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AUSTRALIA'S WELFARE 2003

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The sixth biennial welfare report of the
Australian Institute of Health and Welfare

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The Hon Tony Abbott MP
Minister for Health and Ageing
Parliament House
CANBERRA ACT 2600

Dear Minister

On behalf of the Board of the Australian Institute of Health and Welfare I am pleased to present to you *Australia's Welfare 2003*, as required under Subsection 31 (1A) of the *Australian Institute of Health and Welfare Act 1987*.

I commend this report to you as a significant contribution to national information on welfare services and assistance and to the development and evaluation of welfare policies and programs in Australia.

Yours sincerely

Dr Sandra Hacker
Chairperson of the Board

14 November 2003

For health and welfare
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Preface

This sixth edition of *Australia's Welfare* meets the requirement placed on the Institute by its legislation to provide a comprehensive report every two years on Australia's welfare services and assistance.

Australia has a comprehensive network of support for people with welfare needs. Services are provided by governments, non-government organisations, private providers and by family members and volunteers. Formal services are funded by the Australian, state and territory governments, user charges and the resources of non-government organisations. Informal services depend on the willingness and capacity of many individual Australians to forego other paid and unpaid activities.

Making sense of this complex mosaic is essential if one is to understand the many interdependencies that underpin Australia's welfare system. A change in one program can have a ripple effect on many others. In addition any decrease in the supply of informal care can place great pressure on governments to increase formal services.

Australia's Welfare aims to provide this guide to the Australian welfare system. It includes indicators to assist in forming an overall view, and endeavours to describe the interactions between different welfare sectors. It draws on the wealth of information available from the Institute and other bodies, and contains many references to other sources.

My thanks go to the numerous people who have worked diligently and skilfully to produce this edition. I trust that their efforts have produced a readable and reliable reference for all classes of reader, and that *Australia's Welfare 2003* makes a major contribution to debate about social policy in Australia over the next two years.

Richard Madden
Director
Australian Institute of Health and Welfare

Symbols

N	number
m	million
b	billion
$	Australian dollars, unless another country is specified
%	per cent
nec	not elsewhere classified
’000	thousands
n.p.	when used in a table, means not published by the data source
n.a.	when used in a table, means not available
nfd	not further defined
. .	when used in a table, means not applicable
—	when used in a table, means nil or rounded to zero (including null cells)
*	when used in front of a numerical value in a table, means the value is subject to sampling variability too high for most practical purposes and/or the relative standard error of the value is 25% to 50%
**	when used in front of a numerical value in a table, means the value is subject to sampling variability too high for most practical purposes and/or the relative standard error is more than 50%

1 Introduction

Australia's Welfare 2003 is the sixth biennial report on Australia's welfare. It builds on the material provided in previous editions.

The coverage of *Australia's Welfare* has progressively widened, keeping pace with growing recognition of the interplay between formal services, informal services, public and community housing and cash payments. The report therefore continues to describe welfare services and assistance in the areas of ageing and aged care, disability, family and children, housing and homelessness. It also provides a broader context to understand the overall welfare of Australians.

Two special chapters, on welfare indicators and on informal care in the community, illustrate this broader focus. The chapter on welfare indicators follows on from the discussion in 2001 where a range of conceptual approaches to the measurement of welfare needs, service performance and outcomes was presented, and a framework of information proposed. In this edition, that work has been substantially augmented, with available data sources being mined to populate the indicators framework developed in the earlier work. The chapter on informal care discusses the extent of the care provided by informal carers, the characteristics of caregivers and some possible future scenarios with regard to the future supply of and demand for informal carers. These calculations take into account current trends in both men's and women's labour force participation as well as the changes associated with the ageing of the population.

Both these chapters complement the work of the chapters covering welfare expenditure and labour force, ageing and aged care, disability and disability services, children's and family services (including children in need of protection) housing assistance and services for homeless people. These chapters build on and develop the material presented in earlier editions, providing an account of recent policy developments, and describing the need for assistance, client profiles and changing patterns of service provision.

The remainder of this chapter explores the issues that need to be examined and supported by the production of high-quality welfare data and information (Section 1.1). An account of the national information agreements, structures and processes that facilitate and actively progress the national welfare services information agenda is reported in Section 1.2. Some of the approaches to collecting and reporting on welfare services that reflect new or stronger emphasis about the delivery of welfare services, including evidence-based policy, 'whole-of-government' approaches to service delivery, and outcomes of government-funded policies and programs, are discussed in Section 1.3.

1.1 Issues of government and community interest

Since the 2001 report there have been a number of major developments in the delivery of welfare services. The implementation of several reforms at the federal and state/territory level has seen an increased recognition of the need for evidence that is well presented and understood to support research and inform government and community-based decision making.

At a similarly broad level, one of the four national research priorities announced by the Australian Government in late 2002, 'Promoting and Maintaining Good Health', suggests there is likely to be strong demand for statistics and information on children and young people (including their health and wellbeing), population ageing (including ageing well and ageing productively), Indigenous Australians and the welfare services labour force and rural and remote Australia.

Children and youth have been identified as an area of particular interest in a number of government forums.

Children and young people incorporating prevention and early intervention and care and protection were also among the three priority areas identified by the Community Services Ministerial Advisory Committee (CSMAC) in late 2002 for policy review and development. The National Agenda for Early Childhood is due for release shortly by the Australian Government Taskforce on Child Development, Health and Wellbeing, and is expected to indicate information needs as well as policy directions. Other intergovernmental and expert committees, including the Child and Youth Health Intergovernmental Partnership and the Australian Government's Inter-departmental Committee on Youth, are further evidence of the priority being placed by government on the child and youth area. Welfare services and assistance provided to children are discussed in Chapter 6 of *Australia's Welfare 2003.*

Population ageing has received considerable government and community attention in recent years, but the momentum is increasing as the population ages. Ageing well and ageng productively is a priority goal of the National Research Priority 'Promoting and Maintaining Good Health' and the structural ageing of the population is also a priority identified by CSMAC in late 2002. The Australian Government 2003–04 Budget included the release of the Intergenerational Report, with the commitment that a report of this kind on the impact of population ageing on the Australian economy would be undertaken by Treasury as part of the Budget process every 5 years. The Australian Government has funded a $7.2 million review of the residential aged care sector (The Review of Pricing Arrangements in Residential Aged Care). Population ageing and older people is clearly an area on which good statistical evidence will continue to be in demand for the foreseeable future.

New Commonwealth–State and Territory Disability and Housing Agreements have been put in place, to continue the shared focus of all Australian governments on these key welfare sectors.

Indigenous Australians, including their social, economic and health circumstances, were identified as an area of concern by the Council of Australian Governments (COAG) in 2001. A number of developments have occurred aimed at improving the statistics and evidence available on the welfare of Indigenous Australians, and efforts continue in this direction. The AIHW and ABS have recently released their third joint biennial publication on *The Health and Welfare of Aboriginal and Torres Strait Islander People* and the Productivity Commission is shortly to release a report focusing on the situation of Indigenous Australians. In 2002 CSMAC created a subgroup, the Advancing Reconciliation Working Group, to drive its activities pertaining to Aboriginal and Torres Strait Islander peoples. CSMAC also funded work in 2002 on Indigenous identification in administrative by-product collections relating to community services, with a view to improving data quality. The AIHW created a new work Unit in 2003 to coordinate and undertake work on Indigenous health and welfare.

The welfare services labour force was identified as a priority area by CSMAC in late 2002, a decision in keeping with more broadly based government concerns around labour supply over the next two decades. This issue of labour supply, while closely related in general terms to population ageing, has particular salience in the welfare services sector. While labour shortages are already evident in nursing, teaching and some areas of medicine, similar shortages in disability services, child protection, child care, aged care and homelessness services are either already appearing or predicted to occur. Many community services sector jobs are not well paid, and in an environment where labour is in short supply staffing shortages may occur. A number of government reviews and consultancies have already occurred in relation to specific professions such as nursing. Chapter 4 describes the numbers and characteristics of workers and volunteers who comprise the welfare services labour force but it is presently constrained by the limited availability of national data. Broadly based information is available through analyses of the 2001 population census but sector-specific information (on, for example, the disability services or residential aged care workforce) is limited. CSMAC has recently identified national data on the child care labour force as requiring development.

In addition, the circumstances of *Australians living in rural and remote regions* remains an issue of importance, and efforts to develop easily accessible statistical information at the regional level will be an ongoing challenge for providers and custodians of national statistics.

1.2 The national information infrastructure

Information agreements provide the structure and processes needed to support the national statistical effort in both welfare and health statistical work. These agreements are signed by the relevant government departments in all jurisdictions, the Australian Bureau of Statistics (ABS) and the AIHW. Three such Agreements are currently in operation in the welfare sector: the National Community Services Information Agreement (signed 1997) (NCSIA), the National Housing Data Agreement (signed 1999) and the Agreement on National Indigenous Housing Information (signed 2000). A similar agreement in the health sector has been in operation since 1995.

On reaching the end of its original 5-year time span in 2002, the National Community Services Information Agreement was extended pending a review commissioned by CSMAC. At its October 2003 meeting, CSMAC endorsed a proposal that the Agreement be continued. The new Agreement will be prepared following extensive consultation and will be presented to Community Services Ministers for endorsement.

The new Commonwealth–State Housing Agreement (CSHA) again incorporates an agreement concerning the collection and dissemination of nationally consistent housing data.

Under each of these Agreements, information management groups, data committees and working groups are established to promote the development, collection and use of nationally consistent statistics. In addition, within program areas, groups of administrators support the development of nationally consistent data collections across jurisdictional boundaries. Such groups include the National Disability Administrators, Home and Community Care (HACC) Officials and the Supported Accommodation Assistance Program (SAAP) Coordination and Development Committee.

The National Community Services Information Management Group

The development and management of the NCSIA and related structures and processes is the responsibility of the National Community Services Information Management Group (NCSIMG). The Group has established a data committee, sector-specific working groups and ad hoc project groups to assist in its work. Sector-specific work is reported in the various chapters in this report. The data committee and ad hoc project groups undertake NCSIMG projects that cut across community services subsectors. The program of work priorities identified in the initial National Community Services Information Development Plan has been completed. NCSIMG is currently reviewing its work plan priorities for 2003–2005 in association with the review of the Information Agreement.

Significant sector-wide projects in the last 2 years include the revision of the *National Community Services Data Dictionary*, with Version 3 being released in 2003, preliminary work on integrating data definitions and data models across the community services and health sectors, an analysis of the quality of Indigenous identifiers in community services data collections and development of a web-based resource to assist the community services sector to improve the quality of Indigenous statistics. The Group has also worked with the Australasian Juvenile Justice Administrators on the development of a national minimum data set for juvenile justice and has supported a range of child protection projects.

Since 2001, Version 2 of the National Classifications of Community Services has been completed and endorsed by NCSIMG. The second version of the classifications focuses on service activities and service delivery settings with the recommendation that the definitions included in the national data dictionaries be used in identifying target groups.

The National Community Services Data Dictionary

The *National Community Services Data Dictionary* (NCSDD) is the authoritative repository for nationally endorsed definitions of data elements of relevance to community services (AIHW 2000). The data elements are intended to serve as the building blocks with which data items, National Minimum Data Sets (NMDS) and collection systems can be constructed for specific services and purposes.

For many areas of community services, NMDSs have been or are being developed with the purpose of defining minimum information requirements for national reporting. These data sets also support performance indicators. NMDSs are usually accompanied by subject specific data dictionaries, which set out the definitions of MDS data elements and give background information and guidance as to how data should be recorded.

Version 3 of the NCSDD will be published in 2003. It will include additional and revised definitions based on the International Classification of Functioning, Disability and Health (ICF), updated definitions following a major review by the ABS and the first set of integrated definitions of items common to both the NCSDD and the *National Health Data Dictionary* (NHDD). NCSIMG members have committed their agencies to using the NCSDD definitions wherever possible, representing a significant step towards nationally consistent community services data in Australia.

Electronic access to data dictionaries developed by the AIHW is available through the Knowledgebase on the AIHW web site <www.aihw.gov.au>. The Knowledgebase is an open-access electronic metadata repository where users can view and comment on Australian health, community services and housing assistance related data definitions and standards. It provides precise definitions of data, related topics or terms, and any related officially agreed NMDSs, performance indicators, definitions and standards.

Sector-specific data developments in community services

A number of important data development activities have been undertaken jointly by the AIHW, the Commonwealth and the states and territories since the release of *Australia's Welfare 2001*. These relate to the development or redevelopment of program-specific data sets and data dictionaries and are discussed in the relevant chapters. Since 2001, the redeveloped Commonwealth State/Territory Disability Agreement (CSTDA) National Minimum Data Set (NMDS) has been finalised, piloted and implemented. Data from the first annual collection will be available for dissemination in 2004. Also of relevance to disability services is the testing work on a disability question for possible inclusion in the 2006 population census being undertaken by the ABS in consultation with relevant organisations and jurisdictions.

Following the finalisation of the ICF, the Institute, in its role as a World Health Organization Collaborating Centre, developed and published an Australian ICF User Guide. A number of countries have requested and received our agreement to translate the User Guide into other languages.

Standard data items and associated documentation were developed to undertake censuses of the Day Therapy Centre program, the Extended Aged Care at Home program and the Community Aged Care Packages program. Censuses were completed in each of these three areas, with results due for release in late 2003.

NMDSs for juvenile justice and children's services (child care and preschool services) have been developed and pilot tested, with reports on the results of the pilot tests due for completion in 2003. In addition, improvements and modifications were made to the SAAP collection and to the Child Protection collections.

Data developments across the community services and health sectors

Supported by a contribution from CSMAC, the AIHW has taken preliminary steps to identify and develop consistent data dictionary entries for an agreed set of items (largely socio-demographic) that were common to both the NCSDD and the NHDD. Those items have been endorsed by NCSIMG for inclusion in the NCSDD V3 and by the equivalent health sector group for inclusion in the NHDD Version 12 supplement (to be published in 2004). This work has been undertaken in consultation with the National Housing Data Agreement Management Group (NHDAMG).

The second element of the integration project involved preliminary work on integrating the national information models for the health and community services sectors (National Health Information Model V2 and National Community Services Information Model V1).

The National Housing Data Agreement Management Group and the National Indigenous Housing Information Implementation Committee

The 2003 CSHA continues the arrangement established in 1999 to include a subsidiary National Housing Data Agreement (NHDA). The NHDAMG includes representatives of all jurisdictions, the AIHW and the ABS, and has oversight of the NHDA. The management group is supported in its work by the National Housing Data Development Committee. The 2003 CSHA also strengthens existing arrangements to resource national data development work in Indigenous housing assistance, which is managed by the National Indigenous Housing Information Implementation Committee (NIHIIC).

This approach provides a commitment to the development and provision of nationally consistent data and continues, for the duration of the current CSHA, the partnership between the Housing Ministers' Advisory Council and the AIHW to resource national data development work. The NHDA identifies three major work areas comprising development of national minimum data sets, national performance indicators and national data definitions and standards. A new work program for Indigenous housing data development work is currently being finalised by NIHIIC in consultation with the Standing Committee on Indigenous Housing (SCIH).

Both the NHDA and the Agreement on National Indigenous Housing Information are scheduled for review in 2004; the AIHW will contribute to these reviews.

The National Housing Assistance Data Dictionary

The National Housing Data Dictionary is the authoritative source on data definitions recommended for use in Australian housing assistance data collections. In 2003 Version 2, compiled by the National Housing Data Development Committee, was released. Its use will help to ensure that data are uniform and of high quality. While this version of the dictionary covers more housing assistance areas including private rent assistance and community housing than Version 1, there is significant work to be undertaken for Indigenous housing assistance data. This will be a major new area of dictionary development work.

1.3 Enhancing the measurement of welfare

The work undertaken to date to support high-quality statistical work has served us well, but there are challenges on the horizon. In particular, Australian governments have indicated a strong commitment to 'whole-of-government' approaches, sometimes described as a focus on 'person-centred' rather than 'program-centred' systems of service delivery.

While such an approach will undoubtedly produce advantages in delivering community services and housing assistance, it also poses challenges in terms of the kinds of data that are required to support whole-of-government program initiatives. There is already a clear need for 'joined-up-data' which describe the services received by individuals regardless of program funding source (e.g. services received under the CSTDA and the HACC programs), and the experiences and patterns of services as people move between programs and care settings (e.g. between acute hospital care and residential aged care). A person-centred approach to service delivery will require data development, management and analytic strategies that can yield information not simply across jurisdictional boundaries but also across program boundaries and indeed across sectors, rather than simply within one program.

These programs will not always lie within the one sector or department or portfolio, and in any case they will not consistently do so across jurisdictional boundaries. While to date the national data agreements in the spheres of health, community services and housing, and their associated data dictionaries, have remained relatively distinct enterprises, this will need to change in the future if cross-program issues are to be adequately addressed.

There are three related components which require attention in providing more integrated national information that would support whole-of-government approaches: standardisation of individual data elements across collections (as appropriate), the use of statistical data linkage, and the analysis of data from multiple sources.

Standardisation of individual data elements across collections

As described above, substantial progress has been made on the development of standardised data elements across the field of community services and housing, although much remains to be done. The problem of standardisation becomes more complex when seeking to use data from one collection (for instance disability data) in connection with a range of other sectors, such as hospitals, medical services, residential care, and indeed public housing and income support. Legislation to cover provision of welfare services often include definitions. Hence, achieving consistency of individual data elements is not simple and needs to be integrated to the development of programs. At present, however, there is not a consistently used definition of disability across these sectors, let alone consistent data items in the various collections that relate to the services that these people use. The inclusion of a suite of disability data concepts and elements in the NCSDD (V3) is intended to begin to remedy this situation.

As mentioned earlier in this chapter, work has been undertaken under the auspices of the National Community Services Information Management Group and the equivalent health body, the National Health Information Management Group,[1] to develop strategies for integration of the national data dictionaries and associated data definitions and models.

The Institute is also undertaking a redevelopment of the Knowledgebase: Australia's Metadata Registry for health, community services and housing <www.aihw.gov.au/knowledgebase> which will reflect endorsement of data standards across these sectors where integration has been achieved.

Use of statistical data linkage

Linkage of data over time within a program and across programs provides some of the benefits of longitudinal data sets, although at substantially lower cost. It allows longer term patterns of use and changing client profiles to be assessed, can provide information on the way in which people move between services (from community care to residential care, for example), and generates an ongoing evidence base for the policy issues that may require resolution across program or jurisdictional boundaries. If, for example, matched statistical linkage keys existed for older people who use both acute care hospitals and residential aged care, it would be a relatively simple matter to monitor and provide essential regular information on the much-contested issue of older people who spend considerable periods of time in acute hospital beds waiting for placement in residential aged care (the so-called 'bedblocker' debate). Linked data sets could also be developed to provide useful data on the relationship between preschool attendance and primary school performance, or allow the educational outcomes (at the aggregate level) for children on care and protection orders to be routinely monitored.

A number of community services have included 'statistical linkage keys'—sets of codes usually involving selected letters of the client's name, date or year of birth, and sex—for a number of years. The processes governing statistical linkage (i.e. when it can be used and under what circumstances) are strictly controlled, and at the AIHW such work is done only with the approval of a fully constituted Ethics Committee and under the protection of the *Australian Institute of Health and Welfare Act 1987*. When conducted

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[1] Under the recent restructuring of the national health information infrastructure, the functions previously fulfilled by the NHIMG are now the responsibility of a similarly constituted group, the Statistical Information Committee, and of the Health Data Standards Committee.

within appropriate ethical, privacy and legislative protection, statistical linkage can yield valuable information to contribute to policy development and review work, and inform public debate.

It is important to re-emphasise that the kinds of data generated in this way are analysed and used only at the aggregate and not the individual level—they contain a degree of inaccuracy that does not allow the linked information to be reliably used at an individual level. In addition, technical, legal and ethical constraints are employed to protect any identifiable aspects of administrative data records.

Multi-source data

While direct statistical linkage has its role to play in informing policy issues which cross program boundaries or are more appropriately analysed from a whole-of-government perspective, there is also a great deal to be gained from other more broadly based strategies. The integration of statistical data, where information derived from a variety of sources is analysed and then drawn together to construct a more broadly based description than would be possible from any one data set, is a valuable and often highly practical alternative. While there is no linked national data base concerning older people who move from hospital to residential aged care, it is still possible to analyse discharges from hospitals and admissions to residential aged care, looking at patterns of supply, service use and client profiles, and examining changes over time and across regions, in order to gain an insight into what is happening at the boundary between the two services.

This integrated analysis of available data from different data sets, whether across programs (e.g. attempting to relate the data for persons on the Disability Support Pension to that for those receiving services under programs funded through the CSTDA) or between administrative by-product data and national survey data (e.g. the ABS Survey of Disability, Ageing and Carers and the CSTDA NMDS), is, of course, made substantially easier if standard, or at least relatable, definitions and data elements are in use in the various collections under scrutiny.

Standardisation of data items and data definitions is a key building block in improving the national capacity for both statistical data linkage and data integration, in order to provide the more holistic evidence which is increasingly likely to be required to adequately inform both public debate and policy development and review.

The following chapters demonstrate the AIHW's active pursuit of these strategies, with a view to better inform, assist and guide government and the community on the effects of current and future welfare policies and programs; and the welfare needs of Australians.

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2 Indicators of Australia’s welfare

2.1 Introduction

This chapter provides broad summary indicators of the welfare of Australia’s population. This information gives a context for the following chapters that focus on specific aspects of welfare service provision. The chapter advances initial work presented in *Australia’s Welfare 2001*, and will be a regular feature of the biennial report.

The chapter first introduces the conceptual framework for the indicators, then proceeds to describe its elements in turn and to present relevant, succinct data in each area of the framework. The focus is on assembling indicators and data from authoritative Australian literature and statistical publications.

Conceptual framework

An overall conceptual framework for welfare information is depicted in Figure 2.1. ‘Welfare’ is placed at the top of the diagram and may be considered as a concept, a goal, or a vision of individual and societal wellbeing. In practice, it proves hard to define in specific and universally agreed terms. In certain contexts or policy areas, it may nevertheless be quite feasible to agree on definitions and operational goals. The three boxes in the diagram represent more concrete and measurable aspects of welfare and the ‘welfare system’ in human society (see also AIHW 2001a:371–84).

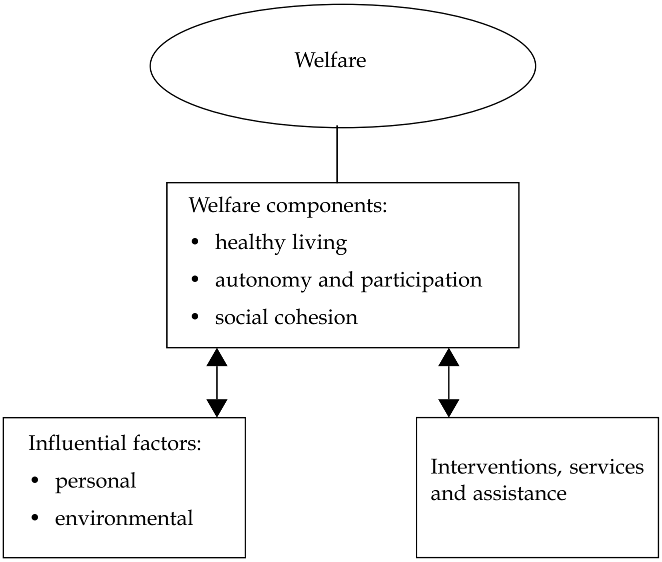

Figure 2.1: Conceptual framework for welfare information

The ‘welfare components’ reflect the welfare of Australian society and in particular, in the context of this chapter, the measurable aspects of welfare status. The ‘interventions’ represent the whole system of formal services, financial assistance and unpaid assistance that contributes to human welfare. The ‘influential factors’ encapsulate features of the physical and social environment, or of individual people, that are considered to have important additional influences on wellbeing (AIHW 2001a:382).

This chapter focuses principally on the welfare components and measures of their status, so as to provide contextual information for the other chapters in this volume that focus on some of the ‘interventions’ or responses of the Australian system. The three main components of welfare, as it is defined here, are: healthy living; autonomy and participation; and social cohesion. Figure 2.2 sets out 13 indicator topics that relate to these major components. The welfare components and related topics are specified on the basis that they are generally accepted to be crucial to human welfare and also might feasibly be the subject of data definition and collection.

These frameworks (Figures 2.1 and 2.2) were developed in *Australia’s Welfare 2001*, based on a review of national and international frameworks and indicator sets (see AIHW 2001a, 2003a). While different models and frameworks for measuring human welfare rely ultimately on elements of judgment, they frequently contain common themes and elements. The frameworks presented here were derived to capture this common agreement, to underpin the development of a set of practical and relevant statistical indicators.

The welfare components in the figures are thus the embodiments of the welfare concept and reflect what is considered purposeful and possible to attempt to measure, within the context of this report:

- ‘Healthy living’ is a major component of welfare because, at the most basic level, health and the sustenance of life itself are prerequisites for many other aspects of welfare. Basic needs, such as food, water, shelter and safety from harm, are essential ingredients in the maintenance of life and health.
- ‘Autonomy and participation’ reflect the fact that people value the freedom and capability to act as autonomous beings, and also to participate in society. Acquiring education and knowledge is fundamental to achieving autonomy and the capacity to contribute to the wider society. Participation in the workforce is the chief means of acquiring economic resources, which are facilitators of autonomy and the medium for acquiring the necessities and many pleasures of life. Transport and communication are key enablers and indicators of participation. Recreation and leisure are recognised as key contributors to human wellbeing; this area, like the others, involves a duality of autonomous choices and social participation.
- ‘Social cohesion’ represents a third main area of human welfare. A cohesive society is one that promotes wellbeing, via a large range of mutually supportive interactions, at the individual, group and social level. This is a relatively new area for statistical measurement but one whose importance is increasingly recognised.

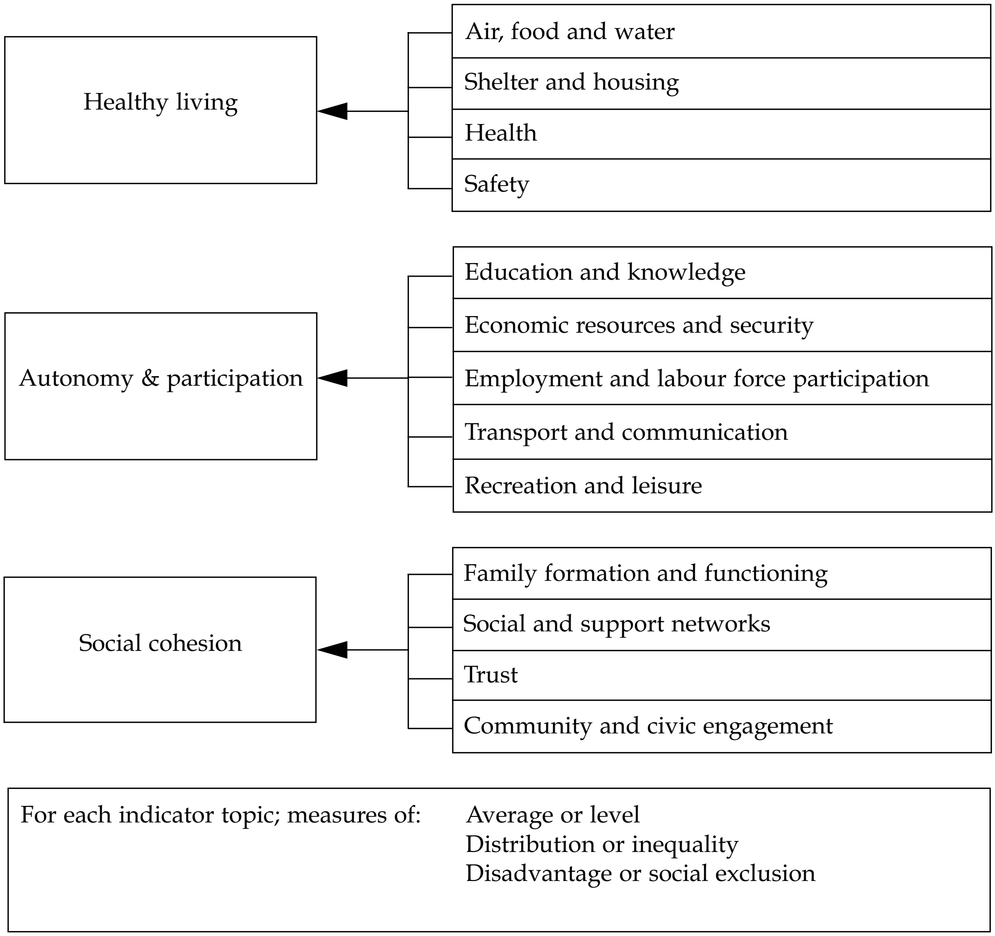

Figure 2.2: Welfare components and related indicator topics and measures

The first component relates to basic needs and organic integrity. The second component relates to self-realisation and social belonging, as experienced by the individual. Third is the health and wellbeing of the social environment, in terms of the supports and interconnections as they affect people (AIHW 2001a; Allardt 1975).

The framework in Figure 2.2 depicts the interconnected, valued components of human welfare and needs that can be measured statistically. It does not assert a theoretical model of cause and effect, nor does it explicitly recognise the interconnectedness of many aspects of social advantage and disadvantage (for instance, education, income, health). While particular studies may seek to explore relations among the various elements (and name some as 'cause' and some as 'effect'), Figure 2.2 simply illustrates the nature and scope of a field of measurement. The predecessor of the figure (in AIHW 2001a) did not relate each indicator topic to just one major component, but left the interconnections non-specific, recognising that many of the indicator topics relate to more than one of the three components; for example, recreation and leisure contribute to healthy living and may also contribute to social cohesion. The mapping used here is considered potentially more useful, as it may later enable summary statements to be made about the three components as well as the individual topics.

Constructing measures of the welfare components

The 13 indicator topics define the broad *subject areas* on which the indicators in this chapter focus, and three broad types of measures are suggested (Figure 2.2):

- measures of average or level (for instance, average incomes);
- measures of distribution or inequality (for instance, income distribution across age groups, population groups, or geographic regions); and
- measures of disadvantage or social exclusion (for instance, poverty and indicators of income-related disadvantage).

Combining these measurement concepts with the indicator topics in the figure synthesises the key ideas from the national and international literature, providing an overall framework for the content and the form of welfare indicators.

Indicators may be reported in many ways, including reporting against defined standards or agreed benchmarks. In contrast, the approach used for this chapter generally lends itself to more relative analyses—over time, or among different population groups.

Choice of indicators

Checklists of the desirable qualities of indicators, and caveats on their use, are common adjuncts to sets of statistical indicators. A list of criteria relevant to the indicators of welfare presented in this chapter is given in Table 2.1. While these criteria may not be met for every indicator, they provide guidance in selecting indicators and in understanding any limitations in interpretation.

Table 2.1: Criteria for indicators of welfare

Criterion	Definition
Valid	The indicator measures the phenomenon it claims to measure—it relates closely to the phenomenon or to an essential aspect/element of the phenomenon.
Relevant	Reflecting important social issues.
Applicable across population groups	The indicator is meaningful for the general population and for the sub-population groups to which the topic is relevant.
Reliable	The indicator is not likely to be influenced by variation in definitions or data collection methods in such a way that comparability over time or between sub-populations is compromised.
Sensitive	When there is a significant change in the phenomenon of interest this will be reflected in a significant change in the indicator.
Robust	A change in the indicator can be clearly interpreted to reflect a corresponding change in the phenomenon; the indicator is not liable to unpredictable or inexplicable fluctuations.
Readily understood	The meaning and intent of the indicator is clear; accompanied by appropriate explanation/guidance, it can be readily understood by a general audience.
Supported by data that are currently available and/or feasible to collect	Consistent time series data are available, or could feasibly be collected to support the indicator, such that the data can reasonably be compared over time to show trends in the phenomenon.

A pragmatic guide to the choice of indicators and specific data has been the availability of authoritative national data, suggesting relevance and reliability. Where such data are not available, the gap is noted.

Chapter outline

This chapter:

- defines indicators within each indicator topic;
- presents the most relevant available data for each indicator, including reference to relevant data elsewhere in this report;
- presents data on distribution across population groups, particularly as defined on the basis of age, sex and Indigenous status; and
- presents some measures of disadvantage or social exclusion.

There are few data on trends in this current report chapter. The material presented here represents a work in progress—it builds on the conceptual work presented in *Australia's Welfare 2001*, and provides a set of indicators that can be used for trend analysis in subsequent editions of this publication.

2.2 Healthy living

This first component of welfare is focused around the basic needs for shelter, food and water, a clean environment, and safety from harm, which are all fundamental to human health.

Overall, the health of the Australian population is good. Based on key indicators such as life expectancy, Australia compares very well internationally. Australians have seen substantial improvements in many aspects of health, over the past century and in more recent time frames.

As a population, our health is supported by generally high levels of nutrition, ready access to good quality water, and low levels of air pollution. Most Australians are adequately housed and the majority of us feel relatively safe in our communities. However, while the overall picture is positive, there are areas of concern. For instance, rates of obesity are high and rising, and many people consume less than the recommended amounts of fresh fruit and vegetables.

Certain population groups experience disadvantage across multiple areas. In particular, compared with other Australians, Indigenous Australians have much poorer health, higher rates of injury-related deaths, are less likely to own their own home and more likely to be homeless. Similar constellations of disadvantage are experienced by Australians of low socioeconomic status.

This section paints a picture of healthy living in Australia, showing its distribution among some key population groups, and where there are pockets of disadvantage.

Air, water and food

Air, water and food are an integral part of the 'healthy living' component of welfare. Ready access to nutritious and safe supplies of food and potable water is one of the basic requirements of human life, and, along with air quality, is fundamental to the current and future health of the individual. The indicators presented below—urban air quality, access to potable and palatable water, reported usual daily intake of fruit and vegetables (an indicator of food and nutrient intake), and prevalence of obesity (nutritional status)—represent key issues in the monitoring of air and water quality, and nutrition, in Australia.

Urban air quality

Australian cities generally have better air quality than most other cities worldwide (Manins et al. 2001). Nonetheless, some urban areas are susceptible to potentially dangerous levels of air pollutants, which can have serious impacts on population health and mortality (EPAV 2000; Lewis et al. 1998; Morgan 2000; Simpson et al. 1997, 2000).

Two air pollutants particularly harmful to human health are particles (as PM10) and ozone. Particles emanate directly from motor vehicle emissions and domestic fuel use. Ozone is a secondary pollutant, formed in part by emissions from motor vehicles, domestic and commercial heating, and industrial activities. Particles (as PM10) and ozone are measured in terms of the number of days per year when the average concentration exceeds the Air NEPM (National Environment Protection Measure) standard level (NEPC 1998).

Table 2.2: Number of days per year when concentrations of PM10 and ozone exceeded the Air NEPM standard level in selected cities, 1990–99

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Number of days when concentration of PM10 exceeded 50 µg/m^3 (over 24 hours)[(a)]										
Sydney	1	12	5	3	12	6	2	2	1	1
Melbourne	n.a.	n.a.	n.a.	5	2	1	1	1	5	1
Brisbane	3	6	1	6	16	1	6	1	1	1
Perth	n.a.	n.a.	n.a.	n.a.	7	3	1	1	3	1
Adelaide	5	6	4	5	6	3	1	1	6	6
Number of days when concentration of ozone exceeded 0.10 ppm (over one hour)[(b)]										
Sydney	5	4	7	8	13	0	1	14	13	n.a.
Melbourne	7	2	1	8	3	2	1	6	1	1
Brisbane	0	2	1	1	1	1	5	3	1	1
Perth	0	2	2	2	2	0	4	2	2	2
Adelaide	0	0	0	0	0	0	0	0	0	0

(a) The maximum allowable is 5 days per year, to be achieved by 2008.

(b) The maximum allowable is 1 day per year, to be achieved by 2008.

Source: Manins et al. 2001.

The annual number of days in which the concentration of particles as PM10 exceeded the NEPM standard level of 50 µg/m^3 fluctuated over the period 1990–99, with most major capital cities reporting a downward trend towards the end of the decade (Table 2.2). The one exception was Adelaide, although the 1998 and 1999 results were most likely the result of anomalous increased fuel burns, possibly from bushfire activity. All major capital cities experienced at least one year when PM10 concentrations of greater than 50 µg/m^3 were recorded on 5 or more days.

Ozone concentrations exceeding 0.10ppm per hour were much more frequent in Sydney between 1990–99 than in any of the other major capital cities. No obvious trend of increase or decrease in ozone pollution occurred for Sydney or Melbourne during this period.

Access to potable water

Water is a critical resource in a country as dry and climatically variable as Australia. While immense amounts of water are used for agriculture and industry, the concentration of Australia's population in cities and towns also demands large supplies of potable water. In rural and remote areas, where water is more scarce and its quality more variable, the issue is at least as important. Access to potable water, or water 'safe to use and aesthetically pleasing…with no unpalatable taste or odour…and no suspended matter, harmful chemical substances or pathogenic micro-organisms' (NHMRC & ARMCANZ 1996) is therefore an important issue in Australia.

A survey of water supply to Indigenous communities in 1999 found that water in 58 of the 169 communities tested, with a combined population of 25,322 people, failed water quality testing in the 12 months prior to the survey (ABS 2000a).

No national data, however, are currently available on actual access to potable water.[1]

Reported usual daily intake of fruit and vegetables

Fruit and vegetable consumption is a key indicator of a healthy diet. Recent evidence has suggested that regular intake provides significant protection from cardiovascular diseases, Type 2 diabetes, some cancers, and eye diseases such as cataract and macular degeneration (see Dreosti 2003 for a review). Furthermore, the consumption of less than five serves of fruit and vegetables a day was estimated to contribute to 2.7% of the total disease burden in Australia in 1996 (AIHW: Mathers et al. 1999). Intake for the average Australian, however, is still generally not substantial enough to maintain optimal health (SIGNAL 2001). To optimise the nutritional health of Australians, it has been recommended that Australians consume two serves of fruit and five serves of vegetables daily. These recommendations were recently endorsed in the updated *Dietary Guidelines for Australian Adults* (NHMRC 2003) and are included as indicators of 'Health behaviour' in the National Health Performance Committee framework (NHPC 2002).

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[1] *Measuring Australia's Progress* assesses water quality in Australia in terms of water management practices (i.e. proportion of water used exceeding 70% of sustainable limits), rather than fitness for human consumption (ABS 2002a).

Table 2.3: Reported usual daily intake of fruit and vegetables, by age, 2001 (per cent)

	Self-reported usual daily intake					
	2 or more serves of fruit a day			4–5 or more serves of vegetables a day		
Age group	**Males**	**Females**	**Persons**	**Males**	**Females**	**Persons**
12–14	56.7	54.8	55.7	22.2	24.2	23.2
15–24	42.1	50.6	46.2	21.1	23.2	22.2
25–34	40.0	50.6	45.3	21.8	27.6	24.8
35–44	43.1	53.3	48.3	24.7	33.3	29.0
45–54	46.6	60.8	53.8	29.6	36.8	33.2
55–64	53.1	70.7	61.8	32.0	42.7	37.3
65–74	60.4	69.1	64.9	34.5	40.0	36.8
75+	83.1	68.4	65.7	36.1	38.6	37.6
Total	**47.1**	**58.1**	**52.7**	**26.4**	**32.8**	**29.7**

Source: ABS 2002b.

Overall, 53% of people aged 12 years and over reported in 2001 eating at least two serves of fruit a day (Table 2.3). More females met the recommended daily intake than males, although males aged 12–14 and, in particular, 75+ years were more likely than females of the same age to eat at least two serves of fruit. Usual daily fruit intake generally increased with age, but proportionally more teenagers under 14 years than people aged 15–54 years ate two or more serves of fruit.

Around 30% of Australians aged 12 years and over reported their usual daily intake of vegetables as being four to five or more serves.[2] As age rose, so too did the proportion of the population who reported usually consuming the recommended daily intake, from around 22% for those aged 15–24, increasing to more than 33% in the over-45s. Females, on the whole and for each age group, were more likely than males to report a usual daily intake of at least four to five serves of vegetables.

Prevalence of obesity

Healthy weight is recognised as a key health indicator, prompted by the rapid rise in the prevalence of overweight and obesity among Australians, and the general epidemic occurring in most developed countries (AIHW 2001b, 2002; WHO 2000). Obesity ranks alongside smoking as the most important preventable cause of ill-health in Australia and is associated with poor psychosocial functioning and mental wellbeing (SIGNAL 2001; Karlsson et al. 2003). While a range of causes, including inherited characteristics, psychological factors, and lifestyle, contributes to a person becoming overweight or obese, healthy eating is seen as playing an important role in its prevention and management. Obesity is, then, an indicator of 'disadvantage' when considering nutritional status.

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[2] Data in the National Health Survey are presented as four to five serves and cannot be broken down further.

Table 2.4: Rates of obesity in Australian adults,[a][b] by sex and age, 2001 (per cent)

	Age group							
	18–24	25–34	35–44	45–54	55–64	65–74	74+	Total
Males	8.0	12.0	17.9	18.9	17.8	14.6	8.9	14.7
Females	7.1	13.5	9.3	19.0	21.8	20.1	10.5	15.4
Persons	**7.6**	**12.8**	**16.1**	**19.0**	**19.7**	**17.4**	**9.9**	**15.1**

(a) Data based on BMI (body mass index) derived from self-reported height and weight measurements. BMI is calculated as Weight (kg)/Height^2(m). Obesity is measured as >30 BMI according to NHMRC recommendations.

(b) Data are age-standardised against Australian population estimates as at 2001.

Source: ABS 2002b.

In 2001, the prevalence of obesity among Australians aged 18 years and over was 15% (Table 2.4) and ranged from 8% in 18–24 year olds to 20% in 55–64 year olds.[3] Males and females generally had similar prevalence rates, but there was some variation in specific age groups. For example, men aged 35–44 years had a higher prevalence rate of obesity (18%) than females in the same age group (9%), while in the 65–74 age group females had a higher rate (20%) than males (15%). Obesity rates higher than the national average were found among men aged 35–64 years and women aged between 45–74 years. Obesity is also becoming a considerable problem for Australia's children. In 1985, its prevalence among 7–15 year olds was 1.4% for boys and 1.2% for girls; by 1995, this had risen to 4.7% of boys and 5.5% of girls (Magarey et al. 2001).[4]

Shelter and housing

Shelter is recognised as a basic human need. Housing satisfies people's need not only for shelter but also for security and privacy. Homes can be places where people build and maintain relationships with friends and family, and pursue recreational activities. Having a fixed place of residence also provides an important base for engaging in more formal interactions, such as getting a job, joining a club, or accessing certain government benefits (ABS 2001a). Housing is also an important determinant of health (see Section 5.2).

Here housing tenure, housing affordability, and homelessness are used as indicators of some key aspects of the housing circumstances of Australians. However, it should be noted that housing adequacy (quality, condition and size of dwelling) and accessibility are also of great importance from a welfare perspective. Poor quality and condition of dwellings and inadequate supply of housing are particularly significant issues in some Indigenous communities (ABS 2000b).

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[3] These data are based on self-reported height and weight measurements and are therefore potentially underestimates of the level of obesity. Previous assessment of this methodology against estimates based on actual measurements indicated that people tend to overestimate their height and underestimate their weight (ABS 1997).

[4] Data for the 1985 and 1995 prevalence estimates came from the 1985 Australian Health and Fitness Survey and National Nutrition Survey, respectively. (See Magarey et al. 2001 for methodology.)

Table 2.5: Tenure type and composition of households, 2000–01

	Owner without a mortgage	Owner with a mortgage	Public renter[a]	Private renter	Total[b]
Number ('000)	2,797	2,351	363	1,536	7,315
Per cent	38.2	32.1	5.0	21.0	100.0
	Household composition—per cent of each tenure type				
Couple only	34.5	20.9	9.3	15.5	24.3
Couple with dependent children only	12.5	41.5	11.2	17.1	22.8
Other couple, one family households	15.0	12.6	*5.4	5.2	11.3
One parent with dependent children	2.7	6.1	23.7	14.3	7.4
Other family households	5.8	4.0	8.8	6.6	5.5
Lone person	28.4	12.1	39.6	30.3	24.6
Group households	1.2	2.8	*2.1	11.0	4.0
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Renting from a state or territory housing authority.

(b) Includes other renters and other tenure type.

Source: ABS 2003a.

Housing tenure

Home ownership is an aspiration for many Australians, and is a policy goal that has long been pursued by Australian governments. Australia has high levels of home ownership by international standards (ABS 2001b).

In 2000–01, 70% of households owned their home, with (32%) or without (38%) a mortgage (Table 2.5). Couple only and lone person households accounted for 35% and 28%, respectively, of households that owned their home outright. Couples with dependent children accounted for 42% of households with a mortgage. Lone person households were the dominant group in both public renter (40%) and private renter (30%) households.

These differences partly reflect age effects—for instance, a large proportion of couple only households are likely to be older couples, and home ownership rates increase with age. Lone persons owning a home are often older people whose partners have died.

Data from the 2001 Census show that, compared with non-Indigenous households, a much smaller proportion of Indigenous households owned or were buying their home (32%, compared with 71% for non-Indigenous households), and a much larger proportion were renting (61%, compared with 25%) (see Table 5.2). A similar pattern was found for people with disabilities in 1998. Only 35% of people with disabilities owned or were buying a house (see Table 5.5 in AIHW 1999), while 53% were renting. Around 39% of all people with disabilities were living in public housing in 1998.

Security of tenure is one of the main benefits of home ownership. Other tenure types, such as good private rental arrangements and social housing, can also provide households with security of tenure and a sense of physical and psychological security (see Section 5.2 for definition of terms and further discussion). Many Indigenous people living in remote communities share land ownership and live in properties administered by Indigenous housing organisations; such arrangements can provide security of tenure and other benefits associated with home ownership (ABS 2003b).

Housing affordability

Affordability measures housing costs relative to a household's ability to meet those costs. While there is no single agreed measure of housing affordability, it is generally accepted that affordability measures should use cut-off points to identify 'low income households', and only low-income households should be considered at risk of having unaffordable housing (AIHW: Karmel 1998). Here we present data for a commonly used measure of housing affordability—households in the lowest two income quintiles that spend more than 30% of their income on housing costs (Affordable Housing National Research Consortium 2001). Data on households in these quintiles that spend more than 50% of their income on housing costs provide an indication of more severe affordability problems.

Based on these measures, in 1999, 10% of all households were experiencing housing affordability problems, and 4% were experiencing severe housing affordability problems (Table 2.6). Private renter households were most likely to have affordability problems—28% had affordability problems and 10% had severe affordability problems.

Real housing costs in Australia increased by 17 per cent over the period 1988 to 1999. More detailed information on affordability and housing costs is provided in Section 5.2.

Table 2.6: Households in the two lowest gross weekly income quintiles: households that spent more than 30% and more than 50% of their gross income on housing costs,(a) by tenure type, 1999

	More than 30%		More than 50%	
Tenure type	**Number ('000)**	**Per cent(b)**	**Number ('000)**	**Per cent(b)**
Owner without a mortgage	102.9	3.7	45.5	1.6
Owner with a mortgage	183.7	8.1	80.1	3.6
Renter—State/Territory housing authority(c)	28.3	7.7	*6.0	1.6
Renter—private landlord	404.9	27.7	152.5	10.4
All tenure types(d)	**742.8**	**10.3**	**289.8**	**4.0**

(a) Housing costs include secured/unsecured mortgage or loan repayments (principal and interest) where the purpose of the loan is to buy or build, add to or alter the dwelling; rental payments; water and general council rates; land tax rates; body corporate or strata title payments; and expenditure on repairs and maintenance for the dwelling.

(b) Per cent of all households.

(c) These ABS data for public renter households differ from administrative data. Administrative data show that 99% of rebated public renter households were paying 25% or less of their assessable income in housing costs in 2001. It is policy in most jurisdictions that rebated public renter households should not pay over 25% of their assessable income in housing costs—see Section 5.3.

(d) Includes other renters.

Source: ABS 2000c:34.

Table 2.7: The whereabouts of homeless people on Census night 1996

	Number	Per cent
Boarding house	23,299	22
SAAP accommodation[(a)]	12,926	12
Friends/relatives	48,500	46
No conventional accommodation[(b)]	20,579	20
Total number	**105,300**	**100**

(a) Provided under the Supported Accommodation Assistance Program.

(b) Includes improvised dwellings and sleepers out.

Source: Chamberlain 1999.

Homelessness

The rate of homelessness within a society can be viewed as an indicator of housing deprivation. Inadequate supply of affordable housing is one important cause of homelessness. People's reasons for being homeless can also include domestic violence, relationship or family breakdown, substance abuse, and discrimination (AIHW 2001a). Therefore, homelessness may also be viewed as an indicator of poor social cohesion.

Defining homelessness and counting homeless people is challenging. Concepts of homelessness used in Australia tend to be based on western cultural constructs, and may not be appropriate to certain groups within Australian society (e.g. Indigenous people—see Chapter 9, and Commonwealth Advisory Committee on Homelessness 2001).

Across Australia, an estimated 105,300 people were homeless on Census night 1996 (Table 2.7). Of these, nearly half were staying with friends or relatives. Between 60% and 70% reported that they had been homeless for 6 months or more.

It is important to recognise that there is a temporal dimension to homelessness, with experiences ranging from brief, one-off episodes to long-term transience. Therefore, point-in-time estimates cannot fully capture the extent of homelessness.

Health

The World Health Organization defines health very broadly, as 'a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity' (WHO 1946). Here we take a somewhat narrower view of health, as one subcomponent of welfare, acknowledging the important links between health and other aspects of welfare. Health can affect participation in many aspects of life, such as education, employment and recreation. Mental health, in particular, may have major impacts on a person's social and support networks, and relationships with family and friends (see, for example, Goldberg et al. 2003).

In this section we present indicators of health status. Several of these are consistent with indicators reported for the 'health status and outcomes' tier of the National Health Performance Framework (NHPC 2002). The other two tiers in that framework are 'determinants of health' and 'health system performance'. Some indicators of important determinants of health are presented in other sections of this chapter—notably obesity (in 'Air, water and food', above) and participation in physical activity (see 'Recreation and leisure' in Section 2.3)—and data on injury mortality are discussed under 'Safety', below.

Life expectancy

Life expectancy is the average number of additional years a person of a given age and sex might expect to live if the age-specific death rates of the given period continued throughout his/her remaining lifetime. It is one of the most common and well-established measures of health.

Life expectancies at birth in Australia are among the highest in the world and have increased significantly over the past 100 years, by almost 30 years for males and 23 years for females (AIHW 2002; OECD 2001a). The main contributors to this increase have been better nutrition and living conditions, widespread immunisation and improved medical treatment, and, more recently, an understanding of the effects of lifestyle and socioeconomic factors on health (AIHW 2000:340).

Females have higher life expectancies than males, at birth and at age 65 (Table 2.8); this is so for both the Indigenous population and the total population. The Indigenous population has substantially lower life expectancy than the total Australian population. This difference is related to much higher death rates, for both males and females, across all age groups (ABS & AIHW 2003:185*)*.

Life expectancy also varies with socioeconomic status—people in more disadvantaged groups tend to have shorter life expectancies. Compared with life expectancies for people in the lowest quintile, life expectancy at birth is nearly 4 years longer for males in the highest quintile, and 2 years longer for females (Table 2.9).

Table 2.8: Life expectancy, by Indigenous status, 1999–2001 (years)

	Life expectancy at birth		Life expectancy at age 65	
	Males	**Females**	**Males**	**Females**
Indigenous Australians[(a)]	56.3	62.8	8.0	9.9
All Australians	77.0	82.4	17.2	20.7

(a) Data on life expectancy for Indigenous Australians are based on experimental life tables that include large adjustments for under-coverage of Indigenous deaths and exclude data for Tasmania and the Australian Capital Territory. These figures have a high level of uncertainty associated with them and should therefore be treated with caution.

Source: ABS 2002c:36, 88.

Table 2.9: Life expectancy at birth, by quintile of socioeconomic disadvantage,[(a)] 1995–97 (years)

	Quintile of socioeconomic disadvantage				
	Lowest	**Second**	**Third**	**Fourth**	**Highest**
Males	74.1	75.2	75.3	76.0	77.8
Females	80.5	81.2	81.2	81.5	82.4

(a) The measure of socioeconomic status used here—the Index of Relative Socioeconomic Disadvantage—categorises Statistical Local Areas based on a range of attributes including levels of income, educational attainment, and unemployment. People are classified according to the average socioeconomic disadvantage of their area of usual residence.

Source: AIHW: Mathers et al. 1999:39.

Table 2.10: Average infant mortality, by Indigenous status, 1999–2001

	Total deaths	Rate per 1,000 live births
Indigenous Australians	296	14.2
Other Australians	1,236	4.8

Notes: This total excludes 27 infants for whom Indigenous status was unknown or missing. Numbers include total deaths for the 3-year period.

Source: AIHW Mortality Database.

Infant mortality

Infant mortality is the number of deaths of children under 1 year of age in a calendar year per 1,000 live births in the same calendar year.

Overall, infant mortality in Australia has declined significantly during the 20th century, from 103 infant deaths per 1,000 live births in 1900, to 5.3 per 1,000 in 2001 (5.9 for males, 4.6 for females) (ABS 2002c:27, 36). However, Australia's infant mortality rate is relatively high compared with other industrialised countries, ranking nineteenth among OECD countries in 1999—Iceland had the lowest rate, with 2.4 infant deaths per 1,000 live births (OECD 2001a:17).

High death rates among Aboriginal and Torres Strait Islander infants contribute to Australia's relatively high overall infant mortality rate. For the period 1999–2001, the average rate for Indigenous infants was three times the rate for other Australian infants (14.2 infant deaths per 1,000 live births, compared with 4.8 for other Australians) (Table 2.10).

Years of life lived with disability

Indicators of functioning and disability are now widely recognised as a key component of national health status measurement (AIHW 2001a:391–2; NHPC 2002:18). Years of life lived with disability provides an estimate of the average number of years, at birth, that a person can expect to spend with different levels of disability.

Table 2.11: Expected years of life with disability and with severe core activity limitation, 1998

	Males		Females	
	Number of years	% of total life expectancy	Number of years	% of total life expectancy
Expected years of life:				
With disability (all severity levels)[(a)]	18.4	24	18.2	22
With severe core activity limitation[(b)]	5.2	7	7.6	9
Free of disability	57.5	76	63.3	78
Total life expectancy at birth (1998)	**75.9**	**100**	**81.5**	**100**

(a) Disability is defined as the presence of one or more of 17 limitations, restrictions or impairments that had lasted, or were likely to last, for at least 6 months, and which restricted everyday activities (see also Chapter 8).

(b) Severe or profound core activity limitation is a subset of all disability and is defined as sometimes or always needing personal assistance or supervision with a core activity (self-care, mobility or verbal communication).

Source: AIHW: de Looper & Bhatia 2001:21.

Based on 1998 data, both women and men in Australia can expect, on average, to experience 18 years lived with disability—that is, 22% of total life expectancy for women and 24% for men (Table 2.11). Of those 18 years, the expected years of life lived with severe or profound core activity limitation was eight for women (9% of total life expectancy) and five for men (7% of total life expectancy) (see Table 2.11 footnotes for definitions).

Mental health

Mental health is one of the seven National Health Priority Areas—areas known to contribute significantly to the burden of disease in Australia and identified for special policy focus. While mental disorders are not a major direct cause of death, they are an important cause of long-term disability (AIHW: Mathers et al. 1999). Mental health disorders can affect a person's ability to carry out their usual activities and responsibilities at home and at work (Andrews et al. 1999), and can be associated with episodes of homelessness (see Chapter 9). Drug and alcohol disorders commonly coexist with other mental disorders.

The indicator presented here is based on self-reported psychological distress. The data were collected in the 2001 National Health Survey using the Kessler 10 Scale (K10), which asked survey respondents about negative emotional states (particularly related to anxiety and depression) experienced during the 4 weeks prior to the survey (ABS 2002b, 2003c).

In 2001, an estimated 508,700 people, or 3.6% of the adult population, experienced 'very high' levels of psychological distress—2.7% of men and 4.4% of women (Table 2.12). A very high level of psychological distress, as measured using the K10, may indicate a need for professional help. The highest rates for females were recorded in the 18–24 and 45–54 age groups, and for males in the 45–64 age group. Other survey data have also shown that a variety of mental health problems are relatively common among children and adolescents (Sawyer et al. 2000).

The overall prevalence of very high level psychological distress of 3.6% in 2001 was an increase from 2.2% in 1997 (1.9% for males and 2.4% for females). A range of factors may have contributed to this rise, including increased prevalence of psychological distress, changes in survey methods, heightened awareness of the symptoms of psychological distress, and/or improved identification and treatment of associated conditions.

Table 2.12: Number and proportion of the adult population reporting very high levels of psychological distress, by age and sex, 2001

	Males		Females		Persons	
Age	Number ('000)	Per cent	Number ('000)	Per cent	Number ('000)	Per cent
18–24	24.9	2.7	46.9	5.4	71.7	4.0
25–34	29.2	2.1	65.2	4.6	94.4	3.4
35–44	35.5	2.5	62.5	4.2	98.0	3.4
45–54	47.7	3.7	73.1	5.5	120.8	4.6
55–64	32.3	3.6	31.9	3.6	64.2	3.6
65–74	*12.0	*1.9	22.7	3.4	34.7	2.7
75 and over	*7.5	*1.9	17.3	3.0	24.8	2.5
All ages	**189.1**	**2.7**	**319.5**	**4.4**	**508.7**	**3.6**

Source: ABS 2002b.

Safety

Safety—actual and perceived—is an important aspect of individual and community wellbeing, affecting both physical and mental health. Safety indicators are frequently expressed in national and international indicator sets as 'negatives'—crime and injury, for instance—that is, effectively as statistics on system breakdown. The effects of these negative events are experienced not only by the victims of crime or of accidental injury, but also by those working to rescue and treat the victims, apprehend perpetrators of crime, or ameliorate the effects of traumatic injury. There are, accordingly, human, financial and economic costs to society. Less directly, individuals and society at large experience the effects in terms of perceptions of danger or, more positively, feelings of safety and security.

Feelings of safety

An estimated 80% of people in 2002 said that they felt safe or very safe at home alone during the day, and 69% felt this way after dark (ABS 2003d). Results varied with age, sex and location. Females were less likely to feel safe than were males, particularly after dark—61% of females felt safe or very safe at home alone after dark compared to 78% of males. People in capital cities felt less safe after dark (67% did so) than those in other areas (73%).

Crime

Data on crime vary with the source and process giving rise to the data. Household surveys provide a picture of cries as experienced by people and households and, for some crimes, present a more complete picture than do data on crimes reported to the police.

Of the 7,479,200 households in Australia in April 2002, it is estimated that, in the 12 months prior to the survey (ABS 2003d):

- 4.7% were victims of at least one break-in to their home, garage or shed;
- 3.4% found signs of at least one attempted break-in; and
- 1.8% had at least one motor vehicle stolen.

Of the 15,215,100 people aged 15 years and over in April 2002, it was estimated that, in the 12 months prior to the same survey:

- 4.7% were victims of at least one assault;
- 0.6% were victims of at least one robbery; and
- 0.2% of people aged 18 years and over were victims of at least one sexual assault.

Australian data on crimes reported to the police, and the victims thereof, are compiled annually by the ABS and are used here as an important indication of the effects of serious crime on people in Australia. However, not all crimes committed are reported to the police and, to the extent that this is so, police data understate the complete picture.

Table 2.13: Victims of crime,[a] by sex, age, and offence category,[b] 2002 (rate per 100,000 persons)

	Murder		Driving causing death		Assault		Sexual assault		Robbery	
Age	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females
0–9	1.0	0.3	0.2	np	144.1	93.6	86.7	194.0	4.4	0.5
10–14	np	np	0.6	0.5	714.9	479.7	90.1	461.7	126.8	19.4
15–19	2.4	0.6	3.4	1.5	1,793.0	1,330.3	64.1	499.1	526.6	120.7
20–24	3.2	2.0	4.0	0.9	1,934.8	1,418.1	30.7	209.6	336.9	119.9
25–34	2.7	2.3	1.3	0.6	1,651.4	1,160.8	19.6	124.0	153.3	65.3
35–44	2.8	1.6	1.1	0.3	1,064.9	764.9	13.9	65.0	82.3	49.2
45–54	1.9	1.2	1.0	0.5	655.4	400.9	4.9	27.5	61.6	42.0
55–64	1.3	1.0	0.3	np	352.7	169.3	2.8	11.1	39.6	34.4
65 and over	1.0	0.4	1.0	0.5	124.9	57.3	1.1	5.8	20.3	27.0
Total [c]	*2.0*	*1.2*	*1.3*	*0.5*	*929.4*	*640.7*	*33.1*	*144.5*	*124.8*	*49.1*
					Persons					
Persons, all ages[c]	1.6		1.0		809.7		90.6		88.9	
Total number[c]	318		204		159,548		17,850		17,517	

(a) Refers to individual person victims only and therefore does not include organisations as victims.

(b) The offence of manslaughter is not included due to small numbers.

(c) Includes victims for whom age and/or sex was not specified.

Source: ABS 2002d.

According to police records, assault was the crime affecting most individuals in 2002—159,548 people, or a rate of 809.7 victims per 100,000 population (Table 2.13). The age groups between 15 and 34 years were the most affected, for both males and females, but rates for males in all age groups were generally higher than for females. The male victim rate for murder (2.0 per 100,000) exceeded the female rate (1.2), and did so in every age group. Female victim rates exceeded male rates in the sexual assault category: 144.5 females per 100,000 were victims of sexual assault, compared to only 33.1 males per 100,000. As with crime generally, it was those in the younger age groups most affected; it is disturbing that the second highest rate for sexual assault was recorded for females in the 10–14 age range.

Comparison of the two data sources—crimes reported to the police and crime victimisation as reported in household surveys—provides an indication of the complexity of understanding crime data. Sexual assaults reported to the police may represent only a fraction of those actually occurring—perhaps 20% of 'most recent incidents' in 2002 (ABS 2002d). Assault victims reported 31% of incidents, while victims of property crime were much more likely to report it (95% for household victims of motor vehicle theft and 75% for household victims of break-in).

Trends in crime are not discussed in this publication (see ABS 2001c, 2003d, 2003e and AIC 2002).

Injury

'Injury and poisoning' is the leading cause of death for younger people—for males aged 1–44 years and females aged 1–24 years (AIHW 2002:36–7). Injury prevention is one of the National Health Priority Areas, in recognition of the significant personal costs of injury as well as the costs to the Australian health and economic system.

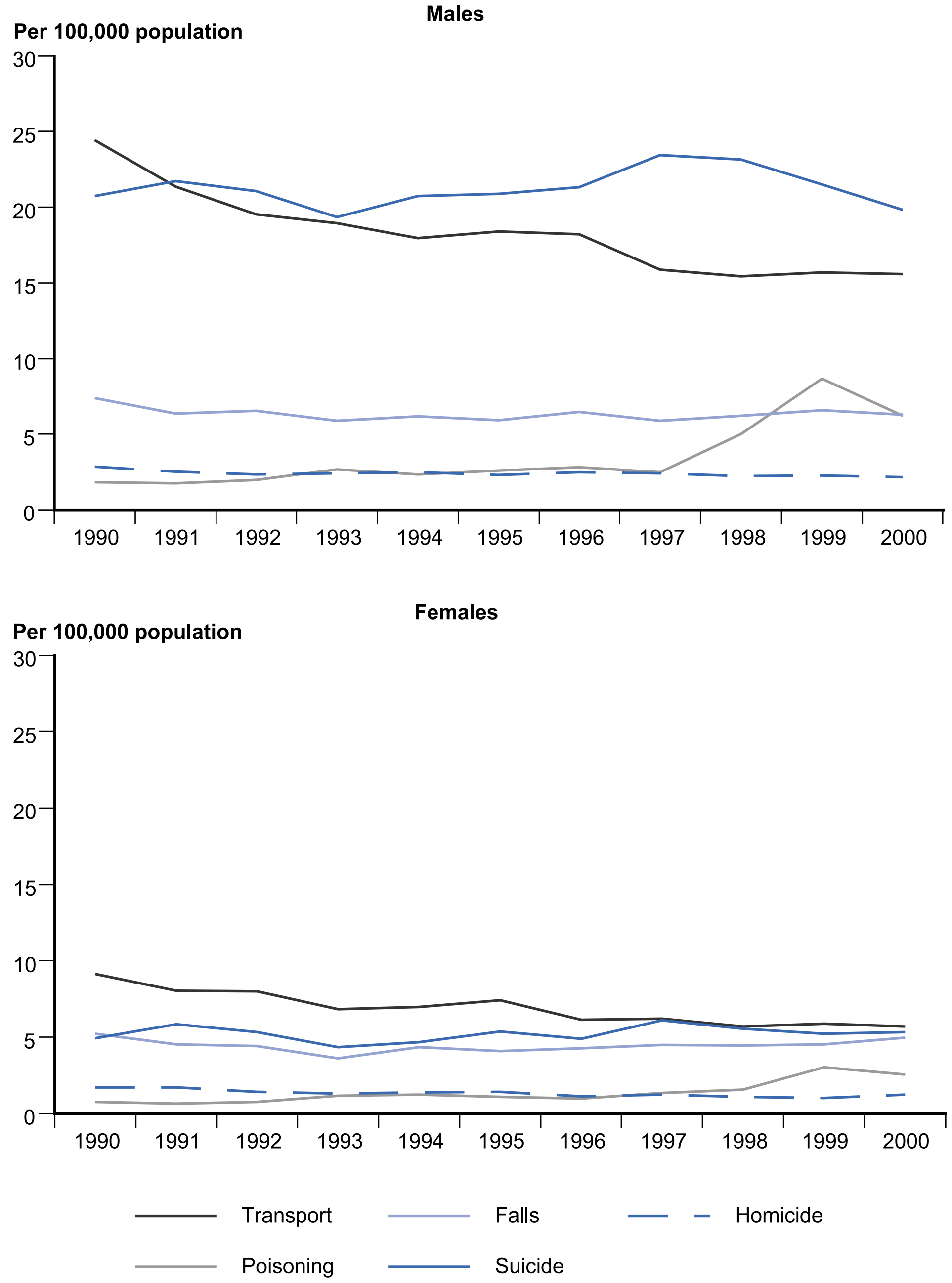
In 2000, there were 8,098 deaths in Australia attributed to injuries and poisoning, a rate of 42.3 per 100,000 population (see Table A2.1). Suicide and transport-related deaths were the most prevalent (12.4 and 10.5 per 100,000, respectively). Overall, the male death rate (58.0) was considerably higher than the female rate (26.8). Relatively high death rates were experienced by males in several categories: suicide (19.6, with higher rates in all age categories 20 years and over); falls among men aged 65 years and over (41.8); poisoning in men aged 20–44 years; and transport-related deaths (15.4, with very high rates in the 15–29 age group). In contrast, the only female categories with a death rate over 10 per 100,000 were transport-related deaths among 15–19 year olds (11.9) and falls among women aged 65 years and over (55.2 deaths).

Not only are there age and sex differentials in injury death rates, there are also socioeconomic differentials (AIHW 2002:187):

> Males in the lowest socioeconomic quintile died at 1.7 times the rate of males in the highest socioeconomic quintile in the period 1995–97…For females in the same socioeconomic groups the differences were less marked.

Injuries significantly affect the health and wellbeing of Indigenous Australians. Injuries (accidents, assaults and intentional self-harm) accounted for 15% of Indigenous deaths in 2000, compared with 6% in the overall population (AIHW 2002:230).

Injury death rates have been subject to considerable change over recent years (Figure 2.3). The steady decline in transport-related deaths between 1990 (16.7 deaths per 100,000) and 2000 (10.6 deaths per 100,000) is perhaps the most notable feature of these trends. Suicide rates for males in 2000 (19.8) exceeded transport-related death rates (15.6), although suicide rates for both males and females have declined from peaks in 1997. The female death rate due to falls has been rising since 1993, possibly reflecting the ageing of the female population. Death rates from poisoning appear to have risen in recent years for both males and females, but the changes between 1998 and 1999 need to be interpreted with some caution because of coding system changes noted in the table footnotes.



Source: Table A2.2.

Figure 2.3: Injury and poisoning deaths, by sex and type of injury, 1990–2000

2.3 Autonomy and participation

Autonomy—the opportunity to make and implement choices in life and to develop the capacities to do so—is fundamental to human wellbeing. A dual need is the need to belong to and participate in human society.

This section of the chapter presents information on important facilitators of autonomy and participation, such as education and knowledge, employment, transport and communication. Economic resources are a key indicator of autonomy and wellbeing in Australian society, indicating the resources available to people to acquire the basic necessities and to choose to spend on more discretionary goods and services. No picture of wellbeing can be complete without information on participation in recreation and leisure activities—activities that again reflect the duality of freedom to make autonomous choices and the sense of belonging fostered by participation.

Education and knowledge

Knowledge and education are vital ingredients in enhancing an individual's autonomy and empowerment, and in building society's collective capability. Education is a process that both involves and promotes participation. Successful education can equip an individual for enhanced participatory roles in society, including in employment, in social and cultural life, and in civic and democratic processes. The focus in this section is on education: levels of participation attainment and literacy in the overall population, and the achievement by school children of national standards in English literacy and numeracy.

Participation in education

Participation rate is a measure of the proportion of the population actively involved in education or training.

Of Australians aged 15–64 years, 20% were participating in education in 2001 (Table 2.14). Participation was highest for the 15–19 age group (76%) and lowest for the 55–64 age group (5%).

Table 2.14: Proportion of the population aged 15–64 participating in education (full-time or part-time), population subgroups by age, 2001 (per cent)

	Age groups						Total
	15–19	20–24	25–34	35–44	45–54	55–64	15–64
Indigenous Australians[(a)]	52.1	18.6	15.3	13.7	10.7	8.2	20.8
Language other than English spoken at home[(a)]	85.5	51.6	19.0	11.1	6.4	3.7	22.5
All Australians[(b)]	76.0	35.7	16.2	11.5	8.0	5.4	20.2

(a) A proportion of Indigenous people also indicated they spoke a language other than English at home, therefore these two categories are not mutually exclusive.

(b) Includes Indigenous status not stated, and Language spoken at home not stated, inadequately described and non-verbal so described.

Source: ABS 2002e.

The Indigenous population had lower participation rates in education than did the general population in the age groups 15–34 years. However, in the older age groups, Indigenous rates were higher than for the total Australian population. This may reflect disadvantage at younger ages—that is, people in older ages may be 'catching up' on the education they missed out on earlier in their lives. Of Indigenous students who stated the type of institution they were attending, the greatest proportion of those aged over 19 were attending a Technical or Further Education institution. The overall participation rate for Indigenous people aged 15–64 was slightly higher than for the population as a whole; this is related to the younger age profile of the Indigenous population compared with the population as a whole, and the higher participation rates among younger age groups (ABS 2002e).

Participation in education for people who reported that they spoke a language other than English at home was higher in the age groups 15–34 years than for the general population, but lower in the older age groups.

Completion of secondary school is important in equipping children with skills and providing opportunities to enable them to pursue further education or find employment. The apparent retention rate is the percentage of full-time students of a given cohort group who continue from the first year of secondary schooling to a specified year level. The term 'apparent' reflects that no adjustments are made for migration into or out of Australia, or movements of students between jurisdictions.

In 2002, 75% of Australians who had entered Year 7/8 stayed at school until Year 12 (Table 2.15). Retention rates for Indigenous students were around half those for all Australians. Apparent retention rates for females have been higher than the equivalent rates for males since the mid-1970s, and have been around 10 percentage points higher since the early 1990s (ABS 2002e), giving rise to concerns about male outcomes in education.

Table 2.15: Year 12 apparent retention rates, by sex and Indigenous status, 2002 (per cent)

	Males	Females	Indigenous	All Australians
Retention to Year 12 as % of cohort entering Year 7/8[(a)]	69.8	80.7	38.0	75.1

(a) Year 7/8 is used as the base year since the first year of secondary school is Year 7 in NSW, Vic, Tas and the ACT, and Year 8 in Qld, SA, WA and the NT.

Source: ABS 2003f.

Educational attainment

Levels of educational attainment in the population provide an indication of the Australia's stock of knowledge and skills derived from formal education (ABS 2002e). The indicator used here focuses on the highest level of formal education completed (for information on how this measure is derived, see ABS 2002f:34–5).

Table 2.16: Level of highest educational attainment, by age, 2002 (per cent)[(a)]

Age group	Bachelor degree or above[(b)]	Certificate or diploma[(c)]	Year 12	Year 11	Year 10 or below
25–34	24.8	26.3	21.6	7.5	19.0
35–44	21.2	26.6	14.9	8.6	27.8
45–54	19.9	26.4	12.9	6.5	33.3
55–64	13.2	25.1	9.1	3.6	47.4
Total 25–64	**20.4**	**26.2**	**15.2**	**6.9**	**30.2**

(a) Percentage of the population within each age group.

(b) Includes Bachelor degree, Graduate diploma or Graduate certificate, and Postgraduate degree.

(c) Includes Certificate I, II, III or IV, Certificate not further defined, Diploma and Advanced diploma.

Source: ABS 2002f.

In 2002, 20% of people aged 25–64 reported a bachelor degree or above as their highest education qualification attained, 26% a certificate or diploma and 15% Year 12 completion (Table 2.16). A relatively high proportion of people aged 55–64 reported that their highest qualification was Year 10 or below (47%, compared with 19% of those aged 25–34 years). There was a clear age effect—with each older age group, the proportion of people with Year 10 or below as their highest educational attainment increased. In 2001, 12% (1,489,300) of people aged 15–64 had not completed Year 10 and did not have a non-school qualification (ABS 2002e:63). While levels of educational attainment among Indigenous Australians have been slowly increasing, they remain well below those of non-Indigenous Australians (ABS 2002a).

The proportion of the population with a tertiary education is comparatively high in Australia. According to OECD data for 2001, the proportion of Australians aged 25–64 years with at least tertiary-level education was 27% for men and 31% for women, compared with the OECD country mean of 24% and 22%, respectively (OECD 2002). However, only 59% of the Australian population aged 25–64 had at least upper secondary, which was below the OECD country mean of 64%.

Literacy among schoolchildren

Reading and numeracy are essential skills needed for functioning in work and everyday life. As part of monitoring national goals for schooling in Australia, achievements for Years 3, 5, and 7 students are assessed against nationally agreed reading and numeracy benchmarks (DEST 2002; MCEETYA 2000b).

Results for Year 3 and Year 5 students were published in 2000 (MCEETYA 2000b). Of Year 3 students, 93% of those participating in the testing achieved the national reading and numeracy benchmarks; for Year 5 students, 87% attained the reading benchmark and almost 90% the numeracy benchmark (Table 2.17). Females were more likely than males to achieve the reading benchmarks but there was no sex difference in the achievement of numeracy benchmarks.

Table 2.17: Year 3 and Year 5 students achieving national educational benchmarks, by sex and Indigenous status, 2000 (per cent)(a)

	National reading benchmark		National numeracy benchmark	
	Year 3	Year 5	Year 3	Year 5
Males	90.9	85.2	92.7	89.4
Females	94.3	89.6	92.8	89.8
Persons	**92.5**	**87.4**	**92.7**	**89.6**
Indigenous Australians(b)	76.9	62.0	73.7	62.8
Non-English-speaking background(b)(c)	90.8	84.9	90.3	87.1

(a) The data in this table represent students who have achieved the benchmark as a percentage of the students participating in the State and Territory testing, including students who were formally exempted (these students are reported as below the benchmark). Students who were absent or withdrawn by parents/caegivers from the testing, and students attending a school not participating in the testing, are not included in the data (MCEETYA 2002b). The proportion of such students ranged form 2.4% of Year 5 students in Queensland to 20% of Year 3 students in the Northern Territory.

(b) Methods used to identify Indigenous and non-English-speaking background students varied between jurisdictions. There is likely to be some overlap between these two groups.

(c) Non-English-speaking background students are defined as a student either born in a non-English-speaking country, or born in Australia with one or both parents born in a non-English-speaking country, or an Indigenous student for whom English is not the first language (MCEETYA 2000a).

Source: ABS 2002e.

Compared with Australian students as a whole, levels of attainment of reading and numeracy benchmarks were slightly lower for students from non-English-speaking backgrounds, and substantially lower for Aboriginal and Torres Strait Islander students. The benchmarks are, by definition, national standards and do not make adjustments for language, culture or other possible influences on these outcomes.

Population literacy

Prose literacy is the ability to understand and use information from various kinds of prose texts, including newspaper and magazine articles. The ABS 1996 Survey of Aspects of Literacy measured prose and document literacy using a five-point scale. Prose literacy of Level 3 or above is used as an indicator of a person's ability to use general printed materials found in everyday life and at work (ABS 2002e; OECD 2000). Those with prose and document literacy below Level 3 could be expected to have difficulties using such materials.

In 1996, 53% of people aged 15–74 years had prose and document literacy of Level 3 or above (ABS 2002e). Rates were highest in the 20–24 age group (64%) and lowest among people aged over 55 years (35% for those aged 55–64 and 24% for those aged 65–74). In all age groups below 45 years, a greater proportion of females than males had prose literacy of Level 3 or above; this situation was reversed for people aged over 55. Australia came 10th out of 22 countries (20 OECD, 2 non-OECD) tested between 1994 and 1998 for their level of adult prose literacy (OECD 2000).

Economic resources and security

Material standard of living is largely determined by people's command over economic resources. Economic security refers to the extent to which people have a reliable source of income and/or accumulated wealth (e.g. property, superannuation) to buffer their material standard of living into the future.

Income and income distribution

Equivalent disposable income is used as a basis for the indicators of income level and distribution in this section. Disposable income is gross income less direct tax and Medicare levy. This measure is adjusted for differences in household composition and size using an equivalence scale, to better reflect the level of economic wellbeing of each member of the household.

In 2000–01, median household equivalent disposable income for Australia was $414 per week (Table 2.18). Median income for households in the highest income quintile was nearly double this figure, and that of households in the lowest quintile was less than half the overall median income.

Mean weekly equivalent disposable income across all households ($469) was higher than median income, reflecting the effect on this measure of the very high incomes of a small proportion of households at the top of the income distribution. Income is distributed asymmetrically in Australia, as in most countries, with a relatively small number of people in very high income households, and a large number of people in low income households. In 2000–01, households in the top two income deciles accounted for 39%of all income received, while households in the second and third deciles from the bottom of the income distribution accounted for only 11%[5] (ABS 2003a).

Table 2.18: Households, equivalent weekly disposable income by quintile, 2000–01 (dollars)

	Equivalent weekly disposable income quintile[(a)(b)]					All households
	Lowest	Second	Third	Fourth	Highest	
Median income ($)	202	292	413	550	802	414
Mean income ($)	180	295	413	555	903	469

(a) The modified OECD equivalence scale has been used to facilitate comparisons of income levels across different household types. Equivalence scales are sets of ratios that show the relative income levels required for households of different size and composition to maintain a similar standard of living. Data in this table have been standardised to the income requirements of a single person household.

(b) Quintiles have been calculated by ranking persons on the basis of equivalent weekly disposable household income and allocating an equal number of persons to each quintile. Due to differences in household sizes this will not give equal numbers of households for each quintile.

Source: ABS 2003a.

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[5] Deciles 2 and 3 are used rather than the bottom quintile (deciles 1 and 2) for looking at the income share of low income households because income data for the bottom decile are considered unreliable.

The ratio of equivalent household income marking the top of the 80th income percentile, to that marking the top of the 20th income percentile, is one of many indicators of income distribution—a higher value for this ratio indicates greater income inequality. In 2000–01 this ratio was 2.63, up slightly from 2.56 in 1994–95 (ABS 2003a). Trends in several income distribution indicators have led the ABS to suggest a possible rise in income inequality over the second half of the 1990s (ABS 2003a:10).

Income disadvantage

Data on low-income households as a proportion of all households are presented here, as a measure of income disadvantage. A measure that has commonly been used in Australia and internationally is the proportion of households whose equivalent disposable income is below 50% of the median for all households (ABS 1998a; OECD 2002).

In 2000–01, over two million Australians were living in households with equivalent weekly disposable income below 50% of the median for all households (Table 2.19). Using this measure, 14% of households and 11% of people across Australia were living in income disadvantage.

This measure may be sensitive to small changes in social security benefits, and thus unstable, because half median income is close to the value of some government benefits (e.g. the Age Pension) (ABS 2002a:96). Therefore, the proportions of households whose equivalent disposable income is below 40% and below 60% of the median for all households are also tabulated:

- 989,700 people were living in households with equivalent weekly disposable income below 40% of the median, that is, 6% of households and 5% of people across Australia; and
- 3,883,400 people were living in households with equivalent weekly disposable income below 60% of the median, that is, 25% of households and 21% of people across Australia.

Table 2.19: Income disadvantage: households with equivalent weekly disposable income below 40%, 50% and 60% of the median for all households, and people and children living in those households, 2000–01

	Households	Children aged <15 living in low-income households	All persons living in low-income households
Below 40% median equivalent weekly disposable income			
Number ('000)	420.9	223.4	989.7
Per cent	5.8	5.7	5.2
Below 50% median equivalent weekly disposable income			
Number ('000)	984.8	471.9	2,062.1
Per cent	13.5	12.1	10.9
Below 60% median equivalent weekly disposable income			
Number ('000)	1,826.0	859.3	3,883.4
Per cent	25.0	22.1	20.6

Note: See Table 2.18 footnote for explanation of 'equivalence'.

Source: 2000–01 ABS Survey of Income and Housing Costs (unpublished data).

Compared with people of all ages, a greater percentage of children were living in income-disadvantaged households—12%, or 471,900 children aged less than 15 years, using the measure of below 50% of median equivalent disposable weekly income. The OECD has used this measure as an indicator of rates of child poverty (for children aged under 18 years). In the mid-1990s, Australia ranked 9th lowest among 16 OECD countries on this indicator; the lowest rates of child poverty were found in the Nordic countries and Belgium (OECD 2002:53).

It is important to note that some of the most economically disadvantaged groups in Australian society, in particular people who are homeless and not staying in private dwellings at the time of the survey, may not be captured in the household-based survey used to produce these data.

In recent decades there has been considerable debate about the definition of poverty in Australia and about appropriate estimation methods (AIHW 2001a:392). A current Senate Committee Inquiry is renewing this debate and, by July 2003, had attracted almost 250 submissions. Estimation has received much coverage in submissions. The Social Policy Research Centre recognises the problem, and concludes:

> Poverty research now faces a severe credibility crisis, as its principal tools are widely perceived to no longer be capable of providing an accurate and objective basis for monitoring poverty trends and differences. (Saunders 2003)

Financial stress and hardship

Measures of income alone do not give the full picture of economic wellbeing. Other measures may better reflect the extent to which households are constrained in their activities because of a shortage of money (Bray 2001).

The financial stress indicator presented here is based on data from the 1998–99 ABS Household Expenditure Survey, which asked households whether, prior to the survey, they had been unable to do a range of specified activities because of a shortage of money. The activities included taking holidays away from home, paying bills, and being able to afford meals. The three levels of financial stress in Table 2.20 are defined in the table footnote.

In 1998–99, about one-third of all households (2,406,000 households) experienced some financial stress, and 13% a high level of financial stress. Single parents with dependent children were the group that most often experienced financial stress—41% of these households reported high levels. Single people aged under 35 were the group next most likely to experience financial stress.

Table 2.20: Households: level of financial stress,(a) by selected life-cycle groups, 1998–99 (per cent)

Life-cycle group	High	Moderate	No stress	All households Per cent	All households No. ('000)
Lone person aged under 35 years	21.0	21.8	57.2	100.0	327
Couple with dependent children only	13.7	24.5	61.9	100.0	1,697
One parent with dependent children only	40.8	31.5	27.6	100.0	382
Couple, reference person aged 65 years or over(b)	4.2	15.3	80.6	100.0	594
Lone person, aged 65 years or over	7.3	17.4	75.3	100.0	622
All households(c)	**12.6**	**21.2**	**66.2**	**100.0**	**7,123**
All households ('000)	897	1,509	4,717	100.0	7,123

(a) The level of financial stress of a household was determined according to the number of financial stress questions to which it responded negatively (i.e. the number of areas in which the household reported being constrained due to lack of money, based on the 13 questions asked in the survey): No stress—one or no questions answered negatively; Moderate stress—two to four questions answered negatively; High stress: five or more questions answered negatively.

(b) The reference person is normally the higher income recipient of the couple or, when income is the same, the older person.

(c) Includes other life-cycle groups.

Source: ABS: McColl et al. 2001.

Wealth and wealth distribution

Looking at household wealth—or 'net worth', defined as the sum of the household's assets minus the sum of its liabilities—can shed some light on levels of economic security for households.

In 2000, median household net worth was greatest for households composed of a couple with dependants aged 15–24 ($392,100), and lowest for lone-parent households with dependent children aged 0–14 ($16,400) (Table 2.21). Some of the differences between the household types are likely to reflect differences in age and life-cycle stage. For example, couples with dependants aged 15–24 are likely to be older on average than those with younger dependants, and are therefore likely to have had more years in the workforce during which to build up assets.

In 2000, median household net worth was estimated to be $5,600 in the lowest wealth decile and $23,200 in the second decile, compared with $518,900 and $982,400, respectively, for the ninth and tenth wealth deciles (ABS: Northwood et al. 2002).

Table 2.21: Median household net worth, by household type, 2000

Household type	Median household net worth ($'000)
Couple only	243.9
Couple with dependants aged 0–14	153.5
Couple with dependants aged 15–24	392.1
Couple with dependants aged 0–14 & 15–24	277.4
Lone person	111.0
Lone parent with dependants aged 0–14	16.4
Lone parent with dependants aged 15–24	100.2
Other households	202.1

Source: ABS: Northwood et al. 2002.

Saving for retirement is an issue of growing public policy concern. Superannuation assets increased significantly from 16% of total assets in 1996 to 21% in 2000 (ABS: Northwood et al. 2002). This reflects growth in the percentage of employees with superannuation—in 2000, 91% of employees aged 15–64 had superannuation, compared with just 55% in 1988 (ABS 2002f).

Employment and labour force participation

Employment and paid work provide the financial means by which people obtain the goods and services they do not produce themselves. Paid work, in Australian society, is therefore a major source of material wellbeing, the means by which people not only obtain the basic necessities to sustain life but also finance many social and recreational activities. Ideally, employment also provides opportunities for personal development and positive social interaction. Security of employment and the quality of working conditions underpin the success of employment in providing these various sources of individual wellbeing.

Employment is not only a key indicator of individual wellbeing, but is also intricately related to other aspects and experiences of a person's life, notably education, health and economic resources. Participation in employment is a key, recognised aspect of adult participation in society. Employment is, in these ways, an integral aspect of autonomy and social participation.

Labour force participation

Labour force participation rates in 2002 were 63.7% for the population aged 15 years or more—72.4% for men and 55.3% for women (Table 2.22). The overall rate has been fairly steady over the past decade, with a slight fall for men and a rise for women. That is, the gap between male and female participation rates has narrowed from 22 percentage points in 1992 to 17 in 2002 (ABS 2003b). These differences between male and female participation rates need to be kept in mind when considering differences in levels of employment and unemployment.

In 2002, an average of 6.6% of the labour force was unemployed—6.9% for males and 6.3% for females. The long-term unemployment rate was 1.3% of the labour force in 2002. The extended labour force underutilisation rate is a broader measure, developed to take into account unemployment, underemployment and also some groups who are not in the labour force but would like to work (see footnote to Table 2.22). This rate was 13% in 2002.

Table 2.22: Employment indicators, 2002

	Total ('000)	Total (%)	Males (%)	Females (%)
Employment and labour force participation				
Labour force (LF) size and participation rate	9,889	63.7	72.4	55.3
Employed (number and % of total population)	9,232	47.3	n.a.	n.a.
Unemployed (number and % of LF)	656.8	6.6	6.9	6.3
Long-term unemployed (% of LF)	n.a.	1.3	n.a.	n.a.
Extended labour force underutilisation rate	n.a.	13.0	n.a.	n.a.
Employment basis and conditions				
Part-time workers (% of total employed)	n.a.	27.9	14.4	45.2
Employees without leave entitlements (% of all employees)	n.a.	27.3	23.5	31.6
Average hours worked (full-time workers)	40.8	. .	. .	. .
Full-time workers working 50+ hours per week (% of full-time employees)	n.a.	24.3	n.a.	n.a.

Notes

1. Reference periods are annual averages for the year ending 30 June, except for: employees without leave entitlements (August), labour force underutilisation (September).
2. Definitions in brief:
    - Employed person: person aged 15 years or more who, during the reference week of the labour force survey, worked for one hour or more for pay, profit or commission.
    - Unemployed person: person aged 15 years or more who was not employed during the reference week but who had actively looked for work or was currently available for work.
    - The labour force comprises employed and unemployed persons.
    - Underemployed person: employed person working less than 35 hours per week who is willing and available to work more hours.
    - Extended labour force underutilisation rate: the number of people who are unemployed or underemployed, plus two groups of people who are marginally attached to the labour force (i.e. people actively looking for work, not available to start work in the reference week, but available to start within 4 weeks, and 'discouraged jobseekers' who could start within 4 weeks but were not actively seeking work because they believed they could not find a job for specified reasons), as a percentage of the labour force augmented by these two groups of people marginally attached to the labour force.

Source: ABS 2003b.

Employment basis and conditions

In 2002, 28% of all people employed were part-time workers—14% of employed males and 45% of employed females. For both sexes these proportions have risen since 1992, when they were 10% for males and 41% for females (Table 2.22; ABS 2003b).

The proportion of male full-time workers without leave entitlements has risen markedly over the decade, while the proportion for females has remained relatively stable. In 2002, 24% of males and 32% of females employed full-time had no leave entitlements; in 1992, these figures were 16% and 31%, respectively.

Average weekly hours worked by full-time workers were 40.8 in 2002, with no noticeable trend over the decade since 1992 when the average was 40.6 hours (ABS 2003b). In 2002 24% of full-time workers worked 50 or more hours per week, representing a modest rise from 22% in 1992.

Employment and labour force differentials

There were marked differences in employment and labour force experience in June 2002 depending on age, sex and, for women, marital status (ABS 2002g). The ages that might be termed 'middle working ages', from 25 to 54 years, shared a fairly similar labour force pattern characterised by:

- high rates of participation (over 80% — well above the national average of 64% in June 2002), although these were lower for females, especially younger married females;
- unemployment rates below the national average of 6.3% in June 2002; however, in all age groups, unemployment rates were higher for unmarried males and females than for the overall sex and age group.

After age 55 years, labour force participation rates decreased for each older age group — and were 37% for people aged 60–64 years, and 6.6% for people aged 65+ — and unemployment rates were relatively low (3% for those aged 60–64 years).

The age group 15–19 years is characterised by relatively low labour force participation rates for both males and females and relatively high unemployment rates. The unemployment figures for this age group include people studying at school or tertiary institutions who are looking for work. The age group 20–24 years shares some similar characteristics, although its pattern is closer than the younger group's to the 'middle working age' pattern (ABS 2002g).

The employment patterns of young people aged 15–24 years have changed in recent decades, with increases in educational participation and many combining part-time work with full-time study. In 1995, 72% of young people were in the labour force, with 55% of them working full-time; in 1975, 68% were in the labour force but 81% of them worked full-time (ABS 1996a: 97).

Employment patterns also vary geographically. In capital cities, the unemployment rate for 2001–02 was 6.3%, and in the rest of Australia it was 7.3% (ABS 2003b).

People with disabilities have had poorer employment outcomes than others for two decades at least (AIHW 2001a: 311–12). Their participation rates in 1998 were 53%, compared with 80% for those with no disability, and only 35% for those with 'severe core activity restrictions' (i.e. needing assistance with self-care, mobility or communication). Unemployment rates were also differentiated: 11.2% for those with disabilities, 7.9% for those with no disabilities and 10.6% for those with 'severe core activity restrictions' (whose unemployment rates may be dominated by their low participation rates[6]).

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[6] These rates were age standardised to enable more valid comparisons, since disability rates are age-related.

Table 2.23: Indigenous labour force status of persons aged 15 years and over, 2001

	Indigenous	Non-Indigenous	Total[(a)]
In the labour force:			
Employed: CDEP[(b)]	17,805	1,900	19,769
Employed: Other	78,446	7,950,402	8,076,660
Employed: Not stated[(c)]	4,142	192,184	202,177
Unemployed	25,044	628,623	660,709
Total labour force	*125,437*	*8,733,109*	*8,959,315*
Not in the labour force	115,422	5,060,381	5,265,426
Unemployment rate (%)	20.0	7.2	7.4

(a) Includes not stated.

(b) Community Development Employment Projects scheme.

(c) Includes employed persons who did not state industry sector.

Source: ABS 2003g.

Employment outcomes for Indigenous Australians were notably worse than for the population overall (Table 2.23). Their unemployment rate, for instance, was 20% in 2001, compared with 7.2% for the rest of the population. Indigenous employment figures include almost 18,000 Community Development Employment Projects (CDEP) scheme participants, recorded in the Census. This Census figure appears to be an under-count of the 32,000 CDEP participants recorded by ATSIC, probably related to collection methods outside remote areas (ABS & AIHW 2003:25).

Transport and communication

The ability to move around the community, to communicate within it, and to access transport and communication systems are all important aspects and facilitators of successful human functioning (e.g. WHO 2001). Accessibility has been defined as the ease of access with which people can reach a variety of locations, and is achieved not only through mobility but also through communication networks such as telephone systems and the Internet (Ross 1999). Accessibility, in this sense, is essential for everyday life.

Transport

The availability of efficient and affordable transport is important not only for the movement of people and goods but also because it provides significant social and economic benefits, by facilitating access to resources within and around the community, trade opportunities, employment, education, health services, leisure activities and community activities (NSW EPA 2000).

While there is a considerable array of data on transport in Australia, the emphasis is often on economic inputs, distances travelled or resources consumed, rather than the efficacy of transport systems for people’s wellbeing. The question asked in the ABS General Social Survey on perceived level of difficulty with transport may provide a valuable summary indicator of transport accessibility when data become available.

Car use and access

In Australia, the private passenger motor vehicle is the main means of transport for almost all purposes. According to the 2001 Census, 64% of employed people travelled to work by car as either passenger or driver; 3% travelled by 'train only'; 3% by 'bus only'; and 5% either rode a bike or walked (ABS 2002h). Even in the Sydney region, the car dominates; on weekdays in 2001, 48% of all trips were made by motor vehicle drivers, 22% by passengers, 5% by train, 6% by bus, 17% walking and 2% using other modes (TDC 2002).

Access to the private motor vehicle and the affordability of its use are therefore indicators of access to the dominant form of transport in Australia. The average operating cost of the majority of small to medium private vehicle models (5 years old or less) was estimated as ranging between $130 and $180 per week (NRMA 2003),[7] compared with average weekly earnings of Australian employees in early 2003 of $713 per week (ABS 2003g).

Access to public transport

Access to public transport, and the criteria for judging accessibility, may vary by location. In 2000–01, it was estimated that 99% of Australians living outside metropolitan areas, in urban centres and localities of 200 persons or more, were within 'reasonable access distance' of regional rail, coach or air services (that is, within a road distance of 70–120 kilometres of an airport or 16 kilometres of a rail or regional coach stop) (BTRE 2002). Equivalent data are not available for other regions.

Public transport accessibility for people with a disability is important in facilitating full participation in and enjoyment of community life. In 1998, journeys by public transport were undertaken by 47% (1,577,500 of 3,378,500) of people with a disability (aged 5 years and over). For the last journey in the fortnight before the ABS disability survey, 7% (250,400) used public transport, while in contrast, 78% (2,626,400) of people with a disability travelled by private motor vehicle (31% as a passenger and 46% as the driver) (ABS 1999:31, 33). Difficulty with using public transport was identified by 31% (1,050,700) of people with a disability, the most common difficulty being due to steps for getting in/out of vehicles/carriages. Disability standards for accessible public transport were approved by the Commonwealth Parliament and commenced in October 2002 (see Box 8.3).

Communication

The communication of information, ideas and knowledge is important to many aspects of participation, including in education and the economic sphere. Communication networks provide access to information through channels such as the Internet. The Internet increases accessibility to information for cultural or recreational pursuits, as well as providing efficiencies (through facilities such as Internet banking and purchasing). Better communication makes Australian industry more competitive, both domestically and internationally, thereby enabling a higher economic standard of living (ABS 2002a). The focus here is on indicators of people's access to communication systems and equipment (communications enablers), rather than on indicators of communication activities.

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[7] These costs included depreciation, interest, registration, full insurance, NRMA membership, fuel, vehicle maintenance and additional purchase costs.

The Internet has become an increasingly important communication and research tool, providing information about and to organisations, companies, universities and individuals. It is also capable of offering on-line services including education, banking and shopping, thus allowing people to work or study from home and to save time, as well as to communicate with others. Internet access is indicated by the proportion of households connected to the Internet, compared with the total household population—37% in 2000, up from 4% in 1996 (ABS 2002a).

Telephones were one of the major communication devices used extensively throughout the 1990s. The number of fixed phone lines in Australia increased by over a third between 1990 and 1999, from 7.8 million to almost 10.5 million (ABS 2002a). Over the same period there was a rapid rise in mobile phone ownership, from 1 per 100 Australians to 40 per 100 Australians. It does not appear possible, however, to obtain data on combined coverage, or the number of households or people with no access to a telephone; the last national data were published by the ABS in 1990.

Telstra is now required to provide tele-typewriter (TTY) vouchers to people who are certified ‘profoundly deaf’ (HREOC 1995).

The adequacy of mobile phone coverage is of particular interest in a country the size of Australia. There are two main types of mobile phone network: Global system for mobile communications (GSM) and code division multiple access (CDMA) networks. Mobile phone services are also offered via satellite, with coverage over the entire Australian landmass and population; this option is much more costly and not often considered by the average consumer. In 2001–02, Australia’s CDMA network had the largest cellular mobile coverage, providing more than 1.1 million square kilometres of coverage—that is, over 13% of total land area of Australia, with 97% of the total population of Australia within this area. The GSM system covered at least 6.6% of total land area, covering 95% of the population (ACA 2002).

Recreation and leisure

A balanced lifestyle that includes participation in recreation and leisure activities can be a major contributor to a person’s physical and mental health and wellbeing. Recreational activities may involve group or club activities and hence offer opportunities for social interaction and community engagement, in turn adding to the fabric of a cohesive society. So important is the human need for leisure that it is recognised in the UN Declaration of Human Rights, which states that ‘Everyone has the right to rest and leisure, including reasonable limitation of working hours and periodic holidays with pay’ (UN 1948).

Measuring the time actually spent on recreation and leisure appears to be the most straightforward way of summarising participation in recreation and leisure. This is the approach taken in this chapter; it enables the indication of balance in lifestyle, in that time spent on recreation and leisure can be compared with time spent on other activities.

Time use, in this section, is reported as an average across the whole population aged 15+ years and across every day of the week. These estimated averages are based on household surveys and diary records kept by survey respondents (see ABS 1998b and AIHW 2003a). Because people can carry out more than one activity at a time, activities may be tabulated as 'main activities' (for which the time used can be summed to a whole day) or else as 'all activities'.

Overall pattern of time use

Personal care, as a main activity, occupied 46% of people's time in 1997, largely because of the inclusion of 'sleep' in this category, on which people spent an average of 36% of their time (ABS 1998b; AIHW 2003a). Recreation and leisure was the next main activity (19% of people's time), ahead of employment (14%) and domestic activities (10%).

There were male–female differences in this pattern, with males spending, on average, more time on employment-related activities than females (18% of time compared with 9%), slightly more in recreation and leisure (20%, compared with 18%), and less in domestic activities (7%, compared with 13%).

Overall pattern of recreation and leisure activities

Of time spent on recreation and leisure activities, by far the most likely was time spent on audio-visual media—TV, radio, recorded music (130 minutes per day on average, of a total of 268 minutes on recreation and leisure as a main activity). Talking (35 minutes) was a distant second, ahead of sports and outdoor activities (27 minutes), reading, games and crafts, and other activities (Table 2.24). There were a number of sex differences, the most marked being that females spent more time talking, and men spent more time on audio-visual activities and sporting and outdoor activities.

When 'all activities' are considered, the picture of recreation and leisure changes somewhat. Audio-visual activities assume even more importance—130 minutes per day for audio visual media as a *main* activity climbs to 257 minutes per day for *all* audio-visual activities—probably reflecting the ease with which people can undertake other activities combined with these, for instance, listening to the radio while driving or gardening. Sport and outdoor activities changed far less, from 27 minutes per day to 28 (ABS 1998b:Table 15).

Table 2.24: Average daily time spent on recreation and leisure as main activities, by sex, 1997 (minutes)

Main free-time activities[a]	Males	Females	Persons
Sport and outdoor activity	33	20	27
Games/hobbies/arts/crafts	18	15	17
Reading	24	26	25
Audio/visual media	143	118	130
Attendance at recreational courses	1	1	1
Other free time	23	20	21
Talking (including phone)	27	44	35
Writing/reading own correspondence	1	2	1
Associated travel	11	7	9
Other	2	1	1
Total	**283**	**254**	**268**

(a) 'Free time' is a time use category comprising activities such as religious observance, socialising, and a range of activities commonly associated with recreation and leisure.

Source: ABS 1998b:18.

Table 2.25: Average daily time spent on recreation and leisure as main activities, by age and sex, 1997 (minutes)

Age	Males	Females	Persons
15–24	326	263	295
25–34	242	206	223
35–44	233	209	221
45–54	253	233	243
55–64	314	297	305
65 and over	400	377	387
Total	**286**	**257**	**271**

Source: ABS 1998b:55.

The 35–44 age group spent the least time of all age groups surveyed on recreation and leisure activities (221 minutes per day as a main activity). Thereafter the time increased, with those in the age group 55–64 years having the same leisure time as the 15–24 year age group (around 300 minutes per day). The sex differences previously noted held in every age group, although they were greatest in the age group 15–24 years, where females spent about 60 minutes less per day on recreation and leisure than did males of the same age (Table 2.25).

Recreation and employment

People who were employed full-time spent some 30 minutes per day less on recreation and leisure than did those who were employed part-time (Table 2.26). People who were not employed at the time of the survey spent the greatest amount of time on recreation and leisure activities. Females had less leisure time than males, regardless of employment status. In fact, females employed part-time had about the same average time for recreation and leisure as did males employed full time, and those not employed had as much leisure time as part-time employed males.

Table 2.26: Average daily time spent on recreation and leisure as main activities, by employment status and sex, 1997 (minutes)

Employment status	Males	Females	Persons
Employed full-time	225	198	217
Employed part-time	304	226	247
Not employed	392	303	337

Source: ABS 1998b:34.

Physical activity

Physical activity is recognised as an important factor in reducing the risk of certain chronic diseases and their effects. The National Physical Activity Guidelines for Australians recommend 30 minutes of moderate-intensity physical activity on most days of the week.

Data from the Active Australia surveys indicate that the proportion of people aged 18 years and over whose physical activity levels were considered sedentary rose between 1997 and 2000, from 13.4% to 15.3% (AIHW 2003b:3). These people reported no participation in walking, moderate-intensity or vigorous-intensity activity during the week prior to the survey. It should be noted that, in determining a respondent's level of physical activity, the Active Australia Survey does not count physical activity in the course of work.

2.4 Social cohesion

Social cohesion can be described as the 'connections and relations between societal units such as individuals, groups (and) associations' (Berger-Schmitt 2000:2, following McCracken 1998).[8] Embedded within this concept are feelings and attitudes such as shared values, trust, and a sense of belonging, which shape and moderate these connections and relations.

A review of approaches to the concept of social cohesion identified two main themes or 'societal goal dimensions' (Berger-Schmitt 2000):

1. The first dimension concerns the reduction of disparities, inequalities and social exclusion.

2. The second dimension concerns the strengthening of social relations, interactions and ties. This dimension embraces all aspects which are generally also considered as the social capital of society.

Both dimensions are of equal importance to any assessment of social cohesion, since strong social capital on its own may result in exclusion of or discrimination against people not belonging to a particular community or group. In this section, however, the indicators presented focus on the second dimension—social capital.[9] The underlying

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[8] The concept of social cohesion is often interpreted and defined in relation to two other equally important conceptual players in the social statistics field—social capital and social exclusion. However, interpretations of the relationship between these concepts, particularly between social cohesion and social capital, do differ, with social cohesion being seen as encompassing, equal to or an element of social capital (see, for example, Green 2003). Here social cohesion is seen as encompassing social capital.

[9] Social capital as defined by the OECD, and recognised by the ABS, comprises the 'networks, together with shared norms, values and understandings which facilitate cooperation within or among groups' (Cote & Healy 2001:41).

theme of the first dimension (i.e. exclusion) flows through this and the other welfare components of 'Healthy living' (Section 2.2) and 'Autonomy and participation' (Section 2.3), in terms of the measures of distribution, inequality and disadvantage.

Social cohesion is an evolving field in social statistics, in terms of its constituents and interpretation. A lack of recent, nationwide data has hampered any broad assessment of the strength of social cohesion in Australia, although smaller, more regionally based analyses provide an insight. The advent of new social surveys capturing the concept of social cohesion should strengthen the presentation of social cohesion indicators in the future and improve our understanding of their relationship to the notion of a cohesive society.

Nonetheless, current data do provide some evidence about social cohesion in Australia. For example, community engagement is relatively strong, with Australians volunteering at a rate similar to or higher than that found in other developed countries. On the negative side, there are indications of social exclusion in the high imprisonment rates experienced by young males and the Indigenous population, and in the presence of suicide as a major cause of death, again especially for young males. Social and civic trust are difficult to measure and the evidence available is equivocal.

Family formation and functioning

The family[10] is 'the largest source of emotional, practical and financial support in our society' (McDonald 1995:1) and can be conceived of as the wellspring from which some of the dimensions crucial to social cohesion develop, such as trust, social support and the extension of social networks (Coleman 1988; Furstenburg & Hughes 1995; Hughes & Black 2003; Stone & Hughes 2002). The breakdown of the family, in turn, potentially contributes to the disruption of networks forged by family living and the inherent trust that goes with these.

Family formation

Families have undergone significant change in the last three decades. Marriage rates and fertility rates have decreased, de facto relationships and single-parent families are more common, and divorce has increased (AIHW 1997, 1999, 2001a; McDonald 1995, 2003; and see Chapter 6). To reflect these changes, the indicators of family formation and dissolution presented here include social marital status and family type, and age-specific divorce rates. Additional indicators of age-specific marriage rates and fertility rates are discussed in Chapter 6 (Tables 6.1 and 6.2).

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[10] Families are defined in any number of ways, often depending on whose perspective is being sought and the purposes for which a family requires definition. This chapter recognises the ABS definition of the family as 'two or more persons, one of whom is at least 15 years of age, who are related by blood, marriage (registered or de facto), adoption, step or fostering, and who are usually resident in the same household' (ABS 1995:166).

Table 2.27: Social marital status of Australians, by sex and age, 2001 (per cent)

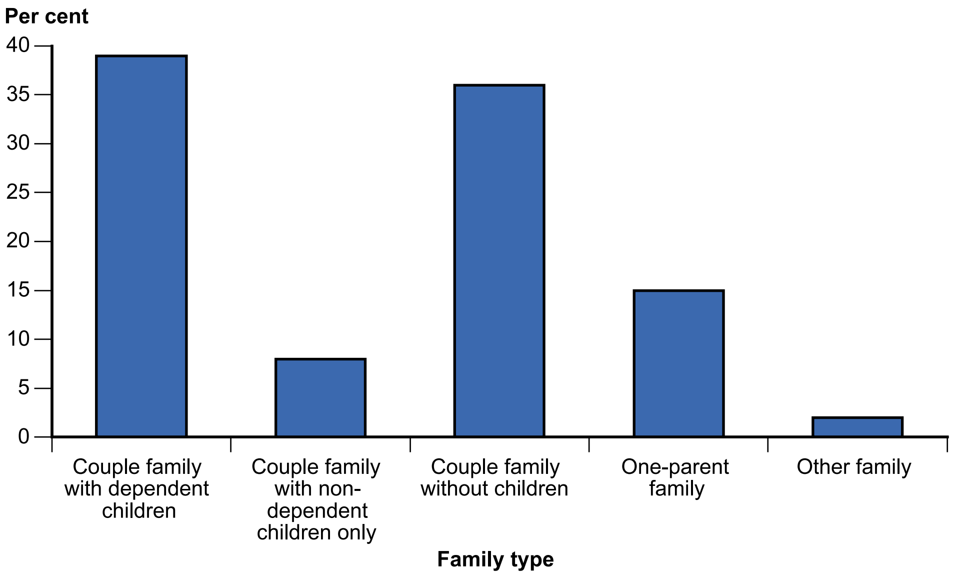
	Age group							
	15–24	25–34	35–44	45–54	55–64	65–74	75–84	85+
				Males				
Registered marriage	2.2	36.2	59.9	66.1	69.2	68.2	61.8	39.8
De facto marriage[(a)]	4.9	14.3	8.5	5.8	3.5	1.5	8.8	0.7
Not married	82.2	39.3	23.4	20.2	18.4	19.5	24.8	33.8
Not applicable[(b)]	10.7	10.2	8.2	7.8	8.9	10.8	12.5	25.7
				Females				
Registered marriage	5.4	46.5	63.3	65.1	63.2	51.8	29.8	8.3
De facto marriage[(a)]	8.2	13.7	7.6	5.1	2.4	0.8	0.4	0.2
Not married	76.7	32.6	24.0	23.8	25.9	37.4	55.2	53.1
Not applicable[(b)]	9.7	7.2	5.2	5.9	8.5	10.0	14.7	38.4

(a) Includes same-sex couples.

(b) Includes persons in non-classifiable households, non-private dwellings, migratory or off-shore census collection districts, and visitors from within Australia.

Source: ABS 2003h.

Social marital status reflects the current marital status of Australians aged 15 years and over, including those people living in registered and de facto marriages. De facto marriages include both heterosexual and same-sex couples. Issues related to the accurate identification of same-sex couples, however, preclude any attempt to separately present these data here.



Source: Table A2.3.

Figure 2.4: Australian family types, 2001

Table 2.28: Age-specific divorce rates,[(a)] 1991 and 2001

	Age group									
	< 24	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60+	Total
Males										
1991	10.6	20.5	19.7	17.0	14.7	12.5	9.0	5.9	2.2	11.6
2000	12.0	19.1	21.1	18.8	16.5	14.2	11.4	7.5	2.7	12.0
Females										
1991	16.1	21.5	18.3	15.6	13.5	10.6	6.5	3.8	1.4	11.5
2000	16.1	21.8	20.5	17.5	15.4	12.6	9.0	5.2	1.8	12.0

(a) Per 1,000 married males and females.

Source: ABS 2002i.

In 2001, over 60% of Australians aged 35–64 were in registered marriages (Table 2.27). Younger Australians (15–24 years) were more often not married, as was the case for women over the age of 75 years. Compared with males, a greater proportion of females between the ages of 15 and 44 years were in registered marriages, particularly for the age group 25–34 (47% of females, compared with 36% of males).

The proportion of people living in de facto marriages varied with age, ranging from 0.7% to 14% for males and 0.2% to 14% for females. De facto marriages were by far more common for younger adults, the highest rates being reported for adults aged 25–34 years (14% for both males and females), followed by 35–44 year olds (9% of males and 8% of females).

The majority of Australian families in 2001 were couple families with dependent children (39%) or couple families without children (36%) (Figure 2.4). One-parent families made up 15% of all families.

The age-specific divorce rate for men and women in 2001 was 12.0 divorces per 1,000 married people (Table 2.28). The highest rates for both men and women occurred between the ages of 25 and 39 years. Divorce rates have increased slightly since 1991, for both sexes and most age groups.

Family functioning

Family functioning is an important mediator of the impact of family structure and exerts possibly greater influence on child development and health outcome(s) than family structures and transitions (Sanson & Lewis 2001). Themes such as family cohesion, as indicated by the strength and quality of relationships, and family support are commonly used in any discussion of family functioning and its relationship with social cohesion (Amato 1998; Coleman 1988; Furstenburg & Hughes 1995). Some potential indicators are briefly discussed below, although universally applied indicators are yet to be developed. Data are presented for two indicators of family breakdown—domestic violence and rates of children who were the subject of a child protection substantiation.

Indicators of family cohesion focus on the quantity and quality of interactions between family members, and hence the quality of existing relationships. One approach is to develop a composite of indicators based on questions relating to the frequency of positive interactions (e.g. talks, attention, conversation, pursuit of common activities) or negative confrontations (e.g. conflict) (Amato 1998; Berger-Schmitt 2000; Coleman 1988). Another approach looks at levels of satisfaction as expressed by different family members. The HILDA survey (see <www.melbourneinstitute.com/hilda/>) provides some data on family cohesion—an appropriate indicator will be developed in the future.

Family members are often the first source people turn to when looking for support. Having the confidence to seek support from immediate family members in times of need suggests the entrenchment of trust and reciprocity (Hughes & Black 2003). The 'Growing up in Australia' survey,[11] a longitudinal study examining the impact of the social and cultural environment on Australian children, will ask respondents about who they turn to when needing emotional support and advice, financial assistance and practical help (e.g. care when sick). The first wave of these data is not due until 2005.

Domestic violence

Domestic violence refers to all potential forms of family violence (Flitcraft 1997), but abuse between married and de facto couples, specifically with the female partner as victim, tends to be the most commonly defined form of domestic violence and is hence the primary subject of policy and research attention. Nationwide data on domestic violence are limited and what is reported is often concealed within general assault (physical or sexual) statistics. In 2002, household survey data reveal that 21% of all assault victims (149,100 persons) were assaulted by a partner (current or ex-) or other family member (Table 2.29). Females (35%) were much more likely than males (9%) to have been assaulted by a partner or other family member.

Table 2.29: Domestic violence: Australians who were assaulted by a partner, ex-partner or other family member, 2002[(a)]

	Males		Females		Persons	
Offenders	**No. ('000)**	**Per cent**	**No. ('000)**	**Per cent**	**No. ('000)**	**Per cent**
Partner	*4.9	*1.3	29.8	9.2	34.7	4.8
Ex-partner	*7.3	*1.9	37.5	11.5	44.9	6.3
Other family member	23.4	6.0	46.1	14.2	69.5	9.7
Total	**35.6**	**9.2**	**113.4**	**34.9**	**149.1**	**20.8**
Total victims of assault[(b)]	392.2	100.0	325.7	100.0	717.9	100.0

(a) Data are based on the most recent incident reported by respondents in the 2002 ABS Crime and Safety Survey.

(b) Other offenders include friend, work/study colleague, neighbour, acquaintance, other known person, and not known personally.

Source: ABS 2003d.

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[11] The 'Growing up in Australia' survey is being funded by the Commonwealth Government and implemented by a consortium led by the Australian Institute of Family Studies and FaCS.

Child abuse and neglect

Child abuse and neglect is the 'physical or psychological damage caused by the abusive behaviour of others, or the failure of others to protect a child from such damage' (James 1994:2). Such abuse is often caused by family breakdown, either due to 'internal' factors such as marital conflict or other dysfunctional family relationships, lack of parenting skills, or problems with coping or self-control, or by 'external' factors such as social isolation.

Notifications of child abuse to community services departments are substantiated if there is reasonable cause to believe that a child has been, was being or is likely to be abused or neglected or otherwise harmed. Community attitudes, and the differences between jurisdictions in child protection policies and practices, affect rates of substantiation and thus the data discussed below should be treated with some caution (see Section 6.5, and AIHW 2003c).

Rates of children who were the subject of a child protection substantiation in 2001–02 generally declined with age, with the highest rates being for children aged under 1 year (range: 1.8–15.6 per 1,000) and the lowest for children aged 15 and 16 years (range: 0.6–5.2 per 1,000) (Table 2.30). The one exception was New South Wales where higher substantiation rates were found for children aged 10–14 years.

Indigenous children were more likely to be the subject of substantiation than non-Indigenous Australian children, for all states and territories. In Victoria, for example, the substantiation rate for Indigenous children was 48.1, compared with 6.1 for non-Indigenous children. The reasons behind the over-representation of Indigenous children in child protection substantiations are complex but may include intergenerational effects of previous separations from family and culture, and poor socioeconomic status (HREOC 1997).

Table 2.30: Rates of children who were the subject of a child protection substantiation,[(a)] by age, Indigenous status, and state and territory, 2001–02

Age	NSW	Vic	Qld	WA	SA	Tas	ACT	NT
<1	4.5	11.1	15.6	4.8	8.8	1.8	6.5	11.6
1–4	4.2	7.4	9.8	2.5	5.6	1.6	3.0	7.1
5–9	5.0	6.2	8.6	2.7	5.9	1.1	3.0	5.1
10–14	5.3	5.8	7.6	2.1	4.8	1.0	2.2	5.3
15–16	3.9	5.2	3.3	1.2	2.4	0.6	1.1	2.6
Indigenous	**15.3**	**48.1**	**14.3**	**13.5**	**31.6**	**0.3**	**6.5**	**9.7**
Non-Indigenous	**4.3**	**6.1**	**7.9**	**1.7**	**4.4**	**1.4**	**2.6**	**3.2**

(a) Per 1,000 children.

Source: AIHW 2003c.

Social and support networks

Social networks embody the informal networks operating in society. Interaction is the key to their maintenance and provides the opportunity to build reciprocal relationships and generate interpersonal trust. Strong social networks may act as reservoirs for support; 'a resource that, once accumulated, can be drawn upon or accessed as needed' (Boisjoly et al. 1995:609). Support may be experienced in any number of guises, including the provision of information, practical help or emotional support. The quality and amount of support offered is often related to the social norms governing a network, the knowledge and will of the network, as well as to its size and density.

The number of contacts with extended family (including those not usually living in the same household) and friends is a commonly used indicator of social network strength in national and community-based surveys. How often individuals see or speak to relatives, friends and neighbours can translate into feelings of acceptance, social trust and shared norms and identities. The quality of social contacts is also important for strengthening these networks because it presents strong evidence for actual and existing bonds (Black & Hughes 2001). No national data are available on the quality of informal social relations.

Family and close friends are often the first people individuals turn to for care and support. Access to social support is reported to have a positive impact on health (Baum et al. 2000; Rosenfeld 1997), to buffer stress (Cassel 1976) and facilitate empowerment (Craig & Mayo 1995). Furthermore, the receipt and delivery of assistance, especially in times of need, can engender feelings, and the actual execution, of reciprocity.

Social detachment

Social detachment can be experienced in terms of isolation, exclusion and non-involvement, particularly if a person is cut off from relationships providing friendship, company, care or support. Rates of suicide and prisoner population are two indicators proposed to reflect the level of social detachment existing in a population (see, for example, ABS 2002c; Berger-Schmitt & Noll 2000; OECD 2003), and hence a subsequent strain on social cohesion. See the section on 'Safety', above, for data on suicide.

On 30 June 2002, there were 22,492 prisoners in Australia (Table 2.31). Males made up 93% of the prison population and their rate of imprisonment was much higher than for females—282.4 males per 100,000 population, compared with 19.2 females per 100,000.

Non-Indigenous Australians made up 80% of the prison population in 2002. The rate of imprisonment was 118.7 persons per 100,000. Around 39% of these prisoners were aged 20–29 and 32% were aged 30–39 years. Males were imprisoned at a rate much higher than females (226.9 and 14.5 per 100,000, respectively).

The imprisonment rate of Indigenous people was more than 10 times higher than that of non-Indigenous people, at 1,806.3 per 100,000 (compared with 118.7). Again, most prisoners were aged between 20 and 39 years, with half of all Indigenous prisoners aged 20–29 years. Imprisonment rates for males in the age groups 20–29 and 30–39 were exceptionally high, at 5,453.1 and 4,616.0, respectively, and over 10 times the rate for non-Indigenous males. For females in these age groups the difference between Indigenous and non-Indigenous rates was even greater.

Table 2.31: Rates of imprisonment,[a] by age, sex, and Indigenous status, 30 June 2002[b]

	Males			Females			Persons		
Age	**No.**	**%**	**Rate[c]**	**No.**	**%**	**Rate[c]**	**No.**	**%**	**Rate[c]**
Non-Indigenous									
17–19	572	3.4	133.6	27	2.4	6.6	599	3.3	71.6
20–29	6,604	39.1	483.5	478	42.8	35.4	7,082	39.3	260.8
30–39	5,322	31.5	360.2	364	32.6	24.1	5,686	31.5	190.5
40–49	2,677	15.9	186.5	176	15.8	12.1	2,853	15.9	98.5
50–59	1,209	7.2	100.6	56	5.0	4.7	1,265	7.0	52.9
60+	497	2.9	32.4	16	1.4	0.9	513	2.9	15.3
Total	*16,881*	*100.0*	*226.9*	*1,117*	*100.0*	*14.5*	*17,998*	*100.0*	*118.7*
Indigenous									
17–19	241	5.8	1,720.0	25	6.8	184.1	266	5.9	964.0
20–29	2,017	48.9	5,453.1	195	53.1	523.2	2,212	49.2	2,978.6
30–39	1,359	32.9	4,616.0	102	27.8	312.0	1,461	32.5	2,350.6
40–49	409	9.9	2,009.3	40	10.9	175.7	449	10.0	1,041.4
50–59	84	2.0	740.4	5	1.4	39.8	89	2.0	372.1
60+	17	0.4	218.4	—	—	—	17	0.4	95.8
Total	*4,127*	*100.0*	*3,441.4*	*367*	*100.0*	*284.8*	*4,494*	*100.0*	*1,806.3*
Total prison population	**21,008**	**93.4**	**282.4**	**1,484**	**6.6**	**19.2**	**22,492**	**100.0**	**148.3**

(a) Data exclude persons held in juvenile institutions, psychiatric custody and policy custody.

(b) Data were collected on all persons held in Australian prisons on the night of 30 June 2002, based on administrative records held by corrective services in each Australian state and territory.

(c) Per 100,000 population in each age group. Rates are age-standardised and were derived using resident and estimated Indigenous population for June 2002.

Source: ABS 2003i.

Trust

Trust is the ‘expectation that arises within a community of regular, honest and cooperative behaviour’ (Fukuyama 1995:26). It is also a response to trustworthiness, or people ‘acting according to the ways expected or promised, taking into account the interests of the other person’ (Black & Hughes 2001:88). Trust and trustworthiness are two sides of the same phenomenon, acting to ‘lubricate’ social interaction and hence the smooth functioning of society.

‘Social trust’ is the trust felt towards more casual acquaintances and strangers and is quite distinct from interpersonal trust, or trust in familiars. Social trust is seen as being more important than interpersonal trust, since social trust indicates a more inclusive form of acceptance (Cox & Caldwell 2000; Hughes et al. 2000). In the early 1980s, 46% of the Australian population felt they could trust most people. Ten years later this rate had dropped to 40%, and stayed at this level in 1995–96 (Hughes et al. 2000, citing Morgan Gallup 1984 and Basanez et al. 1997).[12]

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[12] Trust percentages based on respondents answering yes to the question: ‘Generally speaking, would you say that most people can be trusted or that you can’t be too careful in dealing with people?’.

Table 2.32: Levels of confidence in selected institutions,[a] 1983, 1995 and 2001 (per cent)

	Federal government	Legal system	Police	Major Australian companies	Trade unions	Armed forces
1983[b]						
A great deal	8.6	11.6	27.4	15.6	4.3	22.2
Quite a lot	46.7	48.9	53.0	63.7	19.8	44.6
Not very much	37.4	34.9	17.3	19.2	55.7	28.5
None at all	7.3	4.6	2.2	1.6	20.2	4.6
1995[b]						
A great deal	2.2	4.9	18.5	5.7	2.9	14.7
Quite a lot	23.9	29.8	57.3	52.8	22.7	52.9
Not very much	53.3	53.2	20.2	36.7	51.9	28.0
None at all	20.5	12.1	4.0	4.7	22.4	4.5
2001[c]						
A great deal	6.2	4.9	13.2	2.9	2.3	26.2
Quite a lot	44.6	31.1	55.0	43.5	24.5	58.2
Not very much	37.8	51.3	27.2	44.3	56.6	14.2
None at all	11.3	12.7	4.6	9.4	16.8	1.4

(a) In the text, 'confidence' comprises survey responses 'A great deal' and 'Quite a lot'.

(b) Data from the Australian Values Survey and World Values Survey.

(c) Data from the Australian Election Study.

Sources: Papadakis 1999 analysis of Australian Values Survey 1983 and World Values Survey 1995; SSDA 2001.

Trust in public or high-level institutions is referred to as 'civic trust'. Interactions between different strata in society are considered important in promoting social cohesion since people in these relationships find themselves in a better position to access resources on offer and, potentially, foster socially useful links (Anheier & Kendall 2000; Black & Hughes 2001). Confidence can be viewed as antecedent or complementary to trust. Much of the data relating to the Australian population's views of public institutions are based on feelings of confidence, rather than trust per se, and thus confidence in these institutions will be used as a proxy indicator of trust.

In 2001, Australians had the highest level of confidence in the armed forces (84%) and the police force (68%). Confidence in other institutions—federal government, the legal system, major companies and trade unions—was much lower, with 50% or less of the population surveyed indicating 'a great deal' or 'quite a lot' of confidence in them (Table 2.32).

Trends in confidence in these different institutions show quite varied patterns. Whereas confidence in the police force, legal system and major Australian companies declined between 1983 and 2001—quite markedly for the legal system and major companies, where confidence almost halved—confidence in the armed forces rose by almost 20 percentage points. In the case of the federal government, the trend was more erratic—confidence fell between 1983 and 1995, then increased again in 2001. Trade unions experienced relatively static levels of confidence over this time period, staying at roughly a quarter of the population.

Community and civic engagement

Community and civic engagement denotes the type of participation, including volunteering, that occurs within the more formal social networks operating in the community. These formal networks incorporate the myriad of relations people hold with more distant acquaintances, or associates and colleagues. Such relationships are generally weaker and more diverse but also tend to involve individuals who may not normally associate with one another, that is, they form ‘bridges’ between community members.

The work of non-government organisations (NGOs) typifies such engagement through their dedication to providing not-for-profit services (see, for example, Chapter 4). NGOs play an important role in the provision of welfare, social and other services in Australia and often rely significantly on volunteering and donations from the public. These forms of engagement are described in two indicators presented below: participation in voluntary work and monetary donations to charities and non-profit organisations.

Community engagement

Volunteering generally relies on face-to-face interaction, often drawing people who may not necessarily interact in other circumstances, to work together for the benefit of others. This initial establishment of ‘social bridges’ may in turn engender other sources of cohesion, such as trust, and the further establishment of support networks and norms (Putnam 1983, 2000).

Table 2.33: Participation in voluntary work: time spent, by age and sex, 1995 and 2000

	1995			2000		
	No. (’000)	**Per cent**	**Average hours/year**	**No. (’000)**	**Per cent**	**Average hours/year**
Age group						
18–24	376.0	16.6	135.6	493.3	26.8	122.6
25–34	571.7	20.4	128.0	774.1	27.5	109.2
35–44	863.0	31.7	142.5	1,157.3	40.1	128.3
45-54	614.9	27.7	163.8	897.5	35.4	166.2
55–64	356.4	23.8	208.2	545.5	32.5	255.3
65–74	309.2	23.0	225.1	381.4	30.3	236.2
75+	97.7	14.9	205.8	146.7	17.8	218.0
Sex						
Males	1,522.3	22.9	160.8	2,080.9	30.5	154.4
Females	1,667.1	24.4	160.1	2,314.6	33.0	165.4
Total volunteering	**3,189.4**	**23.6**	**160.4**	**4,395.6**	**31.8**	**160.2**

Note: Voluntary activity includes administration/clerical work/recruitment, befriending/supportive/counselling, coaching/judging/refereeing, fundraising/sales, management/committee work, performing/media production, personal care/assistance, preparing/serving food, repairing/maintenance/gardening, teaching/instruction/providing information, and transporting people and goods (see source for definitions). Voluntary work for the Sydney 2000 Olympic and Paralympic Games is excluded from the data and thus does not account for the higher rate of volunteering in 2000.

Source: ABS 1996b, 2001d.

In 2000, 32% of the Australian population were involved in voluntary work, a rise from 24% in 1995. This increase in volunteering is also found for each age group, and both males and females (Table 2.33). Rates of volunteering varied across age group and sex. In both 1995 and 2000, volunteering was most common among people aged 35–44 years—32% and 40%, respectively. Actual time spent, however, was greater for people over the age of 55 years, who volunteered an average of 200+ hours in both 1995 and 2002. Females were more likely to volunteer than males and, in 2000, devoted slightly more time to voluntary work.

Philanthropy, in this case donations to charitable and non-profit organisations, can be viewed as an adjunct indicator to community engagement, capturing the concept of altruism, which underpins but does not necessarily prompt all voluntary behaviour. Monetary donations in which the donor does not receive any benefit (e.g. prizes from raffle tickets) suggest that the donation is sincerely being made to improve or enhance the circumstances of others. Hence, an indicator capturing such good intent needs to focus only on those donations made for this explicit purpose.

Three-quarters of Australians donated money to charities or non-profit organisations in 2000 (Table 2.34). Females donated at a slightly higher rate than males: 77%, compared with 72%. The age groups 35–44 and 45–54 reported the highest rates of donation (80% each), but the rate was above 70% for all other groups aged over 25 years. Persons aged 18–24 years were the least inclined to donate money. Volunteers (84%) were more likely than non-volunteers (70%) to make donations.

Table 2.34: People who made monetary donations to charities and non-profit organisations, by volunteer status, 2000

	By volunteers		By non-volunteers		Total	
	No. ('000)	**Per cent**	**No. ('000)**	**Per cent**	**No. ('000)**	**Per cent**
Age						
18–24	333.5	67.6	806.3	59.7	1,139.7	61.8
25–34	649.1	83.9	1,357.7	66.5	2,006.8	71.3
35–44	996.6	86.1	1,299.6	75.1	2,296.2	79.5
45-54	792.0	88.2	1,224.4	74.9	2,016.4	79.6
55–64	472.0	86.5	829.7	73.1	1,301.7	77.4
65–74	328.6	86.2	586.5	66.7	915.1	72.6
75+	127.2	86.7	467.5	69.2	594.6	72.3
Sex						
Males	1,719.3	82.6	3,165.0	66.6	4,884.3	71.5
Females	1,979.7	85.5	3,406.8	72.6	5,386.4	76.9
Total	**3,698.9**	**84.2**	**6,571.8**	**69.6**	**10,270.7**	**74.2**

Note: A donation was defined as a 'voluntary transfer of funds made in the preceding 12 months by a person, on an individual not a business basis. The donor should not have received any benefit in return. Excludes purchase of goods and raffle tickets but includes door knocks and sponsoring walkathons etc.'

Source: ABS 2001d.

A second indicator of charitable giving focuses on 'corporate giving', that is, monetary pledges made by for-profit businesses. In the period 2000–01, 8,370 Australian businesses donated $585 million to the community sector,[13] where a donation was defined as an 'unconditional voluntary transfer(s) of money, goods and services to non-related community organisations or individuals' (ABS 2002j:12). Such donations were mostly in the form of money ($334 million), followed by services worth $173 million and goods worth $79 million.

Civic engagement

Civic engagement captures participation associated with the political sphere and the administration of clubs and other organisations. This sort of participation may include being an active member of a political party, recent involvement in protest meetings, signing petitions, and/or having a primary role in the running of a community club or organisation (see, for example, Black & Hughes 2001). No current national data are available on civic engagement.

2.5 Future directions

This chapter presents data on 13 indicator topics within three main components of welfare: healthy living; autonomy and participation; and social cohesion. Together these data provide important indications of the welfare of the Australian population, and a backdrop for the following chapters of this report.

The indicator topics vary in terms of the clarity of the underlying concepts, the level of authoritative agreement as to their construction, and the availability of suitable data. This is perhaps particularly the case for the social cohesion component. There is, thus, scope for further development in all these areas, and future reports will reflect these developments.

For each indicator topic there has been an effort to reflect the three different types of measures considered important: average or level; distribution or inequality; disadvantage or social exclusion. The lack of suitable data or authoritative agreement on measurement have, in some cases, limited the ability to present all three types of measure for each indicator topic, and this is another area for further work. Data from the ABS 2002 General Social Survey and 2003 Indigenous Social Survey, not available at the time of preparing this chapter, should enhance future editions. Most indicators are presented in terms of the most recent available, reliable, point-in-time data, with few trends discussed; it will be a goal for future reports to include more trend data.

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[13] The community sector includes organisations providing activities in arts and culture, community service and welfare, education and training, employment, environment, health, and sports and recreation.

This chapter thus represents the second of three stages of development, in three successive editions of *Australia's Welfare*: in 2001, the development of the frameworks and indicator topics; in 2003, the refinement of the indicators and inclusion of data for all topics; and in 2005, further refinement, new data where available, and more trend analyses.

The AIHW has benefited from discussion of this chapter, and its predecessor in *Australia's Welfare 2001,* with a range of commentators, and continues to welcome comments and suggestions on this area of work.

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3 Informal care

3.1 Introduction

Informal assistance provided by family and friends is the main source of non-parental care of children and care for people with a disability. Shifts in the extent to which the responsibility for such care has fallen to the community or the state throughout Australia's history since European settlement have been presented in *Australia's Welfare 1993* (AIHW 1993) and more recently by Fine (1999). In the early colonial days, government-sponsored orphanages cared for the children of 'unsuitable mothers' and working single fathers. Private boarding of children led to the passing of protective legislation for children in the 1870s. Between Federation and 1970, the family was seen as the central institution in the care of children; however, widespread adoption practices and the operation of orphanages and other large-scale residential facilities for children continued until the middle of the 20th century. Formal child care services expanded during the 1970s, beginning with the passing of the Community Child Care Act in 1972 and followed by implementation of a National Child Care Strategy in 1988. Now, family day care and some forms of home-based child care are part of the system of formal child care services along with institutional-based care such as long day care. Informal care of children is the unregulated care of children by other than the non-resident parent, that is primarily provided by grandparents, other relatives and friends.

Institutions run by charitable organisations dominated care arrangements for aged and disabled persons in the fledgling colonies. Adults needing care were viewed as indigent and were institutionalised to facilities for the destitute. Possibly the first public nursing home, the Liverpool Street Asylum, opened in 1849. Between 1860 and 1950, aged care remained a state government responsibility. Specialised community care began to emerge in the 1950s. The 1980s saw the introduction of the Home and Community Care Program and the Aged Care Reform Strategy established residential care benchmarks. Care in the community is now the preferred and most common care arrangement for most people with a disability or age-related frailty.

Informal carers have played a pivotal role in the deinstitutionalisation of aged care and disability services, chronicled in an earlier edition of *Australia's Welfare* (AIHW 2001). The shift to caring for people with a disability in the community depends on the availability of informal carers to take on a caring role. The narratives of carers highlight that, for many, to do so is not a decision as such. For them, being a carer is a natural expression of their relationship with a family member or friend in a time of need, however long that may be. Yet studies of informal care reveal that caring at home may not always be a carer's first choice and can extend well beyond what most people might expect of family life (e.g. CAA 1999; Schofield et al. 1997). There is widespread recognition that, while caring may be rewarding, carers may also experience the stress of social isolation, physical and emotional strain, and reduced education and employment potential. The appointment of the National Family Carers Voice in 2003 is one of a number of initiatives that represents acknowledgment at the national level of a pressing need for insight and solutions to address the challenges confronting many informal carers.

