Australian Government
Australian Institute of Health and Welfare

Aged care packages

in the community 2010–11:

A statistical overview

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September 2012

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Abbreviations

ABS	Australian Bureau of Statistics
ACAR	Aged Care Approvals Round
ACAT	Aged Care Assessment Team
AIHW	Australian Institute of Health and Welfare
ARIA	Accessibility/Remoteness Index of Australia
ASGC	Australian Standard Geographical Classification
CACP	Community Aged Care Package
CDs	Census Collection Districts
CDC	Consumer Directed Care
COAG	The Council of Australian Governments
DoHA	Department of Health and Ageing
DVA	Department of Veterans Affairs
EACH	Extended Aged Care at Home
EACHD	Extended Aged Care at Home Dementia
HACC	Home and Community Care
MPS	Multi-Purpose Service(s)
PIAC	Pathways in Aged Care
ROACA	Report on the Operations of the Aged Care Act
RoGs	Report on Government Services

Symbols

..	Not applicable
—	Zero or rounded to zero
<	Less than
+	Plus

Summary

This report presents statistics from July 2010–June 2011 about three types of community aged care programs: Community Aged Care Packages (CACP) and Extended Aged Care at Home (EACH) and Extended Aged Care at Home Dementia (EACHD). CACPs are considered to be low-care packages, and the others high-care. Together with its companion report *Residential aged care in Australia 2010–11: a statistical overview,* this report provides an overview of Australian Government-funded aged care.

More high-care packages

The overall number of operational packages at 30 June 2011 was 57,922, an increase of 13% on the number at 30 June 2010. The corresponding increases in the programs were CACP (6%), EACH (46%) and EACHD (55%). There were a total of 8,150 EACH packages and 3,995 EACHD packages.

More women than men receive packages and men start and leave packaged care earlier

Women make up a greater proportion of clients than men (70% for CACP, 63% for EACH and 61% for EACHD). For low-care packages, 16% of women were aged under 75, compared with 23% of men, whereas 44% of female and 38% of male clients were aged 85 or over. This pattern was also evident for high-care clients.

Clients on high-care packages are likely to have carers who live with them

High-care package clients were likely to have carers: 65% of EACH clients had co-resident carers and a further 28% had non-resident carers. Correspondingly, 73% of EACHD clients had co-resident carers, and 19% had non-resident carers. About 54% of CACP clients lived alone, consistent with their lower needs for care.

The care needs of high-care recipients changed more quickly than those of low-care clients

About 62% of EACH and 66% of EACHD clients were on packages for less than two years whereas only 48% of CACP clients remained on packages for the same length of time. Most women left packages due to changing care needs or circumstances or to enter residential care, while most men left due to death.

Providers mainly not-for-profit

The majority of approved providers were from the not-for-profit sector. Proportions of not-for-profit services varied between states and territories from 72% to 93%, with the Australian average being 77% for CACP. In high-care, 86% of EACH and 89% of EACHD services were supported by-not-for-profit providers.

Different patterns of use by Aboriginal and Torres Strait Islander people

People who identify as Aboriginal and Torres Strait Islanders tend to use community aged care services at a higher rate and at younger ages than non-Indigenous people. For example, Indigenous clients aged 60–64 used CACPs at a rate of 18.2 per 1,000 persons, compared with 0.5 per 1,000 for non-Indigenous clients. In addition, 37% of Indigenous CACP clients were under 65, compared with 2% of non-Indigenous clients indicating higher health and care needs at younger ages and the availability of packages to meet this need.

Chapter 1

Introduction

1 Introduction

1.1 Aged care in Australia

The population of Australia is growing older with around 1 in every 7 aged 65 or over (AIHW 2011b). In the last 25 years, and as a proportion of the population, those aged over 65 have increased from 10.5% to 14% and those aged 85 and over from 0.8% to 1.9% (DoHA 2012). The Australian Bureau of Statistics has projected that by 2015, the proportion of the Australian population aged 65 and over is likely to increase from 13.5% to 15.3% (ABS 2011a). Ageing of the population presents several challenges for governments and the community including a demand for formal care services that assist older people (Borowski & McDonald 2007). The Australian Government is committed to encouraging a positive approach to healthy and active ageing. At the same time, however, it aims to ensure that frail older people have timely access to 'high quality, accessible and affordable care through a safe and secure aged care system' (DoHA 2011b). The Australian Government also recognises that most older people prefer to live independently at home for as long as possible. Community aged care programs are designed to assist in achieving that aim so that older people can remain at home with appropriate support consistent with their preferences (DoHA 2011b, 2012).

There are many community aged care programs and this report, *Aged care packages in the community 2010–11: a statistical overview* provides information on three, namely Community Aged Care Packages (CACP), Extended Aged Care at Home (EACH), and Extended Aged Care at Home Dementia (EACHD). These three programs complement each other so information about them tends to be grouped together throughout the report, rather than being presented separately.

Ageing affects all aspects of life and as people grow older they may find that their care needs can no longer be met in a community setting, even with the support of community aged care programs. In these circumstances, residential aged care may need to be considered. The companion publication *Residential aged care in Australia 2010–11: a statistical overview,* reports on the characteristics of people who access residential aged care and the organisations delivering this type of care.

Although both reports can be read separately, taken together they provide a more complete picture of the story about aged care in Australia.

The aged care sector is complex so reporting on any aspect of it is likewise complex. Reports will have a different focus and purpose depending on the element/s of the aged care system covered and the intended audience. This report has a wide audience ranging from specialist aged care providers to interested members of the public. It includes brief references to other reports relevant to community aged care. It also outlines some publications associated with Australian Government initiatives which have the potential to influence future data collections and analysis about community aged care (Section 1.2 and Appendix A).

1.2 Package of aged care reforms released in 2012

The National Health and Hospitals Reform Commission considered that the aged care system needed significant reform to meet the challenges of an older and increasingly diverse population. The Australian Government requested that the Productivity Commission develop detailed options for redesigning Australia's aged care system to ensure that it can meet the challenges it will face in coming decades. Following a period of extensive consultation, the final report *Caring for older Australians,* was released in August 2011 (Productivity Commission 2011).

Subsequently, the Australian Government conducted a consultation process with older Australians, with their families and with industry stakeholders. The views of these groups, as well as the Productivity Commission report itself, contributed to the development of a package of aged care reforms which was released in April 2012 (DoHA 2012). The *Living Longer. Living Better* aged care reform package is intended to '…build a responsive, integrated, consumer-centred and sustainable aged care system, designed to meet the challenges of population ageing and ensure ongoing innovation and improvement.' (DoHA 2012).

The reforms will be implemented in three phases from 2013–14 to 2021–22 and include $486.9 million to support the development of more residential aged care facilities in areas of greatest need (including rural and remote areas) and $880.1 million to expand home care services. Two new types of home care packages will be introduced from July 2013 to allow a seamless continuum of care at home. The new packages will support people with basic and intermediate care needs and will complement the existing CACP and EACH packages. A new dementia supplement will also be introduced from July 2013 to support people with dementia receiving care at home and in residential care.

For more information about the reform package including changes to community aged care, funding and the increase in consumer involvement go to the publishing section of the DoHA website www.health.gov.au .

1.3 The purpose of this report

Typically, reports in the aged care sector provide information and analysis for use in the review and evaluation of existing programs, for making improvements to service delivery systems, and for the development of policy. Consumers and community groups also use the information in reports to assist in their specific goals and objectives, for example, advocacy activities. The Australian Institute of Health and Welfare (AIHW) contributes to these purposes with two annual reports: *Aged care packages in the community 2010–11: a statistical overview* (community aged care report) and the previously noted companion report *Residential aged care in Australia 2010–11: a statistical overview.*

The purpose of the community aged care report is to provide a summary of the packages of care and associated services supplied to the community through the CACP, EACH and EACHD programs. It highlights the characteristics of CACP, EACH, and EACHD clients, as well as patterns of service provision and characteristics of the organisations co-ordinating the care. This includes how clients access and use the services, the locations, and the kinds of organisations providing them.

1.4 Overview of community aged care in Australia

Like the Australian population as a whole, older Australians are a very diverse group. They come from many cultural, social and economic backgrounds and live in many different types of communities ranging from inner city environments in metropolitan areas, to the remote and very remote parts of Australia. As individuals, their needs for aged care services, and where and how they prefer to receive those services, are equally diverse. Community aged care programs are designed to provide a mixture of options, tailored to the individual, to accommodate that diversity. The Australian Government aims for balanced service provision across Australia's vast geographic areas.

Community aged care is one of three main service streams in Australia's aged care system: the other two are flexible care and residential aged care services (mainstream services). Each of these streams offers a variety of programs and most are administered under the provisions of the *Aged Care Act 1997* and the associated Aged Care Principles. One notable exception to this is the Home and Community Care (HACC) Program which is administered outside the Act and is described in greater detail below. Community aged care has strong

connections to residential aged care since many programs are specifically designed to enable older people to live in the community for as long as possible before they need residential aged care. It is worth noting that the use of community aged care packages such as EACH and EACHD has been found to delay entry into permanent residential aged care (AIHW 2011c).

The CACP, EACH and EACHD programs

The CACP, EACH and EACHD programs are alternatives to residential aged care, designed to provide choices of care and individually tailored packages. Broadly speaking, CACP is equivalent to low-care in a residential aged care facility and EACH and EACHD are equivalent to high-care in a residential aged care facility.

The CACP program was introduced as a government supported program in 1992–93 but was subsequently formally established under the *Community Care Subsidy Principles* of the *Aged Care Act 1997*.

Both the EACH and EACHD programs were established under the *Flexible Care Subsidy Principles* of the *Aged Care Act 1997*. The EACH program was introduced in 2001–02, initially as a pilot program, and EACHD was introduced in 2005–06. Although they are administered under Flexible Care programs and are designed to include care services which are equivalent to high-care residential care services, both are delivered in the community. Accordingly they are reported together with CACP as community care service programs.

The three programs offer packages of care for varying levels of assistance depending on the needs and personal circumstances of the client. The services the packages provide are co-ordinated (and may also be delivered) by care providers who are approved under the provisions of the Act (Approved Providers). Client eligibility for the packages is determined through a mandatory assessment carried out by an Aged Care Assessment Team (ACAT). The CACP, EACH and EACHD programs are funded by the Australian Government in the form of subsidies paid to the approved providers (DoHA 2008, 2009, 2011b). For further details about an ACAT assessment, see Box 2.1 and for comparisons between the care offered through either CACP, EACH or EACHD, see Table 2.1.

Other aged care and other community aged care programs

At any one time, an older person may be using more than one of the many aged care services available. With the exception of the CACP, EACH and EACHD programs, these other community aged care programs are not included in this report in any detail. However, since some of them are referred to in other parts of this report, a brief description of selected ones follows. The programs described are the Home and Community Care Program (HACC); the Transition Care, Multi-Purpose Services and Innovative care programs; the Veterans' Home Care program (DoHA 2008) and the Aboriginal and Torres Strait Islander Flexible Aged Care Program (DoHA 2011b).

Significant changes were announced for CACP, EACH and EACHD (and for other community aged care programs such as HACC) in the *Living Longer. Living Better* Aged Care Reform Package released by the Australian Government in 2012 (DoHA 2012). The changes will be implemented from 2012–13 to 2021–22 and are described in greater detail in Section 1.2.

Home and Community Care Program

The HACC program was created in 1984 and is administered under the *Home and Community Care Act 1985*. It is the main provider of home-based aged care in Australia and represents the largest part of the Australian Government's support for community aged care (DoHA 2011b) outside of the *Aged Care Act 1997*. Regular statistical reports are published on the HACC program and the most recent (dated 2011 and reporting on 2009–10 data) is available on the Department's website www.health.gov.au . In addition to the aged care reforms of April 2012, it is important to note that under the *National Health Reform Agreement* (COAG 2011b)

and subject to passage of the relevant legislation, from 1 July 2012 the Australian Government will have full funding, policy, and operational responsibility for services delivered through the HACC program for older Australians, except in Victoria and Western Australia. The changes apply for people aged 65 and over, and for Aboriginal and Torres Strait Islander people aged 50 and over (DoHA 2011b, 2012).

Transition Care, Multi-Purpose Services and Innovative care

In addition to the EACH and EACHD packages, programs delivered as flexible aged care services include Transition Care, Multi-Purpose Services and Innovative care programs. All these services have been established under the Principles of the *Aged Care Act 1997* and are delivered in either a residential or a community setting.

The Transition Care Program is available for older people following a period of hospitalisation. It is a time limited, goal-oriented and therapy-focussed program. It provides older people with a package of services after a hospital stay that includes low intensity therapy (such as physiotherapy, occupational therapy and social work) nursing support and/or personal care. It helps older people complete their restorative process and optimise their functional capacity, while assisting them and their family or carer to make long-term arrangements which may include a move into residential aged care (AIHW 2011d).

The Multi-Purpose Services program is specifically designed to deliver combined services (including aged care, health and community services) in rural and remote communities where separate services would not be viable (DoHA 2011b).

To provide further flexibility for older people, innovative care arrangements and models of delivery can be developed. Programs like this are trialled under the Innovative Care program, prior to being formally assessed for potential of a mainstream roll-out. A current example is the Consumer Directed Care (CDC) program, a community care service delivery model being tested across a number of community aged care environments (DoHA 2011b). Further details about expansion and application of the CDC program and enhanced consumer involvement in aged care are included in the 2012 package of aged care reforms described in Section 1.2 (DoHA 2011b, 2012).

National Aboriginal and Torres Strait Islander Flexible Aged Care Program

The Australian Government provides services specifically for older Aboriginal and Torres Strait Islander people under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSI Flexible Aged Care Program). The services funded under this program provide culturally appropriate residential and community aged care, mainly in rural and remote areas close to Indigenous communities. The aim of the program is to help older Indigenous Australians access culturally appropriate care services as close as possible to their own communities. Further information on the program is available in the *2010–11 Report on the Operation of the Aged Care Act* (DoHA 2011b) and in the package of aged care reforms (DoHA 2012). (Note that Section 11. 3 of the *Aged Care Act 1997* includes Aboriginal and Torres Strait Islander people in its 'special needs' category—Box 4.1).

Veterans' Home Care

The Australian Government Department of Veterans' Affairs (DVA) administers a number of DVA funded community aged care programs that provide assistance to eligible veterans, war widows and widowers. One such program is the Veterans' Home Care program which delivers in-home support services, mostly for low-level care such as domestic assistance and personal care. In 2009–10 there were around 77,000 clients for this program, making it second only to the HACC program in client numbers (AIHW 2011b). There will be changes to this program under the 2012 package of aged care reforms described in Section 1.2 (DoHA 2012).

1.5 Data sources and organisation of the report

- The report uses data from the Department of Health and Ageing's Aged and Community Care Data Warehouse which holds data about the approval of services to care clients and payment of funding to service providers (Appendix 2).
- The report is organised as follows:
- Chapter 1 describes the background to the report, briefly describes the 2012 package of aged care reforms, provides an overview of Australia's community aged care system, outlines the inclusions for each chapter and describes the changes that have been made to the report, for example, provision of online data.
- Chapter 2 reports on the provision of community aged care in terms of characteristics of packages as well as service provision outlets (organisations); for example, how many there are, where they are located and the types of organisations.
- Chapter 3 describes the characteristics of community aged care clients at 30 June 2011; for example, age (including younger clients), sex, marital status, where they live (geographic distribution), where they were born and their preferred language. It includes information on Aboriginal and Torres Strait Islander people.
- Chapter 4 provides information on special needs groups including older Aboriginal and Torres Strait Islander people, older people from non-English speaking backgrounds, and older people in rural and remote areas.
- Chapter 5 describes the patterns of admission, separations, length of stay and leave for clients using the three packages.
- Chapter 6 presents an overview of some trends to emerge in recent years.

The Glossary section explains the way terminology specific to community aged care has been understood and used in the report for example, 'admission', 'care client', 'separation mode' and 'service outlet'.

Most of the reporting about service outlets and package recipients is based on the mainstream services supported by the Australian Government recurrent funding for CACP, EACH and EACHD. However, the data about numbers of packages and provision ratios in Section 2.2 covers Multi-Purpose Services and those receiving flexible funding from the National Aboriginal and Torres Strait Islander Aged Care Strategy. Services provided under the Innovative Care stream are not included in this report.

Lists of in-text tables, figures and boxes are provided following the reference section. These lists include titles of online tables which provide additional detail behind the data information in the text.

1.6 Changes to the 2010–11 report

Selected tables and appendices have been provided electronically for this publication. Data cubes have also been provided on the AIHW website.

This report and its companion on residential aged care (AIHW 2012b) are designed to complement each other and both are available in PDF form from AIHWs website.

A short summary (or 'snapshot') of both reports is also available on the AIHW website.

Chapter 2

Community aged care programs and service provision

2 Community aged care programs and service provision

As noted in the Introduction, older people in Australia are a diverse group with different needs for care as they age. Community aged care programs and services offer packages of care for varying levels of assistance, all tailored to meet an individual client's care needs.

This chapter briefly describes three programs that may be included in tailored packages of care, namely, Community Aged Care Packages (CACP), Extended Aged Care at Home (EACH) and Extended Aged Care at Home Dementia (EACHD) programs. Access to these services is via a mandatory assessment carried out by an Aged Care Assessment Team (ACAT), so a summary of ACAT is included in this section. Information on characteristics of the service outlets (organisations) is also provided, including the number of providers, their locations, as well as information on the number of packages they deliver.

Aged Care Assessment Teams and community aged care packages

Before a person can access a community aged care package, they must be assessed by an Aged Care Assessment Team (ACAT) (from the Aged Care Assessment Program or ACAP) to determine the type and level of assistance required. The operation of ACAT is jointly funded by the Australian Government and the states and territories. An ACAT usually consists of health care professionals with experience in community aged care and knowledge of the aged care system, including residential aged care (Box 2.1). As a result of the assessment, and in consultation with the older person, the ACAT makes recommendations on the preferred setting for receiving care (for example, the person's home) and the level of care (for example, low-level care such as assistance with personal care). In 2008–09, following an ACAT assessment, long-term care in the community was recommended in more than half of cases (57%), with 18% recommended to CACP and 15% for either EACH or EACHD (AIHW 2011b).

The ACAT determines needs as either 'low-care' or 'high-care' (Box 2.1), provides information on suitable combinations of care options (packages of care) and helps arrange referrals if required. An important characteristic of the packages of care developed is case coordination and management as every package is tailored to the individual needs of the client. CACP packages are targeted to those clients with low-care needs while EACH packages cater for older Australians with needs deemed to be high-care. EACHD packages are specifically designed to provide care for clients with the complex and high-care needs associated with dementia-related behaviours. All three programs assist older people to remain living in the community rather than entering residential aged care, if that is their preference. The variations between CACP, EACH, and EACHD packages are set out in Table 2.1.

The services available under each program are not exclusive, so can be taken concurrently with other aged care programs. For example, if an individual is assessed as eligible for either low-level or high-level respite care in a residential aged care facility, they may also access CACP, EACH or EACHD packages at the same time.

Box 2.1: What is an ACAT assessment?

The role of an Aged Care Assessment Team (ACAT) (known as Aged Care Assessment Services (ACASs) in Victoria) is to determine the overall care needs of frail older people and to assist them to gain access to the most appropriate types of care for their individual needs. Where appropriate, an ACAT delegate approves the type of Australian Government -subsidised care from community aged care packages such as CACP, EACH, and EACHD (and residential aged care services). The ACAT assessment includes a decision about which level of care is required for an individual. There are two levels of care available: low-care and high-care.

What is low-care?

Types of care that may be provided as low-care are wide ranging and may include:

- personal care, such as assistance with bathing
- assistance with meal preparation
- transport.

What is high-care?

High-care can require more hours and a greater level of care compared with low-care. High-care includes the types of care provided at a low-care level, plus additional services such as:

- clinical care, for example, nursing services
- continence management
- therapy services
- assistance to access leisure services
- emotional support
- home safety and modification.

Source: (DoHA 2006, 2011b).

Table 2.1: The CACP, EACH and EACHD Programs

	CACP	EACH	EACHD
Year introduced	1992	2002	2006
Number of packages at 30 June 2011	45,777[a]	8,150	3,995
Required for Australian Government subsidised access	ACAT approval	ACAT approval	ACAT approval
Residential aged care equivalent	Low-care	High-care	High-care
Where does it take place?	In the community	In the community	In the community
Type of care available[b]	Assistance may include: • domestic assistance • meals at home and other food services • transport services • home or garden maintenance • social support • personal care • counselling • equipment and home modifications • respite care • linen services	Similar to CACP but to a higher degree, plus: • nursing (at home or at a centre) • allied health/therapy (at home or at a centre)	Same as EACH but also involves care and links to services directed specifically at managing challenging behaviours associated with dementia

(a) Includes packages provided by Multi-Purpose Services and services receiving flexible funding under the Aboriginal and Torres Strait Islander Aged Care Strategy.

(b) (AIHW 2009a)

2.1 Characteristics of service outlets

Packages of care available from the CACP, EACH and EACHD programs are delivered by approved providers from locations called service outlets. Under the *Aged Care Act 1997* the Department of Health and Ageing approves organisations (or incorporated bodies) to offer packages of care. These organisations then become approved provider organisations for that particular service. A single organisation may be approved to provide many aged care services and these may include any of the CACP, EACH and EACHD packages. The same organisation may also be approved to provide residential aged care. Community aged care services offered under the CACP, EACH and EACHD programs are arranged and co-ordinated by the approved provider. The services may be delivered from a single service outlet (by the approved provider) or from a number of service outlets in different locations. Access to the CACP, EACH and EACHD services is via an ACAT assessment. Typically, staff from a service outlet will work with the client (and/or carer) to develop a package of care tailored to meet individual care needs as determined by the ACAT.

For community aged care, the allocated places are typically referred to as packages and they become operational packages once an approved provider is able to offer a package of care to a client (also a care recipient). The *Aged Care Act 1997* '…provides for places to become operational within two years after allocation… Community Aged Care Packages, Extended Aged Care at Home and Extended Aged Care at Home Dementia packages generally become operational soon after allocation.' (DoHA 2011b).

Number of service outlets and packages

Under the *Aged Care Act 1997*, there are three main service streams delivering aged care in Australia: community aged care, flexible care services and residential aged care (mainstream services). The CACP program is part of community aged care mainstream services while EACH and EACHD are part of flexible aged care mainstream services. The service outlets providing CACP, EACH and EACHD packages of care are spread across all Australian states and territories, and across remoteness areas (Box 2.2 explains remoteness).

