Australian Government
Australian Institute of Health and Welfare

Residential aged care

in Australia 2010–11:

A statistical overview

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September 2012

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Abbreviations

ABS	Australian Bureau of Statistics
ACAR	Aged Care Approvals Round
ACAT	Aged Care Assessment Team
ACFI	Aged Care Funding Instrument
ADL	Activities of daily living (ACFI domain)
AIHW	Australian Institute of Health and Welfare
ASGC	Australian Standard Geographical Classification
BEH	Behaviour (ACFI domain)
CACP	Community Aged Care Package
CHC	Complex health care (ACFI domain)
DoHA	Department of Health and Ageing (Australian Government)
DVA	Department of Veterans' Affairs (Australian Government)
EACH	Extended Aged Care at Home (package)
EACHD	Extended Aged Care at Home Dementia (package)
ESS	Extra Service Status
HACC	Home and Community Care
MPS	Multi-purpose Services
RCS	Resident Classification Scale
RACs	*Residential aged care in Australia: a statistical overview* (prepared annually by AIHW, i.e. this publication is the 2010–11 RACs report)
SPARC	System for the Payment of Aged Residential Care
TCP	Transition Care Program

Summary

This report on residential aged care presents statistics from July 2010 to June 2011. Together with its companion report, *Aged care packages in the community 2010–11: a statistical overview,* it provides a comprehensive overview of Australian Government–funded aged care.

Most people living in residential aged care facilities are women, the majority are aged 80 and over and many are widowed

There were around 169,000 people living in residential aged care at 30 June 2011, nearly all on a permanent basis. About three-quarters (77%) were aged 80 and over and 57% were aged 85 and over. The difference in life expectancy between men and women is evident with 70% of permanent residents being female and more women widowed (64%) than their male counterparts (26%).

More places, larger facilities and mostly operated by the not-for-profit sector

The number of operational residential aged care places has grown steadily since 1995 to reach 185,482 at 30 June 2011, representing an increase of 2,632 places (1.4%) over the previous year. There are 2,760 facilities providing care, with the majority of service providers being not-for-profit (60%), which is also the sector that operates the highest proportion of services (67%) in *Very remote* areas. Overall, the facilities themselves are becoming bigger, with 45% offering more than 60 places whereas only 6% offer fewer than 20 places.

Average length of stay is increasing

For permanent residents who left residential aged care between 1 July 2010 to 30 June 2011, over one-third (38%) were in residential care for less than 1 year (27% for less than 6 months). Two-fifths (44%) had a length of stay between 1 and 5 years. Women tended to stay longer than men at an average of 168.1 weeks compared with 109.5 weeks, and most residents left due to death (91%). The average completed length of stay for permanent residents in 2010–11 was 145.7 weeks, an increase of 11% since 1998–99, when it was 131.3 weeks.

Care needs vary according to age

There were 56,531 people admitted to permanent residential care who had an Aged Care Funding Instrument appraisal, with 64% of them requiring high-level care. The proportion of younger residents (aged under 65) requiring high-level care at 30 June 2011 was 85%, with 57% requiring high care in the behaviour domain. By comparison, 76% of residents overall were high care, with 48% having high-care needs in the behaviour domain.

The age profile for Aboriginal and Torres Strait Islander people is different

At 30 June 2011, there were 1,127 residents (0.7%) in permanent residential aged care identifying as Indigenous. These residents had a younger age profile, with 24% under age 65 compared with 4% for all permanent residents in this age group, reflecting a tendency towards poorer health and eligibility for residential aged care at age 50. The composition of the residential care population in the Northern Territory was different from other states and territories, with 37% identifying as Indigenous.

Chapter 1

Introduction

1 Introduction

1.1 Aged care in Australia

The population of Australia is growing older, with around one in every seven aged 65 years or over (AIHW 2011a). In the last 25 years, the population aged 65 and over has increased from 10.5% to 14.0%. In addition, and as a proportion of the overall population, those aged 85 and over have increased from 0.8% to 1.9% (DoHA 2012).

Ageing of the population presents several challenges for governments and the community, including a demand for formal care services that assist older people (Borowski & McDonald 2007). The Australian Government is committed to encouraging a positive approach to healthy and active ageing. At the same time, however, it aims to ensure that frail older people have timely access to 'high quality, accessible and affordable care through a safe and secure aged care system' (DoHA 2011a).

There are three main service streams in Australia's aged care system: residential care services, community care, and flexible care services. Within each of these streams there are a variety of programs, many of which are administered under the provisions of the *Aged Care Act 1997* and the associated *Aged Care Principles*. (A notable exception is the Home and Community Care (HACC) program which is administered outside the Act and is explained in greater detail in Section 1.5). Under the provisions of the Act, the Australian Government funds residential aged care facilities to provide care and support for older Australians whose care needs cannot be met at home, even with community care packages. This publication, *Residential aged care in Australia 2010–11: a statistical overview*, reports on the characteristics of people who use the residential aged care system as well as certain aspects of that system; for example, the types of organisations that provide the services.

The care needs of older people will change over time and as a consequence they may need to use more than one service concurrently or they may move from one stream of care to another. That movement is not always in a single direction (for example, from community care to residential aged care) so this report also includes some information about community aged care and the nature of the dynamic relationships between the care streams. The community aged care system is reported on in more detail in the companion publication (AIHW 2012a).

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

1.2 Package of aged care reforms released in 2012

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

Subsequently, the Australian Government conducted a consultation process with older Australians, with their families and with industry stakeholders. The views of these groups, as well as the Productivity Commission report itself, contributed to the development of a package of aged care reforms which was released in April 2012 (DoHA 2012). The *Living Longer Living Better* aged care reform package is intended to '…build a responsive, integrated, consumer-centred and sustainable aged care system, designed to meet the challenges of population ageing and ensure ongoing innovation and improvement' (DoHA 2012). The reform package changes the way residential aged care is financed and delivered. Included in the reforms is $660.3 million to support the development of more residential aged care facilities in areas of greatest need, to embed consumer-directed care principles into mainstream aged care program delivery and to ensure the sustainability of aged care facilities in regional, rural and remote areas. The reforms will also combine the existing income and asset tests into a new 'strengthened' means-testing arrangement and introduce a lifetime cap on care fees (DoHA 2012). The outcomes of the reforms will be included in subsequent Australian Institute of Health and Welfare (AIHW) reporting on aged care matters as relevant details become available.

For more information about the reform package, including changes to funding and an increase in consumer involvement, go to: <http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-aged-care-review-measures-living.htm>.

1.3 The purpose of this report

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

The aim of this report is to provide a summary of residential aged care provision and describe the characteristics of aged care residents. It therefore includes:

- data about the people who use residential aged care on either a permanent or a respite basis
- how they access and use the care
- where the care they need is provided
- what kinds of organisations provide the care
- where those organisations are located.

Significantly, Chapter 5 includes information on the Aged Care Funding Instrument (ACFI), including the health conditions described in ACFI appraisals. Chapter 6 tracks trends over time about residential aged care and, where available, makes comparisons with data from previous years. Some information about Aboriginal and Torres Strait Islander aged care as well as younger people in residential aged care is also provided in the report. (Sources of more information in these two areas are provided in the relevant sections.)

The care needs of older people in the community can be quite varied and flexible aged care initiatives have been designed to assist in meeting those needs. The focus of the community aged care report (AIHW 2012a) is Community Aged Care Packages (CACPs) and associated services, the Extended Aged Care at Home (EACH) and the Extended Aged Care at Home Dementia (EACHD) programs. Like this report, it provides data on the characteristics of people who use community aged care programs and services, how they access and use them, the locations of the services they use, and the kinds of organisations providing the services they need.

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

1.4 Overview of Australia's residential aged care system

Before the *Aged Care Act 1997*, the components of residential aged care (known as nursing homes and hostels at the time) were regulated and funded as separate entities. Following the *Aged Care Act 1997*, these facilities were regulated under a common Act and funded according to the care needs of residents. Ageing in place was, and still is, encouraged to provide better continuity of care and to foster a safe level of independence for older people.

The *2010–11 report on the operation of the Aged Care Act 1997* states that there are around 185,550 operational residential aged care places across the aged care system as at 30 June 2011 (DoHA 2011a). Australian Government–subsidised residential aged care (which is administered under the Act) is one of the main streams of formal care delivery for frail older Australians and for older people with disability. Residential aged care programs are available on either a permanent or a respite basis, and for low or high levels of care. Although residential aged care is mostly used by older people, there are also some younger people who need to access this type of care and many of them have a disability (AIHW 2012b).

Under Part 2.3 of the Act, access to residential aged care (permanent and/or respite), community care or flexible care requires approval from a multidisciplinary Aged Care Assessment Team (ACAT). An ACAT will assess the care needs of an individual and approve people for residential aged care as well as act as a source of advice and referral about community aged care services (DoHA 2006, 2009a). To be eligible for entry into an Australian Government–subsidised residential aged care service, assessment and approval by an ACAT is mandatory. Those assessed as needing residential care (the care recipient) receive care on either a permanent or a respite basis. For care recipients, residential aged care facilities provide suitable accommodation and related non-clinical services (such as laundry, meals and cleaning) and personal care services (such as assistance with activities of daily living). Nursing care is also available if required as well as any equipment needed to provide either nursing care (for example, nebulisers) or personal care services (for example, lifting machines).

Funding for residential aged care facilities is calculated using the Aged Care Funding Instrument (ACFI), which was introduced by the Australian Government in March 2008 to replace the Resident Classification Scale (DoHA 2009a). Using the ACFI, a residential aged care facility will assess the care needs of residents requiring permanent care—it is not used for residents requiring respite care. Once the care needs have been assessed, the outcomes are then used in determining the funding to be paid to the aged care provider (AIHW 2011b; DoHA 2009a). Chapter 5 of this report contains detailed information about ACFI, including how it is used and under what circumstances.

Residential aged care: permanent

Permanent residential aged care is offered to people who can no longer be supported living in the community. Depending on a person's assessed needs, permanent care is currently offered at two levels: low care and high care (DoHA 2006, 2008). Assessments focus on a person's physical, medical, psychological, cultural and social needs. Permanent residents receiving low-care require accommodation and personal care, and residents receiving high-care require 24-hour nursing care in addition to their low-care needs.

Residential aged care: respite

Residential respite care is short-term care in aged care facilities. It is available on a planned or emergency basis to older people who intend returning to their own home yet need residential aged care on a temporary basis. It supports older people in transition stages of health, as well as being used by carers to provide them with a break from their caring duties. Residential respite care is provided on either a low-care or high-care basis. This kind of care is also an example of the dynamic nature of the relationships between levels of care; for example, respite care may be provided concurrently with a community aged care package.

1.5 Community aged care in brief

Within the aged care system, there is a continuing strong emphasis on the provision of innovative and flexible community care to help people stay in their own homes. A variety of care programs and services are now available and more continue to evolve and develop to meet the changing needs of older people. For example, the HACC Program was created in 1984 and is administered under the *Home and Community Care Act 1985*. It is the main provider of home-based aged care in Australia and represents the largest part of the Australian Government's support for community aged care. Significant changes to funding for the HACC program are a consequence of the reforms of the National Health Reform Agreement (Appendix A) and the 2012 package of aged care reforms (Section 1.2). The Department of Health and Ageing reports regularly on the HACC Program and this information is available on the Department's website (DoHA 2011b).

The connections between residential aged care and community care are strong since many community care programs are specifically designed to enable older people to live in the community for as long as possible before they need residential aged care. For example, the Transition Care Program (TCP) is a time-limited goal-oriented and therapy-focused program for older people who have been assessed as eligible for residential aged care during a hospital stay. In addition to services aimed at restoring function, it aims to optimise independence levels before making longer term arrangements (AIHW 2011c).

A short summary of some other community care programs referred to in this report follows. These and other programs are reported on in more detail in the companion community aged care report (AIHW 2012a).

Community-based programs and services administered under the *Aged Care Act 1997* include Community Aged Care Packages (CACPs), which are tailored to the specific care needs of individuals. These packages are complemented by Extended Aged Care At Home (EACH) and Extended Aged Care At Home Dementia (EACHD) packages and by Multi-purpose Services (MPS) which also provide residential places and community aged care, primarily in rural, regional and remote areas. To provide further flexibility for older people, innovative care arrangements and models of delivery can be developed. Programs like this are trialled under the Aged Care Innovative Pool program before being formally assessed for potential of a mainstream roll-out. A current example is the Consumer Directed Care program, a community care service delivery model being tested across a number of community aged care environments (DoHA 2011a).

In addition, flexible models of care are provided under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. The services funded under this program provide culturally appropriate residential and community aged care for Indigenous people, mainly in rural and remote areas close to Indigenous communities.

Operating outside the Act are the Australian Government–funded National Respite for Carers Program, and as explained previously, the HACC Program.

1.6 Organisation of the report and data sources

The 2010–11 edition of the RACs report provides a summary of residential aged care provision and describes the characteristics of aged care residents.

- Chapter 1 (this chapter) describes the background to the report, briefly describes the 2012 package of aged care reforms, provides an overview of Australia's aged care system (including community aged care), outlines the inclusions for each chapter and describes the changes that have been made to this report compared with earlier reports in the series; for example, provision of online data.
- Chapter 2 reports on the provision of residential aged care services, including the number and distribution of places and the characteristics of service providers. It also includes information on Extra Service Status

as well as some information about the provision of community aged care packages which is provided for comparison purposes.

- Chapter 3 describes the characteristics of residents as at 30 June 2011, including permanent and admitted residents; for example, age, sex, marital status and preferred language. It also includes characteristics specific to Aboriginal and Torres Strait Islander people.
- Chapter 4 contains data on patterns of service use by residents, including admitted and separated residents during 2010–11 and length of stay measures.
- Chapter 5 provides information on the ACFI, discussing variations in the results (for example, across states and territories), and the health conditions identified through ACFI appraisals. It includes information on younger residents living in residential aged care.
- Chapter 6 provides an overview of trends over the last 10 years or more, as well as data on residents' transition from respite to permanent care.

Data on residential aged care places and aged care packages provided in the community have been extracted from the Department of Health and Ageing's (DoHA's) Ageing and Aged Care Data Warehouse. Sources of other data are provided at relevant points throughout the report. Appendix C contains more information about the data used in the report.

Variance may occur from other reporting, depending on the methodology used and the point at which the data were accessed.

The first few tables in Chapter 2 (tables 2.1 and 2.4 to 2.7) include places available through Multi-purpose Services and those provided under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. All other tables in the report include data for mainstream services only.

The Glossary explains the use of or defines terminology specific to aged care; for example, 'high-care resident', 'mainstream places', 'place-day' and 'separation day'.

1.7 Changes to the 2010–11 report

Selected tables and appendixes, previously available only in hard copy, have been provided electronically for this publication. Data cubes have also been provided electronically.

The RACs report and the community aged care report are designed to complement each other and both are available in PDF form for ease of reference.

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

Chapter 2

Residential aged care service provision

2 Residential aged care service provision

This chapter provides information about the number of aged care places available in Australia and where they are located. It describes the aged care approvals process, with data on approved, allocated and operational places. The chapter also includes discussion of provision planning ratios to monitor whether funded places in residential aged care meet the estimated demands for places in the ageing Australian population. Information on aged care facilities is included in this chapter, as well as details of Extra Service Status (ESS) places.

Some data about the provision of community aged care packages are provided for comparison purposes and to aid in forming an overall view of aged care nationally. For further details about community aged care packages see (AIHW 2012a).

2.1 Allocated places

Each year, the planning process undertaken by the Australian Government aims to have new aged care places made available for allocation in each state and territory, having regard to the national planning benchmark, population projections provided by the Australian Bureau of Statistics (ABS) and the level of current and future service provision (Box 2.1). The aim of the process is to ensure an adequate supply of low-care and high-care places to achieve equitable access to services between metropolitan, regional, rural and remote areas (DoHA 2006). Aged Care Planning Advisory Committees, which operate under the *Aged Care Act 1997*, provide advice on the distribution of places to aged care planning regions in each state and territory. Australian Government planning of service provision aims to maintain a national target level of operational aged care places across the programs administered under the *Aged Care Act 1997* (Section 2.4 and Box 2.3). The target ratio is periodically adjusted and, at the time of writing, it was 113 places per 1,000 persons aged 70 and over. The aim was to achieve that target by June 2011 (DoHA 2011a) (see Table 2.7). In addition, the planning process aims to provide places for an array of care options, primarily between community aged care and residential aged care, to meet the needs and preferences of care recipients (DoHA 2009a).

Box 2.1: Allocation of places—the Aged Care Approvals Round (ACAR)

New aged care places are usually made available annually in each state and territory, based on the national target and provision ratio (Box 2.3), taking into consideration the regional distribution of need.

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

To obtain an allocation of places under the *Aged Care Act 1997,* the applicant must be an Approved Provider. Places cannot be allocated to a provider without the necessary Approved Provider status. Organisations who want to provide residential aged care services need to have applied to DoHA for the relevant Approved Provider status for the type of care they wish to provide, before the ACAR round.

Places for Multi-purpose Services (MPS), National Aboriginal and Torres Strait Islander Flexible Aged Care Program, Transition Care Program (TCP) and the Aged Care Innovative Care program are not allocated in the ACAR process.

Source: DoHA 2006, 2008, 2009a.

The ACAR approval process caters for the annual provision of new places that are needed to achieve the target ratio (Box 2.3). Approved providers who receive an allocation of new residential aged care places are required under the *Aged Care Act 1997* to make them operational within 2 years, otherwise the places lapse or the provider needs to apply for an extension. Therefore, there may be time lags from the date residential aged care, CACP, EACH and EACHD places are approved, allocated and then made operational. Generally, community care places become operational more quickly than residential aged places (DoHA 2011a).

The number of new aged care places allocated and available under the ACAR process is governed by two factors. The first is a comparison with the national target of 113 places per 1,000 people aged 70 and over in the general population. The second relates to current levels of service provision, including newly allocated places that have not yet become operational (DoHA 2006, 2011a).

In the ACAR related to this report, the overall allocation of new places included:

- 2,136 low-care residential places
- 3,507 high-care residential places
- 2,408 CACPs
- 4,221 EACH/EACHD packages.

2.2 Operational places

An operational place is one which is either occupied or available for the provision of aged care to an approved care recipient. The number of operational residential aged care places has grown continually since 1995 to reach 185,482 at 30 June 2011, representing an increase of 1.4% on the previous year (Table 2.1). When operational places for CACP, EACH and EACHD and TCP are added to the operational places for residential aged care, the total number of operational aged care places becomes 246,753. The increase in provision of places is intended to correspond to the future needs of an ageing population.

Residential places provided by MPS and services funded under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program are included in the residential aged care totals in Table 2.1. At 30 June 2011 there were 134 MPS across Australia, providing 2,794 residential care places. This was a slight increase from 30 June 2010, when there were 129 MPS providing 2,707 places. Data from DoHA's data warehouse indicate that there were 29 services funded under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program as at 30 June 2011, delivering 386 residential care places, a small decrease from the previous year.

Table 2.1: Number of operational residential aged care, CACP, EACH, EACHD and TCP places, 30 June 2006 to 30 June 2011

Year	Residential aged care	CACP	EACH and EACHD	TCP	Total
2006	166,291	35,383	3,181	595	205,450
2007	170,071	37,997	4,573	1,609	214,250
2008	175,472	40,280	6,240	1,963	223,955
2009	178,290	40,859	6,514	2,228	227,891
2010	182,850	43,300	8,167	2,698	237,015
2011	**185,482**	**45,777**	**12,145**	**3,349**	**246,753**

Note: This table includes 2,794 residential places provided by MPS, and 386 residential places funded under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. Non-residential flexible care packages are counted under CACP. There were 422 CACPs counted under MPS and 259 CACPs funded under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. The table does not include 500 Consumer Directed Care packages and 126 Innovative Care packages.

2.3 How are places distributed nationally?

Distribution of population aged 70 and over across Australia

The provision of places for residential aged care is targeted to people aged 70 and over. Consequently, knowing the geographical areas where these older people live is important. Through the planning and allocation processes, the Australian Government aims to distribute aged care services in an equitable way according to this criterion.

