Residential aged care facilities in Australia 1998

A statistical overview

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Residential aged care facilities in Australia 1998

A statistical overview

Australian Institute of Health and Welfare
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Contents

List of tables

Preface

In 1997, the Commonwealth Department of Health and Family Services and the Australian Institute of Health and Welfare agreed to participate in a joint venture to publish nursing home and hostel data, with the Institute taking over the task of producing the publications. Previously, nursing home and hostel data had been published by the Department of Health and Family Services in two report series—*Nursing Homes for the Aged: A Statistical Overview* and *Hostels for the Aged: A Statistical Overview*. From 1997, the Aged Care Statistics Series, produced by the Aged Care Unit of the Australian Institute of Health and Welfare, replaces those earlier publications, providing access to annual data on both nursing homes and hostels.

The first publication in the series, entitled *Nursing Homes in Australia 1995–96,* was released in December 1997, followed by *Hostels in Australia 1995–96, Nursing Homes in Australia 1996–97* and *Hostels in Australia 1996–97* which were released in 1998. A supplementary report providing additional time-series data, *Nursing Homes in Australia 1992–93, 1993–94 and 1994–95,* was also released (in electronic format only) on the Internet early in 1998.

Under recent reforms to the structure of aged care services, nursing homes and hostels were amalgamated into one system from 1 October 1997. Beginning with the 1997–98 financial year, the Aged Care Statistics series presents a single volume on residential aged care facilities rather than two annual reports (one on hostels, the other on nursing homes). This report is the first to report on the newly created single residential care system. The October 1997 transition between the two systems created a discontinuity in the data series during the first half of the 1997–98 financial year. As a result, this report, entitled *Residential aged care facilities in Australia 1998*, is based on data for the 6-month period from 1 January to 30 June 1998.

The new report also contains some changes from earlier reports in the series. Some are influenced by the needs of information users (e.g. additional analyses have been included at the regional level), while others result from the changes in data availability which occurred with the implementation of the new residential care data system—e.g. the tables relating to ownership of facilities (government, private not-for-profit and private for-profit) have been dropped as this information is not collected by the new data system.

The statistics presented in this report were derived from information held on the Commonwealth System of Payment for Aged Residential Care by the Department of Health and Aged Care.

The information in this publication is presented in the following sections:

- Population and residential aged care service capacity;
- Residents and their characteristics;
- Admissions and separations;
- New residents and their characteristics; and
- Resident dependency.

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Main features

Residential aged care facilities

As at 30 June 1998, there were 3,015 residential aged care facilities in Australia providing a total of 139,917 places—an average of 46 places per facility. While the facilities varied in size (13% had 20 places or fewer and 4% had more than 100 places), a large proportion (40%) of facilities had 21 to 40 places and another 28% had 41 to 60 places.

Comparisons of the number of places as at 30 June 1998 with those available in previous years can be easily undertaken by adding the number of places in hostels to those in nursing homes to provide a 'combined' number of places equivalent to those in residential aged care facilities. Unfortunately, this degree of comparability cannot be so easily accomplished for other measures, particularly those which deal with the flow of residents through facilities (e.g. admissions, separations, occupancy, length of stay etc.). This point will be taken up in more detail in the relevant sections.

Residential aged care supply increased in absolute terms from 139,058 (nursing home beds and hostel places combined) at 30 June 1997 to 139,917 places at 30 June 1998. The ratio of places to persons aged 70 and over, however, declined, from 89.2 (nursing home beds and hostel places combined) per 1,000 people aged 70 and over at 30 June 1997 to 87.4 per 1,000 people aged 70 and over at 30 June 1998. The number of facilities increased by 2.

Over 24 million place-days were used in residential aged care facilities in Australia during the 6-month period from 1 January to 30 June 1998, 23.7 million for permanent care and about 0.45 million for respite care. Overall, about 2% of occupied place-days were used for respite purposes. These data cannot be directly compared with those for previous years, as the available data represent only a 6-month period rather than the 12-month period described by previous reports. As significant seasonal trends characterise these data, a simple doubling of the recorded data for the 6-month period does not provide a reliable or comparable estimate of use patterns for the 12-month period to June 1998.

The occupancy rate was about 96% during the period, compared with 97% for nursing homes and 93% for hostels during 1996–97.

Residents and their characteristics

There were 133,807 residents in residential aged care facilities on 30 June 1998, compared with 132,665 residents in nursing homes and hostels combined on 30 June 1997.

Almost half (48%) of those resident in residential aged care facilities at 30 June 1998 were aged 85 and over. This pattern was very similar across the States and Territories, with the exception of the Northern Territory where only 22% of residents were aged 85 and over. Residents of facilities in remote centres and other remote areas also tended to have a younger age profile, with 33% and 36% respectively aged 85 and over.

Nationally, there were 5,924 residents aged under 65 accommodated in residential aged care facilities (comprising about 4% of all residents). For the Northern Territory, however, the

proportion of residents aged under 65 was considerably higher at 20%. In remote centres and other remote areas, 15% and 10% of residents respectively were under 65 years of age.

The majority of residents (72%) were female. Female residents were older than male residents; over half the female residents were 85 years of age or older, compared with 34% of male residents.

The vast majority of permanent residents received a pension (77% from the then Department of Social Security (now Family and Community Services) and 12% from the Department of Veterans' Affairs (DVA)). About 9% of the permanent residents were self-funded retirees. Less than 2% of the residents had unknown pension status. Female residents were more likely to receive a pension from the Department of Family and Community Services (most commonly the Age pension) and less likely to receive a DVA pension than their male counterparts.

For most respite residents (81%), data were not available concerning pension status. Among the small proportion for whom data were available, the majority were receiving a DVA pension.