Across Australia at 30 June 2011, in mainstream services:

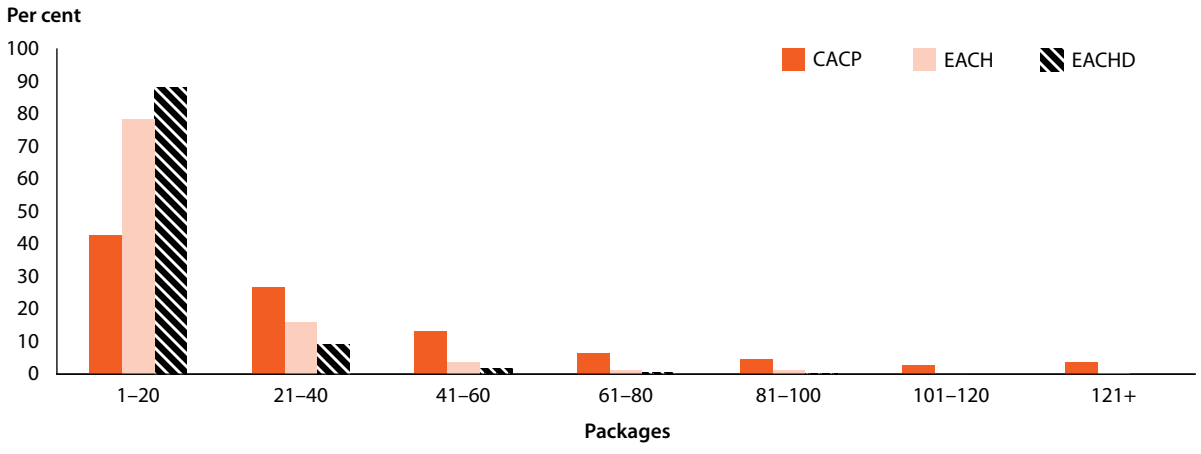
- 1,202 service outlets provided 45,777 CACP packages;
- 495 service outlets provided 8,150 EACH packages; and
- 343 service outlets provided 3,995 EACHD packages.
- This reflects substantial growth in EACH and EACHD from 30 June 2010 when the available operational packages were 5,584 and 2,583 respectively. This showed an increase of 2,566 for EACH and 1,412 for EACHD (Online Table A1.5 and Section 6.3 of this report).

An additional 422 low-care packages were available through Multi-Purpose Services and a further 259 through service providers receiving flexible funding under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program, making a total of 681. These packages are equivalent to a CACP and are counted as such in subsequent sections of this report, making a total of 46,458 CACP packages offered at 30 June 2011.

The majority of service outlets offering EACH and EACHD packages (78% and 83% respectively) provided between 1 and 20 packages. There was greater variability among outlets offering CACP, with 43% of service outlets offering 1–20 packages, 27% offering 21–40 packages and 13% offering 41–60 packages. A small proportion (4%) of CACP service outlets offered more than 120 packages (Figure 2.1).

As might be expected, service outlets offering high numbers of packages were more likely to be located in *Major cities* (Online Table A1.2).

Figure 2.1: CACP, EACH and EACHD service outlets by number of packages, 30 June 2011 (per cent)



Source: Online Table A1.1.

Location of service outlets nationally

The distribution of service outlets by remoteness across the states and territories was broadly consistent with the distribution of the population.

More than half of the service outlets overall were located in *Major cities* (53% for CACP, 58% for EACH and 60% for EACHD) (Figure 2.2). The highest proportion of service outlets were located in New South Wales, with 28% of CACP, 28% of EACH, and 29% of EACHD.

Despite having the smallest population of older people, a total of 58 CACP outlets were located in the Northern Territory (Online Table A1.3). Reflecting the widely dispersed nature of the population in the Northern Territory, 83% of these CACP outlets were located in *Remote* or *Very Remote* areas. Queensland and Western Australia also had notable proportions of CACP outlets in *Remote* and *Very Remote* areas, at 11% and 15% respectively.

Note that under the ASGC (Box 2.2) there are no locations within the Northern Territory classified as being in *Major cities* or *Inner regional* areas. Similarly, Victoria has no locations classified as *Very remote*, Tasmania has no locations classified as *Major cities*, and the Australian Capital Territory consists only of locations classified as *Major cities* or *Inner regional*. These variations in classification and in population distribution contribute to the differences within specific states or territories, and between them. For example, because Tasmania has no *Major Cities* classification, CACP, EACH and EACHD services are concentrated in *Inner regional* areas (Figure 2.2).

Box 2.2: How is remoteness defined?

The term 'remoteness', as used in this publication, refers to a classification defined by the Australian Standard Geographical Classification (ASGC). The ASGC uses measures of access and distance to services offered in urban areas (for example, health and education) to determine classifications of Australian remoteness. These classifications are:

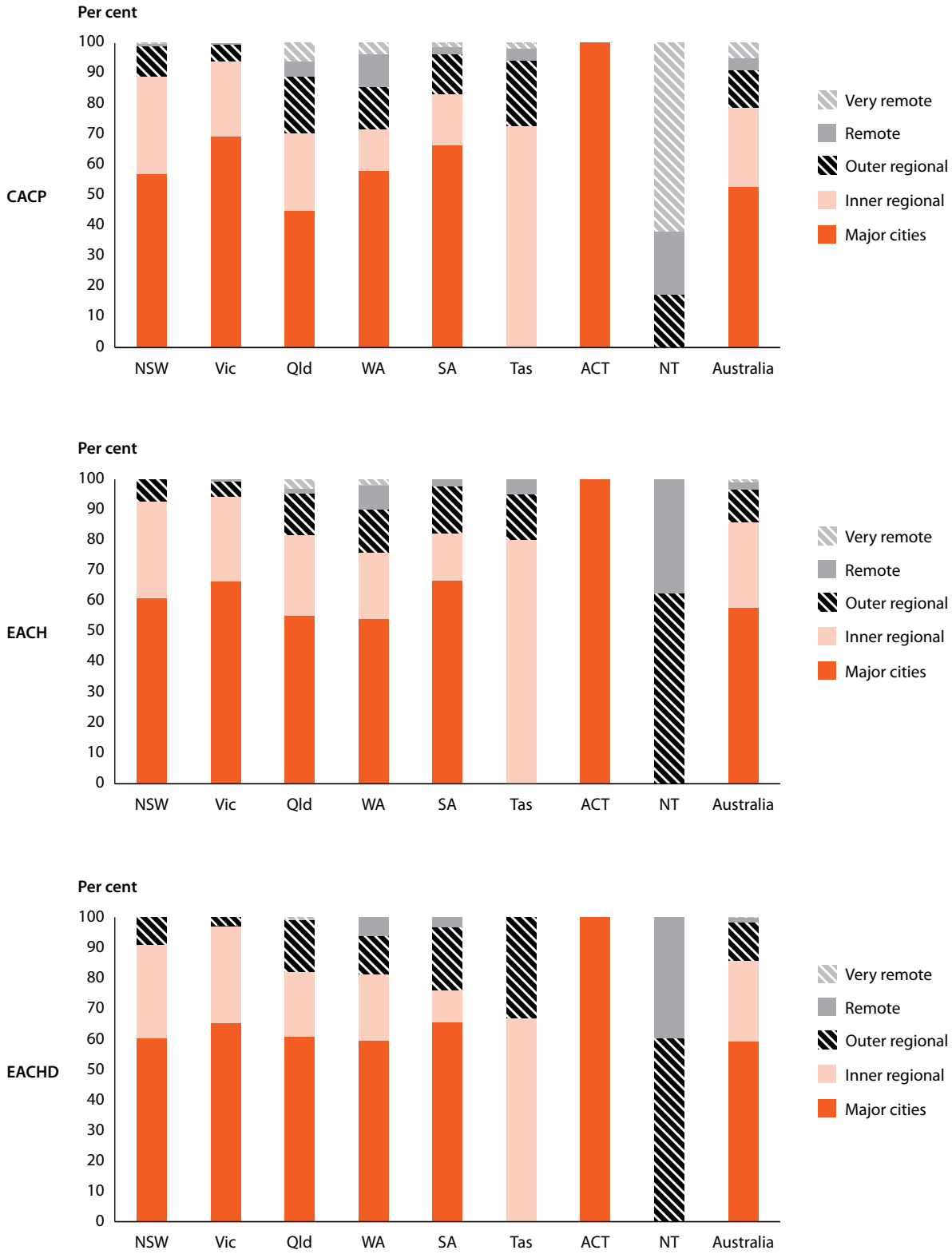
- *Major cities*, for example, Melbourne and Sydney
- *Inner regional*, for example, Hobart
- *Outer regional*, for example, Darwin
- *Remote*, for example, Charleville
- *Very remote*, for example, Tennant Creek.

In *Remote* and *Very remote* areas, and in the Northern Territory and the Australian Capital Territory, population numbers are low. Therefore, comparisons of proportions and interpretation of data between these and other, more highly populated locations must be undertaken with caution.

Further details about remoteness and how it is calculated (including the ARIA index) is provided in the Glossary.

Source: (ABS 2010)

Figure 2.2: CACP, EACH and EACHD service outlets by state/territory and remoteness, 30 June 2011 (per cent)



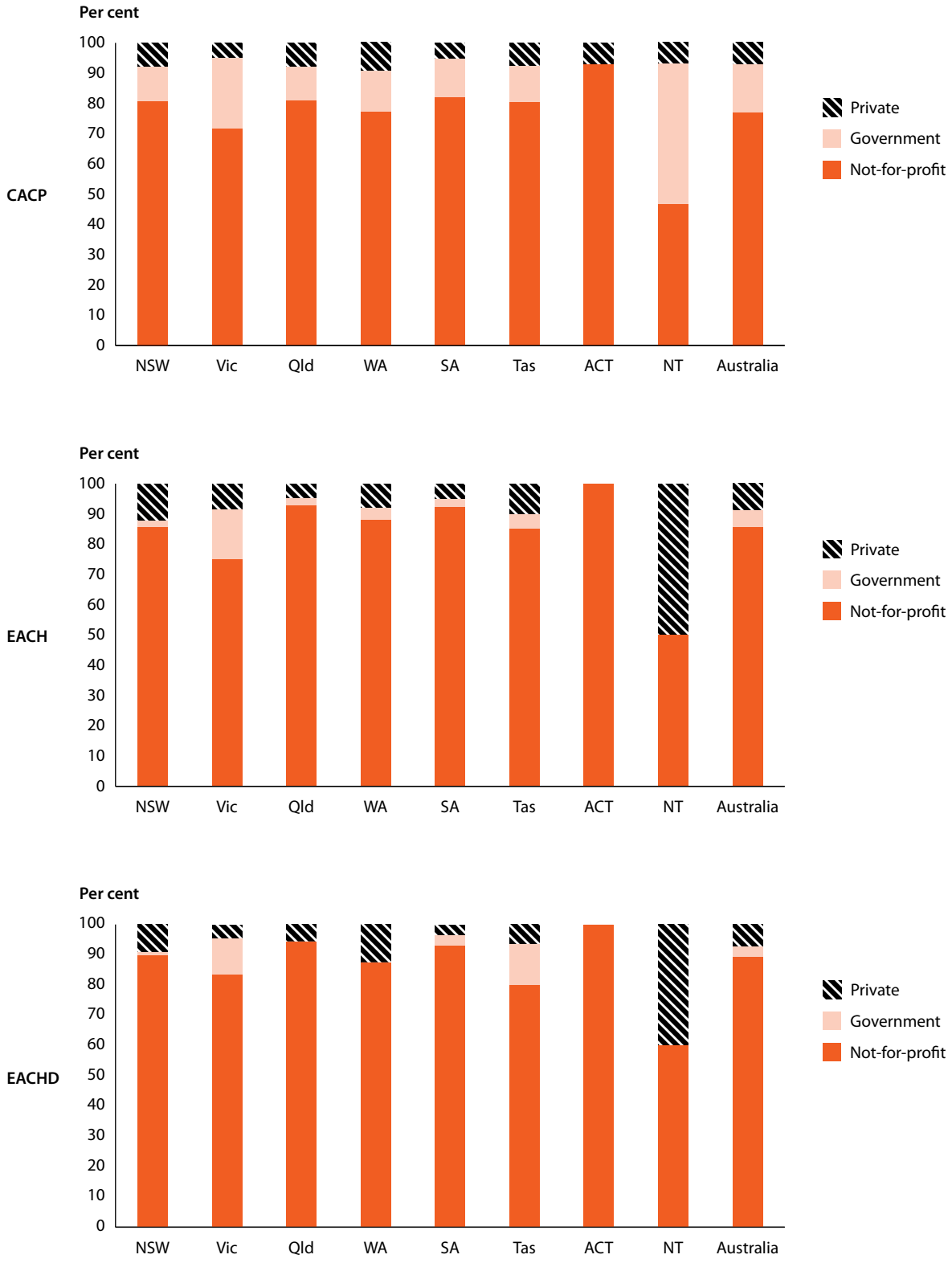
Source: Online Table A1.3.

Types of organisations providing the packages

The majority of service outlets (77% for CACP, 86% for EACH and 89% for EACHD) were run by not-for-profit organisations, namely those classified as charitable, community-based, and religious. Government-run organisations accounted for 16% of CACP service outlets, 6% of EACH, and 4% of EACHD. The remaining service outlets were run by private for-profit organisations accounting for 7% of CACP, 9% of EACH and 7% of EACHD (Figure 2.3).

The distribution of organisation types was broadly similar across packages and within jurisdictions, although it varied across the states and territories. For example, 47% of CACP providers in the Northern Territory were government, whereas the Australian average was about 16%. Victoria had the lowest proportion of not-for-profit providers with almost 72% of outlets being not-for-profit compared with 77% for the national average. The Australian Capital Territory had the highest percentage of not–for-profit organisations across all three programs; 93% for CACP, 100% for EACH compared with a national average of 86%, and 100% for EACHD compared with a national average of 89% (Online Table A1.4).

Figure 2.3: CACP, EACH and EACHD service outlet type by state/territory and remoteness, 30 June 2011 (per cent)



Source: Online Table A1.4.

2.2 Characteristics and availability of packages

This section provides details of the packages available (how many and where they are located), the Australian Government planning process for their provision (see provision ratio in Box 2.4), and information on the distribution of the packages nationally.

How many packages are available?

At 30 June 2011, a total of 57,922 packages were available to 50,893 clients across the three CACP, EACH and EACHD programs. Differences in the number of packages available and the number of clients usually relates to matters such as the availability of staff to operate the service outlets. The package types making up the total is given in more detail in Section 2.1 above and Table 2.2 below. In summary, the numbers by package types are 45,777 for CACP, 422 for Multi-Purpose Services, 259 for National Aboriginal and Torres Strait Islander Flexible Aged Care Program, 8,150 for EACH and for 3,995 for EACHD. There has been a steady increase in the number of packages available since the CACP, EACH and EACHD programs began. See Section 6.1 for more detail.

State and territory distribution

Overall, the total for all three packages for each of the states and territories was broadly consistent with the distribution and proportion of the population aged 70 and over (70+). For example, at 30 June 2011, the largest number of packages for each of the three programs was available in New South Wales, accounting for about 1 in every 3 packages. Victoria (the next most populous state) accounted for about 1 in every 4 (Table 2.2). Proportions for Western Australia and the Northern Territory, however, showed more variance, with a total of 12.3% for all three packages for Western Australia compared with 9.2% of the 70+ population in that state. For the Northern Territory, total packages were 1.5% compared with 0.3% of the 70+ population.

Table 2.2: CACP, EACH and EACHD packages by state/territory[(a)], 30 June 2011 (per cent)

State/territory	CACP	EACH	EACHD	Total	70+ population
NSW	32.9	26.6	23.7	31.4	33.9
Vic	24.3	20.6	19.2	23.4	25.5
Qld	18.6	21.6	24.3	19.4	18.6
WA	10.3	19.1	20.8	12.3	9.2
SA	8.2	5.1	5.1	7.6	8.7
Tas	2.6	2.1	2.5	2.5	2.6
ACT	1.5	3.6	3.4	1.9	1.2
NT	1.6	1.3	1.0	1.5	0.3
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Total (number)	**45,777**	**8,150**	**3,995**	**57,922**	**2,163,500**

(a) Refers to location of service outlets.

Notes

1. Includes CACP offered by Multi-Purpose Services and service providers receiving flexible funding under the Aboriginal and Torres Strait Islander Aged Care Strategy but excludes 500 Consumer Directed Care (CDC) packages.

The provision of CACP, EACH and EACHD

In accordance with the provisions of the *Aged Care Act 1997*, the Australian Government allocates new community and flexible care places through the Aged Care Approvals Round (ACAR) (Box 2.3). The ACAR process aims to identify community needs for aged care and to allocate places in a way that best meets those needs as determined using standardised measures (Box 2.4).This is a competitive process, with places allocated to Approved Providers who demonstrate that they can best meet the needs of older Australians in a particular aged care planning region. Planning for the ACAR is informed by a number of standardised measures (Box 2.4). The ACAR process also aims to ensure a sufficient supply of low-care and high-care places to achieve equitable access to services between metropolitan, regional, rural and remote areas of Australia (DoHA 2011a, 2011b).

Box 2.3: Allocation of places—the Aged Care Approvals Round (ACAR)

Each year, under the *Aged Care Act 1997,* the Australian Government makes new aged care places available in each state and territory. The allocation is based on the national target and provision ratio (Box 2.4), taking into consideration the regional distribution of need. The aim is to balance aged care services between metropolitan, regional, rural and remote areas as well as between people needing different levels and types of care (DoHA 2011a).

The ACAR is a competitive, annual application process that enables organisations to apply for these places. Places are allocated to applicants who can demonstrate that they best meet the needs of the ageing population within both a community and an aged-care planning region.

To obtain an allocation of places, the applicant must be an Approved Provider. Organisations applying for an allocation of places for the first time (for example, CACP, EACH and EACHD) must also apply for approved provider status (DoHA 2011b).

Places for Multi-Purpose Services (MPSs), the National Aboriginal and Torres Strait Islander Flexible Aged Care Program, and the Transition Care Program are not allocated in the ACAR process.

Source: (DoHA 2009)

The planning framework for mainstream services provided under the Act includes the CACP, EACH and EACHD programs. It is based on a national provision level (the target) of operational residential aged care places and community aged care places and is based on a percentage of the population aged 70 and over (70+). For convenience, the target to be achieved is expressed in terms of places per 1,000 people aged 70+ and is known as the 'provision ratio' (Box 2.4). In 2007, the overall aged care provision ratio was increased from 108 to 113 operational places and that target was to be achieved by 30 June 2011. Within this target, of the total of 113 places there should be 88 for residential aged care and 25 for community care. Of the 25 community care places, 4 should be high-care places (EACH or EACHD) and 21 should be low-care places (CACP) (DoHA 2008).

In 2010, the target for high level community care (EACH and EACHD) was temporarily increased from 4 to 6 places, while the target for high-level residential care was temporarily adjusted to 42 places per thousand people aged 70+. This was done to ensure that the overall target of a total of 113 places was achieved in 2011, and that within those, the balance of 48 high-care places (42 in residential aged care and 6 in community aged care) and 65 low-care places (44 in residential aged care and 21 in community aged care) was maintained (DoHA 2011b).

Across Australia, the combined provision ratio for CACP, EACH, and EACHD packages at 30 June 2011 was 26.8. When the Indigenous population aged 50–69 was added, the provision ratio fell slightly to 26.1 (Figure 2.4 and Box 2.4).

At 30 June 2011 the national provision ratio for CACP was 21.5 (Table 2.3). This was about 4 times as high as the provision ratio for EACH and EACHD packages combined (5.6).

Box 2.4: Standardised measures—provision ratios and usage rates

An **operational provision ratio** (referred to as a 'provision ratio') compares the amount of *places* or *packages available*, to a specific population at a point in time, usually a 30 June date. Aged care planning looks at the number of places available per 1,000 people aged 70 and over. Under these circumstances, if a provision ratio is 10, it would mean that there are 10 places *available* for every 1,000 people aged 70 and over.

A **usage rate** measures patterns of use and access to services. The calculation is similar to a provision ratio although it looks at the number of people who are currently *using* a service, compared with all of the people in the population for whom the service is intended. For example, if a usage rate is 10 for a specific age group it would mean that there are 10 people who were using a community aged care package for every 1,000 people in that age group at a specific point in time.

Adjustment for Indigenous Australians

Aboriginal and Torres Strait Islander people in Australia generally have a lower life expectancy compared with other Australians (AIHW 2011a), so may need access to aged care services earlier in life. For this reason, the provision ratios take into account the Indigenous Australian population aged 50–69 as well as the 70 and over age group.

Provision by state and territory

The combined community care provision ratio at 30 June 2011 was similar among the states, ranging from 23.1 packages per 1,000 people aged 70 and over in South Australia to 34.3 in Western Australia (Figure 2.4). Provision in the Australian Capital Territory was higher at 41.3. The highest combined provision ratio was seen in the Northern Territory, with 121.8 packages available per 1,000 people aged 70 and over.

The provision ratio showed little change in most jurisdictions when the Indigenous population aged 50–69 was added (Box 2.4). The most noticeable change was in the Northern Territory, where the ratio dropped by half (from 121.8 to 59.7) due to the high proportion of Indigenous Australians.

Figure 2.4: Combined packages provision ratio for community aged care by state/territory, 30 June 2011(per 1,000 population)

Source: Online Table A1.6.

Provision by remoteness

Combined provision ratios are highly variable across remoteness areas, ranging from 22.9 in *Outer regional* areas to 97.4 in *Very remote* areas (Table 2.3). In *Remote* and *Very remote* regions the variability is marked compared with the more populated regions and is most obvious for EACHD with a range of 1.9 in *Major cities* compared with 0.4 in *Very remote*. The EACHD program is a specialised service so may be more difficult and costly to offer in *Remote* and *Very remote* locations, where population numbers are also small. MPS and places available through flexible funding in the Aboriginal and Torres Strait Islander Aged Care Strategy play an important role in service provision in these locations.

Table 2.3: Community aged care provision ratios by remoteness[(a)], 30 June 2011

Remoteness	CACP	EACH	EACHD	Combined
Major cities	21.5	3.8	1.9	27.2
Inner regional	19.9	3.8	1.7	25.5
Outer regional	17.9	3.3	1.7	22.9
Remote	36.0	3.5	1.3	40.8
Very remote	93.8	3.2	0.4	97.4
Australia	**21.2**	**3.8**	**1.8**	**26.8**

(a) Refers to location of service outlet.

(b) The table does not include 500 Consumer Directed Care packages.

Chapter 3

Client characteristics

3 Client characteristics

This chapter describes some of the characteristics of CACP, EACH, and EACHD clients. It provides information on the numbers of clients, where they receive services, their age and sex, birthplace, preferred language, and living and carer arrangements. Some information about younger clients (those aged under 65) is also provided.

It is important to keep in mind that reference to state and territory and remoteness areas relates to the geographic location of the service outlet providing the service and that only clients in the mainstream services are counted.

3.1 Numbers of clients

With the exception of EACHD (Online Table A1.7), recipients of CACP and EACH are spread across all Australian states and territories and remoteness classifications although the number of clients in *Remote* and *Very remote* regions remains low (Figure 3.1 and Table 3.1). Multi-Purpose Services and services receiving flexible funding under the Aboriginal and Torres Strait Islander Aged Care Strategy provide service delivery in more remote areas.

At 30 June 2011 there were: 41,020 CACP clients; 6,904 EACH clients; and 2,969 EACHD clients. The distribution of client numbers by state and territory was broadly similar across the three programs and corresponded roughly to the distribution of the population aged 70 years and over. For example, 35% of people aged 70 or over lived in New South Wales, which had 35% of CACP clients and 29% of EACH clients and EACHD clients (Table 3.1).