At 30 June 2011, there were 2,163,500 Australians aged 70 and over (Table 2.2). The majority of people of this age group lived in *Major cities* (66%), with most of the remainder living in *Inner regional* (23%) and *Outer regional* (10%) areas (Box 2.2). Only 1% lived in *Remote* areas and 0.3% in *Very remote* areas (Table 2.3).

Box 2.2: How is remoteness defined?

The term 'remoteness', as used in this publication, refers to a classification defined by the Australian Standard Geographical Classification (ASGC) (ABS 2010a). The ASGC uses measures of access and distance to services offered in urban areas to determine classifications of Australian remoteness. These classifications are:

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

Tasmania has no areas classified as *Major cities,* because the ASGC classifies Hobart as *Inner regional.* Similarly, the Australian Capital Territory has no areas classified as *Outer regional, Remote* or *Very remote* areas. In addition, *Remote* and *Very remote* areas, and states and territories such as the Northern Territory and the Australian Capital Territory, have low population numbers. Therefore, comparisons of proportions and interpretation of data between these and other, more highly populated locations must be undertaken with caution.

Further details about remoteness and how it is calculated (including the Accessibility/Remoteness Index of Australia) are provided in the Glossary.

Table 2.2: Distribution of population aged 70 and over by state/ territory, 30 June 2011

State/territory	Population 70+ ('000)	Per cent
NSW	734.2	33.9
Vic	551.1	25.5
Qld	402.3	18.6
WA	198.3	9.2
SA	188.2	8.7
Tas	56.1	2.6
ACT	26.1	1.2
NT	7.3	0.3
Australia	**2,163.5**	**100.0**

Source: SCRGSP 2012 (Online Table 13A.3).

Table 2.3: Distribution of population aged 70 and over by remoteness, 30 June 2011

Remoteness area	Population 70+ ('000)	Per cent
Major cities	1,426.9	66.0
Inner regional	497.3	23.0
Outer regional	210.3	9.7
Remote	22.1	1.0
Very remote	7.4	0.3
Australia	**2,163.5**	**100.0**

Source: SCRGSP 2012 (Online Table 13A.3).

Note: Column totals may be different from column sums due to rounding.

Distribution of places

The distribution of total aged care places among the states and territories and across remoteness areas broadly reflects the distribution of the target population (tables 2.2 to 2.5). Around one-third of places are located in New South Wales, with a further quarter in Victoria (Table 2.4). Less than 1% of places are located in the Northern Territory. In terms of remoteness, around two-thirds of places are in *Major cities* with most of the remainder located in *Inner regional* (22%) and *Outer regional* (9%) areas (Table 2.5). Very few EACH or EACHD places and no TCP places are located in *Very remote* areas, reflecting the difficulty in delivering specialised services in these locations.

Table 2.4: Residential aged care, CACP, EACH, EACHD and TCP places, by state/territory[(a)], 30 June 2011

State/ territory	Residential	CACP	EACH	EACHD	TCP	Total places (Number)	Total places (Per cent)
NSW	63,923	15,062	2,167	947	1,156	83,255	33.7
Vic	47,624	11,103	1,679	769	837	62,012	25.1
Qld	33,438	8,530	1,761	971	606	45,306	18.4
WA	15,766	4,710	1,557	832	286	23,151	9.4
SA	17,268	3,759	416	204	289	21,936	8.9
Tas	4,747	1,196	174	100	97	6,314	2.6
ACT	2,031	671	291	134	49	3,176	1.3
NT	685	746	105	38	29	1,603	0.6
Australia	**185,482**	**45,777**	**8,150**	**3,995**	**3,349**	**246,753**	**100.0**

(a) Refers to the location of the facilities.

Note: This table includes 2,794 residential places provided by MPS, and 386 residential places funded under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. Non-residential flexible care packages are counted under CACP. There were 422 CACPs counted under MPS and 259 CACPs funded under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. The table does not include 500 Consumer Directed Care packages and 126 Innovative Care packages.

Table 2.5: Residential aged care, CACP, EACH, EACHD and TCP places, by remoteness[(a)], 30 June 2011

Remoteness	Residential	CACP	EACH	EACHD	TCP	Total places (Number)	Total places (Per cent)
Major cities	125,530	30,638	5,444	2,748	2,183	166,543	67.5
Inner regional	41,284	9,895	1,902	867	901	54,849	22.2
Outer regional	16,237	3,754	703	349	253	21,296	8.6
Remote	1,705	796	77	28	12	2,618	1.1
Very remote	726	694	24	3	0	1,447	0.6
All regions	**185,482**	**45,777**	**8,150**	**3,995**	**3,349**	**246,753**	**100.0**

(a) Refers to the location of the facilities. The table uses the ASGC Remoteness Structure as developed by the ABS (ABS 2010a).

Note: This table includes 2,794 residential places provided by MPS, and 386 residential places funded under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. Non-residential flexible care packages are counted under CACP. There were 422 CACPs counted under MPS and 259 CACPs funded under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. The table does not include 500 Consumer Directed Care packages and 126 Innovative Care packages.

2.4 Aged care provision ratios

As described in Section 2.1, a planning and allocation process is undertaken annually to determine the geographical distribution and types of aged care places to be made available across Australia. The process aims to maintain a national target level of operational places for the programs administered under the *Aged Care Act 1997*. The current national target ratio for aged care provision is 113 aged care places per 1,000 persons aged 70 and over, and consists of 88 residential aged care places and 25 community care places, which was to be achieved by June 2011. This target ratio does not include TCP places (Box 2.3) (see tables 2.6 and 2.7 for achievements against the target ratio).

Box 2.3: National target ratio and provision ratio

What is the Australian Government target ratio?

In 2007, the target ratio was lifted from 108 to 113 places per 1,000 persons aged 70 and over. This target was expected to be achieved by 30 June 2011 (DoHA 2009a).

Of those 113 places:

- 88 are for residential aged care
  - 44 for high-care places
  - 44 for places
- 25 are for community care places
  - 4 for high-care (EACH and EACHD)
  - 21 for low-care (CACPs).

What does the provision ratio measure?

The provision ratio compares the number of *places available* to a specific population at a point in time, usually a 30 June date. Currently, aged care planning calculates the number of places available per 1,000 people aged 70 and over. Under these circumstances, if a provision ratio is 10, it would mean that there are 10 places available for every 1,000 people 70 and over. In 2010, the target for high-level community care was increased from 4 to 6 places, while the target for high-level residential care was temporarily adjusted to 42 places per 1,000 people aged 70 and over. This was to ensure that the overall target ratio was to be achieved in 2011, together with the balance of 48 high-care and 65 low-care places.

National provision ratios in 2011

The provision ratio for residential places only was 85.7 in 2011 (Table 2.6). This figure is slightly down compared with the previous year because, although there has been a growth in the population aged 70 and over, there is a limited capacity of providers to develop new places in the designated areas of need, particularly in non-urban areas.

The overall provision ratio at 30 June 2011 was 112.5 per 1,000 persons aged 70 and over (Table 2.7) which is very close to the Australian Government's target of 113 places. Provision ratios are calculated for operational residential aged care, CACP, and EACH and EACHD combined, and take account of places provided through MPS and places funded under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. The overall totals are also reported (Table 2.7).

At 30 June 2011, the provision ratios for community aged care were 21.2 packages per 1,000 residents aged 70 and over for CACP (low care) and 5.6 packages per 1,000 residents aged 70 and over for EACH and EACHD combined (high care). For further details, see (AIHW 2012a).

Table 2.6: Aged care places per 1,000 persons[(a)] aged 70 and over, 30 June 2006 to 30 June 2011

Year	Residential	CACP	EACH and EACHD	Total
2006	87.0	18.5	1.7	107.2
2007	86.9	19.4	2.3	108.6
2008	87.7	20.1	3.1	110.9
2009	87.0	19.9	3.2	110.1
2010	86.8	20.5	3.9	111.2
2011	**85.7**	**21.2**	**5.6**	**112.5**

(a) SCRGSP 2012 (Online Table 13A.3).

Note: This table includes 2,794 residential places provided by MPS, and 386 residential places funded under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. Non-residential flexible care packages are counted under CACP. There were 422 CACPs counted under MPS and 259 CACPs funded under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. The table does not include 500 Consumer Directed Care packages and 126 Innovative Care packages. If these packages are included the provision ratios recalculate at Residential (85.8), CACP (21.2), EACH/EACHD (5.7) and Total (112.8).

Geographical variation in provision ratios

Given Australia's geographical size and population distribution, it is not surprising that there is some variation in provision ratios among the states and territories (Table 2.7). The process for allocating aged care places, as set out in the *Aged Care Act 1997*, provides for planning that identifies community needs and allocates places in a way that best meets the identified needs of the community. It is applied at the state and territory level on an agreed aged care planning region basis. Each year, the planning arrangements determine the number and type of places to be made available and the way in which the aged care places are distributed across the aged care planning regions within each state and territory. For example, these arrangements may specify a proportion of places that must be provided to certain groups of people specified in the Act, such as those with special needs (including people who are homeless and culturally and linguistically diverse groups), or for any other particular care requirements within regions, such as the need for residential respite care. Other factors may also be included in adjusting the provision ratio at the regional level, including the availability of service providers and access to health facilities (DoHA 2011a).

The Northern Territory had the highest residential aged care provision ratio (93.8 places per 1,000 persons aged 70 and over), followed by South Australia (91.8). The lowest provision ratios for residential aged care were in the Australian Capital Territory (77.8) and Western Australia (79.5).

The combined ratio of all aged care places per 1,000 people aged 70 and over was much higher in the Northern Territory (219.6) than in any other jurisdiction. This partly relates to the provision of community care places in remote and Indigenous communities. Combined provision ratios in the other jurisdictions were close to the national average of 112.5.

Greater variation in provision ratios for residential aged care is apparent across remoteness areas nationally and among the states and territories (Online Table A1.9). For example, at the national level, the residential care ratio varied from 77.1 in *Remote* areas and 77.3 in *Outer regional* areas to 98.1 in *Very remote* areas, but the ratio in *Very remote* areas varied from 3.3 in New South Wales to 166.7 in South Australia. Some of this variation is accounted for by problems such as geographical isolation, which can be associated with the provision of certain services in remote and Indigenous communities.

Access for Aboriginal and Torres Strait Islander people

Government planning targets are based on providing 113 places per 1,000 people aged 70 or over by June 2011 (Box 2.3). Health conditions related to ageing often affect Aboriginal and Torres Strait Islander people earlier than other Australians (AIHW 2011d). Therefore, Indigenous Australians may access aged care programs at a younger age compared with non-Indigenous Australians. Accordingly, planning in some regions also takes account of the Indigenous population aged 50–69. This means that the provision ratio based on the population aged 70 or over will appear high in those regions with a high proportion of Indigenous people in the population. For example, the Northern Territory has a much higher proportion of Indigenous Australians in residential aged care than any of the other states or territories: 36% of all permanent residents compared with 2% in Western Australia and less than 1% in the other jurisdictions (Online Table A2.7).

As well as having access to aged care facilities funded under the *Aged Care Act 1997*, Indigenous people also have access to facilities funded through the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. These facilities are funded and operated outside the regulatory framework of the Act and are not reflected in planning provision ratios.

At 30 June 2011, there were 28 aged care facilities funded through this program, with funding to deliver over 600 aged care places as well as community infrastructure. The program is able to provide tailored, culturally appropriate care close to the homes, families and communities of older Aboriginal and Torres Strait Islander people. It delivers a mix of residential and community care services in accordance with the needs of the community.

If Indigenous Australians aged 50–69 are included in the calculation of provision ratios, then the residential care provision ratio in the Northern Territory falls from 93.8 to 46.0, and the national ratio falls from 85.7 to 83.7 (Table 2.7). Similarly, the combined ratio in the Northern Territory reduces from 215.6 to 105.7, and the ratio for Australia reduces from 114.1 to 111.4 (Table 2.7). This effect is taken into account in Australian Government planning for adequate service provision.

Whereas the Northern Territory rate at 46.0 is much lower than other states/territories, this reflects the level at which residential aged care is appropriate rather than being an indicator of inequity in provision for the Northern Territory. The combined indicator for residential and community care packages in the Northern Territory aligns closely with the Australian average (Table 2.7). Indigenous people require more health support at younger ages and community care packages play a more important role. Care provided through the MPS and the National Aboriginal and Torres Strait Islander Flexible Aged Care Program demonstrates efforts to tailor delivery to the circumstances of the Northern Territory.

Table 2.7: Aged care places per 1,000 persons[a], by state/territory, 30 June 2011

State/territory	Residential places		Combined places and packages[b]	
	Total (70+ years)	Total (70+ and Indigenous population aged 50–69 years)	Total (70+ years)	Total (70+ and Indigenous population aged 50–69 years)
NSW	87.1	84.7	111.8	108.8
Vic	86.4	85.7	111.0	110.1
Qld	83.1	81.5	111.1	108.9
WA	79.5	76.2	115.3	110.5
SA	91.8	91.0	115.0	114.1
Tas	84.6	82.4	110.8	107.9
ACT	77.8	76.2	119.8	117.3
NT	93.8	46.0	215.6	105.7
Australia	**85.7**	**83.7**	**114.1**	**111.4**

(a) SCRGSP 2012 (Online Table 13A3). The Aboriginal and Torres Strait Islander population aged 50–69 years uses ABS projections (ABS 2009).

(b) Comprises residential aged care, CACP, EACH, EACHD and TCP places but excludes 500 Consumer Directed Care packages and 126 Innovative Care packages.

Note: This table includes 2,794 residential places provided by MPS, and 386 residential places funded under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. Non-residential flexible care packages are counted under CACP. There were 422 CACPs counted under MPS and 259 CACPs funded under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program.

2.5 Residential aged care facilities

Data presented in this section and all further sections **exclude** places provided by MPS and places provided under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. There were 3,180 such places in these two programs at 30 June 2011.

Number of facilities

At 30 June 2011, there were 2,760 facilities providing residential aged care places. This was a decrease of 12 facilities from the previous year (2,772 facilities).

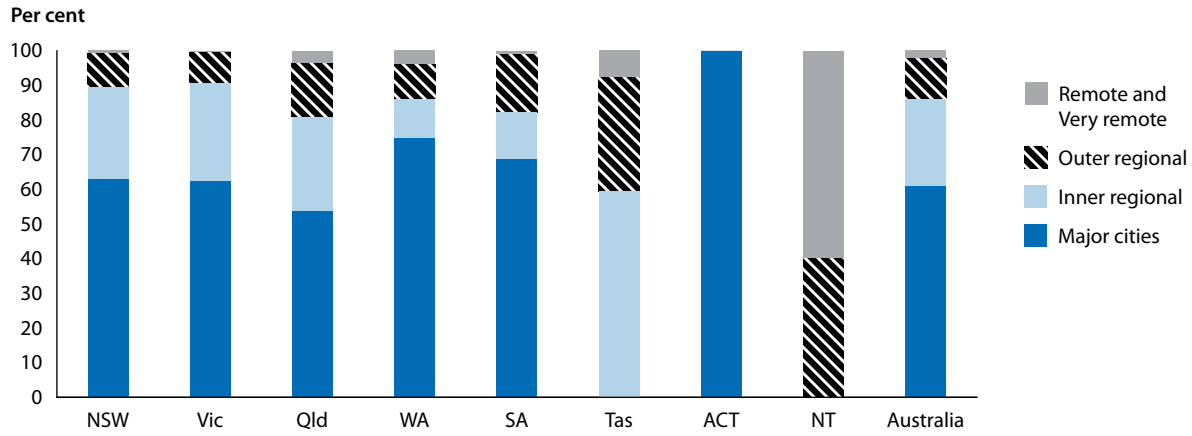
Location of facilities

The distribution of residential aged care facilities shows some striking differences; for example, the Northern Territory compared with Victoria. The totals, however, are broadly in line with the population density (Figure 2.1).

Not surprisingly, most facilities were located in *Major cities* (61%), with a quarter (25%) located in *Inner regional* areas and 12% located in *Outer regional* areas. *Remote* and *Very remote* areas had a small number of facilities (2% in total).

Under the Australian Standard Geographical Classification for remoteness (ABS 2010a), Hobart and Darwin are classified as *Inner regional* and *Outer regional* areas, respectively. Tasmania thus had the majority of its facilities in *Inner regional* areas (59%). In contrast, the Northern Territory had more facilities in *Remote* and *Very Remote* areas (60%) than in *Outer regional* areas (40%) (Figure 2.1).

Figure 2.1: Distribution of residential aged care facilities by state/territory and remoteness, 30 June 2011



Source: Online Table A1.2.

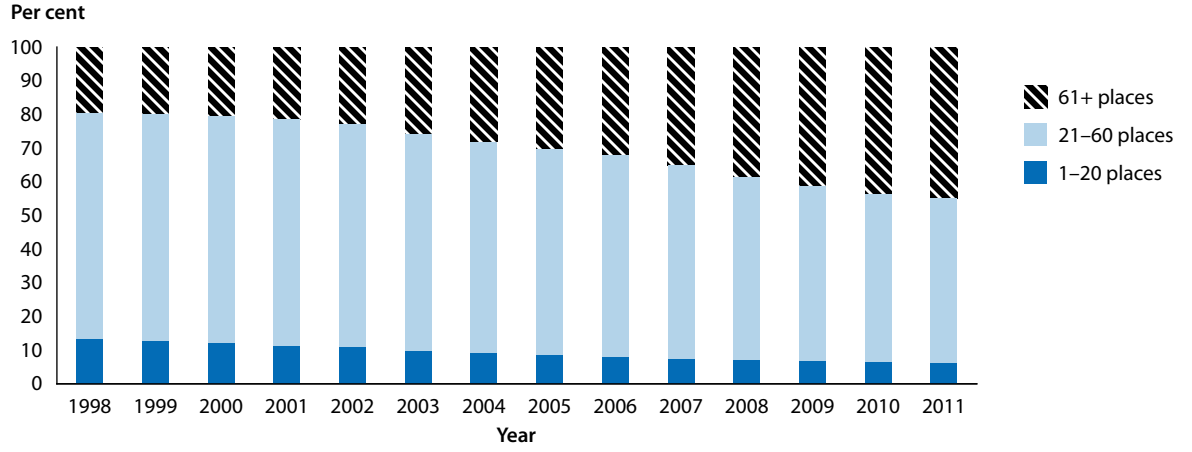
Number of operational places per facility

Compared with the previous year, there were more operational mainstream residential care places at 30 June 2011 (182,302 compared with 179,749 at 30 June 2010). Combined with the reduced number of facilities, this resulted in a higher number of places on average per facility compared with 2010.

This continues a trend resulting from a noticeable change in service structure over the last decade. At 30 June 2005, there were 2,933 facilities providing residential aged care, reducing steadily to 2,760 at 30 June 2011 (Online Table A1.3). Economic factors including changes in building and construction sectors, amalgamation of facilities and providers within the aged care industry, workforce factors and urban and regional planning changes have all had an impact on the aged care sector.

In 2005, 9% of facilities (246) had between 1 and 20 places. This had reduced to 6% (172) by 2011. The proportion of facilities with more than 60 places increased from 30% (892) in 2005 to 45% (1,245) in 2011 (Figure 2.2).

