Australians are also users of other government services covered in this Report, including primary and community health services (chapter 10), public hospitals (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:

* information and assessment services that seek to ensure that older people who may need aged care, and their carers, know about and can access the appropriate support services to meet these needs — services include those provided under the Commonwealth Respite and Carelink Centres and the Aged Care Assessment Program (ACAP)
* residential care services, which provide supported accommodation for older people who are unable to continue living independently in their own homes, services include permanent and respite high and low level care
* community care services, which provide home based care and assistance to help older people remain, or return to, living independently in the community as long as possible — services include those provided under the Home Care Packages Program, Home and Community Care (HACC), and the Department of Veterans’ Affairs (DVA) Veterans’ Home Care (VHC) and Community Nursing programs
* community care respite services which provide support to carers to allow them a break from their usual care arrangements, including 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 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, Aged Care Innovative Pool and National Aboriginal and Torres Strait Islander Flexible Aged Care Program
* specific support services address particular needs such as those identified under the Community Visitors Scheme and the National Aged Care Advocacy Program.

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 communication received assistance from the informal care network of family, friends and neighbours (Australian Bureau of Statistics [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

The *Aged Care Act 1997*, together with the accompanying Aged Care Principles, are the main regulatory instruments establishing the aged care framework, although some services are provided outside of the Act. Key provisions covered include service planning, user rights, eligibility for care, funding, quality assurance and accountability (Productivity Commission 2010). During 2013, a package of bills amending the *Aged Care Act 1997* was passed into law to implement some major reforms to the aged care system (see box 13.21). The 2011 *National Health Reform Agreement* also defines Australian, State and Territory governments’ roles and responsibilities that apply across the aged care and disability services systems (for more details see the Community services sector overview F).

The funding, regulation and policy oversight of aged care services are predominantly the role of the Australian Government, although all three levels of government are involved. Services are largely delivered by non‑government organisations, although State, Territory and local governments deliver some aged care services.

#### Information and assessment

The ACAP is the main program in this category reported on in this chapter. Aged Care Assessment Teams (ACATs)[[1]](#footnote-1) assess and approve clients as eligible for residential and home care services. An ACAT approval is mandatory for admission to Australian Government subsidised residential care (including respite), to receive Home Care 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 2014, they accounted for 26.4 per cent and 37.4 per cent respectively of all Australian Government subsidised residential aged care places. Community‑based organisations and charitable organisations accounted for a further 13.6 per cent and 17.4 per cent respectively. State and local governments provided the remaining 5.1 per cent (figure 13.1).

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| Figure 13.1 Ownership of operational residential places, June 2014**a, b, c** |
| |  | | --- | | Figure 13.1 Ownership of operational residential places, June 2014  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 and 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 Multi‑Purpose Service (MPS) Program, Aged Care Innovative Pool and the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. |
| *Source*: Department of Social Services (DSS) (unpublished); table 13A.15. |
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#### Community care services

The main community care programs reported in this chapter are the HACC, Home Care, DVA VHC and Veterans’ Community Nursing.

The Australian Government has full financial and operational responsibility for HACC services for older people, except in Victoria and WA where it is a joint Australian Government and State governments’ program 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 is responsible for the policy oversight and regulation of the Home Care Packages Program. Religious and charitable organisations are the main providers of Australian Government subsidised Home Care places (figure 13.2).

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| Figure 13.2 Operational Home Care places, by provider type,  June 2014**a, b, c** |
| |  | | --- | | Figure 13.2 Operational Home Care places, by provider type, June 2014  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. c Data exclude the flexible home care places in the following programs: MPS, Aged Care Innovative Pool and the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. |
| *Source*: DSS (unpublished). |
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The Australian Government is also 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.

#### Services provided in mixed delivery setting

Two categories of services are defined in this Report as being provided in mixed delivery settings: flexible care and specific support services.

##### Flexible care services

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

* 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 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 residents of Australian Government funded residential aged care facilities. The Australian Government is responsible for the funding and oversight of most of these programs.

### Funding

Recurrent expenditure on aged care services reported in this chapter was $14.8 billion in 2013‑14 (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 (table 13A.10) and funding provided for older people in specialist disability services, and Australian, State or Territory government capital expenditure are excluded (table 13A.11). 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.5.

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| Table 13.1 Recurrent expenditure on aged care services, 2013‑14 ($ million) |
| |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | NSW | Vic | Qld | WA | SA | Tas | ACT | NT | Aust | | Assessment and information servicesa | 41.8 | 29.9 | 22.1 | 12.8 | 11.2 | 3.5 | 1.4 | 1.7 | 124.3 | | Residential care servicesb | 3 342.8 | 2 637.8 | 1 821.4 | 859.1 | 941.5 | 253.5 | 93.7 | 26.5 | 9 976.3 | | Community care servicesc | 1 063.7 | 1 028.9 | 744.8 | 480.2 | 288.2 | 98.8 | 60.3 | 36.4 | 3 801.2 | | Services provided in mixed delivery settingsd | 291.4 | 191.8 | 139.0 | 73.8 | 97.9 | 19.6 | 12.2 | 27.4 | 853.0 | | **Total** | **4 739.8** | **3 888.3** | **2 727.3** | **1 425.8** | **1 338.7** | **375.4** | **167.7** | **91.9** | **14 754.9** | |
| a Assessment and information services include only Australian Government expenditure on the Aged Care Assessment Program (ACAP), additional Council of Australian Governments (COAG) funding for Aged Care Assessment Teams (ACATs), Commonwealth Respite and Carelink Centres and Carers Information and Support. b Residential care services include Department of Social Services (DSS) and Department of Veterans’ Affairs (DVA) (including payroll tax supplement) and State and Territory governments’ expenditure and funding. c Community care services include Home and Community Care (HACC), Home Care, National Respite for Carers Program (NRCP), Veterans’ Home Care (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. d Services provided in mixed delivery settings include MPS, Transition Care Program (TCP), National Aboriginal and Torres Strait Islander Flexible Aged Care Program and other flexible care and services directed at Workforce and Quality, and Ageing and Service Improvement. |
| *Source*: DSS (unpublished); Department of Veterans’ Affairs (DVA) (unpublished); State and Territory governments (unpublished); table 13A.4. |
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#### Assessment and information services

In 2013‑14, the Australian Government provided funding of $99.7 million nationally for the ACAP (table 13A.6). Australian Government ACAP expenditure per person aged 65 years or over and Aboriginal and Torres Strait Islander Australians aged 50–64 years was $28 nationally during 2013‑14 (table 13A.6). 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 2012‑13 and costs per assessment for 2004‑05 to 2012‑13 are reported in table 13A.57. Expenditure on other access and information services was $24.7 million in 2013‑14 (table 13A.6).

#### 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 government expenditure on residential aged care was $10.0 billion in 2013‑14 (table 13A.5). Australian Government expenditure (including payroll tax supplement) on residential aged care was $9.8 billion in 2013‑14, comprising DSS expenditure of $8.5 billion and DVA expenditure of $1.3 billion (table 13A.7). State and Territory governments’ expenditure was $252.9 million from four categories of residential care expenditure/funding: adjusted subsidy reduction supplement ($18.8 million), enterprise bargaining agreement supplement ($147.0 million), rural small nursing home supplement ($18.9 million) and funding of younger people in residential aged care (excluding for Victoria and WA) ($68.2 million) (tables 13A.7 and 13A.10).

##### 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). At 30 June 2014, the average annual subsidy per residential place, including the Conditional Adjustment Payment (CAP), was $51 078 nationally (table 13A.16). 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). 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.16. A veteran with a service related mental health condition can also receive a Veterans’ supplement for additional care needs.

##### Capital expenditure

Capital expenditure on aged care services in 2013‑14 is summarised in table 13A.11. The Australian Government provided $26.1 million in 2013‑14 for the Rural and remote building fund. State governments also provided $6.0 million in 2013‑14 for capital expenditure on residential aged care services (table 13A.11). 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, Home Care 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 2013‑14 was $3.8 billion (table 13A.4). Expenditure on HACC, Home Care, NRCP and DVA community nursing comprised most of this expenditure (table 13.2).

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| Table 13.2 Governments’ expenditure on selected community aged care programs, 2013‑14 ($million) |
| |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | NSW | | Vic | | Qld | | WA | | SA | | Tas | | ACT | | NT | | Aust | | | *HACC aged care services expenditure by the Australian, Victorian and WA governments*a | | | | | | | | | | | | | | | | | | |  | 516.0 | | 630.7 | | 411.3 | | 266.4 | | 151.6 | | 51.3 | | 21.0 | | 10.2 | | 2 058.5 | | *Australian Government aged care services expenditure*b | | | | | | | | | | | | | | | | | | | Home Care | | | | | | | | | | | | | | | | | | | Levels 1−2 | 220.4 | | 170.7 | | 110.1 | | 51.6 | | 53.3 | | 15.4 | | 9.0 | | 11.0 | | 641.4 | | Levels 3–4 | 162.7 | | 129.1 | | 136.6 | | 123.2 | | 35.4 | | 13.7 | | 20.5 | | 8.2 | | 629.5 | | NRCP | 68.2 | | 49.6 | | 37.5 | | 20.4 | | 19.1 | | 6.9 | | 4.8 | | 5.8 | | 212.3 | | Veterans’ services | | | | |  | |  | |  | |  | |  | |  | |  | | Community  nursing | 60.0 | | 21.0 | | 23.0 | | 6.0 | | 8.0 | | 6.0 | | 3.0 | | 0.1 | | 127.0 | | VHC | 28.7 | | 19.7 | | 18.5 | | 8.0 | | 7.0 | | 3.8 | | 1.6 | | 0.1 | | 87.4 | |
| HACC = Home and Community Care. NRCP = National Respite for Carers Program. VHC = Veterans’ Home Care a HACC aged care expenditure is the estimated funding from the Australian Government on all people aged 65 years or over and Aboriginal and Torres Strait Islander Australians aged 50–64 years. The exceptions are Victoria and WA where the expenditure is for people of all ages and includes a component of funding ($357.2 million in total) from those two jurisdictions ($252.5 million spent by the Victorian Government in Victoria and $104.7 million spent by the WA Government in WA). b Includes total program expenditure, including expenditure on services provided for younger people with disability. |
| *Source*:DSS (unpublished); DVA unpublished; tables 13A.4 and 13A.8. |
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#### Services provided in mixed delivery settings

In 2013‑14, government expenditure on flexible care and specific support provided in mixed delivery settings was $853.0 million. Three types of flexible care are provided under the *Aged Care Act 1997* (TCP, MPS and innovative care places). The Australian, State and Territory governments jointly fund the TCP and MPS. In 2013‑14, the Australian Government spent $232.3 million and the State and Territory governments spent $102.9 million on the TCP (table 13A.9) and the Australian Government spent $133.0 million on the MPS (State and Territory governments’ expenditure on MPS is not available) (table 13A.9). Australian Government expenditure on a range of other services provided in mixed delivery settings was $384.8 million in 2013‑14 (table 13A.9).