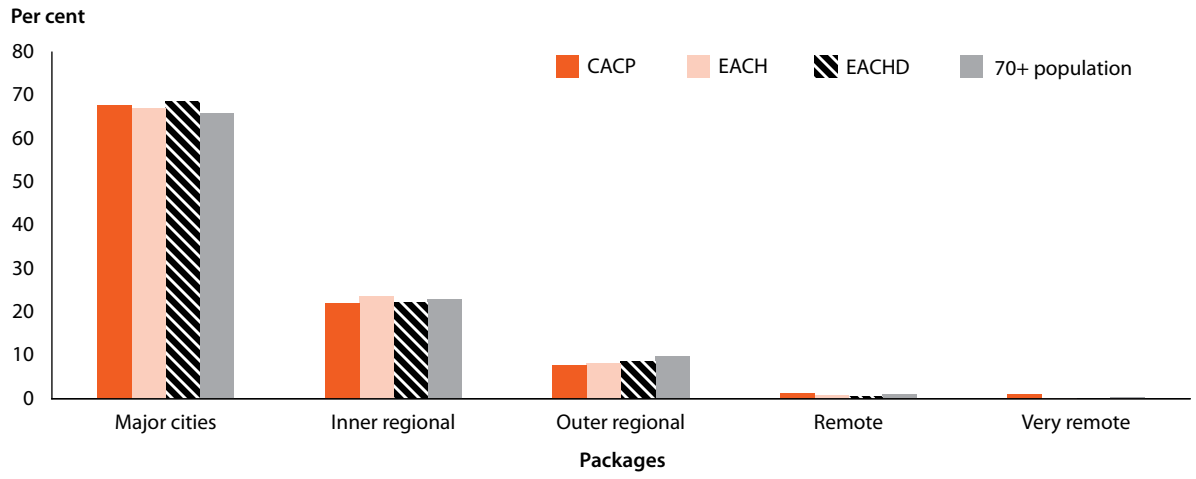
At the national level, the spread of clients across remoteness areas was also broadly similar across packages and reflected the distribution of the older population (Figure 3.1). Providers of aged care services in *Remote* and *Very remote* areas face particular challenges in areas that may also be remote from professional assistance and support and have higher infrastructure costs (DoHA 2011b). In addition, EACH and EACHD packages provide highly specialised care. Taken together these factors may explain the scarcity of EACH and EACHD packages in *Remote* and *Very remote* regions.

Table 3.1: CACP, EACH and EACHD clients by state/territory[(a)], 30 June 2011 (per cent)

State/territory	CACP	EACH	EACHD	70+ population
NSW	34.6	29.1	28.9	33.9
Vic	26.3	23.4	24.6	25.5
Qld	16.1	19.9	20.8	18.6
WA	8.9	15.0	13.2	9.2
SA	8.6	5.9	6.7	8.7
Tas	2.7	2.4	3.1	2.6
ACT	1.4	2.8	1.8	1.2
NT	1.5	1.4	0.9	0.3
Total	*100.0*	*100.0*	*100.0*	*100.0*
Total (number)	**41,020**	**6,904**	**2,969**	**2,163,500**

(a) Refers to location of service outlets.

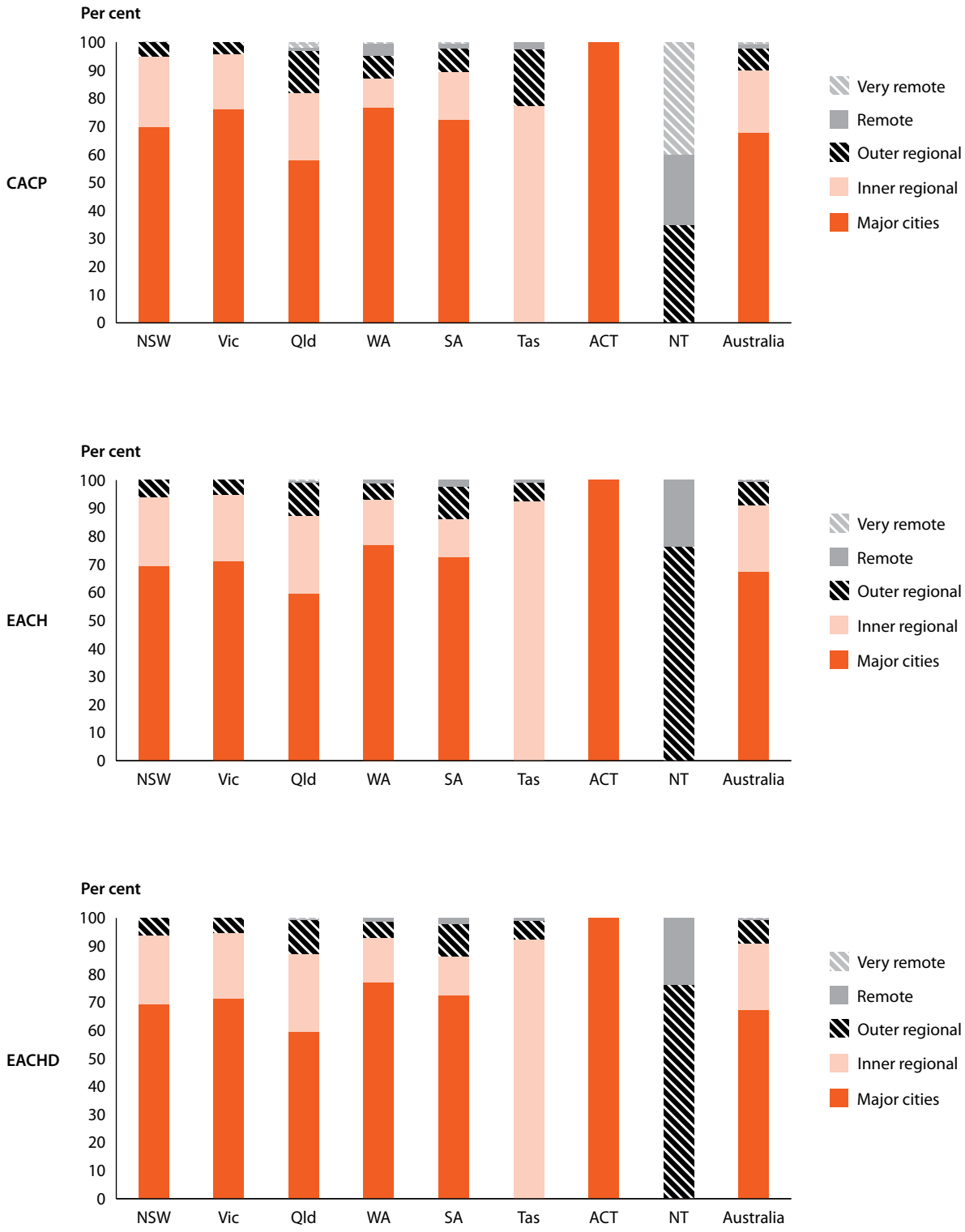
Figure 3.1: CACP, EACH and EACHD clients by remoteness, 30 June 2011 (per cent)



Source: Online Table A2.1.

Greater variation is seen in the distribution of client services across remoteness areas within jurisdictions (Figure 3.2). For example, in most states and territories a greater proportion of EACH compared with CACP services are provided in *Inner regional* areas. Although for the most part the distribution of clients reflects that of the 70+ population, there are some notable differences. For example, 40% of CACP in the Northern Territory were in *Very remote* areas, but only 14% of the older population as a whole lived in these areas. Similarly in Tasmania 92% of EACH services were in *Inner regional* areas, where only 65% of the state's older population live (Online Table A2.1).

Figure 3.2: CACP, EACH and EACHD clients by state/territory, and remoteness, 30 June 2011 (per cent)



Note: Under the ASGC (Box 2.2), Victoria has no locations classified as Very remote; Tasmania has no locations classified as Major cities; the Northern Territory has no locations classified as Major cities or Inner regional; and the Australian Capital Territory consists only of locations classified as Major cities or Inner regional.

Source: Online Table A2.1.

3.2 Age and sex profiles of clients

This section looks at the age and sex of community aged care clients. As previously noted, the Australian Government aged care provision ratio uses the population of people aged 70 and older to plan for the release of new community aged care packages (Box 2.3). It is possible for younger people to access CACP, EACH, and EACHD packages in specific circumstances such as the unavailability of other specialised services (DoHA 2006).

Age distribution

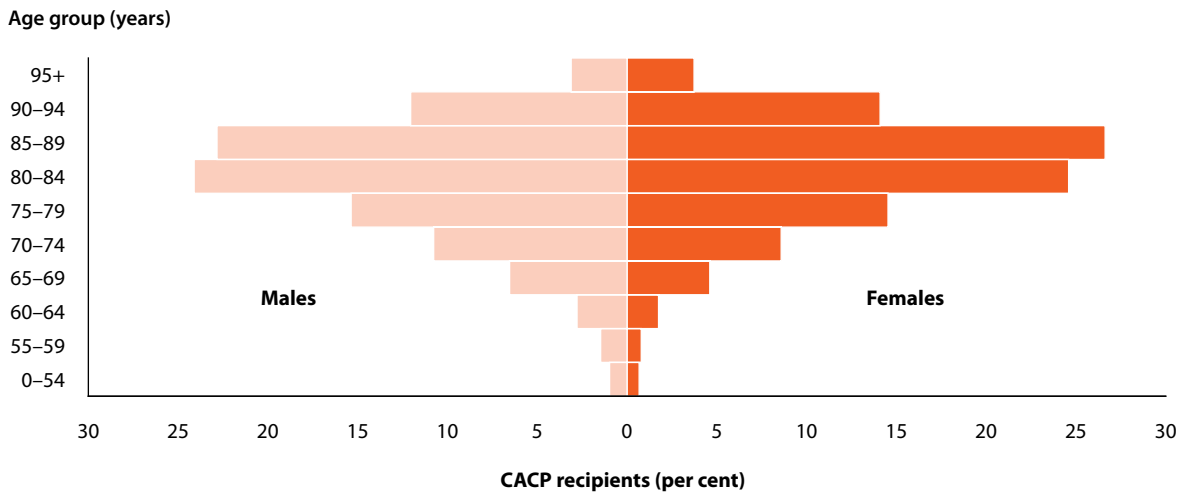
CACP clients generally had the oldest age profile, with a median client age of 84. Two-thirds of CACP clients were aged 80 or more. This was followed by EACHD (median age 83; 63% over 80) then EACH (median age 82; 58% over 80) (tables 3.2, 3.3 and 3.4). The proportion of clients aged 90 and over was 17% for CACP and EACH, and 13% for EACHD.

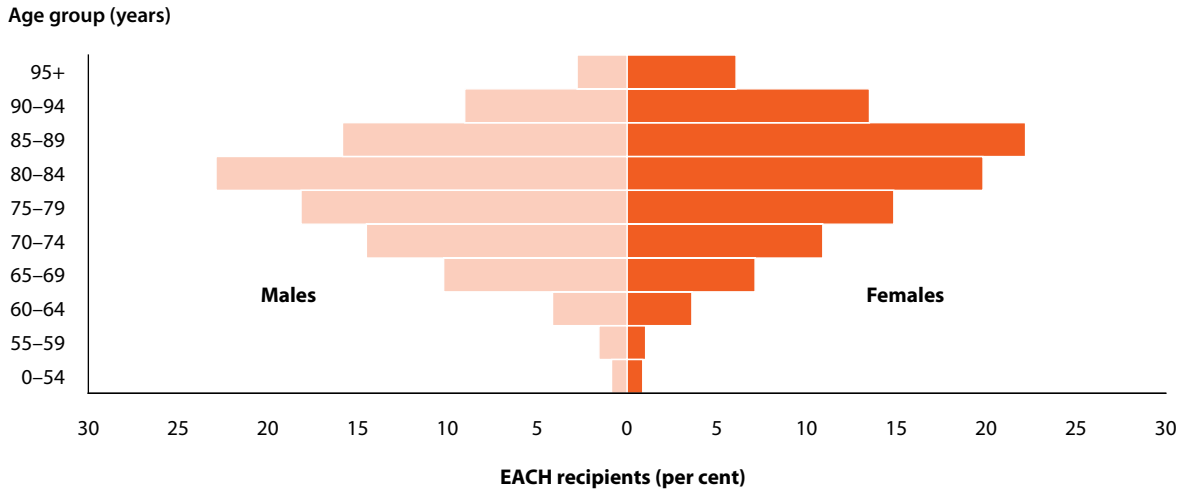
In all three programs, females generally had an older age profile than males (Figure 3.3). Females aged 80 or over made up 48% of all CACP clients whereas males of this age accounted for only 19% of clients. For the same age group in EACH, females again made up a higher proportion than males (38% and 19%, respectively), and for EACHD the proportions were 41% compared with 22%, respectively (Online Table A2.4).

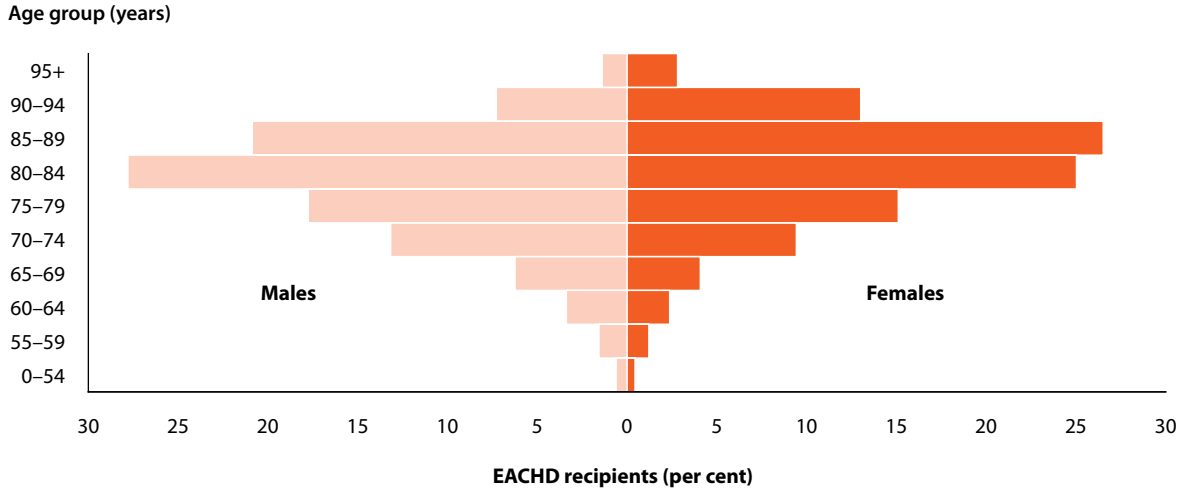
Clients aged 90 and over were catered for in significant proportions in all three programs. For females aged 90 and over, the proportions were 18% for CACP, 20% for EACH and 16% for EACHD. For males aged 90 and over, the corresponding proportions were 15% for CACP, 12% for EACH and 16% for EACHD (Figure 3.3).

Clients aged under 65 made up a smaller proportion of overall clients. The highest proportions were in the EACH program (6%), followed by EACHD (5%) and CACP (4%) (Online Table A2.4). Younger clients (including Aboriginal and Torres Strait Islander clients) are discussed in more detail in Sections 3.3 and 4.3.

Figure 3.3: CACP, EACH and EACHD clients' age and sex, 30 June 2011 (per cent)







Source: Online Table A2.4.

Geographic variation in age distribution

In most of the states and territories, the median ages of CACP clients were similar to the national median age of 83.6, except for the Northern Territory where the median age was 10 years younger (73.0) (Table 3.2). The age distribution of clients in most jurisdictions was also similar to that seen nationally. Overall, 26% of CACP clients were in the age group 85–89 with a further 24% in the 80–84 group. The Northern Territory in general had a younger age profile than the other jurisdictions with 17% of clients in the 80–84 age group and 7% in the 85–89 group. In addition, 57% of Northern Territory CACP clients were aged under 75, compared with 13–22% of clients in this age group in the other states and territories (Online Table A2.2).

The age distribution of EACH clients varied somewhat more across the states and territories than that of CACP clients, with the median age of EACH clients ranging from 76.3 in the Northern Territory to 83.6 in South Australia (Table 3.4). In all states and territories, the greatest proportion of clients were aged 80–84 (71.4%), with high proportions in each jurisdiction (69.6%) also in the 85–89 age group (Online Table A2.2).

For EACHD clients, the lowest median age in the states and territories was 77.2 in the Northern Territory, with the highest being 84.2 in South Australia (Table 3.2). In all jurisdictions except Victoria (75%) and the Northern Territory (65%), 80% of EACHD clients were aged 75 and over.

Table 3.2: CACP, EACH and EACHD clients' median age by sex and state/territory[(a)], 30 June 2011

Package	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
CACP									
Females	84.4	83.0	83.7	84.5	85.0	84.6	85.2	73.5	84.0
Males	83.5	81.7	82.5	82.7	84.2	82.7	83.1	71.4	82.7
Persons	**84.2**	**82.6**	**83.4**	**84.0**	**84.8**	**84.1**	**84.5**	**73.0**	**83.6**
EACH									
Females	83.6	81.1	83.1	83.2	85.1	80.1	82.4	81.5	82.9
Males	80.5	78.5	80.3	80.5	81.6	81.2	79.9	73.1	80.1
Persons	**82.2**	**80.1**	**82.1**	**81.9**	**83.6**	**80.4**	**81.8**	**76.3**	**81.8**
EACHD									
Females	83.5	82.3	84.5	84.1	85.2	85.2	83.2	78.0	83.7
Males	81.6	81.3	81.4	81.6	81.9	83.0	81.7	75.9	81.5
Persons	**82.8**	**81.9**	**83.1**	**82.8**	**84.2**	**83.2**	**82.4**	**77.2**	**82.7**

Refers to location of service outlet.

The median age for CACP clients in *Very remote* areas (73.5 years) was more than 11 years below the Australian median age (83.6) (Table 3.3). The age structure among package clients in *Very remote* areas was different from other areas and had a much younger profile. For example, only 28% of clients in *Very remote* areas were aged over 80 compared with 69% for *Major cities*, 65% for *Inner regional, 60*% for *Outer regional* and 46% for *Remote* areas (Online Table A2.3).

The median age of clients was highest in *Major cities* in all three programs. The tendency for median age to drop with increasing remoteness is most clearly seen in the CACP program, reducing from 84.0 to 73.5 (Table 3.3). (There are no EACHD clients in *Very remote* regions).

Table 3.3: CACP, EACH and EACHD clients' median age by sex and remoteness[(a)], 30 June 2011

Package	Major cities	Inner regional	Outer regional	Remote	Very Remote	Australia
CACP						
Females	84.3	83.8	82.7	79.6	73.5	84.0
Males	83.4	81.9	81.6	77.5	73.6	82.7
Persons	**84.0**	**83.2**	**82.3**	**78.9**	**73.5**	**83.6**
EACH						
Females	83.2	81.8	83.1	73.9	82.0	82.9
Males	80.2	79.5	80.7	81.1	80.1	80.1
Persons	**82.0**	**80.9**	**82.3**	**79.9**	**80.1**	**81.8**
EACHD						
Females	84.0	83.2	82.3	82.3	..	83.7
Males	81.6	82.2	79.6	78.2	..	81.5
Persons	**83.0**	**82.7**	**81.7**	**79.0**	**..**	**82.7**

(a) Refers to location of service outlet. The table uses the ASGC Remoteness Structure as developed by the ABS (Box 2.2).

.. Not applicable.

Sex distribution

Overall, women made up a greater proportion of clients for all three packages: 70% of CACP clients, 63% of EACH clients and 61% of EACHD clients at 30 June 2011 (Table 3.4). Women account for 56% of the Australian population aged 70 or over (ABS 2011a) and they tend to use these services at a greater rate than men. In later years, this proportion increases with the longer life expectancies of females.

For CACP packages, the client-sex ratio among the states and territories was least noticeable in the Northern Territory and most obvious in Tasmania. In the Northern Territory, for EACHD clients, the proportion of males (54%) was higher than the proportion of females (46%).

Table 3.4: CACP, EACH and EACHD clients by sex and state/territory[(a)], 30 June 2011 (per cent)

Package/sex	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
CACP									
Females	72.3	67.0	70.0	68.8	72.4	74.2	75.8	60.6	70.1
Males	27.7	33.0	30.0	31.2	27.6	25.8	24.2	39.4	29.9
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Total (number)	**14,185**	**10,775**	**6,590**	**3,642**	**3,544**	**1,111**	**559**	**614**	**41,020**
EACH									
Females	66.4	60.1	63.3	59.8	66.7	66.5	59.1	56.0	63.0
Males	33.6	39.9	36.7	40.2	33.3	33.5	40.9	44.0	37.0
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Total (number)	**2,008**	**1,618**	**1,376**	**1,037**	**405**	**167**	**193**	**100**	**6,904**
EACHD									
Females	63.8	56.7	62.1	59.8	67.3	61.3	59.3	46.2	61.1
Males	36.2	43.3	37.9	40.2	32.7	38.7	40.7	53.8	38.9
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Total (number)	**857**	**730**	**617**	**393**	**199**	**93**	**54**	**26**	**2,969**

(a) Refers to location of service outlets.

Sex distribution by remoteness

For CACP clients, the proportion of females reduced with increasing remoteness, from 71% in *Major cities* to 61% in *Very remote* areas (Table 3.5). This trend was less definite in the EACH and EACHD programs.

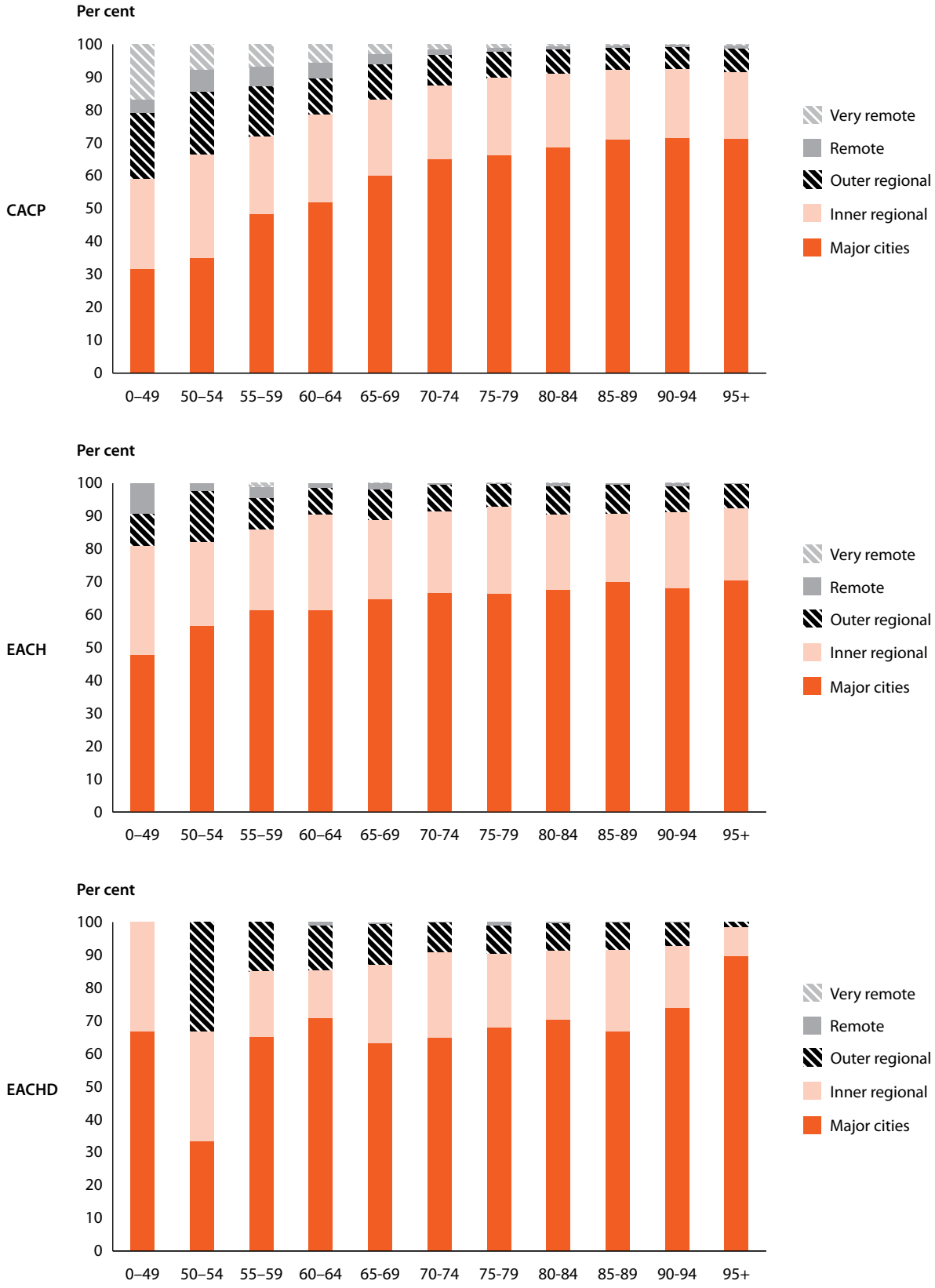
Table 3.5: CACP, EACH and EACHD clients by sex and remoteness[(a)], 30 June 2011 (per cent)

Package/sex	Major cities	Inner regional	Outer regional	Remote	Very remote	Australia
CACP						
Females	71.2	68.2	68.6	65.3	61.2	70.1
Males	28.8	31.8	31.4	34.7	38.8	29.9
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Total (number)	**27,795**	**9,074**	**3,177**	**551**	**423**	**41,020**
EACH						
Females	63.5	63.1	58.7	62.1	28.6	63.0
Males	36.5	36.9	41.3	37.9	71.4	37.0
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Total (number)	**4,637**	**1,635**	**567**	**58**	**7**	**6,904**
EACHD						
Females	62.1	59.7	59.1	31.3	..	61.1
Males	37.9	40.3	40.9	68.8	..	38.9
Total	*100.0*	*100.0*	*100.0*	*100.0*	*0.0*	*100.0*
Total (number)	**2,037**	**662**	**254**	**16**	**0**	**2,969**

(a) Refers to location of service outlets. The table uses the ASGC Remoteness Structure as developed by the ABS (Box 2.2).