Of the 89% of permanent residents for whom data were reported on Indigenous status, 576 (about 0.5%) identified as Indigenous people. Indigenous people had a higher representation among respite residents, comprising 1.2% of those respite residents with known Indigenous status. Data on Indigenous status were not available for about 10% of respite residents.

Almost all residents reported their birthplace and preferred language. Around one in four residents were born overseas. About 10% were born in the UK and Ireland and another 7% in other areas of Europe. Nationally, about 94% of residents indicated that English was their preferred language, and 5% other European languages. The remainder accounted for only 1%.

About 91% of permanent residents reported their marital status prior to admission. Of them, 59% were widowed, 24% either married or in a de facto relationship, 11% never married and 5% divorced or separated. Female permanent residents were over two times more likely to be widowed and over two times less likely to be married or in de facto relationships than their male counterparts. Respite residents had a higher reporting rate on this variable (99% of records contained a response). Respite residents were more likely to be married at the time of admission than were permanent residents. There were some 8% of respite residents who had never married. The gender differences in marital status profiles observed among permanent residents were even more marked among respite residents. Among those respite residents who reported their marital status, 73% of women and 30% of men were widowed, while 17% of women and 51% of men were married or in a de facto relationship.

As all of these measures refer to resident characteristics at a particular point in time (i.e. 30 June 1998), they can be directly compared to the characteristics of the combined nursing home and hostel populations at 30 June in previous years if desired.

Length of stay of current residents

The distribution of length of stay for permanent residents at 30 June 1998 was skewed toward longer periods of stay. Only 7% of permanent residents had been in a residential aged care facility for less than 3 months. About 20% had been resident for between 3 months and 1 year, 53% for 1 to 5 years and 20% for 5 years or more. It should be noted that, for current residents, length of stay is an incomplete measure, showing the time that residents

have spent in residential aged care facilities but not how much more will be spent before leaving the facilities.

Residents of residential aged care facilities in remote centres and other remote areas were somewhat more likely to have long periods of stay; among permanent residents, 25% and 23% respectively stayed for 5 years or longer compared with a national average of 20%.

Unfortunately, the merging of nursing homes and hostels into a single system of care means that measures of length of stay as published for nursing homes and hostels in previous volumes of the Aged Care Statistics Series cannot be directly compared to the data on length of stay presented in this report. This discontinuity arises for several reasons, of which the following is the most important. Current residents of a residential aged care facility may have entered the aged care system as either a hostel or nursing home resident. If they are currently residents in the same type of institution (hostel or nursing home) as their original point of entry, then their recorded length of stay is a valid measure of their time in a residential aged care facility. If, however, they have moved from hostel care to nursing home care (or, in a small proportion of cases, the reverse), then their current length of stay refers only to their nursing home stay (or hostel stay, in the reverse case). As the two databases for nursing home and hostel residents were separate, no 'combined' length of stay measure can be created. For these residents, then, their length of stay refers only to one portion of their time in the residential care system.

Dependency levels

Resident dependency levels are indicated by the Resident Classification Scale (RCS). The RCS replaced the Resident Classification Instrument (RCI) previously used to measure dependency in nursing homes and the Personal Care Assessment Instrument (PCAI) formerly used to measure dependency in hostels. The RCS comprises eight categories which represent eight levels of care (and eight associated levels of funding) in descending order of severity from 1 to 8. The level of Commonwealth care subsidy is based on the level of care need indicated by each RCS category. Categories 1 to 4 represent high care and categories 5 to 8 represent low care. There are no direct links between the new RCS and the old RCI and PCAI classifications. However, RCS categories 1 to 4 can be roughly aligned with nursing home care under the previous system, and RCS categories 5 to 8 with hostel care. The RCS was introduced from 1 October 1997, with the merging of nursing homes and hostels into a single residential care system. From that time, all new residents were classified using the RCS category. Existing residents were progressively reclassified using the RCS (and funded under the relevant new rates) as their existing classifications expired, or their changing circumstances required a re-classification.

Among permanent residents on 30 June 1998, 1,767 (1%) did not have a valid RCS category reported. Of those who did have their dependency level reported, about 58% fell into high-care categories (RCS 1 to 4) and 42% into low-care categories (RCS 5 to 8). RCS categories 2, 3 and 7 captured the highest proportion of permanent residents (25%, 20% and 20% respectively). Almost half of the low-care residents (RCS 5 to 8) fell into the RCS 7 category. The lowest level of care (RCS 8) contained less than 5% of residents on 30 June 1998.

There were few differences between male and female residents in relation to dependency levels. Younger residents demonstrated a slightly higher level of dependency.

As reported in previous volumes of the Aged Care Statistics Series, dependency levels were continuously rising among both nursing home and hostel populations over the years preceding the introduction of the single system in 1997. It was expected that this trend toward increasing dependency levels would continue with the amalgamation of the two

systems into one single system. The main force driving this trend toward increasing dependency was the decreasing level of residential care places available in relation to the number of frail and disabled older people; available residential care places have thus been targeted to a progressively more dependent group of people. This pattern is in keeping with established government policy which aims to provide a greater proportion of care for frail and disabled older people in their homes, rather than in a residential context.

While dependency levels have been increasing in both nursing homes and hostels (AIHW 1997, 1998a, 1998b, 1998c) the relative increase in the number of hostel places has meant that over time, an increasing proportion of the residential care population was accommodated in hostels rather than nursing homes (See the table and figure below). Thus, at 30 June 1994 43% of residents were located in hostels; by 30 June 1997 this proportion had increased to 47%. With the introduction of the single classification scale in October 1997, all residents were subsequently reclassified using the same scale (rather than the two separate scales which had previously operated in hostels and nursing homes).