Figure 2.2: Change in the size of residential aged care facilities, 1998–2011



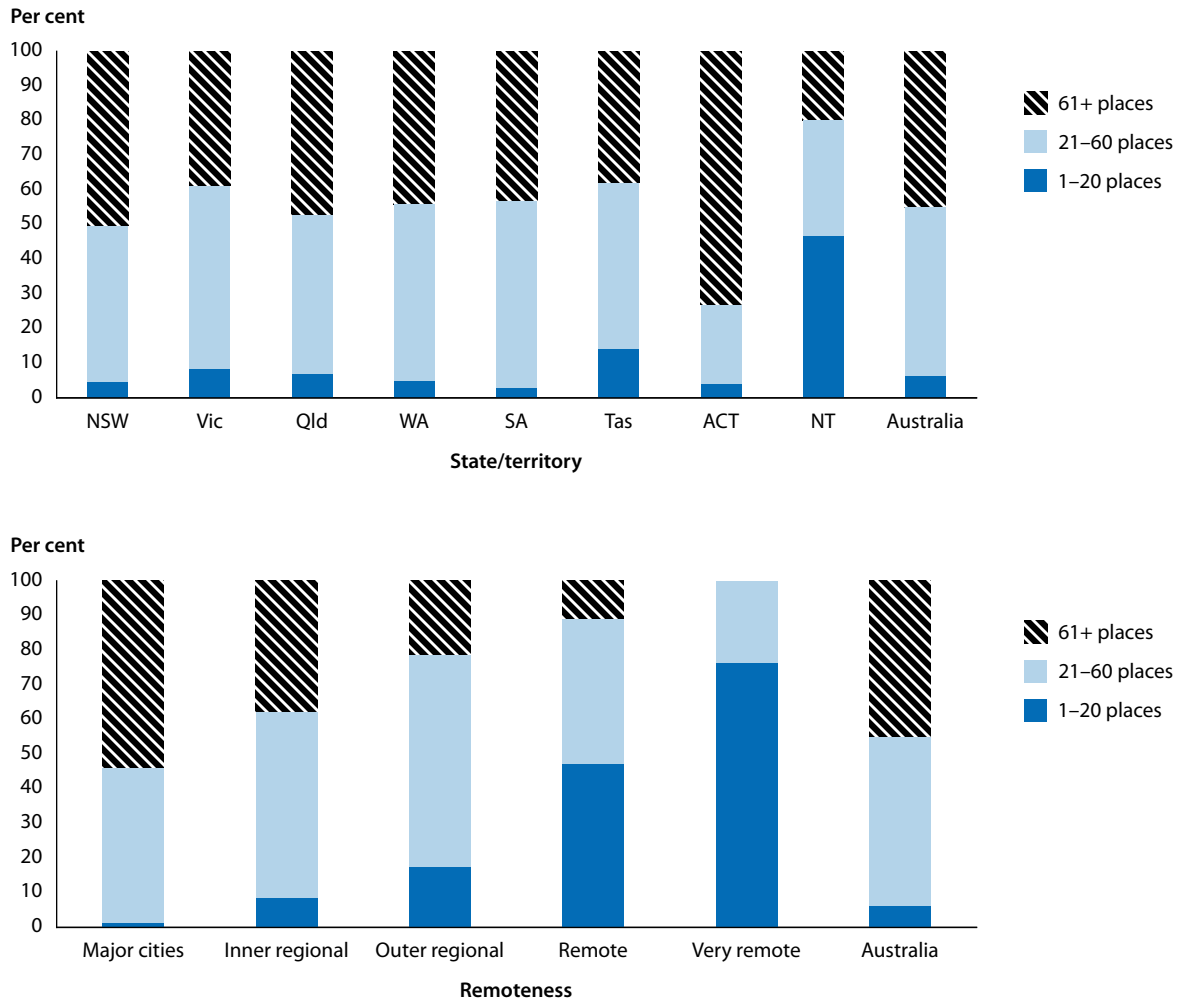
Source: Online Table A1.3.

Geographical variation in size of facilities

The distribution of facility size among the states and territories varied most widely among the smaller jurisdictions (Figure 2.3). In the Australian Capital Territory, 73% had more than 60 places, compared with Tasmania (38%) and the Northern Territory (20%). The Northern Territory had the greatest proportion of small facilities, with nearly half of all facilities in that territory having 20 places or fewer.

As could be expected, large aged care facilities were more common in *Major cities,* with 54% having more than 60 places (Figure 2.3). However, in the *Remote* areas almost all aged care facilities had 40 places or fewer (80%). There were no aged care facilities with over 60 places in *Very remote* areas.

Figure 2.3: Size of residential aged care facilities by state/territory and remoteness, 30 June 2011 (per cent)



Sources: Online tables A1.4 and A1.5.

Who provides residential aged care services?

Residential aged care services in Australia are delivered by providers across a range of sectors. These include private, government (local and state government) and not-for-profit (comprising religious, community-based and charitable) providers. A provider may be responsible for more than one service.

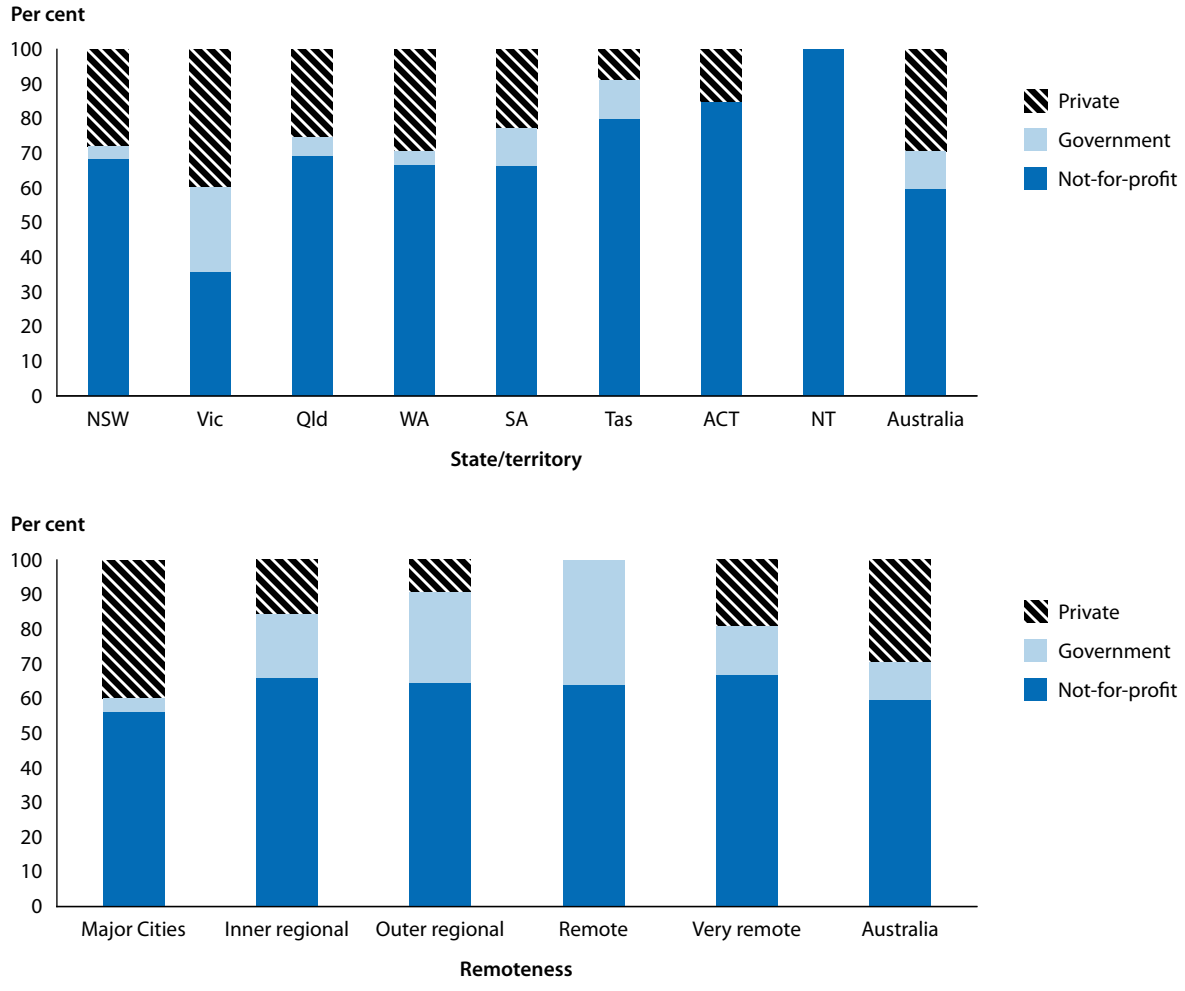
Not-for-profit and private organisations were the main providers of residential aged care services nationally, with 60% and 30% of facilities, respectively (Figure 2.4). The distribution varied markedly, however, among the states and territories. Private ownership of facilities was highest in Victoria (40%); this state also had the lowest proportion of not-for-profit facilities (36%) and the highest proportion of government-owned facilities (25%).

Not-for-profit services dominated in the smaller jurisdictions, accounting for 80% of facilities in Tasmania, 85% in the Australian Capital Territory and all facilities in the Northern Territory. Religious organisations were the most common not-for-profit owners in all jurisdictions except Victoria which has stronger community-based not-for-profit services (Online Table A1.6).

Ownership of services also varied across remoteness areas, with the main difference being the split between private and government ownership (Figure 2.4). Only 4 out of 21 facilities in *Very remote* areas and no facilities in *Remote* areas were privately owned, compared with 674 out of 1,684 (40%) in *Major cities* (Online Table A1.7). By contrast, only 4% of services in *Major cities* were government-owned compared with 36% in *Remote* areas and 14% in *Very remote* areas. *Very remote* areas had the highest proportion of services provided by not-for-profit organisations (67%) (Figure 2.4).

Overall, the not-for-profit sector (comprising religious, community-based and charitable organisations) is the biggest provider of aged care services across Australia, and within that sector, religious organisations dominate.

Figure 2.4: Providers of services by state/territory and remoteness, 30 June 2011



Sources: Online tables A1.6 and A1.7.

2.6 Extra Service Status places

Residential aged care providers can apply for Extra Service Status (ESS) as a competitive process and subject to the conditions of the *Aged Care Act 1997*. ESS is designed to provide a 'higher than average standard of services' for residents in aged care. Where ESS is offered, a resident can elect to pay for the higher services. The services provided include higher quality personal accommodation and furnishings, a greater choice of non-care options such as recreational and communal space, and a wider range of food and meal options (DoHA 2009a, 2011c).

ESS does not involve the provision of a higher level of care to meet a resident's assessed care needs. Aged care facilities are only approved to offer Extra Service if the quality of the extra service/s on offer is significantly higher than average.

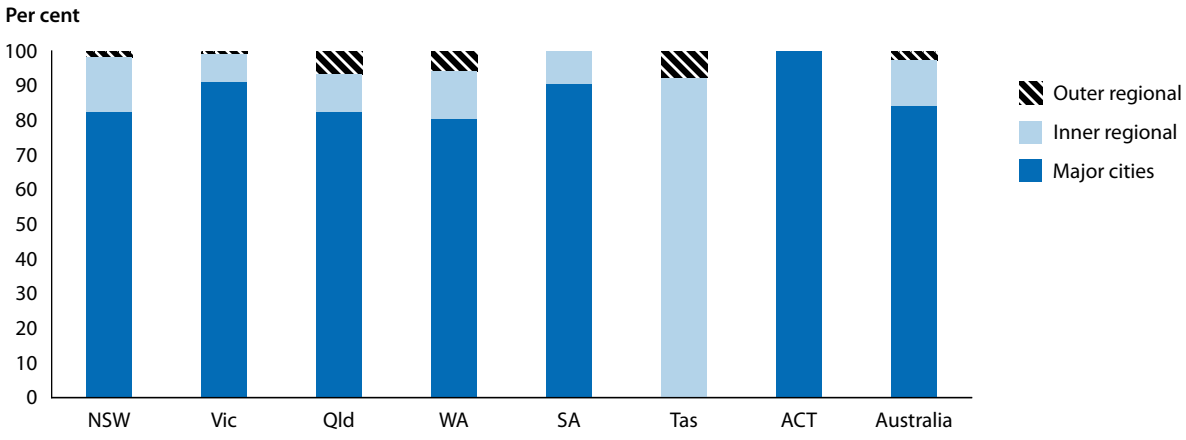
Up to 15% of places in each state or territory may be approved as ESS (DoHA 2011c). ESS attracts a reduced residential care subsidy from the Australian Government. In addition, residents may also be charged an accommodation bond for both high-care and low-care places (DoHA 2009a). Out of the total 2,760 residential aged care facilities, 337 (12%) provided ESS places at 30 June 2011.

Facilities with ESS were concentrated in *Major cities* (84%) and *Inner regional* areas (13%) (Figure 2.5). There were no ESS-approved facilities in the Northern Territory, and no ESS places in remote areas.

Approved facilities offered 14,370 ESS places across Australia, accounting for 8% of all operational places in mainstream services. Nearly one-third of all ESS places (31%) were located in New South Wales and a further third (30%) in Victoria (Online Table A1.8).

A small proportion of ESS places were located in *Inner* and *Outer regional* areas (13% and 3%, respectively). Tasmania, Queensland and Western Australia had higher proportions of their ESS places in *Outer regional* areas (8%, 7% and 6%, respectively) (Figure 2.5).

Figure 2.5: Extra Service Status (ESS) places by state/territory and remoteness, 30 June 2011 (per cent)



Source: Online Table A1.8.

Note: The Northern territory did not have Extra Service places.

Chapter 3

Resident characteristics

3 Resident characteristics

The residential aged care system provides for those older Australians who need care and support in a residential setting and those who need respite care for shorter periods of time. This chapter describes the characteristics of those permanent and respite residents in residential aged care at 30 June 2011. Information on residents' pension status and financial support status is also included. In addition, some data are presented about hospital leave taken during the year to 30 June 2011 and characteristics of residents admitted in 2010–11. (The Glossary explains the specific terms used in this section; for example, 'permanent resident' and 'respite resident').

At 30 June 2011, there were 169,001 residents in mainstream residential aged care services, an increase of 1.6% over the previous year. Of these, 165,032 residents were receiving permanent care (98%), and 3,969 were receiving respite care (2%). Note that the 30 June figures under-represent the importance of respite care, due to the short-term nature of this type of care. The total number of people accessing residential respite care over a year will be much greater than this amount. Admissions for permanent and respite residents over a year are of similar magnitude.

3.1 Age and sex

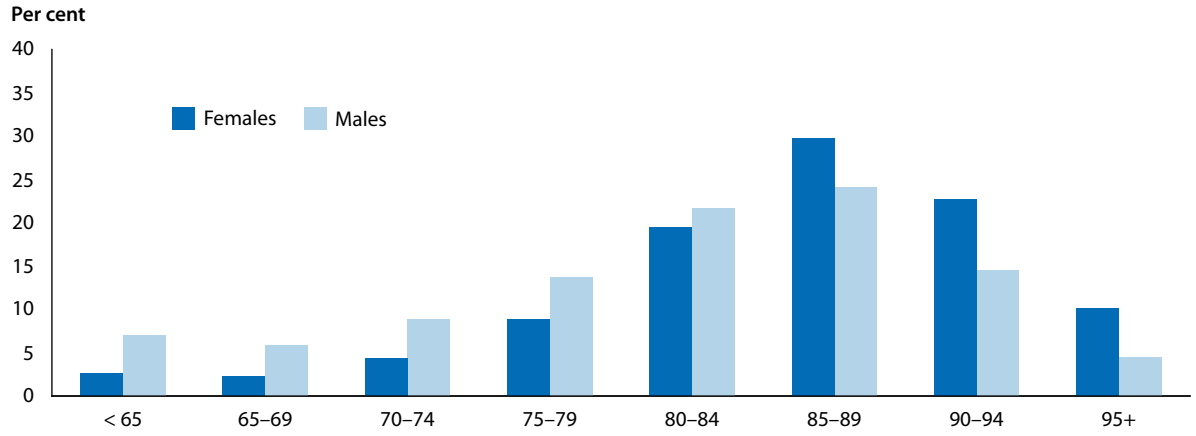
At 30 June 2011, 70% of permanent residents were female (see Figure 3.1). Of all female residents, 63% were aged 85 and over, compared with 43% of their male counterparts. This can be attributed to the greater proportion of females among older age groups in the general population, a factor usually attributed to increased life expectancy.

At 30 June 2011, 57% of permanent residents were aged 85 and over. This proportion has gradually increased since 2000, when 50% of residents were in this age group (see Table 6.1). Those residents in the 85–89 grouping represent the largest number of permanent residents, accounting for 30% of the total (Figure 3.1). At 95 and over, 10% of permanent residents were female (11,810) and 4.5% (2,238) were male (Figure 3.1). By contrast, 4% of residents were aged under 65.

Male residents generally had a younger age profile than female residents with 7% (3,434) entering residential aged care at age 65 or under compared with 2.5% of females (2,937).

Those residents receiving respite care at 30 June 2011 had a younger age profile than permanent residents, with just under half being aged 85 and over (Online Table A2.1).

Figure 3.1: All residents by age and sex, 30 June 2011 (per cent)



Source: Online Table A2.1.

3.2 Geographical location

State and territory

The distribution of residents across the states and territories closely reflected the distribution of the population aged 70 and over (Table 2.2), with just over one-third of residents being in New South Wales and around 0.3% in the Northern Territory.

The age–sex distribution of residents was similar across most jurisdictions. The Northern Territory, however, had a noticeably younger age profile, with 13% of residents aged under 65—more than 3 times higher than the national average of 4% (Online Table A2.2). Consequently, there were a lower proportion of older residents in the Northern Territory: 28% compared with the national average of 57% aged 85 and over, and 11% compared with the national average of 29% aged 90 and over.

Remoteness

The distribution of residents across remoteness areas was also similar to the distribution of the population aged 70 and over (Table 2.3). Two-thirds of residents were in *Major cities* whereas just 0.3% were in *Very remote* areas.

Residents using services in *Remote* and *Very remote* areas had a younger age profile than residents living in other areas (Online Table A2.3). Ten per cent of residents in *Remote* areas and 21% of those in *Very remote* areas were aged under 65, compared with around 4% of those in the other areas.

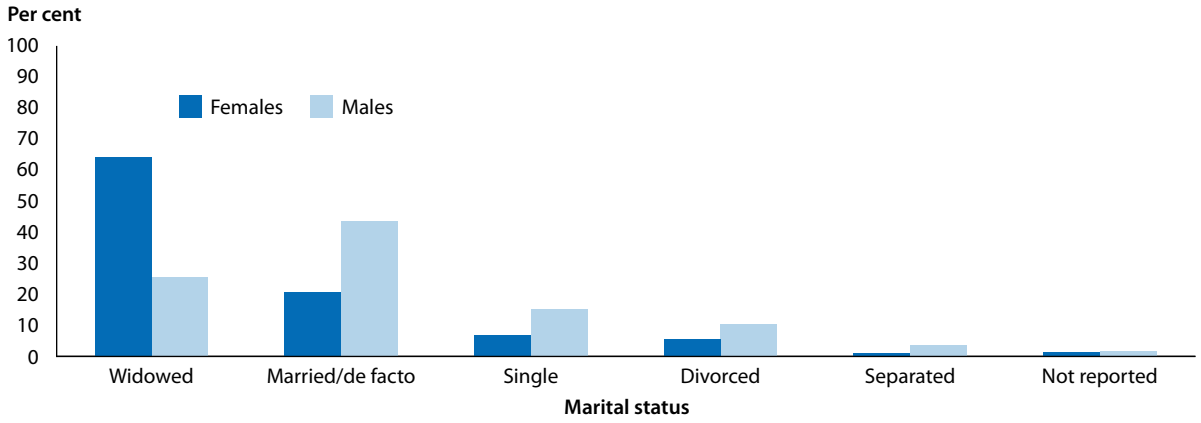
3.3 Marital status

Almost all residents at 30 June 2011 had their marital status recorded at admission. The differences between males and females are significant. Two-thirds (64%) of female permanent residents reported being widowed, compared with just over a quarter (26%) of their male counterparts. Given that married females often outlive their male spouses, it may be more likely that they have less carer support available, so may need to be admitted to residential aged care. A smaller proportion of female permanent residents were married or in a de facto relationship (21%) compared with their male counterparts (44%). Males in permanent residential care were almost twice as likely as females to be single (15% compared with 8%). (Figure 3.2a).

The distribution by marital status among females was similar for permanent and respite care but for males there was some variation. For those males receiving permanent residential aged care, 44% were married or in a de facto relationship whereas 58% of males receiving respite care were married or in a de facto relationship.