.. Not applicable.

Figure 3.4: CACP, EACH and EACHD clients' age by remoteness 30 June 2011 (per cent)



Source: Online Table A2.5.

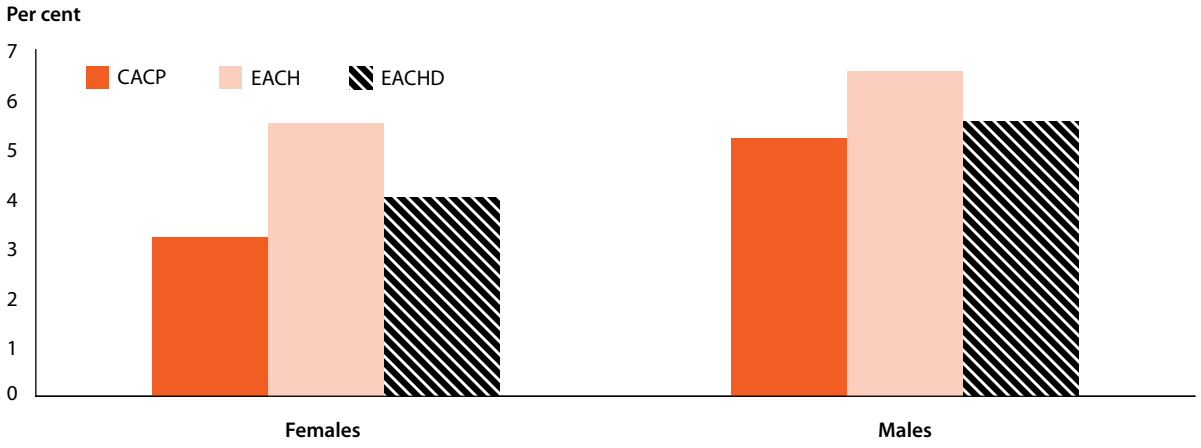
What about younger clients?

Younger people with a disability (those aged under 65) receive assistance with their care needs through services provided by states and territories under the *National Disability Agreement* (FaHCSIA 2008). If appropriate services for a young person with a disability are not available in the local area, and an ACAT assesses the person as fitting the criteria for a community aged care package, then they may receive a CACP, EACH or EACHD package (DoHA 2011a). From 1 July 2011, under the terms of the *2010–2020 National Disability Strategy* (see Appendix 1) the Australian Government will bill states and territories (except for Western Australia and Victoria) for the cost of providing these packages to people aged under 65 and for Indigenous Australians aged under 50 (COAG 2011a).

At 30 June 2011, clients aged under 65 made up 4% of CACP clients, 6% of EACH clients and 5% of EACHD clients. In all three programs a greater proportion of male than female clients were aged under 65 (Figure 3.5). This profile is very different from that of older clients (aged 65 and over) where females dominate. Further information about younger clients and aged care is found in *Younger people with disability in residential aged care: 2010–11* (AIHW 2012c).

As noted in Box 2.4, Aboriginal and Torres Strait Islander people may need to access community aged care packages at an earlier age than non-Indigenous people. A much higher proportion of Indigenous clients using these packages were under 65 compared with non-Indigenous clients. For Indigenous clients, 37% of CACP, 38% of EACH and 27% of EACHD were aged under 65 compared with 2% of non-Indigenous clients using CACP and 5% for both EACH and EACHD (Online Table A3.3).

Figure 3.5: CACP, EACH and EACHD clients aged under 65 by sex, 30 June 2011 (per cent)



Source: Online Table A 3.3.

3.3 Client background

In 2010, 36% of Australians aged 65 or over were born overseas. Older Australians born overseas are likely to be from the United Kingdom, and from the European continent (particularly Italy and Greece) having migrated in the years following World War II (AIHW 2011b). People born in Australia also come from varied backgrounds and this diversity means that the delivery of aged care services must be sensitive to the linguistic, cultural and other social circumstances of individual clients and client carers.

Indigenous status

Indigenous people receiving aged care packages in the community may choose to identify as being of Aboriginal and Torres Strait Islander origin on the application form. This identification is voluntary so the information in this section must be interpreted with that caution in mind.

At 30 June 2011, 4% of CACP, 2% of EACH and 1% of EACHD clients identified as being of Aboriginal and Torres Strait Islander origin (Online Table A3.1). In all jurisdictions except the Northern Territory, CACP clients who identified as Indigenous made up less than 6% of clients. In the Northern Territory, 61% of CACP clients identified as Indigenous (Table 3.6).
Similarly, for EACH and EACHD, most states and territories had smaller proportions of clients who were Indigenous Australians. The greatest proportion of Indigenous clients was in the Northern Territory with 16% and 27% respectively (Table 3.6).

Table 3.6: CACP, EACH and EACHD clients' Indigenous status by state/territory[(a)], 30 June 2011 (per cent)

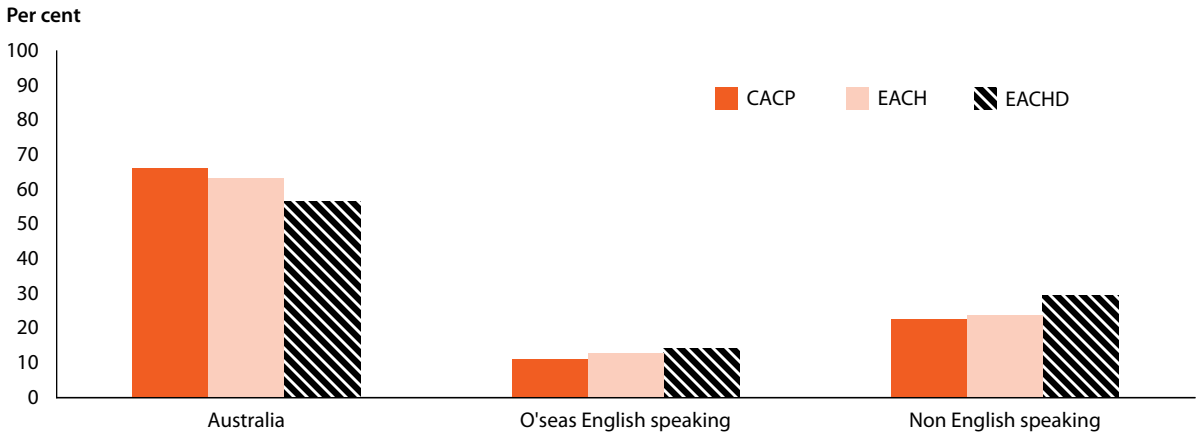
Package/ Indigenous status	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
CACP									
Indigenous	2.9	2.3	4.1	5.6	2.1	1.9	5.7	60.7	4.0
Non-Indigenous	97.1	97.5	95.9	94.4	97.9	98.1	94.3	39.3	96.0
Unknown/not reported	0.1	0.2	0.0	0.0	0.1	0.0	0.0	0.0	0.1
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Total (number)	**14,176**	**10,744**	**6,636**	**3,646**	**3,544**	**1,111**	**559**	**610**	**41,026**
EACH									
Indigenous	1.9	1.6	1.2	1.4	1.0	1.2	1.0	16.0	1.7
Non-Indigenous	98.1	98.4	98.6	98.6	99.0	98.8	99.0	84.0	98.3
Unknown/not reported	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Total (number)	**2,413**	**1,899**	**1,271**	**866**	**577**	**225**	**183**	**112**	**7,546**
EACHD									
Indigenous	0.4	1.5	1.6	1.3	0.0	0.0	1.9	26.9	1.2
Non-Indigenous	99.6	98.5	98.4	98.7	100.0	100.0	98.1	73.1	98.8
Unknown/not reported	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	*100.0*	*100.0*	100.0	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Total (number)	**850**	**730**	**624**	**393**	**199**	**93**	**54**	**26**	**2,969**

(a) Refers to location of service outlets.

Place of birth

The majority of community aged care clients at 30 June 2011 were born in Australia (66% of CACP, 63% of EACH and 56% of EACHD clients). EACHD had the greatest proportion of overseas-born clients (44%), followed by EACH (37%) and CACP (34%) (Online Table A2.6). Of the three programs, EACHD also had the greatest proportion of clients born in non-English speaking countries (19%) followed by EACH (15%) and CACP (15%) (Figure 3.6 and Online Table A2.7). The level of usage by these population groups is broadly similar and usage rates are reported in Table 4.3.

Figure 3.6: CACP, EACH and EACHD clients by country of birth, 30 June 2011 (per cent)



Source: AIHW analysis of the Australian Government Department of Health and Ageing Data Warehouse.

Ten per cent of CACP clients were born in the United Kingdom or Ireland. A similar percentage of EACH and EACHD clients were also from this area (11% and 12%, respectively). The majority of the remaining clients were from the European continent (16% of CACP, 15% of EACH and 21% of EACHD). This mix of nationalities is likely to show considerable change into the future in line with changing international migration patterns.

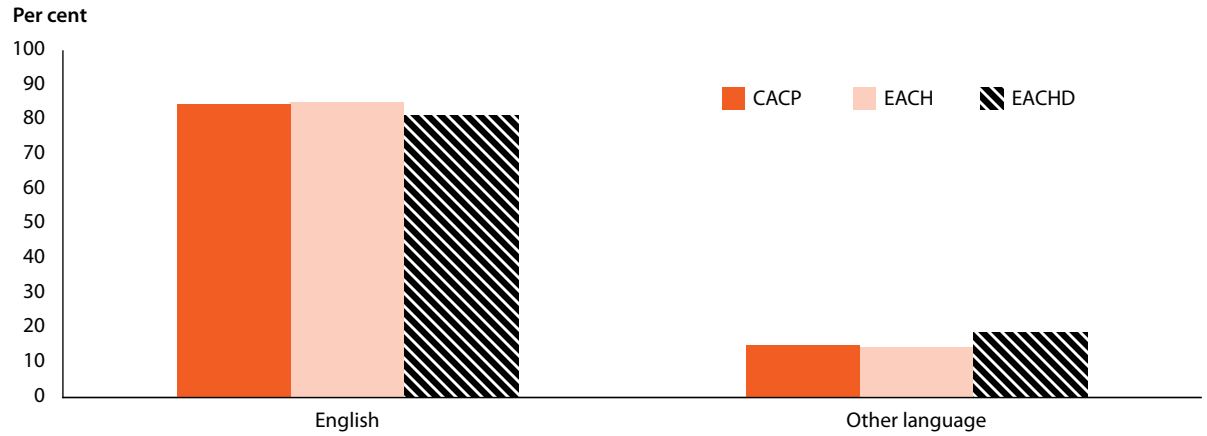
The distribution of client places of birth varied somewhat among the states and territories (Online Table A2.6). The proportion of Australian-born clients varied widely, generally being lowest in Western Australia (from 48–55% across packages) and highest in the Northern Territory (69–85%) and Tasmania (66–83%). In most jurisdictions, the most common place of birth outside Australia was the United Kingdom or Ireland; however New South Wales, Victoria and South Australia all had high proportions of clients born in Southern and Eastern Europe.

Language

English was by far the most commonly preferred language for clients in all three programs, although those with a preference other than English made up 15% of CACP clients, 15% of EACH clients, and 20% of EACHD clients (Figure 3.7).

As might be expected based on the distribution of client places of birth, Southern European languages were the most commonly preferred (7% of CACP, 7% of EACH and 10% of EACHD clients), followed by Eastern European languages (3% of clients for each of the packages) (Online Table A2.7). A very small proportion of clients preferred an Indigenous language (1% of CACP and 0.2% of EACH clients and 0.1% of EACHD clients).

Figure 3.7: CACP, EACH and EACHD clients by preferred language, 30 June 2011 (per cent)



Source: Online Table A2.7.

3.4 Client living arrangements

The usual residence for the majority of CACP clients at 30 June 2011 was a home that they owned or were in the process of buying (64%), followed by public housing (12%) and private rental (6%) (Figure 3.8). Only a very small proportion (0.3%) were living in board or lodging accommodation and 0.1% were in crisis accommodation.

The Northern Territory had the highest proportion of CACP clients living in public housing (22%). The Northern Territory also had the lowest proportion of clients living in accommodation they owned or were buying (22%) although the level of 'not stated' was high at 41% compared with the national figure of 5% (Online table A2.8).

Figure 3.8: CACP clients' residential status by state/territory, 30 June 2011 (per cent)

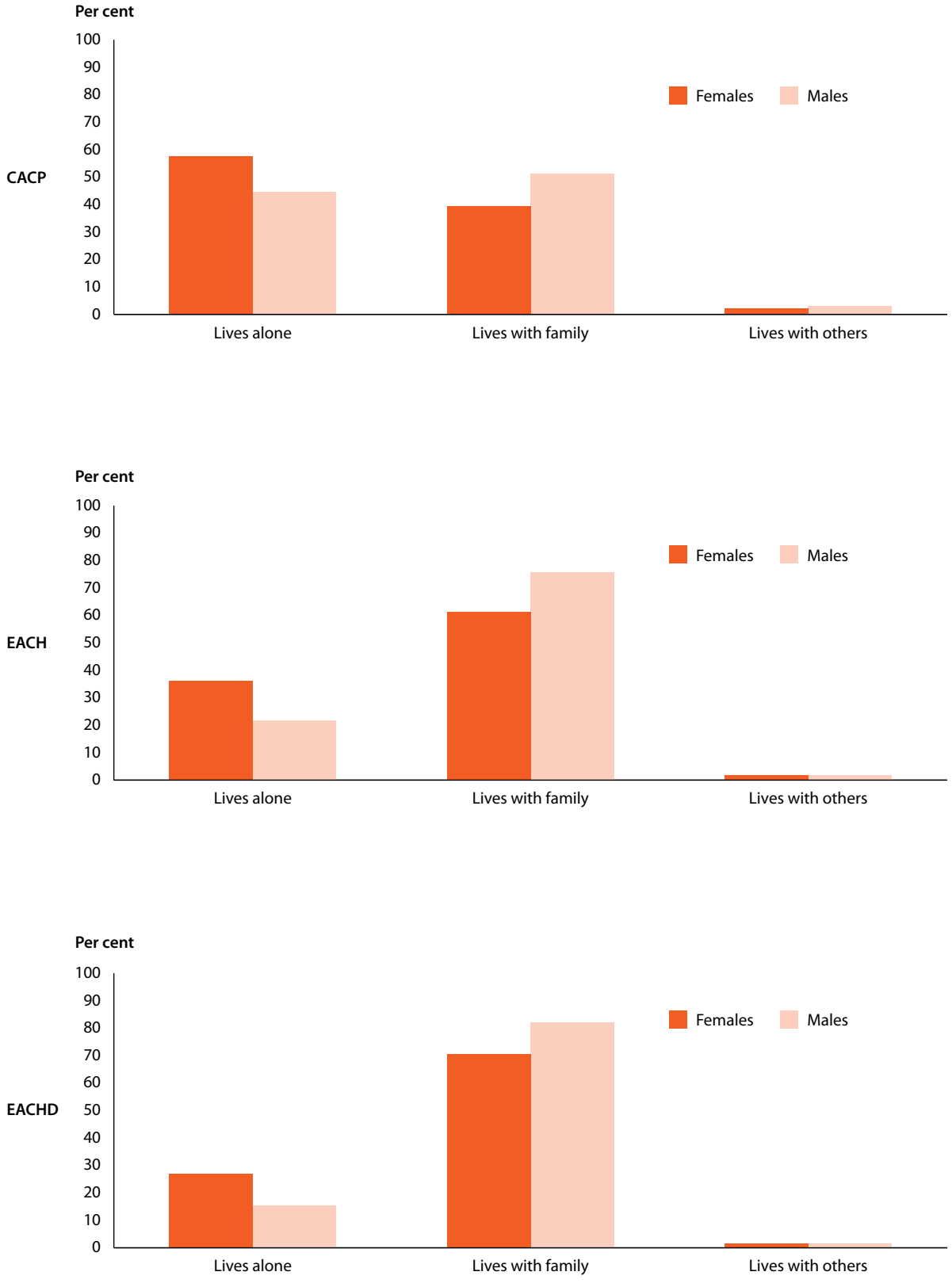
Source: Online Table A2.8.

Living arrangements of community aged care clients

Living arrangements vary for community aged care package clients, from living alone, living with family members (including marriage and de facto relationships), to living with others.

When all three packages are compared, EACH and EACHD had a higher proportion of clients living with family (67% and 75% respectively) than CACP (43%). CACP had a higher proportion of clients living alone (54%) compared with EACH (31%) and EACHD (23%) (Figure 3.9). These findings could be related to the fact that CACP programs are considered to be equivalent to low-care residential services with less formal assistance required than for EACH and EACHD programs. Across all three packages, female clients were more likely than male clients to live alone. This may be because females tend to live longer than males (ABS 2011a; AIHW 2011b).

Figure 3.9: CACP, EACH and EACHD clients by sex and living arrangements, 30 June 2011 (per cent)



Source: Online Table A2.9.

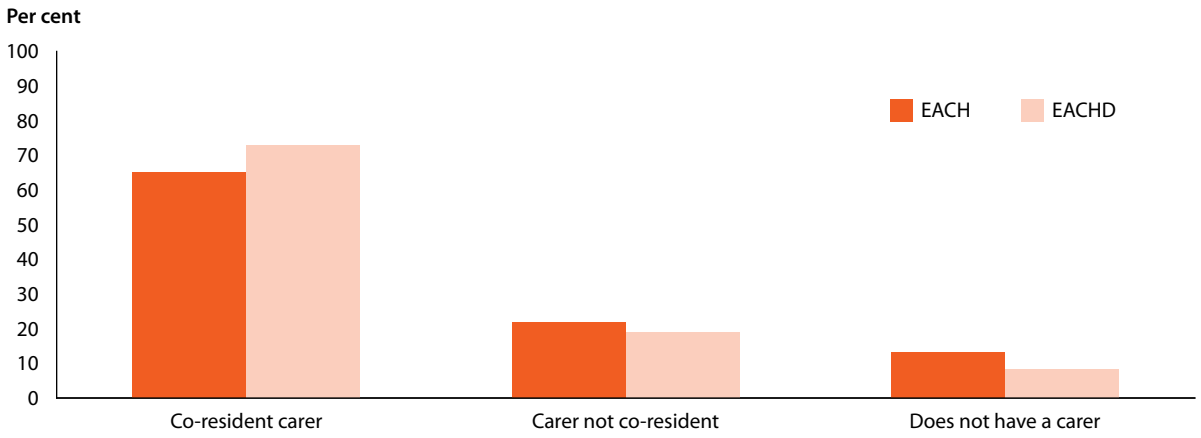
3.5 Community aged care clients and carers

A carer is a person who helps with activities that the care recipient may no longer be able to manage by themselves. The caring activities can include assistance with domestic matters such as gardening and home maintenance, or more specific things such as assistance with meal preparation, personal care (bathing), and enteral feeding. The carer can be paid or unpaid and may be a friend, family member or a professional such as a registered nurse or allied health professional. Current information about carers is available for EACH and EACHD, but not for CACP clients.

A forthcoming source of more detailed information about carers of people with dementia in Australia is the 2012 publication, *Dementia in Australia* (which includes the EACH and EACHD programs). This is an update of an earlier 2007 publication, *Dementia in Australia: national data analysis and development* which provided a profile of people in Australia who experienced dementia and reviewed the quality and availability of data (AIHW 2007). The 2012 publication is primarily designed to provide updated data analysis especially in relation to disease burden, incidence and prevalence of dementia, expenditure and characteristics and service use of people with dementia and their informal carers. Data on the EACHD program is new information included in the 2012 report.

Most clients with EACH or EACHD packages had carers at 30 June 2011; this was more common among EACHD clients (92%) compared with EACH (87%). The majority of carers were living with the client (Figure 3.11).

Figure 3.10: EACH and EACHD clients by carer status, 30 June 2011 (per cent)



Source: Online tables A2.10 and A2.11.

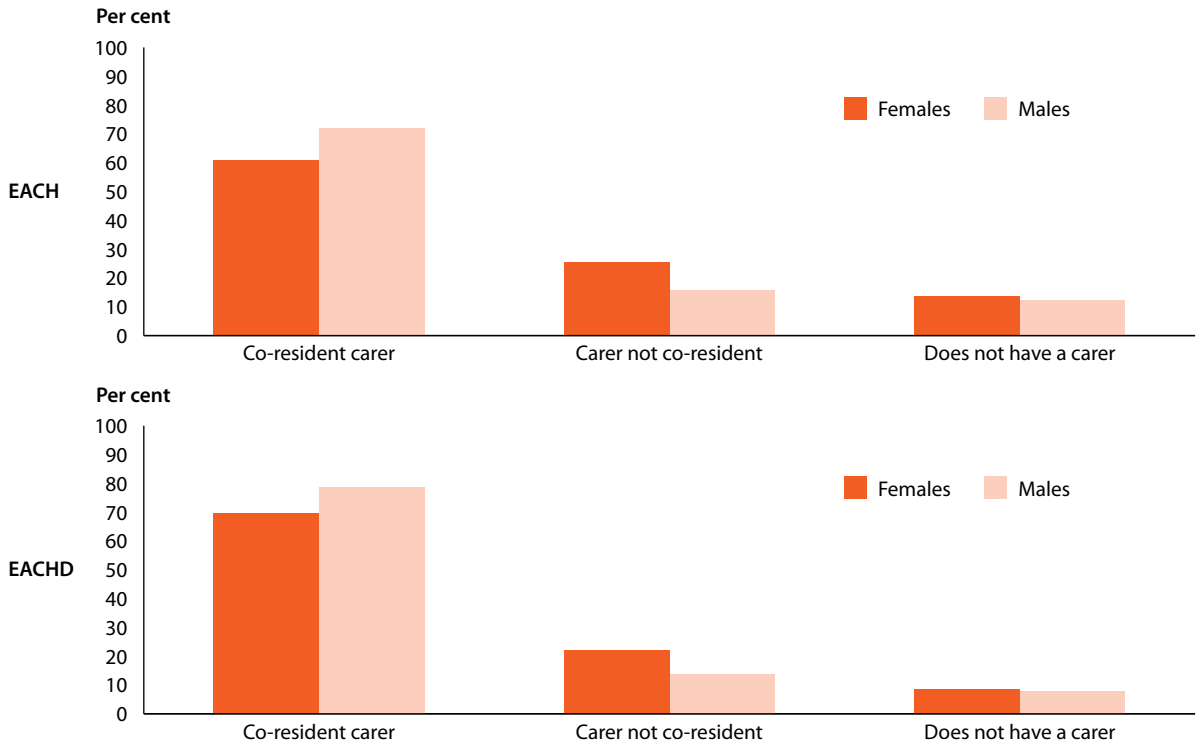
The proportion of clients with co-resident carers varied among the states and territories and was highest in Victoria for both packages at more than 90% (Figure 3.11). The Northern Territory had the second highest proportion of co-resident carers (81%). Carers of EACHD clients were generally more likely to be co-resident than carers of EACH clients.