Informal care has featured as a topic of chapters in previous issues of *Australia's Welfare*. These treatments have suggested that, despite an increased awareness of the role of informal carers in recent decades, there remains some tendency to view the family as a net consumer of welfare—welfare is something provided *to* families rather than being provided *by* families. As such, providers of informal care are sometimes seen as 'dependent' (e.g. because they receive a carer's pension or use respite care services) rather than as contributors to welfare (AIHW 1997:55). A report from the Organisation for Economic Co-operation and Development cautions that informal care 'cannot be simply assumed, or regarded as a free good' (OECD 1996:63).

This dedicated chapter reflects a growing awareness of the importance of informal caring activity. It presents an overview of what we know about carers and their caring activities from existing national data collections and the published literature. Currently, the Australian Bureau of Statistics' Child Care Survey and Survey of Disability, Ageing and Carers are the main sources of national information. The most recent Child Care Survey was conducted in 2002 and the 5-yearly Survey of Disability, Ageing and Carers, last conducted in 1998, is in the field as at date of publication.

Section 3.2 discusses changes in Australia that have raised concerns about the numbers of carers who will be available in the future. Section 3.3 considers the way in which unpaid informal care and formal services are currently used together under the care in the community service delivery model. Section 3.4 looks at informal non-parental care for children. Section 3.5 focuses on those who care for people of all ages with a severe or profound disability. In Section 3.6, the effects that current social trends will have on the availability of carers for people with severe or profound disabilities are examined.

Informal care defined

Caring can be broadly defined as providing assistance and support in response to a need arising in the family or community. As such, it can be provided by workers employed in community service occupations and industries or by volunteers in such organisations (see Chapter 4). However, the vast majority of care for children, and for adults and children who need help in their daily activities because of disability, is provided by family and friends. This ranges from emotional support through financial and practical assistance to supervision and assistance with personal care, mobility and communication for extended periods. This type of care, which is characteristically free of charge and government regulation, is described as 'informal care' and the providers of informal care are referred to as 'carers' for the purposes of this chapter. Other sources might connote 'informal care' and 'carer' differently.

In this chapter, informal care is that provided by an unpaid carer who has assumed responsibility for another's physical, emotional or developmental wellbeing where the care is *not a defining element* of the primary or precedant relationship between the person needing care and the person providing care. There are, inevitably, inconsistencies and ambiguities in this conceptualisation since relationship definitions, and their associated obligations, are subjective. Our scope, therefore, is specified as all informal care *other* *than* that provided by a parent to a dependent child without specific special needs (e.g. disability or handicap)—parenting is not included. Section 3.5 further defines 'primary carer', an important distinction that needs to be made in the context of informal care of people (including children) with a disability.

3.2 Caring in a changing Australia

Just as national and international awareness of the contributions made by informal carers has been growing, there has emerged a concurrent concern about the sustainability of the current patterns of informal care provision, both in terms of pressures on the supply of carers and factors likely to increase demand for care. Some observers of change in the United States have proposed that the ageing of the population will bring with it a larger proportion of the population with health and personal care needs and that this is occurring at the same time as the traditional supply of paid and unpaid caregivers is shrinking (NHPF 2002). These concerns have been shared by some Australian researchers (Schofield & Bloch 1998) who cite a range of relevant changes in the Australian context, including the shift to deinstitutionalisation of care, the growing number of women in the workforce, increased rates of relationship breakdown, and the tendency toward smaller families. The ageing of carers has also been identified as an issue of concern, particularly in relation to older parents who care for their grown children with disabilities (AIHW 2000).

The ageing of the population

Over the past 30 years, the declining birth rate, in combination with increased longevity, has transformed the Australian population. Moreover, as the baby-boom generation moves into old age in the next two to three decades, this ageing pattern will be accentuated.

Australians are living longer than ever before. While 70% of women born in 1905 survived until age 65, 89% of those born in 1950 are expected to reach age 65. The effect is even more dramatic for those surviving to age 85—just 28% of the 1905 birth cohort survived to this age, compared with the 54% of those born in 1950 who are predicted to reach that age (Gibson et al. 1999). In 1992, 11.5% of the population were aged 65 or over and by 2002 this had grown to 12.7%. It is estimated that in 2016 and 2021 the proportions will be 16.4% and 18.4%, respectively. In 2002, 3.2% of the population were aged 80 or over and this will grow to 4.0% by 2016 and 4.4% by 2021 (ABS 2003a).

Since the proportion of people with a disability increases at older ages, more people are likely to require assistance and care in the future. Demand for personal care services, including home nursing, is likely to increase in line with increasing numbers of people with a severe or profound core activity restriction living in the community. The increasing proportion of older people and the corresponding decreasing proportion of working-age people have been raised as issues that may pose challenges to providing welfare services to Australians, or require changes in the current patterns of social participation and service provision. While this has sometimes been referred to as an 'ageing crisis', authors such as Kinnear (2001) have argued that these population changes offer opportunities for progress rather than posing a threat to future sustainability.

Deinstitutionalisation

Over the past three decades, there has been a shift in the system of service delivery for aged care, children in out-of-home care, services for people with a disability, and services for those with mental health problems and those needing acute hospital services. These services have moved from an emphasis on institutional care to one on community-based care and community living (see AIHW 2001:96 for a broadly-based discussion of deinstitutionalisation across these service areas). In 1996 there were 210,186 people living in health and welfare institutions, a decrease of 8% over the decade from 1986. This represents a drop in residency rates from 14.3 people per 1,000 in 1986 to 11.5 per 1,000 by 1996 (AIHW 2001:106).

The shift to community-based care does, however, rely on the unpaid contribution of families and wider social networks. People with varying needs for care are remaining in or returning to the community for care—not just people with a disability and frail older people, but also people with a mental illness and post-acute care patients as well. These changes place multiple demands for support and assistance on a range of community-based programs, home care services, and, importantly for this chapter, on informal carers.

While community family care is preferred by some families, it does not suit all situations and is not the preferred choice of all families. In 2002, the National Disability Administrators commissioned the AIHW to assess the effectiveness of ‘unmet need’ funding allocated under the Commonwealth/State Disability Agreement in 2000–01. The study also sought to identify any remaining unmet need for disability accommodation, in-home support, day programs, respite services and disability employment services. The study estimated that in 2001, 12,500 people needed accommodation and respite services (AIHW 2002:xv, xxi). The study methodology included three discussions with peak organisations of non-government service providers, consumers and carers. It was considered by many participants that the apparent government focus on in-home support ignores ‘the fact that people still need residential accommodation options’, including centre-based respite (AIHW 2002:187).

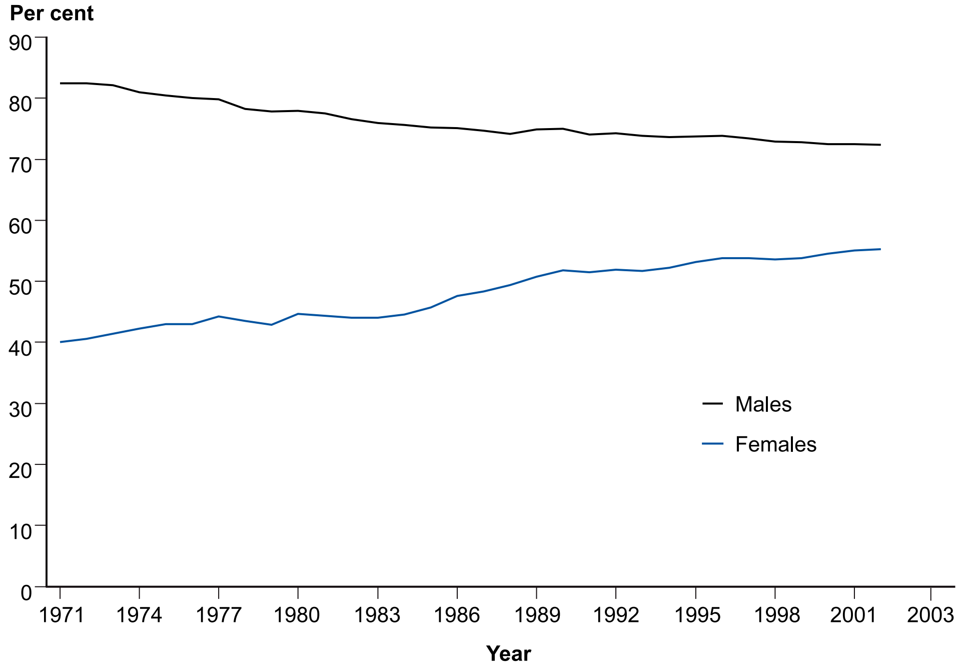
Increased female labour force participation

Female labour force participation grew from less than 40% in 1971 to 55% in 2002 (ABS 1992, 2003c). ABS labour force projections to 2016 indicate a sustained increase in female labour force participation, particularly at ages 45 to 64 which currently comprise over 40% of female primary carers (Table 3.1). At this stage, projections predict that, for 45 to 54 year olds, male and female labour force participation rates will converge from a difference of around 15 percentage points in 2003 to 10 percentage points in 2016.

Table 3.1: Projected labour force participation rates, 2003, 2008, 2013, 2016 (per cent)

	Age group (years)							
	15–19	20–24	25–34	35–44	45–54	55–59	60–64	65+
				Males				
2003	57.1	86.5	92.1	91.6	87.5	71.6	47.6	10.0
2008	56.4	85.7	91.4	90.9	87.0	71.1	47.7	10.3
2013	55.8	85.1	90.8	90.2	86.7	70.8	47.7	10.7
2016	55.4	84.7	90.4	89.8	86.5	70.7	47.7	10.9
				Females				
2003	56.9	78.8	71.7	74.4	71.9	45.4	19.5	2.7
2008	56.3	79.1	73.1	75.6	74.3	49.3	21.2	2.8
2013	55.7	79.2	74.1	76.3	75.9	53.3	23.0	2.8
2016	55.4	79.2	74.5	76.6	76.7	55.6	24.0	2.9

Source: Labour force projections 1999 to 2016 (ABS 1999b).



Sources: ABS 1992, 2003c.

Figure 3.1: Labour force participation rates, 1971–2003

Examination of the patterns of women's labour force participation reveals that this trend has not necessarily reduced the provision of care. First, participation rates have levelled off over the past decade. Most of the growth in women's labour force participation occurred in the 1970s and 1980s, with a particularly steep rise of 5 percentage points between 1985 and 1990 (Figure 3.1). By contrast, during the 1990s, there was a growth of less than 3 percentage points. Second, most of the growth in women's labour force participation has been in part-time employment. In fact, successive cohorts of employed women have actually been less likely to work full-time since 1971 (ABS 2003b). Moreover, many people who currently provide care are also in paid employment, often part-time (Table 3.15). As Howe and Schofield (1996) foreshadowed, changes in labour force participation patterns have not been so large as to potentially threaten the availability of carers in the future.

Additionally, it is not clear that increased labour force participation necessarily translates to lower carer availability. While there is evidence that a portion of carers will leave work or reduce their hours of work to care (e.g. Schofield et al. 1997), it is not clear that participation in the workforce reduces carer availability per se. As Cox and Spalding (1996) argue, entering employment does not mean that women are forsaking caring, rather that they are adding to their responsibilities, or as Doty et al. (1998) suggest, making greater use of a wider informal care network. Research conducted in Northern America has indicated that there is little evidence that this increased workforce participation has resulted in reduced care for older people by women (Aytac and Waite, 1995; Chappell 1990).

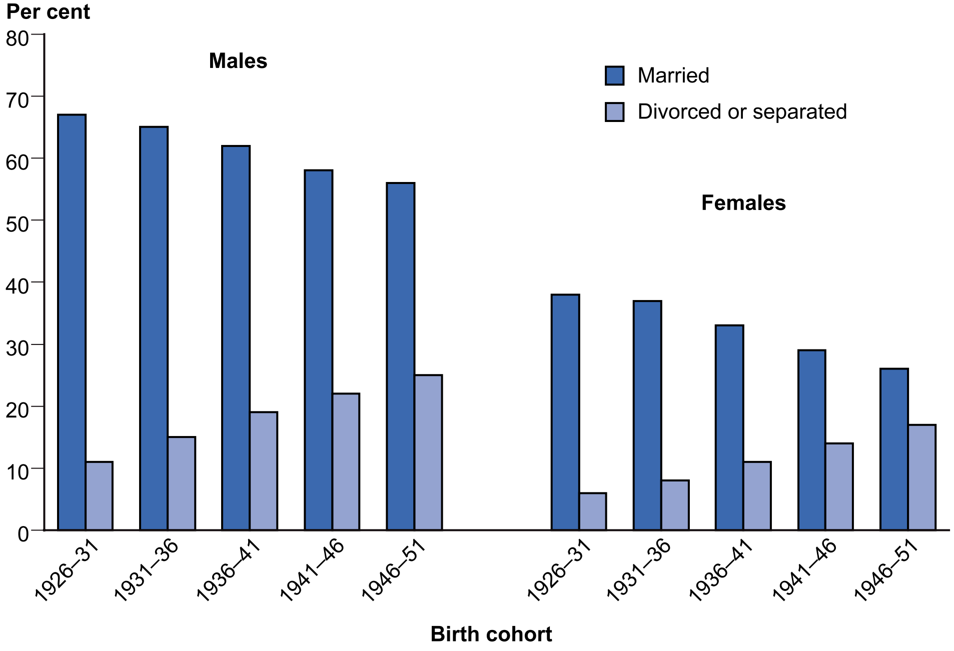
Increased rates of relationship breakdown

Family resources are reduced by the family network disruption that can occur following divorce or separation and this may have implications for the provision of informal care (Millard 1998). Since most assistance to sustain independence at older ages comes from within generations rather than between them, marital status can be used as an indicator of family resources for care and support (Rowland 2003). Current cohorts of older Australians are the most likely to have been legally married for life. As Rowland (2003:253) puts it: 'In the next few decades, the composition of the older population will begin to change as birth cohorts with disrupted marital histories advance into later life. Australia is on the threshold of a decline in family resources as higher proportions experience marriage breakdown and live their later years without spouses, the main carers and supporters of the aged.'

Figure 3.2 shows the marital status, at age 75–79, of age cohorts born in the first half of the last century over a 20-year period. Data for later cohorts are projections. There is a steady decline in the proportion of age cohorts who were married, or are projected to be married, at this age. In the cohort born between 1926 and 1931, 67% of men and 38% of women were married but these proportions are projected to have fallen to 56% and 26% in the cohort born between 1946 and 1951. Over the same 20-year period, the proportion of birth cohorts divorced or separated has risen sharply, from 11% of men to a predicted 25% and from 6% of women to 17%. The difference in the proportions of men and women is due primarily to the larger proportion of widows among women because men tend to die at an earlier age.

These generations with a history of marital breakdown are less likely to have spouses to care for them at older ages. However, there is a countervailing trend, which is that the gap between male and female life expectancies is closing, potentially reducing the duration of widowhood and hence the proportion of widowed women in the population. In the 1946–51 cohort, 79% of men are projected to reach age 65 and 64% are projected to reach age 75, compared with 60% and 39%, respectively, of men born in 1901–06—a large increase over half a century (Rowland 2003). Levels of cohabitation outside of marriage in later life and improved life expectancy for people in couple relationships will determine the net impact of these emerging patterns of marriage breakdown on informal care.

The proportion of families that are headed by sole parents has risen from 9% of all families with dependent children in 1974, to 15% in 1986 and to 19% in 1996 (AIHW 1997:65). This rise is due to relationship breakdown as well as the higher number of children born outside of continuing relationships. The current divorce rate means that each year 40,000 to 50,000 more children join the pool of Australian people with divorced parents (de Vaus 1997). Once again, the effect that repartnering will have on informal caring resources is unknown.



Source: Table 3.2.

Figure 3.2: Marital status of cohorts born 1926–51, at age 75–79

Table 3.2: Marital status at ages 65–69 and 75–79 of cohorts born 1926–51 (per cent)

	Never married		Married		Widowed		Separated or divorced	
Birth cohort	**65–69**	**75–79**	**65–69**	**75–79**	**65–69**	**75–79**	**65–69**	**75–79**
				Males				
1926–31	7	6	75	67	6	16	12	11
1931–36	6	6	73	65	6	15	15	15
1936–41	6	5	69	62	6	14	19	19
1941–46	6	5	66	58	6	14	23	22
1946–51	6	6	63	56	6	14	26	25
				Females				
1926–31	4	5	60	38	27	51	9	6
1931–36	4	5	59	37	26	51	11	8
1936–41	5	5	55	33	25	52	15	11
1941–46	5	5	51	29	25	52	20	14
1946–51	6	6	46	26	24	50	24	17

Source: Rowland 1994.

While the effects of lone parenting will first be felt by the children of these families, in later life the parent may find themselves without the care of their adult children. Very few Australian children do not live with their natural mother (AIHW 1997:66), so it is fathers who are more at risk of losing contact with their children. Even when parents divorce later in life it is father-child relationships that are most likely to be disrupted (Aquilino 1994).

Relationship breakdown also has the potential to affect caring in other ways. Grandparents who are divorced or separated see their grandchildren less often than those who are married or widowed (Millward 1998). Divorce and repartnering of parents or grandparents can lead to dilution of relationships—grandparents, particularly paternal grandparents, may have less contact with their grandchildren and therefore be less likely to provide assistance with child care. In addition, carers often need support to provide assistance to others while living their own lives, and unpartnered carers will go without such support. Being unpartnered often makes parenting harder and potentially increases the need for child care. It can also make it more difficult for people caring for others with a disability. Increased rates of unpartnered Australians have the potential to reduce caring resources.

Smaller families and childlessness

Similar concerns about reduced caring resources have been raised because of the tendency toward smaller families and childlessness. The role of women in social and economic terms has changed substantially over the last 40 years resulting in a marked reduction in child-bearing. Progressively, women have been delaying having children and, partly as a result, having smaller families.

After peaking at 3.55 babies per woman in 1961, the total fertility rate in Australia fell to 1.73 in 2000. The most dramatic decline occurred between 1961 and 1975 when the rate fell by 1.4 children per woman in just 15 years, coinciding with the introduction of the oral contraceptive pill. After a period of relative stability in the 1980s, a steady decline characterised the 1990s. Women are starting their families later in life and as a result, or by desire, are having fewer children. The median age of Australian mothers at first pregnancy rose from 24 years in 1975 to 29 years in 2001 (ABS 2002b).

Lifetime childlessness began to increase among women who were in their reproductive years from the late 1960s onwards (ABS 2002a). An estimated one in four women of reproductive age in 2003 (24%) are expected to remain childless and rates are predicted to be as high as one in three women in parts of the country. The oldest of these women will turn 65 in 2020 and the youngest in 2050. If they remain childless as predicted, they will not have children who could potentially care for them.

Smaller families mean that, in the future, families will have fewer members to call upon for caring—fewer adult children to provide care for older people, fewer siblings to help with child care or to help care for a family member with a disability. However, past fertility patterns mean that this will not affect the number of available carers in the short to medium term. The effect of current patterns of low fertility will not be felt until around 2040, when those born during the 1960s and in their peak child-bearing years in the 1990s reach ages at which they are likely to be in need of assistance. Indeed for at least the next decade, older generations will be family-rich, since Australia's fertility rate peaked during the baby boom at 3.6 births per woman in 1961. Women turning 80 in 2011 (born in 1931) had an average of 2.3 children (ABS 2002b). Moveover, in the short term, childless people may have more capacity to provide informal care to parents or partners because of the absence of children.

Older parent carers of adult children with disabilities

Ageing parents caring for their child with a severe or profound disability often have a different history from people taking on the caring role as a spouse in later life. Many have been providing care for many years, often decades. Analysis of the 1998 ABS Disability, Ageing and Carers Survey found that an estimated 8,000 co-resident principal carers of people with severe or profound disability were parents aged 65 years and over and a further 25,800 were aged 45 to 64 years. Approximately 57% of parents aged 65 and over had been caring for their children for 25 years or more, and 49% of them for 30 years or more. The recipients of their care are often those with an early onset disability, particularly intellectual disability. The ageing carers often find that the caring role has become more difficult and wish to see alternative arrangements put in place for the future care of the person involved (AIHW: Madden et al. 1996).

Further insight into the experience, knowledge and needs of older parent carers has been gained through recent research by Llewellyn et al. (2003). Through a series of interviews with carers, the researchers identified issues affecting the wellbeing and coping ability of carers, including those factors influencing their use of formal services. While caring may have a toll on older parents that may be physical, emotional or financial, they may also be concerned that alternative care arrangements will not provide care as they had been able.

3.3 Context of care

The trend towards community care has seen a move away from the provision of institutional care and the growth of services that can be used to help people in need of care and assistance to stay living at home. This applies to people of all ages who require assistance as a result of disability, and also to child welfare.

The change of emphasis in child welfare is characterised by government assistance such as Parenting Payment and Family Allowance which aims to assist parents in providing for their children. When it is necessary to remove a child from their home, placement with kin is the preferred option, rather than foster placement or institutional care. Today, there are very few larger institutions left and most residential care for children is provided in family group homes or in smaller residential establishments (AIHW 2001: 127).

It was the awareness of the rapid increase in the proportion of the older population that occurred in the 1980s that prompted the development of the Aged Care Reform Strategy of 1985. The reforms brought about by this strategy reduced the number of nursing home beds per 1,000 people aged 70 and over in the late 1980s. A second wave of major aged care reforms in 1997 saw the continued reduction in provision of residential places. The number of operational residential aged care places has declined from 89.2 per 1,000 persons aged 70 and over in 1997 to 81.6 per 1,000 persons aged 70 and over in 2002 (AIHW 2003). The care needs of residents of aged care services have also been rising over time. For example, the proportion of residents classified in the highest care need categories according to the Resident Classification Scale (RCS 1–4) rose from 58% in 1998 to 63% in 2002 (Table 7.17). Over the last decade, there has also been an expansion of Community Aged Care Packages (CACP). The level of provision increased from 3.9 per 1,000 persons aged 70 and over in 1997 to 14.7 per 1,000 persons aged 70 and over in 2002 (AIHW 2003). The Extended Aged Care at Home program is a new program that, like CACP, offers tailored packages of services to people living at home with complex care needs, but whose level of care need is equivalent to that required by someone in high-level residential care.

For younger people with a disability, the 1980s saw changing policies and services that placed greater emphasis on consumer involvement and integration and an emphasis on moving away from institutional models towards community-based services. The first Commonwealth/State Disability Agreement (CSDA) was signed in 1991 and signalled changes in the care of younger people with disabilities. Initiatives arising from this agreement included the closure of institutional-style services such as special purpose nursing homes and hostels, and the opening of community based services, including group homes and community access/recreation services for clients living in the community. Analysis of the CSDA minimum data set collection has shown that 43% of all accommodation support services received in 2002 were through group homes, although there has not been a clear trend of increase or decrease in regard to this service (Table 8.8). Outreach, in-home and drop-in support services increased steadily over the period from 1996 to 2000 (AIHW 2001:121).

Table 3.3: Living arrangements of people with profound or severe core activity restriction(s), 1981, 1988, 1993 and 1998 ('000)

	People with severe or profound restriction			
Living arrangements	**1981**	**1988**	**1993**	**1998[(a)]**
		5–64 years		
Households	244.1	302.5	349.1	606.6
Cared accommodation[(b)]	27.0	24.2	19.2	20.0
Total	**271.1**	**326.7**	**368.3**	**626.6**
Proportion in cared accommodation (%)	9.9	7.4	5.2	3.2
		65+ years		
Households	168.9	217.8	299.4	396.3
Cared accommodation[(b)]	73.9	113.0	103.1	152.9
Total	**242.8**	**330.8**	**402.5**	**549.2**
Proportion in cared accommodation (%)	30.4	34.2	25.6	27.8

a) In the 1981, 1988 and 1993 surveys, three levels of severity of handicap (severe, moderate and mild) were applied to both household and establishment components. In 1993 the severe handicap category was further divided into profound handicap and severe handicap, but the severe handicap category was not applied to the establishment component. In the 1998 survey both the profound and severe core activity restriction categories were applied to the cared accommodation component.

(b) Cared accommodation (1998) and establishments (1981, 1988 and 1993) are defined by ABS as hospitals, nursing homes, hostels, retirement villages and other 'homes'.

Source: AIHW analysis of ABS Disability, Ageing and Carers Survey data, 1981, 1988, 1993, 1998.

The shift to caring for people with a range of disabilities in the community has resulted in higher proportions of people with a severe or profound level of activity restriction living in households rather than in institutions (Table 3.3). For those aged 5–64 years with such a restriction, the percentage living in cared accommodation fell from 10% in 1981 to 3% in 1998. For those aged 65 years and over with such a restriction, the notable drop in proportion in cared accommodation occurred between 1988 and 1993 (from 34% to 26%).

Imputed value of informal care

Any description of the Australian welfare system that is limited to government-funded or registered services underestimates total welfare activity and its cost in real terms. The contribution of unpaid carers far exceeds the expenditure of governments and non-government community service organisations (NGCSOs) on welfare services. The System of National Accounts 1993 recommended that 'satellite accounts' be calculated (Commission of European Communities et al. 1993). These are accounting statements which are separate from, but consistent with, the existing national accounts. By imputing a value for unpaid caring work, such a satellite analysis allows caring to be made visible for the purposes of economic policy. The imputed value of unpaid welfare services is calculated in Chapter 4, using time-use survey data to estimate how much households contribute to caring. It must be noted that, in accordance with previous editions of *Australia's Welfare*, this estimate of caring includes care for people with a disability, child care for other people's children, and care for their own children if sick or disabled. The estimates of the size of the community services labour force that are also in Chapter 4 include volunteers who give unpaid work through organisations, but do not include any other type of unpaid carers.

The imputed value of unpaid welfare work done during 2000–01 is $28.8 billion, compared with $13.7 billion in expenditure mostly incurred by governments and NGCSOs (Table 4.24). In terms of type of care provided by this unpaid work, 66.6% ($19.3 billion) of the gross value was for care provided to other adult family members, friends or neighbours. A further 28.6% ($8.3 billion) was for child care-related activities and the remaining $1.4 billion was for voluntary welfare assistance provided through community service organisations. The unpaid workforce was estimated to be about six times the paid workforce in terms of full-time equivalents (AIHW:2001:42). Unpaid caring work plays a large role in improving the quality of life for many Australians and in reducing the need for expenditure on formal services to the extent that informal, unpaid care has been referred to as the 'invisible welfare state' (OECD 1996:19).

Interplay of informal care and use of formal services

Among all people living in households in 1998 who received assistance with the core activities (self-care, mobility and communication), 3% said they were assisted only by formal service providers while 46% said they received assistance only from informal carers, and 48% said that they received assistance from both informal carers and formal services (Table 3.4).

There is a vast body of published literature on the interplay between informal care and formal community-based services. Much of the work has focused on how the informal and formal care sectors operate together to help older people with high needs for assistance to remain in the community. Projected increases in the number of people with severe disability over the coming decades means that this is of considerable interest in terms of planning for anticipated growth in demand for services. Does access to informal care reduce demand for formal services? If so, is the effect universal, or does it vary according to service type? What are the respective roles of informal care and formal services in different age groups, and for people of culturally diverse backgrounds?

Early studies of the relationship between informal and formal care centred on the hypothesis of substitution (e.g. Greene 1983). This proposes that informal care and formal community-based services are independent enablers that assist people with disabilities to remain in the community. Accordingly, if an individual in need of assistance does not have access to adequate informal care, then formal services can directly substitute for an informal care network.

Supplementation of informal care with formal services is another widely studied theory (e.g. Jette et al. 1995; Schneider et al. 2003). In some situations, supplementation is observed as specialisation, where informal care and formal services operate in different domains to reflect specialisation in the provision of care. The use of formal services to reduce demand on informal care in one domain, such as domestic assistance, to allow informal care to respond to increasing needs in another domain, such as personal care, is another form of supplementation. Jette et al. (1995) have suggested that increasing supplementation of informal care with formal services reflects the progression of an individual along a care continuum that begins with mainly informal care and progresses to mixed formal and informal care. For some people, the continuum ends with informal care being largely substituted by formal (institutional) care. If this is true, cross-sectional studies may be unable to demonstrate clear patterns of substitution and supplementation effects because the degree of either depends on where a person is placed on the care continuum.

Data collected recently in Australia reveal patterns that are consistent with both substitution and supplementation effects. The Sydney Older Persons Study (Edelbrock et al. 2003) examined the relationships between the use of formal services and the level of unpaid informal care by 537 community-dwelling older persons in inner Sydney. After adjusting for level and type of disability, the analysis revealed an inverse relationship between the use of formal services for instrumental activities of daily living (shopping, housework, food preparation, etc.) and the level of available informal care. Persons with higher levels of informal care were found to make heavier use of medical and other professional services. Thus, there was evidence of the use of formal services to substitute for unavailable informal network support as well as specialisation and supplementation among people with access to a relatively high level of informal care.

A report compiled by the Lincoln Gerontology Centre at La Trobe University revealed different patterns in the recommendations made by Aged Care Assessment Teams for people living alone, compared to people who live with others (LGC 2002). Aged Care Assessment Teams are multi-disciplinary teams of health care professionals who assess the circumstances of people who may need to enter residential care (see Chapter 7). In 2000–01, clients living at home alone were more likely to be recommended for residential care (38.6%) than those living with others (34.1%) or a spouse only (29.2%). However, clients living alone at home were more likely to be recommended for low-level residential care (26.2%) than for high-level care (12.4%), which is thought to reflect psychosocial factors as well as physical dependency for people who live alone. Clients who were living with only their spouse at the time of assessment were more likely to be recommended for high level residential care (18.1%) than for low-level residential care (11.1%). Likewise, clients who lived with people in addition to, or other than, a spouse were more likely to be recommended for high-level residential care (18.5%) than for low-level residential care (15.6%) (LGC 2002: Table 17a). The authors suggest that 'the protective effect of being married or living with a family member allows people to remain living in the community until their level of disability requires high-level care' (LGC 2002:55).

Data collected in the 1998 ABS Survey of Disability, Ageing and Carers reveals some age-related patterns in the mixture of formal and informal sources of assistance reported by people with severe disability. While overall, 46% of this population group said that they received assistance only from informal carers, the proportion is substantially higher among people aged 25 to 64 years (58%), compared with the younger and older age groups (37% and 34% respectively) (Table 3.4).

Table 3.4: Type of assistance received by people with a severe or profound restriction living in households, 1998

	Age of person with a severe or profound restriction							
	0–24		25–64		65+		All ages	
Type of assistance	**’000**	**Per cent**	**’000**	**Per cent**	**’000**	**Per cent**	**’000**	**Per cent**
Informal only	72.8	37.4	257.1	58.3	110.1	33.8	440.0	45.7
Informal and formal	107.1	55.0	160.2	36.3	198.7	61.0	466.0	48.5
Formal only	*8.0	*4.1	*7.4	*1.7	11.5	3.5	26.9	2.8
Not applicable or none specified	*6.8	*3.5	16.5	3.7	*5.3	*1.6	28.7	3.0
Total	**194.7**	**100.0**	**441.3**	**100.0**	**325.6**	**100.0**	**961.6**	**100.0**

Source: AIHW analysis of 1998 ABS Survey of Disability, Ageing and Carers confidentialised unit record file.

Table 3.5: Main source of assistance received by people with a severe or profound core activity restriction living in households, 1998

	Under 65 years		65 years and over	
	Number (’000)	**Per cent receiving assistance(a)**	**Number (’000)**	**Per cent receiving assistance(a)**
Need for assistance				
One of ten daily activities(b)	633.4	99.6	324.6	99.6
More than one core activity	264.3	41.5	122.4	37.6
All three core activities	56.0	8.8	17.0	5.2
Total severe or profound	*636.0*		*325.6*	
Main source of assistance is a formal service provider				
Self-care	14.5	4.3	17.8	12.6
Mobility	28.6	6.8	22.2	8.6
Communication	18.0	13.6	—	—
Health care	49.8	16.3	95.4	46.6
Housework	18.6	7.6	60.0	27.3
Property maintenance	40.0	13.9	74.9	31.3
Paperwork	*9.0	*7.4	*5.1	*4.8
Meal preparation	*6.0	*5.2	23.7	20.0
Transport	18.9	6.6	22.8	10.4
Main source of assistance is an informal carer (co-resident and non-resident)				
Self-care	320.0	95.7	123.4	87.4
Mobility	391.8	93.2	235.4	91.4
Communication	114.4	86.4	25.5	100.0
Health care	255.5	83.7	109.2	53.4
Housework	225.4	92.4	160.1	72.7
Property maintenance	248.8	86.1	164.6	68.7
Paperwork	112.2	92.6	101.9	95.2
Meal preparation	109.6	94.8	94.6	80.0
Transport	265.8	93.4	196.1	89.6

(a) As a percentage of people of that age group who received assistance with that particular activity.

(b) Daily activities include three core activities (self-care, mobility and communication) plus health care, housework, property maintenance, paperwork, meal preparation, transport and guidance.

Source: AIHW 2000: Tables 19.2, A15.3.

Older people's relatively higher reliance on formal service providers to complement the care provided by informal carers relates largely to their use of health services and forms of domestic assistance. An estimated 47% of people aged 65 years or over in 1998 who had a severe or profound restriction had used formal services for health care, compared with just 16% of people aged under 65 years with this level of disability who had used health care services (Table 3.5). However, across all main categories of assistance, a higher proportion of both age groups nominated informal care as the main source of assistance.

Formal support services and their assistance to carers

In addition to direct care for clients, formal services provide indirect and direct assistance to carers. Care coordination and planning services such as Community Aged Care Packages help carers to access a range of professional and domestic service providers, and coordinate service delivery on behalf of their care recipients if necessary. Respite care is accessible through a range of programs including services under the Commonwealth–State/Territory Disability Agreement, the Home and Community Care Program, Community Aged Care Packages and Veterans' Home Care.

The expansion of the community care sector has seen developments in programs that specifically target the needs of carers (Boxes 3.1 and 3.2). Respite care is a particularly important area of service provision. In 1998, over one-third of primary carers reported that they had no fall-back carer, yet only an estimated 13% of primary carers had used respite care within the previous 12 months (AIHW 2001:301). There are many possible reasons for this low rate of use of respite care which may include difficulty accessing appropriate services. The National Respite for Carers Program, and increasing awareness of services through the operation of Commonwealth Carelink Centres throughout the states and territories (see Chapter 7), are specific recent responses to this issue.

Financial support for carers

Government pensions and allowances were the principal source of cash income for over one-half (56%) of primary carers and 40% of all carers in 1998. The most common type of government pension or benefit was a Family Allowance or Parenting Payment (23%), followed by the Age Pension (15%). Primary carers receiving the Age Pension accounted for about 70% of primary carers aged 65 years and over in 1998 (AIHW 2000:Table 16.6). Centrelink administers special purpose carer payments. In 1999, Domiciliary Nursing Care Benefit was subsumed into Carer Allowance, and Carer Payment replaced the Carer's Pension (Box 3.2).

Ongoing data development will enable comparisons of service use by carer availability for the wider population who receives disability and aged care services in the community. The redeveloped Commonwealth–State/Territory Disability Agreement (CSTDA) national minimum data set (see Box 8.4), for most service types, requires disability service providers to provide information about all service users during the year rather than just those who receive a service on a snapshot day. As well, there are five new items related to the presence of an informal carer who provides support to the service user. These items include existence of informal carer, whether the carer lives in the same household, the relationship between the carer and the service user, and the age group of carer. The redeveloped collection thus gives new information on carers in Australia, in particular the relationship between formal services and informal care. Data from the 2002–03 CSTDA collection will be available in 2004.

Box 3.1: Commonwealth carer support programs

Commonwealth Carelink Centres

A network of Commonwealth Carelink Centres was established in 2001 to provide an information service to help put older Australians, people with a disability, and their carers in touch with a range of community, aged care and disability services. The network can be accessed by telephoning 1800 052 222, 65 shopfronts in 54 regions throughout Australia, over 90 access points such a free phones in rural and remote localities, or through the Carelink website, www.commcarelink.health.gov.au. During 2001–02, Centres responded to 89,295 requests for information (DoHA 2002b:142).

National Respite for Carers Program

The National Respite for Carers Program, announced in the 1996–97 Federal Budget, funds Commonwealth Carer Respite Centres, state/territory-based Commonwealth Carer Resource Centres, and a number of projects to assist carers of people with dementia, including the National Dementia Behaviour Advisory Service and the Carer Education and Workforce Training Project for dementia. The funding for this program is expected to increase from $19 million in 1996–97 to an estimated $88 million in 2002–03 (DoHA 2002a:15). Announcements in the first half of 2003 have allocated $38.7 million of the 2002–03 Budget to Commonwealth Carer Respite Centres to boost respite services for carers (Andrews K, 2003a; Andrews K, 2003b; Andrews K, 2003c). Some of this funding will specifically target the needs of carers in rural and remote areas ($13.6 million) and ageing carers caring for younger people with disabilities ($3.6 million).

Commonwealth Respite Centres work closely with the Carer Resource Centre in their state or territory to provide comprehensive support for carers and access to carer information and training materials. Respite Centres are operated by a variety of community organisations to assist carers by acting as single contact points for information, and by organising, purchasing, or managing respite care assistance packages for carers. Respite care is available on an in-home or residential basis.

In 2001–02, the National Respite for Carers Program funded the 8 state- and territory-based Carer Resource Centres, 62 regional Carer Respite Centres, 423 regional respite services for carers and 3 national projects to assist carers of people with dementia. Commonwealth Carer Respite Centres assisted approximately 38,250 carers in 2001–02 and Commonwealth Carer Resource Centres helped 29,500 carers (DoHA 2002b:127–8).

Residential respite care

An important component of the carer support system, residential respite care provides assistance to carers facing other critical demands, their own health or personal needs, and the opportunity to take a holiday or participate in lifestyle activities. In 2001–02 47% of admissions to residential aged care were for respite care (Table A7.8; see Chapter 7 for further detail on recent trends in residential respite).

Box 3.2: Financial support for carers of people with an ongoing need for assistance

Carer Payment

The Carer Payment (Adult and Child) is an income-support benefit payable to people who, because of their caring responsibilities, are unable to engage in a substantial level of paid work but are not eligible for other income support payments such as the Age Pension. It is set at the same rate as the Age Pension, and is subject to the same income and asset tests. As at 31 December 2002, 71,210 people were receiving Carer Payment (Centrelink unpublished data). Because the Payment is for people who cannot earn an income because of full-time caring responsibilities, the majority of carers receiving Carer Payment are aged between 25 and 64 years (see Tables A7.5 and A7.7 for information on the distribution of Carer Payment in 2001–02).

Carer Allowance

The Carer Allowance (Adult and Child) is payable to co-resident carers who provide full-time care on a daily basis who need substantial amounts of care because of a disability, severe medical condition or age-related frailty(limited to two adults). The Allowance can be paid to carers in receipt of a government pension or benefit, including Carer Payment. It is not income or asset tested, but eligibility is determined according to an assessment of the care recipient's care needs. The level of the Allowance, adjusted on 1 January each year, is designed to help meet additional costs involved in caring for a person with a disability (see Tables A7.6 and A7.7 for information on the distribution of Carer Allowance in 2001–02).

3.4 Caring for children

Children need a great deal of care over many years and this care is usually provided by one or both of the child's parents. There is a range of situations, however, in which children are cared for by people outside of the immediate family and much of this care is provided informally. In the following section two types of informal care are discussed:

- informal substitute care which occurs when children, for various reasons, cannot live with their parents and live with carers in another home; and
- informal child care in which the child lives in the family home with one or both parents, but is sometimes cared for by others, regularly or irregularly, outside of formal care arrangements such as centres and pre-schools.

Informal substitute care

Substitute care refers to care that is provided to children and young people whose parents are unwilling, unable or otherwise deemed unsuitable to care for them. Substitute care by relatives has more favourable outcomes for children than care by non-relatives because it is more stable and provides continuity (Patton 2003). The provision of formal substitute care services in Australia is the responsibility of state and territory governments and includes situations where the state or territory makes some form of financial payment for the cost of care. However, sometimes a child lives in a home other than that of their parents, but the state or territory government does not contribute to the cost of the care—this is informal substitute care. Families providing informal substitute care for children are potentially more vulnerable than those formally caring for children out-of-home because they are not offered the same level of financial or other forms of support.

As this type of care is provided outside of formal systems, there are few data available about its prevalence. In 1997 there were approximately 12,000 children aged 0–14 who were living with their grandparents but not their parents, and in 1996 there were 20,100 young people aged 15–17 living with relatives other than parents (ABS 1999c). However, these figures include children who have been placed in substitute care by the state which reimburses the costs of looking after these children. The ABS will publish next year more information on the number of grandparents providing care for their grandchildren from its 2003 Family Characteristics Survey.

Centrelink customer data show that, in December 2002, 26,415 people aged over 55 years received payments such as Family Tax Benefit to assist with the costs of raising children, but this group would include older parents as well as grandparent carers. The number of mature age recipients of this benefit grew by 27% in the two years from December 2000 (Wallace-Green 2003), suggesting that older people caring for children is becoming more common. There is also anecdotal evidence that suggests that informal substitute care has increased over the last decade, with the most common reasons for this being substance abuse, relationship breakdown and mental illness (Patton 2003).

Relatives, particularly grandparents, who unexpectedly have to resume parenting either formally or informally, often experience huge life change as a result of assuming full-time care, and this can be distressing. They may become socially isolated from their peers because of the demands of raising children and, as a result, lose important social support networks that they need as they age. Family relationships are also likely to be disrupted in these circumstances. Grandparents may feel a sense of loss for their child-free years. They may also have health concerns that make parenting more difficult. Overseas evidence suggests that relatives caring for children can face financial hardship in taking on the parenting role. Some kinship carers give up full-time employment to care for grandchildren, while others have to return to work from retirement to increase their income (Patton 2003).

Informal substitute carers provide a valuable service that deserves the support of the community. In 2003, the Council on the Ageing (COTA) conducted a series of forums on grandparents who care for their grandchildren. COTA will report to the Minister for Children and Youth Affairs on financial and legal issues facing grandparents in this situation and what support mechanisms grandparents need to assist them in their caring role.

Informal child care

Most families need someone else to look after their children at times, so that parents or guardians can work or do other things. Commonly it is grandparents (often grandmothers), (step) brothers or sisters, and other relatives including non-resident parents, who provide informal child care.

The ABS Child Care Survey provides data on the informal child care provided over a particular week for children aged under 12 years (ABS 2003d). The care was most commonly used for work-related reasons, personal reasons or was care that the parent felt was of benefit to the child. The data do not describe informal carers in detail, but measure how much child care is arranged in Australia, for whom, and who provided that care. This means that where children received care from more than one kind of informal carer in the survey week, they are counted more than once. For example, a child who received care from their grandmother and a neighbour will appear in both care by grandparents and care by other person categories.

Table 3.6: Weekly cost of informal care of children aged 0–11 years, 2002

	Cost of care per child					
Informal care provider	**No cost**	**$1–19**	**$20–59**	**$60–99**	**$100 or more**	**Total**
			('000)			
Child's grandmother/grandfather	581.0	2.4	7.0	0.6	0.8	591.6
Child's (step) brother/(step) sister	63.9	3.8	2.9	—	—	70.5
Child's non-residential parent	97.3	—	—	—	—	97.3
Child's other relative	102.4	2.2	3.3	1.2	2.6	111.6
Other people						
Family friend	115.7	7.6	11.9	2.3	3.3	140.8
Babysitter	6.2	15.3	20.6	3.6	1.1	46.8
Nanny	0.9	1.6	1.5	2.1	6.5	13.8
Neighbour	17.4	2.3	1.2	0	—	20.8
Other	6.4	1.7	1	0.3	0.6	10.1
Total other people	*144.7*	*26.1*	*36*	*8.4*	*10.7*	*227.2*
			Per cent			
Child's grandmother/grandfather	98.2	0.4	1.2	0.1	0.1	100.0
Child's (step) brother/(step) sister	90.6	5.4	4.1	0.0	0.0	100.0
Child's non-residential parent	100.0	0.0	0.0	0.0	0.0	100.0
Child's other relative	91.8	2.0	3.0	1.1	2.3	100.0
Other people						
Family friend	82.2	5.4	8.5	1.6	2.3	100.0
Babysitter	13.2	32.7	44.0	7.7	2.4	100.0
Nanny	6.5	11.6	10.9	15.2	47.1	100.0
Neighbour	83.7	11.1	5.8	0.0	0.0	100.0
Other	63.4	16.8	9.9	3.0	5.9	100.0
Total other people	*63.7*	*11.5*	*15.8*	*3.7*	*4.7*	*100.0*

Note: Children may appear in more than one category.

Source: Unpublished data from 2002 Child Care Survey.

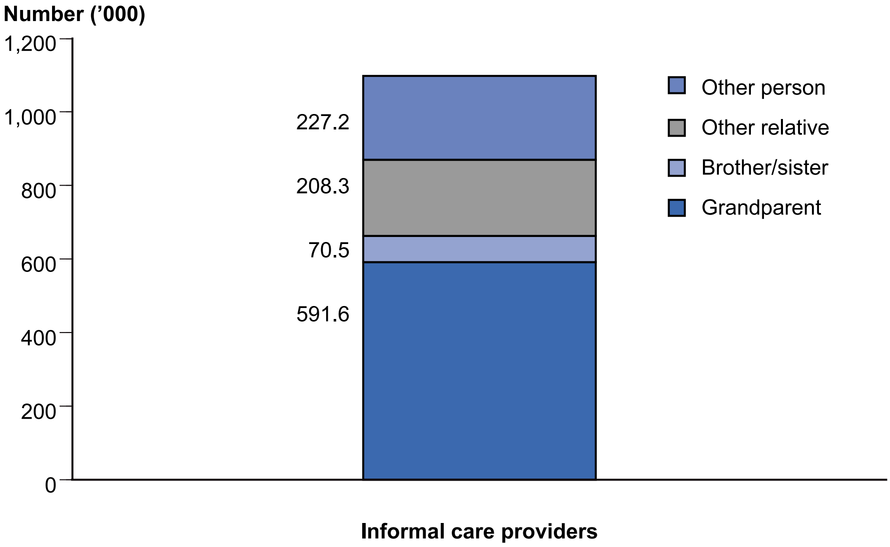
Most informal care in 2002 (89%) was unpaid (Table 3.6). For example, 98% of care by grandparents, 91% of care by (step) brother or sister and 84% of care by neighbours was done at no cost. Almost all of the remainder was paid for at minimal cost. The care by 'other people' category includes a mixture of carer types: care by other organisation, child looked after self, family friend, babysitter, nanny, neighbour, and other. A breakdown of this category reveals that almost all care by family friends and neighbours was free of charge, but the majority of care that nannies provided was paid for at market rates—almost half (47%) cost $100 or more.

Informal child carers

This section describes who provided care for the 1,019,200 children using informal care, (either alone or in combination with formal care)—one-third (33%) of children aged under 12 years (ABS 2003d).

Over half of all care (58%) was provided by grandparents, 22% was provided by other people, 20% was provided by other relatives, and 7% was provided by brothers and sisters (Figure 3.3).

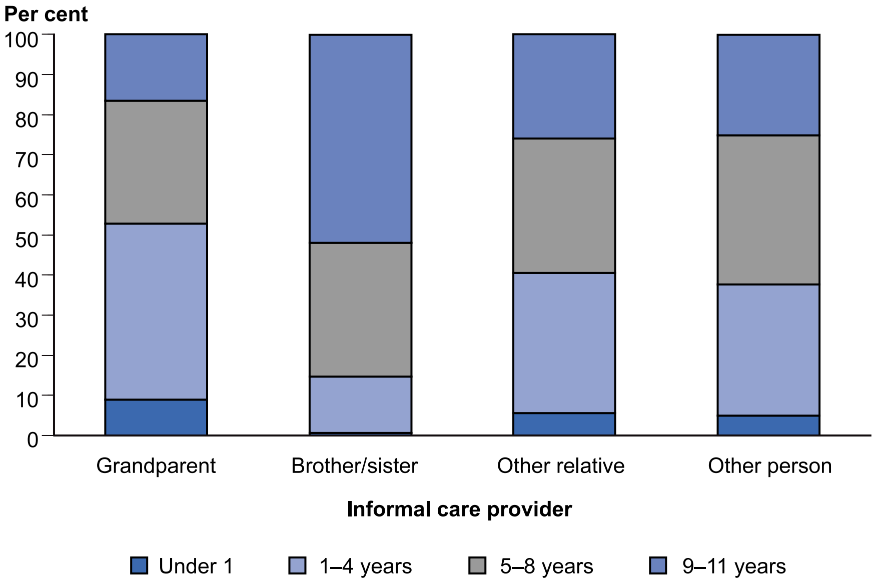
Over half (53%) of care by grandparents was for children aged under 5 years, with 9% being for babies aged less than 1 year (Figure 3.4). Care by other people and other relatives was less often for children aged under 1 year (5% and 6%) but more often for children aged 5 or over—62% and 59% of children, respectively. Siblings most commonly cared for older children, with 52% of care being for children aged 9–11 years.



Note: Children may appear in more than one category.

Source: ABS 2003d.

Figure 3.3: Informal care of children aged 0–11 years, by provider, 2002



Note: Children may appear in more than one category.

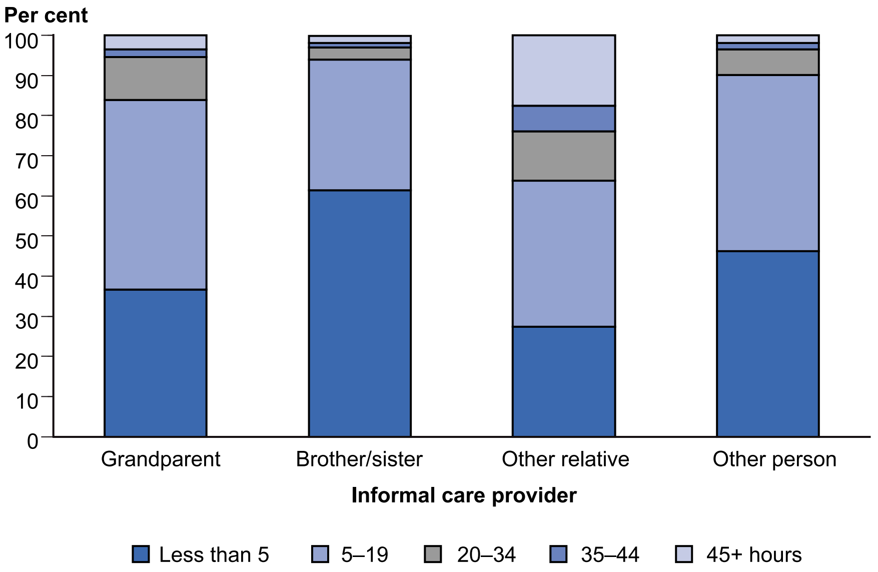
Source: ABS 2003d.

Figure 3.4: Informal care of children aged 0–11 years, by age of child, 2002

Amount and frequency of care provided

The number of hours of care per week varied between carers (Figure 3.5). Siblings and other people tended to provide fewer hours of care per week—for 19 hours or less in 94% and 90% of cases, respectively. In fact, 61% of (step) brother and sister care was for less than 5 hours per week. Grandparents also tended to care for shorter amounts of time, though some provided extensive care—in 11% of cases, children being cared for by grandparents were looked after for 20–34 hours per week. A quarter of care provided by other relatives (24%) was for 35 hours or more, which included care for 45 hours or more in 18% of cases.

Almost half (46%) of all children using informal care received care on 1 day a week, and a further quarter (25%) received care on 2 days a week. One in 10 children received informal care on more than 4 days a week.



Note: Children may appear in more than one category.

Source: ABS 2003d.

Figure 3.5: Informal care of children aged 0–11 years, number of hours of care per week by care provider, 2002

Trends in informal child care provision

The number of children who used informal child care in Australia declined by 12.6% between 1993 and 2002 (Table 3.7). This fall coincided with increased accessibility of formal child care services—the total number of children using Commonwealth-supported child care services more than doubled between 1991 and 2002, from 262,200 to 623,900 (Table 6.12).

Prior to the 1999 child care survey, care by grandparents was not given its own category, so Table 3.7 has care by grandparents included in the 'other relatives' category. The biggest percentage reduction between 1993 and 2002 was in care by (step) brothers and sisters which halved (down by 56%) coinciding with a big expansion in outside school hours care services, the use of which doubled between 1993 and 2002. Care by other people also fell steadily over this time, down by 42%. Care by other relatives (including grandparents) peaked in 1999 at 884,100 children, before settling back to 766,400 children in 2002 (ABS Child Care Survey unpublished data).

Nevertheless, the number of children using informal care is greater than the number using formal care—just over three-quarters of a million are in formal care, compared with just over a million in informal care. Furthermore, just over half of all children (51%) did not use any form of child care in the survey reference week.

Table 3.7: Number of children aged 0–11 years using informal care, 1993 to 2002 ('000)

Informal care provider	1993	1996	1999	2002	% change 1993 to 2002
Brother/sister	159.1	165.1	74.2	70.5	–55.7
Other relative[(a)]	707.1	726.0	884.1	766.4	13.1
Other person	389.1	318.0	294.0	227.2	–41.6
Total children using informal care	**1,166.2**	**1,128.3**	**1,162.1**	**1,019.2**	**–12.6**

(a) Includes grandparents.

Source: ABS Child Care Surveys, 1993, 1996, 1999, 2002.

Box 3.3: ABS 1998 Survey of Disability, Ageing and Carers: informal assistance and carers

Informal assistance

Informal assistance is unpaid help or supervision that is provided to a person with one or more disabilities or persons aged 60 years or over living in households. It includes only assistance that is provided for one or more of the specified tasks comprising an activity because of a person's disability or because they are older.

Carer

A carer is a person of any age who provides any informal assistance, in terms of help or supervision, to persons with disabilities or long-term conditions, or persons who are elderly (i.e. aged 60 years or over). The assistance must be ongoing, or likely to be ongoing, for at least 6 months. Assistance to a person in a different household relates to 'everyday types of activities', without specific information on the activities. Where the care recipient lives in the same household, the assistance is for one or more of the following activities: communication; health care; housework; meal preparation; mobility; paperwork; property maintenance; self-care; transport.

Primary carer

A primary carer is a person of any age who provides the most informal assistance, in terms of help or supervision, to a person with one or more disabilities. The assistance must be ongoing, or likely to be ongoing, for at least 6 months and be provided for one or more of the core activities (communication, mobility and self-care).

Source: ABS 1999a:65, 71.

3.5 Caring for people of all ages with a disability

This section examines the role of informal carers of people of all ages with a disability who require assistance with certain activities (see Chapter 8 for a discussion of the conceptualisation of disability in the International Classification of Functioning, Disability and Health). Material in this section draws largely on the results of the 1998 ABS Survey of Disability, Ageing and Carers and the findings of other key studies of informal care. It focuses on primary carers, who individually provide the most help to a person who needs assistance. The section begins with a demographic profile of primary carers. This is followed by a description of the needs of care recipients and the translation of those needs into caring activity. The section concludes with a discussion of the impact that caring has on carers. Detailed information on primary carers and their care recipients is collected in national surveys of disability, ageing and carers conducted by the ABS (1988, 1993, 1998).

Carers and caring

In the context of disability services and aged care, the term 'carer' loosely applies to anyone engaged in caring for a person in the community who has a disability or age-related health condition. However, the literature distinguishes 'principal' or 'primary' carers as those who individually provide the most informal assistance to a person. While definitions vary and some are more inclusive than others, most embody aspects of care intensity and duration. The definition of primary carer used here is consistent with that employed in the 1998 ABS Survey of Disability, Ageing and Carers, hereafter referred to as 'the ABS survey'. Accordingly, a primary carer is the main provider of assistance with the core activities to someone with a disability (Box 3.3). This definition and the method used to identify carers in the 1998 ABS survey has generated detailed national data on a well-defined group of carers.

Box 3.4: ABS 1998 Survey of Disability, Ageing and Carers: core activities and associated level of restriction

Disability

For ABS survey purposes, a person has a disability if he/she has a condition that restricts everyday activities and lasts for 6 months or longer. Impairments include, but are not limited to, loss of sensory perception (sight, hearing, speech), chronic pain, respiratory conditions, loss of limb or motor function, learning difficulties, intellectual impairment, mental illness, disfigurement and deformity, and disorders of the nervous system.

Core activities are:

- *self-care – bathing or showering, dressing, eating, using the toilet, and managing incontinence;*
- *mobility – moving around at home and away from home, getting into or out of a bed or chair, and using public transport; and*
- *communication – understanding and being understood by others: strangers, family and friends.*

A core activity restriction may be

- *profound – unable to perform a core activity or always needing assistance;*
- *severe – sometimes needing assistance to perform a core activity;*
- *moderate – not needing assistance, but having difficulty performing a core activity; or*
- *mild – having no difficulty performing a core activity but using aids or equipment because of disability.*

Note: In the text of this chapter, a 'severe or profound core activity restriction' is sometimes referred to as a 'severe or profound restriction'.

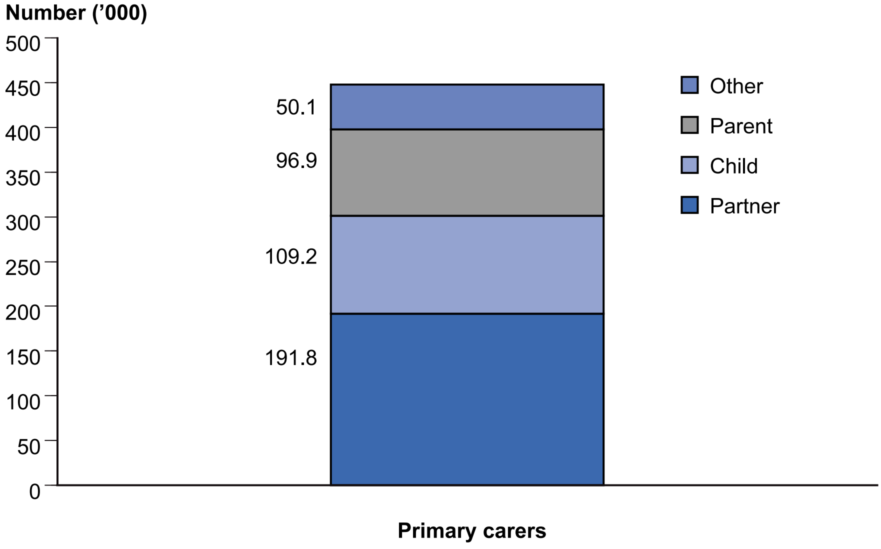
Source: ABS 1999a:66.

According to the ABS survey, 19% of all informal carers of people with a disability were primary carers. Primary carers assist one or more persons with a severe or profound core activity restriction who always or sometimes need assistance with the core activities of self-care, mobility and communication (Box 3.4). Primary carers typically function within an extensive network of family and social exchanges (Howe et al. 1997). Many are close relatives of the person they care for and the assistance they provide is an extension of family relationships. Carers distinguish their role as being 'beyond that of wife, husband, mother, father, daughter, son, sibling and friend' (Schofield et al. 1997). They feel a deeper sense of responsibility that is associated with caring for someone with a disability or long-term health condition.

Who are carers of people with a disability?

According to the ABS survey, approximately 450,900 people were informal primary carers in 1998. In 2002, approximately 2.5 million people would have performed informal caring, excluding child care, including an estimated 490,700 primary carers.[1]

In 1998, 43% of primary carers were the partners of their care recipient. Children gave care to their parents (24% of primary carers) and parents gave care to their children (22%). Around 11% of primary carers were other relatives or friends (Figure 3.6).



Source: Table 3.13.

Figure 3.6: Primary carers aged 15 years or over, 1998

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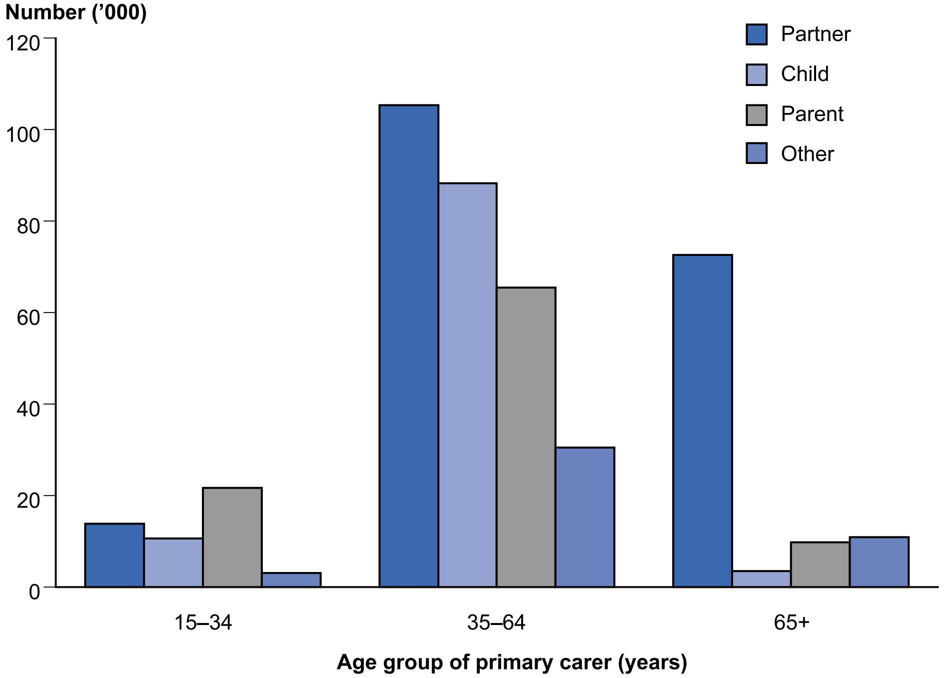
[1] Based on 1998 age-specific prevalence rates, by sex, of carers and primary carers applied to ABS estimates of the population as at 30 June 2002.

Primary carers are predominantly women—in 1998, 70% of primary carers were female. Among primary carers aged 15 years or over in 1998:

- 43% were spouses or partners of the care recipient;
- 44% of spouse or partner carers were male;
- 89% were immediate family of the care recipient (partner, parent or offspring);
- 69% of primary carers aged 60 or over were caring for a spouse or partner;
- 79% lived with their care recipients; and
- 67% were aged between 25 and 59 and 29% were aged 60 or more.

The person a carer is most likely to be caring for depends largely on the carer's age (Figure 3.7). Of co-resident primary carers aged 15–34 years in 1998, 44% were parents caring for a child with a disability. Over one-quarter (28%) of this age group were people caring for their spouse or partner. This latter proportion is higher among carers in older age groups: 36% of carers in the 35–64 year age band and 75% of carers aged 65 or older were caring for a spouse or partner. Only in the 35–64 year age band did children commonly provide care to their parents—about 1 in 3 carers (31%).



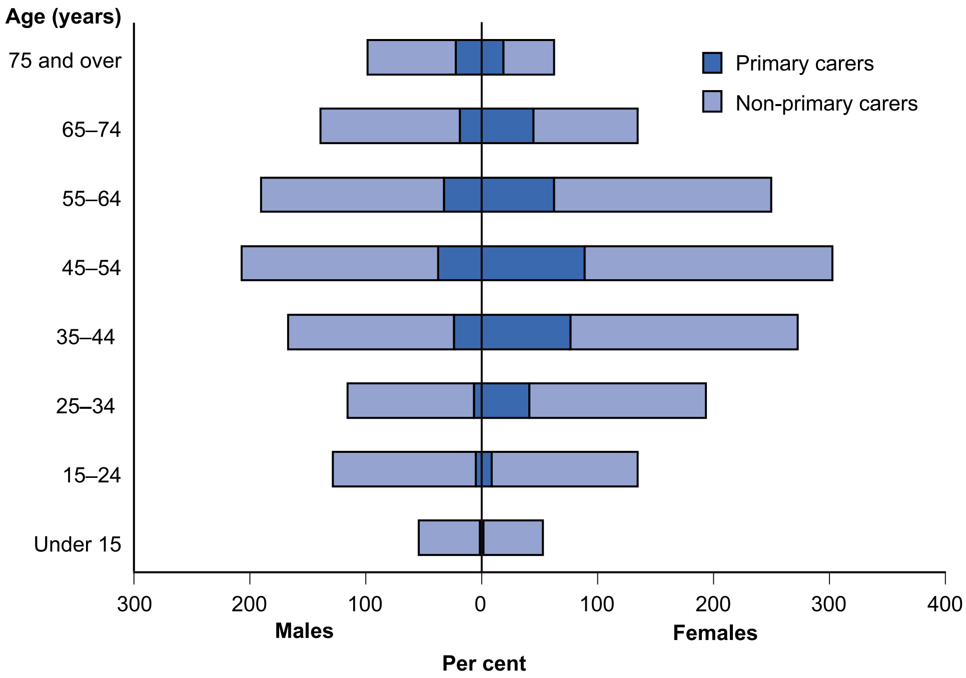
Source: Table 3.8.

Figure 3.7: Age group of co-resident primary carers and relationship to main recipients of care, 1998

Table 3.8: Relationship of co-resident primary carers to main recipients of care, 1998

Age group of primary carer (years)	Main recipient of care Partner	 Child	 Parent	 Other	 Total
			('000)		
15–34	13.8	10.6	21.6	*3.0	49.0
35–64	105.3	88.2	65.5	30.4	289.6
65+	72.6	*3.5	9.7	10.9	96.7
Total	**191.8**	**109.2**	**96.9**	**50.1**	**447.9**
			Per cent		
15–34	28.2	21.6	44.1	*6.1	100.0
35–64	36.4	30.5	22.6	10.5	100.0
65+	75.1	*3.6	10.0	11.3	100.0
Total	**42.8**	**24.4**	**21.6**	**11.2**	**100.0**

Source: ABS 1998.



Source: AIHW analysis of 1998 ABS Survey of Disability, Ageing and Carers confidentialised unit record file.

Figure 3.8: Estimated number of carers by age, sex and carer status, 2002 (based on 1998 age- and sex-specific carer rates)

Female carers were more likely than male carers to be in a primary caring role at all ages except 75 years and over (Figure 3.8).

The peak age group for women to be in a caring role is 45–64 years. In this age group, around 24% of women in 1998 were carers and approximately 7% were primary carers. Women aged between 35 and 64 years comprised 47% of all primary carers in 1998. Men were more likely to be found in a caring role at older ages: 22% of men aged 75 or over were carers and 5% of men in this age group were primary carers.

Overall, 79% of primary carers aged 15 years or over lived with their care recipient. Most partner and parent primary carers lived with their care recipient. Although other categories of primary carers were less likely to reside with their care recipient than spouse, partner or parent carers, 46% of children (including adult children) caring for a parent and 40% of other relative or friend primary carers were co-resident carers.

Age and co-residency of carers and care recipients

In 1998, one in five primary carers were caring for two or more people with a disability. In these cases, identification of the care recipient who received the most assistance as the 'main care recipient' allows a cross-reference of care recipient details with demographic information for all primary carers. Two-thirds of primary carers in 1998 had a main recipient of care aged 45 years or over (Table 3.9).

Over one-half of primary carers aged 25–44 (32% of all primary carers) had a main recipient of care aged under 45 years, and 23% were caring for someone aged 65 or over. This distribution represents a mix of parent, spouse or partner, and adult offspring carers in this age group. In the 45–64 age group, 36% of primary carers were caring for a person also aged 45–64 and 44% cared for a person aged 65 or over, reflecting a mix of mainly partner or spouse, and adult offspring carers. Older primary carers, aged 65 or over, were predominantly caring for another older person (82%); 17% of older carers were caring for a person aged 25–64 years. This group of primary carers consists mostly of spouses or partners, or parents of the main care recipient.

Table 3.9: Age of co-resident and non-resident primary carers ('000), by age of main care recipients,[(a)] 1998

Age of care recipient	Age of primary carer										
	15–24		25–44		45–64		65+		All ages		
	Co-res	Non-res	Co-res	Non-res	Co-res	Non-res	Co-res	Non-res	Co-res	Non-res	Total
Under 15	**0.6	—	51.2	—	10.4	—	**0.9	—	63.1	—	63.1
15–24	**2.2	—	*6.9	**0.5	*8.1	**1.3	—	—	17.2	**1.8	19.0
25–44	*4.9	—	30.7	**2.8	15.8	*3.1	*5.5	**0.9	56.9	*6.8	63.7
45–64	*3.9	*0.8	10.9	*6.3	65.6	*3.2	10.0	**0.3	90.5	10.7	101.2
65+	—	**1.0	9.6	25.5	44.0	41.9	70.9	*8.1	124.5	76.5	201.0
Total	**11.6**	****1.8**	**109.2**	**35.1**	**143.9**	**49.6**	**87.4**	***9.3**	**352.2**	**95.8**	**447.9**

(a) Each primary carer may care for more than one person, but nominates only one as the main care recipient.

Source: AIHW 1999: Table A7.6.

Non-resident carers were more likely than co-resident carers to have a main care recipient aged 65 years or over: 80% of non-resident primary carers cared for an older Australian, compared with 35% of co-resident carers. Co-resident carers comprised 76% of primary carers aged 25–44 years and 74% of primary carers aged 45–64 years. In contrast, 90% of primary carers aged 65 years or over lived with their care recipient, reflecting the predominance of spouses and partners among older carers (as seen in Figure 3.7).

Of primary carers who had a main care recipient aged 65 or over, 17% (35,100) were aged 25–44 years and 43% (85,900) were aged 45–64 years. Thus, around 60% of primary carers who cared for an older person were of working age and 56% of this group were non-resident carers.

The reasons for taking on a primary caring role

The reasons for caring for someone with a disability are undoubtedly complex. The ABS Survey of Disability, Ageing and Carers allowed carers to give one or more reasons for taking on a primary caring role. Frequent responses included family responsibility (57%), a desire to provide the best possible care (44%), and emotional obligation (39%) (Table 3.10). Individuals often care *for* people because they care *about* them. It is also evident that many individuals feel a responsibility to care for family members—factors such as there being no choice, no other family or friends willing or able to care, and no other care being available or affordable, also figured in decisions to care.

There were some differences in responses depending on the relationship of the carer and care recipient. Spouse and parent carers exhibited similar response patterns. They were more likely than offspring carers to report a desire to provide the best possible care (53% and 49% versus 33%). Fifty per cent or more of each relationship group cited family responsibility as a motivating factor and this was the most frequent response of offspring carers (in 72% of cases). Around half of other relative or friend carers cited family responsibility (51%) and emotional obligation (44%) as prime motivating factors.

Table 3.10: Reasons for primary carers (15 years and over) taking on the caring role,[(a)] 1998 (per cent)

	Relationship to main recipient of care				
Reasons	**Partner**	**Offspring**	**Parent**	**Other friend or relative**	**Total**
Can provide better care	52.6	33.3	49.3	24.3	43.9
Family responsibility	49.8	72.4	58.6	50.5	57.4
No other family or friends available	23.5	30.1	17.8	34.6	25.2
No other family or friends willing	11.1	18.6	14.0	21.1	14.7
Emotional obligation	36.8	43.2	35.2	44.1	38.8
Cost of alternative care	26.4	16.7	21.6	*11.7	21.3
No other care arrangements available	9.2	8.9	16.9	*7.4	10.5
No choice	21.2	13.7	35.2	*13.5	21.2
Other reason/not stated	9.4	*7.9	16.4	*14.1	11.0
Total carers ('000)	**192.1**	**111.7**	**94.4**	**49.7**	**447.9**

(a) Carers may report more than one reason.

Source: AIHW analysis of 1998 ABS Survey of Disability, Ageing and Carers; ABS 1999a:Table 36.

While the literature cites examples of intense caring in the absence of love and affection, relationship history is an important determinant of the impact and outcome of caring for both carer and care recipient (Cahill 1999). Cahill's work suggests that wives tend to perceive caring as a natural extension of their marriage relationship, whereas daughter (or daughter-in-law) carers had more complex reasons. They more often felt that external factors meant that they had no real choice but to take on the role of primary carer: 'Their motivation seemed shaped by several different structural and contextual constraints including gender, labour market positioning, the availability of others within the kinship network, and commitment to other family care responsibilities' (Cahill 1999:243).

The Later Life Families Study in 1996 examined intergenerational exchange in interviews of 721 people aged between 50 and 70 years. The help that is given in families depends on a range of factors (Millward 1998). Important among these are the structural dimensions of family cohesion, such as family structure, proximity of relatives and the frequency of contact between family members. Interpersonal factors such as satisfaction with the quality of the parent–child relationship, and beliefs about intergenerational obligations, were also important predictors of the exchange of assistance. It is likely that such factors also impact on the propensity of individuals to take on the more extensive role of primary carer. Many Australians accept that adult children have some responsibilities and obligations for the wellbeing of their elderly parents, but this acceptance is by no means universal, unequivocal or without qualification (de Vaus 1996). There was a strong acceptance that adult children should keep in contact with older parents, do things with them wherever possible, and help them where needed, but not at any cost. Few people agreed that adult children should be prepared to have elderly parents live with them, that they should live near parents so that they can help out or that a daughter should give up her job to care. There was considerable variation in the preparedness to take on such extensive caring.

The type of assistance given by carers

Just over 1,000 carers who took part in the 1999 National Survey of Carer Health and Wellbeing (CAA 2000) volunteered information on how they spent time on caregiving activities. They broadly divided caring time into:

- direct personal care (34.3%);
- support activities such as organising health services, transport, financial management, laundry and meal preparation (30.6%); and
- supervision to prevent self-harm and harm to others, emotional support and companionship, and arranging activities for the development of children with certain disabilities (35.1%).

For a carer to be identified as a primary carer in the 1998 ABS survey, they must have been providing ongoing assistance to their care recipient(s) with at least one of the three core activities of self-care, mobility and communication. Results show that over 60% of primary carers helped their care recipients with self-care tasks such as dressing, bathing, using the toilet and managing incontinence; three-quarters (74%) helped with mobility; and just under half (45%) assisted in communication (Table 3.11).

Table 3.11: Primary carers (5 years and over) who assist with core activities of daily living,[a] 1998

	Age of main recipient of care[b]									
	<15		15–44		45–64		65+		All ages	
	’000	%	’000	%	’000	%	’000	%	’000	%
Whether carer usually assists with self-care										
Usually assists	60.5	74.0	68.1	45.4	60.7	66.6	92.0	73.4	281.3	62.8
Does not usually assist	21.2	26.0	81.9	54.6	30.4	33.4	33.2	26.6	166.8	37.2
Total	*81.7*	*100.0*	*150.0*	*100.0*	*91.1*	*100.0*	*125.2*	*100.0*	*448.1*	*100.0*
Whether carer usually assists with mobility										
Usually assists	40.3	49.3	119.3	79.5	71.8	78.8	101.9	81.4	333.3	74.4
Does not usually assist	41.4	50.7	30.7	20.5	19.3	21.2	23.3	18.6	114.8	25.6
Total	*81.7*	*100.0*	*150.0*	*100.0*	*91.1*	*100.0*	*125.2*	*100.0*	*448.1*	*100.0*
Whether carer usually assists with communication										
Usually assists	48.7	59.6	76.8	51.2	26.5	29.1	48.5	38.7	200.5	44.7
Does not usually assist	33.0	40.4	73.2	48.8	64.7	70.9	76.7	61.3	247.6	55.3
Total	*81.7*	*100.0*	*150.0*	*100.0*	*91.1*	*100.0*	*125.2*	*100.0*	*448.1*	*100.0*

(a) See Box 3.4.

(b) Where a primary carer provides assistance to more than one person the person who receives the most care is called the main care recipient.

Source: AIHW analysis of 1998 ABS Survey of Disability,Ageing and Carers confidentialised unit record file.

Some differences appear with respect to the age of the main care recipient. For example, higher proportions of primary carers with young (under 15) and old (65 or over) care recipients helped with self-care than carers of people in the middle age groups, whereas primary carers with younger care recipients were less likely to report assisting with mobility. Relatively more primary carers with care recipients aged under 15, or 15–44 years, reported assisting in communication than carers of middle-aged and older people. To some extent, these results reflect the predominant main disabling conditions of the different age groups (see Box 3.5). Primary carers were also the main providers of assistance with higher level activities such as health care, shopping, meal preparation, housework and paperwork. Few people with a severe or profound core activity restriction living in the community in 1998 relied solely on formal providers, but almost half received assistance from informal carers as well as formal service providers.

Who receives the caring?

Estimates based on results from the 1998 ABS Survey of Disability, Ageing and Carers suggest that approximately 3.7 million people with a disability, as broadly defined in the survey, were living in households in 2002 (Table 3.12). However, neither disability nor advanced age automatically implies a need for assistance. According to the survey, 43% of people with a disability, and 54% of older persons (65 years or over) living in households had no need for assistance beyond that which people routinely exchange (ABS 1999a:Tables 12 and 23). Among the estimated 3.7 million people with a disability in the community, approximately 1 million, or 5.4% of the household population, always or sometimes required assistance with core daily activities because of a severe or profound level of restriction. People aged 65 or over accounted for an estimated 35% (369,000) of the household population with a severe or profound restriction in 2002. Of the remainder, around 30% (316,700) were aged 45–64 years; 21% (221,900) were aged 15–44 years and approximately 14% (146,900) were children under the age of 15 (Table 3.12).

Table 3.12: Estimated number of people with a disability living in households, 2002[(a)(b)]

Age/sex	Profound or severe core activity restriction ’000	Profound or severe core activity restriction Per cent of age group	All with a disability ’000	All with a disability Per cent of age group
Males				
0–14	99.2	4.9	197.6	9.7
15–44	106.6	2.5	526.2	12.2
45–64	150.2	6.5	645.5	28.0
65+	135.1	12.2	548.4	49.6
Total	*491.1*	*5.0*	*1,917.7*	*19.7*
Females				
0–14	47.8	2.5	105.9	5.5
15–44	115.2	2.7	462.2	10.8
45–64	166.7	7.3	624.3	27.2
65+	233.1	16.3	624.1	45.1
Total	*562.8*	*5.7*	*1,816.5*	*18.3*
Persons				
0–14	146.9	3.7	303.4	7.6
15–44	221.9	2.6	988.8	11.5
45–64	316.7	6.9	1,269.3	27.6
65+	369.2	14.8	1,171.3	47.0
Total	**1,054.7**	**5.4**	**3,732.8**	**19.0**

(a) ABS preliminary estimates of total population as at 30 June 2002.

(b) Based on 1998 prevalence rates: people living in households who reported a severe or profound core activity restriction, or any disability, as a proportion of the survey population.

Source: AIHW analysis of ABS 1998 Survey of Disability, Ageing and Carers Confidentialised Unit Record File.

Prevalence and nature of severe or profound disability in the household population

Rates of severe or profound disability are quite low in the household population aged under 65 years and are similar for males and females, except at very young ages where males aged 5–14 years experience a higher rate of severe and profound core activity restriction than females (AIHW 2000:Table 12.1). Rates of severe and profound restriction among people of both sexes aged 65 or over and living in households are double those of the 45–64 age group. At older ages, women were more likely to report a severe or profound restriction than men (16% versus 12%), owing in part to the older age structure of the female population in this age group. Although 65% of people with a severe or profound restriction who are currently living in the community are aged under 65 years, high rates of severe and profound restriction at older ages in a rapidly ageing household population have implications for future needs for assistance in the community.

The ABS survey collected information on a possible array of activity restrictions and disabling conditions for each person with a disability and asked care recipients to identify the disabling condition and consequent activity restriction that caused most problems in everyday life, the so-called ‘main disabling condition’ and ‘main activity restriction'. The need for assistance is a complex function of many factors that is rarely explained by just one medical condition or type of restriction (see Chapter 8 for a full discussion of the conceptualisation of disability). However, it is reasonable to assume that conditions and restrictions underlying the most serious or frequently encountered problems are closely associated with the nature and intensity of care. Information on the prevalence of disabling conditions among all people with a severe or profound restriction can be found in Chapters 7 and 8 and in other AIHW publications (see, for example, AIHW 2001:263–4; 2000:Tables 14.5, 14.6). The main interest here is on disabling conditions and restrictions in people with a primary carer, who represent a subset of all people with a severe or profound restriction. The main disabling condition and main activity restriction recorded in survey data can be determined for people who had a co-resident primary carer. Although this precludes a description of care recipient characteristics for people with a non-resident carer, the profiles presented here give an insight into the nature of caring, hence its potential impact on primary carers.

Main disabling conditions and main restrictions in people with a co-resident primary carer

People with a co-resident primary carer in 1998 reported a diverse range of main disabling conditions so that, individually, each condition accounts for a low proportion of care recipients. Main disabling conditions in care recipients with a co-resident carer vary according to age, with markedly higher prevalence of intellectual and developmental disorders in young care recipients and a predominance of musculoskeletal disorders in the older age groups (Box 3.5). In terms of main activity restrictions, chronic, recurring pain or discomfort affected 5% or more care recipients in every age group. Restriction in physical activities or work was a main restriction for 5% or more care recipients in all but the youngest age group, 0–14 years. Age-related patterns are evident for certain types of main restriction. Learning and speech difficulties and mental illness were more common main restrictions in the younger age groups of care recipients (0–14 and 15–44) in 1998. Incomplete use of feet or legs was a common main restriction in care recipients aged 15 or over with a co-resident carer, and was particularly prominent in the older age groups of care recipients.

These results do not reflect the prevalence of certain conditions and restrictions among people with a primary carer, since each condition and type of restriction can also be reported as secondary to the main condition or restriction. Rather, they highlight the types of conditions and restrictions that care recipients associate with the problems that they frequently encounter.

Need for and receipt of assistance

Within the 1998 household population:

- 958,000 people with a severe or profound core activity restriction reported a need for assistance with at least one of ten daily activities (see Boxes 3.3, 3.4) and two-thirds of these people were aged under 65 years;
- 386,700 people with a severe or profound restriction reported a need for assistance with more than one core activity; and
- 73,000 people required assistance with all three core activities of daily living (AIHW 2000:104–6).

Box 3.5: ABS 1998 Survey of Disability, Ageing and Carers: care recipient main disabling conditions and main restrictions

The 'main disabling condition' is the condition reported by each care recipient to be associated with most of the problems that he or she experienced. The 'main restriction' is the area of activity that caused most problems for each care recipient. Main disabling conditions and main restrictions are listed below if they were recorded for 5% or more care recipients, by age, with a co-resident primary carer in 1998 (358,200 care recipients). Main restriction categories of memory loss, reading difficulty and incontinence were excluded from the analysis due to survey data limitations.

Care recipients aged under 15 years

Main disabling conditions: cerebral palsy; attention deficit disorder or hyperactivity; mental retardation or intellectual disability; autism and related disorders; other developmental disorders.

Main restrictions: slow at learning or understanding; speech difficulties; mental illness; incomplete use of arms or fingers; chronic, recurring pain or discomfort.

Care recipients aged 15–44 years

Main disabling conditions: back problems (dorsopathies); mental retardation or intellectual disability; cerebral palsy; Down syndrome.

Main restrictions: chronic, recurring pain or discomfort; slow at learning or understanding; restriction in physical activities or work; incomplete use of feet or legs; incomplete use of arms or fingers; nervous or emotional condition; mental illness; loss of hearing.

Care recipients aged 45–64 years

Main disabling conditions: back problems (dorsopathies); arthritis and related disorders; other diseases of the nervous system including transient ischaemic attack; stroke.

Main restrictions: chronic, recurring pain or discomfort; restriction in physical activities or work; incomplete use of feet or legs; incomplete use of arms or fingers; mental illness.

Care recipients aged 65 or over

Main disabling conditions: arthritis and related disorders; stroke; back problems (dorsopathies); sight loss.

Main restrictions: incomplete use of feet or legs; restriction in physical activities or work; chronic, recurring pain or discomfort; loss of sight; breathing difficulties; incomplete use of arms or fingers; loss of hearing; difficulty gripping or holding things.

Source: AIHW analysis of 1998 ABS Survey of Disability, Ageing and Carers confidentialised unit record file.

People under 65 with a severe or profound restriction were more likely than older people to require assistance with the three core activities (9% versus 5%). Almost one in four children aged under 15 years with such restriction needed help with three core activities (AIHW 2000:106). Differences in the type of assistance received by younger and older people with severe or profound restrictions reflect constraints related to predominant disabling conditions and the circumstances of different stages of life.

Those in need of assistance because of severe or profound activity restriction typically received help from a combination of formal services and informal carers, mainly family and friends. Unpaid informal carers were the main source of all types of assistance for people with severe and profound restrictions living in the community. For persons with a primary carer, formal services were often used to supplement the assistance provided by the carer and provide direct carer support. In cases where a primary carer was not available, formal services might be accessed to complement more casual forms of assistance from informal carers by substituting some forms of care that would otherwise be performed by a primary carer (Howe & Schofield 1996). In this context, formal services include those funded by government welfare programs, and privately organised for-profit and not-for-profit services, including volunteer organisations.

Of people who received assistance from a co-resident primary carer in 1998, approximately 65% needed help at times with five to nine activities of daily living, 60% always needed help with up to four daily activities and a further 27% always needed help with five or more activities (Table 3.13). Youth and old age can compound the need for assistance as seen in similar proportions of the youngest and oldest age groups reporting a constant need for help with five or more activities (40% and 31% respectively). The next section examines in greater detail the characteristics of people who provide this on going care and the impact of the caring role on their lives.

Table 3.13: Main care recipients[(a)] with a co-resident primary carer,[(b)] number of daily activities for which assistance was needed, 1998

	Age of main care recipient									
	0–14		15–44		45–64		65+		Total	
	’000	%	’000	%	’000	%	’000	%	’000	%
Number of activities for which assistance was needed										
1–4	32.7	52.2	19.6	25.4	29.2	31.9	24.6	19.6	106.0	29.8
5–9	27.9	44.5	50.0	64.9	60.4	66.0	94.6	75.5	232.8	65.3
10+	—	—	*4.7	*6.1	**0.7	**0.8	*5.2	*4.2	10.6	3.0
Not applicable	**2.1	*3.4	**2.8	*3.6	**1.2	**1.3	**0.8	**0.7	*6.9	*2.0
Total	**62.7**	**100.0**	**77.0**	**100.0**	**91.5**	**100.0**	**125.2**	**100.0**	**356.4**	**100.0**
Number of activities for which assistance was always needed										
1–4	28.7	45.7	43.6	56.6	62.2	68.0	77.6	62.0	212.1	59.5
5–9	19.9	31.7	15.8	20.6	15.8	17.2	35.4	28.3	86.9	24.4
10+	*5.2	*8.2	**2.2	**2.9	—	—	*3.1	*2.4	10.4	2.9
Not applicable	*9.0	*14.3	15.3	19.9	13.5	14.8	*9.1	*7.3	47.0	13.2
Total	**62.7**	**100.0**	**77.0**	**100.0**	**91.5**	**100.0**	**125.2**	**100.0**	**356.4**	**100.0**

(a) In cases where a carer provided assistance to more than one person, the care recipient who received the most care was designated the main care recipient (i.e. table does not report on all care recipients).

(b) The 1998 ABS survey collected information on the needs of all people with a disability, but these can be reliably associated with an informal carer only when the carer is a co-resident primary carer (see Box 3.3 for a definition of primary carer).

Source: AIHW analysis of 1998 ABS Survey of Disability, Ageing and Carers confidentialised unit record file.

Impact of the caring role

Many factors influence the impact of the caring role on carers, including the personal characteristics and circumstances of caregiver and receiver, the nature and strength of their relationship, and the level of social support available to them.

Caring intensity varies according to the severity and nature of activity restrictions and age of the care recipient, living arrangements, availability of secondary carers and access to affordable formal support services. In 1998, informal caring occupied one in three primary carers aged 15 years or over for 40 or more hours per week (Table 3.14). On average, older carers reported spending more time caring than younger carers, with one-half of primary carers aged 65 or over indicating that they performed caring activities for 40 hours or more per week. The higher caring load among older carers is associated with a higher rate of co-residency. Co-resident primary carers report higher caring loads on average than non-resident carers.

The constancy and time consuming nature of long-term caring have been cited as specific causes of carer stress (CAA 2000:30). Three-quarters of primary carers in 1998 had spent at least 5 years in the caring role, and 40% had been caring for at least 10 years (AIHW 2000:Table 16.4). Among those caring for a person aged 15 or over, 177,700 primary carers could not leave their main care recipient for more than a few hours without supervision and 63,800 carers could not leave their care recipient unattended for an hour or more (ABS 1999a:Table 33).

Table 3.14: Primary carers (15 years and over): hours of caring for main care recipients,[(a)] 1998

	Amount of time per week									
	<20 hours		20–39 hours		40+ hours		Not stated		Total	
	'000	%	'000	%	'000	%	'000	%	'000	%
					Co-resident primary carers					
15–44	48.0	39.6	23.5	19.4	42.0	34.6	*7.8	*6.4	121.4	100.0
45–64	48.5	33.4	24.3	16.8	66.9	46.1	*5.3	*3.7	145.0	100.0
65+	21.9	25.1	13.5	15.5	46.7	53.5	*5.2	*6.0	87.3	100.0
All ages	**118.4**	**33.5**	**61.3**	**17.4**	**155.7**	**44.0**	**18.3**	**5.2**	**353.6**	**100.0**
					All primary carers					
15–44	77.8	49.3	27.3	17.3	44.3	28.1	*8.5	*5.4	158.0	100.0
45–64	88.5	45.7	28.8	14.9	69.1	35.7	*7.3	*3.8	193.7	100.0
65+	27.1	28.2	15.1	15.7	48.6	50.5	*5.5	*5.7	96.4	100.0
All ages	**193.5**	**43.2**	**71.2**	**15.9**	**162.1**	**36.2**	**21.3**	**4.8**	**448.1**	**100.0**

(a) A primary carer may care for more than one person with a disability, but nominates one person as the main recipient of care.

Source: AIHW analysis of 1998 ABS Survey of Disability, Ageing and Carers confidentialised unit record file.

Caring times observed in the Victorian Carers Program longitudinal study of carers and care recipients, reported in Schofield et al. (1997), ranged from the minimum qualifying time for inclusion in the study (4 hours per week) to 168 hours per week. Twenty-seven per cent of these carers reported spending over 100 hours per week in direct care. Duration of care ranged from 1 month to 50 years, with carers of children most likely to have provided care for 5 years or more. These and similar findings from the ABS survey highlight the importance of carer support from informal networks and formal respite care services.

Carer health and wellbeing

AIHW analysis has shown that age-specific rates of disability are significantly higher for primary carers than for the total population at most ages under 65 years (AIHW 2000:141). Of those surveyed in 1998, just over 39% (177,500) had a disability and 9% (41,900) had a severe or profound core activity restriction. Many primary carers are themselves older people, so that a higher rate of disability might be expected. Consequently, many primary carers are providing support for someone who is severely restricted in their activities, while also coping with their own, often serious, health conditions and activity restrictions. The physical and psychological demands of the caring role itself can lead to adverse health outcomes for carers.

The ABS survey asked primary carers to assess the impact of caring on various aspects of their physical and emotional wellbeing. High numbers of primary carers reported that their caring role had resulted in a changed overall state of wellbeing (29%); feelings of dissatisfaction (67%); fatigue and weariness (34%); and feelings of worry or depression (31%) (AIHW 2000:Table 16.10). Many said that caring had taken a toll on personal relationships. While one in three primary carers felt that caring had strengthened their relationship with the care recipient, 22% said that the relationship was strained. Nearly a quarter of primary carers said that they had lost or were losing touch with friends because of caring commitments.

Younger carers in the Victorian Carers Program study, particularly adult daughters and daughters-in-law, were more negative about their circumstances than older spouse carers (reported in Schofield et al. 1998). The study found that female carers in general experienced more psychological distress and overload than male carers. Self-reported measures of health and wellbeing for female primary carers were compared to those for a representative random sample of women with usual household and parenting responsibilities. Overall, carers reported lower life satisfaction, higher overload and poorer self-rated health status. Relinquishing primary caring responsibilities during the study period was associated with improved life satisfaction, reduced feelings of overload and lower levels of family conflict.

Bergquist and others (1993) have highlighted the strain that caring for aged parents can place on people in their fifties and sixties because of competing priorities and family responsibilities. At this stage of life many people experience changing life patterns while continuing to work and provide support to adult children and possibly grandchildren. Two factors said to contribute most to a positive experience of caring for an elderly parent are having the support of other family members and a sense that there was some choice in the decision to provide care (Millward 1999).

Carers who took part in the 1999 National Survey of Carer Health and Wellbeing reported declines in physical, mental or emotional health as a result of their caring responsibilities (CAA 2000). Providing mobility assistance (lifting or transferring) presented difficulties for 38% of long-term carers. Around 60% of carers reported major negative effects on their life choices including restrictions in their ability to take part in paid work, education or other career opportunities. The survey reported on the emotional and physical demands faced by families caring for children with severe or profound disabilities, highlighting parents' anxiety about the future welfare of their disabled children. Responses to questions about personal wellbeing referred to the physical demands of caring, constant responsibility, and the emotional and psychological impact of behavioural disorders in care recipients as specific causes of carer stress.

The Young Carers Research Project (CA 2001) revealed that many young carers feel a sense of isolation and alienation from their peers because the caring role varies considerably from usual adolescent experience. Caring responsibilities can interrupt education and make the transition from home to independent living more difficult for some young carers.

Labour force participation of carers

Given the time demands of caring for someone with a disability it is not surprising that patterns of labour force participation among carers differ from those of the wider population. Carers of working age are less likely than non-carers to be in paid employment. Part-time employment rates are similar for primary carers (23%), non-primary carers (21%) and non-carers (20%) (Table 3.15). However, carers report lower rates of full-time employment—22% of primary carers and 41% of non-primary carers in 1998 were employed full-time, compared with 51% of non-carers. To some extent, these results are confounded by differences in the age and sex distribution of carers when compared with the general population of workers aged 15 to 64 years.

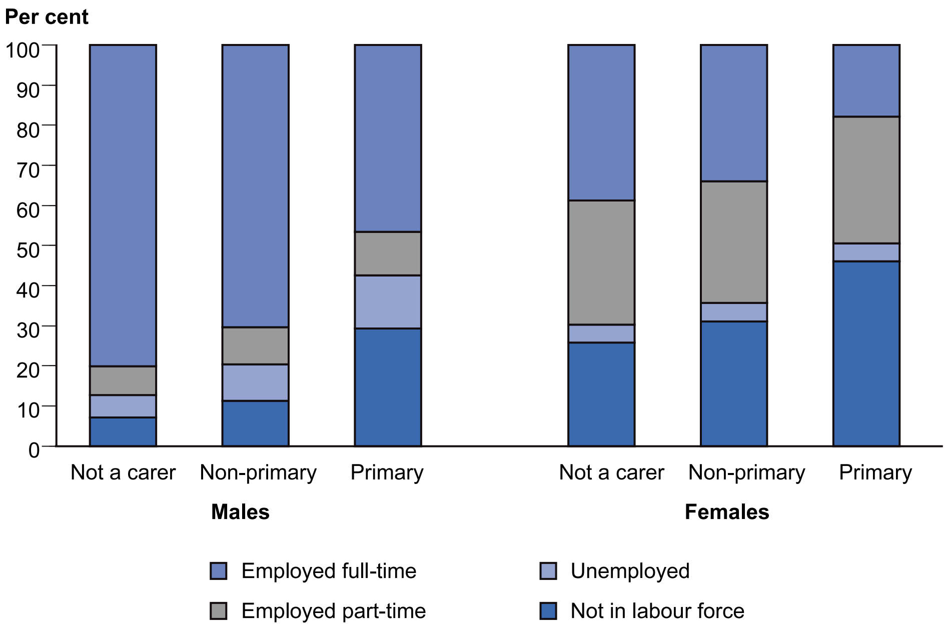
Table 3.15: People aged 15–64 years living in households, carer status by labour force status and source of income, 1998 (per cent)

	Carer status			
	Primary carer	**Carer (not primary)**	**Not a carer**	**Total ('000)**
Labour force status				
Employed full-time	21.6	41.4	51.1	49.1
Employed part-time	23.0	21.3	20.0	20.2
Total employed	44.6	62.7	71.1	69.3
Unemployed	6.0	7.7	6.1	6.3
Not in the labour force	49.4	29.6	22.9	24.4
Total	*100.0*	*100.0*	*100.0*	*100.0*
Principal source of cash income				
Wages or salary	33.2	49.7	58.6	56.8
Own business or partnership income	6.1	7.7	8.3	8.2
Other private income	5.5	5.2	3.9	4.1
Government pension or allowance	49.2	29.7	20.3	22.2
Not stated	5.9	7.8	8.9	8.7
Total	*100.0*	*100.0*	*100.0*	*100.0*

Source: AIHW 2000:Table 16.5.

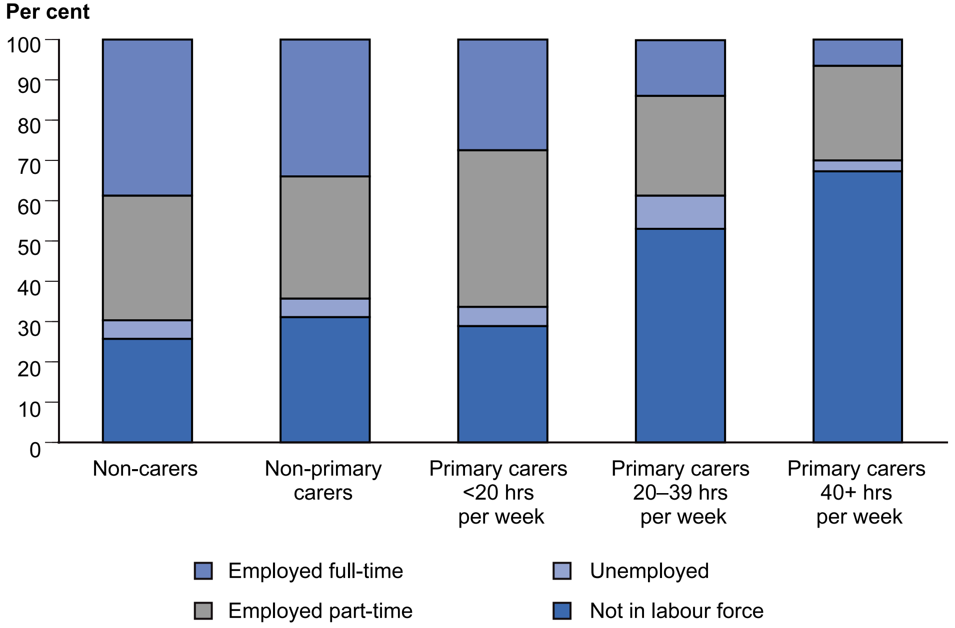
Narrowing the focus to persons of prime working age confirms lower labour force participation among male and female primary carers compared with other (non-primary) carers, and those without caring responsibilities (Figure 3.9). Reduced participation is mainly at the expense of full-time employment. Approximately 47% of male primary carers were employed full-time in 1998 versus 80% of men not involved in informal caring. Similarly, 18% of female primary carers aged 25–54 were in full-time paid employment versus 39% of women who did not perform informal caring.

For females at least, ABS survey data on labour force participation in relation to weekly hours of caring are sufficiently reliable to examine the relationship between these variables. Labour force participation among female primary carers aged 25–54 years who provided fewer than 20 hours of informal assistance was similar to that of non-primary carers (71% and 69% respectively) (Figure 3.10). Primary carers providing assistance to someone for 20 hours or more per week reported lower rates of part-time and full-time employment. Among female primary carers age 25–54 years performing 40 hours or more per week, 30% were employed and 67% were not in the labour force, compared with 70% and 26% respectively of women aged 25–54 without caring responsibilities. In 1998, 31,200 primary carers (6,800 men and 24,400 women) reported being in paid employment while performing 40 hours or more of informal caring per week.



Source: AIHW analysis of 1998 ABS Survey of Disability, Ageing and Carers confidentialised unit record file.

Figure 3.9: Labour force status and carer status of persons aged 25–54 years, 1998



Source: AIHW analysis of 1998 ABS Survey of Disability, Ageing and Carers confidentialised unit record file.

Figure 3.10: Labour force status and level of caring of females aged 25–54 years, 1998

Paid employment could have a protective effect from the negative aspects of caring. Schofield and colleagues (1998) identified caring and not having full-time work as significant predictors of major health problems in the past year. Table 3.16 summarises income, living costs and employment outcomes reported by primary carers in 1998. Further breakdown by sex is not possible due to the high sampling error associated with small numbers of male carers in detailed reporting categories. According to the ABS survey, 11% of primary carers aged 25–54 years and 17% of those aged 55–64 years had left work in order to commence caring or increase their hours of care. Around 21% of employed primary carers had reduced their hours of paid work, and the same proportion of employed carers reported a reduction in income associated with caring.

The impact of ceasing or reducing paid employment to perform informal caring can extend well beyond the actual or intended period of caring. Among 108,700 primary carers aged 25–54 who were not in the labour force at the time of the 1998 ABS survey, 57% (61,600) said that return to work was not relevant and a small proportion (2%) did not anticipate any difficulty. The remaining 47,100 primary carers expected to face problems that could prevent a return to paid employment. Making suitable alternative care arrangements was the most commonly reported specific difficulty in a list that included inflexible work hours, disruption to care recipient, and loss of skills while caring. However, almost one-third of this group (15,700) cited 'other reasons', suggesting that more research is needed if such problems are to be addressed (AIHW analysis of 1998 ABS survey confidentialised unit record file).

Table 3.16: Primary carers (aged 15 and over), impact of caring on hours of work, income and living costs, 1998 (per cent)

	Age group				
	15–24	**25–54**	**55–64**	**65+**	**Total**
Effect on income					
Income not affected	71.5	39.3	49.2	57.2	45.9
Income has increased	**2.4	*2.8	**2.0	**1.9	2.5
Income has decreased	**5.4	27.2	18.8	*6.8	20.7
Has extra expenses	**16.7	25.5	26.0	28.1	25.8
Not applicable/not stated	**4.0	5.2	**4.0	*6.0	5.2
	100.0	**100.0**	**100.0**	**100.0**	**100.0**
Effect on living costs					
Difficulty meeting costs	**14.5	34.6	28.3	17.1	29.1
No difficulty meeting costs	**7.6	17.5	16.3	15.8	16.6
Not applicable/not stated	77.9	47.9	55.4	67.2	54.3
	100.0	**100.0**	**100.0**	**100.0**	**100.0**
Effect on hours paid work					
Applicable	42.8	51.4	22.4	*3.7	35.8
No effect	*86.4	71.5	64.9	*76.6	71.4
Reduced hours	—	21.8	*22.7	**10.4	20.9
Increased hours	**13.6	*6.7	**12.3	**13.0	7.7
Not applicable	*57.2	48.6	77.6	96.3	64.2
	100.0	**100.0**	**100.0**	**100.0**	**100.0**
Reason left work					
To commence or increase care	—	11.4	17.2	*4.4	10.6
Total number ('000)	**13.6**	**259.0**	**79.1**	**96.4**	**448.1**

Source: AIHW analysis of 1998 ABS Survey of Disability, Ageing and Carers confidentialised unit record file.

The ability to remain employed while caring and to return to employment after a prolonged period of caring could become an increasingly important factor in women's predisposition to provide ongoing informal care. Flexible working arrangements and the availability of affordable support are likely to also impact on the extent to which employed men can take on a greater share of informal caring. Conversely, the moral imperative to care for disabled family members will influence many older workers' employment decisions. Structural and numerical ageing of the population will see a shrinking labour force supporting growing numbers of people in need of assistance. For governments aiming to maximise labour force participation over the coming years, the need to also realise the 'carer dividend' in the large cohort of older working-age baby boomers could prove to be a significant policy challenge (OECD 1996:298).

3.6 The future availability of carers

Concerns have been raised about the future availability of people to care for those who need assistance in the light of changes in Australia: the ageing of the population, declining fertility rate, and increased rates of female labour force participation and of relationship breakdown (see Section 3.2). There are changes that might counteract these trends: male longevity and healthy ageing. At all ages, women have historically enjoyed greater average life expectancy than men and, while this remains the case, the gap between male and female life expectancies is closing. Conceivably, gains in male longevity will produce relatively higher numbers of older, co-resident spouse and partner carers, compared with those observed in 1998. In addition, the National Strategy for an Ageing Australia emphasises ways of ensuring that more Australians are active and healthy in their later years, giving them a great capacity to contribute to the community, including caring for others. These factors may ameliorate the need for primary carers in the future.

Here an analysis is presented that attempts to consider the effects of these trends on the numbers of primary carers available over the next 10 years. This analysis was prepared as part of a collaborative project with the Department of Health and Ageing.

Effects of social trends on future numbers of primary carers

There is considerable conjecture about the impact of these social trends on the future provision of informal care. Given the paucity of data to support or refute such propositions, the AIHW undertook an analysis to compare the effect of emerging social trends on future numbers of primary carers. The objective was not so much to forecast the number of primary carers, as to gauge the relative impact of factors, among those discussed in this chapter, on the community's capacity to provide primary carers. Specifically, the analysis considered the likely impact of:

- an overall decline in the propensity of people to care;
- a decrease in the availability of primary carers that could result from a reduced propensity of women to reduce paid employment in order to provide care; and
- an increase in the availability of carers that could result in higher numbers of co-resident spouses and partners at older ages (owing to converging male and female average life expectancy).

These scenarios are compared against a 'baseline propensity to care' scenario. This scenario adopts the 1998 rates of carers by age, sex, labour force participation category and living arrangement for the projections to 2013. It assumes that the proportions of people in similar life circumstances who become carers will be the same in the future as were reported in 1998.

A summary of the scenarios is provided in Box 3.6 and full details of the methods and analytical results of each stage of calculations are provided in an AIHW information paper (AIHW: Jenkins et al. 2003). Projections were separately calculated for each of the age groups 10–24 years, 25–59 years, and 60 years or over. Caring rates in these age groups reflect the propensity to care among the young, working-age, and older populations respectively. The effect of these factors on the number of primary carers was examined at 5-year intervals, commencing in 1998 through to 2013.

This scenario modelling approach uses the results of the 1998 ABS Survey of Disability, Ageing and Carers and population projections by age, sex and labour force participation category supplied by Department of Treasury, and consistent with those in the *Intergenerational Report* (Costello 2002). Projected population proportions by living arrangement category, taken from the ABS *Household and Family Projections* (ABS 1999) were used in conjunction with the Treasury population figures.

To adopt the 1998 results as a starting point is to assume that caring in the community is primarily driven by the number of people who are available and willing to provide care. This places little emphasis on the interaction between the provision of care and changing levels in the need for care. It would be an extreme theoretical position to propose that the supply of informal care bears little relation to demand. This would be to assume that the drivers of social change will act to increase or decrease the number of carers as the case may be, regardless of the growing needs of those affected by disability or illness in an ageing household population. Nevertheless, it has been observed that many people with very considerable care needs do not have a primary carer so that, clearly, the relationship between demand and supply is complex and multi-faceted. The scenario projections are based on the numbers of people responding to the care needs of others by acting in a primary caring role in 1998, with future projections based on specified changes in behaviour that have been hypothesised to affect the likelihood of people becoming a primary carer. The past, if not current, impact of the prevalence of disability on population rates of informal care (measured as proportions of primary carers in given population groups) is reflected in the 1998 survey results. By assuming that disability prevalence in the household population does not alter markedly over the next decade, a key factor that might otherwise influence supply was held constant. This section summarises the methods and main results of the scenario projections (AIHW: Jenkins et al. 2003).

A baseline 'propensity to care' scenario

The 10–24 age group was broken down only by sex because further stratification produced 1998 population estimates, hence carer rates, that are subject to high sampling error. Thus, the baseline 'propensity to care' for 10-24 year olds was measured in terms of the proportions of this age group, by sex, who were primary carers in 1998.

The overall baseline scenario incorporates changing patterns in the age and sex structure of the population, changing patterns of labour force participation in the working-age population (including increasing female labour force participation), and changing patterns in spouse and partner cohabitation at older ages that are all built into the underlying population projections.

In the baseline scenario, population dynamics alone, with respect to age, sex, labour force participation and living arrangement according to age group, are seen to increase the number of primary carers from 450,900 in 1998 to 573,900 in 2013 (Table 3.17). In this scenario, 59,900 additional carers will be sourced from the working-age population and 62,300 additional carers will be aged 60 years or over. The proportion of primary carers who are of working age, 25–59 years, will fall from around 67% in 1998 to a projected 63% in 2013. While the proportion of carers who are employed males is projected to be stable at around 17%, throughout the projection period, employed women as a proportion of all primary carers are projected to decrease from 49% in 1998 to 46% in 2013. People aged 60 years and over are projected to rise from 29% of all primary carers in 1998 to 34% in 2013.

Table 3.17: Estimated (1998) and projected (2003, 2008, 2013) numbers of primary carers, according to baseline 'propensity to care' scenario

Sex/age	1998	2003	2008	2013
Males				
10–24	*6,200	6,500	6,600	6,700
25–59	78,700	87,000	92,900	96,400
60+	48,600	55,200	63,700	72,700
Total	*133,500*	*148,700*	*163,200*	*175,800*
Females				
10–24	10,100	10,400	10,600	10,600
25–59	223,100	243,100	257,200	265,200
60+	84,200	90,500	103,700	122,400
Total	*317,300*	*344,000*	*371,500*	*398,200*
Persons				
10–24	16,300	16,900	17,300	17,300
25–59	301,700	330,100	350,100	361,600
60+	132,800	145,700	167,400	195,100
Total	**450,900**	**492,700**	**530,800**	**573,900**

Scenarios to assess the impact of emerging social trends

Questions about the impact of a reduced willingness of women to reduce paid employment to care, an increase in older people in couple relationships, or an overall decline in the propensity to care were expressed as three scenarios for the future of informal care: the 'overall decreasing propensity to care' scenario, the 'women's career preference' scenario and the 'converging life expectancies' scenario (Box 3.6). An arbitrary choice of a 20% effect size, whether it be an increase or decrease, is common to all scenarios. This effect was applied linearly throughout the projection period. For example, a 20% decrease in carer rates by 2013 was modelled as a 6.7% decline in propensity to care between 1998 and 2003, a 13.3% decline between 2003 and 2008, and a full 20% decline in the final 5 years to 2013.

The overall decreasing propensity to care scenario assesses the impact of a decline in carer rates across all combinations of age, sex, labour force participation category (for the working-age population), and living arrangement (for the older population), that reaches 20% by 2013. Similarly, the career preference scenario measures the impact of a decline in carer rates across combinations of age and labour force participation category for the population of women aged 25–59 years. In this scenario, it is assumed that the projected populations at other levels of age, sex, labour force participation category or living arrangement experience baseline propensities to care. That is, the number of carers in categories other than working-age women, continue to be influenced by population dynamics with respect to age, sex, labour force participation and living arrangement as defined for this study. This approach was repeated in the converging life expectancies scenario, in which a 20% linear increase in the proportion of spouse and partner carers was applied to population projections for the 60 years and over age group by 5-year age group to 80 years and over, sex, and living arrangement, while baseline propensities were assumed for all other projection categories.

Box 3.6: Scenarios for the projection of informal carers to 2013

Baseline propensity to care scenario

The baseline propensity to care scenario assumes that 1998 patterns of care continue, in relation to each combined level of age group, sex, labour force participation category (for ages 25–59 years) and living arrangement category (for ages 60 years and over). The proportions of male and female primary carers recorded in each age group by labour force participation category or living arrangement, depending on age, in the 1998 ABS Survey of Disability, Ageing and Carers were applied to corresponding Treasury population projections. The driving forces of change in the number of primary carers according to this scenario are thus the changing age and sex structure of the population and changing patterns of labour force participation that are implicit in the Treasury projections. For example, if 3% of men aged between 55 and 64 years, who were not in the labour force or were unemployed in 1998, were primary carers, then that rate is applied to the projected population for the same group in 2008. The result is an estimate of the number of male primary carers aged 55–64 years, unemployed or not in the labour force in 2008. Although there is a change in absolute number of primary carers, it still represents 3% of men in this projection category.

Overall decreasing propensity to care scenario

The 'overall decreasing propensity to care' scenario evaluates the impact of an across-the-board 20% decrease in the proportion of primary carers by age, sex, and labour force participation (at ages 25–59 years) or living arrangement (at ages 60 years or over) category, by 2013. This scenario is an attempt to quantify the relative impact on future numbers of primary carers if a range of social factors conspired to reduce the propensity of people across all projection categories to act as carers. The absolute number of carers may still increase under these conditions because of increasing numbers of people moving into age groups that have relatively high proportions of primary carers. The resulting change in primary carer numbers, relative to the baseline propensity to care scenario, measures the impact of an overall decline in the propensity to care, taking into account anticipated population dynamics.

Women's career preference scenario

In 1998, 7% of female primary carers aged 25–59 years said that they had reduced paid employment, or left work altogether, to take on a role as primary carer. There is considerable debate as to whether working-age women of the future will make that choice. The 'women's career preference scenario' assesses the impact of an arbitrary 20% reduction over the projection period in the proportion of women who reduce paid employment to care. The 1998 patterns of care are assumed to continue in relation to other age, sex and labour force participation (or living arrangement) categories. The figure of 20% is arbitrary, thus a sensitivity analysis using alternative reductions of 10% and 30% was undertaken.

Converging life expectancies scenario

The 'converging life expectancies' scenario assesses the impact of an arbitrary 20% increase over the projection period in the proportion of primary carers aged 60 years or

(continued)

Box 3.6 (continued): Scenarios for the projection of informal carers to 2013

over who are the spouse or partner of their care recipient. A sensitivity analysis was undertaken, by applying alternative increases of 10% and 30%. For this scenario, Treasury-projected populations by 5-year age group, at ages 60 years or over, were classified into spouse/partner in a couple family, or 'other living arrangement' groups using ABS household and family projections (ABS 1999b). The 1998 patterns of care were assumed to continue in relation to other age, sex and labour force participation categories.

A projected total carer pool was calculated by aggregating primary carer numbers across the three broad age groups, consistent with the assumptions of each scenario. For the baseline propensity to care scenario, baseline propensity projections in each of the age groups 10–24, 25–59 and 60 years or over were summed. Likewise, for the overall decline in propensity to care scenario, projections based on a decreasing rate of primary carers, by projection category in each age group, were summed. Total carers in the career preference scenario are the sum of projected female carers aged 25–59 years in this scenario, and baseline propensity to care projections for both sexes at ages 10–24 years, males aged 25–59 years, and both sexes at 60 years or over. Finally, total carers in the converging life expectancies scenario are the sum of baseline propensity to care projections for males and females at ages 10–24 years and 25–59 years, and the scenario projection for the 60 years and over age group, based on higher proportions of cohabiting couples. The results reveal that, of these single-effect scenarios, only an overall decline in propensity to care would have a marked impact on the number of primary carers in 2013 (Table 3.18).

Table 3.18: Scenario projections of numbers of primary carers (10 years and over), by sex, 2003, 2008 and 2013

Scenario	2003	2008	2013
		Males	
Baseline propensity to care	148,700	163,200	175,700
Overall decreasing propensity to care	138,800	141,400	140,600
Women's career preference	148,700	163,200	175,700
Converging life expectancies	151,900	170,600	188,500
		Females	
Baseline propensity to care	344,000	371,600	398,200
Overall decreasing propensity to care	321,100	322,000	318,600
Women's career preference	342,400	368,100	392,900
Converging life expectancies	347,600	379,600	412,200
		Persons	
Baseline propensity to care	492,700	534,800	573,900
Overall decreasing propensity to care	459,900	463,500	459,200
Women's career preference	491,100	531,300	568,600
Converging life expectancies	499,500	550,200	600,700

Scenario projections in the context of future need

But what of the relationship between projected numbers of primary carers and the projected population in need of assistance? To answer this question, the projected number of primary carers in 2013 for each scenario was expressed as a rate per 100 persons with a severe or profound core activity restriction. Assuming 1998 rates of severe or profound restriction by age and sex, this latter population is projected to be in the vicinity of 1.4 million persons by 2013 (AIHW: Jenkins et al. 2003). In 1998, there were an estimated 450,900 primary carers and just over 1 million people with a severe and profound restriction (living in households, retirement homes, hospitals or cared accommodation). However, around 20% of primary carers in 1998 assisted more than one person with a severe or profound restriction and a large number of people in need of assistance received help from informal care networks but did not nominate any one person as a primary carer. For these reasons, a 'care ratio' facilitates a comparison of the scenarios taking into account potential need for care, without actually measuring the level of informal care in the community. The 1998 ratio of 43 primary carers per 100 persons with a severe or profound core activity restriction provides a benchmark against which to compare the 2013 scenario care ratios.

There is little difference between the 2013 care ratios of the baseline propensity to care, women's career preference and converging life expectancies scenarios. All fall slightly below the 1998 estimate. Under the baseline scenario of 1998 propensities to care by age, sex, labour force participation and living arrangement, there are projected to be 40 primary carers per 100 persons with a severe or profound restriction, or a care ratio of 0.40. Baby boomers who survive the projection period will age from between 37 and 51 years in 1998 to between 52 and 66 years in 2013. In 1998, people aged between 35 and 64 accounted for 64% of all primary carers (ABS 1999a:Table 28). Despite projected high growth in the population for age groups that register relatively high proportions of primary carers, 1998 carer rates will not quite keep pace with growth in the population with a severe or profound restriction. The women's career preference scenario also generates a care ratio of 0.40 in 2013. During this particular projection period, a 20% reduction in the proportion of women aged 25 to 59 who are willing to forgo hours of paid employment relative to 1998 is largely offset by high numerical growth in traditional primary carer age groups due to ageing of the baby-boomer generation. The converging life expectancies scenario, with a care ratio of 0.42, appears to maintain the 1998 status quo, suggesting that a 20% increase in the proportions of co-resident spouse and partner carers at older ages could offset higher numbers of people needing assistance. Each of these three scenarios describes a situation in which the demand for formal services increases mainly as a result of the increase in the number of people needing and providing assistance, rather than in any dramatic shift in the provision of informal care.

In contrast, an overall decline in the propensity to care, by 20% in 2013, would reduce the care ratio to just 32 primary carers per 100 persons with a severe or profound core activity restriction. A reduction in care potential of this magnitude would compound the effect of growth in the population in need of assistance on demand for formal care. It suggests that, under these conditions, a significant number of people who might have had a primary carer if the 1998 propensity to care were maintained would instead be relying on formal services and more casual forms of informal care.

Discussion of scenarios

Social commentators have been preoccupied with the impact on informal care capacity of increasing labour force participation among women, particularly at ages 45 and over. The scenario posed here examines a situation in which, within each population group of employed women, by age and labour force status, the proportion who would cease or reduce paid employment actually reduces by 20% over the projection period. The proportions to which this reduction applies are those observed in each age and labour force category in 1998. Overall, 7% of female primary carers aged 25–59 years in 1998 reported having resigned or reduced hours of paid work to provide care; however, the proportion varies across age and labour force categories. A reduced willingness of women to sacrifice employment that results in a 20% reduction in these proportions by 2013 could be regarded as a pessimistic outlook. While it is not unreasonable to expect female workforce participation (particularly women aged 55 and over) to continue to rise over the next decade in line with current trends, it is less likely that all of those continuing or returning to work will not provide care in some capacity. Other research has suggested that women are more likely than men to arrange their working hours to fit with other family caring responsibilities (Fine 1994). In this respect the scenario presented here is somewhat of an extreme position. Yet under the proposed conditions, the ratio of carers to people with a severe or profound core activity restriction would be the same as if there were no change in carer rates over the projection period (both 0.40).

These results emphasise that a large proportion of female carers is actually in the labour force, highlighting the need to specifically consider employed carers in the ongoing development of carer support programs. Employed women made up 34% (102,400) of all primary carers in 1998. The ability of many women to balance paid work and family caring responsibilities and to continue to do so into the future will no doubt depend upon the availability of other family and community supports. As the 1999 National Survey of Carer Health and Wellbeing reports, respite care and other services are seen by carers as an integral part of their lives and essential to their ability to continue in their role as carers (CAA 2000).

The projections also indicate that an increase in the number of older co-resident spouses and partners is likely to be only a small source of additional carers over the next decade. A 20% increase in the rate of caring among co-resident spouses and partners is perhaps an optimistic scenario. While life expectancies are improving, particularly for men, and, as Mathers (1996) reports, severe disability-free life expectancies are increasing in line with life expectancies, these factors are only two of a multitude of variables influencing the availability of people to care for their spouse or partner. The scenario assumes that surviving partners will remain married rather than become divorced or separated and that, in addition to physical capability, these partners will have the necessary skills and emotional ability to undertake the caring role. These assumptions may not always find support in reality. For example, Sammut (1996) describes some of the difficulties faced by carers of those with dementia who can sometimes exhibit disturbing symptoms that are physically exhausting for their carers.

The projections suggest that a considerable decline in the proportion of working age women who reduce workforce participation to care, or increase in the rate of older spouse and partner carers, do not have major implications for the future availability of informal carers. However, even given the one-off effect of large numbers of baby boomers entering age groups with traditionally high rates of primary carers, a 20% decline in the propensity to care across all categories of age, sex, labour force participation and living arrangement would not go unnoticed. The plausibility of a scenario in which there is a broad decline in carer availability is difficult to assess, not least because of the multitude of variables relevant in determining carer supply, many of which are not well understood.

The scenario projections are based on data for primary carers: that is, individuals providing the most assistance to persons with a disability. Many people with a disability receive help from more than one person, usually other family members (Miller & McFall 1991). This group of additional carers is not included in the projections. Thus, the scenarios presented above which project a decline in primary carers do not allow for the possibility that these carers will be replaced by carers in other circumstances beyond those identified in the model. A survey of carers by Braithwaite (1990) found that 25% of primary carers took on the role because there was no one else to do so, and for 28% other potential carers had refused. According to the 1998 ABS survey (ABS 1999a), 30% of carers of parents felt that there were no other family or friends available and 19% felt that no one else was willing to take on the role of primary carer. In contrast, Miller and McFall (1991) have observed that additional informal assistance varied in intensity and size (in terms of the number of additional carers) as a function of, among other things, the need of the recipient, with greater care needs finding more support from an additional carer network. The contribution of additional carers and the implications of this for future care needs are difficult to assess and were beyond the scope of the analysis.

Carer accessibility, in terms of geographic location, is a further consideration in the interpretation of the scenario projections. There is an assumption that additional primary carers will be available in a practical sense. Thus, the phenomenon of geographic ageing and the tendency of many people to retire to coastal destinations will play a part in future patterns of informal care.

While these limitations are important to note, they do not detract from the strength of the conclusions. The scenarios presented here offer an empirical base for some likely projected future trends, indicating the likely scope of changes over the period from 1998 to 2013. Shifts in carer responsibility that results from the changing availability of the group identified as primary carers will have implications for formal services and for the caring responsibility placed on others in informal networks. The effectiveness of these extended networks is related to the availability of relevant formal services and programs and to policies which facilitate broader community support.

3.7 Conclusion

This examination of caring reveals the enormous contribution that Australians make to the welfare of those who need special assistance. Most of the care provided to children, and to people with a disability, is provided by parents, spouses, adult children, grandparents, siblings, aunts and uncles, and friends and neighbours. They perform a range of tasks including personal care, assistance with mobility and communication, domestic assistance, the provision of meals and transport, and advocacy and social support. People are supported in their caring role by formal assistance from governments and other organisations—assistance comes in the form of financial support and the coordination and provision of services. However, the vast majority of care is given by those close to the care recipient—their family and friends.

When parents *are* unable, for whatever reason, to raise their children, other relatives, often grandparents, step in and provide out-of-home care, sometimes informally, ensuring some continuity and stability for children.

When individuals need assistance due to disability, primary carers make a huge contribution to their care. Almost three-quarters (70%) of primary carers are women, many in their mid- to later life. Partners and spouses often care for one another, particularly in later years, and close to half (44%) of partner or spouse carers are men. Parents provide ongoing care to children with a disability. For some, the primary caring role imposes a considerable burden, but it is a role that people take on out of a sense of responsibility and the desire to provide the best possible care. They report fewer hours of paid employment than others, and almost half of all primary carers who were not in the labour force reported difficulties that would prevent them from returning to paid employment.

Families are changing. Women are more likely to work, people marry later, have children later and have fewer children, and childlessness has increased. Divorce rates are high and there are more blended and step-families, and families tend to be more mobile. As the analysis of the future availability of primary carers showed, some of these changes may signal a lower ratio of potential carers to those in need of ongoing assistance in the future. Women are most likely to be affected by a lack of informal carers because they are more likely to survive into old age, more likely to have related physical and psychological impairments and more likely to be financially vulnerable. Others for whom the availability of informal care may be reduced include divorced fathers, the childless, those geographically isolated from their families, and those on low incomes. However, these changes are occurring gradually over a very long time frame, allowing for gradual change in government policies and service provision.

The 'ageing' experience is also changing. As the National Strategy for an Ageing Australia notes, the needs and expectations of the current aged population will not be the same as the needs of the aged in 2010. Greater numbers of people are ageing in a better state of health. Roles of older Australians are changing, with less acceptance of traditional ideas of what old age means. Retirement patterns are changing—men used to have continuous periods of full-time employment while women had very little, but now, both sexes are more likely to work part-time or intermittently. This means that more people have superannuation coverage in Australia than ever before, but that a growing proportion are covered part-time. Traditionally, there has been a sharp division between paid work and retirement. Now the division is becoming more blurred, with high rates of part-time and self-employment both before and after traditional retirement ages (Rosenman 1996). All of these factors will affect the need for and provision of informal caring.

The ageing of carers is an urgent current issue both for families in which a family member has a disability and for governments and service providers. AIHW's 2002 study on the effectiveness of 'unmet need' funding for disability support services, estimated that, in 2001, 12,500 people needed accommodation and respite services (AIHW 2002:xxi). The peak organisation discussions conducted as part of this study highlighted the fact that, particularly for ageing carers, while respite services are useful and appreciated, centre-based respite is also needed. Furthermore, many ageing carers were very mindful that they need to 'hand over'. The fundamental question for many ageing carers, mainly parents, are: 'When can I retire? And if I can't, what happens when I die?' For these people, a policy focus on in-home support does not fully meet their needs (AIHW 2002:ix).

One thing seems clear from this analysis: the provision of informal caring will increasingly depend upon people's ability to combine work and family responsibilities. A wide range of policies will be required to support carers. Family-friendly workplace policies will need to be extended to apply to people who are caring for people with a disability or frail older people, and not just to those with dependent children.

The Stronger Families and Communities Strategy announced in 2000 gives the federal government a vehicle to work in partnership with other levels of government and community agencies in new and innovative ways to support families and to work within communities to build capacity. A component of the strategy is the Longitudinal Study of Australian Children. Data collected between 2003 and 2010 will add to our knowledge of the provision of unpaid informal care of children and how care arrangements change over time. This longitudinal perspective will complement the now triennial Child Care Survey, which was first conducted by the Australian Bureau of Statistics in 1969 as a supplement to the Monthly Population Survey.

Convened in 2003, the National Family Carers Voice is an organisation of individuals with a commitment to and personal experience of caring for adults and children with disabilities. Its charter is to 'gather information about the nature, location, and circumstances of family carers to provide the Government with advice and options for addressing the longer term needs of these important individuals' (Vanstone 2003). The Department of Health and Ageing provides funding to carers organisations such as Carers Australia, the national peak carer organisation. Carers Australia promotes the recognition of carers and provides information and resources to carers through initiatives such as the National Carers Counselling Program. This program operates through the eight state and territory Commonwealth Carer Resource Centres.

More and more Australians are likely to become involved in the ongoing giving and receiving of unpaid care due to population growth in the older age groups and the higher prevalence of severe or profound disability at older ages. In addition, many parents caring for adult children with a disability are facing physical difficulties and anxieties associated with their capacity to continue to provide care in old age. Future levels of provision of unpaid care will be inextricably linked to the levels of workforce participation, retirement income, physical health and wellbeing of older people and their carers, and the potential for people with disabilities to remain in an appropriate living arrangement as they age. The Framework for an Australian Ageing Research Agenda aims to build capacity for further high-quality and coordinated research and analysis of these complex interrelationships (AIHW & DoHA 2003).

Increasingly, carers are being recognised as clients in their own right by programs designed primarily to deliver services to care recipients. Carer interventions extend beyond the provision of respite to services that aim to build on carers' understanding of chronic diseases and symptomatology, and on their capacity to seek assistance from formal services. The AIHW continues to undertake data development work to better measure the situation and circumstances of carers and the services that assist them. In 1999, the AIHW and the National Disability Administrators began a process to review and redevelop the Commonwealth-State/Territory Disability Agreement minimum data set and related data collections (CSTDA MDS). New data items on primary carers have been incorporated into this MDS from 2003 and assessment of carer stress and strain features in state and territory service delivery guidelines.

In order for Australians to meet one another's welfare needs, the contribution of informal caring will need to be fully appreciated. Establishing a strong evidence base regarding the needs and circumstances of carers and care recipients, and achieving greater understanding and promotion of best practice in the delivery of service and assistance to carers, will support the sustainability of this vital component of Australian society.

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4 Welfare services resources

4.1 Introduction

This chapter presents information on resources devoted to welfare services. Specifically, these resources are:

- expenditure on the provision of welfare services[1] (which includes expenditure on wages and salaries); and
- human resources involved in providing or supporting the provision of welfare services, including:
  - people employed in those industries whose primary function is to provide community services;
  - people employed in 'community service' occupations in other industries;
  - people who provide and/or support the provision of welfare services on an 'unpaid' basis, either through community services organisations or as informal carers of family members, neighbours and friends.

Expenditure on welfare services occurs when a service is provided and there is a financial transaction involved. This may be where a fee is raised for the service concerned, a government provides benefit to an individual, a subsidy is given to support the service, or some other form of financial transaction arises. This expenditure is included in the estimates of national expenditure.

In addition, many welfare services provided in Australia do not involve direct financial transactions. These include care provided by families and neighbours to older people, people with disabilities or families with children. They also include the work that volunteers do to support organisations that provide welfare services.

In order to present as broad a picture as possible of the total value of the welfare services that are provided to Australians, it is necessary to include an equivalent dollar value for these 'unpaid' welfare services. The method used in this chapter assumes that the value of the services produced by this unpaid workforce is equal to the cost of labour that would have been incurred had those services been produced by employed persons (see Box 4.1 and AIHW 1995:29 for more details about the valuation methods).

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[1] Not included are income support and long-term housing assistance, and health-related expenditure items (see Box 4.4).

The third expenditure category that is included in the calculation of the total value of welfare services produced in Australia is the imputed value of taxation expenditures. These are estimates of the revenue forgone by governments as a result of concessional taxation treatment in respect of inputs used by some non-government community services organisations (NGCSOs).

Because most direct expenditure on welfare services is financed through government programs, expenditure is generally classified along the lines of the welfare services government purpose classifications used by the Australian Bureau of Statistics in its government financial statistics. These classifications are:

- family and child welfare services
- welfare services for older people
- welfare services for people with disabilities
- other welfare services not elsewhere classified (nec).

Box 4.1: Valuing unpaid time used by the households sector to provide welfare services

The method used in this publication to impute the value of unpaid welfare services involves relating the time spent by members of households to assumed values of the time spent on the work done. There are a number of reasons why this will underestimate the full value of the activity. First, the conditions under which people provide unpaid services are governed more by personal motivation, altruism and dedication than work practice arrangements or the level of remuneration. Second, no account is taken of whether penalty rates or other award provisions might apply should the service have been provided at the particular time of day by a paid employee. Third, there is no recognition of annual leave, superannuation, personal leave and other entitlements that might apply in the case of paid employees. There would also have been overheads involved had the services been provided by paid employees of either government or non-government community services organisations.

The hourly rate that was used for valuing the unpaid time spent providing welfare services was the average hourly pay rates that would have been incurred had an appropriately qualified person been employed to undertake that activity.

The relative hours and wage rates used to value unpaid time were:

- *adult male carers and aides (full-time non-managerial employees) – 38.4 hours per week at $17.34 per hour; and*
- *adult female carers and aides (full-time non-managerial employees) – 37.9 hours per week at $15.32 per hour.*

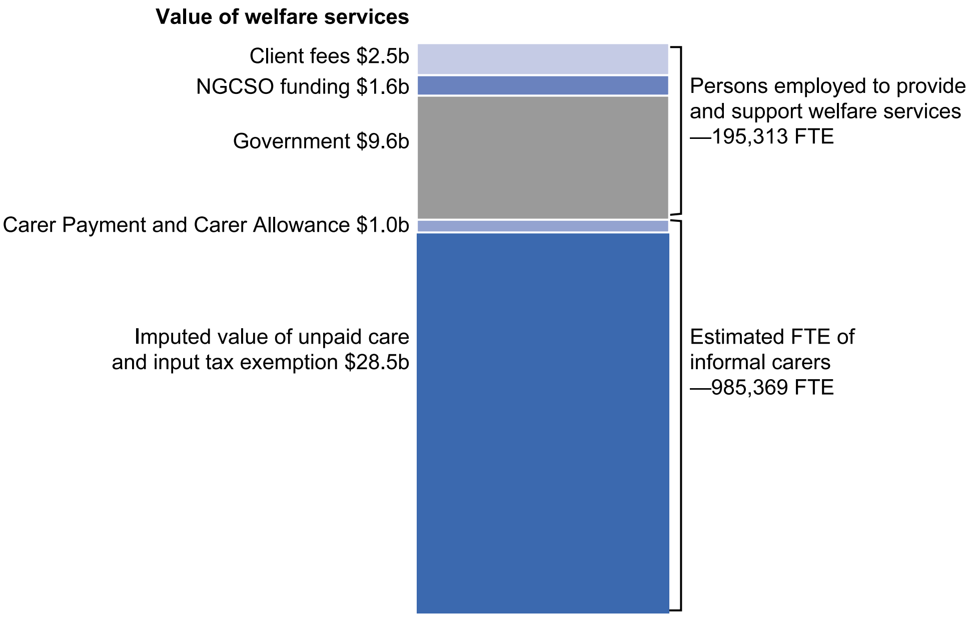
Source: ABS 2001a.

4.2 Total resources

The total value of the welfare services provided during 2000–01 was estimated at $43.2 billion. Of this, 31.8% ($13.7 billion) relates to services for which expenditure was incurred (Figure 4.1). The remaining $29.5 billion was 'imputed' as the value of services where no payments or expenses were actually incurred.

Of the $13.7 billion in expenditure, $13.5 billion was incurred by governments and NGCSOs (see Table 4.3). The remaining $201 million was estimated fees paid by households for informal child care services provided by other members of the households sector (see Box 4.5).[2]

Revenue forgone by governments as a result of concessional taxation treatment for NGCSOs was estimated at $0.7 billion (see Table 4.17). The remaining $28.8 billion was the imputed value of the households sector's unpaid contribution to welfare services (see Section 4.5). Some of this ($1.3 billion) was in the form of voluntary work through organisations but most ($27.4 billion) was the imputed value of informal care in the



Sources: Tables 4.1, 4.17, 4.24.

Figure 4.1: Total resources on welfare services provision, 2000–01

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[2] Informal child care refers to non-regulated care that takes place in the child's home or elsewhere. It includes care by family members, friends, neighbours, paid babysitters and nannies (ABS 2003a:2).

households sector. This included neighbours providing care to others, informal child care arrangements, and informal care of older people and people with disabilities. Some of these informal carers received social security payments in the form of Carer Allowance or Carer Payments which, in 2000–01, totalled $1.01 billion (FaCS 2002:141).[3] This represented 3.7% of the total imputed value of informal care.