### 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 Aboriginal and Torres Strait Islander 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 Aboriginal and Torres Strait Islander 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 and this trend is expected to continue during this century (figure 13.3). The proportion of older people in the population at June 2014 was 14.7 per cent nationally (figure 13.4). 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). A disaggregation by remoteness categorisation is provided in 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‑ and sex‑specific utilisation rates for residential and community care combined, and the projected growth in the size of the aged care planning population, 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).

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| Figure 13.3 People aged 65 years or over as a proportion of the total population**a** |
| |  | | --- | | Figure 13.3 People 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 (2014) *Australian Historical Population Statistics, 2014*, Cat. no. 3105.0.65.001, Canberra; ABS (2013) *Population Projections, Australia, 2012 (base) to 2101*, Cat. no. 3222.0, Canberra. |
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| Figure 13.4 Estimated proportion of population aged 65 years or over, by sex, June 2014 |
| |  | | --- | | Figure 13.4 Estimated proportion of population aged 65 years or over, by sex, June 2014  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. |
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##### Characteristics of older Aboriginal and Torres Strait Islander Australians

ABS estimates that about 102 612 Aboriginal and Torres Strait Islander Australians were aged 50 years or over in Australia at 30 June 2014 (table 13A.2). Although the Aboriginal and Torres Strait Islander population is also ageing, there are marked differences in the age profile of Aboriginal and Torres Strait Islander Australians compared with   
non‑Indigenous Australians (figure 13.5). Estimates show life expectancy at birth in the Aboriginal and Torres Strait Islander 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). Aboriginal and Torres Strait Islander 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.

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| Figure 13.5 Age profile and aged care target population differences between Aboriginal and Torres Strait Islander and other Australians, June 2011 |
| |  | | --- | | Figure 13.5 Age profile and aged care target population differences between Aboriginal and Torres Strait Islander 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. |
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#### Aged care services

##### 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 95 ACATs (94 Australian Government funded) at 30 June 2014 (DSS unpublished). Nationally, there were 52.3 assessments per 1000 people aged 65 years or over and Aboriginal and Torres Strait Islander Australians aged 50–64 years in 2012‑13. The rate for Aboriginal and Torres Strait Islander Australians was 23.1 per 1000 Aboriginal and Torres Strait Islander Australians aged 50 years or over (figure 13.6).

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| Figure 13.6 Aged Care Assessment Team assessment rates,  2012‑13**a, b, c, d, e, f** |
| |  | | --- | | Figure 13.6 Aged Care Assessment Team assessment rates, 2012-13  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 Aboriginal and Torres Strait Islander Australians aged 50–64 years per 1000 people aged 65 years or over and Aboriginal and Torres Strait Islander Australians aged 50–64 years. c Aboriginal and Torres Strait Islander includes all assessments of Aboriginal and Torres Strait Islander Australians aged 50 years or over per 1000 Aboriginal and Torres Strait Islander Australians aged 50 years or over. d The number of Aboriginal and Torres Strait Islander assessments is based on self‑identification of Indigenous status. e Data were extracted from the Ageing and Aged Care Data Warehouse from preliminary data using the snapshot effective date of 31 August 2014. Future extracts of these data may change. f See table 13A.40 for further explanation of these data. |
| *Source*:Aged Care Assessment Program (ACAP) National Data Repository (unpublished); table 13A.40. |
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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 Home Care (see table 13A.41). 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 accommodation, support services (cleaning, laundry and meals) and personal care services
* respite provides short term residential high/low care on a planned or emergency basis (DoHA 2012).

At June 2014, there were 2688 residential aged care services (table 13A.17). The size and distribution across remoteness areas of residential aged care services — which can influence the costs of service delivery — vary across jurisdictions. Nationally, there were 189 283 mainstream operational places (excluding flexible care places) in residential care services at June 2014 (table 13A.17). 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 (ACFI) and the characteristics of residents |
| Aged Care Assessment Team (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 was introduced on 20 March 2008 and replaced the Resident Classification Scale (RCS).  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. 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 approval. * 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. |
| (Continued next page) |
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| Box 13.1 (continued) |
| * 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. |
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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 2014 was 82.6 (41.6 high care and 41.1 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 2007 and 2014 (table 13A.24).

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| Table 13.3 Operational high care and low care residential places, 30 June 2014**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. | 43.7 | 40.9 | 38.2 | 36.0 | 49.5 | 43.3 | 29.8 | 47.2 | 41.6 | | Low care places | no. | 40.7 | 43.2 | 40.6 | 38.4 | 42.0 | 36.7 | 40.8 | 29.2 | 41.1 | | **Total places** | **no.** | **84.5** | **84.1** | **78.8** | **74.4** | **91.5** | **80.0** | **70.6** | **76.4** | **82.6** | | Proportion of places | | | | | | | | | | | | High care places | % | 51.7 | 48.6 | 48.5 | 48.4 | 54.1 | 54.1 | 42.2 | 61.8 | 50.3 | | Low care places | % | 48.2 | 51.4 | 51.5 | 51.6 | 45.9 | 45.9 | 57.8 | 38.2 | 49.7 | |
| 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 The target ratio of 125 aged care places comprises 80 residential places and 45 Home Care Packages. This target is to be achieved by 2021‑22. In recognition of poorer health among Aboriginal and Torres Strait Islander communities, planning in some cases also takes account of the Aboriginal and Torres Strait Islander 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 higher proportion of the population who are Aboriginal and Torres Strait Islander people (such as in the NT). c Includes residential places categorised as high care or low care. d See table 13A.19 for further information regarding the calculation of provision ratios, which may vary from corresponding data published elsewhere. e Data in this table may not add due to rounding. |
| *Source*: DSS (unpublished); table 13A.19. |
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Age‑specific usage rates for permanent residential aged care, by jurisdiction and remoteness, at 30 June 2014 are included in tables 13A.26 and 13A.31, respectively. National, Aboriginal and Torres Strait Islander age‑specific usage rates for all these services by remoteness category are in table 13A.32.

During 2013‑14, the number of older clients (aged 65 years or over and Aboriginal and Torres Strait Islander Australians aged 50–64 years) who received either high or low care in a residential aged care facility was 224 222 nationally for permanent care and 46 851 nationally for respite care (table 13A.3). 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 2013‑14 are in table 13A.30.

##### Community care services

The distinctions between the HACC and Home Care are summarised in table 13.4. DVA VHC and Community Nursing Program services are described below.

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| Table 13.4 Distinctions between HACC and Home Care, 2013‑14 |
| |  |  |  |  | | --- | --- | --- | --- | |  | HACC | Home Care levels 1–2 | Home Care levels 3–4 | | Type of servicesa | Maintenance and support services for people in the community whose independence is at risk | Package of basic to low level care tailored to client needs | Package of intermediate to high level care tailored to client needs | | Relationship to residential care | Aims to prevent premature or inappropriate admission | Level 2 substitutes for a low care residential place | Level 4 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 primarily by the Australian Government and client contributions — State and Territory governments fund younger people using these services (except in Victoria and WA). | Funded primarily by the Australian Government and client contributions — State and Territory governments fund younger people using these services (except in Victoria and WA). | | Target client groupsb | Available to frail older people with functional limitations as a result of profound, severe or 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 | $2.1 billion funding for older clients (includes funding for younger people in Victoria and WA) At least 775 959 olderclientsc | $641.4 million total funding  52 265 operational placesd | $629.5 million total funding  14 689 operational places | |
| a HACC services such as community nursing, can be supplied to someone receiving Home Care levels 1‑2 when additional nursing services are required to support the consumer to remain living at home. b Most HACC clients with lower support needs would not be assessed as eligible for residential care; for example, an individual may receive only an hour of home support per fortnight. At the higher end, some people have needs that would exceed the level available under a Home Care place. c The proportion of HACC funded agencies that submitted Minimum Data Set data for 2013‑14 differed across jurisdictions and ranged from 75 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 Home Care levels 1–2 and flexible community places. See notes to table 13A.14. |
| *Source*:DSS (unpublished); tables 13A.3, 13A.4 and 13A.14. |
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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 2013‑14, the HACC program delivered approximately 9895 hours per 1000 people aged   
65 years or over and Aboriginal and Torres Strait Islander Australians aged 50–64 years (table 13A.33).

Home Care levels 1–2 provides community‑based basic to low level care to older people who are assessed by ACATs as having these care needs, but who are able to live at home with assistance. There were 21.6 places of Home Care levels 1–2 per 1000 people aged 70 years or over and Aboriginal and Torres Strait Islander Australians aged 50–69 years in June 2014 (table 13A.20). Home Care levels 3–4 provides community‑based intermediate to high level care to older people who are assessed by ACATs as having these care needs, but who have expressed a preference to live at home and are able to do so with assistance. There were 6.1 places of Home Care levels 3–4 per 1000 people aged 70 years or over and Aboriginal and Torres Strait Islander Australians aged 50–69 years in June 2014 (table 13A.20). Older people who access a package of Home Care levels 1–4 can also receive supplements for additional care needs including a Dementia and Cognition Supplement, Veterans’ Supplement for veterans with service‑related mental health conditions, an Oxygen Supplement and an Enteral Feeding Supplement.

Age‑specific usage rates for Home Care, by jurisdiction and remoteness, at 30 June 2014 are included in tables 13A.26 and 13A.31 respectively. National, Aboriginal and Torres Strait Islander age‑specific usage rates for permanent residential and Home Care services by remoteness category are in table 13A.32. 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 differences in rates across categories.

Data on the number of older clients (aged 65 years or over and Aboriginal and Torres Strait Islander Australians aged 50–64 years) who received HACC and Home Care in 2013‑14 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 Home Care during 2013‑14 are in table 13A.30.

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| Table 13.5 Number of community aged care older clients, by program, 2013‑14 |
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| *Source*:DSS (unpublished); table 13A.3. |
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The services of the VHC program target veterans and war widows/widowers with low care needs. 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. There were 63 741 people approved for VHC services in 2013‑14 (table 13A.12). The average number of hours provided per year for veterans who were eligible to receive VHC services was 52 nationally in 2013‑14 (figure 13.7).