Similar proportions of female and male clients had a co-resident carer (Figure 3.12). However, female clients were less likely to have a co-resident carer. There was some variability across age groups with the older groups less likely to have co-resident carers (Table 3.7).

Figure 3.11: EACH and EACHD clients by carer status and state/territory, 30 June 2011 (per cent)

Source: Online tables A2.10 and A2.11.

Figure 3.12: EACH and EACHD clients by carer status and sex, 30 June 2011 (per cent)



Source: Online tables A2.10 and A2.11.

Table 3.7: EACH and EACHD clients by carer status/living arrangements and age group (years), 30 June 2011 (per cent)

Package/carer status	0–59	60–64	65–69	70–74	75–79	80–84	85–89	90+	Total
					Per cent				
EACH									
Resident carer	73.8	68.1	72.0	71.0	72.8	66.6	59.3	52.5	65.0
Non-resident carer	12.4	16.0	12.4	15.7	16.8	21.5	27.2	32.3	21.8
No carer	13.8	16.0	15.6	13.3	10.5	11.9	13.4	15.3	13.2
Total persons	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Total persons (number)	**145**	**263**	**571**	**845**	**1,110**	**1,447**	**1,370**	**1,153**	**6,904**
EACHD									
Resident carer	78.2	75.6	78.8	76.8	78.1	73.9	67.7	67.7	73.0
Non-resident carer	14.5	14.6	9.6	16.1	13.4	19.1	22.9	24.3	18.8
No carer	7.3	9.8	11.6	7.1	8.6	7.0	9.4	8.0	8.3
Total persons	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Total persons (number)	**55**	**82**	**146**	**323**	**479**	**775**	**722**	**387**	**2,969**

Chapter 4

Special needs groups

4 Special needs groups

For a variety of reasons, some groups of people in Australia are recognised as being more vulnerable and as a consequence, needing extra or different kinds of assistance in comparison with other Australians. The *Aged Care Act 1997* identifies several such groups in the context of aged care service needs (Box 4.1).

This chapter describes some of the characteristics of clients from selected special needs groups and compares them with other community aged care clients. Information is presented for three groups:

- people in *Outer regional*, *Remote* and *Very remote* areas
- Aboriginal and Torres Strait Islander people
- people from non-English speaking backgrounds (also known as 'CALD' or culturally and linguistically diverse people).

Box 4.1: *The Aged Care Act 1997,* (Allocation Amendment Principles 2009) and special needs groups

Allocation Amendment Principles 2009 (No.1)

The *Aged Care Act 1997* details how funding for aged care services is provided. It was intended, amongst other things, to take into account:

- the type of care, including providing a choice in type of care
- the importance of an aged care system that responds to both clients' needs and their families'/carers' needs
- fair access by all groups of people to aged care services
- the responsibilities of service providers for their clients' outcomes
- the outcomes for clients of aged care services
- how to plan for targets and meet the needs of the aged care system.

Special needs groups

- Certain groups of people have been identified in the *Aged Care Act 1997* (section 11.3) and related *Allocation Amendment Principles 2009*, as having particular care needs. These are:
- people from Aboriginal and Torres Strait Islander communities
- people from non-English speaking backgrounds
- people who live in rural or remote areas
- people who are financially or socially disadvantaged
- veterans—including partners or widows and widowers of somebody in the Australian Defence force or allied defence force
- people who are homeless or at risk of becoming homeless
- care-leavers, who are people that as children lived in out-of-home care or foster care.

Source: The *Aged Care Act 1997 (section 11-3)* and the associated *Allocation Amendment Principles*.

4.1 People in rural and remote areas

Under the Australian Standard Geographical Classification (ABS 2010) remoteness areas are defined by population size, distance from major centres and likely access to services (Box 2.2). As a consequence, people living in *Outer regional, Remote* and *Very remote* regions are generally considered to be at a disadvantage due to the difficulty they may have in accessing certain kinds of services (see Table 2.3).

Planning ratios and allocation of places (Box 2.4) take these potential disadvantages into account for people in the 70 and over age bracket. For younger people (aged 70 and under) the CACP, EACH and EACHD programs may be the only resources available to meet their needs, especially in more remote areas.

Community aged care clients in *Outer regional*, *Remote* and *Very remote* areas have a younger age profile than those in *Major cities* and *Inner regional* areas. CACP clients in *Outer regional*, *Remote* and *Very remote* areas make up a relatively small proportion of total clients (1 in every 10). However, clients from these areas make up close to 1 in 3 clients among those aged under 60. As age increased, the proportion of those in *Outer regional, Remote*, and *Very remote* areas reduced, to slightly more than 1 in every 13 clients among those aged 90 and over (Table 4.1).

In *Outer regional, Remote*, and *Very remote* areas EACH clients made up about 1 in every 11. The greatest proportion of clients in these areas was in the under 60 age group (16%). The proportion of clients in each of the older age groups remained fairly constant, at around 1 in 10.

EACHD also had about 1 in every 11 clients in *Outer regional, Remote*, and *Very remote* areas. The greatest proportion of clients in these areas was also in the under 60 age group (18%). The proportion of clients in these areas decreased with age to about 1 in 17 for those aged 90 and over (Table 4.1).

Table 4.1: CACP, EACH and EACHD clients' age group (years) by remoteness[(a)], 30 June 2011 (per cent)

Package/remoteness	0–59	60–69	70–79	80–89	90+	Total
CACP						
Major cities	42.0	57.7	65.8	69.8	71.4	67.8
Inner regional	26.5	24.2	23.0	21.6	20.9	22.1
Outer regional	16.9	10.7	8.3	7.1	6.6	7.7
Remote	6.1	3.6	1.5	0.9	0.9	1.3
Very remote	8.5	3.8	1.3	0.5	0.3	1.0
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**721**	**2,973**	**9,853**	**20,487**	**6,986**	**41,020**
EACH						
Major cities	57.9	63.5	66.4	68.6	68.7	67.2
Inner regional	26.2	25.8	25.7	21.9	22.7	23.7
Outer regional	11.0	8.8	7.4	8.6	7.8	8.2
Remote	4.1	1.8	0.4	0.7	0.7	0.8
Very remote	0.7	0.1	0.1	0.1	0.1	0.1
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**145**	**834**	**1,955**	**2,817**	**1,153**	**6,904**
EACHD						
Major cities	58.2	65.8	66.6	68.5	76.5	68.6
Inner regional	23.6	20.6	23.9	22.9	17.3	22.3
Outer regional	18.2	12.7	8.6	8.2	5.9	8.6
Remote	0.0	0.9	0.9	0.4	0.3	0.5
Very remote	0.0	0.0	0.0	0.0	0.0	0.0
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**55**	**228**	**802**	**1,497**	**387**	**2,969**

(a) Refers to location of service outlets. The table uses the ASGC Remoteness Structure as developed by the ABS (Box 2.2).

4.2 Aboriginal and Torres Strait Islander people

As previously noted, Aboriginal and Torres Strait Islander people differ in their aged care needs compared with non-Indigenous Australians. For example, their patterns of service-use are different, including a higher use of community-based services such as CACP (Cotter et al. 2011).

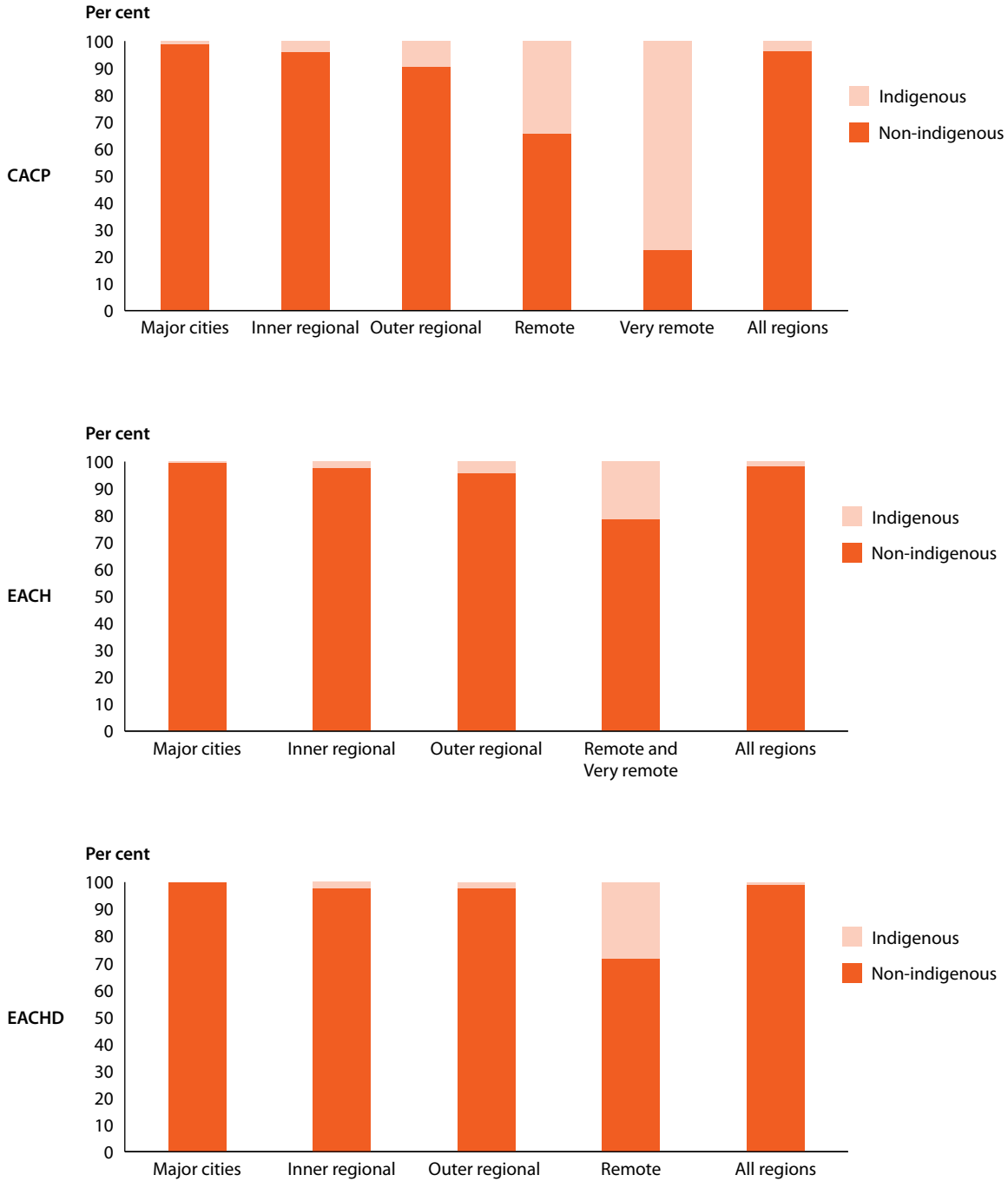
Those who identify as Aboriginal and Torres Strait Islander represent a higher percentage of younger community aged care recipients when compared with non-Indigenous Australians. The percentages (in round figures) of Indigenous and non-Indigenous people under 65 for CACP is 37% compared with 2%; for EACH it is 38% compared with 5%, and for EACHD it is 22% compared with 4% (Online Table A3.1).

At 30 June 2011, 4% of CACP clients overall had identified as being of Aboriginal and Torres Strait Islander origin but there is significant variability by remoteness. In *Very remote* regions, 78% of CACP clients were Indigenous, while in *Remote* areas, the proportion was 38% (Figure 4.1 and Online Table A3.1).

For the EACH program, clients identifying as being of Aboriginal and Torres Strait Islander origin made up a smaller proportion of overall clients across all geographic regions (2%). On the other hand, more than a quarter of the 65 EACHD clients in *Remote* and *Very remote* regions identified as Indigenous (Figure 4.1).

Indigenous clients made up a very small proportion of all EACHD clients (1%), and this reflects the current distribution of these packages in more accessible areas in the remoteness classifications. For example, 5% of the 254 EACHD clients in *Outer regional* areas were Indigenous (Figure 4.1).

Figure 4.1: CACP, EACH and EACHD by Indigenous status and remoteness, 30 June 2011 (per cent)



Source: Online Table A3.1

CACP usage rates by Indigenous status

In the younger age groups, CACP usage rates for Indigenous Australians were higher than those for other Australians (see too Cotter et al. 2011). For Indigenous clients in the 60–64 age group, the usage rate was 18.2 people in 1,000, compared with 0.5 in 1,000 among other Australians. Among those aged 55–59, the usage rates were 9.8 and 0.2 people in 1,000, respectively (Table 4.2). Overall, the usage rate among Indigenous females was around twice that for Indigenous males, a pattern reflected in the non-Indigenous population. In summary, for all age groups, Indigenous usage is higher than for other Australians.

Table 4.2: CACP usage rates by age, sex and Indigenous status[a], 30 June 2011 (per 1,000 population)[b]

Age group (years)	Indigenous			Other Australian		
	Females	Males	Persons	Females	Males	Persons
under 50	0.1	0.1	0.1	0.0	0.0	0.0
50–54	5.7	4.3	5.0	0.1	0.1	0.1
55–59	11.9	7.5	9.8	0.2	0.2	0.2
60–64	22.2	13.7	18.2	0.6	0.4	0.5
64–69	37.8	24.8	31.8	2.4	1.5	2.0
70–74	57.5	40.6	50.2	6.1	3.5	4.8
75+	92.0	62.1	80.2	29.1	15.6	23.4
Total	**3.7**	**2.0**	**2.8**	**2.5**	**1.1**	**1.8**

(a) Recipients with unknown status have been pro-rated across categories.

(b) Ratios are calculated using ABS projections (ABS 2009) and the Australian population figures released in December 2011 (ABS 2011a).

(c) Rates are calculated to 1 decimal place.

4.3 People from non-English speaking backgrounds

The migration patterns in Australia referred to earlier can mean that not all older Australians have English as their preferred language. As a consequence they may experience difficulties such as lack of understanding about the type and availability of aged care services and with communicating their individual needs and preferences (Box 4.2). In general, this group of older people tend to use community aged care differently to older Australians from an English-speaking background.

Box 4.2: English and non-English speaking background

In data sources where information about language is not available, English-speaking status may be assumed by looking at country of birth. Countries that are considered to have English as the main language are:

- Australia
- New Zealand
- United Kingdom
- Ireland
- United States of America
- Canada
- South Africa.

If a person is born in a country other than these, they are considered to be from a non-English speaking background.

According to the 2010 General Social Survey, about 15% of adults born in non-English speaking countries considered that they did not speak English well (ABS 2011d).

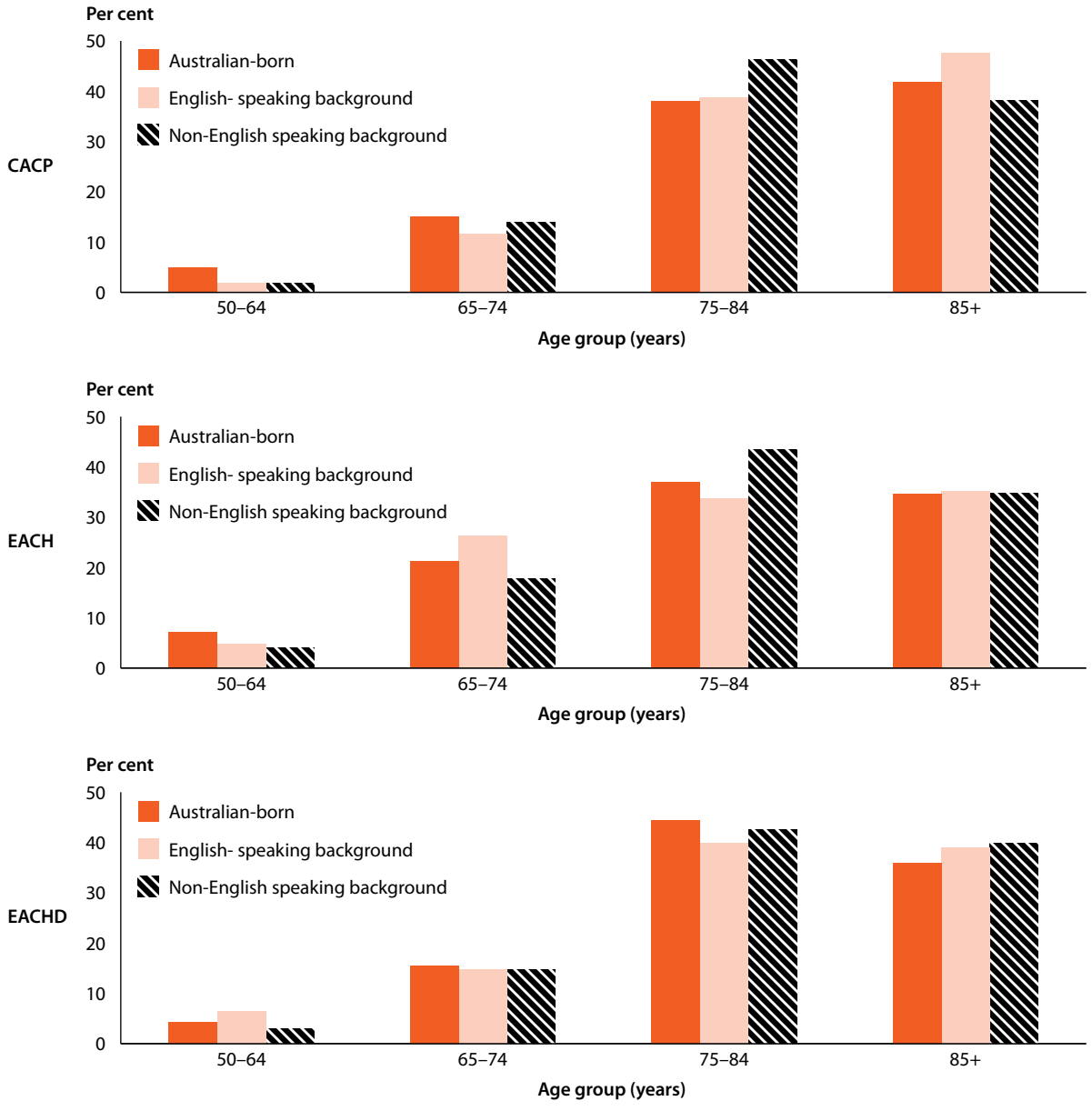
Age profile

CACP clients from a non-Australian but English-speaking background had an older age profile compared with other clients, with almost half (49%) aged 85 or over (see Figures 4.2 and Online Table A3.2). A larger proportion of Australian-born CACP clients (4.7%) were aged 50–64 compared with either of the overseas-born groups (total of 3.6%).

Among EACH clients, the non-English speaking group had an older age profile than the Australian-born or other English-speaking groups, with 79% aged 75 or over compared with 72% for the other two language groups.

The age distribution of EACHD clients by place of birth was less variable with the most common age group being 75–84. Unlike CACP and EACH, for EACHD the overseas-born English-speaking group had the largest proportion of younger clients (aged 50–64).

Figure 4.2: CACP, EACH and EACHD clients by age and English-speaking status, 30 June 2011 (per cent)



Source: Online Table A3.3.

Usage rates

The numbers in the age distribution for EACHD recipients were too small to allow meaningful usage rates to be calculated by age group and English-speaking status, so the numbers for EACH and EACH were combined.

Overall, people born in non-English-speaking countries had higher usage rates compared with those born in Australia or other English-speaking countries (Table 4.3). In the 85 and over age group for EACH and EACHD combined, overseas-born, non-English-speaking clients had a usage rate of 12.7 per 1,000, compared with 10.3 per 1,000 for overseas–born, English-speaking people, and 7.4 per 1,000 for Australian-born clients (Table 4.3).

Table 4.3: Age specific usage rates for CACP and EACH/EACHD clients by English-speaking status[(a)] based on country of birth, 30 June 2011 (per 1,000 population)

Package/age group (years)	Australian born	Overseas born		Total
		English speaking	Non-English speaking	
CACP				
55–64	0.6	0.2	0.2	0.5
65–69	2.6	1.3	1.7	2.2
70–74	5.6	3.6	5.1	5.2
75–79	10.8	8.6	12.0	10.8
80–84	21.6	21.1	26.5	22.6
85+	39.6	43.6	49.9	42.0
Total persons (55+)	**7.3**	**5.9**	**7.5**	**7.1**
EACH and EACHD				
55–64	0.2	0.1	0.2	0.2
65–69	0.8	0.6	0.6	0.8
70–74	1.6	1.7	1.6	1.6
75–79	2.7	2.8	3.3	2.8
80–84	4.6	4.9	6.4	5.0
85+	7.4	10.3	12.7	8.7
Total persons (55+)	**1.6**	**1.7**	**2.0**	**1.7**

(a) English-speaking status is based on country of birth.

Notes

Recipients with unknown status have been pro-rated.

Usage rates were calculated at the AIHW using ABS migration statistics (ABS 2008) and the ABS population estimates released in December 2011 (ABS 2011a).

Data for EACH and EACHD are combined due to small numbers.

Chapter 5

Patterns of use

5 Patterns of use

When an approved provider accepts a client via an ACAT assessment (Box 2.1), they negotiate a package of care together based on that assessment and the availability of services. Once the service begins, the client is counted as an admission and classed as a care recipient. Clients may begin and end (separate) services for a variety of reasons, including hospitalisation or entry to residential aged care (Box 5.1). This chapter presents information about the number of admissions and separations (patterns of use) for CACP, EACH, and EACHD in 2010–11. It also describes reasons for separation, length of stay (duration of care), leave types and variations in leave by package type across geographic regions (state or territory and remoteness) and according to sex.

Box 5.1: Definitions of admission, separation and separation mode

A care recipient starting a community aged care package is counted as an **admission**.

A **separation** is counted when a recipient stops using a package. The reason given for leaving a community aged care package is called the **separation mode**.

Most **leave** from a package is for hospital treatment or social reasons, like visiting family interstate, and this normally means the package is maintained for a period of time. ('Box 5.2' has definitions of the various types of leave).

5.1 Admissions

During the period 1 July 2010 to 30 June 2011 there were 20,953 CACP admissions, 5,105 EACH admissions and more than 2,669 EACHD admissions (Table 5.1).

The distribution of admissions across the states and territories was broadly consistent with population size, with around 1 in every 3 being in New South Wales whereas the Northern Territory had the lowest proportion of total admissions (Table 5.1). However, when compared with the proportion of people aged 70 or over there were relatively fewer admissions in Victoria and relatively more in Western Australia than might be expected (Table 5.1).