The paid workforce involved in providing and/or supporting welfare services in 2000–01 was estimated at 195,000 full-time equivalent (FTE) workers. The unpaid workforce was estimated to be about five times the paid workforce (in terms of FTEs).

4.3 Expenditure on welfare services and its funding

This section analyses expenditure on welfare services in Australia both in terms of who incurs the expenditure and who provides the funding for that expenditure.

In this context, the term ‘expenditure’ is used to define the expenses or payments that are incurred when welfare services are being provided.

In paying for the expenditure, service providers use their own financial resources or funds provided by other sources (usually governments), and fees by clients. This is referred to as ‘funding’.

Expenditure on welfare services

The $13.7 billion total expenditure on welfare services in 2000–01 constituted 2.1% of gross domestic product (GDP) (Table 4.1). Per person expenditure averaged $707, up by $21 per person on the previous year (Table 4.2).

Because of the break in the time series data after 1997–98 (Box 4.2), it is not appropriate to calculate average growth rates covering the whole period from 1992–93 to 2000–01. Instead, the growth rates following the break in series are compared with those that applied prior to the break.

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[3] Carer Allowance is an annually indexed income supplement available to people who provide daily care and attention to a person who is frail aged, has severe disability or a medical condition. Carer Allowance is not income and assets tested. Carer Payment is an income support payment for people whose caring responsibilities prevent them from undertaking substantial workforce participation. It is means tested and paid at the same rate as other social security income support payments. In 2000–01, Carer Allowance and Carer Payments were respectively $82 and $400 per fortnight.

Table 4.1: Welfare services expenditure as a proportion of GDP[(a)] and annual growth rate, 1992–93 to 2000–01

	Current prices		Constant prices[(b)]	
	Expenditure ($m)	Expenditure (% of GDP)	Expenditure ($m)	Growth rate (%)
1992–93	7,125	1.7	7,974	..
1993–94	7,726	1.7	8,584	8.4
1994–95	8,355	1.8	9,277	8.2
1995–96	9,069	1.8	9,975	7.5
1996–97	9,958	1.9	10,807	8.3
1997–98	10,874	1.9	11,694	6.2
Break in time series				
1998–99[(c)]	11,883	2.0	12,369	—
1999–00[(c)]	13,073	2.1	13,500	9.1
2000–01	13,690	2.1	13,690	1.4
Average annual growth rate				
1992–93 to 1997–98	—	—	—	8.4
1998–99 to 2000–01	—	—	—	5.2

(a) GDP(I)—the income-based estimate of GDP was used.

(b) For recurrent expenditure, the implicit price deflator for GFCE was used to deflate both government and non-government current price expenditure to 2000–01 prices. For capital expenditure, Gross Fixed Capital Formation—Chain Price Index was used.

(c) Estimates were revised (see detail in AIHW 2003a:26–8).

Sources: Welfare services expenditure—AIHW database; GDP—ABS 1999a,1999b, 2001b.

Box 4.2: Cash and accrual accounting

Prior to 1998–99, governments in Australia consistently reported expenditure on a cash basis. This meant that payments were recorded in the financial year in which they were made, regardless of whether they were for services provided in that year.

Since 1998–99, governments in most jurisdictions have adopted accrual accounting as the basis for their financial reporting. Under accrual accounting, only expenses that are incurred or accrued within the year are reported, irrespective of whether any related cash transactions actually occurred during that year. Accrual accounting also provides for the reporting of 'non-cash' transactions, such as depreciation (an estimate of the value of capital used up in the process of production of goods and services) and unfunded superannuation.

Because of the change in reporting of expenditure from cash to accrual, there is a break in the time series after 1997–98.

Real growth in total expenditure (i.e. after removing the effects of inflation) between 1998–99 and 2000–01 averaged 5.2% per year, compared with 8.4% between 1992–93 and 1997–98. Real growth in per person expenditure between 1998–99 and 2000–01 averaged 3.8% per year, compared with an average growth rate of 6.9% over the period 1992–93 to 1997–98 (Table 4.2).

Table 4.2: Welfare services expenditure per person, and annual growth rate, 1992–93 to 2000–01

	Expenditure per person ($)		
	Current prices	Constant prices[a]	Growth rate in constant prices (%)
1992–93	405	450	..
1993–94	435	483	7.3
1994–95	465	516	7.0
1995–96	498	548	6.1
1996–97	540	587	7.0
1997–98	584	628	7.0
Break in time series			
1998–99	631	657	—
1999–00	686	709	7.9
2000–01	707	707	–0.2
Average annual growth rate[b]			
1992–93 to 1997–98	—	—	6.9
1998–99 to 2000–01	—	—	3.8

(a) For recurrent expenditure, the implicit price deflator for GFCE was used to deflate both government and non-government current price expenditure to 2000–01 prices. For capital expenditure, Gross Fixed Capital Formation—Chain Price Index was used.

(b) Average annual growth rates are calculated using exponential growth.

Sources: Expenditure—AIHW database; Population—ABS 1996a, 1998a, 1998b, 1999c, 2002.

Three broad sectors incurring expenditure are governments, NGCSOs and households. In 2000–01, expenditure incurred by NGCSOs was just over half ($6.9 billion) of total welfare services expenditure. Therefore the role of NGCSOs is predominantly as provider of services, though funding for the services they provide may come from sources other than their own (Box 4.3, Table 4.3, and Table 4.14). A further $6.6 billion was incurred by governments—Commonwealth, state and territory, and local. Identified expenditure by the households sector—in the form of informal child care services for which payments were made—made up the remaining $0.2 billion.

Between 1998–99 and 2000–01, the share of expenditure incurred by NGCSOs increased from 47.6% to 50.6%. This was because their expenditure grew at a faster rate than that of the government and households sectors, part of which was due to governments channelling expenditure through NGCSOs rather than providing direct services themselves. Between 1998–99 and 1999–00, expenditure incurred by NGCSOs increased in nominal terms (i.e. in current prices) by 12.0%, while over the year to 2000–01, it grew by 9.4%. The comparable figures for the government sector were 8.5% and 0.4%, and for the households sector declines of 1% and 2% (calculated from Table 4.3).

Between 1992–93 to 1997–98, the highest real growth in recurrent expenditure by the Commonwealth Government and state and territory governments was in welfare services for older people (14.7%) (Table 4.4). This was followed by welfare services for families and children (9.2%), other welfare services (8.0%), and welfare services for people with a disability (4.9%). Between 1998–99 to 2000–01, the highest real growth was in welfare services for people with a disability (6.7%) which was the area with the lowest growth in the earlier period. The second highest growth occurred in other welfare services (6.1%). This was followed by welfare services for families and children (5.7%) and welfare services for older people (4.1%).

Table 4.3: Total expenditure on welfare services, 1992–93 to 2000–01 ($m)

	Sector incurring expenditure (current prices)			
Year	Governments[(a)]	NGCSOs	Households sector[(b)]	All sectors[(b)]
1992–93	3,192	3,933	. .	7,125
1993–94	3,392	4,334	. .	7,726
1994–95	4,049	4,306	. .	8,355
1995–96	4,117	4,952	. .	9,069
1996–97	4,124	5,562	272	9,958
1997–98	4,386	6,227	261	10,874
Break in time series				
1998–99	6,020	5,656	207	11,883
1999–00	6,533	6,335	205	13,073
2000–01	6,558	6,931	201	13,690

(a) Government expenditure calculated by subtraction.

(b) Includes only estimated client fees paid by households for informal child care services from 1996–97 to 2000–01.

Sources
Governments—Commonwealth: compiled from DHHCS 1991, 1992; DHHLGCS 1993; DHSH 1995a, 1995b; DHFS 1996, 1997, 1998; DHAC 1999, 2000, DoHA 2001, 2002; DHRD 1994, 1995; FaCS 1999, 2000, 2001, 2002; Department of Immigration and Ethnic Affairs unpublished data; Department of Veterans' Affairs unpublished data. State/ territory: Recurrent expenditure—CGC 2002, CGC unpublished data; Capital expenditure—ABS unpublished public finance data. Local government: ABS unpublished public finance data.

NGCSOs—1992–93 estimated based on Industry Commission 1994; 1993–94 estimated based on Industry Commission 1995; 1994–95 to 2000–01 estimates based on a sample of NGCSOs' financial reports; 1998–99 to 2000–01, revised estimation method based on information from ABS 1998c, 2001c.

Households sector—Child care service clients' contribution estimated from ABS 1997, 2000a.

Box 4.3: Non-government community services organisations (NGCSOs)

NGCSOs are organisations, operating on either a for-profit or not-for-profit basis, that are privately managed to provide community services for families with children, youth, adults, older people, people with disabilities, and people from different ethnic backgrounds. Some receive funding from governments, some are fully self-funding, and others rely on a combination of funding sources, including fees charged to clients, to support their activities. In 1999–00, expenditure incurred by the not-for-profit organisations accounted for 23% of total NGCSO expenditure (ABS 2001c:15).

The not-for-profit NGCSOs' own funding comes from a variety of sources, including donations, legacies and bequests, fund-raising activities and a range of commercial activities, including opportunity shops. It also includes funding out of commercial income, such as income from employment services (for organisations providing services for people with disabilities). Also included are interest and dividends received from financial investment, and profits from sale of assets. Own source funding does not include clients' fees, which are regarded as funding by households.

These not-for-profit NGCSOs also benefit from input tax exemption whereas the for-profit NGCSOs do not.

Table 4.4: Recurrent government expenditure (in 2000–01 prices)[(a)] across welfare service categories, 1992–93 to 2000–01

	Families and children		Older people		People with disabilities		Other welfare services (nec)		Total welfare services	
	Amount ($m)	Growth rate (%)	Amount ($m)	Growth rate (%)	Amount ($m)	Growth rate (%)	Amount ($m)	Growth rate (%)	Amount ($m)	Growth rate (%)
1992–93	1,575	. .	1,139	. .	1,543	. .	405	. .	4,681	. .
1993–94	1,786	13.4	1,310	15.0	1,713	11.0	417	3.0	5,226	12.1
1994–95	2,069	15.8	1,575	20.3	1,672	–2.4	506	20.4	5,819	11.3
1995–96	2,327	12.5	1,639	4.0	1,696	1.4	539	7.2	6,201	6.6
1996–97	2,451	5.3	1,938	18.2	1,796	5.9	541	0.3	6,725	8.5
1997–98	2,448	–0.1	2,258	16.5	1,963	9.3	596	10.2	7,265	8.0
Break in time series										
1998–99	2,760	. .	2,131	. .	2,640	. .	726	. .	8,257	. .
1999–00	3,154	14.3	2,159	1.3	2,803	6.2	830	14.3	8,946	8.3
2000–01	3,085	–2.3	2,308	6.9	3,008	7.3	818	–1.5	9,218	3.0
Average annual growth rate[(b)]										
1992–93 to 1997–98		9.2		14.7		4.9		8.0		9.3
1998–99 to 2000–01		5.7		4.1		6.7		6.1		5.7

(a) For recurrent expenditure, the implicit price deflator for GFCE was used to deflate current price expenditure to 2000–01 prices.

(b) Average annual growth rates are calculated using exponential growth.

Sources: Commonwealth expenditure—compiled from DHHCS 1991, 1992; DHHLGCS 1993; DHSH 1995a, 1995b; DHFS 1996, 1997, 1998; DHAC 1999, 2000, DoHA 2001, 2002; DHRD 1994, 1995; FaCS 1999, 2000, 2001, 2002; Department of Immigration and Ethnic Affairs unpublished data; Department of Veterans' Affairs unpublished data. State/ territory recurrent expenditure—CGC 2002, CGC unpublished data.

Box 4.4: Health-related items not included in estimates of expenditure on welfare services

Funding by the Commonwealth Government:

- *high-level care residential care subsidy – $2.7 billion*
- *extended aged care at home – $8.4 million.*

Funding by the households sector:

- *client fees for high-level residential care – $736.9 million.*

If these items were included, total government funding would have increased from $9.6 billion to $12.3 billion and funding by the households sector would have increased from $2.5 billion to $3.3 billion.

Funding for welfare services

In 2000–01, governments in Australia contributed $9.6 billion (70%) of the funding for welfare services (Table 4.5). The remaining 30% came from the non-government sector, comprising NGCSOs and households. Households paid $2.5 billion in fees to service providers (both government and non-government) for some welfare services, while

NGCSOs contributed $1.6 billion (11.6%) from their own (non-fee) revenue sources. The amounts do not include health-related expenditure (Box 4.4).

Over time, changes in the way services are delivered and funded, the types of services that are provided, demographic changes and many other factors leave their imprint on welfare services expenditure. They result in changes not only in the overall level of expenditure on welfare services, but also in the relative funding shares of the different financing sectors and the rates of growth in funding by those sectors.

Between 1992–93 and 1997–98, governments financed, on average, 65% of expenditure on welfare services (Table 4.5). The remaining 35% came from households and NGCSOs. The government sector's share of funding increased in the 1998–99 to 2000–01 period—so that it averaged 70%, while the non-government sector's average share fell to 31%.

Table 4.5: Funding sources of welfare services and their proportions, 1992–93 to 2000–01

	Government sources[a]				Non-government sources			Total expenditure
	Commonwealth	State/ territory	Local	Total	NGCSOs	Households[b]	Total	
				Amount ($m)[c]				
1992–93	2,113	2,447	22	4,582	934	1,609	2,542	7,125
1993–94	2,494	2,469	46	5,008	990	1,728	2,718	7,726
1994–95	2,892	2,551	99	5,542	995	1,818	2,813	8,355
1995–96	3,074	2,737	157	5,968	1,039	2,062	3,100	9,069
1996–97	3,264	3,147	121	6,531	1,143	2,284	3,427	9,958
1997–98	3,273	3,593	219	7,084	1,229	2,561	3,790	10,874
Break in time series								
1998–99	3,771	4,299	229	8,299	1,368	2,216	3,585	11,883
1999–00	4,042	4,727	235	9,004	1,550	2,519	4,070	13,073
2000–01	4,329	5,032	212	9,573	1,578	2,539	4,117	13,690
				Proportion (%)				
1992–93	29.7	34.3	0.3	64.3	13.1	22.6	35.7	100.0
1993–94	32.3	32.0	0.6	64.8	12.8	22.4	35.2	100.0
1994–95	34.6	30.5	1.2	66.3	11.9	21.8	33.7	100.0
1995–96	33.9	30.2	1.7	65.8	11.5	22.7	34.2	100.0
1996–97	32.8	31.6	1.2	65.6	11.5	22.9	34.4	100.0
1997–98	30.1	33.0	2.0	65.1	11.3	23.6	34.9	100.0
Break in time series								
1998–99	31.7	36.2	1.9	69.8	11.5	18.6	30.2	100.0
1999–00	30.9	36.2	1.8	68.9	11.9	19.3	31.1	100.0
2000–01	31.6	36.8	1.5	69.9	11.5	18.5	30.1	100.0
				Average proportion (%)				
1992–93 to 1997–98	32.2	31.9	1.3	65.4	11.9	22.7	34.6	100.0
1998–99 to 2000–01	31.4	36.4	1.7	69.5	11.6	18.8	30.5	100.0

(a) Government expenditure data includes subsidies and personal benefits such as child care rebates, which are not included in GFCE. The figures here are therefore different from those published in ABS 2000b.

(b) Households contribution in the form of client fees to NGCSOs is generally obtained in the process of estimating NGCSOs' contribution. Client fees for government services are obtained from CGC and ABS public finance.

(c) In current prices.

Note: Totals may not add due to rounding.

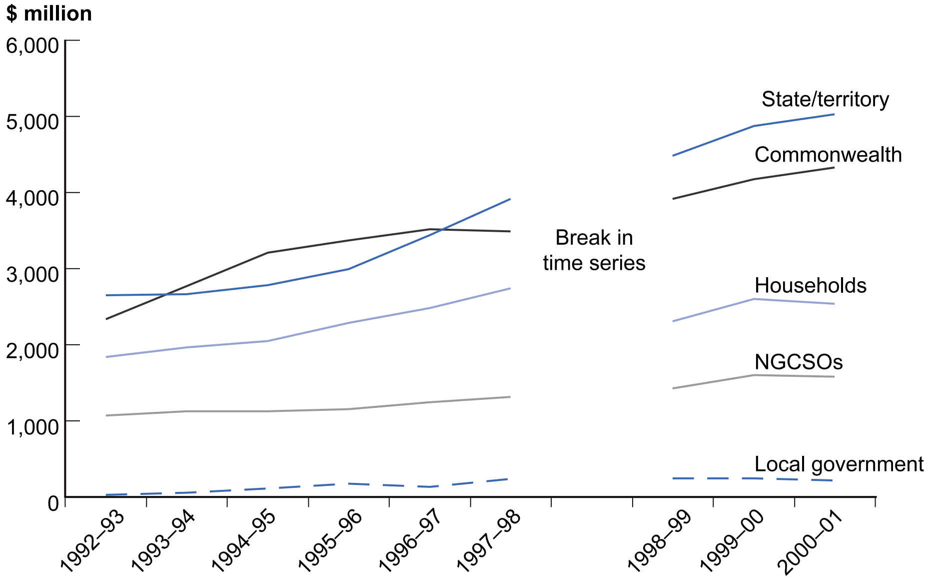
Sources: AIHW 2003a and AIHW Welfare expenditure database.

From 1998–99, government and non-government funding grew, in real terms, at annual average rates of 5.3% and 5.1%, respectively. Rapid growth in welfare services expenditure occurred between 1998–99 and 1999–00 (9.1%). This was a result of strong growth in both non-government funding (12.7%) and government funding (7.6%). In the latest year, from 1999–00 to 2000–01, though increasing in nominal terms in both sectors, total welfare services expenditure in real terms grew at a lower rate (1.4%), attributable to a 3.0% growth in government funding and a decline in funding by the non-government sector of 2.1% (Figure 4.2, Table 4.6).

Government sector

The increase in the government sector's share of funding was largely the result of an increase in the proportion met by the state and territory governments. Their share of funding, which averaged 31.9% between 1992–93 and 1997–98—with a low of 30.2% in 1995–96 and a high of 34.3% in 1992–93—rose to an average of 36.4% in the period 1998–99 to 2000–01 (Table 4.5).

Although the Commonwealth Government's share of funding had reached as high as 34.6% (1994–95) in the earlier period, its average over that period was 32.2% and from 1998–99 its share fell slightly to an average of 31.4%. The share of Commonwealth funding was higher than that of state and territory governments between 1993–94 and 1996–97, after which funding by state and territory governments was higher. The areas where slower growth in Commonwealth funding compared with state and territory funding, occurred were family and child welfare services, and other welfare services (Table A4.2).



Source: Table 4.6.

Figure 4.2: Total funding of welfare services (in 2000–01 prices), 1992–93 to 2000–01

Table 4.6: Growth rates in funding of welfare services, 1992–93 to 2000–01

	Government sources[a]				Non-government sources			Total expenditure
	Commonwealth	State/ territory	Local	Total	NGCSOs	Households[b]	Total	
				Amount ($m)[c]				
1992–93	2,337	2,647	25	5,008	1,067	1,838	2,905	7,914
1993–94	2,771	2,666	51	5,488	1,125	1,962	3,087	8,574
1994–95	3,212	2,782	110	6,103	1,122	2,051	3,174	9,277
1995–96	3,373	2,991	173	6,537	1,152	2,286	3,438	9,975
1996–97	3,515	3,438	131	7,083	1,242	2,482	3,724	10,807
1997–98	3,488	3,918	234	7,640	1,315	2,739	4,054	11,694
Break in time series								
1998–99	3,915	4,482	242	8,639	1,424	2,306	3,730	12,369
1999–00	4,174	4,877	243	9,294	1,602	2,603	4,205	13,500
2000–01	4,329	5,032	212	9,573	1,578	2,539	4,117	13,690
				Growth rate (%)				
1992–93 to 1993–94	18.6	0.7	104.3	9.6	5.4	6.7	6.2	8.4
1993–94 to 1994–95	15.9	4.3	116.1	11.2	–0.2	4.5	2.8	8.2
1994–95 to 1995–96	5.0	7.5	56.9	7.1	2.6	11.5	8.3	7.5
1995–96 to 1996–97	4.2	14.9	–24.2	8.4	7.9	8.5	8.3	8.3
1996–97 to 1997–98	–0.8	14.0	78.6	7.9	5.8	10.4	8.9	8.2
Break in time series								
1998–99 to 1999–00	6.6	8.8	0.5	7.6	12.5	12.9	12.7	9.1
1999–00 to 2000–01	3.7	3.2	–12.9	3.0	–1.5	–2.5	–2.1	1.4
				Average annual growth rate (%)				
1992–93 to 1997–98	8.3	8.2	56.5	8.8	4.3	8.3	6.9	8.1
1998–99 to 2000–01	5.1	6.0	–6.4	5.3	5.3	4.9	5.1	5.2

(a) Government expenditure data includes subsidies and personal benefits such as child care rebates, which are not included in GFCE. The figures here are therefore different from those published in ABS 2000b.

(b) Households contribution in the form of client fees to NGCSOs is generally obtained in the process of estimating NGCSOs' contribution. Client fees for government services are obtained from CGC and ABS public finance.

(c) In 2000–01 prices.

Note: Totals may not add due to rounding.

Sources: AIHW 2003a and AIHW Welfare expenditure database.

Local governments also provided a small proportion of the funding for welfare services expenditure—the average increased from 1.3% between 1992-93 and 1997–98, rising to 1.7% between 1998–99 and 2000–01.

Recurrent funding by Commonwealth and state and territory governments across broad welfare services areas

This section looks at the recurrent funding of welfare services (i.e. not including outlays on capital) by the Commonwealth and the state and territory governments, which in 2000–01 was $9.2 billion and represented 67.2% of total funding.

Of the $9.2 billion, the state and territory governments provided almost $5.0 billion and the Commonwealth just under $4.3 billion (Table 4.7).

Table 4.7: Recurrent funding of welfare services by the Commonwealth and by state and territory governments, 1992–93 to 2000–01 (current prices)

	Commonwealth		State/territory		Total	
	Amount ($m)	Proportion (%)	Amount ($m)	Proportion (%)	Amount ($m)	Proportion (%)
1992–93	1,893	46.2	2,208	53.8	4,100	100.0
1993–94	2,311	50.1	2,299	49.9	4,611	100.0
1994–95	2,724	52.0	2,517	48.0	5,241	100.0
1995–96	2,937	52.2	2,691	47.8	5,628	100.0
1996–97	3,098	50.2	3,071	49.8	6,168	100.0
1997–98	3,187	47.4	3,531	52.6	6,718	100.0
Break in time series(a)						
1998–99	3,672	46.3	4,254	53.7	7,925	100.0
1999–00	3,988	46.0	4,676	54.0	8,664	100.0
2000–01	4,253	46.1	4,965	53.9	9,218	100.0

(a) See Box 4.2 for details.

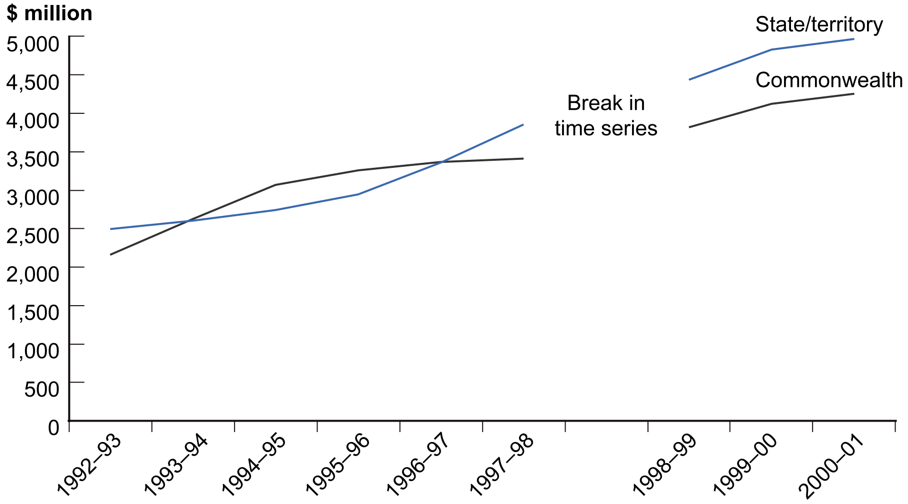
Sources: Commonwealth—compiled from DHHCS 1991, 1992; DHHLGCS 1993; DHSH 1995a, 1995b; DHFS 1996, 1997, 1998; DHAC 1999, 2000, DoHA 2001, 2002; DHRD 1994, 1995; FaCS 1999, 2000, 2001, 2002; Department of Immigration and Ethnic Affairs unpublished data; Department of Veterans' Affairs unpublished data. State/ territory—Recurrent expenditure—CGC 2002, CGC unpublished data.

In all the years from 1997–98 to 2000–01, overall recurrent funding of welfare services by the state and territory governments exceeded that provided by the Commonwealth (Figure 4.3). Before 1997–98, with the exception of 1992–93, funding by the Commonwealth had been consistently higher than funding by states and territories.

Except for welfare services for older people, the average level of funding provided by the state and territory governments was greater than that provided by the Commonwealth throughout the entire period under review (Tables 4.8, 4.9, 4.10, 4.11).

In 2000–01, total government funding of welfare services for families and children was $3.1 billion (Table 4.8). Of this amount, the states and territories accounted for 54%, and the Commonwealth 46%. During the period 1992–93 to 1997–98 funding for these services was shared about equally by the Commonwealth Government and state and territory governments. Since then, however, the state and territory share has risen and the Commonwealth share fallen.

In 2000–01, total government funding of welfare services for older people was $2.3 billion (Table 4.9). Of this amount, 69% was by the Commonwealth and 31% by the states and territories. Historically, the Commonwealth has consistently spent more than the states and territories on these services. From 1992–93 to 1997–98, its share of government funding averaged 61.4%. This increased to an average of 69.2% over the period 1998–99 to 2000–01.



Source: Table A4.2.

Figure 4.3: Recurrent funding for welfare services by the Commonwealth and state and territory governments, 1992–93 to 2000–01 (in 2000–01 prices)

Table 4.8: Recurrent government funding of welfare services for families and children, 1992–93 to 2000–01 (current prices)

	Commonwealth		State/territory		
	Amount ($m)	Proportion (%)	Amount ($m)	Proportion (%)	Total ($m)
1992–93	612	44.2	772	55.8	1,384
1993–94	759	48.2	814	51.8	1,573
1994–95	953	52.2	872	47.8	1,825
1995–96	1,088	52.5	986	47.5	2,074
1996–97	1,161	52.6	1,045	47.4	2,206
1997–98	1,089	49.1	1,129	50.9	2,219
Break in time series[(a)]					
1998–99	1,172	44.3	1,474	55.7	2,646
1999–00	1,438	47.1	1,615	52.9	3,053
2000–01	1,405	45.6	1,679	54.4	3,085
Average proportions					
1992–93 to 1997–98		50.2		49.8	
1998–99 to 2000–01		45.7		54.3	

(a) See Box 4.2 for details.

Sources: Commonwealth—compiled from DHHCS 1991, 1992; DHHLGCS 1993; DHSH 1995a, 1995b; DHFS 1996, 1997, 1998; DHRD 1994, 1995; FaCS 1999, 2000, 2001, 2002; Department of Immigration and Ethnic Affairs unpublished data; Department of Veterans' Affairs unpublished data. State/ territory—Recurrent expenditure—CGC 2002, CGC unpublished data.

Table 4.9: Recurrent government funding of welfare services for older people, 1992–93 to 2000–01 (current prices)

	Commonwealth[a]		State/territory		
	Amount ($m)	Proportion (%)	Amount ($m)	Proportion (%)	Total
1992–93	587	58.6	414	41.4	1,001
1993–94	801	69.3	354	30.7	1,155
1994–95	911	65.4	482	34.6	1,394
1995–96	917	62.7	545	37.3	1,462
1996–97	1,024	58.5	725	41.5	1,749
1997–98	1,172	56.9	888	43.1	2,060
Break in time series[b]					
1998–99	1,418	69.3	629	30.7	2,047
1999–00	1,424	68.2	665	31.8	2,089
2000–01	1,615	69.9	694	30.0	2,308
Average proportions					
1992–93 to 1997–98		61.4		38.6	
1998–99 to 2000–01		69.2		30.8	

(a) Not included are high-level residential care and Extended Aged Care at Home (EACH). In 2000–01, high-level residential care was estimated at $2.7 billion, and EACH at $8.4 million.

(b) See Box 4.2. for details.

Sources: Commonwealth— compiled from DHHCS 1991, 1992; DHHLGCS 1993; DHSH 1995a, 1995b; DHFS 1996, 1997, 1998; DHAC 1999, 2000, DoHA 2001, 2002; DHRD 1994, 1995; FaCS 1999, 2000, 2001, 2002; Department of Veterans' Affairs unpublished data. State/territory—Recurrent expenditure—CGC 2002, CGC unpublished data.

Table 4.10: Recurrent government funding of welfare services for people with disabilities, 1992–93 to 2000–01 (current prices)

	Commonwealth		State/territory		
	Amount ($m)	Proportion (%)	Amount ($m)	Proportion (%)	Total
1992–93	548	40.2	814	59.8	1,362
1993–94	596	39.3	919	60.7	1,516
1994–95	698	44.1	864	54.6	1,583
1995–96	729	45.1	887	54.9	1,616
1996–97	728	42.0	1,005	58.0	1,733
1997–98	744	38.9	1,167	61.1	1,911
Break in time series[a]					
1998–99	906	35.8	1,628	64.2	2,534
1999–00	915	33.6	1,809	66.4	2,723
2000–01	1,017	33.8	1,991	66.2	3,008
Average proportions					
1992–93 to 1997–98		41.6		58.2	
1998–99 to 2000–01		34.3		65.7	

(a) See Box 4.2 for details.

Sources: Commonwealth—compiled from DHHCS 1991, 1992; DHHLGCS 1993; DHSH 1995a, 1995b; DHFS 1996, 1997, 1998; DHRD 1994, 1995; FaCS 1999, 2000, 2001, 2002; DHAC 1999, 2000, DoHA 2001, 2002; DHRD 1994, 1995; Department of Veterans' Affairs unpublished data. State/territory—Recurrent expenditure—CGC 2002, CGC unpublished data.

In 2000–01, recurrent government funding of welfare services for people with disabilities was $3.0 billion (Table 4.10). Of this amount, state and territory governments funded 66%, and the Commonwealth Government 34%.

Since 1992–93, the state and territory governments have consistently provided higher levels of funding for these services because of the Commonwealth/State Disability Agreement. Between 1992–93 and 1997–98, their share of funding had averaged 58.2% and from 1998–99 to 2000–01 it was 65.7%. Details of service types can be found in Chapter 8.

Other welfare services (not elsewhere classified) relate to those that are not specifically targeted at one or more of the defined classes of welfare service recipients (i.e. older people, people with disabilities, and families and children). These include services for Aboriginal and Torres Strait Islander people; services for women who have been subjected to domestic violence; prisoners' aid; care of refugees; homeless persons' assistance; premarital education; and information, advice (financial and other), referral and crisis support services.

In 2000–01, recurrent government expenditure on these welfare services totalled $0.8 billion. Of this amount, state and territory governments funded 74%, and the Commonwealth Government 26%.

Between 1992–93 to 1997–98, state and territory governments accounted for, on average, 61.0% of the combined expenditure by the two levels of governments. This increased to 73.9% in the period 1998–99 to 2000–01 (Table 4.11).

Table 4.11: Recurrent government funding of other welfare services, 1992–93 to 2000–01 (current prices)

	Commonwealth		State/territory		
	Amount ($m)	Proportion (%)	Amount ($m)	Proportion (%)	Total
1992–93	147	41.4	207	58.6	354
1993–94	156	42.4	211	57.6	367
1994–95	162	36.7	278	63.3	440
1995–96	202	42.6	273	57.4	475
1996–97	185	38.4	295	61.5	480
1997–98	182	34.4	347	65.6	529
Break in time series[(a)]					
1998–99	176	25.2	522	74.8	698
1999–00	211	26.4	588	73.6	799
2000–01	217	26.5	601	73.5	818
Average proportions					
1992–93 to 1997–98		39.0		61.0	
1998–99 to 2000–01		26.1		73.9	

(a) See Box 4.2 for details.

Sources: Commonwealth—compiled from DHHCS 1991, 1992; DHHLGCS 1993; DHSH 1995a, 1995b; DHFS 1996, 1997, 1998; DHRD 1994, 1995; FaCS 1999, 2000, 2001, 2002; Department of Immigration and Ethnic Affairs unpublished data; State/territory—Recurrent expenditure—CGC 2002, CGC unpublished data.

Table 4.12: Recurrent funding of welfare services by the Commonwealth Government, 1992–93 to 2000–01 (current prices)

	Welfare services category								
	Families and children		Older people		People with disabilities		Other welfare services (nec)		
	Amount ($m)	Prop (%).	Amount ($m)	Prop (%).	Amount ($m)	Prop (%).	Amount ($m)	Prop (%).	Total ($m)
1992–93	612	32.3	587	31.0	548	29.0	147	7.7	1,893
1993–94	759	32.8	801	34.6	596	25.8	156	6.7	2,311
1994–95	953	35.0	911	33.5	698	25.6	162	5.9	2,724
1995–96	1,088	37.1	917	31.2	729	24.8	202	6.9	2,937
1996–97	1,161	37.5	1,024	33.0	728	23.5	185	6.0	3,098
1997–98	1,089	34.2	1,172	36.8	744	23.3	182	5.7	3,187
Break in time series[(a)]									
1998–99	1,172	31.9	1,418	38.6	906	24.7	176	4.8	3,672
1999–00	1,438	36.1	1,424	35.7	915	22.9	211	5.3	3,988
2000–01	1,405	33.0	1,615	38.0	1,017	23.9	217	5.1	4,253
Average proportions									
1992–93 to 1997–98	35.1		33.5		25.0		6.4		
1998–99 to 2000–01	33.7		37.4		23.8		5.1		

(a) See Box 4.2 for details.

Sources: Compiled from DHHCS 1991, 1992; DHHLGCS 1993; DHSH 1995a, 1995b; DHFS 1996, 1997, 1998; DHAC 1999, 2000, DoHA 2001, 2002; DHRD 1994, 1995; FaCS 1999, 2000, 2001, 2002; Department of Immigration and Ethnic Affairs unpublished data; Department of Veterans' Affairs unpublished data.

Commonwealth funding

More than two-thirds of the Commonwealth's total recurrent funding went to two welfare service category areas—services for families and children, and services for older people (Table 4.12). From 1992–93 to 1997–98, an average of 35.1% of its funding was spent on welfare services for families and children. After 1998–99, this reduced slightly, to 33.7%. Funding of services for people aged 65 and over, on the other hand, represented a higher proportion of the Commonwealth total funding (37.4%) from 1998–99 to 2000–01 than it had before 1998–99, when it averaged 33.5%.

Funding of welfare services for people with disabilities (recipients of welfare services who are under 65 years old) and other welfare services (nec) both represented lower shares (23.8% and 5.1%, respectively) of total Commonwealth funding after 1997–98 than they had up to 1997–98 (25.0% and 6.4%, respectively). Welfare services for older people accounted for over one-third and expenditure on welfare services for people with a disability for about a quarter in both periods.

State and territory funding

State and territory governments provided a total of $4,965 million in funding of welfare services in 2000–01 (Table 4.13). Of this, $1,991 million, or 40.1%, was on services for people with disabilities and $1,679 million (33.8%) on services for families and children. The remainder was split between services for older people (14.0%) and other welfare services (not elsewhere classified) (12.1%).

Table 4.13: Recurrent funding of welfare services by state/territory governments, 1992–93 to 2000–01 (current prices)

	Welfare services category								
	Families and children		Older people		People with disabilities		Other welfare services (nec)		
	Amount ($m)	Prop (%).	Amount ($m)	Prop (%).	Amount ($m)	Prop (%).	Amount ($m)	Prop (%).	
1992–93	772	35.0	414	18.8	814	36.9	207	9.4	2,207
1993–94	814	35.4	354	15.4	919	40.0	211	9.2	2,299
1994–95	872	34.9	482	19.3	864	34.6	278	11.1	2,497
1995–96	986	36.6	545	20.3	887	33.0	273	10.1	2,691
1996–97	1,045	34.0	725	23.6	1,005	32.7	295	9.6	3,071
1997–98	1,129	32.0	888	25.1	1,167	33.0	347	9.8	3,531
Break in time series[(a)]									
1998–99	1,474	34.7	629	14.8	1,628	38.3	522	12.3	4,254
1999–00	1,615	34.5	665	14.2	1,809	38.7	588	12.6	4,676
2000–01	1,679	33.8	694	14.0	1,991	40.1	601	12.1	4,965
Average proportions									
1992–93 to 1997–98	34.5		20.9		34.7		9.9		
1998–99 to 2000–01	34.3		14.3		39.1		12.3		

(a) See Box 4.2 for details.

Sources: CGC 2002, CGC unpublished data.

Over the period from 1998–99 to 2000–01, funding for recurrent expenditure on services for people with disabilities averaged 39.1%, ranging from 38.3% in 1998–99 to 40.1% in 2000–01. Funding of these services had, prior to 1998–99, taken up 34.7% of recurrent funding by state and territory governments.

Funding of services for families and children remained relatively stable over the whole period. It averaged 34.5% between 1992–93 and 1997–98, and 34.3% between 1998–99 and 2000–01.

The area where the largest movements in funding occurred was in services for older people. Funding of these services, which had accounted for, on average, 20.9% of funding for welfare services between 1992–93 and 1997–98, averaged 14.3% in the years after 1997–98.

Non-government sector

Most of the non-government sourced funding was in the form of fees paid by households for services. These represented, on average, 22.7% of total funding for welfare services between 1992–93 and 1997–98 and an average of 18.8% from 1998–99 to 2000–01. The other non-government funding source—NGCSOs—provided, on average, just under 12.0% of all funding for welfare services each year from 1994–95 (Table 4.5).

All funding provided by NGCSOs is attributed, in this analysis, to services that they provide. As mentioned earlier, expenditure incurred by NGCSOs was about half of national expenditure on welfare services (see Table 4.3). Their own funding accounted for just under a quarter of that total NGCSO expenditure (Table 4.14).

Table 4.14: Funding sources of welfare services provided by NGCSOs, 1992–93 to 2000–01 (current prices)

	Governments[a]	NGCSOs[b]	Client fees	Total NGCSO expenditure on welfare services
		Amount ($m)		
1992–93[c]	1,846	934	1,153	3,933
1993–94[c]	2,074	990	1,270	4,334
1994–95[c]	1,973	995	1,338	4,306
1995–96[c]	2,305	1,039	1,608	4,952
1996–97[c]	2,552	1,143	1,831	5,526
1997–98[c]	2,895	1,229	2,103	6,227
Break in time series				
1998–99	2,805	1,368	1,482	5,656
1999–00	2,951	1,550	1,833	6,335
2000–01	3,383	1,578	1,969	6,931
		Proportion (%)		
1992–93[c]	46.9	23.7	29.3	100.0
1993–94[c]	47.9	22.8	29.3	100.0
1994–95[c]	45.8	23.1	31.1	100.0
1995–96[c]	46.5	21.0	32.5	100.0
1996–97[c]	46.2	20.7	33.1	100.0
1997–98	46.5	19.7	33.8	100.0
Break in time series				
1998–99	49.6	24.2	26.2	100.0
1999–00	46.6	24.5	28.9	100.0
2000–01	48.8	22.8	28.4	100.0

(a) Includes Commonwealth government grants to providers of child care services.

(b) Includes revenue from fund-raising and from business undertakings, such as opportunity shops and sheltered workshops.

(c) Estimates of total expenditure on welfare services by NGCSOs for these years are based on NGCSO income as the recurrent expenditure of these organisations is almost the same as their recurrent income (Industry Commission 1995:C16).

Sources: Child care fees—estimated by AIHW from ABS 1997, 2000a; Government funding—ABS unpublished data and DHFS, DHAC and DFACS unpublished data; NGCSO funding—estimated by AIHW.

Box 4.5: Households sector

The households sector comprises all resident households which are small groups of people who share accommodation, pool some or all of their income and wealth, and collectively consume goods and services. They are primarily consumers of goods and services but also are producers of services in the form of unincorporated enterprises (ABS 2000b:59).

As consumers of services, they are 'funders' when they pay fees for these services. This funding is well defined in respect of services provided by NGCSOs and governments. However, many services are provided within households as well as to other households as 'informal services', some of which also attract fees. The only client fees data available for these informal services, however, are in respect of child care services. It is possible that informal care provided to older people and people with disabilities may also attract fees, but these are not captured in the reported expenditure data.

Table 4.15: Client fees for welfare services, 1998–99 to 2000–01 (current prices)

	Providers of services			
Year	Governments	NGCSOs	Households—informal	Total
		Amount ($m)		
1998–99	528	1,482	207	2,216
1999–00	482	1,833	205	2,519
2000–01	369	1,969	201	2,539
		Proportion (%)		
1998–99	23.8	66.9	9.3	100.0
1999–00	19.1	72.7	8.1	100.0
2000–01	14.5	77.6	7.9	100.0
3-year average	18.9	72.6	8.4	100.0

Sources: Government services—ABS public finance unpublished data; NGCSO services—estimated by AIHW based on a sample of NGCSO financial statements; Households—estimated by AIHW from ABS 1997, 2000a.

Most of the fees paid by clients was in respect of services provided by NGCSOs. In 2000–01, they attracted 77.6% of all client fees, up from 66.9% in 1998–99 (Table 4.15).

On the other hand, the proportions of client fees that were used to fund expenditure incurred by both governments and households (informal child care services) declined steadily over the period.

Government-provided services, which accounted for 23.8% of all client fee funding in 1998–99, fell to 14.5% in 2000–01 (from $528 million to $369 million). This reflects a move in client-funded usage towards services provided by NGCSOs and away from those provided by government agencies, a consequence of the government sector's out-sourcing policies. An example of this is in home and community care (HACC) packages, which are provided by NGCSOs, local government and state and territory government agencies. From 1994–95 to 1997–98 (the last year where statistics are available by organisation type), expenditure by NGCSOs rose consistently. In 1994–95, services provided by NGCSOs accounted for 43% of the total expenditure. In 1997–98, it was 53% (DHAC 1995, 1996, 1997, 1998).

The proportion of client fees attributable to informal child care, for example, fell from 9.3% ($207 million) in 1998–99 to 7.9% ($201 million) in 2000–01, as a higher proportion of the informal care was provided by grandparents at no cost.

International comparisons

This part of the chapter attempts to place Australia's spending on welfare services within an international context. It does this by comparing data obtained from the OECD's social expenditure database showing government expenditure reported by nine developed economies within the OECD—including Australia. The countries whose data are compared with Australia's are Canada, France, Germany, Japan, New Zealand, Sweden, the United States and the United Kingdom.

Table 4.16: Comparison of government expenditure on welfare services by selected OECD countries, 1992, 1995, 1998

	OECD financial year					
	1992		1995		1998	
	% of GDP	Rank order	% of GDP	Rank order	% of GDP	Rank order
Australia[(a)]	1.08	5	1.19	5	1.40	5
Canada	1.17	3	1.00	6	2.42	2
France	1.11	4	1.91	2	1.90	3
Germany	1.34	2	1.46	3	1.61	4
Japan	0.27	8	0.33	8	0.57	8
New Zealand	0.21	9	0.11	9	0.10	9
Sweden	5.88	1	5.08	1	5.53	1
United Kingdom	1.06	6	1.27	4	1.30	6
United States of America	0.74	7	0.74	7	0.58	7
Mean[(b)]	**1.43**		**1.45**		**1.71**	

(a) There is a discontinuity for Australia between 1995 and 1998.

(b) Unweighted mean.

Sources: Australia—AIHW welfare services expenditure database; other countries—OECD unpublished data.

The OECD data show that levels of spending on welfare services as a proportion of GDP by selected countries with relatively similar economic profiles varied, ranging in 1998 from 0.1 per cent for New Zealand to 5.5 per cent for Sweden. Many factors impact on such intercountry comparisons, not the least of which is the fact that the OECD data include only expenditure by governments. They do not, therefore, make allowances for possible differences in levels of involvement of the non-government sector in funding welfare services. Other differences identified by the OECD as contributing to the range of results include:

- country-specific classifications and reporting of expenditure on welfare services;
- social welfare policies;
- demographic structure; and
- cultural differences in the provision of social welfare.

In 1998, the latest year for which internationally comparative data are available, the nine selected OECD countries including Australia spent an average of 1.7% of GDP on government-funded welfare services. Australia was the fifth highest of the nine (Table 4.16). In both 1992 and 1998, Sweden was consistently the highest spender at 5.9% and 5.5% respectively. At the other end of the scale, New Zealand reported expenditure of 0.2% and 0.1%.

4.4 Tax expenditures

Tax expenditures are tax concessions such as exemptions, deductions, rebates, reduced tax rates and deferral of tax liability. The tax deductibility of donations to NGCSOs is an example of a tax expenditure in the community services sector. Tax expenditures are measured in terms of the amount of tax revenue forgone by government as a result of concessional taxation treatment (for more detail, see AIHW 1997:35–8).

For NGCSOs, tax expenditures are a significant form of assistance, accounting for 6.1% of total expenditure in 2000–01 (Table 4.17).

Prior to the 2000 taxation reforms, many NGCSOs were exempt from wholesale sales tax, which had been a growing form of imputed tax expenditure flowing to them. The replacement of the wholesale sales tax with a broad-based goods and service tax (GST) meant that this particular form of imputed tax expenditure no longer applied after 1999–00. Under the new tax regime, NGCSOs can register with the Australian Taxation Office and claim back the GST they paid on inputs used in providing services. While this effectively exempts their services from the GST, this is not classified by Treasury as a tax expenditure and this different treatment of the GST, compared with the wholesale sales tax, has led to a break in the tax expenditure time series.

Estimated total revenue forgone from tax expenditures in the community services sector increased from $323 million in 1993–94 to $836 million in 2000–01. These are likely to be underestimates as many potential tax expenditures in this area are not costed due to a lack of data and difficulties in choosing a suitable tax benchmark (see AIHW 1999:28–9 for more details).

Table 4.17: Estimates of tax expenditures[(a)] in respect of NGCSOs, 1993–94 to 2000–01[(b)] ($m in current prices)

	1993–94	**1994–95**	**1995–96**	**1996–97**	**1997–98**	**1998–99**	**1999–00**	**2000–01**
Tax deductibility for donations to benevolent institutions	73	73	69	88	86	120	123	135
Commonwealth tax exemptions on inputs								
Fringe benefits tax	30	70	75	150	180	190	210	240
Wholesale sales tax (WST)	120	119	137	153	172	207	231	—[(c)]
State/ territory tax exemptions on inputs								
Payroll tax	80	79	91	102	115	138	154	168
Land tax	40	40	46	51	57	69	77	84
Stamp duty and bank taxes	100	99	114	127	144	172	193	210
Total government input tax exemptions excluding WST	*250*	*408*	*463*	*583*	*668*	*568*	*634*	*701*
Total tax expenditure excluding wholesale sales tax	**323**	**481**	**533**	**672**	**754**	**689**	**757**	**836**
Total welfare services expenditure	7,726	8,355	9,069	9,958	10,874	11,883	13,073	13,690
Tax expenditure as a proportion of total expenditure (%)	4.2	5.8	5.9	6.7	6.9	5.8	5.8	6.1

(a) Tax expenditures are recorded against the year in which the liability was incurred, not the year the expenditure is paid.

(b) 1994–95 to 2000–01 figures are AIHW estimates, except for the FBT exemption which was provided by Treasury.

(c) This form of taxation was abolished from 1 July 2000, following the introduction of the 'New Business Tax System' by the Commonwealth Government.

Note: Totals may not add due to rounding.

Sources: AIHW 2003a; Industry Commission 1995; Treasury 1997, 1999, 2001, 2002; AIHW welfare services expenditure database.

Real growth in tax expenditure over the 8-year period averaged 12.6% per year. The fringe benefits tax exemption had the highest real growth of all tax expenditures, with revenue forgone increasing by 29.7% per year between 1993–94 and 2000–01. This suggests a growing reliance of the sector on fringe benefits as part of employee remuneration.

The revenue forgone from government input tax exemptions made up the bulk of revenue forgone from all tax expenditures in the sector, averaging 84.8% of the total over the 8-year period.

4.5 Human resources in welfare services

Human resources in community services comprise people employed in community services (that is, those who work on a paid basis), as well as two types of unpaid workers: volunteers who work for community service organisations; and unpaid time used in households to provide welfare services.

According to the ABS Census, in 2001 there were 237,056 people in Australia who were employed in 29 community services occupations (those that provide direct services). However, not all people in these occupations work in community services industries. For example, preschool teachers (a community services occupation) work predominantly in the education industry. Moreover, the community services industries also comprise some other occupations that provide managerial and infrastructure support for the delivery of these services rather than directly provide them. Figure 4.4 illustrates the way in which community services occupations and industries overlap.

	Community services industries	**Other industries**	**Total**
Community services occupations	111,836 persons employed in community services occupations in community service industries e.g. children's care workers in child care services industry	125,220 persons employed in community services occupations in other industries e.g. counsellors in education industry	237,056 (195,313 FTE)
Other occupations	89,548 persons employed in other occupations in community services industries e.g. managers, accountants and auditors, tradespersons, and computing preofessionals who support community services industries		
Total	201,384		

Source: AIHW & ABS 2003.

Figure 4.4: The relationship of community services occupations to community services and other industries, Australia, 2001

Because many workers in community services occupations are employed part-time (50.6% in 2001, see Table 4.19), it is also useful to know the extent of provision of these services in terms of their equivalent full-time workforce. This can be estimated for some of these workers from the ABS Labour Force Survey and the Community Services Industry Survey. From these surveys it can be estimated that, in 2000–01, there were 195,313 FTE workers employed in occupations that provided, or supported the provision of, community services in Australia. These included 179,240 FTE who were in community services industries (that is, all of the occupations shown in the community services industry boxes in Figure 4.4), but only a portion of those employed in other industries (9,931 FTE who were employed by governments in occupations that supported the provision of services and a further 6,142 FTE who were in various other industries). There is no source of data from which the full-time equivalent of the approximately 125,000 people who provide community services in the remaining industries can be estimated (Table 4.18).

The paid labour force accounts for only a fraction of total time spent providing welfare services, however—by far the largest contribution comes from the 7.4 million households in Australia in 2001 (ABS 2003b) many of whom directly care for relatives and friends or indirectly assist other members of the community in need of care through charitable organisations. Based on data from the ABS Time Use survey 1997 it can be estimated that in 2000–01 these households provided 1.8 billion hours in informal welfare services, which is equivalent to a full-time workforce of just under 1 million people (see Table 4.23). A small fraction of this workforce can be attributed to volunteers in community and welfare organisations. The ABS Survey of Voluntary Work shows there were almost 1.3 million people in 2000 who contributed 181.1 million hours of voluntary work for community and welfare organisations in Australia, which was equivalent to approximately 100,000 full-time workers (ABS 2001d).

Paid work

The main focus of this section will be on community services occupations (outlined by the dark box in Figure 4.4), as these workers make up the community services workforce employed in the actual delivery of welfare services.

People employed in community services occupations

In 2001, just under half (47.2%) of all workers employed in community services occupations worked in community services industries (Table 4.18). These industries comprise two broad groups: child care services and community care services (which includes accommodation for the aged, residential and non-residential services, and other undefined community and community care services).

In 2001, 83.8% of workers in community services occupations were female, and half of all workers (50.6%) worked part-time (Table 4.19). Child and youth services workers were predominantly female (93.4%) and were generally younger than other community services workers, with 26.2% aged 45 or over. The highest proportion of workers who were Indigenous were in family services occupations (5.8%). Aged or disabled care workers were the oldest, with 50.1% aged 45 or over, and 70% worked part-time. Other community services workers (social security inspectors and social and community workers) were the least likely to work part-time (29.1%).

Table 4.18: Persons employed in community services occupation groups, by industry, 2001

Industry	Child and youth services workers	Family services workers	Disability workers	Aged or disabled care workers	Other community services workers	Total
Community services industries						
Child care services	51,013	250	92	228	827	52,410
Community care services						
Accommodation for the aged	23	37	38	3,614	303	4,015
Residential care services, nfd	1,698	992	2,603	4,984	1,547	11,824
Non-residential care services, nec	2,466	4,485	2,878	19,938	7,416	37,183
Community services, nfd	725	527	276	1,171	1,724	4,423
Community care services, nfd	139	138	222	1,127	355	1,981
Total community services	*56,064*	*6,429*	*6,109*	*31,062*	*12,172*	*111,836*
Other industries						
Health & community services, nfd	481	372	340	5,877	1,264	8,334
Government administration	2,051	2,329	1,207	2,141	13,859	21,587
Defence	14	10	6	6	51	87
Education	31,119	208	21,030	513	1,191	54,061
Nursing homes	31	45	87	4,281	412	4,856
Hospitals(a)	194	287	78	561	2,403	3,523
Community health centres	209	257	131	643	1,584	2,824
Other health industries(b)	437	478	377	2,170	2,561	6,023
Other industries (incl. not stated)	11,072	1,263	1,530	4,538	5,493	23,896
Total other industries	*45,637*	*5,249*	*24,786*	*20,730*	*28,818*	*125,220*
Total	**101,701**	**11,678**	**30,895**	**51,792**	**40,990**	**237,056**

(a) Includes psychiatric hospitals, and hospitals and nursing homes not further defined.

(b) Includes Health services not further defined.

Source: AIHW & ABS 2003.

Table 4.19: Persons employed in community services occupations: selected characteristics, 2001

Occupation	% aged 45+	% part-time	% female	% Indigenous	Number
Child and youth services	26.2	49.7	93.4	2.2	101,701
Family services	42.9	40.1	76.9	5.8	11,678
Disability services	43.7	53.7	84.8	1.2	30,895
Aged or disabled care	50.1	70.0	84.8	2.0	51,792
Other community services	38.7	29.1	86.5	4.8	40,990
Total	**36.7**	**50.6**	**83.8**	**2.7**	**237,056**

Source: AIHW & ABS 2003.

The 2001 Census of Population and Housing showed that in general, people employed in community services occupations had relatively low incomes, with only 15.9% overall receiving $41,600 or more per year, compared with 39.6% of people employed in health occupations. This ranged from 36.9% of community and social workers to 8.5% of child and youth services workers (mainly pre-primary teachers) and 3.6% of aged or disabled person carers (AIHW & ABS 2003). (Income reported includes money received from earnings and other sources, such as annuities, dividends and interest, and welfare payments, and is used as a proxy for earnings where other sources of data are not available.)

Table 4.20: Average weekly earnings and hours paid for full-time adults, selected community services occupations, 2002

Occupation	Average weekly earnings[(a)]	Hours paid for[(b)]
Social welfare professionals[(c)]	$668.40	37.7
Miscellaneous social professionals[(d)]	$649.20	n.p.
Welfare associate professionals	$574.00	38.5
Carers and aides	$402.60	38.1
Child care workers	$424.10	n.p.
Family day care workers	$370.30	37.4
Special care workers	$372.00	39.7
Personal care and nursing assistants	$463.90	37.7

(a) Total earnings for full-time employed adults. Includes ordinary time and overtime earnings.

(b) Total hours paid for, full-time employed adults. Includes ordinary time and overtime hours.

(c) Includes social workers, welfare and community workers, counsellors.

(d) Includes other social professionals.

Source: ABS 2003c.

The relatively low incomes for those in community services occupations may be partly explained by their relatively high proportions employed part-time (51%) and on a casual basis. Moreover, casual workers are less likely to be trade union members (only 11% in 1999, compared with 31% for permanent employees) (ABS 2000c). The majority of community services workers are unlikely to have the assistance of a trade union to negotiate rates of pay and working conditions.

Income levels for child and youth services workers have received considerable attention in recent years. Their income levels were relatively low in 2001—half (49%) of all child and youth workers received less than $20,800 per year in 2001—but this was partly due to the number of hours worked, as 49.7% of the group worked part-time (AIHW & ABS 2003).

Average weekly earnings data can be obtained from the ABS biennial survey of employee earnings and hours. This survey provides earnings data (including the composition of average weekly earnings) for various categories of employees, by occupation group and industry.

The survey showed that average weekly earnings for workers in community services occupations varies by occupation. Professionals working full-time in social and welfare areas, such as social workers, received average weekly earnings of between $574 and $668 in 2002 (Table 4.20). This compares with $424 per week for child care workers and around $370 for family day care workers and special care workers (who provide care and supervision for children in residential child care establishments and security institutions; care to people in refuges; or household support and assistance to people in need of care or therapy programs).

Trends in community services occupations

The number of workers in comparable community services occupations in Australia increased by 50,078 (26.8%) between 1996 and 2001 (Table 4.21). This growth was substantially higher than the total growth in all occupations over the period (8.7%).

Table 4.21: Persons employed in community services and all occupations, 1996 and 2001

Occupation	1996	2001	Difference	% difference
Child and youth services				
Child care coordinator	7,136	6,437	–699	–9.8
Pre-primary school teacher	12,588	14,166	1,578	12.5
Youth worker	5,389	6,166	777	14.4
Pre-school aide	3,077	4,685	1,608	52.3
Child care worker	31,200	45,189	13,989	44.8
Family day care worker	16,578	10,997	–5,581	–33.7
Nanny	6,578	5,300	–1,278	–19.4
Hostel parent	1,629	1,450	–179	–11.0
Child or youth residential care assistant	3,595	487	–3,108	–86.5
Children's care worker nfd	5,503	6,814	1,311	23.8
Total	*93,273*	*101,691*	*8,418*	*9.0*
Family services				
Welfare worker	6,226	8,985	2,759	44.3
Family counsellor	1,400	1,310	–90	–6.4
Family support worker	1,001	1,383	382	38.2
Total	*8,627*	*11,678*	*3,051*	*35.4*
Disability workers				
Special needs teacher	8,825	9,665	840	9.5
Teacher of the hearing impaired	609	830	221	36.3
Teacher of the sight impaired	254	236	–18	–7.1
Special education teacher, nec	1,013	711	–302	–29.8
Residential care officer	1,015	2,825	1,810	178.3
Disabilities services officer	4,930	6,232	1,302	26.4
Integration aide	2,877	10,396	7,519	261.3
Total	*19,523*	*30,895*	*11,372*	*58.2*
Aged or disabled care				
Aged or disabled person carer	35,943	51,792	15,849	44.1
Other community services				
Welfare centre manager	983	829	–154	–15.7
Social workers	7,193	9,110	1,917	26.7
Community worker	15,804	17,113	1,309	8.3
Rehabilitation counsellor	1,206	1,532	326	27.0
Drug and alcohol counsellor	756	1,099	343	45.4
Welfare associate professional, nfd	61	527	466	763.9
Parole or probation officer	828	1,110	282	34.1
Social security inspector	2,291	9,302	7,011	306.0
Refuge worker	480	368	–112	–23.3
Total	*29,602*	*40,990*	*11,388*	*38.5*
Total community services	**186,968**	**237,046**	**50,078**	**26.8**
Total all occupations	**7,636,319**	**8,298,606**	**662,287**	**8.7**

Source: AIHW & ABS 2003.

There was considerable variation, however, among the various community services occupations. Child and youth services occupations increased by 8,418 workers (9.0%) to 101,691 in 2001. There was a decrease in family day care worker, nanny, child or youth residential care assistants and childcare coordinator occupations, and an increase of 13,989 child care workers, reflecting the trend away from care in the child or carer's home and residential care to care in child care centres.

Between 1996 and 2001, the number of family services workers increased by 35.4%, although one occupation from this group, family counsellors, decreased by 6.4%. Disability workers increased by 58.2%, with a marked increase in the number of integration aides and residential care officers. The number of aged and disabled person carers increased 44.1% to 51,792 in 2001.

Box 4.6: Aged care nurses

In common with most other countries, Australia has, as a consequence of the post-World War II 'baby boom', a population 'bulge' now reaching retirement ages, and this is affecting workers who provide welfare services. The combined effect of these two movements is likely to be an increased pressure on the providers of health and welfare services to older people.

The mainstay of the aged care nursing workforce comprises nurses employed in the areas of practice of geriatrics/gerontology and community/district/domiciliary nursing (numbering 33,335 and 8,043 nurses, respectively, in 1999). These nurses supply health care and welfare services in residential aged care establishments and in the community. In 2002 the Senate Community Affairs Committee Inquiry into Nursing identified aged care as the area of nursing 'in greatest crisis' (SCAC 2002).

Highlighting this finding, the table below shows that over the period from 1993 to 1999 there have been declines in the number of nurses in both these areas of activity (of 20% and 12%, respectively). This compares with a 3.6% total growth in nurse numbers over the period.

For geriatrics/gerontology, there was a sharper decline of enrolled nurses (29%) than of registered nurses (12%). This was in marked contrast to community/district/domiciliary nursing, where enrolled nurse numbers rose by 37% and registered nurse numbers dropped by 16%.

Nurses employed in selected areas, 1993 to 1999

Area of nursing[(a)] /type of nurse	1993	1999	% change 1993 to 1999
Geriatrics/gerontology	41,685	33.335	–20.0
Community/district/domiciliary nursing	9,123	8,043	–11.8
All nurses[(b)]	216,696	224,594	3.6

(a) Nursing activity categories only contain clinical nurses.

(b) Total comprises clinical and non-clinical nurses and activity categories not shown here.

Source: AIHW 2003b.

Other community services worker numbers increased by 38.5% between 1996 and 2001. The 17,113 community workers made up the largest occupation in the group and, together with the 9,302 social security assessors and the 9,110 social workers, comprise 87% of this group.

Variation in staffing of welfare services across Australia

There were 1,228 community services workers per 100,000 population in Australia in 2001 (Table 4.22), compared with 2,354 health workers per 100,000 population (AIHW & ABS 2003), but there was considerable variation among the states and territories. The Australian Capital Territory and the Northern Territory had the highest rates of community services workers with 1,694 and 1,589, respectively. New South Wales had the lowest rate (1,077) with Sydney having 970 per 100,000 population.

In Queensland, South Australia and Tasmania, the capital city had higher rates of community services workers than the remainder of the state, but in New South Wales, Victoria, Western Australia, and the Northern Territory there were more workers per 100,000 people outside of the capital cities.

Table 4.22: Persons employed in community services occupations per 100,000 population, 2001

	Client group					
Capital city[(a)] /balance of state or territory	**Child and youth services**	**Family services**	**Disability services**	**Aged or disabled care**	**Other community services**	**Total community services occupations**
Sydney	487	58	122	118	185	970
Balance of New South Wales	502	73	157	262	217	1,205
New South Wales	*493*	*63*	*135*	*189*	*197*	*1,077*
Melbourne	501	67	184	214	216	1,182
Balance of Victoria	497	109	275	490	229	1,600
Victoria	*500*	*79*	*209*	*291*	*220*	*1,298*
Brisbane	647	42	175	219	200	1,282
Balance of Queensland	603	43	142	305	175	1,268
Queensland	*623*	*42*	*157*	*266*	*187*	*1,275*
Perth	453	46	181	255	223	1,159
Balance of Western Australia	482	59	144	365	264	1,314
Western Australia	*461*	*49*	*171*	*285*	*234*	*1,201*
Adelaide	504	49	137	383	281	1,353
Balance of South Australia	487	43	125	538	227	1,149
South Australia	*499*	*47*	*133*	*425*	*266*	*1,371*
Hobart	483	61	144	427	332	1,447
Balance of Tasmania	465	55	137	512	235	1,404
Tasmania	*474*	*58*	*140*	*470*	*283*	*1,425*
Australian Capital Territory	*892*	*64*	*171*	*292*	*275*	*1,694*
Darwin	717	65	162	173	351	1,467
Balance of Northern Territory	598	149	236	270	476	1,729
Northern Territory	*661*	*104*	*196*	*218*	*409*	*1,589*
Australia	**524**	**61**	**162**	**265**	**215**	**1,228**

(a) Capital cities are statistical divisions as defined in ABS Australian Standard Geographical Classification (ASGC), ABS Cat. no. 1216.0.

Source: AIHW & ABS 2003.

Unpaid work

The discussion that follows relates to care provided either through organisations as volunteers or caring for others in an informal setting. This work by the households sector complements the services provided by governments and NGCSOs.

Volunteers and voluntary work through organisations

The information in this section is based on ABS surveys of voluntary work and time use (ABS 1996b, 2001d, 1999d). The voluntary work survey covers organisations whose work is for the wider social benefit of the general community. It also includes volunteers doing administrative, accounting and fund-raising work. Data extracted from the 1997 Time Use Survey relate to direct services/assistance provided through 'community—health and welfare' organisations.[4]

In 1995 and 2000, the Australian Bureau of Statistics carried out national surveys of voluntary work, which collected data on people who gave unpaid help in the form of time, service or skills, through an organisation or group. In 2000, almost 1.3 million people worked as volunteers for community and welfare organisations in Australia, contributing 181.1 million hours—just over one-quarter (26%) of all hours worked by volunteers. Community and welfare organisations specifically provide welfare services to the general community and to target population groups. Examples are Rotary, Lifeline, Royal Blind Society, Meals on Wheels, neighbourhood centres, and information and referral services. Voluntary work performed for these organisations complements the contribution of the community services workforce to welfare services in Australia.

The four most common voluntary work activities were fund-raising, management and committee work, administration, and preparing or serving food. Female volunteers also commonly provided counselling, supportive listening and befriending.

The 2000 Survey revealed that many volunteers working for community and welfare organisations have an ongoing commitment. Most in 2000 (70%) worked at least once a week and another quarter (25%) at least once a month. Over 40% had been volunteering for the organisation for between 1 and 5 years. Further, over one quarter (28%) had done so for more than 10 years.

Who volunteers for community and welfare organisations?

Women were more likely than men to volunteer for community and welfare organisations—11% of females and 8% of males in 2000, and this was the case in all age groups (Figure 4.5). Generally, participation increased with age, with 10% of 45–55 year olds and 16% of 65–75 year olds volunteering, compared with 6% of people in the age group 18–24 years.

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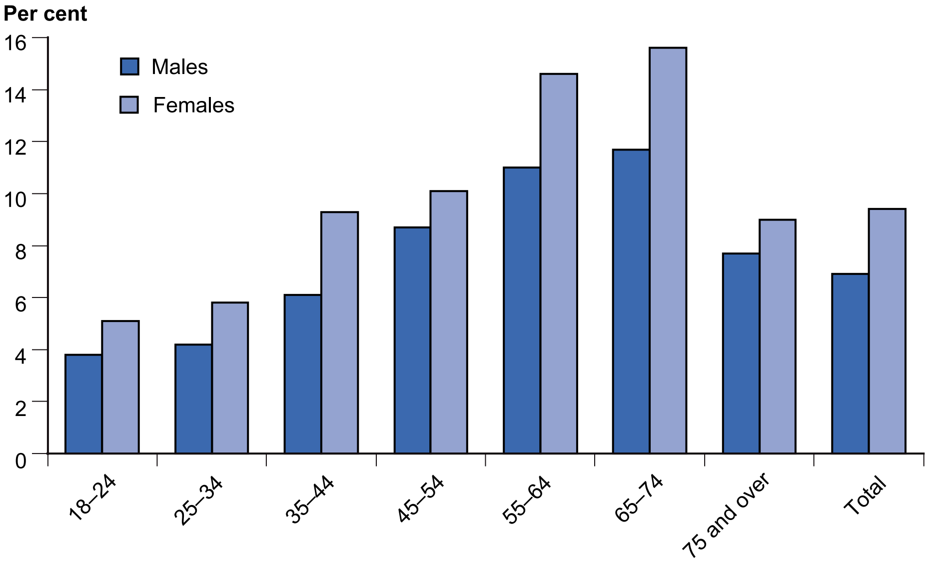
[4] In extracting data on voluntary work, a combination of two variables were used: primary activity 'priactr' coded to 700–799, which are related to direct care; and 'forwhom' coded to 14 'Community—health and welfare'.



(a) Refers to the proportion of people in each age group who volunteered for a community or welfare organisation during the survey reference period.

Source: Table A4.1.

Figure 4.5: Volunteers[(a)] in community and welfare organisations, 2000

The likelihood of doing voluntary work was related to people's employment status, and the patterns were different for men and women (see Table A4.1). Women had higher participation rates if they were not in the labour force (11%) , unemployed (12%) or employed part-time (12%) than if they were employed full-time (8%). Men were more likely to volunteer if they were not in the labour force (10%) than if they were employed part-time (8%), employed full-time (7%) or unemployed (4%).

Hours worked

Women contributed more hours to community and welfare organisations than men—100.7 million hours in 2000, compared with 80.5 million hours, although the median of hours volunteered by men (52 hours per year) was higher than for women (48).

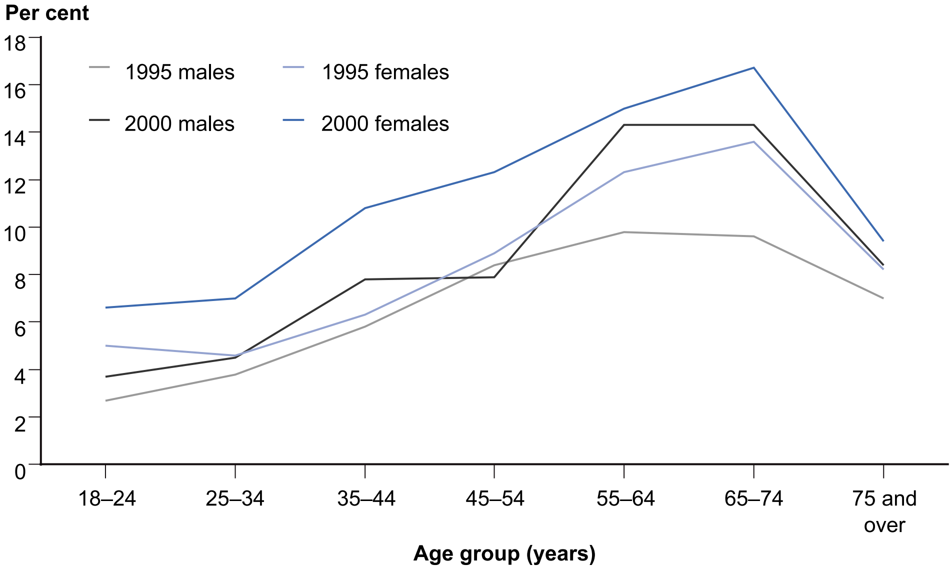
Time spent on direct welfare services based on the Time Use Survey revealed that females caring for others through organisations accounted for 57 million hours (67% of the total time spent on these activities). Males spent 28 million hours (see Table 4.23). For the age group 15–64, the corresponding proportions were 84% for females and 16% for males. For the age group 65+, however, they were 39% and 61% for females and males, respectively.

Trends in volunteering

The proportion of the population who undertook voluntary work for community and welfare organisations increased substantially between the two survey years. In 1995, the estimated number of volunteers aged 18 years and over was 933,700, representing 7% of the population of the same age. By 2000, the estimated 1,298,000 volunteers represented 9% of the population.

Between 1995 and 2000 the estimated number of volunteers grew by 34% for males and 43% for females. The 35–44 year age group showed the largest increase over the period (up 63%) (Figure 4.6). For men, the largest increases were in the 55–64 years and the 75 and over age groups (up 64% and 56%, respectively). For women, the largest increases were in the 35–44 year age group (up 81%). The median number of hours worked per volunteer fell from 50 in 1995 to 48 hours per year in 2000.

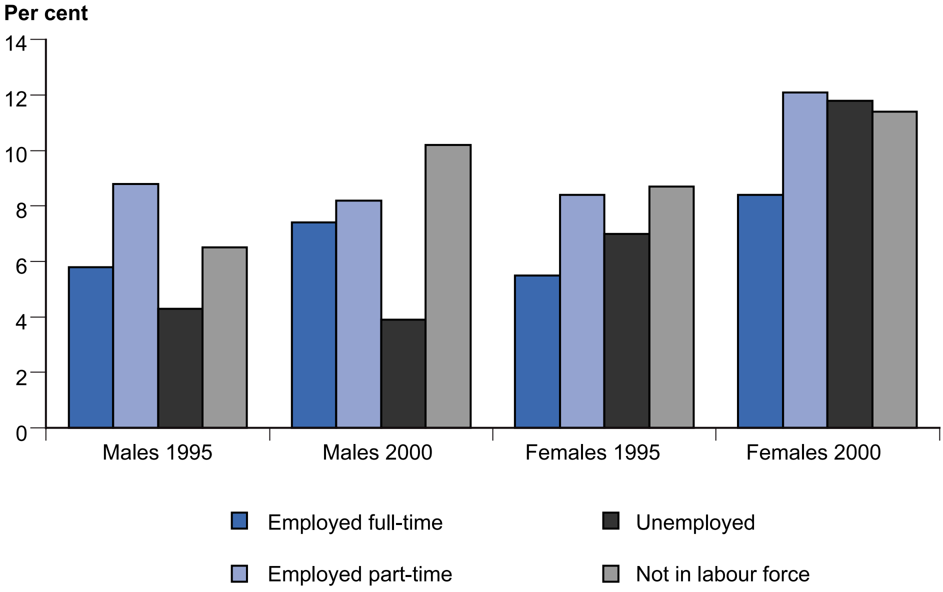
The greatest growth in participation by labour force status between 1995 and 2000 was for those in part-time employment (up 52%) and full-time employment (up 42%). Changes over the period were quite different for males and females, with volunteer numbers for males not in the labour force rising by 60% — much higher than the 21% increase for females. On the other hand, the strong increases in the number of female volunteers in the other three categories (i.e. full-time, part-time and unemployed) of 65%, 65% and 67% respectively were much greater than those for males (32%, 15%, –37% respectively) (Figure 4.7, Table A4.1).



(a) Refers to the proportion of people in each age group who volunteered for a community or welfare organisation during the survey reference period.

Source: Table A4.1.

Figure 4.6: Trends in volunteers[(a)] in community and welfare organisations, 1995 and 2000



(a) Refers to the proportion of people in each group who volunteered for a community or welfare organisation during the survey reference period.

Sources: ABS 1996b, 2001d.

Figure 4.7: Employment status and volunteers[(a)] in community and welfare organisations, 1995 and 2000

Informal care

Care or assistance provided to others in an informal setting comprises child care[5] and care for adults in need of assistance in activities of daily living. For both types of care, females spent more hours in providing care to others than their male counterparts.

In 2000–01, it is estimated that 378 million hours (72%) of child care-related activities were undertaken by females and 146 million hours (28%) by males (Table 4.23). For care of adults, 686 million hours (58%) were by females and 506 million hours (42%) were by males.

Valuing unpaid welfare services

A 'replacement cost' method was adopted to impute a value for the welfare services provided by members of households that were not provided in the course of their employment. That method assumes that:

- the only costs involved were direct labour costs; and

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[5] Time spent caring for own children who are not sick was not classified as a welfare service.

- the value of the labour provided was equal to the labour costs that would otherwise be incurred by service providers if they had employed paid workers to provide the services in question.

The total imputed value of $28.8 billion (Table 4.24) includes care by those who were in receipt of Carer Allowances or Carer Payments—at $1.0 billion in 2000–01.

Time used by members of households to provide welfare services that were not in the course of their employment was valued at $29.0 billion in 2000–01. Of this, an estimated $0.2 billion was for informal child care services where a fee was charged. This means that the net value of unpaid welfare services provided by household members in 2000–01 was $28.8 billion.

Table 4.23: Estimates of time spent by households in providing welfare services, 2000–01

			Voluntary work and care		
		Child care–related	**For adults independent of organisations**	**Through organisations**	**Total**
			Million hours per year		
Aged 15–64 years	Males	127	438	8	574
	Females	333	567	43	944
	Persons	462	1,005	51	1,518
Aged 65+ years	Males	18	68	20	105
	Females	44	120	14	177
	Persons	62	187	33	283
All	Males	146	506	28	680
	Females	378	686	57	1,121
	Persons	**524**	**1,192**	**84**	**1,801**
			Number of volunteers (FTE)		
All	Males	79,119	275,002	15,001	369,152
	Females	207,964	377,168	31,082	616,214
	Persons	**287,083**	**652,170**	**46,113**	**985,366**
			Percentage of hours per year		
Aged 15–64 years	Males	22.1	76.3	1.4	100
	Females	35.3	60.1	4.6	100
	Persons	30.4	66.2	3.4	100
Aged 65+ years	Males	17.1	64.8	19.0	100
	Females	24.9	67.8	7.9	100
	Persons	21.9	66.1	11.7	100
All	Males	21.5	74.4	4.1	100
	Females	33.7	61.2	5.1	100
	Persons	**29.1**	**66.2**	**4.7**	**100**

Note: Totals may not add due to rounding.

Source: Estimated by AIHW based on ABS Time Use Survey Unit Record File (ABS 1999d).

Table 4.24: Estimates of the value of time households devoted to welfare services, 2000–01 ($m)

Service type	Men	Women	Persons
Child care–related	2,525	5,798	8,320
Voluntary work and care			
Care for adults	8,775	10,511	19,287
Voluntary work through organisations	480	866	1,346
Total gross value	**11,780**	**17,173**	**28,953**
Proportion of value	**40.7**	**59.3**	
Less paid informal child care			201
Net value of unpaid work			**28,753**

Sources: Time—Estimated by AIHW based on ABS Time Use Survey Unit Record File (ABS 1999d); Employee earnings—ABS 2001a, 2003b.

In terms of type of care provided using this unpaid work, 66.6% ($19.3 billion) of the gross value was for care of other adult family members, friends or neighbours. A further 28.6% ($8.3 billion) was for child care–related activities and the remaining $1.4 billion was for voluntary work through community services organisations.

Time used by men accounted for 40.7% of the gross value of the unpaid time used for welfare services, and women 59.3%.

4.6 Summary

The total value of resources devoted to providing welfare services in Australia in 2000–01 was estimated at $43.2 billion, $13.7 billion of which was expenditure on services. The balance ($29.5 billion) was made up of the imputed value of input tax exemptions ($0.7 billion), and unpaid services provided by members of the households sector (valued at $28.8 billion).

The $13.7 billion of recurrent expenditure represented 2.1% of GDP. Expenditure on welfare services as a proportion of GDP increased steadily over time, from 1.7% in 1992–93 to 1.9% in 1997–98. It increased to 2.1% in 1999–00 and remained at that level in 2000–01.

Per person expenditure in current prices increased from $405 in 1992–93 to $584 in 1997–98, corresponding to an average real growth of 6.9% per year. Between 1998–99 and 2000–01, it increased from $631 to $707, or by 3.8% in real terms.

In 2000–01, 70% ($9.6 billion) of total funding was by the government sector, 19% ($2.5 billion) by households, and 12% ($1.6 billion) by NGCSOs. Of the total government sector funding, 45% was by the Commonwealth, 53% by state and territory governments and 2% by local governments.

Services for older people accounted for 38% of the Commonwealth government recurrent funding. Of the balance, 33% was funding for families and children, 24% for services to people with disabilities, and 5% for other welfare services.

Of the total state and territory government recurrent expenditure, welfare services for people with disabilities accounted for 40%, for families and children 34%, and for older people 14%. The remaining 12% was for other welfare services.

The predominant role of NGCSOs continues to be one of services provider. The expenditure they incurred in 2000–01 ($6.9 billion) represented more than half of the total expenditure on welfare services in that year. Expenditure incurred by NGCSOs rose from $3.9 billion in 1992–93 to $6.2 billion in 1997–98. Between 1998–99 and 2000–01, it increased from $5.7 billion to $6.9 billion.

Most of the funding for NGCSO services came from other funding sources: 49% from governments and 28% from fees charged to clients. The NGCSOs, themselves, provided 23% from their own funds.

Internationally, Australia's public sector expenditure on welfare services in 1998 was 1.4% of GDP. This was similar to Germany (1.6%) and the UK (1.3%).

The human resources involved in providing and supporting welfare services comprise people employed in community services work, volunteers working through community organisations, and those who provide mainly home-based informal welfare services. It is estimated that the unpaid hours of care provided by household members was equivalent to a full-time equivalent of 1 million. This is about 5 times more than the number of those in the paid workforce, estimated at 195,313 FTE.

The information on community services labour resources provided in this chapter, from the ABS Census of Population and Housing, indicates strong growth in the number of people working in community services industries and occupations, with the latter increasing by 27% in the 5 years to 2001. The ABS surveys of voluntary work conducted in 1995 and 2000 showed the number of volunteers increasing by nearly 40% between those years.

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5 Assistance for housing

5.1 Introduction

This chapter examines current information on housing assistance: household types, characteristics of the recipients of housing assistance, the nature of assistance, and government expenditure.

The demand for housing in Australia continues to grow. Recent research suggests that over the 9-year period 2002 to 2011 an additional 1,149,000 dwellings are projected to be required in Australia (McDonald 2003b). Whether due to cost, availability or adequacy, not all Australians will be able to secure housing in the private market. To address this, government provides a range of housing assistance to overcome the problems that households face in obtaining or retaining suitable accommodation and to provide households with the flexibility to meet changing demand.

A key issue for low-income households is access to affordable housing that meets their needs. The Affordable Housing National Research Consortium commissioned a series of papers in 2001 to explore the nature of housing affordability in Australia. Their analysis identified that housing affordability problems have intensified significantly over the past 15 years and that housing for low-income households, in particular, is failing to meet the rising demand. The report also surmised that the existing housing subsidies provided through both the Commonwealth–State Housing Agreement (CSHA) and the social security system (Commonwealth Rent Assistance), although making a vital continuing contribution to housing affordability, are inadequate (at current and prospective overall volumes of support) by themselves to deal with the worsening situation (Affordable Housing National Research Consortium 2001).

In addition, maintaining current levels of social housing that is affordable requires high levels of housing subsidy where the rental income received from tenants may not cover the costs of housing provision. Just as housing costs have risen for private households, the costs to government and community have also increased along with the value of rebates (see Section 5.3).

How governments may provide affordable housing to meet growing needs forms part of the current policy debate and research agenda. This includes examination of the size and role of social housing, options to improve the availability of low-rent private dwellings to low-income households and the role of home ownership (Ministerial Taskforce on Affordable Housing 2002). In Australia, the social housing sector, comprising public and community housing, charges rents as a proportion of the household's assessable income up to a ceiling equal to market rent. As a result, most households in social housing pay between 20% and 25% of their assessable income in rent. Due to these arrangements, only the social housing sector can guarantee to provide housing that is affordable.

In 1999, 31% of private renters, 18% of those with a mortgage and 4% of those who own their homes outright were paying more than 30% of their income on housing costs (AIHW 2001a). While for some households these high costs may be influenced by lifestyle choices, a significant proportion may be experiencing housing stress.[1] Impacts can include financial hardship, overcrowding and homelessness, family instability, social isolation, reduced access to the labour market and lower levels of educational attainment (Affordable Housing National Research Consortium 2001; Ministerial Taskforce on Affordable Housing 2002). Household affordability has also been found to be a key factor in relation to health, with rising housing costs associated with reduced health status (Affordable Housing National Research Consortium 2001; Phibbs 1999).

Successive governments have reinforced the goal of home ownership, with the Australian social security system traditionally being underpinned by high rates of owner occupation (McDonald 2003a). Assistance to home owners is provided through a range of programs and policies, including subsidies such as the first home owners grants, exemption from capital gains tax and exemption from social security assets testing (see Section 5.4).

Related to housing affordability is the sustainability of specific housing markets and forms of housing assistance. For example, home purchase may be attempted but not maintained for some households where economic and social environments change. In addition, access to private rental is difficult for some household types as private rental markets often cater to specific household types where there are good returns on investments and long-term growth potential. This may result in growth in high rental value stock, with low rent stock not increasing in line with demand.

The 2003 Commonwealth–State Housing Agreement

The Commonwealth and the states and territories have negotiated the 2003 Commonwealth–State Housing Agreement (CSHA), which is designed to provide strategic directions and funding certainty for the provision of housing assistance across Australia in the 5 years from 1 July 2003. It includes provision for bilateral housing agreements between the Commonwealth and each state and territory, allowing each jurisdiction more flexibility in delivering housing assistance according to its priorities and circumstances (Box 5.1).

Under the 2003 CSHA, Commonwealth, state and territory governments have continued to fund the Australian Housing and Urban Research Institute (AHURI) to generate policy relevant research in the related fields of housing and urban development. AHURI is a joint venture between governments and universities. Each year, research themes and key topics are reviewed by government, academic and university representatives, and key research areas identified. Up to $2.6 million per annum is available for research to be undertaken by AHURI research centres, which are located in all states and territories. There are nine broad research themes for 2003:

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[1] Housing stress is defined by the National Housing Strategy (1991) as 'Income units are said to be in financial housing stress if they pay more than 30% of income on housing and are in the lowest 40% of the income distribution range'.

Box 5.1: The 2003 Commonwealth-State Housing Agreement (CSHA)

The 2003 Commonwealth–State Housing Agreement will provide an estimated $4.75 billion, primarily for public, community, Indigenous and crisis housing.

The new CSHA consists of a multilateral agreement accompanied by bilateral agreements between the Commonwealth and each state and territory. The CSHA specifies the guiding principles, funding arrangements and operating procedures. It also specifies an outcomes measurement framework based on bilateral information and a core set of nationally consistent indicators and data for benchmarking purposes. This includes the National Housing Data Agreement (NHDA) as a subsidiary agreement to the CSHA. Under the NHDA, the Commonwealth and the states and territories will provide such data as are required under the Data Agreement, according to specified standards, and will provide specific funding for data management and other purposes.

The bilateral housing agreements allow for flexibility in the delivery of housing assistance according to each jurisdiction's needs and priorities.

The major guiding principles underlying the Commonwealth–State Housing Agreement include:

- *to maintain a core Social Housing sector to assist people unable to access alternative suitable housing options;*
- *to develop and deliver affordable, appropriate, flexible and diverse housing assistance responses that provide people with choice and are tailored to their needs, local conditions and opportunities;*
- *to provide assistance in a manner that is non-discriminatory and has regard to consumer rights and responsibilities, including consumer participation;*
- *to commit to improving housing outcomes for Indigenous people in urban, rural and remote areas, through specific initiatives that strengthen the Indigenous housing sector and the responsiveness and appropriateness of the full range of mainstream housing options;*
- *to promote innovative approaches to leverage additional resources into Social Housing, through community, private sector and other partnerships; and*
- *to ensure that housing assistance supports access to employment and promotes social and economic participation.*

The Commonwealth and the states and territories agree that the bilateral agreements will be the main instruments for approving housing assistance outcomes and objectives. The agreements contain an integrated outcomes-measurement framework that identifies objectives and outcomes to be achieved during the life of the agreement and details how performance in achieving those objectives and outcomes is to be measured.

Source: Commonwealth of Australia.

1. Housing assistance programs;
2. Housing futures;
3. Program integration and housing assistance;
4. Urban management and infrastructure;
5. Transforming communities;
6. Indigenous housing;
7. Homelessness and marginal housing;
8. The housing system; and
9. The policy horizon.

5.2 The economic and social background

This section presents current data around some of the policy issues raised in the previous section relating to the importance of housing assistance for health and welfare, changes in the demographic profile, housing affordability, tenure changes and security, and the distribution of government assistance.

In Australia, housing assistance is an important element of Commonwealth, state and territory governments' social policy and welfare frameworks. The Commonwealth and the states and territories have developed and implemented strategies aimed at providing housing assistance to people on low incomes or with special needs, and at preventing and reducing homelessness. These include the Commonwealth–State Housing Agreement (see Box 5.1), the Stronger Families and Communities Strategy, the National Homelessness Strategy, and the Building a Better Future: Indigenous Housing to 2010 statement.

Housing assistance by its nature differs from most of the community services programs discussed in other chapters of this report, as it provides shelter which is basic to general health and wellbeing (AIHW 2001a). A lack of housing assistance can also be a trigger that contributes to the need for broader types of welfare assistance. For example, an eviction in some circumstances can lead to children being placed in 'foster' care, changing education and job opportunities and a life event that may impact on a person's physical and mental wellbeing.

Health and housing

Extensive research has shown a strong link between housing and health. Overcrowding, dwelling condition and tenure type have all been identified as housing-related factors that can impact on health (see, for example, Dunn 2000; Howden-Chapman & Wilson 2000; Waters 2001).

In May 2001, Australian Housing Ministers adopted a new policy of 'safe, healthy and sustainable housing for Indigenous Australians'. Implementation of this policy is designed to provide better housing and housing-related infrastructure, which it is hoped will lead to improved environmental health outcomes for Indigenous people. Box 5.2 describes the nine healthy living practices contained in this strategy.

Box 5.2: Approaches to healthy housing

Under the National Framework for the Design, Construction and Maintenance of Indigenous Housing. Nine healthy living practices have been identified as part of the strategy:

- *washing people, particularly children under 5 years of age*
- *washing clothes and bedding*
- *removing waste safely from the living area*
- *improving nutrition – the ability to store, prepare and cook food*
- *reducing crowding and the potential for the spread of infectious disease*
- *reducing negative contact between people and animals, vermin or insects*
- *reducing the negative impact of dust*
- *controlling the temperature of the living environment*
- *reducing trauma (or minor injury) around the house and living environment.*

Source: Commonwealth, State and Territory Housing Ministers' Working Group 1999.

The World Health Organization (1998) has recognised that poorly constructed and maintained houses can put people's health and lives at risk. In its 1998 World Health Report it identified several features of the housing environment that directly or indirectly impact on the health of occupants, including:

- the structure of the shelter, including the extent to which it protects the occupants from the elements;
- the provision of adequate water supplies;
- the provision of proper sanitation and waste disposal; and
- overcrowding, which can lead to household accidents and the increased transmission of airborne infections such as acute respiratory infectious diseases, pneumonia and tuberculosis.

Overcrowding

The impact of overcrowding on people's health and wellbeing is difficult to isolate, as overcrowding is often associated with other factors such as a low socioeconomic status and higher unemployment. However, overseas studies have shown that overcrowding is associated with a number of negative health outcomes such as meningococcal disease, tuberculosis, rheumatic fever, respiratory infections, *Haemophilus influenzae* and *Helicobacter pylori* infection (Howden-Chapman & Wilson 2000). It has also been shown to be associated with higher rates of smoking and hazardous drinking, and with poorer self-reported mental and physical health in adults (Waters 2001). Waters points out that 'it is difficult to speculate on whether overcrowding in Australian homes is likely to have a direct effect on health' (Waters 2001:17).

Housing New Zealand has just commenced a 5-year Crowding and Health Study. This study will assess the relationship between household overcrowding and hospitalisation rates for diseases such as meningococcal disease, pneumonia and skin infections, and whether moving to a less crowded house reduces the risk of such diseases (Wellington School of Medicine and Health Sciences 2003). This follows the implementation of a pilot program, the Healthy Housing program, which focuses on reducing diseases associated with overcrowding and generally improving the condition of Housing New Zealand properties (Housing New Zealand Corporation 2003).

Dwelling condition

The condition of housing stock can have a significant impact on the health of occupants. For example, cold housing, mould and dampness in the home are associated with wheezing, breathlessness, cough, meningococcal infection and asthma (Shaw et al. 1999). Breakdown in the 'health hardware' of homes—water, waste removal and power facilities, has contributed to the high incidence among Indigenous people, especially children, of such conditions as skin and eye infections, diarrhoeal disease, respiratory illness and hepatitis (Commonwealth, State and Territory Housing Ministers' Working Group on Indigenous Housing 1999).

Tenure type

Home owners tend to have better health than people who rent. For example, people who own their own home have a healthier and longer life and have lower death rates than those in rented properties (Waters 2001). People in rental accommodation have been found to be more likely than home owners to report fair or poor health and to visit the doctor more often. Howden-Chapman and Wilson (2000) suggest that security of tenure and control over accommodation may be important contributors to the health benefits of home ownership.

Homelessness has also been found to be associated with poor health. In general, homeless people have been found to have much poorer health than the general population (Dunn 2000).

Welfare and housing

The most noticeable effect of housing assistance on welfare is its ability to improve a household's command over goods and services, by reducing the amount of household budget that has to be allocated to meet housing costs.

In 1998–99, the Australian Bureau of Statistics (ABS) estimated that one-third of households (2.4 million) were regarded as under financial stress (see Table 2.20). These households reported two or more financial stress indicators—for 1.5 million households the degree of stress was moderate, while 900,000 were reported as experiencing higher financial stress.

Burke and Ralston (2003) reported that, in 1998–99, 39% of public renters and 45% of low-income private renters could not afford to pay for utilities. This compares with 16% for all households. In addition, 8% of public renters and 13% of low-income private renters went without a meal, compared with 3% of all households. Public renters and low-income renters are also nearly five times more likely to seek assistance from welfare agencies: 16% and 15% respectively, compared with 4% for all households (see Table A5.2).

Financial stress also affects a household's ability to achieve security of tenure, which has a range of non-housing benefits. For example, frequent moves have been shown to negatively impact on children's school performance, particularly if the move is unplanned and occurs during the school year. This may be particularly difficult for low-income families who are often forced to move into a completely new area to access crisis or other affordable housing. Families can also experience increased pressure on relationships due to the leaving behind of important social networks and links to the local community (Phibbs 2002).

In a study of public housing tenants in Queensland (Morrison 2000), tenants were asked about the impact of public housing on their lives. The most frequent response was that it provided security of tenure and a sense of physical and psychological security. In addition, parents felt that the stability provided by public housing was of significant benefit to their children. Morrison's study also showed that the stability provided by security of tenure has a positive impact on locating and maintaining employment.

A lack of affordable housing can lead to overcrowding, which has been shown to have an impact on children's academic achievement. Those living in crowded conditions do not perform as well in reading, language and arithmetic as those children with private home space. Children who live in overcrowded conditions have also been shown to be more likely to experience broken sleep, due to sharing rooms, and to be more aggressive than their non-crowded peers (Phibbs 2002).

Spatial aspects of housing

Social and economic reforms such as economic restructuring accompanying globalisation have produced new forms of economic and social disadvantage and the need for housing assistance has changed from that previously experienced. Recently, housing assistance has been placed in a broader context and more focus is being placed on its ability to address such issues as social polarisation, social exclusion, social fragmentation, spatial concentration and ghettoisation (Dodson & Berry 2002).

Similarly, 'gentrification' has placed increasing pressure on the need for housing assistance to be part of the reshaping of urban areas. Gentrification involves the movement of high-income and high-labour force populations to previously declining inner urban locations, resulting in housing market price shifts displacing the existing less advantaged residents (Smith 1996). This has led to the displaced lower socioeconomic status and disadvantaged inner-city populations having to move to outer urban locations (Freestone & Murphy 1998; Logan 1985).

The studies of spatial inequality and polarization within Australian cities, particularly that of Wulff and Reynolds (2000), have noted that low-income households have been increasingly concentrated in outer suburbs. Locationally sensitive socioeconomic studies of Sydney and Melbourne found that most disadvantage was present in the 'old industrial' areas, such as the west, north and south-east of Melbourne. These areas were noted as experiencing housing and income disadvantage, higher unemployment, lower labour force participation, higher rates of early retirement for men and women, and high unemployment among young people—all indicators of disadvantage (McDonald 1995; McDonald & Matches 1995).

The community in which a person lives can also impact on their employment, educational, health and social outcomes. For example, areas with high traffic noises can contribute to language delays in children, and broken sleep patterns can affect educational attainment. Findings from an American study of disadvantaged families who were moved to a 'white, middle class suburb' (Rosenbaum 1991) indicated:

- lower drop-out rates (5%, compared with 20%);
- slight improvement in grades;
- higher proportion completing college (40.3%, compared with 23.5%);
- higher rates of college enrolment; and
- higher rates of employment, and better pay and conditions for employed youth.

Employment outcomes have been shown to be affected by a number of factors, including access to employment opportunities and to public transport. In addition, the availability of support services such as job assistance programs, training programs and child care is also important. The community can play a key role in employment outcomes, as news of jobs available may frequently be gained through 'informal knowledge networks' (Bryson 2000).

Demographic changes and the housing profile

Between 1971 and 2001, the Australian population increased from 13.1 million people to 19.0 million, with a concurrent rise in the number of households from 3.7 million to 7.1 million. This number is projected to grow to approximately 10.0 million by 2021 (ABS 2001c; AIHW 2001a).

The number of one-person households increased from 14% of all households in 1971 to 23% in 2001, with one-person households projected to show the greatest percentage increase of all household types between 1996 and 2021. This is partially related to the ageing of the population and the fact that older women, in particular, are more likely to live alone than others (see Table A7.2). In the 5 years between the two most recent population censuses, there was strong growth in lone person households relative to family and group households (Table 5.1).

Table 5.1: Australian household types 1996 and 2001 ('000s)

Household type	1996	2001
Family[(a)]	4,583	4,866
Lone person	1,433	1,616
Group	266	263
Total[(b)]	**6,496**	**7,072**

(a) Comprises one, two and three family households.

(b) Includes 'Visitors only' and 'Other not classifiable' households.

Source: ABS 2001c.

While the number of households has increased, household size has decreased, with the average number of people per household falling from 3.3 in 1971 to 2.6 in 2001 (ABS 2001c). This is consistent with the finding that the number of lone person households is increasing. The average household size in Australia is projected to decline to between 2.2 and 2.3 persons per household by 2021 (ABS 1999). These anticipated changes mirror the trends projected for Canada, New Zealand and the United States (AIHW 2001a).

Tenure types

In 2001, 42% of Australian households fully owned their home, 28% were still purchasing their home and 25% were renting (Table 5.2). Indigenous Australians are less likely to own or be purchasing a home than renting (32% being purchased or fully owned and 61% renting). This situation is reversed for non-Indigenous Australians, of whom 71% are either purchasing or fully own their home and 25% are renting.

Of the approximately 2.0 million households who rented their dwelling, the greatest proportion of these (74%) were renting privately, 17% were renting from a state housing authority and 2% were in community housing (Table 5.3). Indigenous Australians are more than 3 times more likely to be living in public or community housing than non-Indigenous Australians (55%, compared with 18%).

Table 5.2: Type of tenure for occupied family and lone person private dwellings, 2001

	Indigenous		Non-Indigenous		Total	
Tenure type	**Number**	**Per cent**	**Number**	**Per cent**	**Number**	**Per cent**
Fully owned	14,712	12.8	2,732,152	42.9	2,746,864	42.4
Being purchased	22,419	19.4	1,799,445	28.3	1,821,864	28.1
Being rented	70,648	61.2	1,562,920	24.5	1,633,568	25.2
Other tenure type	3,399	2.9	140,158	2.2	143,557	2.2
Not stated	4,181	3.6	132,210	2.1	136,391	2.1
Total	**115,359**	**100.0**	**6,366,885**	**100.0**	**6,482,244**	**100.0**

Note: The totals for each state do not add up to the exact total for Australia. This is because cells containing small values are randomly adjusted to avoid releasing information about particular individuals, families or households. The effect of random adjustment is statistically insignificant.

Source: ABS 2003b.

Table 5.3: Type of landlord for rented private dwellings, 2001

	Indigenous		Non-Indigenous[(a)]		Total	
Landlord type	**Number**	**Per cent**	**Number**	**Per cent**	**Number**	**Per cent**
Private rental[(b)]	29,428	41.7	1,337,542	74.8	1,366,970	73.6
Public rental	23,974	33.9	293,197	16.4	317,171	17.1
Community housing	14,628	20.7	29,683	1.7	44,311	2.4
Other landlord type	1,587	2.2	105,883	5.9	107,470	5.8
Not stated	1,027	1.5	21,371	1.2	22,398	1.2
Total	**70,644**	**100.0**	**1,787,676**	**100.0**	**1,858,320**	**100.0**

(a) Includes 'Group', 'Visitors only' and 'Other not classifiable' households. These household types are excluded from Indigenous counts.

(b) Includes 'Private landlord not in same household', 'Real estate agent', 'Employer—government', 'Employer —other'.

Source: ABS 2002c.

Households in very remote regions are less likely than those in more populated areas to either fully own or to be purchasing their home (Table 5.4). In addition, the proportion of households purchasing their home decreases with increasing remoteness, from 29% in major cities down to 11% in very remote areas. Very remote Australia has more than 20 times the national average of community housing (21%, compared with 0.7%), which largely comprises Indigenous community housing (see Table 5.10).

Both public rental and private rental sectors contain a higher than average proportion of sole parents and single person households. Nearly one-quarter of public housing tenants are sole parents and almost 40% are lone persons. Couple-only households and lone person households are the most likely to own a home without a mortgage (35% and 28% of all homeowners without a mortgage respectively), whereas the largest proportion (42% of all homeowners with a mortgage) of couples with dependent children are the most likely to own a home with a mortgage (Table 2.5).

Table 5.4: Location of occupied private dwellings containing family or lone person households, 2001 (per cent)

	Major cities	Inner regional areas	Outer regional areas	Remote areas	Very remote areas	Total
Total households						
Fully owned	41.2	43.9	44.2	38.2	25.4	41.9
Being purchased[(a)]	28.9	28.6	24.3	19.7	11.1	28.1
Private rental[(b)]	19.6	18.0	20.1	26.0	25.1	19.4
Public rental[(b)]	5.1	3.9	4.5	5.8	5.9	4.8
Community housing[(b)]	0.4	0.5	0.8	2.2	20.8	0.7
Other tenure[(c)]	2.7	3.0	3.8	5.5	7.3	3.0
Not stated	2.1	2.0	2.2	2.5	4.4	2.1
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total dwellings (number)	**4,282,474**	**1,371,240**	**683,021**	**103,327**	**42,182**	**6,482,244**

(a) Cells in this table have been randomly adjusted to avoid the release of confidential data.

(b) Includes dwellings being purchased under a rent/buy scheme.

(c) Includes dwellings being occupied rent-free.

Source: ABS 2003b.

Tenure choices

Home ownership is the most desired form of tenure across all income ranges, ages and household composition types. The reasons for aspiring to home ownership are many, but include security, privacy, freedom to do your own thing, investment value and, in the long run, lower cost compared with renting. Between 1988 and 1997–98, there was an increase in the median age of first home purchasers from 30.2 to 31.5 years (Table 5.5). This was due to a decline in the percentage of young households (25–34 years) moving into home ownership, from 42% to 35%. The proportion of households becoming first home buyers also decreased in this period, from 70% in 1988 to 66% in 1997–98 (Baum & Wulff 2001).

While there are no data to confirm the reasons for this trend, various authors suggest the following:

- household compositional changes: including the changes in the nature of gender roles and the traditional roles to adulthood, and the increase in single person households which reduces the household's ability to service a loan;
- wider social changes: including the introduction of HECS and the requirement for repayments, delaying the ability to save for a housing deposit, and the increased uncertainty in the workplace due to increasing part-time and casual work;
- changes in affordability; and
- alternative sources of investment for households: there is an apparent trend among younger investors towards shares. Badcock and Beer (2000:1) found that 'people are now putting their capital into wealth-creating assets as opposed to bricks and mortar'.

Table 5.5: Age distribution of first home buyers, and age-specific home ownership rates,[(a)] 1988 and 1997–98

	First home buyers		All owner occupiers	
	1988	1997–98	1988	1997–98
Age of income unit reference person	Per cent	Per cent	Rate	Rate
15–24 years	14.6	10.7	4.6	4.1
25–34 years	55.8	55.6	42.3	34.5
35–44 years	19.2	22.9	70.5	61.7
45–54 years	5.7	6.0	76.7	75.7
55 years or older	4.7	4.8	78.4	78.1
Total income units (per cent)	**100.0**	**100.0**	**53.9**	**54.2**
Total income units ('000)	**391.0**	**463.4**	**4,095.8**	**4,948.2**
Median age (years)	**30.2**	**31.5**	**49.4**	**51.0**

(a) As a proportion of all income units in each age group.

Source: ABS 2000c.

Box 5.3: Public rental versus private rental: the perceived advantages for potential clients

Public rental	Private rental
Affordability *More affordable than private rental, even with Commonwealth Rent Assistance (CRA), because of the income-related subsidy.*	***Flexibility*** *Assistance is not tied to housing and is therefore flexible to changing circumstances (e.g. tenants are not trapped in declining areas).*
Location and need *Public housing is provided where there is need (albeit in small numbers), whereas low-cost private rental is only available in certain locations.*	***Choice*** *Greater choice of dwelling (size, quality, location). Clients can choose their own standards and make their own trade-offs between, say, price and quality, or price and location.*
Security *Greater security of tenure—cannot be evicted at landlord's discretion.*	***Addresses lack of income*** *CRA directly confronts the main problem facing low-income households (i.e. lack of income).*
Support *Clients may be more easily able to get support to maintain tenancy.*	***Non-bureaucratic management*** *Frees tenants from the controls of public landlordism.*
Non-discriminatory *Better controls against discrimination due to Indigenous status, gender, household type, ethnicity or disability.*	***Fewer entry hurdles*** *Clients do not have to meet a whole range of eligibility criteria to gain housing.*

Source: Burke 2002.

Those not purchasing their own home either rent privately, rent in the social sector[2] or are homeless (see Chapter 9). Private and social rental housing both have advantages and disadvantages which contribute to the desirability of these tenures (see Box 5.3).

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[2] In this chapter, social housing applies to all non-private rental housing and includes, but is not restricted to, public housing, community housing, Indigenous-specific community housing and crisis accommodation. It aligns with the ABS concept of a private dwelling, but excludes those renting in the private market and those living in their own home.

In a 1991 housing and location preferences survey carried out in Adelaide, the main advantages of public housing were affordability (42%), security of tenure (23%) and not having to do maintenance (15%). In contrast, 49% of private renters either could not identify one single advantage or said there were no advantages, 19% said choice of location and 7% listed choice of landlord (Baum & Wulff 2001).

Housing affordability

Trends in housing affordability

In 1999, 10% of all households in the two lowest gross weekly income quintiles were paying more than 30% of their income on housing, and 4% were paying more than half of their income on housing (see Table 2.6).

Real housing costs in Australia rose by 17 per cent between 1988 and 1999, from $109 to $128 per week. Purchasers experienced the biggest cost increase, with public tenants having the smallest increase (Table 5.6). The major contributors to the large rise in cost for purchasers were interest rates and increasing real house prices (Burke & Ralston 2003).

Table 5.6: Average weekly household disposable income, 1988–89 to 1998–99 ($ per week in constant 1999 dollars)

	1988–89	1993–94	1998–99
All incomes			
Owner	656	627	655
Purchaser	851	860	920
Renting, public	471	409	385
Renting, private	694	628	675
All tenure	**711**	**675**	**725**
Low income			
Owner	368	357	380
Purchaser	492	474	538
Renting, public	339	323	294
Renting, private	389	389	398
All tenure	**394**	**379**	**405**

Souce: Burke & Ralston 2003.

Over this period, there was some fluctuation in average weekly household disposable (after tax) income across tenures (Table 5.7). For public housing tenants, there was a steady decline which may have been largely due to the increased targeting of public housing to people on very low incomes. The percentage of households below the second quintile in public housing rose from 68% in 1988–89 to 72% in 1998–99 (Table A5.3).

Between 1988 and 1999, the proportion of income in real terms committed to housing costs by public housing tenants increased from 15% to 19%, and for low-income private renters the increase was from 32% to 33% (Table 5.7). During this same period, home purchasers consistently paid more in terms of dollar value for their housing, followed by private renters, whereas home owners paid the least (Table 5.8).

Table 5.7: Amount of disposable income after housing costs ($ per week in constant 1999 dollars)

	1988	1993	1999
Renting public			
Housing expenses	69	73	73
Remaining income	402	293	313
% income spent on housing	14.6	19.9	18.9
Renting private (low income)			
Housing expenses	125	126	133
Remaining income	266	265	265
% income spent on housing	32.0	32.2	33.4
Renting private (all)			
Housing expenses	141	147	153
Remaining income	553	414	522
% income spent on housing	20.3	26.2	22.7

Source: Burke & Ralston 2003.

Table 5.8: Weekly mean housing cost, 1988–89 to 1998–99 (constant 1999 dollars), by tenure

Tenure type	1988–89	1993–94	1998–99
Owner	41	42	45
Purchaser	195	240	228
Public renter	69	73	73
Private renter	141	147	153
All	**109**	**122**	**128**

Source: Burke & Ralston 2003.

Home ownership affordability

A recent study by the Housing Industry Association speculated that young Australians are being priced out of the home ownership market due to an unprecedented deterioration in housing affordability (HIA 2003:i). The increase in housing prices relative to income was seen as a result of indirect taxes and land shortages.

The study calculated that indirect taxes accounted for 20–35% of the purchase price of a new house and land package, with the variation in the value of these taxes dependent on the local government area in which new houses were developed. The study noted more than 20 different state and local government taxes and levies on new housing, with the result that:

- in 2002, an estimated $11 billion was levied on new housing—an average of $67,000 per house; and
- over the past decade, indirect taxes have increased by 300% while general inflation only increased by 25%.

Included in this trend was the shift in taxation for community-wide urban infrastructure (e.g. public transport upgrades, major roads and social facilities), such that purchasers of new homes are now bearing the majority of the cost (rather than the cost being shared by the broader tax-paying community).

Box 5.4: The Commonwealth Inquiry into First Home Ownership

Terms of reference

Identify and analyse all components of the cost and price of housing, including new and existing housing for those endeavouring to become first home owners;

Identify mechanisms to improve the efficiency of the supply of housing and associated infrastructure; and

Identify any impediments to first home ownership, and assess the feasibility and implications of reducing or removing such impediments.

Particular attention should be given to the following matters as they affect the cost and availability of residential land and housing in both metropolitan and rural areas:

- *the identification, release and development of land and the provision of basic related infrastructure;*
- *the efficiency and transparency of different planning and approval processes for residential land;*
- *the efficiency and transparency of taxes, levies and charges imposed at all stages of the housing supply chain;*
- *the efficiency, structure and role of the land development industry and its relationship with the dwelling construction industry and how this may be affected by government regulations;*
- *the effect of standards, specifications, approval and title requirements on costs and choice in new dwelling construction; and*
- *the operation of the total housing market, with specific reference to the availability of a range of public and private housing types, the demand for housing, and the efficiency of use of the existing residential housing stock.*

Source: Productivity Commission 2003.

The report also identified the important impact of decisions around the release of land for new housing, noting that problems with land development approval have led to shortages of land for urban development. For example it was estimated that, in the Sydney region, demand for new housing in the next 5 years will be just over 27,000 dwellings. However, only 5,000 new lots are to be released annually. This shortage of land has increased land prices, increasing the relative share of land in total house prices, and ultimately increasing the overall cost of home ownership. In 1976–77, the share of land in the cost of the house ranged from 16% to 32%, while in 2002 it ranged from 32% to 60%. In Sydney, Brisbane and Perth, this proportion has doubled.

In recognition of the significant effect that government taxes, benefits and other activities have on affordability, particularly in relation to first home purchasers, the Commonwealth Government commissioned an Inquiry into First Home Ownership (Box 5.4). The Treasurer has asked the Productivity Commission to undertake a public inquiry to evaluate the affordability and availability of housing for first home buyers recognising that ‘the ability to achieve home ownership continues to be of vital importance in maintaining family and social stability’. The Inquiry Report is due on 31 March 2004 (Productivity Commission 2003).

The availability of affordable rental housing

While there was a 34% increase in total private rental stock between 1986 and 1996, there was a significant decline in stock at the lower end of the rental market. The number of low-rent stock fell from 246,800 to 177,400 dwellings, a reduction of 28%, and the number of high-rent stock rose from 131,300 to 231,600 dwellings, an increase of 76%.[3] The largest increase occurred in the ‘moderate to high’ category, where there was a 96% rise in rental stock (AIHW 2001a:59).

In addition, the decline in real expenditure on public housing (see Section 5.3) means that people on low incomes are increasingly being forced to seek housing in the private sector. The apparent loss of low-cost rental housing stock raises the question of the degree to which the private rental market can provide a range of housing options for low-income households (Yates & Wulff 2000). Section 5.3 of this chapter provides details of the affordability of housing under various government programs.

Household size per dwelling

There are large differences in levels of housing utilisation across tenure types. Renters have the highest incidence of overcrowding, with 8% needing one or more additional bedrooms compared with 5% across all households. Owners without a mortgage have the highest incidence of underutilisation, with 85% having one or more bedrooms spare. Life-cycle factors may influence this result, especially the incidence of older persons living alone after dependent children have moved out of home (AIHW 2001a).

Condition of housing stock

The 1999 ABS Australian Housing Survey showed that approximately one in five (19%), of respondents reported major structural problems with their home (AIHW 2001a). In addition, 16% reported the need for interior repairs, and 17% reported the need for exterior repairs to their home . The situation is worse for Indigenous Australians, for whom 23% reported a need for interior repairs, and nearly one in three needed external repairs to their home (Table 5.9).

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[3] Low-rent stock includes dwellings for which households pay $1–$99 per week, using 1996 prices. High-rent stock includes dwellings for which households pay $200 and over per week, using 1996 prices.

Table 5.9: Need for exterior and interior repairs, 2001 (per cent)

	All households	Indigenous households
Need for interior repairs[(a)]	16.1	22.9
Need for exterior repairs[(a)]	17.0	30.5
Estimated number of households ('000)	**7,216.9**	**145.0**

(a) Excludes 'Desirable but low need'.

Source: ABS 2001c.

Table 5.10: Condition of permanent dwellings managed by Indigenous housing organisations, 1999

	Urban Indigenous housing organisations	Discrete community Indigenous housing organisations	All Indigenous housing organisations
Minor or no repair	3,998	10,992	14,990
Major repair	725	3,299	4,024
Replacement	162	1,628	1,790
All IHO-managed permanent dwellings[(a)]	**4,885**	**16,402**	**21,287**

(a) Includes 'Dwelling condition not stated'.

Source: ABS 2001a.

Indigenous Australians living in rural and remote areas are also more likely to be living in an improvised dwelling, or one that needs major repair or replacement, compared with those living in urban settings. The 2001 Census reported a total of 1,453 Indigenous households living in improvised dwellings, of which 1,023 (70%) were in outer regional, remote or very remote areas (ATSIC 2002b). In addition, the Indigenous Community Housing Infrastructure and Needs Survey (ABS 2002c) found that for dwellings located in discrete communities,[4] 10% (1,628) needed replacement and 20% (3,299) needed major repair. This contrasts with 3% (162) needing replacement and 15% (725) needing major repair in urban settings (Table 5.10).

In 1999, renter households were almost 3 times more likely than owner-occupiers to be living in a dwelling in need of essential or essential and urgent repairs (14%, compared with 5%). In addition, renters were also more likely to report structural problems than owners (32%, compared with 14%) (Table 5.11).

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[4] A discrete Indigenous community is a geographic location, bounded by physical or cadastral (legal) boundaries, and inhabited or intended to be inhabited predominantly (i.e. greater than 50% of usual residents) by Aboriginal or Torres Strait Islander peoples.

Table 5.11: Condition of occupied dwellings, 1999 (per cent of dwellings)

	Tenure type of household		
	Owner[(a)]	Renter	Total[(b)]
In need of repairs[(c)]	53.7	64.1	56.8
In need of essential/essential and urgent repairs[(c)]	5.0	13.7	7.5
With major structural problems	**13.6**	**32.1**	**19.0**

(a) Comprises owners with or without a mortgage.

(b) Includes rent-free and other tenure arrangements.

(c) External and/or internal repairs.

Source: 1999 AHS in ABS 2002a.

Security of tenure

In the 1991 Survey of Housing and Location in Adelaide, 48% of home owners and 23% of public renters listed security of tenure as the main advantage of that tenure. However, for private renters, lack of security of tenure was the main disadvantage for 11% of those surveyed (Baum & Wulff 2001).

Social housing provides a greater security of tenure than private rental (Table 5.12). In 1999, 83% of state housing authority tenants had indefinite tenure, compared with only 23% of private renters. Private renters were also much more likely to have a month-by-month lease than those renting from a state housing authority (25%, compared with 7%).

While length of stay in a dwelling does not measure security of tenure, it can reflect the level of security a tenant has. Over half (52%) of state housing authority tenants had lived in their current dwelling for 5 years or more, compared with only 12% of private renters. Indigenous renters do not enjoy the same level of continuity of tenure as the general population, regardless of whether they are renting privately or through a state housing authority. In 1999, only 23% of Indigenous public renters had lived in their current dwelling for 5 years or more (Table 5.13). In fact, almost half of all Indigenous public renters (49%) had lived in their current dwelling for less than a year, compared with 16% for all public renters.

Table 5.12: Characteristics of renter households, 1999 (percentage of households in rent type)

	Private landlord	State housing authority
Had a fixed-term lease	47.6	5.9
Had a month-by-month lease	25.1	6.6
Had indefinite tenure	22.5	82.6
Satisfied with security of tenure	86.0	94.4
Satisfied with service provided by landlord	76.0	72.0
Change to household composition in previous year	33.6	14.5
Had lived in current dwelling for less than 1 year	47.7	15.9
Had lived in current dwelling for 5 years or more	12.4	51.7
Tenure of previous dwelling same as current dwelling	59.4	35.8
Owned another residential dwelling	11.0	. .

Source: ABS 2002a.

Table 5.13: Indigenous households, housing history of reference person by tenure type, 1999 (per cent)

	Owners		Renters			
Selected characteristics of reference person	**Without mortgage**	**With mortgage**	**Public**	**Private**	**Total[(a)]**	**Total[(b)]**
Years in current dwelling						
One or less	*24.0	35.6	49.2	68.8	61.9	52.5
Two	**18.3	*13.5	*9.5	*12.0	11.2	12.1
Three	**10.5	*8.8	*7.7	*6.8	*7.5	8.7
Four or more	*47.2	42.0	33.6	*12.4	19.3	26.6
Total	***100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Number of times moved in last 5 years (reference person)						
None	*45.5	33.0	23.2	*10.7	14.5	20.6
Once	*34.4	31.7	*19.2	*10.1	15.4	21.2
Twice	**7.9	*15.3	*17.4	*14.6	15.3	14.4
Three or more	**8.7	*16.0	38.5	60.9	52.2	40.7
Total[(c)]	***100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Estimated number of households	***5,300**	**30,500**	**26,700**	**38,800**	**75,900**	**115,300**

*estimate has a relative standard error of 25% to 50%

** estimate has a relative standard error greater than 50%

(a) Includes other renter.

(b) Includes rent-free and other tenure.

(c) Includes number of times not known.

Source: ABS 2000a.

Workforce participation and tenure type

Table 5.14 shows the distribution across tenure types of principal income earners in 1999 who were neither on an age or disability pension nor in the workforce. Of all public tenants, 59% were not in the work force, compared with only 6% of all purchasers and 22% of all private tenants. The average for all tenures was 16%. In the two lowest quintiles, the differences were reduced but not greatly: in 38% of all households in the lowest quintile, the principal income earner was not in the workforce. For purchasers, however, it was only 20%, and for public tenants 77%. Given that all these income earners were in the same broad income category, this raises the question of what factors other than income are operative in shaping ability to participate in the workforce and seek out different tenure outcomes.

The majority of public renter households not on an age or disability pension were on some other type of Centrelink payment in 2002 (see Table 5.25 for details of Centrelink payment types at the income unit level).

Table 5.14: Principal income earners not in the workforce, 1999

	All principal income earners		Principal income earner (lowest quintile)	
Tenure type	**Per cent**	**Number**	**Per cent**	**Number**
Owner	15.9	318,722	33.3	226,010
Purchaser	6.3	128,399	19.6	95,805
Public renter	58.7	139,502	76.8	108,221
Private renter	22.3	329,860	52.2	256,646
All	**15.9**	**916,484**	**38.2**	**686,682**

Source: Burke & Ralston 2003.

The value and distribution of government assistance

Housing assistance varies in size and type across tenures. The value in 2002 of the major government programs and policies that provide assistance across tenures is shown in Table 5.15.

The distribution of government housing benefits and taxes has been illustrated in recent research by Yates (2002; see also AIHW 2003i). The most obvious is the assistance provided through capital and recurrent funding through the CSHA and CRA to public and private renters. The effect of this form of assistance is immediate and fairly easily measured.

A less obvious form of assistance is provided through the taxation and regulatory mechanisms of government. These areas of assistance may provide benefits to households over a lifetime and not be immediately obvious. In particular, the relatively high level of home ownership in Australia and the investment by Australians in their own home or as small property investors are facilitated by the assistance provided through tax and regulatory markets.

Table 5.15: Government expenditure on housing programs and policies, 2000–01

	$ billion
Commonwealth–State Housing Agreement (CSHA)	1.4
Commonwealth Rent Assistance (CRA)	1.7
ATSIC Community Housing and Infrastructure Program(a)	0.2
First Home Owner Grant (FHOG)	1.4
ATSIC Home Ownership Program(a)	0.1
Non-taxation of imputed rent(b)	8.0
Non-taxation of capital gains(b)	13.0

Sources: (a) ATSIC 2002a; (b) AIHW 2003i.

These major forms of government assistance in 1999 were estimated to be distributed across income groups as follows[5] (Table 5.16):

- CRA expenditure provided recipients on average with $1,655 per year in benefits. The greatest value of benefits went to lower income households with over three-quarters of total CRA expenditure being received by households in the lowest two income quintiles (AIHW 2003i).
- The First Home Owner Grant (FHOG) provided eligible home purchasers with at least $7,000 per eligible household. This 'one-off' form of assistance is not means tested.
- The average annual value of rent rebates provided to public renters was $3,698 per year. The greatest value of benefits went to lower income households—the lowest two income quintiles received over 90% of the total value of rent rebates (AIHW 2003i).
- On average it is estimated that home owners without a mortgage received the equivalent of $4,400 per year through tax expenditures. The value of this increased across income quintiles from $0 in the lowest income quintile to $8,800 for those households in the top income quintile.
- Home owners with a mortgage are estimated to have received the equivalent of $900 on average per year through tax expenditures, ranging from $0 in the lowest income quintile to $2,100 per year in the highest quintile.

Table 5.16: Value of direct and indirect assistance to households (annual average amount per eligible household ($)), 1999

	Household quintile (by weekly income from all sources)					All
	1st quintile	2nd quintile	3rd quintile	4th quintile	5th quintile	households
Recurrent expenditure						
CRA amount	1,645	1,694	1,709	1,342	979	1,655
FHOG amount[(a)]	7,000	7,000	7,000	7,000	7,000	7,000
Capital expenditure						
Public renters subsidy	3,550	3,990	3,710	3,325	. .	3,698
Tax expenditure						
Outright owners	0	2,100	2,500	4,600	8,800	4,400
Home purchasers	0	400	100	500	2,100	900

(a) Estimate of FHOG value for 1999 based on value at time of introduction on 1 July 2000.

Source: AIHW 2003i.

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[5] These estimates are based on data from the 1999 ABS Australian Housing Survey and differ from values of assistance that can be calculated from the administrative data presented in Section 5.3. No single standard methodology for estimating tax expenditures is available and the estimated tax expenditures presented in this chapter are based on a set of assumptions that, if varied, would produce different results.

5.3 Housing assistance to low-income renters

Assistance across rental sectors

As noted in Section 5.1, assistance to renters is an important part of Australia's social policy and programs. Interest in what such assistance provides focuses on both the housing and non-housing outcomes. The impact of rental assistance over a lifetime and on social and economic participation has been the subject of recent research (King 2002). Similarly, the impact of assistance in supporting tenants to access needed services and contribute to community activity has been assessed in recent surveys of public and community housing tenants (see Figures 5.5 and 5.7).

In 2001–02, the value of assistance provided to private renters was almost $1.9 billion. This comprised $1.8 billion from the Commonwealth Rent Assistance (CRA) program, and almost $80 million through CSHA private rent assistance.

In 2001–02, the Commonwealth, state and territory governments provided over $1,392 million for housing programs under the CSHA (Table 5.17), with public and community housing accounting for the majority of this funding. The Commonwealth paid to the states and territories $91 million for the Aboriginal Rental Housing Program, $64 million for community housing and nearly $40 million for the Crisis Accommodation Program.

In addition to social housing provided through the CSHA, the former Aboriginal and Torres Strait Islander Commission provided $199 million for its Community Housing and Infrastructure Program for 2001–02 (see Table 5.15).

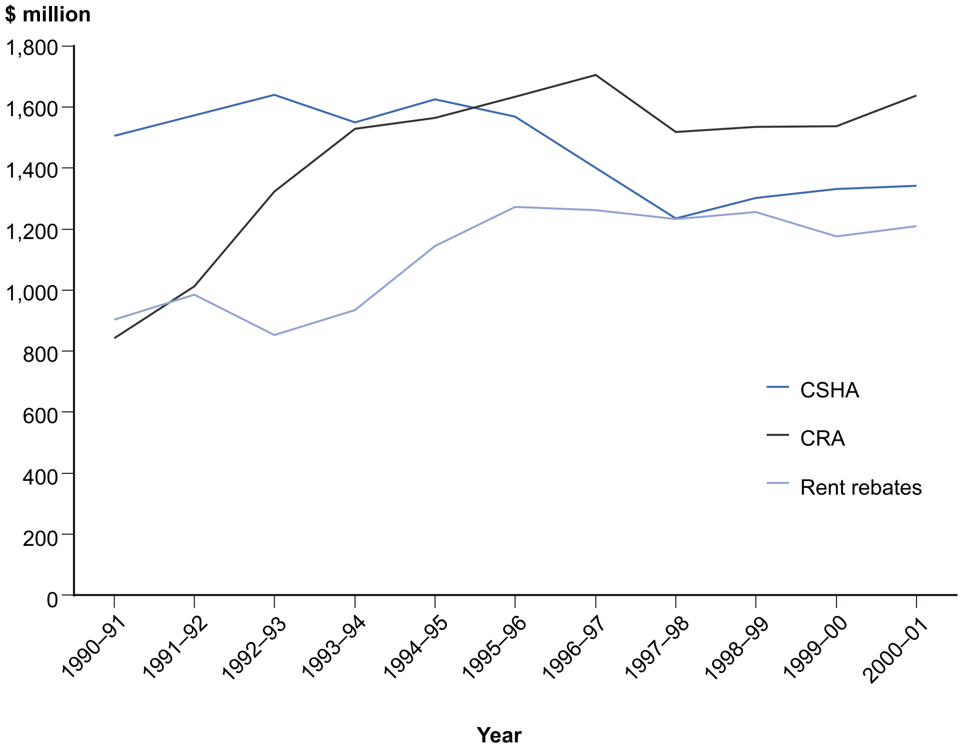
Over the period 1990–91 to 2000–01, there were significant shifts in government expenditure for the CSHA and CRA and in the value of public housing rental rebates (Figure 5.1). In 1990–91, government expenditure for the CSHA was 44% higher than for CRA. However, an increase of 95% for CRA expenditure and an 11% decrease for CSHA expenditure resulted in CRA expenditure surpassing that for the CSHA. The value of public housing rental rebates increased over the period until it was only 10% lower than expenditure through the CSHA.

Table 5.17: CSHA funding, 2000–01 and 2001–02 ($m)

Funding arrangement	2000–01	2001–02
Base funding grants[(a)]	843.1	833.6
Aboriginal Rental Housing Program	91.0	91.0
Crisis Accommodation Program	39.7	39.7
Community Housing Program	64.0	64.0
State matching grants	368.8	364.1
Total	**1,406.5**	**1,392.4**

(a) Includes Public Housing, Home Purchase Assistance and Private Rental Assistance Programs.

Sources: FaCS 2003a, FaCS 2003b.



Source: Table A5.1.

Figure 5.1: Government expenditure on CSHA funding, CRA and total value of public rent rebates, 1990–91 to 2000–01 (1999–00 constant prices)

The figure should be interpreted with caution due to the differing nature of the programs. CRA is a recurrent expenditure program that is driven by demand (SCRCSSP 2002). Increases in CRA expenditure over the period are due to the extended coverage of the program and also to increases in the maximum rates of CRA during the early 1990s (FaCS 2001a, 2001b). CSHA expenditure includes recurrent and capital components. The capital component has provided funding for public housing stock totalling over $30 billion that is continually used for housing assistance (FaCS 2001a). A decline in CSHA expenditure does not necessarily result in a decrease in available CSHA stock; however, recurrent expenditure may be reduced.

Figure 5.2 shows the distribution of recipients of rental assistance across the private, public and community rental sectors. The different data sources limit comparisons across sectors and highlight the need to improve data in the future (see Section 5.5).

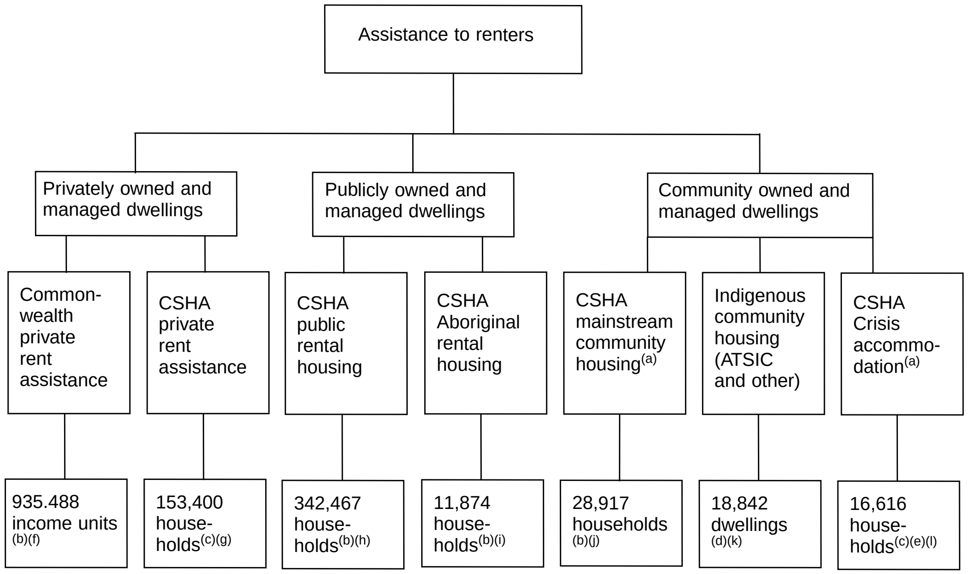
In June 2002 in the private rental market, 935,488 income units received Commonwealth Rent Assistance (CRA) (AIHW 2003a). Although it is not possible to readily identify how many households this represents, estimates based on 1999 ABS housing survey data indicate that in 1999 the 594,600 income units identified as receiving CRA were living in 426,200 households. This represents a ratio of 1.4 income units per household

(AIHW 2003i; see also AIHW: Karmel et al. 1998:191). Under the CSHA, private rental assistance was also provided to 153,400 households in 2001–02 (see Table 5.21). Because of the overlapping nature of these two types of assistance and because the data cannot be adjusted to avoid double-counting, the data cannot be added together to obtain a total number of households receiving some form of private rental assistance.

In June 2002, 342,467 households occupied mainstream public housing, paying either rebated or non-rebated rent. A further 11,874 households were occupying public housing specifically for Indigenous Australians, provided through the CSHA Aboriginal Rental Housing Program (see Table 5.22).

At least 28,917 households in June 2002 lived in mainstream community housing provided through the CSHA and state and territory community housing programs and other organisations not dependent on government funds (AIHW 2003c).

The 2001 ATSIC Community Housing and Infrastructure Needs Survey identified 18,842 permanent and temporary occupied dwellings that were managed by Indigenous community organisations (ABS 2002c:15).



(a) Additional dwellings are funded under programs other than CSHA; however, data about these dwellings are not available.

(b) At 30 June 2002. Figures are not consistent with those reported in the 2003 Report on Government Service Provision as they are from a different data set.

(c) For year ending 30 June 2002.

(d) March to June 2001. The number of community owned or managed dwellings has been used as the proxy in this figure. The figure may be an over-representation as dwellings may be uninhabitable (i.e. CHINS reported that 11% of community owned or managed Indigenous dwellings needed replacement and 21% needed major repair). However, the figure may be an under-representation as there may be more than one household per dwelling.

(e) Household data were provided by Victoria, Queensland and Western Australia only.

Sources: (f) AIHW 2003a; (g) see Table 5.21; (h) AIHW 2003g; (i) AIHW 2003b; (j) AIHW 2003c; (k) ABS 2002c; (l) AIHW 2003d.

Figure 5.2: Recipients of rental assistance across rental sectors, 2002

In 2001–02, 16,616 households received crisis accommodation through the CSHA Crisis Accommodation Program in Victoria, Queensland and Western Australia (AIHW 2003d). Information about types of assistance provided to homeless persons through the Supported Accommodation Assistance Program can be found in Chapter 9.

In addition to the CSHA-funded and Indigenous targeted housing, other organisations also provide community housing. For example, several community housing organisations provide housing to aged persons using stock outside the CSHA that was established through subsidies provided by the Commonwealth Government under the Aged Persons' Homes Act. This housing is commonly referred to as Independent Living Units and approximately 33,000 dwellings were constructed between 1954 and 1996 (McNeils & Herbert 2003:viii). The size of this non-CSHA mainstream sector is significant (NCHF 1999). It should also be noted that some affordable housing initiatives funded under the CSHA may provide housing through not-for profit housing organisations but are not represented in CSHA community housing data as they are not funded through this program (see Box 5.5).

Assistance to private renters

In Australia, the current forms of housing assistance to the private rental market cover a range of policies and programs. The major types of assistance are:

- government budget outlays, including financial assistance to households to pay rent, bond and relocation costs;
- taxation expenditure, providing incentives for investors and landlords through negative gearing;
- government regulations and standards for tenants and landlords, including residential tenancy legislation and 'affordable housing' planning regulations; and
- other services, such as tenant advice services and automatic rent deductions for income support recipients.

As discussed in Section 5.2, private rental accommodation has unique attributes that make it a desirable form of assistance for some renters. Private renters have greater choice regarding the size, location and quality of their dwelling. Such choice may involve a trade-off between these factors and price, but it allows private renters to have direct control of their standard of living.

Commonwealth Rent Assistance

Commonwealth Rent Assistance (CRA) is a non-taxable income supplement paid through Centrelink to individuals and families who rent in the private rental market. Recipients of income support payments, including customers who receive more than the base rate of Family Tax Benefit Part A, who pay private rent above minimum thresholds may be eligible for CRA (FaCS 2003b). CRA is generally not paid to home owners/purchasers, people living in public housing, or residents of aged care facilities with government-funded beds.

Table 5.18: Income units having ongoing entitlement to and receiving CRA, June 2002 (per cent)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
	(CRA recipients as percentage of Centrelink client income unit type)								
Single sharer	26.9	24.6	31.0	25.2	19.3	19.3	27.4	16.6	26.1
Single, no children	22.1	20.9	28.4	24.3	18.8	19.7	15.5	16.5	22.7
Sole parent, 1 or 2 children	42.4	36.1	48.1	39.2	36.5	33.3	22.9	18.4	40.6
Sole parent, 3 or more children	40.3	33.5	48.4	34.8	35.1	34.6	18.6	14.9	38.9
Partnered, no children	10.3	7.2	13.5	8.9	5.6	6.6	5.8	7.7	9.3
Partnered, 1 or 2 children	28.4	20.0	31.7	20.5	17.8	16.9	23.4	11.0	24.9
Partnered, 3 or more children	24.0	15.9	28.9	16.3	15.4	15.0	17.7	9.7	21.3
Couple, no children, temporarily separated or separated due to illness	8.5	7.7	14.2	11.5	10.3	8.5	4.7	7.3	9.8
Total	**23.5**	**19.9**	**29.1**	**22.7**	**17.8**	**18.1**	**17.8**	**14.7**	**22.9**
Total Centrelink income units (number)	**1,299,041**	**975,392**	**781,877**	**367,994**	**349,786**	**120,943**	**42,923**	**37,826**	**3,975,782**

Source: AIHW 2003a.