Dependency levels of permanent residents in residential aged care facilities, 30 June 1994 to 1998 (%)

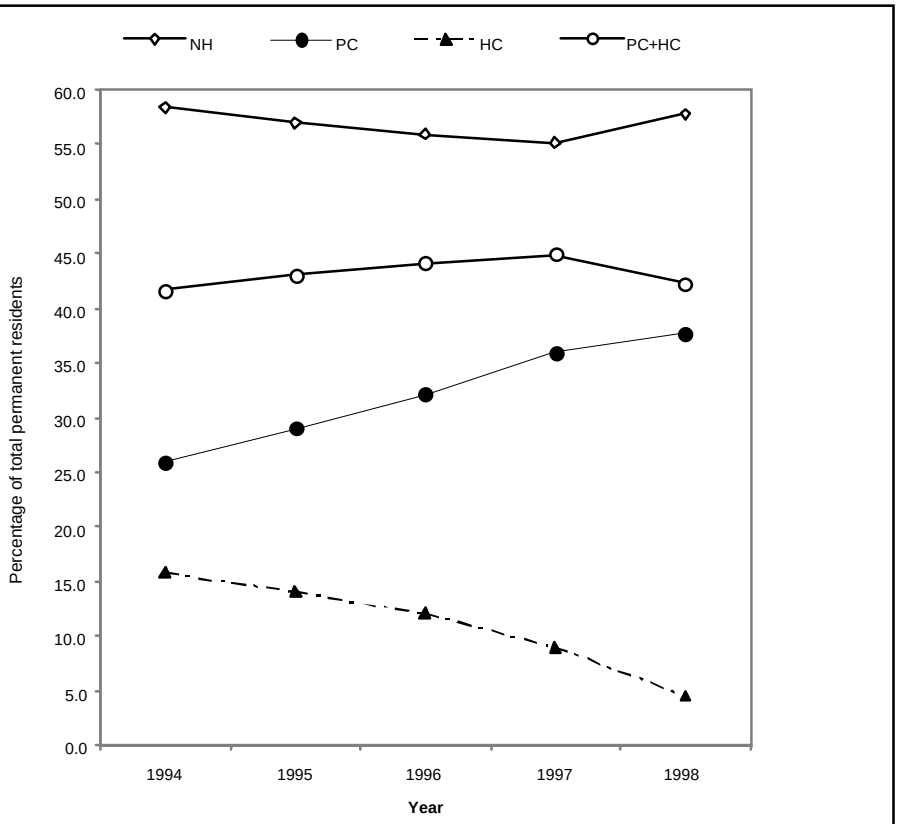
	NH (high care)	PC+HC (low care)	PC (personal care in hostels)	HC (hostel care in hostels)
Females				
1994	57.5	42.5	27.3	15.3
1995	55.9	44.1	30.5	13.6
1996	54.8	45.2	33.6	11.6
1997	53.9	46.1	37.5	8.6
1998*	57.1	42.9	38.4	4.5
Males				
1994	60.9	39.1	22.1	17.0
1995	59.8	40.2	25.1	15.0
1996	59.0	41.0	27.9	13.1
1997	58.4	41.6	31.7	9.9
1998*	59.6	40.4	35.7	4.6
Persons				
1994	58.4	41.6	25.9	15.7
1995	57.0	43.0	29.0	14.0
1996	55.9	44.1	32.1	12.0
1997	55.1	44.9	35.9	8.9
1998*	57.8	42.2	37.7	4.5

* NH=RCS 1 to 4, PC=RCS 5 to 7 and HC=RCS 8.

Note: The data in this table were extracted from residential aged care service datasets provided to the Australian Institute of Health and Welfare by the Department of Health and Aged Care.

The restructuring thus removed the 'barrier' between hostel and nursing home care; a major reason for its implementation was the perception that a significant proportion of hostel residents were actually as dependent as those who were being cared for in nursing homes. At 30 June, 1998, 58% of residents were classified in the RCS 1 to 4 categories (roughly

equivalent to the 'old' nursing home care). Over the preceding 4 years, the proportion of residents accommodated in nursing homes had been progressively falling, from 58% at 30 June 1994 down to 55% at 30 June 1997; the 58% recorded in 1998 is thus a reversal of that trend. For RCS categories 5 to 8 (roughly equivalent to the 'old' aged person's hostels), the reverse pattern is evident; the proportion of residents accommodated in hostels increased from 42% at 30 June 1994 to 45% at 30 June 1997, then dropped back to 42% (i.e. at RCS levels 5 to 8) at 30 June 1998.



Trends and patterns of dependency levels of permanent residents in residential aged care facilities, 30 June 1994 to 1998

Source: The previous table.

The proportion of residents in the lowest care category (Hostel Care hostel residents under the previous system, RCS category 8 under the current system) has changed quite dramatically over the past 5 years. At 30 June 1994, 16% of residents in the aged care system (i.e. nursing homes plus hostels) were categorised as Hostel Care hostel residents. By 30 June 1996 this proportion had dropped to 12%, falling further to 9% at 30 June 1997, and then, following the restructure, to 5% (at RCS level 8) by 30 June 1998 (see the above table and figure).

The table shows no clear evidence that the impact of the restructuring on dependency profiles was experienced differently by men and women. However, the decrease in the proportion of residents accommodated in nursing homes which had occurred up until 1997 was more pronounced among women than among men, as was the increase which occurred in 1998. On the other hand, the decrease in the proportions accommodated in hostels at the Hostel Care level (or RCS 8) was slightly more pronounced among male than female residents.

The data reported above refer to current residents of aged care facilities. Current residents include those admitted into a facility either before or after the restructure of the residential care system. The dependency profile of newly admitted residents provides a useful indication of the most recent trends in residential care. The dependency levels of newly admitted permanent residents during the period from 1 January to 30 June 1998 suggest that we may expect a continuing shift toward higher levels of care in the future. After excluding the 967 residents whose dependency levels were not reported, 59% were classified as high-care and 41% as low-care. These proportions are very similar to those for existing residents, yet admitted residents are by definition at the beginning of their residential aged care facility stay—many will progress to higher levels of dependency in the course of their stay. A situation where the dependency profile of newly admitted residents is similar to or more dependent than that of current residents thus suggests that the recent trend toward increasing dependency levels is likely to continue.