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| Figure 13.7 Average number of hours approved for Veterans’ Home Care, 2013‑14 |
| |  | | --- | | Figure 13.7 Average number of hours approved for Veterans' Home Care 2013-14  More details can be found within the text surrounding this image. | |
| *Source*:Department of Veterans’ Affairs (DVA) (unpublished); table 13A.12. |
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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 2013‑14, 25 977 veterans received these services (table 13A.12) and the average number of hours provided for each recipient was 9.3 per 28 day period (table 13A.12).

##### Services provided in mixed delivery setting

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

* At 30 June 2014, the Australian Government had allocated 4000 places to transition care, all were operational, across 87 services nationally. The average length of stay in 2013‑14 was 60 days (8.6 weeks) nationally for completed episodes (table 13A.66).
* At 30 June 2014, there were 147 operational MPS program services with a total of 3525 operational flexible aged care places (includes residential and community places). Some of the MPS providers serve more than one location (DSS 2014).
* At 30 June 2014, there were 30 aged care services funded to deliver 739 flexible aged care places under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (DSS unpublished).

## 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). |
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The Council of Australian Governments (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 area of health and aged care, and health indicators in the National Indigenous Reform Agreement (NIRA) establish specific outcomes for reducing the level of disadvantage experienced by Aboriginal and Torres Strait Islander Australians. Both agreements include sets of performance indicators. The Steering Committee collates NIRA performance information for analysis by the Department of Prime Minister and Cabinet. Performance indicators reported in this chapter are aligned with health performance indicators in the most recent version of the NHA, where 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 2015 Report. For data that are not considered directly comparable, text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability and data completeness 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).

DQI 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, in addition to material in the chapter or sector overview and attachment tables. 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 2015 Report can be found at www.pc.gov.au/rogs/2015.

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| Figure 13.8 Aged care services performance indicator framework |
| |  | | --- | | Figure 13.8 Aged care services performance indicator framework  More details can be found within the text surrounding this image. | |
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## 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). Data presented for this indicator are organised by the relevant special needs groups.

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| Box 13.3 Use by different groups |
| ‘Use by different groups’ has four measures defined as follows:   * the number of Aboriginal and Torres Strait Islander Australians using residential services, Home Care, Home and Community Care (HACC) and Transition Care services, divided by the number of Aboriginal and Torres Strait Islander Australians aged 50 years or over (because Aboriginal and Torres Strait Islander Australians tend to require aged care services at a younger age than the general population), compared with the rate/proportions at which the total aged care target population (people aged 65 years or over and Aboriginal and Torres Strait Islander Australians aged 50–64 years) access these services * the rate of contacts with Commonwealth Respite and Carelink Centres for Aboriginal and Torres Strait Islander Australians compared with the rate for all people * 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 Department of Veterans’ Affairs (DVA) Gold or White card holder * 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 Aboriginal and Torres Strait Islander 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 Aboriginal and Torres Strait Islander communities, people from culturally and linguistically diverse backgrounds, 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, people who are care leavers[[2]](#footnote-2), parents separated from their children by forced adoption or removal and lesbian, gay, bisexual, transgender and intersex people. |
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| Box 13.3 (continued) |
| Several factors need to be considered in interpreting the results for this set of measures:   * Cultural differences and geographic location can influence the extent to which Aboriginal and Torres Strait Islander 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.   In previous editions of this Report, proxy measures of access (number of recipients/hours per 1000 aged care target population) were reported across states and territories for people born in non‑English speaking countries (for residential care, Home Care and HACC) and for people who live in regional or remote areas (for HACC). Data for these measures are no longer reported due to data quality concerns regarding the derived relevant aged care target populations used for the denominators. Data are still available by State and Territory on the proportion of all residential and Home Care recipients who are from non‑English speaking countries (table 13A.24) and nationally on the number of residential and Home Care recipients per 1000 aged care target population for people from regional and remote areas (tables 13A.21 and 13A.31‑32).  Data reported for the four measures for this indicator are:   * comparable (subject to caveats) across jurisdictions for all measures and comparable over time for the ‘access to residential services by financially disadvantaged users’ and ‘access by veterans’ measures, but not comparable over time for measures that use the aged care target populations as they are based on different Census years (see footnotes to table 13A.2 for details) * complete for the current reporting period (subject to caveats). All required 2013‑14 data are available for all jurisdictions.   Data quality information for these measures is at www.pc.gov.au/rogs/2015. Data quality information for some service types (HACC and Transition Care) is under development. |
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##### Access to residential aged care services by Aboriginal and Torres Strait Islander Australians

Nationally at 30 June 2014, Aboriginal and Torres Strait Islander Australians had lower rates of use of aged care residential services (18.5 per 1000 Aboriginal and Torres Strait Islander Australians aged 50 years or over), compared with the population as a whole (51.1 per 1000 people aged 65 years or over and Aboriginal and Torres Strait Islander Australians aged 50–64 years) (figure 13.9).

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| Figure 13.9 Residents per 1000 aged care target population, 30 June 2014**a, b** |
| |  | | --- | | Figure 13.9 Residents per 1000 aged care target population, 30 June 2014  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 Aboriginal and Torres Strait Islander Australians aged 50–64 years. b Aboriginal and Torres Strait Islander residents data are per 1000 Aboriginal and Torres Strait Islander Australians aged 50 years or over. |
| *Source*:DSS (unpublished); tables 13A.22 and 13A.25. |
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##### Access to Home Care by Aboriginal and Torres Strait Islander Australians

Nationally at 30 June 2014, the number of Aboriginal and Torres Strait Islander recipients of Home Care per 1000 Aboriginal and Torres Strait Islander Australians aged 50 years or over was 22.1, compared to a total of 17.2 per 1000 of the aged care target population (people aged 65 years or over and Aboriginal and Torres Strait Islander Australians aged 50–64 years) (figure 13.10).

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| Figure 13.10 Home Care recipients per 1000 aged care target population, 30 June 2014**a, b, c** |
| |  | | --- | | Figure 13.10 Home Care recipients per 1000 aged care target population, 30 June 2014  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 Aboriginal and Torres Strait Islander Australians aged 50–64 years. b Aboriginal and Torres Strait Islander recipients data are per 1000 Aboriginal and Torres Strait Islander Australians aged 50 years or over. c The ACT has a very small Aboriginal and Torres Strait Islander population aged 50 years or over (table 13A.2), and a small number of places result in a very high provision ratio. |
| *Source*:DSS (unpublished); tables 13A.22 and 13A.25. |
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##### Access to HACC aged care services by Aboriginal and Torres Strait Islander Australians

Nationally in 2013‑14, the number of Aboriginal and Torres Strait Islander HACC recipients per 1000 Aboriginal and Torres Strait Islander Australians aged 50 years or over was 197.9 compared to a total of 218.3 per 1000 of the aged care target population (people aged 65 years or over and Aboriginal and Torres Strait Islander Australians aged 50–64 years) (figure 13.11).

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| Figure 13.11 HACC recipients per 1000 aged care target population, 2013‑14**a, b** |
| |  | | --- | | Figure 13.11 HACC recipients per 1000 aged care target population, 2013-14  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 Aboriginal and Torres Strait Islander Australians aged 50–64 years. b Aboriginal and Torres Strait Islander recipients data are per 1000 Aboriginal and Torres Strait Islander Australians aged 50 years or over. |
| *Source*:DSS (unpublished) Home and Community Care (HACC) Minimum Data Set; table 13A.23. |
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There are substantial differences in the age profile across the Aboriginal and Torres Strait Islander and non‑Indigenous populations. This reflects the difference in morbidity and mortality trends between Aboriginal and Torres Strait Islander Australians and the general population. The proportion of older Aboriginal and Torres Strait Islander HACC clients (aged 65 years or over) who are aged 80 years or over is 26.9 per cent and the proportion of non‑Indigenous HACC clients who are aged 80 years or over is 54.5 per cent (figure 13.12).

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| Figure 13.12 Older recipients of HACC aged care services by age and Indigenous status, 2013‑14**a, b, c** |
| |  | | --- | | **Proportion of older Aboriginal and Torres Strait Islander HACC clients, by age cohort**  **Figure 13.12 Older recipients of HACC aged care services by age and Indigenous status, 2013-14  Proportion of older Aboriginal and Torres Strait Islander 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 13.12 Older recipients of HACC aged care services by age and Indigenous status, 2013-14  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 6.3 per cent (table 13A.36). c The Aboriginal and Torres Strait Islander proportions are derived using data contained in table 13A.37. |
| Source: DSS (unpublished); table 13A.37. |
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##### Access to TCP services by Aboriginal and Torres Strait Islander Australians

Nationally, the number of Aboriginal and Torres Strait Islander TCP clients per 1000 Aboriginal and Torres Strait Islander Australians aged 50 years or over was 1.6 compared to a total of 6.5 clients per 1000 non‑Indigenous people aged 65 years or over (figure 13.13).

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| Figure 13.13 TCP clients per 1000 aged care target population,  2013‑14**a, b, c** |
| |  | | --- | | Figure 13.13 TCP clients per 1000 aged care target population, 2013-14   More details can be found within the text surrounding this image. | |
| a Non‑Indigenous recipients data are per 1000 people aged 65 years or over. b Aboriginal and Torres Strait Islander recipients data are per 1000 Aboriginal and Torres Strait Islander Australians aged 50 years or over. c Data for Aboriginal and Torres Strait Islander recipients are not published for Tasmania and the ACT. |
| *Source*:DSS (unpublished); table 13A.3. |
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##### Access by Aboriginal and Torres Strait Islander Australians to Commonwealth Respite and Carelink Centres

Commonwealth Respite and Carelink Centres provide information on a range of community services and supports available locally or anywhere in Australia, the costs of services, assessment processes and eligibility criteria. The national rate at which Aboriginal and Torres Strait Islander Australians contacted Respite and Carelink Centres at 30 June 2014, was 26.2 people per 1000 Aboriginal and Torres Strait Islander Australians aged 50 years or over. The rate for all Australians was 93.4 per 1000 people aged 65 years or over and Aboriginal and Torres Strait Islander Australians aged 50–64 years. These figures varied across jurisdictions (figure 13.14).