CRA is paid at a rate of 75 cents for every dollar above the thresholds until a maximum rate is reached. The maximum rates and thresholds vary according to a customer's family situation and the number of dependent children they have. For singles without children, the rent thresholds and maximum rate also vary according to whether or not accommodation is shared with others. Rent thresholds and maximum rates are indexed twice each year (March and September) to reflect changes in the Consumer Price Index (CPI) (FaCS 2003b).

The Commonwealth Government provided more than $33 million rent assistance per week in June 2002. This was equivalent to over $1,749 million per annum in 2002 (AIHW 2003a).

Across Australia, approximately 23% of the 4 million Centrelink clients received CRA in June 2002 (Table 5.18; see also Table A5.4). This varied across states and territories from 15% in the Northern Territory to 29% in Queensland. Sole parents most frequently accessed CRA—41% of Centrelink clients who were sole parents with 1 or 2 children and 39% of Centrelink clients who were sole parents with 3 or more children. Only 9% of couples with no children received CRA. Over the 2 weeks ending 30 June 2002, 935,488 income units received rent assistance while 909,062 of them had an ongoing entitlement to CRA nation-wide.

Nationally, 2% of income units receiving CRA were Indigenous. The proportion varied between 0.6% and 3.2% for all states/territories, except for the Northern Territory where 15.3% of income units receiving CRA were Indigenous (Table A5.5).

Table 5.19: CRA recipients as a percentage of all Centrelink client income units, June 2002

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Indigenous	24.0	22.0	25.0	11.6	13.8	21.2	19.1	4.3	18.0
Non-Indigenous	23.5	19.9	29.3	23.3	17.8	18.0	17.8	26.3	23.0
Total	**23.5**	**19.9**	**29.1**	**22.7**	**17.8**	**18.1**	**17.8**	**14.7**	**22.9**
Total Indigenous Centrelink income units (number)	**28,700**	**5,194**	**29,226**	**17,492**	**5,676**	**2,747**	**445**	**19,931**	**109,411**

Source: AIHW 2003a.

Of all Centrelink clients in June 2002, 23% with an ongoing entitlement received CRA (Table 5.19). Of Indigenous clients, only 18% received CRA compared with 23% of non-Indigenous clients. Compared with the Indigenous national average of 18%, Western Australia and the Northern Territory had low proportions of Indigenous clients receiving CRA, at 12% and 4% respectively. These jurisdictions also had the largest differences between the proportions of Indigenous and non-Indigenous income units receiving CRA.

Nationally, 32% of all income units accessing CRA in June 2002 contained a person with a disability. This percentage varied from 28% in the Australian Capital Territory to 37% in the Northern Territory (Table 5.20).

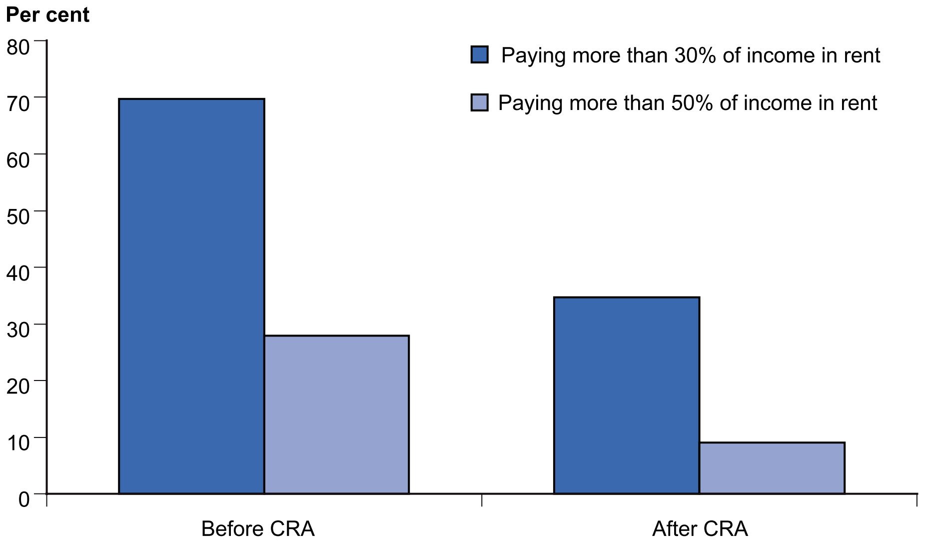
Newstart Allowance recipients represented the largest subpopulation of CRA recipients (22%). Across Australia, the proportion ranged from 19% in the Australian Capital Territory to 30% in the Northern Territory. In the ACT, 25% of CRA recipients were Youth Allowance recipients, compared with the national average of 10%. The other payment type showing a large deviation from national data is the Age Pension in the Northern Territory—national and Northern Territory percentages of CRA recipients also receiving the Age Pension were 16% and 8% respectively (Table A5.6).

The vast majority of clients were in either major cities or inner regional areas. Remote and very remote areas accounted for only about 1% of clients. The rate of entitlement to CRA among the income units who received above the minimum Family Tax Benefit declined significantly with the increase in remoteness (AIHW 2003a).

Table 5.20: Disability status of income units having entitlement to and receiving CRA, June 2002 (per cent)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
With disability	31.5	31.7	33.2	33.8	34.3	31.1	27.5	37.1	32.4
Without disability	68.5	68.3	66.8	66.2	65.7	68.9	72.5	62.9	67.6
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total number	**305,804**	**194,521**	**227,852**	**83,635**	**62,164**	**21,897**	**7,631**	**5,558**	**909,062**

Source: AIHW 2003a.



Source: Table A5.7.

Figure 5.3: Ratio of housing costs to income before and after CRA receipt, 30 June 2002

CRA is designed to improve housing affordability by reducing the proportion of income that has to be spent on housing. A comparison of the proportions of income spent on rent before and after CRA indicated that the impact of assistance was substantial (Figure 5.3). On average, about 42% of income was spent on rent before CRA and the proportion was reduced by about 12 percentage points to less than 30% after CRA. CRA shifted the distribution of affordability towards the higher end. This was demonstrated by the changes in the pattern of the proportion of income spent on rent. Before CRA, 9% of income units spent up to 20% of their income on rent, 10% spent 20–25%, 11% spent 25–30% and 28% spent over 50%. These proportions of income units were 26%, 22%, 17% and 9%, respectively, after CRA (AIHW 2003a).

CRA reduced the costs of housing in relation to income for all age groups and narrowed the gap between the highest and the lowest.

The provision of CRA to private renters directly addresses the main issue for low-income households (i.e. lack of income) and assists in making private rental accommodation more affordable. As assistance is not tied to housing, it is more flexible to changing circumstances and allows private renters to have greater autonomy in their choice of home. Although clients need to meet eligibility criteria before receiving CRA, there are fewer entry hurdles to overcome than for public housing assistance.

CSHA private rent assistance

Funding is also provided under the CSHA, to enable people to access and maintain accommodation in the private rental market (AIHW 2003f). The types of assistance include:

- bond loans;
- assistance with rent payments, including advance rent payments and cash assistance additional to CRA; and
- relocation expenses, other one-off grants such as housing establishment grants, and advice and information.

In 2001–02, the states and territories provided almost $80 million of CSHA-funded private rent assistance to over 153,000 Australian households. More than half of this assistance was in the form of bond loans (Table 5.21). The diversity of types of assistance, the way in which assistance is targeted across states and territories, and the lack of consistent national data make it difficult to gain a national perspective. For example, a single episode of assistance may involve a one-off rent payment subsidy to prevent eviction and homelessness, or it may take the form of long-term assistance such as provision of a rental supplement over several months to resolve a housing affordability problem.

Table 5.21: Assistance provided under CSHA private rent assistance, 2001–02

	NSW(a)	Vic	Qld(b)	WA	SA	Tas	ACT	NT	Aust.
				Total households assisted (number)(c)					
Bond loans	18,409	12,932	18,147	15,254	13,966	3,573	. .	695	82,976
Rental grants/subsidies	10,692	26,470	830	. .	17,341	1,256	. .	. .	56,589
Relocation expenses	1,191	1,942	. .	. .	. .	168	. .	. .	3,301
Other one-off grants	4,525	1,576	. .	. .	. .	4,433	. .	. .	10,534
Total households assisted	**34,817**	**42,920**	**18,977**	**15,254**	**31,307**	**9,430**	**. .**	**695**	**153,400**
				Total value of assistance ($'000)					
Bond loans	14,485.0	7,364.1	10,580.0	5,340.0	6,998.0	944.7	. .	420.8	46,132.6
Rental grants/subsidies	15,738.0	5,067.2	737.0	. .	6,272.0	167.6	. .	. .	27,981.8
Relocation expenses	1,034.0	375.1	. .	. .	. .	33.8	. .	. .	1,442.9
Other one-off grants	3,858.0	381.0	. .	. .	. .	n.a.	. .	. .	4,239.0
Total value of assistance	**35,115.0**	**13,187.4**	**11,317.0**	**5,340.0**	**13,270.0**	**1,146.1**	**. .**	**420.8**	**79,796.3**

(a) Figures represent the number of households that were approved for assistance in the 2001–02 financial year, not the actual number of households assisted.

(b) The proxy for number of households assisted is the number of bond loans paid to the Rental Tenancies Authority and the number of rental grants paid to the agent/lessor.

(c) Households may be eligible for more than one type of assistance.

Source: AIHW 2003f.

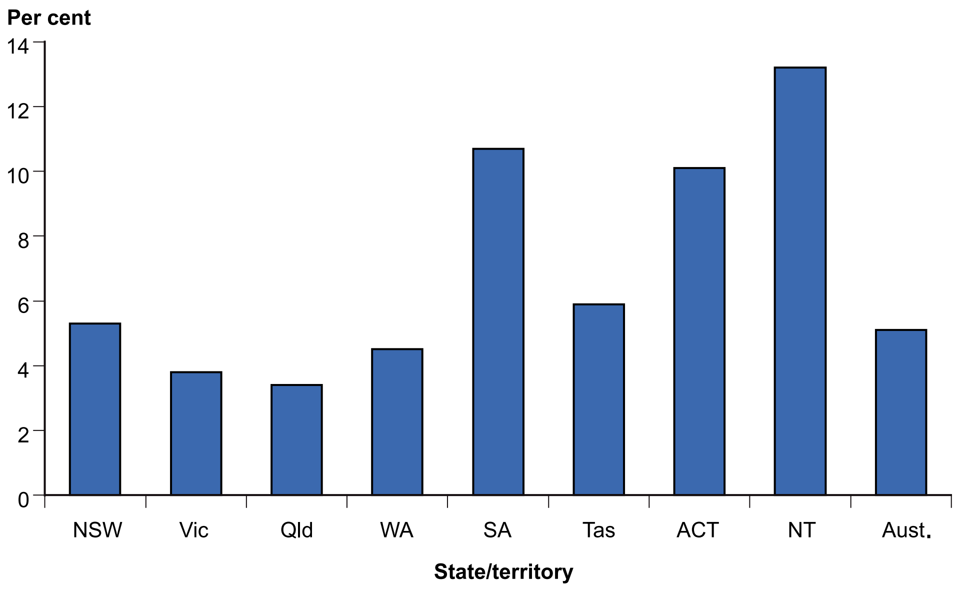
Public housing, including the CSHA Aboriginal Rental Housing Program

Australia has relatively low levels of public housing (AIHW 2001a). In 1999, about 5% of all households lived in public housing tenures, the proportion ranging from 3% in Queensland to 13% in the Northern Territory (Figure 5.4).

Following the introduction of the 1999 CSHA, the level of public housing stock at the national level decreased from 362,967 dwellings in 1999–00 to 354,124 dwellings in 2001–02 (Table A5.9). This reduction was a result of several factors, including: the transfer of public housing dwellings to other social housing stock; headleasing of dwellings; ageing stock requiring maintenance and upgrades; and the reconfiguration of stock to better meet client needs (AIHW 2001a).

Public rental housing is the major CSHA program and it provides a range of assistance to public housing tenants through:

- outlays covering rebate/subsidised rent, repairs, maintenance and upgrade, housing modification, construction and purchase;
- security of tenure;
- government regulations and standards: appeals mechanisms, regulations aimed at ensuring only low-income households access low-income rental housing, allocations policy, rent policy; and
- priority allocation and relocation, and coordination of support services.



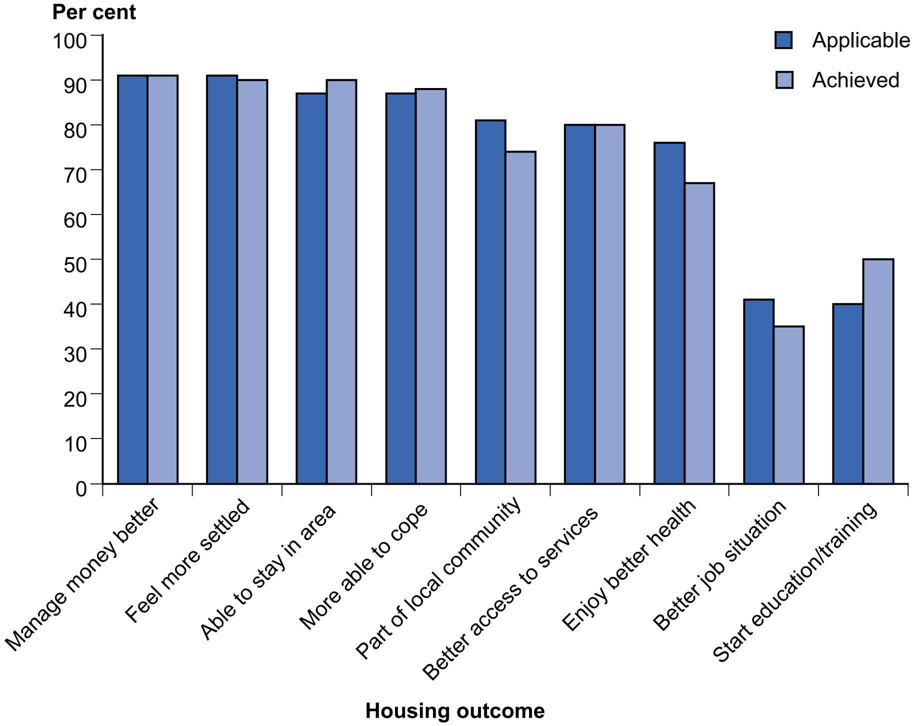
Source: Table A5.8

Figure 5.4: Proportion of households in public housing, 1999

Public housing assistance has many attributes that make it a desirable form of accommodation for some households (see Section 5.2). Perhaps its main feature is that it provides affordable housing to low-income households. As the value of assistance is directly related to household income, public housing assistance is more affordable than private rental, even after accounting for CRA. The affordability of public housing is discussed in further detail later in this section.

Public housing is a more supportive form of rental accommodation than renting from the private sector. It controls against discrimination due to Indigenous status, gender, household type, ethnicity or disability. There is also greater security of tenure for households and it may be easier to gain support to help maintain a tenancy. Low-cost private rental housing is not readily available in certain locations, whereas public housing provides low-cost accommodation where it is needed.

The importance of housing assistance for health and welfare has been discussed in a range of literature (see Section 5.1). In the 2001 National Social Housing Survey with public housing, tenants were asked whether various housing-related outcomes were applicable to them and whether living in public housing had helped them to achieve the outcome. Being able to manage money better and feeling more settled were the most widely cited and achieved housing outcomes (Figure 5.5). Of tenants who cited the outcome as applicable, more than two-thirds reported that they had achieved better health, 35% had improved their employment situation and 50% had improved their education.



Source: Table A5.10.

Figure 5.5: Housing outcomes for public housing tenants, 2001

In June 2002, 342,467 households occupied 342,819 public rental housing dwellings (AIHW 2003g). There were 354,124 public housing dwellings in total. Of the 11,305 vacant dwellings, 6,700 were untenantable.

The majority of households in public rental housing at 30 June 2002 were households comprising single income units (80%). The two largest subgroups of public housing tenants were single adult households and sole parents with dependent children (45% and 18% respectively). Couples with dependent children represented only 7% of public housing tenants (Table 5.22).

One-third of main tenants cited 'other government pension/benefit', such as Parenting Payment, Youth Allowance or Service Pension, as their principal source of income (Table 5.23). Aged and disability pensions were the principal source of income for a significant proportion of main tenants (23% and 24% respectively). Only 9% of tenants cited unemployment benefits as their principal source of income. For details of income units in public housing receiving Centrelink payments, see Table 5.25.

Nearly 50% of tenants in public housing at 30 June 2002 were listed as the main tenant (Table 5.24). Dependants of the main tenant/spouse represented 29% of tenants, while spouses represented only 8%. This is in keeping with the finding that 18% of households in public housing comprise sole parents and their dependent children (Table 5.22).

Table 5.22: Public rental housing including Aboriginal Rental Housing Program (state/territory owned and managed Indigenous housing), by household type and household composition, June 2002

	Public rental housing		ARHP (STOMIH)		All	
	Number	Per cent	Number	Per cent	Number	Per cent
Household type						
Single (all members of household belong to single income unit)	274,652	80.2	8,332	70.2	282,984	79.9
Group (two or more unrelated people where all persons are aged 15 years or over)	30,357	8.9	1,118	9.4	31,475	8.9
Multiple (neither of the above conditions apply)	36,141	10.5	2,376	20.0	38,517	10.9
Unknown/missing	1,317	0.4	48	0.4	1,365	0.4
Total	**342,467**	**100.0**	**11,874**	**100.0**	**354,341**	**100.0**
Household composition						
Single adult	158,553	46.3	2,119	17.9	160,672	45.3
Couple only	32,866	9.6	675	5.7	33,541	9.5
Couple with dependent children	21,570	6.3	1,394	11.7	22,964	6.5
Sole parent with dependent children	60,549	17.7	3,969	33.4	64,518	18.2
Group household	30,357	8.9	1,118	9.4	31,475	8.9
Multiple household	36,141	10.5	2,376	20.0	38,517	10.9
Other household	1,114	0.3	175	1.5	1,289	0.3
Unknown/missing	1,317	0.4	48	0.4	1,365	0.4
Total	**342,467**	**100.0**	**11,874**	**100.0**	**354,341**	**100.0**
Total number of occupants	**712,286**		**48,773**		**761,059**	

Source: NHDA Public housing and ARHP STOMIH NMDS.

Table 5.23: Principal source of income of main tenant[(a)] in public rental housing including the Aboriginal Rental Housing Program (state/territory owned and managed Indigenous housing), June 2002

	Public rental housing		ARHP (STOMIH)		All	
	Number	**Per cent**	**Number**	**Per cent**	**Number**	**Per cent**
Wages/salary	27,996	8.3	1,716	14.3	29,712	8.5
Disability Pension	82,189	24.3	1,711	14.3	83,900	23.9
Age Pension	79,435	23.4	989	8.3	80,424	22.9
Unemployment benefit	31,570	9.3	1,255	10.5	32,825	9.4
Other government pension/benefit (e.g. Youth Allowance, Service Pension)	112,709	33.3	6,196	51.7	118,905	33.9
Other (superannuation/compensation)	4,481	1.3	94	0.8	4,575	1.3
Nil income	486	0.1	14	0.1	500	0.1
Not stated/unknown	1	0.0	—	—	1	0.0
Total	**338,867**	**100.0**	**11,975**	**100.0**	**350,842**	**100.0**

(a) Some households do not have a main tenant. Also some households may have more than one main tenant and numbers will differ from household-based tables.

Source: NHDA Public housing and ARHP STOMIH NMDS.

Table 5.24: Public housing and Aboriginal Rental Housing Program (state/territory owned and managed Indigenous housing), relationship of occupants to reference person, June 2002

	Public rental housing		ARHP (STOMIH)		All	
	Number	**Per cent**	**Number**	**Per cent**	**Number**	**Per cent**
Main tenant	361,368	50.7	12,791	26.2	374,159	49.2
Spouse	57,041	8.0	2,276	4.7	59,317	7.8
Dependant of main tenant /spouse (aged <16 years)	202,574	28.5	16,493	33.8	219,067	28.8
Independent (related to main tenant/ spouse and aged 16 years or more)	60,758	8.5	3,438	7.1	64,196	8.4
Resident (unrelated to main tenant)	24,697	3.5	1,313	2.7	26,010	3.4
Dependant of resident (aged <16 years)	5,664	0.8	836	1.7	6,500	0.8
Unknown	184	0.0	11,626	23.8	11,810	1.6
Total	**712,286**	**100.0**	**48,773**	**100.0**	**761,059**	**100.0**

Source: NHDA Public housing and ARHP STOMIH NMDS.

The increased targeting of public housing to low-income households or those with special needs has resulted in an increase in the proportion of tenants who are recipients of Centrelink benefits. Centrelink data show that at June 2002 there were approximately 332,000 income units living in public housing that were Centrelink clients (Table 5.25). Recipients of age and disability pensions represented the largest proportion, followed by single parents (29%, 28% and 22% respectively). Nearly one in three income units contained an adult with a disability identified by Centrelink (Table 5.26).

Table 5.25: Primary Centrelink payment received by income units in government rental accommodation, June 2002 (per cent)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total[(a)]
Age Pension	29.8	28.4	24.8	29.9	33.2	21.9	24.3	19.8	28.7
Carer Payment	2.2	1.9	2.0	1.6	1.6	2.0	1.1	1.0	1.9
Disability Pension	29.1	26.6	26.8	25.1	30.6	29.9	23.5	20.9	27.8
Family Tax Benefit	2.9	2.7	5.0	3.5	2.7	2.6	6.2	7.4	3.4
Newstart Allowance	10.9	11.1	10.5	12.2	11.6	15.1	12.4	17.5	11.4
Parenting Payment (couple)	1.2	1.3	1.7	1.7	0.9	1.2	1.8	2.2	1.3
Parenting Payment (single)	20.6	23.8	25.4	22.0	15.6	22.1	24.5	27.6	21.6
Widow Allowance	1.3	1.4	1.6	1.5	1.1	1.0	1.1	0.7	1.3
Youth Allowance	0.6	0.9	0.5	0.8	1.0	2.7	2.5	1.5	0.8
Other payments	1.5	1.9	1.7	1.6	1.7	1.5	2.6	1.3	1.7
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**120,163**	**60,917**	**47,778**	**31,786**	**43,381**	**12,434**	**9,282**	**6,099**	**332,121**

(a) Includes 281 overseas Centrelink clients.

Source: Commonwealth housing data set including CRA, June 2002.

Table 5.26: Disability status of income units in government accommodation receiving government income support, June 2002 (per cent)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total[(a)]
Client or partner:									
With disability	31.7	32.3	34.4	32.0	34.9	35.1	33.0	30.9	32.8
Without disability	68.3	67.7	65.6	68.0	65.1	64.9	67.0	69.1	67.2
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**120,163**	**60,917**	**47,778**	**31,786**	**43,381**	**12,434**	**9,282**	**6,099**	**332,121**

(a) Includes 281 overseas Centrelink clients.

Source: Commonwealth housing data set including CRA, June 2002.

Households with special needs and greatest need

Two accessibility measures under the 1999 CSHA examine the proportion of new tenancies allocated to households with a household need status, covering those defined as households with ‘special needs’ and households with ‘greatest need’. National standards for measuring such needs were introduced in 2000–01 to improve the consistency of these measures (Box 5.5).

The ‘special needs’ measure focuses on people who are unable to access appropriate accommodation in the private rental market because of discrimination or lack of appropriate housing stock (e.g. modified housing for people with a disability).

In 2001–02, 44% of housing allocations were made to households in the ‘special needs’ category (AIHW 2003g). South Australia had the highest proportion of households in the ‘special needs’ category that were allocated housing (74%) followed by New South Wales and the Northern Territory (51% and 52% respectively). The Australian Capital Territory had the lowest (31%).

Box 5.5: 'Special needs' and 'Greatest need' national standards

Special needs national standard

Special needs households are defined as low-income households:

- *that satisfy the Indigenous household definition;*
- *that have a household member with a disability;*
- *where the principal tenant is aged 24 years or under;*
- *where the principal tenant is aged 75 years or more.*

Greatest need national standard

Greatest need households are defined as low-income households that at the time of allocation:

- *were homeless; or*
- *their life or safety was at risk in their accommodation; or*
- *their health condition was aggravated by their housing needs; or*
- *their housing was inappropriate to their needs; or*
- *they had very high rental housing costs.*

Source: AIHW 2002b.

Table 5.27: 'Special needs' reasons for new households being allocated public rental housing,[(a)] 1 July 2001 to 30 June 2002 (per cent)

	NSW	Vic	Qld	WA	SA[(b)]	Tas	ACT	NT	Aust.
Principal tenant aged 24 years and under[(c)]	20.3	36.5	33.9	34.4	32.9	57.6	82.9	34.4	31.7
Principal tenant aged 75 years or more[(c)]	7.9	14.1	10.5	6.8	8.3	4.7	8.1	4.0	8.9
Indigenous	15.3	8.3	30.7	20.4	11.1	21.8	7.3	61.6	18.5
Disability[(d)]	56.5	41.1	24.9	38.4	47.7	15.8	1.6	n.a.	40.8
Total special needs allocations (number of households)	**5,491**	**2,471**	**2,373**	**1,678**	**1,732**	**837**	**371**	**513**	**15,466**
Total new allocations for whom details of whether or not they have special needs are known (number of households)	**10,780**	**6,993**	**6,563**	**4,639**	**2,355**	**1,739**	**1,182**	**986**	**35,237**

(a) Excludes Aboriginal Rental Housing Program (state/territory owned and managed Indigenous housing). A unique household may satisfy more than one special need category. These households are counted under each category that applies and are counted more than once in the percent distribution but are counted only once in the total number of households.

(b) In SA special needs details are recorded for the principal tenant only.

(c) For households where more than one tenant was identified as the principal tenant, the oldest person has been selected as the principal tenant when determining special needs status.

(d) The NT does not have a disability identifier in their information management system.

Sources: AIHW analysis of NMDS data files; AIHW 2003g.

Nationally in 2001–02, the highest proportion of special needs allocations was made to households that contained a household member with a disability (41%), followed by households where the principal tenant was aged 24 years or under (32%). However, in the Northern Territory, more than 61% of special needs allocations were to Indigenous households. Queensland, Western Australia and Tasmania also made a substantial number of special needs allocations to Indigenous households (Table 5.27).

The 'greatest need' measure focuses on people who require priority access to housing due to their circumstances, such as homelessness, living in a life-threatening situation or inappropriate accommodation. Segmented waiting lists assist in identifying people with these urgent housing needs.

Priority allocations comprised 36% of housing allocations in 2001–02 (AIHW 2003g). The Australian Capital Territory had the highest proportion of priority allocations (85%) and Queensland had the lowest (5%). The Queensland result was influenced by the low percentage of priority housing applicants on the waiting list as, in low wait-time areas, households with priority housing needs may be allocated housing without being registered on the waiting list or with a priority classification. In addition, in Queensland, the Community Rent Scheme also leases houses from the private sector to provide housing to those households who are in priority need.

Nationally, the main reasons given for seeking priority access to housing assistance were homelessness (46%) and health condition aggravated by housing (26%) (Table 5.28). However, in Tasmania, the available housing being inappropriate to the applicant's needs was the main reason for seeking assistance (33%).

Table 5.28: 'Greatest need' reasons for new households being allocated public rental housing,[(a)] 1 July 2001 to 30 June 2002 (per cent)

	NSW	Vic	Qld	WA	SA	Tas	ACT(b)	NT(c)	Aust.
Homeless	27.7	68.2	26.9	11.2	65.7	25.0	53.9	n.a.	45.5
Life or safety at risk in accommodation	11.8	5.7	9.1	14.8	0.7	13.5	6.3	n.a.	8.5
Health condition aggravated by housing	56.9	13.7	48.4	33.8	n.a.	22.7	0.0	n.a.	26.2
Housing inappropriate to needs	3.5	12.0	15.6	0.6	n.a.	32.7	22.3	n.a.	10.9
High housing costs	n.a.	n.a.	n.a.	n.a.	n.a.	6.1	17.5	n.a.	2.1
Other(d)	n.a.	0.5	n.a.	39.6	33.6	n.a.	n.a.	n.a.	6.8
Total greatest need allocations (number)	**3,406**	**4,354**	**320**	**886**	**1,573**	**1,562**	**984**	**141**	**13,226**
Total new allocations (number)	**10,836**	**6,993**	**6,563**	**4,639**	**3,755**	**1,940**	**1,165**	**986**	**36,877**

(a) Table excludes the Aboriginal Rental Housing Program (state/territory owned and managed Indigenous housing).

(b) In all jurisdictions, one priority reason was provided per household, with the exception of the ACT which provided multiple reasons per household. To achieve consistency in results across jurisdictions, the figures reported for the ACT have been weighted to reflect the number of greatest need households assisted (992) rather than the number of priority reasons (2,663).

(c) The proportion of greatest need allocations by priority reason cannot be determined as priority reason codes were not provided.

(d) In WA, the 'other' category is used to capture those households that experience a range of priority reasons including living in housing that is inadequate, unsafe or expensive and other situations.

Sources: AIHW analysis of NMDS state data files; AIHW 2003g.

Table 5.29: Tenant's overall satisfaction with the service provided by the public rental housing agency,[(a)] 2001 (per cent)

	Aged under 24 years	Aged over 75 years	Disability	Indigenous	All tenants
Very satisfied	13	38	30	20	28
Satisfied	35	44	39	36	41
Neither satisfied or dissatisfied	17	6	9	12	10
Somewhat dissatisfied	21	6	12	16	11
Very dissatisfied	8	2	7	12	6
Total	**94**	**95**	**96**	**95**	**96**

(a) Figures quoted use the national weighted average. Excludes the Aboriginal Rental Housing Program (state/territory owned and managed Indigenous housing).

Note: Totals do not add to 100% because the field 'Don't know/No opinion' and responses not answered correctly have been excluded.

Source: NFO Donovan Research 2001.

Satisfaction with amenity/location of dwelling

The National Social Housing Survey of public housing, undertaken by state and territory housing agencies, elicits responses from tenants chosen at random in relation to their satisfaction with their CSHA-funded dwelling in terms of the quality of services provided and the dwelling's amenity and location. The results of the survey are compiled and form part of the CSHA national performance indicator framework.

In 2001, 69% of tenants were either very satisfied or satisfied with the service provided for public housing (Table 5.29). Tenants who were aged under 24 years expressed the least satisfaction with the service provided by public housing (48% either satisfied or very satisfied), whereas tenants who were aged over 75 years expressed the most satisfaction (82% either satisfied or very satisfied). Of all tenants, 17% were either somewhat dissatisfied or very dissatisfied. Indigenous tenants and those aged under 24 years were most likely to be somewhat dissatisfied or very dissatisfied, at 28% and 29% respectively (NFO Donovan Research 2001).

Rent rebates

Rents for public housing are generally charged as a proportion of the household's assessable income up to a ceiling equal to a market rent. Housing authorities have different definitions of 'assessable income', take different household members' incomes into account, have different rates of payment according to different income thresholds, and value market rents differently. Often these varying arrangements are summarised broadly, so that it can be said that most households pay between 20% and 25% of their assessable income in rent. In 2001–02, 99% of rebated public housing households paid 25% or less of their assessable income on rent (AIHW 2003g). This contrasts with low-income households in the private rental market receiving Commonwealth Rent Assistance, where 35% of income units pay more than 30% of their income on rent (refer to Figure 5.3).

The difference between the market rent and the rent charged is called the 'rent rebate'. Public housing tenants in June 2002 paid on average 69% of the market rent value of the dwelling (Table 5.30). This indicates that public housing tenants would pay an additional 46% rental costs if they rented comparable accommodation in the private rental market. The difference between public housing and private rental costs is largest in New South Wales and smallest in Tasmania.

Table 5.30: Public rental households: rent charged as a proportion of market rent for each dwelling,[(a)] June 2002 (per cent)

NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust.
56.5	70.3	84.1	76.9	83.2	87.0	70.2	76.2	68.6

(a) Adjusted for CRA. Excludes the Aboriginal Rental Housing Program (state/territory owned and managed Indigenous housing).

Source: AIHW 2003g.

Community housing

Community housing is delivered by non-profit community, church and local government providers and offers a range of housing choices that may not be available through the public or private housing markets. The number of community housing dwellings in Australia is small, compared with public housing, private rental and home ownership—it represents less than half of 1% of all housing tenures (ABS 2002b). Its importance as a sector is the ability to provide flexible housing responses to people who may have special needs, live in remote areas or require supported accommodation services with links to aged, disability and health services.

Government assistance to community housing providers and tenants takes many forms:

- rebated/subsidised rent and Commonwealth Rent Assistance for tenants, recurrent funding of organisations and the undertaking of repairs, maintenance and upgrades, and capital funding for dwelling and infrastructure construction;
- taxation benefits, including charitable tax status for organisations;
- government regulations and standards that provide skills development, accreditation, development of specific building guidelines, and regulations aimed at ensuring only low-income households access low-income rental housing; and
- other activities of government, including sector coordination, partnerships and incentives, and coordination of support services and transition paths to long-term accommodation.

Two major types of community housing are available in Australia (Table 5.31):

- long- to medium-term housing, such as that provided under the CSHA mainstream community housing programs and the Indigenous Community Housing and Infrastructure Program; and
- transitional or crisis housing, which provides accommodation to people in need in the short to medium term.

Table 5.31: Types of community housing

Description	Examples
Long- to medium-term housing	
Specific tenant needs—market failure to provide for particular long-term needs	Aged community housing, including retirement villages operated by charities
	Community housing for disabled persons, such as group houses
	Respite care
Specific tenant needs—market failure to provide culturally appropriate housing/rural and remote issues	Indigenous community housing Refugees
Transitional or crisis housing	
Specific tenant needs—market failure to provide for particular short-term/transitional needs	Group homes—rehabilitation Half-way houses

Box 5.6: Example of how community housing operates to provide affordable and sustainable accommodation

The Brisbane Housing Company is an independent not-for-profit organisation that works in partnership with community groups and the private sector to build or buy affordable housing for low-income families and individuals. Incorporated in July 2002 the company expects to establish up to 600 new dwellings over 4 years. It will meet the needs of a variety of tenants using a mix of boarding houses, units and houses.

The approach utilised by the company involves:

- *structuring rent to maximise residents' access to Commonwealth Rent Assistance; and*
- *using the company's charitable status to receive charitable contributions and to minimise GST.*

The company aims to redress the lack of low-cost rental accommodation in inner city Brisbane by offering below-market rents to households on low incomes. Its operation is based on an initial equity injection by the Queensland Government and by the Brisbane City Council. The company will use income from rents to manage and maintain its properties, with any surplus used to fund further expansion.

Note: The Brisbane Housing Company like other affordable housing initiatives funded under the CSHA may not be represented in CSHA community housing data as they are not funded through this program.

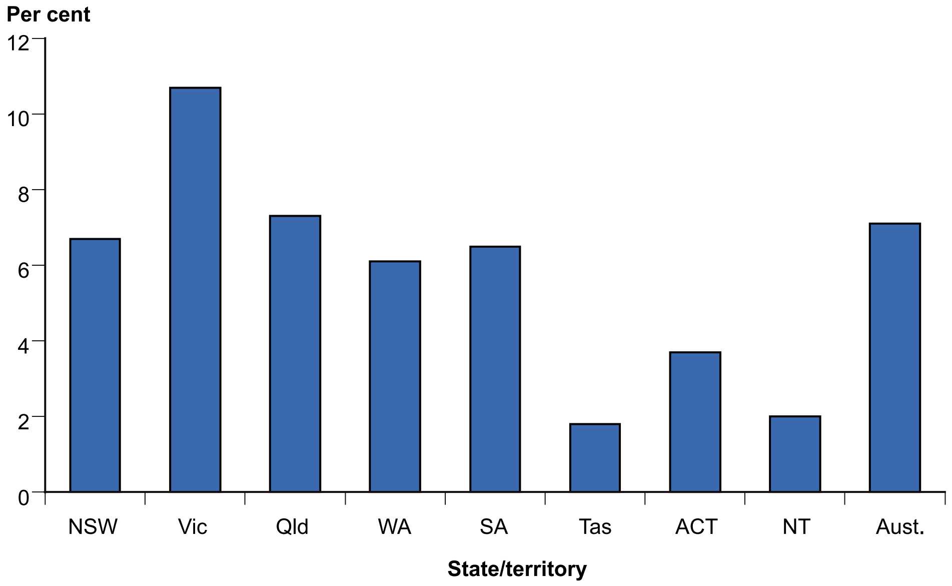
Source: Queensland Department of Housing 2003.

The nature of housing need and the management models used to provide community housing often result in a mix of these two types of housing by a single provider. For example, a community housing provider supporting drug rehabilitation may offer tenancies with a high level of support over a transition period following institutionalisation and also housing without support services for longer term tenure. The flexibility in the provision of community housing provides affordable accommodation for low-income tenants and also allows for the proper maintenance of houses as well as growth. An example of this approach is the Brisbane Housing Company (Box 5.6).

CSHA Community Housing

The diversity in the types of community housing programs within a jurisdiction is significant and variation exists between the states and territories. These different program boundaries make construction of nationally consistent definitions of the types of assistance in this sector difficult (AIHW 2001a:75).

The size of the community housing sector varies between jurisdictions, reflecting not only the differing emphasis states and territories place on community housing as an alternative to public housing but also on its role in deinstitutionalisation (NCHF 1998:3). As at 30 June 2002, Victoria had the highest proportion of CSHA community housing (11%) and Tasmania had the lowest (2%) (Figure 5.6).

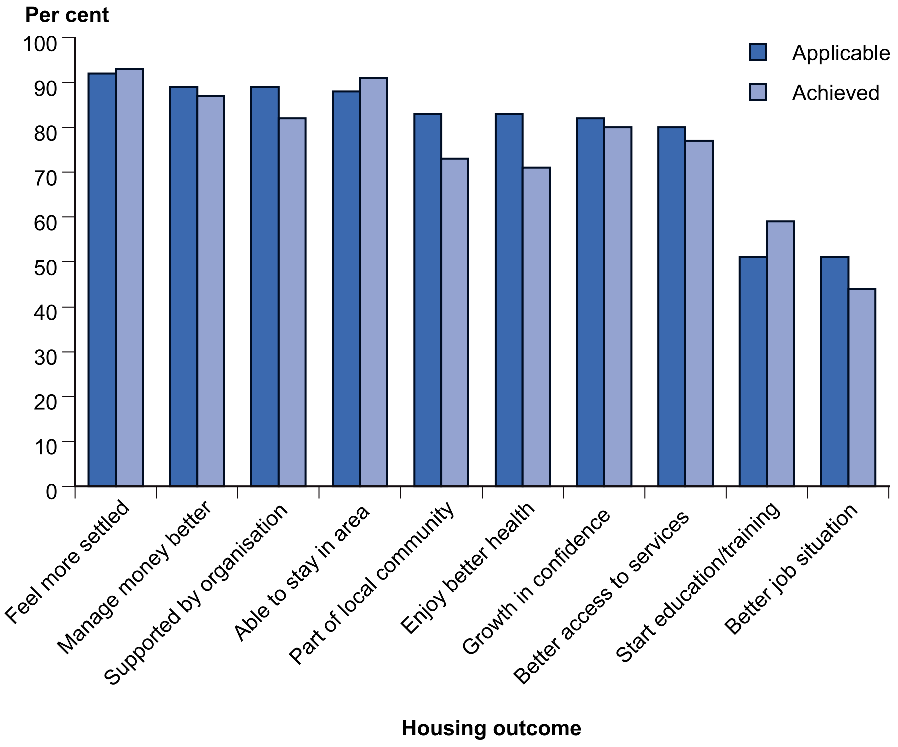


Source: Table A5.12.

Figure 5.6: Community housing dwellings as a proportion of all public and community housing dwellings, 2002

The transfer of substantial amounts of public housing stock to community housing management has been one of the national trends in community housing. Also worth noting is the significant percentage of community housing stock that is head-leased from the private rental sector. In 2001–02, over 7,000 of a total of 27,178 CSHA community housing dwellings were head-leased. The 1999 public housing data repository was only able to identify 2,000 units of public housing stock that had been head-leased from the private rental market (AIHW 2001a:77, 2003c).

Additional support for claims regarding the importance of housing for health and welfare is provided in the 2002 National Social Housing Survey of community housing (NFO Donovan Research 2002). For community housing tenants, feeling more settled was the most widely cited and achieved outcome, followed by managing money better, being supported by the organisation and being able to stay in the area (Figure 5.7). Of tenants who cited the outcome as applicable, 71% reported they had achieved better health, 59% had started education/training and 44% had improved their employment situation after being allocated community housing.



Source: Table A5.12.

Figure 5.7: Housing outcomes for community housing tenants, 2002

Table 5.32: Household need status of new households in CSHA Community Housing Program, 1 July 2001 to 30 June 2002 (per cent)

Household need status	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust.
Special needs	66.8	n.a.	64.1	72.8	70.3	39.4	27.5	n.a.	68.4
Priority housing need	78.5	83.7	85.0	93.5	69.6	28.7	74.2	n.a.	85.1

Note: Special needs data for the ACT ares unreliable as some organisations provided incorrect data about special needs allocations.

Source: AIHW 2003c.

Households with special needs and greatest need

In 2001–02, 68% of new households assisted with community housing had a special need (Table 5.32, Box 5.5). Western Australia and South Australia made the highest proportion of special needs allocations (73% and 70% respectively), while the Australian Capital Territory had the lowest proportion of special needs allocations (28%). Priority allocations to households in greatest need comprised 85% of community housing provision. Western Australia had the highest proportion of priority allocations (94%) and Tasmania had the lowest (29%). Prior to moving into community housing, 43% of tenants surveyed had been unable to afford private rental housing, 20% had been homeless and 9% had been living in a violent or dangerous situation (NFO Donovan Research 2002).

Satisfaction with community housing

The results from the 2002 community housing survey indicate that 77% of tenants were satisfied or very satisfied with the service provided by their community housing provider. As with most customer satisfaction surveys, including the public housing survey, the level of satisfaction with community housing increases with age (NFO Donovan Research 2002). Tenants aged 65 years or over were more likely than tenants aged 15–34 years to be very satisfied (47% and 32% respectively) and were less likely to be dissatisfied (6% and 15% respectively).

Tenants living in shared accommodation (i.e. have a room in a shared house or live in a larger rooming house) were more likely to be dissatisfied (16%) than those living in a separate house, attached house or self-contained unit (11%, 7% and 10% respectively). Although overall levels of satisfaction were similar for Indigenous and non-Indigenous tenants, Indigenous tenants were less likely to be very satisfied (23% and 40% respectively) (see Table A5.13).

The Indigenous Community Housing and Infrastructure Program

In 2001–02, the former Aboriginal and Torres Strait Islander Commission (ATSIC) provided over $199 million for community housing through its Community Housing and Infrastructure Program (Table 5.33). This included $76 million for construction and acquisition of houses, $20 million for upgrades and renovations and $6 million for asset and tenancy management. Community housing responds to a diversity of circumstances and allows for greater community participation in decision-making processes.

Table 5.33: Funds expended on the Community Housing and Infrastructure Program, 2001–02

	Expenditure ($)
Construction and acquisition of houses	76,337,103
Upgrades and renovations	20,780,638
Asset and tenancy management	6,284,567
Water supply	8,343,006
Power supply	13,106,469
Sewerage services	8,136,265
Internal roads and drainage	9,041,441
Other housing-related infrastructure	15,905,334
Development and support	41,461,114
Total	**199,395,937**

Source: ATSIC 2002a.

Delivery of the Community Housing and Infrastructure Program is through Indigenous Housing Agreements with the states and territories. This requires the pooling of all Indigenous-specific funds at the state and territory level, which is then managed through the state and territory Indigenous housing authorities. As a result, it is not possible to accurately estimate the number of houses provided and upgraded, the number of people housed, or the number of houses managed by Indigenous housing organisations specifically from ATSIC funding (ATSIC 2002a).

ATSIC–Army Community Assistance Program

The ATSIC–Army Community Assistance Program is a cooperative arrangement between the Army, the Department of Health and Ageing and ATSIC. The aim of the program is to alleviate the poor health of Indigenous Australians by targeting primary and environmental health infrastructure. In 1996, $12 million was spent on the first round of projects. This was followed up with additional funding of $40 million in 1998, of which $35 million has been committed and $5 million is available for a new project in 2004 (ATSIC 2002a).

Crisis community housing assistance

Government and churches and other welfare bodies use community housing organisations to provide a range of housing services to assist people who are in situations of actual or impending crisis or who are homeless. These programs have strong links to health and community services agencies that assist people in crisis. In the health area, housing agencies work closely with mental health and alcohol and drug abuse service providers; in the community services area, the major link is with supported accommodation and crisis services provided through the Supported Accommodation Assistance Program (SAAP).

The CSHA Crisis Accommodation Program (CAP) provides emergency accommodation, and funds are used for the purchase, lease and maintenance of dwellings that provide accommodation assistance to people who are homeless or in crisis. At 30 June 2002, there were 3,258 CAP-funded dwellings in Australia (Table 5.34).

The links between crisis housing assistance and other housing assistance were shown in the SAAP National Data Collection Annual Report for 2001–02 (AIHW 2002a).

Table 5.34: Number of dwellings funded through the CSHA Crisis Accommodation Program, 30 June 2002

NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust.
1,216	200	967	394	214	122	54	91	3,258

Source: AIHW 2003d.

While domestic violence was the main reason for seeking assistance from SAAP agencies (22%), accommodation-related matters were also main contributors. In particular, usual accommodation becoming unavailable, eviction/previous accommodation ended and financial difficulties were the main accommodation-related reasons given for seeking assistance (11%, 12% and 9% respectively).

SAAP clients moved into a range of tenure types after receiving SAAP assistance: 19% into other SAAP/emergency housing, 19% into private rental accommodation, and 17% into public or community housing.

There was variation in housing outcomes between Indigenous and non-Indigenous clients. The majority (27%) of Indigenous clients moved into public or community housing, while private rental accommodation was the most common form of housing for non-Indigenous clients (21%) immediately after a support period (AIHW 2002a).

Further information about the types of assistance provided to homeless persons through SAAP can be found in Chapter 9.

5.4 Assistance to home owners and purchasers

Assistance for home purchase or ownership includes:

- government outlays, such as for the First Home Owner Grant, CSHA home purchase assistance and the Aboriginal and Torres Strait Islander Home Ownership Program;
- taxation expenditures, including the non-taxation of imputed rent from owner occupation, rates and land tax concessions, and capital gain and stamp duty exemptions;
- government regulations and standards in housing and financial markets; and
- other assistance, such as home purchase advisory and counselling services.

First Home Owner Grant

To offset the impact of the introduction of the goods and services tax, from 1 July 2000 the Commonwealth Government established the First Home Owner Grant. The grants are administered by the states and territories and provide Australian citizens who purchase a new or established dwelling with a one-off $7,000 payment. Assistance is not means-tested, but the applicant must not have previously owned a home and the property must be intended to be a principal place of residence. During March 2001, the Commonwealth introduced an Extra First Home Owner Grant for New Homes, providing an additional $7,000 grant, non-means-tested, for first home owner applicants constructing or purchasing a new dwelling. This additional grant was reduced to $3,000 from 1 January 2002 and ceased on 30 June 2002. The states and territories also administered this grant (FHOG 2001).

Between July 2000 and June 2002, over 360,000 grants were provided to first home owners through the First Home Owner Grant (Table 5.35). This assistance totalled almost $3 billion (ABS 2003a).

Table 5.35: Number of First Home Owner Grant recipients, July 2000 to June 2002

Amount received	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust.
$7,000(a)	93,937	80,140	63,044	30,342	25,604	9,017	6,079	2,480	310,643
$10,000	646	510	867	341	134	17	42	33	2,590
$14,000	11,062	12,699	11,157	7,015	3,432	539	522	511	46,937
Total	**105,645**	**93,349**	**75,068**	**37,698**	**29,170**	**9,573**	**6,643**	**3,024**	**360,170**

(a) Includes some applicants receiving under $7,000.

Source: ABS 2003a.

Table 5.36: CSHA home purchase assistance, 2001–02

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust.
	Total households receiving assistance (number)								
Direct lending	. .	116	96	3,998(a)	16,784	204	. .	247	21,445
Deposit assistance	. .	. .	22	. .	. .	255	. .	472	749
Interest rate assistance	. .	. .	83	146(b)	3,769	. .	. .	427	4,425
Mortgage relief	209(c)	8	15	. .(b)	91	. .	75(d)	. .	398
Home purchase advisory and counselling services	17,444(e)	. .	. .	3,998(f)		. .	. .	. .	21,442
Other types of assistance	. .	47	10	547	. .	292	. .	. .	896
Total households receiving assistance	**17,653**	**171**	**226**	**8,689**	**20,644**	**751**	**75**	**1,146**	**49,355**
	Value of assistance ($m)								
Direct lending	. .	8.0	6.6	372.0	163.6	9.0	. .	26.7	586.0
Deposit assistance	. .	. .	. .	. .	. .	1.1	. .	0.7	1.8
Interest rate assistance	. .	. .	n.a.(g)	0.2(b)	10.0	. .	. .	0.3	10.5
Mortgage relief	0.7	. .	0.1	. .(b)	. .	. .	0.2	. .	1.0
Home purchase advisory and counselling services	. .(h)	. .	. .	0.1(f,i)	. .	. .	. .	. .	0.1
Other types of assistance	. .	0.3	0.1	1.1	. .	0.8	. .	. .	2.3
Total value of assistance	**0.7**	**8.4**	**6.8**	**373.5**	**173.6**	**10.9**	**0.2**	**27.7**	**601.7**

(a) Proxy for new households is the number of new loans provided.

(b) Subsidised loans are provided at an interest rate of 6.5%. As market rates during the year were 6.5% or below, no one-off interest rate or mortgage relief assistance was provided. Only ongoing households received interest rate assistance.

(c) The proxy for new households is the total number of Mortgage Assistance approvals for 2001–02.

(d) Mortgage relief program ceased on 1 January 2001.

(e) Includes only the total number of calls to the Home Purchase Assistance Information and Advisory Service during 2001–02. Excludes general information provided in regard to other forms of assistance.

(f) All households receive counselling prior to receiving direct lending. The proxy for new households is the number of new direct lending loans.

(g) Interest rate assistance is linked to direct lending as part of the product package and so a specific value could not be provided.

(h) No dollar value is attributed to the provision of advisory services.

(i) No monetary assistance is provided; however, an estimated cost for providing counselling is $25 per session.

Source: AIHW 2003e.

CSHA home purchase assistance

Home purchase assistance under the CSHA is designed to make home ownership (including shared home ownership) more accessible for people who are otherwise unable to obtain private sector finance for home ownership. Active CSHA home purchase programs exist where market circumstances allow the purchase of dwellings by low-income people. A range of programs is available, which vary across the states and the territories, including direct lending, deposit assistance, interest rate assistance, home purchase advisory and counselling services, and mortgage relief (AIHW 2003e).

In 2001–02, the total value of home purchase assistance provided to households by the states and territories through the CSHA was more than $601 million (Table 5.36). The different types and monetary values of the services provided indicate the difficulty in making comparisons between states and territories.

Aboriginal and Torres Strait Islander Home Ownership Program

The ATSIC Home Ownership Program assists eligible Aboriginal people and Torres Strait Islanders, most of whom would not qualify for assistance from commercial-sector lending institutions, to purchase their own home. In 2001–02, 494 eligible applicants received loans totalling more than $60 million, which was an increase from the $54 million made available in 2000–01 (Table 5.37). These loans enabled 1,634 Indigenous people to be housed in their own home (ATSIC 2002a). Over 18,600 Aboriginal people and Torres Strait Islanders have been assisted with purchasing their own homes since the implementation of this program. In 2001–02 ATSIC also introduced the Deposit Gap Loan, which funds up to 20% of the purchase price of a property. This allows eligible applicants to borrow funds from banks or other commercial lenders to purchase or build a home (ATSIC 2002a).

Table 5.37: ATSIC Home Ownership Program loans, 2001–02

Region	Approved	Managed
Adelaide	20	234
Alice Springs	6	49
Brisbane	58	430
Broome	5	62
Coffs Harbour	45	321
Darwin	34	192
Hobart	9	86
Melbourne	51	308
Perth	33	396
Rockhampton	39	200
Sydney	32	345
Tamworth	25	207
Townsville	70	517
Wagga Wagga	67	489
Total	**494**	**3,836**

Source: ATSIC 2002a.

Taxation expenditures

Currently, there are no official estimates on the assistance provided through the taxation system to households owning or purchasing their home. However, recent research has shown that its impact is significant (Bourassa et al. 1995; Pender 1994; Yates 2002).

Owner-occupied housing is treated differently from other assets because the service, or imputed rent, from the dwelling is not taxed. Assets such as bank savings, shares and investment properties produce income that is taxed; owner-occupied housing provides an imputed income stream that is not. On the other hand, costs associated with producing the service are not tax exempt; for example, mortgage interest payments cannot be deducted from a person's taxable income. This presents a short-term disadvantage for purchasers, but the long-term advantage of a non-taxed imputed rent has been calculated to more than outweigh this at given rates of mortgage repayment (Bourassa et al; 1995 Yates 2002).

The capital gains tax exemption for gains on the disposal of a taxpayer's main residence (Treasury 2001:27) is also recognised as an important area of housing assistance.

The value of indirect assistance provided to owner-occupied housing through taxation expenditures in 2001 was estimated to be $21 billion (Yates 2002). This consisted of:

- $13 billion arising from the non-taxation of capital gains under the post-1999 approach to taxing capital gains; and
- $8 billion arising from the non-taxation of imputed rent, consisting of a $13 billion benefit from the non-taxation of net imputed rent and a $5 billion cost from the non-deductibility of mortgage interest costs.

On a household basis in 1999, the value of assistance relating to capital gains and imputed rent was on average $4,400 per household per year for owners without a mortgage and $900 for owners with a mortgage. This compares with $3,698 for public renters and $1,655 for private renters (see Table 5.16).

Rates and land tax concessions

State and territory taxes also provide assistance to home owners, for example through transaction tax exemptions for first home buyers and land tax exemptions. Land tax exemption has been raised as a source of horizontal inequity between renters and owner-occupiers and as a disincentive to rental property investment (NHS 1991b:59; Yates 1994:22).

Assistance is also provided to pensioners, who receive subsidies for their local government rate payments. These subsidies are funded by state and territory governments, which reimburse local governments. The size and number of subsidies vary across jurisdictions and no comparable information is available.

5.5 Data development

Under the National Housing Data Agreement (NHDA) and the Agreement on National Indigenous Housing Information (ANIHI), a variety of data development initiatives have been implemented to improve housing assistance data availability and consistency. The major components of the NHDA Management Group work program are based on four priority policy areas for national data: public rental housing, private rental market assistance, community housing, and Indigenous housing. Indigenous housing priorities are being progressed jointly with the National Indigenous Housing Information Implementation Committee which operates under the ANIHI (AIHW 2001a).

The compatibility of mainstream and Indigenous housing data with the health and community services information is an objective of both the NHDA and the ANIHI. These agreements support relevant work across areas such as priority access to housing services and the links to community services programs such as the Supported Accommodation Assistance Program.

Basic counting units—households or income units

Unlike many other areas of this report, housing uses several different counting units and these create difficulties in comparing data. For example, waiting lists may be based on a person's characteristics, eligibility for CRA is based on income unit characteristics, and the level of rebate for public renters is based on household-level information. While most social housing is based on tenancy agreements that equate with the common notion of household, the major counting unit in private rental assistance is income units.

The 1998–99 ABS Household Expenditure Survey identified 18.5 million persons living in 7.1 million households representing 9.3 million income units. For 22% of households there is more than one income unit in the household (ABS 2001d:Table 1).

Figure 5.8 illustrates the various relationships between dwelling, household, income unit and person. Dwelling A contains a single household with one income unit comprising one parent with two dependent children. Dwelling B contains two households with two income units comprising a couple with two dependent children and a single person income household. Dwelling C contains one household with three single person income units.

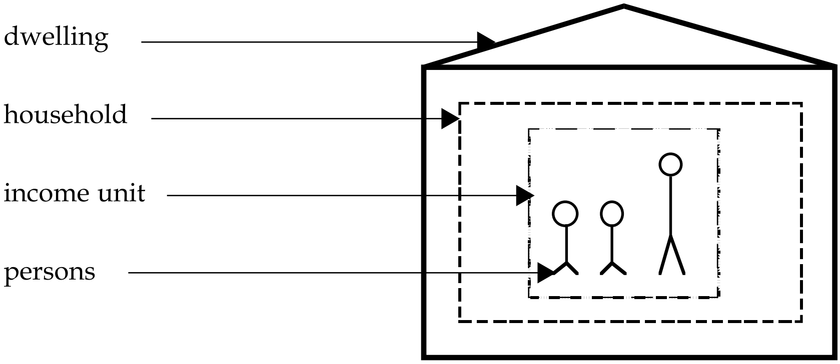
To improve the comparability of administrative data and census and survey data across tenures, it is vital that these three concepts are counted in a consistent way. Current data do not facilitate this task. The Centrelink CRA data are provided at income unit level and are currently unable to be converted to household level. In contrast, the CSHA data are at household level. Aligning CRA and CSHA data is considered a priority area by Commonwealth and state/territory jurisdictions.

Table 5.38: Ratio of income unit to household, 1999

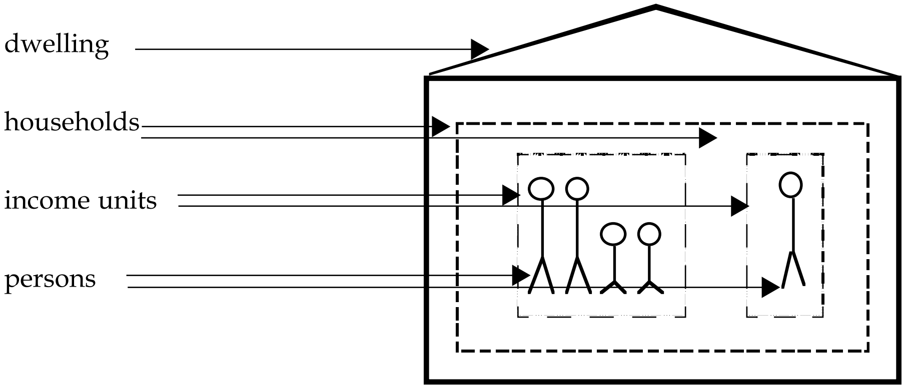
	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust.
Total number of income units assisted	178,968	138,603	148,716	64,465	38,150	20,588	821	4,323	594,634
Total number of households assisted	124,886	93,067	111,868	46,490	30,010	16,599	562	2,679	426,161
Ratio of income unit to households	**1.43**	**1.49**	**1.33**	**1.39**	**1.27**	**1.24**	**1.46**	**1.61**	**1.40**

Source: Australian Housing Survey, 1999, confidentialised unit record files.

Dwelling A: Single household, single income unit



Dwelling B: Multiple household, multiple income units



Dwelling C: Group household, multiple income units

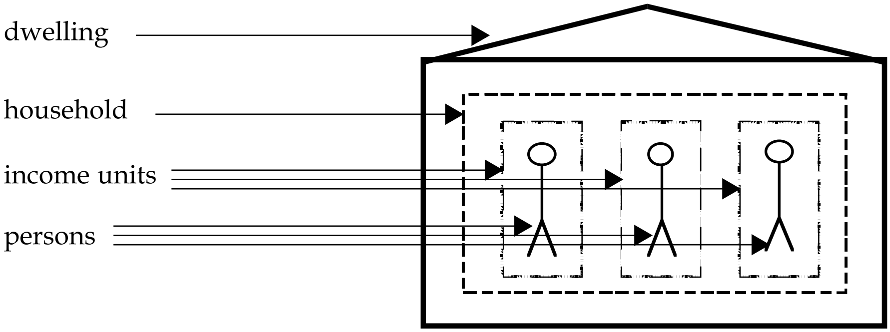


Figure 5.8: Diagrams representing housing data concepts

Many analyses are carried out at the household level rather than at the income unit level. As well, since many households share resources, the receipt of CRA by one income unit in a household may impact on the financial position of the household as a whole. The 1999 Australian Housing Survey provided data at both income unit and household level (Table 5.38). The average ratio of income unit to household among private renters receiving CRA was 1.4. However, there were variations across jurisdictions, the highest ratio being in the Northern Territory where there were 4,323 income units receiving CRA but they represented only 2,679 households.

Improving the measures of number of households in tenure types

Currently, there is variation in the way different tenures are identified in Census, survey and administrative data:

- Home ownership rates at the national level may vary by several percentage points in the same time period (AIHW 2001a:56).
- Public rental housing numbers vary due to identification and definition differences, particularly in the treatment of public rental dwellings that are specifically targeted to Indigenous households (AIHW 2003h).
- Difficulties in measuring the size of the community housing sector arise due to the diversity of programs, variation in funding sources, and provider capacity to supply reliable data (AIHW 2001a:75).

Table 5.39: Households in public rental housing and the Aboriginal Rental Housing Program (state and territory owned and managed Indigenous housing): comparison of Census 2001 and National Housing Data Repository figures, 2001

	NSW	Vic	Qld	SA	WA	Tas	NT	ACT	Aust.
Census 2001									
Number of households renting from state or territory housing authority	114,130	54,805	47,286	44,686	29,399	11,611	5,167	9,858	316,942
Administrative data									
Total number of all households at 30 June 2001 in:									
Public housing	126,214	62,522	48,942	48,539	30,883	12,428	5,759	11,016	346,055
ARHP (STOMIH)	3,794	1,032	2,591	1,708	2,299	298	. .	. .	11,722
Total	*130,008*	*63,554*	*51,533*	*50,247*	*33,182*	*12,726*	*5,759*	*11,016*	*357,777*
Per cent difference between Census and administrative data									
Based on public housing administrative data only	9.6	12.3	3.4	7.9	4.8	6.6	10.3	10.5	8.4
Based on public housing and ARHP (STOMIH) administrative data	12.2	13.8	8.2	11.1	11.4	8.8	10.3	10.5	11.4

Note: ARHP (STOMIH) tenants would be expected to indicate ‘Dept of Housing’ as the landlord, not community housing.

Sources: Census 2001 (Basic Community Profiles, Table B19); CSHA Public Housing and ARHP 2000–2001,L18.

The release of the 2001 Census data has illustrated the importance of understanding differences between similar data from different sources. A comparison of Census 2001 and National Housing Data Repository figures shows that the Census identified 316,942 dwellings as being rented from state or territory housing authorities, while administrative data identified 357,777 where the landlord was the housing authority. This comprised 346,055 public rental households and 11,722 households assisted under the Aboriginal Rental Housing Program (Table 5.39).

Through the NHDA Management Group, state and territory housing authorities work with the ABS and the AIHW to improve the understanding of data differences and their impact on policy and program reporting and analysis.

5.6 Conclusion

Housing assistance aims to meet housing needs as well as contribute to broader outcomes, such as the improved social and economic wellbeing of individuals, families and communities.

Population growth along with changes in household formation and in housing markets has affected the demand for housing assistance. Recent economic and social changes have also contributed to changes in the demand for and supply of housing. There is evidence of a change in home ownership patterns, indicating that home ownership is occurring at a later stage in the family life-cycle. Also, the private rental sector has grown faster than other segments of the housing market but the supply of low-cost private rent dwellings has not shown a similar increase.

The effect of tax expenditures in providing short- and long-term benefits to home owners and their influence on the type of housing stock produced is increasingly being recognised as an important area of housing assistance.

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6 Children's and family services

6.1 Introduction

Children's and family services include a wide range of services provided by governments or with government funding. They include child care and preschool services, parent education and advice, family support and early intervention services, and child protection and out-of-home care services. Services for families and children can be provided or funded by all three tiers of government.

Income support for children and families is mainly the responsibility of the Commonwealth Government. The Commonwealth has also provided funding for child care and family support services since the 1970s. Currently, the Commonwealth's 'Stronger Families and Communities' strategy provides funds for a range of services aimed at supporting families with children, and strengthening family relationships and community networks. The strategy is also funding the 'Growing up in Australia' longitudinal survey (see Box 6.1).

State and territory governments are responsible for child protection and out-of-home care services, including providing income support for children in home-based out-of-home care (see Section 6.5). In addition, they provide support to families through a broader range of services, such as child care, preschools, parental education and advice, and family support services. State and territory governments also provide rehabilitative, supervisory and care services to juvenile justice clients who have committed or allegedly committed offences. Some of these clients may also be involved with child protection services and/or Supported Accommodation Assistance Program (SAAP) services.

Both the Commonwealth Government and the state and territory governments are increasingly focusing on early intervention and prevention services. These services are seen to be effective in preventing serious family problems occurring, and reducing the need for more intrusive child protection interventions.

The Commonwealth Government has recently focused its attention on the early years of life (including the antenatal period) and has set up a taskforce to develop a National Agenda for Early Childhood. The Commonwealth is also working with the states and territories on a number of strategies to improve the situation of the most disadvantaged children in the community, for instance, Indigenous children in the child protection system (see Box 6.1).

The sections that follow report on those family and children's services for which national data are available: child care and preschool services, child protection and out-of-home care services, and adoptions. It is not possible, however, to provide a national picture on the full range of family and children's services. In particular, it is very difficult to compile national data on many of the services provided by state and

Box 6.1: Government initiatives on child development, health and wellbeing

The Commonwealth Government has funded a longitudinal survey of Australian children, 'Growing up in Australia', that will go into the field in the first half of 2004. The survey will examine the long-term outcomes for children's development and wellbeing. It will follow two cohorts of children – 2,000 children 12 months and younger and 2,000 children aged 4 years.

As a response to research findings on the importance of the early years of childhood for outcomes in later life, in September 2001 the Commonwealth Government established a Task Force on Child Development, Health and Wellbeing. The aim of the taskforce is to develop a 'whole of government' approach to the early years of life. Thus all Commonwealth departments relevant to children's issues are represented on the taskforce, including Family and Community Services (Chair), Education, Science and Training, and Health and Ageing.

On 22 September 2002, the Minister for Children and Youth Affairs, the Hon. Larry Anthony, announced the development of a National Agenda for Early Childhood, which would focus on early child and maternal health, early learning and care, and supporting child-friendly communities. The agenda is not intended to change the traditional Commonwealth, state and territory responsibilities for children's issues, but will examine ways for jurisdictions to work more collaboratively. The Commonwealth Task Force is in charge of managing the development of the National Agenda.

A consultation paper, 'Towards the Development of a National Agenda for Early Childhood', was released on 20 February 2003 by the Minister for Children and Youth Affairs, the Hon. Larry Anthony, and Professor Fiona Stanley, 2003 Australian of the Year. Consultations with key stakeholders were held between March and June 2003. Focus groups with parents were held in late July and August 2003.

Together with the states and territories, the Commonwealth is developing a National Action Plan for Foster Children and Carers. The aim of this Action Plan is to address the issue of better supporting foster carers and children in foster care. At its last meeting, the Council of Australian Governments (COAG) acknowledged that child abuse remains a major problem in the Australian community.

The Commonwealth and state and territory governments are working together under the COAG Aboriginal Reconciliation Framework on Indigenous child protection issues, including examining the most appropriate ways to respond to Indigenous families at risk and in crisis, improving outcomes for Indigenous children and addressing causal factors.

Sources: AIHW 2001b; Anthony 2002a; Commonwealth Task Force on Child Development, Health and Wellbeing 2003.

territory governments, as the type and nature of such services and data collected about them vary markedly across jurisdictions (AIHW 2001a).

The chapter begins in Section 6.2 with some background information on the social and economic changes to families that have occurred over the last decade. Section 6.3 provides data on Commonwealth family payments, as well as on Commonwealth expenditure on these payments. Section 6.4 examines the use of formal and informal child care and preschool services, the provision of and trends in formal child care services, and the outcomes of these services. Sections 6.5 on child protection and out-of-home care services and 6.6 on adoptions present information on the trends in these areas in the last 5 years. Section 6.7 discusses data developments in the children's services, child protection and juvenile justice areas. The chapter is summarised in Section 6.8.

6.2 Families and children in Australia

There have been major social and economic changes in Australia in the last 30 years that have led to significant alterations in the structure of families with dependent children. Some of the more important family changes include:

- declining fertility rates and an increasing preference for smaller families;
- increasing numbers of de facto relationships;
- increasing divorce rates;
- increasing numbers of one-parent families;
- increasing labour force participation rates of women of child-rearing age; and
- increasing joblessness in families (Gregory 1999; McDonald 2000).

Many of these changes began in the late 1960s, with the pace of change increasing during the 1970s and 1980s. This section focuses on social and economic changes in families over the last decade, as well as on the current state of families in Australia. It is necessary to recognise these alterations in family structures and patterns, as they have important implications for the types of services needed to support families and also because they provide a useful context in which the data on trends in children's and family services can be interpreted.

Family formation and dissolution

Patterns of family formation continued to change during the 1990s and into the 21st century. In particular, there were decreases in marriage rates at younger ages, an increase in cohabitation before marriage, decreases in fertility rates, further delays in family formation, and increases in the proportion of children born outside marriage.

Between 1991 and 2000, age-specific first marriage rates for people aged less than 30 years decreased. The rate for 25–29 year olds fell from 94 per 1,000 to 71 per 1,000 unmarried males and from 110 per 1,000 to 90 per 1,000 for unmarried females. For the older age groups, the rates decreased slightly, or increased. The first marriage rate for 30–34 year olds fell from 73 per 1,000 to 71 per 1,000 for males and rose from 69 per 1,000 to 75 per 1,000 for females. During this same decade, the median age of both men and women at first marriage increased by approximately 2 years (Table 6.1). Cohabitation before marriage has become more common over this period, with the proportion of couples living together before marriage increasing from 58% to 72% between 1991 and 2001 (ABS 2002a).

Table 6.1: Indicators of family formation and dissolution, 1991 and 2000

	Males		Females	
	1991	2000	1991	2000
Age-specific first marriage rates(a)				
19 and under(b)	1.9	1.0	9.5	4.9
20–24	46.6	25.4	82.4	46.6
25–29	94.0	70.7	109.6	90.2
30–34	73.0	71.0	69.4	74.6
35–39	42.5	42.8	36.6	38.6
40–44	21.7	23.6	16.8	20.1
45–49	12.6	12.9	11.0	11.3
50 and over	3.8	4.4	2.1	2.8
Median age at first marriage	26.7	28.5	24.5	26.7
Divorce rate(c)	11.6	12.0	11.5	12.0

(a) Per 1,000 never married male or female population of the appropriate ages, at 30 June for each year shown.

(b) Per 1,000 never married male or female population aged 15–19 years, at 30 June for each year shown.

(c) Per 1,000 married males or females respectively, at 30 June for each year shown.

Source: ABS 2002a.

Divorce rates began to increase in the late 1960s, accelerated during the 1970s and stabilised during the 1980s (McDonald 1995). Through the 1990s and into the new century, family dissolution remained fairly stable. From 1991 to 2000, the divorce rate rose slightly for men from 11.6 per 1,000 to 12.0 per 1,000 and for women from 11.5 per 1,000 to 12.0 per 1,000. While there was an overall increase, the divorce rate did fluctuate somewhat during this period. There was also an increase between 1991 and 2001 in the number of children aged 0–17 years affected by divorce: from 10.2 per 1,000 to 11.1 per 1,000 (ABS 2002a, 2003a). Similarly to the divorce rate, the number of children affected by divorce also fluctuated within this period.

In recent years, falling fertility rates have been observed around the world. In Australia, the total fertility rate decreased from 1.86 in 1991 to 1.73 in 2001 (Table 6.2). In countries that are similar to Australia in social, cultural and economic terms, fertility rates have also continued to fall. For example, in 2001 the fertility rate fell to 1.63 in the United Kingdom, while it dropped to 1.52 in Canada in 1999. The fertility rate in New Zealand in 2001 was 1.97, and while this rate is higher than in many advanced countries, it too is falling (McDonald 2003).

Between 1991 and 2001, the median age of mothers at birth increased by 1.5 years, from 28.5 to 30.0 years. In addition to the decline in the total fertility rate and the increase in the age at which mothers are giving birth, the number of births to unmarried women has also been increasing.

Table 6.2: Birth indicators, 1991, 2000 and 2001

	1991	2000	2001
Median age of mother at confinement	28.5	29.8	30.0
Total fertility rate (no. children per woman)	1.86	1.75	1.73
Per cent of children born outside marriage	23.0	29.2	30.7
Per cent of births where paternity acknowledged	95.3	96.5	96.3

Source: ABS 2001a.

The proportion of children born outside marriage increased from 23% of births in 1991 to 31% in 2001. Children born outside marriage include those born in de facto relationships, as well as those born to single mothers. While there was a rise in the proportion of children born outside marriage, there was also a small rise in the proportion of births where paternity was acknowledged: from 95% to 96%.

These changes in family formation and dissolution are reflected in the changes in the characteristics of families with dependent children.

Characteristics of families

One of the most significant changes in families between 1992 and 2002 was the large increase in the number of one-parent families. The estimated number of one-parent families with dependent children aged 0–14 years increased by 51% over the decade to reach 508,300 in 2002. Over the same period, the number of couple families with dependent children aged 0–14 remained steady at 1,710,400 in 1992 and 1,705,100 in 2002. In June 2002, there were 2,213,400 families with children aged 0–14 years, with 77% of these being couple families and 23% one-parent families (ABS 2002b).

The trends in divorce and remarriage rates in recent decades have partly contributed to the alterations in the structure and nature of families, including to the number of step and blended families. In 2001, data from the Australian Bureau of Statistics (ABS) Census of Population and Housing showed that of all couple families with children (regardless of age), 6% were step-families, while an additional 4% were blended families (ABS 2003a).

Children

The number of children in Australia aged 0–17 years increased by 215,368 (5%) between June 1992 and June 2002 (Table 6.3). While the number of children in the 5–12 and 13–17 year age ranges increased, the number of children aged 0–4 years slightly decreased. This fall reflects the declining fertility rate.

Table 6.3: Estimated number of children aged 0–17 years and as a proportion of the total population, selected years from 30 June 1992 to 30 June 2002

Age (years)	1992	1994	1996	1998	2000	2002
			Number ('000)			
0–4	1,284.7	1,298.0	1,297.0	1,289.5	1,279.0	1,270.4
5–12	2,034.9	2,057.1	2,090.4	2,118.4	2,153.4	2,171.5
13–17	1,266.2	1,257.7	1,289.4	1,309.3	1,334.6	1,359.2
Total children 0–17	*4,585.7*	*4,612.9*	*4,676.8*	*4,717.3*	*4,767.0*	*4,801.1*
Total population	**17,494.7**	**17,854.7**	**18,310.7**	**18,711.3**	**19,153.4**	**19,662.8**
			As a percentage of total population			
0–4	7	7	7	7	7	6
5–12	12	12	11	11	11	11
13–17	7	7	7	7	7	7
Total children 0–17	*26*	*26*	*26*	*25*	*25*	*24*

Source: ABS 2003c.

While the overall number of children increased over the decade, they represent a falling proportion of the total Australian population. At 30 June 1992 this group constituted 26% of the population, compared with 24% at 30 June 2002. Across all states and territories, their proportion was around 23–25%, except in the Northern Territory where it was markedly higher at 30% (see Table A6.1).

Families and employment

The 1990s was a period of relatively strong economic growth, with the number of employed people increasing from 7.7 million in 1992 to over 9 million at June 2002 (ABS 2002c). There was a corresponding fall in the unemployment rate: from 10.7% in June 1992 to 6.3% in June 2002.

The labour force participation rates of women of child-rearing age continued to rise in the decade up to June 2002, though the increase was not as great as in previous decades. The rates for women aged 25–34 years, for example, increased from 53% in 1982, to 66% in June 1992, and again to 71% in June 2002.

The growth in employment between 1992 and 2002 benefited families with dependent children. The number of couple families with dependent children aged 0–14 years and both partners employed increased by 89,900, and the number of employed sole parents with children aged 0–14 by 97,500 (Table 6.4).

While the number of families with both parents in employment grew between 1992 and 2002, there was also an increase in the number of one-parent families with no parent employed—73,600 over the period. In contrast, there was a decrease of 44,800 in the number of couple families in which neither partner was employed.

In 2002, among families with children aged 0–14 years, 57% of couple families had both parents in employment and 46% of sole parents were in employment. In contrast, 7% of couple families and 54% of sole-parent families had no parent employed.

Table 6.4: Employment patterns of families with dependent children aged 0–14 years, 1992 and 2002

	1992		2002	
Employment patterns and family type	**Number (’000)**	**Per cent**	**Number (’000)**	**Per cent**
Couple families				
Both partners employed	884.0	51.7	973.8	57.1
One partner only employed				
Husband employed	607.2	35.5	550.5	32.3
Wife employed	51.1	3.0	57.6	3.4
Neither partner employed	168.1	9.8	123.1	7.2
Total	**1,710.4**	**100.0**	**1,704.9**	**100.0**
One-parent families				
Parent employed	137.0	40.6	234.7	46.2
Parent not employed	200.2	59.4	273.8	53.8
Total	**337.2**	**100.0**	**508.5**	**100.0**

Source: ABS 2002b.

Aboriginal and Torres Strait Islander families

The profile of Aboriginal and Torres Strait Islander families differs from that of other Australian families in a number of ways. Indigenous families are more likely to be one-parent families and to have on average a larger number of children and larger households. For example, the median Indigenous household (which is more likely than other Australian households to contain more than one family) had 3.4 persons, compared to 2.6 persons in other Australian households. Indigenous parents also tend to be younger and to have lower levels of education than other Australian parents. Indigenous families are much more likely to be economically disadvantaged, with lower employment rates of parents and lower median incomes. In 2001, the median weekly income for Indigenous households was 81% of that of other Australian households (Daly & Smith 1996, 2003).

6.3 Assistance for families

The Commonwealth Government provides support for families in the forms of family assistance payments and income support payments (see Box 6.2). Family assistance is designed to help middle- and low-income families with the costs of raising children, including recognising the indirect costs of reduced workforce participation by some families with young children. Higher assistance is targeted to families with low incomes. Income support in the form of Parenting Payment is available for sole parents with no income or a low income and for parents whose partner has no income or is on a low income.

Family assistance underwent a fundamental restructure in the tax reform package that came into effect on 1 July 2000. Two new payments were introduced—Family Tax Benefit (FTB) Parts A and B—which combined 10 forms of assistance that were previously available in the tax and transfer systems (AIHW 2001b:146). Families can choose to receive the FTB throughout the financial year as direct fortnightly payments or can wait until the end of the financial year and claim through their tax assessment. The system of family assistance is administered by the Family Assistance Office, which is located in Centrelink, Australian Taxation Office and Medicare branches.

Another new feature of the FTB payment is income-reconciliation at the end of the financial year (Whiteford et al. 2001:32). Since payments are income-tested, families choosing to claim the FTB as a direct payment are required to estimate their income for the forthcoming financial year. At the end of that year, their income is assessed to ascertain whether their estimation corresponds with their actual income, and if not, whether they have been ‘overpaid’ or are entitled to an additional payment. If their actual income is greater than their estimated income, they are required to pay back the amount of overpayment. If it is lower, they receive an extra payment. This system was introduced so that families receiving assistance through the payments system received the same entitlement as if they had chosen to claim assistance through the tax system. The same system applies to Child Care Benefit (CCB) payments.

In recognition of the difficulties that many families faced with overpayments in the first year of the scheme’s operation, in July 2001 the government announced that the first $1,000 of overpayments of the FTB and/or CCB for each family for the financial year

Box 6.2: Commonwealth family payments and tax relief

- ***Family Tax Benefit Part A****—paid to low- and middle- income families with dependent children under 21 and/or dependent full-time students aged 21 to 24. It is paid for each dependent child in the family. The payment is subject to an income and assets test. There are three rates of Family Tax Benefit Part A: maximum rate, payable below a low-income threshold; part (or broken) rate, payable for families with incomes between the low-income threshold and the base rate threshold; and the base rate, which is payable for families with incomes above the base rate threshold and below the means-tested threshold. Maximum and part rates vary with the age of the child, with payments increasing for teenagers and young people.*

- ***Family Tax Benefit Part B****—provides additional assistance to single-income families, including single parents, with a child under 16 or a child aged 16–18 years studying full-time. Higher rates are payable where families have a child under 5. The payment is not means-tested for single parents. For couple families, the payment is means-tested on the income of the partner with the lower income (secondary income).*

- ***Parenting Payment****—income support payment for one parent with responsibility for caring for a child under 16 years of age. The two main streams are the Parenting Payment (single) paid to single parents with no income or a low income and the Parenting Payment (partnered) paid to the primary carer in a couple family where both parents have no income or a low income. For couple families, the Parenting Payment is income-tested on family income.*

- ***Maternity Allowance****—an income-tested lump sum payment for each newborn or adopted child in the family.*

- ***Maternity Immunisation Allowance****—payable at age 18 months for fully immunised children (appropriate for the age).*

- ***Double Orphan Pension****—for children whose parents are both dead, or one parent is dead and the other cannot care for the child, and for refugee children under certain circumstances.*

- ***Baby Bonus****—a tax offset which repays mothers for the tax that they paid on their income (up to a limit) in the year before the birth of their first child or (if they already have a child) the first child born to them after 1 July 2001. The refundable tax offset is paid each year until the child is 5 years. Mothers who had no earnings or were low-income earners in the year before the child's birth are entitled to a minimum payment each year. The Baby Bonus is means-tested on the mother's taxable income after the birth of the child.*

Sources: ATO 2003; FaCS 2002a; FAO 2003.

2000–01 would be waived (Vanstone 2001). Families, however, continued to experience problems with overpayments. By September 2002, 1,885 complaints had been made to the Commonwealth Ombudsman about various aspects of the new family assistance system (including 157 complaints relating to the CCB). A subsequent investigation by the Ombudsman of the family assistance scheme highlighted the Ombudsman's concerns with the effects on families of various aspects of the scheme, including the large number and size of debts and the impact on low-income families. While the Minister for Family and Community Services announced some changes to the administration of FTB and CCB payments in September 2002, the Ombudsman's report released in February 2003 recommended some broader policy changes to the system (Commonwealth Ombudsman—Australia 2003).

A new payment—the Baby Bonus—providing tax relief to families with children was announced in the 2002–03 Budget and applies to the first child in the family or the first child born on or after 1 July 2001 (Commonwealth of Australia 2002:10). There were also changes to the assistance provided for child care at the time the tax reform package was introduced, with the CCB replacing Childcare Assistance and the Childcare Rebate (see Box 6.5). The CCB is also administered through the Family Assistance Office.

Trends in family assistance

The vast majority of FTB recipients (more than 90%) receive assistance through fortnightly payments from Centrelink: 1.9 million families in 2000–01. Around 40,000 received Centrelink lump sum payments and another 97,000 were paid lump sums through the tax system as a tax offset (FaCS 2002b: 26).[1] It is estimated that for 2003–04, 95% of families will choose fortnightly payments through Centrelink and another 2% will opt for a lump sum through Centrelink (Commonwealth of Australia 2003).

Detailed data are not available on recipients who chose to receive family assistance payments through the tax system. However, it is likely that these would be higher income families who are entitled to the lower rates of assistance. No data are yet available on Baby Bonus recipients.

Almost 1.8 million families with nearly 3.5 million children received FTB Part A as a fortnightly payment at June 2001 and June 2002 (Table 6.5). In both years, more than half of these families were paid more than the base rate—59% at 30 June 2002. Around 1.2 million families with almost 2.3 million children received FTB Part B. Almost half of those receiving the payment were sole parents—48% at June 2002. Around 210,000 families were paid the Maternity Allowance in both 2001 and 2002 and just over 200,000 families received the Maternity Immunisation Allowance in each of these years.

In both years, the number of parents receiving Parenting Payment (single) was just over twice the number receiving Parenting Payment (partnered)—over 400,000 compared with around 200,000.

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[1] Note that families may appear in more than one of these categories, since they may use more than one payment system during the year.

Table 6.5: Number of recipients of family assistance and income support payments for families, 30 June 2001 and 30 June 2002 ('000)

	Recipients		Children	
Type of payment[(a)]	**2001**	**2002**	**2001**	**2002**
Family Tax Benefit Part A				
Maximum rate (with income support payment)	509.8	485.9	962.2	914.8
Maximum rate (without income support payment)	127.2	134.4	243.8	253.7
Broken rate	406.1	431.6	874.7	927.7
Base rate	725.4	708.7	1,333.0	1,298.5
Below base rate	31.2	34.2	68.5	76.5
Total	*1,799.7*	*1,794.8*	*3,482.2*	*3,471.2*
Family Tax Benefit Part B				
Maximum rate (for sole parents)	559.4	570.7	951.2	965.2
Maximum rate (for couples)	290.0	300.4	622.7	638.8
Broken rate (for couples)	331.7	328.0	702.3	689.3
Total	*1,181.1*	*1,199.1*	*2,276.2*	*2,293.3*
Maternity Allowance	210.1	212.2	214.4	216.1
Maternity Immunisation Allowance	203.9	206.8	207.5	210.6
Double Orphan Pension	1.2	1.2	1.6	n.a.
Parenting Payment (single)	416.7	427.8	. .	. .
Parenting Payment (partnered)	205.4	191.6	. .	. .

(a) The data on FTB recipients relate to those who claim fortnightly payments.

Note: For Maternity Allowance and Maternity Immunisation Allowance, the number of customers assisted is the number who received a payment during the financial year. For Parenting Payment recipients, the number of customers assisted is the number who received a payment in June (not at 30 June).

Sources: FaCS 2001, 2002b.

Commonwealth expenditure on assistance for families

Commonwealth expenditure on the main types of family assistance and income support payments for 2000–01 and 2001–02 is shown in Table 6.6. The FTB is clearly the largest expenditure item in both years, accounting for $10.9 billion (or 65%) of total expenditure in 2001–02, with Parenting Payment (single and partnered) accounting for another $5.6 billion (33%).

Table 6.6: Commonwealth expenditure on family assistance and income support payments, 2000–01 and 2001–02 ($m)

Type of expenditure[(a)]	**2000–01**	**2001–02**
Family Tax Benefit Parts A & B	10,076.5	10,927.7
Maternity Allowance and Maternity Immunisation Allowance	217.9	216.9
Double Orphan Pension	2.0	2.0
Parenting Payment (single & partnered)	5,325.7	5,571.7

(a) FTB expenditure data relate to expenditure through Centrelink only. In 2000–01, revenue forgone through FTB claims through the tax system was $11m. From 2001–02 onwards, these claims are recorded in the budget documentation as an expenditure.

Sources: FaCS 2001, 2002b; Treasury 2002.

6.4 Child care and preschool services

Formal child care services provide care and developmental activities for children usually between the ages of 0 and 12 years. Informal child care is provided by relatives and friends and other individuals such as paid babysitters and nannies. Child care enables parents to participate in employment, education and training, community activities and personal activities—it may also be used for family support reasons. As a condition of government funding and regulation, child care services must promote and enhance children's emotional, intellectual, social and physical development. Preschool services offer educational and developmental programs for children in the year or two before full-time school. Most child care services are supported by the Commonwealth Government, while preschool services are mainly funded by the states and territories (see below.)

This section discusses child care and preschool data sources; the need for child care and preschool services; the use of child care; and the provision and delivery of government-supported child care services. The section concludes by examining service outcomes in terms of accessibility (including affordability) and quality.

Data sources

There are a number of different data collections relating to child care and preschool services (Box 6.3). The information used in this chapter, however, is mainly drawn from the ABS Child Care Survey and the Commonwealth Child Care Census and Centrelink administrative data. While the ABS survey and the Commonwealth census are used to present a picture of the overall patterns of use, the data are not directly comparable. The ABS survey collects information from parents on the use of 'child care' by children aged 0–11 years, with 'child care' including all formal child care services and preschools, as well as informal care. The census collects information from Commonwealth-supported child care service providers, with children using these formal services generally being 0–12 years.

Box 6.3: Child care and preschool services data collections

The ***Australian Bureau of Statistics (ABS) Child Care Survey*** *is conducted every 3 years and is a supplement to the ABS Labour Force Survey. The latest survey was conducted in 2002. This is an Australia-wide sample survey on the use of and demand for child care and preschool services.*

The ***Commonwealth Child Care Census (CCC)*** *is a census of Commonwealth-supported child care service providers, conducted by the Department of Family and Community Services (FaCS). The census collects information from Commonwealth Child Care Support service providers on their staff, the children and parents using the service and various other aspects of service provision. The latest census of all Commonwealth-supported services was carried out in May 2002.*

State and territory government *data collections contain information about the child care and preschool services that these governments fund and/or license. There are, however, great variations in the nature and extent of these collections.*

Data on child care and preschool services funded solely by states and territories are not used in this chapter. It is difficult to combine data from the various jurisdictions to present a national picture of child care services, because of factors such as differences in the scope and coverage of the collections and in the classifications and definitions used.

While data on child care and preschool services are currently collected and reported by 'funded/licensed' services type (Box 6.4), it is important to note that this no longer captures the reality of service provision. In the past decade, services have changed considerably, both in the way that they are provided and the way that parents and children use them. Service providers have moved into a more flexible type of service provision in order to meet parents' and children's needs and market demands. 'Funded service type' thus no longer fully describes what services are provided to children. Many 'long day care centres', for instance, provide long day care, a preschool program (or access to a program), part-time care and outside school hours care (AIHW 2002a:xiii).

Currently Commonwealth, state and territory data collections use different data collection forms for the various funded/licensed types of children's services, for instance, different forms for 'long day care centres', 'outside school hours care services' and 'preschools'. A pilot test, conducted in 2002, for a proposed Children's Services National Minimum Data Set was successful in using the one collection form to obtain data from all service providers using the same mode of service delivery—centre-based, home-based or mobile—but providing different types of funded services. This is discussed in more detail in Section 6.7.

The need for child care and preschool services

All parents of children 12 years of age and younger could potentially need someone other than themselves to care for their children. In 2002, there were nearly 3.5 million children aged 12 years and under in Australia, representing the potential population needing some form of child care (see Table 6.3). Of these children, around 257,000 were 4 years of age and potentially needing preschool services (ABS 2003b).[2]

One of the main reasons parents need child care is to participate in the workforce. At June 2002, there were around 805,000 couple families and 173,000 one-parent families with at least one child under 5 years (see Table A6.2). In half of the couple families, both parents were in the labour force as were 41% of sole parents. When the youngest child was 5 years or older, a higher proportion of families had both parents (or the sole parent) in the labour force. Where the youngest child was 5–9 years, for instance, both parents in 68% of couple families and 58% of sole parents were in the labour force.

These findings reflect the increasing labour force participation of all mothers. For example, at August 2001, 35% of mothers with a child under 1 year were in the labour force, compared with 53% of mothers whose youngest child was aged 2 and 66% whose

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[2] The age at which children are eligible to attend preschool services, however, varies somewhat between jurisdictions (Press & Hayes 2000:64).

youngest child was 6 years of age (Figure 6.1). By the time their youngest child was 2 years old, almost half (49%) of all mothers were in paid employment.

Box 6.4: Formal child care services—funding/licensing types and definitions

Long day care centres *are facilities (purpose-built or modified to provide child care) in which staff provide care and developmental activities primarily for children under school age. These centres are generally open for at least 8 hours per day, 5 days per week, 48 weeks of the year.*

Preschool services *offer educational and developmental programs for children in the year or two before they begin full-time school. Dedicated preschools offer sessional programs during school terms only. Sessional programs generally involve a distinct group of children meeting for around two to four sessions per week, each session lasting half the normal school day or the full school day. Many long day care centres provide a preschool program run by a qualified early childhood teacher.*

Family day care schemes *comprise networks of individuals who provide care and developmental activities in their own homes for children 0–12 years. Family day care providers are recruited and supported by a central coordination unit, which administers the scheme.*

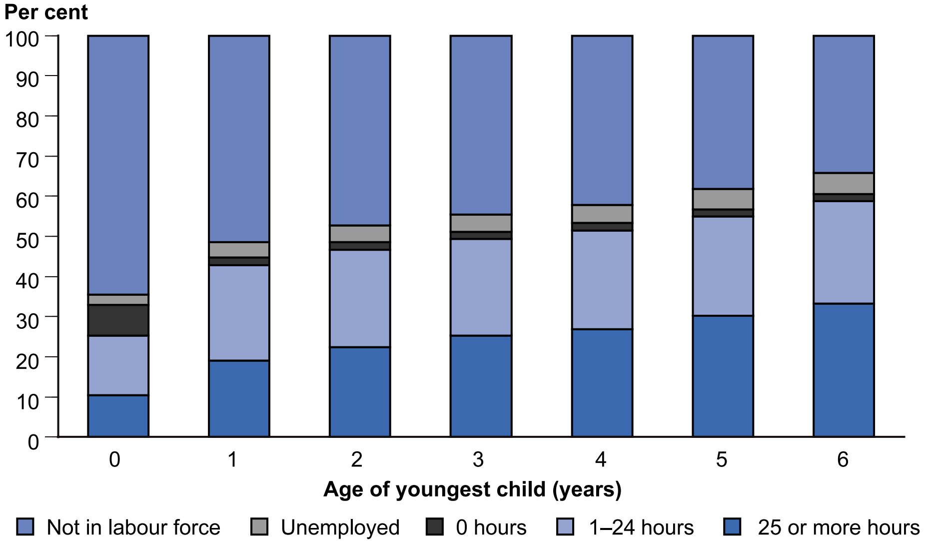
In-home care *is child care provided in the child's home by an approved carer. It can be provided by a family day care scheme, a long day care centre or a private nanny service. This service assists families who cannot access other child care services and who need more flexible forms of child care. This includes families living in rural areas, parents who work non-standard hours or shifts and parents with a sick child or a child with a disability.*

Outside school hours care services *offer care and developmental activities for primary school-aged children out of school hours. The main types of services provided are before school care, after school care, vacation care and care on 'pupil-free' days.*

Occasional care services *were originally set up to provide child care for children under school age, to assist parents who need care for short periods of time, for reasons such as attending adult education classes, medical appointments, going shopping, or simply for respite. Nowadays, many occasional care services provide regular part-time care, for working parents.*

Other formal services *include multifunctional services, multifunctional Aboriginal children's services (MACS) and mobiles. Multifunctional services are located in rural areas and provide a number of different child care services for children 0–12 years from the one building. MACS are culturally specific services for Aboriginal and Torres Strait Islander children. Mobiles provide services such as preschool services, playgroups, older children's activities, toy and book library services, and parental support and advice for families living in rural and remote areas.*

Source: AIHW 2000a.



Note: Mothers working '0' hours were in paid employment, but did not work during the census week (e.g. on maternity leave).

Source: Table A6.3.

Figure 6.1: Labour force status and hours worked by employed mothers, August 2001

It is important to note that the potential need for child care is not the same as the expressed need for child care. Potential need is a broader concept and can include those who have not yet expressed a need for child care, but who may do so in the near future and/or start to use child care. Not all parents in the workforce will express a need for child care. For instance, in couple families where parents are in paid employment, one parent may work at home, or they may work different hours.

While parents' participation in employment creates much of the need for child care in Australia, there are other reasons. Parents may need child care to participate in employment and training, for personal reasons, as a form of family support and/or because they think it is beneficial for the child. Child care services are important in satisfying children's needs for companionship and play opportunities and for their general development.

The use of child care

The ABS estimated that, in June 2002, just under half (49%) of the 3.1 million children aged 0–11 years in Australia (1.5 million) were in child care in the reference week (Table 6.7). The ABS definition of 'in care' includes children using formal child care and preschool services as well as those being cared for in informal arrangements by 'family members, friends, neighbours, paid babysitters and nannies' (ABS 2003c:2).

Table 6.7: The use of informal and formal care, by age of child, 2002 (per cent)

	Age of child (years)								
Type of care	**Under 1**	**1**	**2**	**3**	**4**	**5**	**6–8**	**9–11**	**Total**
Formal only	4.2	15.7	25.5	37.5	54.1	17.3	8.3	4.7	15.8
Both	2.8	11.2	15.6	25.2	28.8	10.9	4.7	2.6	9.6
Informal only	26.9	30	24	13.4	5.4	21.5	27.3	25.4	23.3
Total children in care	*33.9*	*57.0*	*65.1*	*76.1*	*88.4*	*49.7*	*40.4*	*32.6*	*48.7*
Children who did not use care	66.1	43.0	34.9	23.9	11.6	50.3	59.6	67.4	51.3
Total children	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total number of children ('000)	242.2	247.4	249.3	252.3	250.9	257.6	793.4	806.8	3,100.0

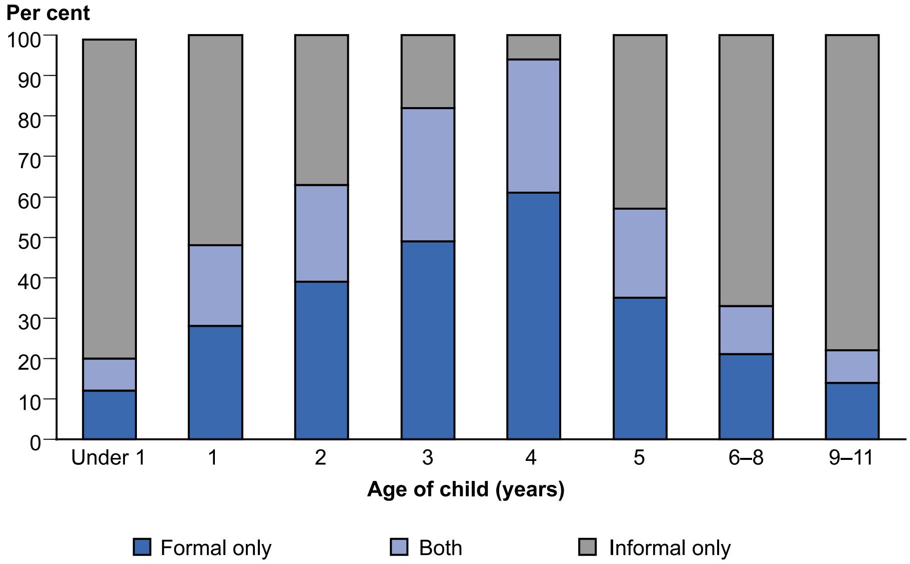
Source: ABS 2003b.

The total number of children using child care was around the same in June 2002 as in June 1993, but the types of care used changed markedly over the period, both for those aged 0–4 years and those aged 5–11 years (see Table A6.4). Between 1993 and 2002, there was a substantial increase in the number of children who used only formal care, a smaller rise in the number who used both formal and informal care and a corresponding fall in the number using only informal care. The number of children using only formal care increased by 39% for children 0–4 years and by 60% for those aged 5–11 years. In contrast, the number of children aged 0–4 years who used only informal care fell by 28%, compared with 16% for those aged 5–11 years.

The distributions of children in care across the various types of care were thus very different in 2002 from 1993. In June 1993, 11% of all children 0–11 years were using only formal care, 29% only informal care and 8% both types of care. In contrast, by June 2002, 16% of children were using only formal care, 23% only informal care and 10% both types of care. The increase in the use of formal care is clearly related to improvements in accessibility of care (including affordability), which are discussed in later sections.

The proportion of all children using care varied with the age of the child, being higher for each year of age up to age 4. In 2002, 34% of children aged less than 1 year were using care, compared with 88% of children aged 4 years. The proportion was markedly lower at age 5 (50%) and lower again at ages 9–11 years (33%). Most children aged 5 years and older are at school and thus less likely to need care.

The types of child care used also varied with the age of the child. Informal care was the most common both for very young children and for those aged 6 years and over. In 2002, the proportion of children in child care who were using only informal care was 79% for those aged under 1 year, 6% for those aged 4 and 78% for those aged 9–11 (Figure 6.2).



Source: Table A6.5.

Figure 6.2: The use of informal and formal child care, 2002

The use of formal care varied correspondingly, being higher for each year of age up to age 4. For children aged under 1 year using care, 12% were in formal care only and 8% were using both formal and informal care, while for children aged 4 years the corresponding percentages were 61% and 33%. The high proportion of children using formal care at age 4 reflects the fact that over half (59%) were attending preschool services (ABS 2003b). Among those aged 5 years using care, the proportion who used formal care was significantly lower, with 35% using only formal care and 22% using both formal and informal care. Among children aged 9–11 using care, 14% were using only formal care and 8% both formal and informal care.

Types of formal and informal care

Children in 2002 used various types of care (Table 6.8). It should be noted that where a child was in more than one type of care during the survey period, they were counted for each type.

Among children aged 0–4 years in care, the most common type was care by a grandparent (39%), then care in a long day care centre (35%), followed by preschool (24%). Care by a grandparent was also the most common type (39%) for children aged 5–11. Before and after school care was the next most common type (23%), followed by an unrelated informal carer (20%).

Table 6.8: Children aged under 12 years in child care, by type of care, 2002

	0–4 year olds		5–11 year olds	
Type of care	**Number ('000)**	**% of total in care**	**Number ('000)**	**% of total in care**
Formal care				
Before and after school care	*4.3	0.5	166.8	23.4
Long day care centre	282.2	35.3	14.8	2.1
Family day care	76.8	9.6	19.1	2.7
Occasional care	33.8	4.2	*2.4	0.3
Preschool	195.2	24.4	44.0	6.2
Other formal care	8.5	1.1	*3.2	0.4
Total children who used formal care(a)	*552.4*	*69.1*	*235.0*	*33.0*
Informal care				
Grandparent	312.6	39.1	279.1	39.2
Brother/sister	10.4	1.3	60.1	8.4
Other relative	84.5	10.6	123.8	17.4
Other person	85.9	10.8	141.3	19.9
Total children who used informal care(a)	*456.0*	*57.1*	*563.2*	*79.2*
Total children in care	**799.0**	**100.0**	**711.5**	**100.0**

*Estimate has a relative standard error of between 25% and 50% and should be used with caution.

(a) Components do not add to total as children could use more than one type of care.

Source: ABS 2003b.

While grandparents were the most common carers for children in both age groups, children cared for by grandparents and other informal carers were more likely to be in care for shorter periods of time than children in formal care.

Hours in care

The majority of children (84%) in child care were there for less than 30 hours per week (Table 6.9). Only 6% were using care for 45 hours or more per week.

Children using only informal care were much more likely to be in care for fewer hours than those using only formal care or those using both formal and informal care. For example, 36% of children using only informal care were in care for less than 5 hours per week, compared with 17% using only formal care and 3% using both.

Table 6.9: Children aged under 12 years in child care, by the number of hours per week in care, 2002 (per cent)

	Number of hours (per week)						
Type of care	**Less than 5**	**5–9**	**10–19**	**20–29**	**30–44**	**45 or more**	**Total**
Formal only	17.4	25.0	34.7	11.9	8.9	2.0	100.0
Both	3.2	11.5	32.0	21.1	20.5	11.6	100.0
Informal only	36.4	23.6	19.6	7.7	5.7	7.1	100.0
Total in care	**23.7**	**21.7**	**27.0**	**11.7**	**9.6**	**6.3**	**100.0**
Total number of children in care ('000)	358.1	327.3	407.6	176.7	145.4	95.4	1,510.5

Source: ABS 2003b.

Children who used both types of care were most likely to be in care for longer periods: 32% for 30 hours or more per week, compared with 13% using only informal care and 11% only formal care.

Reasons for using child care

The main reason parents gave for using child care differed by the type of care and the age of the child (Table 6.10). For children aged 0–4 years, the most common reason for using formal care was that it was considered beneficial for the child (44%), closely followed by work-related reasons (39%), while informal care was mostly used for work-related reasons (45%), followed by personal reasons (43%).

For around half or more of children aged 5–11 in care, parents reported that the main reason was 'work-related' (70% of children in formal care and 47% in informal care). Parents using formal care were more likely to report that they mainly used it because it was 'beneficial for the child' (18% of children) rather than for 'personal reasons' (9%). Parents using informal care, on the other hand, were more likely to report that they used it for 'personal reasons' (33%) rather than it was 'beneficial for the child' (3%).

It is important to note that the proportion of children whose parents gave 'work-related' as the main reason for using care does not indicate the employment status of parents of children using care. For instance, 'work-related' was given as the main reason for using formal care for 48% of children 0–11 years in formal care, yet both parents (or the sole parent) of 60% of children 0–11 years using formal care were employed.

Table 6.10: Children aged under 12 years in child care, by main reason parents gave for using care, 2002

	Formal care		Informal care	
Main reason	**Number ('000)**	**Per cent**	**Number ('000)**	**Per cent**
		0–4 year olds		
Work-related	214.2	39	204.7	45
Personal	75.9	14	196.5	43
Beneficial for the child	244.2	44	12.0	3
Other	18.1	3	42.8	9
Total	**552.4**	**100**	**456.0**	**100**
		5–11 year olds		
Work-related	164.6	70	267.5	47
Personal	21.1	9	186.7	33
Beneficial for the child	41.6	18	19.0	3
Other	7.7	3	90.1	16
Total	**235**	**100**	**563.2**	**100**

Note: 'Work-related' includes working, looking for work and studying/training for work. 'Personal' includes non-work-related study or training, shopping, social or sporting activities, giving parents a break, doctor's visits and voluntary/community activities. 'Beneficial for the child' includes 'good for the child' and 'prepare the child for school'.

Source: ABS 2003b.

The provision of formal child care services

The Commonwealth Department of Family and Community Services (FaCS) supports the provision of formal child care services through Commonwealth Child Care Support (Box 6.5). A range of strategies promotes the supply, accessibility, flexibility, quality and affordability of child care services (FaCS 2002b:73). Through this program, the Commonwealth assists parents to participate in the workforce and the community, helps families balance work and parenting, supports child care that contributes to children's education and development, and promotes child care as an early intervention and prevention strategy for vulnerable families.

Box 6.5: Commonwealth Child Care Support

There are two categories of funding under this program – Child Care Benefit and the Child Care Support Broadband. The Child Care Support Broadband is currently under review (see Box 6.6).

Child Care Benefit *assists families with their child care costs (see Box 6.7).*

- *Most long day care centres, all family day care schemes, most outside school hours care services, a small number of occasional care services and some multifunctional services are approved to offer the Child Care Benefit (CCB) to eligible children using their services. These services offer the maximum rate of CCB (depending on family income) for up to 50 hours of work-related care and up to 20 hours of non-work-related care a week. Service providers are required to participate in the Commonwealth's quality assurance processes (where this applies).*
- *Service providers not approved for the CCB (such as state/territory-only funded occasional care and preschool services) and individuals providing informal care can register for the CCB. Parents using registered services can claim the minimum CCB if they use care for work-related reasons.*

Child Care Support Broadband funding supports child care services by providing:

- *funding for training and resource activities – funds are given to various contracted and approved agencies that provide training and support activities to interested child care providers;*
- *operational subsidies, including travel grants;*
- *additional funding to support the inclusion of children with special needs into child care services;*
- *set-up grants and grants for purchase of equipment;*
- *direct service provision; and*
- *other program support such as accreditation.*

Source: FaCS 2003a.

Priority of access guidelines are in operation for parents wanting to access Commonwealth-supported child care services (FaCS 2000). These guidelines give first priority to ‘a child at risk of serious abuse or neglect’, followed by ‘a child of a single parent who satisfies, or of parents who both satisfy, the work/training/study test’. ‘Children in Aboriginal or Torres Strait Islander families; children in families which include a person with a disability; children in families on low incomes; children in families with a culturally diverse background; children in socially isolated families; and children of single parents’ are given priority within each category.

In the past 2 years, the Commonwealth has introduced a number of initiatives in relation to child care, including the implementation of new quality assurance systems and the redevelopment of Child Care Support Broadband funding.

All state and territory governments fund dedicated preschool services for children in the year or two before they begin school full-time (Press & Hayes 2000:77). Currently in all jurisdictions except Queensland, the first year of full-time school is the year prior to entry into Year 1. Queensland is currently in its first year of trialling a full-time year prior to Year 1, with a proposal to implement this state-wide in 2006 (Beattie 2002).

States and territories also provide some funding for child care services—mainly occasional care services, vacation care services and, in some jurisdictions, long day care centres. For instance, in Victoria, the state government provides funding for occasional care services and TAFE long day care centres. State and territory governments are also responsible for licensing/regulating child care services within their jurisdiction. The Commonwealth Government and some state and territory Governments have accreditation processes in place for some of their funded services.

As noted previously, nationally comprehensive and comparable data on state and territory funded preschool and child care services are not available, although illustrative data are published in the *Report on Government Services* (SCRCSSP 2003:ch. 14).

Because of the lack of national data, the following sections will focus solely on formal child care services supported by the Commonwealth, using data from the Commonwealth Child Care Census and administrative data collections (see Box 6.3).

Ownership of child care services

Although the Commonwealth has a major role in supporting the provision of child care services, it does not directly provide such services. In June 2001, two-thirds (67%) of long day care centres were owned by private-for-profit bodies, while the vast majority of other types of funded services (96% or more) were owned by community-based bodies (Table 6.11).

Eligibility for Commonwealth fee relief was extended to private-for-profit long day care centres from 1 January 1991, but private-for-profit bodies were not eligible for support to provide other types of funded services until much later. Private-for-profit in-home care (nanny) services became eligible for ‘in-home care’ funding from 1 January 2001, while private-for-profit bodies became eligible for support to provide family day care and outside school hours care services in specified geographic areas from 1 July 2001.

Table 6.11: Commonwealth-supported child care services, by type of ownership, 30 June 2001 (per cent)

Type of ownership	Long day care centres	Family day care[(a)]	Outside school hours care	Occasional/ other care[(b)]
Private-for-profit	66.9	3.2	3.6	0.7
Community-based[(c)]	33.1	96.8	96.4	99.3
Total	**100.0**	**100.0**	**100.0**	**100.0**
Total number of agencies	4,073	408	5,407	162

(a) Family day care coordination units. Also includes family day care schemes offering in-home care, and stand-alone in-home care services.

(b) Includes occasional care centres, multifunctional Aboriginal children's services and other multifunctional services.

(c) Includes services operated by community-based groups, religious organisations, charities, local governments, and by or in state government premises.

Source: FaCS 2001 administrative data.

One new development in the child care area has been the floating of private-for-profit child care businesses as public companies on the stock exchange. The first company was floated in 2001, with others listing on the exchange in the last quarter of 2002. At April 2003, there were four public child care companies, mainly involved in running and/or managing child care centres (Marney 2002; Salmons 2003). At this time, the largest public child care company owned more than 120 long day care centres and was planning to take over one of the other companies.

Trends in Commonwealth-supported child care

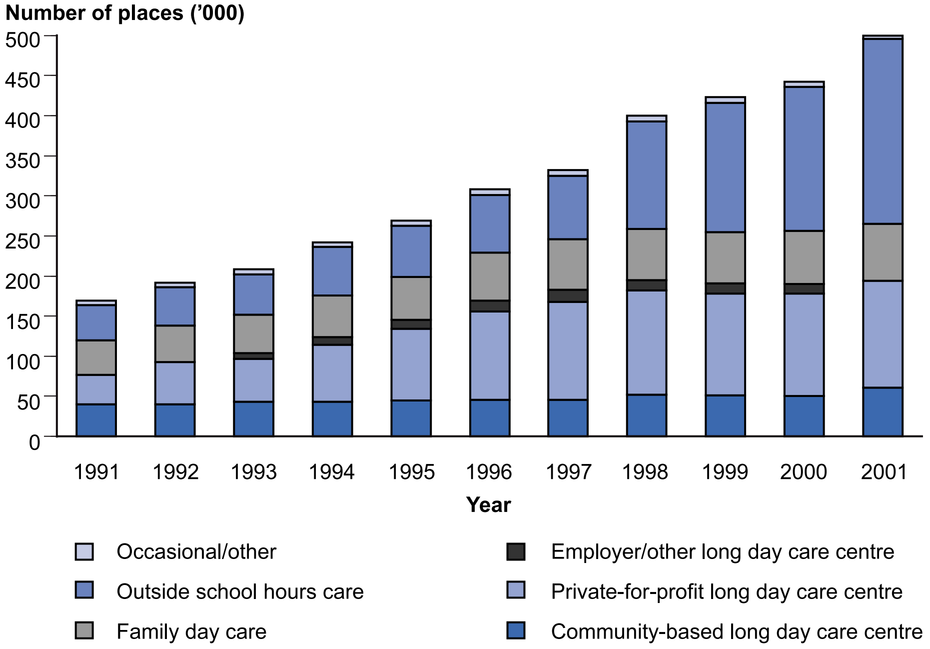
Number of service providers and child care places

Between 1991 and 2001, the total number of services supported by the Commonwealth increased two and a half times (from 3,972 to 10,050 services) (Table A6.6), while the total number of Commonwealth-supported places increased almost threefold (from 168,276 to 500,034) (Figure 6.3).

Long day care centre places increased two and a half times between 1991 and 2001, from 76,267 to 193,809 places (Table A6.7). Between 1991 and 2001, the number of places in community-based centres grew by 55%, while the number in private centres increased almost four times. This led to a huge change in the profile of Commonwealth-supported long day care centre places over the period. In 1991, just over half of all places (52%) were in community-based centres, but by 2001 the proportion had dropped to just under a third (32%).

Places in family day care services grew steadily between 1991 and 2001, increasing by two-thirds (67%), (from 42,501 to 70,840). Since 2001, 'family day care places' include in-home care places, both those in family day care schemes and in 'stand-alone' in-home services, such as private nanny agencies.

There was enormous growth in outside school hours care places between 1991 and 2001, with the number increasing fivefold (from 44,449 to 230,511). It is important to note that the large increase between 1997 and 1998 was mainly due to the inclusion of some Commonwealth-supported places not previously recorded in the database, and to changes in the counting methodology.



Source: Table A6.7.

Figure 6.3: Commonwealth-supported child care operational places, 1991–2001

The Commonwealth has focused on increasing the supply of outside school hours care places in recent years (FaCS 2001). Consequently, these places have grown at a faster rate than other types of places. Between 2000 and 2001, outside school hours care places increased by 28%, compared with a growth of 2% in long day care centre places and 7% in family day care/in home-care places.

For each long day care centre and outside school hours care service provider, the total number of child care places is equivalent to the total number of children who can use the service at any one time during the hours that the service operates.

Number of children

The number of children using child care services is higher than the number of places, since most children are not in care full-time (AIHW 2002a:26). The total number of children using Commonwealth-supported child care services more than doubled between 1991 and 2002, from 262,200 to 623,900 (Table 6.12). In 2002, more than half of these children (59%) were using long day care centres and 24% were using before and after school care services.

Table 6.12: Number of children in Commonwealth supported-child care services, by type of service, 1991–2002

	Long day care	Family day care	Before/after school care	Vacation care	Other formal care[(a)]	Total
1991	135,400	61,000	46,800	. .	19,000	262,200
1992	158,400	66,100	50,700	. .	26,500	301,700
1993	190,600	78,800	53,500	. .	20,900	343,800
1994	227,300	88,700	63,900	n.a.	16,800	396,700
1995	251,000	85,600	n.a.	n.a.	n.a.	n.a.
1996	n.a.	n.a.	96,400	24,300	19,100	n.a.
1997	294,700	85,000	99,500	31,000	n.a.	n.a.
1999	301,500	83,100	107,400	69,300	16,100	508,200
2000	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
2001	n.a.	95,800	n.a.	n.a.	n.a.	n.a.
2002	367,100	95,600	148,000	103,600	13,100	623,900

(a) Includes occasional care centres, multifunctional Aboriginal children's services and other multifunctional services.

Notes

1. These data measure occurrences of care and include some double-counting where children attend more than one service. Totals for 1999 and 2002 exclude children in vacation care, since many of these children would also have been attending before/after school care.
2. Figures for 1991–94 are estimates based on previous years' census data. Figures for 1995–97 are from the CP Census conducted in August of each year and are weighted for non-response. However, not all service types were surveyed in each of these years. Figures for 1999 and 2002 are from the census conducted in May in each of those years and are weighted for non-response.
3. Components may not add to totals due to rounding.

Sources: AIHW 1999a; FaCS unpublished data.

Characteristics of children in Commonwealth-supported child care

The majority of children using Commonwealth-supported services were in 'work-related care', that is, from families with both parents (or a sole parent) in the labour force or studying/training for work. With the exception of occasional care services, the proportion of children in work-related care in 2002 ranged from 83% in multifunctional services to 96% in before/after school care (see Table A6.8). Even in occasional care services, which were originally set up for non-work-related care (see Box 6.4), 49% of children were in care for work-related reasons.

The age distribution of children in the different types of care varied, reflecting the different aims of these services. Long day care services, for instance, are targeted to children below school age. In 2002, the majority of children in long day care and family day care services were aged 0–4 years, while almost all the children in outside school hours care services were aged 5 and older (Table 6.13). There was, however, a strong indication of a more flexible type of service provision, with 27% of children in family day care and 11% of children in privately owned long day care centres being 5 years of age and older and thus using these services for school-aged care.

Table 6.13: Percentage of children in Commonwealth-supported child care services, by age of child and type of service, 2002

	Age of children (years)					
Type of service	**Under 1**	**1–2**	**3–4**	**5**	**6+**	**Total**
Long day care centres	3	34	53	6	3	100
Community-based	4	39	52	3	1	100
Private-for-profit	3	32	53	6	5	100
Family day care	5	36	32	6	21	100
Before/after school care	0	0	1	12	86	100
Vacation care	0	<1	1	10	89	100
Occasional /other care(a)	5	43	43	3	6	100

(a) Includes occasional care centres, multifunctional Aboriginal children's services and other multifunctional services.

Notes

1. Double-counting may occur for children in before/after school care and vacation care services.
2. Data are weighted for service provider non-response.
3. Some individual percentages may add to less or greater than 100 due to rounding.

Source: FaCS 2003b.

The Commonwealth provides specific funding to assist parents and children with special needs to access services (AIHW 1999a:99). Parents and children with special needs include children from one-parent families, children and/or parents with a disability, children of Aboriginal or Torres Strait Islander descent, children from 'culturally diverse backgrounds', and children at risk of abuse or neglect.

Funding is provided through the Child Care Broadband. One of main issues in the redevelopment of the Broadband (see Box 6.6) is to address the Commonwealth Child Care Advisory Council report's recommendation that access to child care services for families with additional needs and their participation in these services should be improved (Community Link Australia 2002). While still awaiting the outcome of the review, the federal government committed additional funding for the Special Needs Subsidy Scheme (SNSS) in the 2003–04 Federal Budget. The SNSS assists children with high support needs to access child care services by providing funding for services to employ additional child care workers, to assist them with special equipment and to train workers to support these children.

In 2002, children from one-parent families constituted the largest group of children with special needs using Commonwealth-supported child care services (22%), followed by children from a culturally diverse background (11%) (Table 6.14). The proportion of children from other groups with special needs was 3% or less. The use of care by children with special needs varied by service type. The relatively high proportion of children in multifunctional services who were Aboriginal and Torres Strait Islander is because this category includes multifunctional Aboriginal children's services (MACS) which are specifically provided to meet the cultural needs of these children.

Box 6.6: Commonwealth child care initiatives 2002 and 2003

- *A revised accreditation system for long day care centres was introduced in January 2002, while a new accreditation system for family day care services commenced in July 2002 and the outside school hours care quality assurance system in July 2003.*
- *From 11 April 2002, funding for the Special Needs Subsidy Scheme (SNSS), which supports the inclusion of children with a disability into child care services, was capped at $20 million.*
- *On 14 September 2002, the Minister for Children and Youth Affairs, the Hon. Larry Anthony, announced a new peak body on child care – the Child Care Reference Group. Its members are drawn from the major child care peak bodies and include the chair of the National Accreditation Council.*
- *On 23 September 2002, the Hon. Larry Anthony announced some future directions for child care services in response to the Commonwealth Child Care Advisory Council's report* Child Care: Beyond 2001 *(CCCAC 2001):*
  - *The Child Care Support Broadband (see Box 6.5) would be assessed and redeveloped, and a department taskforce was appointed to lead this process. The Taskforce would work closely with the Child Care Reference Group and there would be broad consultation on the Broadband redevelopment.*
  - *A 'Think Tank' would be convened to develop strategies to address child care workforce issues and the recommendations set out in the CCCAC report. This would involve state and territory governments, FaCS and other relevant Commonwealth departments, child care sector representatives, and child care worker education and training providers.*
- *In December 2002, a consultant was engaged to manage the Broadband redevelopment consultation process which would start in February 2003 and to prepare a report recommending new Broadband arrangements by the middle of 2003.*
- *On 28 February 2003, it was announced that the Think Tank on child care workforce issues would be convened in Canberra on 8–9 April 2003. Participants discussed issues critical to the future of the child care profession and developed a number of recommendations and strategies to address these issues.*
- *The 2003–04 Federal Budget committed $25.8 million over 4 years for the Special Needs Subsidy Scheme (SNSS). It was estimated that this would assist an additional 1,250 children with high support needs (such as those with a disability) to access child care services.*

Sources: Anthony 2002b, 2002c, 2003a, 2003b, 2003c; Community Link Australia 2002; NCAC 2003.

Table 6.14: Children with special needs as a proportion of all children using Commonwealth-supported child care services, 2002 (per cent)

Type of special need	Long day care centres	Family day care	Occasional care	Multi-functionals, MACS, In-home care	Before/after school care	Vacation care	All services[(a)]
Children from one-parent families	19	26	n.a.	33	28	n.a.	22
Child with disability	2	4	2	6	2	3	3
Parent with disability	1	<1	1	3	<1	<1	<1
Child at risk of abuse/neglect	<1	1	1	3	<1	<1	<1
Aboriginal or Torres Strait Islander	2	1	1	32	1	2	2
Culturally diverse background	12	8	10	2	11	8	11
Total number of children in care	367,129	95,630	8,637	4,454	148,044	103,562	623,894

(a) Total excludes children in vacation care, since many of these children would also have been attending before/after school care.

Notes

1. Data on family type were not collected for occasional care services.
2. Some children may be included in more than one special needs category.
3. These data are weighted for agency non-response.

Source: FaCS 2003b.

The proportion of children in Commonwealth-supported child care (22%) who were from one-parent families was higher than the proportion in the population. In 2002, 19% of Australian children aged 0–11 were from one-parent families (ABS 2003c). It is hardly surprising that one-parent families are more likely to use child care services than other families, given that they are likely to have a greater need for child care because there is no co-resident parent available to provide care.

In contrast, the proportion of children in child care who had a disability and the proportion who were Aboriginal or Torres Strait Islander was lower than the proportion of these groups of children in the population.[3] Of children in Commonwealth-supported child care services in 2002, 3% had a disability. In contrast, the latest data for children with a disability show that, in 1998, 4% of children in Australia aged 0–4 years and 9% aged 5–14 had a disability (ABS 1999:14). Similarly, only 2% of children in these child care services were of Aboriginal and Torres Strait Islander descent, whereas

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[3] In making these comparisons, however, it is important to note that the definitions of ‘disability’ and ‘Aboriginal and Torres Strait Islander’ used in the ABS population surveys are not identical to those used in the Commonwealth Child Care Census, and the methods used in collecting these data are different.

Indigenous children were estimated to constitute 4.6% of the Australian population aged 0–12 years in June 2001 (ABS and AIHW 2003). However, the Commonwealth Child Care Census data do not include children attending Commonwealth-supported flexible and innovative services, many of whom are Indigenous.

No population data are available to classify Australian children according to the definition of 'culturally diverse background' used in the Commonwealth Child Care Census—'child with a culturally diverse background, including those with a parent born overseas in a country where the first language is not English'. There are also no population data on parents with a disability or children at risk of abuse or neglect.

Number of workers

In May 2002, there were an estimated 77,086 paid workers in child care services, an increase of 19% from the 64,899 paid workers in 1997. There was also a small number of unpaid workers—3,624 in 2002; this includes students on work experience, volunteers and parent helpers (Table 6.15). The number of family day care providers (all of whom were paid) fell by 9% between 1997 and 2002, while the number of places rose by 13% between 1997 and 2001 (see Table A6.7). This suggests that family day care providers increased their working hours and/or the number of children in their care.

Table 6.15: Estimated numbers of paid and unpaid child care workers, 1997, 1999, 2002

	1997		1999		2002	
Type of service	Paid workers	Unpaid workers	Paid workers	Unpaid workers	Paid workers	Unpaid workers
Long day care centres	40,070	2,911	39,710	3,464	48,012	2,975
Community-based	13,703	841	12,950	1,073	18,021	1,221
Private-for-profit	26,367	2,070	26,760	2,391	29,991	1,754
Family day care coordination unit staff	1,663	53	1,612	32	1,729	37
Family day care providers	14,039	*	12,691	*	12,816	*
Before/after school care[(a)]	7,633	452	8,329	347	11,786	464
Vacation care	3,514	320	8,111	601	12,560	557
Occasional /other care	1,494	221	1,382	196	2,170	135
In-home care coordination unit staff	. .	. .	. .	. .	144	13
In-home care provider	. .	. .	. .	. .	429	*
Total[(b)]	**64,899**	**3,367**	**63,724**	**4,039**	**77,086**	**3,624**

*Family day care providers and in-home care providers are all paid workers.

(a) Includes occasional care centres, multifunctional Aboriginal children's services, multifunctional children's services and also in-home care services in 2002 (weighted).

(b) Totals do not include workers in vacation care, since many of these would have also been working in before/after school care services.

Note: Data are from the FaCS Child Care Census and are weighted.

Sources: FaCS 1997, 1999, 2003b.

Although the number of child care workers in service types other than family day care increased between 1997 and 2002, in recent years there has been an unmet demand for child care workers. The Commonwealth Child Care Advisory Council's report *Child Care: Beyond 2001*, notes that workers in the child care field typically have low wages, poor working conditions, limited career paths and low status in the community (CCCAC 2001). Consequently, there has been a high turnover of staff, resulting in a severe shortage of child care workers. This is confirmed by a number of recent reports on workforce issues in the child care area (Community and Health Works 2002; Finger 2002). One report also found that the number of students undertaking a diploma in child care was decreasing (Community and Health Works 2002). Many of the students who had completed a diploma were undertaking further training in early childhood studies in order to work in dedicated preschools or primary schools, where the pay, conditions and status were higher than in child care. A 'Think Tank' was convened in April 2003 by the Commonwealth Minister for Children and Youth Affairs to address the child care workforce issues (see Box 6.6). As shown in Chapter 4 (see Section 4.5), workers in the child care field in 2002 earned considerably less than many other community services workers, with average full-time earnings of $424 per week for child care workers and $370 per week for family day care workers.

Table 6.16: Commonwealth expenditure on child care services, 1991–92 to 1999–2002 ($m in current and constant prices)

	Childcare Assistance[(a)]	Childcare Rebate	Child Care Benefit	Other services (a) (b)	JET[(c)]	Depart-mental running costs	Total (current prices)	Total (constant 2000–01 prices)	Deflator[(d)]
1991–92	289	. .	. .	145	. .	14	449	525	85.6
1992–93	384	. .	. .	154	. .	16	555	634	87.5
1993–94	497	. .	. .	170	. .	23	691	784	88.1
1994–95	592	87	. .	181	. .	34	894	1,009	88.6
1995–96	657	121	. .	191	10	36	1,014	1,124	90.2
1996–97	711	127	. .	206	7	41	1,092	1,187	92.0
1997–98	640	123	. .	218	5	40	1,026	1,097	93.5
1998–99	677	121	. .	182	10	102	1,091	1,135	96.1
Break in series									
1999–00	749	164	. .	195	11	158	1,278	1,320	96.8
2000–01	0.2	–14.6	1,037	180	7.3	146	1,356	1,356	100.0
2001–02	0.8	0.1	1,316	187	11	131	1,646	1,607	102.4

(a) Including Special Purpose Payments.

(b) Other services for families with children. Includes: Operational subsidy and capital funding.

(c) Jobs, Education and Training Program. Child care for eligible parents undergoing training (AIHW 1999a:99).

(d) The Government Final Consumption Expenditure deflator has been used to adjust expenditure for inflation. The first seven columns of the table are in current prices, the eighth column in constant prices.

Note: From 1999–00, expenditure is reported on an accrual basis. Prior to 1999–00, it is reported on a cash basis.

Sources: ABS 2002d, FaCS 2002b.

Government expenditure on child care

Between 1991–92 and 1998–99, Commonwealth expenditure on child care services more than doubled in real terms (constant prices), increasing from $525 million to $1,135 million (Table 6.16). Expenditure first became reported on an accrual basis, rather than on a cash basis, in 1999–00 resulting in a break in time-series data. In the 2 years from 1999–00 to 2001–02, child care expenditure increased by 22% in real terms, from $1,320 million to $1,607 million.

Over the period 1991–92 to 2001–02, there was a shift from expenditure on service provision to expenditure on measures that reduce the costs of child care for parents. The proportion of Commonwealth expenditure on 'Other services for families with children' (which included capital loans, capital grants and upgrades, and operational subsidies) fell from 32% of total expenditure to 11%, while the proportion of expenditure on fee subsidies (Childcare Assistance and the Childcare Rebate prior to July 2000 and Child Care Benefit subsequently) increased from 64% to 80%.

Outcomes

The aims and objectives of government support for child care services are to provide services that are accessible, affordable and of high quality, and that allow parents to participate in the labour force and undertake other activities. As a condition of government funding and regulation, these services must promote and enhance children's emotional, intellectual, social and physical development.

The long-term effects of child care on children continue to be the subject of considerable research and debate. One of the main aims of the Commonwealth's longitudinal study of Australian children, for instance, is to assess the impact of non-parental care on children's development and wellbeing (see Box 6.1).

The discussion in this section, however, focuses on service outcomes rather than client outcomes. Service outcomes are discussed in terms of accessibility—including affordability—and quality.

Accessibility

Unmet demand is an important indicator of the accessibility of child care services. One direct measure of unmet demand comes from the ABS Child Care Survey, which asks parents whether they had wanted to use either some formal child care or additional formal care, but had not done so (ABS 2003b:30).

Between 1993 and 2002, accessibility of child care services improved dramatically, with the number of children for whom parents required some or more formal care dropping from 489,200 (16% of children 0–11) to 174,500 (6%) (Table 6.17). The fall was most marked in the earlier years, but even in the last 3 years to 2002, the number dropped by 13%. Between 1999 and 2002, however, the substantial fall in the numbers of children needing before/after school care, preschool and other formal care was offset by a small increase in the numbers needing care in family day care services.

Table 6.17: Children under 12 years of age for whom parents required some or more formal care, 1993, 1996, 1999 and 2002 ('000)

Main type of (additional) formal care required	1993	1996	1999	2002
Before/after school care	125.1	84.9	62.6	47.8
Long day care centres	63.8	39.0	45.4	46.3
Family day care	60.2	29.0	24.5	29.1
Occasional care	191.8	82.1	43.7	37.6
Preschool	30.0	20.3	11.2	*5.1
Other formal care	18.3	6.4	13.7	8.6
Total children who required (additional) formal care	489.2	261.7	201.1	174.5

* Estimate has a relative standard error of between 25% and 50% and should be used with caution.

Source: ABS 2003b.

In 2002, the main reasons for parents not using the formal care they wanted were that care was 'booked out or no places' (35% of children), it was too expensive (17%) and no care existed in the local area or parents had no knowledge of its existence (12%) (ABS 2003b:32). The availability of places was clearly more of an issue than the cost of care. In contrast, the main reasons parents gave in 1999 were that the care available was too expensive (33% of children), there were no places available (14%) and no care existed in the local area or parents had no knowledge of its existence (12%) (ABS 2000:32).

In 2002, there were another 93,300 children whose parents said that they did not want to use any formal care (or any additional care) because of problems with the cost. This was, however, a marked drop from the 159,400 children whose parents gave this response in 1999.

The FaCS National Supply Demand model, which estimated the extent to which Commonwealth-supported services met the demand for work-related child care (see AIHW 2001b:168), has been reviewed and a revised planning model was introduced in July 2003 (FaCS 2002b:81).

Anecdotal evidence, however, suggests that while the level of unmet demand has reduced overall, there is still a shortage of child care places in some areas, both for long day care services and outside school hours care (Cox 2003; Petrys 2003). In the last quarter of 2002, the Commonwealth reallocated around 3,000 outside school hours care places from services that had unused capacity to services that had requested additional places (Anthony 2002d; Roxon 2002). It is also important to note that there is no limit on the number of long day care places that can attract Child Care Benefit and there is some evidence of an oversupply of such places in some areas.

Affordability

The costs of child care for families depend on the fees charged, family income, the number of children in care, the hours of care that they use and the government subsidies that they receive. The affordability of child care is a function of the relationship of cost of child care to parental income. The discussion here will

Box 6.7: Commonwealth Child Care Benefit (CCB)

Between 1 July 2002 and 30 June 2003, where children used ***approved*** *care, families with incomes of $30,806 or less receive the maximum rate of CCB of $133 per week for 50 hours of care for one child not at school – or $2.66 per hour. Above this income level, the CCB tapers down to a minimum rate of $22.35 per child for 50 hours of care per week – or $0.44 per hour. Families with one child in care are eligible only for the minimum rate of CCB when their income is $88,344 or more. The rate of CCB for children at school is 85% of that payable for children not at school. Families with more than one child in care are paid a loaded (additional) rate of CCB, as are families with children using long day care centres and family day care services for part-time care.*

Families with children in work-related care using ***registered*** *care (e.g. state/territory-only funded child care or preschool services, or informal care) can claim the minimum rate of CCB.*

Families using ***approved*** *care can choose to have their CCB paid to the child care services (i.e. directly reduce the fees that they pay) or can receive it in the form of a lump sum from the Family Assistance Office (FAO) at the end of the financial year. Families using* ***registered*** *care can claim CCB from the FAO during the year.*

concentrate on the affordability of long day care services (long day care centres and family day care), since the majority of children in Commonwealth-supported care are using those services (see Table 6.12).

At May 2002, average full-time weekly fees for community and private long day care centres were about the same: $188 and $184 per week respectively (Table 6.18). Average fees for family day care services were considerably lower—$163 for 50 hours of care a week. Average weekly fees varied across the states and territories. They tended to be highest in the Australian Capital Territory and New South Wales and lowest in Queensland and the Northern Territory.

As noted earlier, the Commonwealth Government provides fee subsidies to make child care more affordable for families. The CCB was introduced in July 2000, as part of the new tax system to improve the affordability of care (Box 6.7). The payment is higher in dollar terms than the fee subsidies that it replaced (Childcare Assistance and the Childcare Rebate), but is simpler to calculate and administer (AIHW 1999a:116–18). The payment is indexed annually by the Consumer Price Index (CPI). Despite assistance having been increased, most families receiving the maximum CCB still pay some of the costs of child care, since fees are generally higher than the maximum amount of assistance available. At May 2002, a family with one child in care full-time at a long day care centre and receiving the maximum CCB of $129 per week for 50 hours of care, would have had child care costs of $57 per week ($186 less $129) (Table 6.18).

