Transitioning Australian Respite

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National Respite

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Abbreviations and Glossary

ABS	Australian Bureau of Statistics
ACFI	Aged Care Funding Instrument
Carer	Family, friends and significant other people who support the participant
CDC	

Executive Summary

The Social Policy Research Centre, at UNSW Australia, has conducted a research project with the aim of examining the impacts for participants, carers, communities and government of transitioning respite services into consumer directed care (CDC) markets. The focus was on the major reform

related to respite, carers, consumer directed markets, disability support and older people. We

- Australian Government *Report on Government Services* (2014) (Aged Care Services)
- Australian Institute of Health and Welfare Residential aged care in Australia 2010 11: A statistical overview (2012)
- Carers NSW 2012 Carer Survey .

Drawing on the above data sources, the service mapping provides details of respite outputs across Australia by the type and number of service users, the number of service hours, the service type, the geographical location, and government expenditure.

2. The Australian policy context: The shift to a consumer directed care model

Main points

- The National Disability Insurance Scheme (NDIS) and the Commonwealth Home Support Program (CHSP) reforms focus on personalised services and a shift to consumer directed care in the disability and aged care sectors.
- The NDIS shifts from block to individual funding. It focuses on the needs of the person with disability and makes provision for the carer only insofar as it improves the support of the person with disability.
- The CHSP is characterised by a mix between block funding and a person-centred model. It focuses on the participant and the care relationship, not on the carer, although it continues to fund some respite for carers of frail older people.
- Prior to the NDIS reform, respite was funded by the state and Commonwealth Governments and was provided by private for-profit and not-for-profit organisations.

Prior to recent reform processes, which have involved a shift to CDC, respite services to people with disability, older people and carers were provided through a number of state and Commonwealth programs. State Governments funded respite services for people with disability and their carers as part of a suite of disability services. The joint funded state- and Commonwealth Home and Community Care Program provided respite services for older people and their carers. The Commonwealth-funded National Respite for Carers Program (NRCP) provided respite to carers both of people with disability and older people. A range of other smaller programs at the state and Commonwealth levels provided respite to specific groups of consumers and carers. While funded by the state and Commonwealth Governments, most respite was provided by private for-profit and not-for-profit organisations and local governments.

Two large reform processes with a focus on personalised services and CDC in the disability and aged care sectors are likely to change the way that respite is organised and provided. The NDIS and the CHSP both focus on the needs of the consumer, which raises challenges for a traditional model of respite as a method of meeting the *dual needs*
carer.

The NDIS means a shift from block to individual funding to meet the needs of the person with disability. It addresses the needs of the carer only in that it improves the care and support of the

services. Its aim is to simplify access to information and support to help carers maintain their caring role (DSS, 2015b).

At the same time, there have been efforts in Australia to introduce services that more comprehensively address the needs of carers. In particular, the National Respite for Carers Program (NRCP) and the National Carer Counselling Program were introduced with the aim of addressing two of the areas in which carers report the greatest need for support. They are accessible through Commonwealth Respite and Carelink Centres that were designed to offer a

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3. How can we best understand and evaluate change?

Main points

- Respite consists of short intervals of rest from the routine of a caregiving relationship to support the health and wellbeing of both the carer and the service participants (people with disability, long-term illness, or frailty due to old age).
- The term respite is contested by some disability advocacy groups and scholars in the field,

  t
- The costs and outcomes of respite are difficult to identify, measure and evaluate because

What is respite care?

This section set outs what respite care is, what its history and purposes are, and what its costs, benefits and outcomes are. It is the foundation of the outcomes section of the service framework. Research suggests that the costs, benefits and in particular the outcomes of respite, research suggests that these are difficult to identify, measure and evaluate. This is because the potential outcomes are diffuse; differentiated across beneficiaries, such as participants and carers; subjective and changing; and are sometimes shared within families. Consequently, it is extremely difficult to evaluate the extent to which these kind of outcomes are a result of respite or a result of a wide array of other factors, in
al., 1995). This means researchers have found it difficult to define outcomes that can be quantified and effectively measured. In addition, outcome measures developed through these methods are not necessarily consistent with the outcomes that are valued by those whom respite is meant to support: participants and their carers and families (Bamford et al., 2009, 16). This is problematic as the accounts of service users and what they value should be central to the evaluation of respite service effectiveness (Cotterill et al., 1995). As a result, in understanding the costs, benefits and outcomes of respite, this report draws on the perspectives of those who use respite, focusing on what participants and carers report about why they value respite, how they benefit from it, and where the challenges lie.