Table 5.1: Admissions to CACP, EACH and EACHD by state/territory[(a)], 1 July 2010 to 30 June 2011 (per cent)

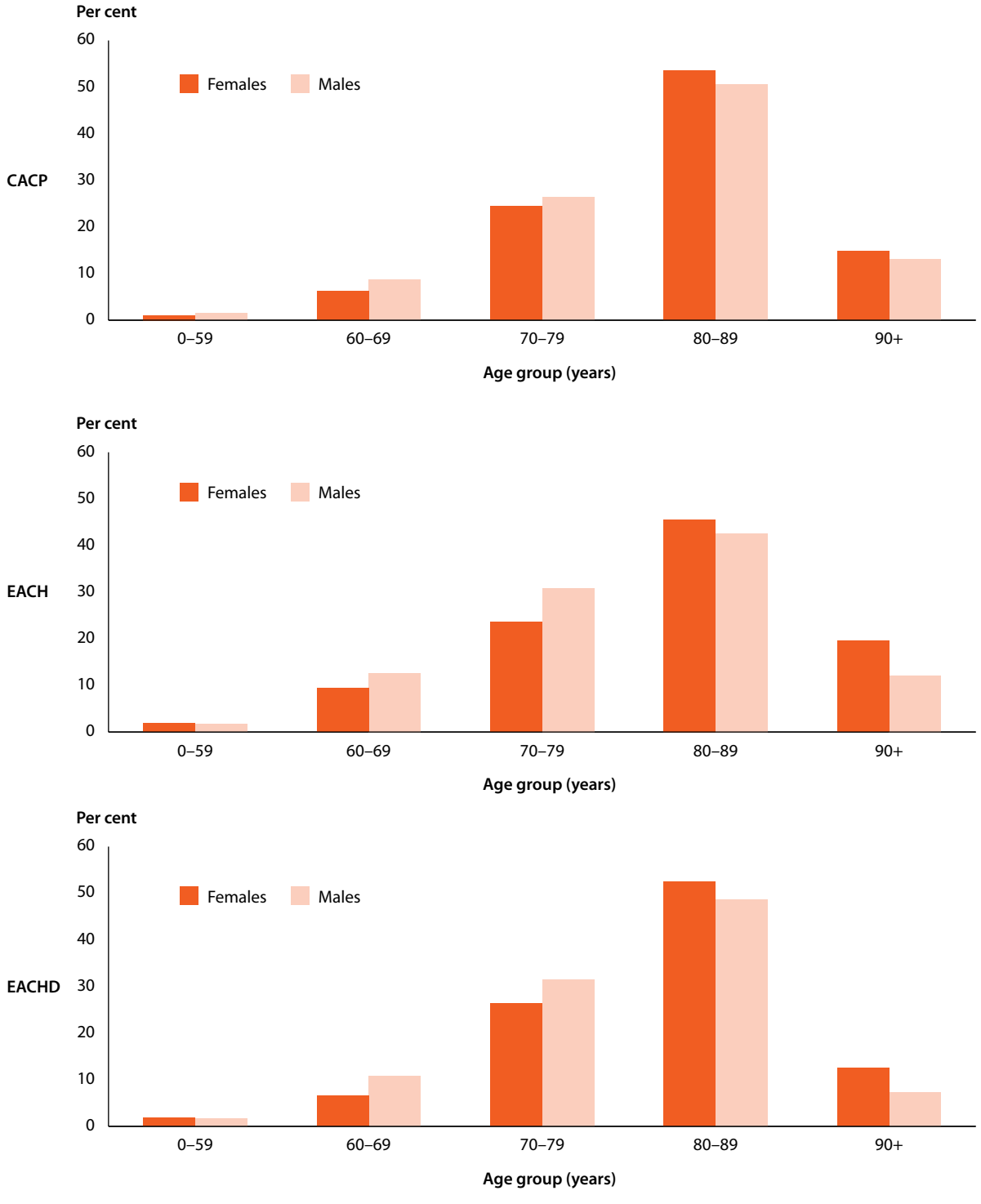
State/territory	CACP	EACH	EACHD	70+ population
NSW	33.3	27.3	25.3	33.9
Vic	22.6	19.0	23.3	25.5
Qld	19.5	24.1	24.4	18.6
WA	11.6	18.3	15.4	9.2
SA	8.0	4.3	5.8	8.7
Tas	2.3	1.9	3.1	2.6
ACT	1.6	3.4	2.0	1.2
NT	1.3	1.5	0.7	0.3
Total	*100.0*	*100.0*	*100.0*	*100.0*
Total (number)	**20,953**	**5,105**	**2,669**	**2,163,500**

(a) Refers to location of service outlets.

Note: Percentages have been rounded to one decimal place and as such may add up to slightly more or less than 100%.

The distribution of admissions by age and sex was similar across the three package types (Figure 5.1 and Online Table A4.1). More admissions were for females than males (66% of CACP, 62% of EACH and 60% for EACHD) and admitted clients were most likely to be aged 80–89 (54% in CACP, 46% in EACH and 53% in EACHD). In the 70–79 and under age groups, admitted clients were more likely to be male than female, the reverse of the pattern in the older age groups.

Figure 5.1: CACP, EACH and EACHD admissions by age and sex, 1 July 2010 to 30 June 2011 (per cent)



Source: Online Table A4.1

5.2 Separations

During the period 1 July 2010 to 30 June 2011 there were 20,064 CACP separations, 3,455 EACH separations and 1,997 EACHD separations (Table 5.1). As with admissions, the distribution of separations among the states and territories was similar for the three program types, and broadly consistent with the spread of the older population.

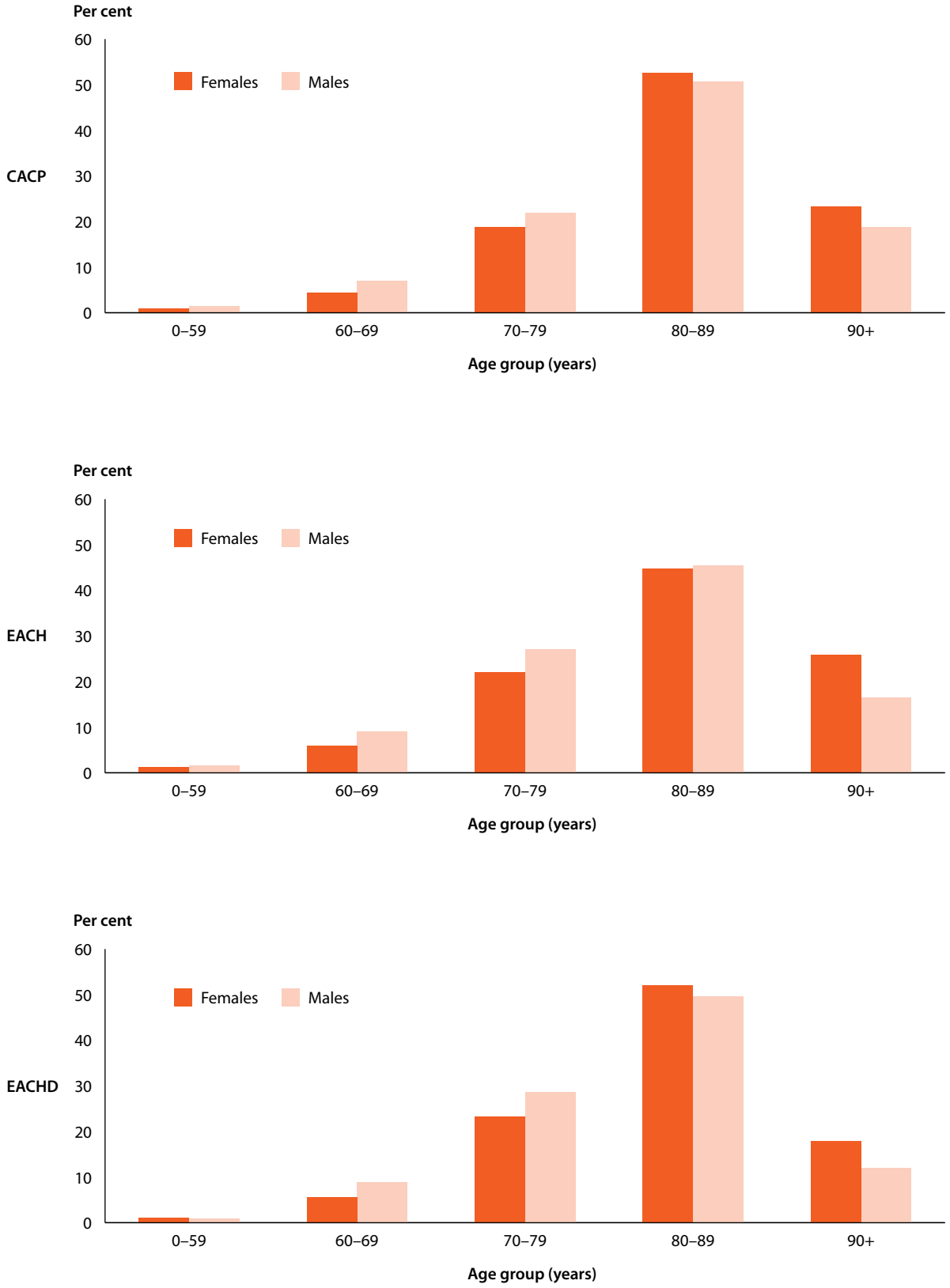
Table 5.1: Separations for CACP, EACH and EACHD by state/territory[(a)], 1 July 2010 to 30 June 2011 (per cent)

State/territory	CACP	EACH	EACHD
NSW	32.9	30.7	29.0
Vic	21.8	20.2	22.3
Qld	19.9	20.8	21.3
WA	11.9	14.5	14.0
SA	8.2	6.0	7.0
Tas	2.3	2.3	3.5
ACT	1.7	3.4	2.3
NT	1.2	2.0	0.7
Total	*100.0*	*100.0*	*100.0*
Total (number)	**20,064**	**3,455**	**1,997**

(a) Refers to location of service outlets.

The age-sex distribution of separations (Figure 5.3 and 5.4) was also similar to that of admissions (Figure 5.1). Females accounted for 67% of separations from CACP, 61% from EACH and 60% from EACHD. As for admissions, proportionally more male separations were in the younger age groups, while separations for older age groups were more likely to be female.

Figure 5.2: CACP, EACH and EACHD separations by age and sex, 1 July 2010 to 30 June 2011 (per cent)



Source: Online Table A4.3.

5.3 Separation modes

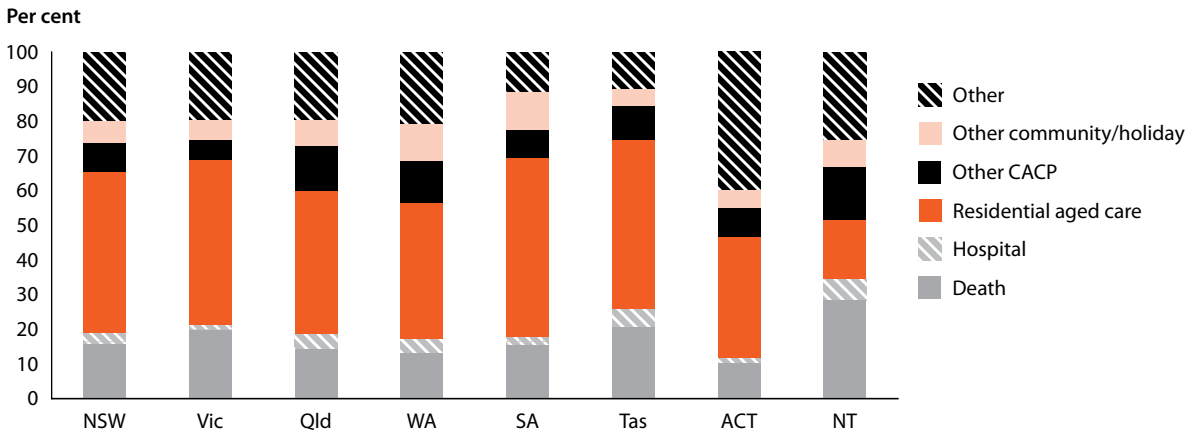
The categories of separation mode reported for CACP differ slightly from those for EACH and EACHD. Although the major categories of *move to residential aged care*, *death*, and *admission to hospital* are the same, the other categories vary. Where the different categories apply, they are briefly explained with CACP being reported separately to EACH and EACHD. In addition, leave information for EACH and EACHD clients in *Outer regional*, *Remote* and *Very remote* areas was combined due to small numbers.

Reasons for clients leaving community aged care (separation)

For all package types, the dominant reason for separations in 2010–11 was relocation to residential aged care (45% of CACP, 47% of EACH and 68% of EACHD separations). Death was also a common cause of separation, accounting for 16% of CACP, 32% of EACH and 17% of EACHD separations. Admission to residential aged care was a much more common reason for separation from EACHD than from either of the other two programs, accounting for almost 2 out of 3 separations. Death accounted for 1 in 3 separations from EACH, a substantially higher proportion than for EACHD (1 in 5) or CACP (around 1 in 6) (Online tables A4.5 and A4.6).

The distribution of separation modes varied somewhat by jurisdiction. For CACP, movement to residential aged care was less common in the Australian Capital Territory (37%) and the Northern Territory (26%), compared with the national average (45%) (Figure 5.3). Separation due to transfer to another CACP was most likely in the Northern Territory (15% compared with 9% nationally), as was admission to hospital (6% compared with 3% nationally).

Figure 5.3: CACP separation modes by state/territory, 1 July 2010 to 30 June 2011 (per cent)

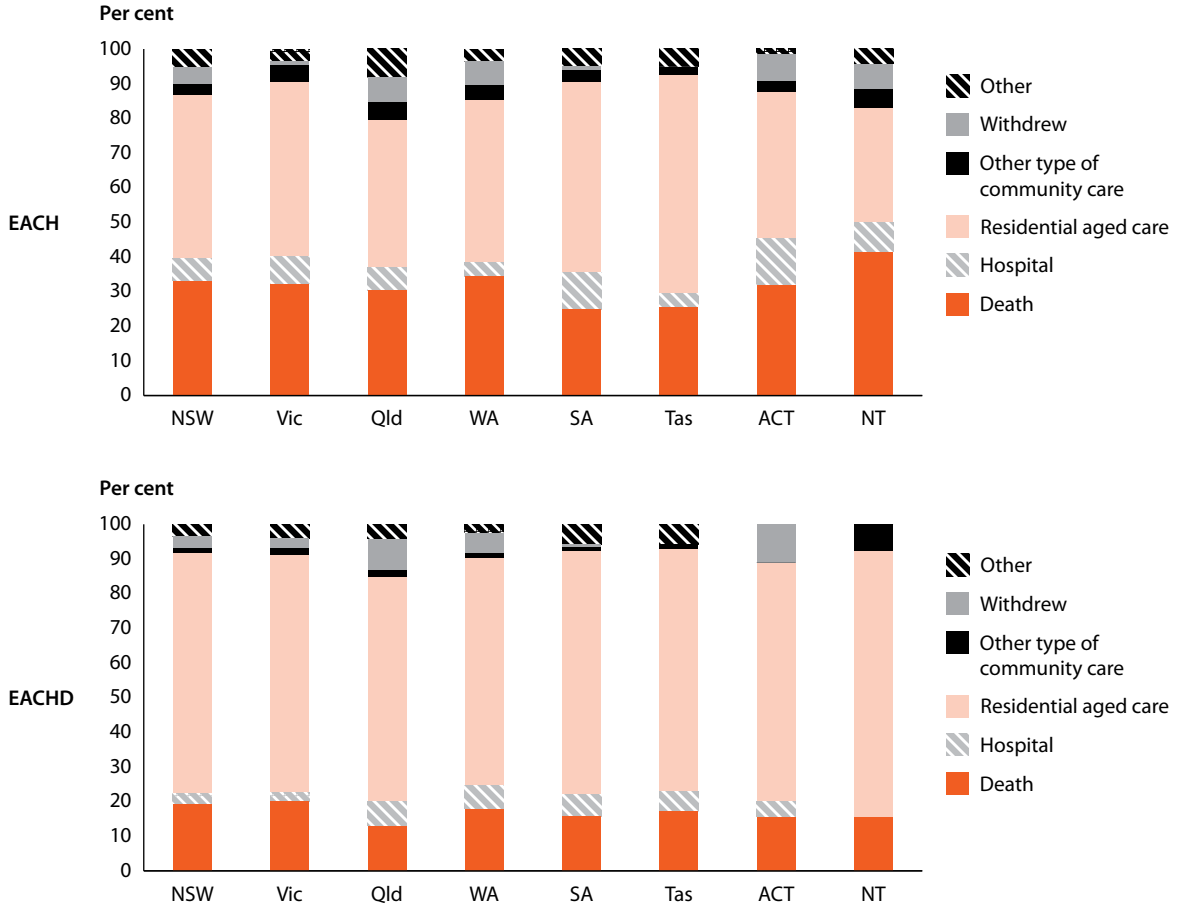


Source: Online Table A4.5.

For the EACH program, movement to residential care was also the least likely in the Northern Territory (33% compared with 47% nationally). Admission to hospital was most likely in the Australian Capital Territory (13% compared with 7% nationally) (Figure 5.4).

Slightly greater variation was seen across the states and territories for EACHD separations. In Queensland, separations were less likely to be due to death (13% compared with 17% nationally) and clients were less likely to enter residential aged care compared with other jurisdictions (65%). Queensland also had a high proportion (9%) of clients withdrawing from a package as did the Australian Capital Territory (11%).

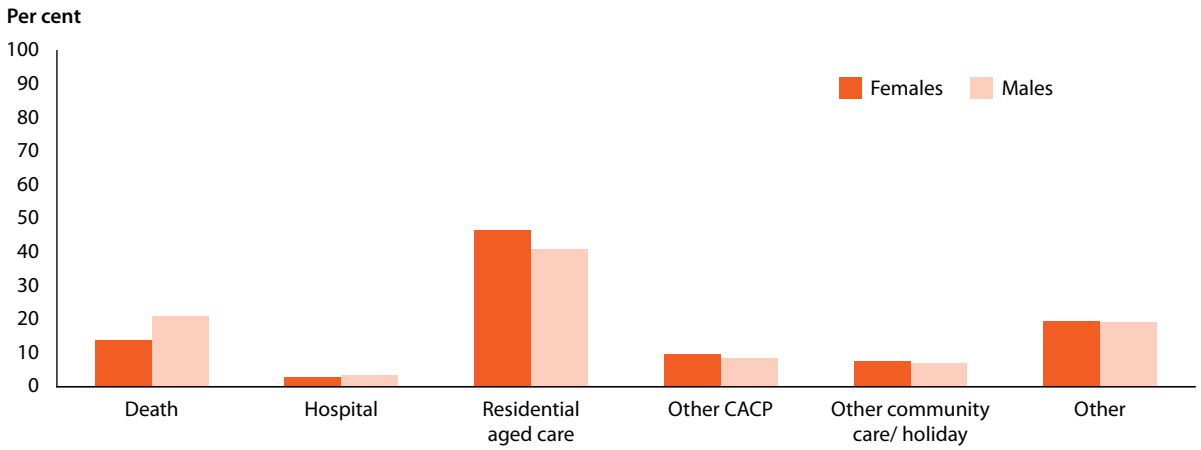
Figure 5.4: EACH and EACHD separation modes by state/territory, 1 July 2010 to 30 June 2011 (per cent)



Source: Online Table A4.6.

For CACP, females were more likely to separate and move to residential aged care (47%) compared with males (41%) whereas males were more likely to separate due to death (21%) compared with females (14%) (Figure 5.5).

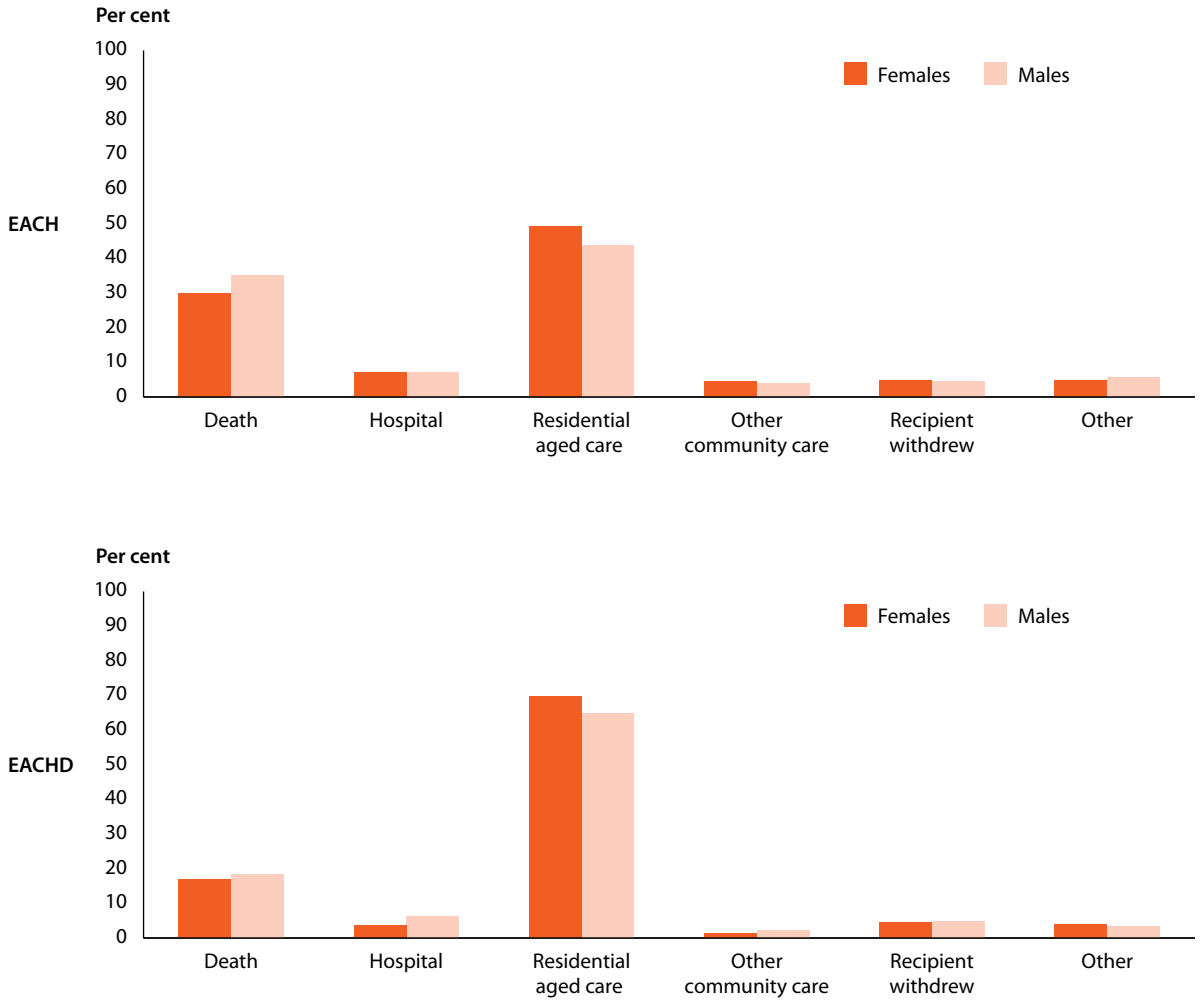
Figure 5.5: CACP separation modes by sex, 1 July 2010 to 30 June 2011 (per cent)



Source: Online Table A4.7.