Table 6.18: Average full-time weekly fees for Commonwealth-supported long day care, by type of service, May 2002 ($)

Type of service	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Long day care centres	196	184	172	176	181	186	203	171	186
Community	201	186	167	178	180	185	198	169	188
Private	193	182	173	173	182	189	211	175	184
Family day care	172	156	151	171	176	178	188	155	163

Notes

1. Community = Community-based, state and local government long day care centres. Private = Private-for-profit long day care centres.
2. Data for family day care services are for 50 hours of care per week.

Source: FaCS 2003b.

From 1 July to 30 September 2002, it is estimated that around 534,370 families received the CCB. Of these, about 36% were paid the maximum rate for the number of hours they used and around 14% received the minimum rate, with the remainder receiving part rates (Commonwealth of Australia 2003).

It is important to note that, in 2002, most children in long day care services were not using full-time care—the average hours of attendance for a child in a Commonwealth-supported long day care centre were 19.9 hours per week, and in family day care 18.6 hours per week (SCRCSSP 2003:Table 14A.8). Thus, when examining the affordability of child care, it is more appropriate to look at costs for part-time care.

In 2001, the AIHW examined changes in the affordability of long day care services between 1991 and 2000 (after the introduction of the CCB) (AIHW 2001b). The analysis looked at affordability for five different hypothetical families with one child using 20 hours of paid care a week and with one child using 40 hours of paid care a week. Child care costs (fees charged, less government assistance) as a percentage of disposable income were taken as the indicator of child care affordability. This analysis has now been extended to include May 2002 (Table 6.19).

The affordability of child care services for all types of families improved with the introduction of the CCB (AIHW 2001b:171). Between 2000 and 2002, however, affordability declined for families using all types of long day care services, except for the lowest income families using family day care services (Table 6.19). These families using this type of care continued to pay nothing—because the CCB covered the cost entirely.

Child care became less affordable over this period because fees rose more than the CCB, which is indexed to the Consumer Price Index (CPI). Since the increase in fees charged was greatest in private-for-profit centres, the decline in affordability particulary afftected parents using these services, especially the lowest income families. In 2002 as in 2000, child care was least affordable for a sole-parent pensioner using 40 hours of care in a community-based centre, with child care costs accounting for 13% of disposable income.

Table 6.19: Cost of child care as a proportion of disposable income, July 2000 and May 2002

	20 hours		40 hours	
Type of service/ family type and income level	**2000**	**2002**	**2000**	**2002**
Community-based long day care centres				
Sole parent receiving Parenting Payment—Studying	4.8	5.1	12.5	13.0
Sole parent working—0.75 AWE	3.2	3.3	8.3	8.4
Couple family with one income—AWE	3.6	3.8	8.6	9.0
Couple family with two incomes—1.75 AWE	4.5	4.7	9.6	10.0
Couple family with two incomes—2.5 AWE	4.9	5.0	9.9	10.2
Private long day care centres				
Sole parent receiving Parenting Payment—Studying	3.9	4.6	10.6	12.1
Sole parent working—0.75 AWE	2.6	3.0	7.0	7.8
Couple family with one income—AWE	3.0	3.5	7.5	8.5
Couple family with two incomes—1.75 AWE	4.2	4.6	8.9	9.6
Couple family with two incomes—2.5 AWE	4.6	4.9	9.4	9.9
Family day care services				
Sole parent receiving Parenting Payment—Studying	0.0	0.0	0.0	0.0
Sole parent working—0.75 AWE	0.0	0.0	0.0	0.0
Couple family with one income—AWE	0.8	0.9	1.7	2.1
Couple family with two incomes—1.75 AWE	3.0	3.3	6.0	6.6
Couple family with two incomes—2.5 AWE	3.9	4.1	7.4	8.4

Notes

1. Gross income includes any earned income and Centrelink payments and allowances. Net income is gross income minus tax and Medicare levy.
2. In couple families with one income, one parent is working, the other studying. In other couple families, both parents are working.
3. For couple families with two incomes, the taxable income split is assumed to be 1:0.75.
4. Average weekly earnings (AWE) at November 2002, were $688.40.

Sources: ABS 2002e; AIHW 2001c, AIHW analysis of 2002 data.

Quality

Legislative regulations (or funding guidelines) and accreditation (or quality assurance) systems are the two mechanisms for assuring quality in the child care sector. The regulations specify the minimum standards which must be met (or 'quantifiable inputs') in order for the service to operate. These standards relate to the physical environment, health and safety, staff–child ratios, staff qualifications and program activities. Licensing provisions exist for many, but not all, types of child care services. Accreditation processes (or quality assurance systems), on the other hand, focus on measuring the quality of aspects of the services that are delivered, for instance staff responsiveness to children in their care (NCAC 2003).

All states and territories license and regulate centre-based long day care and occasional care services. Family day care schemes and/or providers are licensed and regulated in New South Wales, Queensland, Western Australia and the Australian Capital Territory. While outside school hours care services are licensed and regulated in the Australian Capital Territory, Queensland, Western Australia and Tasmania are about to introduce licensing. Since child care licensing regulations vary across jurisdictions, in the early 1990s, sets of national standards for long day care centres, family day care and outside school hours care services were developed by the Commonwealth and state/territory governments and endorsed by the (then) Community Services Ministers Conference. The extent to which these national standards have been implemented varies across jurisdictions.

The Commonwealth Government is responsible for accrediting all Commonwealth-supported long day care centres, family day care schemes and outside school hours care services through its accreditation systems which are administered by the National Childcare Accreditation Council (NCAC) (Box 6.8). All services are required to participate in quality improvement processes in order to be approved for the CCB and other relevant Commonwealth funding (NCAC 2003).

Box 6.8: Quality improvement systems

A revised Quality Improvement and Accreditation System (QIAS) *for long day care centres was introduced in January 2003 (NCAC 2003). This new system differed from the previous one in three main ways: a reduction in the number of quality care principles (from 52 to 35) against which centres are assessed; a change in the period between reviews, from 1, 2 or 3 years to a standard two and a half years for all centres; and for centres with 30 or more licensed places, a change in the period for accreditation visits from 1 to 2 days.*

Family Day Care Quality Assurance (FDCQA): *Since 1 July 2001, family day care schemes have been required to participate in a quality assurance scheme that was developed in consultation with the family day care sector. The FDCQA follows a similar process to that for long day care centres – services are assessed against 32 family day care quality principles and there is a period of two and a half years between reviews.*

Outside School Hours Care Quality Assurance (OSHCQ) : *From 1 July 2003, outside school hours care services are required to participate in quality assurance systems that have been developed in consultation with the outside school hours care sector. Commonwealth-supported outside school hours care services are required to register to participate in the system by 30 September 2003 in order to be approved for the CCB. Services will be assessed against 30 outside school hours care quality principles, with two and a half years between reviews.*

Source: NCAC 2003.

Table 6.20: Accreditation status of Commonwealth-supported long day care centres, 1997, 1999, 2001, 2003

	June 1997		July 1999		April 2001		June 2003	
Accreditation status	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Accredited	2,799	68	3,584	87	3,669	91	3,683	87
Plan of action—not accredited	283	7	269	6	205	5	270	6
Undergoing process[(a)]	1,052	25	289	7	149	4	300	7
Total	**4,134**	**100**	**4,142**	**100**	**4,023**	**100**	**4,253**	**100**

(a) Includes in self-study, in review and in moderation or awaiting council decision.

Source: NCAC 2003, NCAC unpublished data.

At June 2003, 87% of Commonwealth supported-long day care centres were accredited and another 7% were undergoing the process of accreditation (Table 6.20). Only 6% of centres were not accredited and were working through a plan of action approved by the NCAC to bring them up to standard. Between June 1997 and June 2003, the proportion of centres that were accredited increased from 68% to 87%, while the proportion undergoing the process of accreditation fell from 25% to 7%.

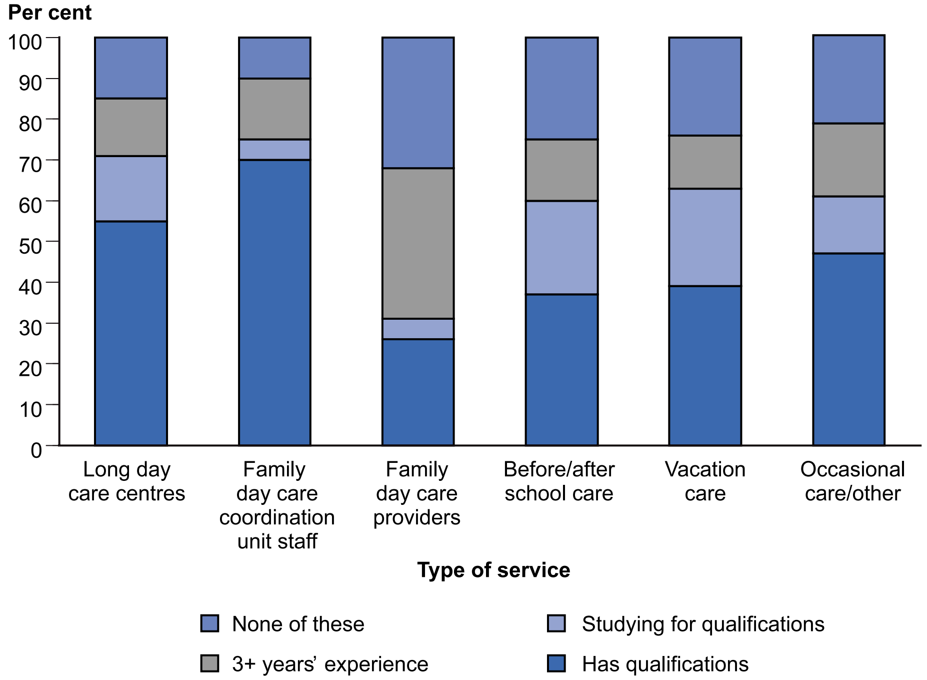
As at June 2003, 13% of the 325 family day care schemes registered with the NCAC for accreditation were accredited and the other 87% were undergoing the process of accreditation.

The quality of care has been shown to be strongly related to whether or not staff working in child care services have had appropriate training in the child care area (Fleer 2002:39). State and territory child care licensing regulations all contain specifications of 'recognised qualifications' for various staffing positions. As noted previously, there are widespread concerns about child care services being able to recruit and keep qualified staff.

Information on 'relevant qualifications' held by child care workers was collected in the Commonwealth Child Care Census for every service type—most of these 'relevant qualifications' are recognised for licensing purposes (Press & Hayes 2000:73–5). While 'relevant qualifications' vary slightly by service type, they generally include qualifications in early childhood and primary teaching, child care, nursing and 'other relevant' areas such as social work and business management.

In 2002 the proportion of workers with relevant qualifications varied considerably among the different types of services (Figure 6.4). For instance, around a quarter (26%) of family day care providers had relevant qualifications compared with over a third of before/after school care workers (37%) and just over half of workers in long day care centres. The proportion with no relevant qualification, but currently studying for one, ranged from 5% in family day care to 24% in vacation care. The proportion who had no relevant qualifications and were not studying for any, but who had worked in the child care sector for more than 3 years, was highest for family day care providers (37%) and lowest for workers in private-for-profit long day care centres (11%).

In-service training is also provided to improve child care workers skills and competencies. In some jurisdictions, it is required under state and territory regulations. In 2002, 60% or more of workers in all types of child care services had undertaken in-service training in the previous 12 months (see Table A6.9). Family day care workers were the most likely to have done so—80% of providers and 86% of coordination unit staff.



Source: Table A6.9.

Figure 6.4: Qualifications of workers in Commonwealth-supported services, 2002

6.5 Child protection and out-of-home care services

Child protection is the responsibility of the community services department in each state and territory. Children who come into contact with the department for protective reasons include those:

- who have been or are being abused or neglected or otherwise harmed; and
- whose parents cannot provide adequate care or protection.

The aim of child protection services is to protect children and young people who are at risk of harm within their families, or whose families do not have the capacity to protect them. The services include:

- 'receiving and responding to reports of concern about children and young people, including investigation and assessment where appropriate;
- providing support services to strengthen the capacity of families to care safely for children;

- initiating intervention, including applying for a care and protection order through a court if necessary and placing children and young people in out-of-home care to secure their safety;
- ensuring the ongoing safety of children and young people by working with families to resolve protective concerns;
- working with families to reunite children (who were removed for safety reasons) with their parents as soon as possible; and
- securing permanent alternative care when children are unable to live with their parents' (SCRCSSP 2003:15.2).

This section examines trends in the number of child protection notifications, investigations and substantiations, children on care and protection orders and children in out-of-home care over the last 5 years. Some data on trends for Indigenous children are also provided.

Child protection in the new millennium

It has been recognised that a forensic investigation is generally not the most appropriate way of dealing with many of the families reported to child protection authorities. It is also widely understood that child protection is a complex area, usually involving children with a variety of needs, coming from families that have a range of problems (VicDHS 2002). A large number of the reports that come to community services departments are not about child abuse, but about situations in which parents are not coping with their parental responsibilities. These families usually lack the skills and resources to cope with raising a family (AIHW 2001b).

Most of the community services departments have made modifications, sometimes involving the introduction of new legislation, to the way they respond to reports of concerns about children. These changes aim to enhance the safety of children and ensure that the children and their families receive services that meet their needs (SCRCSSP 2003). Where the reports do not involve child maltreatment, children and their families are being referred to family support services rather than being investigated. In some jurisdictions, such as Western Australia and Tasmania, these cases are streamed to family support services instead of being recorded as a notification.

The community services departments provide a range of family support services. These may include information and referral, education/skill development, counselling, mediation and therapy, residential and in-home support, and advocacy (AIHW 2001a).

In an effort to keep children with their families, where this is appropriate, the departments also provide intensive family support services. These provide similar strategies to family support services in general but are more intensive in nature—they average at least 4 hours per week and last for up to 6 months.

Unlike general family support services which can be provided at any time during the process, that is prior to or post notification, intensive family support services are only provided once a child is in the child protection system. They are aimed at preventing the separation of children from their families due to child protection concerns or to reunify families where separation has already occurred (SCRCSSP 2003).

Box 6.9: Definitions of *notification, investigation* and *substantiation*

Notification *is a contact made to the authorised department by persons or other bodies making allegations of child abuse and neglect, child maltreatment or harm to a child. The data on child protection notifications, investigations and substantiations in the national data collection relate to those notifications received by community service departments between 1 July and 30 June of the relevant financial year.*

Investigation *is the process whereby the community services department obtains more detailed information about a child who is the subject of a notification and makes an assessment of the degree of harm or risk of harm for the child. After an investigation is completed, a notification will either be 'substantiated' or 'not substantiated'.*

Substantiation *is a notification that is substantiated where it is concluded after investigation that the child has been, is being or is likely to be abused or neglected or otherwise harmed.*

Data sources

The Australian Institute of Health and Welfare has been responsible for collecting national child protection data since the early 1990s. The data are, however, limited to three main areas of child protection:

- child protection notifications, investigations and substantiations (formerly referred to as child abuse and neglect);
- children on care and protection orders; and
- children in out-of-home care.

In addition, some preliminary national data on Intensive Family Support Services have been collected since 1999–00. These are specialist services that seek to prevent the separation of children from their families, or to reunify families where separation has already occurred. The data are fairly limited and not all jurisdictions can provide all the information. There are no other national data on family support services or on the other work undertaken by child protection workers to keep children safe.

The national child protection data were extracted from the administrative systems of the state and territory community services departments according to definitions and counting rules agreed to by the departments and the Institute. For more information about child protection processes, refer to *Child Protection Australia 2001–02* (AIHW 2003).

Children who are in need of protection

The purpose of child protection services is to respond to reports of concerns about children and to identify children who are in need of protection from abuse, neglect or harm. Concerns about children can be brought to the attention of the community services departments by parents, other relatives or children themselves, by people outside the family or by professionals who have contact with children and families.

Many of the families involved with the community services departments have complex needs and experience a range of problems. These may include low socioeconomic status, residential instability, crowded dwellings, domestic violence, alcohol and substance abuse and psychiatric disability (Prent & Lewis 1996; Weatherburn & Lind 1997).

For example, a 2002 Victorian study examined the characteristics of parents of children in substantiated cases. It was found that 73% of the parents of children in substantiated cases of child abuse and neglect had at least one issue or problem. Of these, 52% experienced domestic violence, 33% substance abuse, 31% alcohol abuse, 19% had a psychiatric disability, 4% a physical disability and 3% an intellectual disability. At least two of these characteristics were experienced by 44% of the parents (VicDHS 2002).

Socioeconomic status is another important factor, with the available data indicating that children in the child protection system are most likely to be from families with low socioeconomic status. Data on the socioeconomic status of families in the child protection system are not available at the national level, but studies in a number of jurisdictions have demonstrated the link between child protection and low socioeconomic status.

The Victorian study, for example, found that families who were investigated by child protection services were likely to be on a pension, benefit or low income (75%) and likely to be in a sole-parent family (45%) (VicDHS 2002). A South Australian study (Hood 1998), examining referrals from the child protection services to the Women's and Children's Hospital, found that 82% of the children referred lived in areas in the two lowest socioeconomic clusters. A New South Wales study also found that reports (or notifications) of child abuse and neglect to the Department of Community Services were correlated with poverty and unemployment (Weatherburn & Lind 1997).

The high rates of Indigenous children in the child protection system are consistent with these findings. The national data show that Aboriginal and Torres Strait Islander children are up to eight times more likely than other Australian children to be the subject of a child protection substantiation, and are six times more likely to be in out-of-home care (AIHW 2003). The intergenerational effects of previous separations from family and culture, poor socioeconomic status and cultural differences in child-rearing practices are important reasons for this over-representation (HREOC 1997).

Family disruption appears to be another important factor that is associated with involvement in the child protection system. The national data show that children from one-parent families and from step or blended families are over-represented in child protection substantiations (AIHW 2003). This is likely to be related to the compounding stresses that sole parents may face. For example, one in five sole parents live in poverty (Harding et al. 2001).

Trends in the use of child protection services

The Institute has national data on the number of child protection investigations and substantiations for the years 1990–91 to 2001–02, and on the number of notifications for the years from 1995–96 to 2001–02 (see Box 6.9 for definitions of these terms).

Before examining national trends it is important to note that each jurisdiction has its own legislation, policies and practices in relation to child protection, and the data it provides reflect some important variations in what it does and in how it counts child protection matters. These differences are apparent in the variation in the rates of children aged 0–16 years in child protection notifications, investigations and substantiations.

In relation to substantiations in 2001–02, for example, rates ranged from 8.3 per 1,000 children in Queensland to 1.4 per 1,000 in Tasmania (Table 6.21). One of the reasons for the low rate in Tasmania is that more of the less serious cases are channelled towards family support services instead of being recorded as a notification and are therefore not investigated or substantiated. In Queensland, there has been a broadening of what is classified as child abuse and neglect, which contributed to an increase in the rate of substantiations. For more information about the differences between jurisdictions, see *Comparability of Child Protection Data* (AIHW 1999b) and *Child Protection Australia* (for example, AIHW 2003). As the policies and practices have changed so markedly since the Institute began collecting the national data, only trends in the past 5 years will be examined.

Notifications, investigations and substantiations

The national trend in notifications is one of increasing numbers between 1997–98 and 2001–02 (Figure 6.5). Across Australia, the number of notifications increased by 40% over this 5-year period to reach 137,938 in 2001–02.

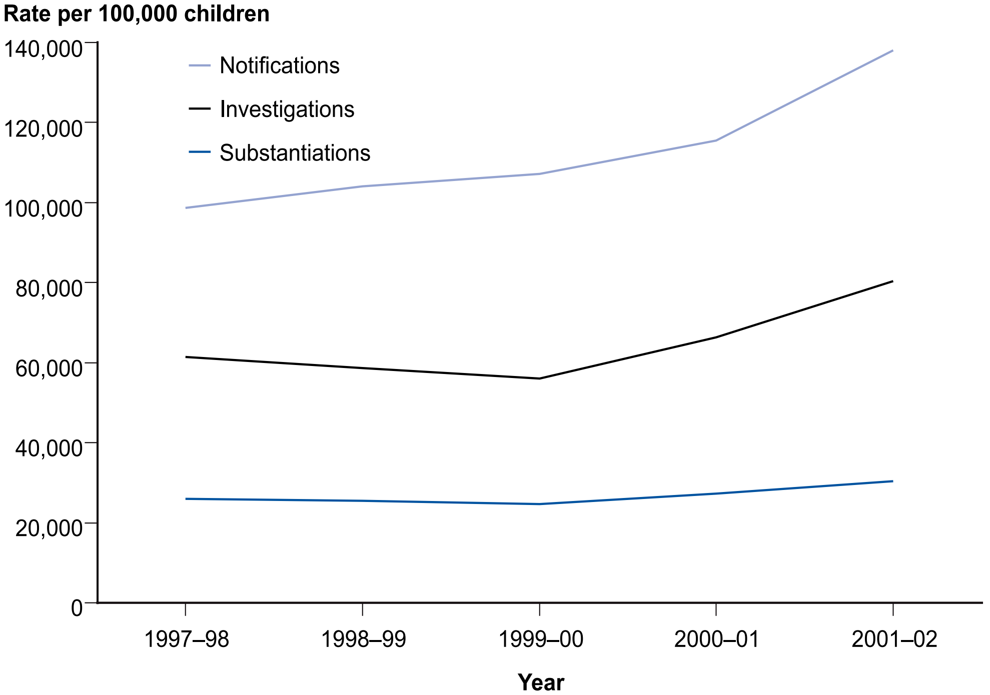
Possible reasons for the rise in the number of notifications include:

- increases in the number of children who require a child protection response, for example, because of an increase in the incidence of child abuse and neglect or inadequate parenting causing harm to a child;
- increased reporting by professionals as a result of the mandatory reporting provisions in most jurisdictions;
- increased awareness in the community about child abuse and neglect and the role of community services departments in this area.

Not all notifications are investigated. Some do not warrant an investigation, some are dealt with by other means, such as family support or referral to another service, and some are unable to be investigated as the information is incomplete or the child is unable to be located.

Between 1997–98 and 2001–02, the number of investigations across Australia increased by 31% to reach over 80,000. While the number of substantiations also rose over the past 5 years, from 26,025 to 30,473 (17%), the increase was not so striking when compared with notifications and investigations.

The national rate per 1,000 children aged 0–16 years in notifications increased by 28%, from 17.1 in 1997–98 to 21.9 in 2001–02 (Table 6.21). However, the rates of children who were the subject of an investigation or of a substantiation rose only 12% and 14% respectively. This indicates that while notifications to community services departments increased considerably, the number of cases that the departments investigated and also the number of children for whom there was substantiated harm or risk of harm did not. This was probably due to the shifts in child protection policies and practices which included channelling the less serious cases to family support services rather than to a forensic investigation.



Source: Table A6.10.

Figure 6.5: Notifications, investigations and substantiations, 1997–98 to 2001–02

Table 6.21: Rates of children aged 0–16 years who were the subject of a notification, investigation and substantiation, per 1,000 children, 1997–98 to 2001–02

Year	NSW	Vic	Qld	WA	SA	Tas	ACT	NT [(a)]	Total
					Notifications				
1997–98	17.1	24.0	15.3	4.9	22.5	7.1	12.0	10.9	17.1
1998–99	16.9	24.7	16.5	5.1	25.3	3.5	17.3	n.a.	17.8
1999–00	16.4	24.9	16.9	5.2	28.5	2.1	13.0	20.3	17.9
2000–01	20.7	25.7	18.8	5.7	21.4	2.7	9.2	20.9	19.5
2001–02	25.3	25.9	21.9	5.9	23.3	4.0	9.2	23.5	21.9
					Investigations				
1997–98	10.8	11.1	10.2	4.2	10.5	4.8	9.2	10.5	9.9
1998–99	9.2	11.1	9.3	4.7	11.5	3.1	15.8	n.a.	9.4
1999–00	8.0	10.2	9.3	4.7	11.4	1.9	10.4	10.0	8.6
2000–01	10.8	10.7	11.0	4.8	11.9	2.0	7.0	11.7	10.0
2001–02	13.3	10.4	12.3	4.8	12.7	3.3	6.2	13.4	11.1
					Substantiations				
1997–98	5.0	5.9	5.1	2.4	4.7	1.1	4.7	5.5	4.9
1998–99	4.5	6.3	5.1	2.5	5.2	1.1	5.2	n.a.	4.8
1999–00	3.9	6.3	5.6	2.3	5.1	0.7	2.6	6.2	4.7
2000–01	4.4	6.3	7.4	2.5	5.0	1.9	2.8	5.8	5.3
2001–02	4.8	6.5	8.3	2.4	5.3	1.4	2.7	5.8	5.6

(a) Northern Territory could not provide data for 1998–99 and was not included in the totals for that year.

Sources: AIHW 2003; AIHW unpublished data.

National trends, however, mask the different trends that have occurred in each state and territory. Increases in numbers of children in the child protection system in one jurisdiction can cancel out decreases that occur in another, so that what has occurred in each jurisdiction can vary significantly from the national trends.

In particular, policy changes within jurisdictions can have a major impact on the numbers of children in the child protection system. For example, after the proclamation of the New South Wales *Children and Young Persons (Care and Protection) Act 1998* in December 2000, the rate per 1,000 children in child protection notifications increased considerably, from 16.4 in 1999–00 to 25.3 in 2001–02. According to the New South Wales Department of Community Services there are three main reasons for this:

- the DoCS Helpline was introduced, which is a centralised intake system;
- the scope of mandatory reporting was widened to include anyone who works with children; and
- DoCS provided training and awareness for the new legislation as well as ongoing community awareness programs (NSWDCS 2001).

While the rates in New South Wales increased by more than 50% between 1999–00 and 2001–02 for both notifications and investigations, the rate of substantiations rose only by 23%.

Queensland and the Australian Capital Territory have also proclaimed new Acts during the past 5 years. Since the proclamation of new legislation in Queensland, the rates have increased. The reasons for the rise in notifications and investigations are similar to those in New South Wales, namely a more centralised intake system and the employment of more staff. The increase in substantiations may be due to a broadening of what is defined as child abuse, neglect or harm. In the Australian Capital Territory, on the other hand, where rates decreased markedly, there is now an increased emphasis on family support and prevention services, which means more children and families are diverted to these types of services rather than being recorded as a notification. These are examples of how the trends in the child protection data are more an indication of how the jurisdictions deal with children who are notified to the department, than of changes to the levels of harm to children in the community.

Care and protection orders and out-of-home care

Children on care and protection orders

At any point in the child protection process, the community services department can apply to the relevant court to place the child on a care and protection order. Such action is usually only taken as a last resort in situations where the department believes that continued involvement with the family is warranted. This may occur in situations where supervision and counselling are resisted by the family, where other avenues for resolution of the situation have been exhausted, or where removal of a child into out-of-home care requires legal authorisation.

Box 6.10: Care and protection orders and out-of-home care

Care and protection orders *are legal or administrative orders or arrangements which give community services departments some level of responsibility for a child's welfare. The level of responsibility varies with the type of order or arrangement. These orders include guardianship and custody orders; supervision and other finalised orders; and interim and temporary orders.*

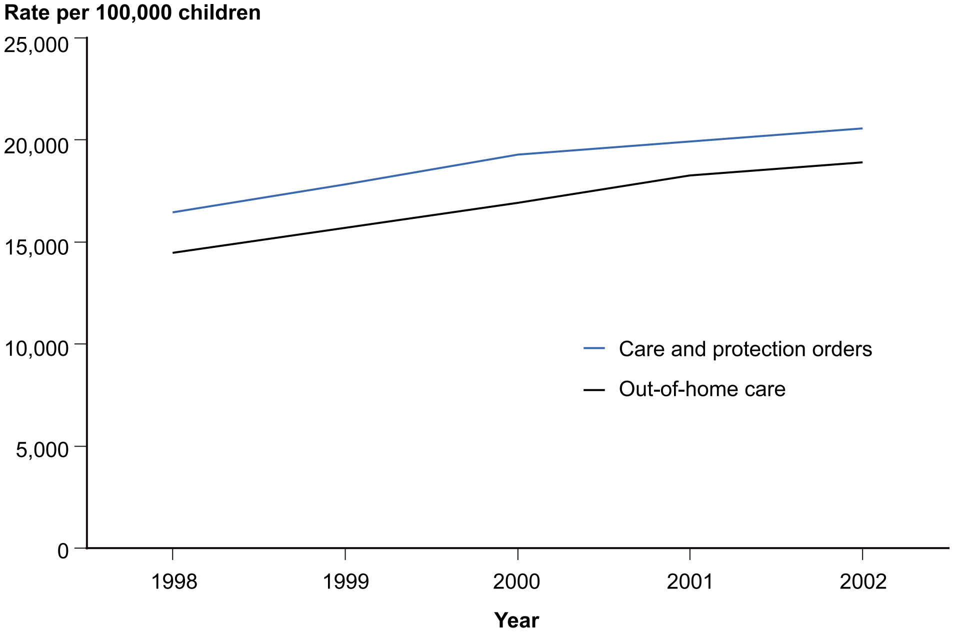
Out-of-home care *is defined as out-of-home overnight care for children and young people under 18 years of age where the state or territory makes a financial payment. It includes residential care, foster care and relative/kinship care. Children in out-of-home care can be placed in a variety of living arrangements or placement types. The following categories are used in the national data collection:*

- ***Home-based care*** *– where placement is in the home of a carer who is reimbursed for expenses incurred in caring for the child. This category is further divided into:*
  - ***relative/kinship care*** *– where the caregiver is a family member or a person with a pre-existing relationship to the child;*
  - ***foster care*** *– where care is provided in the private home of a substitute family which receives a payment that is intended to cover the child's living expenses;*
  - ***other home-based care*** *– care in private homes that does not fit into the above categories.*
- ***Residential care*** *– where placement is in a residential building whose purpose is to provide placements for children and where there are paid staff. This category includes facilities where there are rostered staff, where there is a live-in carer (including family group homes), where staff are off-site (for example, a lead tenant or supported residence arrangement), as well as other facility-based arrangements.*
- ***Independent living*** *– where children are living independently, such as those in private boarding arrangements.*

In the national data, the number of children on orders and the number of children in out-of-home care are counted at 30 June of the relevant year and are therefore a prevalence measure.

There was a 25% increase in the number of children on care and protection orders across Australia between 30 June 1998 and 30 June 2002, from 16,449 to 20,557 (Figure 6.6). The rate of children on orders also rose from 3.5 to 4.3 per 1,000 children over the same period (AIHW 2003).

The number of children on orders increased between 1998 and 2002 in all jurisdictions except Tasmania. Increases in numbers were particularly large in Western Australia (over 70%), in the Northern Territory (41%) and in New South Wales (37%) (AIHW 2003:33).



Sources: Tables 6.22, A6.11.

Figure 6.6: Children on care and protection orders, and children in out-of home care, 1998–2002

Children in out-of-home care

While children may be placed in out-of-home care as well as on a care and protection order, the two data collections are separate (see Box 6.10 for definitions). The trend in out-of-home care has been one of increasing numbers of children using these services. Between June 1998 and June 2002, the number of children in out-of-home care in Australia rose from 14,470 to 18,880, an increase of 30% (Table 6.22, Figure 6.6). The rate of children in out-of-home care also increased over this period, from 3.1 per 1,000 to 3.9 per 1,000 (AIHW 2003).

The number of children in out-of home care rose in all jurisdictions between 1998 and 2002. There were particularly large increases in New South Wales, where the numbers grew by 44%, and in Queensland and Western Australia (39% and 36% respectively).

There is likely to be a range of complex reasons for the growth in the number of children on care and protection orders and in out-of-home care since 1996. At the broad level it indicates that there are increasing numbers of children whose families are considered unable to adequately care for them. This may be due to greater pressures on families through, for example, increases in joblessness, family disruption, substance abuse or family violence. The rise is consistent with the higher number of child protection notifications that occurred in most jurisdictions during the same period.

Table 6.22: Number of children aged 0–17 years in out-of-home care, 30 June 1998–2002

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
1998	5,603	3,615	2,346	1,093	1,055	442	179	137	14,470
1999	6,359	3,581	2,613	1,192	1,045	533	174	177	15,674
2000	7,041	3,867	2,634	1,326	1,131	548	200	176	16,923
2001	7,786	3,882	3,011	1,436	1,175	572	215	164	18,241
2002	8,084	3,918	3,257	1,494	1,196	544	224	163	18,880

Source: AIHW 2003.

Types of out-of-home care

There was some change in the types of out-of-home care in which children were placed between 30 June 1998 and 30 June 2002. The number of children in residential care fell markedly over this period, from 1,415 to 1,057 (Table 6.23). This decrease continues the longer term trend towards the deinstitutionalisation of children that began in the late 1960s (see Johnstone 2001). It should be noted that residential facilities nowadays are generally small, with less than 10 children living together. They can enable large sibling groups to be placed together and can cater for children with complex needs. Children in residential care also tend to be older.

Over the same period, there was a 36% increase in the number of children who were in home-based care arrangements, from 12,661 to 17,271. This reflects the policy of placing children, particularly young children, in a home-based rather than a residential environment where possible.

Table 6.23: Children in out-of-home care, by type of care, 30 June 1998–2002

Type of care(a)	1998	1999	2000	2001	2002
			Number		
Foster care	8,089	8,212	n.a.	9,429	9,668
Relative/kinship care	4,446	5,254	n.a.	6,940	7,439
Other home-based care	126	183	n.a.	192	164
Total home-based care	*12,661*	*13,649*	*15,169*	*16,561*	*17,271*
Residential care	1,415	1,314	1,222	1,177	1,057
Independent living(b)	183	218	208	203	221
Other(c)	211	316	324	300	331
Total	**14,470**	**15,497**	**16,923**	**18,241**	**18,880**
			Per cent		
Foster care	56	53	n.a.	52	51
Relative/kinship care	31	34	n.a.	38	39
Other home-based care	—	1	n.a.	1	1
Total home-based care	*87*	*88*	*90*	*91*	*91*
Residential care	10	9	7	6	6
Independent living(b)	1	1	1	1	1
Other(c)	2	2	2	2	2
Total	**100**	**100**	**100**	**100**	**100**

(a) Data on type of home-based care could not be provided by all jurisdictions in 2000.

(b) Includes unknown living arrangements.

(c) Excludes 177 children from the Northern Territory because data on type of care could not be provided.

Sources: AIHW 1999c, 2000b, 2001d, 2002b, 2003.

The type of home-based care has changed in the past 5 years. Although foster care is still the main type of out-of-home care, the proportion of children in foster care has fallen, from 56% to 51%. On the other hand, the proportion of children living with relatives/kin increased from 31% to 39% for the same period. This may be the result of a number of factors, for example, a policy shift to enable children to stay with their extended families wherever practical and a decrease in the availability of foster parents.

Trends for Aboriginal and Torres Strait Islander children

The over-representation of Aboriginal and Torres Strait Islander children in the child protection system has been well documented. For example, in Victoria and Western Australia in 2001–02, their rates in substantiations were 8 times higher than for other children (AIHW 2003).

This section discusses trends for Aboriginal and Torres Strait Islander children in child protection substantiations, on care and protection orders and in out-of-home care. The quality of the data on Indigenous status is one of the major issues to be considered when analysing trends for Aboriginal and Torres Strait Islander children since data quality varies across jurisdictions and over time. Although the recording of Indigenous status still remains an issue, increases in the recorded number of Aboriginal and Torres Strait Islander children in the child protection system over time may therefore be due to improvements in the quality of the data and to greater self-identification, rather than to an actual increase in number of Aboriginal and Torres Strait Islander children.

Substantiations

The available data indicate that the number of substantiations involving Aboriginal and Torres Strait Islander children increased by 28%, from 3,205 in 1997–98 to 4,095 in 2001–02 (Table 6.24). This occurred in all jurisdictions except Tasmania and the Australian Capital Territory. In some jurisdictions the numbers fluctuated over the period, for example in Queensland the number fell between 1997–98 and 1999–00 but then rose substantially between 2000–01 and 2001–02. In South Australia and Western Australia, in contrast, the numbers increased steadily over the entire period.

The pattern of substantiated abuse and neglect for Aboriginal and Torres Strait Islander children differs from the pattern for other children. Indigenous children were more likely to be the subject of a substantiation of neglect than other children. For example, in Western Australia, 50% of Indigenous children in substantiations were the subject of a substantiation of neglect, compared with 24% of other children. In Queensland, the corresponding percentages were 50% and 37% respectively (AIHW 2003:18).

Table 6.24: Number of child protection substantiations involving Indigenous children, 1997–98 to 2001–02

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
1997–98	749	514	1,085	302	330	3	44	178	3,205
1998–99[(a)]	1,026	n.a.	856	327	337	8	25	n.a.	n.a.
1999–00	839	629	770	365	435	5	19	194	3,256
2000–01	1,023	650	946	383	438	2	24	167	3,633
2001–02	1,101	630	1,206	426	483	2	11	236	4,095

Sources: AIHW 1999c, 2000b, 2001d, 2002b, 2003.

Table 6.25: Indigenous status of children on care and protection orders and children in out-of-home care, at 30 June 1998–02

	Children on care and protection orders			Children in out-of-home care		
	Indigenous	Other children	Total	Indigenous	Other children	Total
1998	2,868	13,581	16,449	2,634	11,836	14,470
1999[(a)]	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
2000	3,861	15,401	19,262	3,496	13,427	16,923
2001	4,146	15,637	19,783	4,037	14,168	18,205
2002	4,264	16,293	20,557	4,199	14,681	18,880

(a) The system used to record the Indigenous status of children in New South Wales was changed in 1998–99 resulting in a large increase in the number of Aboriginal and Torres Strait Islander children in the child protection system. Victoria could not provide data on Aboriginal and Torres Strait Islander children in June 1999.

Source: AIHW 1999c, 2000b, 2001d, 2002b, 2003.

Care and protection orders and out-of-home care

Between June 1998 and June 2002, the number of Aboriginal and Torres Strait Islander children on care and protection orders increased by nearly 50%, from 2,868 to 4,264 (Table 6.25). The number of other children on care and protection orders rose by only 20% over the same period.

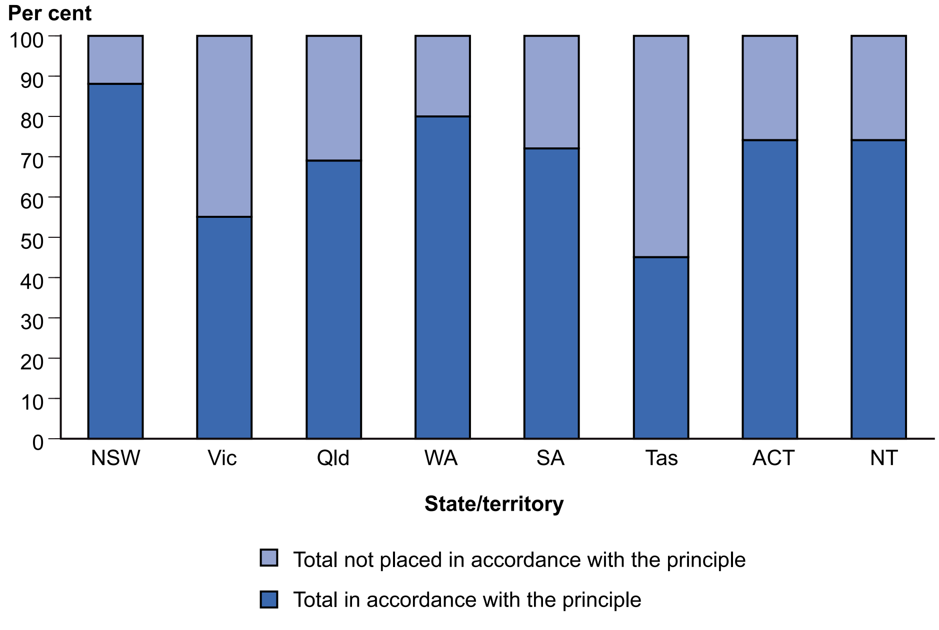
The trend for Aboriginal and Torres Strait Islander children in out-of-home care was also one of increasing numbers, rising from 2,634 in 1998 to 4,199 in 2002 (59% increase). In comparison, the number of other children in out-of-home rose by 24%.

The Aboriginal Child Placement Principle

The Aboriginal Child Placement Principle outlines a preference for the placement of Aboriginal and Torres Strait Islander children with other Aboriginal and Torres Strait Islander people when they are placed outside their family (Lock 1997:50). The Principle has the following order of preference for placement:

- with the child's extended family
- within the child's Indigenous community
- with other Indigenous people.

All jurisdictions have adopted the Aboriginal Child Placement Principle either in legislation or policy. The impact of the principle is reflected in the relatively high proportions of Aboriginal and Torres Strait Islander children who were placed either with Indigenous caregivers or with relatives (Figure 6.7).



Source: Table A6.12.

Figure 6.7: Aboriginal and Torres Strait Islander children in out-of-home care by whether placed in accordance with the Aboriginal Child Placement Principle, at 30 June 2002

At 30 June 2002, the proportion of Aboriginal and Torres Strait Islander children who were placed in accordance with the principle ranged from 88% in New South Wales to 45% in Tasmania. The relatively low proportion of children who were placed with an Indigenous carer or relative in Tasmania is probably related to the small size of the Indigenous population as well as issues related to the identification of Indigenous status in that state (AIHW 2003).

6.6 Adoptions

When an adoption order is granted, the legal relationship between the child and the biological parents is severed. The legal rights of the adopted child are as if he or she had been born to the adoptive parents, and the legal rights that exist from birth with regard to the birth parents (inheritance and name, for instance) are removed. A new birth certificate is issued to the child bearing the name(s) of his or her adoptive parent(s) as the legal parent(s), and the new name of the child, where a change has occurred (AIHW 2002d).

In Australia, each state and territory has responsibility for all aspects of adoptions within its jurisdiction, and has its own legislation, policies and practices in relation to adoption. This section examines adoptions between 1997–98 and 2001–02. Data are also provided on the adoptions of Aboriginal and Torres Strait Islander children.

Box 6.11: Categories of adoption used in the national data collection

Placement adoptions*—adoptions of children who are legally available and placed for adoption but who have had no previous contact or relationship with the adoptive parents. Placement adoptions are broken down into the following two categories:*

- ***local placement adoptions****—adoptions of children who were born in Australia or who were permanent residents of Australia before the adoption; and*
- ***intercountry placement adoptions****—adoptions of children from countries other than Australia.*

'Known' child adoptions*—adoptions of children who have a pre-existing relationship with the adoptive parent(s) and who are generally not available for adoption by anyone other than the adoptive parent(s). 'Known' child adoptions include adoptions by step-parents, other relatives and carers.*

Before 1998–99, adoptions were categorised as either relative or non-relative adoptions. The difference between the old and the new categories is that adoptions by carers are now included with adoptions by step-parents and other relatives, whereas prior to 1998–99 they were included with adoptions by non-relatives.

Data sources

As with child protection, the community services departments in each state and territory fund the Institute to collect, analyse and publish national data on adoptions. These data come from the administrative systems of each state and territory community services department. The categories used to classify adoptions in the national data collection are outlined in Box 6.11. For more information about the data and definitions, refer to the *Adoptions Australia* series (for example, AIHW 2002d).

Trends in adoption

The number of adoptions in Australia has fluctuated in the last 5 years, with no real trend apparent. Overall, however, the numbers have fallen, from 577 in 1997–98 to 561 in 2001–02 (Table 6.26). This decrease continues the trend that began in the early 1970s when there were nearly 10,000 adoptions in Australia (AIHW 2002d).

The decrease in recent years was primarily due to the fall in the number of adoptions of Australian-born children—both local adoptions (previously referred to as 'adoptions by non-relatives') and 'known' child adoptions (previously referred to as 'adoptions by relatives'). The small number of local placement adoptions is attributable to the decrease in the number of Australian-born babies who are available for adoption. Factors that contribute to this decrease include the availability of more effective birth control and changed community attitudes to single parents. There is also a greater use of guardianship and custody orders for children who are living with relatives/kin or carers—such as the permanent care order in Victoria—instead of adoption.

Table 6.26: Number of adoptions in Australia, by type of adoption, 1997–98 to 2001–02

	Adoptions of Australian children by non-relatives	Adoptions of Australian children by relatives	Intercountry adoptions	Total
1997–98	178	154	245	577
	Local placement adoptions	**'Known' child adoptions**		
1998–99	127	172	244	543
1999–00	106	159	301	566
2000–01	85	140	289	514
2001–02	107	160	294	561

Note: From 1998–99 the categories for adoptions were changed. Carers who had a previous relationship to the child were included with adoptions by step-parents and other relatives in the category 'known' child adoptions. Prior to 1998–99 adoptions by carers were included in the category 'adoptions by non-relatives' (see Box 6.11).

Source: AIHW 2002d.

Local placement adoptions

The way that local placement adoptions are conducted has undergone major changes since the 1990s. To a varying degree, in different jurisdictions, adoption has changed from a guarded practice, where files were sealed and parties to the adoption had no contact with each other, to an open practice where each party to the adoption can have some say in what happens to the child. AIHW started collecting information on the level of contact in 1998–99. These data indicated that most local placement adoptions involved agreement to some type of information exchange or contact between the parties. The proportion of relinquishing parents requesting 'no contact' decreased from 10% in 1998–99 to 6% in 2001–02 (Table 6.27).

In addition, a large area of activity for community services departments, in relation to adoption, is in assisting people who were party to an adoption prior to 'open' adoption practices to gain information about their adoption. In all jurisdictions, people party to an adoption can apply for either identifying or non-identifying information regarding the adoption. This may lead to contact between the parties, for example between an adoptee and their birth mother. If a party to the adoption wishes to remain anonymous, a veto may be lodged which makes it illegal for the other parties to either gain information and/or have contact. Such vetoes are not available in Victoria. In 2001–02, there were 4,159 information applications lodged in Australia, compared with 88 contact and information vetoes (AIHW 2002d).

Table 6.27: Local placement adoptions, by type of agreement between parties to the adoption, 1998–99 to 2001–02

	1998–99		1999–00		2000–01		2001–02	
Type of agreement	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Contact and information exchange	23	32	46	74	46	64	75	79
Contact only	1	1	—	—	2	3	1	1
Information exchange only	41	57	11	18	16	26	13	14
No contact	7	10	5	8	5	7	6	6
Unknown	55	. .	20	. .	7	. .	2	. .
Not applicable	0	. .	24	. .	9	. .	10	. .
Total	**127**	**100**	**106**	**100**	**85**	**100**	**107**	**100**

Sources: AIHW 2000c, 2001e, 2002c, 2002d.

‘Known’ child adoptions

The number of ‘known’ child adoptions decreased by 14% between 1998–99 (when ‘known’ child adoptions were first counted) and 2001–02 (see Table 6.26). Most ‘known’ child adoptions over this period were adoptions by step-parents (69%) who wished to legally incorporate the child into the new family, but this practice has become less common (AIHW 2002d). This has occurred during a period when the number of step-families has increased, indicating that the legal status of children in step-families is less likely to be changed than in previous years. This has been a policy shift by the community services departments.

There were also 172 (or 27% of all ‘known’ child adoptions) children adopted by carers between 1998–99 and 2001–02 (AIHW 2002d). Most of these children were in New South Wales where the new legislation encourages the use of permanency planning, particularly for children in long-term out-of-home care.

Adoptions by relatives, other than step-parents, are generally discouraged because of the confusion and distortion that may occur to biological relationships. There were 16 adoptions by relatives other than step-parents between 1998–99 and 2001–02 (AIHW 2002d). When children need to be placed in the care of relatives other than parents, most jurisdictions have policies that promote the use of guardianship or custody orders rather than adoption (Stonehouse 1992).

Intercountry adoptions

The number of intercountry adoptions increased by 20% between 1997–98 and 2001–02 from 245 to 294 adoptions (Table 6.26). This is likely to be related to continuing decreases in the number of local children available for adoption. In addition, the opening of adoption in some countries, such as China, has led to an increase in the number of these adoptions.

An important development in relation to intercountry adoptions is the ratification by Australia of the Hague Convention on the Protection of Children and Cooperation in Respect of Intercountry Adoptions in December 1998. The Convention streamlines the processes required for intercountry adoptions and establishes uniform procedures to be followed by the countries who are parties to the convention (see AIHW 2002d). As at August 2003, 40 countries have ratified, and 9 countries have signed but not yet ratified, the Convention. This number is likely to increase over the next few years.

In December 1999, Australia and China signed a bilateral agreement that allows Australian residents to adopt children from China. Since then, there have been 55 adoptions from China (Table 6.28).

Between 1997–98 and 2001–02, the majority of children in intercountry adoptions came from South Korea (28%), followed by Ethiopia (14%), India (13%) and Thailand (11%). The number of children who are adopted is determined by the number of children that overseas countries allocate for adoption by Australian parents, rather than the policies of Australian community services departments.

Table 6.28: Intercountry adoptions, by country of origin, 1997–98 to 2001–02

Country of origin	Number	Per cent	Country of origin	Number	Per cent
South Korea	384	28	Mauritius	29	2
Ethiopia	190	14	Taiwan	28	2
India	175	13	Guatemala	24	2
Thailand	147	11	Other[(b)]	24	2
Romania	82	6	Hong Kong	23	2
Colombia	66	5	Bolivia	22	2
Philippines	63	5	Sri Lanka	18	1
China[(a)]	55	4	Total	1,373	100
Fiji	43	3			

(a) Adoptions of children from China are counted from 1999–00.

(b) Includes: Canada, Croatia, Honduras, Lebanon, Macedonia, Malta, Papua New Guinea, Poland, Tonga, Uganda and the USA.

Source: Unpublished AIHW data.

Adoptions of Aboriginal and Torres Strait Islander children

Between 1997–98 and 2001–02, there were 19 Aboriginal and Torres Strait Islander children adopted in Australia (AIHW 2003). The relatively low number of Indigenous adoptions is because it is recognised that the practice of adoption may not be appropriate for Aboriginal and Torres Strait Islander people. If an Aboriginal and Torres Strait Islander child is orphaned or abandoned, the role of caregiver is traditionally assumed by an appropriate member of the community, without a formal adoption (Boss 1992).

The Aboriginal Child Placement Principle, which outlines a preference for the placement of Aboriginal and Torres Strait Islander children with other Aboriginal and Torres Strait Islander people when they are placed outside their family, applies to adoption as well as to out-of-home care (Lock 1997). In 12 of the 19 adoptions of Aboriginal and Torres Strait Islander children between 1997–98 and 2001–02, the adoptive parents were Aboriginal and Torres Strait Islander and/or relatives (AIHW 2003).

6.7 Data development

Child care and preschool services

Data development within the children's (child care and preschool) services field has made significant progress over the last few years. The AIHW and the Children's Services Data Working Group (Children's Services DWG) of the National Community Services Information Management Group have continued working on the development of the Children's Services National Minimum Data Set (Children's Services NMDS).

In October 2001, the Children's Services DWG agreed to undertake a pilot test of the first stage of the data set in 2002, with the AIHW coordinating this work. The main aim of the pilot test was to measure the feasibility of the proposed data collection, including the scope of the collection and the set of data items, and its potential to produce nationally consistent, comparable, comprehensive and useful data for child care and preschool services.

Members of the Children's Services DWG recruited service providers willing to participate in the pilot test. It was decided that it was important to represent the complexity of children's services delivery in selecting the outlets. The service providers chosen thus varied by 'type of funded service', service delivery model (fixed or mobile), service delivery setting (centre, school or home-based) and geographic location (capital city, provincial town, rural and remote). Some services specifically for Indigenous children were also included in the outlet selection.

Following the field test conducted in 2000, it had been agreed that the data collection would be structured around the services offered to children, rather than the types of funded and/or licensed services. Thus, rather than basing the collection forms on 'funded service type', three data collection forms were developed based on service delivery mode and setting—Centre-based, Family Day Care/In-Home Care, and Mobile. The same questions were generally used in each type of form, but some were specific to the service delivery mode or setting.

The pilot test was conducted in mid-August 2002. Forty-three service providers across all states and territories participated, with a total of 3,000 children using their services and 200 workers/caregivers providing the services.

Following the pilot test, the AIHW drafted a report and presented the findings to the Children's Services DWG. The pilot test specifically confirmed that the Children's Services NMDS could produce good quality national data on child care and preschool services across Australia. It was feasible to use the same forms and the same questions for service providers offering different types of funded services (for instance, long day care centres and preschools), even where funding came from different jurisdictions and different departments within the one jurisdiction. Although concerns had previously been expressed about the potential to collect information on individual children and individual workers (rather than aggregate data), all service providers reported the data in this form. It appeared, however, that some modifications would need to be made to the data set. While basing the data collection on 'services offered to children' worked well when collecting information on children and workers, it appeared that there is a need to structure information by 'funded service type' when collecting data on service provision.

The Children's Services DWG is currently considering how to progress the development and implementation of a national children's services data collection.

Child protection

Since 2000, the National Child Protection and Support Services data group has been developing a national reporting framework. This framework aims to more accurately reflect the current responses of states and territories to child protection and child concern reports. It will also aim to increase the consistency and comparability of the reported data (AIHW 2001b).

In August 2002, the framework was endorsed by the data group on behalf of the jurisdictions. The next stage of progressing this work will be the development of a data dictionary. This will continue during 2003–04.

Juvenile justice

Background

Development of comparable national juvenile justice data has for some time been recognised as a priority in the community service and justice areas. As a result, in April 1999, the Community Services Ministers Advisory Council (CSMAC) agreed to provide some funding towards the establishment of a National Minimum Data Set for Juvenile Justice (Juvenile Justice NMDS).

In early 2000, the AIHW was invited to undertake the first stage of the project—reporting to both the Australasian Juvenile Justice Administrators (AJJA) and the National Community Services Information Management Group (NCSIMG). This initial stage involved determining the scope of the Juvenile Justice NMDS and developing a data model, data items and data definitions. It also involved formulating recommendations on how the data set should be implemented. A reference group with representatives from all states and territories, the Australian Institute of Criminology, the Australian Bureau of Statistics and the Queensland Criminal Justice Commission was established to provide input and guidance for this initial stage. The outcome, including a Draft Juvenile Justice Data Dictionary, is documented in the *Report on the Development of a Juvenile Justice National Minimum Data Set* (AIHW 2001f).

The Juvenile Justice NMDS and the recommendations in the report were endorsed by the AJJA, the NCSIMG and CSMAC in early 2001. AJJA agreed to continue to fund the AIHW to manage the testing and further development of the data set and to develop national juvenile justice indicators. The Juvenile Justice Data Working Group was established later that year to work with the AIHW on the second stage of this project. The working group has representatives from all jurisdictions (the departments responsible for juvenile justice), the Australian Institute of Criminology, the ABS, the AIHW and the Department of Family and Community Services.

The Juvenile Justice NMDS

In developing the Juvenile Justice NMDS, the aim was to establish a national unit record data collection that provides more complete and comparable data on the clients of juvenile justice departments than is currently available. It includes data items to facilitate the collection of basic information on the characteristics of juvenile justice clients (i.e. young people under the supervision or case management of the juvenile justice department in each jurisdiction as a result of having committed or allegedly committed an offence). Information on their age, sex, Indigenous status, and last known home address can be recorded. The data set is also designed to collect information on the episodes or periods of supervision or case management of these clients. As a result, it can indicate the movement of young people into and out of the supervision of the departments, the length of time on supervision, and progressions through the juvenile justice system to more serious types of sentences (for example, from probation to detention). The data set in its current form is limited in its scope and coverage to those young people who are clients of juvenile justice departments. This is only a small proportion of young people who come into contact with the broader juvenile justice system. It is hoped that work can be undertaken in the future to improve the national comparability of police and court data.

Current status

The Juvenile Justice NMDS is still in draft form. Before its implementation as a national data collection, it is vital that the agreed data items and definitions be fully tested to ensure that they are meaningful, unambiguous and able to be collected. To this end, field testing of the data set was undertaken in early 2002 and a full-scale pilot test is currently being conducted in all jurisdictions.

A final report, including details of the outcome of the pilot test, recommendations on implementation and detailed national juvenile justice indicators, is due to be presented to the AJJA by the AIHW in November 2003.

6.8 Conclusion

Over the last decade, there have been ongoing changes in family structures and patterns that have implications for children's and family services. There were decreases in marriage rates at younger ages and in fertility rates, further delays in family formation, and increases in the number of children born outside marriage. There were increases in both the number of sole-parent families and the number of families with no parent in employment. Family assistance underwent a fundamental restructure in 2000, with the introduction of two new payments, Family Tax Benefit, Parts A and B. The vast majority of parents receive these payments fortnightly from Centrelink rather than at the end of the year through the tax system. A new payment—the Baby Bonus—provides tax relief to families with a new baby.

The number of children using child care changed little between 1993 and 2002, but there was a shift from informal to formal care use. The number of Commonwealth-supported service providers and child care places increased substantially between 1991 and 2001, with the number of outside school hours care places growing at a faster rate than other types of places in the last year (2000–01). Although the number of child care workers has grown in recent years, supply does not appear to have kept up with demand.

Commonwealth expenditure on child care services more than doubled in real terms between 1991–92 and 1998–99 and then increased by 22% between 1999–00 and 2001–02. Between 1991–92 and 2001–02, there was a shift from Commonwealth expenditure on child care service provision (operational subsidies and capital funding) to expenditure on measures that reduce the costs of child care for parents (fee subsidies). In 2001–02, 80% of expenditure was on the Child Care Benefit.

The introduction of the Child Care Benefit in July 2000 improved the affordability of child care and the utilisation of services. Unmet demand for formal care fell between 1999 and 2002. Affordability fell slightly between July 2000 and May 2002. A new accreditation system for family day care services was introduced in July 2001, a revised accreditation system for Commonwealth-supported long day care centres in January 2003 and a new accreditation system for outside school hours care services in July 2003.

Child protection is a dynamic area, with policies and procedures constantly evolving. While this makes it difficult to interpret long-term trends, it is still clear that the number of children in the child protection system is increasing. As the numbers of children on care and protection orders and in out-of-home care increased by 25% and 30% respectively, there is an indication that a growing number of parents are unable or unwilling to care for their children. These families often suffer from a myriad of problems which may include low socioeconomic status, unemployment, residential instability, crowded dwellings, domestic violence, alcohol and substance abuse, and psychiatric disability.

The decrease in adoptions over the past 5 years was primarily due to the fall in the number of adoptions of Australian-born children—both local adoptions and 'known' child adoptions. The small number of local adoptions is attributable to the decline in the number of Australian-born babies who are available for adoption. There was an increase in the number of intercountry adoptions over the same period, with most of the children being adopted from South Korea, Ethiopia and India.

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7 Ageing and aged care

7.1 Introduction

In recent years, the priority attached to ageing issues has increased substantially at both a national and international level. The proportion of the population in the older age groups is increasing, and this population ageing has been identified as an issue that will present opportunities and challenges for Australia, as it will for many countries. Its implications for all aspects of social and economic life are increasingly being recognised, including those for labour and capital markets, government pensions and assistance, services and informal support systems.

Policy development

At the international level, in April 2002 delegates from 190 countries, including Australia, met in Madrid for the United Nations' Second World Assembly on Ageing. The Assembly recommended the International Plan of Action on Ageing to the General Assembly of the United Nations. This called for changes in attitudes, policies and practices at all levels in all sectors to ensure that people everywhere are able to age with security and dignity and to continue to participate in their societies as citizens with full rights. In the Asia–Pacific region, the Macao Plan of Action on Ageing provided a means of taking forward the International Plan in a manner tailored for the region (UN 2002a, 2002b). In addition, the World Health Organization adopted the term 'active ageing' to describe the process 'of optimising opportunities for health, participation and security in order to enhance quality of life as people age' (WHO 2002:12). Active ageing aims to extend healthy life expectancy and quality of life for all people as they age, including those who are frail, disabled and in need of care.

Within Australia, the Commonwealth Government's *National Strategy for an Ageing Australia* (Andrews & DoHA 2001) offered a framework for responding to the changes that population ageing would bring. The strategy concluded that the implications of population ageing affect more than aged care service planning and provision, and that a whole-of-government approach is required that takes into account a range of policy areas and addresses the issues ageing raises for individuals and for the larger community. As part of this whole-of-government approach, the Intergenerational Report, tabled with the 2002–03 Commonwealth Budget, explored the economic implications of population ageing in terms of the funding of future public expenditure and the broader impact on Australia's economic wellbeing and living standards (Costello 2002). This report indicated that Australia is economically better placed than many other OECD countries to deal with population ageing.

Concerns over the implications of population ageing have prompted responses to ensure the sustainability of economic, health and social support systems which are directly influenced by the changing age structure of the population. At the same time, recognition has been given to those positive aspects of ageing which contribute to national wellbeing. Financial independence in retirement, participation in community life, including both paid and volunteer work, and healthy ageing are examples of those positive aspects of ageing being discussed and promoted in current debates. Indeed, a consistent theme in social and economic planning and policy in relation to ageing is the recognition of the opportunities that population ageing offers. In order to take advantage of these opportunities as a society, it is important to enhance quality of life as people age by optimising prospects for health, social participation and security. As the Declaration adopted by the Second World Assembly on Ageing stated:

> The potential of older persons is a powerful basis for future development. This enables society to rely increasingly on the skills, experience and wisdom of older persons, not only to take the lead in their own betterment but also to participate actively in that of society as a whole. (UN 2002a:Article 10, Annex I, Resolution 1)

Service development

The goal of the Australian aged care service system has been the 'provision of a cohesive framework of high quality and cost-effective care services for frail older people and their carers' (DHFS 1996:117). Complementary to this objective is the broader goal of achieving positive and healthy ageing to improve the physical, emotional and mental wellbeing of older people. Thus, programs concerned with ageing are not just about responding to the dependency of older people but also about supporting people to lead independent lives and to continue to participate in all aspects of life including social, economic, cultural, spiritual and civic affairs as they age.

Reflecting the cross-sector implications of population ageing, the period since 2001 has seen a push towards the further integration and consolidation of ageing issues into broader community concerns. In addition, the need for a response not only from government but also from business, community organisations and individuals has also been recognised. With respect to service provision, increasing emphasis on community care and decreasing emphasis on residential care has continued. This trend began with the implementation of the Home and Community Care Program (HACC) in 1985, and its rapid expansion in subsequent years. The development of respite care services, and the introduction and rapid growth of Community Aged Care Packages in the 1990s further supported the growth of community-based care.

More recently, a number of initiatives have continued the expansion of community care. In 2001–02, the Commonwealth Government announced its intention to establish Extended Aged Care at Home (EACH) as an ongoing program. Operating as a pilot program since 1998, EACH provides high-level aged care to people in their own homes. In addition, Commonwealth Carelink Centres were established to provide a single contact point for comprehensive information about community, aged care and other support services. Also in 2001, Commonwealth funding was provided to identify best-practice models for Day Therapy Centres to better coordinate these allied health services with other health and aged care services (DoHA 2002b:128). Further reflecting the importance of best practice in service provision, the national Innovative Pool was established in the 2001–02 financial year to provide a means of testing alternative service models through the provision of flexible care places. Some of the first projects were developed, in collaboration with state governments, to test service delivery models to assist older Australians leaving hospital but not yet able to live independently at home. Other projects under this program, such as those providing care for people with dementia, will pilot methods that assist people to age in place in residential aged care accommodation or to remain living in their own homes.

A number of other developments since the publication of *Australia's Welfare 2001* (AIHW 2001a) are summarised in Box 7.1. Most notably, in 2002, a pricing review of the residential aged care sector began, and the House of Representatives Standing Committee on Ageing was established to inquire into long-term strategies to address the ageing of the Australian population. In March 2003, a new Strategy for Community Care to reform the community care system was put forward for consultation. This reform strategy seeks to facilitate a more integrated community care system through such measures as instituting a common information system across all similar programs and establishing commonality in points of access, assessment processes, eligibility requirements, standards of service provision, user fees and accountability processes. Among the benefits that these proposed reforms anticipate are greater equity of access and simplified entry points for people requiring care and, for service providers and administrators, more streamlined administrative requirements.

Chapter outline

The primary focus of this chapter is people aged 65 and over, and those programs, services and assistance directed towards both meeting their care needs and assisting their continued independence and participation in the community. The age group 65 and over is used as this is the age traditionally considered to be associated with retirement and the beginning of old age. It should be noted, however, that the population aged 65 and over is not used by government as either a planning or funding tool for the programs discussed, and that younger people can and do access these services. The use of services by younger people is examined in Chapter 8.

The range of services and assistance available to older people in Australia is extensive and by no means all such provisions are included in this chapter. For example, programs concerned with housing, hospital care, medical care and pharmaceuticals are discussed either in other chapters in this publication or in *Australia's Health* (Chapter 5; AIHW 2002b). Moreover, it must be remembered that older people are also eligible for, and make use of, various other benefits and services that are available to the general population.

Section 7.2 discusses current and future patterns of population ageing as it is experienced in Australia, and sets current trends in the context of population change over the last 20 years. It puts disability levels among older people into perspective, and describes those health factors and limitations which can predispose them to need services and assistance. Section 7.3 provides an overview of the support and services available to older people, and identifies recent national data development activities that will allow improved analysis of the sector. Sections 7.4 to 7.7 present data on aged care services and assistance, the clients of such services and the expenditure involved. Section 7.8 discusses outcomes for older people in relation to aged care services. A brief summary follows in Section 7.9.

Box 7.1: Events in aged care, 2001 to 2003

2001

Extended Aged Care at Home *(EACH) program was established following successful implementation of a pilot in 1998.*

Veterans' Home Care*, a Department of Veterans' Affairs program to provide home-based services to veterans, commenced in January.*

Commonwealth Carelink Centres *were established to provide single contact points for comprehensive information about community, aged care and other support services.*

The national ***Innovative Pool*** *of flexible care places was established. The Innovative Pool allows for the development of pilots for innovative service provision to test alternative models to meet specific needs. Most pilots are developed in collaboration with state and territory governments.*

The ***Safe at Home Initiative*** *was established to assist frail older people to remain in their homes through the provision of personal alert systems.*

The report of the **Two Year Review of Aged Care Reforms***, commissioned by the Commonwealth government in 1998, was released. Chaired by Professor Len Gray, the review's purpose was to evaluate the impact of the reforms (DHAC: Gray 2001).*

2002

The next phase of the ***National Strategy for an Ageing Australia****—a report entitled* An Older Australia, Challenges and Opportunities for All*—was released by the Minister for Ageing in February (Andrews & DoHA 2001).*

The ***House of Representatives Standing Committee on Ageing*** *was established to inquire into long-term strategies to address the ageing of the Australian population over the next 40 years.*

The ***Second World Assembly on Ageing*** *took place in Madrid, Spain. The Assembly adopted the Madrid International Plan of Action on Ageing.*

The **Intergenerational Report** *was tabled with the 2002–03 Commonwealth Budget. The report explored the economic implications of population ageing in terms of the funding of future public expenditure and the broader impact on Australia's economic wellbeing and living standards (Costello 2002).*

The ***Myer Foundation****, a philanthropic body, supported the development of a report entitled* 2020: A Vision for Aged Care in Australia *(Myer Foundation 2002). Based on research, discussion and policy dialogue of leading aged care experts from public, private and not-for-profit sectors, this vision provided an authoritative contribution to public debate on the future of aged care that is independent of government perspective.*

The ***National Advisory Committee on Ageing*** *was established to facilitate discussion about the consequences of the ageing population for the development of policies and programs.*

(continued)

Box 7.1 (continued): Events in aged care, 2001 to 2003

Development of a ***National Aged Care Workforce Strategy*** *began. The purpose of the strategy is to identify the workforce profile of the aged care sector and its needs until 2010. Current workforce needs led the Commonwealth Government to provide some funding in the May 2002 Budget for scholarships for aged care nursing students and for training for personal care workers (Andrews 2002).*

A ***Review of the Pricing Arrangements in Residential Aged Care*** *began. This review examines long-term financing options for the aged care sector, taking into account underlying cost pressures and the care outcomes required under accreditation.*

2003

The ***Resident Classification Scale Review*** *was completed and a report of recommendations released (Aged Care Evaluation and Management Advisors 2003). As a response to the report, trials to test a decrease in paperwork for staff of residential aged care services began in May 2003 (Andrews 2003d).*

A new ***Strategy for Community Care****, which is aimed at supporting care recipients to access the right service, was put forward for consultation (Andrews 2003b).*

A recommendation of the Two Year Review of Aged Care Reforms *(DHAC: Gray 2001) was to create a simpler system for entry to residential aged care. In response, the* ***Entry Pack for Residential Aged Care****, including a new form and information booklet, was launched in April (Andrews 2003c).*

7.2 Ageing in Australia

This section presents an overview of the structure of Australia's current population and sets this picture in the context of population changes that have occurred in the preceding 20 years and that are expected to occur in the next 20 years. The social backdrop within which these changes are occurring influences strategies adopted to meet the resulting challenges. While many older Australians experience disability-free lives, a proportion requires assistance and care. The health of the community and the disability levels people experience in older ages are important considerations in understanding current service and support needs and anticipating future needs.

Population structure and change

Population ageing occurs when growth in the older population outpaces growth in the younger population. Changing patterns of fertility and mortality are the two main drivers of population ageing. Social and technological change has resulted in substantial increases in life expectancy, with life expectancy at birth increasing by more than 20 years and life expectancy at age 65 increasing by 7 years for women and 5 years for men over the past century (AIHW 2002c:101). At the same time, Australia's total fertility rate has been declining. Having reached a peak at the height of the 'baby boom' (3.5 births per woman in 1961), it now sits at its lowest level in Australia's history: 1.7 births per woman, well below the replacement fertility level of 2.1 (ABS 2002d:45). This, however, is still relatively high compared with most OECD countries. Over the next 10 years, the oldest of the baby-boomer generation will reach 65, the age traditionally considered to be associated with retirement and the beginning of old age. It is this population shift that has been identified as an issue that will present opportunities and challenges for Australia, as it will for many countries. It has implications for all aspects of social and economic life, including government pensions and assistance, health and welfare services and informal support systems, and these factors will in turn have implications for the experience of ageing.

On 30 June 2002, people aged 65 years and over represented 12.7% of Australia's total population, or 2.5 million people (ABS 2003a). Of people aged 65 and over, 54% were aged 65–74 years, 35% were aged 75–84, and 11% were aged 85 and over. Thus, while over half of all older people were aged between 65 and 74, there was a significant minority (over 280,000) aged 85 and over. Fifty-six per cent of older people (65+) were women. As age increases, this predominance becomes progressively more evident: in the 65–69 age group, the proportions of men and women were almost equal; by age 85 and over, there were over twice as many women as men. In absolute numbers, in June 2002 there were 280,000 more women than men aged 65 and over in Australia (Table 7.1).

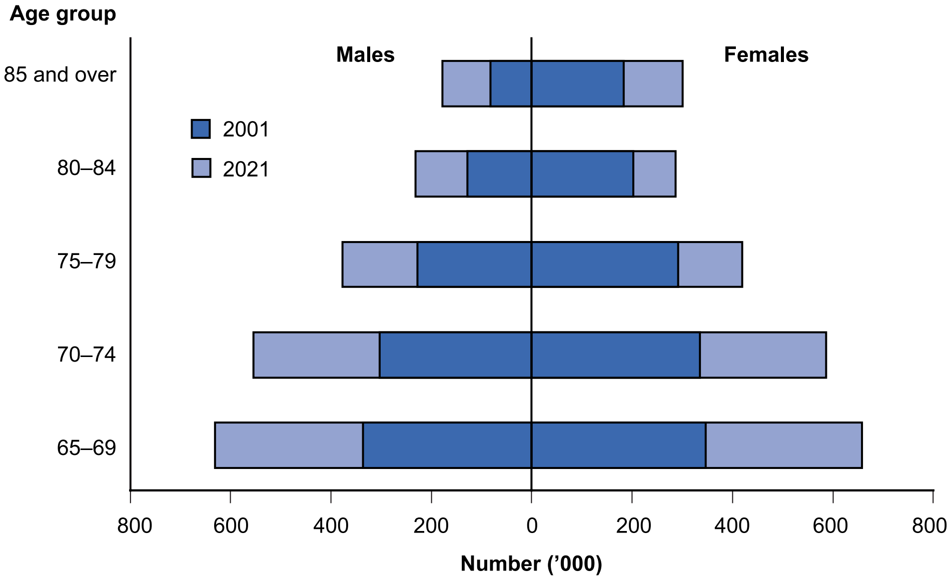
The Australian population is ageing numerically in that the number of older people is increasing, and structurally in that the proportion of people who are aged at least 65 is rising. In the 20 years up to 2021, the number of people aged 65 and over is expected to increase by 73%, from 2.4 million in 2001 to 4.2 million in 2021 (Figure 7.1). These older Australians are projected to then comprise 18% of the population (see Table A7.1). The number of people aged 85 and over, among whom we find those most likely to be in need of services and assistance, is also projected to expand rapidly over this period: from 265,200 in 2001 to 478,600 in 2021. This represents an increase of 80% in this age group. As a proportion of the population, the number of people aged 85 and over is projected to rise from 1.3% in 2001 to 2.1% in 2021.

While the above growth rates are high, it is not the first time Australia has experienced a rapid rate of increase of the older population. Over the decade 1981–91, the population aged 65 and over rose by 34%, higher than between 1991 and 2001 (23%) and higher than it will in the 10 years up to 2011 (26%). It is only in the decade 2011 to 2021, as increasing proportions of the Australian baby-boom generation reaches 65, that the rate of growth, at 39% over the decade, is projected to be higher than previously experienced; thereafter it will drop again. In the age group 85 and over, the last two decades saw overall growth rates of 50% (1981–91) and 69% (1991–2001). The projected rates for the next two decades are 50% and 23%. Thus, between 2011 and 2021, the structure of the aged population will shift towards a younger profile for the first time in three decades (AIHW 2002c:4–5). However, as baby boomers get progressively older, the population aged 65 years and over will again move towards an older structure.

Table 7.1: Persons aged 65 years and over, 30 June 2002

Age	Males	Females	Persons	Males	Females	Persons
		Number			Per cent	
65–69	343,500	354,600	698,100	31.1	25.6	28.0
70–74	303,000	331,900	634,900	27.4	24.0	25.5
75–79	233,200	294,200	527,300	21.1	21.2	21.2
80–84	137,500	211,700	349,300	12.4	15.3	14.0
85+	87,800	192,600	280,400	7.9	13.9	11.3
Total	**1,105,000**	**1,385,000**	**2,490,000**	**100.0**	**100.0**	**100.0**

Source: ABS 2003a.



Source: Table A7.1.

Figure 7.1: Population aged 65 years and over, 2001 and 2021

A chief source of concern in the patterns of change that are occurring in the population structure is that, as the population ages, the growth in the number of people of working age will be less than the growth in the number of people outside these ages. In a report submitted to the House of Representatives Standing Committee on Ageing in January 2003, the Department of Treasury predicted that the growth in Australia's working population would slow to zero by 2042 (Treasury 2003a); that is, the pool of people of traditional working age (15 to 64) who are potentially able to support those traditionally considered to be of non-working age (under 15 and 65 and over) will cease to grow. In addition, the increase in the population aged 65 and over will outweigh the decrease in the population under 15 years of age. As a consequence, a number of government initiatives have been developed to reduce barriers and disincentives for continued participation in the workforce up to and beyond age 65. For example, the Commonwealth Government has abolished compulsory age retirement for its public service; also, legislation is currently being developed to prohibit age discrimination across a broad spectrum of areas including employment (Attorney-General's Department 2002).

Social context

While population ageing is expected to present a challenge for Australia in many areas including planning for health and community services, it has been widely recognised that the difficulty of these challenges—such as the increasing costs they are likely to bring—can be substantially lessened or overcome by undertaking appropriate action at an early stage. In March 2000, the Healthy Ageing Task Force (a joint federal, state and territory body)[1] released the *Commonwealth, State and Territory Strategy on Healthy Ageing* (HATF 2000). The initiatives outlined in this strategy seek to benefit individuals and the community as a whole. In addition, the following extract points to the economic benefits to be gained by bringing this strategy forward:

> Initiatives which aim to improve the health and wellbeing of older people, encourage them to remain productive, continue and extend their contribution to family and community life and plan for later life, will contribute to the cost associated with ageing being minimised and managed over the long term. (HATF 2000:6)

This strategy identified a number of areas where action should be taken to achieve positive ageing. Included among these actions were: improving community attitudes to ageing and older people; improving the health and wellbeing of older people; providing appropriate and affordable support so that older people can meet their needs and aspirations and remain in their own homes for as long as possible; and making use of research and good quality data to improve care and support and prevent illness.

The review of healthy ageing research in Australia (Kendig et al. 2001), undertaken for the Community Services Ministers' Advisory Council, suggested a number of broad priority areas for research. Improving and maintaining health was just one of seven areas identified. The remaining priority areas reflect the wider definition of healthy ageing as extending beyond health and community services issues in to broader aspects of wellbeing including social interactions, employment, housing and transport. In addition, as a move to increase the quality and quantity of statistical evidence available for policy development, in 2002 a project—Building Ageing Research Capacity—was established under a joint initiative of the Office for an Ageing Australia and the Australian Institute of Health and Welfare. The main purpose of the project is to maximise collaboration and coordination between Australian researchers on issues related to ageing. The key outputs of this project will be the development of an Australian Ageing Research Agenda and of the Ageing Research On-line (ARO) web site.

At the broad policy level, the *National Strategy for an Ageing Australia* (Andrews & DoHA 2001) focused on providing opportunities for, and removing barriers to, people's

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[1] Renamed the Positive Ageing Task Force in 2002 to reflect the broader focus of the group, this body continues to coordinate strategies concerned with positive ageing issues across jurisdictions.

participation in society and access to services across their lifespan, not just in old age. The report discusses strategies for supporting and encouraging healthy ageing, in its broadest definition, across the life course as well as better health in older age.

As discussed above, the importance of factors other than health in positive—or active—ageing have been recognised both in Australia and internationally. Older people participate in society in a variety of ways, from paid and unpaid work to involvement in spiritual and cultural affairs. It is estimated that in 2000–01 people aged 65 and over spent a total of 283 million hours during the year providing welfare services, including both voluntary work and care. This accounted for 16% of welfare service hours provided by the household sector (Table 4.23). Also, in the 1998 Survey of Disability, Ageing and Carers, 94% of people aged 65 and over living in households reported participating in community, cultural and leisure activities away from home in the 3 months preceding the interview. Activities included church activities (29%), voluntary work (19%) and other special interest group activities (18%; ABS 1999a:42). Programs which promote active ageing aim to encourage and support people so that they can participate in these endeavours. A brief overview of the social context within which such programs operate follows.

Living arrangements

As only 5% of people aged over 65 live permanently in residential aged care (see Table A7.12), the overwhelming majority of older people live in households in the community. These people have a variety of living arrangements: at the time of the 2001 population census, 59% lived with a spouse or partner, 10% lived with other relatives (often their child), and 30% lived on their own. A small number of older people (2%) lived in group households or with an unrelated family (see Table A7.2).

People aged 75 and over are more likely to be living on their own than younger people, and, because of their greater longevity, older women are more likely to live alone than their male counterparts. Thus in 2001, 51% of women aged 75 and over lived alone and 31% lived with a spouse or partner; the corresponding figures for men aged 65 to 74 years were 16% and 78%.

Income and work

Australians today are living longer, and so spending longer in retirement, than those in preceding generations. Income security during these years is important if older people are to be able to participate in society as much as they can.

The sources and amounts of the incomes of older Australians vary widely but continue to reflect past social policies concerning pensions and self-funded retirement. Income security is provided to older people through government pensions and allowances, and in 1999–00 these were the main source of income for three-quarters of income units with the reference person aged 65 or over (Table 7.2).[2] A proportion of people work past pension age, and in 1999–00 earned income was the main income source for 5% of older income units. Although 91% of employees in Australia had superannuation in 2000, the main effects of government measures designed to compel employers to contribute to superannuation accounts for their employees have yet to be seen in retirement income

Table 7.2: Main source of income of income units with reference person aged 65 and over, 1999–00 (per cent income units)

Gross weekly income ($)	Government pensions and allowances	Superannuation	Earned income[(a)]	Other[(b)]	Total
<200	33.9	*3.7	*7.4	14.7	[(c)]28.5
200–399	55.3	27.2	*9.7	24.0	46.7
400–599	9.8	35.4	21.3	18.2	13.3
600–799	*0.6	14.8	*11.2	7.5	3.1
>800	*0.4	18.9	50.3	35.6	8.4
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**1,197,800**	**134,700**	**78,700**	**179,400**	**1,604,500**
Total (row per cent)	**74.7**	**8.4**	**4.9**	**11.2**	**100.0**

(a) Includes wage and salary and income from own business.

(b) Includes investments, property and other sources of income.

(c) Includes zero and negative incomes.

Source: AIHW 2002c:Table A8.1.

data (ABS 2002c). In 1999–00, superannuation was the main source of income for 8% of older income units. The remaining 11% had other sources of income, including income from property, shares and other sources of wealth.

Reflecting the pension income and assets tests, in 1999–00 only 11% of older income units relying on government payments had gross income greater than $400 per week; the corresponding proportions for those reliant on superannuation and earned income were 69% and 83%, respectively. Income units whose main source of income is paid work tend to have higher incomes than others. In 1999–00, this group had the largest proportion of older income units with incomes greater than $800 per week, at 50% of income units with the reference person aged 65 or over compared with 8% for all income groups.

Income support

The Age Pension and pensions from the Department of Veterans' Affairs (DVA) are the two main sources of income support for older people (see Box 7.2 for a brief description). In December 2002, 66% of Australians (or 2,226,234) aged 60 and over (and 82% of people aged 65 and over) received either the Age Pension or a DVA payment (full and part pensions) (see Table A7.4). The proportion of people receiving payments from either of these sources increases with age, ranging in 2002 from 73% for 65–69 year olds to 89% of people aged 80–84. For both pension types, the majority of pensioners were women (61% of Age pensioners and 57% of DVA pensioners).

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2 To examine the income of people, income units are often used rather than individuals, simply because income often tends to be shared among more than one person. Under the ABS definition, an income unit is a person or group of related persons within a household, whose command over income is assumed to be shared. Income sharing is assumed to take place within married (registered or de facto) couples, and between parents and dependent children.

Box 7.2: Income support

Age Pension

The Age Pension is assets and income tested, and in December 2002 was available to men aged 65 and over and women aged 62 and over. The qualification age for women, which was 60 years until 1 July 1995, has been gradually increasing and will be raised to age 65 by 2014. The maximum single rate of pension is set at a minimum of 25% of male total average weekly earnings. Each member of a couple receives approximately 83% of the single rate of pension. The maximum single rate is adjusted every 6 months in line with the consumer price index. As at March 2003, a single person on the maximum rate Age Pension received $220.15 per week, and a couple $367.50 per week. In December 2002, 1,836,471 people were receiving either a full or part pension (see Table A7.4).

DVA pension and benefits

The Service Pension is paid to veterans, eligible partners, widows and widowers. It is similar to the Age Pension, being paid at the same rate and subject to income and assets tests. In general, it is available 5 years earlier than the Age Pension; however, it may be granted at an earlier age in cases of invalidity. There are also other forms of income support available from DVA which are neither taxable nor subject to means testing. These include the war widow(er)'s pension and disability compensation. Depending on their income and assets, people on the war widow(er)'s pension may also be eligible for the income support supplement (ISS). Allowances payable in association with the Service Pension and ISS include a pharmaceutical allowance, rent assistance, telephone allowance and remote area allowance. In December 2002, there were 389,763 people receiving a DVA pension (see Table A7.4).

Senior Australians' Tax Offset

Introduced in the 2001–02 Budget, this change to the taxation system means that older Australians are now entitled to income-tested tax offsets regardless of the source of their income; previously such offsets were available only to DVA and Age pensioners. Eligibility commences at age 65 for men and 62 for women. The effect of the offsets is that individuals who earn below $20,000 per year and couples who earn a combined amount of less than $32,612 per year do not pay income tax. As income rises, the amount of the tax offset is reduced by 12.5 cents per dollar earned above the tax-free income levels. This scaled reduction means that some tax offset is available to individuals with a taxable income up to $37,840 per year, and couples with a combined income up to $58,244. Had this offset not existed, it is estimated that the Australian Taxation Office would have collected an additional $1,310 million in tax from around 375,000 older Australians, including 200,000 pensioners, in the 2001–02 financial year (Treasury 2003b:45).

Workforce participation

The above picture of high levels of dependency on pension payments is expected to change in the coming years as the effects of increased superannuation coverage flow through. This increase is due both to the introduction of the national superannuation contributory system in the 1980s along with the Superannuation Guarantee in 1993, and to the greater participation of women in the workforce. While the participation of men aged over 45 years in the labour force has remained reasonably stable over the last 15 years, participation rates for women have grown substantially. Between 1988 and 2002, the rate for women aged 55–59 increased from 33% to 51%, while that for women aged 60–64 increased from 16% to 27% (Table 7.3). This rise for women means that overall in all age groups over 45 there has been an increase in labour force participation since 1988. In December 2002, just over 6% of people aged 65 and over were in the labour force.

The decline in labour force participation with age, observed in Table 7.3, is not solely due to a desire to retire. People with a disability are less likely than others to participate in the labour force, with participation decreasing with increasing core activity restriction. Also, among those in the labour force, people with a disability are more likely to be unemployed than people without a disability. Consequently, as disability rates increase with age, in many cases retirement may be the result of an inability to work due to disability. Comparisons of age-specific rates of receipt of the Disability Support Pension with labour force participation rates for men suggest that as many as half of the men aged 60 to 64 who are not in the labour force are receiving this pension (Tables 7.3, 7.4; ABS 1999a:35; AIHW 2001a:450).

Given the projected rise in the ratio of older people and children to working-age people, policies aimed at changing patterns of participation in the labour force, as well as those aimed at changing patterns for saving for retirement, will have increasing prominence (Costello 2002:23–4). Currently there are initiatives to encourage older people to stay in the workforce until age 65 and beyond, where possible, and to delay their decision to retire. For example, the Pension Bonus Scheme provides a lump sum payment upon retirement for those who defer their choice to take up the Age Pension and continue to work. Also, in the 2001–02 Commonwealth Budget, the Senior Australians' Tax Offset was introduced to encourage independent income and to equalise the taxation treatment of pensioners and non-pensioners (see Box 7.2). This measure extended tax offsets already available to pensioners to non-pensioners on low incomes.

Table 7.3: Labour force participation rates, December 1988, 1993, 1998, 2002 (per cent)

Sex/age	1988	1993	1998	2002
Males				
45–54	89.3	88.5	87.8	88.3
55–59	73.3	73.0	72.8	74.3
60–64	47.8	50.6	45.8	49.0
65+	9.7	9.2	9.7	10.4
Females				
45–54	58.2	65.7	69.8	74.5
55–59	33.0	37.4	44.0	50.5
60–64	15.7	15.5	18.0	26.8
65+	2.7	2.8	2.9	3.3
Persons				
45–54	74.1	77.3	78.8	81.4
55–59	53.3	55.4	58.7	62.6
60–64	31.5	33.1	31.9	38.0
65+	5.6	5.6	5.9	6.4

Note: Percentages are as a proportion of persons in the age/sex group.

Sources: ABS 1989, 1994, 1999b, 2003b.

Volunteer work

Older people make a significant contribution through volunteer work. In the 12 months to June 2000, nearly 530,000 people aged 65 and over (or 25%) participated in some form of volunteer work through a formal organisation or group (AIHW 2002c:16–17). Older volunteers tend to contribute more hours to voluntary work than younger people and while, in 2000, people aged 65 and over made up 12% of the total number of volunteers, they provided 17% of the total hours contributed. Like younger people they have a variety of reasons for volunteering, the most common being to help others or the community, for personal satisfaction and to do something worthwhile. The type of voluntary work performed by older people varies depending on their age and sex. For example, in 1999–00, women aged 65 and over were more likely to volunteer for fund-raising and sales activities or the preparation and serving of food. Men were more likely to be involved in administrative and clerical or management and committee type work.

Carers

Many older people provide care for family and friends who need assistance in their daily lives. Using data from the ABS Survey of Disability, Ageing and Carers, in 1998 an estimated 401,000 people aged 65 and over provided assistance to people with a disability (ABS 1999a:43). Nearly one-quarter of these care providers were the primary carer of the care recipient, that is they provided the most assistance, in terms of help or supervision, to the care recipient. People aged 65 and over accounted for 22% of primary carers of people with a disability. Chapter 3 contains a detailed examination of the role of carers in Australian society.

There are a number of aged care programs that support carers in the community, and these are discussed in Section 7.4. In addition, depending on their circumstances, carers may be able to access two government payments: the Carer Payment and the Carer Allowance. People receiving these payments may be caring for more than one person (see Tables A7.5 to A7.7).

The Carer Payment is an income-support benefit payable to people who, because of their caring responsibilities, are unable to engage in a substantial level of paid work and who are not eligible for other income support payments (see Box 8.7). It is set at the same rate as the Age Pension and is subject to the same income and assets tests. Because it is for people forgoing paid work due to caring responsibilities, relatively few older people receive it. In December 2002, a total of 71,210 people were receiving the Carer Payment; people aged 65 and over accounted for just over 4% (1,129) of the 26,333 people caring for people aged 65 and over, and 1% (633) of the 46,103 people caring for younger people (see Table A7.5). Older recipients of the Carer Payment were more likely to be men than younger recipients: among older recipients looking after people aged 65 and over, 40% were men, compared with 33% of all recipients looking after people aged 65 and over.

The Carer Allowance is payable to co-resident carers who provide full-time care on a daily basis for up to two people who need substantial amounts of care because of a disability or a severe medical condition or because they are frail older people (see Box 8.7). The allowance can be paid to carers whether or not they are in receipt of a government pension or benefit and is not income or assets tested. It is adjusted on

1 January each year, and in 2003 was set at $87.70 per fortnight (Centrelink 2003). In December 2002, 294,806 people were receiving the Carer Allowance. The majority (56%, or 51,638) of recipients looking after people aged 65 and over were themselves aged at least 65, while just under 5% (9,340) of recipients caring for younger people were aged 65 and over (see Table A7.6). As with the Carer Payment, older recipients were more likely to be men than younger recipients: 38% of older recipients looking after people aged 65 and over were men, with the corresponding figure for all recipients looking after older people being 32%. This difference was even more marked among recipients caring for people aged under 65: among all such carers, 15% were men compared with 44% of older recipients caring for younger people.

Ageing and disability

Key factors affecting the ability of many people to take part in the spectrum of activities of life—from workforce participation to independent living—include illness or injury and the related level of disability which arises. While many older Australians are free from a disability for which they require assistance, a proportion have more intensive care and assistance needs.

The surveys of disability, ageing and carers conducted by the ABS provide information about the prevalence of disability in the older population. The most recent data are drawn from the 1998 Disability, Ageing and Carers Survey, the fourth since 1981. In this survey, disability is defined as the presence of one or more of 17 limitations, restrictions or impairments. These 17 categories include a variety of problems ranging from loss of speech to 'any … long term condition that restricts every-day activities' (ABS 1999a:4).

The prevalence of disability in the older population in 2001 has been estimated using the age-sex specific rates of disability derived from the 1998 ABS survey (Table 7.4). This method assumes a constant rate of disability in the older population over time, an assumption which has been the subject of considerable debate in the international and national literature in recent years. A summary of this debate can be found in *Australia's Welfare 2001* (AIHW 2001a:201–3). Internationally, the evidence is somewhat mixed on whether disability rates are declining or increasing. However, to date, the Australian evidence suggests a relatively stable picture of severe restriction rates in the older population.

In 2001, over half of all people aged 65 and over (54% or 1.3 million) were estimated to have some form of disability. Having a disability does not imply need for assistance. Core activity restriction—which relates to difficulty or need for assistance with self-care, mobility or communication—provides a more useful indicator of level of difficulty experienced or help needed in performing activities basic to living than does the overall disability measure. Core activity restriction is categorised into four levels: people who are unable to perform a core activity or who always need help to do so (profound core activity restriction); people who sometimes need help (severe core activity restriction); people who do not require help but have difficulty with a core activity task (moderate core activity restriction); and people who do not require help but who use aids and equipment to undertake core activity tasks (mild core activity restriction). The group of older people most likely to be in need of assistance from aged care programs providing higher levels of care are those with a severe or profound core activity restriction.

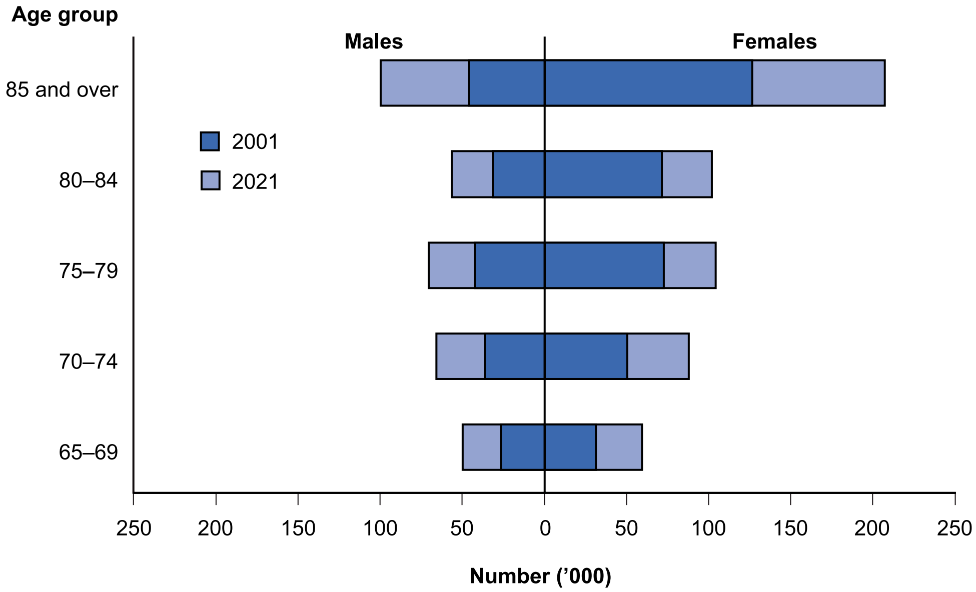
Among older people, the rates of severe or profound core activity restriction are quite low until age 75. In 2001, for those aged 65–74 years, an estimated 11% were so affected. The rates rise quite markedly with age, however, so that by age 85 and over, 65% of the population had a severe or profound core activity restriction.

The expected increase in the number of older people with a severe or profound core activity restriction between 2001 and 2021 has been calculated using ABS population projections (ABS 2000) and assuming constant rates of disability in the older population over the period (Figure 7.2). In 2001, there were an estimated 534,500 people aged 65 and over with such a restriction. This is expected to rise to 902,900 in 2021—an increase of 70% over the 20-year period. The number of people aged 85 and over with a severe or profound restriction is expected to increase by 78% (to 307,100).

Table 7.4: Disability status of persons aged 65 years and over, 2001

	65–74	75–84	85+	Ages 65+
With disability		**Per cent of age group**		
Severe or profound core activity restriction	10.8	25.5	65.0	21.9
Moderate core activity restriction	9.9	10.5	8.0	9.9
Mild core activity restriction	16.9	20.7	10.4	17.5
Without specific activity restrictions	6.5	4.1	1.0	5.1
Total with disability	***44.1***	***60.8***	***84.4***	***54.3***
No disability	***55.9***	***39.2***	***15.6***	***45.7***
Total	**100.0**	**100.0**	**100.0**	**100.0**

Source: AIHW 2002c:Table A17.1.



Source: Table A7.1.

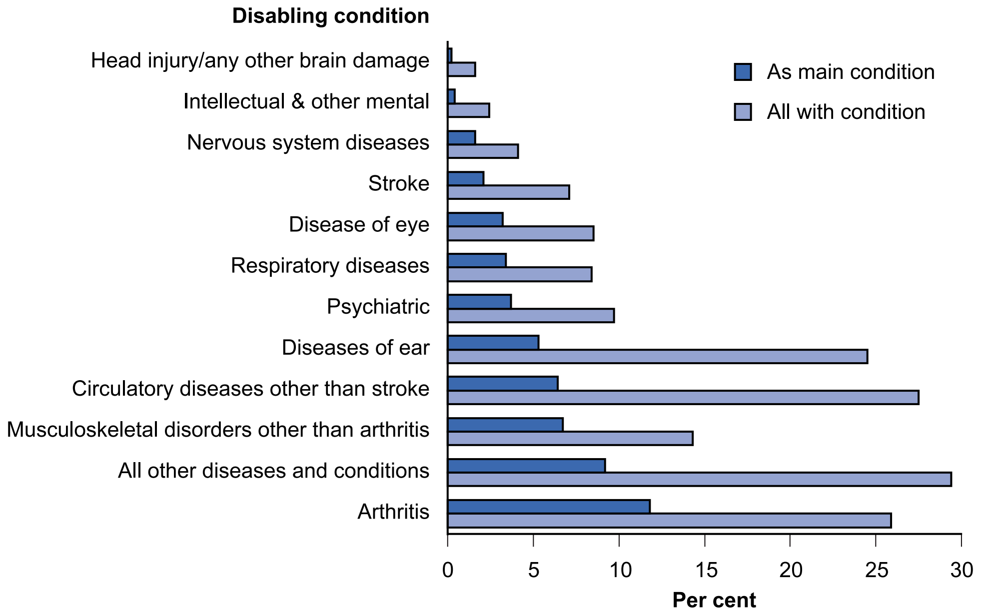
Figure 7.2: Older people with a severe or profound core activity restriction, 2001 and 2021

While rates of severe or profound core activity restriction increase at older ages, the majority of people with such a restriction continue to live in the community, rather than in an institutional setting. According to the 1998 ABS survey, among people with a severe or profound restriction, 84% of 65–79 year olds and 55% of those aged 80 and over lived in the community, with the remainder living in some form of institutional care (AIHW 1999a:171).

Causes of disability

In order to improve the health and wellbeing of older people and to encourage appropriate individual behaviours and treatment practices, it is advantageous to have an understanding of the size and impact of health problems in the population, the causes of disability and loss of health, and to be able to identify the best ways to bring about change to prevent illness. It is possible to identify the conditions that most commonly give rise to disability among people aged 65 and over using the 1998 survey, in which a main condition was defined as 'a long-term condition identified by a person as the one causing the most problems' (ABS 1999a:69).

Figure 7.3 shows the prevalence of various disabling conditions as reported by those aged 65 and over. The extent to which conditions were identified as the main disabling condition is also presented. Among main conditions reported, arthritis was most common (12%), followed by other musculoskeletal disorders (7%). Circulatory conditions were also important, with stroke (2%) and other circulatory diseases (6%) being reported as the main disabling condition for a total of 9% of respondents.



Source: Table A7.3.

Figure 7.3: Prevalence of main and all disabling conditions in people aged 65 and over, 1998

Circulatory conditions and musculoskeletal disorders are also very prominent when all disabling conditions are considered: 7% and 28% of older people reported stroke and other circulatory diseases, respectively, as a disabling condition, while 26% and 14% reported arthritis and other musculoskeletal disorders. In addition, diseases of the ear were a common disabling condition (25%).

While these figures show the conditions that give rise to a disability, they do not take into account the severity of the disability or the extent to which it affects people's lives. Severity can be measured according to whether the condition results in premature mortality, which is captured by the Years of Life Lost (YLL) measure. Alternatively, it can be measured by estimating the number of healthy years of life lost, which is captured by Years of Life lost due to Disability (YLD). These measures take into account both the incidence of illness and the severity or level of impact on life and functioning due to that illness (AIHW 2000a:50). Previous analysis has identified dementia, adult-onset hearing loss and stroke as the leading causes of non-fatal disease burden. The leading causes of premature death among older Australians as measured by Years of Life Lost are cardiovascular diseases and cancers (AIHW: Mathers et al. 1999:218–24). Further work on the burden of disease is being conducted by the AIHW to update these 1993–94 estimates.

Dementia

Because of its place as one of the leading causes of disease burden, a particular concern associated with the ageing of the population is the increase in the number and proportion of the older population with dementia, and the associated need for both home-based and residential care. In 1993–94, dementia accounted for the largest proportion of disease costs for any one condition. The prevalence of dementia can be difficult to estimate for a number of reasons; for example, in the mildest stages of dementia there may be little contact with the health or aged care services that would result in a diagnosis. Even when this contact does occur, the diagnosis of other conditions or diseases may be seen as more relevant to treatment than making a clinical assessment of dementia. Age-specific prevalence estimates were calculated by Jorm, Korten and Henderson (Henderson & Jorm 1998; Jorm et al. 1987) using meta-analysis of international studies. Their results suggest that the prevalence of dementia increases with age, rising from 1% among people aged 65–69 to 6% among 75–79 year olds and up to 24% for those aged at least 85. If these rates are used as a basis for calculating prevalence in the population (assuming constant prevalence rates over time), there were an estimated 153,800 persons with dementia aged 65 and over in Australia in 2001. This equates to 6.4% of the older population (AIHW 2002c:36).

The severity of the effects of dementia on the lives of people affected by this condition provide an indication of the extent to which they are likely to require assistance. Using the 1998 ABS survey, estimates can be derived of the prevalence of dementia or Alzheimer's disease. Because the survey uses self-reporting of health and disability status, these estimates are likely to be too low. However, the data can be used to examine the disability status of people with dementia.

Table 7.5: Disability status of people with dementia, including Alzheimer's disease, 1998

Age	With a disability: Severe or profound core activity restriction	Moderate or mild core activity restriction	Disability without core activity restriction	Total	No disability	Total
			Number			
65–74	11,500	*2,000	**—	13,600	**500	14,000
75–84	33,800	**300	**100	34,100	**400	34,500
85+	48,100	**500	**100	48,600	**600	49,200
Total	**93,400**	***2,700**	****200**	**96,300**	***1,500**	**97,800**
			Per cent			
65–74	82.3	*14.1	**0.2	96.6	*3.4	100.0
75–84	97.9	**0.8	**0.2	98.9	**1.1	100.0
85+	97.7	**1.0	**0.1	98.8	**1.2	100.0
Total	**95.6**	***2.8**	****0.2**	**98.5**	***1.5**	**100.0**

Note: Estimates are based on all reported long-term conditions.

Source: AIHW analysis of ABS 1998 Survey of Disability, Ageing and Carers.

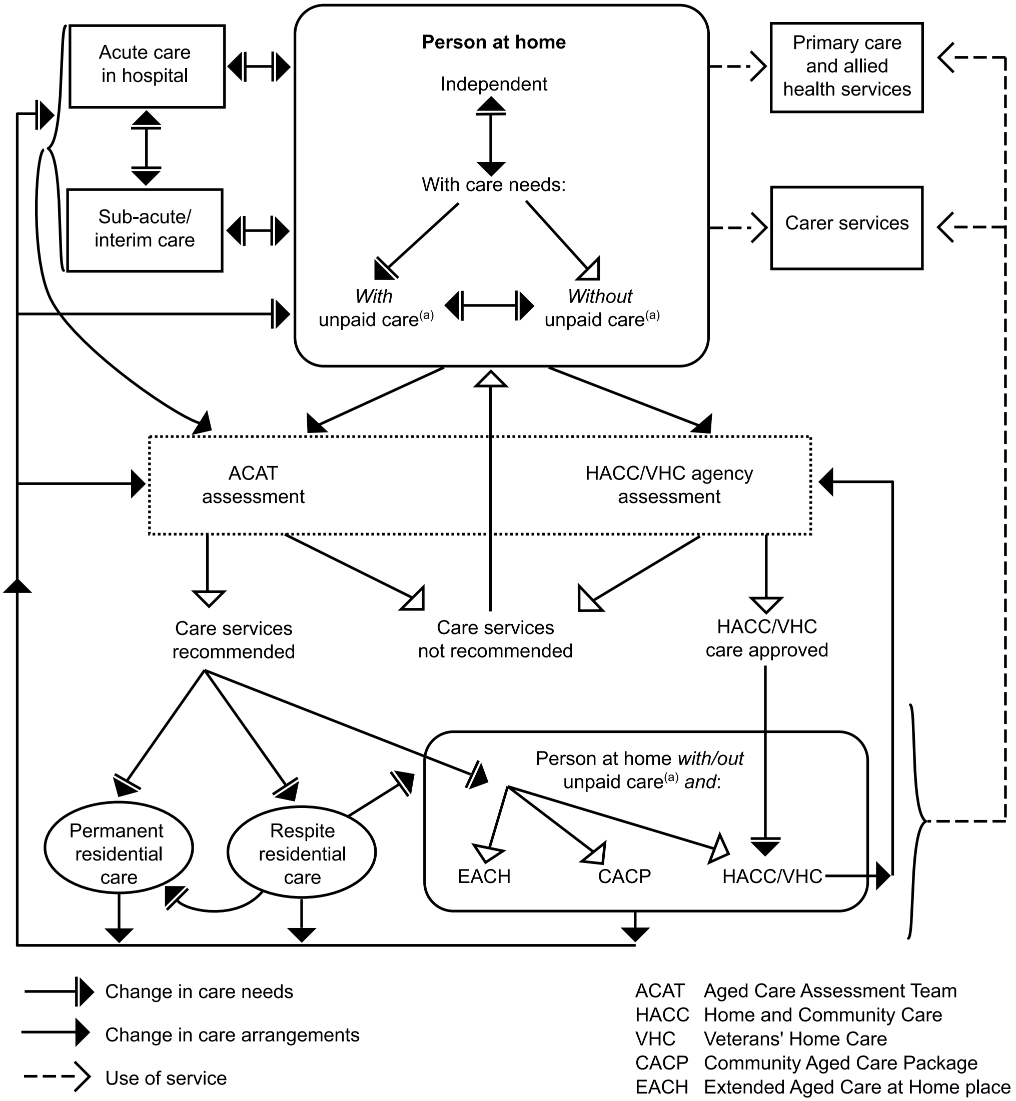
Nearly all people aged 65 and over reporting dementia, including Alzheimer's disease, had a disability (99%), with almost as many (approximately 96% of sufferers) having a severe or profound core activity restriction (Table 7.5). This proportion increases from 82% in the 65–74 age group, to 98% in the 75–84 and 85 and over age groups. The prevalence of dementia among clients of residential aged care services is discussed in Section 7.6. The care needs of clients with and without dementia are also compared.

While many older people live independently in the community, others require support. The care services available to older people are discussed in the following sections.

7.3 Support and care for older people

Support and care for older people are available from a variety of sources, and many people make their own arrangements. Care may be provided by friends and relatives, or by service providers either in the community or in a residential service. The range of services people can access is discussed in broad terms below. Sections 7.4 to 7.6 contain a more detailed description of these services and their clients.

People may change their care arrangements and access a range of government-funded services as their care needs change (Figure 7.4). While living at home, they may use a number of care services, and such services can be accessed whether or not they are receiving care from friends and relatives. However, the types of services they can access often depend on a formal assessment of their care needs. Services for people with assistance needs that could be expected to be met by residential aged care require a recommendation from an Aged Care Assessment Team. Such services include permanent residential care, respite residential care, Community Aged Care Packages (equivalent to low-level residential care) and Extended Aged Care at Home places (equivalent to high-level residential care). Some community-based services are available more broadly—for example, Home and Community Care—and these services are

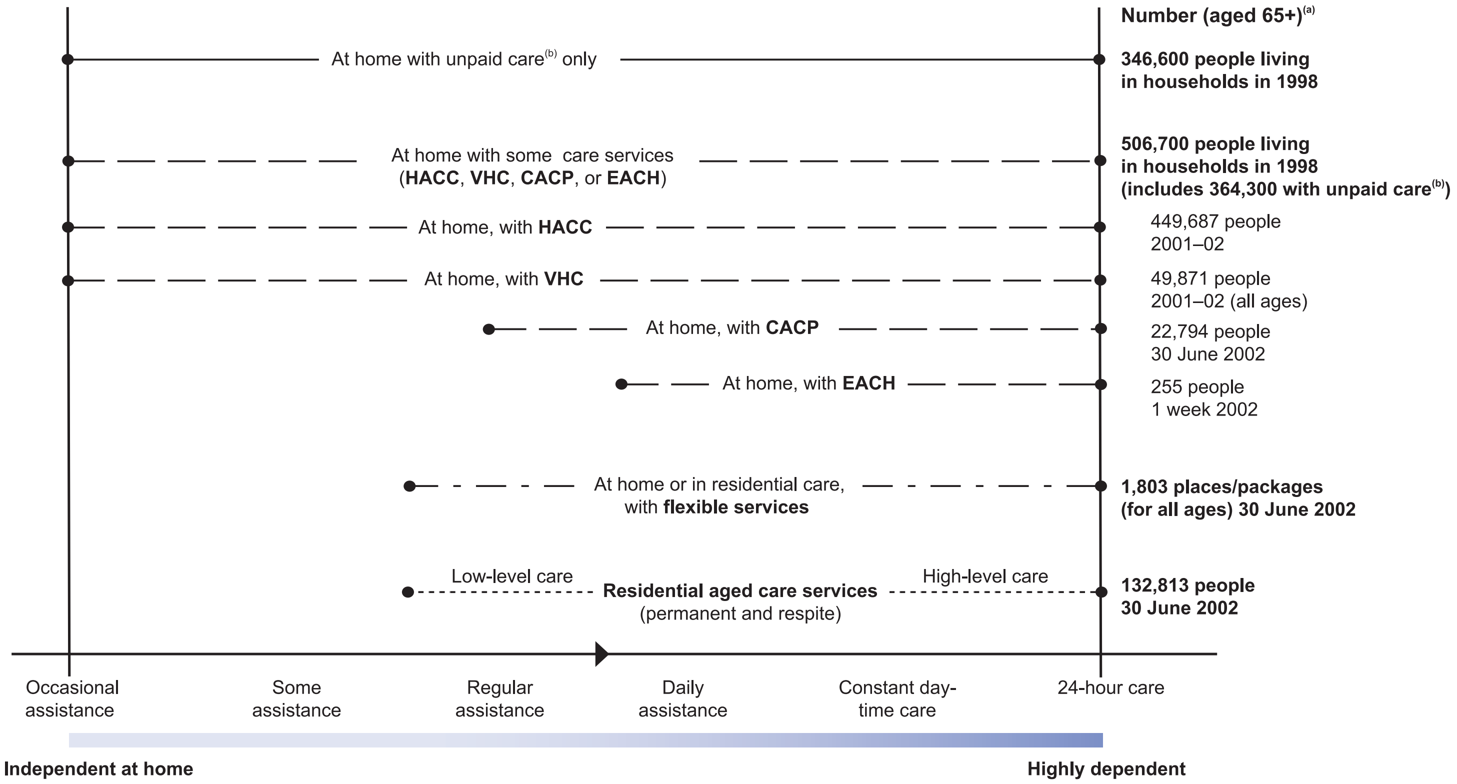


ACAT	Aged Care Assessment Team
HACC	Home and Community Care
VHC	Veterans' Home Care
CACP	Community Aged Care Package
EACH	Extended Aged Care at Home place

(a) Excluding payments from government pensions and benefits.

Note: Figure includes selected government-funded programs only.

Figure 7.4: Changing care arrangements of older people



(a) Due to data availability, numbers refer to different time periods.

(b) Excluding payments from government pensions and benefits.

Note: Selected government-funded programs only. Hospital services not included.

Sources: Table A7.12; ABS 1999a:40; AIHW 2003c.

Figure 7.5: Care alternatives for older people

provided after people are assessed by the agency as eligible. People also use a variety of hospital and primary care services (for example, general practitioners) and allied health services, such as podiatry, physiotherapy and occupational therapy. In addition to the services available to people with care needs, services are available to support their carers. Apart from government-funded services, people may make their own arrangements to meet their care needs, buying in services—like domestic assistance, home maintenance and nursing services—as they are required (not included in Figure 7.4).

While aged care programs target people with particular levels of care needs, not all people with those needs access services; that is, the shift from living independently at home without care to permanent residence in an aged care service is not an automatic progression. There are various care alternatives that can be accessed as care needs increase (Figure 7.5). Some people may never move into residential aged care but may stay living in the community under their own care arrangements. In other cases, people may remain in their home with a mixture of unpaid care and government-funded care services. Such care services may involve either a relatively low level of assistance, for example through day centres, or may be the intensive care included in the Extended Aged Care at Home program. Finally, residential care is available to people unable to remain living at home, either in the short term or permanently.

The importance of care by friends and relatives in the aged care system is brought out in Figure 7.5. In 1998, over 711,000 older people were living at home with unpaid carers providing support, either with or without the assistance of services. In comparison, on 30 June 1998 there were 127,900 people aged 65 and over in residential aged care and 8,800 in the same age group who were recipients of Community Aged Care Packages (AIHW 1999b:28, AIHW analysis of ACCMIS).

Accessing services

As can be seen from the above, there is a wide range of services for older people and their carers available through a number of channels. However, before people can make use of these services, they need to be able to access them.

Commonwealth Carelink Centres

To help people find appropriate services, in 2001 the Commonwealth Government set up a network of Commonwealth Carelink Centres. These centres provide a single point at which comprehensive information about community, aged care and other support services can be obtained. They have been operating since April 2001 and the service targets both those in need of support and those providing support or advice to others. By June 2002, the network included a free call 1800 number, 65 shopfronts in 54 regions throughout Australia and over 90 access points such as free phones in rural and remote localities (DoHA 2002b:137). Commonwealth Carelink Centres are operated by a wide range of organisations, including not-for-profit and for-profit non-government organisations, and government agencies. During 2002–03, the centres responded to approximately 13,000 requests for information per month.

Table 7.6: Aged Care Assessment Team assessments, by recommended long-term living arrangement, 1998–99 to 2001–02

Recommendation	**1998–99**	**1999–00**	**2000–01**	**[(a)]2001–02**
		Number		
Community recommendations				
Coordinated community care[(b)]	15,209	18,525	28,015	33,874
Other[(c)]	69,733	70,445	67,358	65,015
Total	*84,942*	*88,970*	*95,373*	*98,889*
Residential recommendations				
Low care	36,072	37,635	39,474	39,885
High care	41,639	42,007	43,896	43,220
Total	*77,711*	*79,642*	*83,370*	*83,105*
Other[(d)]	4,775	4,642	4,692	4,776
No recommendation required				
Client died	1,381	1,394	1,329	2,277
Client transferred	4,162	3,812	3,049	2,843
Assessment cancelled	2,393	1,858	2,685	2,616
Total	*7,936*	*7,064*	*7,063*	*7,736*
Unknown	3,551	3,266	3,432	3,359
Total	**178,915**	**183,584**	**193,930**	**197,865**
		Per cent[(e)]		
Community recommendations				
Coordinated community care	8.9	10.5	15.0	17.8
Other	40.8	39.9	36.0	34.2
Total	*49.7*	*50.4*	*51.0*	*52.0*
Residential recommendations				
Low care	21.1	21.3	21.1	21.0
High care	24.4	23.8	23.5	22.7
Total	*45.5*	*45.1*	*44.6*	*43.7*
Other	2.8	2.6	2.5	2.5
Unknown	2.1	1.9	1.8	1.8
Total	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**170,979**	**176,520**	**186,867**	**190,129**
Assessments per 1,000 for people aged 65 and over[(f)]	**66.9**	**68.0**	**70.3**	**71.3**

(a) Includes data for Tasmania estimated from 2000–01 data in conjunction with the growth rate in assessments for the rest of Australia between 2000–01 and 2001–02.

(b) Includes care provided under Community Aged Care Packages and the Community Options Program.

(c) Includes assessments recommending a range of community services (such as home nursing, meals, respite and Carer Allowance), and also assessments in which no community services were recommended.

(d) Includes accommodation not in a private house or residential care; for example, boarding houses.

(e) Excludes deaths, cancellations and transfers.

(f) Assumes 93.4% assessments were for people aged 65 and over (based on data for January–June 2000).

Sources: AIHW 2001a:216; LGC 2000, 2001, 2002; LGC 2001–02 unpublished data.

Assessment

Aged Care Assessment Teams (ACATs) play a crucial role in the Australian aged care system. They determine eligibility for Community Aged Care Packages, Extended Aged Care at Home places, and admission to residential aged care. They also function as a source of advice and referral concerning HACC services but do not determine eligibility for these services. In the process of determining eligibility, the teams generate data on the clients they assess: their age and sex, their dependency levels, and their assessed level of need for services. Implementation of the new national minimum data set (MDS) for the Aged Care Assessment Program (ACAP MDS V2) commenced in April 2003, following the release of the data dictionary in late 2002 (AIHW 2002a).

Both need and availability of high-care services guide recommendations by ACAT teams. Using data from the first version of the ACAP MDS, Table 7.6 shows the outcomes of assessments by Aged Care Assessment Teams over the 4-year period 1998–99 to 2001–02. In 2001–02, there were just over 190,100 assessments, excluding incomplete assessments due to the death of the client, cancellation of the assessment or transfer to other assessment teams. An estimated 93% of these assessments were for people aged 65 and over, so that during the year there were 71 completed assessments for every 1,000 people aged 65 and over. Excluding cases with an unknown recommendation, just over half of assessments (53%) resulted in community recommendations for long-term living arrangements, 45% for residential care and 3% for other arrangements such as living in a boarding house. Among recommendations for community care, just over one-third were for coordinated care—that is, either with a Community Aged Care Package, or through the Community Options Program funded as part of the Home and Community Care Program. Slightly more recommendations for residential care were for high care (23%) than for low care (21%).

Over the 4 years examined there was a small but steady increase in the proportion of assessments resulting in community recommendations and a fall in the proportion resulting in residential recommendations. However, among community recommendations, the proportion recommended for care packages doubled (from 9% of assessments to 18%). This reflects the large growth in Community Aged Care Packages over the period, with the number of packages nearly doubling between 30 June 1999 and 30 June 2002 (see Table 7.15).

Table 7.7: Dependency status of Aged Care Assessment Team clients, 1998–99 to 2001–02 (per cent)

	1998–99	1999–00	2000–01	2001–02
Mobility				
Walks independently	64.4	63.9	64.0	62.4
Does not walk independently	35.6	36.1	36.0	37.6
Number	*173,011*	*179,353*	*187,201*	*190,167*
Continence				
Fully continent	61.5	61.4	61.3	60.9
Not fully continent	38.5	38.6	38.7	39.1
Number	*170,148*	*176,309*	*183,743*	*186,145*
Orientation				
Aware–time and place	65.7	67.1	67.5	68.0
Not aware	34.3	32.9	32.5	32.0
Number	*169,075*	*174,753*	*183,460*	*186,398*
Total number (including unknown cases)	**178,915**	**183,584**	**193,930**	**197,865**

Sources: AIHW 2001a:217; LGC 2002; LGC 2001–02 unpublished data.

As part of the assessment, ACATs measure the level of dependency of clients in three key areas: mobility, continence and orientation. In 2001–02, about one-third of those assessed had difficulties in these areas (Table 7.7). For the period 1998–99 to 2001–02, there was no clear change in the dependency profile of ACAT clients as measured by these three items. Also, throughout that period 20% of clients had a primary diagnosis of dementia, that is dementia was the diagnosis that was the main reason for the person presenting for an ACAT assessment (LGC 2002:36, figure excludes Western Australia). Clients with restrictions in the areas of mobility, continence or orientation were more likely to be recommended for residential care. Over 40% of the clients who had any one of these restrictions in 2000–01 were recommended for high-level residential care (LGC 2002:63).

In the next four sections, the range of aged care services is discussed in some detail. Since the last edition of this publication, there have been a number of developments in the data available to describe these programs (Box 7.3).

Box 7.3: Data development in aged care services

The ***Aged Care Assessment Program*** *(ACAP) Data Dictionary Version 1.0 was published in late 2002. It contains definitions of all data elements that Aged Care Assessment Teams are required to report as part of the ACAP Minimum Data Set Version 2.0 and a set of national program-level performance indicators (AIHW 2002a). The new ACAP MDS V2.0 was implemented in January 2003 and has been expanded to include information about carers, including use and recommendation of respite care, and information describing a client's health profile and need for assistance with activities of daily living.*

Client Characteristics Meta-data in Residential Aged Care*, released in 2003, aims to facilitate analysis of client characteristics data across programs by mapping data items (AIHW: Jeffery 2003). The report makes specific recommendations to improve the comparability of data across programs and consistency with national standards by the inclusion of guidelines for the reporting of client characteristics on the Resident Entry Record form, the addition of further codes in various collections, and the inclusion of the ACAP MDS V2.0 data into the Aged and Community Care Management Information System (ACCMIS).*

The ***Day Therapy Centre*** *Data Collection project involved the development of the* Day Therapy Centre Program Data Dictionary Version 1.0 *(AIHW 2003b), a data collection mechanism including field tests with providers (AIHW: Petrie & Van Doeland 2002), and development of a Guide for Use as a companion document to the Data Dictionary.*

A 4-week census of Day Therapy Centres was carried out from 21 October 2002 (AIHW forthcoming-b). The questions in the census were based on definitions from the Data Dictionary. The project provides the first comprehensive data on service provision by these centres. Centre clients funded through residential aged care services were not included in the census.

A 1-week census of ***Community Aged Care Packages*** *was carried out between 16 September and 14 October 2002, producing the first comprehensive data on the volume of service provided by these packages (AIHW forthcoming-a).*

(continued)

Box 7.3 (continued): Data development in aged care services

A 1-week census of ***Extended Aged Care at Home*** *places was carried out from 6 May 2002, resulting in the first comprehensive data on service provision through this program (AIHW forthcoming-c).*

The **Report on the Comparability of Dependency Information across Aged and Community Care Programs** *examines the comparability of dependency information for clients of Home and Community Care, the Aged Care Assessment Program and Community Aged Care Packages, to assess consistency with national and international standards and identify possible modifications to these items (AIHW: Van Doeland & Benham forthcoming).*

A ***Home and Community Care*** *(HACC) dependency measure has been developed in a study conducted by the Centre for Health Service Development at the University of Wollongong. A report has been released which contains a literature review, details of a field test carried out using the preferred instruments, and recommendations for implementation (Eagar et al. 2002). A two tiered assessment process is proposed, consisting of a simple functional screening, followed by a more detailed assessment for those requiring it.*

The ***Continence Aids Assistance Scheme*** *Data Dictionary Version 1.0 was completed and released in late 2001 (AIHW: Broadbent 2001).*

7.4 Care services in the community

While many older people live in their homes either by managing on their own, or with help from relatives and friends, others rely on a range of care services. In some cases, without these services people would not be able to remain living in the community, but would need to move into residential care. There are three main programs which provide care to people living in their own homes: Home and Community Care (HACC), Veterans' Home Care (VHC) and Community Aged Care Packages (CACP). A fourth program—the Extended Aged Care at Home (EACH) Program—is in the process of being extended following a successful pilot phase and currently provides services to only a small number of people. In addition, there are a number of other programs which support people and their carers; for example, Day Therapy Centres and the National Respite for Carers Program. These programs are discussed below. States and territories also provide a range of services independently of the Commonwealth Government; these services are not examined.

In addition to general service usage levels among people aged 65 or more, also of interest is the rate of service use among those who need care. In general, aged care services are targeted at frail or disabled older people. The 1998 ABS Survey of Disability, Ageing and Carers identified people who fall into the disability categories of having a mild, moderate, severe or profound core activity restriction. In analyses undertaken by the AIHW, the mild and moderate restriction categories are not included as they refer to people who do not require assistance with core activities of daily living according to the definition employed in the ABS survey. Accordingly, in this chapter, where possible, we report usage relative to the number of people with a severe or profound core activity restriction, as defined by the ABS, to give an indication of take-up by people requiring assistance with core activities of daily living.

Home and Community Care

The HACC program provides community care services to older people and to people of all ages with disabilities, and their carers. The aim is to enhance the independence of people in these groups and avoid premature or inappropriate admission to long-term residential care. The program is jointly funded by the Commonwealth and the state and territory governments.

The bulk of home- and community-based services for older people are provided under the auspices of this program. It is important to recognise, however, that the target population is people of all ages with a moderate, severe or profound level of disability (and their carers), and that an ACAT assessment is not a prerequisite to accessing the program. However, many clients assessed by Aged Care Assessment Teams are recommended for HACC services. The program includes home nursing services, delivered meals, home help and home maintenance services, transport and shopping assistance, allied health services, home- and centre-based respite care, and advice and assistance of various kinds. HACC also provides brokered or coordinated care for some clients, through community options or linkages projects.

Since the inception of the HACC program in 1985, both the quantity and variety of services have increased substantially, as has government expenditure (see Table 7.13). By mid-2002, there were approximately 3,500 service providers across the country who were part of this program (DoHA 2002a:7). The implementation of the new HACC minimum data set in January 2001 allows more detailed analysis of the HACC program than has previously been possible, and while not all agencies participate in the collection (74% provided data in 2001–02), it is possible to present data on the demographic profile of service users, and the services they receive (see Box 7.4 for data issues affecting the interpretation of results from the HACC MDS).

As stated above, the HACC program includes as part of its target group younger people with disabilities as well as older people and their carers. During the 12 months between 1 July 2001 and 30 June 2002, 583,156 clients were reported as receiving services through Home and Community Care (DoHA 2002d). Of these, 449,687 were aged 65 or more (Table 7.8). The target group for the HACC program specifies people of all ages with a moderate, severe or profound disability, and their carers. It is estimated that in 2001 in Australia there were 534,500 people aged 65 and over with a profound or severe core activity restriction, that is who always or sometimes needed help with a core activity task, and a further 241,000 with a moderate restriction, that is people who did not need help but had difficulty with a core activity task (see Tables 7.4 and A7.1). Information on services provided to people aged under 65 with a disability are discussed in Chapter 8.

Patterns of service use

During 2001–02, among every 1,000 people aged 65 and over in the population at least 181 accessed HACC services (see Table A7.12). In general, people are increasingly more likely to access these services as they get older, with at least 87 per 1,000 people aged

Box 7.4: Home and Community Care Minimum Data Set

Version 1 of the HACC minimum data set was implemented in January 2001. Data are collected by HACC agencies on the use of HACC services by individuals, and forwarded to the HACC National Data Repository. Data items collected include client characteristics, carer information, and types and volume of service used. People may be assisted by more than one agency, and in the data set clients are counted using a statistical linkage key (not name).

Not all agencies providing HACC services submit data for the HACC minimum data set. Consequently, estimates from it of the numbers of people assisted, and of the volume of service, understate the total amount of service provided. For 2001–02 the estimated participation rate among HACC agencies was 74%. Rates varied across states and territories, ranging from an estimated 56% of agencies in the Northern Territory to 94% in Western Australia (DoHA 2002d:5). Participation rates have been increasing, and for the January quarter 2003 the estimated agency participation rate was 85%.

Indigenous status of clients is reported in the HACC MDS. However, AIHW comparisons of numbers of HACC clients who identified as Indigenous with estimates of Indigenous people in particular age groups as derived from the 2001 Population Census suggest that the reported number of Indigenous people using HACC services is too high (ABS 2002b). Consequently, because of concerns with the quality of information on Indigenous status, only very limited analysis of HACC service provision to this group is presented in this chapter.

During 2003, an evaluation of version 1 of the HACC MDS was undertaken by Alt Beatty Consulting and the Australian Institute for Primary Care of the Lincoln Gerontology Centre. The consultancy examined both the collection process used for the data set and the quality of the data. Results were not available at the time of publication.

65 to 74 doing so in 2001–02, compared with at least 425 per 1,000 aged 85 and over (see Table 7.11). For every 1,000 people aged 65 and over with a severe or profound core activity restriction, there were at least 814 using HACC services.[3]

During 2001–02, assessment, case management and planning was the service reported for the largest number of older HACC clients (39%) (Table 7.8). Other services commonly reported were assistance with domestic chores (35%), meals (21%), nursing (20%) and transport services (17%). Centre-based day care, and personal care, were both reported for 10% of clients, while respite care was reported for 1% of clients. Based on reported service use, during 2001–02 on average HACC clients used 2.0 of the service groups listed in the table.

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[3] Note that this is a ratio of clients to potential users and not a usage rate, as disability status is not available in the HACC MDS and not all HACC clients will necessarily have a profound or severe core activity restriction as defined by the ABS.

Table 7.8: Services received by Home and Community Care clients aged 65 and over, 2001–02

	Per cent of clients
Assessment, case management and case planning[(a)]	38.7
Domestic assistance	35.1
Meals (at home and at a centre)[(a)]	21.3
Nursing (home and centre-based)[(a)]	19.9
Transport services	16.6
Home maintenance	14.4
Counselling and social support[(a)]	13.1
Allied health (at home and at a centre)[(a)]	11.5
Personal care	9.6
Centre-based day care	9.5
Provision of aids/car modifications[(a)]	4.8
Home modification	3.1
Respite care[(b)]	1.1
Other food services	0.5
Linen services	0.2
Total clients (number)	**449,687**

(a) Service type includes more than one service category.

(b) In the case of respite care, the carer is considered the HACC client. Anecdotal evidence indicates that the provision of respite care may be under-reported.

Notes

1. Not all HACC agencies submitted data to the HACC MDS. For 2001–02, an estimated 74% of agencies submitted data.
2. 0.5% of clients had missing/unknown age. These clients have been assumed to be aged 65 and over.

Source: DoHA and AIHW analysis of the HACC MDS.

Veterans’ Home Care

Similar in purpose and content to the HACC program, Veterans’ Home Care is designed to help veterans, war widows and widowers with low-level care needs to enjoy a healthier lifestyle and remain living in their own homes longer. The program, which began in January 2001, has a preventive focus and, through the early intervention of home support services, aims to reduce the use of formal medical services and delay entry to aged care facilities. While available generally to eligible veterans and war widows(ers), the program targets those aged 70 years and over.

Provision of services is based on assessed need. Assessments are undertaken by regional assessment agencies, which also arrange for the services to be provided. Services include domestic assistance, personal care, safety-related home and garden maintenance (limited to 15 hours in a financial year) and respite care. Except for respite care, clients are required to pay a co-payment for Veterans’ Home Care services.

Veterans and war widow(er)s continue to be eligible to be assessed for the full range of services provided under HACC through arrangements with state and territory governments. Veterans and war widow(er)s currently receiving HACC services are able to transfer to Veterans’ Home Care. However, clients can access different services from both of the programs at the same time.

Table 7.9: Services received by Veterans' Home Care clients, July–September 2002

	Clients		Mean amount
	Number	Per cent	(hours:minutes)
Domestic assistance	39,544	86.0	11:30
Home and garden maintenance	13,222	28.8	2:10
Respite care[(a)]	4,389	9.5	28:40
Personal care	2,039	4.4	15:30
Total	**45,965**	. .	14:00

(a) Includes in-home and emergency respite only, not residential respite. Residential respite may also be coordinated through Veterans' Home Care.

Source: DVA unpublished data, correct as at 23 June 2003.

Patterns of service use

During 2001–02, 49,871 people of all ages received services through Veterans' Home Care, with some services being accessed more than others. Domestic assistance and safety-related maintenance were the services most commonly provided (to 81% and 36% of clients, respectively, during the year), while in-home and emergency respite care was provided to 14% of clients, and personal care to 6%. Many people received more than one service, with clients averaging 1.4 services each over the year.

The different services involve varying amounts of assistance (Table 7.9). During the July quarter 2002, in-home and emergency respite care averaged the highest number of hours of care (28 hours 40 minutes per client using respite care over the 3-month period). Personal care—provided to relatively few clients—averaged 15 hours 30 minutes per client, while domestic assistance involved an average of 11 hours 30 minutes. Home and garden maintenance averaged the least time—2 hours 10 minutes. Overall, an average of 14 hours of services and/or assistance was provided to clients during the quarter.

Community Aged Care Packages

Community Aged Care Packages provide support services for older people with complex needs living at home who would otherwise be eligible for admission to 'low-level' residential care. They provide a range of home-based services, excluding home nursing assistance (which may, however, be provided through HACC), with care being coordinated by the package provider. To receive a package, older people must be assessed by an Aged Care Assessment Team as needing the type of assistance provided by a package; that is, their needs are such that they can only be met by a coordinated package of care services.

Unlike the HACC program which is jointly funded by the Commonwealth and state and territory governments, the Community Aged Care Packages (CACP) program is solely Commonwealth funded. From a small beginning of 235 packages in 1992, the program has expanded rapidly. The bulk of this growth occurred after 1997, with the number of packages increasing more than four-fold over 5 years, from 6,124 packages in 1997 to 26,425 operational packages in 2002 (including flexible care and Multi-purpose Service packages, discussed separately later). This growth rate is much higher than that of the population aged 70 and over, and of residential care places (see Table 7.15; AIHW 2003a:2). Consequently, an increasing proportion of older people in need of assistance are receiving care through Community Aged Care Packages. On 30 June 2002 there were 24,585 people in receipt of a Community Aged Care Package; 22,794 of these recipients were aged 65 and over (see Table A7.10). These figures do not include supplementary clients or recipients of flexible care and Multi-purpose Service packages.[4]

Patterns of service use

On 30 June 2002, 9 per 1,000 people aged 65 and over were receiving care under a Community Aged Care Package (not including supplementary clients or recipients of flexible care and Multi-purpose Service packages). This equates to 41 CACP recipients for every 1,000 people aged 65 and over with a severe or profound core activity restriction (see Table A7.12). As with HACC services, use of a Community Aged Care Package increases with age, from 3 per 1,000 people aged 65–74 to 31 per 1,000 people aged 85 and over (see Table 7.11).

A range of services can be included in a Community Aged Care Package, including domestic assistance, personal care, social support, rehabilitation support, respite care, meals and food preparation, home maintenance, transport and linen services. In 2002, data on the type and quantity of services people received were collected for the first time, via the CACP census (AIHW forthcoming-a).

Table 7.10: Length of support provided to Community Aged Care Package recipients aged 65 and over,[(a)] separations during 2001–02

	Number	Per cent
<4 weeks	678	5.7
4–<8 weeks	880	7.4
8–<13 weeks	1,073	9.1
13–<26 weeks	2,054	17.4
26–<39 weeks	1,410	11.9
39–<52 weeks	1,076	9.1
1–<2 years	2,409	20.4
2–<3 years	1,009	8.5
3–<4 years	625	5.3
4+ years	599	5.1
Total	**11,813**	**100.0**

(a) ‘Length of support’ includes continuous time as a CACP recipient from a particular provider. Disjoint periods on a CACP by the same person are not combined, but are counted separately.

Note: Figures do not include clients of Multi-purpose and flexible services.

Source: AIHW analysis of DoHA ACCMIS database.

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[4] Package recipients are permitted to take leave from their packaged care for a number of reasons; for example, for a holiday, residential respite care, or for a stay in hospital. In these situations, the subsidy paid for these packages may be used to fund care for other recipients who are eligible for placement in a package. These recipients are called ‘supplementary care recipients’.

In 2001–02, there were just over 11,800 separations from packages by people aged 65 and over (Table 7.10). Of these, nearly half of the recipients had been receiving the package for more than 9 months, with 29% having been in receipt of one for between 1 and 3 years. Five per cent of clients had been assisted through the same service provider for more than 4 years. Given the very rapid growth in the program in recent years, as the rate of program growth slows and hence the proportion of clients in 'new' packages decreases, it is likely that the proportion of clients using packages for long periods will be higher in the years to come.

The most common reasons for the cessation of a package are clients moving into residential aged care or the death of the client: in 2001–02, almost half (46%) of all separations—including those for younger people—were to residential aged care, while 20% were the result of the death of the care recipient (AIHW 2003a:44). In addition, 6% of separations were the result of a recipient leaving one care package to take up another.