Background

In the first instance, respite care emerged in response to a reported need by families and carers of a person with disability, long-
(Ashworth and Baker, 2000) from their caring responsibilities (Robinson, 1994; Bamford et al., 2009). The time and space would provide them with the opportunity to rest or to undertake activities that would contribute to their emotional, social, physical and material health and wellbeing. It would also, it was hoped, ultimately contribute to the ongoing health and wellbeing of the care relationship.

More recently, there has been much greater emphasis on the importance of respite in providing a break for the service participants, (Robinson, 1994; Bamford et al., 2009; Kirkley et al., 2011). The important role of respite in supporting independence, social participation and a range of other outcomes for the participant has become increasingly central, so that the service objectives, equally contribute to the emotional, social, physical and material health and wellbeing of both the carer and the participant. Research with participants, however, suggests that the term respite can be viewed in a pejorative way, suggesting
., 2004). In recognition of this change in the function of what was traditionally respite, and in response to

mford et al., 2009).

The *dual objectives* of respite in meeting important outcomes for the health and wellbeing of both the carer and the participant have become central. At the same time, the broader outcomes for the care relationship and for all family members have now become a focus of policy and service provision, such that in some countries, respite has now become a service that is provided to

As such, the costs, benefits and outcomes of respite are experienced by participants, carers, and other family members and the outcomes are not just for individuals but for relationships between participants and carers and other family members. From this point, the report replaces the phrase es positive and negative outcomes.

Outcomes of respite

The review of the literature identified a wide range of outcomes of respite for different individuals, relationships, groups and the community. The literature is concentrated on the outcomes for *individual* participants and carers and on improving emotional, relational, social, physical and material wellbeing. It is also more heavily focused on the perspectives and experiences of carers rather than those of participants, and more research needs to be done that draws on the perspectives of participants. Howev

mental health. For example, studies of people with dementia found that they valued respite

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respite improved the cognitive abilities of the participant and improved behavioural challenges (Arksey et al., 2004).

Research also suggests that respite can create positive outcomes for the physical health of both carers and participants (Arksey et al., 2004). For example, carers report being able to overcome tiredne

Respite can also be beneficial for the participant , particularly where it is designed to meet their therapeutic needs (Canadian Healthcare Association, 2012), and where it provides opportunities for diagnosis of medical conditions or needs (Arksey et al., 2004). Respite can also -promoting self- VON Canada, 2002). For example, carers report getting rest, catching up on sleep (Cramer and Carline, 2008; Laragy and Naughtin, 2009), taking a walk or doing other exercise or just having some time for themselves (Arksey et al., 2004; VON Canada, 2002).

Respite can also have positive outcomes for individual wellbeing by increasing autonomy for both participant and carer, creating enhanced freedom, choice, and diversity in tasks and activities or a

without worrying about the wellbeing of the person they care for (Laragy and Naughtin, 2009), a sense of freedom and choice about the activities they can undertake during periods of respite, and more control over their use of time (VON Canada, 2002; Arksey et al., 2004). Participants report

.,

th, what they do, what they eat, what they spend

., 1995).

Social and economic participation

Respite can also generate positive outcomes for the social and economic participation of participants and carers by improving their opportunities for engagement with institutions and community activities. Both participants (Arksey et al., 2004) and carers (Cramer and Carline, 2008) report that respite offers opportunities to participate in social and recreational activities, to reduce feelings of isolation (Cotterill et al., 1995) and to build social and life skills (Canadian Healthcare Association, 2012), including connectedness to the community. Carers who participated in work or further education reported that respite supported them in managing and completing these activities: their caring and work responsibilities (Arksey et al., 2004), and continue in and complete their education (Hamilton and Adamson, 2013).