Among EACH and EACHD clients, females were also more likely to enter residential aged care than their male counterparts (49% compared with 44% in EACH, and 70% compared with 65% in EACHD) (Figure 5.6). In the EACH program, males were again more likely than females to separate due to death (35% compared with 30%) (Online Table A4.8).

Figure 5.6: EACH and EACHD separation modes by sex, 1 July 2010 to 30 June 2011 (per cent)



Source: Online Table A4.8.

5.4 Length of stay

Length of stay describes how long a person was using a specific community aged care package. It is calculated by counting the days between when a package began and when the client separated from the package (Box 5.1). In this section, length of stay is only calculated for episodes of care completed in 2010–11, that is, where the separation occurred between 1 July 2010 and 30 June 2011.

In considering the data presented below, it should be remembered that following a pilot program in 2001, EACH packages were introduced in 2002 with 171 packages, and EACHD in 2006 with 601 packages (Online Table A1.5).Therefore at 30 June 2011, few EACH clients could have stayed 9 years or more, and no EACHD client could have stayed longer than 6 years.

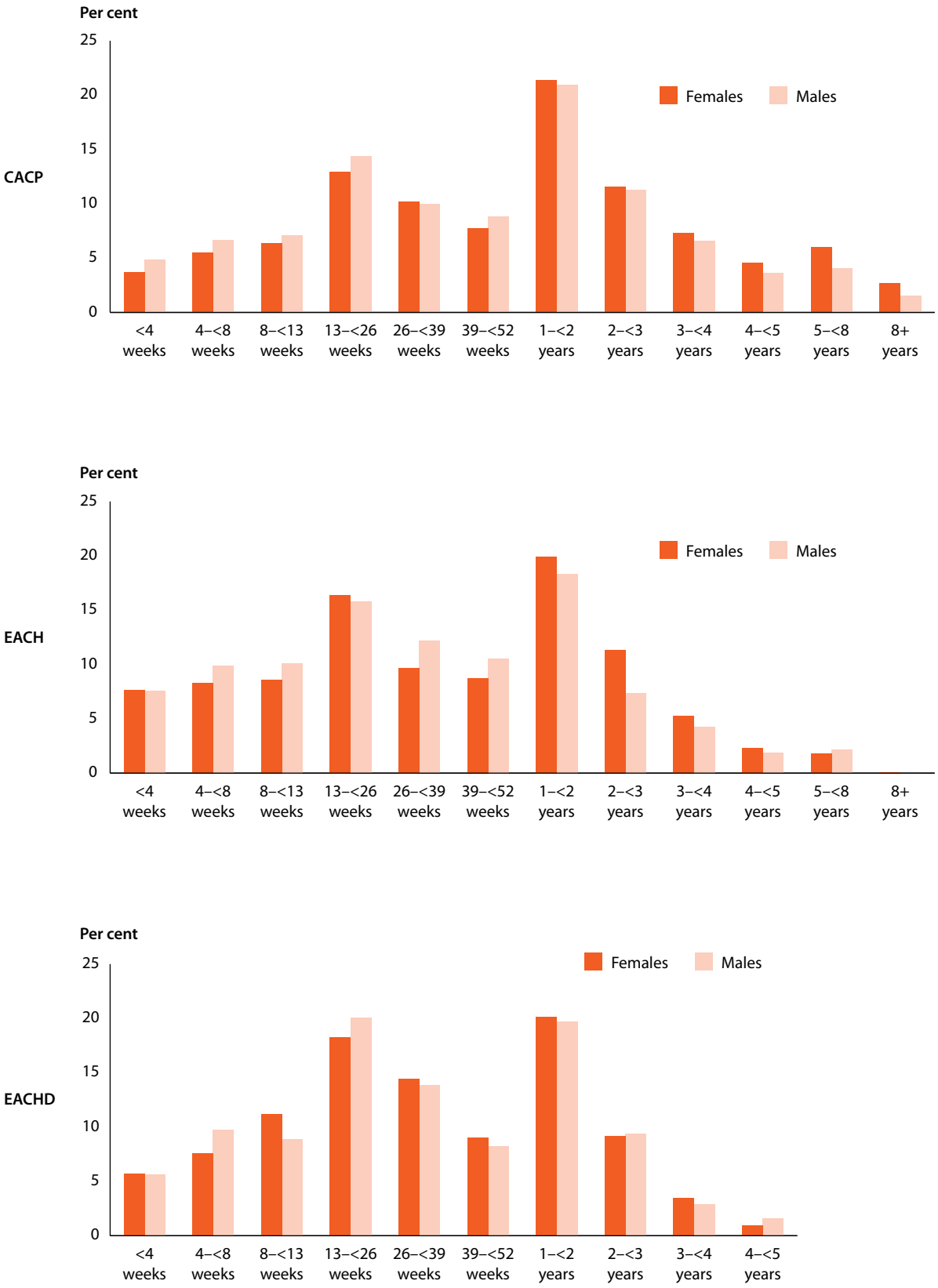
For CACP clients, 30% had length of stay greater than 2 years compared with 19% for EACH clients and 14% for EACHD clients. Length of stay between 1 and 2 years was the most common band across all three packages (Table 5.2).

Generally, the proportion of males in the shorter length of stay periods was higher than for females with this trend reversing in the longer length of stay periods (Online Table A4.9).

Table 5.2: CACP, EACH and EACHD separations by length of stay, 1 July 2010 to 30 June 2011 (per cent).

Length of stay	CACP	EACH	EACHD
<4 weeks	4.1	7.6	5.7
4 to 8 weeks	5.9	8.9	8.5
8 to 13 weeks	6.6	9.2	10.3
13 to <26 weeks	13.4	16.2	19.0
26 to <52 weeks	18.2	20.1	22.9
1 to <2 years	21.2	19.3	20.0
2 to <3 years	11.5	9.8	9.3
3 to <4 years	7.1	4.9	3.3
4 to <5 years	4.3	2.1	1.2
5 to < 8 years	5.4	1.9	0.0
8+ years	2.3	0.0	0.0
Total	**100.0**	**100.0**	**100.0**
Total (number)	**20,064**	**3,455**	**1,997**

Figure 5.7: CACP, EACH and EACHD length of stay by sex, 1 July 2010 to 30 June 2011 (per cent)



Source: Online Table A4.9.

5.5 Leave types and use across packages

Leave is important for community aged care recipients (Box 5.2). It gives them the option of time away from their package without worrying whether it will be available to them when they return. It also allows them to be socially active and visit family and friends, factors which encourage social inclusion.

Box 5.2: What is leave?

The three types of leave are *social and respite leave*, *hospital leave* and *transition care leave*.

Social and respite leave

For each financial year, CACP, EACH, and EACHD clients can have up to 56 days of social and respite leave, with a maximum of 28 days for social leave. For CACP clients this leave is not counted until after the fifth consecutive day, and then it is counted in its entirety.

Hospital leave

CACP clients have access to unlimited days of hospital leave, and still retain their eligibility to receive a CACP package on leaving hospital. Approved providers may continue to receive the community care subsidy.

EACH and EACHD clients may take unlimited hospital leave and retain their eligibility to receive an EACH/EACHD package on leaving hospital. Approved providers may continue to receive the flexible care subsidy for up to 28 consecutive days only.

Transition Care leave

CACP, EACH, and EACHD clients who have been to hospital and immediately go into the Transition Care Program can have up to 84 consecutive days leave per financial year (plus extra time if their transition care is extended) for this purpose. For example, a client could be discharged (released) from hospital, and receive transition care either in their own home or in another facility. Once the time with the transition care program is completed then the client can return to their care package (AIHW 2011d).

Source: (DoHA 2006, 2011a).

Leave for CACP is recorded differently from EACH and EACHD. For CACP, there is no breakdown by claimable or non-claimable leave (Box 5.3). For this reason, data are reported for CACP separately from EACH and EACHD. Only the first leave event was examined and therefore actual use of leave may be higher than reported.

Box 5.3: Claimable and non-claimable leave

Service providers may receive funding from the Australian Government for the packages they provide. The terms *claimable leave* and *non-claimable leave* are partly related to the service provider's ability to obtain funding for the time the client is on leave.

Claimable leave is:

- leave that falls under an approved category of leave
- leave that does not add up to more than the maximum leave days per financial year for the client
- leave for which the service provider will still be funded for that package during the absence of their client.

Non-claimable leave is:

- leave that does not fall under any of the approved leave categories
- leave that falls under one of the leave categories, yet exceeds the maximum days allowed per financial year for the client
- leave for which the service provider will not be funded for that package during the absence of their client.

In most circumstances, if a client had already used their maximum leave and wanted to take more, they may do so by continuing to pay their ongoing contribution to hold their package. This should be no more than the agreed fee and be negotiated as part of the Care Recipient Agreement negotiated by the approved provider and the client at the commencement of the service.

Source: (DoHA 2006, 2011a).

Leave by state and territory

During 2010–11, leave was taken by 14,840 CACP clients (36% of all clients at 30 June 2011), 3,062 EACH clients (44%) and 1,155 EACHD clients (52%) (Online tables A4.12 and A4.13). The majority of leave taken was claimable.

Within those totals, patterns of leave across the packages and the states and territories saw some variability.

Social and respite leave

CACP clients tend to have lower care needs so have a greater ability to take social leave and use social leave more than EACH and EACHD clients (27% compared with 14% and 18.1% respectively).

The higher care needs of EACH and EACHD clients is reflected in the greater proportion of respite leave for these programs (31% and 44%, respectively) compared with that for CACP (18%). For EACH clients, respite leave was highest in the Northern Territory (67%), followed by Tasmania (59%) and Victoria (54%).

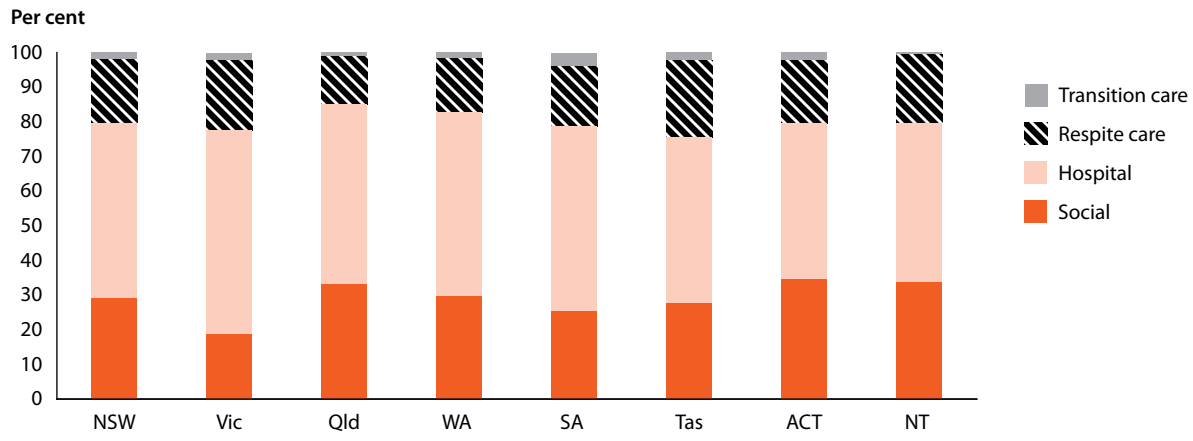
Hospital leave

Hospital leave was the most common form of leave overall (53% in CACP, 54% in EACH and 37% in EACHD) (Online Figures A4.13 and A14). Hospital leave for CACP clients was highest in Victoria (59%) and lowest in the Australian Capital Territory (50%) (Figure 5.8).

Transition Care leave

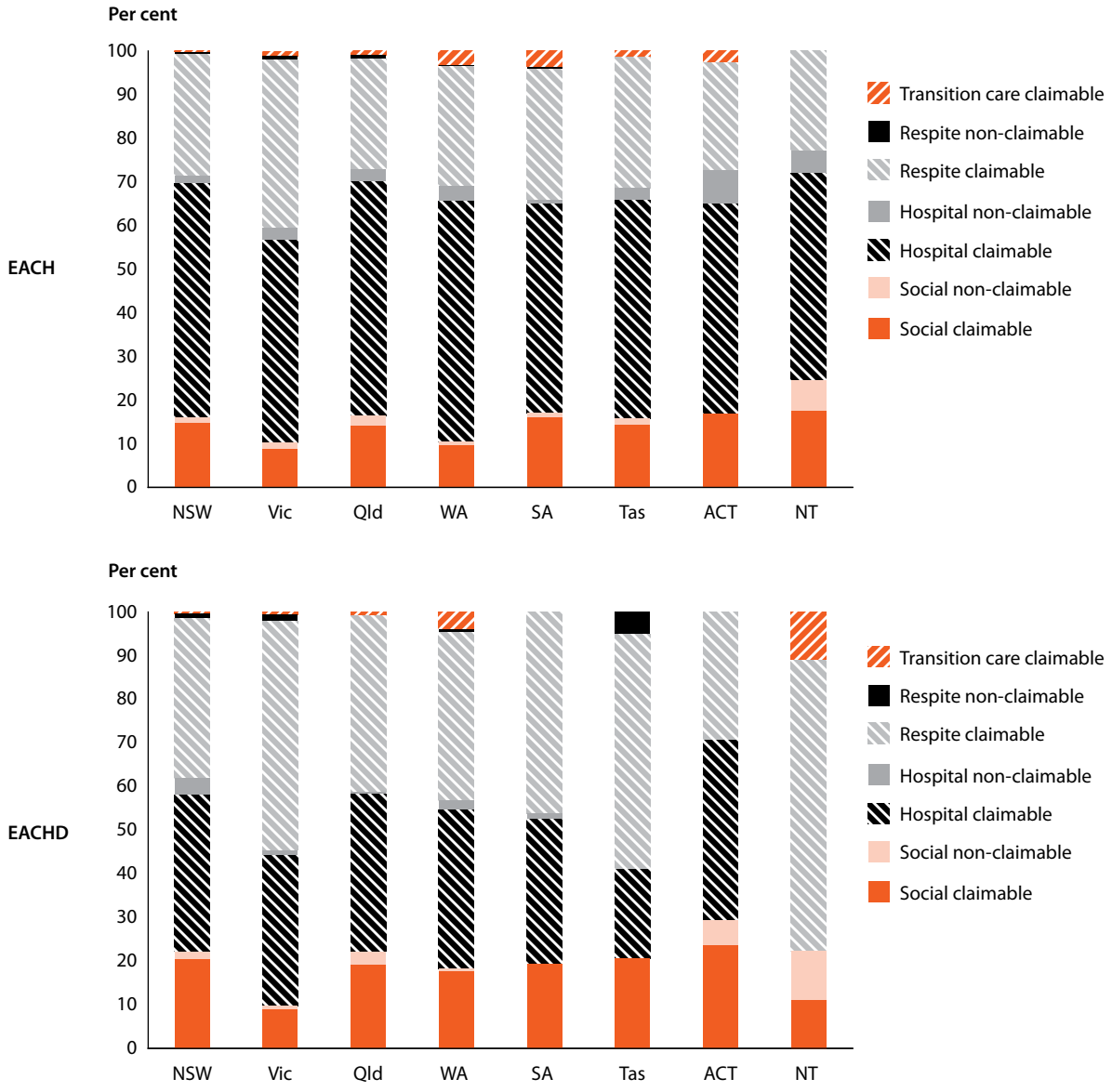
Transition Care leave was least common with a range of between 1– 2% for all three programs. Notably, EACHD clients in the Northern Territory and Western Australia had markedly higher leave for Transition Care at 11% and 4% respectively.

Figure 5.8: CACP clients leave events by state/territory, 1 July 2010 to 30 June 2011 (per cent)



Source: Online Table A4.12.

Figure 5.9: EACH and EACHD clients' leave by state/territory, 1 July 2010 to 30 June 2011 (per cent)



Source: Online Table A4.13.

Leave by remoteness

As mentioned previously, leave information for EACH and EACHD clients in *Outer regional*, *Remote* and *Very remote* areas was combined due to small numbers. Comparison of data for this combined region with those for clients in *Major cities* and *Inner regional* areas showed very little variation (Online Table A4.15).

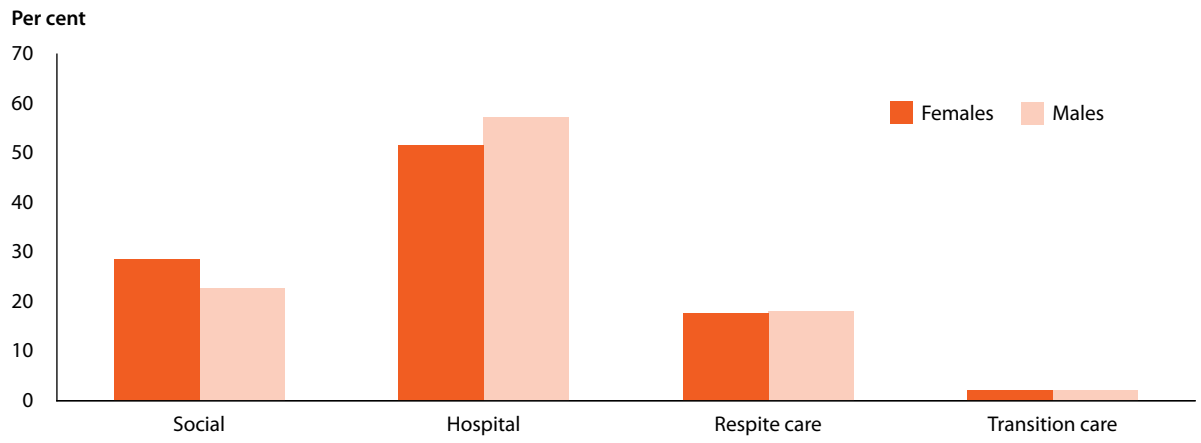
CACP clients in *Very remote* areas were more likely to have social leave (35%) and less likely to have hospital leave (31%) than clients in other areas (Online Table A4.14). Across Australia, the corresponding proportions became closer with increasing remoteness. For example, in *Major cities*, social leave and hospital leave were 27% and 56% respectively, and in *Remote* regions 31% and 45% respectively (Online Table A4.14).

Leave by sex

Female CACP clients were more likely than their male counterparts to use social leave (28% compared with 22%) and less likely to use hospital leave (52% compared with 59%). The use of respite and Transition Care leave for females and males under CACP packages was almost the same (Figure 5.10).

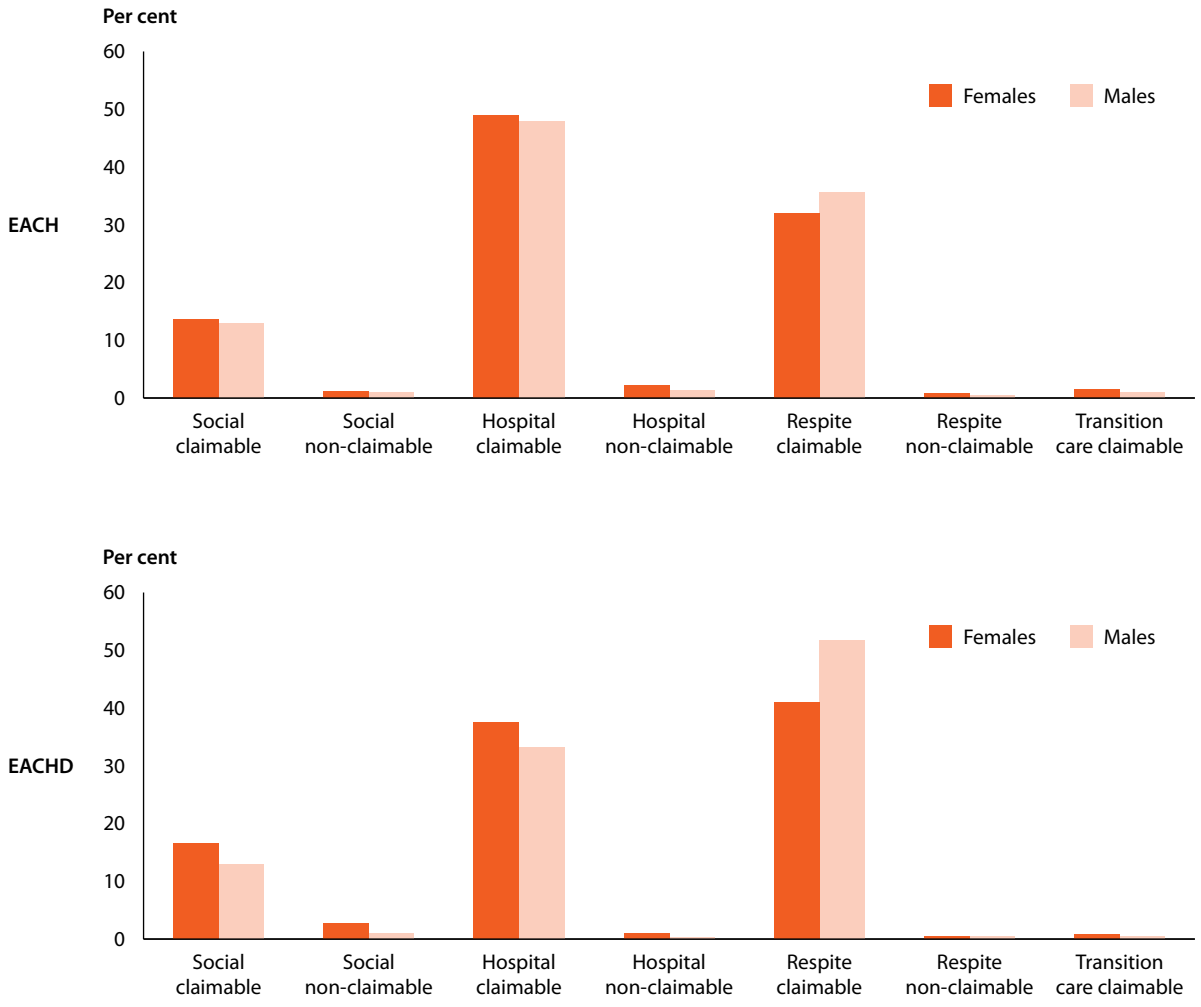
Little variation in leave types was evident between male and female EACH clients although there are around one-third more female than male clients (Figure 5.11 and Online Table A4.17). Among EACHD clients, females were more likely to use social leave, (19%) compared with males (13%). Females were also more likely to use hospital leave, at 37% compared with males, 33%, whereas males were more likely to use respite leave, at 52% compared with 41% of females.

Figure 5.10: CACP leave type by sex, 1 July 2010 to 30 June 2011 (per cent)



Source: Online Table A4.16.

Figure 5.11: EACH and EACHD leave type by sex, 1 July 2010 to 30 June 2011 (per cent)



Source: Online Table A4.17.

Chapter 6

Trends in community aged care

6 Trends in community aged care

The CACP, EACH and EACHD programs have been available for varying periods of time with EACHD the most recently introduced (in 2006). Clear trends in the use of those packages are therefore not as obvious as they are in residential aged care which has been reported upon since 1998 (AIHW & Commonwealth Department of Health and Ageing 1997; AIHW: Liu 1998). There is, however, some emerging information about trends which are described in this chapter.

Note that any further trends will be reported in subsequent years as information about the effect of the Australian Government's package of aged care reforms becomes available.

6.1 Increases in the number of packages

The number of packages available since the three programs began has been increasing consistently over time.

CACP was introduced in 1992 with 235 packages. It has grown steadily since then reaching 45,777 at 30 June 2011.