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| Figure 13.14 Commonwealth Respite and Carelink Centres, contacts per 1000 aged care target population, by Indigenous status, 30 June 2014**a, b, c, d** |
| |  | | --- | | Figure 13.14 Commonwealth Respite and Carelink Centres, contacts per 1000 aged care target population, by Indigenous status, 30 June 2014   More details can be found within the text surrounding this image. | |
| a Contacts include phone calls, visits, emails and facsimiles. b Aboriginal and Torres Strait Islander contacts refer to contacts by Aboriginal and Torres Strait Islander Australians per 1000 Aboriginal and Torres Strait Islander Australians aged 50 years or over. c All contacts refers to contacts per 1000 aged 65 years or over and Aboriginal and Torres Strait Islander Australians aged 50–64 years. d Indigenous status is determined through people making contact self‑identifying themselves as Aboriginal and Torres Strait Islander. Therefore, there is likely to be substantial under reporting of Indigenous status. |
| *Source*:DSS (unpublished); table 13A.39. |
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##### 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 2014 was 165 658 (table 13A.13). The number of veterans in residential care per 1000 eligible veterans aged 65 years or over at 30 June 2014 was 149.0 (figure 13.15). Nationally, DVA expenditure on residential aged care subsidy per client was $53 108 (including payroll tax) in 2013‑14 (table 13A.13). Total DVA expenditure on residential aged care per 1000 eligible veterans aged 65 years or over was $7911 (figure 13.15).

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| Figure 13.15 Veterans use of and DVA expenditure on, residential care, 2013‑14**a, b** |
| |  | | --- | | **Service use** | | Figure 13.15 Veterans use of and DVA expenditure on, residential care, 2013 14  Service use  More details can be found within the text surrounding this image. | | **Expenditure** | | Figure 13.15 Veterans use of and DVA expenditure on, residential care, 2013-14  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 Eligible veterans are veterans with a DVA Gold and White card holder residents as at June 2014. c The number of eligible veterans aged 65 years or over used to derive these results, includes those whose age was unknown. |
| *Source*:DVA (unpublished); DSS (unpublished); table 13A.13. |
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##### 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 2013‑14 was 33.5 per cent nationally (figure 13.16). Targets for financially disadvantaged users range from 16 per cent to 40 per cent of places, depending on the service’s region.

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| Figure 13.16 New residents classified as supported residents, 2013‑14**a** |
| |  | | --- | | Figure 13.16 New residents classified as supported residents, 2013-14  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 2013 to 19 September 2013 — $112 243.20, from 20 September 2013 to 19 March 2014 — $113 784.00 and from 20 March 2014 to 30 June 2014 — $116 136.00). |
| *Source*:DSS (unpublished); table 13A.27. |
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The proportion of all permanent resident care days classified as concessional, assisted or supported during 2013‑14 was 40.9 per cent nationally (figure 13.17).

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| Figure 13.17 Permanent residents’ care days classified as concessional, assisted or supported, 2013‑14**a** |
| |  | | --- | | Figure 13.17 Permanent residents' care days classified as concessional, assisted or supported, 2013-14  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 2013 to 19 September 2013 — $112 243.20, from 20 September 2013 to 19 March 2014 — $113 784.00 and from 20 March 2014 to 30 June 2014 — $116 136.00). |
| *Source*: DSS (unpublished); table 13A.27. |
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#### 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 of place — high or low residential aged care and Home Care levels 1‑2 or Home Care levels 3‑4) per 1000 people in the aged care planning population:   * aged 70 years or over * aged 70 years or over and Aboriginal and Torres Strait Islander 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 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 places 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).  In recognition of poorer health among Aboriginal and Torres Strait Islander communities and that planning in some cases also takes account of the Aboriginal and Torres Strait Islander population aged 50–69 years, the provision ratio is also reported for operational places per 1000 people aged 70 years or over and Aboriginal and Torres Strait Islander Australians aged 50–69 years. A provision ratio based on the population aged 70 years or over will appear high in areas with a higher proportion of the population who are Aboriginal and Torres Strait Islander people (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.  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 2014 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/rogs/2015. |
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Nationally, the combined number of high care residential places, low care residential places, and Home Care places at 30 June 2014, was 111.3 per 1000 people aged   
70 years or over (figure 13.18). Transition Care places add an additional 1.7 per 1000 people aged 70 years or over (table 13A.19), however, these places are not included in the national provision ratio (box 13.4). The number of operational aged care places per 1000 people aged 70 years or over by care type was:

* 41.6 places for residential high care
* 41.1 places for residential low care
* 22.4 places for Home Care levels 1‑2
* 6.3 places for Home Care levels 3‑4 (figure 13.18).

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| Figure 13.18 Operational residential and Home Care places per 1000 people aged 70 years or over, 30 June 2014**a, b, c, d, e, f, g** |
| |  | | --- | | Figure 13.18 Operational residential and Home Care places per 1000 people aged 70 years or over, 30 June 2014  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 places per 1000 people aged 70 years or over. However, in recognition of poorer health among Aboriginal and Torres Strait Islander communities, planning in some cases also takes account of the Aboriginal and Torres Strait Islander 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 higher proportion of the population who are Aboriginal and Torres Strait Islander people (such as the NT). d Includes residential places categorised as high care or low care. e Home Care places are included in the Australian Government planning targets. f Home Care places data include flexible community care places under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program, MPS Program and Innovative Pool Program. g See table 13A.19 for further information regarding the calculation of provision ratios. |
| *Source*:DSS (unpublished); table 13A.19. |
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The number of operational aged care places can also be shown using an aged care planning population that incorporates Aboriginal and Torres Strait Islander Australians aged 50–69 years (figure 13.19). Use of this ‘adjusted’ aged care planning population has a noticeable effect on the NT, which has a large proportion of Aboriginal and Torres Strait Islander Australians.

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| Figure 13.19 Operational residential and Home Care places per 1000 people aged 70 years or over and Aboriginal and Torres Strait Islander Australians aged 50–69 years, 30 June 2014**a, b, c, d, e, f** |
| |  | | --- | | Figure 13.19 Operational residential and Home Care places per 1000 people aged 70 years or over and Aboriginal and Torres Strait Islander Australians aged 50–69 years, 30 June 2014  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 Home Care places are included in the Australian Government planning targets. d Includes residential places categorised as high care or low care. e Home Care places data include flexible community care places under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program, MPS Program and Innovative Pool Program. f TCP places are not shown, see table 13A.20. |
| *Source*:DSS (unpublished); table 13A.20. |
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Data on the number of residential and Home Care operational aged care places per 1000 people aged 70 years or over and Aboriginal and Torres Strait Islander Australians aged 50–69 years by remoteness areas are in table 13A.21.

#### 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 most recent approval date for the type of care for which the client is being admitted. * The proportion of people who commenced Home Care who did so within three months of their ACAT approval. ACAT approval refers to the most recent approval date for the type of care which the client is commencing.   Data are also presented for these service types on the proportions who enter/receive these services within other periods of time.  Higher proportions of admission to residential high care or commencement of Home Care within three months of ACAT approval are desirable.  This indicator needs to be interpreted with caution. 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 Home Care 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:   * did not enter residential care or commence Home Care (for example, who died before entering care) * ultimately decided 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 Home Care places; 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 2013‑14 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/rogs/2015. |
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Overall, 19.3 per cent of all people entering residential high care during 2013‑14 did so within seven days of being approved by an ACAT, compared with 22.0 per cent in 2012‑13 (table 13A.42). In 2013‑14, 47.0 per cent entered within one month of their ACAT approval and 69.4 per cent entered within three months of their approval (figure 13.20), compared with 50.0 per cent and 72.0 per cent respectively in 2012‑13 (table 13A.42). The median time for entry into high care residential services was 35 days in 2013‑14 compared to 30 days in 2012‑13 (table 13A.42).

Nationally in 2013‑14, a greater proportion of people entering high care residential services entered within three months of approval (69.4 per cent), compared with the proportion entering low care residential services within that time (62.3 per cent). Further data on elapsed time by remoteness, Socio Economic Indexes for Areas (SEIFA) and Indigenous status are included in table 13A.43–45.

Overall, 59.2 per cent of all people commencing Home Care during 2013‑14 received it within three months of being approved by an ACAT. This proportion varied across jurisdictions. Nationally, 30.7 per cent started receiving Home Care within one month of being approved by an ACAT (figure 13.21). Data to 2012‑13, on ‘elapsed time’ for CACP, EACH and EACH are in table 13A.42.

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| Figure 13.20 People entering high care residential care within specified time periods of their ACAT approval, 2013‑14 |
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| *Source*:DSS (unpublished); table 13A.42. |
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| Figure 13.21 People commencing Home Care within three months of their ACAT approval, 2013‑14 |
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| *Source*:DSS (unpublished); table 13A.42. |
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#### 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 approvals are mandatory for admission to Australian Government subsidised residential care, or for receipt of Home Care (Community Aged Care Packages [CACPs], Extended Aged Care at Home [EACH] packages, and EACH Dementia [EACH‑D] in the 2012‑13 reporting year) or Transition Care.  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 2012‑13 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 2012‑13 was 36.5 per cent and the proportion recommended to remain in the community was 52.4 per cent (figure 13.22). The remaining 11.1 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.

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| Figure 13.22 Recommended long‑term care arrangements of ACAT clients, 2012‑13**a, b, c** |
| |  | | --- | | Figure 13.22 Recommended long-term care arrangements of ACAT clients, 2012-13   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 were extracted from the Ageing and Aged Care Data Warehouse from preliminary data using the snapshot effective date of 31 August 2014. Future extracts of these data may change. |
| *Source*:DSS (unpublished) Ageing and Aged Care Data Warehouse from ACAP Minimum Data Set; table 13A.46. |
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##### 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, living in households, who have 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 caution, 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 have 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.47).

##### 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 Aboriginal and Torres Strait Islander 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 caution, 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 * 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 |
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| Box 13.8 (continued) |
| * 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 from 2011‑12 are not comparable to data for earlier years * complete for the current reporting period (subject to caveats). All required 2012‑13 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 2012‑13 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/rogs/2015. |
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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 Aboriginal and Torres Strait Islander Australians aged 50–64 years whose separation was 35 days or longer was 10.9 per cent nationally in 2012‑13 (figure 13.23). The number of ‘aged care type’ patient separations for people aged 65 years or over and Aboriginal and Torres Strait Islander Australians aged 50–64 years was 12 290, of a total 2.2 million nationally (table 13A.48).