Extended Aged Care at Home

The Extended Aged Care at Home (EACH) program aims to deliver care at home that is equivalent to high-level residential care. This program began as a pilot in 2000, offering care to 300 clients in ten areas across Australia. In 2001–02, the Commonwealth Government announced its intention to establish EACH as an ongoing program, and provided funding for the continued development of its management and quality assurance framework (DoHA 2002b:127). An allocation of an additional 160 EACH places was announced for 2002–03. As with CACPs, access to an EACH place is through assessment by an Aged Care Assessment Team.

Information on the characteristics of recipients of EACH places, and the services they receive, was collected in the 2002 EACH 1-week census. Many of the services available to EACH recipients are similar to those provided to CACP recipients. In addition, nursing and allied health care services can be provided to EACH care recipients as part of the package. At the time of the 2002 EACH census, almost 290 people were EACH care recipients; 11% of these clients were aged under 65 (AIHW forthcoming-c).

Day Therapy Centres

Prior to 1987, the Commonwealth funded a number of nursing home proprietors in the not-for-profit sector to provide therapy services in a day care setting. Under this arrangement, nursing home and hostel residents and people living in the community could receive a number of specialist services. In 1987, a revision of funding methodologies resulted in the establishment of Day Therapy Centres to provide therapy services specifically to hostel residents and people in the community; equivalent services for nursing home residents were to be included under funding for nursing homes.

The purpose of Day Therapy Centres is to assist people to maintain or recover a level of independence which will allow them to remain either in the community or in low-level (formerly hostel) residential care (DoHA 2002c). There are currently around 150 Commonwealth-funded centres operating nationally. The centres vary in size and in the range of therapy services that they provide. They are used more commonly in some states and territories than others, with provision depending on the need and availability of equivalent services through other programs. For example, almost half of Day Therapy Centre clients live in South Australia (AIHW forthcoming-b). Usually, a Day Therapy Centre will develop an agreed care plan for the client which may include the provision of therapy from other service providers where necessary—an ACAT assessment referral is not required for access to the centres.

Data on the people using Day Therapy Centres, their care needs, and the services they use are available from a census of centres carried out over 4 weeks from 21 October 2002 (see Box 7.3). Centre clients funded through residential aged care services were not included in the census. During the census period, almost 17,000 people living in the community (including just over 15,200 aged 65 or more) were reported using Day Therapy Centres. Services provided included nursing services, podiatry, physiotherapy, diversional therapy and occupational therapy (AIHW forthcoming-b).

Respite care and National Respite for Carers Program

With the trend towards increasing home-based care and reduced rates of residential care, respite care has emerged as an important area of service provision. This has been evident in a number of government policy initiatives, in particular in the development of the National Respite for Carers Program, and in respite care being a key component of the Staying at Home measures announced in the 1998–99 Budget and extended in the 2002–03 Budget.

Respite care may be provided in the home, at a centre during the day, or in a residential service. In 2001–02, 10% (42,900) of older HACC clients used centre-based day care and 1% (4,900) used in-home respite care services (see Table 7.8).[5] In addition, 14% (6,800) of Veterans' Home Care clients received in-home or emergency respite care during 2001–02. Preliminary analysis of the 2002 CACP census suggests that a small proportion of recipients access respite assistance (AIHW forthcoming-a).

In addition to the above respite services, nearly half of admissions into residential aged care are for respite care: among the 86,120 admissions for older people into residential care in 2001–02, just over 40,700 (47%) were for respite care (see Table A7.8). While the ratio of respite to permanent admissions remained fairly constant between 1998 and 2002, and the number of respite admissions increased by 6% over that period, there was a fall in the total number of days used in residential respite care. This fall was the result of a decrease in the average length of stay for all respite care admissions, from 3.5 weeks in 1998–99 to 3.2 weeks in 2000–01 and 2001–02. As a consequence, the total number of respite bed-days provided dropped by 2% over the period (Tables 1.8, 3.9 and 3.10 in: AIHW 2000b, 2001b, 2002d, 2003c).

The National Respite for Carers Program began with its announcement in the 1996–97 Commonwealth Budget. It funds Commonwealth Carer Respite Centres, state- and territory-based Commonwealth Carer Resource Centres, and a number of projects to assist carers of people with dementia, including the National Dementia Behaviour

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[5] In the case of respite care, the carer is considered the HACC client. Anecdotal evidence suggests that the provision of respite care may be under-reported.

Advisory Service and the Carer Education and Workforce Training Project for dementia. In line with the growing recognition of the importance of carers in supporting older people living in the community, the funding for this program has increased from $19 million in 1996–97 to $92.6 million in 2002–03. This growth includes an additional $80 million over 4 years provided in the 2002–03 Budget.

The Commonwealth Carer Resource Centres in each state and territory provide carers with information and advice about their caring role, including the services and assistance available to them. The Respite Centres work closely with the Resource Centre in their state or territory to ensure comprehensive support for carers and access to carer information and training materials. The Respite Centres are run by a wide variety of community organisations, and assist carers by acting as a single contact point for information needed by carers, and by organising, purchasing or managing respite care assistance packages for carers.

Overall, in 2001–02, the program funded the 8 state- and territory-based Commonwealth Carer Resource Centres, 62 regional Commonwealth Carer Respite Centres, 423 regional respite services for carers and 3 national projects to assist carers of people with dementia. The Respite Centres assisted approximately 38,250 carers in the same period, and the Resource Centres helped 29,500 carers. These numbers were up from the previous year, with the corresponding numbers being 29,000 and 27,450 carers, respectively (DoHA 2002b:127–8, 141–2).

Other programs

The above discussion centres on the main services available to older people living in the community. In addition, there are many smaller programs—both Commonwealth and state and territory—targeting older people. Examples include the Safe at Home Initiative, Assistance with Care and Housing for the Aged (ACHA), and the Homefront program for veterans.

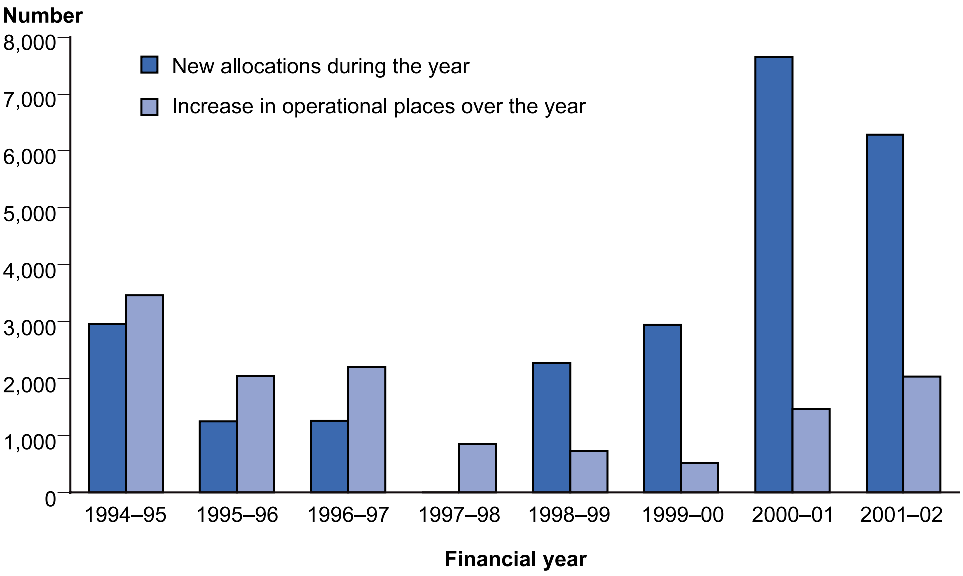
7.5 Residential care

Residential aged care services provide accommodation and support for older people who can no longer live at home. To enter residential care, people must have the appropriate recommendation from an Aged Care Assessment Team. Two levels of care are available: low-level care (Resident Classification Scale (RCS) categories 5 to 8, see later), and high-level care (RCS categories 1 to 4). Short-term respite care services are also available. Depending on their financial circumstances, residents contribute to the cost of their care (see Section 7.7). All residential care services are required to meet a number of national standards (see Section 7.8).

Since the aged care reforms following the *Aged Care Act 1997*, the number of operational residential aged care places has been increasing by an average of 1% a year, rising from 139,917 at 30 June 1998 to 146,268 operational places at 30 June 2002, (including flexible and Multi-purpose Service places; AIHW 2003c:2). As at 30 June 2002, there were 2,961 residential aged care services in Australia providing these places. By 30 June 2003, there were 150,496 operational residential care places (provisional estimate).

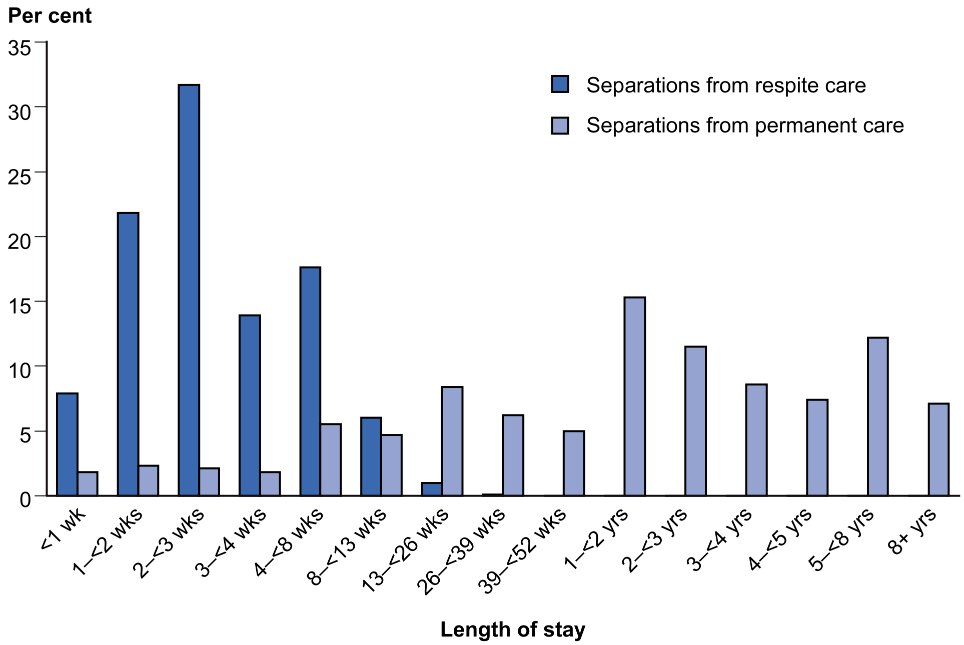
Given the time lags between residential places being approved and allocated and then becoming operational, consideration of operational places alone does not give the complete picture of changes in place provision. The development of residential aged care places (and similarly new Community Aged Care Packages) can only occur where places have been formally allocated to a provider. This usually occurs as part of a governmental Approvals Round (AIHW 2001a:224). In recent years, a modest number of places have been made available outside the Approvals Round process for allocation to flexible care, emergency care and Multi-purpose Services (see below).

The time period between allocation and a residential aged care place becoming available to clients varies. While the majority of Community Aged Care Packages become available for use reasonably quickly, residential aged care places may take longer to come on line, especially where capital works are involved. The time lag between allocation of residential places and their becoming operational is apparent in Figure 7.6 which shows that, while allocations began to increase during 1998–99, the number of new operational places in a year did not start to increase until 2 years later. As can be seen, in the last few years there have been substantially more approvals than new operational places coming on line. In addition, a further 6,105 places will be allocated in the 2003 Aged Care Approvals Round. Since the majority of allocated places do generally become operational, this suggests that we should see greater growth in the coming years in the number of operational places than has been the case in the recent past. This predicted pattern is a direct result of the high level of new allocations which occurred in the last three Approvals Rounds compared with the preceding period.



Source: Table A7.14.

Figure 7.6: New residential aged care allocations and operational places, 1994–95 to 2001–02



Source: Table A7.9.

Figure 7.7: Length of stay of older clients (65+) who left residential aged care during 2001–02

Mix of respite and permanent care

People may use residential care either as their permanent place of residence, or for the short-term accommodation and care associated with respite care. Residential respite care is important both for people who need a higher level of care just for the short term and as a component of the carer support system, whether for emergency care, to provide a 'break' while carers attend to other affairs or take a holiday, or for instances where carers themselves encounter health, personal or family problems. On 30 June 2002, respite residents made up just under 2% (2,290) of 132,813 aged care service residents aged 65 and over (AIHW 2003c:29–30). These figures, however, under-represent the importance of respite care because, as stated earlier, respite care accounted for nearly half (47%) of the 86,120 admissions for older people during 2001–02 (see Table A7.8). The disparity is explained by the short-term nature of respite care: three-quarters of older people who left residential respite care during 2001–02 stayed fewer than 4 weeks, compared with just 8% of permanent residents (Figure 7.7). On the other hand, almost one-fifth (19%) of clients ceasing permanent residence had been a resident for more than 5 years.

As the name 'respite' suggests, most of the people who are admitted for respite care return to the community. During 2001–02, at the end of 68% of episodes of respite care, the resident returned to the community (AIHW 2003c:56–7). In only 1% of episodes, the person died while in residential respite care, with the remainder either going to another residential aged care service or to hospital (14% and 5%, respectively). The story for permanent residents is quite different, with 83% of separations resulting from the death of the resident, and just 4% involving a return to the community. The remainder of people who left a permanent residential aged care service were evenly split between going to hospital and moving to another aged care service (following 6% and 5% of separations, respectively).

Patterns of service use

Currently, residential aged care is the second most commonly used aged care program after HACC. On 30 June 2002, 52 out of every 1,000 people aged 65 and over (or 5%) were permanent aged care residents, with just 1 additional person per 1,000 being in residential respite care (see Table A7.12; AIHW analysis of ACCMIS database). Use of residential care increases substantially with age, from 10 permanent residents per 1,000 people aged 65–74 to 247 per 1,000 people aged 85 and over (see Table 7.11). Comparing use with the number of people with a disability, on 30 June 2002 for every 1,000 people aged 65 and over with a severe or profound core activity restriction, there were 236 people in permanent residential aged care and 4 people in residential respite care.

Overall, during the 12 months to 30 June 2002, per 1,000 people aged 65 and over, 68 used permanent residential aged care and there were 16 respite admissions into residential services. Again, comparing use with the number of people with a disability, for every 1,000 people aged 65 and over with a severe or profound core activity restriction, 308 people used permanent residential aged care over the year and there were 74 admissions into residential respite care. As with permanent residential care, residential respite care is accessed more by older than younger people: there were five respite admissions over the year per 1,000 people aged 65–74, 21 per 1,000 aged 75–84 and 59 per 1,000 aged 85 and over (see Table 7.11).

Flexible aged care services

In addition to the services already described, the Commonwealth Government provides flexible aged care services through Multi-purpose Services in rural and remote communities, and through services under the National Aboriginal and Torres Strait Islander Aged Care Strategy (the Strategy). Multi-purpose Services were trialled in 1990 and expanded in 1994. As at June 2003, there were 83 Multi-purpose Services providing 1,810 flexible aged care places, consisting of 1,643 residential places and 167 Community Aged Care Packages. Flexible services provided under the Strategy began operating in 1996. In June 2003, there were 28 operational flexible services providing 420 flexible aged care places, comprising 155 high care places, 151 low care places and 114 Community Aged Care Packages.[6]

Data on clients of the Multi-purpose Services and the National Aboriginal and Torres Strait Islander Aged Care Strategy are not currently included on the national database for residential aged care and Community Aged Care Packages (the Aged and Community

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[6] Numbers of places and packages for 2003 are provisional estimates only.

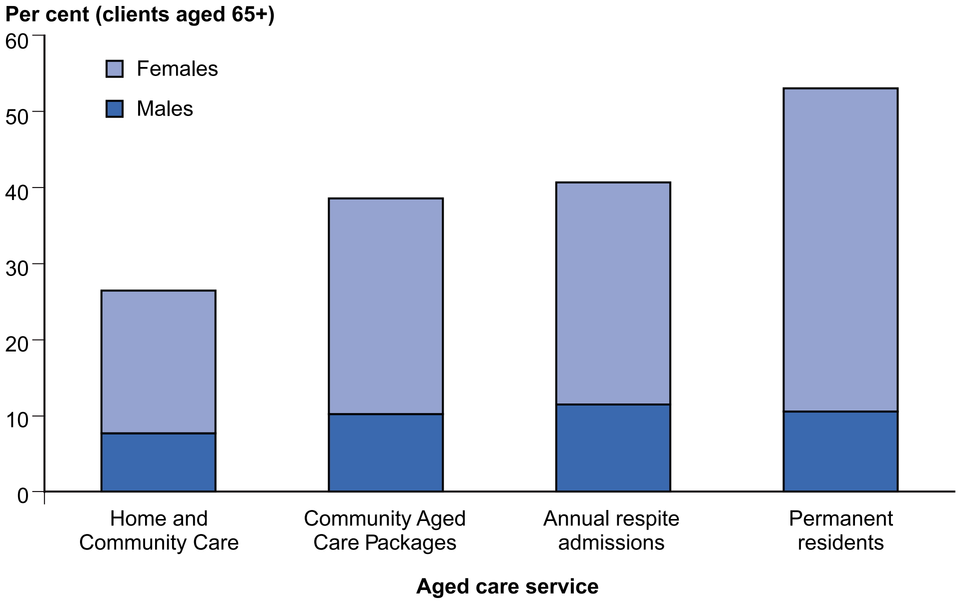
Care Management Information System, known as ACCMIS). Consequently, there is no information on the precise number and characteristics of people using these services.

7.6 Client profiles

The programs covered in this section are Home and Community Care, Community Aged Care Packages and residential aged care. Data limitations do not permit other programs to be included in this discussion of client profiles.

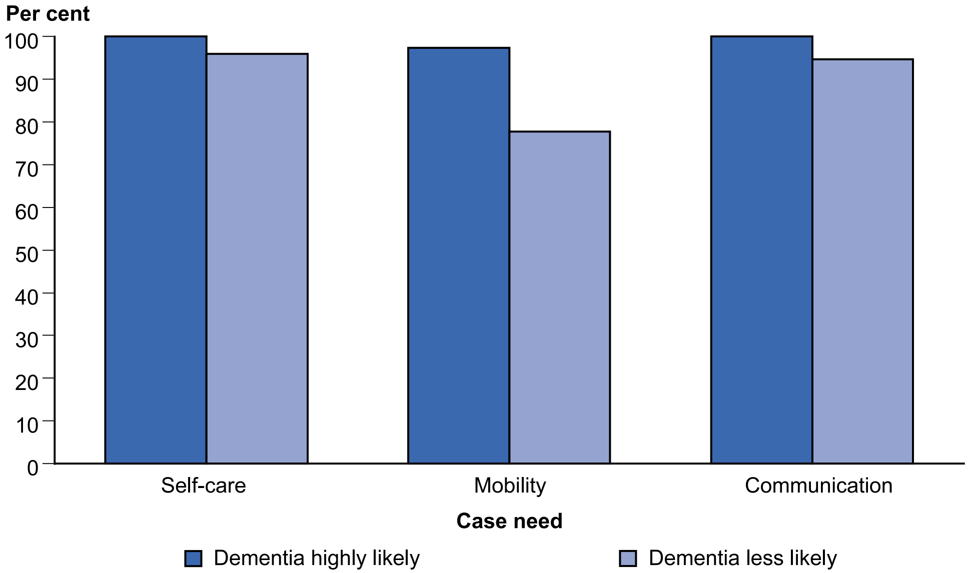
Age and sex

People in residential aged care tend to be older than those accessing formal care in the community (see Table A7.10). In addition, those in permanent care have an older profile than people using respite care. HACC clients have the youngest profile among the services examined. As stated above, the HACC program includes as part of its target group younger people with disabilities as well as older people and their carers. Consequently, in 2002, 23% of HACC clients were people aged under 65. For Community Aged Care Packages, 7% of recipients were under 65. Residential aged care services had the smallest proportion of clients aged under 65, with fewer permanent than respite residents being under this age (4%, compared with 6%). Conversely, residential care has the oldest profile of the three programs. These patterns across programs continue for clients aged 65 and over: 53% and 41% of permanent and respite aged care residents, respectively, were aged 85 or more , compared with 39% of people using Community Aged Care Packages and 26% of HACC clients (Figure 7.8).



Source: Table A7.10.

Figure 7.8: Use of aged care services by clients aged 85 and over, as a percentage of older clients (65+), 2002



Source: Table A7.11.

Figure 7.9: Care needs and dementia diagnosis for older permanent aged care residents (65+), 30 June 2002

Clients of aged care services are predominantly women. In 2002, for all services except residential respite, at least 70% of clients aged 65 and over were women; among those using residential respite care, 63% were women. Permanent aged care residents had the highest ratio of female to male clients (2.8 to 1; see Table A7.12). The ratio was lowest among residential respite admissions (1.7 to 1).

Dependency

Currently data on dependency characteristics of clients of aged care services are only available for people in permanent residential aged care. However, information on the dependency of CACP recipients was collected in the 2002 census and this will allow for analysis of dependency levels among clients of Community Aged Care Packages (see Box 7.3).

In June 2002, over 96% of permanent residents had needs in the areas of eating, bathing, dressing, toileting and managing incontinence (i.e. with self-care), and with communication (i.e. with understanding others or being understood). The majority also had problems related to mobility (84%; see Table A7.11). Furthermore, most had care needs related to their behaviour (95%) or other needs such as particular medical and social needs (99.6%). From this it can be seen that an overwhelming majority of aged care residents have multiple care requirements.

As noted earlier, one-fifth of the people assessed by Aged Care Assessment Teams have a primary diagnosis of dementia. While data on diagnosed dementia are not specifically collected for people in residential aged care, information on people's ability to understand and undertake living activities—a core indicator of dementia—is reported as part of the Resident Classification Scale. In June 2002, among the 128,852 permanent residents aged 65 and over for whom RCS data are available, only 13% had no difficulty understanding and undertaking living activities; 27% had some difficulty, 29% had major difficulty and 31% had extensive difficulty. These figures suggest that at least 31% of permanent residents are highly likely to have had dementia, and this figure may be as high as 60%. Although most people in residential care have significant care needs, those identified as having extensive difficulty with understanding and undertaking living activities (i.e. those who are highly likely to have dementia) had higher care needs than other residents (Figure 7.9). The largest difference was seen in the area of mobility, with 97% of permanent residents highly likely to have dementia requiring assistance with mobility, compared with 78% of other residents.

Use by country of birth

The use of particular aged care services varies across population groups. A relatively high number of CACP recipients were born in non-English-speaking countries: 21%, compared with 16% of HACC clients and around 11% of aged care residents. On the other hand, residential aged care had the highest proportion of older clients born overseas in English-speaking countries (15% of residential respite admissions and 14% of permanent residents of aged care services, compared with 11% of HACC clients and 12% of CACP recipients; see Table A7.12).

The age and sex profiles of different population groups vary. In particular, a greater proportion of older overseas-born people are male, compared with their Australian-born counterparts. Also, among those aged 65 and over, people born in non-English-speaking countries have a younger age profile than those born elsewhere. Some of these differences are apparent in the observed usage patterns of the groups. For example, for all programs examined, the median age of older clients born in non-English-speaking countries was lower than that for those born elsewhere, and the ratio of female to male clients was lower among clients born overseas than among those born in Australia. The lowest ratio was observed among residential respite admissions for people born in non-English-speaking countries (1.4 to 1).

The pattern of increased use with age was evident for both Australian-born and overseas-born people for all services (Table 7.11). However, Australian-born people—especially the very old (85+)—were more likely to access HACC services than other people: 452 per 1,000 Australian-born people, compared with 336 per 1,000 born overseas in an English-speaking country and 369 per 1,000 born in a non-English-speaking country. People born in non-English-speaking countries were more likely than others to be CACP recipients. In contrast to their higher CACP use, however, they used both respite and permanent care less than other groups at all ages.

Table 7.11: Age-specific usage rates and cultural diversity of clients of selected aged care services, 2002 (per 1,000)

Age	HACC clients 2001–02	CACP recipients 30 June 2002	Residential respite admissions 2001–02	Permanent aged care residents 30 June 2002
Australian-born				
65–74	94.0	3.0	5.0	11.5
75–84	257.9	10.8	21.7	58.2
85+	452.0	30.4	60.5	258.2
Overseas-born: main English-speaking countries				
65–74	66.6	2.0	4.8	7.8
75–84	203.5	10.5	22.3	53.6
85+	335.6	30.3	67.6	262.3
Overseas-born: non-English-speaking countries				
65–74	76.8	2.9	3.1	6.8
75–84	226.4	15.9	15.4	41.7
85+	368.7	37.7	42.1	169.7
All				
65–74	86.7	2.8	4.5	10.0
75–84	245.3	11.7	20.7	54.7
85+	424.7	31.4	59.0	247.0

Note: See notes to Table A7.12.

Sources: ABS 2003a, 2003c; AIHW analysis of HACC MDS and DoHA ACCMIS database; AIHW analysis of ABS 1998 Survey of Disability, Ageing and Carers.

Use by Indigenous status

Aboriginal and Torres Strait Islander peoples have a shorter life expectancy than their non-Indigenous counterparts. As a result of their poorer health status, Indigenous people tend to need and use aged care services at a younger age than other people, and consequently the examination here of their use of these services includes people aged 50 and over.

A relatively high percentage of CACP recipients are Indigenous: 3% of CACP recipients aged 50 and over identified as Indigenous, compared with 0.8% of people aged 50 and over at 30 June 2001 (see Table A7.13; ABS 2003a). Under 1% of permanent aged care residents identified themselves as Indigenous. It is estimated that Indigenous Australians made up just over 3% of HACC clients aged 50 and over. However, there are indications that this is an overestimate (see Box 7.4).

Table 7.12: Age-specific usage rates and Indigenous status of clients of selected aged care services, 2002 (per 1,000)

Age	CACP recipients 30 June 2002	Residential respite admissions 2001–02	Permanent aged care residents 30 June 2002
Indigenous			
50–64	11.3	2.7	4.9
65–79	48.3	17.2	26.3
80+	67.2	57.2	116.6
Non-Indigenous			
50–64	0.4	0.6	1.5
65–79	4.3	7.4	17.1
80+	25.3	45.5	166.4
All			
50–64	0.5	0.6	1.6
65–79	4.5	7.4	17.2
80+	25.4	45.5	166.2

Notes

1. At the time of preparation, estimated resident population for Indigenous people was not available for 2002. Therefore, program use has been compared to 30 June 2001 estimated resident population numbers. This will result in a slight over-estimation of usage rates.
2. See notes to Table A7.13.

Sources: ABS 2003c; AIHW analysis of DoHA ACCMIS database.

Differences in the age profile of Indigenous and non-Indigenous people are reflected in client profiles for all aged care services. For example, Indigenous recipients of Community Aged Care Packages have a younger median age than non-Indigenous recipients (70 versus 82 years). However, although the sex ratio among older Indigenous and non-Indigenous Australians is very similar (47% and 48% of people aged 50 and over were male for the two groups, respectively), Indigenous clients of services have a lower female to male ratio than non-Indigenous clients (see Table A7.13; ABS 2003a).

At all ages, Indigenous people had much higher usage rates of Community Aged Care Packages than all other groups examined: 48 and 67 per 1,000 among people aged 65–79 and 80 and over, respectively. The next highest rates were observed among those born in non-English-speaking countries: 16 and 38 per 1,000 for people aged 75–84 and 85 and over, respectively (Tables 7.11 and 7.12). While Indigenous people aged 80 and over had lower usage rates than non-Indigenous people of permanent residential aged care, at ages 50–79 their rates were higher. Indigenous people used respite services more frequently during 2001–02 than non-Indigenous people at all ages.

7.7 Expenditure

Overall, the largest source of funds for the aged care system is the Commonwealth Government, which has primary responsibility for funding residential aged care. It also provides funding for a number of other programs, including Community Aged Care Packages, Multi-purpose and flexible services, Aged Care Assessment Teams, and the Home and Community Care and Veterans' Home Care programs. The HACC program is cost-shared with state and territory governments, with contributions from local government. State and territory governments also provide some funding for other areas of aged care, including residential aged care and assessment services. Governments are not, however, the only source of funding in the aged care system. Users of programs meet part of the costs, and non-government community services organisations contribute funds to some services (see Chapter 4). In addition, volunteers contribute to the sector.

Government expenditure

Total recurrent government expenditure on aged care services increased from $4,552.9 million in 1998–99 to $5,769.5 million in 2001–02 (Table 7.13). The largest area of expenditure in 2001–02 was $4,228.6 million for residential aged care, representing 73% of expenditure, compared with 79% in 1998–99. Over $1,000 million in capital and recurrent funds were provided for the HACC program in 2001–02; of this, an estimated $786.3 million was used to deliver services to people aged 65 and over. Home and Community Care accounted for around 14% of expenditure across the 4-year period. On the other hand, expenditure on Community Aged Care Packages increased steadily and, at $246.3 million, accounted for 4.3% of government expenditure on aged care services by 2001–02, compared with 2.7% in 1998–99. Expenditure on the Carer Allowance, where the care recipient was aged 65 and over, also rose significantly over the period, both in absolute terms and as a proportion of total expenditure: in 2001–02, $190.5 million was spent on the allowance, accounting for 3.3% of expenditure. Funding for National Respite for Carers grew quickly between 1998–99 and 2000–01, and was $68.5 million in 2001–02.

Both the Veterans' Home Care program and Commonwealth Carelink Centres were set up in 2000–01. Expenditure on the program reached almost $52 million in 2001–02, and $11.5 million was spent on the centres in that year. The Extended Aged Care at Home program has developed from a pilot program to being operational across Australia and the proportionally large expenditure increase from $2.8 million in 1998–99 to $8.9 million in 2001–02 reflects this expansion.

Comparisons of program expenditure as expressed in constant prices show whether there has been growth in expenditure after allowing for inflation. In real terms, total government expenditure on aged care services increased by 19% over the 4 years examined. The policy emphasis on developing and supporting programs that enable older Australians to remain in the community, where possible, is reflected in the expenditure data. Overall, expenditure on residential aged care rose 11% in real terms between 1998–99 and 2001–02. Expenditure on HACC services (provided to people aged 65+) is estimated to have risen by 16% between 1998–99 and 2001–02. However, Veterans' Home Care and HACC provide similar services, and if the expenditures on these programs are amalgamated, the rise in real terms for these home-based services was 24% over this period. The emphasis on developing community support programs is also demonstrated in CACP expenditure, which rose by 90% between 1998–99 and 2001–02. In addition, Carer Allowance expenditure increased by 150%, and funding for the National Respite for Carers Program rose by 82%. Over the 4-year period, expenditure on the accreditation of residential aged care providers doubled.

Table 7.13: Recurrent government expenditure on aged care services, 1998–99 to 2001–02

Program[(a)]	1998–99	1999–00	2000–01	2001–02
		Current prices ($m)		
Residential aged care	3,584.3	3,741.4	3,955.6	4,228.6
Community Aged Care Packages	121.8	148.9	194.6	246.3
Home and Community Care	636.0	676.1	725.1	786.3
Veterans' Home Care	. .	. .	13.9	51.9
Extended Aged Care at Home	2.8	6.8	8.4	8.9
Day Therapy Centres	27.3	27.8	28.5	29.3
Multi-purpose and flexible services	25.4	30.7	49.8	74.0
National Respite for Carers	35.3	45.8	68.6	68.5
Carer Allowance[(b)]	71.6	140.8	179.6	190.5
Assessment	38.6	40.1	41.7	43.6
Commonwealth Carelink Centres	. .	—	12.1	11.5
Accreditation	5.9	7.8	10.4	12.5
Other	3.8	5.3	15.4	17.5
Total	**4,552.9**	**4,871.4**	**5,303.8**	**5,769.5**
		Constant 2000–01 prices ($m)		
Residential aged care	3,729.8	3,865.9	3,955.6	4,130.3
Community Aged Care Packages	126.7	153.9	194.6	240.6
Home and Community Care	661.8	698.6	725.1	768.0
Veterans' Home Care	. .	. .	13.9	50.7
Extended Aged Care at Home	2.9	7.0	8.4	8.7
Day Therapy Centres	28.4	28.7	28.5	28.6
Multi-purpose and flexible services	26.4	31.8	49.8	72.3
National Respite for Carers	36.7	47.3	68.6	66.9
Carer Allowance[(b)]	74.5	145.5	179.6	186.1
Assessment	40.1	41.4	41.7	42.6
Commonwealth Carelink Centres	. .	—	12.1	11.2
Accreditation	6.2	8.0	10.4	12.2
Other	4.0	5.5	15.4	17.1
Total	**4,737.7**	**5,033.5**	**5,303.8**	**5,635.3**

(a) To improve the coverage of aged care programs, the programs included in the table have changed slightly from those in the corresponding table in the previous edition of this publication (AIHW 2001a:Table 6.25). In particular, expenditure on Day Therapy Centres, Extended Aged Care at Home packages and 'Other' programs have been included for the first time. Consequently, the numbers in the two publications are not strictly comparable.

(b) Includes Domiciliary Nursing Care Benefit. The Carer Allowance replaced the Domiciliary Nursing Care Benefit in July 1999.

Notes

1. Expenditure on residential aged care includes DoHA, DVA and state and territory funding. The state and territory funding for 2001–02 has been estimated based on DoHA administrative data and AIHW calculations.
2. Home and Community Care expenditure includes Commonwealth and state and territory funding for the aged (estimated for 65+), and funding for HACC National Initiatives ($0.4m in 2001–02).
3. Veterans' Home Care expenditure includes funding for all ages.
4. National Respite for Carers expenditure includes funding for the Carer Support Strategy ($1.3m in 2001–02).
5. Carer Allowance expenditure on older people is based on the proportion of care recipients aged 65 and over of carers receiving the allowance (29.5% in March 2002).
6. 'Other' comprises Assistance with Care and Housing for the Aged (ACHA, all years), Dementia Education and Support program (from 1999–00), Safe at Home (from 2000–01) and Continence Management program (all years, includes Continence Aids Assistance Scheme from 2000–01).
7. Constant dollar values were calculated using the GFCE deflator, referenced to 2000–01.

Sources: AIHW 2001a:Table 6.25; AIHW health expenditure database; DHAC 1999, 2000, DHAC unpublished data; FaCS 2000.

Table 7.14: Recurrent government expenditure on aged care services, expressed as dollars per person aged 65 and over with a severe or profound core activity restriction, 1998–99 to 2001–02

Program(a)	**1998–99**	**1999–00**	**2000–01**	**2001–02**
		Constant 2000–01 prices ($)		
Residential aged care	7,465.5	7,595.2	7,400.9	7,477.0
Community Aged Care Packages	253.6	302.4	364.1	435.5
Home and Community Care	1,324.7	1,372.5	1,356.6	1,390.4
Veterans' Home Care	. .	. .	26.0	91.8
Extended Aged Care at Home	5.9	13.7	15.8	15.8
Day Therapy Centres	56.9	56.4	53.3	51.8
Multi-purpose and flexible services	52.9	62.4	93.2	130.9
National Respite for Carers	73.6	92.9	128.4	121.2
Carer Allowance(a)	149.1	285.8	336.0	336.8
Assessment	80.4	81.3	78.1	77.2
Commonwealth Carelink Centres	. .	—	22.7	20.4
Accreditation	12.4	15.8	19.4	22.1
Other	8.0	10.8	28.9	30.9
Total	**9,482.8**	**9,889.3**	**9,923.4**	**10,201.6**
		Annual growth rate (per cent)		
Residential aged care	. .	1.7	–2.6	1.0
Community Aged Care Packages	. .	19.2	20.4	19.6
Home and Community Care	. .	3.6	–1.2	2.5
Veterans' Home Care	. .	. .	. .	(b)252.9
Extended Aged Care at Home	. .	132.7	15.1	0.3
Day Therapy Centres	. .	–0.7	–5.5	–2.8
Multi-purpose and flexible services	. .	17.9	49.4	40.4
National Respite for Carers	. .	26.4	38.1	–5.6
Carer Allowance(a)	. .	91.7	17.6	0.2
Assessment	. .	1.2	–4.0	–1.2
Commonwealth Carelink Centres	. .	. .	(c). .	–10.1
Accreditation	. .	27.3	23.4	13.8
Other	. .	35.2	166.5	6.2
Total	**. .**	**4.3**	**0.3**	**2.8**

(a) See Table 7.13.

(b) Large increase is from start-up in 2000–01.

(c) Not appropriate to present due to very small start-up expenditure in the preceding year.

Notes

1. See notes to Table 7.13 for information on expenditure derivation.
2. Population estimates by disability status are obtained using age/sex disability rates from the ABS 1998 Survey of Disability, Ageing and Carers in conjunction with the estimated resident population. The estimates assume constant disability rates over time within age/sex groups.
3. Constant dollar values were calculated using the GFCE deflator, referenced to 2000–01.

Sources: Table 7.13; ABS 2003a; AIHW analysis of ABS 1998 Survey of Disability, Ageing and Carers.

The segment of the older population most likely to be in need of assistance from aged care programs in general is people aged 65 and over with a severe or profound core activity restriction. Table 7.14 shows whether real (constant price) program expenditure has been keeping pace with the increasing number of people in this group. In 1998–99, total aged care expenditure in real terms broadly equated to $9,483 per person aged 65 and over with a severe or profound restriction. By 2001–02, this figure had risen by 8%

to $10,202. Growth in expenditure calculated in these terms varied from year to year, growing by 4% between 1998–99 and 1999–00, by less than 1% the following year and by 3% in 2001–02.

The above pattern was not consistent across programs. Relative to the number of people aged 65 and over with a severe or profound core activity restriction, expenditure on residential aged care rose slightly between 1998–99 and 2001–02, from $7,466 per person to $7,477. On the other hand, CACP expenditure showed consistent large annual growth, rising by 72% from $254 to $436 per person. Relative expenditure on National Respite for Carers and the Carer Allowance also rose considerably, from the equivalent of $74 and $149 per person to $121 and $337, respectively; however, most of this growth happened before 2001–02. If the expenditures on HACC and the Veterans' Home Care program are merged, by 2001–02 the combined expenditure of these programs broadly equated to $1,482 per person aged 65 and over with a severe or profound core activity restriction—12% higher than in 1998–99.

User contributions

Users of many aged care services pay a contribution towards the provision of the service. For example, clients of the HACC program may pay a service fee, depending on the care that they receive. However, if such a contribution causes financial difficulty for the user, the provider is obliged to reduce or waive charges. Similarly, CACP recipients may be required to make a contribution. Although no national data are available on user charges for community care services, there are some data for residential care.

For full-pensioner permanent residents and all respite residents, the daily care fee is set at 85% of the Age Pension. For part-pensioner and non-pensioner residents who are on higher incomes, income-tested fees are charged at the rate of 25 cents for every additional dollar of income up to a maximum level of 3 times the pensioner rate or the cost of care, whichever is the lower. In 1999–00, the basic daily care fee yielded $1,060.7 million in user charges, and the income-tested component an additional $21.4 million. In 2000–01, the comparable figures were $1,102.6 million and $54.5 million. Basic daily care fees raised $1,172.1 million in 2001–02, while the income-tested payments contributed $70.1 million. These amounts together represented 23% of the $5,470.7 million available to residential aged care services from the Commonwealth, state and territory governments and residents, compared with 22% in 1999–00.

7.8 Outcomes

As with other welfare services, the measurement of outcomes for aged care services is an important tool for examining the delivery and quality of the services provided. However, outcome measurement lends itself more readily to the acute care context, where desired outcomes can be more clearly specified, than to aged care services. Aged care with its varied client mix, combining a range of chronic and acute conditions and receiving varied services from the formal sector and supported by a myriad of informal sector activities, does not readily lend itself to specific outcome measures (Gibson 1998:ch. 8). In care contexts where successful management may be followed by death or a deterioration in health status, such measures are problematic. These caveats aside, it is still possible to report on measures relevant to program achievements. This section presents data on the accessibility and quality of aged care services.

Accessibility

Supply of residential aged care places and packages

One of the tools used to plan the provision of residential aged care places and packages is the planning ratio; this ratio is based on achieving a desired number of places and packages for the number of people likely to need these services. Because Community Aged Care Packages provide care equivalent to low care in residential aged care, and the recently introduced Extended Aged Care at Home places provide care equivalent to high care in residential aged care, residential aged care places, Extended Aged Care at Home places and Community Aged Care Packages are intrinsically linked; they are therefore combined to present a comparison of the provision of aged care services against the planning ratio. The planning ratio target in 2002 was 100 operational places and packages per 1,000 persons aged 70 years and over, including places in flexible care; it has been set at this level since the early 1980s (AIHW 1993:208, 222; DoHA 2002b:124). In the mid-1990s, provision sat at around 93 places and packages per 1,000 (AIHW 2002d:2). However, this ratio rose slowly after 1999 as new aged care places and packages were made available, increasing from 94.0 at 30 June 1999 to 96.5 in 2002 (Table 7.15). An additional 5,653 places and packages became operational during 2002–03 (provisional estimate).

While in recent years the provision of residential aged care places has declined relative to the number of people aged 70 and over, CACP provision has increased rapidly, leading to a rise in the combined provision ratio of places and packages. At 30 June 1999, there were 8.4 packages and 85.6 residential aged care places per 1,000 people aged 70 or more; in 2002, the corresponding figures were 14.7 and 81.6 (not including the small number of EACH places operational in 2002: 0.2 per 1,000 people aged 70+). In terms of the more closely targeted measure of supply per 1,000 people aged 65 and over with a severe or profound core activity restriction, provision changed from an estimated 27.8 packages and 283.4 places in 1999, to 47.8 packages, 0.5 EACH places and 264.8 residential aged care places in 2002. Consequently, on this measure over the 4 years, there was little total change: from 311.2 to 313.1 places and packages per 1,000 people aged 65 and over with a severe or profound restriction.

Use of residential aged care places and packages

The use of places and packages by older people reflects the relative growth in the provision of Community Aged Care Packages. Between 1999 and 2002, the use of packages grew for both men and women in all age groups (Table 7.16). In particular, use by the very old (85+) grew by 170%, from 18.4 people per 1,000 in 1999 to 31.4 in 2002. Conversely, the use of residential aged care places fell: over the 4-year period, among people aged 85 and over use of residential aged care went from 274.6 people per 1,000 in 1999 to 250.7 in 2002.

Table 7.15: Operational residential aged care places and Community Aged Care Packages, 30 June 1999 to 30 June 2002

			Places/packages per 1,000 persons	
		Number of places/ packages	**Aged 70+**	**Aged 65+ with a severe or profound core activity restriction**
1999	Community Aged Care Packages	13,896.5	8.4	27.8
	Residential aged care places	141,697.5	85.6	283.4
	Total	**155,594.0**	**94.0**	**311.2**
2000	Community Aged Care Packages	18,308.5	10.8	35.5
	Residential aged care places	142,341.5	83.6	275.7
	Total	**160,650.0**	**94.4**	**311.1**
2001	Community Aged Care Packages	24,629.5	14.0	46.1
	Residential aged care places	144,012.5	82.2	269.4
	Total	**168,642.0**	**96.2**	**315.5**
2002	Community Aged Care Packages	26,425.0	14.7	47.8
	Extended Aged Care at Home places(a)	290.0	0.2	0.5
	Residential aged care places	146,268.0	81.6	264.8
	Total	**172,983.0**	**96.5**	**313.1**
2003(b)	Community Aged Care Packages	27,850.0	n.y.a	n.y.a
	Extended Aged Care at Home places	290.0	n.y.a	n.y.a
	Residential aged care places	150,496.0	n.y.a	n.y.a
	Total	**178,636.0**	**n.y.a**	**n.y.a**

(a) In June 2002, EACH places were still formally provided under pilot projects.

(b) 2003 data supplied by DoHA are provisional figures.

Note: Population estimates by disability status are obtained using age/sex disability rates from the ABS 1998 Survey of Disability, Ageing and Carers in conjunction with the estimated resident population. The estimates assume constant disability rates over time within age/sex groups.

Sources: ABS 2003a; AIHW 2003c:2, AIHW analysis of ABS 1998 Survey of Disability, Ageing and Carers; DoHA unpublished data.

Table 7.16: Age-specific usage rates of residential aged care and Community Aged Care Packages, 30 June 1999 to 2002 (per 1,000)

	Males				Females				Persons			
	65–74	**75–84**	**85+**	**65+**	**65–74**	**75–84**	**85+**	**65+**	**65–74**	**75–84**	**85+**	**65+**
CACP												
1999	1.2	4.8	16.2	*3.4*	2.2	8.7	19.3	*6.7*	1.7	7.1	18.4	5.2
2000	1.5	5.7	19.8	*4.2*	2.6	10.7	24.1	*8.3*	2.1	8.6	22.7	6.5
2001	1.8	6.8	24.6	*5.2*	3.1	12.8	29.8	*10.2*	2.5	10.3	28.2	8.0
2002	2.1	7.5	26.6	*5.8*	3.6	14.7	33.7	*11.8*	2.8	11.7	31.4	9.2
Residential aged care(a)												
1999	10.8	44.3	177.3	*33.2*	11.8	73.7	317.2	*72.5*	11.3	61.6	274.6	55.2
2000	10.4	42.7	173.1	*32.9*	11.4	70.1	308.9	*71.6*	10.9	58.8	267.3	54.6
2001	10.1	41.0	166.1	*32.1*	11.0	68.0	298.9	*70.6*	10.6	56.7	257.9	53.6
2002	9.8	40.2	159.8	*31.9*	10.6	67.2	292.1	*70.4*	10.2	55.8	250.7	53.3
Total												
1999	11.9	49.1	193.5	*36.6*	14.0	82.4	336.5	*79.2*	13.0	68.7	293.0	60.5
2000	11.9	48.4	192.9	*37.1*	14.1	80.8	333.0	*80.0*	13.0	67.4	290.0	61.1
2001	11.8	47.8	190.6	*37.3*	14.1	80.9	328.7	*80.8*	13.0	67.0	286.1	61.6
2002	11.9	47.7	186.4	*37.8*	14.2	81.9	325.8	*82.2*	13.1	67.5	282.1	62.5

(a) Includes permanent and respite residents.

Note: Table does not include clients of Multi-purpose and flexible services.

Sources: ABS 2003a; AIHW analysis of DoHA ACCMIS database.

Table 7.17: Level of dependency of permanent aged care residents aged 65 and over, at 30 October 1998, 30 June 2000 and 30 June 2002

	High care					Low care					
	RCS1	RCS2	RCS3	RCS4	*RCS1–4*	RCS5	RCS6	RCS7	RCS8	*RCS5–8*	Total
						Number					
1998	9,236	31,627	23,969	6,113	*70,945*	9,492	12,014	25,087	4,893	*51,486*	122,431
2000	17,616	32,205	20,817	5,819	*76,457*	11,068	12,933	21,154	2,977	*48,132*	124,589
2002	24,028	32,438	19,002	5,971	*81,439*	13,627	14,036	17,969	1,781	*47,413*	128,852
						Per cent					
1998	7.5	25.8	19.6	5.0	*57.9*	7.8	9.8	20.5	4.0	*42.1*	100.0
2000	14.1	25.8	16.7	4.7	*61.4*	8.9	10.4	17.0	2.4	*38.6*	100.0
2002	18.6	25.2	14.7	4.6	*63.2*	10.6	10.9	13.9	1.4	*36.8*	100.0

Notes

1. Assessments were unavailable for 3,079 residents in 1998, 2,825 residents in 2000 and 1,671 residents in 2002.
2. Table does not include clients of Multi-purpose and flexible services.

Source: AIHW analysis of DoHA ACCMIS database.

The increasing provision of Community Aged Care Packages is part of the general policy of enabling people with lower care needs to remain in their homes with the assistance of community care programs. At the same time as this growth in CACPs, there has been a rise in the profile of care needs of permanent residents (Table 7.17). In October 1998, 58% of older residents had high care needs; by June 2002, this had risen to 63%. In addition, the greatest increase seen in the eight RCS care need categories (RCS1–RCS8) was in the highest care group (RCS1); this group accounted for 8% of older permanent residents in 1998 but 19% in 2002. A shift towards higher care needs was also seen among low care residents: in 1998, one-quarter (25%) of residents aged 65 and over were in the lowest two care groups (RSC7 and RCS8), compared with 15% in 2002.

The high occupancy rate being experienced in residential care services indicates high demand for residential places: in 2002, this rate was 96% (AIHW 2003c:26). Difficulties in assessing unmet demand for residential aged care places led Professor Gray to recommend in the two year review of aged care reforms that:

> … the Department [DoHA] review and enhance indicators of supply and demand for residential and community care to ensure the adequacy and reliability of these measures, particularly with respect to the balance, within overall provision of high care and low care, given the effects of ageing in place. (DHAC: Gray 2001:35).

While the overall provision of residential aged care places and packages has been keeping pace with the growth in the population aged 70 and over, the ageing of the older population, combined with the increasing use of aged care services with increasing age, is likely to be placing greater pressure on the accessibility of aged care. In 1999, 238,900 (or 10.2% of people aged 65+) were aged 85 and over; by 2002, this had risen by 17% to 280,400 (or 11.3% of older people). Over the same period, the number of people aged 65–74 increased by just under 2%, or from 1,307,800 to 1,333,000 people (ABS 2003a). While the combined use of residential aged care places and packages rose slightly for people age 65–74, among the very old (85+) use fell steadily between 1999 and 2002, from 293.0 people per 1,000 in 1999 to 282.1 in 2002 (Table 7.16). Data on age-specific usage rates of HACC services and unmet demand for all programs would be required to determine whether this trend was due to decreasing accessibility or falling demand. Such data are not currently available.

Standards and quality of care

National standards and quality appraisal data are currently only available for residential aged care services. However, the collection of national data on service standards quality within the HACC program is expected to begin in 2003.

While there are no national service quality data on the HACC program available for this publication, a plan is being implemented that will see all HACC-funded agencies undergoing an external appraisal, based on the HACC National Service Standards Instrument, by the end of the 2003–04 financial year. Results from the instrument, which includes the Consumer Survey Instrument, will be used to assess services provided against the HACC Standards (see AIHW 1999a:188 and AIHW 2001a:221 for discussion of instrument development).

National data on standards and quality of residential aged care are available from the Aged Care Standards and Accreditation Agency. Replacing the Outcome Standards Monitoring Program, this agency was established in 1997 to oversee and improve service quality within residential aged care, via accreditation of services and promotion of high-quality care (for more details, see AIHW 2001a:249–51). By 1 January 2001, all residential aged care services had received an accreditation decision from the agency, and performance against the accreditation standards to December 2000 (round one accreditations) were presented in the previous issue of this publication.

Since then, some changes have occurred in the appraisal and accreditation process. Residential aged care services were previously rated on a four-level rating scale on each of four accreditation standards, based on the 44 expected outcomes of the standards: management systems, staffing and organisational development; health and personal care; residents' lifestyle; and physical environment and safe systems (AIHW 2001a:442–3). The practice of rating each of the four has been discontinued and instead, for round two accreditations, the Accreditation Agency simply records compliance (or non-compliance) with each of the 44 expected outcomes. Results will be available after the second round of accreditations is completed at the end of 2003.

Table 7.18: Accreditation status of residential aged care services, 31 December 2002

	Number	Per cent
Accredited for 3 years	2,811	95.4
Accredited for between 1 and 3 years	90	3.1
Accredited for 1 year	43	1.5
Granted exceptional circumstances[(a)] following decision not to accredit	1	0.3
Not accredited and not granted exceptional circumstances	0	0
Total	**2,945**	**100.0**

(a) Section 42-5 of the *Aged Care Act 1997* allows the Secretary of the Department of Health and Ageing to determine that a residential aged care service meets its accreditation requirement, if exceptional circumstances apply.

Source: Aged Care Standards and Accreditation Agency unpublished data.

At this stage, only data on the accreditation status of residential aged care services are available (Table 7.18). As at 31 December 2002, 95% of the 2,945 operating residential, aged care services were accredited for 3 years, and 3% were accredited for between 1 and 3 years. All but one of the remaining 44 services were accredited for 1 year. Just one service was not accredited but was granted accreditation under exceptional circumstances.

7.9 Summary

Population ageing

Over the next 10 years, the oldest of the baby-boomer generation will reach 65, the age traditionally considered to be associated with retirement and the beginning of old age. The resulting population shift has implications for all aspects of social and economic life, including government pensions and assistance, health and welfare services and informal support systems.

In the 20 years up to 2021, the number of people aged 65 and over is expected to increase by 73%, from 2.4 million in 2001 to 4.2 million in 2021. The number of people aged 85 and over, among whom we find those most likely to be in need of services and assistance, is also projected to expand rapidly over the same period: from 265,200 to 478,600—an increase of 80%. While the projected growth rates for the next two decades are high, it is not the first time Australia has experienced a rapid rate of increase of the older population. In the age group 85 and over, the 1981–91 and 1991–2001 decades saw overall growth rates of 50% and 69%, respectively, compared with projected growth rates of 50% and 23% for 2001–11 and 2011–21.

Social context

Older people participate in society in a variety of ways, from paid and unpaid work to involvement in spiritual and cultural affairs. Programs which promote active ageing aim to encourage and support people so that they can participate in these endeavours.

As only 5% of people aged over 65 live permanently in residential aged care, the overwhelming majority of older people live in households in the community, mostly with a spouse or partner (59% in 2001) or on their own (30%). At the end of 2002, 83% of people aged 65 and over were in receipt of the Age Pension or a DVA payment, and 6% were in the labour force. This picture of high levels of dependency on pension payments is expected to change in the coming years as the effects of increased superannuation coverage flow through. In addition, over the last 15 years, labour force participation rates for women have risen substantially; for example, between 1988 and 2002, the participation rate for women aged 60–64 increased from 16% to 27%.

In the 12 months to June 2000, nearly 530,000 people aged 65 and over (or 25%) participated in some form of volunteer work through a formal organisation or group, with older people contributing 17% of the total volunteer hours worked. Furthermore, many older people care for family and friends: in 1998, an estimated 401,000 people aged 65 and over provided assistance to people with a disability. In December 2002, a considerable number of older people were providing full-time care on a daily basis to people and so were receiving the Carer Allowance: 51,600 allowance recipients aged 65 and over were providing care to people of a similar age, and 9,300 were caring for younger people.

Aged care services

Increasing emphasis on community care and decreasing emphasis on residential care has continued. For all aged care services, the proportion of people using a service increases with age.

The bulk of home- and community-based services for older people are provided under the auspices of the Home and Community Care Program. In 2001–02, at least 450,000 people aged 65 and over received HACC services—or 181 people per 1,000. The Community Aged Care Packages program has continued to grow, from 18,309 packages on 30 June 2000 to 27,850 on 30 June 2003.

With the trend towards increasing home-based care and reduced rates of residential service provision, respite care has emerged as an important area of service provision. During 2001–02, 10% of older HACC clients (42,900) used centre-based day care and 1% (4,900) used in-home respite care services; also, 14% (6,800) of Veterans' Home Care clients received in-home or emergency respite care. Furthermore, 47% (40,700) of admissions into residential aged care for older people during 2001–02 were for respite care.

Currently, residential aged care is the second most commonly used aged care service after HACC. At 30 June 2002, 52 out of every 1,000 people aged 65 and over (or 5%) were permanent aged care residents, with just 1 additional person per 1,000 being in residential respite care. On 30 June 2003, there were 150,496 operational residential aged care places, including flexible and Multi-purpose Service places.

The profile of care needs of permanent residents has continued to shift towards higher care needs. By June 2002, 63% of older residents had high care needs. Nearly all residents have multiple care needs. However, clients with dementia tend to have greater care needs than other people.

At all ages, Indigenous people have much higher CACP usage rates than all other groups examined, and access respite services more frequently than non-Indigenous people. While Indigenous people aged 80 and over had lower usage rates than non-Indigenous people of permanent residential aged care, at ages 50–79 their usage rates were higher.

Australian-born people—especially the very old—were more likely to access HACC services than other people. People born in non-English-speaking countries were more likely to be CACP recipients than Australian-born people or people born in other English-speaking countries. In contrast, their usage rates of both respite and permanent care were lower than those for other groups at all ages.

Expenditure

Total expenditure on aged care services was $5,769.5 million in 2001–02, an increase of 19% in real terms over the previous 4 years. The proportions allocated to each area of expenditure have changed, with relatively more going to community care and less to residential aged care in 2001–02 than in 1998–99. Overall, the increase in expenditure on aged care services kept pace with the growth in the number of older people likely to need some assistance.

Future outlook

The implications of population ageing for all aspects of social and economic life are increasingly being recognised. In the future, programs concerned with ageing will not just be about responding to the dependency of older people but will be more and more concerned with supporting people to lead independent lives and to continue to participate in all aspects of life as they age. Recent initiatives to this end include measures to enable and encourage older people to stay in the workforce until age 65 and beyond and to delay their decision to retire (for example, the Pension Bonus Scheme), and legislation currently being developed to prohibit age discrimination across a broad spectrum of areas including employment.

With respect to aged care service provision, there have recently been a number of developments aimed at improving service delivery and ensuring that services can meet the needs of their clients. These include the development of a National Aged Care Workforce Strategy, the Review of the Pricing Arrangements in Residential Aged Care and the release of a consultation paper concerning a Strategy for Community Care.

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8 Disability and disability services

8.1 Introduction

This chapter presents an overview of disability in Australia and services for people with a disability.

Disability is conceptualised as multidimensional, relating to the body functions and structures of people, the activities they do, the life areas in which they participate, and factors in their environment which affect these experiences (Box 8.1, Figure 8.1). Increasingly, disability is recognised as something that affects most people in the population, to varying degrees and at varying life stages; it can be measured along a continuum and estimates vary with the particular definition used.

Services of relevance to people with a disability may seek to ameliorate disadvantage associated with any of these components of disability, including the environmental factors. This chapter focuses chiefly on people aged under 65 years,[1] and on services and assistance directed primarily towards their activities and participation in various areas of life:

- formal services and assistance, such as income support, specialist disability services, and relevant generic services;
- equipment or environmental modifications; and
- support from family and friends.

Section 8.2 outlines recent developments in the disability field, including data developments. Section 8.3 gives an overview of disability in the Australian population, and the need for services and assistance. Section 8.4 supplies data on services and assistance provided. Section 8.5 discusses outcomes for people with disability, with a special focus, in this edition, on people with communication restrictions. Section 8.6 concludes the chapter.

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[1] People who have acquired a disability before reaching 65 years of age, are generally regarded as the responsibility of the disability services sector. People who acquire disabilities at older ages are generally the responsibility of the health or aged care services sector.

8.2 Recent developments

The disability field is strongly influenced by philosophical ideas about human society and how it functions, by the theory and practice of human service provision including access to generic services by people with disabilities, by economic trends and funding patterns and practices, and by demographic change in the population. This section briefly explores some recent developments affecting the disability services field.

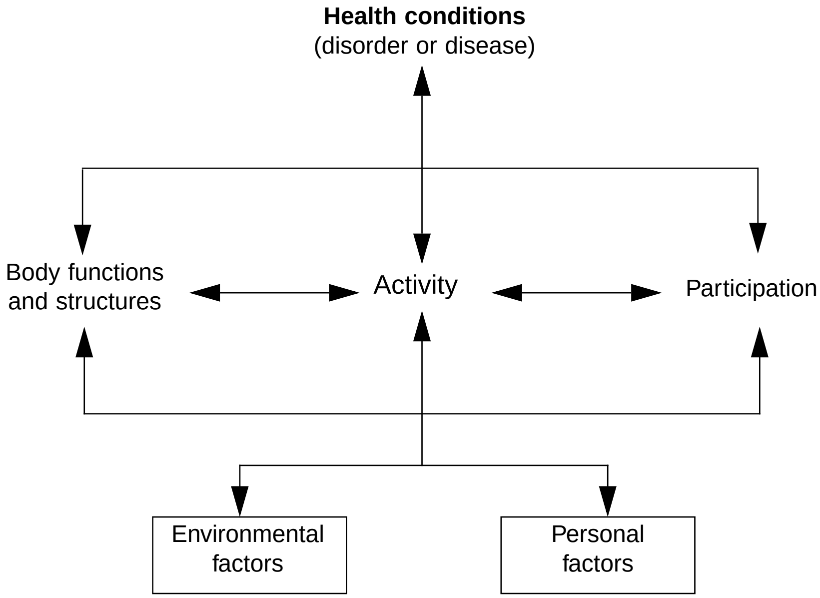

Figure 8.1: Interactions between components of the International Classification of Disability and Health

Human rights and ethics

Most policies in the disability field have, in recent decades, been underpinned by a human rights philosophy—encapsulated in the basic principle that people with disabilities should have the same opportunities to participate in society as do others (see, for example, AIHW 1993:266–79; UN 1994). The United Nations is now seeking input from member states to develop proposals for an international convention to promote and protect the rights of people with disabilities. In the Asia–Pacific region, the UN has fostered a 'framework for action towards an inclusive, barrier-free and rights-based society for person with disabilities' (ESCAP 2002).

International agreement on definitions and classifications of disability (Figure 8.1, Box 8.1) opens the way for these to contribute to clarity in the scope and terminology of such agreements. Indeed, the ICF is recognised as aligning with the existing UN Standard Rules on the Equalization of Opportunities for Persons with Disabilities and

Box 8.1: The International Classification of Functioning, Disability and Health (ICF)

Functioning and disability are multidimensional concepts, relating to the body functions and structures of people, the activities they do, the life areas in which they participate, and the factors in their environment which affect these experiences. In the ICF, a person's functioning or disability is conceived as a dynamic interaction between health conditions and environmental and personal factors (WHO 2001:6).

Disability is the umbrella term for any or all of: an impairment of body structure or function, a limitation in activities, or a restriction in participation. The key components of disability are defined as follows:

- ***Body functions** are the physiological functions of body systems (including psychological functions).*
- ***Body structures** are anatomical parts of the body, such as organs, limbs and their components.*
- ***Impairments** are problems in body function and structure, such as significant deviation or loss.*
- ***Activity** is the execution of a task or action by an individual.*
- ***Participation** is involvement in a life situation.*
- ***Activity limitations** are difficulties an individual may have in executing activities.*
- ***Participation restrictions** are problems an individual may experience in involvement in life situations.*

***Environmental factors** make up the physical, social and attitudinal environment in which people live and conduct their lives. These are recorded as either facilitators or barriers (both on a 5-point scale) to indicate the effect they have on the person's functioning.*

The ICF contains a hierarchy of classifications and codes for each of its main components: Body Functions and Structures, Activities and Participation, and Environmental Factors. Measures can be recorded against each of the neutral codes, to indicate the extent of 'problem' with any of these aspects of functioning. Environmental Factors can be recorded as being either barriers to or facilitators of a person's functioning.

The ICF was endorsed for international use by the World Health Assembly in May 2001. It is regarded by the World Health Organization as one of the two core international classifications for health and health-related information, the other being the International Classification of Diseases and Related Health Problems (ICD).

The potential value of using the ICF in Australia is that it:

- *recognises the role of environmental factors in the creation of disability and the importance of participation as a desired outcome, as well as the relevance of underlying health conditions and their effects; and*
- *provides a framework within which a wide variety of information relevant to disability and functioning can be developed, assembled and related.*

Source: AIHW 2003d.

other rights formulations (Madden 2003; UN 1994; WHO 2001:5). The focus of the ICF on environment is seen as particularly relevant to its application in human rights initiatives (Bickenbach et al forthcoming).

The rapidly changing field of genetics is another area where scientific developments are stirring active ethical debate (Box 8.2).

Disability Discrimination Act

The *Disability Discrimination Act 1992* (DDA) is one of the major national expressions of the human rights approach to disability, making discrimination on the grounds of disability unlawful, and providing a framework for the setting of access standards in significant fields (see Box 8.3 for an overview of recent progress on standards). Individual people may make complaints under the DDA, and standards can be set in order to achieve system-wide change. These standards are set after negotiation with industry to agree the nature and time scale of the changes to be effected. DDA standards have two major purposes: 'to set legislative deadlines for achieving equal access for people with disabilities in the areas covered by the DDA; and to provide more definite and certain benchmarks for accessibility and equality than is provided by the general anti-discrimination model' (HREOC 2003:1). While change is slow, the Act is credited with some positive shifts over the last 10 years— standards for accessible public transport, increased emphasis on 'universal' building design, voluntary industry standards in banking and finance, and a requirement that Telstra provide telephone typewriter services (TTYs) to hearing impaired people (Innes 2003). The Human Rights and Equal Opportunity Commission deals with complaints under the DDA (HREOC 2003).

The Commonwealth Government launched a new Commonwealth Disability Strategy, in recognition of its own legislative responsibilities to ensure that 'people with disabilities have the same access to buildings, services, information, employment, education, sport and recreational activities as everyone else in the community' (Commonwealth of Australia 2000). The strategy encourages Commonwealth agencies to prepare action plans and provides a performance framework for reporting on progress.

An inquiry into the DDA was announced in February 2003, to examine its effectiveness in achieving its stated goals of eliminating discrimination, ensuring equality of people with disabilities before the law, and promoting recognition and acceptance of the rights of people with disabilities. The review is also considering the extent to which the DDA restricts competition, and is to quantify the costs and benefits of the DDA approach and examine mechanisms for improving efficiency and 'minimising compliance costs and paper burden on small business' (Productivity Commission 2003a:6).

Income support and employment

Both nationally and internationally, there are efforts to understand the rising numbers of people receiving disability-related income support, and to clarify the relationship between, on the one hand, measures to support people with a disability in their search for work and in employment once obtained and, on the other, the features of programs that provide income support to replace or supplement earnings otherwise unavailable

Box 8.2: Genetics and ethics

The rapid development of genetic science and technology continues to focus attention on ethical issues of fundamental significance to the disability field. An increasing number of tests for genetic diseases are becoming available as a result of the human genome project and other advances in genetics. These enable an embryo to be screened for one or more genetic disorders during early pregnancy with the option of abortion if any are found. Pre-implantation genetic diagnosis (PGD) is also becoming more common. This involves the creation of embryos using in–vitro fertilisation (IVF) techniques that are then tested for particular genetic disorders. Embryos without the disorder can be transferred to the mother's womb and embryos with the abnormality allowed to succumb.

Some disability rights activists argue that the trend towards preventing the birth of children with genetic impairments is based on misinformation about the lives of people with a disability as well as a lack of support for families with such children (e.g. Newell 2002). They ask the fundamental question as to whether disability represents an element of the diversity of humanity rather than a negative characteristic that should be eliminated. On the other hand, the use of PGD has raised the possibility that parents with a disability may wish to have a child with the same disability, for example deaf parents may choose to have deaf children. The ethics of such a choice are under debate. One viewpoint argues that it would be unethical to deliberately have a child with a disability; another suggests that certain disabilities could be in the long-term interests of the child as they will share the same experiences as their affected parents (Human Fertilisation and Embryology Authority and Advisory Committee on Genetic Testing 1999).

In Australia, these issues have been highlighted by the recent controversy over the use of embryonic stem cells in scientific research. After considerable community debate, the Commonwealth parliament passed the Research Involving Human Embryos Act *at the end of 2002. Under this Act, researchers are able to get approval to use surplus embryos from Australian IVF clinics, but cannot create embryos specifically for research. Some disability advocates have welcomed this legislation believing that embryonic stem cell research will lead to the development of cures for conditions such as spinal cord injuries, motor neurone disease, Parkinson's disease and multiple sclerosis. Others argue that this focus on 'miracle cures' is a diversion from the real day-to-day needs of people with disabilities and the resources required for these to be met. They see it as a return to the 'disability as tragedy' mentality that inhibits the acceptance of people with disabilities as valued community members with worthwhile lives.*

Recently, IVF itself has been found to be associated with an increase in disability. A study of Western Australian children born between 1993 and 1997 found that infants conceived by IVF had twice the risk of a major birth defect, diagnosed by 1 year of age, as naturally conceived infants (Hansen et al. 2002). The reasons for this difference are not known.

Advances in genetic testing also have widespread implications for the privacy and confidentiality of an individual's genetic information and fairness in its use by such bodies as insurers, employers, courts, schools, adoption agencies and the military. The Australian Law Reform Commission and the Australian Health Ethics Committee have conducted an

(continued)

Box 8.2 (continued): Genetics and ethics

inquiry into the ethics of human genetic samples and information. The aims of the inquiry were to see how best to protect privacy, to protect against unfair discrimination and to ensure the highest ethical standards in research and practice (ALRC & NHMRC 2003).

The inquiry set out to find 'a sensible path that meets twin goals: to foster innovations in genetic research and practice that serve humanitarian ends and to provide sufficient reassurance to the community that such innovations will be subject to proper ethical scrutiny and legal control' (ALRC 2002:2) and has made a large number of recommendations. It has proposed that a careful mix of strategies is required—stronger ethical oversight, stronger regulations, industry codes, education campaigns, an independent expert advisory body, and revised privacy and discrimination laws. It is recommended that employers should be able to collect and use an employee's genetic information only where this is reasonable and relevant within the terms of anti-discrimination and occupational health and safety legislation, and that a person should not be denied employment on the basis of predictive genetic information. One recommendation is that the Commonwealth Disability Discrimination Act 1992 *should be amended to ensure that it covers unlawful discrimination based on a person's real or perceived genetic status.*

or inadequate. As part of its welfare reforms, the Commonwealth released a consultation paper *'Building a Simpler System To Help Jobless Families and Individuals'*. The paper canvasses various options for change, including a 'broader path to reform' with an income support system that 'might provide standard rates of income support and income and assets test, with additional assistance for particular needs (such as the costs of disability and participation) and more flexible participation requirements for a greater number of people' (FaCS 2002d:11).

A recent study by the OECD of related policies and experiences in 20 member countries, including Australia, found that:

- disability benefit recipiency rates are high and increasing in many countries and rates of cessation from disability benefits are generally low;
- 'mental and psychological problems are responsible for between one quarter and one-third of the disability benefit recipiency levels' and for much of the increase in these levels (OECD 2003:10); almost one in three current and new Australian recipients in 1999 were classified with 'mental illness' (according to 'stock' and 'inflow' figures; OECD 2003:86); and
- age profiles revealed a tendency for benefits to be concentrated among people over age 50, and for vocational rehabilitation and training, and supported employment programs, to be directed more towards younger age groups.

The policy conclusions suggested an approach to reshape disability policy based on 'a framework of mutual obligations' (OECD 2003:155).

In Australia in recent years, the Commonwealth Department of Family and Community Services has been engaged in a range of reforms designed to encourage and support people with disabilities to find and retain employment. Case-based funding for

Box 8.3: Recent progress in implementing the Disability Discrimination Act

Disability Standards for Accessible Public Transport

The Disability Standards for Accessible Public Transport were approved by both Houses of Parliament and commenced on 23 October 2002. The standards establish minimum accessibility requirements to be met by providers and operators of public transport conveyances, infrastructure and premises. The standards take into account the range of disabilities covered by the DDA and apply to the full range of public transport conveyances, premises and infrastructure, with some limited exceptions. There is a compliance timetable that allows for incremental compliance with the relevant requirements over 30 years, with milestones at the fifth, tenth, fifteenth, twentieth and thirtieth years.

The Disability Discrimination Act 1992 *(DDA) was amended to allow the Human Rights and Equal Opportunity Commission to grant exemptions to disability standards in relation to public transport in appropriate circumstances. These amendments to the DDA commenced on 19 August 2002.*

Disability Standard for Access to Premises

The Building Access Policy Committee is currently developing a draft standard, to be included in the Building Code of Australia. The Australian Building Codes Board, which is a member of the committee, released a Directions Report in December 2001, seeking feedback on proposals. Public information sessions were conducted in all capital cities in February and March 2002. Further public comment will be sought on the draft standard once it is released.

Disability Standards for Education

Draft standards were released for consultation in 2000. The Department of Education Science and Training has since been working with stakeholders to finalise the draft standards and a Regulation Impact Statement for further consideration by the Ministerial Council on Education, Employment, Training and Youth Affairs.

Source: Information provided by Civil Justice Division, Attorney-General's Department, 2003.

disability employment assistance is being introduced and evaluated, so as to fund agencies in relation to the support needs of people with disabilities seeking or being supported in work (FaCS 2002a). Measures to assist business services to achieve quality assurance certification, and remain viable while supporting people with 'low productive capacity', were announced in the 2003 Commonwealth budget (FaCS 2003a). The certification procedure requires all disability-funded agencies to achieve independent certification against the 12 national Disability Service Standards by the end of 2004 (FaCS 2002e). (See Section 8.4 for data on income support, and use of specialist and generic employment services.)

National developments in disability support services

The second Commonwealth/State Disability Agreement (CSDA) was in place from 1997–98, and was due to expire in June 2002. The term was extended to allow for ongoing negotiations over a new Agreement. The extended negotiations over the new Commonwealth State/Territory Disability Agreement (CSTDA) focused, in their later stages, on funding issues, in the context of an awareness of unmet need for disability support services and the need for indexation in the light of population growth and service cost increases (see Section 8.5; AIHW 2002b; SPRC 2002). The new Agreement was signed in 2003 and will terminate on 30 June 2007.

The preamble of the new CSTDA was developed jointly by National Disability Administrators and the National Disability Advisory Council, with input from state-based disability advisory bodies. It describes a shared vision based in a rights framework, with governments agreeing to 'work cooperatively to build inclusive communities where people with a disability, their families and carers are valued and are equal participants in all aspects of life', and recognising that 'people with a disability have rights equal with other members of the Australian community, and should be enabled to exercise these rights' (CSTDA 2003). It acknowledges the principles and objectives of the *Commonwealth Disability Services Act 1986*, the *Disability Discrimination Act*, and complementary state and territory legislation (for an historical overview, see AIHW 1993:266–79).

Five key policy priorities were agreed, to:

- strengthen access to generic services by people with disabilities;
- strengthen across government linkages;[2]
- strengthen individuals, families and carers;
- improve accountability, performance reporting and quality; and
- improve long-term strategies to respond to, and manage demand for, specialist disability services.

A new feature of the agreement is the performance reporting framework which, according to principles set out in the schedules to the agreement, will 'provide the basis for a publicly available report to demonstrate achievements in the delivery of specialist disability services and national progress in implementing agreed national policy priorities' (CSTDA 2003). The framework will rely chiefly on data from the new CSTDA National Minimum Data Set, developed by the National Disability Administrators in partnership with the AIHW (Box 8.4).

Current features of government policies in disability support services are consistent with those outlined in the last biennial report—deinstitutionalisation, the search for flexible community-based services, breaking down service 'stovepipes', clearer

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[2] Bilateral agreement between the Commonwealth and each of the states and territories is being negotiated and will aim to improve the interface between employment services and community access services.

Box 8.4: Redevelopment of the CSTDA NMDS

Since 1994, the CSDA Minimum Data Set (MDS) 'snapshot' collections have provided information about services delivered under the CSDA and the people receiving those services.

In 1999, in recognition of the changing information needs in the disability services field, the National Disability Administrators and the AIHW began a process to review and redevelop the CSDA MDS and related data collections. The redevelopment was undertaken over 2 years and the collection was fully implemented nationally in October 2002. In anticipation of the signing of the CSTDA, the redeveloped collection is now referred to as the Commonwealth State/Territory Disability Agreement National Minimum Data Set (CSTDA NMDS).

The process of redevelopment focused strongly on asking policy makers and other stakeholders about their main information needs. As well as government departments responsible for CSTDA-funded services, CSTDA service providers, consumers, non-government organisations, carers, peak organisations and others interested in the disability services field were given the opportunity to comment on, participate in and test the redeveloped collection (see AIHW 2003b for further information on the redevelopment).

The most significant change in the redeveloped collection is that, for most service types, service providers are required to provide information about all service users (referred to as 'consumers' in the snapshot collections). A small number of new data items have been introduced, including items on primary carers, in recognition of the mutual support among people with disabilities, carers and formal services, and the fact that the importance of ageing carers in particular is now recognised in program goal statements.

contractual funding arrangements, and a concern with population ageing and growth in demand (AIHW 2001a:271–3). Portability, both within states and across state boundaries, is also recognised as an important goal. Ongoing efforts towards regionalisation or localisation of services, and associated community consultation mechanisms, are occurring in a number of Australian jurisdictions, for instance Queensland, Northern Territory and New South Wales, as well as in Victoria and Western Australia which have had longer standing regional structures and processes.

Advocacy and advice

Disability policy in Australia is strongly influenced by organisations representing people with disabilities and non-government organisations providing services in the sector.

The National Disability Advisory Council, appointed by the Commonwealth Minister for Family and Community Services, provides 'consumer focused advice on matters referred by the Minister', encourages consultation between the Commonwealth Government and consumers, carers and disability service providers, and may also seek references from the Minister on matters it considers need investigation (FaCS 2003a). The topics of the council's working groups indicate the scope of its interests: the CSTDA; employment; deinstitutionalisation, community housing and accommodation;

welfare reform and income support; health care; the ageing/disability interface; education and training; rights and access. This national body has state counterparts with which it consults on national issues.

Jointly chaired by the National Disability Advisory Council chair and a commissioner of the Aboriginal and Torres Strait Islander Commission, an interim National Indigenous Disability Network has been formed and has begun meeting.

An Australian Federation of Disability Organisations is in the process of being formed. In January 2001, new funding arrangements for disability peak organisations funded through FaCS were announced, and eight of these organisations were given the task of developing the new Federation (NEDA 2003).

ACROD describes itself as the national industry association for disability services. Its national office takes a particular interest in national policies affecting people with disabilities, including the negotiation of the CSTDA, the issue of unmet need for disability support services, and Commonwealth policies on income support and employment services for people with disabilities (ACROD 2003). Its state and territory offices focus on their own jurisdiction's issues and responsibilities. ACROD has, in the last year, launched a new magazine, *dis*parity, containing a wide range of articles about aspects of disability philosophy and policy.

Insurance—who pays for disability?

Insurance has been in the public policy spotlight in recent years, with financial difficulties being experienced by public liability and medical indemnity insurers. Most recently, an inquiry has been announced into national workers compensation and occupational health and safety (OHS) frameworks, reflecting the need for a consistent national approach to scope, definitions and benefits structures, and concern that 'the coverage of employees under workers' compensation and OHS programmes appears to have declined due to changes in the composition of the workforce and working arrangements' (Productivity Commission 2003b:2).

Much of the publicity surrounding the discussions of insurance has focused on the financial difficulties of insurers, of professionals such as doctors, of employers and of community organisations facing rising costs that threaten areas of their activity. A third (229) of respondents to an Australian Council of Social Science survey of community service organisations reported difficulty in obtaining insurance cover in the 2001–02 financial year. Of these, 162 (71%) said the difficulty was due to the increased cost of cover and 90 (29%) said they had been refused cover (ACOSS 2003:22).

However, these personal injury compensation and insurance schemes exist to compensate and support the victims of accidental and, in some cases, catastrophic injury. The varying scope and benefits of the different insurance schemes, and the gaps left between them, have caused discussion to be reopened about basic questions concerning community responsibility for sharing the costs of disability (e.g. Blair 2003). The plethora of systems across Australia results in wide variations in support available for people with similar needs, depending on how their disability arose.

Medical indemnity and national data

A Medical Indemnity Forum was held in April 2002 to discuss the problems of rising medical indemnity costs and the financial viability of medical indemnity insurers. A number of initiatives arose out of the forum.

In general, the largest single component of very large damages awards in medical indemnity claims is for future care costs. Ministers agreed that urgent work was needed to develop proposals for providing more efficient access to compensation. A group was established, under the auspices of the Australian Health Ministers' Advisory Council (AHMAC), to undertake a 'long term care project', with the aim of developing a workable model to provide an equitable and effective way of managing the long-term care needs and costs for people catastrophically injured in adverse medical events.

Health ministers also decided that a 'national database for medical negligence claims' should be established, to assist in determining future medical indemnity strategies. The absence of a national database to date has made it difficult to analyse trends in the number, nature and cost of medical indemnity claims. A working group was convened under the auspices of AHMAC, and the AIHW was subsequently commissioned to work with the group to further develop proposals for a national medical indemnity collection for the public sector. The data collection commenced on 1 January 2003.

Conceptual and data development

The AIHW has continued its disability data development work program, advised by its broadly based advisory group, the Advisory Committee on Australian and International Disability Data. The aim of this work program is to provide data infrastructure, including disability definitions and concepts, to enable relevant and consistent disability data to be collected in Australian population and service collections, both specialist and generic. Two main achievements since the last biennial report are the completion of the Australian ICF User Guide and the inclusion of related data elements in the National Community Services Data Dictionary (AIHW 2003d, 2003e).

The User Guide is designed to promote the use of the ICF in Australia, by:

- providing information about the ICF to assist Australian understanding of its contents and usefulness;
- informing the user about current and emerging applications in Australia;
- providing advice about 'getting started' and using or applying the ICF; and
- promoting a consistent and constructive approach to using the ICF, particularly in those areas left to the user's discretion.

This work, in coming years, will focus on encouraging the use of the ICF and disability data definitions in the National Community Services Data Dictionary in a wider range of data collections, including those relating to the aged and community care, health services, housing and homelessness, and longitudinal data sets. In this context, a recent review of aged care dependency measures illustrated the value of the ICF as a 'Rosetta Stone' or common framework to help relate and evaluate similar measures within a common framework (T.B. Ustun pers. comm.; AIHW: Van Doeland & Benham 2003).

ICF concepts have been included in the CSTDA NMDS (see Box 8.4). The question on support needs incorporates both the ICF and national population survey concepts, to ensure that NMDS data can be related to national population data and also to some international data collections.

The Australian Bureau of Statistics is pilot testing a possible disability question for the 2006 population census. The advantages of successfully developing a useful question would be significant—in particular, being able to provide better information on disability among relatively small population groups, especially Indigenous Australians, and in small geographical areas for planning purposes. Approaches successfully used in other countries, for instance in the Canadian 2001 census, offer encouragement that a path forward can be found.

There are promising new initiatives to improve information on major disabilities. Notable among these is the proposed new National Cerebral Palsy Register, being developed with the aim of compiling data nationally on the 'widely different origins and clinical manifestations … best studied in subgroups', with the research thus able to benefit from the compilation of a nationally consistent data set (Watson 2002).

8.3 Prevalence of disability and need for assistance

This section presents an overview of disability prevalence and need for assistance in the Australian population. Trends and recent changes in population patterns of disability prevalence are then analysed.

Overview

Estimates of the prevalence of disability, and of various disability types and severities, are based on the ABS 1998 Survey of Disability, Ageing and Carers (ABS 1999).[3] The survey's current terminology is set out in Box 3.5. Its concepts correspond reasonably well with the ICF (see Section 8.1) and in future years its terminology will align more closely; at present, the main variation is that 'activity limitations' in the ICF translate to 'activity restrictions' in the ABS survey.

In 1998, 3,610,300 people reported one or more of 17 impairments, limitations or restrictions which had lasted, or were likely to last, for at least 6 months and which restricted everyday activities[4] (AIHW 2001a:Tables 7.1, A7.1). Of these, 2,385,100 were aged under 65 (14.6% of the population of that age), and of them 2,048,700 people (12.5%) had at least one specific activity restriction.[5] Among these people, 655,000

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[3] The 1998 survey provides the most recent available data. A new survey in the series is being conducted in 2003, and results are to be available in 2004.

[4] The ABS 1998 disability survey equates this to 'disability' (ABS 1999).

[5] The ABS 1998 survey collected information about 'specific activity restrictions', of which there are five categories: restrictions in the three 'core' activities of daily living (self-care, mobility and communication), and restrictions in schooling and employment.

(4.0%) of the population aged under 65, had a severe or profound core activity restriction, which means that they sometimes or always needed personal assistance or supervision with one or more of the core activities—self-care, mobility and communication. In the text of this chapter, 'a severe or profound core activity restriction' is generally abbreviated to 'a severe or profound restriction'.

Of all people aged under 65, with a severe or profound restriction living in households, an estimated 264,300 (41.6%) needed assistance with more than one core activity, including 56,000 (8.8%) who needed help with all three (AIHW 2001a:Table 7.2).

Box 8.5: Disability groups

Intellectual/learning disability *is associated with impairment of intellectual functions with limitations in a range of daily activities and with restriction in participation in various life areas. Supports may be needed throughout life, the level of support tending to be consistent over a period of time but may change in association with changes in life circumstances.*

Psychiatric disability *is associated with clinically recognisable symptoms and behaviour patterns frequently associated with distress that may impair personal functioning in normal social activity. Impairments of global or specific mental functions may be experienced, with associated activity limitations and participation restrictions in various areas. Supports needed may vary in range, and may be required with intermittent intensity during the course of the condition. Changes in level of support tend to be related to changes in the extent of impairment, or in the environment.*

Sensory/speech disability *is associated with impairment of the eye, ear and related structures and of speech, structures and functions. Extent of impairment and activity limitation may remain consistent for long periods. Activity limitations may occur in a various areas, for instance communication and mobility. Availability of a specific range of environmental factors will affect the level of disability experienced by people in this grouping. Once in place, the level of support tends to be relatively consistent.*

Physical/diverse disability *is associated with the presence of an impairment, which may have diverse effects within and among individuals, including effects on physical activities such as mobility. The range and extent of activity limitation and participation restriction will vary with the extent of impairment as well as with environmental factors. Environmental adjustments and support needs are related to areas of activity limitation and participation restriction, and may be required for long periods. Levels of support may vary with both life changes and extent of impairment. Included in this broad category is the subcategory* ***Acquired brain injury*** *which is used to describe multiple disabilities arising from damage to the brain acquired after birth. It can occur as a result of accidents, stroke, brain tumours, infection, poisoning, lack of oxygen, degenerative neurological disease, etc. Effects include deterioration in cognitive, physical, emotional or independent functioning.*

Source: AIHW 2003e.

Main disability groups

In Australia, disability groups, such as 'intellectual disability' and 'physical disability', provide a broad categorisation of disabilities based not only on underlying health conditions and impairments, but also on activity limitations and participation restrictions. These groupings are generally recognised in the disability field and in legislative and administrative contexts in Australia (AIHW 2003e). Descriptions of the groups to be discussed in this section are provided in Box 8.5.

Box 8.6: Four sets of prevalence estimates of disability groups

The four approaches used to obtain the estimates in Table 8.1 provide a spectrum of estimates that may suit different purposes. For instance, the first two types may be useful for epidemiological studies and studies on morbidity and disability. The other can be used as broad summary measures in planning generic services or disability-specific support services for people with a disability.

All the estimates start with the base 'disability' population defined by the ABS 1998 Survey of Disability, Ageing and Carers. The four types of estimates differ in terms of their use of the survey information about impairment, main disabling condition, all disabling conditions, activity limitations and participation restriction, as well as need for assistance with core activities.

Estimates based on reported ***main disabling condition*** *relate to conditions that were identified by the survey respondents as causing the most problems, compared with any other disabling conditions they may also have had. Using this method, the estimates of different disability groups are exhaustive and mutually exclusive. The numbers in each group total the number of people with a disability defined by the 1998 survey.*

The remaining three sets of estimates are based on ***all disabling conditions*** *and are in diminishing size, corresponding to an increasingly restrictive definition of the group, according to severity, need for assistance or activity limitation.*

People may experience more than one type of impairment or disabling condition. The prevalence of a particular disability group will be underestimated if only main disabling conditions are considered. The estimates based on all disabling conditions are the most inclusive of the four types of estimation. These estimates include all reported disabling conditions, whether or not these were main disabling conditions. The disability experience of people with multiple disabling conditions may be classified into more than one disability group.

The approach using data on ***all disabling conditions plus activity limitations and participation restrictions*** *relies on multidimensional information. The five disability groups from the previous approach are now narrowed down by applying a 'filter' – only people who have reported activity limitations or participation restrictions in one or more activities of daily or social life are retained in the group.*

The approach using data on ***all disabling conditions plus a severe or profound restriction*** *is similar to the previous approach except that a more exclusive 'filter' is used to select only people who reported a severe or profound restriction.*

The AIHW has previously published a series of reports reviewing the existing definitions, data sources and estimates of prevalence relating to three disability groups—intellectual, physical, and acquired brain injury—and provided estimates of the size and profile of these groups based chiefly on the 1993 ABS Survey of Disability, Ageing and Carers (AIHW: Fortune & Wen 1999, Wen & Fortune 1999, Wen 1997). These estimates have now been updated using the 1998 survey data (Table 8.1; see also AIHW 2003f). The ICF and ICD-10 frameworks were used as the main guides for classification of disability groups and disabling conditions.

Prevalence estimates vary with the scope and level of disabilities under consideration. Four sets of estimates are accordingly provided, to support different applications and also to illustrate the variation arising from the different bases of estimation (Box 8.6, Table 8.1).

Table 8.1: Estimates of main disability groups in Australia, 1998

	Aged under 65		Aged 65+		All ages	
Estimates based on:	**Number ('000)**	**% of people aged <65**	**Number ('000)**	**% of people aged 65+**	**Number ('000)**	**% of total population**
All disabling conditions						
Intellectual	376.9	2.3	126.1	5.6	503.0	2.7
Psychiatric	504.1	3.1	264.8	11.7	768.9	4.1
Sensory/speech	685.7	4.2	718.9	31.7	1,404.6	7.5
Acquired brain injury	159.0	1.0	52.0	2.3	211.1	1.1
Physical/diverse	1,903.9	11.6	1,124.6	49.6	3,028.5	16.2
All disabling conditions and activity limitations and participation restrictions						
Intellectual	370.4	2.3	126.1	5.6	496.5	2.7
Psychiatric	493.5	3.0	263.6	11.6	757.1	4.1
Sensory/speech	597.9	3.6	689.0	30.4	1,286.9	6.9
Acquired brain injury	150.8	0.9	50.8	2.2	201.6	1.1
Physical/diverse	1,771.2	10.8	1,082.2	47.7	2,853.4	15.3
All disabling conditions and severe or profound restrictions						
Intellectual	184.8	1.1	117.1	5.2	301.9	1.6
Psychiatric	209.9	1.3	188.4	8.3	398.3	2.1
Sensory/speech	218.7	1.3	305.5	13.5	524.2	2.8
Acquired brain injury	75.2	0.5	38.2	1.7	113.3	0.6
Physical/diverse	517.2	3.2	458.3	20.2	975.4	5.2
Main disabling condition						
Intellectual	209.0	1.3	*3.7	0.2	212.7	1.1
Psychiatric	197.2	1.2	87.3	3.8	284.5	1.5
Sensory/speech	235.8	1.4	193.8	8.5	429.6	2.3
Acquired brain injury	35.7	0.2	*3.5	0.2	39.2	0.2
Physical/diverse	1,709.7	10.4	934.4	41.2	2,644.1	14.2
Total with a disability	**2,387.4**	**14.5**	**1,222.7**	**53.9**	**3,610.1**	**19.3**

Notes

1. Estimates marked with * have an associated relative standard error (RSE) of between 25% and 50% and should be interpreted accordingly.
2. Estimates in this table may differ from those in Table A7.4 of the 2001 edition of this report. The previous estimates used ABS definitions that could be compared with earlier editions of this report that used the ABS 1998 and 1993 disability survey data. The ABS definitions have changed since the 1993 survey. The estimates based on all disabling conditions use not only information from responses to the survey screening questions but also the reported disabling conditions coded using the ICD-10 code.

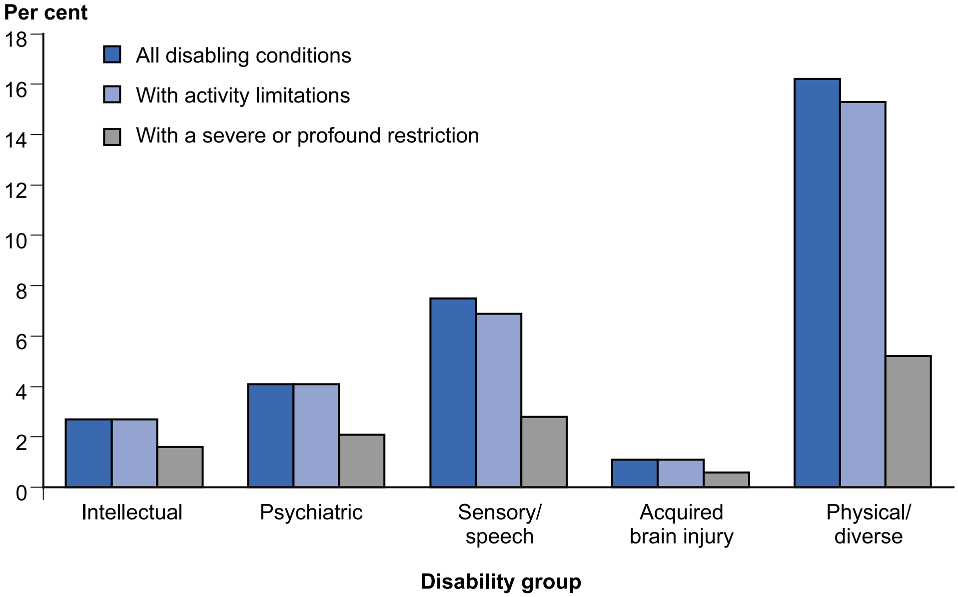
Source: AIHW analysis of ABS 1998 Survey of Disability, Ageing and Carers confidentialised unit record file.

Physical/diverse disabilities were the most prevalent, whichever of the four estimates is considered. Based on consideration of all reported conditions, an estimated 3,028,500 (16.2%) Australians of all ages reported one or more physical/diverse disabilities. Of these, 2,853,400 (15.3% of the total population) also reported one or more activity limitations or participation restrictions and, using the most narrow scope, 975,400 (5.2%) had a severe or profound restriction.

One or more intellectual disabilities were reported by an estimated 503,000 people in 1998, or 2.7% of Australians of all ages, based on consideration of all reported conditions. Of these, 496,500 people (2.7% of the total population) also reported one or more activity limitations or participation restrictions. A more restricted approach includes only people with a severe or profound restriction. In 1998, among Australians with one or more intellectual disabling conditions, 301,900 (1.6% of the total population) had a severe or profound restriction.

Similarly, concentrating on the 'all disabling conditions' estimates, with increasingly narrow focus (Table 8.1, Figure 8.2):

- psychiatric disability was reported for 768,900 people (4.1%), of whom 757,100 (4.1%) had activity limitations or participation restrictions, and 398,300 (2.1%) had a severe or profound restriction;
- sensory/speech disability was reported by 1,404,600 people (7.5%), of whom 1,286,900 (6.9%) had activity limitations or participation restrictions, and 524,200 (2.8%) had a severe or profound restriction



Source: Table 8.1.

Figure 8.2: Estimates of main disability groups based on all reported disabling conditions, 1998

- acquired brain injury was reported by 211,100 (1.1%), of whom 201,600 (1.1%) had activity limitations or participation restrictions, and 113,300 (0.6%) had a severe or profound restriction associated with acquired brain injury.

Trends in population patterns of disability prevalence

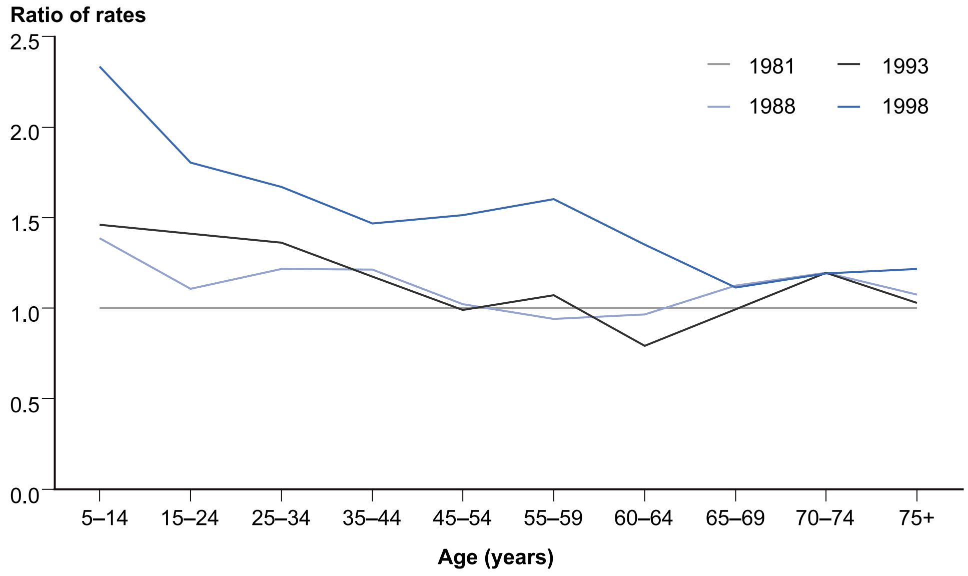
Trends in disability prevalence are of great policy interest in Australia, and it is only by careful consideration of different patterns of change in subgroups of the population, and changes to population survey methods, that these trends can be more completely understood. This section first discusses changes in overall disability prevalence in recent decades—with the main focus on people with severe or profound restrictions—and then describes trends in three broad age groups (under 15 years, 15–64 years and 65+). Each of these age groups has distinct patterns of prevalence and features of policy relevance: the older ages in the 15–64 age group are currently subject to growth largely because of the post-war 'baby boom'; the 65+ age group is itself ageing for various reasons including enhanced life expectancy; and the youngest age group, also subject to influences from the health system, is the group that informs policy makers of likely longer term needs for services.

Demographic change is affecting reporting disability prevalence, in particular the rapid ageing of the working-age population and the ageing of the older population. Comparative analyses of disability prevalence during 1981–98 suggest that such population ageing has had a strong impact on the prevalence of severe or profound restrictions, particularly in the decade to 1998 (AIHW 2000a).

The age-standardised rates of severe or profound restriction were relatively stable during the 1980s and early 1990s, remaining at around 4% of the Australian population. However, between 1993 and 1998, the rate increased from 4.3% to 5.5% (see Table A8.1). This marked increase was largely the result of changes in survey methods which, in 1998, brought more people with a disability into the scope of the survey (AIHW 2001a:267–9; ABS: Davis et al. 2001).

In order to understand the differences in trends among various age groups, the age-specific prevalence rates of severe or profound restrictions for each of the four ABS disability surveys (1981, 1988, 1993 and 1998) have been compared. The comparison is based on the ratios of the age-specific prevalence rates of severe or profound restrictions for 1988, 1993 and 1998 to those for 1981. Ratio values of 1.0 indicate no change between the rates of the 1981 survey and the rates of the three subsequent surveys; those over 1.0 indicate an increase in rates and those under 1.0 a decrease. These comparisons indicate that the rates for 1998 were higher in most age groups than those for the previous surveys (Figure 8.3). The increases were particularly marked among children aged 5–14 and the working-age population, particularly the older working-age population).

Some light can be shed on changes in reported disability prevalence by looking at the associated changes in reported prevalence and patterns of long-term health conditions. The overall prevalence of most disabling conditions increased over the period 1981–98



Source: Table A8.2.

Figure 8.3: Ratio of the age-specific prevalence of rates of severe or profound restrictions, 1981, 1988, 1993 and 1998

(AIHW 2003f:Table 8.3). There were noticeable increases in reported rates of diseases of the ear, respiratory diseases and musculoskeletal conditions, and marked increases in intellectual and psychiatric conditions over the period 1993–98.

Changes in disability prevalence among children aged under 15 years

There has been a substantial increase in the rates of severe or profound restriction among children, in particular boys. Between 1993 and 1998, the rates for males aged 5–14 increased from 2.7% to 4.9%, more than twice the average increase for males aged 15–64 (Table A8.1).

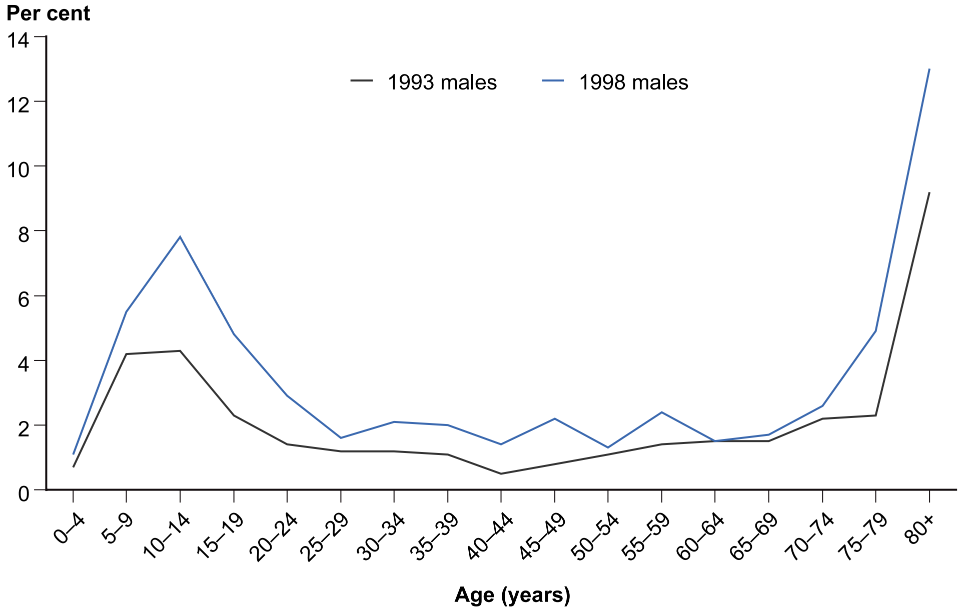
A number of factors may have contributed to this trend. The high rates for children of school age may partly reflect the impact of the educational system on the identification of disability. 'Intellectual/learning' disabling conditions may have a particular impact on school performance. Between 1993 and 1998, the main area of increase in the prevalence of disabling conditions among children of school age was 'intellectual conditions' (AIHW 2003f:Table 8.4).

In 1998, about 42,700 children aged 0–14 with a disability reported an Attention Deficit Hyperactivity Disorder (ADHD), either as a main disabling condition or an associated disabling condition. Of these, 38,700 considered ADHD as their main disabling condition, which was about 70% of the total number of intellectual/learning main disabling conditions reported in 1993 by children of that age with a disability. While ADHD was not separately classified in the 1993 survey, it is likely that these figures are contributing to an increase in reported intellectual disability in these age groups. An increase in prescriptions for the most commonly prescribed drugs to treat ADHD may indicate an increase in the diagnosis of the disorder (ABS: Davis et al. 2001; AIHW 2001a). Both higher levels of diagnosis and heightened awareness among parents, educators and health professionals may have contributed to the increase in reported ADHD.

The change of wording in the screening question, from 'slow at learning or understanding' (1993 survey) to 'difficulty learning or understanding' (1998 survey), may have encouraged reporting of intellectual disability, in particular among males (Figure 8.4). The sharp increase in positive response rates to this screening question was notable in the 5–14 age group, and also among males aged 75 or older (which could be associated with dementia-related conditions).

Changes in disability prevalence among population of working age (15–64)

Among the working-age population, the age-standardised rate of severe or profound restrictions increased from 2.4% in 1993 to 3.3% in 1998, while the rate had been relatively stable between 1981 and 1993. The increase in 1998 was very evident in the older working-age population, particularly the 55–59 age group (see Table A8.1, Figure 8.3).



Source: Table A8.3.

Figure 8.4: Males reporting slowness (1993) or difficulty (1998) with learning or understanding, by age, 1993 and 1998

Apart from changes in age-specific prevalence rates, population growth also impacts on disability prevalence through changes in population size and age structure. The ‘bulge’ of the baby-boom generation is currently affecting the age profile of the working-age population, as it moves progressively up the age pyramid. This demographic trend is expected to impact on future disability prevalence, especially in the 55–64 age group in the next 10 years (AIHW 2000a, 2003f).

There is some evidence of a decline in mortality and an increase in life expectancy among some people with an early onset disability (AIHW 2000a:40). These changes may be attributable to a number of factors, such as developments in medical technology, and improvements in health care and social services.

The increase in severe or profound restrictions during 1993–98 may also be influenced by changes in reported prevalence and patterns of long-term health conditions. The age-standardised rate of musculoskeletal conditions for people aged 15–64 with a disability increased from 5.5% in 1993 to 7.5% in 1998 (AIHW 2003f:Table 8.4). The additional screening question about chronic pain could have contributed substantially to the increase in the reporting of these conditions.

Changes in disability prevalence among population aged 65+

The ageing of the aged population has had a strong impact on the prevalence of severe or profound restriction in this age group. Compared with the 1981 survey, the three later surveys reported substantially higher disability prevalence for the older population. The rate of severe or profound restrictions for people aged 65+ rose sharply between 1993 and 1998, from 17.1% to 19.6% (see Table A8.1). The estimated number of people aged 75 or over with such restrictions increased markedly (AIHW 2000a:Table 13.2).

It has been suggested that about half of the increase in the rate of severe or profound restrictions in this age group was due to changes in survey design and the other half to population ageing and probably an actual rise in prevalence among the oldest age groups of the population (ABS: Davis et al. 2001).

Changes in the 1998 survey screening question on learning and understanding things may have increased the number of people reporting conditions associated with dementia (see Figure 8.4). The separate identification of head injury, stroke and other brain damage may have led to greater reporting of these conditions, especially stroke among the older population. Comparative analyses indicated, for the older population, a large rise in the rate of psychiatric disabling conditions during 1993–98, and sharp increases in the rate of circulatory diseases in both the 1993 and 1998 surveys (AIHW 2003f:Table 8.3).

Trends in injury and perinatal conditions

Trends in injury and perinatal conditions can influence disability prevalence. Injury is an important cause of mortality and morbidity in Australia. Over the past two decades, age-standardised rates of death due to injury declined significantly, but less than overall rates of death, due to all causes. During the middle and late 1990s, injury death rates remained static, while all-cause death rates continued to decline (AIHW 2002a).

The Australian Spinal Cord Injury Register data show that 261 new cases occurred during the financial year 1999–2000. About one-third of these were caused by motor vehicle accidents. The age-adjusted incidence rate of spinal cord injury was 1.40 per 100,000 population in that year, a small decrease from 1.45 in 1998–99 (AIHW NISU: O'Connor 2001).

Between 1990 and 1994, the reported overall incidence rate of major congenital malformations declined from 179.8 to 164.4 per 10,000 births. Between 1995 and 1997, the rate remained fairly constant at around 175 per 10,000 births (AIHW: Al-Yaman et al. 2002).

There is a correlation between low birthweight and disability (Bennett 1997). In 1999, there were 17,208 low-birthweight babies (<2,500 g), or 6.7% of all births. Of these, 3,782 were very low-birthweight babies (<1,500 g) and 2,150 were extremely low-birthweight babies (<1,000 g). There was an increase in the proportion of extremely low-birthweight babies between 1991 and 1999 (AIHW NPSU: Nassar & Sullivan 2001).

8.4 Services and assistance

This section provides information on the assistance available for people with a disability. Formal services and assistance include:

- income support, particularly disability-specific income support;
- specialist disability support services; and
- relevant generic services, particularly those that specifically target people with a disability.

Income support

Commonwealth payments and allowances

The Commonwealth Government is the main source of income support for people with a disability and their carers (Box 8.7).

The Disability Support Pension was the most common payment in 2002 for people with a disability, with close to 659,000 recipients and accounting for over $6.4 billion expenditure in 2001–02 (Table 8.2). This was followed by the Commonwealth Department of Veterans' Affairs Disability Pension which was received by over 159,000 veterans at a cost of $1.2 billion. Combined, the Carer Allowance (Child and Adult) payments accounted for $645.7 million expenditure and were received by close to 300,000 recipients in June 2002 (115,404 Carer Allowance Child and 153,863 Carer Allowance Adult) (Tables 8.2, 8.3).

As experienced in many countries (see Section 8.2), there has been an upward trend in Disability Support Pension recipient numbers for the last decade (and previously) (Table 8.3). Recent Australian studies have begun to analyse this continuing trend.

Box 8.7: Commonwealth disability-related payments and allowances

Disability Support Pension *(DSP) is a means-tested income support payment for people aged at least 16 years but under Age Pension age (at date of claim lodgement), who have a physical, intellectual or psychiatric impairment and an overall impairment rating of at least 20 points on the impairment tables. As a result of the impairment, recipients must have an inability to work full-time at full award wages in open employment, and be unable to undertake educational or vocational training which would equip them for work, within the next 2 years of their life. People of the same age who are permanently blind are also eligible for the DSP.*

Mobility Allowance *is a non-means-tested income supplement, paid to people with a disability aged 16 or over to help with transport costs to employment, vocational training, voluntary work or any combination of these activities, or job search, who are unable to use public transport without substantial assistance. It is also payable to recipients of Newstart Allowance and Youth Allowance.*

Sickness Allowance *is paid to people over 21 years of age but under Age Pension age, who are temporarily incapacitated for work or full-time study because of disability, illness or injury and who have a job or full-time study to return to. It is not payable to Youth Allowance recipients who become incapacitated for study.*

Carer Allowance *(Child/Adult) is an income supplement payment available to people caring for a child with a disability or severe medical condition or for an adult with a disability. The person being cared for must require a lot more daily care and attention than a person of the same age who does not have a disability. The Child Disability Assessment Tool and the Adult Disability Assessment Tool are used to assess eligibility for children and adults, respectively. An important eligibility requirement is that the care recipient and carer must live together in the same private residence. Carer Allowance is free of income and assets tests and may be paid on top of Carer Payment or other payments.*

Carer Payment *(DSP/AP/other) is an income support payment for people whose caring responsibilities prevent them from substantial workforce participation. The recipient must be providing constant care permanently or for an extended period of time to: a person (aged 16 and over) who has a severe physical, intellectual or psychiatric disability that qualifies the carer under the Adult Disability Assessment Tool; or a child (aged under 16 years) with a profound disability; or two or more children with disabilities The recipient of Carer Payment cannot receive it as well as another income support payment, and the person being cared for must be receiving a social security pension or payment (e.g. DSP, Age Pension) or satisfy specific income and assets tests. The recipient is not required to live with or adjacent to the person being cared for, but must be providing constant care.*

Wife Pension *(DSP/AP) is paid to female partners of DSP or Age Pension recipients who were on these payments as at 30 June 1995. Since 1 July 1995, this payment has been closed to new applicants.*

(continued)

Box 8.7 (continued): Commonwealth disability-related payments and allowances

Newstart Allowance (incapacitated) *and* ***Youth Allowance (incapacitated)*** *is an exemption from 'activity test requirements' available to people – 21 years or more or under 21 years, respectively – who, due to a medical condition, illness or injury, are temporarily unable to work or, in the case of Youth Allowance, to study.*

Disability Pension *is a compensation payment to veterans for injuries or diseases caused or aggravated by war service or certain defence service on behalf of Australia. Non-veterans may also receive it if they are dependants of deceased or incapacitated veterans.*

Continence Aids Assistance Scheme *is a program offering assistance to people who have permanent and ongoing incontinence as a result of a neurological condition or severe impairment. The aim of the program is to help eligible clients to meet the costs of continence aids.*

Table 8.2: Commonwealth disability-related payments and allowances, recipients and expenditure (all ages), 2001–02

	Recipients as at June 2002	Administered expenses 2001–02 ($m)
Disability Support Pension	658,915	6,404.4
Mobility Allowance	41,997	67.9
Sickness Allowance(a)	9,522	93.7
Carer Allowance (Child/Adult)(b)	269,267	(c)645.7
Carer Payment (DSP/AP/other)	67,260	(d)595.8
Wife Pension (DSP)	44,238	402.0
Newstart Allowance (incap.)	76,882	(e)n.a.
Youth Allowance (incap.)	5,792	(e)n.a.
Continence Aids Assistance Scheme	16,331	9.1
Disability Pension (DVA)	159,425	1,200.0

(a) From July 2002 FaCS introduced a revised method of counting Sickness Allowance, Newstart Allowance, Mature Age Allowance, Partner Allowance, Widow Allowance, Special Benefit, Youth Allowance and Austudy Payment clients, based on eligibility and entitlement.

(b) Excluded from these counts: 2,216 received both Carer Allowance (Adult) and Carer Allowance (Child) and 11,708 received Carer Allowance (Child) Health Care Card only.

(c) Administered expenses and recipients for Carer Allowance (Child) and Carer Allowance (Adult) are combined.

(d) Administered expenses and recipients for Carer Payment (DSP), Carer Payment (AP) and Carer Payment (other) are combined.

(e) Administrative expenses for Newstart Allowance (incapacitated) and Youth Allowance (incapacitated) are not available as they are included in the larger funding budget for these two programs.

Sources: DVA 2002; FaCS 2002b; FaCS unpublished data.

Cai (2002) found that, while both the increase in inflow rate and the decrease in outflow rate contributed to the growth in recipient numbers, it has been the increase in the inflow rate since the early 1990s which has been the more significant. Other factors, including labour market conditions, policy changes and benefits levels, are also explored in this detailed analysis. In another study, of flows into the Disability Support Pension, it was found that most entrants were aged 50 and over and were likely to enter from outside the income support system and to exit to the Age Pension (Chalmers & Siminski 2003).

Table 8.3: Recipients of disability-related payments and allowances (all ages), June 1993–June 2002

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Disability Support Pension	406,572	436,234	464,430	499,235	527,514	553,336	577,682	602,280	623,926	658,915
Mobility Allowance	16,160	20,795	22,851	54,985	26,595	28,975	31,001	35,154	37,574	41,997
Sickness Allowance[(a)]	46,579	47,132	47,311	33,215	15,759	16,285	11,181	10,733	10,942	9,522
Carer Allowance (Child)[(b)]	61,174	69,693	78,898	90,644	95,520	90,830	100,452	116,955	111,691	115,404
Carer Allowance (Adult)[(b)]	35,025	37,169	38,408	42,047	44,103	45,675	51,857	84,104	123,350	153,863
Carer Payment (DSP)	8,056	9,450	10,633	13,483	15,735	18,556	21,392	24,500	28,171	34,963
Carer Payment (AP)	6,507	7,441	8,324	9,500	10,954	11,740	13,407	15,346	18,097	20,227
Carer Payment (other)	482	808	1,141	2,054	2,869	3,683	5,271	7,704	10,922	12,070
Wife Pension (DSP)	108,327	116,036	121,839	107,803	91,307	79,892	68,523	59,934	51,225	44,238
Wife Pension (AP)	33,520	36,539	39,611	41,125	36,577	36,233	32,196	31,362	26,476	23,730
Newstart Allowance (incap.)	n.a.	n.a.	n.a.	n.a.	n.a.	48,792	59,670	68,016	76,850	76,882
Youth Allowance (incap.)	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	3,929	5,883	5,959	5,792
Disability Pension (DVA)	156,923	156,286	157,298	159,079	160,145	161,829	162,810	162,730	162,505	159,425

(a) From July 2002 FaCS introduced a revised method of counting Sickness Allowance, Newstart Allowance, Mature Age Allowance, Partner Allowance, Widow Allowance, Special Benefit, Youth Allowance and Austudy Payment clients, based on eligibility and entitlement.

(b) Excluded from these counts in 2002: 2,216 received both Carer Allowance (Adult) and Carer Allowance (Child) and 11,708 received Carer Allowance (Child) Health Care Card only.

Sources: AIHW 2001a; DVA 2002; FaCS 2002b; FaCS unpublished data.

The study also highlighted the importance of initiatives to assist young people, particularly males, to make a successful transition from school to the labour market. High rates of disability among female sole-parent recipients were also found.

Several other payments and allowances experienced upward trends in recipient numbers between 1993 and 2002 (Table 8.3). The number of people receiving the Carer Allowance (Adult) almost doubled between 2000 and 2002 (from 84,104 to 153,863). Similarly, there was a noticeable increase in the number of people receiving the various Carer Payments, which rose overall by close to 20,000 recipients over the same period.

Several reasons have been suggested to explain the increase for these payment types, including: demographic changes (e.g. ageing population and an associated rise in the number of people with a disability); greater awareness of these payments; reduction in access to other forms of income support (e.g., widow and wife pensions); and the increase in number of people with disabilities and medical conditions being cared for at home (FaCS 2002b). The Wife Pension (DSP/AP) has continued its downward trend in response to the payment being closed to new applicants since 1995.

Concession cards

The Commonwealth Government provides a range of concession cards for eligible people with a disability and their carers (Box 8.8). These cards entitle the holder to various concessions on specific Commonwealth, state and territory, and local government services, as well as some private sector concessions. Eligibility for some concession cards is dependent upon receipt of a disability-related or income support payment or pension. The concession areas vary across the country, and concessions are granted at the states' and territories' discretion. Such coverage may include ambulance travel for isolated patients, glasses, dental care, taxi subsidies, and so on. The core areas agreed by state and territory governments are energy consumption, water and sewerage, municipal rates and transport (including public transport, motor vehicle registration and licence fees).

Box 8.8: Commonwealth concession cards (all ages)

*A **Pensioner Concession Card** is automatically issued to people receiving a number of income support payments, including Disability Support Pension and Carer Payment recipients, as well as people aged over 60 years who have been continuously receiving one of the following payments for more than 9 months: Newstart Allowance, Sickness Allowance, Widow Allowance, Partner Allowance, Parenting Payment or Special Benefit. The card entitles the holder to Commonwealth health concessions, such as low-cost medicines under the Pharmaceutical Benefits Scheme, as well as additional health, household, educational and recreational concessions from state and local government authorities. In June 2002, close to 3.1 million people were covered by a Pensioner Concession Card.*

*A **Health Care Card** is automatically issued to people receiving most types of income support payments from Centrelink, including: Newstart Allowance, Sickness Allowance, Mobility Allowance (if not getting DSP) and Carer Allowance (Child) (for the direct use of the child only). The card entitles the holder to Commonwealth health concessions, such as low-cost medicines under the Pharmaceutical Benefits Scheme, as well as a more limited range (than the Pensioner Concession Card) of state and local government concessions. Holders of the Health Care Card receiving Sickness Allowance may also be entitled to free hearing services and redirection of their postal articles (for a maximum of 6 months) free of charge. In June 2002, over 1.7 million people were covered by the Health Care Card.*

*The **Gold Repatriation Health Card** entitles some veterans, including disabled veterans and their dependants, to free treatment for all health conditions. The **White Repatriation Health Card** provides access to health services for veterans with specified conditions/disabilities. As at June 2002, there were 281,448 Gold Card holders and 59,268 White Card holders.*

Sources: DVA 2002; FaCS unpublished data.

Table 8.4: Worker's compensation claims with non-fatal outcomes resulting in work absences of 60 days or more, 1999-2000

	Age group (years)						
Nature of injury or disease	**<20**	**20–29**	**30–39**	**40–49**	**50–54**	**55+**	**Total**
Injury/poisoning							
Fractures	144	744	910	896	470	528	3,692
Sprains/strains of joints and adjacent muscles	433	3,562	5,222	5,788	2,458	2,222	19,690
Contusions with intact skin surface & crush injury	74	342	429	430	218	210	1,703
Open wound	130	459	346	292	133	126	1,486
Other injury poisoning	109	461	521	455	198	193	1,933
Total injury/poisoning	*890*	*5,568*	*7,428*	*7,861*	*3,477*	*3,279*	*28,504*
Nervous system and sense organs	4	71	124	158	86	83	526
Musculoskeletal system and connective tissue diseases	27	263	512	561	250	208	1,821
Mental disorders	26	261	478	737	351	184	2,037
Other diseases/not stated/not available	22	136	207	227	122	168	888
Total	**969**	**6,299**	**8,749**	**9,544**	**4,286**	**3,922**	**33,776**

Notes

1. Some figures include minor random adjustments in order to account for small cell values, for confidentiality reasons.
2. Of the 33,776 claims, male claimants accounted for 22,182 claims.
3. Totals include not stated.

Source: National Workers Compensation Statistics database, viewed 23 April 2003, <www.nohsc.gov.au/OHSInformation/NOSI/>.

Personal injury compensation schemes

Other significant sources of income support for people with a disability are the personal injury compensation schemes, mainly for work- and transport-related injuries. These schemes operate under specific legislation in each state and territory and require contributions from employers and road users respectively. They generally aim to replace lost income and to cover medical expenses incurred.

The National Workers Compensation Statistics database includes claims for workers compensation, made under the Commonwealth, state and territory legislation as a result of a fatality, or temporary or permanent disability requiring an absence from work of 1 week (5 working days) or more.

During 1999–2000, 33,776 claims were made for workers compensation involving events with non-fatal outcomes in the most serious category recorded, that is resulting in 60 days or more absence from work (Table 8.4). Of these, 84% involved injury or poisoning, followed by mental disorders (6%), then diseases of the musculoskeletal system and connective tissue. The most common claims recorded under the injury or poisoning category included 'sprains and strains of joints and adjacent muscles', accounting for 69% of all injuries and poisoning, followed by 'fractures' (13%) and 'contusions with intact skin surface and crush injury' (6%). Two-thirds (66%) of all claimants for these events were male.

Disability support services

CSDA-funded disability support services

Services provided under the Commonwealth/State Disability Agreement (CSDA) are designed for people who need ongoing support with everyday life activities. Under the second CSDA (1998), it was agreed that the Commonwealth has responsibility for the planning, policy setting and management of employment services, while the states and territories have responsibility for all other specialist services, including accommodation support, community support and respite.[6] Advocacy, print disability, alternative formats of communication, and information services are considered shared responsibilities under this agreement.

While, in practice, services are generally directed to people aged under 65 years, the CSDA places no age-based restrictions on access to them. The new CSTDA specifies that the disability should be manifest before the age of 65 years (for further details on the new agreement, see Section 8.2).

Information on disability support services provided or funded under the CSDA is collected in the framework of the CSDA Minimum Data Set (MDS), developed in 1993 and jointly maintained by the AIHW and the Commonwealth, states and territories, under the auspices of the National Disability Administrators (comprising the heads of government disability services throughout Australia).

Consumers and service providers supply data on a ‘snapshot’ day to funding departments in each jurisdiction, and the Institute collates these data nationally. Since 1999 a statistical linkage key has been collected; this enables the number of consumers to be estimated from data on services received without any consumers being personally identified (see AIHW 2003a for further information). The use of a snapshot day permits the number of consumers to be estimated at a point in time and can also be regarded as a sample of the people who use CSDA-funded services. The number of consumers in this snapshot sample, as a proportion of consumers over the year, will differ by service type. In particular, it will be greater for accommodation and most community access services, which in general are used on a more frequent basis than employment, community support and respite services. The collection has been redeveloped and, from 2002–03, will cover consumers for the full financial year (see Box 8.4).

CSDA service types and funding

The total government expenditure on disability support services by Australian governments under the CSDA in 2001–02 was $2.75 billion, an increase of 7.9% in real terms from the level in 2000–01. Accommodation support services accounted for over half of this expenditure ($1,412 million) (Table 8.5). Around one-tenth of funding was spent on each of the following: community access services ($304 million), community support services ($299 million), and employment services ($261 million). Total expenditure on respite services accounted for 6% of funds ($156 million), and a further $221 million was spent on administration.

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[6] See AIHW 2003a for a complete list of services and their definitions.

Table 8.5: CSDA funding of services by Australian governments, by service group, 2001–02 ($'000)

Service group	**NSW**	**Vic[(a)]**	**Qld[(b)]**	**WA[(c)]**	**SA[(d)]**	**Tas**	**ACT[(e)]**	**NT[(f)]**	**C'wth[(g)]**	**Australia**	**Per cent**
Accommodation support	529,683	416,581	160,580	126,361	108,534	43,517	20,020	6,756	—	1,412,032	51.4
Community support	74,657	92,766	34,114	50,089	26,614	6,311	6,021	8,517	—	299,088	10.9
Community access	86,975	129,426	40,563	15,450	12,302	10,674	2,325	1,354	4,606	303,675	11.1
Respite	57,798	36,633	26,562	13,689	7,397	6,190	2,490	770	4,525	156,052	5.7
Employment	—	—	—	—	—	—	—	—	261,247	261,247	9.5
Other support	7,321	30,275	4,205	8,802	5,891	1,284	200	232	6,006	64,214	2.3
Advocacy, info and print disability	832	6,005	3,653	1,307	1,870	1,562	873	66	12,694	28,862	1.1
Subtotal	*757,267*	*711,685*	*269,676*	*215,698*	*162,607*	*69,538*	*31,928*	*17,695*	*289,077*	*2,525,171*	*92.0*
Administration	77,364	62,746	24,706	9,981	12,232	3,580	4,142	1,899	24,066	220,716	8.0
Total	**834,631**	**774,431**	**294,382**	**225,679**	**174,839**	**73,118**	**36,069**	**19,594**	**313,143**	**2,745,886**	**100.0**

(a) Service reclassifications were made in Vic in 2000, 2001 and 2002. See SCRCSSP 2003: Table 13A.21 for more information.

(b) Method of apportioning government administration expenditure in Qld changed in 1999–2000 and again in 2000–01 as a result of improved financial reporting systems and with the establishment of Disability Services Queensland.

(c) WA's 2000–01 expenditure for accommodation support, community support, community access and respite reflects increased state business plan funding, including Commonwealth unmet need funding. An improved cost allocation and payments database has been used for WA data in 2001–02.

(d) Expenditure for SA decreased from 2000–01 to 2001–02 because some funding was transferred out of disability services (from accommodation support) and reporting changed (in community support, advocacy, information and print disability and other support) to be consistent with the CSTDA Schedule A State Funding. Administration and total expenditure excludes some government agencies receiving funding from Department of Human Services.

(e) In the ACT, only services under the Disability Services funding program are counted. Excludes services funded through the HACC program.

(f) Expenditure variations in 2001–02 for the disability service types reflect changes in service provision under an individual funding model.

(g) Commonwealth administrative expenditure is an estimate only and is based on average staffing levels.

Source: SCRCSSP 2003:Table 13A.21.

The Commonwealth Government's direct funding ($289 million) to disability support services under the CSDA was mostly for employment services. The Commonwealth also provided some of the funds expended by state and territory governments ($501 million). Its overall contribution to total CSDA funding was 30% (SCRCSSP 2003).

The CSDA MDS collection reported on 8,142 service outlets in 2002 (AIHW 2003a). The majority of service outlets (74%) were provided by the non-government sector. Accommodation support services accounted for the largest proportion of service outlets (3,478 or 43%), followed by community access services (18%) and community support services (15%).

Consumers of CSDA services

The number of consumers receiving CSDA-funded services on a snapshot day in 2002 was 65,809, in comparison with 62,752 in 1999 (Tables 8.6, 8.7). Similar to previous years, close to three-fifths of consumers (37,677) were male (AIHW 2003a). In 2002, accommodation support services were accessed by over 22,000 consumers, followed by community access (18,866) and employment services (18,242). Just over one-third of all consumers were in Victoria. New South Wales had the next highest proportion (26%), followed by Queensland (14%). Western Australia and South Australia each contributed around 10% of all consumers.

Recent years have seen a steady rise in the numbers of consumers accessing CSDA-funded services on the snapshot day. These increases are occurring within the context of population growth and ageing, and increased funding and service provision in recognition of the growth in demand from these demographic changes, and the existing unmet need for these services (see Section 8.5). Between 1999 and 2002, the proportion of consumers accessing accommodation support services remained constant, at around 34%, as with employment services (28%) and respite (5%) (Table 8.7). A shift can be seen in the number of consumers accessing community support and community access services between 2001 and 2002 (27% to 20% for community support, and 25% to 29% for community access). This change may be attributed to the reclassification of some service types as a result of the redevelopment of the CSDA MDS (AIHW 2003a).

Table 8.6: Consumers of CSDA-funded services on a snapshot day, by service type and state and territory, 2002

Service group	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia	Per cent
Accommodation support	6,069	7,412	3,314	1,987	2,373	798	297	124	22,373	34.0
Community support	3,105	4,724	1,409	2,344	1,189	149	213	80	13,211	20.1
Community access	3,960	8,938	2,253	1,093	1,692	654	220	57	18,866	28.7
Respite	612	1,151	515	459	339	46	56	36	3,214	4.9
Employment	5,924	4,485	2,616	2,245	2,032	521	288	134	18,242	27.7
Total consumers	**17,343**	**23,096**	**9,065**	**6,676**	**6,655**	**1,829**	**797**	**389**	**65,809**	**100.0**

Notes

1. Consumer data are estimates after use of a statistical linkage key to account for individuals who received more than one service on the snapshot day. Totals may not be the sum of the components since individuals may access more than one service type on the snapshot day. There were 41 consumers who accessed services in more than one state or territory, mainly in 'border' areas.
2. Data for consumers of the following CSDA-funded service types are not collected: advocacy, information/referral, combined information/advocacy, mutual support/self-help groups, print disability/alt. formats of communication, research & evaluation, training & development, peak bodies, and other support services.

Source: AIHW 2003a.

Table 8.7: Consumers of CSDA-funded services on a snapshot day, by service group, 1999–2002

	1999		2000		2001		2002[(a)]	
Service group	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Accommodation support	20,916	33.3	21,335	34.2	21,775	34.1	22,373	34.0
Community support	15,720	25.1	17,159	27.5	17,011	26.7	13,211	20.1
Community access	14,901	23.7	14,895	23.9	15,703	24.6	18,866	28.7
Respite	3,010	4.8	2,598	4.2	2,702	4.2	3,214	4.9
Employment	17,734	28.3	17,373	27.9	17,730	27.8	18,242	27.7
Total	**62,752**	**—**	**62,341**	**—**	**63,830**	**—**	**65,809**	**—**

(a) Due to the re-categorisation of the service type 'recreation/holiday programs' in 2002, the service groups 'community support' and 'community access' should be considered together in 2002 when comparing with previous years data.

Notes

1. Consumer data are estimates after use of a statistical linkage key to account for individuals who received more than one service on the snapshot day.
2. Data for consumers of the following CSDA-funded service types were not collected: advocacy, information/referral, combined information/advocacy, mutual support/self-help groups, print disability/alt. formats of communication, research & evaluation, training & development, peak bodies, and other support services.
3. Data provided by the Commonwealth are preliminary and cover 99% of Commonwealth-funded services.

Sources: AIHW 2000c, 2001b, 2002c, 2003a, 2003c.

Table 8.8: Consumers of CSDA-funded accommodation services on a snapshot day, 2002

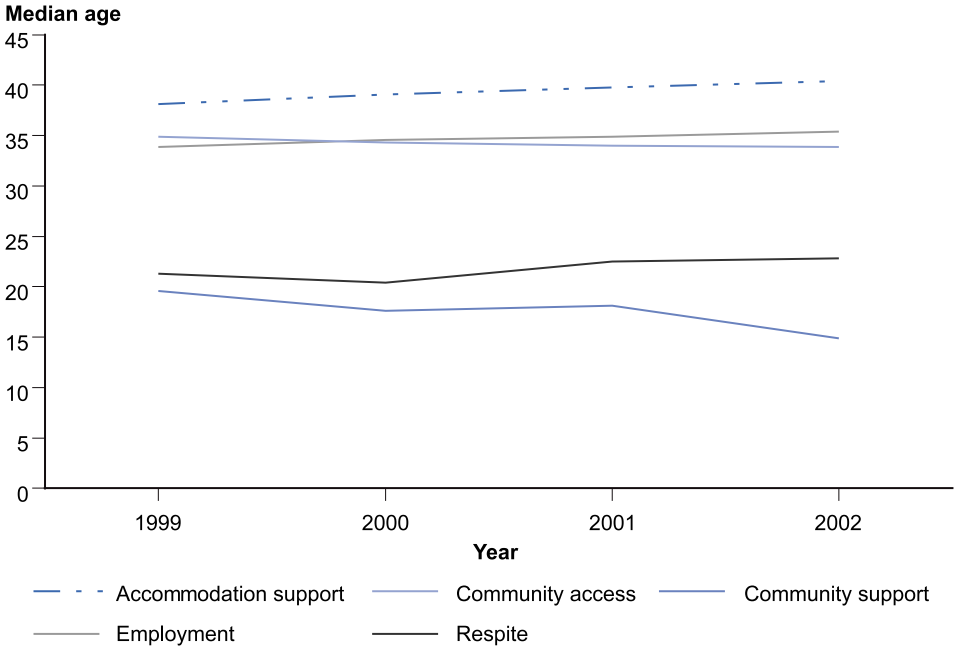
	Age group (years)							
Service type	**0–4**	**5–14**	**15–24**	**25–44**	**45–64**	**65+**	**Not stated**	**Total**
Large residential/institution	0	20	176	2,069	1,727	377	11	4,380
Small residential/institution	0	1	57	362	204	24	1	649
Hostels	0	27	29	266	242	62	16	642
Group homes	2	97	1,009	5,114	2,835	369	102	9,528
Attendant care/personal care	0	6	87	453	491	67	39	1,143
In-home accommodation support	7	105	614	2,700	1,565	282	140	5,413
Alternative family placement	3	108	98	20	7	0	15	251
Other accommodation support	1	15	162	206	94	5	48	531
Total	**13**	**376**	**2,211**	**11,111**	**7,110**	**1,180**	**372**	**22,373**

Note: Consumer data are estimates after use of a statistical linkage key to account for individuals who have received more than one service on the snapshot day.

Source: AIHW analysis of the 2002 CSDA MDS data.

Usage of specific accommodation support services on the 2002 snapshot day varied across age groups (Table 8.8). Group homes were the most utilised accommodation service type overall (used by 9,528 of 22,373 consumers, or 43%). However, for those aged 5–14 years, both alternative family placement and in-home accommodation support were the most common. For those aged 65 years or over, 377 of 1,180 people (32%) were living in large residentials/institutions, a much higher rate than for those in this accommodation type overall (4,380 of 22,373, or 20%).

The median age of consumers of CSDA-funded services gradually rose over the years 1999–2002: from 33.1 to 34.0 (see Table A8.4). Median ages for those using accommodation support, employment services and respite increased between 1999 and 2002, despite a small decline between 1999 and 2000 for respite services (Figure 8.5).



Note: The re-categorisation of the service type 'recreation/holiday programs' from 'community support' to 'community access' is partially responsible for the fall in median ages of consumers of community support services between 2001 and 2002.

Source: Table A8.4.

Figure 8.5: Median age of consumers of CSDA-funded services on a snapshot day, by service group, 1999–2002

In contrast, the median age for consumers of community access and community support services fell. The most obvious decline was for community support services between 2001 and 2002. This appears to be at least partially due to the re-categorisation of service types (see AIHW 2003a). In particular, the reclassification of recreation services from community support to community access would have contributed to this decline.

Close to 40,000 people receiving CSDA-funded services in 2002 reported an intellectual disability as their primary disability (Table 8.9). The next most frequently reported were physical disability (8,002) and psychiatric disability (4,896). Consumer trends for 1999–2002 reveal that the proportions of consumers in most primary disability groups remained steady over this 3-year period. However, there was considerable variation in the patterns of service use among different primary disability groups (AIHW 2003a:Figure 3.4).

Of all reported disability groups (that is, primary disability and all other significant disability groups), intellectual and physical disabilities remain the two most commonly reported disabilities. Just over two-thirds (69%) of consumers reported intellectual as one of their disabilities, while 29% reported physical. Despite being reported as a primary disability by less than 1% of consumers, speech disabilities are the third most common overall, reported by 22% of consumers as one of their primary disability groups.