Personal relationships

Respite can also provide positive outcomes for the personal relationships of participants and carers, ensuring greater longevity of the caring relationship and providing opportunities to cultivate or strengthen their relationships with family or friends (VON Canada, 2002).

Carers report using the time offered by respite to spend time with friends, sustain existing friendships (Cotterill et al., 1995) and build new friendships (Arksey et al., 2004). Carers also report using the time to work on family relationships (Arksey et al., 2004) and in particular, they identified

the importance of having time to spend with their partners and other family members (Cramer and Carline, 2008). Families also report better relationships and cohesion as a result of having access to periods of respite (Cotterill et al.

which the carer can enjoy the break and use the time in the way that they wish that is important for creating the positive outcomes.

Negative outcomes

While the emphasis in the above sections is on the positive outcomes associated with respite, its provision can also affect carers and participants in negative ways (Cotterill et al., 1995). For example, carers sometimes feel guilty or anxious about whether the person they care for will be looked after (Laragy and Naughtin, 2009). Some carers report that the use of respite feels like a personal failure (Arksey et al., 2004). Participants have also reported negative outcomes of respite, including feeling alone, excluded, unsafe, and anxious about being in respite, particularly if the service was unfamiliar (Arksey et al., 2004). In a study on people with dementia, sometimes the change to the routine created by respite triggered behavioural difficulties that were troubling for both the participant and the carer (Laragy and Naughtin, 2009). The research suggests, however, that negative outcomes were often a result of inadequate, inappropriate or poor quality respite services. Some reports, for example, stated that the complexity of organising respite added more stress, or that carer stress was actually increased when the respite service was perceived to be inadequately addressing the needs of the participant (Arksey et al., 2004, Laragy and Naughtin, 2009).

What are respite services?

Respite care is provided or organised by respite services and takes a number of forms. This section discusses who provides respite and in what form, and informs the *outputs* section of the service framework. The international and Australian literature suggest that respite services are usually characterised by the *setting*

Service framework for understanding respite outcomes and outputs

Drawing on the Australian and international literature on the outcomes of respite this section sets out a service framework. This is a conceptual tool for understanding continuity and change in respite outputs and outcomes in the new policy context. In order to be able to fulfill this function, the service framework attempts to use language that is neutral and transferable across disability and aged care service systems, participant and carer groups, and the current and future service contexts being examined.

or independent from, specific service arrangements in Australia and the other countries surveyed. To create an abstracted framework, the research team underwent the following process:

- It compiled a list of (positive and negative) outcomes of respite that were raised in the literature (see previous section).

4. What might policy changes entail for respite in Australia?

Main points

- Consumer directed care (CDC) typically involves the provision of cash or vouchers to consumers so that they can select and purchase services directly and receive them where they prefer in their homes and communities.
- CDC can take many forms, including personalisation, self-directed care, direct payments, individual budgets (piloted in England from 2005 to 2007), personal budgets (introduced into
-for-
- Results from the 2011 and 2013 English POET surveys found that:
  Personal budgets had a positive impact on the life of both personal budget holders and carers, including control of their support, wellbeing, physical health, and relationships with

The previous sections have set out the policy reform processes in Australia that are likely to change the way that respite is conceived, organised and delivered, before setting out a conceptual service framework for understanding these changes. The framework is a method of exploring and evaluating how respite outputs may be altered as a result of the changing service context, including possible alterations to the *character* of respite (location and activities, including transport), the *amount and availability* of respite (quantity and timing), and *who has access* to respite (geographical distribution and reach, or accessibility to different groups). It also provides a method of understanding the implications of these alterations for respite outcomes across different groups of participants and carers.

This section explores the possibilities for change resulting from the policy reform processes of the

Australia: England, the United States and Canada, before discussing several other European examples.