As would be expected, the dependency levels of residents who left residential facilities (through death or a move elsewhere) were higher than those for both current and recently admitted residents.

Admissions and separations

Permanent care

There were 39,652 admissions to residential aged care facilities in the first half of 1998, of which 53% (21,165) were for permanent care. Between 1 January and 30 June 1998, there were 38,501 separations from residential aged care facilities. Separations after a period of permanent care accounted for 53% of total separations.

Among those leaving permanent care, 79% died, 5% returned to the community, 8% moved to another residential aged care facility and 6% were discharged to hospitals (2% were not reported). Among those who died, 17% stayed for less than 3 months, 22% for between 3 months and 1 year, 45% for 1 to 5 years and 16% for 5 years and more. Those with shorter periods of stay were more likely to return to the community and less likely to die in a facility than were those with longer periods of stay.

Among permanent residents, one in five separations had been in a residential aged care facility for less than 3 months, another 22% for between 3 and 12 months, 44% for 1 to 5 years and 15% for 5 or more years. The median length of stay among those leaving a residential aged care facility (through death or to go elsewhere) was about 79 weeks; the average (mean) length of stay was 128 weeks (145 weeks for women and 99 weeks for men). The length of stay was heavily skewed toward long-stay residents. Residents of those facilities in remote zones had a longer than average length of stay (155 weeks in remote centres and 143 weeks in other remote areas).

As already noted, length of stay for residents in residential aged care facilities cannot be compared with previously published statistics on the residents of hostels and nursing homes. Similarly, admissions and separations data are not comparable to those for earlier years. This occurs because the movement between a hostel and nursing home level of care, which would previously have counted as both an admission and a separation, is now internal to the residential aged care system. In addition, these data describe a 6-month period, which, owing to seasonal fluctuations in admissions patterns, cannot be simply doubled to produce an estimate of admissions over the 12-month period to 30 June 1998.

Respite care

On 30 June 1998, respite residents made up less than 2% of all residents, which is similar to the proportion of respite residents in nursing homes and hostels combined on 30 June 1997. This figure under-represents the importance of respite care, however, as it accounted for some 47% of 39,652 admissions during the first 6 months of 1998. This apparent anomaly is explained by the short-term nature of respite care; while a large number of respite residents are admitted over the course of the 6-month period, there are relatively few resident at any one point in time.

Over 14% of respite separations had an unspecified destination on departure from the facility. Of those for whom data were available, 74% returned to the community. A further 18% were transferred to the same or another facility, and 5% were discharged to hospitals. Deaths accounted for about 3%.

For those leaving respite care during the 6-month period under review, the average length of stay was about 3.5 weeks. The longest average length of stay was in other remote areas (5.1 weeks).

Characteristics of newly admitted residents

The characteristics of newly admitted residents (that is, those admitted between 1 January and 30 June 1998) provide a useful indication of current patterns and trends in admissions to residential aged care facilities, as distinct from current residents, some of whom were admitted many years ago. In a context where policy changes affecting residential care have been substantial over the past decade, differences (or the lack of differences) between new permanent admissions and current residents provide some useful indications of the impact of policy changes. It is also the case that, as 99% of current residents were admitted for permanent care, the characteristics of current residents are effectively the characteristics of current permanent residents. In this discussion of newly admitted residents, the characteristics of permanent and respite residents are considered separately.

One further significant difference between current and newly admitted residents concerns data quality. Overall, newly admitted residents have much higher reporting rates on resident characteristics than do current residents, indicating a marked improvement in data quality over time. Data were available on all required characteristics for virtually all newly admitted residents, excepting pension status where the rates were somewhat lower (91% and 38% response rates for permanent and respite admissions respectively). Because of these differences in the proportion of missing data, comparisons of the characteristics of current residents and newly admitted permanent residents should exclude missing data; where the proportion of missing data is large this naturally reduces the robustness of the comparison.

Among permanent admissions, 63% were aged 80 or older (68% of females and 55% of males). The majority of permanent admissions were women (63%). Women had a much older age profile than men, with over 42% of women being 85 or older, compared with only 30% of men. This age profile is slightly younger than that of current permanent residents, of whom 70% were aged 80 and over (76% of women and 56% of men). In both groups, women pre-dominated and had an older age profile. The proportion of women among current residents was somewhat higher (73%) than that among newly admitted residents, consistent with their longer average length of stay.

Newly admitted permanent residents were more likely to be widowed, married or in a de facto relationship, and less likely to be never married, when compared with current

permanent residents. Among those receiving respite care, newly admitted residents were less likely to be widowed and more likely to be married than were current residents.

The proportion of people who were receiving a DVA pension was higher among newly admitted permanent residents than it was for current residents (12% of current residents and 16% of newly admitted permanent residents after excluding the unknown cases). As was the case for current respite residents, the majority of newly admitted respite residents did not have pension status reported. As already noted previously with regard to dependency, newly admitted residents tended to have marginally higher dependency levels, overall, than did current residents.

Most residents were living a house or flat prior to admission to a residential aged care facility during the first 6 months of 1998. As would be expected, this pattern was even more prominent among respite admissions than permanent admissions. The 12% of permanent admissions entering from other facilities are probably largely a result of residents moving from respite care to permanent care, or moving from low care (previously hostel) to high care (previously nursing home).

About 40% of newly admitted permanent residents lived alone prior to their admission for permanent care, 22% with their spouse only and 13% with their children (and / or the children' s families). Among those admitted for respite care, 36% of new residents were living alone. As would be expected, a high proportion was living with a spouse only (28%) or with their children (20%).