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| Figure 13.23 Proportion of separations for ‘aged care type’ public hospitals patients that were 35 days or longer**a, b, c, d, e, f, g, h** |
| |  | | --- | | Figure 13.23 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 Aboriginal and Torres Strait Islander 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 from 2011‑12 include public patients in private hospitals, these patients were not included in earlier years. |
| *Source*:Australian Institute of Health and Welfare (AIHW) (unpublished); table 13A.48. |
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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 10.4 per 1000 patient days nationally in 2012‑13 (figure 13.24).

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| Figure 13.24 Hospital patient days used by patients waiting for residential aged care**a, b, c, d, e, f** |
| |  | | --- | | Figure 13.24 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.49. |
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##### 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 2014 data are available for all jurisdictions.   Data quality information for this indicator is under development. |
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Nationally, from 2005‑06 to 2013‑14, 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 75.0 per cent to 92.8 per cent (figure 13.25). For 2013‑14, the proportion in major cities (93.1 per cent) was similar to other areas, with the lowest proportion in outer regional areas (91.1 per cent) (table 13A.28).

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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*:Department of Health and Ageing (DoHA) (unpublished). |
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| Figure 13.25 Proportion of residents who changed from low care to high care and remained in the same aged care service**a** |
| |  | | --- | | Figure 13.25 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.28. |
| *Source*:Department of Health and Ageing (DoHA)/DSS (unpublished); table 13A.28. |
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Nationally, 61.2 per cent of low care places in 2013‑14 were occupied by residents with high care needs. The proportion of all operational places taken up by residents with high care needs was 76.8 per cent (figure 13.26).

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| Figure 13.26 Utilisation of operational residential places, 30 June 2014**a** |
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| a Includes residential places categorised as high care or low care. |
| *Source*:DSS (unpublished); table 13A.29. |
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#### 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 that 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.  Australian Government funded residential services are 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 an accreditation agency (currently the Australian Aged Care Quality Agency, which replaced the Aged Care Standards and Accreditation Agency Ltd (ACSAA) on 1 January 2014). A service applies 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 the accreditation agency then considers the report, in conjunction with any submission from the residential service and other relevant information (including information from the Department of Social Services [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.  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 2014 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/rogs/2015. |
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Accreditation decisions and further information relating to the accreditation standards and the Australian Aged Care Quality Agency (Quality Agency) are publicly available (Quality Agency 2014). Further information on the number of residential aged care facilities that had an audit in 2013‑14 and the outcomes of these audits is available in the latest *Report on the Operation of the Aged Care Act 1997* (DSS 2014). The accreditation process is summarised in box 13.11.

As at 30 June 2014, 496 residential aged care services had a re‑accreditation decision in 2013‑14. Of these, 87.9 per cent were granted three years accreditation (table 13.6). Data on re‑accreditation decisions during 2013‑14 by remoteness and size of facility are in tables 13A.51‑52. Of all re‑accredited residential aged care services, 96.7 per cent had an accreditation status of a period of three years, as at 30 June 2014 (table 13.6).

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| Table 13.6 Residential aged care services re‑accredited for three years, 30 June 2014**a, b** |
| |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | NSW | Vic | Qld | WA | SA | Tas | ACT | NT | Aust | | *Services re‑accredited during 2013‑14* | | | | | | | | | | | Total no. | 131 | 139 | 105 | 55 | 45 | 13 | 3 | 5 | 496 | | % 3 year accredited | 90.1 | 89.9 | 81.0 | 92.7 | 86.7 | 100.0 | 100.0 | 40.0 | 87.9 | | *All re‑accredited services* | | | | | | | | |  | | Total no. | 868 | 747 | 441 | 237 | 258 | 77 | 25 | 12 | 2 665 | | % 3 year accredited | 98.2 | 97.5 | 93.4 | 96.6 | 96.5 | 100.0 | 92.0 | 58.3 | 96.7 | |
| a Data as at 30 June 2014 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 2014. |
| *Source*: Australian Aged Care Quality Agency(unpublished); tables 13A.50 and 13A.53. |
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Nationally, as at 30 June 2014, 100.0 per cent of residential aged care services were compliant with building certification, fire safety, and privacy and space requirements (table 13.7).

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| Table 13.7 Residential aged care services compliant with building certification, fire safety and privacy and space requirements, at 30 June 2014 |
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| *Source*: DSS (unpublished) and table 13A.17. |
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##### 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 Aged Care Complaints Scheme (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 from 2012‑13 are not comparable to data for 2011‑12 * complete for the current reporting period (subject to caveats). All required 2013‑14 data are available for all jurisdictions.   Data quality information for this indicator is under development. |
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During 2013‑14, the Scheme received 3903 complaints that were within the scope of the Scheme to handle. The number of complaints per 1000 care recipients was 22.4 nationally in 2013‑14 (figure 13.27). Of the complaints dealt with by the Scheme in 2013‑14, 88.9 per cent related to residential care services, 8.4 per cent related to Home Care services and 1.5 per cent related to HACC services. A further 1.2 per cent of complaints were not linked to a corresponding care type (DSS unpublished).

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| Figure 13.27 Complaints received by the Aged Care Complaints Scheme which are within its scope to handle |
| |  | | --- | | Figure 13.27 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. | |
| *Source*:DoHA/DSS (unpublished); table 13A.54. |
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In 2013‑14, 78.5 per cent of complaints were resolved through early resolution and 21.5per 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, 97.5 per cent were resolved without the need for a direction to the approved provider (figure 13.28).

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| Figure 13.28 Proportion of in‑scope complaints that were resolved without the need for a direction |
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| *Source*:DoHA/DSS (unpublished); table 13A.54. |
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##### 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). Reporting of compliance with service standards for community aged care services for Home Care, NRCP and HACC has changed for this year’s Report to provide more meaningful and greater detail about community aged care service compliance with the service standards than the previous reporting of an overall rating of a service’s processes and systems. Historical data using the new reporting format is included in tables 13A.55‑56 to enable comparison.

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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 reviews of community aged care services that met all expected outcomes under each of the Home Care Common Standards:   * Standard 1 — Effective management — the service provider demonstrates effective management processes based on a continuous improvement approach to service management, planning and delivery. * Standard 2 — Appropriate access and service delivery — each service user (and prospective service user) has access to services and service users receive appropriate services that are planned, delivered and evaluated in partnership with themselves and/or their representatives. * Standard 3 — Service user rights and responsibilities — each service user (and/or their representative) is provided with information to assist them to make service choices and has the right (and responsibility) to be consulted and respected. Service users (and/or their representative) have access to complaints and advocacy information and processes and their privacy and confidentiality and right to independence is respected.   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 Home Care Packages Program and National Respite for Carers Program (NRCP) 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.  A high or increasing proportion of community aged care reviews that met all expected outcomes under each standard of the Home Care Common Standards is 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. 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 2013‑14 data are available for all jurisdictions.   Data quality information for this indicator is under development. |
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Nationally, a total of 545 reviews of community aged care organisations providing Home Care and NRCP services were completed in 2013‑14 (table 13.8). All relevant expected outcomes for Standard 1 — effective management, were achieved in 67.2 per cent of these reviews (table 13.8). All relevant expected outcomes for Standard 2 — Appropriate access and service delivery, were achieved in 74.6 per cent of these reviews (table 13.8). All relevant expected outcomes for Standard 3 — Service user rights and responsibilities, were achieved in 85.5 per cent of these reviews (table 13.8).

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| Table 13.8 Compliance with service standards for community aged care services — Home Care and NRCP, 2013‑14 |
| |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | *NSW* | *Vic* | *Qld* | *WA* | *SA* | *Tas* | *ACT* | *NT* | *Aust* | | *Number of reviews completed* (no.) | | | | | | | | |  | |  | 198 | 94 | 107 | 46 | 63 | 9 | 2 | 26 | 545 | | *Proportion of reviews achieving all relevant expected outcomes for the standard* (%) | | | | | | | | | | | Standard 1**a** | 77.8 | 63.8 | 24.3 | 100.0 | 95.2 | 66.7 | 50.0 | 42.3 | 67.2 | | Standard 2**b** | 76.3 | 84.0 | 42.1 | 100.0 | 96.8 | 77.8 | 100.0 | 53.8 | 74.6 | | Standard 3**c** | 93.4 | 96.8 | 59.8 | 100.0 | 87.3 | 77.8 | 100.0 | 57.7 | 85.5 | |
| a Standard 1 — Effective management. b Standard 2 — Appropriate access and service delivery c Standard 3 — Service user rights and responsibilities. |
| *Source*:DSS (unpublished); table 13A.55. |
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Nationally, a total of 621 reviews of HACC services were completed in 2013‑14 (table 13.9). All relevant expected outcomes for Standard 1 — effective management, were achieved in 44.2 per cent of these reviews (table 13.9). All relevant expected outcomes for Standard 2 — Appropriate access and service delivery, were achieved in 58.7 per cent of these reviews (table 13.9). All relevant expected outcomes for Standard 3 — Service user rights and responsibilities, were achieved in 65.3 per cent of these reviews (table 13.9).

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| Table 13.9 Compliance with service standards for HACC, 2013‑14 |
| |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | *NSW* | *Vic* | *Qld* | *WA* | *SA* | *Tas* | *ACT* | *NT* | *Aust* | | *Number of reviews completed* (no.) | | | | | | | | |  | |  | 104 | 204 | 154 | 37 | 100 | 14 | 1 | 7 | 621 | | *Proportion of reviews achieving all relevant expected outcomes for the standard* (%) | | | | | | | | | | | Standard 1**a** | 45.2 | 22.0 | 60.4 | 59.0 | 53.0 | 71.4 | 100.0 | 57.1 | 44.2 | | Standard 2**b** | 57.7 | 28.0 | 81.8 | 74.0 | 78.0 | 85.7 | 100.0 | 42.9 | 58.7 | | Standard 3**c** | 89.4 | 31.0 | 85.7 | 74.0 | 73.0 | 85.7 | 100.0 | 57.1 | 65.3 | |
| a Standard 1 — Effective management. b Standard 2 — Appropriate access and service delivery. c Standard 3 — Service user rights and responsibilities. |
| *Source*:DSS (unpublished); Victorian and WA governments (unpublished); tables 13A.56. |
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##### 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 2015 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 Aged Care Assessment Program (ACAP) divided by the number of assessments completed * expenditure per hour of service for HACC — Australian, Victorian and WA governments expenditure on services (some of the expenditure in Victoria and WA 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 caution. 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 Australian, 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 2012‑13 data are available for all jurisdictions. |
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| Box 13.15 (continued) |
| 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 2012‑13 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 2012‑13 averaged $560 nationally (figure 13.29).