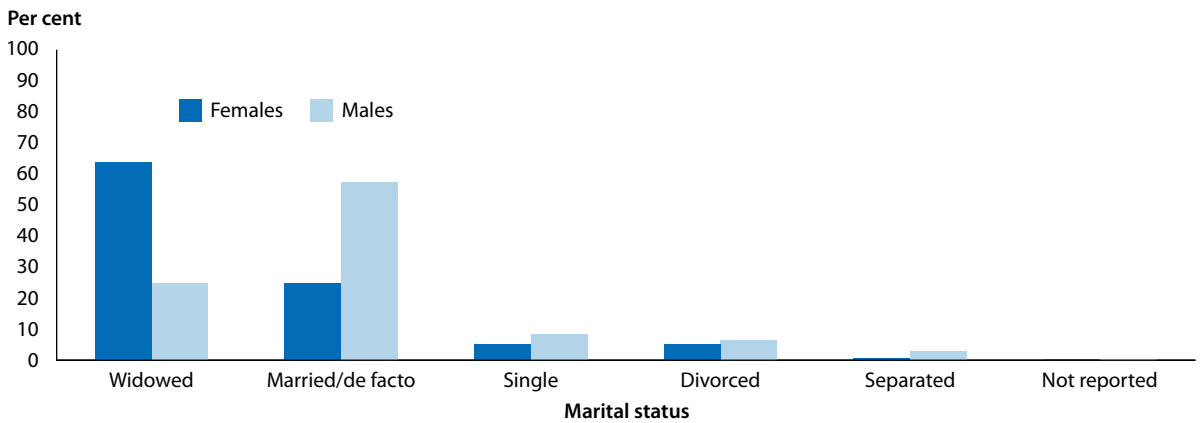
The distribution by marital status was similar across most of the states and territories. The Northern Territory, however, had lower proportions of residents receiving permanent and respite care who were in a married or de facto relationship (21% and 26%, respectively) compared with the national averages (28% and 37%, respectively) (Online tables A2.4–A2.6). Higher proportions of residents in the Northern Territory were single or separated compared with the other jurisdictions.

Figure 3.2a: Permanent residents by marital status and sex, 30 June 2011 (per cent)



Source: Online Table A2.4.

Figure 3.2b: Respite residents by marital status and sex, 30 June 2011 (per cent)



Source: Online Table A2.4.

3.4 Indigenous status

Of the 165,032 permanent aged care residents at 30 June 2011, 0.7% (1,127) residents identified as Aboriginal and Torres Strait Islander which is lower than their percentage in the population as a whole (Table 3.1). A slightly higher proportion of respite residents (1.2%) at 30 June 2011 identified as Aboriginal and Torres Strait Islander. For both groups, males were slightly more likely than females to identify as Indigenous.

The Northern Territory had the highest proportion of Aboriginal and Torres Strait Islander people among its permanent residents (37%). Among respite residents, 35% of those in the Northern Territory identified as Indigenous, compared with the national average of 1.2% (Online tables A2.7 and A2.8). The number of respite residents in the Northern Territory at 30 June 2011, however, was considerably lower than in most other jurisdictions, so any comparisons should be treated with caution as percentages vary considerably year by year.

The highest numbers of Indigenous permanent aged care residents were in Queensland (278) and Western Australia (275) (Online Table A2.7).

Table 3.1: Permanent and respite residents by Indigenous status and sex, 30 June 2011

	Permanent		Respite	
Indigenous status	**Number**	**Per cent**	**Number**	**Per cent**
Females				
Indigenous	671	0.6	27	1.1
Non-Indigenous	114,044	98.4	2,460	98.9
Unknown	1,163	1.0	0	0.0
Total females	*115,878*	*100.0*	*2,487*	*100.0*
Males				
Indigenous	456	0.9	20	1.3
Non-Indigenous	48,261	98.2	1,462	98.7
Unknown	437	0.9	0	0.0
Total males	*49,154*	*100.0*	*1,482*	*100.0*
Persons				
Indigenous	1,127	0.7	47	1.2
Non-Indigenous	162,305	98.3	3,922	98.8
Unknown	1,600	1.0	0	0.0
Total persons	**165,032**	**100.0**	**3,969**	**100.0**

Source: Online tables A2.7 and A2.8.

3.5 Country of birth

Country of birth was recorded for almost all residents in residential aged care at 30 June 2011 (that is, for both permanent and respite residents). Around 30% of permanent and respite residents reported being born overseas (Table 3.2). The most common overseas place of birth was the United Kingdom or Ireland, accounting for 10%. Western Australia had the greatest proportion of residents born overseas, with residents in this state being almost twice as likely to be from the United Kingdom or Ireland (20%) as the national average.

Among residents born outside of the main English-speaking countries, the most common region of birth was South Eastern and Eastern Europe. Victoria and the Australian Capital Territory had the greatest proportions of permanent and respite residents from this region. This is perhaps a reflection of migration patterns to Australia since the end of World War II; that is, those migrants are now older (AIHW 2011a) and that is reflected in these figures.

Table 3.2: Permanent and respite residents, birthplace[(a)] by state/territory, 30 June 2011 (per cent)

Birthplace	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Australia	72.7	67.9	78.2	60.5	68.0	83.8	64.1	78.0	71.2
Other Oceania/New Zealand/ Antarctica	1.1	0.6	2.1	0.8	0.4	0.7	1.1	0.6	1.1
United Kingdom and Ireland	8.2	9.1	9.7	19.8	15.1	8.9	14.1	6.4	10.4
Northern/Western Europe	2.5	3.4	2.9	3.5	3.8	2.5	5.8	4.5	3.1
Southern Europe	3.2	5.6	1.8	4.4	4.1	0.5	2.4	1.1	3.7
South Eastern and Eastern Europe	5.6	7.7	2.3	4.2	6.2	1.9	7.9	3.2	5.4
North Africa/Middle East	1.4	1.0	0.2	0.5	0.3	0.1	0.5	0.0	0.8
Sub-Saharan Africa/South Africa	0.5	0.6	0.5	1.3	0.2	0.4	0.3	0.2	0.6
South-east Asia	1.0	1.0	0.5	1.9	0.4	0.2	0.9	3.2	0.9
North-east Asia	1.7	0.8	0.4	0.4	0.2	0.2	0.7	1.1	0.9
Southern Asia/Central Asia	0.8	1.2	0.4	1.8	0.6	0.3	1.2	0.6	0.9
North America	0.2	0.2	0.3	0.4	0.2	0.3	0.5	0.6	0.3
Other America/Caribbean	0.4	0.2	0.2	0.1	0.0	0.1	0.3	0.4	0.3
Other	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0
Not stated/Not classified	0.6	0.7	0.5	0.3	0.4	0.2	0.3	0.0	0.5
Total persons	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total persons (number)	**58,355**	**43,556**	**30,280**	**14,175**	**15,955**	**4,333**	**1,878**	**469**	**169,001**

(a) This table uses the Standard Australian Classification of Countries (ABS 2011a).

Note: Column totals may not equal column sums due to rounding.

3.6 Preferred language

Preferred language was also recorded for almost all residents at admission. Consistent with country of birth data, English was the preferred language for the majority (90%) of residents in aged care at 30 June 2011 (Table 3.3). Corresponding to the countries of birth and with the exception of English, the most common other preferred languages were those from Southern Europe and Eastern Europe, totalling around 7%. Australian Indigenous languages were preferred by a substantial proportion (25%) of residents in the Northern Territory.

Given Australia's proximity to Asia, and changes in migration patterns, it is worth noting that the total of preferred Asian languages for residents receiving permanent and respite care is 1.2%. Within that, the Eastern Asian category (including Chinese and Vietnamese) represents the largest proportion at 0.8%.

Table 3.3: Permanent and respite residents, preferred language[(a)] by state/territory, 30 June 2011 (per cent)

Preferred language	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Australian Indigenous	0.0	0.0	0.0	0.9	0.0	0.0	0.0	25.2	0.2
English	89.1	87.2	96.5	90.7	89.7	97.8	90.9	67.0	90.3
Other Northern European	0.8	0.9	0.5	0.9	1.5	0.7	1.4	1.1	0.8
Southern European	4.3	6.7	1.4	4.0	4.9	0.6	2.6	2.3	4.3
Eastern European	2.8	3.2	0.9	2.1	3.0	0.8	3.7	1.5	2.5
South-west Asian/North African	0.7	0.3	0.0	0.1	0.1	0.0	0.2	0.0	0.3
Southern Asian	0.2	0.1	0.1	0.0	0.1	0.0	0.3	0.2	0.1
South-east Asian	0.4	0.4	0.1	0.3	0.2	0.0	0.4	1.1	0.3
Eastern Asian	1.5	0.8	0.3	0.4	0.2	0.0	0.5	1.1	0.8
African (excluding North African)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Oceanic	0.1	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0
Other	0.1	0.1	0.1	0.2	0.0	0.0	0.0	0.4	0.1
Not stated	0.1	0.1	0.1	0.1	0.2	0.0	0.0	0.2	0.1
Total persons	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total persons (number)	**58,355**	**43,556**	**30,280**	**14,175**	**15,955**	**4,333**	**1,878**	**469**	**169,001**

(a) This table uses the Standard Australian Classification of Languages (ABS 2011b)

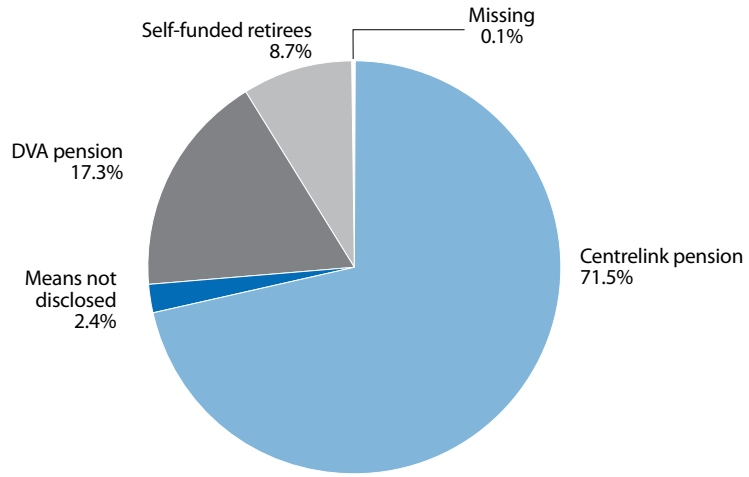
Note: Column totals may not equal column sum due to rounding.

3.7 Income source

A large proportion of permanent residents at 30 June 2011 (89%) received a government pension, either from Centrelink (72%) or the Australian Government Department of Veterans' Affairs (DVA) pension (17%) (Figure 3.3). There was little difference between the proportion of males and females receiving pensions (Online Table A2.9).

Self-funded retirees comprised just under 9% of permanent residents (9% of females and 8% of males) (Online Table A2.9). The Australian Capital Territory had a much higher proportion of permanent residents who were self-funded retirees (18%) compared with other states and territories. The Northern Territory was the jurisdiction with the greatest proportion of permanent residents receiving a Centrelink pension (88%) but the smallest proportion receiving a DVA pension (6%), meaning that the overall proportion of pensioners was similar to that in most other jurisdictions.

Figure 3.3: Permanent residents by income source, 30 June 2011 (per cent)



Source: Online Table A2.9.

3.8 Support for financially disadvantaged residents

There is an obligation under the *Aged Care Act 1997* to ensure that financially disadvantaged people have equitable access to residential aged care. Income and asset rules determine eligibility for special conditions to apply for limits on daily care fees, accommodation charges and accommodation bonds.

Since 1 October 1997, the conditions around eligibility have changed. Appendix B provides a detailed description of the different conditions and terminology used for residents receiving financial help across three different time periods. The tables below describe 'Residents receiving financial help', which includes concessional, assisted, supported and partially supported residents. Online tables A2.10 and A2.11 provide a detailed breakdown of concessional, assisted and supported residents.

Nationally, over one-third (40%) of permanent residents at 30 June 2011 received financial help (Table 3.4). The proportion of permanent residents receiving financial help was greatest in the Northern Territory (69%) and lowest in the Australian Capital Territory (35%).

Table 3.4: Financial support status of permanent residents by state and territory[a], 30 June 2011

Financial support status	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
					Number				
Residents receiving financial help	22,535	15,805	12,393	6,033	6,616	1,760	648	309	66,099
Other residents	34,048	26,866	17,418	7,880	8,925	2,479	1,180	137	98,933
Total persons	**56,583**	**42,671**	**29,811**	**13,913**	**15,541**	**4,239**	**1,828**	**446**	**165,032**
					Per cent				
Residents receiving financial help	39.8	37.0	41.6	43.4	42.6	41.5	35.4	69.3	40.1
Other residents[b]	60.2	63.0	58.4	56.6	57.4	58.5	64.6	30.7	59.9
Total persons	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Refers to the location of the services.

(b) Includes a small number of pre 1997 reform residents.

Financial support for residents became more likely with increasing remoteness (Table 3.5). Nearly 69% of permanent residents in *Very remote* areas at 30 June 2011 received financial help compared with 39% of those in *Major cities*.

Table 3.5: Financial support status of permanent residents by remoteness[a], 30 June 2011

Financial support status	Major cities	Inner regional	Outer regional	Remote	Very remote	Australia
			Number			
Residents receiving financial help	44,329	15,172	5,914	514	170	66,099
Other residents	69,194	22,186	7,054	421	78	98,933
Total persons	**113,523**	**37,358**	**12,968**	**935**	**248**	**165,032**
			Per cent			
Residents receiving financial help	39.0	40.6	45.6	55.0	68.5	40.1
Other residents[b]	61.0	59.4	54.4	45.0	31.5	59.9
Total persons	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Refers to the location of the services.

(b) Includes a small number of pre-October 1997 reform residents.

3.9 Resident admissions

Residents are 'admitted' each time they enter residential aged care, so if an individual leaves care for a period of time (for example, to go to hospital), then on return to care they are 'admitted' again. Data in this section relate only to an individual's *last* admission for the year 1 July 2010 to 30 June 2011, not to any other admission/s which they may have had during the year. By comparison, data presented in Section 4.1 relate to *all* admissions during 1 July 2010 to 30 June 2011.

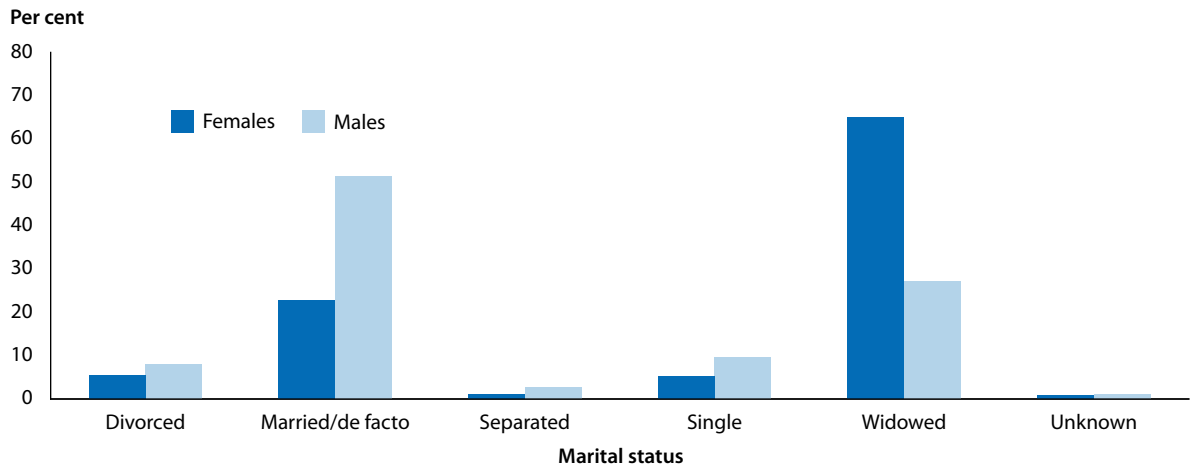
Between 1 July 2010 and 30 June 2011, there were 58,172 persons admitted to permanent residential care and more than 43,533 admitted to respite care (Online tables A2.12 and A2.13). Around three-quarters of individuals admitted to permanent and respite care were aged 80 years and over (74% and 72%, respectively). The proportion of older residents has been increasing over the past decade (see Chapter 6 for more details).

Marital status of admitted residents

Half of the residents admitted to permanent and respite care between 1 July 2010 and 30 June 2011 were widowed. A slightly higher percentage of the respite residents (38%) were married or in de facto relationships compared with permanent residents (34%) (Online tables A2.12 and A2.13).

The majority (65%) of permanent female residents were widowed, and approximately a quarter were married or in a de facto relationship (23%) (Figure 3.4). By contrast, around a quarter of permanent male residents were widowed (27%), with the majority being married or in a de facto relationship (51%).

Figure 3.4: Marital status and sex of admissions to permanent residential care, 1 July 2010 to 30 June 2011

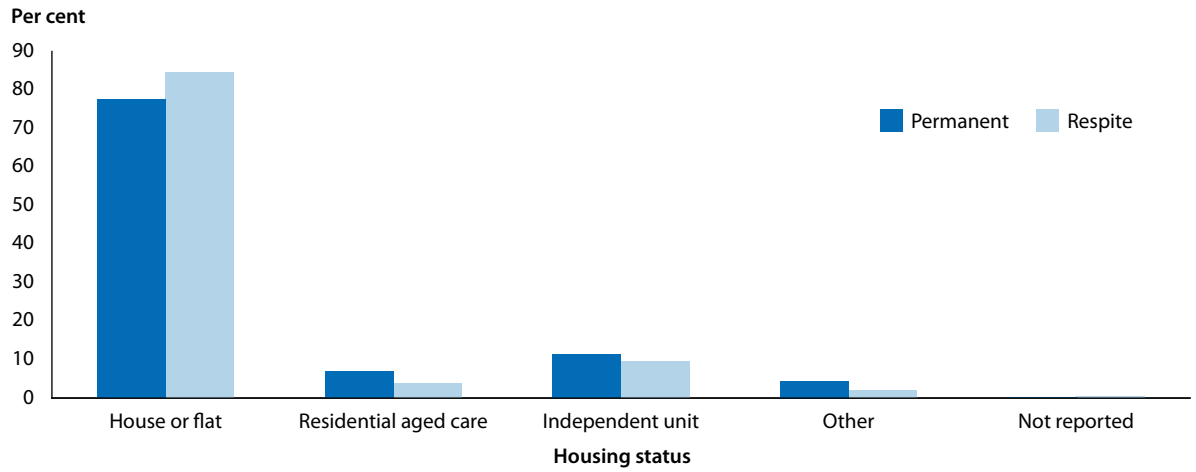


Sources: Online Table A2.12.

Housing status

The majority of residents admitted from 1 July 2010 to 30 June 2011 had been living in a house or flat before admission (76% of permanent residents and 84% of respite residents) (Figure 3.5). Around 11% of permanent residents and 9% of respite residents had been living in independent units (that is, a self-care, individual residence situated within a retirement village or aged care facility).

Figure 3.5: Usual housing status and care type of admissions to residential aged care, 1 July 2010 to 30 June 2011



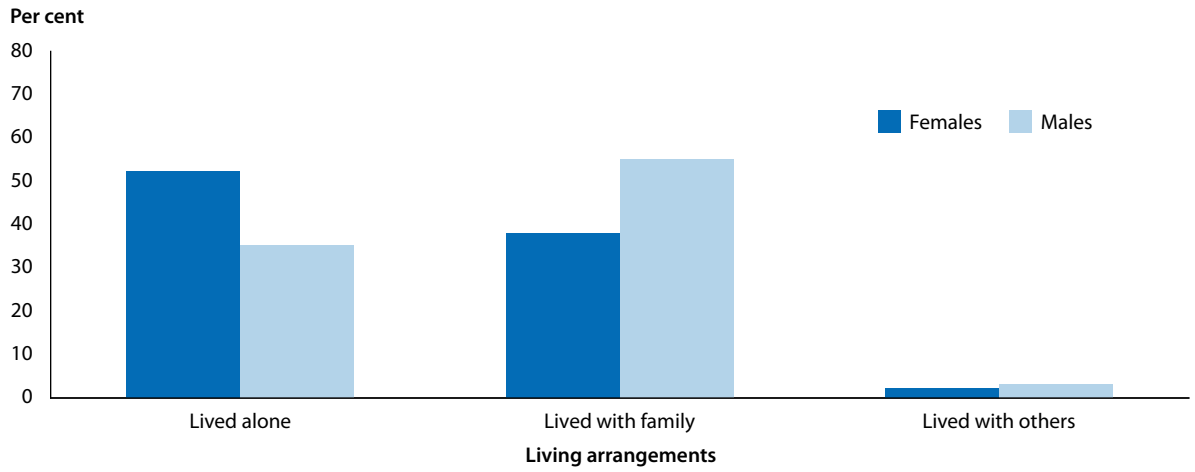
Source: Online Table A2.14.