Differences between permanent and respite admissions

People admitted for respite care differed considerably from those admitted for permanent care with regard to their family and living arrangements. Those admitted for respite care were more likely, at the time of admission, to be living in the community with carers. While the vast majority of people admitted for both permanent and respite care were either married or widowed, those admitted for respite care were more likely to be married and less likely to be widowed than those admitted for permanent care. People admitted for respite care were also more likely to be living with a spouse than those admitted for permanent care. While respite admissions were less likely to be single and living alone than permanent admissions, it is noteworthy that 36% of respite admissions were living alone at the time of entry. On average, persons admitted for respite care were somewhat younger than those admitted for permanent care. Over 80% of respite admissions were living in a house or flat prior to admission. This proportion compares to 71% of permanent admissions.

State and Territory variations

Residential aged care facilities

The level of provision of residential aged care varied across the States and Territories. Victoria had the lowest level of provision at 83.4 places per 1,000 people aged 70 and over. Tasmania (85.5) and the Australian Capital Territory (86.9) were also below the national average (87.4). The Northern Territory had the highest level of provision at 98.0 places per 1000 people aged 70 and over followed by Queensland (91.7) and Western Australia (89.3). The higher level of provision in the Northern Territory is a consequence of a comparatively young population profile and a comparatively large Indigenous population; as a result of

their poorer health status, Indigenous people require access to residential aged care facilities at younger ages, on average, than do non-Indigenous people.

The size of the residential aged care facilities differed across jurisdictions. At the larger end of the continuum were facilities in the Australian Capital Territory (averaging 64 places per facility), New South Wales (52) and Queensland (52). At the smaller end were facilities in the Northern Territory (averaging 24 places per facility) and Tasmania (36). Tasmania and Western Australia had a large proportion of small (20 or fewer beds) facilities—about 25% and 19% respectively. In the Northern Territory, however, almost half the facilities (60%) fell into this category, and none had more than 60 beds.

Over half the facilities in the Australian Capital Territory had more than 60 beds, as did 28% of those in New South Wales and 26% of those in Queensland. Victoria, Western Australia and Tasmania had relatively few facilities of this size (less than 14%).

Occupied place-days for respite care accounted for about 1.9% of total occupied place-days in all States, with the smallest proportions provided in Victoria (1.7%) and the highest in the Northern Territory (4.8%). Overall occupancy rate ranged from 94% in Western Australia to 98% in Tasmania.

Remote areas exhibited a lower occupancy rate (85%) than did other regions, which ranged between 95% for remote centres and 98% for other metropolitan (i.e. non-capital city) centres.

Residents

The age profiles of residents were similar in all States, with those in the Territories being somewhat younger. In particular, one in five residents was aged under 65 in the Northern Territory, compared to a national average of one in twenty-five. This difference is largely explained by the larger proportion of Indigenous residents in Northern Territory residential aged care facilities, who tend to be admitted at an earlier age than non-Indigenous residents.

Western Australia had the highest proportion of overseas-born residents (37% of permanent residents and 38% of respite residents) compared to the national average of 24% for permanent residents and 26% for respite residents. Queensland, Tasmania and the Northern Territory had the lowest proportions (between 13% and 20% of permanent residents and between 10% and 22% of respite residents). The majority of migrants were born in the UK and Ireland.

In terms of preferred languages, some State- and Territory-based variations were also apparent. Among permanent residents, for example, the proportion of those who reported a preferred language other than English ranged from 9% in Victoria to 1% in Tasmania. The Northern Territory was an extreme outlier, with 24% preferring a language other then English (including 16% who preferred an Australian Indigenous language).

The separation mode for permanent residents varied slightly across the States and Territories, excepting the Northern Territory which was again an extreme outlier. For the Northern Territory, the mortality rate among separations was low (65%), while a comparatively high proportion (19%) returned to the community. Among the remaining jurisdictions, Tasmania had the highest mortality rate (91%) and the lowest proportion returning to the community (3%), while Western Australia had the lowest mortality rate (73%) and the highest proportion moving to another facility (11%).

For respite residents, State and Territory variations in separation mode were also marked. About 80% of respite separations returned to the community in Tasmania, compared to only 57% in New South Wales and South Australia (with the national average being 64%). However, there was a high level of missing data on this variable for respite residents (14%

nationally, but rising as high as 22% in New South Wales and 19% in the Northern Territory). After excluding the missing data, the pattern changes slightly. Tasmania still had the highest proportion (83%) returning to the community and South Australia the lowest, but New South Wales had a higher proportion (74%) returning to the community. Another emerging pattern is that those States and Territories with a lower rate of return to the community tended to have a higher rate of transfer to another facility. Thus, in Western Australia and South Australia, 23% to 25% of respite separations involved a transfer to another facility, compared with the national average of 18% after excluding the missing data.

The length of stay for separations from residential aged care facilities during the 6-month period to June 1998 also varied among the States and Territories. Permanent separations in the Northern Territory and Queensland had the longest average length of stay (161 and 140 weeks respectively) and those in Victoria had the shortest (116 weeks). Among those leaving respite care, the average length of stay varied from 2.7 weeks in Tasmania to 3.9 weeks in South Australia.

Dependency levels among residents differed across the States and Territories. About 53% of permanent residents were in the high-care categories (RCS 1 to 4) in Western Australia and the Australian Capital Territory compared with 69% in the Northern Territory. Nationally, 58% of residents fell into this category.

Regional variations

Residential aged care facilities

Provision levels for residential aged care varied across types of geographic regions. Metropolitan areas had the highest levels of provision at 89.9 places per 1000 people aged 70 and over. Remote zones (including remote centres and other remote areas) had the lowest levels of provision (75.4 places per 1000 people aged 70 and over). The level of provision in rural zones (including large rural centres, small rural centres and other rural areas) was 81.7 places per 1,000 people aged 70 and over. As expected, residential aged care places were concentrated in population centres—capital cities, large rural centres and remote centres all had higher than average levels of provision. Remote centres were particularly well serviced at 128.5 places per 1,000 people aged 70 and over. About 58% of residential aged care facilities, which accounted for 65% of residential aged care places, were located in capital cities (62% of persons aged 70 and over live in capital cities).