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| Figure 13.29 Australian Government expenditure on aged care assessments, per assessment (2012‑13 dollars)**a, b, c, d, e** |
| |  | | --- | | Figure 13.29 Australian Government expenditure on aged care assessments, per assessment (2012-13 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 were extracted from the Ageing and Aged Care Data Warehouse from preliminary data using the snapshot effective date of 31 August 2014. Future extracts of these data may change. d Time series financial data are adjusted to 2013‑14 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2013‑14 = 100) (table 2A.51). See chapter 2 (sections 2.5‑6) 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.57. |
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Australian, Victorian and WA governments’ expenditure per hour of HACC service during 2012‑13 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 13.30).

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| Figure 13.30 State and Territory governments’ expenditure per hour of HACC service, by service type, 2012‑13**a, b** |
| |  | | --- | | Figure 13.30 State and Territory governments’ expenditure per hour of HACC service, by service type, 2012-13  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 the NT for allied health and nursing. |
| *Source*:DSS (unpublished); table 13A.58. |
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##### 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 Aboriginal and Torres Strait Islander Australians aged 50–64 years. Expenditure per person in the aged care target population is reported for residential care, Home Care and multi‑purpose and Aboriginal and Torres Strait Islander specific services combined and reported separately for the three main service types: residential care services, Home Care and HACC.  This is a proxy indicator of efficiency and needs to be interpreted with caution 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 person can reflect improving efficiency or a decrease in service standards. |
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| Box 13.16 (continued) |
| Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions for all services, but a break in series means that data from 2012‑13 are not comparable to data for earlier years * complete for the current reporting period (subject to caveats). All required 2013‑14 data are available for all jurisdictions.   Data quality information for this indicator is under development. |
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Governments’ expenditure on residential care, Home Care and on Multi‑Purpose and Aboriginal and Torres Strait Islander specific services combined per person aged 65 years or over and Aboriginal and Torres Strait Islander Australians aged 50–64 years was $3233 nationally in 2013‑14 (figure 13.31).

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| Figure 13.31 Governments’ expenditure on selected programs, per person in the aged care target population, 2013‑14**a** |
| |  | | --- | | Figure 13.31 Governments’ expenditure on selected programs, per person in the aged care target population, 2013-14  More details can be found within the text surrounding this image. | |
| a Results include State and Territory governments expenditure on residential aged care services and funding of younger people with disability (people aged under 65 years and Aboriginal and Torres Strait Islander Australians aged under 50 years) in residential and home care. The majority of expenditure included is from the Australian Government (DSS and DVA). |
| *Source*:DSS (unpublished); tables 13A.7−9. |
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Nationally, governments’ expenditure on residential care services per person aged 65 years or over and Aboriginal and Torres Strait Islander Australians aged 50–64 years was $2828 in 2013‑14 (figure 13.32).

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| Figure 13.32 Governments’ real expenditure on residential services per person in the aged care target population (2013‑14 dollars)**a, b, c** |
| |  | | --- | | Figure 13.32  Governments’ real expenditure on residential services per person in the aged care target population (2013-14 dollars)  More details can be found within the text surounding this image. | |
| a Includes a payroll tax supplement provided by the Australian Government. Actual payroll tax paid may differ. b Results include State and Territory governments’ expenditure and funding for younger people with disability (people aged 64 years or under and Aboriginal and Torres Strait Islander aged 49 years or under) in residential aged care (see tables 13A.4 and 13A.7 for details). c Time series financial data are adjusted to 2013‑14 dollars using the GFCE chain price deflator (2013‑14 = 100) (table 2A.51). See chapter 2 (sections 2.5‑6) for details. |
| *Source*:DoHA/DSS (unpublished); DVA (unpublished); table 13A.59. |
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Australian Government expenditure on Home Care per person aged 65 years or over and Aboriginal and Torres Strait Islander Australians aged 50–64 years was $360 in 2013‑14 (figure 13.33).

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| Figure 13.33 Australian Government expenditure on Home Care per person in the aged care target population, 2013‑14**a** |
| |  | | --- | | Figure 13.33 Australian Government expenditure on Home Care per person in the aged care target population, 2013-14  More details can be found within the text surrounding this image. | |
| a Results include State and Territory governments’ funding for younger people with disability (people aged under 65 years and Aboriginal and Torres Strait Islander aged under 50 years) receiving Home Care (see tables 13A.4 and 13A.8 for details). |
| *Source*:DSS (unpublished); table 13A.62. |
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Nationally, in 2013‑14, Australian, Victorian and WA governments’ expenditure on HACC services was $523 per person aged 65 years or over and Aboriginal and Torres Strait Islander Australians aged 50–64 years (figure 13.34). 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.60.

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| Figure 13.34 Australian, Victorian and WA governments’ real expenditure on HACC services per person in the aged care target population (2013‑14 dollars)**a, b, c, d** |
| |  | | --- | | Figure 13.34 Australian, Victorian and WA governments’ real expenditure on HACC services per person in the aged care target population (2013-14 dollars)  More details can be found within the text surrounding this image. | |
| a For Victoria and WA, these data represent expenditure under the HACC Review agreements. HACC total program expenditure is adjusted (reduced) to take into account the proportion of people who are older (around 75 per cent in Victoria and 80 per cent in WA) and will not match data reported in table 13A.8. b Expenditure per person in the older HACC target population (people aged 65 years or over and Aboriginal and Torres Strait Islander Australians aged 50–64 years) is in table 13A.60. c Reports provisional HACC data that have not been validated and may be subject to revision. d Time series financial data are adjusted to 2013‑14 dollars using the GGFCE chain price deflator (2013‑14 = 100) (table 2A.51). See chapter 2 (sections 2.5‑6) for details. |
| *Source*:DSS (unpublished); table 13A.61. |
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### 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’ is 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 defined by three measures, the estimated proportions of older people (aged 65 years or over) who:   * participated in social or community activities away from home in the last three months * had face‑to‑face contact with family or friends not living in the same household in the last week, month or three months * did not leave home or did not leave home as often as they would like.   These measures are reported by disability status (profound or severe, other disability, all disability, without disability) and for all older people. Disability status is used as a ‘proxy’ to identify those older people who might need more assistance to support their social participation in the community.  High or increasing proportions of social participation in the community are desirable, as it indicates higher levels of wellbeing and independence.  Data reported for this measure are:   * comparable (subject to caveats) across jurisdictions * complete (subject to caveats) for the current reporting period. All required 2012 data are available for all jurisdictions.   Data quality information for this indicator is under development. |
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Nationally in 2012, the estimated proportion of people aged 65 years or over who participated in any social or community activities away from home in the last three months was 93.2 ± 0.6 per cent (table 13A.63). Participation in these activities was 82.7 ± 1.8 per cent for people with profound or severe disability, 94.5 ± 0.3 per cent for other people with disability and 95.6 ± 0.5 per cent for those without disability (figure 13.35).

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| Figure 13.35 Participation of people aged 65 years or over in any social or community activities away from home in the last three months, by disability status, 2012**a, b, c** |
| |  | | --- | | Figure 13.35 Participation of people aged 65 years or over in any social or community activities away from home in the last three months, by disability status, 2012  More details can be found within the text surrounding this image. | |
| a Data used to derive this figure have been randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals (table 13A.63). b The rates reported in this figure include 95 per cent confidence intervals. c Data for the NT should be used with caution as very remote areas were excluded from the Survey of Disability, Ageing and Carers. This translates to exclusion of around 23 per cent of the NT population. |
| *Source*: ABS (unpublished) *Survey of Disability, Ageing and Carers 2012;* table 13A.63. |
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Nationally in 2012, the estimated proportion of people aged 65 years or over who had   
face‑to‑face contact with family or friends not living in the same household at least once in the last week was 78.1 ± 1.0 per cent (table 13A.64). Older people without disability were more likely than those with profound or severe disability to have face‑to‑face contact with family or friends not living in the same household in the last week (78.9 ± 1.3 per cent compared to 74.8 ± 1.4 per cent) (figure 13.36). Data on face‑to‑face contact with family or friends not living in the same household, in the last month and last three months are in table 13A.64.

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| Figure 13.36 People aged 65 years or over who had face‑to‑face contact with family or friends not living in the same household in the last week, by disability status, 2012**a, b, c, d** |
| |  | | --- | | **Figure 13.36 People aged 65 years or over who had face-to-face contact with family or friends not living in the same household in the last week, by disability status, 2012  More details can be found within the text surrounding this image.** | |
| a Data used to derive this figure have been randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals (table 13A.64). b The rates reported in this figure include 95 per cent confidence intervals. c At least once in the last week includes people who had face‑to‑face contact with family or friends not living in the same household every day or at least once in the last week. d Data for the NT should be used with caution as very remote areas were excluded from the Survey of Disability, Ageing and Carers. This translates to exclusion of around 23 per cent of the NT population. |
| *Source*: ABS (unpublished) *Survey of Disability, Ageing and Carers 2012;* table 13A.64. |
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Nationally in 2012, the estimated proportion of people aged 65 years or over who did not leave home or did not leave home as frequently as they would like was 16.2 ± 0.8 per cent (figure 13.37). A higher proportion of older people with profound or severe disability   
(46.8 ± 2.5 per cent) did not leave home or did not leave as often as they would like, than for other older people especially those without disability (6.4 ± 0.7 per cent). Nationally, the two main reasons older people did not leave home as frequently as they would like was their own disability/condition or they could not be bothered/nowhere to go(table 13A.65).

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| Figure 13.37 People aged 65 years or over who did not leave home or did not leave home as often as they would like, by disability status, 2012**a, b, c, d** |
| |  | | --- | | Figure 13.37 People aged 65 years or over who did not leave home or did not leave home as often as they would like, by disability status, 2012  More details can be found within the text surrounding this image. | |
| a Data used to derive this figure have been randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals (table 13A.65). b The rates reported in this figure include 95 per cent confidence intervals. c Data for people with ‘other disability’ in the NT and for older people without disability in the ACT and the NT have a RSE of between 25 per cent and 50 per cent. d Data for the NT should be used with caution as very remote areas were excluded from the Survey of Disability, Ageing and Carers. This translates to exclusion of around 23 per cent of the NT population. |
| *Source*: ABS (unpublished) *Survey of Disability, Ageing and Carers 2012*; table 13A.65. |
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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 Transition Care Program (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 caution. The TCP operates with some differences across jurisdictions including differences in health and aged care service systems, local operating procedures and client groups. Variation in the average MBI scores on entry and exit from the program may reflect 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 2013‑14 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/rogs/2015. |
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The average Modified Barthel Index (MBI) score on entry to the TCP in 2013‑14 was 72 nationally. The average MBI score on exit from the TCP was 82 nationally (figure 13.38). This was an average increase in the score of 10 nationally.