Prior living arrangements

Almost half the residents admitted to permanent care between 1 July 2010 and 30 June 2011 had lived alone before admission (Figure 3.6a). Most of the remainder had lived with family. Females were more likely than males to have lived alone before their admission.

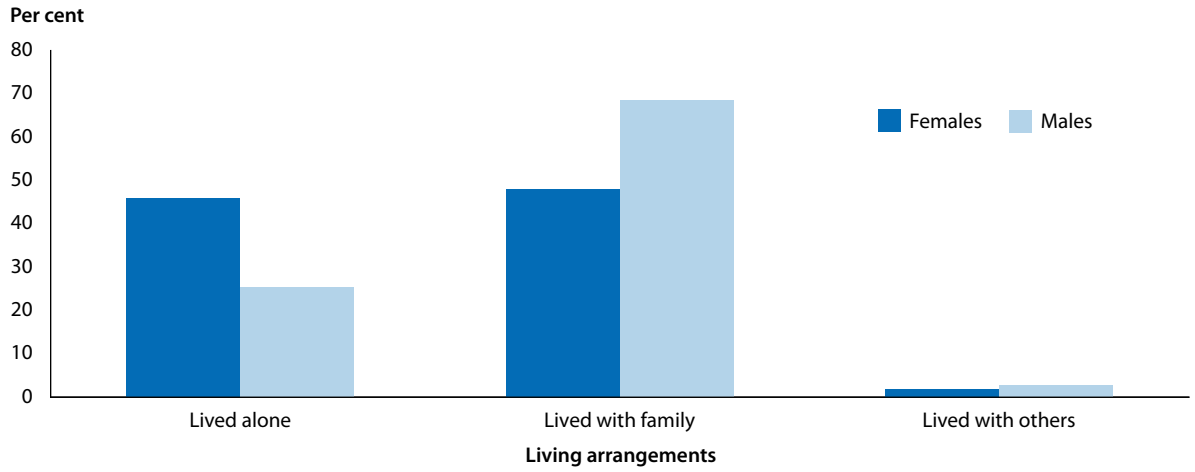
Over half of the residents admitted to respite care between 1 July 2010 and 30 June 2011 had lived with family before their admission (Figure 3.6b). This was much more common among males than females (69% compared with 48%, respectively).

Figure 3.6a: Prior living arrangements and sex of admissions to permanent residential aged care, 1 July 2010 to 30 June 2011



Source: Online Table A2.15.

Figure 3.6b: Prior living arrangements and sex of admissions to residential respite care, 1 July 2010 to 30 June 2011

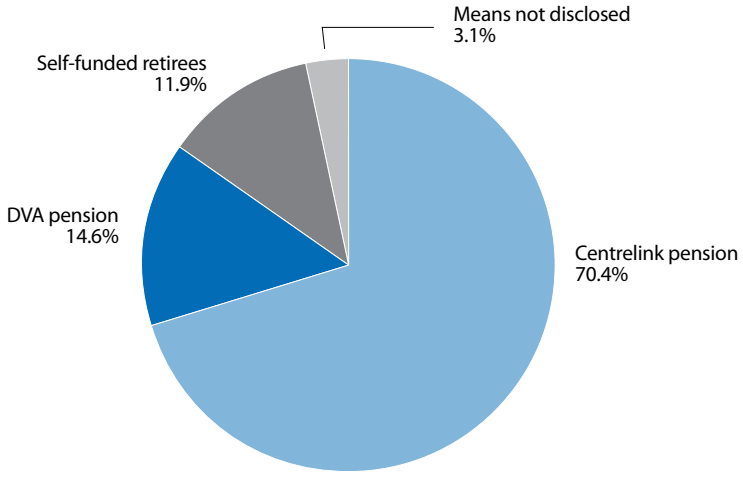


Source: Online Table A2.15.

Income source

The majority (85%) of residents admitted to permanent care between 1 July 2010 and 30 June 2011 were receiving a government pension (Figure 3.7). Self-funded retirees accounted for 12% of admissions. The distribution of income sources was similar for males and females (Online Table A2.16). Not surprisingly, it was also similar to the income source for permanent residents (Figure 3.3).

Figure 3.7: Income source of admissions to permanent residential aged care, 1 July 2010 to 30 June 2011



Source: Online Table A2.16.

Chapter 4

Patterns of use

4 Patterns of use

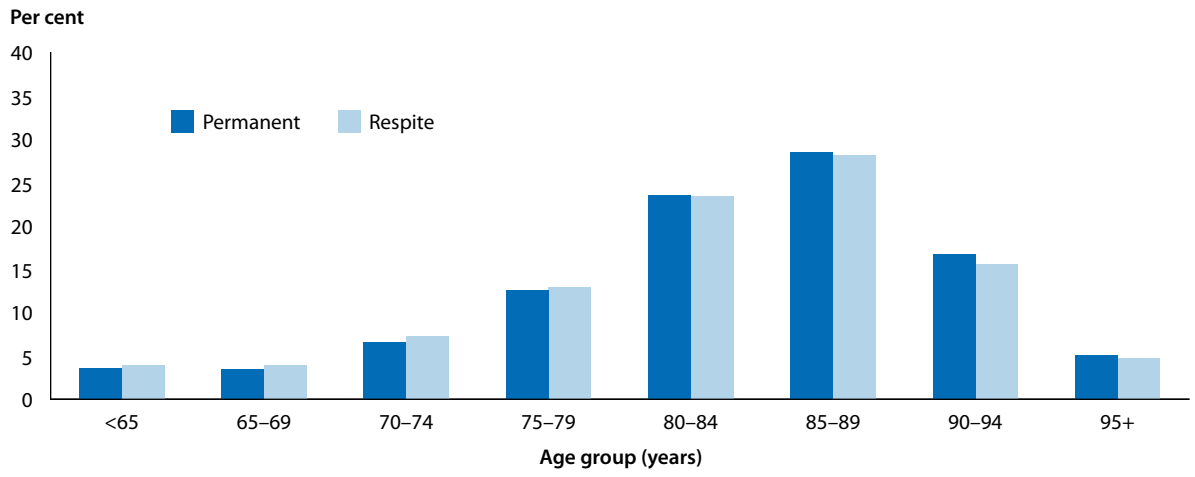
This chapter explores a number of areas relating to residential aged care use, including admissions, separations, length of stay, usage rates, turnover and occupied place-days.

4.1 Admissions

Between 1 July 2010 and 30 June 2011, there were 118,178 admissions to residential aged care: just over 58,900 for permanent care and 59,276 for respite care (Table 4.1). The majority (74%) of residents admitted to permanent care in 2010–11 were aged 80 and over. The most common age group was 85–89, accounting for 29% of permanent admissions and 28% of respite admissions (Figure 4.1). Interestingly, the age distribution of permanent and respite residents was similar.

The Northern Territory had a greater proportion of younger residents admitted to residential aged care compared with the other jurisdictions; 15% of permanent and 20% of respite residents admitted in the Northern Territory were aged under 65, compared with around 4% of residents in the other states and territory (Online tables A3.1 and A3.2).

Figure 4.1: Permanent and respite admissions, age at admission, 1 July 2010 to 30 June 2011 (per cent)



Source: Table 4.1.

Table 4.1: Permanent, respite and all admissions, age at admission by sex, 1 July 2010 to 30 June 2011

	Permanent		Respite		All admissions	
Age group (years)	Number	Per cent	Number	Per cent	Number	Per cent
Females						
<65	979	2.7	1,180	3.3	2,159	3.0
65–69	907	2.5	1,057	2.9	1,964	2.7
70–74	1,993	5.5	2,100	5.8	4,093	5.7
75–79	4,115	11.4	3,976	11.0	8,091	11.2
80–84	8,258	22.9	8,354	23.1	16,612	23.0
85–89	10,910	30.2	10,963	30.3	21,873	30.3
90–94	6,779	18.8	6,433	17.8	13,212	18.3
95+	2,182	6.0	2,121	5.9	4,303	6.0
Total females	*36,123*	*100.0*	*36,184*	*100.0*	*72,307*	*100.0*
Males						
<65	1,122	4.9	1,168	5.1	2,290	5.0
65–69	1,122	4.9	1,293	5.6	2,415	5.3
70–74	1,877	8.2	2,179	9.4	4,056	8.8
75–79	3,314	14.5	3,658	15.8	6,972	15.2
80–84	5,604	24.6	5,559	24.1	11,163	24.3
85–89	5,901	25.9	5,758	24.9	11,659	25.4
90–94	3,061	13.4	2,768	12.0	5,829	12.7
95+	778	3.4	709	3.1	1,487	3.2
Total males	*22,779*	*100.0*	*23,092*	*100.0*	*45,871*	*100.0*
Persons						
<65	2,101	3.6	2,348	4.0	4,449	3.8
65–69	2,029	3.4	2,350	4.0	4,379	3.7
70–74	3,870	6.6	4,279	7.2	8,149	6.9
75–79	7,429	12.6	7,634	12.9	15,063	12.7
80–84	13,862	23.5	13,913	23.5	27,775	23.5
85–89	16,811	28.5	16,721	28.2	33,532	28.4
90–94	9,840	16.7	9,201	15.5	19,041	16.1
95+	2,960	5.0	2,830	4.8	5,790	4.9
Total persons	**58,902**	**100.0**	**59,276**	**100.0**	**118,178**	**100.0**

Note: Includes residents who may have been admitted more than once.

4.2 Separations

Between 1 July 2010 and 30 June 2011, there were 115,497 separations (Box 4.1) from residential aged care. Just over 56,420 separations were of permanent residents, which accounted for nearly half the total separations (49%). The remaining 59,075 were respite separations (Online Table A3.3).

Box 4.1: Separations

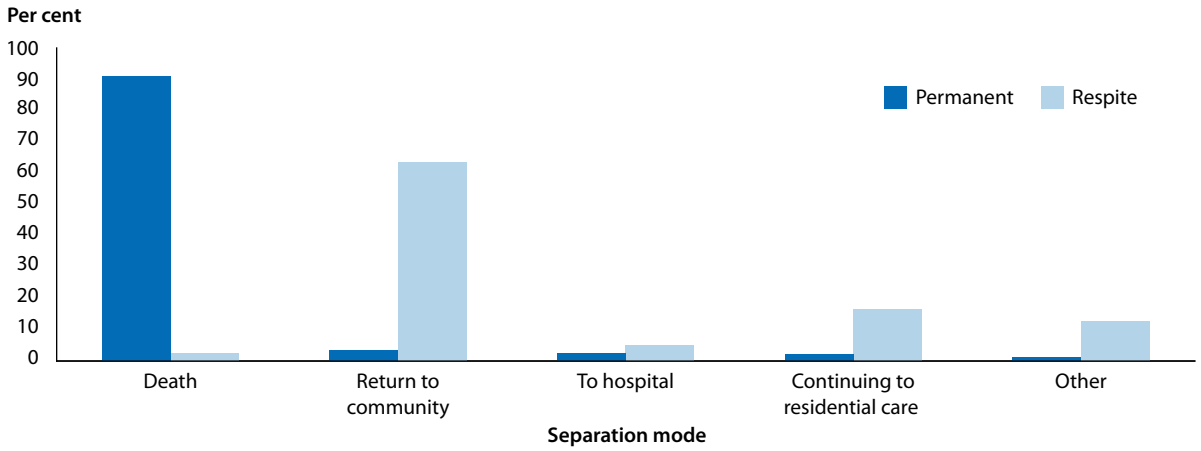
A separation occurs when a resident leaves residential aged care and does not re-enter the same or another service within 2 days.

The categories of reasons for separation (called the **separation modes**) are:

- death
- return to community
- admission to hospital
- move to another aged care service
- other.

Among permanent residents, death was the major reason for separation, accounting for 91% of cases (Figure 4.2). A small proportion of residents returned to the community (4%), whereas 2% moved to a different residential aged care setting. As could be expected given the nature and purpose of respite care, just under two-thirds of separating respite residents returned to the community whereas 17% moved to other residential care. Only 2% of respite residents separated due to death.

Figure 4.2: Permanent and respite separations by separation mode, 1 July 2010 to 30 June 2011 (per cent)



Source: Online tables A3.5 and A3.6.

The distribution of separation modes for permanent residents was similar among most states and territories. The Northern Territory, however, had a higher proportion of separations returning to the community (5%) and lower separations due to death (85%) than elsewhere (Online Table A3.5).

More variation among the jurisdictions was evident for separations from respite care (Online Table A3.6). Tasmania had a high proportion of respite residents returning to the community (82%), whereas this proportion was relatively low in both New South Wales and South Australia (56% and 57%, respectively).

4.3 Length of stay

The concept of a length of stay depends on what is being measured (Box 4.2).

Box 4.2: Measuring length of stay

There are two standard measurements for length of stay:

1. **Length of stay of an existing resident** up to a particular point in time (in this publication, up to 30 June 2011). For existing residents, length of stay is an incomplete measure. It shows the amount of time residents have already spent in residential aged care, but not how much more time will be spent before leaving.

2. Total or completed **length of stay of a separated resident** up to the point of leaving residential aged care. If a resident moves from one service to another in less than 2 days (known as a transfer), then this is ignored, and the admission date used in the measure is the earlier admission date, or the first admission considering all transfers.

Length of stay of existing permanent residents

At 30 June 2011, almost one-third of existing permanent residents had been in residential aged care for 2–5 years (Table 4.2). Just over one-quarter had been in care for less than 1 year. One-fifth of residents had a length of stay between 1 and 2 years, while another fifth had been in care for 5 years or more.

The distribution by length of stay was similar across remoteness areas. There was a trend toward a longer stay in *Remote* and *Very remote* areas, but this may be subject to more annual variation because of the relatively small numbers of residents in these areas.

Table 4.2: Existing permanent residents, length of stay to date by remoteness[(a)], 30 June 2011 (per cent)

Length of stay	Major cities	Inner regional	Outer regional	Remote	Very remote	Australia
<26 weeks	14.5	15.3	15.9	14.0	15.7	14.8
26 – <52 weeks	12.2	12.8	12.3	12.1	12.5	12.3
1–<2 years	19.6	19.9	19.2	18.4	18.1	19.6
2–<3 years	14.3	14.6	14.5	14.9	14.5	14.4
3–<4 years	10.7	10.7	10.4	10.1	8.1	10.7
4–<5 years	7.7	7.6	7.2	8.6	6.0	7.7
5–<8 years	12.7	12.1	12.2	12.5	10.9	12.5
8+ years	8.3	7.1	8.1	9.5	14.1	8.0
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**113,523**	**37,358**	**12,968**	**935**	**248**	**165,032**

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

Note: Percentages have been rounded to one decimal place and may not add to 100%.

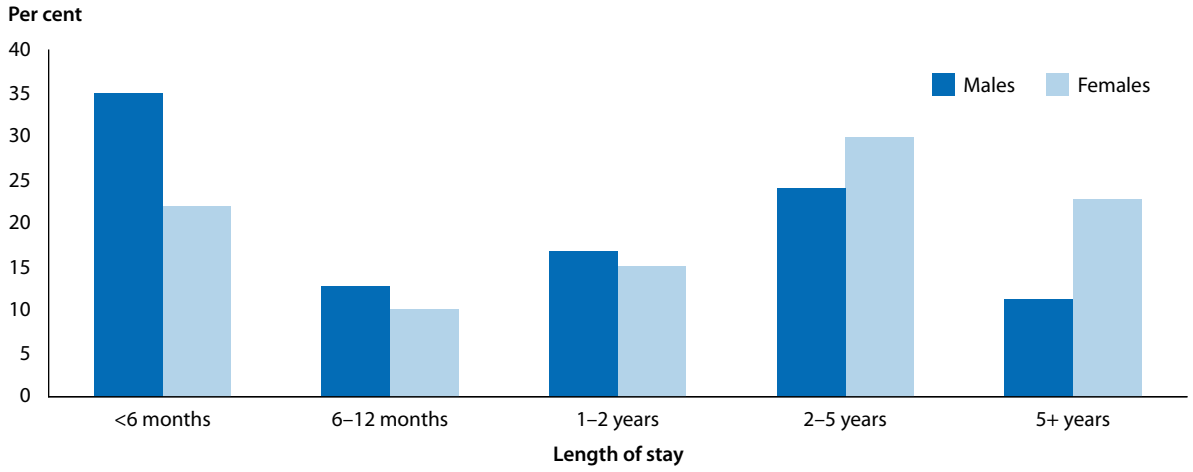
Completed length of stay

For permanent residents who separated from residential aged care during 1 July 2010 to 30 June 2011, over one-third (38%) were in residential care for less than 1 year (27% for less than 6 months) (Online Table A3.7). Two-fifths (44%) had a length of stay between 1 and 5 years.

Almost half of all male residents had been in residential care for less than 1 year, compared with around one-third of females (48% and 32%, respectively) (Figure 4.3).

As noted previously, most permanent residents (91%) left due to death (Figure 4.2). Of these, one-fifth had stayed 5 years or more whereas one-quarter had been in care for less than 6 months. A small proportion of residents (4%) returned to the community; almost half of these (48%) had stayed for less than 3 months (Online Table A3.8).

Figure 4.3: Completed length of stay of permanent residents, by sex, 1 July 2010 to 30 June 2011



Source: Online Table A3.7.

4.4 Average length of stay

Permanent residents

Among the permanent residents who separated between 1 July 2010 and 30 June 2011, the average length of stay for those leaving residential care was 145.7 weeks (tables 4.3a and 4.4a). Females on average stayed around 54% longer than males (168.1 compared with 109.5 weeks).

The average length of stay of residents at the time of separation varied slightly among the states and territories. Permanent separations in South Australia had the longest average length of stay (155.8 weeks) after those in the Northern Territory (179.1 weeks) but the small numbers in the Northern Territory give averages which vary considerably from year to year.

Average length of stay was longer in *Remote regions* (175.2 weeks) and *Very remote* regions (218.1 weeks) compared to the all regions average of 145.7 weeks.

Respite residents

Among the respite residents who separated between 1 July 2010 and 30 June 2011, the average length of stay for those leaving residential care was 3.5 weeks (tables 4.3b and 4.4b). The average length of stay varied among the jurisdictions, from 4.0 weeks in New South Wales to 2.3 weeks in Tasmania. Across the non-remote areas, the longest average length of stay was in *Major cities* at 3.7 weeks.

From 1998–99 to 2010–11, the average completed length of stay for permanent residents has increased by around 10%, from 131.3 weeks to 145.7 weeks. By contrast, average completed length of stay for respite care has fluctuated in a narrow band around 3.5 weeks (see Table 6.3).

Table 4.3a: Average length of stay (weeks), separations of permanent residents, by sex and remoteness[(a)], 1 July 2010 to 30 June 2011

	Major cities	Inner regional	Outer regional	Remote	Very remote	All regions
Females	168.8	164.3	171.8	189.0	202.0	168.1
Males	109.4	105.1	118.6	152.9	234.8	109.5
Persons	**146.3**	**141.1**	**151.2**	**175.2**	**218.1**	**145.7**

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

Table 4.3b: Average length of stay (weeks), separations of respite residents, by sex and remoteness[(a)], 1 July 2010 to 30 June 2011

	Major cities	Inner regional	Outer regional	Remote	Very remote	Australia
Females	3.8	3.2	3.4	3.2	4.8	3.6
Males	3.6	3.0	3.2	2.9	3.4	3.4
Persons	**3.7**	**3.1**	**3.3**	**3.1**	**4.1**	**3.5**

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

Table 4.4a: Average length of stay (weeks), separations of permanent residents, by sex and state/territory[(a)], 1 July 2010 to 30 June 2011

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Females	166.5	166.0	172.0	162.6	179.0	159.6	169.5	183.0	168.1
Males	107.5	108.6	112.0	110.0	114.6	98.6	118.1	174.4	109.5
Persons	**143.7**	**144.1**	**148.3**	**142.9**	**155.8**	**137.8**	**148.6**	**179.1**	**145.7**

(a) Refers to the location of the services.