The size of residential aged care facilities differed across types of geographic areas. As expected, residential aged care facilities in rural and remote zones were smaller than those in metropolitan areas. Non-metropolitan areas accounted for 35% of residential aged care facilities but only 28% of the total places. About 82% of the facilities in other remote areas had 20 or fewer places.

Rural and remote zones except the large rural centres provided higher proportions of respite services than metropolitan areas. Occupied place-days for respite care accounted for less than 2% of total occupied place-days in metropolitan areas, compared with 3.5% in other remote areas. Large rural centres had the lowest proportion (1.7%).

Average occupancy rates also showed some regional variations. Other metropolitan areas had the highest occupancy rate (97.6%) and other remote areas had the lowest (84.6%). The remaining regional types had occupancy rates around 95–96%.

Residents

Residents of those residential aged care facilities located in remote centres and other remote areas had a younger age profile. There were about 15% and 10% of residents aged under 65 years in remote centres and other remote areas respectively, compared with less than 5% in other areas. Moreover, only 52% of residents in remote centres and 58% of residents in other remote areas were aged 80 years and over, compared with about 70% or more in the other areas. Females were somewhat less numerically dominant in residential aged care facilities in remote zones (including remote centres and other remote areas) than in facilities in other areas (60% compared to 71%).

The current residents in remote zones showed somewhat longer lengths of stay than those in the other areas. Between 23% and 25% of current residents in remote zones had stayed for 5 years or more compared with between 18% and 20% of residents in the remaining areas. This pattern is further confirmed by the average length of stay among permanent residents who left residential aged care facilities over the 6-month period from 1 January to 30 June (i.e. separations). The length of stay for these departing residents was between 142 and 155 weeks for those in remote zones compared with between 122 and 128 weeks in the remaining areas. Similarly, for respite residents departing over the 6-month period, those in other remote areas showed a longer average length of stay of 5.1 weeks compared with between 3.1 and 3.5 weeks in the other regions. In general, there were a number of significant differences in the use and characteristics of residential aged care facilities in remote centres and other remote areas when compared with facilities in other geographic areas.

The data and their limitations

Introduction

Residential aged care services in Australia were restructured in 1997–98. The two separate categories of residential care (nursing homes and hostels) were combined into a single program from 1 October 1997—residential aged care facilities. As a result, the two previous data collection systems (the Nursing Home Payment System (NHPS) and the Commonwealth Hostel Information Payment System (CHIPS)) were replaced on 1 October 1997 by a single system—the System of Payment for Aged Residential Care (SPARC). This new system is the primary data source for this report.

The new system inherited all existing records on the NHPS at 1 October 1997. For the data on the CHIPS, only those records that related to the following two groups of people were carried over:

1. those who were in a hostel at 1 October 1997; and
2. those who had a valid Aged Care Assessment Team (ACAT) assessment covering 1 October; they were regarded as potential residents.

In other words, the records for residents discharged from hostels before 1 October 1997 are not available on SPARC although they are still available on CHIPS.

The SPARC contains information gathered through a number of instruments. Among those instruments, the following three are directly relevant to this report.

- 'Aged Care Application and Approval', a form completed by persons applying for admission to a residential aged care facility or someone (normally a carer) on behalf of the applicant;
- 'Application for Classification', a form completed by the residential aged care facility to determine the residents overall level of care needs; and
- 'Monthly Claim Form', a form for claiming Commonwealth benefits completed by the residential aged care facility as part of the monthly funding cycle.

Population data are from the Australian Institute of Health and Welfare's general population databases supplied by the Australian Bureau of Statistics.

Resident information

All residents admitted to a residential aged care must have a valid Aged Care Application and Approval form. This form is valid for 12 months from the date of the approval decision. ACATs with delegation are authorised to approve the application form.

The information entered into the SPARC from the Aged Care Application and Approval form is the major source for the following data items in the tables:

- Sex
- Date of birth

- Marital status
- Pension status
- Indigenous status
- Country of birth
- Preferred language
- Resident's usual residence (prior to admission)
- Resident's living arrangements (prior to admission).

Not all residents had all the above characteristics reported on the SPARC.

Resident Classification Scale

The RCS application form is forwarded to State/Territory offices of the Commonwealth Department of Health and Aged Care by residential aged care facilities for each resident admitted. On the basis of the information provided, residents are assigned to one of eight service-need categories for the purpose of funding. The information provided on the RCS status of residents is reported in Section 5 of this report.

Claim for Commonwealth Benefit

The Claim for Commonwealth Benefits form is sent to approved facilities each calendar month as part of the payment cycle. It shows claim details for the previous month plus a 'forecast' schedule for the current month. The facility checks the information and records data on separations and absences (hospital and social leave) for these residents. It also adds information on any newly admitted residents for the current month.

The claim form is the source for the following data items in the tables:

- Date of admission
- Date of separation
- Separation mode
- Admission type.

Populations used in the tables in this report

It should be noted that tables in this publication refer to several different subpopulations and, consequently, may not be directly comparable. The subpopulations covered in the tables in this report are summarised below.

Section 2: Residents and their characteristics

All tables in this section relate to the number of residents who were in residential aged care facilities on 30 June 1998. This population includes all approved residents and totalled 133,807 persons (131,170 for permanent care and 2,637 for respite care).

Section 3: Admissions and separations

There were 21,165 admissions for permanent care (permanent admissions) and 18,487 admissions for respite care (respite admissions) over the period from 1 January to 30 June 1998. Tables 3.1 to 3.3 relate to these populations.