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| Figure 13.38 Transition Care Program — average MBI score on entry and exit, 2013‑14**a, b** |
| |  | | --- | | Figure 13.38 Transition Care Program — average MBI score on entry and exit, 2013-14  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 TCP across jurisdictions. |
| *Source*:DSS (unpublished); table 13A.66. |
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#### 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 equity and 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, including possible improvements to the current reporting on the TCP.

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 reform implemented since 1 July 2014 that will have a significant effect on reporting in the next version of this Report is the removal of the distinction between high care and low care in permanent residential aged care (table 13.21). A number of other reforms implemented since 1 July 2014 are also 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 *Caring for Older Australians Report*. 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 from 1 July 2014 include the following:   * Two fee estimators were made available for consumers, families and carers to estimate fees payable for entering residential or home care. * Income testing for home care fees commenced including reduction in subsidies. * Providers commenced publishing residential care accommodation prices on the My Aged Care website. * A means test replaced separate income tests for residential aged care fees and assets test for accommodation payments. * Refundable Accommodation Deposits (RADs) and Daily Accommodation Payments (DAPs) replaced accommodation bonds and accommodation charges for new residential aged care recipients. * Restrictions on accommodation pricing in high care residential settings were removed. |
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| Box 13.21 (continued) |
| * There was an increase in the accommodation supplement paid to new or significantly refurbished residential care facilities. The maximum level of the accommodation supplement in residential care facilities was increased from $32.58 to $52.84 per day to certified providers who meet the ‘significant refurbishment’ criteria. * The Schedule of Specified Care and Services for residential care services was reviewed and modernised. * ACAT approvals for residential aged care are now indefinitely valid, unless approval is for a specific period. * The distinction between high care and low care in permanent residential aged care was removed, all permanent residential aged care is now provided on an ‘ageing in place’ basis. * The Aged Care Pricing Commissioner commenced approving costs for extra services and accommodation prices greater than $550 000. |
| *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 |  |
| In an effort to ensure that we get the best outcomes for older Australians, now and into the future, a number of changes were implemented on 1 July 2013 and 1 July 2014.  These changes lay the groundwork for longer term changes that will be needed to meet increasing demands on our aged care system.  In 2013‑14, the recurrent expenditure on aged care was $14.8 billion and included aged care support and assistance provided under and outside the *Aged Care Act 1997*.  Reporting on aged care services in 2013‑14 was revised to reflect changes for community and flexible aged care, with continued improvements being made to the coverage and quality of the data.  The provision of Government funded aged care services for older people include information and assessment, residential care, community care, respite and services that are delivered in mixed settings, such as flexible care and specific support services.  The demand for aged care services will continue to be driven by the size and health of the older population.  The Government is continuing to introduce further changes to the aged care system, including the way that care is provided to older people in their homes and community. Home care packages will be delivered on a consumer directed care basis — giving consumers more choice, control and flexibility in the way their care and support is provided.  The functionality of My Aged Care will be increased, providing a simple and effective entry point into the aged care system, while also providing increased transparency and information on aged care services.  The Commonwealth HACC Programme, the Day Therapy Centres Programme, the National Respite for Carers Programme and the Assistance with Care and Housing for the Aged programme will be rolled into one programme — the Commonwealth Home Support Programme. This will provide basic maintenance, care, support and respite services for older people living in the community and their carers.  The changes to aged care are also aimed at reducing the red tape burden on aged care providers to increase business flexibility and allow them to focus on meeting the needs of their consumers.  The Government will continue to work with the aged care sector to deliver quality, affordable and accessible aged care and carer support services for older people. | **”** |

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| **“** | New South Wales Government comments |  |
| The NSW Government’s first report on progress with implementation of its 2012 Ageing Strategy covers activities undertaken by government and non‑government agencies during 2013‑14. A key action is to prevent and address abuse against older people. The Elder Abuse Helpline and Resource Unit started operating in March 2013. The revised interagency policy on *Preventing and responding to the abuse of older people* is being implemented across NSW.  Keeping people healthy and out of hospital is a priority for NSW Health under the Ageing Strategy. Initiatives include the NSW Aboriginal Health Plan  2013–2023, developed in partnership with the Aboriginal Health and Medical Research Council, identifies six key strategic directions to close the gap in Aboriginal health outcomes including specific actions designed to achieve the goal of keeping Aboriginal people healthy and out of hospital.  The NSW Minister for Health launched its Advance Planning for Quality Care at End of Life: Action Plan 2013–2018 in July 2013. Projects include developing a standardised Resuscitation Plan for NSW; developing an End of Life Model of Care; piloting 'AMBER Care Bundles' as a means of better identifying those in the last months of life; releasing state standards for death auditing including assessing for prior advance care planning; and finalising release of a resource for health professionals on end of life decisions and the law in NSW.  The NSW Healthy Eating and Active Living Strategy 2013–2018 provides a whole of government framework to promote and support healthy eating and active living in NSW and to reduce the impact of lifestyle‑related chronic disease.  A key direction of the NSW State Health Plan launched in June 2014 is to deliver truly integrated care. Consistent with the NSW Health Integrated Care Strategy, it sets a new direction for the health system and for transforming the way services are provided for patients. The NSW Government will be investing $120 million over four years in new and innovative models of integrated care.  NSW Health will continue to manage the Aged Care Assessment Program in NSW through to 30 June 2016 after which responsibility for delivery of ACAT services moves under the Commonwealth’s My Aged Care gateway. It also continues to operate the 1378 Transition Care places allocated to NSW. At June 2014, 44 Transition Care services provided 138 (10 per cent) residential places, 1205 (87.5 per cent) community places and 35 (2.5 per cent) ‘mixed setting’ places.  The Agency for Clinical Innovation (ACI), one of the NSW Health pillars, is developing a Framework for integrating the care of older people with complex health needs. Another ACI project is CHOPS (Care of Confused Hospitalised Older Persons) in recognition that confusion or cognitive impairment is a common condition for older people in hospital. The ACI has developed *Key Principles for Care of Confused Hospitalised Older Persons* to assist hospitals identify key components of best practice management of confusion in the older person that will support optimal patient care across NSW. | **”** |