Table 4.4b: Average length of stay (weeks), separations of respite residents, by sex and state/territory[(a)], 1 July 2010 to 30 June 2011

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Females	4.0	3.1	3.3	3.3	3.9	2.3	3.4	3.5	3.6
Males	3.9	2.9	3.1	2.9	3.7	2.2	3.2	3.3	3.4
Persons	**4.0**	**3.0**	**3.2**	**3.1**	**3.9**	**2.3**	**3.3**	**3.4**	**3.5**

(a) Refers to the location of the services.

4.5 Resident turnover

The amount of turnover in the residential aged care system is a function of the number of admissions, length of stay and the overall growth or reduction in the type and number of places in the system. It is calculated as the number of admissions over the financial year divided by the number of operational places.

Generally, the turnover for permanent and respite residents has been relatively stable from 2000–01 to 2010–11, with variations in narrow bands (Table 4.5). Approximately one-third of permanent places are associated with admissions in a year, whereas respite places are used about 14 to 17 times a year.

Table 4.5: Admissions and turnover rate, by type of residential aged care, 2000–01 to 2010–11

Type of care	2001–02	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08	2008–09	2009–10	2010–11
Permanent										
Admissions	47,345	51,200	53,356	52,462	52,964	52,196	53,737	56,983	57,937	58,902
Turnover rate	0.33	0.36	0.35	0.34	0.33	0.32	0.32	0.33	0.33	0.33
Respite										
Admissions	43,309	45,445	46,632	48,295	49,727	50,987	51,293	54,535	57,503	59,206
Turnover rate	17.17	17.07	16.84	16.32	14.98	15.34	15.05	14.84	14.10	14.3
Combined										
Admissions	90,654	96,645	99,988	100,757	102,691	103,183	105,030	111,518	115,440	118,178
Turnover rate	0.63	0.65	0.64	0.63	0.63	0.62	0.61	0.64	0.64	0.65

Note: Turnover rate is calculated separately for permanent and respite residents by firstly allocating permanent and respite places according to the number of residents in each category as at 30 June 2011. Turnover is defined as admissions over the financial year divided by places.

4.6 Usage rates

A usage rate is a way of measuring patterns of use and access to services. It is similar to a provision ratio (Box 2.3), but it looks at the number of *people* who are currently *using* a service, as a proportion of the people in the population for which the service is intended. In this section, usage rates are expressed as a number per 1,000 of the population being considered.

For example, if a usage rate is 10 for a specific age group, it would mean that there were 10 people for every 1,000 people in that age group who were *using* residential aged care during a particular time period. By comparison, the provision ratio 10 would mean that, at a specific point in time, there were 10 places *available* for every 1,000 people aged 70 or more.

Usage rates for permanent residential aged care in this section have been calculated by English-speaking status (based on country of birth) and by Indigenous status.

Usage by English-speaking status

Usage rates are compared across age groups. The highest usage rates were in the 85 and over age group and the Australian-born group had higher usage rates than either the overseas-born English-speaking or overseas-born non-English-speaking groups (233.5, 232.9 and 191.8 per 1,000 people, respectively). A similar pattern is evident in all age groups (Table 4.6).

Table 4.6: Age- and sex-specific rates for permanent residents, by English-speaking status, 30 June 2011 (per 1,000 population)

Age (years)	Australian-born	Overseas-born, English-speaking	Overseas-born, LOTE[(a)]	Total
Females				
<54	0.1	0.1	0.0	0.1
55–59	1.4	0.7	0.5	1.1
60–64	2.8	1.7	1.6	2.4
65–69	6.4	3.5	3.7	5.4
70–74	15.2	10.4	9.8	13.3
75–79	37.2	30.2	27.7	34.2
80–84	92.5	87.5	78.7	89.2
85+	276.8	282.8	232.9	270.0
Total females	*10.1*	*13.0*	*9.0*	*10.2*
Males				
<54	0.1	0.1	0.1	0.1
55–59	1.6	0.9	0.8	1.4
60–64	3.3	1.9	1.9	2.8
65–69	7.2	4.0	4.3	6.1
70–74	14.3	9.0	9.4	12.3
75–79	28.0	23.2	21.4	25.7
80–84	58.2	50.8	48.7	55.1
85+	148.9	150.8	127.5	144.9
Total males	*4.1*	*5.6*	*4.7*	*4.4*
Persons				
<54	0.1	0.1	0.0	0.1
55–59	1.5	0.8	0.6	1.2
60–64	3.0	1.8	1.8	2.6
65–69	6.8	3.7	4.0	5.8
70–74	14.8	9.7	9.6	12.8
75–79	33.1	26.8	24.6	30.2
80–84	78.3	70.1	64.7	74.4
85+	233.5	232.9	191.8	225.9
Total persons	**7.1**	**9.2**	**6.9**	**7.3**

(a) LOTE = Language other than English.

Notes

1. Recipients with unknown status have been pro-rated across the overseas-born groups.
2. Due to the unavailability of regular population estimates by language preference, English-speaking status is based on country of birth. People born in Australia, Ireland, United Kingdom, New Zealand, United States of America, Canada and South Africa are assumed to be from an English-speaking background.
3. Population estimates by country of birth are derived from ABS customised report (ABS 2010b).

Usage by Indigenous status

Usage rates for Indigenous Australians were much higher at younger ages than in the non-Indigenous population and this overall trend continues in older age groups. Population estimates for 5-year age groupings above age 75 are not currently available for general use. The usage rate for Indigenous people aged 60–64 was nearly 3 times that for non-Indigenous people of this age, at 7.1 compared with 2.5 per 1,000. In the 70–74 age group, Indigenous usage was 27.8 per 1,000 compared with non-Indigenous usage of 12.7 per 1,000. Both Indigenous and non-Indigenous males had markedly lower usage rates in the 75 and over age group compared to females in that age group (Table 4.7).

Table 4.7: Age- and sex-specific usage rates for permanent residents, by Indigenous status[(a)], 30 June 2011 (per 1,000 population)[(b)]

	Indigenous			Non-Indigenous		
Age (years)	Females	Males	Persons	Females	Males	Persons
<50	0.1	0.1	0.1	0.0	0.0	0.0
50–54	1.6	2.5	2.1	0.5	0.6	0.5
55–59	4.0	4.8	4.4	1.1	1.3	1.2
60–64	7.5	6.7	7.1	2.3	2.7	2.5
65–69	13.9	17.6	15.6	5.3	6.0	5.7
70–74	28.0	27.6	27.8	13.2	12.2	12.7
75+	110.4	78.0	97.6	128.6	64.1	101.3
Total	**2.4**	**1.6**	**2.0**	**10.4**	**4.4**	**7.4**

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

(b) Rates are calculated using ABS projections and the Australian population figures released in 2011 (ABS 2011c) and ABS projections for Aboriginal and Torres Strait Islanders (ABS 2009).

4.7 Occupied place-days

The number of occupied place-days in a year is a good indicator of the level of activity in residential aged care. Occupied place-days are calculated by adding client days in residential care from 1 July 2010 to 30 June 2011. Over the year from 1 July 2010 to 30 June 2011, 61.2 million place-days were used in mainstream aged care facilities in Australia. Most of these (59.7 million place-days, or 98% of the total) were for permanent care (Online Table A3.9).

As might be expected, the majority of permanent place-days were in *Major cities* (69%), and just under a quarter were in *Inner regional* areas (23%). There was a similar pattern for respite days, with a high proportion of occupied place-days in *Major cities* (64%), followed by *Inner regional* (26%). These proportions reflect the distribution of the older Australian population and the corresponding distribution of places (tables 2.2 to 2.4). Among the states and territories, the Northern Territory had the highest proportion of permanent occupied place-days in *Very remote* areas (10%), with all other states and territories having less than 1% of occupied place-days in these areas (Online Table A3.9). Similarly, in the Northern Territory there was a relatively high proportion of respite occupied place-days in *Very remote* areas (16%).

4.8 Hospital leave

Hospital leave enables a permanent aged care resident to take leave from the aged care facility to receive hospital treatment.

Overall, of the 165,000 permanent residents in care at 30 June 2011, one-quarter had used hospital leave in the preceding 12 months (Table 4.9). Hospital leave was most likely to have been taken by residents in *Major cities* (27%) and least likely by those in *Inner regional* areas (21%).

Table 4.8: Permanent residents at 30 June 2011 with hospital leave between 1 July 2010 and 30 June 2011[(a)], by remoteness and state/territory (per cent)

State/territory	Major cities	Inner regional	Outer regional	Remote	Very remote	Australia
NSW	27.7	22.3	25.0	41.2	0.0	26.2
Vic	24.2	20.6	21.7	19.0	..	23.3
Qld	28.7	24.6	23.0	31.7	32.3	27.1
WA	25.7	23.6	22.5	15.5	18.9	25.0
SA	25.8	17.1	25.6	18.5	0.0	24.7
Tas	..	14.4	13.2	13.3	11.8	14.1
ACT	28.0	0.0	..	..	..	28.2
NT	..	..	29.4	15.2	25.6	24.7
Total proportion taking leave	**26.5**	**21.4**	**23.0**	**22.7**	**24.6**	**25.1**
Total persons (number)	**113,523**	**37,358**	**12,968**	**935**	**248**	**165,032**

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

.. Not applicable.

Chapter 5

Care needs of residents based on the Aged Care Funding Instrument (ACFI)

5 Care needs of residents based on the Aged Care Funding Instrument (ACFI)

This chapter describes some patterns in the care needs of all residents as assessed using the Aged Care Funding Instrument (ACFI) described in Box 5.1. The chapter provides information about residents admitted to permanent residential aged care and existing residents receiving permanent residential aged care. For both groups, it describes variations in care levels across ACFI domains, age groups (including younger people), geographical areas, separations and length of stay, and provides information about the main health conditions recorded in ACFI (including dementia). The variations described here can be further analysed using the data provided online; for example, Table 5.2 concerns ACFI domains by age and could be cross-tabulated by gender using the online data.

The ACFI is a funding tool used to appraise a resident's dependency or need for care across three care domains: activities of daily living (ADL), behaviour (BEH) and complex health care (CHC) (Box 5.1). The resident's score in each of these three domains is used to determine the level of care required for that domain. The score is then used to arrive at the level of subsidy paid to service providers for each resident's care needs. In other words, the ACFI attempts to separate out and to measure (score) only those care elements which contribute most to the cost of care and to fund accordingly.

Residents are appraised as having either a *Nil*, *Low*, *Medium* or *High* need for care in each of the three domains, where *Nil* means they have a minimal or no need for assistance in that area. Appraisal is based on 12 questions and assessments as well as diagnosed health conditions (Box 5.1). The ACFI also records up to three mental or behavioural diagnoses and up to three other medical diagnoses. The assessments and diagnoses for an individual resident are then used to determine an overall classification for them and to classify their care needs as either low care or high care (Box 5.2).

Box 5.1: The Aged Care Funding Instrument (ACFI)

An assessment undertaken with the ACFI is called an appraisal. Each ACFI appraisal has information on:

- up to three mental or behavioural diagnoses
- up to three other medical diagnoses
- five questions about the need for assistance with activities of daily living (ADL): nutrition, mobility, personal hygiene, toileting and continence
- five questions on the need for assistance with the residents behaviour (BEH): cognitive skills, wandering, verbal behaviour, physical behaviour and depression
- two questions on the need for assistance with the use of medication and complex health care procedures (CHC).
- The resident's need for assistance in relation to each question is given a rating of A, B, C, or D (with A as the lowest need and D the highest). The rating corresponds to a score. The scores are then added up and used to categorise the needs as *Nil*, *Low*, *Medium* or *High* within each of the three domains (see Box 5.2). Subsidy levels are based on the resident's rating for each of the three funding/care domains.

The ACFI replaced the Resident Classification Scale (RCS) on 20 March 2008 and is used to assess new residents. Existing residents were reappraised using the ACFI on the anniversaries of their RCS appraisals. This transition process is now complete.

Source: (DoHA 2009a).

As part of the package of aged care reforms outlined in Section 1.2, further changes to the ACFI have been introduced.

Box 5.2: Defining low and high care under the ACFI from 1 January 2010

The criteria for defining ACFI high care and low care changed from 1 January 2010. Under the new definition, for a resident to be assessed as high care, they must have:

a score of *High* in the activities of daily living (ADL) domain; or

a score of *High* in the complex health care (CHC) domain; or

a score of *High* in the behaviour (BEH) domain, together with a score above *Nil* in at least one of the ADL and CHC domains; or

a score of *Medium* or *High* in at least two of the three domains.

Otherwise a resident is classified as low care.

Source: (DoHA 2009b).

5.1 Variations in residents by ACFI appraisals

Admissions from 1 July 2010 to 30 June 2011

From 1 July 2010 to 30 June 2011, there were 56,531 people admitted to permanent residential aged care who had an ACFI appraisal. The appraisals for these residents indicate that most needed some level of assistance with ADL, with 36% appraised as *High* , 28% appraised as *Medium* and 32% appraised as *Low* in this domain (Figure 5.1). For the BEH domain, one-third (34%) were appraised as *High*, while around a quarter were appraised as *Medium* (26%) and 27% as *Low*. They were less likely to need assistance in the CHC domain than with ADL or BEH, with only one-quarter (25%) appraised as *High* in the CHC domain, and just over half appraised as *Low* or *Nil*. They were also more likely to have a *Nil* need for care with BEH or CHC (each 13%) than with ADL where only 3% had minimal or no care needs. Just under 64% of people admitted required high-level care (Table 5.1 and Online Table A4.4).

Table 5.1: Dependency levels of permanent residents at admission, 1 July 2010 to 30 June 2011, and permanent residents and younger people (aged under 65), 30 June 2011 (per cent)

	Admissions, 1 July 2010 to 30 June 2011			Permanent residents, 30 June 2011			Younger residents (<65 years), 30 June 2011		
	High care	Low care	Total	High care	Low care	Total	High care	Low care	Total
Sex									
Females	60.2	39.8	100.0	76.1	23.9	100.0	87.9	12.1	100.0
Males	69.8	30.2	100.0	76.7	23.3	100.0	82.2	17.8	100.0
Persons	**63.9**	**36.1**	100.0	**76.3**	**23.7**	100.0	**84.8**	**15.2**	100.0

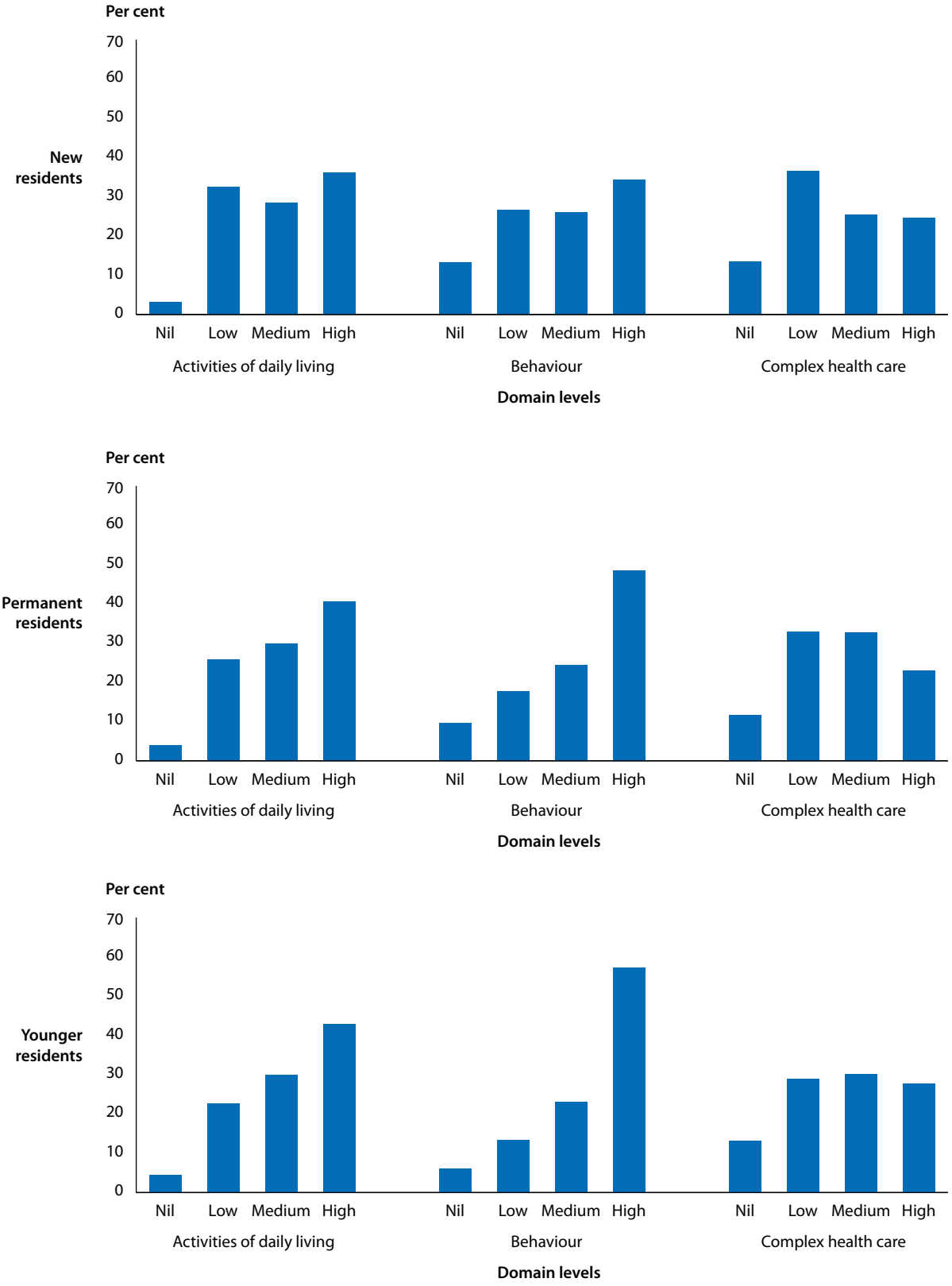
Permanent residents at 30 June 2011

There were 125,175 permanent residents at 30 June 2011 with an ACFI appraisal of high-care. Of those, nearly 13% had a high-care classification across all three domains, with 13% appraised as *High* in both the ADL and BEH domains and *Medium* in the CHC domain. This was the most common combination of care needs for high-care permanent residents (Online Table A4.2).

There were 38,941 permanent residents who received a low-care appraisal (Online Table A4.3). Of those, 15% were appraised as *Low* in all three domains, with the most frequent combination being *Medium* care in the BEH domain and *Low* care in the other two domains. Almost 4% required only minimal or no assistance in all three domains and so received a *Nil* rating.

Fewer admitted residents had high care needs in the ADL and BEH domains compared to permanent residents at 30 June 2011—36% compared to 41% in the ADL domain and 34% compared to 48% in the BEH domain (Table 5.2 and Figure 5.1)

Figure 5.1: Level of ACFI domains for permanent admissions, 1 July 2010 to 30 June 2011, and permanent residents and younger people (aged under 65), 30 June 2011



Sources: Online tables A4.4, A4.5 and A4.6.

5.2 Variation in care needs according to age

Over three-quarters of permanent residents (77%) at 30 June 2011 were 80 or older, and nearly 3 in 10 (28%) were aged 85–89. This pattern is also true for permanent residents (74% and 29%, respectively) and residents admitted during the year (Online tables A2.1 and A3.1). Details on younger residents are in Section 5.3.