Tables 3.4 to 3.10 refer to separations from a residential aged care facility over the period from 1 January to 30 June 1998. There were 20,265 separations of permanent residents and 18,236 separations of respite residents.

If time-series comparisons are being undertaken using previous reports in the series, it is important to note that the data in this section relate to a 6-month period, as distinct from the 12-month period reported in previous publications in this series.

Section 4: Newly admitted residents

Tables in this section refer to the number of people admitted into residential aged care facilities during the first 6 months of 1998. Each person is counted once. There were 20,938 new residents for permanent care and 15,753 new residents for respite care. Again, the 6-month period for which data are available requires care in time-series comparisons to previous years where 12 months of data are reported on newly admitted residents.

Section 5: Resident dependency

Tables 5.1 and 5.2 in this section relate to the number of permanent residents as at 30 June 1998 (129,403 persons) who had been classified using the RCS. Permanent residents who did not have an RCS allocated (1,767 persons) are excluded from the tables. Respite residents are not included in this section.

Tables 5.3 and 5.4 relate to people (19,971) who were admitted to a residential aged care facility for permanent care during the period from 1 January to 30 June 1998. Multiple admissions are excluded from these tables. People without an RCS (967 people) are excluded from the tables.

Tables 5.5 to 5.6 represent those permanent residents (19,281) who separated from the residential aged care facilities during the period from 1 January to 30 June 1998. 900 people without an RCS are excluded from the tables. Multiple separations are also excluded from these tables.

Tables 5.3 to 5.6 are based on a 6-month period; this should be taken into account on any time-series analyses undertaken using these data.

Data limitations

It should be noted that the accuracy of some specific data items may be limited. Such cases include:

- Some residents admitted under previous arrangements and State Government nursing home residents did not report their century of birth and they have been assigned a century of birth arbitrarily. Consequently, in a small number of cases errors may have been made e.g. a resident 102 years of age could be coded as 2 years old. Effort has been made to minimise this error against other available information. For example, if a resident is coded as 3 years old on the one hand and also reported as married or receiving an age pension on the other, the adjusted age of the resident is 103 years for this report. Such adjustments have been made for only a minimal number of residents.

- Information on whether an admission was from an acute hospital, previously available on NHPS, is not available on SPARC; therefore, relevant tables have had to be dropped from this report.
- Death indicator—In some cases, residential aged care facilities may not be equipped to care for some terminally ill residents. Accordingly, such residents are transferred to acute-care institutions prior to death; hence there is an under-enumeration of discharges due to death.
- Length of stay—The length of stay of a resident is based upon the time between the date of admission and the date of separation in relation to completed stays, and between the date of admission and 30 June 1998 for current residents' incomplete stays. When a person is transferred from one facility to another, the date of admission to the first facility is the date from which the length of stay is calculated.
- Unlike previous publications in the Aged Care Statistics Series, this report covers only a 6-month period (1 January to 30 June 1998). This is due to the implementation of the new system (SPARC) midway through the first 6 months of the financial year (1 October 1997). This discontinuity makes comparisons of the admissions and separations for 1997–98 with those in previous years complex, and fraught with the likelihood of error. The numbers cannot be simply doubled to provide a rough guide, as admissions and separations are not evenly spread across a year. Moreover, transfers between what were previously nursing homes and hostels under the old system are now internalised to the system. Previously, they would have counted as admissions and separations, but now they are simply transfers from one service to another.
- The types of a residential aged care facility, such as government, private for-profit and private not-for-profit, previously recorded on both the NHPS and the CHIPS, are no longer identifiable on the new system (SPARC). Tables relating to this variable can therefore no longer be presented in this series.

Section 1

Population and residential aged care service capacity

Population data in this section are derived from population estimates compiled by the Australian Bureau of Statistics. Other data are derived from the Commonwealth Department of Health and Aged Care database on approved residential aged care facilities for the aged as at 30 June 1998.

Section 2

Residents and their characteristics

These tables are based on those residents in residential aged care facilities at 30 June 1998. Some basic characteristics of the residents are presented.

Section 3

Admissions and separations

These tables refer to admissions to and separations from residential aged care facilities between 1 January and 30 June 1998. An individual can have more than one admission during the period. Transfers are excluded from the tables in this section.

Section 4

Characteristics of newly admitted residents

The tables in this section refer to people who were admitted to residential aged care facilities during the period from 1 January to 30 June 1998.

Section 5

Resident dependency

The tables in this section describe dependency levels among the residents in residential aged care facilities. Resident dependency levels are based on the Resident Classification Scale which classifies residents into eight categories. Category 1 represents the highest dependency level and category 8 the lowest.

Glossary

Aged Care Assessment Team (ACAT)

Multidisciplinary team of health professionals responsible for determining eligibility for entry to a residential aged care facility.

Admission day

The first day of a person's stay in a residential aged care facility. In the case of a person transferring between facilities, where the time between leaving one facility and entering another is less than 2 days, it is the date of the initial admission. Permanent and respite admissions are treated separately. For example, if a person transfers from a respite stay to a permanent stay, a new permanent admission is created.

Care recipient

A person assessed by an Aged Care Assessment Team as having significant care needs which can be appropriately met through the provision of residential care, community care, and / or flexible care.

CHIPS

CHIPS is the abbreviation for 'Commonwealth Hostel Payment System' which used to be the information system for hostels.

DVA

DVA is the abbreviation for 'Department of Veterans' Affairs' which is a Commonwealth government department.