England

Individual and personal budgets have been a central element of the personalisation agenda for reforming the delivery of adult social care in England (Glendinning et al., 2009; Jones et al., 2014). Individual budgets brought together local authority social care, housing-related support services, adaptations and equipment budgets into a single individual budget to be spent flexibly according to individual priorities and preferences (Glendinning et al., 2008, 2009; Jones et al., 2014). Although they were successfully piloted in 13 English local authorities from the end of 2005 until the end of 2007, the complications associated with administering funding streams from different agencies and authorities led the English Government to replace individual budgets with personal budgets that consisted only of one stream of social care funds.

Individual budgets: Individual budgets aimed to give more choice and control to older people and people with disability over their support needs. An independent evaluation of the pilot was undertaken using a Randomised Controlled Trial design, which entailed randomly allocating service users to either the individual budget group or a comparison group consisting of users of standard social care services (Glendinning et al., 2008). Findings from 263 structured interviews and 40 semi-structured interviews with older people from the independent evaluation of the pilot individual budgets predominantly on personal care, with little

service package for the comparison group. However, on average, carers of individual budget users appeared to spend more time on care

wellbeing, control over important things in life, control over their support, volunteering, relationships with friends, and relationships with paid supporters (Hatton & Waters, 2013).

More than half of the carers reported that having a personal budget for the person they cared for improved their life in four of the nine areas which were explored in the second survey: finances (52 per cent), having the support you need to continue caring and remain well (69 per cent), quality of life (60 per cent) and physical and mental wellbeing (53 per cent). However, having a personal budget for the person they cared
people who were important to them (51 per cent) and to their ability to do paid work (69 per cent, although 41 per cent were over 65). Carers of older people were least likely to report improvements in all but one of the eight life domains that were explored for carers, i.e. ability to do paid work (Hatton & Waters, 2013).

Overall, the two surveys show that personal budget holders and carers reported positive experiences of the impact of personal budgets on their lives, although experiences of the personal budget process varied across councils. According to Hatton and Waters (2013), a limitation of their study is the over-representation, compared to the national picture, of direct payment users in both the 2011 and 2013 National Personal Budgets Surveys (Hatton & Waters, 2013), and this criticism is picked up by Slasberg, Beresford and Schofield (2012a, pp. 1030-1031), who criticise the POET study for being unrepresentative. Slasberg et al. (2012b) distinguish three key elements of the UK social care reform:

- personalisation of support to give people greater control over their lives and overcome
- personal budgets to enable purchase of support and services most appropriate to the individuals
- self-directed support, which is calculated through Resource Allocation System (see
  - the individuals to empower them as consumers.

-

support the goals of personal budgets and personalization and suggest reforming this component of CDC in the UK. They report evidence from a freedom of information request to a number of councils which shows that, on average, the upfront budget figure that is given to the participant is considerably different to the actual budget that is allocated to them once their support planning is

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actually given creates uncertainty for participants (with a disempowering rather than an empowering effect) and service providers. Slasberg et al. (2012b) also analysed data from the National Adult Social Care Information Service (NASCIS) showing that local councils, who administer self-directed budgets in the UK, significantly increased staffing levels after the introduction of the self-directed support reform while at the same time, the volume of support delivered was reduced. Slasberg et al. (2012b) suggest a reduction of around 20 per cent in productivity, with more staff delivering less work.

Wilberforce et al. (2011) discuss the (early) impact of individual budgets on service providers and their workforces. They report data from 16 interviews with managers of social care providers and seven commissioning managers, which were undertaken as part of the independent evaluation of

the individual budgets pilot study. Wilberforce et al. (2011) found that many service users, particularly older people, had simply not requested anything different from their service providers.

ing greater expectations about

regards to short-

many providers felt that budget holders were being unrealistic and aimed to temper their

- the quality controls, which refer to the monitoring of the services purchased with the cash entitlement. Timonen et al. there are some quality controls in England, and comprehensive monitoring takes place in Finland and t

  monitored in Ireland

Several of these countries also provide a form of carer assessment or brokerage resembling that of the UK, which offer mechanisms for recognis
system of carer assessments that refers the carer to respite and counselling support, and the

provided with a case manager to help them navigate the service infrastructure and co-ordinate the range of health and social care servic

2012).