Table 8.9: Disability group(s) of consumers of CSDA-funded services on a snapshot day, 1999–2002

	Primary disability group				All reported disability groups, including primary			
	1999	2000	2001	2002	1999	2000	2001	2002
	(Number)				(Number)			
Intellectual	38,225	37,479	37,575	39,909	42,744	42,446	42,752	45,398
Specific learning/ADD[(a)]	729	923	942	911	2,002	2,062	2,213	4,351
Autism	1,937	2,133	2,299	2,500	3,666	4,064	4,267	4,956
Physical	7,904	7,673	7,911	8,002	17,718	17,826	18,123	19,354
Acquired brain injury	2,143	2,290	2,761	2,427	2,911	3,122	3,613	3,371
Neurological	1,759	1,738	1,916	2,266	8,792	9,002	9,636	10,689
Deafblind	213	168	179	170	516	518	528	558
Vision	1,606	1,359	1,553	1,716	6,117	5,930	6,102	7,047
Hearing	837	847	885	854	3,856	3,736	3,744	3,944
Speech	333	335	334	405	11,855	12,450	12,146	14,463
Psychiatric[(b)]	5,149	5,381	5,419	4,896	8,995	9,323	9,735	9,767
Developmental delay	1,411	1,576	1,439	1,106	1,908	2,200	2,015	1,880
Not stated	506	439	617	647	n.a.	n.a.	n.a.	n.a.
Total	**62,752**	**62,341**	**65,831**	**65,809**	—	—	—	—

(a) The increase in the number of consumers reporting this disability type as another significant disability is partly due to the improved collection procedures in one jurisdiction.

(b) Although psychiatric disability proportions fell between 2001 and 2002, these figures are not directly comparable due to policy changes in SA. The decrease is not completely accounted for by the drop in numbers within this jurisdiction (see AIHW 2003a).

Notes

1. Consumer data are estimated after use of a statistical linkage key to account for individuals who received more than one service on the snapshot day.
2. Data for consumers of the following CSDA-funded service types were not collected: advocacy, information/referral, combined information/advocacy, mutual support/self-help groups, print disability/alt. formats of communication, research & evaluation, training & development, peak bodies, and other support services.
3. The total for 'all reported disability groups' adds to more than the total number of consumers, since consumers may be counted in more than one disability group.
4. Data provided by the Commonwealth for the years 1999–2002 are preliminary and therefore do not cover 100% of Commonwealth-funded services.

Sources: AIHW 2000c, 2001b, 2002c, 2003a, 2003c.

Indigenous Australians accessing CSDA-funded services

On the 2002 snapshot day, 1,670 or 2.5% of CSDA consumers (or 2.7%, excluding the 5% of consumers for whom Indigenous status was not known) were identified as being of Aboriginal or Torres Strait Islander origin, or both (Table 8.10). This was very similar to the proportion (2.6%) of Indigenous Australians in the general population aged under 65 in 2002 (AIHW 2003a:Table 3.11). However, it is likely that this amounts to under-representation in or poor access to these services, as the limited evidence available points to higher rates of disability among Aboriginal and Torres Strait Islander peoples (AIHW 1997a:304).

Table 8.10: Consumers of CSDA-funded services on a snapshot day, by support needed and Indigenous status, 2002

Frequency of support needed in activities of daily living	Indigenous		Non-Indigenous		Total	
	Number	Per cent	Number	Per cent	Number	Per cent
Always or unable to do	772	46.2	25,650	42.3	27,364	41.6
Sometimes	642	38.4	22,854	37.7	24,359	37.0
None but uses aids	51	3.1	2,098	3.5	2,241	3.4
None	194	11.6	9,372	15.4	9,976	15.2
Not known	11	0.7	714	1.2	1,869	2.8
Total	**1,670**	**100.0**	**60,688**	**100.0**	**65,809**	**100.0**

Notes

1. Consumer data are estimates after use of a statistical linkage key to account for individuals who have received more than one service on the snapshot day.
2. Data for consumers of the following CSDA-funded service types were not collected: advocacy, information/referral, combined information/advocacy, mutual support/self-help groups, print disability/alt. formats of communication, research & evaluation, training & development, peak bodies, and other support services.
3. Totals include 3,451 consumers whose Indigenous status was not stated.
4. Data provided by the Commonwealth are preliminary and cover 99% of Commonwealth-funded services.

Source: AIHW 2003a.

Overall, two-fifths (42%) of all CSDA consumers reported needing continual support in ‘activities of daily living’ (self-care, mobility and/or communication). A slightly higher proportion of Indigenous consumers reported this need (46%), compared with other consumers reporting (42%). Approximately 15% of Indigenous consumers reported needing no support with activities of daily living (including those who needed only aids), compared with 19% of non-Indigenous consumers.

Life areas and frequency of support for CSDA-funded consumers

Data on the support needs of consumers in nine main life areas are collected through the CSDA MDS. The data item provides a framework consistent with international classification standards and Australian population data and into which the common assessment tools used in the disability services field can be mapped (see AIHW 2003b: ch. 8).

For simplicity of analysis, data on the overall support needs are grouped into three main life areas:

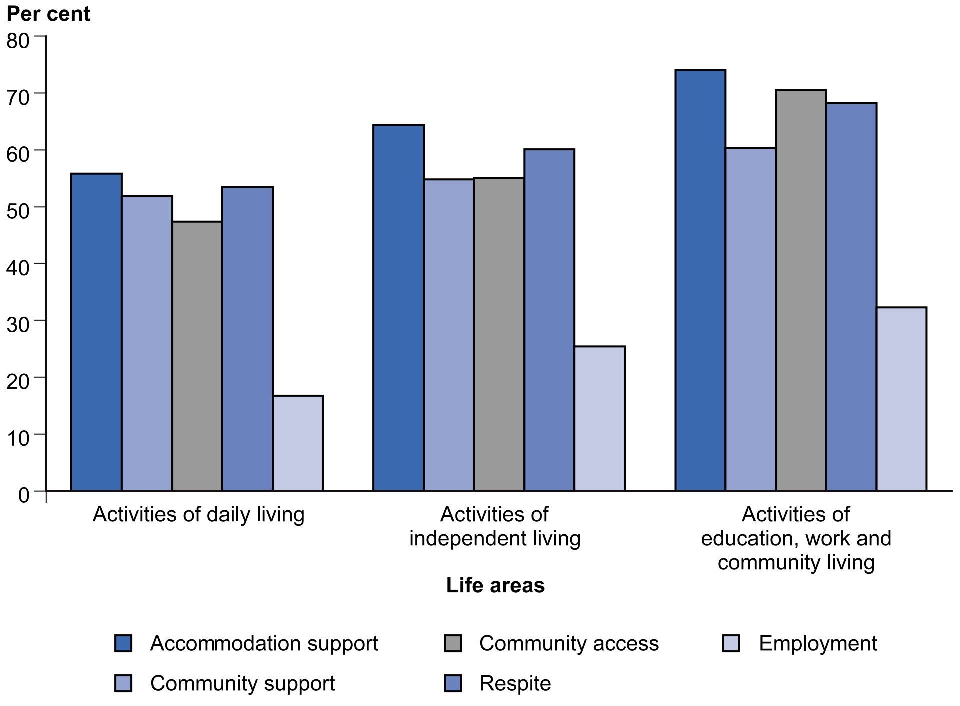
- Activities of daily living (ADLs)—self-care; mobility; and communication.
- Activities of independent living (AILs)—interpersonal interactions and relationships; learning, applying knowledge, and general tasks and demands; and domestic life.
- Activities of work, education and community living (AWECs)—education; community (civic) and economic life; and working.

Consumers of accommodation support services have the highest need for continual support in the three main life areas (ADL 56%, AIL 64% and AWEC 74%) (Figure 8.6). CSDA consumers receiving employment support services constitute the lowest proportion requiring continual support (ADL 17%, AIL 25% and AWEC 32%).

Of the three life areas, the 'activities of work, education and community living' group is found to have the largest proportion of consumers always needing support (58%). This proportion varies between service groups, from just under one-third (32%) of employment consumers, to almost three-quarters (74%) of accommodation support consumers. The 'activities of independent living' group has the next largest proportion always needing support, with 48% of consumers. Also for this category, employment services has the smallest proportion (25%) and accommodation support the largest (64%). Finally, just over two-fifths (42%) of consumers reported that they always needed support with 'activities of daily living', ranging from 17% for employment services to 56% for accommodation support.

Consumer location

The 2002 CSDA MDS snapshot collection was the first time that consumer postcode has been available for all states and territories. It was also the first time that these data have been analysed using the Remoteness Areas of the Australian Standard Geographical Classification, replacing the former national standard classification of metropolitan urban, rural, remote and other areas (see AIHW 2003a for further information).



Note: Activities of education, work and community living are analysed for consumers aged 5 years and over, as consumers under 5 are allowed to respond 'not applicable due to age'.

Source: Table A8.5.

Figure 8.6: Consumers of CSDA-funded services needing continual support in different life areas, by service group, 2002

Table 8.11: Location of consumers of CSDA-funded services on a snapshot day, 2002

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
People aged under 65 years									
All Australians	5,747,855	4,196,712	3,212,033	1,696,456	1,294,388	408,032	294,203	192,464	17,044,642
Major cities	4,142,136	3,102,506	1,686,038	1,193,174	926,970	0	293,559	0	11,344,383
Inner regional	1,154,404	877,670	810,116	204,474	161,639	258,428	644	0	3,467,903
Outer regional	409,199	211,578	578,966	165,881	152,648	139,795	0	103,702	1,761,768
Remote	34,678	4,959	86,457	84,204	39,504	7,548	0	40,660	298,010
Very remote	7,438	0	50,456	48,724	13,627	2,260	0	48,102	172,579
Consumers									
All consumers	17,194	22,278	9,065	6,594	6,591	1,823	792	389	64,685
Major cities	11,779	14,668	4,940	5,100	5,262	0	781	0	42,515
Inner regional	4,131	6,278	2,431	728	639	1,360	8	0	15,552
Outer regional	1,201	1,319	1,535	533	595	454	(a)2	199	5,836
Remote	68	13	115	166	82	9	(a)1	125	578
Very remote	15	—	44	67	13	0	—	65	204
Consumers per 1,000 population									
All consumers	3	5.3	2.8	3.9	5.1	4.5	2.7	2	3.8
Major cities	2.8	4.7	2.9	4.3	5.7	—	2.7	—	3.7
Inner regional	3.6	7.2	3	3.6	4	5.3	12.4	—	4.5
Outer regional	2.9	6.2	2.7	3.2	3.9	3.2	—	1.9	3.3
Remote	2	2.6	1.3	2	2.1	1.2	—	3.1	1.9
Very remote	2	—	0.9	1.4	1	0	—	1.4	1.2

(a) These consumers resided in outer regional and remote areas outside of the ACT but accessed services within the ACT.

Notes

1. The number of consumers in each Remoteness Area (RA) was estimated based on consumers' residential postcodes. Some postcode areas were split between two or more RAs. Where this was the case the data were weighted according to the proportion of the population of the postcode area in each RA.
2. Consumer data are estimates after use of a statistical linkage key to account for individuals who received more than one service on the snapshot day. Totals for Australia may not be the sum of the components since individuals may have accessed services in more than one state or territory on the snapshot day.
3. Data for all consumers exclude 1,124 consumers whose location was not known. Location was classified as 'not known' only if all the postcodes provided by all services attended by the consumer were not stated.
4. Data for consumers of the following CSDA-funded service types were not collected: advocacy, information/referral, combined information/advocacy, mutual support/self-help groups, print disability/alt. formats of communication, research & evaluation, training & development, peak bodies, and other support services.
5. Data provided by the Commonwealth are preliminary and cover 99% of Commonwealth-funded services.

Source: AIHW 2003a.

Table 8.11 reveals that, based on the population of Australians under 65 years of age, it was inner regional areas that had the highest rates of consumers (4.5 per 1,000 population). This was followed by major cities (3.7), outer regional areas (3.3), remote (1.9) and finally very remote areas (1.2).

Victoria and South Australia had the highest rates overall (5.3 and 5.1, respectively). For major cities, South Australia had the highest rate (5.7 per 1,000), while for inner regional areas Victoria had the highest rate (7.2). Victoria also had the highest rate in outer regional areas (6.2), and the Northern Territory in remote areas (3.1). It is possible that the locations of consumers may be influenced by the availability of and access to disability services, and people with disabilities may move to be closer to these services.

The proportion of Indigenous consumers using services on the 2002 snapshot day increased with the remoteness of their geographical location (Table 8.12). Indigenous consumers represented 2.5% of consumers overall, but they comprised a smaller proportion in capital cities (1.4%). Much larger proportions were found in outer regional (7.4%), remote (24.1%) and very remote (50.0%) areas.

Table 8.12: Location of consumers of CSDA-funded services on a snapshot day, by Indigenous status, 2002

	Major cities	Inner regional	Outer regional	Remote	Very remote	Not known	Total
				Number			
Indigenous	616	373	431	139	102	9	1,670
Non-Indigenous	40,178	14,325	5,177	426	98	484	60,688
Not stated	1,727	854	228	13	5	625	3,451
Total	**42,520**	**15,552**	**5,836**	**578**	**204**	**1,118**	**65,809**
				Per cent			
Indigenous	1.4	2.4	7.4	24.1	50.0	0.8	2.5
Non-Indigenous	94.5	92.1	88.7	73.7	47.8	43.3	92.2
Not stated	4.1	5.5	3.9	2.2	2.2	55.9	5.2
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Notes

1. Consumer data are estimates after use of a statistical linkage key to account for individuals who received more than one service on the snapshot day.
2. The number of consumers in each Remoteness Area (RA) was estimated based on consumers' residential postcodes. Some postcode areas were split between two or more RAs. Where this was the case the data were weighted according to the proportion of the postcode area in each RA.
3. Data for consumers of the following CSDA-funded service types were not collected: advocacy, information/referral, combined information/advocacy, mutual support/self-help groups, print disability/alt. formats of communication, research & evaluation, training & development, peak bodies, and other support services.
4. Data provided by the Commonwealth are preliminary and cover 99% of Commonwealth-funded services.

Source: AIHW analysis of 2002 CSDA MDS data.

Table 8.13: People aged 10–64 years in aged care homes by age, sex and state/territory, 30 June 2002

Age (years)	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
10–29	28	12	24	2	4	2	0	1	73
30–49	391	216	217	88	54	22	4	12	1,004
50–64	1,794	1,202	1,023	377	293	124	38	56	4,907
Total 10–64	**2,213**	**1,430**	**1,264**	**467**	**351**	**148**	**42**	**69**	**5,984**
Total 10–64 (% of all permanent residents)	4.6	4.3	5.1	4.1	2.7	4.0	3.0	20.5	4.4

Note: There were also 132 respite residents aged between 10 and 64 at 30 June 2002.

Source: AIHW analysis of data supplied by DoHA from the ACCMIS Warehouse.

Other disability support services

Residential aged care and HACC

People who have a disability and are aged less than 65 years may receive accommodation and other support services within the aged care sector. Nationally, there were 5,984 people aged 10–64 years living permanently in aged care homes on 30 June 2002, accounting for 4.4% of permanent residents of all ages (Table 8.13); in addition, there were 132 respite residents aged under 65. As in previous years, residents aged 50–64 accounted for over 80% (4,907) of people under 65 in residential aged care. However, there were 73 permanent residents aged 10–29 in these services. Permanent residents aged under 65 as a percentage of all permanent residents varied considerably among the states and territories, ranging from 2.7% in South Australia to 20.5% in the Northern Territory. The higher rate in the Northern Territory could be related to its higher proportion of Aboriginal and Torres Strait Islander people, who have patterns of earlier admission to residential aged care than the rest of the population (AIHW 2002d:50). The issue of 'younger people in nursing homes' has become of such concern that a coalition of peak disability organisations has formed, to advocate moving these people out of aged care facilities and into community based placements with appropriate support (Young People in Nursing Homes Consortium 2003).

During the 12 months to 30 June 2002, an estimated 583,156 clients received services from the Home and Community Care (HACC) program (see Table A7.10). Of these, at least 133,469 clients (or 23% of all HACC clients) over this period were aged under 65 years (see Box 7.4 for further details about this program).

Rehabilitation and hearing services

CRS Australia is funded by the Commonwealth Government to provide vocational rehabilitation services to people with disabilities with the aim of assisting them to gain or retain employment. A total of 17,091 new clients received a program of assistance in the financial year 2001–02, along with 13,114 existing clients. Of the 10,790 new clients who completed a rehabilitation program, 6,103 achieved an employment outcome of 13 weeks or more (FaCS 2002b).

Over half (57.3%) of new CRS Australia clients had a physical disability, followed by 26% with a psychiatric disability and 5.3% with acquired brain injury. People with a sensory disability accounted for 4.4% of new clients, while 3.3% had an intellectual or learning disability.

The Office of Hearing Services purchases hearing services from a national network of private sector service providers and Australian Hearing, which is the sole government-funded provider of hearing services. Australian Hearing specifically delivers services to children and young adults up to the age of 21 and age pensioners. Hearing services were provided to 167,107 clients in the period 2000–02. Of these clients, 123,366 were pensioners and veterans, 35,236 were children, and 8,505 were 'Other', such as COMCARE and CRS clients or defence personnel (Australian Hearing 2002).

Equipment and related services

A range of government and non-government equipment services is available to people with disabilities (AIHW: Bricknell 2003). These services target specific disability or population groups (e.g. people with hearing impairments, war veterans) or are more generic in provision, supplying an array of aids and equipment specifically to assist people with self-care, mobility, communication and other needs.

In 1998, 48% of people with a disability used some form of aid. Of this group, 40% were under the age of 65 years. The use of aids and equipment was more likely in older age groups and for those with more severe core activity restrictions (AIHW: Bricknell 2003).

Medical aids were the most used of the six aid and equipment categories listed in Table 8.14. At least 40% of all aids used by people with disabilities in each age group were medical aids. Mobility aids were the second most used aid for people aged 15–29, 30–44 and 45–64, accounting for 17–18% of all aids used. Self-care or communication aids were the third most commonly used aid.

Table 8.14: People aged 0–64 years with a disability, by use of aids and equipment and age group, 1998

	0–14 yrs		15–29 yrs		30–44 yrs		45–64 yrs	
Type of aid	**No. ('000)**	**Per cent**	**No. ('000)**	**Per cent**	**No. ('000)**	**Per cent**	**No. ('000)**	**Per cent**
Self-care	28.4	15.9	24.3	12.3	47.2	13.2	117.9	15.1
Mobility	21.2	11.8	33	17.1	60.1	16.8	137.8	17.7
Communication	28.5	15.9	24	12.1	58.5	16.4	119.1	15.3
Hearing	10.1	5.6	10.2	5.1	19	5.3	73.3	9.4
Meal preparation	*3.0	1.7	*4.3	2.2	13.2	3.7	20.9	2.7
Medical	88.1	49.1	101	51.2	159.7	44.6	309.5	39.8
Total aids used	**179.3**	**100.0**	**197.4**	**100.0**	**357.7**	**100.0**	**778.5**	**100.0**
Number of users	118.2		134.8		222.4		483	
Average no. of aids	1.5		1.5		1.6		1.6	

Notes

1. Estimates marked * have an associated relative sampling error or between 25% and 50%. These estimates should be interpreted accordingly.
2. Self-care aids include eating, showering, toileting, incontinence and dressing aids. Mobility aids include electric wheelchair/scooters, manual wheelchairs, canes, crutches, walking sticks, walking frames, seating/bedding aids, car aids and other mobility aids. Communication aids include low- and high-tech reading and writing aids, low- and high-tech speech aids, mobile/cordless phones and fax machines. Hearing aids include hearing aids proper and cochlear implants.

Source: AIHW: Bricknell 2003.

For children under 15 years, self-care and communication aids each accounted for 16% of all aids. Aids for mobility made up 12%. Around 5–6% of all aids used by people under 45 years were hearing aids or cochlear implants. For people aged 45–64 years, this proportion rose to 9%.

Little difference existed between age groups in the average number of aids used. People aged under 30 years used on average 1.5 aids each, compared with an average of 1.6 aids used by people aged between 30 and 64 years.

Relevant generic services

Health services

People with disabilities, like the rest of the population, need to access health services as a result of illness, and there is growing interest in the question of how effective this access is.

Durvasula and Beange (2001) reviewed emerging evidence that people with intellectual disabilities have poorer health outcomes, in terms of lower life expectancy and more prevalent health problems, and that they do not access health services, in particular preventive health care, to the same extent as the rest of the population. The same authors have found higher mortality rates among people with intellectual disability in a Sydney area (Durvasula et al. 2002). It has been suggested that people with intellectual disabilities are more likely to develop other physical and mental health problems than the general population (Lennox & Beange 2000). Despite this, it appeared that people with intellectual disabilities were less likely to undergo health screening and were less exposed to health promotion than other patients attending general health services. Possible barriers in providing general health care for people with developmental disabilities include a lack of comprehensive medical histories and insufficient physical access to community facilities (Burbidge 2003; Parmenter et al 1999). Health professionals treating people with various disabilities have on occasion not had sufficient knowledge of a specific condition, preventing the provision of effective health care (Buzio 2001; Parmenter et al. 1999). Specific health targets have been suggested for this population group in order to counter these risks, for instance standards about the frequency of checking dental health, hearing and vision (Beange et al. 1999).

The need for health service improvements within the disability services sector has again been highlighted by the NSW Community Services Commission (Mullane 2002). In 1999–2000, 'a total of 69 deaths of people with disabilities were notified to the Disability Death Review Team. Of these 51 deaths were reported to be linked to underweight (17 people), swallowing difficulties (23 people) and/or tube feeding (11 people).'

Gaps in health service delivery to people with high/complex needs were identified. Improvements needed included the reduction of risk factors such as dysphagia, respiratory infection and underweight, and improved processes in the area of palliative care and end-of-life decision making. 'Less than optimal procedures and practices around infection control' were observed.

The Centre for Developmental Disability Studies in Sydney has been involved in programs funded by the NSW Health Department to sensitise hospital staff to the needs of people with disabilities, and is developing a training package for doctors relating to cervical screening for women with disabilities (Parmenter 2003).

Education and training

Students with disabilities may attend either 'special' schools, or mainstream schools that offer 'special' or 'support' education services or classes that address their specific educational needs. Enrolment in special education services or programs, in both mainstream and special schools, is conditional on satisfying specified criteria, which are determined by the government of the state or territory in which the student resides. Services provided and criteria used to assess the severity of disability and subsequent eligibility for education support programs vary between jurisdictions. For example, criteria relating to social or emotional impairment exist in some jurisdictions, such as New South Wales, but not in others, for example the Australian Capital Territory (SCRCSSP 2003).

In 2002, there were 101,930 students with disabilities: 80,689 in government schools, of whom 81% attended mainstream schools, and 21,241 in non-government schools, of whom 91% attended mainstream schools (Table 8.15). The proportion of students with disabilities attending mainstream schools in the government sector varied between jurisdictions, from 66% in Victoria to 95% in Tasmania and the Northern Territory. Similarly, in the non-government sector, the proportion attending mainstream schools varied from 88% in New South Wales to 100% in the Northern Territory. This may reflect jurisdictional variation in the availability of special schools and in enrolment integration policies.

Students with a disability as a proportion of all students attending government and non-government schools ranged from 2% in Queensland to 10% in the Northern Territory. In all jurisdictions, the proportion was greater in government schools than in non-government schools.

Post-school education data are available for Vocational Education and Training students. In 2001, 4% of such students identified themselves as having a 'permanent or significant disability'. The percentage was highest in Tasmania (6%) and lowest in Western Australia (3%) (SCRCSSP 2003).

A senate inquiry into the education of students with disabilities reported on 'whether current policies and programs for students with disabilities are adequate to meet their education needs', making 19 recommendations covering teacher training, the development of schooling options and funding models, and related services (Commonwealth of Australia 2002:v). The report recommended the development of national definitions of disabilities; the AIHW submission to the inquiry recommended use of existing international and national standards as a basis for improving consistency.

Table 8.15: Students with disabilities attending government and non-government schools, 2002[(a)]

	NSW	Vic	Qld	WA[(b)]	SA	Tas	ACT	NT	Total
Government schools									
Mainstream	16,755	12,211.0	10,121.9	7,930	10,924	2,805.5	1,160	3,695	65,595.9
Special	3,915	6,170.5	2,534.5	883	939	148.1	299	193	15,093.0
Total	*20,670*	*18,381.5*	*12,656.4*	*8,813*	*11,863*	*2,953.6*	*1,459*	*3,888*	*80,688.9*
Percentage attending mainstream schools	81.1	66.4	80	90	92.1	95	79.5	95	81.3
Percentage of all government school students	2.8	3.4	2.9	3.5	6.8	4.7	3.9	11.9	3.5
Non-government schools[(c)]									
Mainstream	7,954.9	4,718.8	2,296.3	1,282.6	2,360.6	295.4	259.7	193.6	19,361.9
Special	1,105.0	491.1	91.6	28.8	148.0	13.2	1.2	0	1,878.9
Total	*9,059.9*	*5,209.9*	*2,387.9*	*1,311.4*	*2,508.6*	*308.6*	*260.9*	*193.6*	*21,240.8*
Percentage attending mainstream schools	87.8	90.6	96.2	97.8	94.1	95.7	99.5	100	91.2
Percentage of all non-government school students	2.6	1.9	1.3	1.3	3.2	1.5	1.2	2.3	2
Total students with disabilities	**29,729.9**	**23,591.4**	**15,044.3**	**10,124.4**	**14,371.6**	**3,262.2**	**1,719.9**	**4,081.6**	**101,929.7**
Total all students ('000)	1,099.8	817.9	629.4	355.5	252.4	83.9	60.7	41.2	3,340.9
Percentage of all school students	2.7	2.9	2.4	2.9	5.7	3.9	2.9	9.9	4.9

(a) Full-time equivalent (FTE) students are not the actual number attending. For example, a student attending for half the normal school hours will be half an FTE student. The number of enrolled students will normally be greater than the number of FTE.

(b) Data for government special schools in WA include education support schools and education support centres.

(c) Data for non-government schools include students at kindergarten level. Data for government schools in NSW include students at kindergarten level; in Vic, exclude kindergarten level and early special education facilities; in Qld, exclude kindergarten level and may include early special education facilities depending on where they are based; in WA, include kindergarten or pre-primary level; in SA, exclude preschools; in Tas, include kindergarten level but exclude early special education facilities; in NT, include preschools; and in the ACT include kindergarten or pre-primary level.

Source: DETYA 2002 Non-government Schools Census, unpublished data; and data provided to AIHW by state and territory education authorities.

Employment assistance

Job seekers with a disability can access employment assistance via the disability employment assistance 'gateway', which is an assessment and referral service provided by Centrelink. Via the gateway, job seekers can be helped to access any of three options: disability employment assistance or vocational rehabilitation services funded by the Commonwealth Department of Family and Community Services (FaCS), or the Job Network services funded by the Commonwealth Department of Employment and Workplace Relations (DEWR). Job seekers who wish to access FaCS-funded services may do so either by approaching Centrelink or by going directly to a service provider.

All job seekers accessing Job Network services undergo a Job Seeker Classification Instrument assessment to identify the relative difficulty applicants have in gaining employment and to determine the level of assistance they should receive within the Job Network. Job seekers accessing disability employment assistance funded by FaCS are also required to undergo this assessment if they are assisted under case-based funding.

Previously, the streaming of job seekers with a disability to one of the three disability employment service options was based on an assessment of their employment needs as determined by Work Ability Tables. After a review carried out by DEWR and FaCS (FaCS 2002c), the Work Ability Tables were found not to provide a profile of the job seeker's specific needs for ongoing employment support services or rehabilitation and were replaced by the Disability Employment Indicators on 31 March 2003 after a 4-month trial. These indicators take a more functional approach, seen to be applicable across a range of disability types without making any assumptions about a person's ongoing support needs according to their disability type. This assessment may be triggered as a result of the Job Seeker Classification Instrument, or used as a stand-alone assessment.

During the period March 2002 to February 2003 inclusive, there were 53,079 referrals for 49,269 people to disability employment assistance and vocational rehabilitation. Of these, 33,433 referrals (63%) came through Centrelink and 19,646 (37%) had gone initially to service providers (FaCS unpublished data).

'Positive outcomes' were achieved by 60% of the 14,368 people with disabilities who received job matching assistance from the Job Network, 39% of those who received job search training assistance and 41% of those who received intensive assistance (Table 8.16).

Intensive assistance is one of three main programs available to job seekers through the Job Network. It provides individually tailored assistance in preparing for and obtaining suitable employment, and is the service used most by job seekers with a disability (Table 8.16). In 2001–02, job seekers with a disability accounted for 41,783 intensive assistance exits (or 16% of all such exits). Of these, 41% achieved a positive outcome of either being employed or in training or education, 3 months after completion of the program. This compares with 50% of all job seekers achieving a positive outcome.

Table 8.16: Number of job seekers accessing the Job Network and positive outcomes as at 30 June 2002

	Job seekers with a disability		All job seekers	
	Number	Positive outcomes	Number	Positive outcomes
Job matching (placements)	14,368	59.9%	239,031	70.4%
Job search training (exits)	4,033	39.1%	80,854	47.6%
Intensive assistance (exits)	41,783	41.2%	270,093	50.1%

Source: DEWR 2003.

Housing and accommodation assistance

In 2001–02, about 6,310 new public housing allocations were made to households with special needs due to disability, accounting for 41% of all special needs allocations (see Table 5.27). Also in 2001–02, there were 172 community housing providers that targeted people with a disability, and these providers assisted 4,318 households with a disability (AIHW 2003h).

In 2002, of all income units receiving FaCS Commonwealth Rent Assistance (CRA), 294,275 (32%) were ones in which the principal client had a disability. Nationally, average weekly rents for CRA recipients were slightly lower for income units in which the principal client had a disability ($118.4), compared with all income units ($130.8) (AIHW 2003g).

Table 8.17: SAAP support periods: Main source of income prior to seeking assistance, by reasons for seeking assistance, 2001–02 (per cent)

Reason for seeking assistance	Disability Support Pension	DVA Disability Pension	Total receiving a disability pension	All SAAP clients
Usual accommodation unavailable	23.1	24.7	23.2	21.8
Time out from family/other situation	14.8	16.9	14.9	18.4
Relationship/family breakdown	19.5	22.6	19.7	30.3
Interpersonal conflicts	15.4	16.3	15.5	18.1
Physical/emotional abuse	13.2	23.5	13.7	21.2
Domestic violence	14.1	30.4	14.7	27.0
Sexual abuse	3.0	4.7	3.1	3.1
Financial difficulty	40.4	27.1	39.8	32.6
Eviction/previous accommodation ended	18.9	16.0	18.7	20.1
Drug/alcohol/substance abuse	23.0	16.6	22.7	15.4
Emergency accommodation ended	4.4	4.5	4.4	4.1
Recently left institution	5.0	3.4	5.0	3.0
Psychiatric illness	17.6	8.0	17.2	5.0
Recent arrival to area with no means of support	16.5	13.7	16.4	10.7
Itinerant	12.3	5.1	12.0	7.0
Other	9.3	7.6	9.2	9.2
Gambling	2.6	1.6	2.6	1.4
Total number of support periods	**18,100**	**800**	**18,900**	**133,800**

Notes

1. A small number of records are excluded from this table due to missing information.
2. This table does not include support periods at high-volume SAAP agencies as the question on reason for seeking assistance was not included on the client form for high-volume agencies.
3. Clients may give multiple reasons for seeking assistance, so percentages do not sum to 100.
4. Figures have been weighted to adjust for agency non-participation and client non-consent.

Source: SAAP Client Collection.

The prevalence of homelessness among people with a disability appears to be significant, although available data are limited. In 2001–02, 14% of support periods provided under the Supported Accommodation Assistance Program (SAAP) were for clients who reported the Disability Support Pension or DVA Disability Pension as their main source of income. This figure may be an underestimate, as information on source of income is not collected for SAAP high-volume agencies, whose clients are predominantly men, and a higher percentage of male than female SAAP clients report a disability pension as their main source of income.

Compared with all SAAP clients, a greater proportion of clients receiving a disability pension reported financial difficulty as a reason for seeking assistance (40%, compared with 33% for all clients) (Table 8.17). They were also more likely to report drug, alcohol or substance abuse (23%, compared with 15%) and psychiatric illness (17%, compared with 5%), and less likely to report relationship breakdown (20%, compared with 30%) and domestic violence (15%, compared with 27%) as reasons for seeking assistance.

Unpaid care

For those people aged under 65 years with a disability, who need help with self-care, mobility or communication, most assistance is provided by family and friends. For all activities surveyed in 1998, informal co-resident carers supplied the vast majority of assistance (Table 8.18). Formal services provided about the same level of help as carers who did not reside with the person who needed the help. Many people did not receive the assistance required, including some 27,000 who needed help with self-care and 31,000 who needed help with mobility.

In recognition of the importance of unpaid care and its relationship to the support provided by formal services, Chapter 3 in this edition is devoted to the topic.

Table 8.18: People aged under 65 years with a severe or profound core activity restriction living in households: main source of assistance, activity in which help needed, 1998 ('000)

	Type of provider				
Activity with which help needed	**No provider**	**Informal co-resident**	**Informal non-co-resident**	**Formal provider**	**Total**
		Under 65 years			
Self-care	26.7	305.5	14.5	14.5	361.2
Mobility	30.6	343.9	47.9	28.6	451.0
Communication	*6.0	113.6	**0.8	18.0	138.3
Health care	16.6	240.9	14.6	49.8	321.9
Housework	*8.6	207.5	17.9	18.6	252.6
Property maintenance	21.0	209.7	39.1	40.0	309.9
Paperwork	*8.7	98.0	14.2	*9.0	129.9
Meal preparation	*6.0	104.8	*4.8	*6.0	121.6
Transport	*8.8	224.3	41.5	18.9	293.6

Note: Estimates marked with ** have an associated relative standard error (RSE) of 50% or more. Estimates marked with * have an associated RSE of between 25% and 50%. These estimates should be interpreted accordingly.

Source: AIHW 2000a:Table A15.3.

8.5 Outcomes

This section provides a brief overview of outcomes for people with a disability in the community, particularly those with communication restrictions. This is followed by recent national data on service-related outcomes; the focus is on a major recent study of unmet need for disability support services and the section does not attempt to provide a complete review of the research that has occurred in the last 2 years on evaluating or improving specific services.

The outcomes of disability services may be considered in three broad categories: consumer outcomes, community outcomes, and service-related outcomes. Consumer outcomes are defined here in terms of broad participation in the community, and the ICF domains for activities and participation provide a useful, standard framework for their measurement. Community outcomes reflect an aggregation of individual consumer outcomes, and also factors that can only be measured at community level, such as community attitudes to disability and equity of access to services. Service-related outcomes may relate to how well a service is achieving specified outcomes for clients or how well it is conducting its business, for instance in terms of efficiency or service quality (AIHW 2000b, 2001a:302–7).

People-related outcomes

Outcomes for people with a disability have been reported in previous editions, using the ICF framework to shape an examination of the extent of their participation in a broad range of life areas (AIHW 1999b:255–65; AIHW 2001a:308–13). These outcomes are reported relative to others in the community, in line with the United Nations Standards (UN 1994). Similar broad indicators of participation are now being included in the annual report on government services (see, for instance, SCRCSSP 2002:697–705).

People with disabilities in 1998 were participating in many areas of Australian life, although often not to the same extent as the overall population. They tended to report lower levels of health, and were less likely to have finished school or be active in the paid workforce. They tended to have lower incomes than the rest of the population, although the receipt of government payments diminished these differences. The main focus of their social activities was family and friends, who were also the main providers of assistance to them.

These analyses in previous editions of this report have revealed some positive trends in recent years. People with disability were more likely in 1998 to be living in the community than in previous years. There appeared to be increasing rates of school attendance, especially in ‘ordinary’ school classes. While people with a disability, especially those with severe or profound restrictions, had poorer labour market outcomes (both participation and employment rates) than did others, improvements in the general labour market did flow through to them.

The influence of the environment on disability outcomes, including via the provision of aids and equipment, is an area where better information is required. Available data have been sought and summarised in a recent report (AIHW: Bricknell 2003). Aids and equipment are clearly of great importance to people with a disability, with almost 50% of them using some form of equipment in 1998. The number of aids used rose with the severity of restriction, people with a profound core activity restriction using 3.5 aids on average, and people with primary carers more likely to be using aids (see also Section 8.4).

Communication restrictions

Communication is a basic human activity and need, and a key element in social participation. Communication is one of the three 'core activities' in the ABS Survey of Disability Ageing and Carers, and the need for assistance with any one of these defines the ABS notion of 'severe or profound core activity restriction'. However, data on people with such restrictions are predominantly data about people with mobility or self-care needs; in 1998 there were 516,400 people in households needing assistance with self-care, 724,600 with mobility and 166,900 with communication (AIHW 2000a:107). It is therefore of interest to describe more fully the outcomes for this smaller but important group, especially in view of the finding that, among people receiving disability support services, effective spoken communication has been found to be closely related to the need for other supports, for instance self-care (AIHW 1999a).

This section explores the relationship between communication restrictions and other outcomes for people with a disability. It is useful to keep in mind the definitions and methods of the ABS survey when considering data from it (Box 8.9).

Box 8.9: 'Communication' in the ABS population survey

Communication activities in the ABS survey included understanding or being understood by family and friends and/or strangers.

Communication restrictions were rated as:

- *profound, when the person was unable to communicate or always needed help with the activity;*
- *severe, if the person sometimes needed help, had difficulty understanding or being understood by family and friends, or could communicate more easily using sign language or other non-spoken forms of communication;*
- *moderate, if the person needed no help but had difficulty communicating;*
- *mild, if the person needed no help, had no difficulty, but used 'aids and equipment'.*

Survey results were based on personal interviews where possible. Proxy interviews were conducted for people aged under 15 years and for those aged 15–17 years whose parents did not permit them to be personally interviewed.

Questions about assistance with communication were asked only in respect of people aged 18 years or more with a disability where the interview was by proxy, and persons aged 5–17 years with a disability and interviewed by proxy, where the person was reported as being slow at learning/understanding, having a mental illness, or a hearing loss, or loss of speech, or a nervous/emotional condition, or head injury, or brain damage.

Source: ABS 1999.

Table 8.19: Level of communication restriction among people with a disability living in households, 1998

Level of communication restriction	Core activity restriction[(a)]				Total with a disability	
	Severe or profound		Not severe or profound			
	No. ('000)	Per cent	No. ('000)	Per cent	No. ('000)	Per cent
Profound	58.3	6.1	0.0	0.0	58.3	1.7
Severe	118.6	12.3	0.0	0.0	118.6	3.5
Moderate	28.9	3.0	55.2	2.2	84.1	2.5
Mild	83.6	8.7	266.0	10.8	349.5	10.2
Total with communication restriction	289.4	30.1	321.2	13.0	610.6	17.8
No restriction	672.2	69.9	2,143.2	87.0	2,815.4	82.2
Total	**961.6**	**100.0**	**2,464.4**	**100.0**	**3,426.0**	**100.0**

(a) Refers to a person's overall severity level of core activity restriction, which is determined by their highest level of restriction in self-care, mobility and communication activities.

Source: AIHW analysis of ABS 1998 Survey of Disability, Ageing and Carers confidentialised unit record file.

In 1998, of the 3,426,000 people with a disability living in households, 961,600 or 28.0% had a severe or profound restriction (Table 8.19). Of these, 18.4% had a severe or profound communication restriction, 11.7% had a mild or moderate restriction, and almost 70% had no communication restriction. This table and the following analysis focus on people with severe or profound core activity restrictions, and explore the differences within this group, between those with communication restrictions of any severity and others.

Communication and schooling

Of people aged 5–20 with severe or profound restrictions and living in households, most had a communication restriction—93,700 or 62% (Table 8.20). Those with such restrictions were much more likely than the others to be attending a special school (19.7%, compared with 5.6%) and much less likely to be attending school in an ordinary class (42.8%, compared with 58.7%).

Table 8.20: People aged 5–20 with a severe or profound restriction living in households, by school attended and communication restriction, 1998

	Communication restriction		No communication restriction	
	No. ('000)	Per cent	No. ('000)	Per cent
Ordinary school class	40.1	42.8	33.6	58.7
Ordinary school (special class)	25.3	27.0	6.8*	11.9
Special school	18.5	19.7	3.2*	5.6
Not applicable	9.8	10.5	13.6	23.8
Total	**93.7**	**100.0**	**57.2**	**100.0**

Note: Estimates marked with * have an associated relative standard error (RSE) of between 25% and 50%. These estimates should be interpreted accordingly.

Source: AIHW analysis of ABS 1998 Survey of Disability, Ageing and Carers confidentialised unit record file.

Table 8.21: People aged 15–64 years with a severe or profound restriction living in households: labour force status and employment restrictions, by communication restriction, 1998 (per cent)

	Communication restriction	No communication restriction
Labour force status		
Employed	20.8	32.8
Unemployed	*3.7	*3.8
Total in the labour force	24.5	36.6
Not in the labour force	75.5	63.4
Employment restrictions		
Restricted in type of job	44.0	42.3
Restricted in number of hours	13.0	29.2
Difficulty in changing job or getting a better job	37.4	34.5
Need for time off work	*7.3	15.2
Need for employer provided equipment and/or special arrangements	20.4	12.8
Need for ongoing supervision or assistance	20.6	*7.7
Need for support person	53.4	46.8
Other employer arrangements		
A disability support person or someone at work to assist/train on the job	14.5	*3.3
Special equipment	9.7	*4.6
Training or retraining	*7.5	**1.0
Different duties	*4.8	*4.6
Severity of employment restriction		
Profound	51.4	43.8
Severe	22.5	10.8
Moderate	23.4	36.8
Mild to no employment restriction	**2.6	*8.6
Total number ('000)	**79.2**	**413.1**

Notes

1. Estimates marked with * have an associated relative standard error (RSE) of between 25% and 50%. Estimates marked with ** have an associated RSE of 50% or more. These estimates should be interpreted accordingly.
2. Total may not equal the sum of the components as the questions on employment restriction were asked separately in the survey.

Source: AIHW analysis of ABS 1998 Survey of Disability, Ageing and Carers confidentialised unit record file.

Communication and employment

In 1998, there were 79,200—or 16% of the 492,300 people aged 15–64 years with severe or profound restrictions, living in households—who had a communication restriction (Table 8.21). As for education, the presence of communication restrictions correlated with poorer employment outcomes and more employment restrictions, compared with outcomes for others with severe or profound restrictions not including communication. Those people with communication restrictions were:

- more likely to be not in the labour force—75.5% were not, compared with 63.4% of those without a communication restriction;
- less likely to be employed—20.8%, compared with 32.8%;
- more likely to need equipment or special arrangements (20.4%), supervision or assistance (20.6%) or a support person (53.4%); these figures compare with 12.8%,

7.7% and 46.8% respectively, for people with severe or profound restrictions but no communication restriction;

- more likely to have severe or profound employment restrictions—73.9% (compared with 54.6% of people without a communication restriction).

Communication restrictions, age, sex and assistance

There were some marked differences between males and females with communication restrictions (AIHW 2003i). Of people aged under 65 years with a severe or profound restriction, 69% of those with communication restrictions were male. Communication restrictions also correlated with a particular pattern of care, in that people with such restrictions were much more likely to be receiving a combination of both informal and formal assistance—65% (compared with 32.9% of those with other severe or profound restrictions).

An interesting feature of communication restrictions emerges when Tables 8.20 and 8.21 are compared. There were more people with severe or profound core activity restrictions and communication restrictions in the relatively narrow age range 5–20 years (93,700) than there were among those aged 15–64 years (79,200). This appears to reflect a compounding of two effects: that relatively more people in younger age groups in 1998, particularly males, reported severe or profound restrictions (Figure 8.3), and that it was more likely that people in these age groups reported communication restrictions—62% (93,700 of 150,900, Table 8.20), compared with 16% (79,200 of 492,300, Table 8.21). There is a range of possible factors here, the most obvious being that, in the earlier years of life, schools and parents are aware of learning and communication difficulties and may be actively addressing them. In older years these problems may ameliorate because of earlier interventions, or people may find activities and environments where these restrictions have less effect on their lives and are hence less likely to be reported in the survey. This statistical pattern aligns with the finding that relatively more young males were recorded as having difficulty with 'learning and understanding things' (see Figure 8.4), and with the peaking in intellectual disability estimates in these age ranges (AIHW: Wen 1997).

Service-related outcomes

Service planning and budgeting rely on four separate but interrelated components: dealing with unmet need or demand; planning for growth in the target population; ensuring viability in the face of wages, insurance and other cost growth; and taking the initiative on 'creative service strategies' in the light of these realities as well as developments in service philosophy, evaluation research and stated consumer priorities (Shean 2003). The National Disability Administrators recently commissioned two related studies to inform them on the first three topics (AIHW 2002b; SPRC 2002).[7] The SPRC study suggested that growth of 2.3% nationally would be needed to deal with population increase and some anticipated cohort effects of service use patterns; further, it was suggested that indexation for wages growth would best address the need to adjust for cost increases.

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[7] The first two topics had been the subject of a previous study commissioned by the Administrators (AIHW 1997b).

The AIHW study was to:

- assess the effectiveness of unmet need funding in reducing unmet need for disability services; Australian governments had made available additional funding for these services, totalling $519 million over the 2 years 2000–01 and 2001–02; and
- identify any remaining unmet need for disability accommodation, in-home support, day programs, respite services and disability employment services, in order to obtain an understanding of current shortfalls in services.

The outcomes of the project were to inform discussion and negotiations regarding the third Commonwealth/State Disability Agreement (CSDA).

Effectiveness of unmet need funding

The unmet need funding was found to have been effective in putting additional services on the ground. Estimates of the size of these effects varied considerably according to the data used. Using CSDA MDS data as a basis, the numbers of new accommodation places and new community access places were estimated as 920 and 1,315 respectively (AIHW 2002b:xviii).

These additional services were recognised and appreciated in the field, according to discussions with peak disability groups held in the course of the study. The views of the field were perhaps best summed up by one participant in these discussions who commented: ‘I now feel more confident that there is a chance of some assistance in areas where there was virtually none’.

Further, the nature of some of the additional services—particularly the focus on flexibility, the use of individual packages and local area coordination mechanisms—was positively viewed. Where there was flexibility and responsiveness, there were stories of consumers, carers and service providers working together to achieve good outcomes, and often cost-effective ones. The effectiveness of these newer services had been verified by literature drawn on by jurisdictions in developing new approaches.

Nevertheless, these peak discussions also raised issues about the effectiveness of CSDA services and the program overall (AIHW 2002b:111–13). One participant pointed out that effectiveness was, ultimately about ‘doing human things well’—how services are delivered may matter as much as what is delivered. Other themes included: choice regarding the nature and timing of services; consumer autonomy including, for instance, involvement in planning; mutual respect; and stability and quality of staffing. Issues relating to program management were also raised: the need for balance, in terms of promoting flexibility and innovation while still maintaining a significant body of stable, cost-effective services and infrastructure.

Despite the new resources provided, there was still a view that greater focus was needed on proactive planning and case management, so as to move from only offering assistance to people when they reach crisis, to planning transitions with people ahead of time.

Ageing carers

A number of jurisdictions specifically addressed the issue of ageing carers by providing individualised packages or programs using the Commonwealth unmet needs funds; these numbers totalled nearly 3,000 people across six jurisdictions (AIHW 2002b).

The main messages from the consultations with peak organisations regarding ageing carers were:

- Respite is useful and appreciated.
- Centre-based respite is needed as well as in-home respite.
- What is often on ageing carers' minds is 'handing over' or retiring. Packages and residential arrangements are greatly valued when they allow the carer to begin withdrawing from the primary role.

As one carer put it: 'In-home support should not be a life sentence … for 38 years I haven't had a chance to be myself'. For these people, the need is to plan and be assured of future care and accommodation arrangements, often for a son or daughter they have cared for over many years. This assurance is critical to their physical and mental health as they themselves age.

Remaining unmet need for specific services

A number of data sources were used to develop and refine the estimates of remaining unmet need. Population survey data were useful as they relate to all people across the community who report specific needs for assistance. As well, data from those jurisdictions that maintain registers of service needs or have holistic application processes (holistic in the sense that they avoid double-counting of applicants) were extrapolated to provide national indications of urgent unmet needs for service. Orders of magnitude of estimates based on these different approaches were compared, and estimates refined in a process of triangulation. The AIHW made the estimates on a conservative basis, with the aim of providing reliable 'lower bound' estimates.

The resulting estimates of remaining unmet need in 2001 (Table 8.22) were:

- 12,500 people needing accommodation and respite services;
- 8,200 places for community access services (which could in practice be accessed by more than one person); and
- 5,400 people needing employment support.

There was further evidence that the service system for people with disabilities was under pressure:

- Jurisdictions reported that they were providing most new services to people with very urgent needs. There appeared to be between 6 and 24 times more people seeking services and on jurisdiction registration or waiting lists in 2000–01 than were removed from these lists (usually because they were offered a service). Waiting times reported were long (AIHW 2002b:114–36).
- Pressures at the service boundaries were evident: aged care services, housing, transport, health and equipment services were examples of related service areas where the study team heard evidence of pressure or scarcity (AIHW 2002b:196–204).
- Qualitative evidence came from the peak discussions about the nature and effects of unmet need (AIHW 2002b:179–92).

Table 8.22: Estimates of unmet need for specific services, 2001

	Estimate of unmet need	Description of group
Accommodation and respite	12,500 people	People needing assistance at least 3–5 times per day with ADL[(a)] or less frequent assistance with multiple ADLs, who need assistance from a formal service but cannot get it because no service is available, it costs too much, they are otherwise unable to arrange a service, or it does not provide sufficient hours. *Confirmed by:* Numbers of people on state registers in three jurisdictions
Community access[(b)]	8,200 places	Places for people not in the labour force, aged 18–64 years, who need at least daily assistance with two or more ADLs; they are not studying; the main reason they are not currently looking for a job is their own disability or illness; they wish to go out more often but are not doing so because of their disability or illness. *Confirmed by:* Numbers of people on state registers in three jurisdictions
Employment support[(b,c)]	5,400 people	Unemployed people who *either* need at least daily assistance with any ADL *or* need at least weekly assistance with guidance, PLUS People not in the labour force who could work with special assistance; the main reason they are not currently looking for a job is their own disability or illness; they *either* need at least daily assistance with any ADL *or* need at least weekly assistance with guidance.

(a) Activities of daily living (ADLs) are self-care, mobility and communication.

(b) Community access and employment estimates exclude people who are currently attending any day program.

(c) Employment estimates were prepared before the 2002–03 Commonwealth budget announcements. These estimates may need to be revised if there is change in assumptions about the expected labour force participation of people currently receiving the Disability Support Pension, or in policy on eligibility for services.

Source: AIHW 2002b.

8.6 Conclusion

Disability is something that affects most people in the population, to varying degrees and at different life stages. For those most profoundly affected, disability can be a dominant feature of their lives, requiring great amounts of time, effort and, frequently, passionate advocacy.

Disability is a multidimensional concept that can be measured in various ways, depending on the scope and definition used.

In 1998, 3,610,300 people of all ages (19.3% of the population) reported 'disability' in the sense that they had one or more of 17 impairments, limitations or restrictions which had lasted or were likely to last for at least 6 months and which restricted everyday activities in some way. Of these, 2,385,100 people were aged under 65 (14.6% of the population in that age group), of whom 655,000 (4% of the population aged under 65) had a severe or profound core activity restriction, meaning that they sometimes or always needed assistance or supervision with self-care, mobility or communication.

The major disability groups in 1998 similarly ranged in size depending on the definition of disability used. Prevalence estimates were as follows:

- According to the broadest approach, 16.2% of Australians of all ages (11.6% of those aged under 65) reported physical/diverse disability; 2.7% (2.3% of people aged under 65), intellectual disability; 7.5% (4.2% of those aged under 65), sensory/speech disability; 4.1% (3.1% of under-65s), psychiatric disability; and 1.1% (1% of under-65s), disability related to acquired brain injury.
- A more restricted approach includes only those people with a severe or profound restriction. Among these people 5.2% of the total population (3.2% of people aged under 65) had 'physical/diverse' disability; 1.6% (1.1% of those aged under 65), intellectual disability; 2.1% (1.3% of under-65s), psychiatric disability; 2.8% (1.3% of under-65s), sensory/speech disability; and 0.6% (0.5% of under-65s), acquired brain injury .

Trends in disability prevalence are being affected by a complex range of factors. Particularly important are the effects of population ageing, and the ageing of the baby-boom generation in particular, as well as the emerging new features of disability in younger age groups. Services, then, are being provided and managed in a context of growth in the target population.

A number of major programs of national significance provide services and support to people with disabilities.

The largest income support programs are:

- the Disability Support Pension, with almost 660,000 recipients in June 2002 and expenses of $6.4 billion in 2001–02;
- the Disability Pension (DVA), with almost 160,000 recipients in June 2002 and $1.2 billion expenses; and
- the Carer Allowance (Child), with 115,404 recipients, and the Carer Allowance (Adult), with 153,863 recipients; together these allowances had combined expenses of $645.7 million in 2001–02.

Disability support services under the CSDA were provided to 65,809 people on a snapshot day in 2002. National expenditure on this program totalled $2.75 billion in 2001–02, of which 51.4% went to accommodation support services—services whose clients have the highest support needs.

A range of other services are accessed by people with disabilities, including home and community care (HACC) services; rehabilitation, hearing and equipment services; education, employment and housing. While almost 6,000 people aged under 65 were permanent residents of aged care homes on 30 June 2002, this 'access' is widely considered to reflect unmet need for more suitable services, particularly for those people—more than 1,000—aged under 50 years. Generic health services are also the subject of increasing attention from the disability sector, in terms of their adequacy and responsiveness to the special needs of people with disabilities.

Service outcomes, then, are mixed. Significant resources and intense efforts are expended on the provision of services to people with disabilities. All Australian governments are involved in initiatives to increase funding and enhance the quality of services. However, as well as the question marks over generic services such as aged care and health, there are recognised shortfalls in the provision of disability support services: 12,500 people needing accommodation or respite services in 2001; 5,400 needing employment support; and a shortfall of 8,200 places for community access programs.

Family and friends provide most of the assistance to people with disabilities. Older carers are increasingly expressing their need to plan and be assured of their son's or daughter's future care and accommodation arrangements, and their concerns about the shortfalls in support services.

People with disability are participating in a wide range of areas of Australian life, although generally not to the same extent as the overall population. A picture of this participation has been built up in successive editions of these biennial reports and is summarised in Section 8.5. This 2003 edition focuses on the interesting area of 'communication'. Communication restrictions were found to correlate with poorer education and employment outcomes. Communication restrictions, like intellectual disability, appear to be more likely to be reported for people, particularly males, in younger age ranges.

Disability data and their infrastructure have improved over the 10 years since these biennial reports began but, as with services, further improvements beckon. There is now an agreed international classification (the ICF) on which data concepts and collections can be built, and the Australian ICF User Guide has been developed to promote its sensible use in Australia and these concepts are now reflected in national data dictionaries. There are also key national data collections that use these concepts and standards, including the main population survey and the national collection on disability support services. The national data collection for disability support services under the CSTDA has been redeveloped and will enable a much more complete picture of these services and their users. Efforts are again being made to develop a suitable question on disability for the population census. All this represents significant progress towards enhanced and more consistent disability data.

These achievements provide a foundation for further improvements in national disability data, perhaps in the area of income support, as well as for a wide range of health and other generic services. The challenge will be to implement cost effective data enhancements so that better and 'joined up' information is available, useful to people working in the various fields dealing with human functioning and disability, and meaningful to and desired by the people with disabilities.

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9 Services for people experiencing homelessness

9.1 Introduction

Homelessness has been part of Australia's social environment since the arrival of the First Fleet. Young homeless boys, for example, were transferred from the inner city to ships anchored in the harbour as early as the 1820s. A comprehensive literature review of the history of homelessness in Australia since this time has been compiled by Coleman (2000). Over this period, the traditional notions of homelessness have changed considerably, as have the populations of homeless people.

In the post-war period in Australia, homelessness was most often associated with older, alcoholic men living on 'skid row'. The causes were generally identified as chronic alcoholism and estrangement or disaffiliation from mainstream society (MacKenzie & Chamberlain 2003). Rather than a process, it was thought of as a permanent way of life brought about by the personal circumstances of the homeless.

Since the 1960s and 1970s, there has been an increase in the topicality of, and public awareness about, homelessness. This led to the release, in the 1980s, of the Burdekin Report on youth homelessness (HREOC 1989), which gave rise to headlines such as 'homeless children dying' (Chamberlain & Johnson 2003). As a result, the homeless population was acknowledged to be more diverse than previously thought, with more women, young people and families recognised as experiencing homelessness.

In 1973, the *Homeless Person's Assistance Act 1973* was passed and put into practice the following year as the Homeless Persons' Assistance Program, and government-funded services for the homeless rapidly expanded. Such policy responses were based on, and continue to be informed by, considerations about the causes of homelessness.

The increase in homelessness over the last 20 years has coincided with stubborn levels of unemployment, often long term, and increasing underemployment and casualisation of the workforce. At the same time, there has been a decrease in affordable housing, an increase in family breakdown, a continuing deinstitutionalisation of mental health patients, and an increase in the availability of hard drugs (MacKenzie & Chamberlain 2003). Locating the reasons for homelessness at this structural level is a departure from explanations that focus on the individual, such as identifying the cause as alcoholism or 'fecklessness'.

It is generally agreed, however, that the causes of homelessness cannot be solely attributed to either structural or individualistic (agency) factors. Chamberlain and Johnson (2003), after reviewing the literature on causation in the social sciences, suggest that structural and individualistic factors are intimately related, with neither existing independently of the other. It is ‘the interrelation of agency and structure that causes some people and not others to become homeless in any given set of circumstances’ (Neale 1997 cited in Chamberlain & Johnson 2003:10).

Structural factors affecting homelessness include adverse housing and labour markets, poverty, discrimination and family restructuring. Individual risk factors can include poverty, unemployment, sexual or physical abuse, family disputes and breakdowns, a background of care, experience of prison, substance abuse, school exclusion, and/or poor physical or mental health. There are also specific events that often act as triggers for homelessness, which can include leaving home after family conflict, eviction, widowhood, leaving care or prison, a sharp deterioration in mental health or an increase in substance misuse (Robinson 2001).

A consideration of such factors allows policy makers and researchers to chart the processes that lead into and out of homelessness and to identify possibilities for successful interventions. This in turn assists governments to address the structural contributions to homelessness.

This chapter begins (Section 9.2) with an overview of the developing definitions of homelessness. It also profiles some of the complexities involved in defining homelessness, with a special focus on Indigenous Australians and those who live in public spaces, giving a contextual background for the provision of services to homeless people. Section 9.3 provides current data on the Supported Accommodation Assistance Program (SAAP), including time-series information on the growth of the program and on state and territory profiles. It covers the characteristics of homeless people using SAAP, where these people stayed before SAAP, the reasons they gave for seeking assistance, the services provided to them, and information on those people who were unsuccessful in becoming SAAP clients. The section also presents information, available for the first time, on the characteristics of people who may be being excluded from SAAP services. Some important development issues in SAAP data collection are then discussed.

Sections 9.4 and 9.5 profile a range of Commonwealth and state and territory government initiatives specifically targeting the homeless population and aimed at prevention and early intervention, as well as crisis management. The chapter concludes with a summary section (9.6).

9.2 Developing definitions of homelessness

Post-World War II literature on homelessness can be categorised into four ‘waves’ according to the different kinds of definitions on which it was based (Coleman 2000). First wave definitions of homelessness focused on older, single white males. Second wave definitions expanded the definition to recognise the complexity and diversity of homelessness, and were advocacy-based, emphasising the lived experience of homelessness.

In response, third wave definitions attempted to delimit the extent of homelessness. Service delivery definitions formed part of this third wave and generally focused on defining a homeless population for whom services would be provided. Coleman argued that this definition obscured those homeless who had become adapted to homelessness.

One pre-eminent example of a service delivery definition is provided by the *SAAP Act 1994* (Section 4). This definition has been suggested as the 'official' Australian definition of homelessness (Chamberlain & Johnson 2001; FaCS 1999:19). The Act defines a person as homeless if, and only if, he or she has 'inadequate access to safe and secure housing' (FaCS 1999:19). This is often paraphrased as 'considered not to have access to safe, secure and adequate housing'.

The Act then goes on to refer to what this might mean, citing housing situations that may damage health; threaten safety; marginalise a person from both personal amenities and the economic and social support a home normally offers; where the affordability, safety, security or adequacy of housing is threatened; or where there is no security of tenure. A person is also considered homeless under the Act if living in SAAP or other emergency accommodation.

Coleman proposed that the most recent literature, the fourth wave, has re-evaluated these earlier, narrower definitions and renewed debate about our understandings of homelessness. One such fourth wave definition that has received wide coverage and has been adopted by a number of authors is a cultural definition of homelessness. It was initially proposed by Chamberlain and Mackenzie (1992) and was used by Chamberlain (1999) in his work on the 1996 Census.

Cultural definitions of homelessness propose that it should be defined by reference to the community standards for housing of the place and time in which the definition is to be used. The minimum community standards embedded in the present-day housing practices of Australia, it has been argued, encompass having 'a room to sleep in, a room to live in, kitchen and bathroom facilities of [your] own, and an element of security of tenure' (Chamberlain & Johnson 2001:39). By this argument, people with lower housing standards than these would be considered homeless.

Chamberlain and Johnson also argue that, according to the same community standards, there are some segments of the population who cannot expect to achieve this level of housing conditions, including older people in nursing homes, students in halls of residence, and those living in seminaries and in prisons. People in these situations, then, should not be counted as homeless as a result of not experiencing the usual minimum community housing standards.

Using this cultural definition, Chamberlain and Johnson (2001:39) divided homelessness into three subgroups: people with no conventional accommodation (termed the primary homeless), people moving between temporary accommodation (the secondary homeless), and people living in boarding houses on a long-term basis (the tertiary homeless). In the 1996 Census, these subgroups were targeted by new questions identifying people who were 'sleeping rough' in improvised homes or tents or on benches, in parks, and so on (the primary homeless) and people with no usual address staying temporarily with friends or relatives (the secondary homeless). People staying in boarding houses (who were presumed to be the only housed sector of the community living in conditions not meeting the identified minimum community housing standards) were identified as the tertiary homeless. Also included in the Census count were individuals using SAAP services (Table 9.1).

Other researchers, while basically accepting a three-tiered approach to defining homelessness, have given greater weight to security of tenure or a lack of other options when considering whom to consider the tertiary homeless. The Final Report from the Technical Forum on the Estimation of Homelessness in Australia (Strategic Partners Pty Ltd 2001), for example, referred to lack of security of tenure and to accommodation which is unsafe or harmful to health in their interpretation of tertiary homeless. The Western Australian Homelessness Taskforce (WA State Homelessness Taskforce 2002) took this one step further by adding a reference to situations where there are no other options and there is insecurity of tenure. Both include people living in *some* boarding houses, as well as *some* caravan parks, rooming houses or special accommodation houses as the tertiary homeless.

The Final Report (Strategic Partners Pty Ltd 2001:11) also agreed to add a preamble to Chamberlain and MacKenzie's amended categories, to 'provide a context to, and describe, the living situations of homeless people'. This starts with 'homelessness is one extreme of a spectrum of disadvantage in terms of access to safe, affordable and secure housing. Homelessness has an implication of lack of options or choice', then continues by citing the SAAP Act definition before categorising homelessness into three tiers (Box 9.1). This package of preamble and amended categories was chosen by the Western Australian taskforce, among others, to provide a basis for their investigation into homelessness in that state.

More recently, MacKenzie and Chamberlain (2003) have developed their understanding of homelessness by creating a 'typology' of homelessness careers. The typology attempts to abstract the salient features of homelessness, and emphasises the major processes whereby people become homeless—the how rather than the why of homelessness.

Table 9.1: The whereabouts of homeless people on Census night, by state/territory, 1996 (per cent)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Boarding house	29	26	23	16	19	16	6	9	22
SAAP accommodation	11	19	9	11	22	19	40	2	12
Friends/relatives	47	48	49	53	48	53	54	18	46
No conventional accommodation	13	7	19	20	11	12	—	71	20
Total	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*
Total homeless (number)	**29,608**	**17,840**	**25,649**	**12,252**	**6,837**	**2,014**	**1,198**	**9,906**	**105,304**
Per 10,000 population	*49.4*	*41.0*	*77.3*	*71.5*	*48.1*	*43.9*	*40.3*	*532.1*	

Source: Chamberlain 1999.

Box 9.1: Homelessness: a definition

Primary homelessness or sleeping rough

People without conventional accommodation, such as people living on the streets, in parks, squatting in derelict buildings or using cars or railway carriages and makeshift dwellings.

Secondary homelessness or stop gap accommodation

People who move frequently from one form of transitional shelter to another. It covers: people using emergency accommodation (such as hostels for the homeless or night shelters); young people staying in youth refuges; women and children escaping domestic violence (staying in women's refuges); people residing temporarily with other families, acquaintances and friends (because they have no accommodation of their own).

Tertiary homelessness or insecure tenure/marginally housed

People whose living arrangements do not provide them with security of tenure as provided by a lease, or who are living in accommodation which is unsafe or harmful to their health. Such accommodation might include some boarding houses, caravan parks, rooming houses or special accommodation houses (Strategic Partners Pty Ltd 2001).

This typology, they claim, says as much about exit points from homelessness as it does about pathways into chronic homelessness, while the career paths allow identification of points of intervention, and draw attention to the notion that 'at risk' should be understood in different ways for different groups. The authors argue that three fundamental paths into chronic homelessness can be identified.

These three career paths are, first, youth becoming homeless because of family conflict and continuing into adult homelessness; second, homelessness arising from family violence, especially domestic violence; and, third, homelessness arising from a housing crisis, where poverty and accumulated debt underpin the slide into homelessness. In this typology the first two paths may be initiated by episodic periods of homelessness or housing uncertainty, but the last is generally an 'unambiguous predicament'.

This work follows on from earlier considerations about the effect of temporal dynamics on homelessness. Neil and Fopp, for instance (quoted in FaCS 1999:20), suggested that such temporal dynamics could be captured by a three-level characterisation: homeless for a short time, episodically homeless, and homeless for long periods of time. Chamberlain and Johnson (2000), in their earlier work on homelessness careers, had also suggested a three-level characterisation: at risk of homelessness (describing people when they are experiencing a crisis that places their housing at risk), temporary homelessness (describing people who experience a period of homelessness, followed by re-establishing a home), and chronic or ongoing homelessness.

An alternative depiction of the effects of temporal dynamics is captured by the notion of 'iterative homelessness' (Robinson 2003), which describes the passage of homeless people through several forms of inadequate housing. The usefulness of this notion derives from the insight that the occurrence of repeated movements between inadequate housing is as important a consideration as the forms of inadequate housing.

Outstanding issues in defining homelessness

Chamberlain required a definition of homelessness that facilitated an estimation of the number of homeless people on Census night, 1996. Note that the discussion here is based on the definition and methodology employed in the 1996 Census data. While some 2001 Census data on housing are available at the time of writing, the derived homelessness data, unfortunately, are not.

Chamberlain's approach was to define three groups of the homeless, based on their access to, or use of, 'conventional' accommodation, and to target these groups with specific questions, some included in the Census for the first time for this specific purpose. This approach led to the first widely accepted counting of the homeless, but there are a number of unresolved difficulties to defining and enumerating the homeless population in Australia.

Chamberlain and Johnson claimed that there was no subjectivity in this definition. Further, they claimed that subjectivity was both undesirable and unworkable in *any* definition—'it is intuitively absurd to claim that people living in the same accommodation can either be "housed" or "homeless", depending on their point of view' (Chamberlain & Johnson 2001:48). Even so, some subjectivity is not entirely absent from Chamberlain's implementation of his definition.

A case in point is the classification of boarding houses. The Census distinguished between persons who were resident in private and non-private dwellings. Non-private dwellings had 19 categories of both communal and transitory accommodation, including 'hotel, motel' and 'boarding houses, private hotel'. In trying to apply his definition in a practical way, Chamberlain had some difficulties with these classifications.

For example, when accommodation for workers in remote communities was classified by the Australian Bureau of Statistics as a boarding house, Chamberlain was unwilling to let the classification stand. These and other such dwellings were reclassified, based on a consideration of tenants' work status and income. Similar considerations also led to some hotels being reclassified as boarding houses. In addition, not all the tenants in the remaining dwellings classified as boarding houses were counted as homeless, with owners, staff and guests with another usual address removed from the count.

Further, through the identification of (most) tenants of (most) boarding houses as the sole tertiary homeless, Chamberlain privileged the easily enumerated 'rooms and amenities' aspect of his own suggested community standards over 'security of tenure', which is arguably more nebulous. We have already seen that the Western Australia Homelessness Taskforce and the Technical Forum on the Estimation of Homelessness in Australia both included considerations on security of tenure in their adopted definitions. This led them to conclude that only some boarding house residents, along with some caravan residents among others, should be considered as being homeless.

There are also difficulties with Chamberlain's definition of the primary homeless and its application in the 1996 Census. The primary homeless, according to Chamberlain, are those with no conventional dwellings, where 'conventional' is measured against Australia's current community standards for housing. Chamberlain grouped together people identified by the Census as sleeping out, living in tents or caravans outside of caravan parks or living in improvised dwellings as belonging to this category. The primary homeless, then, included people living in sheds, in ‘humpies’, squatting in derelict buildings, sleeping on the streets, in parks or under bridges, or using cars, railway carriages or other ‘improvised’ dwellings.

This ‘one size fits all’ definition of the primary homeless obscures a number of complex definitional and service delivery issues. Perhaps the first point to be made here is the diversity of accommodation arrangements that this category encompasses, ranging from the traditional picture of someone ‘sleeping rough’ on a park bench to someone with significantly better housing standards, such as living in a shed with amenities.

Chamberlain claimed that it is ‘likely’ or ‘probable’ that the majority of people identified as having no conventional accommodation were living in improvised dwellings, rather than actually sleeping out, although no figures on these proportions are available. The jurisdiction with the greatest proportion of people identified as not living in conventional accommodation was the Northern Territory (71%). Western Australia and Queensland (20% and 19%, respectively) had the next highest proportions (see Table 9.1). An Indigenous/non-Indigenous breakdown, by jurisdiction, of those people identified as not living in conventional accommodation (Table 9.2) shows that these three jurisdictions also had the largest proportions of Indigenous people in this category (89%, 54% and 38%, respectively). Note that this table is derived from 90% of cases, so the total number of primary homeless is slightly less than that in Table 9.1.

While it is not known how many of the Indigenous people identified as not living in conventional housing are living on Aboriginal land, it is known that in the 1996 Census improvised dwellings for Indigenous households essentially related to remote areas (ATSIC 2002). It seems highly probable, then, that the high numbers of the Indigenous primary homeless, especially in the Northern Territory, Western Australia and Queensland, are heavily influenced by the number of Indigenous people living in ‘humpies’ and other improvised dwellings in remote Indigenous communities.

Table 9.2: Indigenous and non-Indigenous people with no conventional accommodation on Census night, by state/territory, 1996 (per cent)

	NSW	Vic	Qld	WA	SA	Tas	NT	Australia
Indigenous	7	1	38	54	27	4	89	50
Non-Indigenous	93	99	62	46	73	96	11	50
Total	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*
Total (number)	**3,685**	**1,202**	**4,707**	**2,341**	**698**	**230**	**6,710**	**19,579**

Notes

1. Percentages are derived from information on 90 per cent of cases.
2. The Australian Capital Territory is excluded because the number of persons was less than 10.

Source: Chamberlain 1999.

Some changes were made in the 2001 Census that will have an impact on the number of Indigenous Australians who are now considered homeless. With these changes, the count of Indigenous dwellings in remote areas which are categorised as 'improvised' has decreased significantly, while the count of these dwellings in urban areas has increased, as has the number of Indigenous improvised dwellings consisting of just a single person (ATSIC 2002). However, the underlying issue of what it means to be homeless for Indigenous Australians remains.

Another methodological issue which received attention in the 2001 Census is the problem of counting people who are actually 'sleeping rough'. This undertaking is very reliant on local knowledge, and the 1996 figures almost certainly underestimated the numbers of both Indigenous and non-Indigenous homeless in this situation. For example, Memmott and Fantin (2001, cited in Memmott, Long & Chambers 2003) claimed that there were as many as 227 people living an itinerant lifestyle in the Darwin and Palmerston area. The Census counted only 50 such people in the wider Darwin area, and Chamberlain (1999) acknowledged that the 1996 count of this segment of the homeless population was conservative.

Further, of the more than 21,000 people nationwide identified as the primary homeless on Census night 1996 (see Table 9.1), 95% reported that they were at their usual address and over three-quarters had been in the same housing circumstances a year before Census night (Chamberlain 1999). This raises the broader issue of the service delivery implications for those segments of the population who are labelled as the primary homeless.

Both these questions—the definition of homelessness for Indigenous Australians and the service delivery implications for all those labelled as the primary homeless—deserve some more examination in order to better understand the milieu in which services for the homeless are delivered.

Indigenous homelessness

In a seminal report, Keys and Young put forward a number of definitions which emphasised the multi-layered and multidimensional nature of Indigenous homelessness. These incorporated 'spiritual homelessness', with its historical background of dispossession, as well as aspects of Indigenous family dynamics. Underpinning these is the understanding that 'home' can have a different meaning for Indigenous Australians. Paraphrasing an Indigenous SAAP worker, it 'is about a sense of belonging … four walls and a roof don't make a home' (Keys & Young 1998:27).

It is difficult to reconcile this view with Chamberlain's definition of homelessness. Memmott in fact has argued that the objectivity sought by cultural definitions such as Chamberlain's is undermined by the existence of very different cultural contexts within Australian society, each of which may maintain their own values and meanings related to housing' (Memmott et al. 2003:iii).

It seems that this is well illustrated in the Indigenous context. Indeed, a number of Indigenous people living with no walled and roofed dwelling strongly argue that they are both 'placed' and 'homed' and call themselves 'parkies', 'goomers', 'long grassers' or 'river campers' (Dillon and Savage, 1994, cited in Memmott 2002:11).

Memmott himself suggests not using the term ‘homeless’ in an Indigenous context. Instead, he identifies a segment of the Indigenous population as ‘public place dwellers’. He characterises these as ‘those who do not pay for accommodation, have a visible profile (socialising, sheltering, drinking, arguing and fighting in public), have low incomes of which a substantial part is often spent on alcohol, have generally few possessions (minimal clothes and bedding), and usually conform to a “beat” of places where they camp and socialise in particular public or semi-public areas’ (Memmott et al. 2003:i).

For Memmott these people can have a variety of housing circumstances, from sleeping rough to living in houses, albeit in problematic circumstances. There does, however, seem to be a suggested commonality in the characteristic of camping and socialising in public or semi-public areas. He proposes five categories of such public place dwellers: those living in public places; those occasionally spending time in public places; spiritual forms of homelessness; crowding, where it causes considerable stress to families and communities; and individuals escaping unsafe or unstable family circumstances. The authors further subdivide those living in public places into those who intend to eventually return home and those who live a ‘permanent public place dwelling lifestyle’ (Memmott et al. 2003:27).

Goldie (2002) argues that the most common response to such public place dwellers, which applies to both Indigenous and non-Indigenous people, is the legal regulation of public spaces. This may happen at the local level by council by-laws and night patrols, as well as by state and territory legislation. This legal regulation is commonly implemented by civil ordinances, municipal by-laws or other assorted laws against vagrancy, loitering, begging, noise nuisance, drinking in a public place, sleeping in cars or parks at night, or ‘move on’ regulations.

A snapshot of the concerns of Indigenous public place dwellers is provided by the ‘Long Grassers’ of the Darwin/Palmerston area, named after a type of grass that grows locally. As has been said, the number of Long Grassers is probably in the hundreds and the Darwin City Council’s response to such homelessness is typical of many other local council responses. As an example, the City Council’s by-law 103 makes sleeping in a public space any time between sunset and sunrise an offence, while under by-law 100 it is an offence to stash bags, bedding, cooking gear or other goods in public spaces.

Goldie (2002) reports that over 70% of the people fined under by-law 103 between 1 February 2001 and 31 January 2002 were Indigenous, in an area where Indigenous people comprise only 9% of the population. Not surprisingly, then, an issue of major concern identified by the Long Grassers (Memmott, Paul and Fantin, Shaneen, cited in Goldie 2002:279) is the extent to which their daily activities are criminalised by the fact of being carried out in a public setting.

The service delivery needs of the Long Grassers are complex and far ranging. Immediate concerns about the criminalisation of their behaviours are being addressed by a challenge to the validity of by-law 103, currently before the Human Rights and Equal Opportunity Commission. Another response addresses community concerns about their health and wellbeing as well as about the impact of some people’s anti-social behaviour.

Box 9.2: 'Itinerants' Project, Darwin/Palmerston

The project began in 1999, when community groups met to discuss the 'itinerant' issues. In 2000, the Darwin office of ATSIC and the Northern Territory Government commenced a jointly funded Policy Research Project to consider the issues surrounding Indigenous 'itinerants' in the Darwin/Palmerston area.

The project developed an Action Plan, which was endorsed by the Northern Territory Government in March 2002. In its totality it reflects the multiple and complex needs of public place dwelling Indigenous people. The rationale behind the Project is to 'encourage "itinerants" in Darwin and Palmerston to find pathways away from the destructive cycle of alcohol and substance abuse, which characterises the lifestyle of many of the client group, towards either a return to home or a more productive lifestyle with appropriate accommodation in town' (Project Coordinator, pers. comm.).

This plan not only incorporates accommodation, patrolling, education and alcohol responses, but also responses to regional issues specific to remote communities. The accommodation component involves a range of strategies, from basic camping facilities, to managed and supported accommodation options, through to conventional housing.

The Northern Territory Government committed $500,000 to initiatives in year one of the project (2002) and 50 different organisations and agencies are involved in the four main working parties. The project incorporates cultural protocols developed by the Larrakia, the traditional owners of the region, which call on mutual understanding and respect between visitors and the Larrakia nation.

This approach, the 'Itinerants' Project (Box 9.2), is proactive, rather than punitive, and incorporates strategies for improving the health and safety of the Long Grassers and ensuring the protection of their rights to urban areas, while at the same time addressing the negative impact of some of the groups' behaviour on themselves, their relatives and acquaintances, and on the wider community. It also illustrates how a holistic and whole-of-government approach to Indigenous homelessness can incorporate respect for Traditional Law through the use of cultural protocols.

Dwelling in public places

According to Coleman (2000), public spaces have become places of significance to people experiencing homelessness, and may come to be equated with 'home'. Her recent study in Fortitude Valley, Brisbane, reported that homeless people 'slept, ate, washed, had sex, drank, smoked and injected drugs, listened to music, carried out business, played cards, met friends, begged, maintained and cleaned their spaces, and gathered for early morning coffee and sandwiches' in public spaces (Coleman 2002:8). Even for people who are marginally housed, public spaces are often the only spaces they have in which they can exercise some degree of control—meet with friends, have a drink, or escape the sometimes chaotic conditions they are accommodated in.

Coleman also argues that, for those people dwelling in public spaces, the most important concern is having no control over, or legitimacy in, the places they call home. This aligns with the concerns of the Long Grassers, reported above, about the extent to which their activities are criminalised when carried out in a public space. As Goldie (2002) has pointed out, activities that would probably not be noticed when carried out in a dwelling, such as sleeping, being partially or wholly naked, having sex, becoming intoxicated and noisy, or taking drugs, create ire and induce a legal response when carried out in a public space.

This lack of control or legitimacy is reflected in the extent of the complaints about public place dwellers from 'mainstream' communities, commonly concerning the above-mentioned 'anti-social' behaviour, and in the responses to such complaints. Coleman, however, places the source of conflict between members of mainstream and homeless communities in a broader context than ire over anti-social behaviour. Access to public space 'is increasingly based on the ability to pay for that access. Public space is leased to private business. Private security guards patrol public space. The standard for behaviour is whether it interferes with businesses or not' (Coleman 2002:9). Increasingly, she argues, it is the market citizen, or consumer, who is recognised as the legitimate user of public space as public space itself becomes a commodity.

Coleman's analysis locates the problems that public place dwellers face as arising from our consumer society. Whether one agrees with this analysis or not, it is clear that the rapid redevelopment of inner suburbs in urban areas means that previously derelict locations and key inner city locations throughout Australia have become disputed territory for the homeless. Public amenities such as toilets are also becoming increasingly rare, and benches have been removed or are designed to inhibit lying down. In some railway stations, a ticket must be bought before the warmth or facilities of the station can be enjoyed (Lipman 2002).

Whatever the preferred framework for analysing the conflict arising from homelessness in public places, there is general agreement that it is at the local level where government decisions have the most day by day impact. Homeless people routinely utilise parks, toilets, and other public infrastructure, much of which is the responsibility of local councils. Further, local council policies, such as those touching on town planning, health regulations and community development activities, among others, also necessarily impact on homeless people. Successful interventions at this level often include elements of assertive and persistent outreach, incorporating streetwork, assessment, and referral and advocacy (Twardowski 2002).

The difficulties of such interventions at the local council level are well illustrated in Brisbane. Here, as elsewhere in Australia, the redevelopment of the inner suburbs has had a detrimental effect on the homeless of the area, including the Indigenous people for whom particular localities have been long-term meeting places (Eastgate 2001). This redevelopment has led to a loss of affordable inner city dwellings, and the corresponding increased pressure on public spaces has led to complaints by some local residents, businesses and public space users, generally concerning noise, drunkenness or mess and litter.

The great challenge posed by public place dwellers is 'whether we can accommodate [them]—not just in houses, warm beds and secure rooms. It is whether we can accommodate them in our communities, in the way we design and use public space—and of course in our hearts' (Coleman 2002:9). Brisbane Council is attempting to meet this challenge by its commitment to responding to public homelessness in a reasonable, practical and inclusive manner, and to treat homeless people as legitimate members of the community, not just as a problem to be solved (Eastgate 2001).

An initial trial based on these values, while ultimately unfruitful, provides an excellent case study in the challenges posed by public place dwellers and the difficulties governments face in designing interventions to address those challenges (Box 9.3). It should be said that a follow-up initiative was designed by Brisbane Council, this time at Kurilpa Point, a low-profile Indigenous gathering place located in the midst of an industrial precinct, without the family use or real estate value of New Farm Park. Here, in response to complaints about rubbish (often possessions), the council has established storage facilities, in a trial that this time shows greater promise of success.

This section has touched upon the challenges posed by the presence of the homeless, itinerants and the marginally housed in public spaces, and on local initiatives to find alternative and satisfactory responses to these challenges. It is, however, the Commonwealth and state/territory governments that hold legislative responsibility for funding the services assisting homeless people. The next section presents Australia's flagship program for assisting people who are homeless or at risk of homelessness: the Supported Accommodation Assistance Program (SAAP).

Box 9.3: New Farm Park public space initiative, Brisbane

The local council, in partnership with a community agency, set aside a designated space in New Farm Park for members of Brisbane's Indigenous community, long-term users of the park. A park shelter was established, along with port-a-loos, a shower and a barbeque, all surrounded by a shade cloth and perimeter fence. The community agency liaised with the users of the park to establish a set of operating rules, and facilitated park users' access to support services.

Some level of success was achieved in all three aims of the trial: to improve safety and living conditions for Indigenous park users, to reduce the impact of their presence on other users, and to raise awareness of homelessness issues. The ultimate failure of the trial was put down to over-intensive media coverage of the initiative and to a concerted lobbying by some local residents and businesses as well as the political Opposition. This led both to unwelcome intrusions from hostile visitors, and to an increase in numbers using the park, not all of whom felt bound by the original operating rules with consequent occasional disruptions. This last point highlights a common dilemma in the construction of such designated spaces, namely, that their very presence can promote an itinerant lifestyle and increase the number of people drawn to use that public space.

The Brisbane City Council eventually discontinued this trial (Eastgate 2001).

9.3 Supported Accommodation Assistance Program

Since SAAP was established in 1985, it has been refined through periodic reviews and three extensive national evaluations. Jointly administered under the Commonwealth and state and territory community services portfolios, it has been widely recognised as a world-class program. Nevertheless, it is constantly reviewed to keep up with advances in best practice. It is not only an important part of Australia's overall response to homelessness, but also an integral part of Australia's broader social safety net (FaCS 1999).

Pre-SAAP, a range of independent programs existed for the homeless and for women escaping domestic violence. These sectors had quite different histories. The historical roots of single men's shelters, for example, stretch back to at least the early 1900s, when the major cities had shelters providing generally overcrowded temporary accommodation. In contrast, refuge models were developed in the 1970s to support young people and for women escaping domestic violence, and at the time were considered highly innovative. These independent programs were reviewed in 1983 and SAAP was launched in 1985, when eight separate programs were brought together under a joint Commonwealth and state/territory program, with new funds provided to enable growth in service provision.

Table 9.3: SAAP funding, 1996–97 to 2001–02 (current and constant 2001–02 dollars)

Reporting period	Total recurrent funding	Funding to agencies	Funding per support period	Funding per client
		Current $		
1996–97	219,771,000	200,539,000	1,280	2,410
1997–98	223,661,000	212,768,000	1,300	2,260
1998–99	229,889,000	220,328,000	1,350	2,430
1999–00	245,511,000	231,717,000	1,470	2,570
2000–01	268,537,000	251,367,000	1,470	2,700
2001–02	285,039,000	268,960,000	1,520	2,810
		Constant 2001–02 $		
1996–97	251,587,000	229,571,000	1,470	2,760
1997–98	251,833,000	239,568,000	1,460	2,550
1998–99	253,840,000	243,284,000	1,490	2,680
1999–00	261,539,000	246,845,000	1,570	2,740
2000–01	276,056,000	258,405,000	1,510	2,780
2001–02	285,039,000	268,960,000	1,520	2,810

Notes

1. Funding per support period and per client are based on recurrent allocations to agencies.
2. 'Total recurrent funding' for 1999–00, 2000–01 and 2001–02 includes relatively small amounts provided through the PADV Program (see AIHW2002a:Table 10.1, footnote 2).
3. 'Funding to agencies' in 2001–02 includes $7,842,000 provided by the Victorian funding department which was in addition to the SAAP funding agreement between that state and the Commonwealth. The states and territories generally provide additional funds for supporting SAAP activities which are not part of the SAAP agreement. Additional funds provided by other states and territories were not reported and are not shown here.
4. Support period figures have been weighted to adjust for agency non-participation.
5. Client figures have been weighted to adjust for agency non-participation and client non-consent.

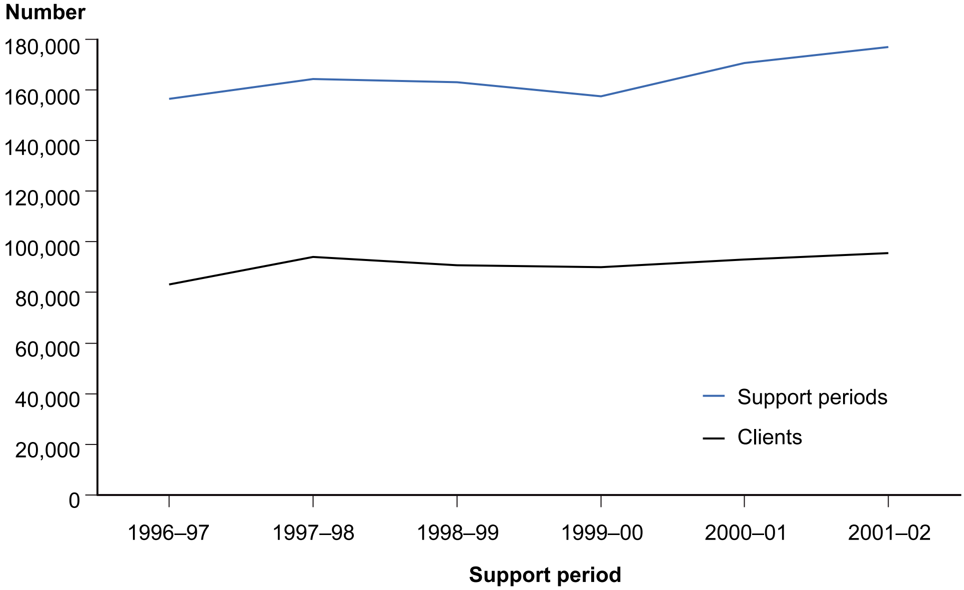
Source: AIHW 2002a.

A national data collection was launched in 1996 to describe the usage and nature of the services provided to SAAP clients and their accompanying children. Over the course of the National Data Collection, recurrent funding for SAAP has risen by 30%, from $219.8 million in 1996–97 to $285.0 million in 2001–02 (Table 9.3). Adjusting for inflation, this funding has increased in real terms by 13%.

Of the total recurrent funding, a small percentage is allocated for purposes such as administration, training, research and evaluation, with the remainder going to SAAP agencies. Recurrent funding to SAAP agencies, adjusted for inflation, has increased by 17% in real terms over the 6 years. Funding per client also saw an increase, from $2,760 per client in 1996–97 to $2,810 in 2001–02, expressed in real terms.

The diverse nature of client needs is reflected in the considerable variety of services that SAAP agencies provide. These may include the provision of supported accommodation and/or various services such as meals, counselling, advocacy, or living skills development. A client will normally receive a wide range of such services in any support period.

Trends in the number of clients provided with SAAP services and trends in support periods showed a similar pattern over the 6 years, although the number of support periods rose more strongly over the last 2 years (Figure 9.1). In 1996–97, an estimated 83,200 clients were provided with support; the figure rose to 94,100 in 1997–98 and then fell to 90,000 by 1999–00. In 2000–01 the number of clients increased again to 93,000. The highest number of clients of any of the 6 years was recorded in 2001–02, with 95,600 clients provided with SAAP services.



Source: AIHW 2002a:Table 10.2.

Figure 9.1: SAAP support periods and clients, 1996–97 to 2001–02

SAAP IV, the current and fourth 5-year agreement of the program, commenced in July 2000. Research on high-need clients and on Indigenous homelessness, and a review of unmet demand, are among the considerations that have informed the revised policy and framework of SAAP IV.

The current allocation of funds to programs across the states and territories is largely based on the levels of funding of homelessness services at the commencement of the first SAAP agreement in 1985, on the limitations placed on the distribution of Commonwealth 'Movement to Award' funding, and on the ability of state and territory Governments to match subsequent Commonwealth indexation and growth funding. Commonwealth growth funding under SAAP has been allocated on a per capita basis, with positive adjustments for smaller jurisdictions.

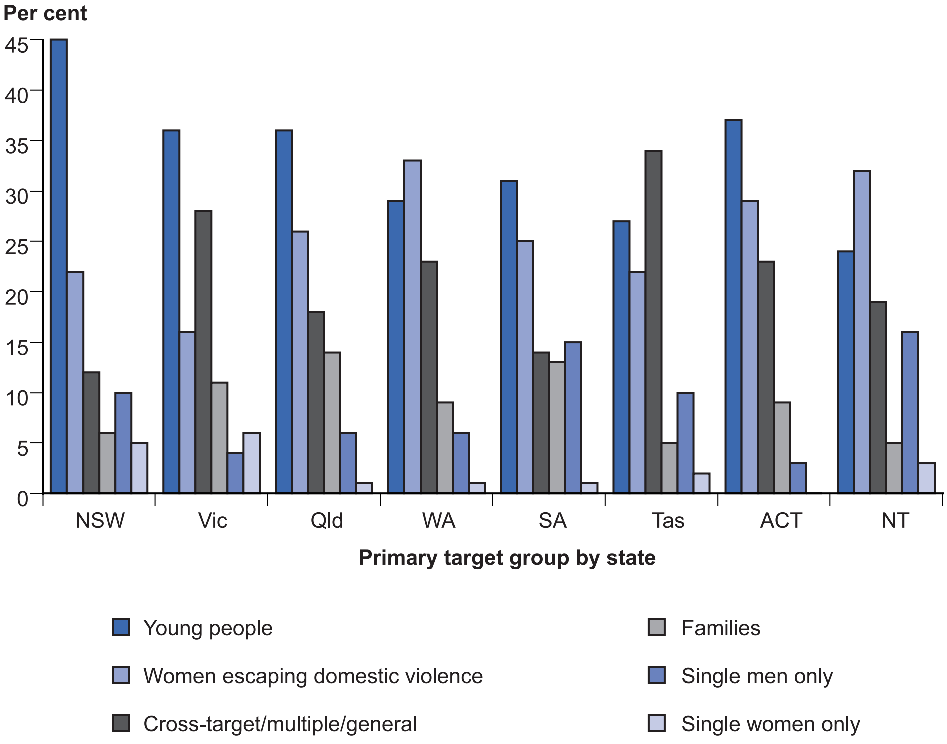
Profile of SAAP in the states and territories

Population size is the base determinant for SAAP funding allocation, although the four smallest jurisdictions receive relatively more funding than the larger ones (see Figure 9.3). The development of particular services since SAAP's inception has largely been an outcome of submission-based funding patterns, and the program has continued to evolve around specific target and interest groups. The mix of SAAP services is further influenced by state-level planning divergences. The 500 services funded at the commencement of the program have now grown in number to nearly 1,300.

As a result of these somewhat ad hoc factors, different states and territories have very diverse mixes of SAAP agencies (Figure 9.2). Many of these agencies target quite highly specific client groups such as single men, single women, women and children escaping domestic violence, young people within particular age ranges, and families, although there are other SAAP agencies with a broader or more general client group focus. These different sectors often have quite different operational procedures, although a commonality does exist in the prevalence of congregate care models of service provision, where clients share communal living arrangements.

Figure 9.2 shows that, in five of the eight states and territories, the majority of agencies target young people. These services cater for young people under 25 years within various nominated age ranges. Most agencies in Western Australia and the Northern Territory target women escaping domestic violence, while in Tasmania the majority are general, multiple or cross-target agencies.

This illustrates the differences that exist between jurisdictions on how SAAP funds are allocated. In Tasmania, for example, refuges with a broader client target group (cross-target, multiple target or general refuges) receive over a third of that state's recurrent allocation, while in New South Wales such services receive around 12% of the funding. Again, in the Northern Territory, 16% of recurrent funding is allocated to single men's refuges, while in the Australian Capital Territory such services are allocated 3% of the funding (AIHW 2002b, 2002c, 2002g).

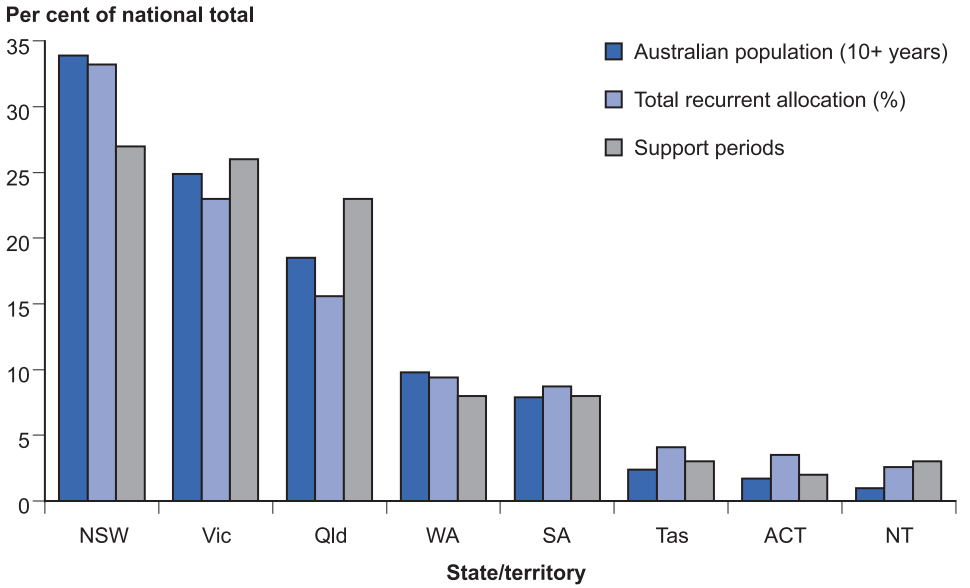


Sources: AIHW 2002b, 2002c, 2002d, 2002e, 2002f, 2002g, 2002h, 2002i.

Figure 9.2: Primary target groups of SAAP agencies, 2001–02 (per cent)

Across the nation in 2001–02, agencies targeting young people (37% of agencies) received the largest proportion (35%) of recurrent SAAP funding, with agencies targeting women escaping domestic violence (23% of all agencies) receiving the next largest allocation (29%). The majority of SAAP services (55%) are based in capital cities, with 7% based in other metropolitan centres, 31% in large and small rural centres and the remaining 7% in remote areas (AIHW 2002a:Table2.2).

It is more difficult to compare support periods across states and territories because of the very different operational procedures employed by different sectors of SAAP services. For example, some single men's shelters, and some other high-volume agencies, have recurring clients who are regularly accommodated overnight but leave the service the next day. If each of these overnight accommodation periods is counted as a support period, as is often the case when the client is not assured of a bed the next night, then a single client can have many support periods over a relatively short period of time. This is evidenced by the sharp rise since the last *Australia's Welfare* (AIHW 2001) in the proportion of support periods for Queensland, which is largely due to a single, high-volume agency joining the collection and employing such reporting practices.



Source: AIHW 2002a:5.

Figure 9.3: Comparison between SAAP funding allocations, Australian population and support periods, 2001–02

A fuller understanding of the count of support periods is given by comparing the mean and median lengths of closed support periods across the jurisdictions (Table 9.4). This shows that in Queensland more than half of the closed support periods were for 1 day or less (a closed support period is one that finished before the end of the reporting year), by far the shortest median length of support. Queensland, along with the Northern Territory, also had the shortest average (mean) length of closed support periods, at 23 days.

Of interest too is the number of clients supported by SAAP in 2001–02 (Table 9.4). As population numbers and characteristics vary across the states and territories, per 10,000 population figures allow a meaningful comparison of the extent of SAAP coverage across Australia. It should be noted here that the rates used in the rest of this chapter are not indicative of the per capita size of the homeless population (see Table 9.1 for those estimates), but rather are indicative of the number of people accessing SAAP.

With 191 clients for every 10,000 people aged 10 years and over (age-adjusted), the Northern Territory well over three times the national average of 56 clients for every 10,000 population, age-adjusted. The next highest level of people accessing SAAP was in Tasmania (91), while New South Wales had the lowest level (46 clients per 10,000).

Table 9.4: SAAP clients, and mean and median length of support periods, 2001–02

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Clients	26,400	29,200	18,400	9,000	8,800	3,700	1,900	3,100	95,600
Clients per 10,000 population (10+ years)	46	69	59	54	67	91	69	191	56
Mean length (days) of closed support periods	42	63	23	32	64	56	76	23	44
Median length (days) of closed support periods	5	13	1	3	9	20	15	4	4

Notes

1. Number excluded due to errors and omissions (weighted): 0 clients and 1,348 closed support periods.
2. Number of clients within a state or territory relates to clients who ever received assistance from a SAAP agency in that state or territory. Since a client may have support periods in more than one state or territory, state and territory figures do not sum to the national figure.
3. 'Clients per 10,000 population 10+ years' shows how many people out of every 10,000 aged 10 years and over in the general population became clients of SAAP. The rate is estimated by comparing the number of SAAP clients aged 10 years and over with the estimated resident population aged 10 years and over at 30 June just prior to the reporting period. Age-standardised estimates have been derived to allow for different age distributions in the various jurisdictions. The Australian estimated resident population at 30 June 2001 (final estimates) has been used as the reference population.
4. Figures have been weighted to adjust for agency non-participation.

Source: SAAP Client Collection; ABS 2001a.

SAAP agencies provided services to 95,600 clients nationally during 2001–02. These SAAP clients, as parents and guardians, may have had children with them. Such children are not included in the client count as they are counted separately as accompanying children. In 2001–02, there was an estimated 50,700 of these accompanying children (AIHW 2002a:54). This is the first year this figure is available, and for the first time a single estimate of the total number of people in SAAP services can be made available. During 2001–02, it is estimated that a total of around 146,300 people, which includes adults and children, accessed SAAP services.

Nationally, the rate of SAAP use stayed fairly stable over the six years between 1997 and 2002 (Table 9.5). The highest rate of use was in 1997–98, when 59 people out of every 10,000 aged 10 years and over (age-standardised) became SAAP clients. The lowest rate across the period was in 1999–00: 55 people per 10,000.

The states and territories showed more variation in the rate of SAAP use. Even allowing for its relatively young age profile, the Northern Territory had by far the highest rate every year, ranging between 167 and 183 clients for every 10,000 people aged 10 plus (age-adjusted). This was around three times the national average in all years. New South Wales was the only state with rates below the national average every year, although Western Australia had below average rates every year except 2001–02.

Table 9.5: Number of SAAP clients per 10,000 population, 1997–98 to 2001–02

	1997–98	1998–99	1999–00	2000–01	2001–02
NSW	54	50	47	46	47
Vic	71	73	70	68	69
Qld	56	51	52	58	58
WA	52	49	52	59	53
SA	70	60	61	61	70
Tas	97	90	90	91	97
ACT	79	72	74	72	63
NT	179	183	170	167	169
Total number	**59**	**56**	**55**	**56**	**56**

Notes

1. Number excluded due to errors and omissions (weighted): 0.
2. Since a client may be supported by agencies in more than one state or territory, national numbers of clients per 10,000 population are not the simple mean of the state and territory figures.
3. ‘Clients per 10,000 population aged 10+’ shows how many people out of every 10,000 aged 10 and over in the general population become clients of SAAP. The rate is estimated by comparing the number of SAAP clients aged 10 and over with the estimated resident population aged 10 and over at 30 June just prior to the reporting period. Age-standardised estimates have been derived to allow for different age distributions in the various jurisdictions. The Australian estimated resident population at 30 June 2001 (final estimates) has been used as the reference population.

4 Figures have been weighted to adjust for agency non-participation and client non-consent.

Sources: SAAP Administrative Data and Client Collections; ABS 2001a.

Across Australia, the number of support periods per client averaged 1.8 during 2001–02, slightly higher than in previous years (Table 9.6). The largest increase in average number of support periods per client between any two reporting periods was in Queensland between 1999–00 and 2000–01. This increase, from 1.85 to 2.31, was due to the inclusion in the Client Collection of a high-volume agency in that state, as reported earlier.

Clients accessing SAAP agencies in New South Wales and the two territories had relatively high repeat-use rates in all years, averaging two or more support periods per client in nearly every year except 2001–02. Only New South Wales and Queensland averaged more than two support periods per client in 2001–02, although New South Wales has shown a slight but steady decrease in the average number client since the collection began. High repeat-use rates are sometimes negatively referred to as ‘churning’, suggesting that clients benefit little during repeat SAAP stays. However, for many clients, such as those with high needs, re-engagement with SAAP services over time can be a positive experience.

Table 9.6: Average number of SAAP support periods per client, 1997–98 to 2001–02

	1997–98	1998–99	1999–00	2000–01	2001–02
NSW	2.15	2.15	2.07	2.02	2.00
Vic	1.65	1.76	1.74	1.73	1.73
Qld	1.83	1.81	1.85	2.31	2.44
WA	1.74	1.77	1.73	1.85	1.88
SA	1.93	1.97	1.88	1.84	1.79
Tas	1.71	1.86	1.89	1.76	1.74
ACT	2.39	2.22	2.33	2.18	1.87
NT	2.04	2.14	1.92	2.13	1.94
Australia	**1.72**	**1.77**	**1.73**	**1.80**	**1.82**

Notes

1. Number excluded due to errors and omissions (weighted): 0.
2. Clients may have support periods at agencies in more than one state or territory. Consequently, the number of clients multiplied by the average number of support periods for clients that ever visited a particular state or territory is greater than the number of support periods provided within that state or territory. This has changed since the 1999–00 annual report (AIHW 2000), in which clients were tabulated according to the state or territory of the agency they first visited in the financial year.
3. Since a client may have support periods in more than one state or territory, national numbers of support periods per client is not the simple mean of the state and territory figures.
4. Figures have been weighted to adjust for agency non-participation and client non-consent.

Sources: SAAP Administrative Data and Client Collections.

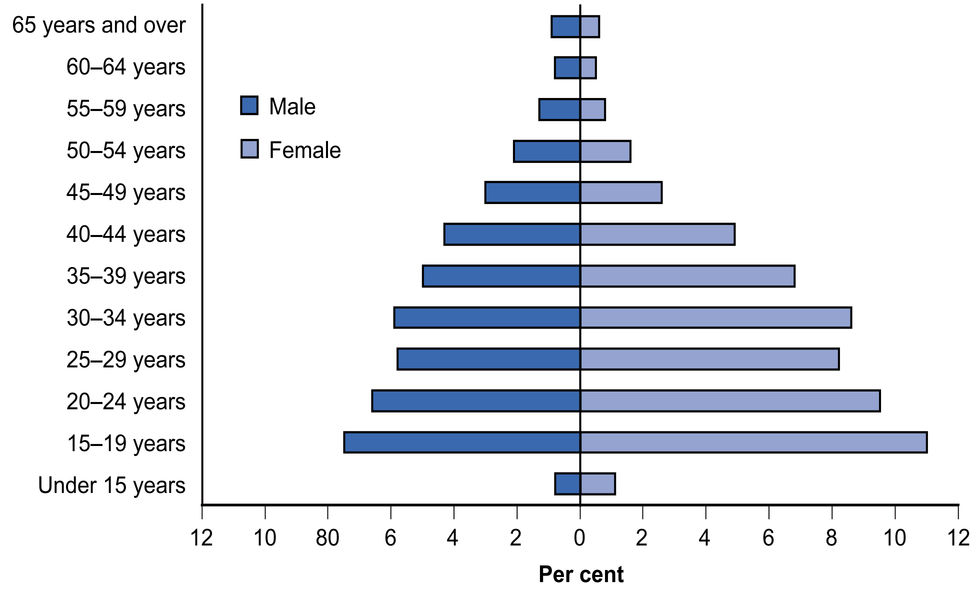
Characteristics of SAAP clients

Figure 9.4 shows the age and gender distribution of SAAP clients in Australia during 2001–02, presented in 5-year age groupings. For every age group 45 years and over, there were more male SAAP clients than female, while in all age groups less than 45 years there were more females than males. The majority of clients (86%) were less than 45 years of age. The largest group of clients for both males and females was the 15–19 year olds, with 19% of all clients being in this age group. The next largest group was the 20–24 year olds (16% of clients). In contrast, less than 5% of all clients were over the age of 54.

More females (53,300) than males (41,700) accessed SAAP services. Almost 2% of young Australian women aged 18–19 years received some form of assistance from the program during 2000–01. Young women aged 15–17 years and 20–24 years were also frequent users of SAAP services, with just under one and a half per cent in each age group being assisted. The average age of female clients was 30 years, while for men it was 33 years (AIHW 2002a:16–17).

Eighty-five per cent of SAAP clients were born in Australia (Table 9.7); this includes the 17% of SAAP clients who identified as Indigenous Australians. Overall, Indigenous Australians were over-represented as SAAP clients relative to their population size: less than 2% of Australians aged 10 years and over identified as Indigenous (see Note 3 in Table 9.7).

Just under 5% of SAAP clients were born overseas in countries where English is the main language spoken (Canada, Ireland, New Zealand, South Africa, the United Kingdom and the United States). Just over 10% were born in countries where English is not the main language spoken, which includes all other countries excluding Australia.



Source: AIHW 2002a.

Figure 9.4: Age and gender distribution of SAAP clients, 2001–02

Table 9.7: Cultural and linguistic diversity of SAAP clients, 2001–02 (per cent)

					Australian population 10+	
	Male	**Female**	**Total**	**Number**	**Per cent**	**Number**
Indigenous Australians	11.9	20.4	16.7	15,400	1.9	314,456
Australian-born non-Indigenous people	74.0	63.3	68.0	62,900	72.1	12,095,081
People born overseas, English proficiency group 1	5.7	4.1	4.8	4,500	10.1	1,701,641
People born overseas, English proficiency groups 2–4	8.3	12.1	10.4	9,700	15.9	2,668,041
Total	*100.0*	*100.0*	*100.0*	. .	*100.0*	. .
Total (row %)	**43.8**	**56.2**	**100.0**	**. .**	**. .**	**. .**
Total (number)	**40,600**	**52,000**	**. .**	**92,500**	**. .**	**16,779,219**

Notes

1. Number excluded due to errors and omissions (weighted): 3,072 clients.
2. English proficiency groups are based on country of birth—see Glossary.
3. ‘Australian population 10+’ refers to the estimated resident population aged 10 years and over at 30 June 2001 (final estimates). The figures for Indigenous Australians are from experimental estimates based on the 1996 Census produced by the ABS. The number of ‘Australian-born non-Indigenous people’ is derived from the Australian-born population minus the number of Indigenous Australians.
4. Figures have been weighted to adjust for agency non-participation and client non-consent.

Sources: SAAP Client Collection; ABS 1998, 2001b.

There was some variation between male and female clients in terms of cultural and linguistic diversity. A higher proportion of female clients than male clients identified as Indigenous Australians (20%, compared with 12%). There was also a higher proportion of female clients than male clients among people born overseas where English was not the main language spoken (12%, compared with 8%). Among Australian-born non-Indigenous clients, however, who comprised 68% of all SAAP clients, there were relatively more males than females (74%, compared with 63%).

Where people stayed before assistance

Nationally in 2001–02, SAAP or other emergency accommodation was the most common type of housing immediately before support (in 20% of closed support periods), reflecting the proportion of homeless people who have consecutive periods of support before moving on from SAAP. Private rental was the next most common housing type before entering SAAP (16%), followed by boarding in a private home and living rent-free (14% and 13%, respectively) (Table 9.8).

Table 9.8: SAAP closed support periods: type of accommodation immediately before SAAP support, 2001–02 (per cent)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total	Number
SAAP or other emergency housing	23.3	16.0	23.3	17.9	19.9	17.6	29.2	10.6	19.7	20,200
Living rent-free in house/flat	13.5	15.2	12.7	8.7	11.6	14.1	21.4	13.8	13.4	13,700
Private rental	15.3	17.9	17.7	11.6	12.3	20.1	8.2	8.6	15.7	16,000
Public or community housing	8.2	8.4	7.1	18.6	12.3	9.5	7.5	30.7	10.4	10,600
Rooming house/hostel/ hotel/caravan	7.1	8.8	9.0	7.3	6.8	6.1	2.6	9.0	7.9	8,000
Boarding in a private home	11.0	15.5	14.1	14.1	17.0	13.5	10.2	6.5	13.5	13,800
Own home	3.0	5.2	3.3	3.3	5.5	2.8	1.6	1.7	3.8	3,900
Living in a car/tent/park/ street/squat	10.3	8.2	8.7	11.0	8.0	10.1	8.3	12.7	9.4	9,600
Institutional	7.2	3.4	3.2	5.5	5.5	5.0	8.9	4.1	5.0	5,100
Other	1.0	1.4	0.8	1.9	1.1	1.1	2.1	2.5	1.3	1,300
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	. .
Total (number with valid data)	*26,600*	*30,100*	*16,600*	*11,300*	*7,200*	*4,600*	*2,200*	*3,700*	. .	*102,300*
Number with missing data	4,400	4,900	2,300	2,000	700	500	100	400	. .	15,300
Total (number)	**31,000**	**34,900**	**18,900**	**13,300**	**7,900**	**5,100**	**2,300**	**4,100**	. .	**117,500**

Notes

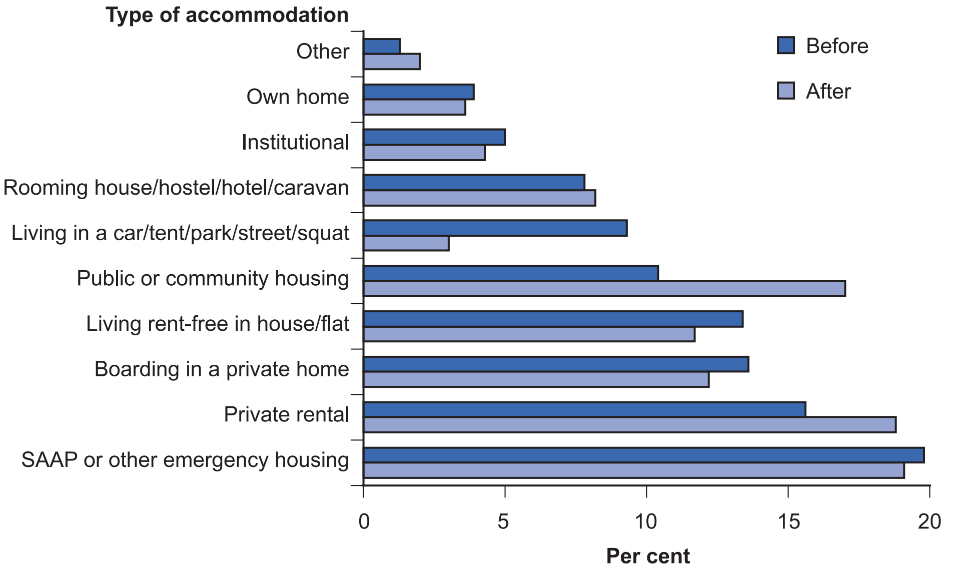
1. Table excludes high-volume records because not all items were included on the high-volume form.
2. Figures have been weighted to adjust for agency non-participation and client non-consent.

Source: SAAP Client Collection.

The jurisdictions differ from this overall profile of where clients were staying immediately before support (Table 9.8). Clients in the Northern Territory had come from SAAP or other emergency accommodation in only 11% of closed support periods. It was more likely for these clients to have previously been in public or community housing (31%). In the Northern Territory, there is a large amount of Indigenous community housing in remote areas. In Western Australia, SAAP clients were just as likely to have come from public or community housing as from SAAP or other emergency accommodation (in 19% versus 18% of closed support periods).

Clients in both Tasmania and Victoria were just as likely to have come from private rental accommodation (20% and 18%, respectively), compared to SAAP or other emergency accommodation (18% and 16%, respectively). In contrast, in the Australian Capital Territory, most clients had been previously housed in SAAP or other emergency accommodation (almost 30%). The Australian Capital Territory also had clients previously living rent-free in 21% of closed support periods, and the highest percentage of support periods where clients were previously living in an institution (9%).

It is interesting to note that the state and territory numbers of people living in a car, tent, park, street or squat before accessing a SAAP service showed relatively small variation, ranging from a low of 8% of closed support periods in Victoria, South Australia and the Australian Capital Territory to a high of 13% in the Northern Territory.



Source: AIHW 2002a:46.

Figure 9.5: Type of accommodation immediately before and after SAAP support, 2001–02

On first glance, this seems somewhat surprising because the number of people with no conventional accommodation, as estimated by the 1996 Census (see Table 9.1), shows much larger variation across the jurisdictions. The Census figure, of course, included both those 'sleeping rough' as per the SAAP definition, and people living in improvised dwellings. However, as the earlier discussion pointed out, the state/territory differences in the Census were heavily influenced by the inclusion of Indigenous people living in remote communities in improvised dwellings, and this probably accounts for much of the Census variation. The SAAP figures, though, do support the Census figures showing that people sleeping rough, as a proportion of population, are over-represented in the Northern Territory, although better estimations of the actual degree of this over-representation are still to be derived.

Figure 9.5 shows a comparison of accommodation before and after support periods, on a national level. The biggest shift was in the use of public housing. Clients were more likely to be accommodated in public housing after support than before (in 17% after compared with 10% before).

There was also a noticeable decrease in clients living in a car, tent, park, street or squat (3% after compared with 9% before). SAAP or other emergency accommodation and private rental were still the most common types of housing after support, although there was a notable increase in private rental from 16% to 19%. As there is a significant amount of missing data relating to clients' circumstances after support, these figures should be approached with some caution.

Why people sought assistance

The SAAP Client Collection collects information on, among other things, the main reasons why clients seek assistance, although it only does so from general SAAP agencies. High-volume agencies, which generally have a higher client turnover, use a shortened form that does not collect this information. There are also SAAP agencies that provide casual assistance, such as meals, information and showers, and which only participate in the Casual Client Collection.

Of the 1,286 agencies funded in 2001–02, 52 did not participate in any data collection and a further 24 contributed only to the Casual Client Collection. Of the remaining 1,210 agencies participating in the Client Collection, 41 used only high-volume forms and 7 used both high-volume and general forms. The information, then, on why clients sought assistance is derived from 96% of the agencies participating in the Client Collection, which between them accounted for 76% of all support periods. The high-volume agencies (4% of agencies in the collection) accounted for 24% of support periods in the same period, reflecting the fact that such agencies generally have a much higher client load than general agencies.

This is of particular interest because of the higher prevalence of older single men in high-volume agencies. Just under three-quarters of all high-volume agencies either target single men or are general agencies, and single men 25 years and over accounted for 83% and 50%, respectively, of all support periods at these agencies in 2001–02 (Table 9.9). This client group is far more likely than any other to seek assistance for substance abuse (AIHW 2002a:27), which means the importance of substance abuse as a reason for seeking assistance is understated throughout this section.

Table 9.9: SAAP support periods: client group, by primary target group of agencies, 2001–02 (per cent)

Client group	Agency target group: Young people	Single men only	Single women only	Families	Women escaping DV	Cross-target/ multiple/ general	Total	Number
Male alone, under 25	38.6	13.9	0.8	2.4	0.4	7.9	13.0	22,500
Male alone, 25+	2.0	82.7	0.8	5.8	0.6	50.2	32.5	56,300
Female alone, under 25	41.5	0.4	18.4	3.8	7.7	5.1	12.3	21,200
Female alone, 25+	1.8	1.5	55.9	6.7	33.5	15.7	14.7	25,500
Couple, no children	3.1	0.4	0.4	5.3	0.3	4.7	2.6	4,500
Couple with children	2.0	0.2	0.8	23.5	0.5	3.7	3.0	5,100
Male with children	0.6	0.3	—	6.0	0.1	1.5	1.0	1,700
Female with children	8.7	0.4	21.9	44.9	56.3	10.4	20.1	34,900
Other	1.7	0.2	0.9	1.6	0.7	0.8	0.9	1,600
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	. .
Total (row %)	**19.8**	**17.7**	**2.2**	**5.0**	**21.4**	**34.0**	**100.0**	**. .**
Total (number)	**34,300**	**30,600**	**3,900**	**8,600**	**37,100**	**58,900**	**. .**	**173,400**

Notes

1. Number excluded due to errors and omissions (weighted): 3,522.
2. Figures have been weighted to adjust for client non-consent and agency non-participation.

Source: SAAP Client and Administrative Data Collections.

The most prevalent main reason nationally in 2001–02 for clients seeking assistance was domestic violence, in 22% of support periods (Table 9.10). The next most common main reasons were eviction or previous accommodation ended (12%), usual accommodation unavailable and relationship or family breakdown (both in 10% of support periods).

Over the years of the collection, domestic violence has consistently been the most prevalent reported main reason clients sought assistance, with little change in the reported percentages since 1996–97. One reason which has shown a steady increase over the years is usual accommodation unavailable, rising steadily from 4% of support periods in 1997–98 to 10% in 2001–02.

There has also been a slight but fairly consistent decline over time in the percentage of support periods where people sought assistance because of relationship or family breakdown (down from 14% in 1996–97 to 10% in 2001–02). There has been a decrease, too, in people needing assistance because of financial difficulty, falling from 13% of support periods in 1996–97 to 9% in 2001–02.

Table 9.10: SAAP support periods: main reason for seeking assistance, 1996–97 to 2001–02 (per cent)

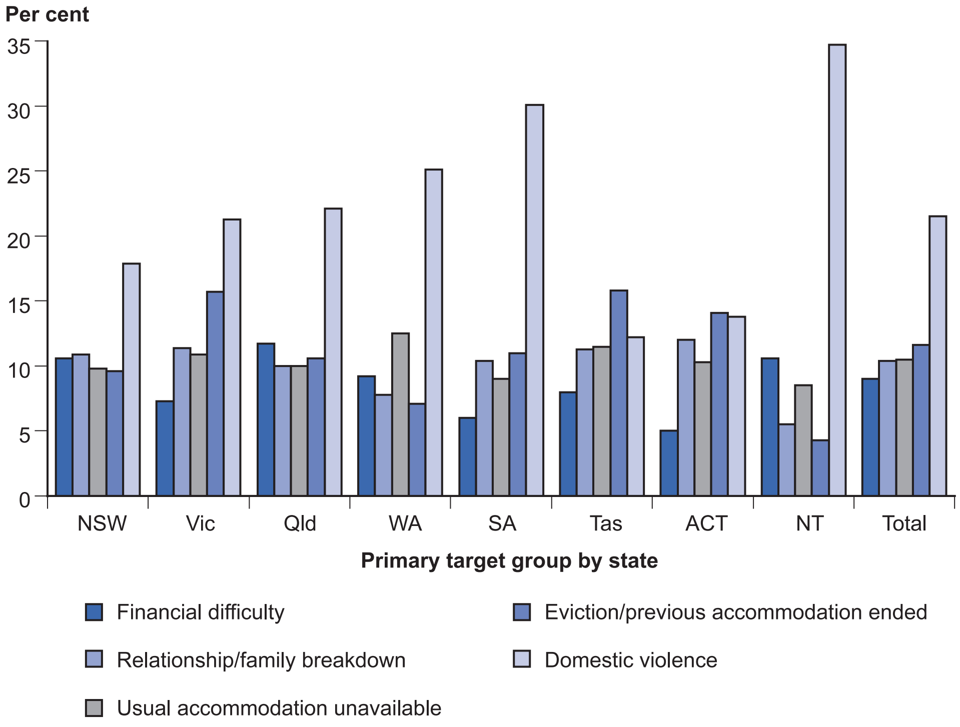
	1996–97	1997–98	1998–99	1999–00	2000–01	2001–02
Long-term homeless	4.8	n.a.	n.a.	n.a.	n.a.	n.a.
Usual accommodation unavailable	n.a.	3.7	5.1	8.0	9.2	10.4
Time out from family/other situation	3.8	4.1	4.4	4.8	5.0	5.1
Relationship/family breakdown	14.1	11.9	11.8	11.8	10.4	10.4
Interpersonal conflict	3.8	3.2	3.6	3.0	2.8	2.6
Physical/emotional abuse	3.6	3.5	3.2	3.2	3.6	3.0
Domestic violence	22.0	23.7	23.7	23.2	23.0	21.6
Sexual abuse	1.2	1.0	0.9	0.6	0.5	0.7
Financial difficulty	12.9	13.4	12.4	10.5	9.5	9.0
Gambling	n.a.	n.a.	n.a.	n.a.	0.2	0.3
Eviction	5.3	n.a.	n.a.	n.a.	n.a.	n.a.
Eviction/previous accommodation ended	n.a.	10.0	10.4	10.1	10.7	11.6
Drug/alcohol/substance abuse	5.4	6.3	6.1	6.0	5.5	5.5
Emergency accommodation ended	1.7	1.4	1.3	1.3	1.6	1.8
Recently left institution	1.7	1.5	1.5	1.6	1.6	1.7
Psychiatric illness	1.7	1.5	1.4	1.6	1.5	1.7
Recent arrival to area with no means of support	3.5	4.8	5.2	5.3	5.4	5.7
Itinerant	4.5	4.1	3.8	3.6	3.1	2.9
At imminent risk but not homeless	2.8	n.a.	n.a.	n.a.	n.a.	n.a.
Other	6.1	5.7	5.2	5.1	6.4	6.0
Total (%)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**54,481**	**73,447**	**110,000**	**110,500**	**119,000**	**125,000**

Notes

1. Number excluded due to errors and omissions (weighted): 1,313 (96–97); 926 (97–98); 895 (98–99); 1,336 (99–00); 4,203 (00–01); 8,796 (01–02).
2. Table excludes high-volume records because not all items were included on the high-volume form.
3. Figures have been weighted to adjust for agency non-participation and client non-consent.

Source: SAAP Client Collections.

Figure 9.6 illustrates the top five Australia-wide main reasons in 2001–02, showing the diversity between states and territories in why clients sought assistance. Domestic violence, for example, was the most prevalent main reason in 35% of support periods in the Northern Territory, but in only 12% in Tasmania. Such figures were no doubt influenced to some extent by the mix of services in each jurisdiction. Agencies targeting women escaping domestic violence, for example, received the largest proportion of the Northern Territory's recurrent funding (see Figure 9.2), as was also the case in Western Australia. In Tasmania, in contrast, the largest proportion of recurrent funding went to general, multiple or cross-target agencies.



Source: Table 9.11.

Figure 9.6: SAAP support periods, top five main reasons for seeking assistance, 2001–02

Again, in the Northern Territory, 16% of recurrent funding was allocated to single men's agencies, while in the Australian Capital Territory the figure was 3% (see Figure 9.2). Further, single older males have the highest prevalence among all client groups citing financial difficulty as a main reason for seeking assistance (AIHW 2002a:27). Because of the relatively high percentage of funding allocated to men's refuges in the Northern Territory, it is perhaps not surprising then to find financial difficulty as a main reason in 11% of support periods in the Northern Territory and in 5% of support periods in the Australian Capital Territory.

In Tasmania and the Australian Capital Territory (Table 9.11), eviction or previous accommodation ended just exceeded domestic violence (in 16% and 14% of support periods, respectively) as the most prevalent main reason for seeking assistance in 2001–02. In Queensland and the Northern Territory financial difficulty was the second most prevalent main reason (12% and 11%, respectively).

Further, recent arrival with no means of support was as one of the top five main reasons for seeking assistance in both the Northern Territory and Tasmania (in 9% of support periods for both). In the Northern Territory, this was the third most common main reason. In Western Australia, drug and alcohol or substance abuse was as the third most common main reason (10%). All these figures, as was noted earlier, understate the actual prevalence of substance abuse in homelessness.

Table 9.11: SAAP support periods: main reason for seeking assistance, 2001–02 (per cent)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total	Number
Usual accommodation unavailable	9.8	10.9	10.0	12.5	9.0	11.5	10.3	8.5	10.5	13,300
Time out from family/other situation	4.8	3.8	6.9	5.9	5.5	4.8	6.8	7.8	5.1	6,500
Relationship/family breakdown	10.9	11.4	10.0	7.8	10.4	11.3	12.0	5.5	10.4	13,200
Interpersonal conflict	2.2	2.5	3.2	2.9	3.0	4.3	2.8	2.2	2.7	3,400
Physical/emotional abuse	2.4	2.3	3.6	3.9	3.8	3.2	2.8	6.6	3.0	3,800
Domestic violence	17.9	21.3	22.1	25.1	30.1	12.2	13.8	34.7	21.5	27,300
Sexual abuse	0.5	0.5	0.5	0.4	1.5	3.6	0.7	0.5	0.7	900
Financial difficulty	10.6	7.3	11.7	9.2	6.0	8.0	5.0	10.6	9.0	11,500
Gambling	0.7	0.1	0.2	0.1	0.2	0.3	0.3	0.2	0.3	400
Eviction/previous accommodation ended	9.6	15.7	10.6	7.1	11.0	15.8	14.1	4.3	11.6	14,700
Drug/alcohol/substance abuse	9.3	3.3	3.4	9.8	2.7	4.3	4.1	2.4	5.6	7,100
Emergency accommodation ended	1.3	2.6	0.9	2.2	1.3	2.2	2.5	1.1	1.8	2,300
Recently left institution	1.8	1.6	1.3	1.6	2.5	1.8	2.3	0.8	1.7	2,100
Psychiatric illness	2.4	1.5	1.7	1.0	1.5	2.1	2.0	0.4	1.7	2,200
Recent arrival to area with no means of support	5.9	3.6	8.2	5.3	5.1	8.6	7.2	8.6	5.6	7,200
Itinerant	2.7	3.4	2.5	3.0	3.1	2.5	3.4	1.6	2.9	3,700
Other	7.3	8.2	3.4	2.2	3.4	3.5	9.8	4.2	5.9	7,600
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	. .
Total (number)	**34,000**	**38,900**	**18,500**	**14,000**	**9,400**	**5,500**	**2,600**	**4,200**	**. .**	**127,100**

Notes

1. Number excluded due to errors and omissions (weighted): 6,773.
2. Table excludes high-volume records because not all items were included on the high-volume form.
3. Figures have been weighted to adjust for agency non-participation and client non-consent.

Source: SAAP Client Collection.

Services provided to SAAP clients

A SAAP client may be provided with many diverse services in any one support period. These might include different types of accommodation, financial assistance, a range of counselling, court support, drug rehabilitation, meals, showers or a variety of other services. Information is collected by the Client Collection on 34 different types of services that might be provided to clients, which can be grouped under six headings (see Table 9.12, Note 2 for the constituent services).

Across Australia, the three types of services most often provided in 2001–02 were housing and accommodation (in 76% of all support periods), general support or advocacy (74%) and meals and other basic support services (67%) (Table 9.12). Specialist services, as might be expected, were the least likely to be provided (30%). No services were provided directly to clients in 2% of support periods, but agencies may have arranged referrals for clients in these cases.

These three types of support were also the most often provided in the states and territories, except for South Australia where counselling was more likely to be provided than meals and other basic support services (in 60% and 51% of all support periods, respectively). Housing and accommodation was the most commonly provided service in four of the jurisdictions: New South Wales, Queensland, Western Australia and the Northern Territory. However, in the Australian Capital Territory and Tasmania, general support and advocacy were just as likely to be provided as housing and accommodation (89% for both in the Australian Capital Territory and 68% in Tasmania). General support and advocacy was the most commonly provided service in Victoria (77%).

The pattern of service use differed between client groups (Table 9.13). Unaccompanied males aged 25 years or over were proportionately more often provided with accommodation services than other clients (in 87% of their support periods), while couples without children received these services relatively less frequently (68%). Couples, either with or without children, and males with children were more likely than others to receive financial or employment services, while women, with or without children, were relatively more often provided with counselling services.

Table 9.12: SAAP support periods: broad types of services provided to clients, 2001–02 (per cent)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Housing/accommodation	84.3	57.4	86.2	85.6	65.8	67.6	89.2	89.3	76.2
Financial/employment	28.9	43.1	54.0	37.0	32.3	36.9	56.9	44.0	40.5
Counselling	37.0	48.8	59.5	48.4	60.2	55.4	76.5	50.4	49.7
General support/advocacy	70.4	77.3	77.2	59.1	82.1	68.0	89.2	72.7	74.0
Specialist services	23.0	20.0	51.8	34.3	19.1	10.9	45.1	39.8	30.1
Meals and other basic services	80.8	42.0	79.4	74.1	51.2	57.6	87.8	87.4	67.2
No services provided directly	0.9	3.8	1.2	1.2	1.7	2.9	0.6	0.3	1.8
Total (number)	**46,410**	**43,338**	**40,612**	**14,254**	**14,120**	**5,652**	**2,626**	**4,758**	**171,770**

Notes

1. Number excluded due to errors and omissions (weighted): 0 closed support periods.
2. Clients were able to receive multiple services so percentages do not total 100. The 34 individual service types have been grouped into six major classifications as follows:
    - Housing/accommodation—SAAP or CAP accommodation (including THMs), assistance to obtain/maintain short-term accommodation, and assistance to obtain/maintain independent housing.
    - Financial/employment—employment and training assistance, assistance to obtain/maintain a benefit or pension or other government allowance, financial assistance or material aid, and financial counselling and support.
    - Counselling—incest or sexual assault counselling and support, domestic violence counselling and support, family or relationship counselling and support, emotional support and other counselling, and assistance with problem gambling.
    - General support/advocacy—living skills or personal development assistance, assistance with legal issues or court support, advice or information, retrieval, storage or removal of personal belongings, advocacy or liaison on behalf of clients, assistance with immigration issues, and brokerage services.
    - Specialist services—psychological services, psychiatric services, pregnancy support, family planning support, drug or alcohol support or intervention, physical disability services, intellectual disability services, culturally appropriate support, interpreter services, and health or medical services.
    - Meals and other basic services—meals, laundry or shower facilities, recreation, transport, and other support not elsewhere specified.
3. Figures have been weighted to adjust for agency non-participation.

Source: SAAP Client Collection.

Table 9.13: SAAP support periods: services provided to clients, by client group, 2001–02 (per cent)

	Male alone <25	Male alone 25+	Female alone <25	Female alone 25+	Couple no children	Couple with children	Male with children	Female with children	Other	Total
Housing/ accommodation	77.7	87.1	69.7	69.9	67.7	71.1	69.0	70.3	65.3	76.6
Financial/ employment	39.6	38.9	39.5	43.7	52.0	50.9	46.5	43.1	36.3	41.3
Counselling	39.7	36.7	57.5	66.2	40.2	43.8	43.3	70.5	49.8	51.2
General support/ advocacy	76.1	72.0	77.2	75.6	73.8	75.8	75.7	79.2	67.1	75.3
Specialist services	24.1	35.7	27.2	39.4	24.9	17.9	14.1	28.3	27.8	31.1
Meals and other basic services	68.7	82.7	62.2	68.0	44.2	37.5	39.8	56.7	47.3	67.9
No services provided directly	2.4	1.1	2.5	1.4	3.5	3.6	3.9	1.6	3.3	1.8
Total (number)	**22,000**	**55,700**	**20,700**	**24,900**	**4,400**	**5,000**	**1,700**	**34,000**	**1,500**	**169,900**

Notes

1. Number excluded due to errors and omissions (weighted): 7,018.
2. For constituent services included in these broad service groupings, see Note 2 of the previous table.
3. Clients were able to receive multiple services, so percentages do not total 100.
4. Figures have been weighted to adjust for agency non-participation and client non-consent.

Source: SAAP Client Collection.

Unaccompanied people aged 25 years or more received both basic and specialist services relatively frequently. Unaccompanied women over 25 were more likely than any other client group to be provided with specialist services (in 39% of their support periods), while unaccompanied males over 25 were more likely than any other client group to receive meals and other basic support services (83%).

Unmet demand for accommodation

As mentioned earlier, population size has been the major determinant of the allocation of SAAP funds across the states and territories, while within the jurisdictions it is historical factors and submission-based funding outcomes that have largely driven the mix of established services. Neither of these factors necessarily correlates strongly with the level of existing need for SAAP services. The 1996 Census indicates, for example, that the level of homelessness may vary across jurisdictions, although the actual extent of this variation needs clarification. These data also do not inform us about the impact that climatic, geographic and social factors can have at a regional level.

Furthermore, as shown in Table 9.1, the total 1996 homelessness figures reported by Chamberlain were influenced by the count of individuals using SAAP services in each of the jurisdictions. The two different components of this total homelessness count, derived from the Census itself and the SAAP component, can both be regarded as indicators of homeless populations for whom services may be needed and, in the case of SAAP, provided.

The Census, within the limitations outlined in previous sections, suggests potential needs for services, although exactly which services may be needed in any given situation is not well or not completely understood. Some of this need for services, or at least for housing services, can be quantified through a count of people who present at SAAP agencies seeking accommodation. The National Data Collection Agency attempts to measure requests for accommodation, as well as the capacity at which SAAP services are operating, through the Demand for Accommodation Collection, running for 2 separate weeks during the year. Because of seasonal factors, and because people can have several unmet requests in a year, extrapolating from these data to annual figures is not possible.

There is a range of methodological difficulties inherent in this collection, one of which is determining the extent of under-counting. Factors contributing to under-counting include the extent of hidden need, which can be caused by people not seeking accommodation when they require it, or seeking accommodation at non-SAAP agencies or using housing departments' short-term brokerage services. Under-counting can also depend on the extent of SAAP agencies' (non)compliance in the collection, and none of these factors can be fully measured with any confidence.

There is also a variety of reasons for a request for accommodation being unmet. Perhaps there are no beds available, or the type of accommodation requested is not provided, or there are staffing issues. All these, and similar, reasons lead to an unmet request for accommodation being considered *valid*.