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| **“** | Victorian Government comments |  |
| A number of important change initiatives were underway in Victoria in 2013‑14, that will contribute to shaping Victoria’s role in ageing and aged care for the future.  Victoria and the Commonwealth have been negotiating a complex range of issues associated with implementing changed roles and responsibilities in Home and Community Care (HACC). They include base funding for agencies following transition and the means for retaining the benefits of the Victorian HACC system.  Some important features of Victoria’s HACC system are being built into the new Commonwealth Home Support Program and the Aged Care Gateway or single point of access to services. The acceptance by the Commonwealth Government of a wellness promoting model of service delivery as a key policy focus and the importance of face to face assessment when a person makes initial contact with the Aged Care Gateway is welcomed.  Victoria and the Commonwealth have also jointly engaged with service providers and other stakeholders across the State.  In September 2013, Mr Gerard Mansour was appointed as the first Commissioner for Senior Victorians and Chair of the newly appointed Ministerial Advisory Committee of Senior Victorians (MACSV).  The terms of reference of the MACSV include the development of a whole of government older persons action plan, provision of advice to the Minister and departments across Government, and consideration of opportunities for improving the perceptions of older people in society and opportunities for intergenerational collaboration.  The prime focus of the work of the MACSV in this period has been the development of *Seniors Count! — The Victorian Seniors Participation Action Plan*, which was finalised by the MACSV in June. | **”** |
|  | Queensland Government comments |  |
| **“** | The Queensland Government is committed to delivering its primary role of providing a quality health system for all Queenslanders by delivering public hospital and health services such as elective surgery and emergency department services. In recognition of its primary role, the Queensland Government is continuing 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 2013‑14, Queensland Hospital and Health Services (HHSs) continued to examine their role in providing residential aged care services to determine whether these could be more appropriately delivered by non‑government providers. In addition, HHSs have continued to assess 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, whist strengthening the capacity of the non‑government sector.  The Queensland Government will continue to be a provider of residential aged care services and 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.  HHSs have continued to work 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, similar to 2012‑13, has contributed to the continued downward trend in the number of longer stay older patients remaining in public hospitals who are in need of aged care services. In addition, the Government has continued to support a range of clinical networks such as the Queensland Clinical Senate, the Statewide Dementia Clinical Network and the Statewide Older People’s Clinical Network to drive service improvements in the care of older people.  Queensland provided 733 transition care places across the state assisting more than 3000 older people in 2013‑14 to regain or maximise their level of independence following discharge from hospital. | **”** |
| **“** | Western Australian Government comments |  |
| During the past 12 months the Western Australian (WA) Aged Care Advisory Council has supported two key dementia initiatives for the health and community care sectors in WA. The overarching aim is to achieve better outcomes and quality of life for people with dementia and their carers through improved service delivery.  The establishment of the Dementia Partnership Project in conjunction with Alzheimer’s Australia WA in January 2014 represents a significant investment in the community care sector and its capacity to provide high quality support to people living with dementia in the community. Utilising a train the trainer, change management model the Dementia Partnership Project has already provided mentoring for community care providers, opportunities for professional development and established a network of 13 Dementia Champions across 10 community care service providers.  In respect of acute hospitals, work commenced on the objective of improving hospital performance when screening, assessing and supporting patients with cognitive impairment. A key output is development of a framework for improvement that can be applied by hospitals. These projects are founded on recommendations from the WA models of care for dementia and delirium and the work aligns with the national Framework for Action on Dementia.  State‑wide implementation of the WA Assessment Framework was achieved during the past twelve months with the outcome being improved pathways, communication and information sharing arrangements, and all relevant client information being available on the web‑based client management system. The colocation and shared in‑take process of country Regional Assessment Services with the Aged Care Assessment Teams has led to significantly improved coordination of care and reduced duplication of assessment.  Reablement interventions are also being utilised by a number of Regional Assessment Services with results independently evaluated as part of the ‘Measuring the impact of community care’ research commissioned by the WA Home and Community Care Program. Findings of this research continue to inform assessment and service delivery practice in WA and will be shared with the Commonwealth to inform the development and implementation of the Home Support Program.  The Department of Health has completed a Tender process for the provision of 331 Transition Care places to ensure the continued access in the metropolitan and rural areas. In accordance with National *Transition Care Program Guidelines* Quality Improvement Framework, WA completed the community based Transition Care services quality audits in April 2013 and has commenced the 2nd residential audit cycle. | **”** |
| **“** | South Australian Government comments |  |
| In 2013‑14, SA has implemented a wide range of initiatives as part of its vision for an all ages friendly state outlined in the *Prosperity Through Longevity: South Australia’s Ageing Plan Action 2014–2021* released in February 2014.  In June 2014 the SA Government released its *Strategy to Safeguard the Rights of Older South Australians 2014–2021*, which focuses on preventing the abuse of older people carried out by someone the older person knows and trusts. It raises awareness of physical, psychological, social, sexual, chemical and financial abuse, accidental or deliberate that can occur particularly during times of increased vulnerability and provides direction for preventing and responding to elder abuse issues. To activate the strategy, SA is undertaking development of a state government action plan for initiatives to enable a range of responses to key strategic areas to be implemented under the action plan over a seven year time frame. This will be released in 2014‑15.  On 27 November 2013 the Parliamentary Select Committee on the Review of the *Retirement Villages Act 1987* tabled its report and recommendations. The state government response has comprised of three elements: the establishment of a retirement Village Residents’ Advocacy Service, Better Practice Guidelines and proposed legislative amendments seeking to achieve a balance between the interests of residents and operators.  The *Advanced Care Directives Act 2013* will commence legal operation on 1 July 2014. The new rights based legislation enables adults to put in place clear legal arrangements for their future health care, residential, accommodation and personal matters and/or appointed trusted people to make such decisions in the event of future incapacity, whether temporary or permanent. A user friendly toolkit has been prepared and will be promoted widely to support this important safeguard for South Australians.  SA provided restorative care services to older people across the state through its 347 Transition Care Program places and provided health and aged care services to people living in rural and remote areas across the state through 14 Multi‑purpose Health Services. | **”** |
| **“** | Tasmanian Government comments |  |
| * Tasmania’s population is ageing more rapidly than any other Australian jurisdiction. Tasmania has the highest proportion of the population who are over 65 years of age (17.7 per cent) and it is anticipated that future demand for aged care services will increase at a significantly faster rate than the rate of availability. Tasmania is also likely to have more people per capita with dementia than any other state or territory. * 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 as older people use a broad range of Tasmanian Government health and human services, including public hospital services. * It is likely that there will continue to be a complex relationship 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. * From 2006 until 2014, the Australian Government funded Long Stay Older Patients (LSOP) initiatives underpinned effective programs in Tasmania for diverting older people away from, or reducing their necessary stay in, hospital care. Tasmania’s public 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 funding provided through the *National Partnership Agreement (on Financial Assistance for LSOP ― 2011‑12 to 2013‑14*), enabled Tasmania to support older patients in public hospitals who no longer required acute or subacute care but were waiting for residential aged care. Most State and Territory governments’ reported that this Australian Government funding enabled the implementation of valuable interventions to mitigate the problem of longer stay older patients. * The Tasmanian Government is concerned that, with the expiry of the current funding arrangement in June 2014, the successful programs now in place are at risk and that the numbers of older people remaining for excessive periods in hospital will again increase due to the sufficient unavailability of safe and appropriate aged care services. * Despite an increase in demand, total expenditure on aged care services in Tasmania decreased by 4.8 per cent in 2013‑14 compared to the previous year (partly as a result of the winding down of the LSOP program) and this decrease is likely to be greater in 2014‑15 with the discontinuation of the program and a decrease in related Australian Government funding. | **”** |
| **“** | Australian Capital Territory Government comments |  |
| * In September 2014, the ACT signed the new *Agreement for the Payment of Flexible Care Subsidy for Transition Care* and the associated *Transition Care Programme Guidelines 2014*. The ACT was an active member of the Transition Care Working Group (TCWG) and provided feedback on both the draft Agreement and Programme Guidelines leading to the final documents. * In line with the new 2014–16 ACT Aged Care Assessment Program Agreement was signed in August 2014, the ACT continued to contribute to the Commonwealth’s Government’s aged care reforms through the development of a national screening and assessment form and training requirements for the screening and assessment workforce as part of the My Aged Care initiative. * Following the launch of the ACT Palliative Care Services Plan 2013‑17 in October 2013, the ACT Palliative Care Clinical Network (the Network) has been formed. Meeting monthly, the Network is currently finalising its Action Plan for the implementation of measures including strategies to support people to die at home, and models of care that work to minimise unwanted interventions at end‑of‑life, especially for Residential Aged Care Facility residents, such as exploration of extended scope of practice for ACT Ambulance Services. * Launched in May 2013, the ACT Chronic Conditions Strategy 2013‑18 sets the direction for the care and support of those living with chronic conditions in the ACT. Sizable projects during the reporting period have included the development of ACT localised integrated HealthPathways of care (a jointly funded project by ACT Health and ACT Medicare Local (ACTML) to progress chronic disease management and coordination); and the promotion of Advance Care Plans (ACP). Promotion included a joint project undertaken with ACTML to provide education and support to local GPs, Residential Aged Care Facilities and the local community. In March 2014 a promotional campaign "Be My Voice" was conducted to increase uptake of ACP generally. | **”** |
| **“** | Northern Territory Government comments |  |
| * The Australian Government Department of Social Services continues to provide Aged Care Funding for Dementia Nurse Services, Specialist Community Care Nurses and HACC Equipment program for HACC clients in the Northern Territory. (Eligibility: 65 years and over; and 50 years and over for Aboriginal and Torres Strait Islander persons) * The Equipment program has continued to grow since its establishment in July 2012, providing assessments and equipment for HACC eligible aged clients across the NT. The delivery of this program is currently contracted to the NT Department of Health until 30 June 2015. * The NT continues to provide comprehensive aged care assessments as per the Aged Care Assessment Program agreement. In the period from 1 July 2013 to 30 June 2014 the NT Aged Care Assessment Teams (ACAT) received 1163 referrals. A total of 988 referrals resulted in delegated assessments and approvals. The delivery of this program is currently under contract to the NT Department of Health until 30 June 2016. * Throughout the last year the ACAT teams have continued to successfully utilise the electronic Aged Care Evaluation software throughout the NT, which enables the electronic transfer of ACAT assessments direct to Medicare * During 2013‑14, the NT Transition Care Program provided services to frail aged persons throughout the NT. The goal oriented, time‑limited and therapy focussed care is for older persons following a hospital stay. There are 29 allocated places under the Transition Care Program in the NT. These packages are provided throughout the Territory and are managed and co‑ordinated by the NT Department of Health. * The NT Psychogeriatric Service gained approval for ongoing funding for two positions in each of the Health Services. The program continues to provide intervention, assessment and case management to elderly people with mental health disorders, cognitive impairment and ageing issues. * Memory Clinics continue to be delivered collaboratively by the Community Geriatrician and the Dementia Nurse Services. These are delivered in Darwin, Palmerston, Alice Springs, Katherine and have included several remote locations. The number of people referred for cognitive assessment, diagnosis and management continues to escalate and it is expected specialist staff increases will be required to meet this increasing demand. | **”** |

## 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 (Aboriginal and Torres Strait Islander and non‑Indigenous) aged 65 years or over and Aboriginal and Torres Strait Islander Australians aged  50–64 years. This is the population 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. |
| **Commonwealth Home and Community Care Program** | Services to support frail older people and their carers, who live in the community and whose capacity for independent living is at risk, or who are at risk of premature inappropriate admission to long‑term residential care. Older people are people aged 65 years and over and Aboriginal and Torres Strait Islander people aged 50 years and over. |
| **Comparability** | Data are considered comparable if (subject to caveats) they can be used to inform an assessment of comparative performance. Typically, data are considered comparable when they are collected in the same way and in accordance with the same definitions. For comparable indicators or measures, significant differences in reported results allow an assessment of differences in performance, rather than being the result of anomalies in the data. |
| **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. |
| **Completeness** | Data are considered complete if all required data are available for all jurisdictions that provide the service. |
| **Dementia services program** | Includes flexible and innovative support, respite, counselling, information and referral services, education and leisure. The program includes meeting individual and immediate needs which cannot be met by other services, through carer respite services and other carer support agencies. Inpatient services are excluded. |
| **Disability** | A limitation, restriction or impairment that has lasted, or is likely to last, for at least six months and restricts everyday activities. |
| **EBA supplement** | Payments made to supplement services for the extra costs associated with public sector enterprise bargaining agreements over and above those required by other wage Awards. |
| **Elapsed time** | 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. |
| **HACC target population** | The HACC target population is people in the Australian community who, without basic maintenance and support services provided under the scope of the HACC Program, would be at risk of premature or inappropriate long term residential care, including older and frail people with moderate, severe or profound disabilities. The HACC target population is estimated by applying the proportion of all people with moderate, severe or profound disability in households, by sex and five year age groups, from the ABS *Survey of Disability, Ageing and Carers* (SDAC) to population projections for the total population in each jurisdiction. To calculate the Aboriginal and Torres Strait Islander 50–64 year component of the HACC target population for older people, the proportion of all people aged 50–64 years in households with moderate, severe or profound disability was multiplied by an additional Indigenous factor of 1.9 (from ABS unpublished analysis) and then applied to DSS Aboriginal and Torres Strait Islander population projections in the 50‒64 years age groups in each jurisdiction. The HACC target population for June 2014 is based on SDAC 2012 while HACC target populations for previous years are based on SDAC 2009. See table 13A.2 for details about the total population projections and the Aboriginal and Torres Strait Islander population used in these calculations. |
| **High/low care recipient** | On entry, a resident is classified as high or low care based on their approval 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 disability** | A person with a profound disability is unable to do, or always needs help with, a core activity task.  A person with a severe disability:   * sometimes needs help with a core activity task, and/or * has difficulty understanding or being understood by family or friends, or * can communicate more easily using sign language or other non‑spoken forms of communication.   A person with a moderate disability needs no help, but has difficulty with a core activity task. |
| **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 health services and treatment under the *Veterans’ Entitlements Act 1986* (VEA), *Safety, Rehabilitation and Compensation Act 1988* (SRCA) or the *Military Rehabilitation and Compensation Act 2004* (MRCA). |

## 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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## 13.8 References

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1. 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-1)
2. 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). [↑](#footnote-ref-2)