In several European countries, e.g. Italy, Spain, Greece, Austria, Germany and Ireland, public cash for care schemes providing benefits to dependents have driven an increase in the employment of migrant care workers (Di Rosa, Melchiorre, Lucchetti, & Lamura, 2011). In Southern European countries, foreign-born workers often consist of unskilled, mainly live-in domestic workers, primarily women, who are often employed by families in a grey economy characterised by illegal immigration and/or work status. In Northern European countries, they are more likely to consist of long-settled migrants who are employed by formal care service providers (Di Rosa et al., 2011).

United States and Canada

Throughout the 1960s and 1970s in the US and Canada, community-

a paradigm shift and policy change was driven primarily by local initiatives and state/provincial projects. Hutchinson et al. (2006) point out that, unlike Britain, in North America there has not been a national policy direction or national legislation to enable people to access direct payments. This lack of a federal policy framework has affected the extent to which direct payments could develop and flourish in the United States and Canada (Hutchinson, et al., 2006, p. 52). As a consequence,

streams (Glendinning et al., 2009). Some have recommended that outputs and outcomes could be

Table 2 Conceptualising respite outcomes and outputs in the new policy landscape

NDIS outputs	NDIS outcomes	CHSP outputs	CHSP outcomes
Support services relating to:			

Describing respite: A consequence of the new outputs and outcomes frameworks may be a change in the way that respite is described and discussed by governments, service providers, participants and carers. Moreover, the language used when describing respite may need to change in order to fit within the new output and outcomes categories. In the case of the NDIS, it is possible

to the NDIS Guidelines on Pricing and Payment of Supports:

> plan. Some supports on the list may have been renamed to be more participant centred.
>
> For example, the term respite is not used in the NDIS list, but many supports for participants will have a flow on effect of providing participants families and carers with time away from caring. These activities may include activitie

These sentiments that are built into the NDIS are likely to have a flow-on effect on the way in which services describe their respite products to their clients. For example, some services already refrain from using the word respite to describe their respite outputs and some are considering new ways of framing and marketing what they traditionally called respite (Service Leadership Group Roundtables 1, 2 and Consumer Reference Group).

There is some concern that changing the language used to describe respite so that it fits into a respite effect for carers rather than respite in itself (Service Leadership Group Roundtable 1). Moreover, support for the person

programs at the state and Commonwealth levels. State governments funded respite services for people with disability and their carers as part of a suite of disability services. The jointly state- and Commonwealth-funded Home and Community Care Program provided respite services for older people and their carers; the Commonwealth-funded National Respite for Carers Program (NRCP) provided respite to carers both of people with disability and older people, and a range of other smaller programs at the state and Commonwealth levels provided respite to specific groups of participants and carers. Such programs included young carers respite and information services, mental health respite carer support, and emergency respite, which are currently accessed through the Commonwealth Respite and Carelink Centres.

The changes under the NDIS and CHSP will alter who is entitled to respite under which funding stream, and who may have access to respite in the future. The main changes that will affect which groups are entitled to receive respite include the following:

- Supports under the NDIS are only available to people with a *permanent and significant disability* and their families and carers, and supports to families and carers are limited to those that ultimately meet the needs of the participant (or person with disability).
- The HACC and NRCP programs have been rolled into the CHSP, which means that only people *aged 65 and over* (or Aboriginal and Torres Strait Islander peoples aged 50 and over) and their carers are entitled to receive supports under these schemes.
- The CHSP only provides services to older people with *basic* needs and their carers; the intention is that older people in need of more intensive support will receive care through community aged care packages or in residential aged care facilities.
- It is not yet clear what will happen to the disability services currently provided by the states, but it appears likely that many states will roll their state funding for these services into the NDIS.

This has a number of implications for who is entitled to receive respite, with particular implications for several groups.