Table 9.14: Valid unmet requests for SAAP accommodation: main reason why requests for accommodation were not met, 22–28 August 2001 and 8–14 May 2002 (per cent requests by groups)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total	Number
Insufficient accomm. available	80.3	87.7	84.3	79.8	87.8	87.3	93.6	67.3	84.4	6,770
Type of accommodation requested is not provided	5.0	5.8	5.8	3.5	5.1	4.2	2.1	14.0	5.3	424
Insufficient staff to provide support	3.2	2.4	3.2	0.6	—	1.3	0.6	0.9	2.4	191
Facilities for disability, cultural and other special needs not available	3.1	0.8	2.1	2.3	1.3	5.5	0.9	15.0	2.1	171
Other	8.4	3.3	4.7	13.7	5.9	1.7	2.7	2.8	5.8	464
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	. .
Total (row %)	**25.0**	**30.2**	**22.8**	**7.7**	**5.9**	**2.9**	**4.1**	**1.3**	**100.0**	**. .**
Total (number)	**2,007**	**2,423**	**1,825**	**620**	**474**	**236**	**328**	**107**	**. .**	**8,020**

Notes

1. Cases excluded due to missing data: 0.
2. Adjustments have been made for missing data.
3. Figures are unweighted.
4. In a small number of cases, requests for SAAP accommodation were unmet due to the age of a male child (applicable to domestic violence agencies only). To ensure confidentiality, these cases are not presented separately but are included in the 'other' category.

Source: SAAP Unmet Demand Collection and Administrative Data Collection.

Generally, the reason is that no beds are available. This was the case across Australia for 84% of valid unmet requests for accommodation in 2001–02 (Table 9.14). This reason for turning away potential clients accounted for a high of 94% of all valid unmet requests in the Australian Capital Territory, and a low of 67% in the Northern Territory. In contrast, the Northern Territory had the highest rates for unmet requests because the type of accommodation requested was not provided (14%) and because special facilities were unavailable (15%). Overall, 80% of all unmet requests (or 8,020) were considered to be valid in 2000–02.

On the other hand, a request can be unmet, for example, when a person is too young, too old, or the wrong gender for the agency they approach—that is, they are outside the target group set by the agency. Or a person may be offered accommodation but, for whatever reason, they refuse that offer. These two cases represent the majority of situations where an unmet request is considered invalid. Overall 20% of unmet requests for accommodation (or 1,958) were considered *invalid* in 2001–02 (Table 9.15). In an average of 67% of these invalid requests, the person or group seeking accommodation approached an agency catering to a different target group.

In Tasmania, 75% of all (invalid) requests were unmet for this reason, compared with only 47% in South Australia. South Australia also had the highest level of potential clients who refused an offer of accommodation, with 47% of (invalid) requests being unmet for this reason. In the Northern Territory, 35% of (invalid) requests went unmet because of people refusing an offer of accommodation, while Queensland had the lowest level of such refusals (20%). No data are available on why potential clients refuse offers of accommodation.

Table 9.15: Invalid unmet requests for SAAP accommodation: main reason why requests for accommodation were not met, 22–28 August 2001 and 8–14 May 2002 (per cent requests by groups)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total	Number
Agency inappropriate —wrong target group	70.0	62.8	72.9	66.7	47.1	75.4	62.3	63.0	67.2	1,316
Agency inappropriate —non-accommodation	0.8	13.6	7.2	0.5	5.9	—	4.3	1.9	5.1	99
Potential client refused accommodation	29.2	23.7	19.9	32.8	47.1	24.6	33.3	35.2	27.7	543
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	. .
Total (row %)	**32.8**	**19.2**	**22.1**	**10.4**	**6.1**	**3.1**	**3.5**	**2.8**	**100.0**	**. .**
Total (number)	**643**	**376**	**432**	**204**	**119**	**61**	**69**	**54**	**. .**	**1,958**

Notes

1. Cases excluded due to missing data: 0.
2. Adjustments have been made for missing data.
3. Figures are unweighted.

Source: SAAP Unmet Demand Collection and Administrative Data Collection.

Table 9.16 shows the average daily demographic profile of potential clients and their accompanying children (i.e. all people with valid unmet requests for accommodation). People with (valid) unmet requests for accommodation in 2001–02 were more likely to be females than males in all jurisdictions except the Australian Capital Territory, where there was an equal proportion of requests from males and females. The Northern Territory had the highest proportion of females making requests (65%), and is also the state with the highest proportion of agencies targeting women, including single women and those escaping domestic violence (see Figure 9.2).

Table 9.16: Characteristics of adults and accompanying children requiring but not receiving SAAP accommodation, 22–28 August 2001 and 8–14 May 2002 (average daily percentage)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total	Number
Gender										
Male	45.5	47.6	45.0	46.2	42.9	40.5	50.0	34.6	45.7	357.7
Female	54.5	52.4	55.0	53.8	57.1	59.5	50.0	65.4	54.3	424.4
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*781.8*
Age										
Under 12 years	24.9	23.3	36.7	31.8	36.8	17.9	34.8	27.2	29.3	228.9
12–14 years	6.9	3.6	5.9	5.1	2.8	4.8	3.6	3.1	5.1	39.7
15–17 years	14.7	11.9	12.2	15.1	10.3	7.9	9.3	12.3	12.6	98.5
18–19 years	5.3	8.6	5.0	5.0	8.2	4.8	5.0	9.9	6.3	49.6
20–24 years	10.2	17.3	10.2	11.1	12.4	14.7	10.0	6.8	12.4	96.9
25–44 years	21.8	27.6	23.3	20.7	19.7	28.2	21.8	25.9	23.7	185.6
45–64 years	5.9	3.4	2.6	2.1	2.7	2.4	1.4	5.6	3.6	27.8
65 years and over	0.5	0.4	0.2	0.2	—	—	0.5	0.6	0.5	2.5
Unknown	9.7	3.9	3.9	8.8	7.0	19.4	13.6	8.6	6.7	52.4
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*781.8*
Birthplace										
Australia	72.6	72.8	84.1	71.7	85.4	67.4	75.5	88.0	76.8	570.7
Other English-speaking countries	2.8	3.2	1.9	1.5	0.9	—	0.5	1.2	2.2	16.5
Non-English-speaking countries	6.9	13.4	2.0	5.4	1.2	0.8	3.9	1.2	6.4	47.6
Unknown	17.7	10.6	12.0	21.4	12.5	31.8	20.2	9.6	14.5	107.9
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*742.8*
Indigenous status										
Indigenous	14.2	3.6	15.3	31.3	24.1	1.4	18.6	60.4	15.0	93.6
Not Indigenous	57.4	71.8	58.5	38.7	56.3	34.3	53.7	32.0	58.1	362.6
Unknown	28.4	24.6	26.1	30.0	19.6	64.3	27.7	7.7	26.8	167.4
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*623.7*

Notes

1. Data on age and gender were missing for an estimated 167.3 people per day out of 949.1.
2. Data on birthplace were missing for an estimated 206.3 people per day out of 949.1.
3. Data on Indigenous status were missing for an estimated 325.4 people per day out of 949.1.

Source: SAAP Unmet Demand Collection.

The jurisdictions also showed some variations in the usual age of people unable to be accommodated. In Tasmania, around 18% of these people were aged under 12 years, while in both Queensland and South Australia 37% were in this age group. Victoria and Tasmania were the only states where people with valid unmet requests were more likely to be in the 25–44 age group (28% for both) than in under–12s.

The majority of valid unmet requests for accommodation in all jurisdictions were from people born in Australia. Tasmania showed a lower proportion of such people (67%) than any other jurisdiction, but also had the highest proportion of people whose birthplace was unknown (32%). Victoria had the highest proportion of people born in non-English-speaking countries who were unable to be accommodated (13%). The Northern Territory had both the largest proportion born in Australia (88%) and the smallest proportion for whom the birthplace was unknown (10%). Because of the high level of missing data for birthplace, all these figures must be interpreted with caution.

Although Table 9.16 also provides data on Aboriginal and Torres Strait Islanders with unmet requests for SAAP accommodation, caution needs to be taken in any interpretation because of the large proportions of people of unknown status and the very high level of missing information. Indigenous status was unknown for 27% of all people with unmet requests, and in Tasmania this figure rose to 64%. The Northern Territory had the smallest proportion for whom Indigenous status was unknown (8%), and the largest proportion of unmet requests from Indigenous people (60%). It is interesting to note that Indigenous Australians comprise 17% of all SAAP clients (see Table 9.7) but only 15% of people turned away from SAAP, and this latter figure includes accompanying children as well as adults.

There are two turnaway rates, designed to give a measure of whether there is sufficient SAAP accommodation to meet demand (Table 9.17). These rates do not include accompanying children and are only calculated for people seeking immediate accommodation. The first turnaway rate shows the average daily number of people who could not be accommodated, expressed as a percentage of all people making requests for SAAP accommodation—both those successfully seeking accommodation and those who were unsuccessful, on an average day during the collection period.

This turnaway rate shows that, of those seeking immediate accommodation, an average of over 55% were turned away. In the Australian Capital Territory, 40% could not be accommodated, while in Victoria and the Northern Territory over 72% were turned away.

The second turnaway rate shows the average daily number of people who could not be accommodated, expressed as a percentage of all people who (successfully and unsuccessfully) requested accommodation on a particular day plus those already accommodated in SAAP agencies.

This turnaway rate indicates that on any one day during the collection, people with unmet requests for accommodation comprise only a small percentage (4% overall) of the total number of people involved in SAAP. This rate varies from a high of 7% in the Australian Capital Territory to a low of 2% in South Australia.

Table 9.17: Turnaway rates of adults needing immediate accommodation, 22–28 August 2001 and 8–14 May 2002 (daily average number)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
People with unsuccessful requests for accommodation[(a)]	80.6	72.1	83.2	29.2	17.3	12.0	15.3	5.8	315.4
People with successful requests for accommodation	83.7	27.6	79.1	28.1	16.0	5.6	5.8	8.6	254.6
Total number of people making requests for accommodation	*164.3*	*99.7*	*162.3*	*57.3*	*33.3*	*17.6*	*21.1*	*14.4*	*570.0*
Turnaway rate (% of total daily requests for accommodation)	**49.1**	**72.3**	**51.3**	**50.9**	**52.0**	**68.0**	**40.2**	**72.6**	**55.3**
Total number of people already accommodated in SAAP	*2,473.4*	*1,876.8*	*1,260.2*	*602.4*	*760.8*	*180.5*	*212.2*	*143.6*	*7,509.9*
Turnaway rate (% of total daily demand for accommodation)	**3.2**	**3.7**	**6.2**	**4.6**	**2.2**	**6.2**	**6.7**	**3.9**	**4.0**

(a) Adults with a valid unmet request for immediate accommodation.

Notes

1. Cases excluded due to missing data: 0.
2. Figures are for accommodation required within 24 hours.
3. Rates include children under 18 who present alone, but do not include accompanying children.

Sources: SAAP Unmet Demand Collection and Client Collection

SAAP services and exclusion practices

Research on 'high needs' clients informed the development of SAAP IV, and led to the publication, in 1999, of what has been called the 'High Needs Report' (Ecumenical Housing Inc. & Thomson Goodall Assoc. 1999). This report suggested that some people were being excluded from SAAP services, and that the most frequently cited client issues which could create barriers to access were mental illness, substance disorder, alcohol disorder, behavioural disorder and intellectual disability.

Service models based on communal living arrangements, or congregate care, have also been identified as a possible barrier to entry into SAAP services. The Victorian Homelessness Taskforce commented that these were inappropriate for some clients and could even contribute to a worsening of a client's circumstances. They found, for example, that such living arrangements could increase the risk of drug use, especially among young people (Vic DHS 2002:70).

The Western Australia Homelessness Taskforce also identified congregate care models of operation with strict entry requirements as a barrier to accessing SAAP services. This taskforce reported that both the tightness of the target groups and congregate care living arrangements have resulted in people who are outside the nominated target groups feeling excluded (WA State Homelessness Taskforce 2002:105–6). As Robinson (2001:11) reports, 'some see them as rough places where dormitories or other communal spaces have to be shared with potentially threatening strangers, who may have drink and drug problems. For others there are too many rules, for example barring pets, partners or drink.'

Table 9.18: SAAP agencies: characteristics of people excluded by eligibility policies, New South Wales, 2002 (per cent)

	Agency target group							
	Young people	Single men only	Single women only	Families	Women escaping DV	Cross/ multiple/ general	Total	No.
People with mental illness	57.8	52.0	46.2	56.3	51.7	48.1	53.7	125
People with drug & alcohol disorders	64.4	52.0	30.8	87.5	63.3	51.9	61.0	140
People with an intellectual disability	40.0	24.0	30.8	37.5	30.0	25.9	33.3	75
People with a physical disability	51.1	40.0	38.5	25.0	43.3	18.5	41.6	95
People with health issues	17.8	28.0	15.4	6.3	13.3	7.4	15.6	35
People with male accompanying children	66.7	76.0	38.5	25.0	16.7	33.3	46.3	105
People with female accompanying children	65.6	76.0	30.8	6.3	5.0	22.2	39.8	90
People who have been black-listed	26.7	60.0	15.4	31.3	26.7	25.9	29.9	70
People exhibiting violent behaviour	83.3	88.0	53.8	81.3	76.7	70.4	78.8	180
People with other challenging behaviours	15.6	36.0	15.4	6.3	13.3	11.1	16.0	35
People unable/unwilling to pay	26.7	20.0	30.8	18.8	8.3	11.1	19.0	45
People unable to live independently/semi-independently	23.3	24.0	61.5	62.5	48.3	29.6	35.5	80
People not willing to enter into a case management plan	40.0	8.0	23.1	37.5	16.7	14.8	26.4	60
People in the Juvenile Justice System	10.0	36.0	15.4	25.0	11.7	11.1	14.7	35
People with acquired brain injury	31.1	12.0	7.7	18.8	10.0	14.8	19.5	45
Other	41.1	28.0	23.1	37.6	21.8	14.8	30.3	70
No exclusions made	3.3	0.0	0.0	0.0	5.0	7.4	3.5	10
Not applicable, no policy	0.0	0.0	0.0	0.0	0.0	7.4	0.9	—
Total (row %)	**39.0**	**10.8**	**5.6**	**6.9**	**26.0**	**11.7**	**100.0**	**. .**
Total (number)	**90**	**25**	**15**	**15**	**60**	**25**	**. .**	**230**

Notes

1. Number excluded due to errors & omissions: 0.
2. Survey respondents were able to tick more than one option, so percentages do not total 100.
3. Figures have been rounded.

Sources: AIHW, NDCA SAAP Access & Exiting Project Collection.

Regardless of the type of living arrangements, a psychotic, violent or drug-affected client can negatively impact on the wellbeing of other clients and staff, and create a dilemma for SAAP agencies, who have duty of care obligations to all clients, staff and volunteers. Meeting these obligations may require more specialist skills or resources than are available and difficulties can arise in matching the casework requirements of a high-needs client with the needs of existing clients. Inappropriate placement in such situations may lead to generally poor outcomes for everyone.

Recently, New South Wales SAAP service providers were surveyed to identify, in a more evidence-based, quantitative way, the characteristics of people who were most likely to be excluded from SAAP services. The New South Wales Community Services Commission, the independent watchdog for clients of community services in that state, and now part of the Ombudsman's Office, commissioned the survey. The survey forms part of a larger project about eligibility for, access to, and early exiting of people from, SAAP accommodation-based services.

These data are drawn solely from participating agencies in New South Wales, and as such are indicative only, especially given some of the state-level differences already canvassed. Nonetheless, they can provide insight into those sectors of the homeless population who may be excluded from SAAP.

Table 9.18 shows the common characteristics of people explicitly excluded by the policies of SAAP agencies in New South Wales. Overall, 180 of the 230 agencies had policies excluding people exhibiting violent behaviour (79% of agencies), 140 agencies (61%) have policies excluding people with drug and alcohol disorders, and 125 agencies (54%) have policies that exclude people with a mental illness. This table should be read in conjunction with the data on how strictly such policies are enforced. For example, 24% of single men agencies, but only 15% of young people's services, apply their exclusions regardless of the severity of the characteristic (NSW CSC 2002:Table 11). The complete report from the CSC is expected to be available later this year.

Under some circumstances, a homeless person who otherwise fulfils the eligibility criteria of a SAAP agency might still be denied access to that agency—exclusion in practice (Table 9.19). Note that when answering this and the other questions reported on here, agencies were able to choose multiple options.

The most common circumstances in which an otherwise eligible person might be denied access, across all sectors, was when that person did not want to abide by the rules of the service. Sixty-eight per cent of the 230 agencies responding to this question would exclude a homeless person in these circumstances. Sixty per cent of agencies would also deny access to an eligible person whose needs were too high for the service, the second most common circumstance.

Table 9.19: SAAP agencies: reasons for exclusion of people meeting agencies' eligibility criteria, New South Wales 2002 (per cent)

	Agency target group							
	Young people	Single men only	Single women only	Families	Women escaping DV	Cross/ multiple/ general	Total	No.
Past experience with the person	53.3	60.0	30.8	43.8	33.3	37.0	45.0	105
Person's needs are too high for service	77.8	44.0	53.8	43.8	46.7	55.6	59.7	140
Person not compatible with other clients in the service (house dynamics)	74.4	44.0	30.8	62.5	41.7	51.9	56.7	130
Accommodation not physically accessible	50.0	40.0	69.2	37.5	43.3	29.6	45.0	105
No access to the specialist services required by the person	16.7	8.0	23.1	12.5	16.7	14.8	15.6	35
Person not compatible with shared accommodation	41.1	36.0	15.4	25.0	38.3	29.6	35.9	85
Person not compatible with independent accommodation	28.9	16.0	61.5	37.5	30.0	25.9	29.9	70
Staff numbers/ratio of staff to clients	43.3	16.0	23.1	43.8	16.7	44.4	32.5	75
Too many clients with the same high-level needs	57.8	20.0	46.2	56.3	33.3	37.0	44.2	100
Person not willing to commit to case plan	33.3	16.0	23.1	18.8	15.0	11.1	22.5	50
Person does not want to abide by rules of service	72.2	72.0	53.8	56.3	73.3	55.6	68.4	160
Other	18.9	28.0	38.5	18.8	6.7	14.8	17.4	35
Total (row %)	**39.0**	**10.8**	**5.6**	**6.9**	**26.0**	**11.7**	**100.0**	**. .**
Total (number)	**90**	**25**	**15**	**15**	**60**	**25**	**. .**	**230**

Notes

1. Number excluded due to errors & omissions: 0.
2. Survey respondents were able to tick more than one option, so percentages do not total 100.
3. Figures have been rounded.

Sources: AIHW, NDCA SAAP Access & Exiting Project Collection.

What is also evident from this table is that the various SAAP sectors, targeting different sectors of the homeless population, have very different clientele and operational procedures. So, for example, for 72% of the 25 single men's refuges responding to this question, a homeless person not wanting to abide by the rules was a sufficient reason to deny them access. By contrast, this response was given by only 54% of single women only agencies. For single men's services, past experience with the person was a more likely factor in denying access than it was for any other sector, with 60% of these services having this as a circumstance under which they would exclude an otherwise eligible homeless person. For single women only, by contrast, this figure was 31%.

Table 9.20 presents details on the approximate number of people who were turned away from SAAP services in New South Wales during the 6 months prior to September 2002 for reasons other than the service was full. These were people eligible for assistance but denied access because of some particular personal characteristic. The numbers reported must be taken as approximations only because of variations in the record-keeping methods of agencies, with some only able to make best estimates of the numbers of people denied access in the previous 6 months.

Table 9.20: SAAP agencies: number of people turned away for reasons other than unmet demand, New South Wales, March–September 2002

	Agency target group						
	Young people	Single men only	Single women only	Families	Women escaping DV	Cross/ multiple/ general	Total
People with mental illness	75	35	—	10	40	130	290
People with drug & alcohol disorders	165	130	5	15	80	70	470
People with an intellectual disability	5	0	—	0	5	0	10
People with a physical disability	5	5	0	0	7	0	15
People with health issues	—	5	—	0	5	0	10
People with male accompanying children	20	5	5	5	10	15	65
People with female accompanying children	50	5	5	0	25	105	195
People who have been black-listed	40	15	0	—	20	50	130
People exhibiting violent behaviour	165	55	5	5	20	30	275
People with other challenging behaviours	115	10	—	—	10	—	140
People unable/unwilling to pay	5	15	0	5	—	0	25
People not willing to enter into a case management plan	40	5	0	5	—	15	65
People unable to live independently/ semi-independently	85	5	5	10	5	10	115
People not prepared to access specialist services offered by the service	20	0	—	0	0	5	25
People with criminal convictions	10	0	0	0	—	—	15
People who are temporary visa holders	0	0	0	—	5	0	5
People in the Juvenile Justice System	20	—	0	0	0	—	20
People with acquired brain injury	—	0	0	—	5	—	5
Other	555	40	5	35	105	320	1,065
No exclusions made	0	0	0	0	—	—	5
Unknown	5	0	—	—	5	—	10
Total	**1,380**	**330**	**30**	**90**	**347**	**750**	**2,955**
Total (row %)	**41.1**	**9.8**	**4.3**	**6.7**	**25.2**	**12.9**	**100.0**
Total (number of agencies)	**65**	**15**	**5**	**10**	**40**	**20**	**165**

Notes

1. Number excluded due to errors & omissions: 0.
2. Numbers are approximate only as differences exist in agencies' record-keeping methods and recording accuracy.
3. Survey respondents were able to tick more than one option, so percentages do not total 100.
4. Figures have been rounded.

Sources: AIHW, NDCA SAAP Access & Exiting Project Collection.

By far the largest number of people turned away from all New South Wales agencies, except those catering to single men, is listed under 'other', with around 1,065 people denied access because of uncategorised personal characteristics. Preliminary analysis of these 'other' shows that around 400, or 38%, arose from agencies incorrectly indicating people they had turned away because there were no beds (i.e. genuine unmet demand). A further 151 were people who were turned away because they did not meet the agencies' eligibility criteria.

For single men's agencies, the most common characteristic of people turned away was 'having a drug & alcohol disorder', with approximately 130 people denied access in the previous 6 months on this account. Agencies targeting young people turned away 165 people because of this characteristic over the same period, while agencies targeting women escaping domestic violence turned away around 80 people. For both these types of agencies, this was the most common categorised personal characteristic that led to access being denied. Agencies for young people also turned away around 165 people because they were exhibiting violent behaviour.

The High Needs Report, which informed the development of SAAP IV, identified a lack of skill in assessment processes and inappropriate service models as barriers to accessing SAAP services (Ecumenical Housing Inc. & Thomson Goodall Assoc. 1999:13). The conclusion was that additional work was required to better understand and quantify levels of need, and required responses. The data gathered in the CSC survey, only a portion of which are presented here, are a step in this process and provide some insight into the structure and workings of barriers to access.

At the time of writing, the Commonwealth Department of Family and Community Services is also in the process of developing a high and complex needs assessment tool for SAAP agencies. This, it is hoped, will enable the development of common assessment approaches across jurisdictions. Parallel initiatives in other program areas include cross-programs needing common data and assessment items, broad-based initial assessment approaches in primary care services, and the development of specialist integrated responses to people whose needs span a range of areas and responsibilities (Thomson Goodall Associates 2002:6).

Future directions in data collection

In July 2000, the SAAP Coordination and Development (CAD) Committee sponsored a review of the National Data Collection to support the new SAAP IV initiatives. The review analysed SAAP stakeholder information requirements and assessed how well the current data collection system met those requirements. It argued for a need to improve the timeliness, relevance and accessibility of program information, while streamlining data collection processes and maximising cost effectiveness. This will also enable information from the SAAP sector, which has an established role in Australia's social and economic system, to be considered within the broader social policy context.

The result of the review was the development of an information management plan , a key objective of which is a change in the paradigm for understanding SAAP information (Community Link Australia 2000). This shift sees a move away from thinking about 'data collection' and towards thinking about 'information management'.

As part of this shift, a web site has been established (FaCS 2003a). This will encourage information management by showcasing quality research and data relevant to SAAP policy and service planning.

In July 2002, CAD announced funding for regional and service-based research grants as a way of continuing to improve SAAP information. A number of agencies have already successfully tendered for research projects, ranging from an examination of caravan parks as SAAP accommodation to looking at best-practice early intervention models for Indigenous services. Also included is research on women clients, accompanying children, repeat SAAP users, squatting, and Indigenous family violence (FaCS 2003a).

CAD is also funding the development and piloting of tools to measure client outcomes in SAAP services. Both this and the previous research grants were established in response to feedback from stakeholders about the need to more fully tell the story of what SAAP does. The Client Outcomes research, especially, recognises that not all changes achieved by SAAP services are captured by the National Data Collection. The project aims to identify outcome measurement tools that are 'appropriate, useful, contribute to service improvement and enable aggregation of information at a program level'. The successful measurement of client outcomes as well as client satisfaction is linked with an ongoing emphasis on developing case-management approaches in SAAP. This is seen as especially relevant for those clients whose needs require a high level and complexity of service provision.

9.4 Other Commonwealth initiatives

A number of Commonwealth initiatives assist the homeless. These include the National Homelessness Strategy, Housing Assistance programs, and the Stronger Families and Communities Strategy, all of which have evolved in tandem with the understanding of the complexities of factors affecting the homeless. These programs and strategies are placed within broader government policies that prioritise funds to those most in need, and the transferring of services to the private and community sector (FaCS 1999 in Jerome et al. 2003).

The National Homelessness Strategy is directed specifically at preventing and reducing homelessness, and has four themes: prevention, early intervention, working together, and crisis transition and support. It builds on the Reconnect program, established by the Prime Ministerial Youth Homelessness Taskforce, to help reconnect young homeless people, and those at risk of homelessness, with their families and communities. It also builds on the Partnerships against Domestic Violence (PADV) program, launched in 1997 at a National Domestic Violence Summit.

National Homelessness Strategy

There are two broad strands to the National Homelessness Strategy (NHS), which was announced in May 2000 (FaCS 2003c). First, there are specific initiatives directed at building a knowledge base on homelessness. These include the Commonwealth Advisory Committee on Homelessness, the NHS Demonstration Projects, Partnerships against Domestic Violence and the Family Homelessness Prevention Pilots.

Second, the NHS operates in conjunction with various Commonwealth programs that provide services to the homeless and those at risk of homelessness. Information and learning derived from the demonstration projects and other research and evaluation, are fed back to ensure that the Commonwealth Department of Family and Community Services (FaCS) programs and policies meet the needs of the homeless.

One of the specific initiatives—the Demonstration Projects—has six priority areas:

- improving access for homeless people to the Job Network and Centrelink
- supporting families in housing stress
- developing a strategic direction to prevent Indigenous homelessness
- developing information and education tools for young people
- developing strategies to prevent people exiting institutional care from becoming homeless
- developing strategies to prevent young people who have been in care from becoming homeless.

A range of NHS Demonstration Projects target the youth sector (Box 9.4).

Box 9.4: NHS Youth Demonstration Projects

Waarvah Pierson Services (Qld)*: This project is targeting young people at risk of homelessness who have high truancy rates or contact with the Juvenile Justice System or care and protection system. The project will develop culturally appropriate homelessness prevention information through 12 months action research providing cultural field activities, support, community links and cultural networks.*

Preventing Centrelink Breaches *(Australian Federation of Homelessness Organisations): This project aims to reduce the number of young people being breached by Centrelink, to assist young people to understand the way income support services operate and the requirements they are expected to meet.*

Schools Research Project *(NFO CM Research): This project conducted research on information and education tools for 14–18 year olds about issues that may increase the risk of young people experiencing homelessness.*

Rooms for Rent—a CD *(St Vincent de Paul): This project, conducted by St Vincent de Paul in New South Wales, produced and distributed 4,000 copies of a CD that provides information on share house living to SAAP agencies, Job Placement and Employment Training providers, schools, youth services, and individual young people.*

Roofs for Youth *(Youth Affairs Council Western Australia): The Youth Affairs Council worked with real estate agents to develop strategies aiming to increase 16–21 year old independent young people's access to, and retention of, private rental properties.*

Young Offenders Support Program: *This project aimed to prevent youth homelessness by helping young people to make the transition from juvenile detention to family/community life by supporting them in addressing barriers that prevent their securing and maintaining stable housing.*

Partnerships against Domestic Violence program (PADV)

In the 1999–00 Budget, the Commonwealth provided a further $25 million over 4 years to continue Phase 2 of the PADV program (PM&C 2001). This funding, which took the Partnerships up to June 2003, had four fronts where action was being pursued. These included community education, work with perpetrators of domestic violence, Indigenous family violence and children at risk.

Phase 2 also saw the establishment of the Australian Domestic and Family Violence Clearinghouse. This provides a central point for the collection and dissemination of all Australian domestic and family violence policy, practice and research information, as well information on international efforts in these areas.

Family Homelessness Prevention Pilot (FHPP)

The FHPP was announced in the 2001 Federal Budget, with a commitment over a 3-year period of $5 million under the NHS (FaCS 2002). The program aims to pilot prevention and early intervention strategies for families at risk of homelessness. Eight services have been funded, from regions in each state and territory, for a period of approximately 2 years.

Centrelink and community agencies are working together to deliver and coordinate a diverse range of services for families who are identified as being at risk of homelessness. In addition, local Centrelink social workers will offer priority assistance to FHPP clients. The services are located at Belconnen (ACT), Wyong (NSW), Beenleigh (Qld), Salisbury—an Indigenous-specific service (SA), Mandurah (WA), Darwin/Palmerston (NT), Dandenong (Vic) and Launceston (Tas), and began operation in the second half of 2002.

Youth homelessness

Two Commonwealth programs specifically target homeless young people: Reconnect, and Job Placement and Employment Training (JPET). These multifaceted programs help young people start on pathways back to their families, their communities, education and employment. Early intervention programs such as the National Agenda for Early Childhood, the National Plan for Foster Care and the Family Relationships Services program are also, in part, youth homelessness prevention programs, providing better care and support for younger children and building more resilient families.

Reconnect

Reconnect is a community-based early intervention program for young people aged 12–18 years who are homeless or at risk of homelessness, and their families. The objective of the program is to improve the level of engagement of these young people with family, work, education, training and the community.

As at July 2003, there were 98 Reconnect services across Australia, including several remote Indigenous-specific services. When fully implemented, up to 100 Reconnect services will be operating, with approximately 7,000 young people and 5,000 parents being assisted per year.

Between December 1999, when Reconnect was established, and July 2003, support was provided to 25,5000 young people and/or their families. The Reconnect data indicate that, overall, around 73.4% of the clients who had consented to the collection of data had reported improvement in their situation at the end of the Reconnect support period (FaCS, pers. comm.).

An evaluation of the program is nearing completion and to date has found that Reconnect is emerging as a particularly effective program in relation to the government's policy objectives aimed at strengthening families and communities. In particular, the evaluation indicates that Reconnect is:

- demonstrating significant improvement in the relationships between young people and their families, helping to re-establish a sense of closeness and to reduce conflict;
- targeting its interventions effectively to prevent early home leaving, so that a significant number of young people return home after Reconnect intervention and/or have their living situations stabilised;
- positively impacting on young people's engagement with education and employment; and
- demonstrating effectiveness in building broader community capacity for early intervention in youth homelessness.

The evaluation has found that demand for Reconnect services is increasing and that services have sought to deal with this through strategies such as increased collaboration with other services or the provision of group programs. However, some Reconnect services have reported that they have had to tighten their eligibility criteria, leading to fears of a loss of responsiveness and flexibility. This will be explored further in the second round evaluation. The evaluation has also reported that there are currently some limitations in the data collection system that make it difficult to assess the extent to which Reconnect services are reaching families from culturally and linguistically diverse communities.

The final report on the program's evaluation is scheduled for release in September 2003. On the strength of the findings to date, the Reconnect program has been extended for a further 4 years to June 2007.

Job Placement and Employment Training (JPET)

The JPET program, administered by FaCS, aims to assist young people aged between 15 and 21 years who are homeless or at risk of becoming homeless. The objective is to enable young people to overcome personal and social barriers to engaging more fully in the life of their communities, and thereby achieve greater social and economic participation.

This objective is to be achieved through:

- provision of assistance that is contextually and culturally relevant;
- utilisation of service providers that are well integrated into local communities;

- flexible program delivery, especially to young people experiencing particular barriers to participation such as refugees, young people leaving care or juvenile justice and those who are geographically isolated;
- immediacy of access to assistance and support; and
- provision of holistic approaches to service delivery.

The program was established in 1996. In 2001–02, 136 agencies were funded, delivering services to 15,595 young people, within a program budget of $17.4 million. The program helped 5,600 young people enter employment and 4,373 with accommodation (FaCS 2003b). The funding for 2003–04 has been increased to $19.4 million.

The 2002 JPET tendering process was placed on hold in November 2002 following receipt of a significant amount of complaints from the sector, and subsequently discontinued in January 2003 in response to the findings of an independent review. In order to ensure program stability and continued access to services for JPET clients, the 135 existing JPET agencies were offered, and accepted, an extension of their funding until 30 June 2004. FaCS is currently developing a new needs analysis and selection process involving extensive consultation with the sector.

9.5 Some state and territory initiatives

South Australia

The South Australian Department of Human Services has developed a Service Coordinated Framework for Vulnerable Adults in the Inner City. Services funded under the framework include an assertive outreach team to assist homeless people in inner Adelaide who have mental health and substance abuse issues. Also funded under this initiative were a redevelopment of the Single Men's Crisis Accommodation and the establishment of a residential facility for women and men who require short-term stabilisation to assist in addressing problematic substance use.

Other initiatives underway in South Australia include:

- five early intervention pilot programs in two country and three suburban locations to prevent the eviction of families from their accommodation;
- a program aimed at young homeless people who have been sexually abused, with services including counselling for clients, and consulting and training for other SAAP services to assist them work with clients who have disclosed sexual abuse; and
- the funding of an Aboriginal component. In addition Karpendi, a service for homeless Aboriginal women which has a strong focus on childcare, health, social and recreational programs, was established.

Western Australia

In July 2001, the Western Australian Government established a taskforce to develop a homelessness strategy for the state. This taskforce reported in January 2002 (WA State Homelessness Taskforce 2002) after consultation with Indigenous, regional, metropolitan, government, non-government and community representatives. In May 2002, the government produced its response to the report (WA DHW 2002), to be followed by quarterly reports on the implementation of the homelessness strategy.

Victoria

In 2002, the Victorian Government introduced a comprehensive framework, the Victorian Homelessness Strategy, to deal with the homeless (Vic DHS 2002). This was developed in conjunction with the Women's Safety Strategy, the Victorian Youth Strategy, the Family and Domestic Violence Crisis Protection Framework, and the Victorian Housing Strategy, as well as with active contributions by the homeless. The report outlines the strategic directions for service delivery, including improving client focus and outcomes, prevention strategies and driving change in the homelessness sector.

Queensland

The state of Queensland is currently in the process of developing a homelessness strategy and has recognised the importance of improving responses to homelessness. Concurrently, Queensland commenced the development of a Queensland Aboriginal and Torres Strait Islander Homelessness Policy, devising strategies to respond to homelessness and public place dwelling in Cairns, Townsville and Mount Isa (Memmott et al. 2003).

Tasmania

Tasmania has recently implemented a Common Assessment Tool to enable clients to experience consistent assessment processes regardless of where they enter the SAAP system. This was part of a restructure of SAAP services aimed at leading to greater coordination and improved client outcomes, especially for clients who require complex service responses. As part of this restructure, specialised non-clinical staff with expertise in homelessness, mental health disorders, and alcohol and drug misuse have been appointed (SAAP National Coordination and Development Committee 2003).

Northern Territory

The Northern Territory has adopted a range of initiatives aimed at improving the service system so that it can optimally respond to the changing needs of clients. These include:

- case management and early intervention for accompanying children;
- a referral and assistance service for adult clients to access education and training;
- funding for an early intervention program to allow young pregnant women, or women with their first baby, access to affordable housing and to parenting and educational skills development; and
- the provision of a domestic violence outreach worker and children's case worker for women and children experiencing domestic violence (SAAP National Coordination and Development Committee 2003).

Australian Capital Territory

In June 2002, Australian Capital Territory Council of Social Service published the Final Report on the Needs Analysis of Homelessness in the Australian Capital Territory (ACT DECS 2002). The report aimed to identify and map the whole range of needs of homeless people in the Territory, without attempting to prioritise those needs. A range of recommendations arose from the report, including development of an Indigenous Homelessness Strategy and establishment of a Working Group on Older Persons Homelessness.

New South Wales

In 1999, the New South Wales Government established the 'Partnership Against Homelessness' to coordinate and improve a wide range of housing and support services for homeless people in New South Wales (NSW DoH 2001). The key aims of the Partnership, involving 10 state government agencies, are to help homeless people access services, to coordinate support services, to improve access to crisis accommodation, and to help those in crisis accommodation find and settle into secure, long-term housing. Several projects have been initiated to meet these aims.

At around the same time, planning for the 2000 Sydney Olympics was underway. Advocates for the homeless were aware that during such events the homeless are often forcibly removed from public spaces, and they began lobbying the government to find alternative solutions. The response was a Code of Conduct (Box 9.5) that recognised the right of all people to use public space.

The success of this approach can be measured by the 'pleasure and surprise' at the improved attitudes of the authorities which many homeless people reported (Vinson & Plant 2001). The Code of Conduct provides a case study in how a cooperative approach combined with education tactics can legitimise the access of the homeless to public spaces, even during high-profile events.

Box 9.5: Sydney Olympics Code of Conduct

The Sydney Olympic Games began on 15 September 2000. A Code of Conduct was negotiated by the New South Wales Olympic Coordination Authority prior to the 2000 Games with key government agencies, including the police, housing, community services and the City of Sydney as signatories. Importantly, the code recognised the right of all people to use public space, and provided guidelines to the police, private security employees and others for dealing with the homeless.

This protocol stated that the homeless were to be left alone unless they requested assistance, presented a security risk or were endangering themselves or others. Where assistance was requested, a specialised agency was available to be called in, and more than 200 extra beds were made available to ensure continuity of temporary accommodation service during the Olympics.

9.6 Summary

Community services, including the SAAP program, have an established role in Australia's social and economic system. SAAP is regularly evaluated against best-practice principles and has shown a steady growth since inception in recurrent allocation of funds (13% in real terms) as well as in the number of clients supported and support periods provided.

SAAP agencies provided services to approximately 146,300 people, including children, during 2001–02. Around 35% of clients (i.e. not including accompanying children) were between the ages of 15 and 24 and, overall, more females (53,300) than males (41,700) received services, although in the age groups over 45 years this finding was reversed.

Eighty-five per cent of SAAP clients were born in Australia, which includes the 17% of clients who identified as Indigenous. Overall, Indigenous Australians were over-represented as SAAP clients relative to their population size: less than 2% of Australians aged 10 years and over identify as Indigenous. Accommodation was the most common type of service provided to SAAP clients (in 76% of all support periods), followed by general support and advocacy (in 74%), with a lot of variation between client groups in the types of services received.

Insufficient accommodation was cited as the most common reason agencies turned away people looking for accommodation. For the first time, the exclusion practices of agencies can be reported, although these data are indicative only as just one state was investigated. It was found that many agencies had policies excluding people who had exhibited violent behaviour, those with substance abuse problems, or those with a mental illness. This may be influenced by duty of care obligations and by concerns that inappropriate placements can lead to poor outcomes all round, as well as by a lack of specialist care resources.

Both the Commonwealth and state and territory governments have a number of initiatives underway to improve service provision, especially to those homeless people whose needs require a high level and complexity of service provision. Intersectoral and collaborative approaches are being implemented at a number of levels by both government and non-government organisations, and homelessness taskforces have been, or are being, established by both the Commonwealth and some of the states and territories. Meanwhile, the SAAP program continues to improve the services provided to those in crisis or with inadequate access to safe and secure housing, with the aim of providing a transition to independence for its clients.

There continues to be ongoing debate concerning whether the use of the SAAP definition restricts the number of people eligible for SAAP assistance, as those who do not want to be housed or returned to the mainstream may be excluded (Coleman 2000). An interesting parallel here, suggested by Memmott, is to 'the expectations of Aboriginal assimilation policies of the 1950s and 1960s' (Memmott et al 2003:16), though this is contentious. In sympathy with this view is the recent literature which stresses the need that homeless people have for social contact and purposive activity (Robinson 2001).

It is possible that historically SAAP has placed too much emphasis on accommodation. However, SAAP data show that many clients are provided with services other than accommodation and there are SAAP agencies providing educational or employment-related activities, building self-esteem and the confidence to re-integrate into the community. There is also evidence of a growth in outreach and support models that do not rely on accommodation.

Coleman (2002) also claimed that the limitations of current definitions are strongly connected to a continual failure to clarify the meaning of 'home'. This has been explored both for Indigenous Australians and for those who call public places home, for whom sleeping rough has ceased to be a crisis event and become an accepted way of life. The legitimacy or otherwise of this choice has been shown to play a major role in the daily lives of such people.

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Appendix tables

Chapter 2 Indicators of Australia's welfare

OECD financial year

For the majority of countries, the year of reporting in the OECD social expenditure database is the calendar year. Australia, Canada, Japan, New Zealand, the United Kingdom and the United States are the exceptions to this rule. Box A2.1 shows the concept of 'year' for member countries, using the 1997 OECD year as an example.

Box A2.1: OECD member countries: periods relating to OECD year 1997

Country	*Financial year*	*Country*	*Financial year*
Australia	*1 Jul 1997 to 30 Jun 1998*	*Korea*	*1 Jan 1997 to 31 Dec 1997*
Austria	*1 Jan 1997 to 31 Dec 1997*	*Luxembourg*	*1 Jan 1997 to 31 Dec 1997*
Belgium	*1 Jan 1997 to 31 Dec 1997*	*Mexico*	*1 Jan 1997 to 31 Dec 1997*
Canada	*1 Apr 1997 to 31 Mar 1998*	*Netherlands*	*1 Jan 1997 to 31 Dec 1997*
Czech Rep.	*1 Jan 1997 to 31 Dec 1997*	*New Zealand*	*1 Jul 1997 to 30 Jun 1998*
Denmark	*1 Jan 1997 to 31 Dec 1997*	*Norway*	*1 Jan 1997 to 31 Dec 1997*
Finland	*1 Jan 1997 to 31 Dec 1997*	*Poland*	*1 Jan 1997 to 31 Dec 1997*
France	*1 Jan 1997 to 31 Dec 1997*	*Portugal*	*1 Jan 1997 to 31 Dec 1997*
Germany	*1 Jan 1997 to 31 Dec 1997*	*Spain*	*1 Jan 1997 to 31 Dec 1997*
Greece	*1 Jan 1997 to 31 Dec 1997*	*Sweden*	*1 Jan 1997 to 31 Dec 1997*
Iceland	*1 Jan 1997 to 31 Dec 1997*	*Switzerland*	*1 Jan 1997 to 31 Dec 1997*
Ireland	*1 Jan 1997 to 31 Dec 1997*	*Turkey*	*1 Jan 1997 to 31 Dec 1997*
Italy	*1 Jan 1997 to 31 Dec 1997*	*UK*	*1 Apr 1997 to 31 Mar 1998*
Japan	*1 Apr 1997 to 31 Mar 1998*	*USA*	*1 Oct 1996 to 30 Sep 1997*

Table A2.1: Injury and poisoning deaths, by age, sex, and type of injury, 2000 (number and rate per 100,000 population)

	Transport		Poisoning		Falls		Suicide		Homicide		All injuries/poisoning	
Age	**No.**	**/100,000**	**No.**	**/100,000**	**No.**	**/100,000**	**No.**	**/100,000**	**No.**	**/100,000**	**No.**	**/100,000**
Males												
0–4	20	3.05	2	0.30	2	0.30	0	0.00	8	1.22	104	15.86
5–14	62	4.50	4	0.29	3	0.22	7	0.51	7	0.51	111	8.06
15–19	195	28.77	22	3.25	5	0.74	89	13.13	16	2.36	358	52.82
20–29	366	26.57	208	15.10	26	1.89	410	29.76	44	3.19	1,159	84.14
30–44	353	16.22	257	11.81	36	1.65	685	31.47	67	3.08	1,588	72.96
45–64	274	12.50	61	2.78	71	3.24	438	19.98	48	2.19	1,067	48.66
65+	189	18.04	21	2.00	438	41.81	234	22.33	14	1.34	1,128	107.66
Total males	*1,459*	*15.35*	*575*	*6.05*	*581*	*6.11*	*1,863*	*19.61*	*204*	*2.15*	*5,515*	*58.04*
Females												
0–4	20	3.21	3	0.48	3	0.48	0	0.00	5	0.80	66	10.59
5–14	27	2.06	3	0.23	4	0.31	1	0.08	6	0.46	51	3.89
15–19	77	11.86	14	2.16	1	0.15	41	6.31	9	1.39	146	22.48
20–29	103	7.56	56	4.11	4	0.29	91	6.68	29	2.13	309	22.67
30–44	101	4.58	95	4.31	8	0.36	181	8.21	40	1.82	461	20.92
45–64	103	4.75	57	2.63	27	1.25	118	5.44	17	0.78	385	17.76
65+	125	9.39	19	1.43	735	55.20	71	5.33	10	0.75	1,162	87.26
Total females	*556*	*5.76*	*247*	*2.56*	*782*	*8.11*	*503*	*5.21*	*116*	*1.21*	*2,580*	*26.75*
Persons												
0–4	40	3.13	5	0.39	5	0.39	0	0.00	13	1.02	170	13.29
5–14	89	3.31	7	0.26	7	0.26	8	0.30	13	0.48	162	6.03
15–19	272	20.49	36	2.71	6	0.45	130	9.80	25	1.88	504	37.98
20–29	469	17.11	264	9.63	30	1.09	501	18.28	73	2.66	1,468	53.57
30–44	454	10.36	352	8.04	44	1.00	866	19.77	107	2.44	2,049	46.78
45–64	377	8.65	118	2.71	98	2.25	556	12.75	65	1.49	1,452	33.30
65+	314	13.20	40	1.68	1,173	49.30	305	12.82	24	1.01	2,290	96.25
Total	**2,015**	**10.52**	**822**	**4.29**	**1,363**	**7.12**	**2,366**	**12.36**	**320**	**1.68**	**(a)8,095**	**42.28**

Note: The 5 topics reported here do not include all injury deaths. Some categories such as burns, fire and scalds are not reported in the table but are included within the total injuries/poisoning category.

(a) Cases where sex was not reported (3) are not included in the table; the total of all injury/poisoning deaths was in fact 8,098.

Source: ABS mortality unit record data collection, 1979–2001 (unpublished data). AIHW National Injury Surveillance Unit processed, checked and combined the relevant data years to facilitate analysis.

Table A2.2: Injury and poisoning deaths per 100,000 population, by sex and type of injury, 1990–2000 (age-standardised)

	1990	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**
Males											
Transport	24.43	21.35	19.52	18.95	17.94	18.38	18.21	15.87	15.42	15.69	15.57
Poisoning	1.82	1.74	1.97	2.67	2.35	2.59	2.82	2.50	5.00	8.67	6.20
Falls	7.37	6.38	6.55	5.87	6.17	5.94	6.49	5.90	6.23	6.59	6.30
Suicide	20.73	21.74	21.08	19.35	20.72	20.87	21.32	23.45	23.14	21.50	19.83
Homicide	2.86	2.51	2.33	2.42	2.47	2.32	2.47	2.41	2.24	2.25	2.14
Total males	*68.37*	*64.82*	*62.00*	*59.11*	*58.91*	*58.77*	*61.17*	*59.78*	*61.35*	*63.27*	*58.44*
Females											
Transport	9.15	8.03	8.00	6.85	6.97	7.41	6.15	6.23	5.71	5.90	5.72
Poisoning	0.76	0.66	0.75	1.17	1.24	1.08	1.00	1.35	1.58	3.04	2.57
Falls	5.23	4.52	4.42	3.62	4.35	4.11	4.27	4.50	4.45	4.52	4.96
Suicide	4.92	5.86	5.32	4.35	4.67	5.38	4.91	6.09	5.56	5.24	5.32
Homicide	1.71	1.70	1.41	1.31	1.37	1.44	1.13	1.23	1.11	1.03	1.24
Total females	*25.74*	*24.93*	*23.87*	*20.49*	*21.26*	*22.60*	*20.55*	*22.32*	*21.70*	*22.82*	*22.97*
Persons											
Transport	16.67	14.62	13.69	12.83	12.37	12.80	12.10	11.01	10.54	10.73	10.60
Poisoning	1.29	1.2	1.35	1.92	1.8	1.84	1.9	1.93	3.29	5.86	4.39
Falls	6.17	5.38	5.38	4.59	5.19	4.95	5.30	5.17	5.27	5.45	5.63
Suicide	12.69	13.65	13.08	11.71	12.57	13.00	12.98	14.64	14.27	13.36	12.26
Homicide	2.29	2.09	1.87	1.86	1.92	1.88	1.80	1.81	1.69	1.65	1.69
All injuries/poisoning	**46.66**	**44.56**	**42.60**	**39.40**	**39.73**	**40.36**	**40.51**	**40.75**	**41.27**	**42.73**	**40.46**

Notes

1. Changes observed between 1998 and 1999 are likely to be due, at least in part, to the transition from ICD-9 to ICD-10. Apparent changes in rates during the transition period should be interpreted with special caution particularly with respect to poisoning, falls and homicide categories.

   Transport: (ICD-9 E800–E848) (ICD-10 V01 to V99).

   Poisoning: (ICD-9 E850–E858, E860–E869) (ICD-10 X40–X49).

   Suicide: (ICD-9 E950–E959) (ICD-10 X60–X84).

   Falls: (ICD-9 E880–E888) (ICD-10 W00–W19; ICD-10 revised for comparability with ICD-9 E880–E888 W00–W19; or X59 and any Multiple Cause code S02, S12, S32, S42, S52, S62, S72, S82, S92, T02, or T14.2).

   Homicide: (ICD-9 E960–E978, E990–E999) (ICD-10 X85 to Y09).

2. The 5 topics reported here do not include all injury deaths. Some categories such as burns, fire and scalds are not in the table but are included within the total injuries/poisoning category.

Source: ABS mortality unit record data collection, 1979–2001 (unpublished data). AIHW National Injury Surveillance Unit processed, checked and combined the relevant data years to facilitate analysis.

Table A2.3: Australian family types,[(a)] Census night 2001

	Family type					
	Couple family with dependent children[(b)]	**Couple family with non-dependent children**	**Couple family without children**	**One-parent family**	**Other family**	**Total**
Number ('000)	1,904.1	417.0	1,764.2	762.6	88.9	4,936.8
Per cent	38.6	8.4	35.7	15.4	1.8	100.0

(a) As defined by the ABS.

(b) Couple families with dependent children comprise couple families with children under 15 years, couple families with dependent students, and couple families with children under 15 and dependent students.

Source: ABS 2002k.

Chapter 4 Welfare services resources

Table A4.1: Volunteer rates in community and welfare organisations, 1995 and 2000 (per cent)

	1995			2000		
	Males	**Females**	**Persons**	**Males**	**Females**	**Persons**
Age group (years)						
18–24	2.7	5.0	3.8	3.7	6.6	5.1
25–34	3.8	4.6	4.2	4.5	7.0	5.8
35–44	5.8	6.3	6.1	7.8	10.8	9.3
45–54	8.4	8.9	8.7	7.9	12.3	10.1
55–64	9.8	12.3	11.0	14.3	15.0	14.6
65–74	9.6	13.6	11.7	14.3	16.7	15.6
75+	7.0	8.2	7.7	8.4	9.4	9.0
Total	**6.1**	**7.7**	**6.9**	**8.0**	**10.7**	**9.4**
Employment status						
Employed full-time	5.8	5.5	5.7	7.4	8.4	7.7
Employed part-time	8.8	8.4	8.5	8.2	12.1	11.0
Unemployed	4.3	7.0	5.4	3.9	11.8	7.7
Not in labour force	6.5	8.7	7.9	10.2	11.4	10.9
Total	**6.1**	**7.7**	**6.9**	**8.0**	**10.7**	**9.4**

Sources: ABS 1996b, 2001d.

Table A4.2: Recurrent government expenditure on welfare services, 1992–93 to 2000–01 ($m in 2000–01 prices)

	Commonwealth	State/territory	Total
Family and child welfare services			
1992–93	698.8	875.8	1,574.6
1993–94	861.8	924.1	1,785.9
1994–95	1,074.7	994.0	2,068.6
1995–96	1,207.1	1,119.8	2,326.8
1996–97	1,262.3	1,188.2	2,450.5
1997–98	1,165.0	1,283.2	2,448.3
1998–99 (accrual)	1,219.0	1,540.6	2,759.6
1999–00 (accrual)	1,485.8	1,668.0	3,153.9
2000–01 (accrual)	1,405.1	1,679.4	3,084.5
Average annual growth rate			
1992–93 to 1997–98	10.8	7.9	9.2
1998–99 to 2000–01	7.4	4.4	5.7
Welfare services for older people			
1992–93	670.3	468.7	1,139.0
1993–94	909.3	400.4	1,309.7
1994–95	1,028.1	547.2	1,575.3
1995–96	1,016.7	622.0	1,638.8
1996–97	1,112.6	824.9	1,937.5
1997–98	1,253.6	1,004.1	2,257.7
1998–99 (accrual)	1,476.0	655.2	2,131.1
1999–00 (accrual)	1,471.7	687.1	2,158.8
2000–01 (accrual)	1,614.5	693.6	2,308.1
Average annual growth rate			
1992–93 to 1997–98	13.3	16.5	14.7
1998–99 to 2000–01	4.6	2.9	4.1
Welfare services for people with a disability			
1992–93	626.2	916.3	1,542.5
1993–94	677.2	1,035.6	1,712.8
1994–95	787.7	884.3	1,672.0
1995–96	808.6	887.3	1,695.9
1996–97	791.2	1,005.2	1,796.4
1997–98	796.0	1,166.8	1,962.8
1998–99 (accrual)	942.9	1,697.4	2,640.3
1999–00 (accrual)	945.0	1,858.1	2,803.2
2000–01 (accrual)	1,016.8	1,990.9	3,007.7
Average annual growth rate			
1992–93 to 1997–98	4.9	5.0	4.9
1998–99 to 2000–01	3.8	8.3	6.7

(continued)

Table A4.2 (continued): Recurrent government expenditure on welfare services, 1992–93 to 2000–01 ($m in 2000–01 prices)

	Commonwealth	State/territory	Total
Other welfare services			
1992–93	167.5	237.6	405.1
1993–94	176.6	240.9	417.4
1994–95	182.4	320.2	502.6
1995–96	224.5	314.6	539.0
1996–97	200.5	340.1	540.6
1997–98	194.7	401.2	595.9
1998–99 (accrual)	182.9	542.9	725.8
1999–00 (accrual)	217.6	612.3	829.9
2000–01 (accrual)	216.7	601.0	817.7
Average annual growth rate			
1992–93 to 1997–98	3.0	11.0	8.0
1998–99 to 2000–01	8.8	5.2	6.1
Total welfare services			
1992–93	2,163.0	2,498.3	4,661.3
1993–94	2,624.7	2,601.0	5,225.6
1994–95	3,072.9	2,745.6	5,818.5
1995–96	3,257.0	2,943.7	6,200.6
1996–97	3,366.7	3,358.4	6,725.1
1997–98	3,409.3	3,855.3	7,264.7
1998–99 (accrual)	3,820.8	4,436.1	8,256.9
1999–00 (accrual)	4,120.2	4,825.6	8,945.8
2000–01 (accrual)	4,253.1	4,965.0	9,218.1
Average annual growth rate			
1992–93 to 1997–98	9.5	9.1	9.3
1998–99 to 2000–01	5.5	5.8	5.7

Note: Totals may not add due to rounding.

Sources: Commonwealth—Compiled from DHHCS 1991, 1992; DHHLGCS 1993; DHSH 1995a, 1995b; DHFS 1996, 1997, 1998; DHAC 1999, 2000; DHRD 1994, 1995; FACS 1999, 2000; Department of Immigration and Ethnic Affairs unpublished data; Department of Veterans' Affairs unpublished data; State/territory—Recurrent expenditure—CGC unpublished data.

Chapter 5 Assistance for housing

Table A5.1: Real government expenditure on CSHA assistance, CRA and rent rebates, 1990–91 to 2000–01 ($m)

	CSHA		CRA		Rent rebates		
	Current prices	**Constant prices 1999–00**	**Current prices**	**Constant prices 1999–00**	**Current prices**	**Constant prices 1999–00**	**1999–00 Deflator**
1990–91	1,322.9	1,505.0	740.0	841.9	794.5	903.9	87.9%
1991–92	1,409.0	1,572.5	907.0	1,012.3	882.9	985.4	89.6%
1992–93	1,485.4	1,639.5	1,199.0	1,323.4	773.2	853.4	90.6%
1993–94	1,419.6	1,549.8	1,401.0	1,529.5	857.0	935.6	91.6%
1994–95	1,509.6	1,625.0	1,453.0	1,564.0	1,063.5	1,144.8	92.9%
1995–96	1,489.8	1,568.2	1,552.0	1,633.7	1,208.8	1,272.4	95.0%
1996–97	1,353.4	1,401.0	1,647.0	1,705.0	1,219.9	1,262.8	96.6%
1997–98	1,207.4	1,234.6	1,484.0	1,517.4	1,205.6	1,232.7	97.8%
1998–99	1,276.6	1,301.3	1,505.0	1,534.1	1,232.8	1,256.7	98.1%
1999–00	1,331.0	1,331.0	1,538.0	1,538.0	1,175.2	1,175.2	100.0%
2000–01	1,406.5	1,342.1	1,717.0	1,638.4	1,268.8	1,210.7	104.8%

Notes

1. Constant dollar values were calculated using 1999–00 GDP deflators.
2. Care should be taken in interpreting data as CRA is a demand-driven recurrent expenditure program, whereas CSHA expenditure includes a component for capital investment that has resulted in approximately $30 billion of public housing assets that are continually used for housing assistance.
3. Market rent is a notional value, and there is a variation across jurisdictions.
4. 1999–00 rebate value excludes NT.
5. The rent rebate figures since 1999–00 are collected through the financial statements for which the method used is different from previous years, as stated in the Housing Assistance ACT annual report.
6. Data on CSHA expenditure include all housing expenditure under the CSHA. However, public housing and community housing account for the majority of CSHA funding.

Source: AIHW 2003i.

Table A5.2: Financial hardship of renters, 1998–99

Financial position	Public tenants	Private tenants—bottom two quintiles	All households
Living standard worse than 2 years ago	36.9	38.3	27.0
Spend more money than we get	21.9	25.2	14.6
Able to save most weeks	14.1	8.3	32.7
Can't afford a holiday	57.8	55.2	27.4
Can't afford to have friends and family over for a meal	15.6	16.0	5.3
Buy secondhand clothes—cant afford new ones	35.9	35.3	11.7
Could not afford $2,000 in an emergency	68.3	53.0	19.3
Could not pay utilities	38.9	45.1	16.1
Went without a meal	8.3	13.2	2.7
Could not pay insurance/registration	12.0	18.1	6.5
Had to pawn or sell items	12.6	18.0	4.3
Sought assistance from welfare agencies	15.8	15.0	3.5
Could not afford to heat home	7.4	10.0	2.3
Proportion of households with one or more members with a health or disability problem	75.0	54.5	51.3

Source: Burke and Ralston 2003.

Table A5.3: Proportion of households below second quintile, 1988–89 to 1998–99

Tenure	1988–89	1993–94	1998–99
Owner	47.4	47.7	49.4
Purchaser	26.2	24.6	25.2
Renting, public	67.8	69.2	72.4
Renting, private	35.1	35.8	36.9
Total	**39.9**	**40.3**	**40.4**

Source: Burke & Ralston 2003.

Table A5.4: Income units having ongoing entitlement to and receiving CRA, June 2002

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust.
Single sharer	46,539	34,487	34,972	13,080	7,970	2,730	2,100	953	142,831
Single, no children	116,038	81,210	83,806	34,160	27,390	9,699	2,612	2,230	357,145
Sole parent, 1 or 2 children	57,606	33,630	44,095	16,766	12,797	4,213	1,249	1,105	171,461
Sole parent, 3 or more children	11,081	5,923	8,925	2,913	2,077	791	188	199	32,097
Partnered, no children	26,260	14,516	19,325	6,149	4,273	1,675	391	276	73,865
Partnered, 1 or 2 children	34,166	17805	24,742	7,495	5,416	1,941	779	523	92,867
Partnered, 3 or more children	13,708	6,653	11,591	2,925	2,069	815	306	258	38,325
Couple, no children, either temporarily separated or separated due to illness	406	297	396	147	172	33	(a)	(a)	1,471
Total CRA income units	**23.5**	**19.9**	**29.1**	**22.7**	**17.8**	**18.1**	**17.8**	**14.7**	**22.9**
Total Centrelink income units	**1,299,041**	**975,392**	**781,877**	**367,994**	**349,786**	**120,943**	**42,923**	**37,826**	**3,975,782**

(a) Not published.

Source: AIHW 2003a.

Table A5.5: Indigenous status of income units having entitlement to and receiving CRA, June 2002 (per cent)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust.
Indigenous	2.3	0.6	3.2	2.4	1.3	2.7	1.1	15.3	2.2
Non-Indigenous	97.7	99.4	96.8	97.6	98.7	97.3	98.9	84.7	97.8
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**305,804**	**194,521**	**227,852**	**83,635**	**62,164**	**21,897**	**7,631**	**5,558**	**909,062**

Source: AIHW 2003a.

Table A5.6: CRA income units: primary payment type for principal client, June 2002

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust.
					Number				
Age Pension	51,076	33,377	35,633	13,365	10,710	3,136	780	451	148,528
Carer Payment	3,511	2,095	2,519	576	518	244	40	35	9,538
Disability Support Pension	51,911	34,032	38,252	13,085	11,165	3,927	962	924	154,258
Family Tax Benefit only	30,218	15,821	22,545	6,144	4,460	1,309	999	693	82,189
Newstart Allowance	63,932	42,806	48,745	20,194	13,572	4,825	1,453	1,637	197,164
Parenting Payment (couple)	8,748	4,430	6,266	1,983	1,362	490	171	100	23,550
Parenting Payment (single)	60,026	34,614	46,371	17,628	13,055	4,387	1,126	1,046	178,253
Widow Allowance	3,619	2,424	2,645	828	602	184	37	32	10,371
Youth Allowance	25,388	20,817	21,555	8,531	5,737	3,138	1,933	580	87,679
Other payments	7,375	4,105	3,321	1,301	983	257	130	60	17,532
Total	**305,804**	**194,521**	**227,852**	**83,635**	**62,164**	**21,897**	**7,631**	**5,558**	**909,062**
					Per cent				
Age Pension	16.7	17.2	15.6	16.0	17.2	14.3	10.2	8.1	16.3
Carer Payment	1.1	1.1	1.1	0.7	0.8	1.1	0.5	0.6	1.0
Disability Support Pension	17.0	17.5	16.8	15.6	18.0	17.9	12.6	16.6	17.0
Family Tax Benefit only	9.9	8.1	9.9	7.3	7.2	6.0	13.1	12.5	9.0
Newstart Allowance	20.9	22.0	21.4	24.1	21.8	22.0	19.0	29.5	21.7
Parenting Payment (couple)	2.9	2.3	2.8	2.4	2.2	2.2	2.2	1.8	2.6
Parenting Payment (single)	19.6	17.8	20.4	21.1	21.0	20.0	14.8	18.8	19.6
Widow Allowance	1.2	1.2	1.2	1.0	1.0	0.8	0.5	0.6	1.1
Youth Allowance	8.3	10.7	9.5	10.2	9.2	14.3	25.3	10.4	9.6
Other payments	2.4	2.1	1.5	1.6	1.6	1.2	1.7	1.1	1.9
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Source: AIHW 2003a.

Table A5.7: Income units: affordability with and without CRA, June 2002.

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust.
Without CRA									
0–30% of income paid in rent	83,104	57,784	72,903	27,105	22,249	8,230	2,165	1,545	275,085
>30–50% of income paid in rent	125,741	81,870	97,218	35,934	24,963	9,430	2,899	2,224	380,279
>50% of income paid in rent	96,928	54,853	57,706	20,587	14,949	4,231	2,567	1,789	253,610
Total	**305,773**	**194,507**	**227,827**	**83,626**	**62,161**	**21,891**	**7,631**	**5,558**	**908,974**
With CRA									
0–30% of income paid in rent	183,158	127,456	155,219	58,820	44,451	17,023	4,300	3,391	593,818
>30–50% of income paid in rent	85,919	49,082	56,076	19,413	13925	3,992	2,381	1,621	232,409
>50% of income paid in rent	36,696	17,969	16,532	5,393	3,785	876	950	546	82,747
Total	**305,773**	**194,507**	**227,827**	**83,626**	**62,161**	**21,891**	**7,631**	**5,558**	**908,974**

Source: AIHW 2003a.

Table A5.8: Type of housing tenure, 1999 (per cent)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT[(a)]	Aust.
Owner without a mortgage	40.6	42.5	34.8	34.3	38.1	40.5	30.7	16.2	38.8
Owner with a mortgage	29.0	32.2	32.7	33.6	30.9	30.1	37.4	29.4	31.3
Public renter	5.3	3.8	3.4	4.5	10.7	5.9	10.1	13.2	5.1
Private landlord renter	21.9	17.3	23.7	21.4	14.6	18.4	17.8	21.5	20.3

(a) Estimates for the NT relate to mainly urban areas only.

Note: Components for each state/territory do not total 100% because other renters (paying rent to the manager of a caravan park, an employer, a housing cooperative, or a church or community group), as well as other types of tenure (rent-free and others), are not included.

Source: ABS 2003a.

Table A5.9: Total number of public housing dwellings at 30 June, 1995–96 to 2001–02

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust.
Data reported prior to 1999 CSHA and NHDA									
1995–96	135,744	62,224	47,618	33,132	58,236	14,813	12,171	8,196	372,134
1996–97	133,714	62,014	49,306	32,839	56,695	14,913	11,945	7,914	369,340
1997–98	124,516	63,860	49,753	33,335	55,319	14,775	12,209	8,023	361,790
1998–99	125,083	67,423	50,273	32,926	54,041	13,590	11,791	7,320	362,447
Data reported under the 1999 CSHA and NHDA									
1999–00	127,513	65,996	50,662	32,697	53,485	13,405	11,758	7,451	362,967
2000–01	128,215	65,310	50,666	32,645	51,760	13,178	11,510	6,038	359,322
2001–02	127,754	64,656	50,157	32,551	49,134	12,656	11,154	6,062	354,124

Note: Excludes the Aboriginal Rental Housing Program (state/territory owned and managed Indigenous housing).

Sources: AIHW 1996, 1999, 1998, 1999, 2000, 2001c, 2003g.

Table A5.10: Housing outcomes for public housing tenants, 2001 (per cent)

	Manage money better	Feel more settled	Able to stay in area	More able to cope	Part of local community	Better access to services	Enjoy better health	Better job situation	Start education/ training
Applicable	91	91	87	87	81	80	76	41	40
Achieved[(a)]	91	90	90	88	74	80	67	35	50

(a) The percentage achieved is of those who said it was applicable.

Note: Excludes the Aboriginal Rental Housing Program (state/territory owned and managed Indigenous housing).

Source: NFO Donovan Research 2001.

Table A5.11: Composition of public rental households, including the Aboriginal Rental Housing Program (state/territory owned and managed Indigenous housing), 30 June 2002

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust.
Single income unit household									
Single person	57,029	28,564	20,602	15,583	26,369	5,861	1,979	4,685	160,672
Couple only	12,450	5,347	4,188	3,409	5,528	1,199	433	987	33,541
Single parent with dependent	22,656	12,875	10,727	6,174	6,046	2,506	1,286	2,248	64,518
Couple with dependent	7,320	3,664	4,655	2,415	2,406	984	612	908	22,964
All single income unit households	*100,240*	*50,504*	*40,192*	*27,582*	*40,587*	*10,605*	*8,860*	*4,414*	*282,984*
Group household (only single income units shared)	12,118	5,965	4,697	2,622	3,903	801	427	942	31,475
Multiple income unit household (other shared)	15,740	6,929	6,592	2,756	3,502	1,009	783	1,206	38,517
Other/ Unknown / missing	1,875	200	59	84	238	62	104	32	2,654
Total all households	**129,188**	**63,544**	**51,520**	**33,043**	**47,992**	**12,422**	**5,624**	**11,008**	**354,341**

Source: AIHW analysis of NHDA Public housing and ARHP STOMIH NMDS.

Table A5.12: Number of CSHA public and community housing dwellings, 30 June 2002

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust.
Community housing dwellings	9,180	7,710	3,967	2,099	3,439	227	434	122	27,178
Public housing dwellings	127,754	64,656	50,157	32,551	49,134	12,656	11,154	6,062	354,124
Total	**136,934**	**72,366**	**54,124**	**34,650**	**52,573**	**12,883**	**11,588**	**6,184**	**381,302**

Note: Excludes the Aboriginal Rental Housing Program (state/territory owned and managed Indigenous housing).

Source: AIHW 2003c, 2003g.

Table A5.13: Housing outcomes for community housing tenants, 2002 (per cent)

	Feel more settled	Manage money better	Supported by organisation	Able to stay in area	Part of local community	Enjoy better health	Grow in confidence	Better access to services	Start education/ training	Better job situation
Applicable	92	89	89	88	83	83	82	80	51	51
Achieved[(a)]	93	87	82	91	73	71	80	77	59	44

(a) The percentage achieved is of those who said it was applicable.

Source: NFO Donovan Research 2002.

Table A5.14: Tenant's level of satisfaction with community housing, 2002 (per cent)

	Very satisfied	Satisfied	Dissatisfied
Age			
15–34	32	41	15
35–44	41	36	12
45–64	41	41	8
65+	47	34	6
Dwelling type			
Separate	39	40	11
Attached	45	34	7
Unit	40	37	10
Shared/rooming	34	35	16
Indigenous status			
Indigenous	23	61	8
Non-Indigenous	40	38	10

Source: NFO Donovan Research 2002.

Chapter 6 Children's and family services

Table A6.1: Estimated number of children aged 0–17 years, 30 June 2002 ('000)

Age (years)	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust.
0–4	431.3	306.5	247.5	125.3	90.6	30.7	20.6	17.6	1,270.2
5–12	727.1	524.4	427.0	217.9	158.7	53.5	35.3	27.1	2,171.1
13–17	450.9	327.4	264.0	142.0	102.3	34.5	22.9	15.1	1,358.9
Total 0–17	**1,609.4**	**1,158.3**	**938.5**	**485.2**	**351.6**	**118.7**	**78.8**	**59.9**	**4,800.3**
Total population	6,640.4	4,872.6	3,707.2	1,927.3	1,520.2	472.7	321.8	198.0	19,660.2
Children aged 0–17 as a percentage of total population	24	24	25	25	23	25	25	30	24

Source: ABS 2003c.

Table A6.2: Families with both parents or a sole parent in the labour force, June 2002 ('000)

Age of youngest child (years)	Both parents (or a sole parent in labour force)	Total families	Per cent of total families
Couple families			
0–4	398.1	804.9	49.5
5–9	324.7	480.0	67.6
10–14	311.6	420.2	74.2
One-parent families			
0–4	70.9	172.8	41.0
5–9	100.9	173.3	58.2
10–14	107.6	162.2	66.3

Note: The labour force includes people who are employed and people who are not employed but are actively looking for work.

Source: ABS 2002b.

Table A6.3: Labour force status and hours worked by employed mothers, August 2001 (per cent)

	Employed				
Age of youngest child (years)	25 or more hours	1–24 hours	0 hours	Unemployed	Not in labour force
0	10.4	14.9	7.6	2.6	64.5
1	19.0	23.8	2.0	3.7	51.4
2	22.4	24.2	2.0	4.1	47.4
3	25.2	24.1	1.9	4.3	44.4
4	26.9	24.5	1.9	4.5	42.1
5	30.2	24.7	1.8	5.2	38.1
6	33.3	25.5	1.8	5.2	34.2

Note: Mothers working '0' hours were in paid employment but did not work during the census week (e.g. maternity leave).

Source: ABS 2001b.

Table A6.4: Children under 12 years in child care, 1993 and 2002 ('000)

Type of care	June 1993	June 2002
	0–4 years	
Formal only	245.9	343.0
Both	193.3	209.4
Informal only	341.7	246.6
Total	**780.9**	**799.0**
	5–11 years	
Formal only	92.8	148.3
Both	64.2	86.7
Informal only	567.0	476.5
Total	**724.0**	**711.5**

Source: ABS 2003b.

Table A6.5: Children aged under 12 years in childcare by type of care, 2002 (per cent)

	Age of child (years)								
Type of care	**Under 1**	**1**	**2**	**3**	**4**	**5**	**6–8**	**9–11**	**Total**
Formal only	12	28	39	49	61	35	21	14	33
Both	8	20	24	33	33	22	12	8	20
Informal only	79	53	37	18	6	43	68	78	48
Total children in care	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Total number ('000)	82.0	140.9	162.3	192.0	221.7	128.1	320.2	263.2	1,510.5

Source: ABS 2003b.

Table A6.6: Number of Commonwealth-supported service providers, by type of service, 30 June 1991–2001

	Long day care centres						
Year	**Community-based[(a)]**	**Private-for-profit**	**Employer/ other non-profit centres**	**Family day care[(c)]**	**Outside school hours care[(d)]**	**Occasional care/other[(e)]**	**Total**
1991	984	1,030	(b)	327	1,304	327	3,972
1992	990	1,295	(b)	342	1,414	497	4,538
1993	1,048	1,369	193	354	1,528	537	5,029
1994	1,061	1,705	249	363	2,494	619	6,491
1995	1,094	2,058	274	370	2,617	653	7,066
1996	1,112	2,456	292	366	3,055	651	7,932
1997	1,122	2,658	306	381	3,544	655	8,666
1998	1,118	2,757	295	360	3,958	648	9,136
1999	1,089	2,639	285	331	4,496	677	9,517
2000	1,093	2,646	273	372	4,706	655	9,745
2001	1,348	2,725	(b)	408	5,407	162	10,050

(a) From 2001 community-based ownership includes services operated by community-based groups, religious organisations, charities, local governments, and by or in state government premises.

(b) 'Employer and other non-profit centres' are included in 'Private-for-profit long day care centres' in 1991 and 1992. However, from 2001, with the introduction of the Childcare Operator System data from the 'employer' category was recoded according to ownership status to either community-based or private-for-profit.

(c) Family day care coordination units. Also includes family day care schemes offering in-home care, and stand-alone in-home services.

(d) From 1993 includes vacation care services funded under Year-Round Care.

(e) From 1993 to 1997 includes occasional care centres, neighbourhood model services, multifunctional Aboriginal children's services, and multifunctional services. After 1997 excludes neighbourhood model services.

Source: FaCS 2003b.

Table A6.7: Number of Commonwealth-supported places, by type of service, 30 June 1991–2001

	Long day care centres						
	Community-based[(a)]	Private-for-profit	Employer/ other non-profit centres	Family day care[(c)]	Outside school hours care[(d)]	Occasional care/other[(e)]	Total
1991	39,567	36,700	(b)	42,501	44,449	5,059	168,276
1992	40,262	53,210	(b)	45,454	48,222	5,634	192,782
1993	42,777	53,920	7,455	47,855	50,340	5,626	207,973
1994	43,399	70,587	9,787	51,651	59,840	6,228	241,492
1995	44,566	88,614	11,295	54,041	64,046	6,365	268,927
1996	45,601	109,691	12,771	60,091	71,846	6,575	306,575
1997	46,294	121,559	15,012	62,714	78,970	6,564	331,113
1998	51,710	129,671	13,173	63,725	134,354	6,711	399,355
1999	50,589	127,128	12,609	64,037	160,955	6,722	422,040
2000	50,368	128,415	12,132	66,294	179,743	6,492	443,444
2001	61,248	132,561	(b)	70,840	230,511	4,874	500,034

(a) From 2001 community-based ownership includes services operated by community-based groups, religious organisations, charities, local governments, and by or in state government premises.

(b) 'Employer and other non-profit centres' are included in 'Private-for-profit long day care centres' in 1991 and 1992. In 2001, with the introduction of the Childcare Operator System, data from the 'employer' category was recoded according to ownership status to either community-based or private-for-profit.

(c) Family day care coordination units. Also includes family day care schemes offering in-home care, and stand-alone in-home services.

(d) The large increase in outside school hours care places between June 1997 and June 1998 is due to the inclusion for the first time of vacation care places previously funded under block grant arrangements and change to a consistent counting methodology.

(e) From 1993 to 1997 includes occasional care centres, neighbourhood model services, multifunctional Aboriginal children's services, and multifunctional services. After 1997 excludes neighbourhood model services.

Source: FaCS 2003b.

Table A6.8: Percentage of children using Commonwealth-approved services who are in care for work-related reasons, 2002

Type of service	Per cent
Long day care centres	84
Family day care	86
Before and after school care	96
Vacation care	93
Occasional care	49
Multifunctionals[(a)]	83

(a) Includes multifunctional children's services, multifunctional Aboriginal children's services and in-home care services.

Source: FaCS 2003b.

Table A6.9: Qualifications and training of workers in Commonwealth-supported child care services, by type of service, 2002 (per cent)

	Level of qualifications					In-service training in last 12 months		
Type of service	Has qualifications	Studying for qualifications	3+ years' experience	None of these	Total	Training undertaken	No training	Total
Long day care centres	55	16	14	16	100	71	29	100
Community-based	55	13	17	15	100	71	29	100
Private-for-profit	54	18	11	16	100	72	28	100
Family day care coordination unit staff	70	5	15	10	100	86	14	100
Family day care providers	26	5	37	32	100	80	20	100
Before/after school care	37	23	15	25	100	60	40	100
Vacation care	39	24	13	24	100	*	*	*
Occasional care/other[(a)]	47	14	18	19	100	67	33	100

*Vacation care does not report on in-service training undertaken by staff.

(a) Includes occasional care centres, multifunctional Aboriginal children's services, multifunctional children's services and In-home care services.

Notes

1. Double-counting may occur for workers in before/after school care and vacation care services.
2. Each worker has been counted once for level of qualifications and once for in service training. However, a 'qualified worker' may also be studying for a qualification and/or have 3 or more years' experience.
3. These data are weighted (adjusted for agency non-response).
4. Workers include paid and unpaid workers.
5. Some rows may add to less than or greater than 100 due to rounding.

Source: FaCS 2003b.

Table A6.10: Number of child protection notifications, investigations and substantiations, 1997–98 to 2001–02

	1997–98	1998–99[(a)]	1999–00	2000–01	2001–02
Notifications	98,568	103,980	107,134	115,471	137,938
Investigations	61,452	58,717	56,083	66,265	80,371
Substantiations	26,025	25,447	24,732	27,367	30,473

(a) An estimate using 6 months of data for the Northern Territory was used to form the national total for 1998–99.

Source: AIHW 2003.

Table A6.11: Number of children aged 0–17 years on care and protection orders, 1998–2002

At 30 June	NSW[(a)]	Vic	Qld	WA	SA	Tas	ACT	NT	Total
1998	5,987	4,215	3,433	799	1,102	520	255	138	16,449
1999	6,948	4,358	3,609	1,019	1,024	440	236	177	17,811
2000	7,661	4,752	3,612	1,105	1,210	470	232	220	19,262
2001	8,105	4,782	3,573	1,320	1,260	453	219	205	19,917
2002	8,229	4,975	3,765	1,384	1,286	463	261	194	20,557

(a) Data for NSW do not include children on supervisory orders.

Source: AIHW 2003.

Table A6.12: Aboriginal and Torres Strait Islander children in out-of-home care, by Indigenous status of carer, at 30 June 2002

Relationship	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
					Number				
Indigenous relative/kin	1,212	87	173	246	42	5	5	22	1,805
Other Indigenous caregiver	339	100	194	87	112	2	12	54	887
Non-Indigenous relative/kin	279	64	115	34	13	6	2	n.a. (a)	513
Indigenous residential care	9	20	10	38	—	—	1	—	78
Total in accordance with the Aboriginal Child Placement Principle	*1,839*	*271*	*492*	*405*	*167*	*13*	*20*	*76*	*3,283*
Other non-Indigenous caregiver	215	176	214	75	62	8	7	21	778
Non-Indigenous residential care	29	42	2	26	3	8	—	6	116
Total not placed in accordance with the Aboriginal Child Placement Principle	*244*	*218*	*216*	*101*	*65*	*16*	*7*	*27*	*894*
Total	**2,083**	**489**	**708**	**506**	**232**	**29**	**27**	**103**	**4,177**
					Per cent				
Indigenous relative/kin	58	20	24	49	18	17	19	21	43
Other Indigenous caregiver	16	18	27	17	48	7	44	52	21
Non-Indigenous relative/kin	13	13	16	7	6	21	7	n.a. (a)	12
Indigenous residential care	—	4	1	8	—	—	4	—	2
Total in accordance with the Aboriginal Child Placement Principle	*88*	*55*	*69*	*80*	*72*	*45*	*74*	*74*	*79*
Other non-Indigenous caregiver	10	36	30	15	27	28	26	20	19
Non-Indigenous residential care	1	9	—	5	1	28	—	6	3
Total not placed in accordance with the Aboriginal Child Placement Principle	*12*	*45*	*31*	*20*	*28*	*55*	*26*	*26*	*21*
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

(a) The relationship of the caregiver to children placed with non-Indigenous caregivers was not available and these children were placed in the 'other' category.

Note: This table does not include Indigenous children who were living independently or whose living arrangements were unknown.

Source: AIHW 2003.

Chapter 7 Ageing and aged care

Table A7.1: Population aged 65 and over, and number with a severe or profound core activity restriction, 2001 and 2021 (projected)

	Total population aged 65 and over		Estimated population aged 65 and over with a severe or profound core activity restriction	
Sex/age	**2001**	**2021**	**2001**	**2021**
Males				
65–69	335,600	630,400	26,400	49,700
70–74	303,600	554,100	35,900	65,500
75–79	227,400	377,000	42,500	70,400
80–84	128,300	231,400	31,300	56,500
85+	81,900	177,800	46,000	99,800
Total	*1,076,700*	*1,970,700*	*182,100*	*341,900*
Females				
65–69	346,900	657,300	31,400	59,400
70–74	334,800	585,900	50,300	88,000
75–79	292,000	418,700	72,800	104,400
80–84	201,800	287,000	71,600	101,800
85+	183,300	300,800	126,300	207,300
Total	*1,358,900*	*2,249,800*	*352,400*	*561,000*

Note: Population estimates by disability status are obtained using age/sex disability rates from the ABS 1998 Survey of Disability, Ageing and Carers in conjunction with the estimated resident population.

Sources: ABS 2000, projected estimated resident population series q; ABS 2003a; AIHW analysis of ABS 1998 Survey of Disability, Ageing and Carers.

Table A7.2: Relationship of older people to others in households, 2001[(a)] (per cent)

	Age group (years)			
	65–74	75+	All	Number
Males				
Husband/wife/partner	78.1	68.7	74.4	678,431
Other related individual (including parent/child)	4.0	6.3	4.9	45,091
Unrelated individual in family household	0.4	0.4	1.4	3,385
Group household	2.0	1.7	1.9	16,973
Lone person	15.5	22.9	18.4	168,018
Total	*100.0*	*100.0*	*100.0*	. .
Total (number)	*549,027*	*362,871*	. .	*911,898*
Females				
Husband/wife/partner	58.4	30.7	45.5	510,127
Other related individual (including parent/child)	11.0	16.9	13.8	154,531
Unrelated individual in family household	0.3	0.3	0.3	3,002
Group household	1.6	1.3	1.5	16,646
Lone person	28.7	50.7	39.0	436,923
Total	*100.0*	*100.0*	*100.0*	. .
Total (number)	*598,025*	*523,204*	. .	*1,121,229*
Persons				
Husband/wife/partner	67.9	46.3	58.5	1,188,558
Other related individual (including parent/child)	7.7	12.6	9.8	199,622
Unrelated individual in family household	0.3	0.3	0.3	6,387
Group household	1.8	1.5	1.7	33,619
Lone person	22.4	39.3	29.8	604,941
Total	**100.0**	**100.0**	**100.0**	**. .**
Total (number)	**1,147,052**	**886,075**	**. .**	**2,033,127**

(a) Excludes ‘Persons in other not classifiable households’ and ‘Persons in migratory or off-shore CDs’. Also, 111,640 visitors in households, most of whom (88%) were from within Australia, have been excluded from the table.

Source: ABS 2002a.

Table A7.3: Prevalence of main and all disabling conditions in people aged 65 and over, 1998 (per cent)

Condition type	Main disabling condition	All disabling conditions
Arthritis	11.8	25.9
All other diseases and conditions(a)	9.2	29.4
Other musculoskeletal disorder	6.7	14.3
Other circulatory diseases	6.4	27.5
Diseases of ear	5.3	24.5
Psychiatric(b)	3.7	9.7
Respiratory diseases	3.4	8.4
Disease of eye	3.2	8.5
Stroke	2.1	7.1
Nervous system diseases	1.6	4.1
Intellectual and other mental(c)	0.4	2.4
Head injury/any other brain damage	0.2	1.6

(a) Includes other physical diseases and conditions such as spina bifida, neoplasms and diseases of urinary system, genital organs and breast.

(b) Includes the groups entitled ‘Psychoses/mood affective disorders’ and ‘Neurotic/stress-related/somatoform disorders’ in ABS publications. This definition has changed since the 1993 survey (see AIHW 1997).

(c) Includes the groups entitled ‘Intellectual and developmental disorders’ and ‘Other mental and behavioural disorders’. This definition has changed since the 1993 survey and now includes Down syndrome (see AIHW 1997).

Source: AIHW analysis of ABS 1998 Survey of Disability, Ageing and Carers.

Table A7.4: Age and DVA pension recipients, December 2002 (per cent)

	Age group							
	60–64[(a)]	65–69	70–74	75–79	80–84	85–89	90+	Total
Age pensioners[(b)]								
Males	. .	12.8	12.6	7.9	3.4	1.9	0.8	39.5
Females	8.4	14.3	13.0	9.9	7.3	4.8	2.8	60.5
Persons	**8.4**	**27.1**	**25.6**	**17.9**	**10.7**	**6.8**	**3.6**	**100.0**
Persons (number)	*154,300*	*497,782*	*469,700*	*327,969*	*197,115*	*124,029*	*65,576*	*1,836,471*
Per cent of age group population[(c)]	*18.0*	*70.3*	*74.5*	*61.8*	*55.0*	*66.4*	*. .*	*54.5*
DVA pensioners								
Males	2.1	1.8	2.4	14.8	16.0	5.1	1.0	43.3
Females	2.2	3.4	9.5	19.3	14.8	5.7	1.8	56.7
Persons	**4.2**	**5.3**	**11.9**	**34.2**	**30.7**	**10.9**	**2.8**	**100.0**
Persons (number)	*16,557*	*20,538*	*46,443*	*133,159*	*119,783*	*42,317*	*10,966*	*389,763*
Per cent of age group population[(c)]	*1.9*	*2.9*	*7.4*	*25.1*	*33.4*	*18.7*	*. .*	*11.6*
Total Age and DVA pensioners as % of age group population[(c)]	**19.9**	**73.2**	**81.9**	**86.8**	**88.5**	**85.1**	**. .**	**66.0**

(a) Eligibility for Age Pension in December 2002 was 62 years for women and 65 years for men.

(b) Includes 7,197 Age Pensions administered by DVA.

(c) Age and DVA pension recipients aged 85–89 and 90+ have been combined to enable the percentage of age group population to be calculated.

Notes

1. 58 cases with unknown age have been excluded.
2. Table includes full and part pensioners.
3. DVA pensioners include any person in receipt of either Service Pension, Disability Pension, War Widow Pension or Orphan Pension.
4. Age pensioners as at 13 December 2002, DVA pensioners as at 28 December 2002, population as at 31 December 2002.

Sources: ABS 2003a; Centrelink unpublished data; DVA Ad Hoc Information System.

Table A7.5: Carers receiving the Carer Payment, 31 December 2002

Age	Males	Females	Persons	Males	Females	Persons
		Number			Per cent	
Carer looking after person(s) aged under 65						
<25	823	1,316	2,139	1.8	2.9	4.6
25–34	1,825	2,927	4,752	4.0	6.3	10.3
35–44	3,445	6,167	9,612	7.5	13.4	20.8
45–54	4,659	9,890	14,549	10.1	21.5	31.6
55–64	6,922	7,496	14,418	15.0	16.3	31.3
<65	*17,674*	*27,796*	*45,470*	*38.3*	*60.3*	*98.6*
65–74	297	267	564	0.6	0.6	1.2
75+	11	58	69	—	0.1	0.1
65+	*308*	*325*	*633*	*0.7*	*0.7*	*1.4*
Total	**17,982**	**28,121**	**46,103**	**39.0**	**61.0**	**100.0**
Carer looking after person(s) aged 65 and over						
<25	196	305	501	0.7	1.2	1.9
25–34	611	879	1,490	2.3	3.3	5.7
35–44	1,836	2,763	4,599	7.0	10.5	17.5
45–54	2,862	6,338	9,200	10.9	24.1	34.9
55–64	2,662	6,752	9,414	10.1	25.6	35.7
<65	*8,167*	*17,037*	*25,204*	*31.0*	*64.7*	*95.7*
65–74	369	568	937	1.4	2.2	3.6
75+	81	111	192	0.3	0.4	0.7
65+	*450*	*679*	*1,129*	*1.7*	*2.6*	*4.3*
Total	**8,617**	**17,716**	**26,333**	**32.7**	**67.3**	**100.0**

Note: Carer Payment recipients may look after more than one person; at the end of December 2002, 71,210 people were receiving the Carer Payment.

Source: Centrelink unpublished data.

Table A7.6: Carers receiving the Carer Allowance, 31 December 2002

Age	Males	Females	Persons	Males	Females	Persons
		Number			**Per cent**	
Carer looking after person(s) aged under 65						
<25	903	3,493	4,396	0.4	1.7	2.1
25–34	2,871	38,252	41,123	1.4	18.5	19.9
35–44	6,511	74,554	81,065	3.2	36.1	39.2
45–54	6,982	37,758	44,740	3.4	18.3	21.7
55–64	8,900	16,984	25,884	4.3	8.2	12.5
<65	*26,167*	*171,041*	*197,208*	*12.7*	*82.8*	*95.5*
65–74	3,562	3,733	7,295	1.7	1.8	3.5
75–84	466	1,299	1,765	0.2	0.6	0.9
85+	47	233	280	—	0.1	0.1
65+	*4,075*	*5,265*	*9,340*	*2.0*	*2.5*	*4.5*
Total	**30,242**	**176,306**	**206,548**	**14.6**	**85.4**	**100.0**
Carer looking after person(s) aged 65 and over						
<25	194	308	502	0.2	0.3	0.5
25–34	631	1,086	1,717	0.7	1.2	1.9
35–44	1,998	4,018	6,016	2.2	4.4	6.6
45–54	3,497	9,381	12,878	3.8	10.2	14.0
55–64	3,653	15,382	19,035	4.0	16.8	20.7
<65	*9,973*	*30,175*	*40,148*	*10.9*	*32.9*	*43.7*
65–74	8,104	18,297	26,401	8.8	19.9	28.8
75–84	9,612	12,525	22,137	10.5	13.6	24.1
85+	1,836	1,264	3,100	2.0	1.4	3.4
65+	*19,552*	*32,086*	*51,638*	*21.3*	*35.0*	*56.3*
Total	**29,525**	**62,261**	**91,786**	**32.2**	**67.8**	**100.0**

Note: Carer Allowance recipients may look after more than one person; at the end of December 2002, 294,806 people were receiving the Carer Allowance.

Source: Centrelink unpublished data.

Table A7.7: Care recipients of carers receiving Carer Payment and/or Allowance, 31 December 2002

	Carer Payment				Carer Allowance			
Age	**Males**	**Females**	**Persons**	**Number**	**Males**	**Females**	**Persons**	**Number**
		Per cent care recipients				**Per cent care recipients**		
0–14	1.3	0.9	2.2	1,639	27.2	14.0	41.3	132,938
15–24	4.3	3.2	7.5	5,567	5.9	3.4	9.3	29,989
25–34	3.9	3.9	7.8	5,787	1.5	1.3	2.8	9,126
35–44	5.0	5.3	10.3	7,647	1.9	1.7	3.7	11,869
45–54	7.4	7.7	15.2	11,251	3.0	2.4	5.4	17,392
55–64	11.2	8.9	20.1	14,890	5.2	3.4	8.6	27,871
<65	*33.0*	*30.0*	*63.0*	*46,781*	*44.8*	*26.3*	*71.1*	*229,185*
65–74	4.8	5.7	10.5	7,795	5.3	4.4	9.6	30,997
75–84	4.3	11.4	15.7	11,622	6.6	6.3	13.0	41,789
85+	2.6	8.2	10.8	8,031	2.3	4.0	6.3	20,284
65+	*11.7*	*25.3*	*37.0*	*27,448*	*14.2*	*14.7*	*28.9*	*93,070*
Total	**44.7**	**55.3**	**100.0**	**. .**	**59.0**	**41.0**	**100.0**	**. .**
Total (number)	**33,194**	**41,035**	**. .**	**74,229**	**190,101**	**132,154**	**. .**	**322,255**

Source: Centrelink unpublished data.

Table A7.8: Residential aged care service admissions, 1998–99 to 2001–02

Care type	1998–99	1999–00	2000–01	2001–02
Aged 65+				
Permanent	43,267	43,422	44,641	45,394
Respite	38,599	40,028	40,983	40,726
Total	*81,866*	*83,450*	*85,624*	*86,120*
All ages				
Permanent	45,433	45,510	46,634	47,345
Respite	41,008	42,647	43,618	43,309
Total	*86,441*	*88,157*	*90,252*	*90,654*

Note: Table does not include clients of Multi-purpose and flexible services.

Source: AIHW analysis of DoHA ACCMIS database.

Table A7.9: Length of stay in residential aged care by people aged 65 or more, separations during 2001–02 (per cent)

	Respite care	Permanent care
<1 week	7.9	1.8
1–<2 weeks	21.8	2.3
2–<3 weeks	31.7	2.1
3–<4 weeks	13.9	1.8
4–<8 weeks	17.6	5.5
8–<13 weeks	6.0	4.7
13–<26 weeks	1.0	8.4
26–<39 weeks	0.1	6.2
39–<52 weeks	—	5.0
1–<2 years	—	15.3
2–<3 years	—	11.5
3–<4 years	—	8.6
4–<5 years	—	7.4
5–<8 years	—	12.2
8+ years	—	7.1
Total	**100.0**	**100.0**
Total (separations)	**40,923**	**44,003**

Notes

1. Table does not include clients of Multi-purpose and flexible services.
2. Figures exclude transfers between service providers for care of the same type (that is, respite or permanent care).

Source: AIHW analysis of DoHA ACCMIS database.

Table A7.10: Clients of selected aged care services, 2002 (per cent)

Sex/age	HACC clients 2001–02	CACP recipients 30 June 2002	Residential respite admissions 2001–02	Permanent aged care residents 30 June 2002
Males				
65–69	3.4	2.0	2.7	1.7
70–74	5.6	3.8	4.9	3.1
75–79	7.4	5.4	8.3	5.0
80–84	7.6	6.8	9.4	6.2
85–89	5.3	6.4	7.3	6.1
90+	2.4	3.8	4.1	4.4
Total males	*31.7*	*28.2*	*36.8*	*26.4*
Females				
65–69	6.2	3.6	2.2	1.6
70–74	10.5	7.2	5.1	3.8
75–79	15.6	13.6	10.3	9.1
80–84	17.2	19.0	16.5	16.5
85–89	12.5	18.2	18.0	21.3
90+	6.2	10.2	11.1	21.2
Total females	*68.3*	*71.8*	*63.2*	*73.6*
Persons				
65–69	9.6	5.6	4.9	3.3
70–74	16.1	11.0	9.9	6.9
75–79	23.0	18.9	18.7	14.0
80–84	24.8	25.8	25.9	22.7
85–89	17.8	24.6	25.4	27.5
90+	8.7	14.0	15.3	25.6
Total persons	**100.0**	**100.0**	**100.0**	**100.0**
Total persons (number)	**447,859**	**22,794**	**40,726**	**130,523**
Clients aged <65 (number)	**132,988**	**1,791**	**2,583**	**5,984**
Clients aged <65 (% clients all ages)	**22.9**	**7.3**	**6.0**	**4.4**

Notes

1. Not all HACC service providers submitted data to the HACC MDS. For 2001–02, an estimated 74% of providers submitted data. Figures for CACP recipients and residential care do not include clients of Multi-purpose and flexible services. Residential respite care annual figures exclude transfers between service providers for respite care.
2. Cases with missing age and/or sex are excluded from the table (affected HACC data only). In the HACC MDS, 481 and 1,828 records for people aged under 65 and aged 65 and over, respectively, had missing sex; cases with missing age (0.5% of HACC clients) were assumed to be aged 65 and over and have been pro-rated accordingly.

Sources: AIHW analysis of DoHA ACCMIS database; DoHA and AIHW analysis of HACC MDS.

Table A7.11: Type of dependency and dementia status of permanent aged care residents aged 65 and over, 30 June 2002 (per cent)

	Dementia status[(a)]			
Dependency item	**Highly likely**	**Less likely**	**Total**	**Number**
Self-care[(b)]	100.0	95.9	97.2	125,219
Mobility[(c)]	97.4	77.8	83.9	108,100
Communication[(d)]	100.0	94.7	96.4	124,159
Total with at least one of the above	*100.0*	*98.8*	*99.2*	*127,806*
Behaviour[(e)]	98.3	93.4	94.9	122,278
Other[(f)]	100.0	99.5	99.6	128,371
Total with at least one of all of the above	*100.0*	*99.8*	*99.9*	*128,676*
Total	**31.0**	**69.0**	**100.0**	. .
Total (number)	**39,925**	**88,927**	**128,852**	**128,852**

(a) Indicated for permanent residents by a response of 'D' (extensive difficulty) to RCS question 8 concerning understanding and undertaking living activities. Among the 128,852 permanent residents aged 65 and over at 30 June 2002 with information on the RCS, 13% had no difficulty understanding and undertaking living activities (A), 27% had some difficulty (B), 29% had major difficulty (C) and 31% had extensive difficulty (D).

(b) Includes at least some assistance or support required in any of the following areas: meals and drinks, personal hygiene, toileting, bladder management and bowel management (RCS questions 3 to 7).

(c) Includes at least some assistance or support required in the area of walking and transfers (RCS question 2).

(d) Includes at least some assistance or support required in any of the following areas: communicating with staff, relatives, friends and others, and in understanding and undertaking living activities (RCS questions 1 and 8).

(e) Includes at least some assistance or support required in any of the following areas: problem wandering or intrusive behaviour, verbally disruptive or noisy, physically aggressive, emotional dependence, danger to self and others and other behaviour (RCS questions 9 to 14).

(f) Includes at least some assistance or support required in any of the following areas: social and human care needs (either for the care recipients or for family and friends), medication, technical and complex nursing procedures, therapy and 'other' services (RCS questions 15 to 20).

Notes

1. Table does not include clients of Multi-purpose and flexible services.
2. RCS assessments were unavailable for 1,671 permanent residents aged 65 and over in 2002.

Source: AIHW analysis of DoHA ACCMIS database.

Table A7.12: Key statistics of clients (aged 65+) of selected aged care services, by cultural diversity, 2002

	HACC clients 2001–02	CACP recipients 30 June 2002	Residential respite admissions 2001–02	Permanent aged care residents 30 June 2002
Clients (%)				
Australian-born	73.6	67.4	73.3	75.1
Overseas-born: main English-speaking countries	10.7	12.0	14.8	13.6
Overseas-born: non-English-speaking countries	15.8	20.6	11.8	11.3
Total	*100.0*	*100.0*	*100.0*	*100.0*
Total (number)	*449,687*	*22,794*	*40,726*	*130,523*
Median age (years)				
Australian-born	80.4	83.1	83.4	85.7
Overseas-born: main English-speaking countries	80.5	83.6	83.8	86.8
Overseas-born: non-English-speaking countries	78.7	81.0	81.4	84.3
All	*80.1*	*82.6*	*83.2*	*85.5*
Ratio of female to male clients				
Australian-born	2.3	2.7	1.8	2.9
Overseas-born: main English-speaking countries	1.9	2.3	1.6	2.7
Overseas-born: non-English-speaking countries	1.9	2.3	1.4	2.1
All	*2.2*	*2.5*	*1.7*	*2.8*
Usage rate (per 1,000 people aged 65+)	**180.6**	**9.2**	**16.4**	**52.4**
Ratio of clients to people aged 65+ with severe or profound disability (per 1,000 people)	**814.1**	**41.3**	**73.7**	**236.3**

Notes

1. The cultural diversity classification is based on country of birth. ‘Australian-born’ includes those born in Australian external territories. The main English-speaking country category for those born overseas comprises people born in New Zealand, Ireland, United Kingdom, United States of America, Canada or South Africa. The non-English-speaking country category for those born overseas comprises people born in other countries.
2. Population estimates by country of birth are derived from ABS estimates by country of birth for June 2001 in conjunction with the estimated resident population for June 2002.
3. Population estimates by disability status are obtained using age/sex disability rates from the ABS 1998 Survey of Disability, Ageing and Carers in conjunction with the estimated resident population for June 2002.
4. Not all HACC agencies submitted data to the HACC MDS. For 2001–02, an estimated 74% of agencies submitted data. Figures for CACP recipients and residential care do not include clients of Multi-purpose and flexible services. Residential respite care annual figures exclude transfers between service providers for respite care.
5. All cases with missing data are included in the table, using pro-rating. Missing rates (age, sex and/or country of birth) were as follows. HACC: 7.0%; CACP (country of birth only): 12.3%; permanent aged care residents (country of birth only): 1.4%; respite admissions (country of birth only): 0.2%.

Sources: ABS 2003a, 2003c; AIHW analysis of HACC MDS and DoHA ACCMIS database; AIHW analysis of ABS 1998 Survey of Disability, Ageing and Carers.

Table A7.13: Key statistics of clients (aged 50+) of selected aged care services, by Indigenous status, 2002

	CACP recipients 30 June 2002	Residential respite admissions 2001–02	Permanent aged care residents 30 June 2002
Clients (%)			
Indigenous	2.8	1.0	0.5
Non-Indigenous	97.2	99.0	99.5
Total	*100.0*	*100.0*	*100.0*
Total (number)	*24,335*	*43,309*	*135,430*
Median age (years)			
Indigenous	70.1	74.5	76.4
Non-indigenous	82.3	82.8	85.3
All	*82.1*	*82.8*	*85.3*
Ratio of female to male clients			
Indigenous	2.0	1.3	1.5
Non-Indigenous	2.4	1.7	2.7
All	*2.4*	*1.7*	*2.7*
Usage rate (per 1,000 people aged 50+)	**4.3**	**7.6**	**23.7**

Notes

1. Figures for CACP recipients and residential care exclude clients of Multi-purpose and flexible services. Residential care annual figures exclude transfers between service providers for respite care.
2. All cases with missing data are included in the table. No data on age and sex were missing. Cases with missing data on Indigenous status have been pro rated within sex/age groups. Missing rates were as follows. CACP: 0.1%; permanent aged care residents: 8.9%; respite admissions (year): 8.1%.

Sources: ABS 2003a; AIHW analysis of DoHA ACCMIS database.

Table A7.14: New residential aged care allocations and operational places, 1994–95 to 2001–02

Financial year	New allocations	Increase in operational places
1994–95	2,955	3,459
1995–96	1,253	2,041
1996–97	1,258	2,207
1997–98	0	859
1998–99	2,266	734
1999–00	2,946	511
2000–01	7,642	1,465
2001–02	6,286	2,032

Note: Table does not include Multi-purpose and flexible services.

Sources: AIHW 2003a; 2003c.

Table A8.1: Comparison of age-standardised prevalence rates of disability for 1981, 1988, 1993 and 1998[a]

	Severe/profound core activity restriction[b]					All with specific restrictions [b]					Total with disability				
	5–14	15–64	65+	Total 5–64	All ages	5–14	15–64	65+	Total 5-64	All ages	0–14	15–64	65+	Total 0–64	All ages
Males															
1981	2.0	2.1	11.6	2.1	**3.2**	5.0	8.9	29.4	8.1	**10.6**	6.2	13.5	42.0	11.8	**15.0**
1988	2.5	2.1	12.7	2.2	**3.4**	7.2	11.5	43.6	10.7	**14.5**	7.0	14.2	53.4	12.5	**16.8**
1993	2.7	2.3	12.4	2.4	**3.5**	7.3	11.4	44.3	10.7	**14.6**	7.6	15.3	56.9	13.4	**18.1**
1998	4.9	3.3	14.8	3.6	**4.9**	10.6	13.3	45.0	12.8	**16.6**	9.8	17.2	57.3	15.4	**19.9**
Females															
1981	1.2	2.2	19.7	2.1	**4.6**	3.0	7.4	35.6	6.6	**10.9**	4.2	11.2	43.6	9.6	**14.2**
1988	1.9	2.5	21.9	2.4	**5.3**	5.1	10.2	46.2	9.3	**14.7**	5.1	12.2	52.2	10.5	**16.2**
1993	1.8	2.4	20.8	2.3	**5.0**	4.5	9.8	44.9	8.9	**14.1**	5.1	12.5	51.2	10.8	**16.3**
1998	2.4	3.4	23.3	3.2	**6.1**	5.7	11.4	45.9	10.0	**15.6**	5.5	14.2	52.5	12.1	**17.6**
Persons															
1981	1.6	2.2	16.2	2.1	**3.9**	4.0	8.1	32.9	7.4	**10.7**	5.2	12.4	42.9	10.7	**14.6**
1988	2.2	2.3	17.9	2.3	**4.3**	6.2	10.9	45.1	10.0	**14.6**	6.1	13.2	52.7	11.5	**16.5**
1993	2.3	2.4	17.1	2.3	**4.3**	5.9	10.6	44.6	9.8	**14.3**	6.4	13.9	53.7	12.1	**17.2**
1998	3.7	3.3	19.6	3.4	**5.5**	8.2	12.4	45.5	11.7	**16.1**	7.7	15.7	54.6	13.8	**18.8**

(a) Disability data were re-derived using criteria common to the four surveys. Rates are age-standardised to the estimated resident population for March 1998.

(b) Only people aged 5 years and over are included. Information on severity of core activity restriction among children aged under 5 years was collected in the 1998 survey but not in the previous surveys. For comparative purposes, information on activity restrictions among children under 5 is not included in the data presented here, and people aged under 5 years have been excluded from the total population used as the denominator to calculate the prevalence rates.

Sources: AIHW 2000a:Table 12.1; AIHW analysis of unpublished data tables from the ABS 1981, 1988, 1993 and 1998 disability surveys.

Table A8.2: Ratios of age-specific prevalence of rates of severe or profound restrictions, 1981, 1988, 1993 and 1998

	Ratios of age-specific rates			
Age (years)	**1981**	**1988**	**1993**	**1998**
5–14	1.0	1.4	1.5	2.3
15–24	1.0	1.1	1.4	1.8
25–34	1.0	1.2	1.4	1.7
35–44	1.0	1.2	1.2	1.5
45–54	1.0	1.0	1.0	1.5
55–59	1.0	0.9	1.1	1.6
60–64	1.0	1.0	0.8	1.4
65–69	1.0	1.1	1.0	1.1
70–74	1.0	1.2	1.2	1.2
75+	1.0	1.1	1.0	1.2

Source: AIHW analysis of unpublished data tables from the ABS 1981, 1988, 1993 and 1998 disability surveys.

Table A8.3: Males reporting slowness/difficulty with learning or understanding, by age, 1993 and 1998 (per cent)

Age (years)	**1993 males**	**1998 males**
0–4	0.7	1.1
5–9	4.2	5.5
10–14	4.3	7.8
15–19	2.3	4.8
20–24	1.4	2.9
25–29	1.2	1.6
30–34	1.2	2.1
35–39	1.1	2.0
40–44	0.5	1.4
45–49	0.8	2.2
50–54	1.1	1.3
55–59	1.4	2.4
60–64	1.5	1.5
65–69	1.5	1.7
70–74	2.2	2.6
75–79	2.3	4.9
80+	9.2	13.0

Source: AIHW analysis of unpublished data tables from the ABS 1993 and 1998 surveys of disability, ageing and carers.

Table A8.4: Median age of consumers of CSDA-funded services on a snapshot day, 1999–2002

Service group	1999	2000	2001	2002
Accommodation support	38.3	39.1	39.8	40.4
Community support	18.5	17.6	18.1	14.9
Community access	34.8	34.3	34.0	33.9
Respite	19.3	20.4	22.5	22.8
Employment	33.9	34.6	34.9	35.4
All services	33.1	33.1	33.6	34.0

Notes

1. Consumer data are estimates after use of a statistical linkage key to account for individuals who received more than one service on the snapshot day.
2. Data for consumers of the following CSDA-funded service types were not collected: advocacy, information/referral, combined information/advocacy, mutual support/self-help groups, print disability/alt. formats of communication, research & evaluation, training & development, peak bodies, and other support services.
3. The re-categorisation of the service type ‘recreation/holiday programs’ from ‘community support’ to ‘community access’ is partially responsible for the fall in median ages of consumers of community support services between 2001 and 2002. The median age of consumers of community support services would be 16.5 years if consumers of ‘recreation/holiday programs’ were still included in this service group. There would be no change in the median age of consumers of community access services (33.9 years) if these consumers were removed from the group.
4. Data provided by the Commonwealth are preliminary and cover 99% of Commonwealth-funded services.

Source: AIHW 2003a.

Table A8.5: Consumers of CSDA-funded services on a snapshot day, by frequency of support needed in different life areas,[a] 2002

Frequency of support needed	Accommodation support No.	Accommodation support %	Community support No.	Community support %	Community access No.	Community access %	Respite No.	Respite %	Employment No.	Employment %	All service groups No.	All service groups %
ADL												
Always or unable to do	12,492	55.8	6,855	51.9	8,950	47.4	1,719	53.5	3,057	16.8	27,364	41.6
Sometimes	7,288	32.6	4,246	32.1	6,076	32.2	1,110	34.5	9,261	50.8	24,359	37.0
None but uses aids	422	1.9	544	4.1	623	3.3	94	2.9	676	3.7	2,241	3.4
None	1,875	8.4	1,104	8.4	2,423	12.8	254	7.9	4,965	27.2	9,976	15.2
Not stated	296	1.3	462	3.5	794	4.2	37	1.2	283	1.6	1,869	2.8
Total	**22,373**	**100.0**	**13,211**	**100.0**	**18,866**	**100.0**	**3,214**	**100.0**	**18,242**	**100.0**	**65,809**	**100.0**
AIL												
Always or unable to do	14,405	64.4	7,238	54.8	10,375	55.0	1,932	60.1	4,630	25.4	31,827	48.4
Sometimes	6,871	30.7	4,486	34.0	6,006	31.8	1,053	32.8	11,386	62.4	26,756	40.7
None but uses aids	272	1.2	332	2.5	547	2.9	55	1.7	353	1.9	1,464	2.2
None	447	2.0	548	4.1	825	4.4	100	3.1	1,411	7.7	3,177	4.8
Not stated/not applicable	378	1.7	607	4.6	1,113	5.9	74	2.3	462	2.5	2,585	3.9
Total	**22,373**	**100.0**	**13,211**	**100.0**	**18,866**	**100.0**	**3,214**	**100.0**	**18,242**	**100.0**	**65,809**	**100.0**
AWEC												
Always or unable to do	16,382	74.1	6,352	60.3	12,989	70.6	2,120	68.2	5,892	32.3	35,893	57.6
Sometimes	4,541	20.5	2,995	28.4	3,616	19.7	766	24.6	10,978	60.2	20,882	33.5
None but uses aids	267	1.2	288	2.7	400	2.2	59	1.9	293	1.6	1,244	2.0
None	602	2.7	469	4.5	538	2.9	87	2.8	778	4.3	2,395	3.8
Not stated/not applicable	329	1.5	426	4.0	842	4.6	77	2.5	301	1.7	1,908	3.1
Total	**22,121**	**100.0**	**10,530**	**100.0**	**18,385**	**100.0**	**3,109**	**100.0**	**18,242**	**100.0**	**62,322**	**100.0**

(a) ADL (activities of daily living); AIL (activities of independent learning); AWEC (activities of work, education and community living).

Notes

1. Consumer data are estimates after use of a statistical linkage key to account for individuals who received more than one service on the snapshot day. Row totals may not be the sum of the components since individuals may have accessed more than one service from the same service type on the snapshot day.
2. Data for consumers of the following CSDA-funded service types were not collected: advocacy, information/referral, combined information/advocacy, mutual support/self-help groups, print disability/alt. formats of communication, research & evaluation, training & development, peak bodies, and other support services.
3. The AWEC category is analysed for consumers aged 5 years and over, as consumers under 5 are allowed to respond ‘not applicable due to age’ for all three of the life areas in this category.
4. Data provided by the Commonwealth are preliminary and cover 99% of Commonwealth-funded services.

Source: AIHW 2003a.

Abbreviations

ABI	Acquired brain injury
ABS	Australian Bureau of Statistics
ACAP	Aged Care Assessment Program
ACAT	Aged Care Assessment Team
ACCMIS	Aged and Community Care Management Information System
ACOSS	Australian Council of Social Service
ACROD	National industry association for disability services
ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
AGPS	Australian Government Publishing Service
AHMAC	Australian Health Ministers' Advisory Council
AHURI	Australian Housing and Urban Research Institute
AIC	Australian Institute of Criminology
AIFS	Australian Institute of Family Studies
AIHW	Australian Institute of Health and Welfare
ANIHI	Agreement on National Indigenous Housing Information
ANZSIC	Australian and New Zealand Standard Industrial Classification
ARHP	Aboriginal Rental Housing Program
ATO	Australian Taxation Office
ATSIC	Aboriginal and Torres Strait Islander Commission
ATY	Accredited Training for Youth
AWE	Average weekly earnings
CA	Carer Allowance
CACH	Commonwealth Advisory Committee on Homelessness
CACP	Community Aged Care Packages
CAD	Coordination and Development Committee [for SAAP]
CAP	Crisis Accommodation Program
CCB	Child Care Benefit

CDA	Child Disability Allowance
CDDS	Centre for Developmental Disability Studies
CGC	Commonwealth Grants Commission
COAG	Council of Australian Governments
COP	Community Options Projects
COTA	Council on the Ageing
CP	Carer Payment
CPI	Consumer Price Index
CRA	Commonwealth Rent Assistance
CRS	Commonwealth Rehabilitation Service
CSC	Community Services Commission
CSDA	Commonwealth–State Disability Agreement
CSHA	Commonwealth–State Housing Agreement
CSMAC	Community Services Ministers' Advisory Council
CSTDA	Commonwealth/State/Territory Disability Agreement
DAS	Disadvantaged Areas Subsidy
DCS	former Department of Community Services (Commonwealth)
DDA	Disability Discrimination Act 1992 (Commonwealth)
DEST	Department of Education, Science and Training
DETYA	former Department of Education, Training and Youth Affairs
DEWRSB	Department of Employment, Workplace Relations and Small Business (Commonwealth)
DHAC	former Department of Health and Aged Care
DHFS	former Department of Health and Family Services (Commonwealth)
DHS	Department of Human Services (Victoria)
DHSH	former Department of Human Services and Health (Commonwealth)
DHW	Department of Housing and Works (Western Australia)
DIMA	former Department of Immigration and Multicultural Affairs
DIMIA	Department of Immigration, Multicultural and Indigenous Affairs
DIST	former Department of Industry, Science and Technology (Commonwealth)
DoH	Department of Housing (NSW)
DoHA	Department of Health and Ageing (Commonwealth)
DP	Disability Pension

DPIE	Department of Primary Industry and Energy
DSP	Disability Support Pension
DSS	former Department of Social Security (Commonwealth)
DTC	Day Therapy Centre
DV	Domestic violence
DVA	Department of Veterans’ Affairs (Commonwealth)
EACH	Extended Aged Care at Home
FaCS	Department of Family and Community Services (Commonwealth)
FAO	Family Assistance Office
FBT	Fringe benefits tax
FHOG	First Home Owner Grant
FHPP	Family Homelessness Prevention Pilot
FTB	Family tax benefit
FTE	Full-time equivalent
GDP	Gross domestic product
GFCE	Government Final Consumption Expenditure
GPP	General Purpose Payment
GST	Goods and Services Tax
HACC	Home and Community Care
HMAC	Housing Ministers Advisory Council
HREOC	Human Rights and Equal Opportunity Commission
HRSCE	House of Representatives Standing Committee on Expenditure
HRSCFCA	House of Representatives Standing Committee on Family and Community Affairs
ICD	International Classification of Diseases
ICF	International Classification of Functioning, Disability and Health
IHR	Independent Homeless Rate
IPD	Implicit Price Deflator
JPET	Job Placement and Employment Training
JSA	Job Search Allowance
LEAP	Landcare and Environment Action Programme
MA	Mobility Allowance
MACS	Multifunctional Aboriginal Children’s Services

MDS	Minimum data set
NCAC	National Childcare Accreditation Council
NCHF	National Community Housing Forum
NCSDD	National Community Services Data Dictionary (AIHW)
NCSIMG	National Community Services Information Management Group
NDA	National Disability Administrators
NDC	National Data Collection (for SAAP)
NDCA	National Data Collection Agency (for SAAP)
NET	National Evaluation Team (for SAAP III)
NGCSO	Non-government community service organisation
NGO	Non-government organisation
NHDA	National Housing Data Agreement
NHS	National Homelessness Strategy
NHS	National Housing Strategy
NMDS	National minimum data set
NMHP	National Mental Health Plan
NMHS	National Mental Health Strategy
NOOSR	National Office of Overseas Skills Recognition
NRCP	National Respite for Carers Program
NWO	New Work Opportunities
OECD	Organisation for Economic Co-operation and Development
OLMA	Office of Labour Market Adjustment
PADV	Partnerships against Domestic Violence
PCAI	Personal Care Assessment Instrument
PM&C	Department of Prime Minister and Cabinet (Commonwealth)
PMSEIC	Prime Minister's Science, Engineering and Innovation Council
PPS	Post Placement Support
QIAS	Quality Improvement and Accreditation System
RCI	Resident Classification Instrument
RCS	Resident Classification Scale
RSE	Relative standard error
SA	Sickness Allowance
SAAP	Supported Accommodation Assistance Program

SAP	Special Assistance Programme
SCARC	Senate Community Affairs References Committee
SCCSISA	Standing Committee of Community Services and Income Security Administrators (predecessor to CSMAC)
SCRCSSP	Steering Committee for the Review of Commonwealth/State Service Provision
SDAC	Survey of Disability, Ageing and Carers (ABS)
SLA	Statistical Local Area
SPP	Specific Purpose Payment
SPRC	Social Policy Research Centre
TAFE	Technical and Further Education
TAP	Training for Aboriginals and Torres Strait Islanders Programme
TFR	Total fertility rate
TUS	Time Use Survey
UN	United Nations
VHC	Veterans' Home Care
WHO	World Health Organization
YA	Youth Allowance
YCIAP	Youth Careers Information and Advisory Programme
YHA	Young Homeless Allowance
YSU	Youth Service Units
YTA	Youth Training Allowance

Australian jurisdictions

ACT	Australian Capital Territory
Aust.	Australia
NSW	New South Wales
NT	Northern Territory
Qld	Queensland
SA	South Australia
Tas	Tasmania
Vic	Victoria
WA	Western Australia

Glossary

accreditation (aged care): A process through which residential aged care homes must go in order to be recognised as approved providers under the *Aged Care Act 1997*.

admission day: The first day of a person's stay in nursing home or hostel. Where the time between leaving one nursing home (or hostel) and entering another is less than two days, the date of the initial admission is defined as the admission day. Permanent and respite admissions are treated separately.

age-specific rate: A rate for a specific age group. The numerator and denominator relate to the same age group.

age-standardised rate: Weighted average of age-specific rates according to a standard distribution of age to eliminate the effect of different age distributions and thus facilitate valid comparison of groups with differing age compositions.

ambulatory care: Care provided to hospital patients who are not admitted to the hospital, such as patients of emergency departments and outpatient clinics. The term is also used to refer to care provided to patients of community-based (non-hospital) health care services.

apparent retention rate: The ratio of the number of students in a given year to the number originally entering secondary school.

capital expenditure: Expenditure in a period on the acquisition or enhancement of an asset. This includes new and second-hand fixed assets (e.g. building, information technology), increase in stocks, lands and intangible assets (e.g. patents and copyrights), capital transfer payments, and net advances which are acquisitions of financial assets (e.g. shares and equities).

community residential services: 24-hour staffed residential units established in community settings that provide specialised treatment, rehabilitation or care for people affected by a mental illness or psychiatric disability.

constant price expenditure: Expenditure which adjusts for the effects of inflation. This adjustment for inflation allows comparison across different years of the quantity of goods and services that are produced by the expenditure.

core activity restriction: A limited capacity to perform tasks associated with the core activities of self-care, mobility and communication (see Box 3.4).

deinstitutionalisation: A term referring to a shift in service delivery away from institutional care, towards care in the home and community.

disposable income: Gross income less direct tax and Medicare levy.

employed person: A person aged 15 years or more who, during the reference week of the labour force survey, worked for one hour or more for pay, profit or commission.

estimated resident population: Australia's population statistics are compiled by the ABS according to the place of usual residence of the population. Usual residence is defined as the place where a person has lived or intends to live for a period of 6 months or more.

full-time equivalent (FTE): A standardised measure used in converting number of persons in part-time employment to number of persons in full-time employment.

full-time/part-time workers: Full-time workers are those who work 35 or more hours per week; part-time workers work between one and 35 hours per week.

Indigenous: A person who identifies himself or herself as being of Aboriginal and/or Torres Strait Islander origin and is accepted as such by the community in which he or she lives. (The 'Commonwealth Definition' given in High Court Judgement 1983).

International Classification of Diseases (ICD): The World Health Organization's internationally accepted classification of death and disease. The tenth revision (ICD-10) is currently in use.

International Classification of Functioning, Disability and Health (ICF): The World Health Organization's internationally accepted classification of functioning, disability and health. The new classification was endorsed by WHO in May 2001.

labour force: The labour force includes people who are employed and people who are unemployed (not employed and actively looking for work).

length of stay (hospital or residential aged care): The time between the date of admission and the date a person has been discharged from a hospital or residential aged care. For a current resident, it is the time between the date of admission and a specified date. A same-day hospital patient is allocated a length of stay of 1 day.

mean: A measure of the centre of a distribution. It is calculated by dividing the total or sum of the values by the number of values.

median: A measure of the centre of a distribution. It is the middle value in a ranked data set.

non-government community service organisations (NGCSOs): Organisations, operated on either a for-profit or not-for-profit basis, privately managed to provide community services for family with children, youth, adults, older people, people with disabilities, and people from different ethnic backgrounds.

non-government organisations (NGOs): Private not-for-profit community managed organisations that receive state and territory government funding specifically for the purpose of providing community support services for people affected by a mental illness or psychiatric disability.

Organisation for Economic Co-operation and Development (OECD): An organisation of 24 developed countries, including Australia.

patient days: The number of full or partial days of stay for patients who were admitted for an episode of care and who underwent separation during the reporting period. A patient who is admitted and separated on the same day is allocated 1 patient day.

permanent admission (aged care): Admission to residential aged care for long-term care purposes.

primary carer: Defined by the ABS as a person of any age who provides the most informal assistance, in terms of help or supervision with one or more disabilities. The assistance has to be ongoing, or likely to be ongoing, for at lease 6 months and be provided for one or more of the core activities (communication, mobility or self-care).

private hospital: A privately owned and operated institution, catering for patients who are treated by a doctor of their own choice. Patients are charged fees for accommodation and other services provided by the hospital and relevant medical and paramedical practitioners. Includes private freestanding day hospital facilities.

projection: is not a forecast but simply illustrates changes that would occur if the stated assumptions were to apply over the period in question.

public hospital: A hospital controlled by a state or territory health authority. In Australia public hospitals offer free diagnostic services, treatment, care and accommodation to all who need it.

recurrent expenditure: Expenditure on goods and services which does not result in the creation of fixed assets or in the acquisition of land, buildings, intangible assets or second-hand plant and equipment. This consists mainly of expenditure on wages, salaries and supplements, purchases of goods and services, and recurrent transfer payments (e.g. age pensions).

respite admission (aged care): Admission to residential aged care for short-term, alternative care purposes.

separation: The formal process by which a hospital records the completion of treatment and/or care for an admitted patient.

stand-alone psychiatric hospital: Establishments devoted primarily to the treatment and care of inpatients with psychiatric disorders.

total fertility rate (TFR): Indicates the average number of babies that would be born over a lifetime to a hypothetical group of women if they were to experience the age-specific birth rates applying in a given year.

transfer payments: Payments made by governments either to other levels of government or to non-government organisations for the purpose of financing the current operation of the recipients (recurrent transfer payments), or of meeting part of the cost of capital expenditure of the recipient (capital transfer payments).

unemployed person: Person aged 15 years or more who was not employed during the reference week but who had actively looked for work or was currently available for work.

Population tables

Table P1: Indigenous Australians (estimated resident populations), and state/territory, 30 June 2001

Sex/age	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Indigenous males									
Less than 1	1,877	326	1,727	858	301	237	43	779	6,151
1–4	7,448	1,450	6,893	3,500	1,289	889	201	2,720	24,400
5–9	9,624	1,940	9,090	4,511	1,735	1,183	292	3,683	32,065
10–14	8,704	1,702	7,923	4,349	1,577	1,269	203	3,417	29,152
15–19	6,899	1,429	6,272	3,355	1,354	982	210	3,007	23,526
20–24	5,250	1,115	4,943	2,667	1,031	658	170	2,758	18,600
25–29	4,963	1,117	4,819	2,711	1,035	563	186	2,669	18,069
30–34	4,642	1,038	4,433	2,483	969	551	166	2,274	16,566
35–39	4,271	856	3,905	2,174	852	520	133	1,895	14,612
40–44	3,787	767	3,296	1,759	715	506	132	1,500	12,471
45–49	3,031	630	2,545	1,432	557	437	100	1,194	9,933
50–54	2,333	529	2,044	1,031	420	325	54	872	7,611
55–59	1,714	316	1,229	688	291	223	32	593	5,089
60–64	1,223	216	869	488	183	154	18	463	3,623
65–69	820	147	673	342	122	109	12	262	2,489
70–74	428	90	402	229	91	55	1	177	1,473
75+	418	131	463	304	82	57	10	229	1,696
Total males	*67,432*	*13,799*	*61,526*	*32,881*	*12,604*	*8,718*	*1,963*	*28,492*	*227,526*
Indigenous females									
Less than 1	1,314	277	1,187	630	284	192	43	563	4,501
1–4	7,553	1,540	7,282	3,527	1,341	876	222	2,807	25,152
5–9	9,026	1,830	8,547	4,194	1,677	1,116	248	3,314	29,967
10–14	8,155	1,698	7,504	3,992	1,549	1,090	238	3,066	27,304
15–19	6,616	1,372	6,268	3,287	1,317	1,016	202	2,966	23,053
20–24	4,942	1,111	5,429	2,752	1,020	702	178	2,664	18,809
25–29	5,374	1,148	5,581	2,736	1,072	608	171	2,644	19,349
30–34	5,165	1,112	5,158	2,686	1,017	630	179	2,342	18,296
35–39	4,703	944	4,430	2,307	904	594	137	2,039	16,065
40–44	3,929	793	3,485	1,821	775	572	126	1,605	13,114
45–49	3,096	637	2,819	1,524	579	401	88	1,276	10,425
50–54	2,472	516	2,167	1,128	445	290	42	954	8,018
55–59	1,651	340	1,477	743	291	176	36	644	5,363
60–64	1,233	245	1,129	587	255	163	18	550	4,185
65–69	901	170	733	426	156	88	6	377	2,859
70–74	615	129	514	288	121	72	5	236	1,981
75+	711	185	674	422	137	80	7	336	2,553
Total females	*67,456*	*14,047*	*64,384*	*33,050*	*12,940*	*8,666*	*1,946*	*28,383*	*230,994*
Total Indigenous persons	**134,888**	**27,846**	**125,910**	**65,931**	**25,544**	**17,384**	**3,909**	**56,875**	**458,520**

Note: Figures are final estimates. Australia totals include Federally Administered Territories.

Source: ABS Australian Demographic Statistics Catalogue No. 3101.0.

Table P2: Australians (estimated resident populations), by state/territory, 30 June 2002

Sex/age	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Males									
0–4	221,446	157,005	127,148	64,054	46,242	15,777	10,413	9,073	651,270
5–9	231,194	167,209	136,057	69,019	50,379	16,989	11,122	8,842	690,947
10–14	233,547	167,935	137,108	71,701	51,846	17,409	11,483	8,465	699,624
15–19	232,530	169,663	136,402	73,114	53,271	17,328	12,643	7,646	702,688
20–24	226,059	171,127	129,207	69,486	50,022	14,513	13,785	8,374	682,646
25–29	234,640	173,491	127,833	67,381	49,523	13,451	12,854	9,151	688,400
30–34	250,625	188,516	136,140	73,910	55,140	15,491	12,711	9,378	742,018
35–39	249,710	182,131	134,244	73,302	55,877	15,959	12,029	8,847	732,212
40–44	254,015	184,094	139,600	75,261	58,234	18,081	12,118	8,195	749,711
45–49	229,232	166,815	127,691	69,824	53,589	16,873	11,347	7,066	682,559
50–54	217,072	156,449	124,622	66,316	51,571	16,213	11,057	6,566	649,985
55–59	185,788	132,202	106,531	53,596	44,081	14,072	8,733	4,732	549,802
60–64	144,745	104,911	81,856	40,719	34,086	11,403	5,936	3,251	426,967
65–69	119,180	85,914	63,339	31,328	28,730	9,134	4,156	1,723	343,536
70–74	106,350	76,810	53,962	26,720	26,446	8,057	3,425	1,195	302,977
75–79	81,829	59,313	41,104	19,944	21,539	6,187	2,587	654	233,162
80–84	48,841	34,654	24,647	11,159	12,919	3,501	1,511	285	137,526
85+	30,195	22,850	15,587	7,479	8,258	2,350	813	250	87,788
Total males	*3,296,998*	*2,401,089*	*1,843,078*	*964,313*	*751,753*	*232,788*	*158,723*	*103,693*	*9,753,818*
Females									
0–4	209,887	149,521	120,348	61,237	44,397	14,894	10,198	8,574	619,151
5–9	219,506	158,473	128,323	65,234	47,885	16,059	10,594	8,252	654,466
10–14	222,288	160,948	130,630	68,183	48,873	16,670	11,087	7,717	666,537
15–19	221,776	163,858	130,601	69,633	50,947	16,691	12,014	7,194	672,784
20–24	219,016	167,922	127,778	66,472	47,503	14,175	13,730	7,511	664,165
25–29	235,996	174,506	130,807	66,263	47,540	14,028	12,760	8,576	690,559
30–34	254,870	195,385	141,229	73,276	53,988	16,304	13,107	9,143	757,385
35–39	248,399	186,911	139,663	73,663	55,486	16,987	12,500	8,060	741,795
40–44	254,897	187,549	143,510	75,637	58,868	18,589	12,897	7,528	759,583
45–49	229,957	171,084	130,135	70,600	54,671	17,282	12,203	6,532	692,579
50–54	215,241	160,527	123,289	64,474	52,813	16,229	11,680	5,659	649,976
55–59	180,268	132,041	102,356	50,120	44,403	13,876	8,714	3,630	535,452
60–64	143,070	105,114	77,884	39,304	34,698	11,244	5,866	2,297	419,519
65–69	123,386	90,934	62,567	32,202	30,240	9,449	4,428	1,337	354,565
70–74	117,462	85,467	57,337	28,567	29,652	8,799	3,688	945	331,928
75–79	104,083	76,873	49,522	24,185	27,798	7,710	3,388	613	294,175
80–84	75,460	54,150	36,123	17,278	20,238	5,758	2,314	424	211,747
85+	67,795	50,186	31,995	16,681	18,489	5,193	1,928	328	192,597
Total females	*3,343,357*	*2,471,449*	*1,864,097*	*963,009*	*768,489*	*239,937*	*163,096*	*94,320*	*9,908,963*
Total persons	**6,640,355**	**4,872,538**	**3,707,175**	**1,927,322**	**1,520,242**	**472,725**	**321,819**	**198,013**	**19,662,781**

Note: Figures are preliminary estimates. Australia totals include Federally Administered Territories.

Source: ABS Australian Demographic Statistics Catalogue No. 3101.0.

Table P3: Population data used in aged care service utilisation calculations in Chapter 7, 30 June 1999 to 2002

	Males	Females	Persons
	Persons aged 65 years and over with a severe or profound core activity restriction		
1999	169,100	330,800	499,900
2000	175,200	341,200	516,300
2001	182,100	352,400	534,500
2002	189,300	363,100	552,400
	Persons aged 70 years and over		
1999	692,189	963,373	1,655,562
2000	715,664	986,538	1,702,202
2001	741,082	1,011,939	1,753,021
2002	761,453	1,030,447	1,791,900

Notes

1. Population estimates by disability status are obtained using age/sex disability rates from the ABS 1998 Survey of Disability, Ageing and Carers in conjunction with the estimated resident population.
2. Population data for 1999–2001 are final estimates; population data for 2002 are preliminary estimates.

Sources: ABS Australian Demographic Statistics Catalogue No. 3101.0; AIHW analysis of ABS 1998 Survey of Disability and Carers.

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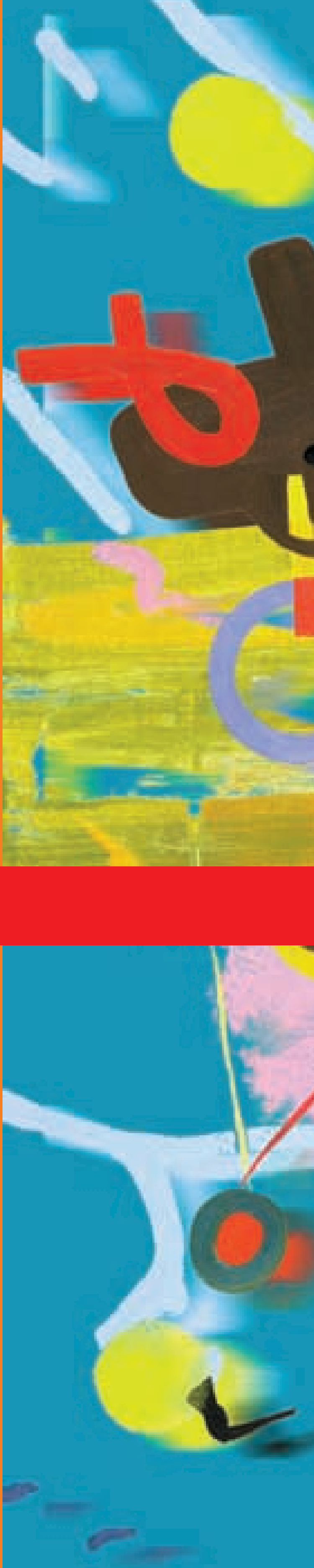

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