Admissions from 1 July 2010 to 30 June 2011

Across age groups, the youngest (under 65) and the oldest (95 and over) of admitted residents had the highest ADL needs, with 42% and 44% respectively appraised as *High* in ADL (Online Table A4.4). The number of these residents appraised as having *High* in the BEH domain reduced with age, from 47% of those under 65 to 28% of those aged 95 and over (Online Table A4.4). Younger residents were also more likely to be appraised as *High* in CHC (35% of those aged under 65, and 31% of those aged 65–69) than those entering care at an older age (22% of those aged 85–94, and 25% of those 95 and older).

These differences may indicate that for most admitted residents, difficulty in carrying out activities of daily living and behavioural issues could have a greater influence than health conditions on the decision to enter care.

Permanent residents at 30 June 2011

Variation in the distribution of appraisals in the three domains for permanent residents was evident across age groups (Online Table A4.7). Residents aged 95 and over were most likely to be appraised as *High* care in the ADL domain (47%). Within this age group, females were more likely than males to be appraised as *High* (49% compared with 40%).

The widest variation was seen within the BEH domain. As age increased, the proportion of residents appraised as *High* decreased. Over half of residents aged under 65 were appraised as *High* (57%), steadily decreasing to 43% of those aged 95 and over. The same trend was evident within the CHC domain, with 28% of residents aged under 65 appraised as *High*, reducing to 24% of those aged 95 and over.

Table 5.2: ACFI domain for permanent residents, by age group, 30 June 2011 (per cent)

ACFI care level	<65	65–69	70–74	75–79	80–84	85–89	90–94	95+	Total
Activities of daily living (ADL)									
High	42.8	38.9	40.9	41.9	40.1	38.6	40.0	47.4	40.6
Medium	30.0	29.3	29.5	29.6	30.2	29.8	29.8	29.1	29.8
Low	22.8	26.6	25.3	24.6	25.7	27.7	26.5	20.8	25.8
Nil	4.4	5.2	4.4	4.0	4.0	3.9	3.7	2.7	3.9
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Total (number)	**6,339**	**5,436**	**9,307**	**16,803**	**32,843**	**46,039**	**33,346**	**14,003**	**164,116**
Behaviour (BEH)									
High	57.4	55.4	54.7	52.9	50.7	47.1	43.6	42.7	48.4
Medium	23.1	23.3	23.6	23.0	23.2	24.3	25.4	26.9	24.3
Low	13.5	14.4	14.3	16.0	16.9	18.4	19.9	19.9	17.8
Nil	6.1	6.9	7.4	8.1	9.2	10.2	11.0	10.6	9.5
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Total (number)	**6,339**	**5,436**	**9,307**	**16,803**	**32,843**	**46,039**	**33,346**	**14,003**	**164,116**
Complex health care (CHC)									
High	27.7	24.8	25.2	24.6	23.2	21.5	21.8	23.6	23.0
Medium	30.2	31.8	32.8	32.7	32.7	32.7	32.8	33.3	32.7
Low	28.9	29.2	30.1	30.9	32.8	34.3	34.0	32.6	32.8
Nil	13.2	14.2	11.9	11.8	11.3	11.5	11.4	10.5	11.6
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Total (number)	**6,339**	**5,436**	**9,307**	**16,803**	**32,843**	**46,039**	**33,346**	**14,003**	**164,116**

5.3 Younger residents and the ACFI

The proportion of younger residents (aged under 65) requiring high-level care at 30 June 2011 was 85%. This figure is much higher than those recorded for older residents, either permanent (76%) or admitted (64%) (Table 5.1). The difference may be explained by the admission of younger residents to residential aged care in circumstances where there is no suitable disability service available in the community.

At 30 June 2011, there were 6,371 permanent aged care residents under the age of 65, accounting for around 4% of permanent residents. Almost all had been appraised using the ACFI. For these residents, the need for care with ADL was generally similar to that for all residents although a slightly lower proportion of younger residents had *Low* care needs and a slightly higher proportion had *High* care need (Figure 5.1).

In addition, younger residents were more likely to have high-level care needs in the BEH and CHC domains, with over half (57%) of young permanent residents requiring high-level care in the BEH domain compared with 48% of all residents. Those younger residents aged 50–54 were the most likely to be appraised as *High* in the BEH domain (60%). For the CHC domain, 28% of younger residents required high-level care, compared with 23% of all residents. The need for CHC, however, was much more common in the youngest residents, with almost half of those aged less than 40 (46%) requiring high-level care in this domain (Online Table A4.6).

The high proportion of younger people who enter residential aged care with higher care needs may reflect the number of people in these age groups who are admitted because of more severe health conditions such as acquired brain injury, stroke, younger onset dementia or other conditions associated with higher care needs (AIHW 2012b).

Younger people are not generally accepted into residential aged care unless suitable disability services for them are not available. The Younger People with Disability in Residential Aged Care (YPIRAC) program is a 5-year program agreed on by the Council of Australian Governments which aims to reduce the number of people with disability aged under 65 who live in residential aged care. More information about that program and the characteristics of younger age permanent residents is published in *Younger people with disability in residential aged care 2010–11* (AIHW 2012b).

5.4 Variation in care needs by geographical location

Admissions from 1 July 2010 to 30 June 2011

The distribution of care levels for admitted residents varied somewhat across the states and territories (Online Table A4.11). For the second consecutive year, South Australia had the largest proportion of residents with a classification of *High* in all three domains: 38% with *High* needs in ADL (36% nationally), 42% with *High* BEH needs (34% nationally) and 35% with *High* CHC needs (25% nationally).

Permanent residents at 30 June 2011

As with admitted residents, there was some variation in care levels for all permanent residents across the states and territories (Online Table A4.12). Greater proportions of permanent residents in South Australia were appraised as *High* in the BEH and CHC domains compared with other jurisdictions, while residents in the Northern Territory were more likely to be appraised as *High* care needs in the ADL domain. A relatively high proportion of residents in Tasmania had *Nil* in BEH (18% compared with the national average of 12%).

5.5 Separation mode by ACFI level of care

A separation occurs when a resident leaves a residential aged care service, with no likelihood of return. The separation mode indicates the destination of a resident at separation, including death.

Between 1 July 2010 and 30 June 2011, 54,931 permanent residents with an ACFI appraisal separated from residential care (Table 5.3). The main reason for separation was death (92%). A small proportion (3%) returned to the community, while 2% were discharged to hospital.

Death was the most common reason for separation among residents appraised as having *High* care needs within the ADL, BEH and CHC domains (96%, 94% and 95%, respectively). As requirements for care decreased, residents were less likely to separate due to death and were more likely than those with higher level care needs to return to the community. Twelve per cent of separating residents with a *Nil* score as the appraisal for ADL returned to the community. The corresponding proportions for the BEH and CHC domains were 6% and 8%, respectively (Table 5.3).

Table 5.3: ACFI level of care for ADL, BEH and CHC at separation, for permanent residents separating between 1 July 2010 and 30 June 2011, by separation mode (per cent)

	ACFI care level				
Separation mode	**High**	**Medium**	**Low**	**Nil**	**Total**
			Activities of daily living (ADL)		
Death	96.2	90.1	79.6	74.4	92.6
Return to community	1.5	3.6	8.1	11.5	2.9
To hospital	1.1	2.9	4.7	4.0	2.0
To other residential care	0.7	2.1	4.2	4.9	1.5
Unknown	0.5	1.3	3.4	5.2	1.0
Total	100.0	100.0	100.0	100.0	100.0
Total (number)	**34,254**	**13,516**	**6,375**	**786**	**54,931**
			Behaviour (BEH)		
Death	93.5	91.8	90.4	86.8	92.1
Return to community	2.2	3.4	4.0	6.1	3.1
To hospital	2.0	2.0	2.5	3.0	2.2
To other residential care	1.3	1.6	1.7	1.7	1.4
Unknown	1.0	1.2	1.5	2.3	1.2
Total	100.0	100.0	100.0	100.0	100.0
Total (number)	**27,519**	**13,985**	**9,098**	**4,329**	**54,931**
			Complex health care (CHC)		
Death	95.3	92.6	89.0	80.2	92.1
Return to community	1.8	2.7	4.4	8.1	3.1
To hospital	1.6	2.0	2.8	4.4	2.2
To other residential care	0.7	1.5	2.2	3.3	1.4
Unknown	0.7	1.2	1.6	4.1	1.2
Total	100.0	100.0	100.0	100.0	100.0
Total (number)	**21,588**	**16,728**	**13,514**	**3,101**	**54,931**

5.6 Length of stay by ACFI level of care

The length of stay for a separated resident is based upon the time between the date of admission and the date of separation, allowing for transfers. For current permanent residents it is the time between the date of admission and 30 June 2011.

The proportion of separations with a *High* appraisal for the ADL domain reduced from 75% for those with a length of stay less than 4 weeks to around 55% for length of stay of under 2 years and then increased again up to 70% for longer length of stays.

The proportions of *High* for the BEH domain at separation increased steadily from 31% to 56% of separations for longer length of stays (Online Table A4.9).

Over two-thirds of residents (69%) separating within 4 weeks of admission had *High* CHC needs. Proportions of high-care needs at separation reduced with increasing length of stay to between 30% and 40% for length of stay over 3 months, becoming more related to the proportions with *Medium* health-care needs (Online Table A4.9).

5.7 Health conditions reported in the ACFI

The ACFI allows reporting of up to three of the resident's most significant diagnoses in each of two categories: mental and behavioural conditions, and other health conditions. The main categories reported for health conditions (excluding mental and behavioural disorders) are provided in Table 5.4.

All permanent residents at 30 June 2011 who had an ACFI appraisal had at least one health condition reported. The data presented here relate to the condition listed first on the appraisal form. The most common types of condition listed were circulatory system diseases (24%) (Table 5.4), which include heart disease, cerebrovascular disease (including stroke) and hypertension. Diseases of the musculoskeletal system and connective tissue (which include rheumatoid arthritis, osteoarthritis and osteoporosis) were the first condition listed for 18% of residents. Around 8% of residents had endocrine, nutritional and metabolic disorders (such as diabetes) as their first-listed medical condition.

Table 5.4: First-listed medical condition[(a)] for permanent residents with an ACFI appraisal, by state and territory, 30 June 2011 (excludes mental and behavioural disorders) (per cent)

Diseases (excludes mental and behavioural disorders)	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Circulatory system	24.6	24.1	24.6	24.6	23.6	25.5	27.0	22.2	24.4
Musculoskeletal and connective tissue	15.8	15.8	18.5	21.0	27.1	18.3	17.8	18.7	17.9
Endocrine, nutritional and other metabolic disorders	8.0	9.7	8.0	7.8	7.9	7.1	6.3	10.6	8.4
Nervous system/Parkinson's	5.8	6.3	6.3	6.4	6.0	7.1	6.2	6.7	6.1
Eye and adnexa	5.4	4.5	5.2	5.7	4.1	4.8	5.6	4.8	5.0
Genitourinary system	5.4	4.7	5.0	5.2	4.2	4.2	4.9	3.9	5.0
Respiratory system	3.3	4.0	4.6	4.0	4.5	4.3	3.2	6.2	3.9
Injury/poisoning/external	3.6	3.4	3.3	3.3	3.1	3.6	3.0	6.0	3.4
Neoplasms (tumours/ cancers)	3.1	3.2	3.4	3.1	2.8	3.3	2.4	1.4	3.2
Digestive system	2.6	2.5	3.6	2.9	2.4	2.7	2.6	2.5	2.8
Ear and mastoid process	1.7	1.8	1.6	1.8	1.3	1.8	2.4	1.2	1.7
Skin and subcutaneous tissue	1.3	1.2	1.3	1.1	1.6	1.5	1.3	0.7	1.3
Blood	0.6	0.6	0.7	0.6	0.6	0.7	1.0	1.2	0.6
Other	18.6	18.4	13.8	12.5	10.9	15.1	16.2	13.9	16.3
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**56,245**	**42,421**	**29,679**	**13,843**	**15,467**	**4,216**	**1,812**	**433**	**164,116**

(a) Coding consistent with the Aged Care Assessment Program (ACAP) data dictionary.

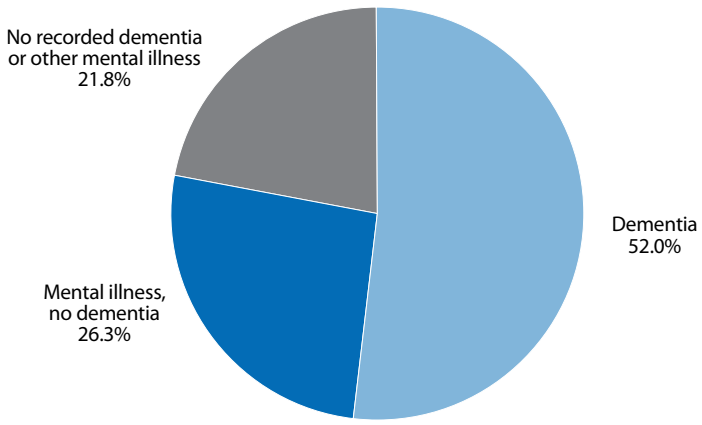
5.8 Dementia, mental illness and the ACFI

Dementia and mental illness have been acknowledged as important challenges for health and aged care policy and service planning. Dementia is a highly disabling neurological disorder which is most often experienced by those aged 80 and over (AIHW 2007).

Diagnoses of up to three mental and behavioural conditions may be recorded in ACFI appraisals. At 30 June 2011, over three-quarters of residents (78%) were reported to have a mental illness (Online Table A4.10). More than half (52%) of the 164,116 permanent residents with an ACFI appraisal had a diagnosis of dementia recorded (Figure 5.2). Over two-fifths of residents with dementia also had a diagnosis of a mental illness. A further 26% of residents had a diagnosis of mental illness without a diagnosis of dementia.

More detailed information about dementia in aged care residents is available in *Dementia among aged care residents: first information from the Aged Care Funding Instrument* (AIHW 2011b) and in the forthcoming (2012) publication *Dementia in Australia* (includes residential aged care and the EACH and EACHD programs). The forthcoming publication is an update of an earlier 2007 publication, *Dementia in Australia: national data analysis and development* (AIHW 2007). The 2007 publication provided a profile of people in Australia who experienced dementia and reviewed the quality and availability of data. The 2012 publication is primarily designed to provide updated data analysis, especially in relation to disease burden, incidence and prevalence of dementia, expenditure and characteristics and service use by people with dementia and their carers. New information on the EACHD program is included in the 2012 report (see <http://www.aihw.gov.au/publications/>).

Figure 5.2: Diagnosed dementia and mental illness for permanent aged care residents with an ACFI appraisal, 30 June 2011



Source: Online Table A4.10.

Chapter 6

Trends in the use of residential aged care

6 Trends in the use of residential aged care

This chapter presents trend data for selected information about residential aged care in Australia. The time period used varies depending on data availability.

6.1 Overall usage

Over the past decade, there has been an increase in the number of permanent and respite residents in residential aged care due to the ageing of the population and the corresponding increase in the number of residential places. Of note is the increase in the number and proportion of residents aged 85 and over (Table 6.1).

From 1999 to 2011 the numbers of permanent residents increased by 32,612 (25%). The proportion of permanent residents aged 85 and over increased by 29,203 (45%): an increase from 49% to 57% of total permanent residents. The numbers of residents receiving residential respite care at 30 June 2011 increased by nearly 1,500 (60%) since 30 June 1999, with the proportion aged 85 and over increasing from 36% to 50% of respite care residents.

Table 6.1: Trends in resident numbers at 30 June, 1999–2011

Year	All permanent residents	All respite residents	Permanent residents (85+ years)	Respite residents (85+ years)	Permanent residents (85+ years) (per cent)	Respite residents (85+ years) (per cent)
1999	132,420	2,479	64,638	903	48.8	36.4
2000	133,387	2,604	66,503	1,034	49.9	39.7
2001	134,004	2,604	67,402	1,008	50.3	38.7
2002	136,507	2,422	69,258	1,035	50.7	42.7
2003	140,297	2,549	71,397	1,024	50.9	40.2
2004	144,994	2,646	74,229	1,097	51.2	41.5
2005	149,091	2,819	77,285	1,174	51.8	41.6
2006	151,737	3,135	80,099	1,334	52.8	42.6
2007	153,426	3,123	82,871	1,445	54.0	46.3
2008	157,087	3,163	85,912	1,487	54.7	47.0
2009	158,885	3,404	88,030	1,644	55.4	48.3
2010	162,597	3,773	91,462	1,787	56.3	47.4
2011	**165,032**	**3,969**	**93,841**	**1,972**	**56.9**	**49.7**

The age of residents at admission to residential aged care has also been increasing (Table 6.2). From 1998–99 to 2010–11, the proportion of permanent residents aged 80 and over at the time of admission increased nearly 10 percentage points for permanent residents (from 64% to 74%) and around 12 percentage points for respite residents (from 60% to 72%). The proportion of residents aged 90 and over increased more slowly, from 15% to 22% for permanent residents and from 12% to 20% for respite residents.

Table 6.2: Proportion of residents aged 80 and over, and aged 90 and over, at admission, 1998–99 to 2010–11 (per cent)

Year	Permanent (80+ years)	Respite (80+ years)	Permanent (90+ years)	Respite (90+ years)
1998–99	64.1	59.7	14.8	12.4
1999–00	65.2	60.0	15.8	13.5
2000–01	67.0	61.9	16.8	14.0
2001–02	68.3	62.6	17.5	14.4
2002–03	69.0	64.2	18.2	15.2
2003–04	70.0	65.2	18.3	16.0
2004–05	70.0	65.0	18.9	16.4
2005–06	70.9	66.3	19.4	17.0
2006–07	71.5	67.9	19.9	18.0
2007–08	72.7	68.9	20.3	18.5
2008–09	73.0	69.9	20.5	18.7
2009–10	73.6	70.9	20.4	19.0
2010–11	**73.8**	**71.9**	**21.7**	**20.3**

Note: Transfers are excluded from admissions.

6.2 Admissions, separations and completed length of stay

From 1998–99 to 2010–11, consistent with the increased supply of places, both permanent and respite admissions rose, as did the number of separations from permanent and respite care (Table 6.3). Average completed length of stay in permanent care increased during this period, while length of stay in respite care remained much the same.

For permanent care, the number of admissions increased by 30% (13,644) and the number of separations increased by 28% (12,343). The average completed length of stay for residents increased by approximately 14.5 weeks (11%) from 1998–99 to 2010–11 with minor fluctuations during that period.

For respite care, admissions increased by 45% (just under 18,470) and separations increased by 44% (18,136). The average completed length of stay remained relatively stable during this time at around 3.0–3.5 weeks.

Table 6.3: Admissions, separations and completed length of stay in residential aged care, 1998–99 to 2010–11

Year	Permanent admissions (number)	Respite admissions (number)	Permanent separations (number)	Respite separations (number)	Average completed length of stay (permanent, weeks)	Average completed length of stay (respite, weeks)
1998–99	45,258	40,806	44,079	40,939	131.3	3.5
1999–00	45,476	42,531	44,615	42,422	137.0	3.3
2000–01	46,545	43,606	45,481	43,586	142.4	3.2
2001–02	47,345	43,309	45,284	43,503	145.5	3.2
2002–03	51,200	45,445	47,467	45,334	143.0	3.1
2003–04	53,356	46,632	48,723	46,544	143.7	3.1
2004–05	52,462	48,295	48,503	48,120	143.3	3.1
2005–06	52,964	49,727	50,720	49,402	145.8	3.1
2006–07	52,196	50,987	51,026	50,977	145.9	3.3
2007–08	53,737	51,293	53,819	51,280	147.8	3.3
2008–09	56,983	54,535	55,310	54,291	147.0	3.4
2009–10	57,937	57,503	54,193	57,139	145.1	3.4
2010–11	**58,902**	**59,276**	**56,422**	**59,075**	**145.7**	**3.5**

Note: Transfers are excluded from admissions and separations.