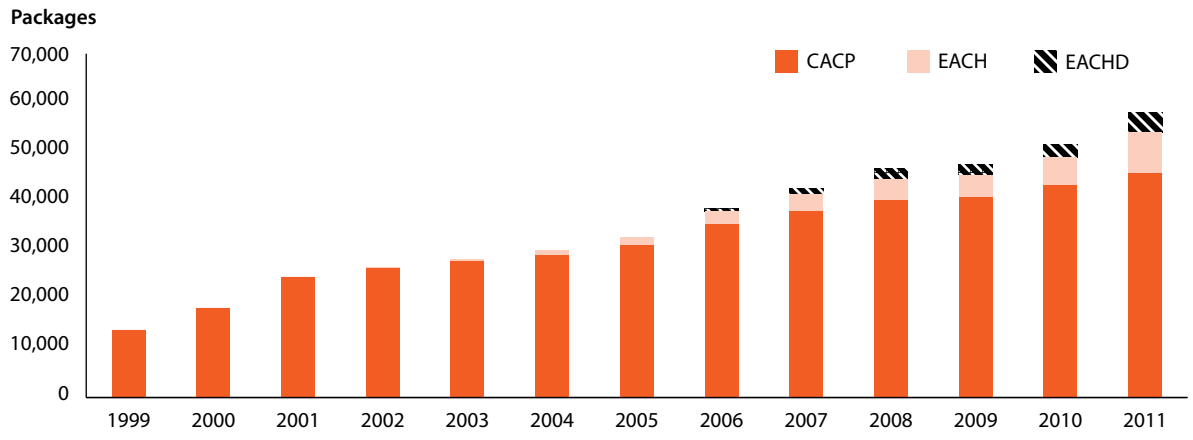
EACH was introduced initially as a pilot program in 2001, and was offered more broadly in 2002 with 171 packages rising to 8,150 at 30 June 2011. This represents an increase of 2,566 since June 2010 (from 5584 to 8150) (Online Table A1.5).

EACHD was introduced in 2006 with 601 packages rising to 3,995 at 30 June 2011. This represents an increase of 1,412 since June 2010 (from 2,583 to 3,995) (Online Table A1.5).

In percentage terms, the increases since 2009–10 have been; 6% for CACP; 46% for EACH and 55% for EACHD (Figure 6.1).

The continual increase is intended to meet the growing demand for community-based aged care, for example, with EACHD packages (DoHA 2012). The Australian Government encourages growth in community aged care by offering funding to service providers for more CACP, EACH, and EACHD packages (DoHA 2011b, 2012).

Figure 6.1: Number of CACP, EACH and EACHD packages, 30 June 1999 to 30 June 2011

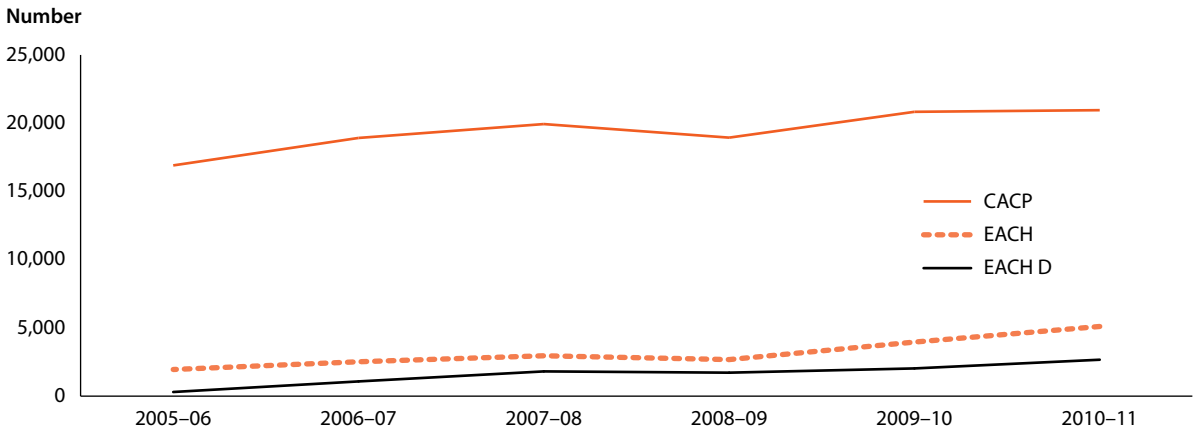


Source: Online Table A1.5

6.2 The number and distribution of admissions

Consistent with the overall and steady increase in all three packages, the total number of admissions for each of the three package types has generally increased since 2005–06, though numbers decreased slightly in 2008–09 (Figure 6.2 and Online Table A4.2).

Figure 6.2: Admissions for CACP, EACH and EACHD, 2005–06 to 2010–11



Source: Online Table A4.2.

The age and sex distribution of admitted clients stayed relatively consistent over the reporting period, with slight variation from year to year (Online Table A4.2). In line with their proportion in the older population, females accounted for 2 out of 3 CACP admissions and 3 out of 5 EACH and EACHD admissions. Around one-third of admitted clients in each program were aged 85 or over. For all three packages, the 80–84 age group consistently represents the highest number of admissions with little variation in percentage terms. For example, for this age group, admission to CACP in 2005–06 was 27% while in 2010–11 it was also 27%; for EACH it was 21% and 22% respectively and for EACHD the percentages are 28% and 27% respectively (Online Table A4.2).

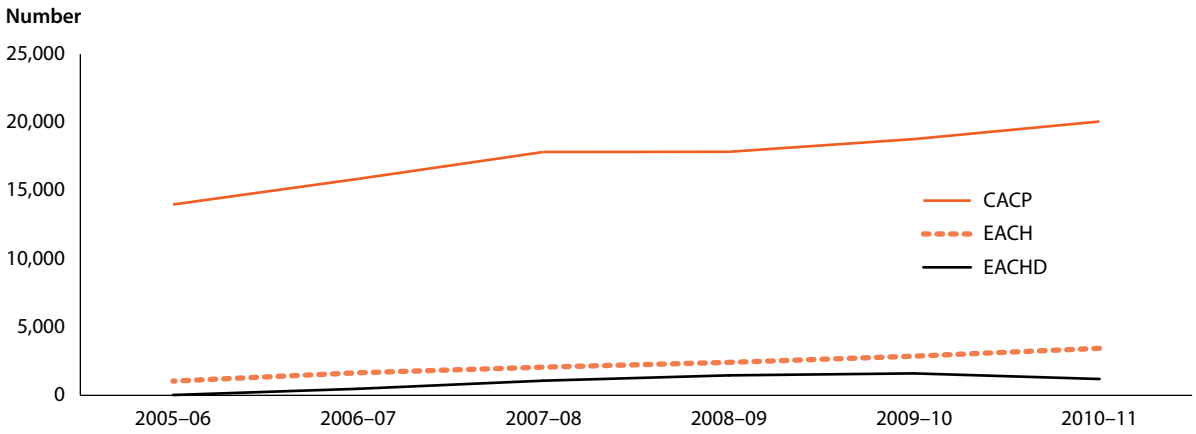
For younger Australians (aged 65 and under), admissions to all three programs have fallen slightly, possibly reflecting efforts to provide more age-appropriate and targeted services for this cohort. For this age group, and from 2005–06 to 2010–11, admissions to CACP decreased from 4% to 3%, for EACH the decrease was from 7% to 5%, and for EACHD it was 6% to 5% (Online Table A4.2).

6.3 The number and distribution of separations

Admissions are closely related to separations. The 85–89 age group is the most represented for separations, with a slight variation with those aged 80–84. For example, separations from CACP remained consistent at around 27% for 85–89, whereas separations in EACHD varied from an average of 27% for the 85–89 age group to an average of 26% for the 80–84 age group. The trend in separations for those aged 80 and over is a slight increase for the CACP and EACH programs, whereas there is a slight decrease for EACHD (Online Table A4.4).

Separations for younger people have fallen, with the greatest variation in the EACH program which fell from 6% in 2005–06 to 4% in 2010–11 (Online Table A4.4).

Figure 6.3: Separations for CACP, EACH and EACHD, 2005–6 to 2010–11



Source: Online Table A4.4.

Glossary

Admission	The occasion on which the client begins to receive community aged care from the service outlet. Admission date may also be referred to as 'date of commencement'.
Aged Care Assessment Team (ACAT)	Multidisciplinary team of health professionals responsible for determining eligibility for care.
Approved provider	A person or organisation approved under Part 2.1 of the *Aged Care Act 1997* to be a provider of aged care for the purposes of payment of subsidies. That care can include Community Aged Care Packages, Extended Aged Care at Home or Extended Aged Care at Home Dementia services (DoHA 2011b).
Birthplace (country of birth)	Country groupings follow Australian Bureau of Statistics conventions (ABS 2011c).
Care client	A person assessed by an Aged Care Assessment Team as having significant care needs that can be appropriately met through the provision of residential care, community care and/or flexible care.
Leave	A situation where the care client temporarily ceases to receive services from the service outlet to take a holiday, enter hospital or temporarily receive alternative care.
Length of stay	The time between the date of admission and the date of separation.
Living arrangements	Refers to the normal cohabitation of the client at the time of assessment.
Mainstream places	Residential aged care and community care places that exclude places in MPS and National Aboriginal and Torres Strait Islander Flexible Aged Care Programs.
Median	The **middle number** in a series after all values have been arranged or sorted from highest to lowest or lowest to highest. There are equal numbers of values above the median as below. For example, the median for the group *75, 76, 80,* ***81****, 81, 81, and 82* is 81. Where there is an even number of values in a group, the median is the midpoint between the two central values. For example, the median of *1,* ***2, 4*** *and 8* is 3.
Multi-Purpose Services (MPS)	Operating in rural and remote communities, these provide a mix of Australian Government-funded and state-funded services, including aged care services best suited to the needs of each community.
Preferred language	Preferred language groupings follow the Australian Bureau of Statistics conventions (ABS 2011b).

Remoteness

The geographical areas used in this report are based on the ASGC Remoteness Structure, developed by the Australian Bureau of Statistics (ABS 2010). This classification categorises all Census Collection Districts (CDs) in Australia according to their remoteness, based on physical road distance to the nearest urban centre. Remoteness is measured by the Accessibility/Remoteness Index of Australia (ARIA). The structure of the classification is as follows:

Major cities	CDs with an average ARIA index value of 0 to 0.2
Inner regional	CDs with an average ARIA index value greater than 0.2 and less than or equal to 2.4
Outer regional	CDs with an average ARIA index value greater than 2.4 and less than or equal to 5.92
Remote	CDs with an average ARIA index value greater than 5.92 and less than or equal to 10.53
Very remote	CDs with an average ARIA index value greater than 10.53.

Respite care	A care package may provide in-home respite and arrange for social activities or other out-of-home services that help prevent social isolation for care recipients and their carer. A care package may also fund short-term respite in response to an emergency or an unplanned event.
Separation	The point at which a client ceases to receive community aged care from a service outlet.
Separation mode	Indicates the destination of a care client at separation, including death.
Service outlet	The physical location from which CACP, EACH or EACHD funded assistance is delivered to care recipients. It is the location (or locations) that the approved provider (and its staff) use to plan, coordinate and manage the provision of care and support to its care clients.
Supplementary care recipients	Care clients receiving regular Community Aged Care Package assistance, but for whom their service providers are not entitled to claim the Community Care Subsidy.
Usual residence status	Refers to the housing tenure before the client's application for a Community Aged Care Package.

Appendix A: Online tables

The online tables referred to in the text and listed below are available on the AIHW website at www.aihw.gov.au. Data cubes are also available on the website.

Table A1.1: CACP, EACH and EACHD service outlet size, 30 June 2011

Table A1.2: CACP, EACH and EACHD service outlet size by remoteness, 30 June 2011 (per cent)

Table A1.3: CACP, EACH and EACHD outlets, state territory by remoteness, 30 June 2011 (per cent)

Table A1.4: CACP, EACH and EACHD services, organisation type by state/territory, 30 June 2011

Table A1.5: Number of CACP, EACH and EACHD packages, 30 June 1992 to 30 June 2011

Table A1.6: Provision ratio by state/territory, 30 June 2011

Table A1.7: Average occupancy rate for CACP, EACH and EACHD, by state/territory and remoteness, 1 July 2010 to 30 June 2011

Table A2.1: CACP, EACH and EACHD clients, state/territory by remoteness, 30 June 2011 (per cent)

Table A2.2: CACP, EACH and EACHD clients, by age group and state/territory, 30 June 2011

Table A2.3: CACP, EACH and EACHD clients, by age group and remoteness, 30 June 2010 (per cent)

Table A2.4: CACP, EACH and EACHD clients by sex and age group (years), 30 June 2011 (per cent)

Table A2.5: CACP, EACH and EACHD clients by age group and remoteness 30 June 2011

Table A2.6: CACP, EACH and EACHD clients by birthplace and state/territory 30 June 2011

Table A2.7: CACP, EACH and EACHD clients by preferred language, 30 June 2011 (per cent)

Table A2.8: CACP clients, usual residence status and state/territory, at 30 June 2011 (per cent)

Table A2.9: CACP, EACH and EACHD, living arrangements by sex, 30 June 2011 (per cent)

Table A2.10: EACH clients' carer status by state/territory, 30 June 2011

Table A2.11: EACHD clients' carer status by state/territory, 30 June 2011

Table A3.1: CACP, EACH and EACHD clients by Indigenous status and remoteness, 30 June 2011 (per cent)

Table A3.2: CACP, EACH and EACHD clients by age and English-speaking status, 30 June 2011 (per cent)

Table A4.1: CACP, EACH and EACHD admissions by age, 1 July 2010 to 30 June 2011 (per cent)

Table A4.2: Admissions to CACP, EACH and EACHD by age and sex, 2005–06 to 2010–11

Table A4.3: CACP, EACH and EACHD separations by age, 1 July 2010 to 30 June 2011 (per cent)

Table A4.4: Separations from CACP, EACH and EACHD by age and sex, 2005–06 to 2010–11

Table A4.5: CACP separation modes, by state/territory, 1 July 2010 to 30 June 2011

Table A4.6: EACH and EACHD separation modes by state/territory 1 July 2010 to 30 June 2011

Table A4.7: CACP separation modes by sex, 1 July 2010 to 30 June 2011

Table A4.8: EACH and EACHD separation modes by sex, 1 July 2010 to 30 June 2011

Table A4.9: CACP, EACH and EACHD length of stay by sex, 1 July 2010 to 30 June 2011 (per cent)

Table A4.10: CACP clients' leave by state/territory and leave type, 1 July 2010 to 30 June 2011 for recipients at 30 June 2011

Appendix B: The reporting environment for community aged care

Over the last 25 years there have been a range of reforms of the aged care system, the most recent of which is the package released by the Australian Government in April 2012 (Section 1.2). Overall, the reforms have increasingly placed emphasis on formal assessment processes and expanded the focus of care provision from residential aged care to enabling a continuum of care. There has also been increasing emphasis on the development of community aged care programs designed to both supplement and complement residential aged care (AIHW 2009b, 2011b).

Since 1997, the (then) Commonwealth Department of Health and Family Services and AIHW agreed to participate in a joint venture to publish nursing home and hostel data, with AIHW taking over the task of producing the publications. Previously, data about nursing homes and hostels (now called residential aged care facilities) had been published by the Department. The first publication in the AIHW series, entitled *Nursing Homes in Australia 1995–96: a statistical overview*, was released in December 1997 (AIHW & Commonwealth Department of Health and Ageing 1997), and its companion *Hostels in Australia 1995–96: a statistical overview*, was released in May 1998 (AIHW: Liu 1998). Since then AIHW has published more and more on aged care-related matters, including regular reports on residential aged care and community aged care. This report, *Aged care packages in the community 2010–11: a statistical overview* and its companion report *Residential aged care in Australia 2010–11: a statistical overview* contribute to the current aged care reporting environment.

Publications of the Australian Institute of Health and Welfare

The two reports AIHW now publishes focus on specific aspects of community aged care and the residential aged care system. They are one element in a number of information sources about aged care and are complemented by other AIHW publications:

In alternating years AIHW publishes two major reports about health and welfare in Australia. Each publication contains a chapter on older Australians. For example, Chapter 6 in *Australia's Welfare 2011* provides information on the characteristics of older Australians, including their health status, community participation and financial resources (AIHW 2011b). *Australia's Health 2012* includes discussion of healthy ageing as not only a (health) state, but also a process; for example, of adapting successfully to life circumstances and engaging in health-promoting behaviours (Chapter 2.7) (AIHW 2012a) <http://www.aihw.gov.au/publication-detail>.

The Pathways in Aged Care (PIAC) series specifically reports on aged care using linked data across aged care programs. One recent example is *Pathways in aged care: do people follow recommendations?*(AIHW 2011c). This publication presents large-scale analysis of the use of aged care services such as changes in use of care programs over time and concurrent use of programs.

The Ageing and Aged Care Unit of AIHW publishes reports on various specific aspects of aged care and some of those publications are referred to in the residential and community aged care reports, for example, *Older people leaving hospital: A statistical overview of the Transition Care Program in 2008–09* (AIHW 2011d).

Report on Government Services

The annual *Report on Government Services* (RoGS) was commissioned in 1993 by the Heads of Government (now Council of Australian Governments or COAG), to assist in the monitoring and review of the effectiveness and efficiency of government services. From 1995, the report has included a chapter on aged care, covering both residential aged care and community care (Chapter 13 in the 2012 edition) (SCRGSP 2012). The report provides an insight into the aged care system concentrating on service delivery performance indicators and the supply of services whereas this report and the community aged care report focus more on the demand for services and the characteristics of people using the services.

Report on the Operation of the Aged Care Act 1997

The *Aged Care Act 1997* introduced a statutory requirement to report annually to Parliament on the operations of the Act. The report (ROACA) is produced by the Australian Government Department of Health and Ageing (DoHA 2011b). The report describes government activities under the Act during the reporting period and includes additional information concerning aged care programs, initiatives and policies.

Council of Australian Government (COAG) Initiatives

There are two initiatives from COAG that are of relevance to aged care: the *National Health Reform Agreement* and the *2010–2020 National Disability Strategy*.

In early 2011 COAG made a commitment to various aged care reforms. These were reaffirmed with the *National Health Reform Agreement* which was finalised with government in August 2011 (COAG 2011b). One aim of the agreement is to develop a nationally consistent and better integrated aged care system. Under this agreement, and subject to relevant legislation being passed, the Australian Government will be responsible for funding basic community care in most states and territories for people aged 65 and over (50 and over for Indigenous Australians). The agreement represents a significant shift towards a greater role in planning, funding, policy, management and delivery of the national aged care system by the Australian Government.

The *2010–2020 National Disability Strategy* was released by COAG in 2011. (The phrase in the strategy 'people with disability' includes the ageing process) (COAG 2011a). The development of the strategy is the first time in Australia's history that all governments have committed to a unified, national approach to improving the lives of people with disability, their families and carers, and to providing leadership for a community-wide shift in attitudes.

As results of the implementation of the agreement and the strategy become available, they will be incorporated into AIHW publications as relevant.

Appendix C: Data sources and limitations of the data

The data presented in this report are from the Australian Government Department of Health and Ageing's Ageing and Aged Care Data Warehouse. This data warehouse has information gathered through a number of instruments. Two are directly relevant to this report:

- The Aged Care Client Record (Form 3020). This is the form used for the application, assessment and approval of a client applying for Australian Government subsidised care for residential aged care, a community aged care package, or flexible care (for example, an Extended Aged Care at Home (EACH) or Extended Aged Care at Home Dementia (EACHD) package or Transition Care package). This form is completed by an Aged Care Assessment Team (ACAT) in consultation with the applicant, and the application for approval is signed either by the applicant or by someone on their behalf. An ACAT Delegate approves the care for which the applicant is eligible before the form is transmitted to Medicare. These types of care are not subsidised without an ACAT approval.
- The Provider Claim Form. This form is completed by the service provider for claiming the flexible care subsidy that is payable for the service for a payment period: normally one calendar month.
- Forms may be completed and transmitted as paper forms or as electronic forms. The word 'form' thus needs to be interpreted accordingly.

Other instruments through which information on the service providers was gathered include the Approved Provider Status Application and the Application for a Determination that an Approved Provider is in a Position to Provide Care—Flexible Care Places. Transition Care providers are required to use a form entitled 'Application for a Determination that an Approved Provider is in a Position to Provide Care—Transition Care Places'.

General population data are taken from the latest Australian Institute of Health and Welfare population databases supplied by the Australian Bureau of Statistics.

Care recipients' details

All care recipients entering Australian Government subsidised care for a CACP, an EACH package or an EACHD package must have a valid approval. A CACP approval is normally valid for a period of 12 months from the date of approval. Approval of applications is the responsibility of the ACAT delegate (DoHA 2006).

The information entered into Ageing and Aged Care Data Warehouse from the Aged Care Client Record is the source of the following data items used in this report:

- sex
- date of birth
- Indigenous status
- Country of birth
- language spoken at home
- usual residence status (at assessment) OR usual accommodation (at assessment)
- living arrangements (at assessment)
- carer status (at assessment).

Some recipient details, such as financial hardship status and carer support status, are obtained from the Provider Claim Form, which are submitted monthly and should be regularly updated.

Care recipients' admission and separation details

The Provider Claim Form is sent to approved service providers at the beginning of a payment period. This form has the details of existing recipients under the care of service providers (the form would be blank for a new provider). It is the responsibility of service providers to check this form for accuracy and record new data and changes relating to new admissions, separations and leave for their care recipients.

The Provider Claim Form is the original source for the following data items:

- date of admission
- date of separation
- separation mode
- length of stay (derived from date of admission and date of separation)
- updates to financial hardship status
- updates to carer status.

Service providers' details

Details about community aged care service providers are collected through the Approved Provider Status Application and the Community Care Service Agreement between the Australian Government and the service provider. These documents are the main source for the following data items:

- location of service outlets (by both state/territory and geographical area)
- number of approved places in service outlets.

Limitations of the data

The following points should be noted when interpreting the data presented in this report.

The data used for this report were those available in the Ageing and Aged Care Data Warehouse in November 2011. However, as this warehouse is 'refreshed' periodically, minor differences in some data will occur, depending on the version used for reporting.

- Some socio-demographic characteristics of care recipients are recorded at the time of application, and some may not reflect their true characteristics while receiving care from these programs. These include usual residence status and living arrangements.
- Due to the non-compulsory nature of self-identified Indigenous status, the number of people presented in this report who identified themselves as of Aboriginal and Torres Strait Islander origin may be an underestimation of the true number using these programs.
- Although the location of service outlets can be used to infer the location of CACP, EACH, and EACHD recipients, it is possible that outlets provide services to care recipients who live outside the outlet's jurisdiction or geographical area.
- The lack of information on areas such as type of assistance received by care recipients, their levels of dependency and (for CACP recipients) carer support means that analysis of recipient's care needs was outside the scope of this report.

Each allocated package is provided to one specific service recipient, referred to as a funded care recipient. However, when all the allocated packages provided by a service are filled but the funding allows for additional services to be provided to other people, service outlets may provide services to additional people, referred to as supplementary recipients. The 2008 Community Care Census (DoHA 2010) collected data about the services received by CACP, EACH and EACHD care recipients between February and May 2008 and followed an earlier census of CACP and EACH which was undertaken in 2002 by AIHW (AIHW 2004). The 2008 Census reported slightly more than 1% (376) of all CACP recipients as supplementary care recipients. This has decreased since the 2002 census where 3% (825) were supplementary recipients. Such recipients are not represented in the CACP reporting.

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Aged care packages in the community 2010–11 describes the key characteristics of services and recipients and also looks at the distribution of services relative to the needs of the population. At 30 June 2011 there were 50, 900 recipients of care packages. About 1,200 providers delivered low-care packages, 500 delivered high-care packages and 340 providers delivered high-care specialised dementia packages.