Geographic areas

The geographic areas used in this report are based on the classification developed by the Department of Primary Industries and Energy, and the Department of Human Services and Health (now the Department of Health and Aged Care) in 1994. This classification categorises all statistical local areas (SLAs) in Australia according to their remoteness, with an index of remoteness being calculated for each SLA in non-metropolitan Australia. Remoteness is measured by population density and distances to large population centres. The structure of the classification is as follows:

Metropolitan areas

• Capital city	State and Territory capital city statistical divisions
• Other metropolitan centre	Urban centres of population 100,000 or more

Non-metropolitan zones

• Rural zone	(Index of remoteness less than or equal to 10.5)
Large rural centres	Urban centre population between 25,000 and 99,999
Small rural centres	Urban centre population between 10,000 and 24,999
Other rural area	Urban centre population under 10,000
• Remote zone	(Index of remoteness greater than 10.5)
Remote centre	Urban centre population 5,000 or over
Other remote area	Urban centre population under 5,000

The System for Aged Residential Care (SPARC) contains SLA codes for each residential aged care facility and these SLA codes were converted to geographic areas according to the above classification.

High care residents

A high care resident is one who is assigned to classification levels 1–4 using the Resident Classification Scale. The level of care required is broadly equivalent to the nursing home care provided under the previous system of residential care.

Hostel for the aged

A hostel is a care facility in which residents receive Hostel Care or Personal Care services unless designated as a co-habitee. In this publication all references to hostels are to hostels for the aged, that is, those hostels are designed to provide services to older people with disabilities. A small number of young people with disabilities live in hostels for the aged. Hostels specifically established for young people with a disability are not included in this publication.

Length of stay

The length of stay of a separated resident is based upon the time between the date of admission and the date of separation. For a current resident, it is the time between the date of admission and 30 June 1998. The admission day and the specified day (30 June 1998) are included but the separation day is excluded from the calculation of length of stay.

Low care residents

A low care resident is one who is assigned to classification levels 5–8 using the Resident Classification Scale. The level of care required is broadly equivalent to the hostel level of care provided under the previous system of residential care.

Nursing and personal care

This refers to care which a care recipient requires for a medically related condition and / or assistance with personal tasks such as washing and dressing.

NHPS

NHPS is the abbreviation for 'Nursing Home Payment System' which used to be the information system for nursing homes.

Nursing home for the aged

All nursing homes approved under the National Health Act other than nursing homes for disabled people. In this publication all references to nursing homes are to nursing homes for the aged. There have been a small number of young people with disabilities living the nursing homes for the aged.

Permanent admission

A permanent admission is an admission to a residential aged care facility for long-term care purposes. The term 'permanent' does not mean staying in a residential aged care facility forever. In fact, many 'permanent admissions' leave residential aged care facilities alive after a short period of stay.

Permanent care

A resident in a residential aged care facility is under permanent care if this resident entered the facility as a permanent admission.

Permanent resident

A resident who was admitted to a residential aged care facility for permanent care (long-term care).

Personal care

Personal care refers to assistance provided to a care recipient to perform personal activities such as bathing, toileting and dressing.

Personal Care Assessment Instrument (PCAI)

The PCAI was forwarded under the previous system of residential care to Commonwealth State offices by hostels for each resident who may have been eligible for a Personal Care subsidy. On the basis of the information provided, residents were assigned to one of three-service need categories for the purpose of funding. The three categories were Personal Care High (PCH), Personal Care Intermediate (PCI) and Personal Care Low (PCL). The PCAI categories were used in previous reports in this series to measure the level of dependency based on the assumption that the level of dependency positively relates to the level of care needs.

Place-day

A place day is a day on which a care recipient is occupying a place. The day that a care recipient enters a residential aged care facility and the day he or she leaves are counted as one day.

Resident

A resident is a person who has been assessed by an Aged Care Assessment Team as requiring residential care and who resides in a Commonwealth-funded residential aged care facility.

Residential care

Personal and / or nursing care that is provided to a person in a residential care facility in which the person is also provided with accommodation that includes appropriate staffing, meals, cleaning services, and furnishings, furniture and equipment, for the provision of that care and accommodation.

Residential aged care facility

A facility consists of a number of approved places at a specific location. In the *Aged Care Act 1997* a facility is called a 'service'.

Resident Classification Instrument (RCI)

The RCI was, under the previous system, forwarded to Commonwealth State offices by nursing homes for each resident admitted. On the basis of the information provided, residents were assigned to one of five service-need categories for the purpose of funding. Category 1 represented the highest level of care needs and category 5 the lowest. The RCI categories were used in previous reports in this series to measure the level of dependency based on the assumption that the level of dependency positively relates to the level of care needs.

Resident Classification Scale (RCS)

The RCS is a nationally consistent instrument which assesses a care recipient's care needs. This scale has 8 classification levels ranging from low (RCS 8) to high care (RCS 1), with each level having a specified subsidy level which is paid to the provider for providing the required care to the care recipient. The RCS was introduced with the amalgamation of hostels and nursing homes into one system of care on 1 October 1997, replacing the RCI (nursing homes) and the PCAI (hostels).

Respite admission

A respite admission is a short-term admission to a residential aged care facility for respite care purpose.

Respite care

Respite care is care given as an alternative care arrangement with the primary purpose of giving the carer or a care recipient a short-term break from their usual care arrangement.

Respite resident

A respite resident is one who was admitted to a residential aged care facility for respite care.

Separation

A separation occurs when a person is discharged from a residential aged care facility and has not re-entered the same or another facility within two days.

Separation day

A separation day is the last day of a person's stay in a residential aged care facility; the day on which the person leaves the facility. In the case of a person transferring between facilities, where the time between leaving one facility and entering another is less than two days, this is not viewed as a separation.

SPARC

SPARC is the abbreviation for 'System of Payment for Aged Residential Care' which is the current information system for residential aged care service.

Separation mode

The separation mode indicates the destination of a resident at separation, including death.

Transfer

A transfer occurs where a person leaves a residential aged care facility on one day and is admitted to another within two days.

Usual housing status

Usual housing status refers to housing tenure prior to the resident's application for admission to a residential aged care facility.

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