Commonwealth Home Support Program, including access to respite services under the scheme. Older people with higher care needs who receive a comm 406.63 Tm[ )]TJETentia([st)-44ETe)(t)-43(.)-4( )]TJE

possible implications for the *nature* of the services that are available and delivered. This includes possible effects on the type of respite service, the location and activities involved, and the amount of respite available. The policy and stakeholder analysis suggests that the shift from block to individualised funding in particular may have an impact on the nature of the respite services

Table 3 Changes to respite output categories under the NDIS and CHSP reforms

Respite outputs	Possible changes
Location In home Centre-based Host-family home Community-based (i.e. recreational locations) Therapeutic/health-based location (i.e. specialist offices, hospital)	May be a challenge to the sustainability of services with: ¶ high capital expenditure ¶ specialised functions ¶ involvement of volunteers
Activities Therapeutic Social Recreational Family-based activities Personal care	May have an impact on the types of activities that participants choose to spend their budgets on - may select more personal care and less social and recreational
Quantity and timing Number of hours Time of day/week (day, overnight, weekend) Available at short notice (i.e. emergency, flexible)	May limit the number of hours of respite that can be funded in an NDIS package
Reach Participants under 65 years Participants over 65 years Carers of people under 65 years Carers of people over 65 years	May limit access to respite for: Older people with high level care needs, and their carers Carers of people with disability who receive services under the NDIS People with disability, chronic or mental illness, or palliative care needs who are under 65 years and not receiving services under the NDIS, and their carers
Region Metropolitan Outer metropolitan Regional Remote	May create difficulties for viability and range of services in regional and remote areas
Transport	May reduce accessibility to respite care by people living in rural and remote areas where services currently provide transport as part of the service

5. Service mapping

Main points

- An estimated 312,539 people with disability accessed disability support services in 2012 13 in Australia of which about 12% (38,072) received respite services.
- People with intellectual and learning disability were more likely to use respite services (18 per cent) compared to people with other types of disability.
- Between 2008/09 and 2012 13, respite services increased by 8 per cent.
- In 2012/13, the majority of the service outlets (54 per cent, n=884) consisted of flexible respite services, followed by centre-based respite/respite homes (29 per cent, n=476), own home respite (10 per cent, n=169), other respite (4 per cent, n=64) and host family/peer support respite (2 per cent, n=37).
- Expenditure on disability support services, adjusted for inflation, has increased by 4 per cent from 2011/12 to 2012/13, and by 23 per cent since 2008/09.
- Between 2011/12 and 2012/13, expenditure for respite services increased at about double the rate of other disability support services: an 8 per cent increase for respite compared to a 4 per cent increase for all disability support services.
- The combined level of fully unmet and partly met need is similar across states; however, some states and territories have a higher number of service users per outlets than others, e.g. Victoria, suggesting a risk for a potential shortage of services, particularly in light of the constant increase in the number of users of respite services in Australia.

identified in the Disability Services National Minimum Data Set (DS NMDS), which includes three main categories that group nine data items on some of the functional needs of service users

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: the activities of daily living (55 per cent); the activities of independent living (64 per cent); and the activities of work, education and community living (61 per cent). Users of respite

three broad life areas comparatively to users of accommodation support, community support, community access and employment services, which entails a high level of dependency.

Table 15 shows that the combined level of fully unmet and partly met need[6] is similar across states; however, some states and territories, such as for example Victoria[7], have a higher number of service users per outlets than others, suggesting a risk for a potential shortage of services, particularly in light of the constant increase in the number of users of respite services in Australia (Table 9). Table 14 shows that Tasmania has a slightly higher fully unmet need for all persons with a disability compared to the other states and territories, whereas Queensland and Western Australia have a slightly higher unmet need for people aged 65 and over.