6.3 Transition from respite care to permanent care

Residential respite care plays an important role in the aged care system. Over half of all admissions to residential aged care in 2010–11 were for respite care (Table 6.3) and a substantial proportion of respite admissions (35%) were subsequently admitted into permanent residential care within the year (Table 6.4).

People are often admitted for respite care more than once a year. In 2010–11, there were 59,276 respite admissions for nearly 41,900 individuals with just over half (50%) of these individuals then being admitted to permanent care within the year. This proportion has increased quite steadily from 43% in 1999–00.

Table 6.4: Respite residents and permanent residential aged care activity, 1999–00 to 2010–11

Year	Respite admissions (number)	Respite residents (number)	Permanent admissions following respite admission (1 per resident) (number)	Permanent admissions following respite admission (per cent)	Respite residents admitted for permanent care (per cent)
1999–00	40,806	32,902	14,017	30.1	42.6
2000–01	42,531	33,263	14,288	30.0	43.0
2001–02	43,606	32,871	13,934	29.5	42.4
2002–03	43,309	34,193	14,661	29.6	42.9
2003–04	45,445	35,021	15,098	29.8	43.1
2004–05	46,632	36,181	15,361	29.2	42.5
2005–06	48,295	37,505	16,325	30.0	43.5
2006–07	49,727	38,919	17,341	31.0	44.6
2007–08	50,987	39,530	17,729	31.5	44.8
2008–09	54,535	41,972	19,250	32.2	45.9
2009–10	57,503	41,847	20,499	35.6	49.0
2010–11	**61,821**	**43,690**	**21,895**	**35.4**	**50.1**

6.4 Permanent residents and usage rates by age

Between 2001 and 2011 there was a steady increase in both the number and proportion of permanent residents aged 85 or older (Table 6.5). The proportion of those aged 85 or older increased steadily from 50% at 30 June 2001 to 57% at 30 June 2011. This represents an increase of 26,439 from 67,402 to 93,841 people.

The number of residents aged 80–84 peaked at 33,593 residents in 2005 and has fluctuated around 33,100 over the last 4 years, while the proportion of residents in this age group has been slowly decreasing since 2004. In contrast, the number and percentage of residents in all of the younger age groups has generally changed little or decreased over this 10-year period.

Usage rates per 1,000 of the population aged 70 and over generally declined over the 2000–2011 period in all age groups (Table 6.6). The strongest trend was in the 85 and over age group, which dropped from 263.2 per 1,000 in 2000 to 225.9 per 1,000 in 2011. This was followed by the 80–84 age group, where usage rates fell from 90.5 to 74.4 per 1,000 between 2000 and 2011. This trend may be linked to the provision of community aged care places (AIHW 2012a).

Table 6.5: Permanent residents at 30 June, by age group, 2001–2011

Age group (years)	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
						Number					
<65	5,948	5,984	6,073	6,240	6,483	6,562	6,467	6,606	6,509	6,476	6,371
65–69	4,237	4,317	4,389	4,439	4,613	4,705	4,840	4,951	5,194	5,273	5,479
70–74	9,368	8,999	8,783	8,720	8,503	8,344	8,298	8,626	8,756	9,141	9,366
75–79	18,450	18,286	18,457	18,454	18,614	18,591	18,005	17,764	17,294	17,096	16,916
80–84	28,599	29,663	31,198	32,912	33,593	33,436	32,945	33,228	33,102	33,149	33,059
85+	67,402	69,258	71,397	74,229	77,285	80,099	82,871	85,912	88,030	91,462	93,841
Total	**134,004**	**136,507**	**140,297**	**144,994**	**149,091**	**151,737**	**153,426**	**157,087**	**158,885**	**162,597**	**165,032**
						Per cent					
<65	4.4	4.4	4.3	4.3	4.3	4.3	4.2	4.2	4.1	4.0	3.9
65–69	3.2	3.2	3.1	3.1	3.1	3.1	3.2	3.2	3.3	3.2	3.3
70–74	7.0	6.6	6.3	6.0	5.7	5.5	5.4	5.5	5.5	5.6	5.7
75–79	13.8	13.4	13.2	12.7	12.5	12.3	11.7	11.3	10.9	10.5	10.3
80–84	21.3	21.7	22.2	22.7	22.5	22.0	21.5	21.2	20.8	20.4	20.0
85+	50.3	50.7	50.9	51.2	51.8	52.8	54.0	54.7	55.4	56.3	56.9
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Table 6.6: Usage rates at 30 June for permanent aged care, by age group, 2000–2011 (per 1,000 population)

Age group (years)	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
<65	0.4	0.4	0.3	0.4	0.4	0.4	0.4	0.4	0.4	0.3	0.3	0.3
65–69	6.5	6.2	6.2	6.1	6.0	6.0	6.0	5.9	6.0	6.0	5.8	5.8
70–74	15.1	14.7	14.1	13.9	13.9	13.6	12.9	13.2	13.0	12.8	12.9	12.8
75–79	37.3	35.5	34.6	34.2	33.6	33.7	32.7	33.3	32.3	31.5	31.0	30.2
80–84	90.5	86.7	85.1	85.0	85.2	83.7	79.5	81.2	78.5	76.8	75.5	74.4
85+	263.2	254.1	250.2	249.2	248.8	245.3	240.3	237.0	235.5	229.6	229.7	225.9
Total	**7.0**	**6.9**	**7.0**	**7.1**	**7.2**	**7.3**	**7.3**	**7.4**	**7.4**	**7.3**	**7.3**	**7.3**

Appendix A: The reporting environment for residential aged care

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

Publications of the Australian Institute of Health and Welfare

The two reports the AIHW now publishes contribute information about specific aspects of the residential and community aged care systems. They are one element in a number of information sources about aged care. Other AIHW publications complement these two reports:

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

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

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

Report on Government Services

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

Report on the operation of the Aged Care Act 1997

The *Aged Care Act* 1997 introduced a statutory requirement to report annually to Parliament on the operations of the Act. The report (abbreviated to ROACA) is produced by the Australian Government Department of Health and Ageing (DoHA 2011a). It contains descriptions and data on government initiatives and government-funded programs concerning residential aged care, community aged care, aged care infrastructure and information and support facilities. This report and its companion community care report complement the information provided in the RoGS and the ROACA reports.

Council of Australian Government (COAG) initiatives

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

In early 2011, COAG made a commitment to various aged care reforms. These were reaffirmed with the National Health Reform Agreement which was finalised with government in August 2011 (COAG 2011a). One aim of the agreement is to develop a nationally consistent and better integrated aged care system. Under this agreement, and subject to passage of the relevant legislation, the Australian Government will be responsible for funding basic community care in most states and territories for people aged 65 and over (50 and over for Indigenous Australians). The agreement represents a significant shift in funding arrangements, with the potential to have a marked effect on service delivery and related reporting for aged care.

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

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

Appendix B: Financial support arrangements

The financial support arrangements are recorded by referring to the time a resident first entered aged care. All permanent residents in aged care at 30 June 2011 were assessed under different financial eligibility criteria, depending on when they were first admitted to care. The *Aged Care Act 1997* introduced major changes to the structure and funding of aged care services. The criteria used to assess financial assistance have changed twice since October 1997 when the *Aged Care Act 1997* was first passed, resulting in three different financial assessment periods:

- pre-reform (pre-October 1997)
- 1 October 1997—19 March 2008
- 20 March 2008 onwards.

Note that the 2012 package of aged care reforms (Section 1.2) have the potential to further change financial arrangements in the aged care sector. What is explained in this appendix, however, was current at the time of analysis and writing.

Pre–October 1997 reforms

This time period relates to financially disadvantaged permanent residents who were admitted to care before 1 October 1997.

1 October 1997—19 March 2008

Permanent residents receiving financial support during this time were referred to as concessional and assisted residents.

Concessional residents who met the criteria for concessional status were eligible for a concessional supplement, which was paid to the service provider. Concessional residents were exempt from accommodation changes or bonds. In addition, a concessional supplement to the basic subsidy was paid to the service provider. The minimum requirements for concessional status were that the resident must:

- be receiving an income support payment
- not have owned a home for the past 2 years
- have assets of less than 2.5 times the annual single basic aged pension, rounded to the nearest $500.

Assisted residents were also eligible for a supplement; however, this was lower than for concessional residents. Assisted residents may have also been required to pay an accommodation bond or an accommodation charge, subject to certain conditions.

Service providers received a lower supplement for assisted residents. The criteria for determining assisted resident status were the same as concessional resident status except that an assisted resident had assets of between 2.5 and 4 times the annual single basic aged pension amount, rounded to the nearest $500.

20 March 2008 onwards

Financially disadvantaged permanent residents admitted to care from 20 March 2008 are referred to as supported residents. Existing residents before 20 March 2008 retain their conditions and benefits for being financially disadvantaged unless they separate from residential aged care for more than 28 days. Clients entering permanent residential aged care may be eligible to be supported residents (on or after 20 March 2008) depending on the value of their assets.

An assets test is undertaken to determine eligibility for a supported resident. Fully supported residents are similar to concessional residents, but a sliding scale of accommodation charges applies as their assets increase. Partially supported residents pay some level of accommodation charge depending on their assets.

A client's home is excluded from this assets test if the home is occupied by either:

- their partner or a dependent child
- their carer, who is eligible for an income support payment, and has occupied the home for the past 2 years
- a close relation, who is eligible for an income support payment, and has occupied the home for the past 5 years.

Facilities are expected to meet regional targets for places for concessional, assisted and supported residents. These targets range from 16% to 40% and are calculated using the Socio-Economic Indexes for Areas (SEIFA) applied to aged care planning regions.

For a full description of details for residents and providers about assisted and concessional status, see *The residential aged care manual* maintained by the Australian Government Department of Health and Ageing, available on the website at <www.health.gov.au>.

Appendix C: Data sources and limitations

Resident data

The main source of resident data in this report is administrative by-product data from the System for the Payment of Aged Residential Care (SPARC) and the National Approved Provider System (NAPS).

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

- Aged Care Client Record—a form which includes the application to receive aged care under the *Aged Care Act 1997*. It is completed by the person applying for care and the record of approval of care is completed by an authorised Aged Care Assessment Team (ACAT) officer.
- Application for Classification—a form containing client evaluation on the Resident Classification Scale (RCS) and completed by the aged care service to determine the resident's overall level of care needs (used up to 20 March 2008). From 20 March 2008, this form was revised to adjust to client appraisal using the Aged Care Funding Instrument (ACFI).
- Monthly Claim Form—a form for claiming Australian Government benefits completed by the aged care service as part of the monthly funding cycle.

The initial transfer of this information is moving from paper copy to electronic transfer. The word 'form' thus needs to be interpreted accordingly.

Residential aged care in Australia was 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. As a result, from that date, SPARC replaced the two previous data collection systems: the Nursing Home Payment System (NHPS) and the Commonwealth Hostel Information Payment System (CHIPS).

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

- those who were in a hostel at 1 October 1997
- those who had a valid ACAT assessment covering 1 October 1997, as they were regarded as potential residents.

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

Under the amalgamated residential aged care system, length of stay refers to the period spent in the combined system, which may include both time spent under low care (previously hostel) and high-care (previously nursing home). This is not comparable to combining length of stay measures from the previous separate nursing home and hostel measures of length of stay.

General population data

Population data are from the AIHW's general population databases supplied by the Australian Bureau of Statistics (ABS) and other ABS-published data.

Resident information

All residents admitted to residential aged care must have a valid Aged Care Client Record form completed by an authorised ACAT officer. This form is valid for 12 months from the date of an approval for low-level care. An approval for high-level care does not lapse.

The information entered into SPARC from the Aged Care Client Record is the major source for the following data items in the tables:

- sex
- date of birth
- marital status
- Indigenous status
- country of birth
- preferred language
- resident's usual residence (before admission)
- resident's usual living arrangement (before admission).

Not all residents have all the above characteristics reported in SPARC.

Application for classification

These forms are now sent directly to Medicare Australia in either electronic or paper form and processed for funding purposes according to the information provided. On the old RCS, a client would normally be reappraised annually on the anniversary of admission by the service provider. The RCS has been replaced with the ACFI from 20 March 2008 and the ACFI was phased in over a year as client RCS appraisals become due. There is no automatic reappraisal of clients in the ACFI appraisal system.

Admission and separation date

The monthly claim form is sent to approved residential aged care facilities each calendar month, either electronically or as a paper form, 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. The facility also adds information on any newly admitted residents for the current month.

The monthly claim form is sent to Medicare Australia. 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

Tables in this publication refer to several different subpopulations and, consequently, may not be directly comparable. The subpopulations covered in this report are summarised below. Excluding the reporting on provision, the data presented relate to mainstream services and their residents, and exclude residents in places provided by Multi-purpose Services or funded through the National Aboriginal and Torres Strait Islander Flexible Aged Care Program, and Aged Care Innovative Pool program places.

Residents at 30 June 2011

All tables on this topic relate to the number of residents who were in mainstream aged care services at 30 June 2011. This population includes all approved residents and totalled 169,001.

All admissions and separations, 1 July 2010 to 30 June 2011

There were 58,902 admissions for permanent care (permanent admissions) and 59,276 admissions for respite care (respite admissions) over the period 1 July 2010 to 30 June 2011. Over the same period, there were 56,422 separations of permanent residents and 59,075 separations of respite residents. Transfers within type are excluded.

Admitted residents, 1 July 2010 to 30 June 2011

Each person is counted once. For the full year reporting, there were 58,172 distinct resident admissions for permanent care and 43,533 distinct resident admissions for respite care. Transfers within type are excluded.

Separated permanent residents, 1 July 2010 to 30 June 2011

Each person is counted once. For the full year reporting, there were 55,850 distinct permanent resident separations and 43,547 distinct resident separations for respite care. Transfers are excluded.

Tables on dependency

The data on the ACFI invariably excludes some clients due to the time lag in data entering the warehouse from which the tables are derived, and the programming structure which cannot allow for the full range of unusual data entry. The general trends in these tables are not altered by the missing data.

Data limitations

The accuracy of certain data items might be limited. Such cases are listed below:

- A reported date of birth implying that a resident is aged less than or equal to 10 years is regarded as an input error and 100 years is added to the age. This only alters a handful of entries in any one year.
- Death indicator: in some cases, aged care services may not be equipped to care for some terminally ill residents. Accordingly, such residents are transferred to acute-care institutions before death; hence, there is an under-enumeration of discharges due to death.
- Length of stay: complete length of stay of a resident is the time between the date of admission and the date of separation; and for residents at 30 June 2011, incomplete length of stay is the time between the date of admission and 30 June 2011. When a person is transferred from one service to another, the date of admission to the first service is the date from which the length of stay is calculated.
- The data on the number of residential places and community care packages stored in the Department of Health and Ageing Ageing and Aged Care Data Warehouse are sourced from the National Approved Provider System (NAPS) and are sensitive to dates of entry. Consequently, the reader may find minor reporting variations depending on the timing of reports as amendments and late additons become current.
- Information on whether an admission was from an acute hospital is not available in SPARC.

Calculations

Cases where data are not applicable, unknown or not reported have mostly been excluded in relevant calculations of percentages and rates presented in the text, which may create minor variance to the totals in some tables. This is the equivalent of distributing missing and unknown responses across known categories according to the relative numerical contribution of the known categories to the total of known responses (sometimes referred to as 'pro-rating').

Glossary

Aged Care Funding Instrument (ACFI)

The ACFI is a resource allocation instrument and focuses on three domains that discriminate care needs among residents. The ACFI assesses core needs as a basis for allocating funding. It was phased in over a year starting from 20 March 2008 to replace the Resident Classification Scale (RCS). See Chapter 5 for more detail.

Admission day

The first day of a person's stay in an aged care service. In the case of a person transferring between services, where the time between leaving one service 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.

Admissions over a year

Transfer clients are omitted from the count of admissions over a year. When the level of admission activity is being described, it is usual to take into account all other admissions in the year of the type being discussed. When client characteristics of admissions over a year are the focus of attention, it is usual to use the defining characteristic of the client at their last admission in the year when building tables.

Aged Care Assessment Team (ACAT)

A multidisciplinary team of health professionals responsible for determining eligibility for entry to residential aged care and other types of care under the *Aged Care Act 1997*.

Care recipient

A person who is receiving aged care provided by an approved provider.

High-care resident

A permanent resident who was assigned to classification levels 1–4 using the RCS or who is appraised as ACFI high care.

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, allowing for transfers. For a current resident, it is the time between the date of admission and 30 June 2011. The admission day and the specified day (30 June 2011) are included, but the separation day is excluded, from the calculation of length of stay.

Low-care resident

A permanent resident who was assigned to classification levels 5–8 using the RCS or who is appraised as ACFI low care.

Mainstream places

Residential aged care places that exclude places in Multi-purpose Services and the National Aboriginal and Torres Strait Islander Flexible Aged Care Program.

Occupied place-days

Occupied place-days are calculated by adding client days from 1 July 2010 to 30 June 2011.

Permanent admission

An admission to residential aged care for expected long-term care.

Permanent care

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

Permanent resident

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

Place-day

A day on which a care recipient is occupying a place and the provider is paid an Australian Government subsidy. The day that a care recipient enters residential aged care and the day he or she leaves are counted as 1 day.

Remoteness

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

Major cities CDs with an average ARIA index value of 0 to 0.2

Inner regional CDs with an average ARIA index value greater than 0.2 and less than or equal to 2.4

Outer regional CDs with an average ARIA index value greater than 2.4 and less than or equal to 5.92

Remote CDs with an average ARIA index value greater than 5.92 and less than or equal to 10.53

Very remote CDs with an average ARIA index value greater than 10.53.

Resident

A person who has been assessed by an Aged Care Assessment Team (ACAT) as requiring residential care and who resides in an Australian Government–funded aged care service.

Resident Classification Scale (RCS)

An instrument which assesses a care recipient's care needs. This scale has eight classification levels ranging from low care (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 Resident Classification Instrument for nursing homes and the Personal Classification Assessment Instrument for hostels. The RCS was replaced by the Australian Care Funding Instrument (ACFI) from 20 March 2008.

Residential aged care service

A service that consists of a number of approved places at a specific location.

Residential care

Personal and/or nursing care that is provided to a person in a residential care service in which the person is also provided with accommodation that includes meals, cleaning services, furniture and equipment. The residential aged care service must meet certain building standards and appropriate staffing in supplying the provision of that care and accommodation.

Respite admission

A short-term admission to residential aged care for respite care purposes.

Respite care

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 resident who is admitted to residential aged care for respite care.

Separation

Occurs when a resident leaves residential aged care and has not re-entered the same or another service within 2 days.

Separation day

The last day of a person's stay in an aged care service; that is, the day on which the person leaves the service. Transfers between services were not viewed as separations in terms of length of stay calculations if the time between leaving one service and entering another was less than 2 days.

Separations over a year

Transfer clients are omitted from the count of separations over a year. When the level of separation activity is being described, it is usual to take into account all other separations in the year of the type being discussed. When client characteristics of separations over a year are the focus of attention, it is usual to use the defining characteristic of the client at their last separation in the year when building tables.

Separation mode

Indicates the destination of a resident at separation, including death.

Supported resident

Following the *Aged Care Amendment Act 2008* clients entering permanent residential aged care with assets below a certain level are eligible to be supported residents (on or after 20 March 2008). The client's level of assets determines the amount of any accommodation charges they pay.

System for the Payment of Aged Residential Care (SPARC)

The current payment system for residential aged care.

Transfer

Occurs where a person leaves an aged care service on one day and is admitted to another within 2 days.

Usual housing status

Refers to housing tenure before the resident's application for admission to residential aged care.

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Table A3.1 Permanent admissions, age at admission, by state/territory 1 July 2010 to 30 June 2011

Residential aged care in Australia 2010–11 provides comprehensive statistical information on residential aged care facilities, their residents, admissions and separations, and residents' dependency levels.

At 30 June 2011, there were nearly 185,500 residential aged care places, an increase of more than 2,600 places compared with 30 June 2010.

More than 85,200 permanent residents (52%) had a recorded diagnosis of dementia at 30 June 2011. Other recorded health conditions included circulatory diseases (40,000 residents) and diseases of the musculoskeletal and connective tissue (29,400 residents).