In 2012/13, respite services were delivered by 1,630 respite service outlets[8], with an average of 23.4 service users per respite service outlet in the 7-day reference week preceding the end of the reporting period in 2012/13 (Table 13). The majority of the service outlets (54 per cent, n=884) consisted of flexible respite services, followed by centre-based respite/respite homes (29 per cent, n=476), own home respite (10 per cent, n=169), other respite (4 per cent, n=64) and host family/peer support respite (2 per cent, n=37) (see Table 6 and Appendix A for a definition of types of respite). Table 6 shows the number of respite service outlets by state and territory, and Table 7 shows their geographical distribution. Table 8 shows that an estimated total of 498,403 hours of respite ser

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Table 4 Number of respite service users by state and territory, 2012/13

Service	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total	%
Own home respite	9	1,114	789	435	473	69	12	4	**2,905**	**10**
Centre-based respite/ respite homes	3,999	4,890	2,606	1,181	1,005	234				

Table 6 Number of respite service outlets by state and territory 2012/13.

Service type	NSW	Vic(a)	Qld	WA	SA	Tas	ACT	NT(b)	Total
Own home respite	2	28	59	39	30	5	2	4	169 (10)
Centre-based respite/respite homes	117	106	123	30	73	9	8	10	476 (29)
Host family/peer support respite	11	10	7		6	1		2	37 (2)
Flexible respite	445	166	110	88	36	24	5	10	884 (54)
Other respite		8	18	13	24			1	64 (4)
Total respite	**575 (35)**	**318 (20)**	**317 (19)**	**170 (10)**	**169 (10)**	**39 (2)**	**15 (1)**	**27 (2)**	**1630 (100)**

Note. Adapted from Table B4 in (AIHW, 2014b, p. 13). Percentage in parenthesis.

Table 7 Respite services by remoteness area, Australia, 2012/13

	Major cities		Inner regional		Outer regional		Remote		Very remote		Not known		Total	
Service group	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Respite	885	54.3	478	29.4	202	12.4	46	2.8	18	1.1	1		1,630	100
Total	**9,529**	**60.9**	**4,067**	**26**	**1,665**	**10.6**	**248**	**1.6**	**147**	**1.6**	**4**	**1.6**	**15,659**	**100**

Note. Adapted from Table B8 in (AIHW, 2014b, p. 18)

Table 8

Table 9 Number of respite services users, 2008/09 to 2012/13

Service group	2008/09	2009 10	2010 11	2011 12	2012 13	Percentage change	
						2008/9 to 2012/13	2011/12 to 2012/13
Respite	34,331	35,978	36,266	37,015	38,072	10.9	2.9
Total state/territory services	*186,961*	*193,218*	*204,226*	*203,371*	*201,675*	*7.9*	*-0.8*
Total	**279,301**						

community support users, and by 40 per cent of community access users. Other common combinations were community support with respite (20,421 service users), accommodation support with community support (20,232 service users), and accommodation support with community access (16,924 service users). Users with the highest level of need for assistance in the activities of daily living were more likely to use multiple service types and to use services across more than one service group than service users with less-frequent or no need for assistance in this life area.

In 2012/13, 136,325 (67 per cent) service users had an informal carer (AIHW, 2014c, p. 19). This

Table 12 Mean hours of respite services received per service user[1], Australia, 2008/09 to 2012/13

Service	

Table 13 Mean hours worked in the reference week by paid and unpaid staff for respite disability support service type outlets, Australia, 2012/13

Between 1 July 2010 and 30 June 2011, there were 118,178 admissions t

Table 21 Hours of HACC respite services received per 1,000 people aged 65 years or over and Indigenous Australians aged 50 64 years, total number and break down by geographical location

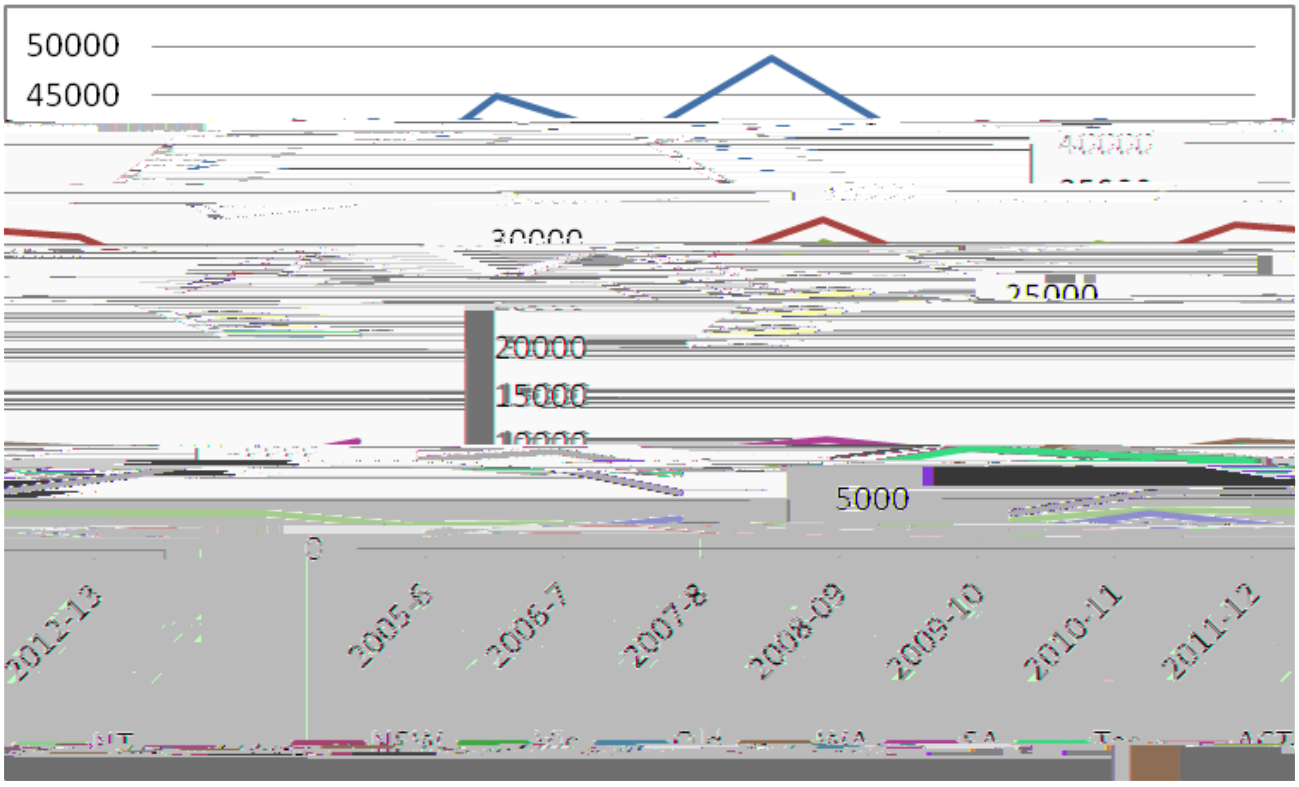
States / territories	Total number per 1000 people	Major cities	Inner regional areas	Outer regional areas	Remote areas	Very remote areas
NSW	232	258	177	697	992	1,085
Vic[1]	189	205	156	454	177	-
Qld	485	501	416	2,217	1,926	1,488
WA	176	197	120	438	214	362
SA	389	442	278	1,096	456	597
Tas						

Table 23 Government expenditure on National Respite for Carers (NRCP), 2012/13 ($ million)

States / territories	Number of people assisted	Expenditure in $ million
NSW	34,262	62.9
Vic	25,646	44.9
Qld	21,491	34.5
WA	7,697	17.1
SA	10,514	17.6
Tas	5,843	6.3
ACT	1,787	4.3
NT	3,131	5.4
Other[1]	-	13.7
Total Australia	**110,371**	**206.6**

Note. Adapted from Table 13A.15 in Australian Government (2014b, p. 4 of Table 13A.15)

Figure 1 Number of people assisted by the National Respite for Carers program, 2005/06 to 2012/13



Note. Adapted from Table 13A.15 in Australian Government (2014b)

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al assistance services in a consumer directed

Appendix A

he 34 individual

Appendix C

Service overview (Australian Government, 2014b, pp.13.2-13.3)

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

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

The formal publicly funded services represent only a small proportion of total assistance provided to older people. Extended family and partners are the largest source of emotional, practical and financial support for older people.